

Title 15: Mississippi Department of Health

Part 12: Bureau of Emergency Medical Services

Subpart 32: Trauma System

Chapter 1 Mississippi Trauma Care System

Subchapter 1 General

Rule 1.1.1. Legal Authority: The Mississippi State Department of Health (the Department) is assigned the responsibility for creating, implementing and managing the statewide trauma care system. The Department shall be designated as the lead agency for trauma care system development. The Department shall develop and administer trauma regulations that include, but are not limited to, the Mississippi Trauma Care System Plan, trauma system standards, trauma center designations, field triage, inter-facility trauma transfer, pediatric trauma care, burn care, trauma data collection, trauma care system evaluation and management of state trauma system funding. The Department shall promulgate regulations specifying the methods and procedures by which Mississippi-licensed acute care facilities shall participate in the statewide trauma system. Those regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities. The Department shall also adopt a schedule of fees to be assessed for facilities that choose not to participate in the statewide trauma care system, or which participate at a level lower than the level at which they are capable of participating. The Department shall take the necessary steps to develop, adopt and implement the Mississippi Trauma Care System Plan and all associated trauma care system regulations necessary to implement the Mississippi trauma care system. The Department shall cause the implementation of both professional and lay trauma education programs. These trauma educational programs shall include both clinical trauma education and injury prevention. As it is recognized that rehabilitation services are essential for traumatized individuals to be returned to active, productive lives, the Department shall coordinate the development of the inclusive trauma system with the Mississippi Department of Rehabilitation Services and all other appropriate rehabilitation systems.

Source: Miss. Code Ann. § 41-59-5

Rule 1.1.2. Mississippi Trauma Advisory Committee: The Mississippi Trauma Advisory Committee (MTAC) is created as a committee of the Emergency Medical Services Advisory Council. The membership of the MTAC is comprised of the members of the Emergency Medical Services Advisory Council (EMSAC); the members of which are appointed by the Governor. The Chairman of EMSAC, the State Health Officer, shall appoint EMSAC members to the MTAC. This committee shall act as the advisory body for trauma care system development, and provide technical support to the department in all areas of trauma care system design, trauma standards, data collection and evaluation, continuous quality

improvement, trauma care system funding, and evaluation of the trauma care system and trauma care programs.

Source: Miss. Code Ann. § 41-59-7

Rule 1.1.3. Mississippi Trauma Advisory Committee Meetings: The Mississippi Trauma Advisory Committee (MTAC) shall meet at least quarterly and report to the State Board of Health at its regularly scheduled meetings on the performance of Trauma System. For attendance at such meetings, the members of the MTAC shall be reimbursed for their actual and necessary expenses including food, lodging and mileage as authorized by law, and they shall be paid per diem compensation. Source: Miss. Code Ann. § 41-59-7; Miss. Code Ann. § 25-3-41; and Miss. Code Ann. § 25-3-69.

Source: Miss. Code Ann. § 41-59-5

Rule 1.1.4. **Definitions:** For the purposes of the Mississippi Trauma Care System, the following abbreviations, acronyms, and terms shall be defined as listed.

1. ACEP - American College of Emergency Physicians
2. ACLS - Advanced Cardiac Life Support.
3. ACSCOT - American College of Surgeons Committee on Trauma.
4. AIS - Abbreviated Injury Scale.
5. ALS - Advanced life support, including techniques of resuscitation, such as, intravenous access, and cardiac monitoring.
6. APLS - Advanced Pediatric Life Support.
7. ATCN – Advanced Trauma Care for Nurses. A course designed for the registered nurse interested in increasing his/her knowledge in management of the multiple trauma patient.
8. ATLS - Advanced Trauma Life Support.
9. Alpha Patient – A trauma patient meeting the criteria for an Alpha (major trauma or critically injured) Alert/Activation (refer to Appendix B).
10. BEMS – Bureau of Emergency Medical Services, Mississippi State Department of Health.
11. BLS - Basic life support techniques of resuscitation, including simple airway maneuvers, administration of oxygen, and intravenous access.

12. Board Certified - Physicians and oral/maxillofacial surgeons certified by appropriate specialty boards recognized by the American Board of Medical Specialties and the Advisory Board of Osteopathic Specialties and the American Dental Association.
13. Burn Fund – Mississippi Burn Care Fund established under Miss. Code Ann. § 7-9-70.
14. BTLS - Basic Trauma Life Support.
15. Bravo Patient – A trauma patient not meeting the criteria for an Alpha Alert/Activation, however, has received injuries requiring immediate attention (refer to Appendix B).
16. Bypass (diversion) - A medical protocol or medical order for the transport of a trauma patient past a normally used EMS receiving facility to a designated medical facility for the purpose for accessing more readily available or appropriate medical care.
17. CAP – Corrective Action Plan.
18. CCRN - Critical Care Registered Nurse.
19. CEN - Certified Emergency Nurse.
20. Catchment Area - Geographic area served by a designated Trauma Center for the purpose of regional trauma care system planning, development and operations.
21. Department - Mississippi State Department of Health, Bureau of Emergency Medical Services, Division of Trauma.
22. Designation - Formal recognition of hospitals by the Department as providers of specialized trauma services to meet the needs of the severely injured patient.
23. E&D – Essential and Desirables chart for each Trauma Center designation level.
24. Emergency Department (or Emergency Room) - The area of an acute care hospital that customarily receives patients in need of emergency medical evaluation and/or care.
25. EMS - Emergency Medical Services.
26. EMSAC – Emergency Medical Services Advisory Council.
27. ENA - Emergency Nurses Association.

28. Field Triage - Classification of patients according to medical need at the scene of an injury or onset of an illness.
29. GCS - Glasgow Coma Scale.
30. Immediately (or immediately available) - (a) unencumbered by conflicting duties or responsibilities; (b) responding without delay when notified; and (c) being within the specified resuscitation area of the Trauma Center when the patient is delivered or when notified by EMS that a patient is enroute, whichever is shorter. Specific times for each physician specialty are in the applicable Trauma Center level chapter.
31. Inclusive Trauma Care System - a trauma care system that incorporates every health care facility within a community in a system in order to provide a continuum of services for all injured persons who require care in an acute care facility; in such a system, the injured patient's needs are matched to the appropriate hospital resources.
32. Injury - the result of an act that damages, harms, or hurts; unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical or chemical energy or from the absence of such essential as heat or oxygen.
33. Injury Prevention - efforts to forestall or prevent incidents that might result in injuries.
34. ISS - Injury Severity Score.
35. Level I Trauma Centers - Hospitals that have met the requirements for Level I as stated in Chapter 2 and are designated by the Department.
36. Level II Trauma Centers - Hospitals that have met the requirements for Level II as stated in Chapter 3 and are designated by the Department.
37. Level III Trauma Centers - Hospitals that have met the requirements for Level III as stated in Chapter 4 and are designated by the Department.
38. Level IV Trauma Centers - Hospitals that have met the requirements for Level IV as stated in Chapter 5 and are designated by the Department.
39. Medical Control - Physician direction over pre-hospital activities to ensure efficient trauma triage, transportation, and care, as well as ongoing quality management.
40. Mid-level Providers/Practitioners – Physician Assistant (PA) and/or Nurse Practitioners (NP)

41. Mississippi Trauma Care System Plan - A formally organized plan developed by the Department which sets out a comprehensive system of prevention and management of major traumatic injuries. The plan is published on a three year cycle.
42. Multidisciplinary Trauma Committee - committee composed of the trauma service Director, other physician members and other members appointed by the Trauma Medical Director that reviews trauma deaths in a system or hospital.
43. MTAC - Mississippi Trauma Advisory Committee.
44. Non-Designated Hospital - A licensed acute care hospital that has applied for designation as a Trauma Center, but has not been designated by the Department.
45. Non-Participating Hospital – A licensed acute care hospital that has informed the Department that they do not desire to participate in the Trauma Care System, or a hospital that does not have a current designation or application for designation on file with the Department.
46. On-Call - Available to respond to the Trauma Center in order to provide a defined service.
47. PALS - Pediatric Advanced Life Support.
48. Pediatric Trauma Center - Hospitals that have met the requirements for Primary, Secondary, or Tertiary Pediatric Trauma Center as stated in Chapter 6 and has been designated by the Department.
49. PHTLS – Pre-Hospital Trauma Life Support.
50. Promptly (or promptly available) – Arrival of on-call physician specialists within the trauma receiving resuscitation area, emergency department, operating room, or other specified area of the Trauma Center within a maximum of 60 minutes from the time of notification to respond.
51. Performance Improvement (PI or Quality Improvement) - A method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary approach to problem solving, and focuses not on individuals, but systems of patient care which might cause variations in patient outcome.
52. Regional Trauma Plan - A document developed by the various Trauma Care Regions, and approved by the Department, which describes the policies, procedures and protocols for a comprehensive system of prevention and management of major traumatic injuries in a specific geographic region.

53. Rehabilitation - Services that seek to return a trauma patient to the fullest physical, psychological, social, vocational, and educational level of functioning of which he or she is capable, consistent with physiological or anatomical impairments and environmental limitations.
54. Research - Clinical or laboratory studies designed to produce new knowledge applicable to the care of injured patients.
55. Residency Program - A residency program of the Trauma Center or a residency program formally affiliated with the Trauma Center where senior residents can participate in educational rotations.
56. RTC – Rural Trauma Course.
57. RTS - Revised Trauma Score, a pre-hospital/trauma center scoring system in which numerical values are assigned to differing levels of Glasgow Coma Scale, systolic blood pressure, and respiratory rate.
58. Senior Resident (or "senior level resident") - A physician licensed in the State of Mississippi who has completed at least two years of the residency under consideration and has the capability of initiating treatment, when the clinical situation demands, and who is in training as a member of the residency program, as defined in regulation, at a designated Trauma Center. Residents in general surgery shall have completed three clinical years of general surgery residency in order to be considered a senior resident.
59. Service Area (or "catchment area") - Geographic area defined by the local EMS agency in its Regional Trauma Plan as the area served by a designated Trauma Center.
60. SHO – State Health Officer.
61. TCR - Trauma Care Region; a geographic area of the state formally organized, in accordance with standards promulgated by the department and has received designation from the department, for purposes of developing and inclusive care system.
62. TCTF – Trauma Care Trust Fund.
63. TMD - Trauma Medical Director; a physician designated by the Trauma Center to coordinate trauma care.
64. TNCC – Trauma Nursing Core Course.

65. TPM - Trauma Program Manager; a designated RN with responsibility for coordination of all activities on the trauma service and works in collaboration with the TMD.
66. Trauma Registry - a database program managed by the Department that hospitals use to track treatment of trauma victims.
67. Trauma Team - A group of health care professionals organized to provide care to the trauma patient in a coordinated and timely fashion. The composition of a trauma team is delineated by hospital policy.
68. Triage - the process of sorting injured patients on the basis of the actual or perceived degree of injury and assigning them to the most effective and efficient trauma care resources, in order to insure optimal care and the best chance of survival (refer to Appendix C).
69. TSA – Trauma System Administrator.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Designation of Trauma Centers

Rule 1.2.1. **Application for Trauma Center Designation:** All Mississippi licensed hospitals with a functioning emergency department must apply for trauma center designation. Hospitals that potentially may be Level IV Trauma Centers may elect not to participate in the system, however, state funding for trauma care is available only to designated hospitals which are actively participating in the Trauma Care System. To receive designation as a Trauma Center, an applicant hospital shall forward a letter of intent to the Department, accompanied by a complete original and two copies of the Department's "Application for Trauma Center Designation". Within 30 days of receipt of the application, the Department shall provide written notification to the applicant hospital that the application has been received by the Department; whether the Department accepts or rejects the application; if accepted, the date scheduled for a consultative visit or a hospital inspection; if rejected, the reasons for rejection and a deadline for submission of the corrected "Application for Trauma Center Designation" to the Department.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.2. Trauma Center Consultative Visit:

1. An applicant hospital may request a Consultative Visit of its facilities. This visit is used to assist the applicant hospital in preparation for a Trauma Center inspection. Results of Trauma Center Consultative Visits will be provided by the Department in writing to the applicant hospital. These results will be held in confidence by the Department. The Department will work with, and provide

assistance to, the applicant hospital to correct any deficiencies noted during the Consultative Review.

2. If an applicant hospital requests a Trauma Center inspection without having first received a Consultative Visit and the hospital fails to meet designation criteria, the inspection shall be deemed a Consultative Visit. Any subsequent inspection for designation as a Trauma Center will be at the hospital's expense.
3. A Consultative Visit, regardless of outcome, confers no designation status upon the applicant hospital. A hospital, having completed a Consultative Visit, may apply for a Trauma Center inspection at any time after receiving the report from the Consultative Review.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.3. Trauma Center Inspections

1. The Department shall provide for the inspection of the applicant hospital, provided that its application has been formally approved by the Department, on the date scheduled and indicated in the Department's acceptance letter to the applicant hospital, unless the Department provides written notification with justification of change to the applicant hospital no later than 14 days prior to the inspection date; or the applicant hospital provides written request with justification for a change in the inspection date to the Department no later than 30 days prior to the inspection date.
2. Results of Trauma Center inspections will be provided by the Department in writing to each applicant hospital. Details related to hospital's inspection will be considered confidential and will not be released.
3. No inspection or designation process provided by any other agency, organization, or group may be substituted for a Department inspection.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.4. Level I, II, and III Trauma Center Inspections

1. The Department shall provide multidisciplinary teams for all on-site Trauma Center inspections.
2. Trauma Center Inspection Teams shall consist of disciplines as follows:
 - a. Level I and II Trauma Centers: As a minimum, teams shall consist of the following representative disciplines: trauma surgeon, emergency physician, and trauma nurse. The Department may add additional team members as necessary. All members of teams for Level I and II Trauma

Center inspections shall reside and practice outside the State of Mississippi.

- b. Level III Trauma Centers: As a minimum, teams shall consist of the following representative disciplines: trauma surgeon and trauma nurse. One member of each Level III team must reside and practice out of the State of Mississippi. The remaining member(s) may reside and practice in Mississippi; however, they may not practice in any hospital or reside in any area of the trauma care region in which the applicant hospital is located.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.5. Level IV Trauma Center Inspections: The Level IV trauma center inspection process shall consist of a review of the completed trauma center application, compliance with all of the "Essential" elements listed in the Mississippi Trauma Care Regulations Essential and Desirables Chart, and satisfactory review of specific trauma registry data reports as identified in the trauma center application. These documents shall be reviewed off-site by the Department's Division of Trauma staff. If the information contained in the completed application and the trauma registry data reports do not demonstrate compliance with the Mississippi Trauma Care Regulations, there will be a request for additional information and an opportunity to supply supplementary data/information for review. If this additional information does not demonstrate compliance with the Mississippi Trauma Care Regulations, an on-site survey inspection may be scheduled. At a minimum, the on-site team shall consist of one member of the Division of Trauma and one of the following representative disciplines: a physician specializing in trauma/emergency medicine or a trauma nurse. The member of the inspection team that is not a Division of Trauma staff member may reside and practice in Mississippi, however; they may not practice in any hospital or reside in any area of the trauma care region in which the applicant hospital is located.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.6. Categories of Trauma Center Designations

1. Complete Designation: The hospital has completed all of the requirements for designation at their application level.
2. Complete Designation with Conditions: The hospital has completed all of the requirements for Complete Designation at their application level with the exception of minor (no patient or operational impact) condition(s). This designation category may be used for initial designations or an interim change in status from Complete Designation due to a temporary loss of a capacity or capability.

3. Any hospital receiving written notification of Complete Designation with Conditions must immediately notify the Trauma Care Region and submit to the Department within thirty (30) days from the receipt of notification a written Corrective Action Plan (CAP) including time lines for completion. The Department, upon receipt, shall either approve or disapprove the plan within thirty (30) days. The Department may require a "Focused Survey" with an inspection team to review the hospitals' CAP for complete implementation. If the Focused Survey team deems the CAP fully implemented, the hospital will receive Complete Designation.
4. No Designation: The hospital has failed to meet the requirements for Complete Designation with Conditions at their application level. Any hospital receiving notice of failure of their Trauma Center inspection shall immediately notify the Trauma Care Region and all pre-hospital providers who routinely transport trauma patients to the hospital of the lack of a Trauma Center designation. Any hospital receiving a No Designation notice shall no longer be permitted to act as, nor be permitted to advertise itself as, a Trauma Center.
5. The hospital shall, within ten (10) working days of notification of No Designation, submit a written CAP, including correction time lines to the Department. Upon receipt of the plan, the Department shall either approve or disapprove the plan within ten (10) working days.
6. Upon completion of the CAP, the hospital shall notify the Department and request a verification visit. The Department shall conduct a focused survey of the hospital to verify completion of the CAP and compliance with regulations. The Department may, subsequently, reinstate the hospital to its original Trauma Center status (if any) or designate the hospital as a Trauma Center (Complete or Complete with Conditions). In addition, the appropriate fee associated with the unmet capability commensurate with the facilities annual assessment shall be made to the Trauma Care Trust Fund (TCTF).

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.7. Appeal Process for Failing a Trauma Center Inspection: If a hospital fails a trauma center inspection, the hospital shall have 30 days from the date of notification of the failure to appeal the decision in writing to the Department. The Department shall make a determination within three months of receipt of the appeal. The Department will provide the hospital with a written report of its decision. If the decision of the Department is unfavorable to the hospital, the hospital may request to be inspected for trauma center designation at another level, but must pay all costs associated with the inspection. In addition, the appropriate fee associated with the unmet capability commensurate with the facilities annual assessment shall be made to the Trauma Care Trust Fund (TCTF).

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.8. Term of Trauma Center Designations: The department shall designate Trauma Centers for a period not to exceed three (3) years. Designations shall remain active for three years provided no substantive changes or variances have occurred. The Department (and Trauma Care Regions for Level IV Trauma Centers only) may perform periodic trauma center audit/reviews at each designated Trauma Center. The State Health Officer (SHO) may extend Trauma Center designations for one (1) year.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.9. Trauma Center Designation Renewal: Trauma Centers desiring renewal of their designation must submit a new application (downloaded from the Department's Trauma website) no later than 90 days prior to expiration of designation. The original signed application and two copies must be submitted to the appropriate Trauma Care Region. The region will review the application and forward the original application and one copy to the Department, along with any comments the region may have regarding the application. The application must be received at the Department no later than 60 days prior to expiration of designation. The Department will acknowledge receipt of the application within 30 days to the applicant hospital and begin the designation process as provided by this regulation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.10. Loss of Required Trauma Care Capability: Any Trauma Center that loses, either permanently or temporarily, physician, nursing, or other patient care specialties required by this regulation, shall report that loss to the Department utilizing the State Medical Asset Resource Tracking Tool (SMARTT) or other designated automated reported system. If the loss will result in diminished capability for a period longer than 30 days, the facility must also submit a Corrective Action Plan (CAP) that addresses how the facility will become compliant.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.11. Suspension of Trauma Center Designation: The State Health Officer may suspend the Trauma Center designation of any hospital for:

1. Documented conditions of serious threat or jeopardy to patients' health or welfare;
2. Failure to comply with laws or regulations;
3. Failure to satisfactorily complete the reinstatement process for hospitals failing a Trauma Center designation inspection or losing Trauma Care capabilities.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.12. Hospitals having their Trauma Center Designation status suspended may reapply for Trauma Center designation after resolution of all issues related to the suspension, and completion of a new Trauma Center application and designation inspection. Should a trauma center's status be suspended, the hospital is responsible for paying the pro-rata fees as set forth in the "Play or Pay" section of these regulations.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.13. Non-Designated Trauma Centers: Any hospital that has not previously been designated as a Trauma Center or whose designation has expired, has submitted a Trauma Center application, and is actively pursuing a Trauma Center designation, including participation in Trauma Region activities and submission of Trauma Registry data, is considered a Non-designated Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.14. Non-Participant Hospitals: Any hospital that has not completed the Trauma Center designation, or has had its Trauma Center designation suspended by the Department, will be considered a Non-Participant hospital. Such facilities shall not advertise itself as a Trauma Center and are not eligible for any funding from the Trauma Care Trust Fund or Burn Fund, as appropriate.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.15. Change of Trauma Center Designation: Trauma Centers will be permitted to change their designation if the following conditions are met in their entirety:

1. The Trauma Center has been inspected and designated by the Department, the designation is current, and the Trauma Center is in full compliance with Department and Region rules, regulations, policies, procedures, and protocols;
2. The request to change designation has been approved by the applicable Trauma Care Region;
3. The Department's Trauma Consultant has reviewed the request and determines that there is no adverse impact to the Region or Trauma Care System;
4. The Mississippi Trauma Advisory Council (MTAC) has recommended approval of the request.
5. The Department Trauma System Administrator (TSA) concurs with the request;
6. The State Health Officer (SHO) or designee issues the new designation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.16. A Trauma Center may make a request to change its designation by sending a letter of intent to the appropriate Trauma Care Region.

1. The Trauma Center will submit an application for the new designation level. *(Note: If the Trauma Center has a current application and inspection report on file with the Department, for a level equal to or higher than the requested level, they will not be required to submit another application.)*
2. The Board of Directors of the Trauma Care Region will review the request, and will recommend approval/disapproval to the Department, along with any conditions.
3. The Department will forward the Region's letter, application package, and inspection report (if applicable) to the Trauma Consultant for review. The consultant will prepare a written report which will include any anticipated positive/negative impacts to the Region and/or Trauma Care System as a result of this action. The Trauma Consultant will also determine if a new inspection is required to substantiate this request, or will prepare a report of inspection compliance based on the file inspection report.
4. The TSA will consolidate all documentation and include the request on the agenda for the next MTAC meeting. The TSA will also include the Department's concurrence or non-concurrence with justification. A representative(s) of the Trauma Center and the Region will be invited to present the request to the MTAC. If a representative of the requesting Trauma Center is not present at the MTAC, the request will be tabled to the next meeting. If the Trauma Center representative does not appear at two consecutive MTAC meetings, the request will be dismissed without action.
5. If the MTAC approves the request, the TSA will forward a letter to the SHO requesting designation of the Trauma Center to the new level. If a non-participation fee is required for the new designation, an invoice will be prepared and sent to the Trauma Center. Designation will only occur after receipt of the non-participation fee.
6. If the MTAC does not approve the request, the TSA will return the application package to the Trauma Center and the Region via certified mail. The Trauma Center will have twenty (20) days after receipt of the returned application to file an appeal with the Department.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.17. Partial Capability: Any Trauma Center that chooses to offer patient care services that are above the level of their Trauma Center designation, must comply with the

standards for the higher level of designation, including response times for physician specialties, protocols and procedures, performance improvement processes, and equipment, training, and personnel as listed on the Essentials and Desirables (“E&D”) chart of the appropriate Trauma Center level. Additionally, the higher patient care must be reviewed by both the hospital and regional PI process.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Financial Support for the Trauma Care System

Rule 1.3.1. Trauma Care Trust Fund: The Trauma Care Trust Fund (TCTF) shall serve as the financial support mechanism for development of the Mississippi Trauma Care System. The Department shall contract with designated Trauma Care Regions for trauma systems development and regional operations. Contracts with each designated Trauma Care Region include financial support for: Administration of regions (including, but not limited to, regional medical director, regional administrative support, telephone, regional trauma committees, hospital trauma registry staff, and trauma registry computer hardware) and funding of documented trauma care (hospitals, physicians, and licensed ambulance services) as defined by regulation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.2. The TCTF is created from multiple funding sources including:

1. Assessment on moving traffic violations as noted in Miss. Ann Code §41-59-75;
2. Assessment on speeding, reckless and careless driving violations as noted in Miss. Ann Code §99-19-73;
3. Assessment on license tags (issuance and renewal) as noted in Miss. Ann Code §27-19-43;
4. Point of sale fee on all terrain vehicles, motorcycles, and boats as noted in Miss. Ann Code §99-19-73; and
5. Funds appropriated by the Legislature from the Health Care Expendable Fund.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.3. Trauma Care Trust Fund Eligibility

1. Trauma Care Trust Fund (TCTF) distribution shall be provided to designated Level I, II, and III Trauma Centers, designated Burn Centers, eligible physicians and eligible licensed ambulance through the Trauma Care Regions. Designated

Level IV Trauma Centers shall not receive reimbursement for trauma care, however, will receive an annual stipend for satisfactory participation in the Mississippi Trauma Care System.

2. Level I Trauma Centers and stand-alone Tertiary Pediatric Trauma Centers located in a state contiguous to the State of Mississippi that participate in the Mississippi Trauma Care System and have been designated by the Department shall be eligible to receive distributions from the TCTF.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.4. Trauma Care Trust Fund Distribution Formula

1. Funds for the administration and development of the Trauma Care System will be budgeted from available funds from the TCTF. Examples of administrative and development costs are, but are not limited to, salaries and benefit costs for personnel (full-time and part-time equivalents) who expend a portion of their time in trauma care administration and/or development, travel and training costs for such personnel, use of trauma care physicians and/or other trauma professionals used in the development and/or maintenance of the trauma care system, development and/or maintenance of accounting and auditing of the use and distribution of the TCTF, administrative costs for designated trauma care regions, and the costs associated with the development and/or implementation of the Trauma Care System (i.e., telecommunication systems, data storage and/or retrieval systems, advertising, equipment, etc.)
2. Eighty-five percent (85%) of the remaining funds from the TCTF are allocated to participating Trauma and Burn Centers which shall further allocate at least thirty percent (30%) of the funds received by Level I, II, and III Trauma Centers and Burn Centers to eligible physicians.
3. Fifteen percent (15%) of the remaining funds from the TCTF are allocated to eligible licensed ambulance services that provide pre-hospital care to trauma victims.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.5. Trauma Care Trust Fund Distribution Calculation: Amounts to be disbursed from the Trauma Care Trust Fund (TCTF) shall be calculated as follows:

1. On or about April 1 and October 1 of each year, or at such other times as the State Health Officer may direct, the Trauma System Administrator (TSA) shall obtain a Treasury report showing the fund balance in the TCTF.
2. To obtain the amount to be distributed, the following amounts will be subtracted from the fund balance:

- a. One half of an amount to be determined by the Department for administrative expenses of the Department Division of Trauma as of the date of the calculation;
 - b. One half of an amount not to exceed Ten Thousand Dollars (\$10,000) for each Level IV Trauma Center which has completed at least one year of satisfactory participation in the Mississippi Trauma Care System as of the date of the calculation (annual stipend);
 - c. One half of an amount not to exceed Ten Thousand Dollars (\$10,000) for each Level IV Trauma Center which has completed at least one year of satisfactory participation in the Mississippi Trauma Care System as of the date of the calculation (educational grant); and
 - d. One half of an amount to be determined by the Department, and approved by the MTAC, for administrative expenses for each Trauma Care Region, as of the date of the calculation.
3. The amount remaining after the above administrative payments have been calculated, reserved and/or expended, shall be distributed according to the TCTF formula (refer to Appendix C for a graphic representation).

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.6. Trauma Card Trust Fund Ambulance Service Distribution

1. Fifteen percent (15%) of the amount remaining after administrative expenses shall be distributed to the Trauma Regions for further distribution to eligible licensed ambulance services. Eligible licensed ambulance services shall be those basic or advanced life support ambulance services licensed by the Bureau of Emergency Medical Services who are active participants in their local trauma region. In the event there is more than one eligible licensed ambulance service active in one county, funding for that county shall be distributed to both services based on call volume or other appropriate criteria as determined by the Trauma Care Region.
2. For purposes of determining amounts to be distributed to licensed ambulance services pursuant to this rule, the following definitions shall apply:
 - a. Census - the most recent decennial United States Census
 - b. Small Counties - those counties with a population of less than 15,000 as identified in the most recent Census.
 - c. Large Counties - those counties with a population greater than or equal to 15,000 as identified in the most recent Census.

- d. Total Fund Balance - that portion of the TCTF that is allocated to licensed ambulance services.
- e. Small County Population Percentage – the sum of Small Counties population as a percent of the total state population as reflected by the Census.
- f. Per Capita Portion - the portion of a Small County’s disbursement that is calculated by multiplying that county’s Small County Population Percentage by the Total Fund Balance.
- g. Dedicated Portion - the portion of a Small County’s disbursement that is calculated by subtracting an amount from the Total Fund Balance and dividing among the Small Counties so that each Small County receives an equal disbursement that is equal to or less than the Large County with the lowest population.
- h. Adjusted Population is determined by adding the population from the Small Counties and subtracting that sum from the state’s total population.
- i. Adjusted Fund Balance - calculated by subtracting the amount dedicated for the smaller counties from the total fund balance.

Per Capita Portion:

Multiply the Small Counties Population Percentage by the Total Fund Balance.

$$\text{Per Capita portion} = (\text{Small Counties Population Percentage} \times \text{Total Fund Balance})$$

Dedicated Portion:

The Dedicated Portion is calculated by subtracting an amount from the Total Fund Balance and adding it to the Per Capita Portion so that the sum of the Per Capita Portion plus the Dedicated Portion is divided by the number of Small Counties, AND the result is less than or equal to the Disbursement received by the Large County with the population closest to or equal to 15,000.

$$\text{Dedicated Portion} = [(\text{Per Capita Disbursement} + \text{Dedicated Portion}) / (\text{Number of Small Counties})] < / = \text{Disbursement of the Large County with lowest population}$$

The Disbursement for small counties is calculated by adding the Per Capita and Dedicated Portions.

$$\text{Disbursement (for Small Counties)} = (\text{Per Capita Portion}) + (\text{Dedicated Portion})$$

The amount to be disbursed for each Large County is calculated as follows:

$$\text{Disbursement} = (\text{census population}) / (\text{Adjusted population}) \times (\text{Adjusted Fund Balance})$$

Rule 1.3.7. Trauma Card Trust Fund Hospital Fixed Distribution

1. Eighty-five percent (85%) of the amount remaining after administrative expenses shall be distributed to the Trauma Regions for further distribution to participating Trauma Centers.
2. Thirty percent (30%) of the amount reserved for distribution to hospitals shall be distributed according to a “Fixed Distribution,” based on the designated level of each eligible Trauma center.
3. For purposes of determining amounts to be distributed to Trauma Centers pursuant to this rule, the following definitions shall apply:
 - a. Number of Facilities – the number of licensed acute care facilities designated as a Level I, Level II or Level III Trauma Centers
 - b. Relative Weights – Level I shall equal 100%; Level II shall equal 87.5%; Level III shall equal 62.5%
 - c. Calculated Weight – Equals the number of facilities designated at a particular level of trauma center multiplied by the relative weight.
 - d. Total Weight – equals the sum of calculated weights
 - e. Disbursement by Hospital Type – equals Total Hospital Fixed Fund / Total Weight X Relative Weight
 - f. Total Disbursement by Hospital Type – equals the sum of Disbursement by Hospital Type
4. To calculate the Hospital Fixed Distribution, the following formula is used (refer to Appendix C for a graphic representation):
 - a. Multiply the number of facilities in each category (Level I, Level II and Level III) by the relative weights of each category. The product of this operation shall be the calculated weight of each type facility.
 - b. Sum the relative weights to obtain the “calculated weight.”
 - c. Divide the total Hospital Fixed Distribution amount by the product of the sum of the relative weights (“calculated weight”) and the relative weight assigned to that category.
 - d. The result is the amount to be distributed to each facility of that particular type (Level I, Level II or Level III).

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.8. Trauma Card Trust Fund Hospital Variable Distribution

1. Fifty percent (50%) of the amount reserved for distribution to hospitals shall be distributed according to a “Variable Distribution” formula.
2. Using patient data collected in the Trauma Registry, assign all trauma cases of each Level I, Level II, and Level II Trauma Center an ISS severity index and category of A, B, C, or D according to the following table:

ISS	ISS Severity Index	ISS Severity Category
1-9	1.02	A
10-15	2.02	B
16-24	3.80	C
>24	6.57	D

3. Using patient data collected in the Trauma Registry, Calculate the number of cases treated by each trauma center which fall within each ISS Severity Category.
4. Multiply the total number of ISS Severity Category A cases by the relative value assignment of 1.02 to arrive at the total number of Category A points.
5. Multiply the total number of ISS Severity Category B cases by the relative value assignment of 2.02 to arrive at the total number of Category B points.
6. Multiply the total number of ISS Severity Category C cases by the relative value assignment of 3.80 to arrive at the total number of Category C points.
7. Multiply the total number of ISS Severity Category D cases by the relative value assignment of 6.57 to arrive at the total number of Category D points.
8. Add the points from Categories A, B, C, and D to arrive at a total number of points for each trauma center.
9. Sum the number of points from all categories and all hospitals to arrive at a total number of points for all trauma centers.
10. Take the number of points for each hospital and multiply that number by the total dollar amount for the 50 percent of the TCTF available for distribution to participating, eligible trauma centers. Take the product of that calculation and divide the resulting number by the total number of points for all trauma centers.

11. The resulting quotient is the dollar amount of the Hospital Variable Fund to be distributed to that trauma center.
12. Sum all the amounts to be distributed pursuant to the Hospital Variable Fund Calculation. The sum of all distributions should not exceed fifty percent (50%) of the eighty-five percent (85%) of the TCTF available for distribution to hospitals.

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.9. Trauma Care Trust Fund Burn Center Distribution: Five percent (5 %) of the amount reserved for distribution to hospitals shall be distributed to designated burn centers within the Trauma Care System. If more than one burn center is operating within the system, the 5% will be distributed based on a pro-rata share of patients as determined by Trauma Registry inputs. *(Note: Trauma patients counted toward burn center distribution cannot be used to determine hospital variable distribution.) If no hospital has been designated as a burn center at the time of the distribution, the 5% shall be included in the Hospital Fixed Distribution.*

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.10. Play or Pay General Requirements:

1. Every Mississippi licensed acute care facility (hospital) having an organized emergency service or department shall participate in the Mississippi Statewide Trauma Care System. Every hospital having an organized emergency service or department shall submit data to the Trauma Registry.
2. Hospitals with the potential to serve as Level I, II, or III Trauma Centers must participate at the highest trauma designation level consistent with its capabilities as assessed by the Department.
3. Any hospital determined capable of participating as a Level IV Trauma Center may make application to be designated as a Level IV Trauma Center. A Level IV Trauma Center is required to submit data to the Trauma Registry and is eligible for \$10,000 for administrative costs and a \$10,000 educational credit as a participant in the Trauma Care System.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.11. Annual Capability Assessment:

1. Each year, all licensed acute care facilities shall complete a survey on forms provided by the Department. The facility will attest to the presence or absence of clinical services. Based on the facility's response, as well as other supporting

evidence, the Department shall render an assessment of the facility's potential to participate in the Trauma Care System.

2. Each facility shall receive a pre-assessment survey during the first week of July of each year to be completed and returned to the appropriate Trauma Care Region by the first week of August.
3. Each Trauma Care Region will review the survey of each facility within the region, and will forward comments on the Department approved form, detailing the level that each facility is capable of participating in the Trauma Care System by the first week of September.
4. On or about the third week in September an invoice and application (as applicable) will be sent by the Department to each facility in response to their respective survey.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.12. Annual Assessment Criteria: **For the purposes of the annual assessment, clinical services must be available 24 hours per day, seven days per week to be considered.**

1. Level I Trauma Center required services:
 - a. Emergency Medicine
 - b. General Surgery
 - c. Orthopedic Surgery
 - d. Neurological Surgery
 - e. Anesthesia
 - f. Post Anesthesia Care Unit (PACU)
 - g. Intensive Care Unit (ICU)
 - h. Surgical Residency Program
2. Level II Trauma Center required services:
 - a. Emergency Medicine
 - b. General Surgery

- c. Orthopedic Surgery
 - d. Neurological Surgery
 - e. Anesthesia
 - f. Post Anesthesia Care Unit (PACU)
 - g. Intensive Care Unit (ICU)
3. Level III Trauma Center required services:
- a. Emergency Medicine
 - b. General Surgery
 - c. Orthopedic Surgery
 - d. Anesthesia
 - e. Post Anesthesia Care Unit (PACU)
 - f. Intensive Care Unit (ICU)

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.13. Play or Pay Non-Participation Fee

1. Any hospital that chooses not to participate in the Trauma Care System as a Level I, II, or III Trauma Center, or participates at a level lower than the level at which it is capable of participating, as determined by the Department, or fails to maintain or becomes incapable of maintaining its designation as a Level I, II or III Trauma Center, or has its designation as a Level I, II, or III Trauma Center suspended by the Department, or becomes “non-designated” as a Level I, II, or III Trauma Center, shall be assessed and shall pay a non-participation fee as defined by this regulation.
2. All fees are due and payable annually before January 1 of each year. Any event above, occurring during the calendar year shall result in the hospital owing a pro-rata portion of the fee. The fee assessed shall be pro-rated on a monthly basis. The fee shall be paid in full upon written notification from the Department.
3. The fee schedule shall be reassessed and adjusted, as necessary, each year by the Mississippi Trauma Advisory Committee.
4. The fee schedule is as follows:

Current Level	Projected Level	Fee for Non Participation
Non Designated	Level II	\$1,492,000.00
Non Designated	Level III	\$ 758,000.00
Level III to	Level II	\$ 423,500.00
Level IV to	Level II	\$1,492,000.00
Level IV to	Level III	\$ 758,000.00

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.14. Play or Pay Appeal Process

1. Following the receipt of an invoice from the Department for a Non-Participation fee, the hospital assessed the fee may request a due process hearing on the assessment. Any such request for hearing must be filed by the assessed facility with the Director of Emergency Medical Services, Mississippi State Department of Health, within twenty (20) days of the date of the assessment.
2. The date of the assessment is defined as the date which the assessment is placed in the United States Mail, postage pre-paid, addressed to the facility assessed, at the address furnished by the hospital to Trauma Registry, or to the address published by the party as its usual and customary business address. The date of the postmark shall be prima facie evidence of the date of the assessment.
3. The Director of Emergency Medical Services, upon receipt of a valid, timely request for a hearing, shall set a date no more than ten (10) calendar days from the receipt of the request for hearing.
4. The hearing officer appointed to conduct the hearing shall be a person chosen or appointed by the Director of the Office of Health Protection. A stenographic record of the hearing shall be made by a certified reporter/stenographer. The record shall consist of all sworn testimony taken, written, documentary or other relevant evidence taken at said hearing.
5. The only issues for adjudication are:
 - a. The timeliness of notice of the assessment and delivery of the same;
 - b. The trauma classification of the party; and
 - c. The calculation of the amount of the assessment.
6. Within twenty (20) days of the receipt by the hearing officer of the certified record, he or she shall render findings of fact and conclusions of law contained in an order. The order so produced by the hearing officer shall be the final order of the Mississippi State Department of Health and shall be appealable to a court of competent jurisdiction.

7. If no appeal from the final order is taken within twenty (20) days of the date of the order, the party assessed shall pay on or before the twentieth (20th) day following the date of the order, the entire fee assessed.

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.15. Delinquent Payments to the Trauma Care Trust Fund:

1. If a hospital fails to submit an application for designation as a Trauma Center and fails to pay the required fee for Non-Participation by January 1, a letter from the Department will be sent via certified mail to the administrator of the hospital and the Trauma Region administrator informing them that payment is due no later than 20 days from the delivery date of the letter, or that the a request for a due process hearing must be received at the Department no later than 20 days from the delivery date of the letter.
2. If the administrator fails to respond, or comply with the requirements of the certified letter, a letter will be sent by the Division of Trauma to the Bureau of Health Facilities Licensure and Certification documenting an alleged violation of the Minimum Standards for the Operation of Mississippi Hospitals, specifically that the governing body of the hospital, through its administrator, failed to take all reasonable steps to comply with all applicable federal, state and local laws and regulations. A copy of the letter will be sent to the hospital administrator and the Trauma Region administrator via certified mail.
3. The Bureau of Health Facilities Licensure and Certification will conduct an investigation of the alleged violation(s). If a finding of Substantiated is returned, the Division of Trauma will recommend to Licensure and Certification that the hospital's license be revoked. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail. A copy of recommendation will also be sent to CMS.
4. Once the hospital has satisfied the requirements of this Sub-chapter, the Division of Trauma will send a letter to License and Certification recommending reinstatement of the hospital's license with/without restrictions, as appropriate. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail and to CMS.
5. If a hospital elects to participate at a level lower than the assessed capability and fails to pay the required fee for Non-participation by January 1, a letter from the Department will be sent via certified mail to the administrator of the hospital and the Trauma Region administrator informing them that payment is due no later than 20 days from the delivery date of the letter, or that the a request for a due process hearing must be received at the Department no later than 20 days from the delivery date of the letter.
6. If the administrator fails to respond, or comply with the requirements of the certified letter, a letter will be sent by the Division of Trauma to the Bureau of

Health Facilities Licensure and Certification documenting an alleged violation of the Minimum Standards for the Operation of Mississippi Hospitals, specifically that the governing body of the hospital, through its administrator, failed to take all reasonable steps to comply with all applicable federal, state and local laws and regulations. A copy of the letter will be sent to the hospital administrator and the Trauma Region administrator via certified mail.

7. The Bureau of Health Facilities Licensure and Certification will conduct an investigation of the alleged violation(s) and if a finding of Substantiated is returned, the Division of Trauma will recommend to Licensure and Certification that the hospital's license be revoked. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail. A copy of recommendation will also be sent to CMS.
8. Once the hospital has satisfied the requirements of this Sub-chapter, the Division of Trauma will send a letter to License and Certification recommending reinstatement of the hospital's license with/without restrictions as appropriate. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail and to CMS.
9. If a hospital fails to maintain designation as a Trauma Center:
 - a. The hospital must immediately notify the Department and the Trauma Region administrator when the loss of capability is experienced, and must present, within 20 days of the event, supporting documentation of the loss of capability and the proposed corrective action.
 - b. The Division of Trauma will review the documentation and corrective action plan, and will determine the effective date of pro-ration of the fee for Non-participation.
 - c. The Department will send a letter via certified mail to the hospital administrator and the Trauma Region administrator informing them that payment is due no later than 20 days from the delivery date of the letter, or that the a request for a due process hearing must be received at the Department no later than 20 days from the delivery date of the letter.
 - d. If the administrator fails to respond, or comply with the requirements of the certified letter, a letter will be sent by the Division of Trauma to the Bureau of Health Facilities Licensure and Certification documenting an alleged violation of the Minimum Standards for the Operation of Mississippi Hospitals, specifically that the governing body of the hospital, through its administrator, failed to take all reasonable steps to comply with all applicable federal, state and local laws and regulations. A copy of the letter will be sent to the hospital administrator and the Trauma Region administrator via certified mail.

- e. The Bureau of Health Facilities Licensure and Certification will conduct an investigation of the alleged violation(s) and if a finding of Substantiated is returned, The Division of Trauma will recommend to Licensure and Certification that the hospital's license be revoked. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail. A copy of recommendation will also be sent to CMS.
- f. Once the hospital has satisfied the requirements of this Sub-chapter, the Division of Trauma will send a letter to License and Certification recommending reinstatement of the hospital's license with/without restrictions as appropriate. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail and to CMS.

Source: Miss. Code Ann. § 41-59-75

Subchapter 4 Mississippi State Trauma Registry

Rule 1.4.1. Applicability to Hospitals and Pre-Hospital Providers

- 1. All Mississippi-licensed hospitals which have an emergency service or department shall participate in the Trauma Registry data collection process, whether or not they participate in the Trauma Care System. All out-of-state hospitals designated as Mississippi Trauma Centers shall participate in the Trauma Registry. Specialized treatment centers, either in-state or out-of-state, that have contracts with the Department to provide care to Mississippi trauma/burn patients, shall participate in the Trauma Registry.
- 2. All trauma data collection instruments shall include the collection of both pre-hospital and hospital patient care data, and shall be integrated into the Department's data management systems. Trauma registry inclusion criteria can be found on the Department's website.

Source: Miss. Code Ann. § 41-59-75

Rule 1.4.2. Timeliness of Submissions: Trauma Registry data shall be submitted by all hospitals to the Department no later than one (1) month plus six (6) days after the end of the current month. For example, Trauma Registry data for the month of January is due on March 6th.

Source: Miss. Code Ann. § 41-59-75

Rule 1.4.3. Trauma Registrar staffing: Each trauma center shall have a sufficient number of trauma registrars to ensure all registry entries are submitted on time and are accurate. Registrars must complete initial training within six (6) months of

hire/assignment. All registrars must complete four (4) hours of continuing registrar education annually.

Source: Miss. Code Ann §41-59-5

Subchapter 5 Trauma Care Regions

Rule 1.5.1. Implementation of a Regional Trauma Care System

1. The Mississippi Trauma Care Plan documents the need for a regional approach toward the development of a statewide trauma care system. This regional development will be coordinated and supported by the legislatively designated "lead trauma agency," the Mississippi State Department of Health.
2. The Mississippi Trauma Care Plan recognizes the uniqueness within differing parts of the state with regard to personnel, resources, environmental issues, distance to tertiary care and population. Accordingly, the Mississippi Trauma Care Plan provides for a system that allows for flexibility at the regional level, incorporates the use of regional leadership to establish regional/local guidelines, and is sensitive to regional needs and resources. As a result the Mississippi Trauma Care Plan ensures a statewide trauma system design that is based on the resources available within each region, while ensuring optimal care to the trauma victim through transfer agreements when resources may not be available within a certain geographical area.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.2. Designation of Trauma Care Regions: To receive state designation as a Trauma Care Region, the hospitals and their respective medical staffs intending to establish the Trauma Care Region shall send a letter of intent to the Department which includes:

1. A description of the area to be served;
2. The names of all Trauma Centers and hospitals participating in the region; and
3. The form of regional administration for the proposed Trauma Care Region.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.3. Establishment of a Region Board of Directors

1. All Trauma Care Regions designated by the Department shall establish a Board of Directors, which shall be recognized as the lead administrative body of that Region. Board members shall be representative(s) of participating and designated trauma care centers, physicians, or any other person deemed appropriate by the Board. The Board shall have administrative authority over the operation of the Trauma Care Region and subsequent trauma system programs.

2. Trauma Care Region boards are authorized to receive funds and to expend funds as may be available for any necessary and proper trauma care program purposes in the manner provided for in these Regulations or in law. Non compliance will result in loss of funding to the region for each corresponding activity.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.4. Administration of the Trauma Care Region

1. After formation of a Trauma Care Region board, the board shall appoint an administrator who shall have authority over the operation of the Trauma Care Region and subsequent trauma care programs, all under the direction of the Trauma Care Region board. Such management may be carried out by an appointed executive manager, by contracting for management services, or by some other means, to be approved by the Department.
2. The functions of a Trauma Care Region include, but are not limited to, the following:
3. Track and assist in the distribution of the Trauma Care Trust Fund to hospitals, physicians, and EMS agencies;
4. Maintain a regional database including, but not limited to, hospitals in the region, designation status, and expiration date;
5. Monitor pre-hospital triage and transport of the trauma patient;
6. Maintain and ensure compliance of the Regional Trauma Plan;
7. Provide training opportunities for physicians, nurses, and EMS and support personnel, maintain a schedule, and ensure notification to qualifying personnel;
8. Monitor the ongoing PI program of each trauma program in the respective region; and
9. Other such activities as may be required by the Department in the annual contractual agreement.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.5. Performance of each trauma region shall be evaluated annually with continued financial support contingent on adequate performance based on outcome measures.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.6. Region Trauma Plans:

1. A Trauma Care Region intending to implement a trauma care system shall submit its Regional Trauma Plan to the Department and have it approved prior to implementation. Within 30 days of receiving the plan, the Department shall provide written notification to the Trauma Care Region of the following:
 - a. That the plan has been received by the Department;
 - b. Whether the Department approves or disapproves of its Regional Trauma Plan; and
 - c. If disapproved, the reason for disapproval of the Regional Trauma Plan;
2. Revisions in the approved Regional Trauma Plan must be submitted prior to implementation.
3. Regional Trauma Plans shall be updated and submitted to the Department every three (3) years.
4. The Trauma Care Region shall certify annually to the Department that its approved Regional Trauma Plan is functioning as described.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.7. Required Elements of a Region Trauma Plan: The Region Trauma Plan shall be comprehensive and the objectives shall be clearly outlined. The Plan shall contain, at the minimum, the following elements:

1. Table of contents;
2. Plan summary;
3. Objectives;
4. Implementation schedule;
5. Administrative structure;
6. Medical organization and management;
7. Inclusive regional design which includes all facilities involved in the care of acutely injured patients, including coordination with neighboring Trauma Care Regions;
8. Documentation of all inter-facility transfer protocols;
9. Written documentation of participation (hospital/medical staff);
10. System design which addresses the implementation of the policies developed;

11. Description of the critical care capability within the Region including but not limited to burns, spinal cord injury, rehabilitation, and pediatrics;
12. Performance improvement process; and
13. General policies of the Trauma Care Region Board of Directors.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.8. General Policies of the Trauma Care Region: A designated Trauma Care Region shall develop policies which provide a clear understanding of the structure of the trauma system and the manner in which it utilizes the resources available to it. Those policies shall address the following:

1. System organization and management;
2. Trauma care coordination within the Region;
3. Trauma care coordination with neighboring Regions and/or jurisdictions, including designated Trauma Care Region agreements;
4. Data collection and management;
5. Coordination of designated Trauma Care Regions and trauma systems for transportation including inter-Trauma Center transfers, and transfers from a receiving hospital to a Trauma Center;
6. The integration of pediatric hospitals, including pediatric triage criteria;
7. Availability of Trauma Center equipment;
8. Availability of trauma team personnel;
9. Criteria for activation of trauma team;
10. Mechanisms for availability/response of clinical specialists;
11. Performance improvement and system evaluation to include responsibilities of the Multidisciplinary Trauma/Peer Review Committee;
12. Training of pre-hospital personnel to include trauma triage;
13. Public information and education about the trauma system;
14. Lay and professional education about the trauma system;
15. Coordination with public and private agencies and Trauma Centers in injury prevention programs; and

16. Expected participation in regional operations by pre-hospital providers and hospitals.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.9. Additional Standards and Prohibitions

1. No health care facility within a Region shall advertise in any manner or otherwise hold itself out to be a Trauma Center unless so designated by the Department.
2. No pre-hospital provider shall advertise in any manner or otherwise hold itself out to be affiliated with the trauma system or a Trauma Center unless the provider of has been so designated or licensed by the Department.
3. All participating hospitals and licensed EMS providers in each Region shall abide by the Region Trauma Plan and policies.
4. Documentation of a pre-hospital provider's Medical Control Plan review and compliance must be submitted to BEMS and the Trauma Care Region annually
5. A Trauma Care Region shall withhold Trauma Care Trust Fund distributions from participating hospitals and licensed EMS providers for non-compliance with Mississippi Trauma Care System Regulations and regional plans and policies.

Source: Miss. Code Ann. § 41-59-75

- Rule 1.5.10. Level IV Trauma Center Site Visits:** At least once during each three (3) year designation period, the Trauma Care Region shall conduct a Site Visit at each Level IV Trauma Center. The primary purpose of this visit will be to ensure compliance with the regulations, with particular emphasis on practitioner training; protocols and procedures; and Performance Improvement. A written report of any deficiencies shall be forwarded to the Department within 30 days of the visit.

Source: Miss. Code Ann. § 41-59-75

Subchapter 6 Inter-facility Transfers Of Trauma Patients

Rule 1.6.1. Inter-facility Transfers

1. Patients may be transferred from Trauma Centers to other Trauma Centers and/or specialty referral centers provided that any such transfer is medically prudent, as determined by the transferring Trauma Center physician of record.
2. All designated Trauma Centers, Pediatric Trauma Centers, and Burn Centers shall accept patients transferred from Trauma Centers of equal or lower levels of designation without regard to the patient's ability to pay for treatment.

Source: Miss. Code Ann. § 41-59-75

Rule 1.6.2. Inter-facility Transfer Policies

1. Trauma Center hospitals shall develop written criteria for consultation and transfer of patients needing a higher/specialty level of care. Trauma Center/specialty referral centers that repatriate trauma patients shall provide data required by the Trauma Registry to the receiving Trauma Center.
2. Trauma Centers/specialty hospitals receiving transferred trauma patients shall provide written feedback to the transferring facility and shall participate in the regional and state performance improvement process.

Source: Miss. Code Ann. § 41-59-75

Chapter 2 Level I Trauma Centers

Subchapter 1 Hospital Organization

Rule 2.1.1. General

1. Level I Trauma Centers shall act as regional tertiary care facilities at the hub of the trauma care system. The facility must have the ability to provide leadership and total care for every aspect of injury from prevention to rehabilitation. As a tertiary facility, the Level I Trauma Center must have adequate depth of resources and personnel.
2. The Level I Trauma Centers in the State of Mississippi have the responsibility of providing leadership in education, trauma prevention, research and system planning.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.2. Hospital Departments/Divisions/Sections

1. The Level I Trauma Center must have the following departments, divisions, or sections:
 - a. Emergency Medicine
 - b. General Surgery
 - c. Orthopedic Surgery
 - d. Neurological Surgery
 - e. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.3. Trauma Program

1. There shall be a written commitment on behalf of the entire facility to the organization of trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a trauma care program may be sufficient. The trauma program must be established and recognized by the medical staff and hospital administration. The trauma program must come under the direction of a board-certified surgeon with special interest in trauma care. An identified hospital administrative leader must work closely with the trauma medical director to establish and maintain the components of the trauma program

including appropriate financial support. The trauma program location in the organizational structure of the hospital must be such that it may interact effectively with at least equal authority with other departments providing patient care. The administrative structure should minimally include an administrator, medical director, trauma program manager (TPM), trauma registrar and the appropriate support staff. Administrative support includes human resources, education activities, community outreach activities, and research. The trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care should be extended to all the involved departments.

2. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for care of the trauma patient;
 - c. Defined trauma team and written roles and responsibilities;
 - d. Appointed Trauma Medical Director with a written job description;
 - e. Appointed Trauma Program Manager with a written job description;
 - f. A written Trauma Performance Improvement plan; and
 - g. Documentation of Trauma Center representative attendance at the Regional Trauma meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.4. Trauma Service: The trauma service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured patient. The trauma service will vary in each organization depending on the needs of the patient and the resources available. The trauma service shall come under the organization and direction of a surgeon who is board certified with special interest in trauma care. All patients with multiple system trauma or major injury shall be evaluated by the trauma service. The surgeon responsible for the overall care of the patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.5. Trauma Medical Director (TMD): Level I Trauma Centers shall have a physician director of the trauma program. The medical director plays an important administrative role. The medical director must be a board-certified surgeon with special interest in trauma care. The medical director will be responsible for developing a performance improvement process and will have overall

accountability and administrative authority for the trauma program. The medical director must be given administrative support to implement the requirements specified by the state trauma plan. The director is responsible for working with the credentialing process of the hospital, and in consultation with the appropriate service chiefs, for recommending appointment and removal of physicians from the trauma team. He should cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients. The director in collaboration with the Trauma Program Manager (TPM) should coordinate the budgetary process for the trauma program. The director must be currently certified in Advanced Trauma Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The trauma director must be actively involved with the trauma system development at the community, regional and state level.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.6. Trauma Program Manager (TPM)

1. Level I Trauma Centers must have a registered nurse working full time in the role of Trauma Program Manager (TPM). Working in conjunction with the TMD, the TPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The TPM is responsible for working with the trauma team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position.
2. The TPM or his/hers designee should offer or coordinate services for trauma education. The TPM should liaison with local EMS personnel, the Department, Trauma Care Region and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.7. Trauma Team: There shall be identified members of the trauma team. Policies should be in place describing the respective role of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of the hospital and its staff. In some instances, a tiered response may be appropriate. If a tiered response is employed, written policy must be in place and the system monitored by the PI process. All physicians and mid-level providers (Physician Assistant/Nurse Practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians. Composition of the trauma team for a severely injured patient includes:

1. Emergency Physician and/or mid-level providers (Physician Assistant/Nurse Practitioner)*
2. General/Trauma Surgeon*
3. Physician Specialist
4. Anesthesiologist
5. Pediatrician
6. Nurses: ED*, OR, ICU, etc.
7. Laboratory Technicians as dictated by clinical needs
8. Mental Health/Social Services/Radiology Technicians
9. Pastoral Care
10. Respiratory Therapist
11. Security officers

* Mandatory for all Alpha and Bravo Alerts/Activations.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the region. Each trauma center may choose to have one or more committees as needed to accomplish the task. One committee should be multi-disciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education and outreach programs for injury prevention. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Emergency Medicine
 - b. General Surgery
 - c. Orthopedics

- d. Neurosurgery
 - e. Anesthesia
 - f. Operating Room
 - g. Intensive Care
 - h. Respiratory Therapy
 - i. Radiology
 - j. Laboratory
 - k. Rehabilitation
 - l. Pre-hospital Care Providers
 - m. Administration
 - n. Pediatrics
 - o. Nursing
 - p. Trauma Program Manager
 - q. Trauma Medical Director (Chairman; must be present > 50%)
2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.
 3. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

Rule 2.2.1. Required Components: Level I trauma centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.

2. Trauma/General Surgery (In-house 24/hours). The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The 24 hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. This may allow the attending surgeon to take call from outside the hospital. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured patient. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. The surgeon on-call must be dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system must be developed to assure early notification of the on-call to any other hospital while on trauma call. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 20 minutes and starts at patient arrival or EMS notification, whichever is shorter.
3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
4. Neurologic Surgery. It is desirable to have the neurosurgeon dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
5. Anesthesia (In-house 24 hours/day) Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

6. The following specialists must be on-call and promptly available 24 hours/day:
 - a. Cardiac Surgery*
 - b. Cardiology
 - c. Critical Care Medicine
 - d. Hand Surgery
 - e. Infectious Disease
 - f. Microvascular Surgery
 - g. Nephrology
 - h. Nutritional Support
 - i. Obstetrics/Gynecologic Surgery
 - j. Ophthalmic Surgery
 - k. Oral/Maxillofacial
 - l. Pediatrics
 - m. Plastic Surgery
 - n. Pulmonary Medicine
 - o. Radiology
 - p. Thoracic Surgery*

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified cardiac/thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

7. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.
8. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 2.2.2. Qualifications of Surgeons on the Trauma Team

1. Basic to qualification for trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the Royal College of Physicians, the American Dental Association and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.
2. Alternate criteria in lieu of board certification are as follows:
 - a. A non-board certified general surgeon must have completed a surgical residency program.
 - b. He/she must be licensed to practice medicine.
 - c. He/she must be approved by the hospital's credentialing committee for surgical privileges.
 - d. The surgeon must meet all criteria established by the trauma director to serve on the trauma team.
 - e. The surgeons' experience in caring for the trauma patient must be tracked by the PI program.
 - f. The TMD must attest to the surgeons' experience and quality as part of the recurring granting of trauma team privileges.
 - g. The TMD, using the trauma PI program, is responsible for determining each general surgeon's ability to participate on the trauma team.
3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level I facility) and determine if the patient needs transport to a higher level of care. If transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the Level I trauma center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines should be written at the local level to determine which types of patients should be admitted to the Level I trauma center or which patients should be considered for transfer to a higher level of care.
4. The general surgery liaison, orthopedic liaison, and neurosurgery liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer

review committee attendance must be greater than fifty percent (50%) over a year's period of time. General Surgery physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other surgeons on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 2.2.3. Qualification of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, career emergency medicine physicians who are board certified in a specialty recognized by the American Board of Medical Specialties, a Canadian Board or other equivalent foreign board meets the requirements.
2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:
 - a. He/she must be licensed to practice medicine
 - b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.
 - c. The physician must meet all criteria established by the trauma and emergency medical director to serve on the trauma team.
 - d. The physician's experience in caring for the trauma patient must be tracked by the PI program.
 - e. The trauma and emergency medical director must attest to the physician's experience and quality as part of the recurring granting of trauma team privileges.
 - f. Residency in Emergency Medicine is desirable.
3. The emergency medicine liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other physicians on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 2.3.1. Emergency Department

1. The facility must have an emergency department, division, service, or section staffed so trauma patients are assured immediate and appropriate initial care. The emergency physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in-house 24 hours/day and immediately available at all times. The emergency department medical director must meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and board certification in emergency medicine.
2. The director of the emergency department, along with the Trauma Medical Director, will establish trauma-specific credentials that should exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification and specialty board certification.
3. The emergency medicine physician will be responsible for activating the trauma team based on predetermined response protocols. He will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the Multidisciplinary Trauma Committee and the trauma PI process.
4. There shall be an adequate number of RN's staffing the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC) and participate in the ongoing PI process of the trauma program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. Nurses must obtain TNCC within 18 months of assignment to the ER.
5. The list of required equipment necessary for the ED can be found on-line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 2.3.2. Surgical Suites/Anesthesia

1. The operating room (OR) must be staffed and available in-house 24 hours/day.
2. The OR nurses should participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.

3. The surgical nurses are an integral member of the trauma team, and must participate in the ongoing PI process of the trauma program and be represented on the Multidisciplinary Trauma Committee.
4. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.
5. The anesthesia department in a Level I Trauma Center should be ideally organized and run by an anesthesiologist who is highly experienced and devoted to the care of the injured patient. If this is not the director, an anesthesiology liaison with the same qualifications should be identified. Anesthesiologists on the trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council for Graduate Medical Education, the American Board of Osteopathic Specialties and have board certification in anesthesia. One anesthesiologist should maintain commitment to education in trauma related anesthesia.
6. Anesthesia must be available in-house 24 hours/day with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia requirements may be fulfilled by anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNA) who are capable of assessing emergent situations in trauma patients and of providing indicated treatment, including initiation of surgical anesthesia. When the CRNA or chief resident is used to meet this requirement, the staff Anesthesiologist will be advised and promptly available at all times and present for operations. Trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the trauma patient. The availability of the anesthesiologist and the absence of delays in operative anesthesia must be documented and monitored by the PI process. The anesthesiologist participating on the trauma team must participate in the Multidisciplinary Trauma Committee and the trauma PI process.
7. The list of required equipment necessary for Surgery can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 2.3.3. Post Anesthesia Care Unit (PACU)

1. Level I trauma centers must have a PACU staffed 24 hours/day and available to the postoperative trauma patient. Frequently it is advantageous to bypass the PACU and directly admit to the ICU. In this instance, the ICU may meet these requirements.

2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education.
3. PACU staffing should be in sufficient numbers to meet the critical needs of the trauma patient.
4. The list of required equipment necessary for PACU can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 2.3.4. Intensive Care Unit (ICU)

1. Level I trauma centers must have an Intensive Care Unit (ICU) that meets the needs of the adult trauma patient.
2. The surgical director for the ICU – which houses trauma patients - must have obtained critical care training during residency or fellowship and must have expertise in the preoperative and post injury care of the injured patient. This is best demonstrated by a certificate of added qualification in surgical critical care from the American Board of Surgery and may also be fulfilled by documentation of active participation during the preceding 12 months in trauma patients' ICU care and ICU administration and critical care-related continuing medical education. The director is responsible for the quality of care and administration of the ICU and will set policy and establish standards of care to meet the unique needs of the trauma patient.
3. The trauma service assumes and maintains responsibility for the care of the multiple injured patient. A surgically directed ICU physician team is essential. The team will provide in-house physician coverage for all ICU trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialties, but must be led by a qualified surgeon as determined by critical care credentials consistent with the medical staff privileging process of the institution.
4. There must be in-house physician coverage for the ICU at all times. A physician credentialed by the facility for critical care should be promptly available to the trauma patient in the ICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.
5. The trauma service should maintain the responsibility for the care of the patient as long as the patient remains critically ill. The trauma service must remain in charge of the patient and coordinate all therapeutic decisions. The responsible trauma surgeon or designee should write all orders. The trauma surgeon should maintain control over all aspects of care, including but not limited to respiratory care and management of mechanical ventilation; placement and use of pulmonary

catheters; management of fluid and electrolytes, antimicrobials, and enteral and parenteral nutrition.

6. Level I Trauma Centers must provide staffing in sufficient numbers to meet the critical needs of the trauma patient. Critical care nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. ICU nurses are integral part of the trauma team and as such, should be represented on the Multidisciplinary Trauma Committee and participate in the PI process of the trauma program.
7. The list of required equipment necessary for the ICU can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 2.4.1. Respiratory Therapy Service: The service must be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatment for the injured patient.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.2. Radiological Service

1. A radiological service must have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological procedures. Sonography, angiography, and MRI must be available to the trauma team. A technician must be in-house and immediately available for computerized tomography (CT) for both head and body. Specialty procedures such as angiography, MRI, and sonography may be covered with a technician on-call. If the technician is not in-house 24 hours/day for special procedures the performance improvement process must document and monitor that the procedure is promptly available.
2. A board-certified radiologist should administer the department and participate actively in the trauma education and PI process. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must insure the preliminary interpretations are promptly reported to the trauma team and the PI program must monitor all changes in interpretation.
3. Written policy should exist delineating the prioritization/availability of the CT scanner for trauma patients. The PI process must ensure that trauma patients are accompanied by appropriately trained licensed providers and that the appropriate

resuscitation and monitoring are provided during transportation to and while in the radiology department.

4. The radiologist must ensure the preliminary interpretations are promptly reported to the trauma team and the PI Program must monitor all changes in interpretation.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.3. Clinical Laboratory Service

1. Clinical laboratory service must have the following services available in-house 24 hours/day:
 - a. Access to a blood bank and adequate storage facilities. Sufficient quantities of blood and blood products must be maintained at all times. Blood typing and cross-match capabilities must be readily available.
 - b. Standard analysis of blood, urine and other body fluids including micro-sampling when appropriate.
 - c. Blood gas and PH determinations (this function may be performed by services other than the clinical laboratory service, when applicable.)
 - d. Alcohol screening is required, and drug screening is highly recommended.
 - e. Coagulation studies.
 - f. Microbiology
2. Sufficient numbers of clinical laboratory technologists shall be in-house 24 hours/day and promptly available at all times. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.4. Acute Hemodialysis: Level I Trauma Centers must have Acute Hemodialysis services. There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the Level I Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.5. Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the Level I Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.6. Rehabilitation/Social Services

1. The rehabilitation of the trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to the trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services should minimally include; Occupational Therapy, Physical Therapy, and Speech Pathology.
2. The nature of traumatic injury requires that the psychological needs of the patient and family are considered and addressed in the acute stages of injury and throughout the continuum of recovery. Adequate number of trained personnel must be readily available to the trauma patients and family. Programs must be available to meet the unique need of the trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.7. Prevention/Public Outreach

1. Level I trauma centers will be responsible for taking a lead role in coordination of appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. Prevention programs must be specific to the needs of the region. The trauma registry data must be utilized to identify injury trends and focus prevention needs.
2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at a Level I trauma center must provide consultation to staff members of other level facilities. For example: Advanced Trauma Life Support (ATLS), Pre Hospital Trauma Life Support (PHTLS), Trauma Nurse Curriculum Course (TNCC), and Transport Nurse Advanced Trauma Course (TNATC) courses can be coordinated by the trauma center. Trauma physicians must provide a formal follow up to referring physicians/designee about specific patients to educate the practitioner for the benefit of further injured patients.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.8. Transfer Guidelines: Level I Trauma Centers shall work in collaboration with the referral trauma facilities in the system and develop inter-facility transfer guidelines. These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.9. Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional and state levels. Since these data relate to specific trauma patients and are used to evaluate and improve the quality of health care services, this data is confidential as provided in Miss. Code Ann. §41-59-77. Level I trauma facilities may be responsible for direct assistance to all other levels of referring facilities in providing data for inclusion in the registry.
2. Each trauma center must develop an internal trauma specific Performance Improvement (PI) plan that minimally addresses the following key components and is fully integrated into the hospital wide program:
 - a. An organizational structure that facilitates performance improvement (Multidisciplinary Trauma Committee).
 - b. Clearly defined authority and accountability for the program.
 - c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.
 - d. Development of expectations (criteria) from evidenced based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.
 - e. Explicit definitions of outcomes derived from institutional standards.
 - f. Documentation system to monitor performance, corrective action and the result of the actions taken.
 - g. A process to delineate credentialing of all trauma service physicians.
 - h. An informed peer review process utilizing a multidisciplinary method.

- i. A method for comparing patient outcomes with computed survival probability.
 - j. Autopsy information on all deaths when available.
 - k. Review of pre-hospital care.
 - l. Review of times and reasons for trauma bypass.
 - m. Review of times and reasons for trauma transfers.
 - n. Audit of trauma deaths.
 - o. Morbidity and Mortality review.
3. Representatives from the Level I Trauma Center shall participate in the Trauma Care Region and statewide performance improvement process.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.10. Education

1. Level I Trauma Centers must have medical education programs including educational training in trauma for physicians, nurses and pre-hospital providers. The Level I trauma centers must take a leadership role in providing educational activities. Education can be accomplished via many mechanisms (i.e. classic CME, preceptorships, fellowships, clinical rotations, telecommunications or providing locum tenens etc).
2. The Level I trauma center is expected to support a surgical residency program. Additionally there should be a senior resident rotation in at least one of the following disciplines: emergency medicine, general surgery, orthopedic surgery, neurosurgery or support a trauma fellowship consistent with the educational requirements of the American Association for the Surgery of Trauma (AAST). The Level I should provide ATLS courses for the region.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.11. Research

1. A trauma research program must be designed to produce new knowledge applicable to the care of the injured patient. The research may be conducted in a number of ways including traditional laboratory and clinical research, reviews of clinical series, and epidemiological or other studies. Publication of articles in peer-review journals as well as presentations of results at local, regional and national meetings and ongoing studies approved by human and animal research

review boards are expected from productive programs. The program should have an organized structure that fosters and monitors ongoing productivity.

2. The research program must be balanced to reflect a number of different interests. There must be a research committee, and identifiable Institutional Review Board process, active research protocols, surgeons involved in extramural educational presentations and adequate number of peer reviewed scientific publications. Publications should appear in peer-reviewed journals. In a three-year cycle, the suggested minimum activity is ten publications (per review cycle) from the physicians representing any of the four following specialties: emergency medicine, general surgery, orthopedic surgery, and neurosurgery.

Source: Miss. Code Ann. § 41-59-5

Chapter 3 Level II Trauma Centers

Subchapter 1 Hospital Organization

Rule 3.1.1. General: A Level II Trauma Center is an acute care facility with the commitment, resources and specialty training necessary to provide sophisticated trauma care.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.2. Hospital Departments/Divisions/Sections: The Level II Trauma Center must have the following departments, divisions, or sections:

1. Emergency Medicine
2. Trauma/General Surgery
3. Orthopedic Surgery
4. Neurological Surgery
5. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.3. Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. The trauma program must be established and recognized by the medical staff and hospital administration. The trauma program must come under the direction of a board-certified surgeon with special interest in trauma care. An identified hospital administrative leader must work closely with the trauma medical director to establish and maintain the components of the trauma program including appropriate financial support. The trauma program location in the organizational structure of the hospital must be placed so that it may interact effectively with at least equal authority with other departments providing patient care. An administrative structure should minimally include an administrator, medical director, trauma program manager (TPM), trauma registrar and the appropriate support staff. Administrative support includes human resources, educational activities, community outreach activities, and research. The trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care should extend to all the involved departments.

2. Compliance with the above will be evidenced by, but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for care of the trauma patient;
 - c. Defined trauma team and written roles and responsibilities;
 - d. Appointed Trauma Medical Director with a written job description;
 - e. Appointed Trauma Program Manager with a written job description;
 - f. A written Trauma Performance Improvement plan;
 - g. Documentation of trauma center representative attendance at the regional trauma advisory committee meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.4. Trauma Service: The trauma service must be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured patient. The trauma service will vary in each organization depending on the needs of the patient and the resources available. The trauma service must come under the organization and direction of a surgeon who is board certified with special interest in trauma care. All patients with multiple system trauma or major injury must be evaluated by the trauma service. The surgeon responsible for the overall care of the patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.5. Trauma Medical Director (TMD): Level II Trauma Centers must have a physician director of the trauma program. The trauma program medical director plays an important administrative role. The medical director must be a board-certified surgeon with special interest in trauma care. The medical director will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the trauma program. The medical director must be given administrative support to implement the requirements specified by the State trauma plan. The director is responsible for working with the credentialing process of the hospital, and, in consultation with the appropriate service chiefs, recommending appointment and removal of physicians from the trauma team. He should cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients. The director in collaboration with the trauma program manager/TPM should coordinate the budgetary process for the trauma program. The director must be currently certified in Advanced Trauma

Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The trauma director must be actively involved with the trauma system development at the community, regional and state level.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.6. Trauma Program Manager (TPM)

1. Level II Trauma Centers must have a registered nurse working full time in the role of Trauma Program Manager (TPM). Working in conjunction with the TMD, the TPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The TPM is responsible for working with the trauma team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position.
2. The TPM or his/hers designee should offer or coordinate services for trauma education. The TPM should liaison with local EMS personnel, the Department, Trauma Care Region(s) and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.7. Trauma Team: The team approach is optimal in the care of the multiple injured patient. There must be identified members of the trauma team. Policies should be in place describing the respective role of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its staff. In some instances, a tiered response may be appropriate. If a tiered response is employed, written policy must be in place and the system monitored by the PI process. The team leader must be a qualified general surgeon. All physicians and mid-level providers (Physician Assistant/Nurse Practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians. Composition of the trauma team for a severely injured patient shall include:

1. Emergency Physicians and/or mid-level providers (Physician Assistant/Nurse Practitioner)*
2. General/Trauma Surgeon*
3. Physician Specialist
4. Anesthesiologist

5. Pediatricians
6. Nurses: ED*, OR, ICU, etc.
7. Laboratory Technicians as dictated by clinical needs
8. Mental Health/Social Services/ Radiology Technicians
9. Pastoral Care
10. Respiratory Therapists
11. Security Officers

* Mandatory for all Alpha Alerts/Activations.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the region. Each trauma center may choose to have one or more committees to accomplish the tasks necessary. One committee should be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, establishment of standards of care, education and outreach programs, and injury prevention. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Emergency Medicine
 - b. General Surgery
 - c. Orthopedics
 - d. Neurosurgery
 - e. Anesthesia
 - f. Operating Room
 - g. Intensive Care
 - h. Respiratory Therapy

- i. Radiology
 - j. Laboratory
 - k. Rehabilitation
 - l. Pre-hospital Care Providers
 - m. Administration
 - n. Pediatrics
 - o. Nursing
 - p. Trauma Program Manager
 - q. Trauma Medical Director (Chairman; must be present > 50%)
2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.
 3. The trauma center may wish to accomplish performance improvement activities at this same committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. This committee must be multidisciplinary, meet regularly, and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

- Rule 3.2.1. Required Components : Level II Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:
1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
 2. Trauma/General Surgery. The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured patient. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative

procedures is mandatory. There must be a back-up surgeon schedule published. It is desirable that the on-call surgeon be dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.

3. Orthopedic Surgery. The orthopedic surgeons on the trauma team must be board certified. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
4. Neurologic Surgery. The neurosurgeons on the trauma team must be board certified. It is desirable to have the neurosurgeon dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
5. Anesthesia (In-house 24 hours/day) Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
6. The following specialists must be on-call and promptly available 24 hours/day:
 - a. Critical Care Medicine
 - b. Hand Surgery
 - c. Infectious Disease
 - d. Microvascular Surgery
 - e. Obstetrics/Gynecologic Surgery
 - f. Ophthalmic Surgery

- g. Oral/Maxillofacial
- h. Plastic Surgery
- i. Radiology
- j. Thoracic Surgery*

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

- 7. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.
- 8. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 3.2.2. Qualifications of Surgeons on the Trauma Team

- 1. Basic to qualification for trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the American Dental Association, the Royal College of Physicians and Surgeons of Canada or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.
- 2. Alternate criteria in lieu of board certification are as follows:
 - a. A Non-board certified general surgeon must have completed a surgical residency program.
 - b. He/she must be licensed to practice medicine.
 - c. He/she must be approved by the hospital's credentialing committee for surgical privileges.
 - d. The surgeon must meet all criteria established by the TMD to serve on the trauma team.

- e. The surgeon's experience in caring for the trauma patient must be tracked by the PI program.
 - f. The TMD must attest to the surgeon's experience and quality as part of the recurring granting of trauma team privileges.
 - g. The TMD, using the trauma PI program, is responsible for determining each general surgeon's ability to participate on the trauma team.
3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level II facility) and determine if the patient needs transport to a higher level of care. If transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the Level II trauma center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines should be written at the local level to determine which types of patients should be admitted to the Level II trauma center or which patients should be considered for transfer to a higher level of care.
 4. The general surgery liaison, orthopedic liaison, and neurosurgery liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. General Surgery physicians must be currently certified in ATLS; ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians, and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other surgeons on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 3.2.3. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, career emergency medicine physicians who are board certified in a specialty recognized by the American Board of Medical Specialties, a Canadian Board or other equivalent foreign board meets the requirements.
2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:
 - a. He/she must be licensed to practice medicine.

- b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.
 - c. The physician must meet all criteria established by the trauma and emergency medical director to serve on the trauma team.
 - d. The physician's experience in caring for the trauma patient must be tracked by the PI program.
 - e. The trauma and emergency medical director must attest to the physician's experience and quality as part of the recurring granting of trauma team privileges.
 - f. Residency in Emergency Medicine is desirable.
3. The emergency medicine liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other physicians on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 3.3.1. Emergency Department

1. The facility must have an emergency department, division, service, or section staffed so trauma patients are assured immediate and appropriate initial care. The emergency physician must be in-house 24 hours/day and immediately available at all times. The emergency department medical director must meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and board certification in emergency medicine.
2. The director of the emergency department, along with the trauma director, will establish trauma-specific credentials that should exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification and specialty board certification. ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.

3. The emergency medicine physician or designee will be responsible for activating the trauma team based on predetermined response protocols. He will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the Multidisciplinary Trauma Committee and the trauma PI process.
4. There should be an adequate number of RN's staffed for the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC) and participate in the ongoing PI process of the trauma program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. Nurses must obtain TNCC within 18 months of assignment to the ER.
5. The list of required equipment necessary for the ED can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 3.3.2. Surgical Suites/Anesthesia

1. It is recommended that the OR be staffed and available in-house 24 hours/day. If the staff is not in-house, hospital policy must be written to assure notification and prompt response. The PI process must document and monitor the ongoing availability of OR crews and absence of delay.
2. The OR nurses should participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.
3. The surgical nurses are an integral member of the trauma team and must participate in the ongoing PI process of the trauma program and must be represented on the Multidisciplinary Trauma Committee.
4. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma patient during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.
5. The anesthesia department in a Level II trauma center should be ideally organized and run by an anesthesiologist who is experienced and devoted to the care of the injured patient. If this is not the case, an anesthesiologist liaison with the same qualifications should be identified. Anesthesiologists on the trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council for Graduate Medical Education, the American Board of

Osteopathic Specialties, or the American Osteopathic Board and should have board certification in anesthesia. One anesthesiologist should maintain commitment to education in trauma related anesthesia. Anesthesiologists must demonstrate evidence of participation in the internal trauma education plan.

6. Anesthesia must be available 24 hours/day with a mechanism established to ensure notification of the on-call anesthesiologist. Anesthesia requirements may be fulfilled by anesthesia chief residents or Certified Registered Nurse Anesthetists (CRNAs) who are capable of assessing emergent situations in trauma patients and of providing an indicated treatment, including initiation of surgical anesthesia. When the CRNA or chief resident is used to meet this requirement, the staff Anesthesiologist will be advised and promptly available at all times and present for operations. Trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the trauma patient. The availability of the anesthesiologist and the absence of delays in operative anesthesia must be documented and monitored by the PI process. The anesthesiologist participating on the trauma team should have the necessary educational background in the care of the trauma patient; participate in the Multidisciplinary Trauma Committee and the trauma PI process.
7. The list of required equipment necessary for Surgery and Anesthesia can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 3.3.3. Post Anesthesia Care Unit (PACU)

1. It is essential to have a PACU staffed 24 hours/day and available to the postoperative trauma patient. If the staff is not in-house, Hospital policy must be written to assure early notification and prompt response. The PI process must document and monitor the ongoing availability of OR crews and absence of delay. Frequently it is advantageous to bypass the PACU and directly admit to the ICU. In this instance, the ICU may meet these requirements.
2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education.
3. PACU staffing should be in sufficient numbers to meet the critical needs of the trauma patient.
4. The list of required equipment necessary for the PACU can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 3.3.4. Intensive Care Unit (ICU)

1. Level II trauma centers must have an Intensive Care Unit (ICU) that meets the needs of the adult trauma patient.
2. The surgical director for the ICU – which houses trauma patients - must have obtained critical care training during residency or fellowship and must have expertise in the preoperative and post injury care of the injured patient. This is best demonstrated by a certificate of added qualification in surgical critical care from the American Board of Surgery and may also be fulfilled by documentation of active participation during the preceding 12 months in trauma patients' ICU care and ICU administration and critical care-related continuing medical education. The director is responsible for the quality of care and administration of the ICU and will set policy and establish standards of care to meet the unique needs of the trauma patient.
3. The trauma service assumes and maintains responsibility for the care of the multiple injured patient. A surgically directed ICU physician team is desirable. The team will provide in-house physician coverage for all ICU trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialties, but must be led by a qualified surgeon as determined by critical care credentials consistent with the medical staff privileging process of the institution.
4. There should be physician coverage for the ICU at all times. A physician credentialed by the facility for critical care should be promptly available to the trauma patient in the ICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.
5. The trauma service should maintain the responsibility for the care of the patient as long as the patient remains critically ill. The trauma service must remain in charge of the patient and coordinate all therapeutic decisions. The responsible trauma surgeon or designee should write all orders. The trauma surgeon should maintain control over all aspects of care, including but not limited to respiratory care and management of mechanical ventilation; placement and use of pulmonary catheters; management of fluid and electrolytes, antimicrobials, and enteral and parenteral nutrition.
6. Level II trauma centers must provide staffing in sufficient numbers to meet the critical needs of the trauma patient. Critical care nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing critical care education. ICU nurses are an integral part of the trauma team and as such, should be represented on the

Multidisciplinary Trauma Committee and participate in the PI process of the trauma program.

7. The list of required equipment necessary for the ICU can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 3.4.1. Respiratory Therapy Service: the service should be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatments for the injured patient.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.2. Radiological Service

1. A radiological service must have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological procedures. It is desirable to have a technician in-house and immediately available for computerized tomography (CT) for both head and body. If the technician is not in-house 24 hours/day for special procedures the performance improvement process must document and monitor that the procedure is promptly available.
2. Sonography and Angiography must be available to the trauma team. It is desirable that MRI services be available to the trauma team. Specialty procedures such as angiography and sonography may be covered with a technician on-call.
3. A board-certified radiologist should administer the department and participate actively in the trauma education and PI process. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must insure the preliminary interpretations are promptly reported to the trauma team and the PI program must monitor all changes in interpretation.
4. Written policy should exist delineating the prioritization/availability of the CT scanner for trauma patients. The PI process must ensure that trauma patients are accompanied by appropriately trained licensed providers and that the appropriate resuscitation and monitoring are provided during transportation to and while in the radiology department.
5. The radiologist must ensure the preliminary interpretations are promptly reported to the trauma team and the PI Program must monitor all changes in interpretation.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.3. Clinical Laboratory Service

1. A clinical laboratory service must have the following services available in-house 24 hours/day:
 - a. Access to a blood bank and adequate storage facilities. Sufficient quantities of blood and blood products should be maintained at all times. Blood typing and cross-match capabilities must be readily available.
 - b. Standard analysis of blood, urine, and other body fluids including microsampling when appropriate.
 - c. Blood gas and pH determinations (this function may be performed by services other than the clinical laboratory service, when applicable).
 - d. Alcohol screening is required and drug screening is highly recommended.
 - e. Coagulation studies
 - f. Microbiology
2. Sufficient numbers of clinical laboratory technologists shall be in-house 24 hours/day and promptly available at all times. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.4. Acute Hemodialysis: There must be a written protocol to transfer the patient to a facility that provides this service if this service is not available at the Level II Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.5. Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the Level II Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.6. Rehabilitation/Social Services

1. The rehabilitation of the trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to the trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services should minimally include; Occupational Therapy, Physical Therapy, and Speech Pathology.
2. The nature of traumatic injury requires that the psychological needs of the patient and family are considered and addressed in the acute stages of injury and throughout the continuum of recovery. Adequate numbers of trained personnel should be readily available to the trauma patients and family. Programs must be available to meet the unique needs of the trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.7. Prevention/Public Outreach

1. Level II Trauma Centers will be responsible for participating with appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. Prevention programs must be specific to the needs of the region. The trauma registry data should be utilized to identify injury trends and focus prevention needs.
2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at the Level II trauma center should provide consultation to staff members at other facilities in the region. Advanced Trauma Life Support (ATLS), Pre Hospital Trauma Life Support (PHTLS), Trauma Nurse Curriculum Course (TNCC), and Transport Nurse Advanced Trauma Course (TNATC) courses for example can be coordinated by the trauma center. Trauma physicians should provide a formal follow up to referring physicians/designee about specific patients to educate the practitioner for the benefit of further injured patients.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.8. Transfer Guidelines: Level II Trauma Centers shall work in collaboration with the referral trauma facilities in the system and develop interfacility transfer

guidelines. These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.9. Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional and state levels. Since these data relate to specific trauma patients and are used to evaluate and improve the quality of health care services, this data is confidential as provided in Miss. Code Ann. §41-59-77. Level II trauma facilities may be responsible for direct assistance to all other levels of referring facilities in providing data for inclusion in the registry.
2. Each trauma center must develop an internal Performance Improvement plan that minimally addresses the following key components and is fully integrated into the hospital wide program:
 - a. An organizational structure that facilitates performance improvement (Multidisciplinary Trauma Committee).
 - b. Clearly defined authority and accountability for the program.
 - c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.
 - d. Development of expectations (criteria) from evidenced based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.
 - e. Explicit definitions of outcomes derived from institutional standards
 - f. Documentation system to monitor performance, corrective action and the result of the actions taken.
 - g. A process to delineate privileges credentialing all trauma service physicians.
 - h. An informed peer review process utilizing a multidisciplinary method.
 - i. A method for comparing patient outcomes with computed survival probability.

- j. Autopsy information on all deaths when available.
 - k. Review of pre-hospital care.
 - l. Review of times and reasons for trauma bypass.
 - m. Review of times and reasons for trauma transfers.
 - n. Audit all trauma deaths.
 - o. Morbidity and Mortality review.
3. Representatives from the Level II trauma center shall participate in the Trauma Care Region and statewide performance improvement process.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.10. Education: Level II Trauma Centers must have medical education programs including educational training in trauma for physicians, nurses and prehospital providers. The Level II trauma centers assist and cooperate with the Level I trauma center in providing educational activities. Education may be accomplished via many mechanisms (i.e. classic CME, preceptorships, fellowships, clinical rotations, telecommunications or providing locum tenens, etc.)

Source: Miss. Code Ann. § 41-59-5

Chapter 4 Level III Trauma Centers

Subchapter 1 Hospital Organization

Rule 4.1.1. General: A Level III trauma center is an acute care facility with the commitment, medical staff, personnel and specialty training necessary to provide initial resuscitation of the trauma patient. Generally, a Level III trauma center is expected to provide initial resuscitation of the trauma patient and immediate operative intervention to control hemorrhage and to assure maximal stabilization prior to referral to a higher level of care. In many instances, patients will remain in the Level III Trauma Center unless the medical needs of the patient require secondary transfer. The decision to transfer a patient rests with the physician attending the trauma patient. All Level III Trauma Centers will work collaboratively with other trauma facilities to develop transfer protocols and a well-defined transfer sequence.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.2. Hospital Departments/Divisions/Sections: The Level III Trauma Center must have the following departments, divisions, or sections:

1. Emergency Medicine
2. Trauma/General Surgery
3. Orthopedic Surgery
4. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.3. Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. The trauma program must be established and recognized by the medical staff and hospital administration. The trauma program must come under the direction of a board-certified surgeon with special interest in trauma care. An administrative structure should ideally include an administrator, medical director, trauma program manager, trauma registrar and other appropriate staff. At minimum, an identified hospital administrative leader should work closely with the trauma medical director to establish and maintain the components of the trauma program

including appropriate financial support. The trauma program location in the organizational structure of the hospital should be placed so that it may interact effectively with at least equal authority with other departments providing patient care. The trauma program should be multidisciplinary in nature and the performance improvement evaluation of this care must extend to all the involved departments.

2. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for care of the trauma patient;
 - c. Defined trauma team and written roles and responsibilities;
 - d. Appointed Trauma Medical Director with a written job description;
 - e. Appointed Trauma Program Manager with a written job description;
 - f. A written Trauma Performance Improvement plan;
 - g. Documentation of trauma center representative attendance at the regional trauma advisory committee meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.4. Trauma Service: A trauma service is an organized structure of care for the patient. The Trauma Service must be established and recognized by the medical staff. The service includes personnel and resources necessary to ensure the appropriate efficient care delivery. The composition of the service will vary depending on the nature of the medical center, available resources and personnel and patient clinical need. The trauma service must come under the organization and direction of a surgeon who is board certified with special interest in trauma care. All patients with multiple system trauma or major injury must be evaluated by the trauma service. Injured patients may be admitted to individual surgeons.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.5. Trauma Medical Director (TMD)

1. Level III Trauma Centers must have a physician director of the trauma program. The TMD plays an important administrative role. The TMD must be a board-certified surgeon with special interest in trauma care. The TMD will be responsible for developing a performance improvement process and, through this

process, will have overall accountability for all trauma patients and administrative authority for the hospital's trauma program. The TMD must be given administrative support to implement the requirements specified by the state trauma plan. The TMD is responsible for working with the credentialing process of the hospital and, in consultation with the appropriate service chiefs, recommending appointment and removal of physicians from the trauma team. He should cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients. The TMD in collaboration with the Trauma Program Manager (TPM) should coordinate the budgetary process for the trauma program

2. The TMD must be currently certified by the American College of Surgeons Advanced Trauma Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The TMD, or his designee, must be actively involved with the trauma system development at the community, regional and state level.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.6. Trauma Program Manager (TPM)

1. Level III trauma centers must have a registered nurse working in the role of Trauma Program Manager (TPM). Working in conjunction with the TMD, the TPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The TPM is responsible for working with the trauma team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position.
2. The TPM or his/hers designee should offer or coordinate services for trauma education. The TPM should liaison with local EMS personnel, the Department, Trauma Care Regions(s) and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.7. Trauma Team: The team approach is optimal in the care of the multiple injured patients. There must be identified members of the trauma team. Policies should be in place describing the roles of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its resources. In some instances, a tiered response may be appropriate. If a tiered response is employed written policy must be in place and the system monitored by the PI process. The team leader must be a qualified general surgeon. All physicians and mid-level providers (Physician Assistant/Nurse Practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board

Certified General Surgery Physicians. Composition of the trauma team for severely injured patients includes:

1. Emergency Physicians and/or mid-level providers (Physician Assistant/Nurse Practitioner)*
2. General/Trauma Surgeons*
3. Physician Specialists
4. Laboratory Technicians as dictated by clinical needs
5. Nursing: ED*, OR, ICU, etc.
6. Auxiliary Support Staff
7. Respiratory Therapists
8. Security Officers

* Mandatory for all Alpha Alerts/Activations.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the region. The major focus will be on PI activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and injury prevention. The committee has administrative and systematic control and oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives (if available in the community) from:
 - a. Emergency Medicine
 - b. General Surgery
 - c. Orthopedics
 - d. Neurosurgery
 - e. Anesthesia

- f. Operating Room
 - g. Intensive Care
 - h. Respiratory Therapy
 - i. Radiology
 - j. Laboratory
 - k. Rehabilitation
 - l. Pre-hospital Care Providers
 - m. Administration
 - n. Pediatrics
 - o. Nursing
 - p. Trauma Program Manager
 - q. Trauma Medical Director (Chairman; must be present > 50%)
2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.
 3. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

- Rule 4.2.1. Required Components: Level III Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:
1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
 2. Trauma/General Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the trauma center

and not on-call to any other hospital while on trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is sooner. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.

3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
4. Anesthesia. Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
5. The following specialists must be on-call and promptly available 24 hours/day:
Radiology
6. It is desirable (although not required) to have the following specialist available to a Level III Trauma Center:
 - a. Hand Surgery
 - b. Obstetrics/Gynecology Surgery
 - c. Ophthalmic Surgery
 - d. Oral/Maxillofacial Surgery
 - e. Plastic Surgery
 - f. Critical Care Medicine
 - g. Thoracic Surgery*
 - h. Microvascular Surgery

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic

surgeon immediately available (within 30 minutes of the time notified to respond).

7. The staff specialist on-call will be notified at the discretion of the trauma surgeon and will be promptly available. The PI program will continuously monitor this availability.
8. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 4.2.2. Qualifications of Surgeons on the Trauma Team

1. Basic to qualification for trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the American Dental Association, the Royal College of Physicians and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.
2. Alternate criteria in lieu of board certification are as follows:
 - a. Non-board certified general surgeon must have completed a surgical residency program.
 - b. He/she must be licensed to practice medicine.
 - c. He/she must be approved by the hospital's credentialing committee for surgical privileges.
 - d. The surgeon must meet all criteria established by the TMD to serve on the trauma team.
 - e. The surgeon's experience in caring for the trauma patient must be tracked by the PI program.
 - f. The TMD must attest to the surgeons' experience and quality as part of the recurring granting of trauma team privileges.
 - g. The TMD, using the trauma PI program, is responsible for determining each general surgeon's ability to participate on the trauma team.
3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care.

The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level III facility) and determine if the patient needs transport to a higher level of care. If transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the Level III trauma center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines should be written at the local level to determine which types of patients should be admitted to the Level III trauma center or which patients should be considered for transfer to a higher level of care.

4. The general surgery and orthopedic liaisons must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. General Surgery physicians must be currently certified in ATLS; ATLS requirements are waived for Board Certified General Surgery physicians, and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other surgeons on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 4.2.3. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, career emergency medicine physicians who are board certified in a specialty recognized by the American Board of Medical Specialties, a Canadian Board or other equivalent foreign board meets the requirements.
2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:
 - a. He/she must be licensed to practice medicine.
 - b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.
 - c. The physician must meet all criteria established by the trauma and emergency medical director to serve on the trauma team.
 - d. The physician's experience in caring for the trauma patient must be tracked by the PI program.
 - e. The TMD and emergency medical director must attest to the physician's experience and quality as part of the recurring granting of trauma team privileges.

- f. Residency in Emergency Medicine is desirable.
3. The emergency medicine liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other physicians on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 4.3.1. Emergency Department

1. The facility must have an emergency department, division, service or section staffed so those trauma patients are assured immediate and appropriate initial care. The emergency physician and/or mid level providers must be in-house 24 hours/day, immediately available at all times, and capable of evaluating trauma patients and providing initial resuscitation. The emergency medicine physician will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The medical director for the department, or his designee, must participate with the Multidisciplinary Trauma Committee and the trauma PI process.
2. The director of the emergency department, along with the TMD, may establish trauma-specific credentials that should exceed those that are required for general hospital privileges (i.e., ATLS verification).
3. There should be an adequate number of RN's staffed for the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of TNCC and participate in the ongoing PI process of the trauma program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. Nurses must obtain TNCC within 18 months of assignment to the ER.
4. The list of required equipment necessary for the ED can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 4.3.2. Surgical Suites/Anesthesia

1. The surgical team must be on-call with a well-defined mechanism for notification to expedite transfer to the operating room if the patient's condition warrants. The process should be monitored by trauma PI program.
2. The OR nurses should participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.
3. The surgical nurses are integral members of the trauma team and must participate in the ongoing PI process of the trauma program and must be represented on the Multidisciplinary Trauma Committee.
4. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma patient during a busy operative schedule.
5. Anesthesia must be promptly available with a mechanism established to ensure notification of the on-call anesthesiologist. The Level III trauma center must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the trauma patient.
6. Anesthesiologists on the trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council for Graduate Medical Education, the American Board of Osteopathic Specialties, or the American Osteopathic Board and should have board certification in anesthesia.
7. Anesthesia requirements may be fulfilled by Certified Registered Nurse Anesthetists (CRNAs) and/or anesthesia residents who are capable of assessing emergent situations in trauma patients and of providing an indicated treatment, including initiation of surgical anesthesia. When the CRNA is used to meet this requirement, the staff Anesthesiologist will be advised and promptly available at all times and present for operations. Trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the trauma patient. The availability of the anesthesiologist and the absence of delays in operative anesthesia must be documented and monitored by the PI process. The anesthesiologist participating on the trauma team should have the necessary educational background in the care of the trauma patient; participate in the Multidisciplinary Trauma Committee and the trauma PI process.
8. The list of required equipment necessary for Surgery and Anesthesiology can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 4.3.3. Post Anesthesia Care Unit (PACU)

1. A Level III trauma center must have a PACU available 24 hours/day to the postoperative trauma patient. Hospital policy must be written to assure early notification and prompt response. Frequently, it is advantageous to bypass the PACU and directly admit to the ICU. In this instance, the ICU may meet these requirements.
2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing critical care education. PACU staffing should be in sufficient numbers to meet the critical need of the trauma patient.
3. The list of required equipment necessary for the PACU can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 4.3.4. Intensive Care Unit (ICU)

1. The ICU must have a surgical director or surgical co-director who is responsible to set policy and administration and establish standards of care to meet the unique needs of the trauma patient. He/she is responsible for the quality of care and administration of the ICU. The trauma medical director must work to assure trauma patients admitted to the ICU will be admitted under the care of a general surgeon or appropriate surgical subspecialists. In addition to overall responsibility for patient care by the primary surgeon, it is desirable to have in-house physician coverage for the ICU at all times. This may be provided by a hospitalist or emergency physician.
2. Level III Trauma Center should provide staffing in sufficient numbers to meet the needs of the trauma patient. There must be a written plan ensuring nurses maintain ongoing critical care education. ICU nurses are an integral part of the trauma team and as such, should be represented on the Multidisciplinary Trauma Committee and participate in the PI process of the trauma program.
3. ICU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education.
4. The list of required equipment necessary for the ICU can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 4.4.1. Respiratory Therapy Service: The service must be staffed with qualified personnel on-call 24 hours/day to provide the necessary treatments for the injured patient.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.2. Radiological Service

1. A board-certified radiologist should administer the department and participate actively in the trauma PI process. The radiologist is a key member of the trauma team and should be represented on the Multidisciplinary Trauma Committee. A certified radiological technician must be available in-house 24 hours/day to meet the immediate needs of the trauma patient for general radiological procedures. Sonography should be available to the trauma team. If the radiology technician and the specialty technician are on-call from home, a mechanism must be in place to assure the technicians are available. The performance improvement process must verify that radiological services are promptly available. Written policy should exist delineating the prioritization/availability of the CT scanner for trauma patients. The use of teleradiology is acceptable. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.
2. The PI process must ensure that trauma patients are accompanied by appropriately trained licensed providers and that the appropriate resuscitation and monitoring are provided during transportation to and while in the radiology department.
3. The radiologist must ensure the preliminary interpretations are promptly reported to the trauma team and the PI Program must monitor all changes in interpretation.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.3. Clinical Laboratory Service

1. The clinical laboratory service shall have the following services available in-house 24 hours/day:
 - a. Access to a community central blood bank and adequate storage facilities. Sufficient quantities of blood and blood products should be maintained at all times. Blood typing and cross-match capabilities must be readily available.
 - b. Standard analysis of blood, urine, and other body fluids includes microsampling when appropriate.
 - c. Blood gas and Ph determinations (this function may be performed by services other than the clinical laboratory service, when applicable).

- d. Alcohol screening is required and drug screening is highly recommended.
 - e. Coagulation studies.
 - f. Microbiology
2. Sufficient numbers of clinical laboratory technologists shall be in-house 24 hours/day and promptly available at all times. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.4. Acute Hemodialysis: There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the Level III Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.5. Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the Level III Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.6. Rehabilitation/Social Services:

1. The rehabilitation of the trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to the trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services should minimally include; Occupational Therapy, Physical Therapy, and Speech Pathology.
2. The nature of traumatic injury requires that the psychological needs of the patient and family are considered and addressed in the acute stages of injury and throughout recovery. A Level III Trauma Center may utilize community resources as appropriate to meet the needs of the trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.7. Prevention/Public Outreach

1. Level III Trauma Centers must work cooperatively with referral facilities to develop and implement an outreach program for trauma care in the region. The Level III Trauma Center will work to plan, facilitate and provide professional education programs for the pre-hospital care providers, nurses and physicians, from referral facilities in their region. Prevention programs should be specific to the needs of the region. The trauma registry data should be utilized to identify injury trends and focus prevention needs.
2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills.
3. The Level III Trauma Center is responsible for working with the other centers to develop education and prevention programs for the public and professional staff. The plan must include implementation strategies to assure information dissemination to all residents in the region.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.8. Transfer Guidelines: The Level III trauma center will have transfer guidelines in place for Level I and Level II Trauma Centers, as well as for specialty referral centers (such as burn, pediatrics, spinal cord injury and rehabilitation) when these services are not available at the trauma center. Level III Trauma Centers should work in collaboration with the referral trauma facilities in their region and develop interfacility transfer guidelines. These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.9. Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional and state levels. Since these data relate to specific trauma patients and are used to evaluate and improve the quality of health care services, this data is confidential as provided in Miss. Code Ann. § 41-59-77. Level I and II trauma facilities may be responsible for direct assistance to Level III Trauma Center, referring facilities in providing data for inclusion in the registry.

2. Each trauma center must develop an internal Performance Improvement plan that minimally addresses the following key components:
 - a. An organizational structure that facilitates performance improvement (Multidisciplinary Trauma Committee).
 - b. Clearly defined authority and accountability for the program.
 - c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.
 - d. Development of expectations (criteria) from evidenced based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.
 - e. Explicit definitions of outcomes derived from institutional standards.
 - f. Documentation system to monitor performance, corrective action and the result of the actions taken.
 - g. A process to delineate privileges credentialing all trauma service physicians.
 - h. An informed peer review process utilizing a multidisciplinary method.
 - i. A method for comparing patient outcomes with computed survival probability.
 - j. Autopsy information on all deaths when available.
 - k. Review of prehospital care.
 - l. Review of times and reasons for trauma bypass.
 - m. Review of times and reasons for trauma transfers.
 - n. Audit of all trauma deaths.
 - o. Morbidity and Mortality review.
3. Representatives from the Level III Trauma Center shall participate in the Trauma Care Region and the statewide performance review process.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.10 Education: Level III Trauma Centers must have internal trauma education programs for physicians, mid-level providers, nurses, and pre-hospital providers (when employed by the hospital).

Effective November 15, 2013

Source: Miss. Code Ann. § 41-59-5

Chapter 5 Level IV Trauma Centers

Subchapter 1 Hospital Organization

Rule 5.1.1. General

1. Level IV Trauma Centers are generally licensed, small, rural facilities with a commitment to the resuscitation of the trauma patient and written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred. These facilities may be staffed by a physician, or a licensed mid-level practitioner (i.e., Physician Assistant or Nurse Practitioner) or Registered Nurse. The major trauma patient will be resuscitated and transferred.
2. This designation does not contemplate that Level IV Trauma Centers will have resources available for emergency surgery for the trauma patient.
3. Level IV Trauma Centers may meet the following standards in their own facility or through a formal affiliation with another trauma center.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.2. Hospital Departments/Divisions/Sections: The Level IV Trauma Center must have the following departments, divisions, or sections: Emergency Medicine

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.3. Trauma Program/Service

1. There must be a written commitment letter from the Board of Directors and the medical staff on behalf of the entire facility which states the facility's commitment to compliance with the Mississippi Trauma Care Regulations. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. A trauma program must be established and recognized by the organization. Compliance with the above will be evidenced by:
 - a. Board of Director's and medical staff letter of commitment;
 - b. Written policies, procedures and guidelines for care of the trauma patient;
 - c. A defined Trauma Team with written roles and responsibilities;
 - d. Appointed Trauma Medical Director with a written job description;
 - e. A written Trauma Performance Improvement Plan;

- f. Appointed Trauma Program Manager with a written job description;
- g. Documentation of trauma center representative's attendance at the Trauma Care Region meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.4. Trauma Medical Director (TMD)

1. The Level IV Trauma Center must have a physician director of the trauma program. In this instance, the physician is responsible for working with all members of the trauma team, and overseeing the implementation of a trauma specific performance improvement process for the facility. Through this process, he/she should have overall responsibility for the quality of trauma care rendered at the facility. The director must be given administrative support to implement the requirements specified by the Mississippi Trauma Plan. The director should assist in the development of standards of care and assure appropriate policies and procedures are in place for the safe resuscitation and transfer of trauma patients. The physician director must have current verification in ATLS. ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.
2. Compliance with the above will be evidenced by:
 - a. Chairing and participating in the committee where trauma performance improvement is presented;
 - b. Administrative support can be documented in the organizational chart which depicts the reporting relationship between the trauma program medical director and administration;
 - c. Trauma specific policies, procedures and guidelines approved by the TMD.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.5. Trauma Program Manager (TPM)

1. The trauma center must have a person to act as a liaison to the regional evaluation process to conduct many of the administrative functions required by the trauma program. It is not anticipated that this would be a full-time role. Specifically, this person is responsible, with the TMD, for coordinating optimal patient care for all injured victims. This position will ideally serve as liaison with local EMS personnel, the Trauma Care Region, and other trauma centers.
2. Compliance with the above will be evidenced by:

- a. Attendance at and participation in the committee where trauma performance improvement is presented;
- b. A written job description of roles and responsibilities to the trauma program which include: management of the trauma program, monitoring of clinical activities on trauma patients, providing staff with trauma related education, implementation of trauma specific performance improvement and supervision of the trauma registry;
- c. Documentation of collaboration with TMD in the development and implementation of trauma specific policies, procedures and guidelines.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.6. Trauma Team

1. The team approach is optimal in the care of the multiple injured patients. The trauma center must have a written policy for notification and mobilization of an organized trauma team to the extent that one is available. The Trauma Team may vary in size and composition when responding to the trauma activation. The physician leader or mid-level provider on the trauma team is responsible for directing all phases of the resuscitation in compliance with ATLS protocol. Suggested composition of the trauma team includes, if available:
 - a. Physicians and/or mid-level providers
 - b. Laboratory Technicians
 - c. Nursing
 - d. Ancillary Support Staff
2. Compliance with the above will be evidenced by:
 - a. A written resuscitation protocol which adheres to the principles of ATLS;
 - b. A written trauma team activation criteria policy which includes physiologic, anatomic and mechanism of injury criteria.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.7. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the system. The major focus will be on PI activities, policy development, communication among all team members, development of standards of care,

education and outreach programs, and injury prevention. The committee oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives (if available in the community) from:

- a. Emergency Medicine
 - b. Respiratory Therapy
 - c. Radiology
 - d. Laboratory
 - e. Rehabilitation
 - f. Pre-hospital Care Providers
 - g. Administration
 - h. Nursing
 - i. Trauma Program Manager
 - j. Trauma Medical Director (Chairman; must be present > 50%)
2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.
 3. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

Rule 5.2.1. Rule 5.2.1 Required Components

1. The trauma center must maintain published on-call schedules for physicians and/or mid-level providers on-call to the facility.
2. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 5.3.1. Emergency Department

1. The facility must have an emergency department staffed so trauma patients are assured immediate and appropriate initial care. There must be a designated physician director. It is not anticipated that a physician will be available on-call to an emergency department in a Level IV Trauma Center; however it is a desirable characteristic of a Level IV. The on-call practitioner must respond to the emergency department based on local written criteria. A system must be developed to assure early notification of the on-call practitioner. Compliance with this criterion must be documented and monitored by the Trauma Performance Improvement process.
2. All physicians and mid-level providers (Physician Assistant/Nurse Practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians. Rural Trauma Course (RTC) may be substituted for ATLS at Level IV Trauma Centers.
3. Emergency nurses staffing the trauma resuscitation area must be a current provider in TNCC. Nurses must obtain TNCC within 18 months of assignment to the ER. Adequate numbers of nurses must be available in-house 24 hours/day, to meet the need of the trauma patient. The nurse may perform other patient care activities within the hospital when not needed in the emergency department.
4. Compliance with the above will be evidenced by:
 - a. Published on-call list of practitioners to the Emergency Department;
 - b. Written trauma specific education plan for nurses;
 - c. Documentation of nursing staffing patterns to assure 24-hour coverage.
 - d. The list of required equipment necessary for the ED can be found on line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 5.4.1. General

1. It is not anticipated that Level IV Trauma Centers have any of the following services available:
 - a. Respiratory Therapy Services
 - b. Radiology Services
 - c. Clinical Laboratory Services
 - d. Acute Hemodialysis
2. There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the Level IV Trauma Center.
3. Should any of these services be available, the facility should make them available to the trauma patient as necessary and within the capabilities of the facility.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.2. Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the Level IV Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.3. Prevention/Public Outreach

1. The Level IV Trauma Center is responsible for working with other trauma centers and the Trauma Care Region to develop education and prevention programs for the public and professional staff.
2. Compliance with the above will be evidenced by documentation of collaborative efforts of trauma specific education and injury prevention programs with other trauma centers and/or the Trauma Care Region.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.4. Transfer Guidelines: All facilities will work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to ensure the most expedient, safe transfer of the patient. The transfer guidelines shall make certain that feedback is provided to the facilities and assure that this information becomes part of the trauma registry. All designated facilities will agree to provide service to the trauma patient regardless of their ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.5. Performance Improvement/Evaluation

1. The trauma center must develop and implement a trauma specific performance improvement plan. Key elements in trauma system planning are evaluation, measurement and improvement of performance. The goal is to decrease variation in care and improve patient outcomes.
2. Compliance with the above will be evidenced by:
 - a. Review of compliance with EMS Triage Guidelines and Protocols;
 - b. Compliance with written Trauma Team Activation Criteria;
 - c. Compliance with the principles of ATLS;
 - d. Peer Review of all trauma deaths to determine timeliness and appropriateness of care and preventability of death;
 - e. Review of trauma related morbidities for appropriateness of care and preventability;
 - f. Nursing Audit (clinical review of nursing documentation and quality of care rendered to trauma patients);
 - g. Review of timeliness and appropriateness of all transfers out;
 - h. Review of prehospital trauma care;
 - i. Review of times/reasons for trauma-related bypass;
3. This information must be documented and reported at a trauma specific meeting or in conjunction with other ongoing performance improvement committees in the facility.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.6. Education: Level IV Trauma Centers must have internal trauma education programs for physicians, mid-level providers, nurses, and pre-hospital providers (when employed by the hospital).

Chapter 6 Pediatric Trauma Centers

Subchapter 1 Tertiary Pediatric Trauma Centers

Rule 6.1.1. General

1. Tertiary Pediatric Trauma Centers shall act as regional tertiary care facilities at the hub of the trauma care system for injured pediatric patients. The facility shall have the ability to provide leadership and total care for every aspect of injury from prevention to rehabilitation. The Tertiary Pediatric Trauma Center must have adequate depth of resources and personnel.
2. A stand-alone Pediatric Trauma Center provides tertiary pediatric trauma care without sharing resources with another facility (i.e., CT scanner, radiology, surgeons, etc). Only Level I Trauma Centers and Stand-alone pediatric hospitals may qualify as a tertiary Pediatric Trauma Center.
3. The Tertiary Pediatric Trauma Centers have the responsibility of providing leadership in pediatric trauma education, trauma prevention, pediatric trauma research, and system planning.
4. The list of required equipment for Tertiary Pediatric Trauma Centers can be found on-line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.2. Hospital Departments/Divisions/Sections

1. The Tertiary Pediatric Trauma Center must have the following department, divisions, or sections:
 - a. Emergency medicine
 - b. General surgery (not required for stand-alone Pediatric Trauma enter)
 - c. Pediatric surgery
 - d. Orthopedic surgery
 - e. Neurological surgery
 - f. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.3. Pediatric Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of pediatric trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a pediatric trauma care program is sufficient. The pediatric trauma program must be established and recognized by the medical staff and hospital administration. The pediatric trauma program must come under the direction of a board-certified surgeon with special interest in pediatric trauma care. An identified hospital administrative leader must work closely with the pediatric trauma medical director to establish and maintain the components of the pediatric trauma program including appropriate financial support. The pediatric trauma program location in the organizational structure of the hospital must be under the overall adult trauma program and must be such that it may interact effectively with at least equal authority with other departments providing pediatric patient care. The administrative structure should minimally include an administrator, pediatric medical director, trauma program manager, trauma registrar, and the appropriate support staff. These resources must be captured under the organization of the adult trauma program. The pediatric trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care should be extended to all the involved departments.

2. Compliance with the above will be evidenced by but not confined to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for care of the pediatric trauma patient;
 - c. Defined pediatric trauma team and written roles and responsibilities;
 - d. Appointed pediatric trauma medical director with a written job description;
 - e. Appointed pediatric trauma program manager with a written job description;
 - f. A written pediatric trauma performance improvement plan;
 - g. Documentation of pediatric trauma center representative attendance at the regional trauma advisory committee meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.4. Pediatric Trauma Service: The pediatric trauma service must be established and recognized by the medical staff and be responsible for the overall coordination

and management of the system of care rendered to the injured pediatric patient. The pediatric trauma service will vary in each institution depending on the needs of the pediatric patient and the resources available. The pediatric trauma service must come under the organization of the adult trauma program (not required for a stand-alone facility) and direction of a surgeon who is board certified with special interest in pediatric trauma care. All pediatric patients with multiple system trauma or major injury must be evaluated by the pediatric trauma service. The surgeon responsible for the overall care of the pediatric patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.5. Pediatric Trauma Medical Director (TMD): Tertiary pediatric trauma centers must have a physician director of the pediatric trauma program. This role can be filled by the TMD of the adult trauma center. The pediatric TMD plays an important administrative role. The pediatric TMD must be a board-certified surgeon with a special interest in pediatric trauma care. The pediatric TMD will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the pediatric trauma program. The pediatric TMD must be given administrative support to implement the requirements specified by the State trauma plan. The pediatric TMD is responsible for working with the credentialing process of the hospital, and in consultation with the appropriate service chiefs, for recommending appointment and removal of physicians from the pediatric trauma team. He/she should cooperate with nursing administration to support the nursing needs of the pediatric trauma patient and develop treatment protocols for the pediatric trauma patient. The pediatric trauma medical director, in collaboration with the trauma program manager, should coordinate the budgetary process for the trauma program. The director must be currently certified in ATLS, maintain personal involvement in care of the injured pediatric patient, maintain education in pediatric trauma care, and maintain involvement in professional organizations. The pediatric TMD must be actively involved with the trauma system development at the community, regional, and state levels.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.6. Pediatric Trauma Program Manager

1. Tertiary pediatric trauma centers must have a registered nurse working in the role of the TPM. The TPM of the adult trauma center may assume this additional role; however, if a pediatric TPM is utilized, the pediatric TPM is to report and be held accountable by the adult TPM. Working in conjunction with the pediatric trauma medical director, the pediatric TPM is responsible for organization of the pediatric trauma program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The pediatric TPM is responsible for working with the pediatric trauma team to assure optimal patient care. There are many requirements for data coordination, PI, education, and prevention activities incumbent upon this position.

2. The pediatric TPM/designee should offer or coordinate services for pediatric trauma education. The pediatric TPM should liaison with local EMS personnel, the Department, the Trauma Care Regions, and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.7. Pediatric Trauma Team: The team approach is optimal in the care of the multiple injured pediatric patient. There must be identified members of the pediatric trauma team. Policies should be in place describing the respective role of all personnel on the pediatric trauma team. The composition of the pediatric trauma team will depend of the characteristics of the hospital and its staff. In some instances a tiered response may be appropriate. If a tiered response is employed written policy must be in place and the system monitored by the PI process. All physicians and/or mid-level providers on the pediatric trauma team responsible for directing the initial resuscitation of the pediatric trauma patient must be certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirement is waived for Board Certified Emergency Medicine and Board Certified General Surgery physicians. A pediatric ED physician and pediatric general/trauma surgeon are required members of the team. Additional members may include:

1. Anesthesiologist
2. Pediatricians
3. Laboratory technicians as dictated by clinical needs
4. Mental health/social services/radiology technicians
5. Pastoral care
6. Respiratory therapist
7. Nurses: ED, OR, ICU, etc.
8. Police/Security officers

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program including the pediatric trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the region. Each trauma center may choose to have one or more committees as needed to accomplish this task. One committee should be multidisciplinary and focus on pediatric trauma program oversight and leadership. The major focus will be on performance improvement (PI) activities,

pediatric trauma policy development, communication among all pediatric trauma team members, and establishment of pediatric trauma standards of care, education, and outreach programs for pediatric injury prevention. The committee has administrative and systematic control and oversees implementation of all pediatric trauma program services, meets regularly, takes attendance, maintains minutes, and works to correct overall pediatric trauma program deficiencies to optimize pediatric patient care. Suggested membership for the committee includes representatives from:

- a. Pediatric Emergency Medicine
 - b. Pediatric Surgery
 - c. Pediatric Orthopedics
 - d. Pediatric Neurosurgery
 - e. Anesthesia
 - f. Operating room
 - g. Intensive care
 - h. Respiratory Therapy
 - i. Radiology
 - j. Laboratory
 - k. Pediatric Rehabilitation
 - l. Pre-hospital care providers
 - m. Administration
 - n. Pediatrics
 - o. Nursing
 - p. Trauma Program Manager
 - q. Clinical managers (or designees) of the departments involved with pediatric trauma care should plan an active role with the committee
2. The pediatric trauma center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from departmental based review. This committee must meet regularly, maintain attendance, and maintain minutes. This committee

must report findings to the overall multidisciplinary trauma committee and hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.9. Required Clinical Components

1. Tertiary pediatric trauma centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:
2. Pediatric Emergency Medicine (in-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival. The ED liaison on the trauma team must be board certified, maintain 48 hours of trauma related CME over a three year period, and must maintain current ATLS certification. The liaison must attend a minimum of 50% of peer review committee meetings annually and must participate in the Multidisciplinary Trauma Committee.
3. Trauma/General/Pediatric Surgery (in-house 24 hours/day). The surgeon covering pediatric trauma call must be unencumbered and immediately available to respond to the pediatric trauma patient. The 24 hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. The surgeon is expected to be in the ED upon arrival of the seriously injured pediatric patient. The surgeon's participation in major therapeutic decisions, presence in the ED for major resuscitation, and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. The surgeon on-call must be dedicated to the trauma center and not on-call at any other hospital while on trauma call. A system must be developed to assure early notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. The surgery liaison on the trauma team must be board certified, maintain 48 hours of trauma related CME over a three year period, and must maintain current ATLS certification. The liaison must attend a minimum of 50% of peer review committee meetings annually and must participate in the Multidisciplinary Trauma Committee. Response time for Alpha Alert/Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 20 minutes from patient arrival.
4. Orthopedic Surgery. The pediatric orthopedic liaison on the pediatric trauma team must be board certified, maintain 48 hours of trauma related CME over 3 years, and it is desirable to maintain current ATLS certification. The orthopedic liaison to the pediatric trauma team must attend a minimum of 50% of the peer review committees annually and participate in the Multidisciplinary Trauma Committee. It is desirable to have the orthopedic surgeon dedicated to the pediatric trauma center solely while on-call, but if not dedicated, a published back-up call schedule

must be available. Response time for all trauma activations is 60 minutes from the time notified to respond.

5. Neurological Surgery. The neurosurgeons on the pediatric trauma team must be board certified. The pediatric neurosurgery liaison must maintain 48 hours of trauma related CME over 3 years, and it is desirable to maintain current ATLS certification. The pediatric neurosurgeon liaison to the pediatric trauma team must attend a minimum of 50% of the peer review committees annually and participate in the Multidisciplinary Trauma Committee. It is desirable to have the neurosurgeon dedicated to the pediatric trauma center solely while on-call, but if not dedicated, a published back-up call schedule must be available. Response time for all trauma activations is 30 minutes from the time notified to respond.
6. Anesthesia (in-house 24 hours/day). Anesthesia must be available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or certified nurse anesthetist (CRNA) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
7. The following specialists must be committed to pediatric trauma care, on-call and promptly available 24 hours/day:
 - a. Cardiac Surgery
 - b. Cardiology
 - c. Critical Care Medicine
 - d. Hand Surgery
 - e. Infectious Disease
 - f. Microvascular Surgery
 - g. Nephrology
 - h. Nutritional support
 - i. Obstetrics/Gynecologic Surgery
 - j. Ophthalmic Surgery

- k. Oral/Maxillofacial
- l. Pediatrics
- m. Pediatric Critical Care Medicine
- n. Pediatric Rehabilitation
- o. Plastic Surgery
- p. Pulmonary Medicine
- q. Radiology
- r. Thoracic Surgery*
- s. Child Life or Family Support Programs

* The trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to pediatric patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available for the injured pediatric patient (within 30 minutes of the time notified to respond).

- 8. Recognizing that early rehabilitation is imperative for the pediatric trauma patient, a physical medicine and pediatric rehabilitation specialist must be available for the pediatric trauma team.
- 9. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.10. Qualifications of Surgeons on the Trauma Team

- 1. Basic qualifications for pediatric trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board of Osteopathic Specialties, the Royal College of Physicians, the American Dental Association and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.
- 2. Alternate criteria in lieu of board certification are as follows:
 - a. A non-board certified general surgeon must have completed a surgical residency program.

- b. He/she must be licensed to practice medicine.
 - c. He/she must be approved by the hospital's credentialing committee for surgical privileges.
 - d. The surgeon must meet all criteria established by the pediatric trauma medical director to serve on the pediatric trauma team.
 - e. The surgeon's experience in caring for the pediatric trauma patient must be tracked by the trauma PI program.
 - f. The pediatric trauma medical director must attest to the surgeon's experience and quality as part of the recurring granting of pediatric trauma team privileges.
 - g. The pediatric trauma medical director using the trauma PI program is responsible for determining each general surgeon's ability to participate on the pediatric trauma team.
3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured pediatric patient to make key decisions about the management of the pediatric trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation, and rehabilitation (as appropriate in a tertiary pediatric trauma center), and determine if the patient needs transport to a higher level of care. If transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the tertiary pediatric trauma center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines should be written at the local level to determine which types of patient should be admitted to the tertiary pediatric trauma center or which patients should be considered for transfer to a higher level of care.
4. The pediatric surgeon liaison and general surgeon liaison (not required for stand-alone pediatric trauma center) must participate in a multidisciplinary trauma committee, the PI process, maintain peer review committee attendance greater than fifty percent (50%) over a year's period of time, and maintain 16 hours of trauma related CME each year. General Surgery and Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related CME every 3 years and must actively participate in an internal trauma education process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.11. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, emergency medicine physicians who are boarded in a specialty recognized by the American Board of Medical Specialists, a Canadian Board or other equivalent foreign board meets the requirements.
2. Alternate criteria for the non-boarded physician working in the Emergency Department are as follows:
 - a. He/she must be licensed to practice medicine.
 - b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.
 - c. The physicians meet all criteria established by the pediatric trauma and emergency medicine directors to serve on the pediatric trauma team.
 - d. The physician's experience in caring for the pediatric trauma patient must be tracked by the trauma PI program.
 - e. The pediatric trauma and emergency medicine directors must attend to the physician's experience and quality as part of the recurring granting of pediatric trauma team privileges.
 - f. Residency in Emergency Medicine is desirable.
3. The emergency medicine liaison must participate in a multidisciplinary trauma committee, the PI process, maintain peer review committee attendance greater than fifty percent (50%) over a year's period of time, and maintain 16 hours of trauma related CME each year. General Surgery and Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related CME every 3 years and must actively participate in an internal trauma education process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.12. Facility Standards-Emergency Medicine

1. The facility must have a dedicated pediatric emergency department so pediatric patients are assured immediate and appropriate initial care. The emergency physician must be in-house 24 hours/day and immediately available at all times. The emergency department medical director must meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and board certification in emergency medicine.

2. The director of the emergency department, along with the pediatric trauma medical director, will establish trauma-specific credentials that should exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification, and specialty board certification.
3. The emergency medicine physician will be responsible for activating the pediatric trauma team based on predetermined response protocols. He will provide trauma leadership and care for the pediatric trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the Multidisciplinary Trauma Committee and the trauma PI process.
4. There should be an adequate number of RN's staffing the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC) and participate in the ongoing PI process of the trauma program. Nurses must obtain TNCC within 18 months of assignment to the ER. There must be a written plan ensuring nurses maintain ongoing trauma specific education.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.13. Facility Standards-Surgical Suites/Anesthesia

1. The operating room (OR) must be staffed and available in-house 24 hours/day.
2. The Surgical nurses should participate in the care of the pediatric trauma patient and be competent in the surgical stabilization of the major pediatric trauma patient. The Surgical nurses are an integral member of the trauma team and must participate in the ongoing PI process of the pediatric trauma program and be represented on the Multidisciplinary Trauma Committee.
3. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergency pediatric patient during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.
4. The anesthesia department in a tertiary pediatric trauma center must be organized and run by an anesthesiologist who has a special interest in the care of the injured pediatric patient. If this is not the director, an anesthesiologist liaison with the same qualifications should be identified. Anesthesiologist on the pediatric trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council of Graduate Medical Education or the

American Board of Osteopathic Specialists and have board certification in anesthesia.

5. Anesthesia must be available in-house 24hours/day with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia requirements may be fulfilled by anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) who are capable of assessing emergency situations in pediatric trauma patient and of providing indicated treatment, including initiation of surgical anesthesia. When the CRNA or chief resident is used to meet this requirement, the staff Anesthesiologist will be advised and promptly available at all times and present for operations. Tertiary pediatric trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the pediatric trauma patient. The availability of the anesthesiologist and the absence of delays in operative anesthesia must be documents and monitored by the trauma PI process. The anesthesiologist liaison participating on the pediatric trauma team must participate in the Multidisciplinary Trauma Committee and the trauma PI process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.14. Facility Standards-PACU

1. Tertiary pediatric trauma centers must have a PACU staffed 24 hours/day and available to the postoperative pediatric trauma patient. Frequently it is advantageous to bypass the PACU and directly admit to the PICU. In this instance, the pediatric intensive care unit may meet these requirements.
2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. PACU staffing should be in sufficient number to meet the critical needs of the pediatric trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.15. Facility Standards-Pediatric ICU (PICU)

1. Tertiary pediatric trauma centers must have a PICU that meets the needs of the pediatric trauma patient.
2. The surgical director for the PICU must have obtained critical care training during a residency or fellowship and must have expertise in the preoperative and post injury care of the injured pediatric patient. This is best demonstrated by a certificate of added qualifications in surgical critical care from the American Board of Surgery and may also be fulfilled by documentation of active participation during the preceding 12 months in pediatric trauma patient PICU care and PICU administrative and critical care-related continuing medical education. The director is responsible for the quality of care and administration of

the PICU and will set policy and establish standards of care to meet the unique needs of the pediatric trauma patient.

3. The pediatric trauma service assumes and maintains responsibility for the care of the multiple injured pediatric patient. A surgically directed PICU physician team is essential. The team will provide in-house physician coverage for all PICU pediatric trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialists, but must be led by a qualified surgeon as determined by critical care credentials consistent with the medical staff privileging process of the institution.
4. There must be in-house physician coverage for the PICU at all times. A physician credentialed by the facility for critical care must be immediately available to the pediatric trauma patient in the PICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.
5. The pediatric trauma service must maintain the responsibility for the care of the patient as long as the patient remains critically ill. The pediatric trauma service must remain in charge of the patient and coordinate all therapeutic decisions. The responsible trauma surgeon or designee should write all orders, maintain control over all aspects of care, including but not limited to respiratory care and management of mechanical ventilation, placement and use of pulmonary catheters, management of fluid and electrolytes, antimicrobials, and enteral and parenteral nutrition.
6. Tertiary pediatric trauma centers must provide staffing in sufficient numbers to meet the critical needs of the pediatric trauma patient. Critical care nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. PICU nurses are an integral part of the pediatric trauma team and as such, should be represented on the Multidisciplinary Trauma Committee and participate in the PI process of the trauma program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.16. Clinical Support Services-Respiratory Therapy: The service must be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatment for the injured pediatric patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.17. Clinical Support Services-Radiological Services

1. A radiological service must have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological

procedures. Sonography, angiography, and MRI must be available to the pediatric trauma team. A technician must be in-house and immediately available for computerized tomography (CT) for both head and body. Specialty procedures such as angiography, MRI, and sonography may be covered with a technician on-call. If the technician is not in-house 24 hours/day for special procedures, the trauma PI process must document and monitor that the procedure is promptly available.

2. A board-certified radiologist should administer the department and participate actively in the trauma education and PI process. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must ensure the preliminary interpretations are promptly reported to the pediatric trauma team and the trauma PI program must monitor all changes in interpretations.
3. Written policy should exist delineating the prioritization/availability of the CT scanner for pediatric trauma patients. The trauma PI process must ensure that pediatric trauma patients are accompanied by appropriately trained licensed providers and that the appropriate resuscitation and monitoring are provided during transport to and while in the radiology department.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.18. Clinical Support Services-Laboratory Services

1. Clinical laboratory service must have the following services available in-house 24 hours/day:
 - a. Access to blood bank and adequate storage facilities. Sufficient quantities of blood and blood products must be maintained at all times. Blood typing and cross-match capabilities must be readily available.
 - b. Standard analysis of blood, urine and other body fluids including micro-sampling when appropriate.
 - c. Blood gas and pH determinations (this function may be performed by services other than the clinical laboratory service, when applicable).
 - d. Alcohol screening is required and drug screening is highly recommended.
 - e. Coagulation studies.
 - f. Microbiology.
2. Sufficient numbers of clinical laboratory technologists shall be in-house 24 hours/day and promptly available at all times. It is anticipated that facilities may

cross-train personnel for other roles. This is acceptable as long as there is no response delay.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.19. Clinical Support Services-Acute Hemodialysis: Tertiary pediatric trauma centers must have Acute Hemodialysis services.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.20. Clinical Support Services-Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the tertiary pediatric trauma center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.21. Clinical Support Services-Rehabilitation/Social Services

1. The rehabilitation of the pediatric trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the pediatric trauma patient, at the earliest stage possible after admission to the tertiary pediatric trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services should minimally include: occupational therapy, physical therapy, and speech pathology.
2. The nature of traumatic injury requires that the psychological needs of the pediatric patient and family are considered and addressed in the acute stages of injury and throughout the continuum of recovery. Adequate number of trained personnel must be available to the pediatric trauma patient and family. Programs, such as Child Life, must be available to meet the unique needs of the pediatric trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.22. Clinical Support Services-Prevention/Public Outreach

1. Tertiary pediatric trauma centers will be responsible for taking a lead role in coordination of appropriate agencies, professional groups, and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. Prevention program must be specific to the needs of the region. The trauma registry data must be utilized to identify injury trends and focus prevention needs.
2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at the tertiary pediatric trauma center must provide consultation to staff members of other level facilities. For example ATLS, Pre-Hospital Trauma Life Support (PHTLS), TNCC, and Transport Nurse Advance Trauma Course (TNATC) courses can be coordinated by the tertiary pediatric trauma center. Trauma physicians must provide a formal follow-up to referring physicians/designee about specific patients to educate the practitioners for the benefit of trauma injured pediatric patients.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.23. Clinical Support Services-Transfer Guidelines: Tertiary pediatric trauma centers should work in collaboration with the referral facilities in the system and develop interfacility transfer guidelines. These guidelines must address criteria to identify high-risk pediatric trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the pediatric trauma patient regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.24. Clinical Support Services-Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional, and state levels. Since these data relate to the specific trauma patients and are used to evaluate and improve the quality of health care services, the data is confidential as provided in Miss. Code An. 41-59-77.
2. The tertiary pediatric trauma center must develop an internal trauma specific Performance Improvement (PI) plan that is pediatric specific and must minimally address the following key components. The pediatric PI plan must be fully integrated into the hospital wide PI program:
3. An organized structure that facilitates performance improvement. (Multidisciplinary Trauma Committee)

- a. Clearly defines authority and accountability for the program.
 - b. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.
 - c. Development of expectations (criteria) from evidence based guidelines, pathways and protocols.
 - d. These should be appropriate, objectively defined standards to determine quality of care.
 - e. Explicit definitions of outcomes derived from institutional standards.
 - f. Documentation system to monitor performance, corrective action, and the result of the actions taken.
 - g. A process to delineate credentialing of all trauma service physicians.
 - h. An informed peer review process utilizing a multidisciplinary method.
 - i. A method of comparing patient outcomes with computed survival probability.
 - j. Autopsy information on all deaths when available.
 - k. Review of pre-hospital care.
 - l. Review of times and reasons for trauma bypass.
 - m. Review of times and reasons for trauma transfers.
 - n. Morbidity and mortality review.
4. Representatives from the tertiary pediatric trauma center shall participate in the Trauma Care Region(s) and statewide performance improvement process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.25. Clinical Support Services-Education: Tertiary pediatric trauma centers must have medical education programs including educational training in pediatric trauma for physicians, nurses, and pre-hospital providers. The tertiary pediatric trauma center must take a leadership role in providing educational activities. Education can be accomplished via many mechanisms (i.e., classic CME, preceptorships, fellowships, clinical rotations, telecommunications or providing locum tenens, etc.)

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.26. Clinical Support Services-Research

1. The trauma research program must be designated to produce new knowledge applicable to the care of the injured patients. The research may be conducted in a number of ways including traditional laboratory and clinical research, reviews of clinical series, and epidemiological or other studies. Publications of articles in peer-review journals as well as presentations of results in local, regional, and national meetings and ongoing studies approved by human and animal research review boards are expected from productive programs. The program should have an organized structure that fosters and monitors ongoing productivity.
2. The research program must be balanced to reflect the number of different interests. There must be a research committee, and identifiable Institutional Review Board process, active research protocols, surgeons involved in extramural educational presentations and adequate number of peer reviewed scientific publications. Publications should appear in peer-reviewed journals. In a three-year cycle, the suggested minimum activity is ten publications (per review cycle) from the physicians representing the membership of the Trauma Team.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Secondary Pediatric Trauma Center

Rule 6.2.1. General

1. A secondary pediatric trauma center is an acute care facility with the commitment, medical staff, personnel and specialty training necessary to provide initial resuscitation of the pediatric trauma patient. Pediatric patients should remain at the secondary pediatric trauma center only for orthopedic injuries. The decision to transfer a pediatric patient rests with the physician attending the pediatric trauma patient. All secondary pediatric trauma centers will work collaboratively with other trauma facilities to develop transfer protocols and a well-defined transfer sequence.
2. As a minimum, only Level III or higher adult trauma centers may qualify as a Secondary Pediatric Trauma Center. All pediatric trauma admissions will be reviewed by the PI process.
3. The list of required equipment for Secondary Pediatric Trauma Centers can be found on-line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.2. Hospital Departments/Divisions/Sections: The secondary pediatric trauma center must have the following departments, divisions, or sections:

1. Emergency Medicine

2. General Surgery
3. Orthopedic Surgery
4. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.3. Pediatric Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of pediatric trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a pediatric trauma care program may be sufficient. The pediatric trauma program must be established and recognized by the medical staff and hospital administration. The pediatric trauma program must come under the direction of a board-certified surgeon with a special interest in trauma care. An administrative structure should ideally include an administrator, medical director, trauma program manager, trauma registrar, and other appropriate staff. As minimum, an identified hospital administrative leader should work closely with the pediatric trauma medical director to establish and maintain the components of the pediatric trauma program including appropriate financial support. The pediatric trauma program location in the organizational structure of the hospital should be placed so that it may interact effectively with at least equal authority with other departments providing patient care. The pediatric trauma program should be multidisciplinary in nature and the performance improvement evaluation of this care must extend to all the involved departments.
2. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for care of the pediatric trauma patient;
 - c. Defined trauma team and written roles and responsibilities;
 - d. Appointed Trauma Medical Director with a written job description;
 - e. Appointed Trauma Program Manager with a written job description;
 - f. A written Trauma Performance Improvement plan;
 - g. Documentation of trauma center representative attendance at the Trauma Care Region(s) meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.4. Pediatric Trauma Service: A Pediatric Trauma Service is an organized structure of care for the pediatric patient. The Pediatric Trauma Service must be established and recognized by the medical staff. The service includes personnel and resources necessary to ensure the appropriate efficient care delivery. The composition of the service will vary depending on the nature of the medical center, available resources and personnel and patient clinic need. The Pediatric Trauma Service must come under the organization and direction of a surgeon who is board certified with special interest in pediatric trauma care. All pediatric patients with multiple system trauma or major injury must be evaluated by the Pediatric Trauma Service. Injured pediatric patients may be admitted to individual surgeons.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.5. Pediatric Trauma Medical Director

1. Secondary pediatric trauma centers must have a physician director of the pediatric trauma program. The pediatric trauma medical director plays an important administrative role. The pediatric trauma medical director must be a board-certified surgeon with special interest in pediatric trauma care. The pediatric trauma medical director will be responsible for developing a performance improvement process and, through this process, will have overall accountability for all pediatric trauma patients and administrative authority for the hospital's pediatric trauma program. The pediatric trauma medical director must be given administrative support to implement the requirements specified by the State Trauma Plan. The director is responsible for working with the credentialing process of the hospital and, in consultation with the appropriate service chiefs, recommending appointment and removal of physicians from the pediatric trauma team. He/she should cooperate with nursing administration to support the nursing needs of the pediatric trauma patient and develop treatment protocols for the pediatric trauma patients. The director in collaboration with the Trauma Program Manager/TPM should coordinate the budgetary process for the pediatric trauma program.
2. The pediatric trauma medical director must be currently certified by the American College of Surgeons Advanced Trauma Life Support (ATLS), maintain personal involvement in the care of the injured pediatric patient. The pediatric trauma medical director, or designee, must be actively involved with the trauma system development at the community, regional and state level.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.6. Pediatric Trauma Program Manager (TPM)

1. Secondary pediatric trauma centers must have a registered nurse working in the role of the TPM. The TPM of the adult trauma center may assume this additional role; however, if a pediatric TPM is utilized, the pediatric TPM is to report and be held accountable by the adult TPM. Working in conjunction with the pediatric trauma medical director, the pediatric TPM is responsible for organization of the pediatric trauma program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The pediatric TPM is responsible for working with the pediatric trauma team to assure optimal patient care. There are many requirements for data coordination, PI, education, and prevention activities incumbent upon this position.
2. The pediatric TPM/designee should offer or coordinate services for pediatric trauma education. The pediatric TPM should liaison with local EMS personnel, the Department, the Trauma Care Regions, and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.7. Pediatric Trauma Team

1. The team approach is optimal in the care of the multiple injured pediatric patients. There must be identified members of the pediatric trauma team. Policies shall be in place describing the roles of all personnel on the pediatric trauma team. The composition of the pediatric trauma team in any hospital will depend on the characteristics of that hospital and its resources. In some instances, a tiered response may be appropriate. If a tiered response is employed, written policy must be in place and the system monitored by the PI process. The team leader must be a qualified general and/or pediatric surgeon. All physicians and mid-level providers on the pediatric trauma team responsible for directing any phase of the resuscitation must be currently certified in ATLS. ATLS requirement is waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.
2. Recommended composition of the pediatric trauma team for severely injured pediatric patients may include:
 - a. Physicians and/or mid-level providers (Physician Assistant/Nurse Practitioner)
 - b. Specialists
 - c. Laboratory Technicians as dictated by clinical needs
 - d. Nursing, ED, OR, ICU, etc
 - e. Auxiliary Support Staff

- f. Respiratory Therapists
- g. Security Officers

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated pediatric trauma center in the system. The major focus will be on PI activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and injury prevention. The committee has administrative and systematic control and oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize pediatric patient care. Suggested membership for the committee includes representatives (if available in the community) from:
 - a. Administration
 - b. Orthopedics
 - c. Anesthesia
 - d. Pediatrics
 - e. Emergency Department
 - f. Prehospital Care Providers
 - g. General and Pediatric Surgery
 - h. Radiology
 - i. Intensive Care
 - j. Rehabilitation
 - k. Laboratory
 - l. Respiratory Therapy
 - m. Nursing
 - n. Trauma Program Manager/TPM
 - o. Operating Room

2. The clinical managers (or designees) of the departments involved with pediatric trauma care should plan an active role with the committee.
3. The pediatric trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.9. Required Clinical Components

1. Secondary pediatric trauma centers must have published on-call schedules and have the following medical specialists immediately available 24 hours/day to the injured pediatric patient:
2. Pediatric Emergency Medicine (in-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
3. Trauma/General or Pediatric Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the pediatric trauma center and not on-call to any other hospital while on pediatric trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 45 minutes from patient arrival.
4. Orthopedic Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the pediatric trauma center and not on-call to any other hospital while on pediatric trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for all trauma activations is 60 minutes from the time notified to respond.
5. Anesthesia. Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be available 24 hours/day. Anesthesia chief residents or certified nurse anesthetist (CRNA) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and

assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

6. The following specialists must be on-call and promptly available:
 - a. Pediatrics
 - b. Radiology
7. It is desirable (although not required) to have the following specialists available to the secondary pediatric trauma center:
 - a. Hand Surgery
 - b. Obstetrics/Gynecology Surgery
 - c. Ophthalmic Surgery
 - d. Oral/Maxillofacial Surgery
 - e. Plastic Surgery
 - f. Critical Care Medicine
 - g. Thoracic Surgery*

* The trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to pediatric patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available for the injured pediatric patient (within 30 minutes of the time notified to respond).
8. The staff specialist on-call will be notified at the discretion of the trauma surgeon and will be promptly available. The PI program will continuously monitor this availability.
9. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.10. Qualifications of Surgeons on the Trauma Team

1. Basic to qualifications for trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialists, the Advisory Board of Osteopathic Specialists, the American Dental Association, the

Royal College of Physicians and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognized by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.

2. Alternate criteria in lieu of board certifications are as follows:
 - a. Non-board certified general surgeons must have completed a surgical residency program.
 - b. He/she must be licensed to practice medicine.
 - c. He/she must be approved by the hospital's credentialing committee for surgical privileges.
 - d. The surgeon must meet all criteria established by the pediatric trauma medical director to serve on the pediatric trauma team.
 - e. The surgeon's experience in caring for the pediatric trauma patient must be tracked by the PI program.
 - f. The pediatric trauma medical director must attest to the surgeon's experience and quality as part of the recurring granting of pediatric trauma team privileges.
 - g. The pediatric trauma medical director, using the pediatric trauma PI plan is responsible for determining each general surgeon's ability to participate on the pediatric trauma team.
3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured pediatric patient to make key decisions about the management of the pediatric trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a secondary pediatric trauma center) and determine if the pediatric patient needs transport to a higher level of care. If transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the pediatric patient is to be admitted to the secondary pediatric trauma center, the surgeon is the admitting physician and will coordinate the pediatric patient care while hospitalized. Guidelines should be written at the local level to determine which types of pediatric patients should be admitted to the secondary pediatric trauma center or which pediatric patient should be considered for transfer to a higher level of care.
4. The general surgeons and emergency physicians must participate in a multidisciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent over a year's period of time. General

surgeons and emergency physicians must demonstrate evidence of participation in the internal trauma education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.11. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, career emergency medicine physicians who are board certified in a specialty recognized by the American Board of Medical Specialties, a Canadian Board or other equivalent foreign board meets the requirements.
2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:
 - a. He/she must be licensed to practice medicine.
 - b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.
 - c. The physicians must meet all criteria established by the pediatric trauma and emergency medical director to serve on the pediatric trauma team.
 - d. The physician's experience in caring for the pediatric trauma patient must be tracked by the PI program.
 - e. The pediatric trauma and emergency medical director must attest to the physician's experience and quality as part of the recurring granting of pediatric trauma team privileges.
 - f. Residency in Emergency Medicine is desirable.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.12. Facility Standards-Emergency Medicine

1. The facility must have an emergency department, division, service or section staffed so those trauma patients are assured immediate and appropriate initial care. The facility should have a dedicated pediatric emergency area so pediatric patients are assured immediate and appropriate initial care. The emergency physician must be in-house 24 hours/day, immediately available at all times, and capable of evaluating pediatric trauma patients and providing initial resuscitation. The emergency medicine physician will provide team leadership and care for the pediatric trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the pediatric trauma patient. The

medical director for the department, or designee, must participate with the Multidisciplinary Trauma Committee and the pediatric trauma PI process.

2. The director of the emergency department, along with the pediatric trauma medical director, may establish trauma-specific credentials that should exceed those that are required for general hospital privileges (i.e. ATLS verification).
3. There should be an adequate number of RNs staffed for the pediatric trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the pediatric trauma resuscitation area must be a current provider of TNCC and participate in the ongoing PI process of the trauma program. Nurses must obtain TNCC within 18 months of assignment to the ER. There must be a written plan ensuring nurses maintain ongoing trauma specific education.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.13. Facility Standards-Surgical Suites/Anesthesia

1. The surgical team must be on-call with a well-defined mechanism for notification to expedite transfer to the operating room if the pediatric patient's condition warrants. The process should be monitored by the pediatric trauma PI program.
2. The OR nurses should participate in the care of the pediatric trauma patient and be competent in the surgical stabilization of the major pediatric trauma patient. The surgical nurses are integral members of the pediatric trauma team and must participate in the ongoing PI process of the pediatric trauma program and must be represented on the Multidisciplinary Trauma Committee.
3. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent pediatric trauma patient during a busy operative schedule.
4. Anesthesia must be promptly available with a mechanism established to ensure notification of the on-call anesthesiologist. The secondary pediatric trauma center must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the pediatric trauma patient.
5. Anesthesiologists on the pediatric trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council for Graduate Medical Education, the American Board of Osteopathic Specialists, or the American Osteopathic Board and should have board certification in anesthesia.
6. Anesthesia requirements may be fulfilled by Certified Registered Nurse Anesthetists (CRNAs) and/or anesthesia residents who are capable of assessing emergency situations in pediatric trauma patients and of providing an indicated treatment, including initiation of surgical anesthesia. When the CRNA is used to

meet this requirement, the staff anesthesiologist will be advised and promptly available at all times and present for operations. Secondary pediatric trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the pediatric trauma patient. The availability of the anesthesiologist and the absence of delays in operative anesthesia must be documented and monitored by the PI process. The anesthesiologist participating on the pediatric trauma team should have the necessary educational background in the care of the pediatric trauma patient and must participate in the Multidisciplinary Trauma Committee and the pediatric trauma PI process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.14. Facility Standards-PACU

1. A secondary pediatric trauma center must have a PACU available 24 hours/day to the postoperative pediatric trauma patient. Hospital policy must be written to assure early notification and prompt response. Frequently it is advantageous to bypass the PACU and directly admit to the ICU. In this instance, the ICU may meet these requirements.
2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing critical care education. PACU staffing should be in sufficient numbers to meet the critical need of the pediatric trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.15. Facility Standards-ICU

1. The ICU must have a surgical director or a surgical co-director who is responsible to set policy and administration and establish standards of care to meet the unique needs of the pediatric trauma patient. He/she is responsible for the quality of care and administration of the ICU. The pediatric trauma medical director must work to assure pediatric trauma patients admitted to the ICU will be admitted to the care of the general surgeon or appropriate surgical subspecialists. In addition to overall responsibility for pediatric patient care by the primary surgeon, it is desirable to have in-house physician coverage for the ICU at all times. This may be provided by a hospitalist or emergency physician.
2. Secondary pediatric trauma centers should provide staffing in sufficient numbers to meet the needs of the pediatric trauma patient. There must be a written plan ensuring nurses maintain ongoing critical care education. ICU nurses are an integral part of the pediatric trauma team and as such, should be represented on the Multidisciplinary Trauma Committee and participate in the PI process of the pediatric trauma program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.16. Clinical Support Services-Respiratory Therapy: The service must be staffed with qualified personnel on-call 24 hours/day to provide the necessary treatments for the injured pediatric patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.17. Clinical Support Services-Radiological Services

1. A board-certified radiologist should administer the department and participate actively in the pediatric trauma PI process. The radiologist is a key member of the pediatric trauma team and should be represented on the Multidisciplinary Trauma Committee. A certified radiologist technician must be available in-house 24 hours/day to meet the immediate needs of the pediatric trauma patient for general radiological procedures. Sonography should be available to the pediatric trauma team. If the radiology technician and the specialty technician are on-call from home, a mechanism must be in place to assure the technicians are available. The PI process must verify that radiological services are promptly available. Written policy should exist delineating the prioritization/availability of the CT scanner for pediatric trauma patients. The use of teleradiology is acceptable. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.
2. The PI process must ensure that pediatric trauma patients are accompanied by appropriately trained licensed providers and that the appropriate resuscitation and monitoring are provided during transportation to and while in the radiology department.
3. The radiologist must ensure the preliminary interpretations are promptly reported to the pediatric trauma team and the PI program must monitor all changes in interpretation.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.18. Clinical Support Services-Laboratory Services: The clinical laboratory service shall have the following services available in-house 24 hours/day:

1. Access to a community central blood bank and adequate storage facilities. Sufficient quantities of blood and blood products should be maintained at all times. Blood typing and cross-match capabilities must be readily available.
2. Standard analysis of blood, urine, and other body fluids includes micro-sampling when appropriate.
3. Blood gas and pH determination (this function may be performed by services other than the clinical laboratory service, when applicable).

4. Alcohol screening is required and drug screening is highly recommended.
5. Coagulation studies.
6. Microbiology.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.19. Clinical Support Services-Acute Hemodialysis: There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the secondary pediatric trauma center.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.20. Clinical Support Services-Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the secondary pediatric trauma center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient. The transfer protocols must include a feedback loop so that the primary provider has a good understanding of the patient outcome.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.21. Clinical Support Services-Rehabilitation/Social Services

1. The rehabilitation of the pediatric trauma patient and the continued support of the family members are important parts of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the pediatric trauma patient at the earliest stage possible after admission to the secondary pediatric trauma center. Secondary pediatric trauma centers will be required to identify a mechanism to initiate rehabilitation services and/or consultations in a timely manner, as well as to develop policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services must include Physical Therapy and Social Service. It is desirable to have Occupational and Speech Therapy.
2. The nature of traumatic injury requires that the psychological needs of the pediatric trauma patient and family are considered and addressed in the acute states of injury and throughout recovery. A secondary pediatric trauma center may utilize community resources as appropriate to meet the needs of the pediatric trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.22. Clinical Support Services-Prevention/Public Outreach

1. Secondary pediatric trauma centers must work cooperatively with referral facilities to develop and implement an outreach program for pediatric trauma care in the region. The secondary pediatric trauma center will work to plan, facilitate and provide professional education programs for the pre-hospital care providers, nurses and physicians, from referral facilities in their region. Prevention programs should be specific to the needs of the region. The trauma registry data should be utilized to identify injury trends and focus prevention needs.
2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills.
3. The secondary pediatric trauma center is responsible for working with other centers to develop education and prevention programs for the public and professional staff. The plan must include implementation strategies to assure information dissemination to all residents in the region.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.23. Clinical Support Services-Transfer Guidelines: The secondary pediatric trauma center will have transfer guidelines in place with tertiary pediatric trauma centers, as well as all specialty referral centers (such as burns, spinal cord injury and rehabilitation) when these services are not available at the secondary pediatric trauma center. Secondary pediatric trauma centers should work in collaboration with the referral trauma facilities in the system and develop interfacility transfer guidelines. These guidelines must address criteria to identify high-risk pediatric patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the pediatric trauma patient regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.24. Clinical Support Services-Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional and state levels. Since these data relate to specific trauma patients and are used to evaluate and improve the quality of health care services, the data is confidential as provided by Miss. Code Ann. §41-59-77. Tertiary pediatric trauma facilities may be responsible for direct assistant to primary and secondary pediatric trauma centers, referring facilities in providing data for inclusion in the registry. All

pediatric admissions that meet Trauma Registry inclusion criteria shall be reviewed by the PI process.

2. Each trauma center must develop an internal Pediatric Performance Improvement plan that minimally addresses the following key components:
 - a. An organizational structure that facilitates performance improvement (Multidisciplinary Trauma Committee).
 - b. Clearly defined authority and accountability for the program.
 - c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.
 - d. Development of expectations (criteria) from evidence based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.
 - e. Explicit definitions of outcomes derived from institutional standards.
 - f. Documentation system to monitor performance, corrective action and the result of actions taken.
 - g. A process to delineate privileges credentialing all trauma service physicians.
 - h. An informed peer review process utilizing a multidisciplinary method.
 - i. A method for comparing patient outcomes with computed survival probability.
 - j. Autopsy information on all deaths when available.
 - k. Review of prehospital care.
 - l. Review of times and reasons for trauma bypass.
 - m. Review of times and reasons for trauma transfers.
 - n. Audit of all trauma deaths.
 - o. Morbidity and Mortality review.
3. Representatives from the secondary pediatric trauma center shall participate in the Trauma Care Region(s) and the statewide performance review process.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Primary Pediatric Trauma Center

Rule 6.3.1. General: Primary pediatric trauma centers are facilities with a commitment to the resuscitation of the pediatric trauma patient and have written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred. All designated Trauma Centers shall, as a minimum, be designated as a Primary Pediatric Trauma Center as a condition of designation in the Mississippi Trauma Care System. The list of required equipment for Primary Pediatric Trauma Centers can be found on-line at the department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.2. Hospital Departments/Divisions/Sections: The Primary Pediatric Trauma Center must have the following departments, divisions, or sections: Emergency Medicine

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.3. Trauma Program/Service

1. There must be a written commitment letter from the Board of Directors and the medical staff on behalf of the entire facility which states the facility's commitment to compliance with the Mississippi Trauma Care Regulations. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. A trauma program must be established and recognized by the organization. Compliance with the above will be evidenced by:
 - a. Board of Director's and medical staff letter of commitment;
 - b. Written policies, procedures and guidelines for care of the adult and pediatric trauma patient;
 - c. A defined Trauma Team with written roles and responsibilities;
 - d. Appointed Trauma Medical Director with a written job description;
 - e. A written Trauma Performance Improvement Plan which includes pediatric trauma indicators;
 - f. Appointed Trauma Program Manager with a written job description;
 - g. Documentation of trauma center representative's attendance at the Trauma Care Region meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.4. Trauma Medical Director (TMD)

1. The Primary Pediatric Trauma Center must have a physician director of the trauma program. In this instance, the physician is responsible for working with all members of the trauma team, and overseeing the implementation of a trauma specific performance improvement process for the facility. Through this process, he/she should have overall responsibility for the quality of trauma care rendered at the facility, both adult and pediatric. The director must be given administrative support to implement the requirements specified by the Mississippi Trauma Plan. The director should assist in the development of standards of care and assure appropriate policies and procedures are in place for the safe resuscitation and transfer of trauma patients. The physician director must have current verification in ATLS. ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.
2. Compliance with the above will be evidenced by:
 - a. Chairing and participating in the committee where trauma performance improvement is presented;
 - b. Administrative support can be documented in the organizational chart which depicts the reporting relationship between the trauma program medical director and administration;
 - c. Trauma specific policies, procedures and guidelines approved by the TMD.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.5. Rule 6.3.5 Trauma Program Manager (TPM)

1. The Primary Pediatric Trauma Center must have a person to act as a liaison to the regional evaluation process to conduct many of the administrative functions required by the trauma program. It is not anticipated that this would be a full-time role. Specifically, this person is responsible, with the TMD, for coordinating optimal patient care for all injured victims, both adult and pediatric. This position will ideally serve as liaison with local EMS personnel, the Trauma Care Region, and other trauma centers.
2. Compliance with the above will be evidenced by:
 - a. Attendance at and participation in the committee where trauma performance improvement is presented;
 - b. written job description of roles and responsibilities to the trauma program which include: management of the trauma program, monitoring of clinical

activities on trauma patients, providing staff with trauma related education, implementation of trauma specific performance improvement and supervision of the trauma registry;

- c. Documentation of collaboration with TMD in the development and implementation of trauma specific policies, procedures and guidelines.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.6. Trauma Team

1. The team approach is optimal in the care of the multiple injured patients. The trauma center must have a written policy for notification and mobilization of an organized trauma team to the extent that one is available. The Trauma Team may vary in size and composition when responding to the trauma activation. The physician leader or mid-level provider on the trauma team is responsible for directing all phases of the resuscitation in compliance with ATLS protocol. Suggested composition of the trauma team includes, if available:
 - a. Physicians and/or mid-level providers
 - b. Laboratory Technicians
 - c. Nursing
 - d. Ancillary Support Staff
2. Compliance with the above will be evidenced by:
 - a. A written resuscitation protocol which adheres to the principles of ATLS;
 - b. A written trauma team activation criteria policy which includes physiologic, anatomic and mechanism of injury criteria for both adult and pediatric patients.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.7. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the system. The major focus will be on PI activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and injury prevention. The committee oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall

program deficiencies to optimize patient care. Required membership for the committee includes representatives (if available in the community) from:

- a. Administration
 - b. Emergency Department
 - c. Prehospital Care Providers
 - d. Radiology
 - e. Rehabilitation
 - f. Laboratory
 - g. Respiratory Therapy
 - h. Nursing
 - i. Trauma Program Manager
 - j. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.
2. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.8. Required Clinical Components/Facility Standards-Emergency Medicine

1. The trauma center must maintain published on-call schedules for physicians and/or mid-level providers on-call to the facility.
2. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
3. The facility must have an emergency department staffed so trauma patients are assured immediate and appropriate initial care. There must be a designated physician director. It is not anticipated that a physician will be available on-call to an emergency department in a Primary Pediatric Trauma Center; however it is a desirable characteristic. The on-call practitioner must respond to the emergency department based on local written criteria. A system must be developed to assure

early notification of the on-call practitioner. Compliance with this criterion must be documented and monitored by the Trauma Performance Improvement process.

4. Emergency nurses staffing the trauma resuscitation area must be a current provider in TNCC. Nurses must obtain TNCC within 18 months of assignment to the ER. Adequate numbers of nurses must be available in-house 24 hours/day, to meet the need of the trauma patient. The nurse may perform other patient care activities within the hospital when not needed in the emergency department.
5. Compliance with the above will be evidenced by:
 - a. Published on-call list of practitioners to the Emergency Department;
 - b. Written trauma specific education plan for nurses;
 - c. Documentation of nursing staffing patterns to assure 24-hour coverage.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.9. Clinical Support Services-General

1. It is not anticipated that a Primary Pediatric Trauma Centers have any of the following services available:
 - a. Respiratory Therapy Services
 - b. Radiology Services
 - c. Clinical Laboratory Services
 - d. Acute Hemodialysis
2. There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the primary pediatric trauma center.
3. Should any of these services be available, the facility should make them available to the pediatric trauma patient as necessary and within the capabilities of the facility.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.10. Clinical Support Services-Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the primary pediatric trauma center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient. The transfer protocols must include a feedback loop so that the primary provider has a good understanding of the patient outcome.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.11. Clinical Support Services-Prevention/Public Outreach

1. The Primary Pediatric Trauma Center is responsible for working with other trauma centers and the Trauma Care Region to develop education and prevention programs for the public and professional staff.
2. Compliance with the above will be evidenced by documentation of collaborative efforts of trauma specific education and injury prevention programs with other trauma centers and/or the Trauma Care Region.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.12. Clinical Support Services-Transfer Guidelines: All pediatric trauma facilities will work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to ensure the most expedient, safe transfer of the patient. The transfer guidelines shall make certain that feedback is provided to the facilities and assure that this information becomes part of the trauma registry. All designated facilities will agree to provide service to the trauma patient regardless of their ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.13. Clinical Support Services-Performance Improvement/Evaluation

1. The trauma center must develop and implement a trauma specific performance improvement plan. Key elements in trauma system planning are evaluation, measurement and improvement of performance. The goal is to decrease variation in care and improve patient outcomes. All pediatric admissions that meet Trauma Registry inclusion criteria shall be reviewed by the hospital and Trauma Region PI process.
2. Compliance with the above will be evidenced by:
 - a. Review of compliance with EMS Triage Guidelines and Protocols;
 - b. Compliance with written Trauma Team Activation Criteria;
 - c. Compliance with the principles of ATLS;
 - d. Peer Review of all trauma deaths to determine timeliness and appropriateness of care and preventability of death;
 - e. Review of trauma related morbidities for appropriateness of care and preventability;

- f. Nursing Audit (clinical review of nursing documentation and quality of care rendered to trauma patients);
 - g. Review of timeliness and appropriateness of all transfers out;
 - h. Review of prehospital trauma care;
 - i. Review of times/reasons for trauma-related bypass;
3. This information must be documented and reported at a trauma specific meeting or in conjunction with other ongoing performance improvement committees in the facility.

Source: Miss. Code Ann. § 41-59-5

Chapter 7 Burn Centers

Subchapter 1 Hospital Organization

Rule 7.1.1. General: The burn center must be an acute care facility licensed in Mississippi. The burn center must have a medical and an administrative commitment to the care of patients with burns. There must be a written commitment on behalf of the entire facility to the organization of burn care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. The burn center must have written guidelines for the triage, treatment, and transfer of burned patients from other facilities. The burn center must maintain an organizational chart relating personnel within the burn center and the hospital. The burn center must maintain current accreditation by the Joint Commission (TJC) or other recognized accrediting organization(s). The list of required equipment for Burn centers can be found on-line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.2. Burn Program

1. The burn center hospital must formally establish and maintain an organized burn program that is responsible for coordinating the care of burned patients. Compliance will be evidenced by, but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for care of the burn patient;
 - c. Defined burn team and written roles and responsibilities;
 - d. Appointed Burn Center Medical Director with a written job description;
 - e. Appointed Burn Center Program Manager with a written job description;
 - f. A written Burn Center Performance Improvement plan;
 - g. Documentation of burn center representative attendance at the regional trauma care meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.3. Burn Center Director

1. The burn center director must be a surgeon with board certification by the American Board of Surgery or American Board of Plastic Surgery; certification of

special qualifications in surgical critical care is desirable. The burn center director must have completed a one-year fellowship in burn treatment or must have experience in the care of patients with acute burn injuries for two or more years during the previous five years. The burn center director must participate in continuing medical education in burn treatment (48 hours of burn/trauma related CME in a 3 year period) and must demonstrate ongoing involvement in burn-related research and community education in burn care and/or prevention.

2. Responsibilities of the burn center director must include, but not be limited to, the following:
 - a. creation of policies and procedures within the burn center that specify the care of burned patients;
 - b. Creation of policies and protocols for use throughout the burn care system for referral care, triage, and transport of burn patients;
 - c. Cooperation with the Trauma Care Region in all aspects of patient treatment;
 - d. Communications on a regular basis with physicians and other authorities about patients who have been refused;
 - e. Direction of the burn center administrative functions, including approval of medical staff credentialing;
 - f. Direction and active participation in the burn center performance improvement program;
 - g. Liaison with adjacent and regional burn centers; and
 - h. Development and participation in internal and external continuing medical education programs in the care and prevention of burn injuries.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.4. Burn Program Manager (BPM)

1. Burn Centers must have a registered nurse, with two (2) or more years of experience as a nurse in a burn center, working full time in the role of Burn Program Manager (BPM), who is administratively responsible for the burn center. The BPM must have at least two (2) years or more of experience in acute burn care and six (6) months or more managerial experience. Working in conjunction with the Burn Center Director, the BPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of burn care. The BPM is responsible for working with the burn team to assure optimal patient care. There are many requirements for data

coordination and performance improvement, education and prevention activities incumbent upon this position.

2. The BPM or his/her designee should offer or coordinate services for burn education. The BPM should liaison with local EMS personnel, the Department, Regional Trauma Care committee(s), trauma centers, and other burn centers.
3. The BPM must participate in 16 or more hours of burn-related education (can be met by attendance at the annual meetings of the American Association for the Surgery of Trauma, ABA, or any ABA-endorsed meetings or continuing education programs, such as ABLIS or ABLIS Now) each year or 48 hours in a three year period.
4. There must be an organizational chart relating the nurse manager to the burn service and other members of the burn team.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.5. Burn Team: The team approach is optimal in the care of the multiple injured patient. There must be identified members of the burn team. Policies should be in place describing the respective role of all personnel on the team. The composition of the team in any hospital will depend on the characteristics of the hospital and its staff. In some instances a tiered response may be appropriate. If a tiered response is employed, written policy must be in place and the system monitored by the PI process. Composition of the burn team for an injured patient shall include:

1. Emergency Physicians and/or mid-level providers (Physician Assistant/Nurse Practitioner)
2. General/Trauma Surgeon
3. Physician Specialists
4. Anesthesiologist
5. Laboratory Technicians as dictated by clinical needs
6. Nursing: ED, OR, ICU, etc.
7. Auxiliary Support Staff
8. Respiratory Therapist
9. Security Officers

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.6. Multidisciplinary Burn Care Committee

1. The purpose of the committee is to provide oversight and leadership to the entire burn program. The exact format will be hospital specific and may be accomplished by collaboration with another designated burn center. Each burn center may choose to have one or more committees as needed to accomplish the task. One committee should be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education and outreach programs for injury prevention. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Suggested membership for the committee includes representatives from:
 - a. Administration
 - b. Operating Room
 - c. Anesthesia
 - d. Plastic Surgery
 - e. Orthopedics
 - f. Emergency Medicine
 - g. General Surgery
 - h. Pre-hospital providers
 - i. Intensive Care
 - j. Radiology
 - k. Laboratory
 - l. Rehabilitation
 - m. Neurosurgery
 - n. Respiratory Therapy
 - o. Nursing
 - p. Burn Program Manager/BPM
2. The clinical managers (or designees) of the departments involved with burn care should play an active role with the committee.

3. The burn center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.7. Policies and Procedures: The burn center must maintain an appropriate policy and procedure manual that is reviewed annually by the burn center director and the nurse manager. The policy and procedure manual must contain, at a minimum, the following policies addressing the following:

1. Administration of the burn center.
2. Staffing of the burn center.
3. Criteria for admission to the burn center by the burn service.
4. Use of burn center beds by other medical or surgical services.
5. Criteria for discharge and follow-up care.
6. Availability of beds and the transfer of burn patients to other medical or surgical units within the hospital.
7. Care of patients with burns in areas of the burn center hospital other than the burn center.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.8. Personnel: The burn center must be granted the necessary authority to direct and coordinate all services for patients admitted to the burn service. The burn center director must make sure that medical care conforms to the burn center protocols. Privileges for physicians participating in the burn service must be determined by the medical staff credentialing process and approved by the burn center director. Qualifications for surgeons who are responsible for the care of burned patients must conform to criteria documenting appropriate training, patient care experience, continuing medical education, and commitment to teaching and research in the care of burned patients.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

Rule 7.2.1. Trauma Evaluation: Patients with burns and trauma must be evaluated and/or stabilized at a trauma center before transfer to a burn center. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.2. Burn Service Coverage: The burn service must maintain an on-call schedule for attending staff surgeons who are assigned to the burn service. The staff surgeons must be promptly available on a 24-hour basis.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.3. Qualifications of Attending Staff Surgeons: The Burn Center Director must appoint qualified attending staff surgeons to participate in the care of patients on the burn service. Attending staff surgeons must be board-certified or board eligible with current Advanced Burn Life Support (ABLS). Certification of special qualifications in critical care is desirable. The attending staff surgeon must have demonstrated expertise in burn treatment. Attending staff surgeons must participate in continuing medical education in burn treatment. Other attending surgeons must demonstrate participation in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.4. Nursing staff: There must be a patient care system in effect that is used to determine nurse staffing for each patient in the burn center. This system must be used to determine daily staffing needs. There must be a burn center orientation program that documents nursing competencies specific to the care and treatment of burn patients, including critical care, wound care, and rehabilitation. Burn center nursing staff must be provided with a minimum of two (2) burn-related continuing education opportunities annually.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.5. Mid-Level Providers: Appropriate credentialed mid-level providers may be used as members of the burn team. These individuals may include, but are not limited to, physician assistants, surgical assistants, or nurse practitioners. They may augment but do not replace the physician member of the team.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.6. Burn Center Referral Criteria

1. Burn injuries that should be referred to a burn center include, but are not limited to the following:

- a. Partial-thickness burns of greater than 10% of the total body surface area;
- b. Burns that involve the face, hands, feet, genitalia, perineum, or major joints;
- c. Third-degree burns;
- d. Electrical burns, including lightning injury;
- e. Chemical burns;
- f. Inhalation injury;
- g. Burn injury in patients with pre-existing medical disorders that could complicate management, prolonged recovery, or affect mortality;
- h. Burn injury in patients who will require special social, emotional, or rehabilitative intervention.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.7. Specialty Services: The following specialists must be available for consultation:

1. General surgery
2. Cardiothoracic surgery
3. Neurological surgery
4. Obstetrics/gynecology
5. Ophthalmology
6. Anesthesiology
7. Pediatrics
8. Orthopedic surgery
9. Otolaryngology
10. Plastic surgery
11. Urology
12. Pulmonary
13. Radiology

14. Nephrology
15. Psychiatry
16. Cardiology
17. Gastroenterology
18. Hematology
19. Neurology
20. Pathology
21. Infectious disease

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 7.3.1. Emergency Department: The emergency department must have written protocols mutually developed with the burn service for the care of acutely burned patients.

Source: Miss. Code Ann. § 41-59-5

Rule 7.3.2. Surgical Suites: The burn center hospital must have operating rooms available 24 hours a day.

Source: Miss. Code Ann. § 41-59-5

Rule 7.3.3. Allograft Use: The burn center hospital's policies and procedures for the use of allograft tissues must be in compliance with all federal, state, and the Joint Commission/other recognized accrediting organizations' requirements, and with standards of the American Association of Tissue Banks.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 7.4.1. Respiratory Therapy Service: Respiratory therapists must be available for the assessment and management of patients on the burn service on a 24-hour basis. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.2. Renal Dialysis, Radiological Services, and Clinical Laboratory: Renal dialysis, radiological services (including computed tomography scanning), and clinical laboratory services must be available 24 hours per day.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.3. Rehabilitation/Social Services

1. There must be a rehabilitation program designed for burned patients that identifies specific goals.
2. The primary burn care therapist must have annual participation in 16 hours or more of burn-related education (can be met by attendance at the annual meetings of the American Association for the Surgery of Trauma, American Burn Association (ABA), or any ABA-endorsed meetings or continuing education programs, such as ABLA or ABLIS Now) each year or 48 hours over a three (3) year period.
3. Social service consultation must be available to the burn service. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.4. Nutritional Support: A dietician must be available on a daily basis for consultation. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.5. Pharmacy: A pharmacist who has at least six (6) months of experience in critical care and the pharmacokinetics implications for patients with acute burn injuries must be available on a 24-hour basis. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.6. Clinical Psychiatry: A psychiatrist or clinical psychologist should be available for consultation by the burn service on a 24-hour basis. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.7. Continuity of Care Program: The burn center must provide the following services:

1. Patient and family education in rehabilitation programs;
2. Support for family members or other significant persons;

3. Coordinated discharge planning;
4. Follow-up after hospital discharge;
5. Access to community resources;
6. Evaluation of the patient's physical, psychological, developmental, and vocational status;
7. Planning for future rehabilitative and reconstructive needs.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.8. **Weekly Patient Care Conferences:** Patient care conferences must be held at least weekly to review and evaluate the status of each patient admitted to the burn center. Each clinical discipline should be represented to appropriately contribute to the treatment plan for each patient. Patient care conferences must be documented in the progress notes of each patient and/or in minutes of the conference.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.9. **Infection Control Program:** The burn center must have effective means of isolation that are consistent with principles of universal precautions and barrier techniques to decrease the risk of cross-infection and cross-contamination. The burn center hospital must provide ongoing review and analysis of nosocomial infection data and risk factors that relate to infection prevention and control for burn patients. This data must be available to the burn team to assess infection risk factors that relate to infection prevention and control for burn patients.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.10. **Mass Casualty Plan:** The burn center must have a written multiple-casualty plan for the triage and treatment of patients burned in a multiple casualty incident occurring within its service area. The multiple casualty plan must be reviewed and updated as needed, and on an annual basis by EMS representatives and the burn center director.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.11. **Burn Prevention:** The burn center will be responsible for taking a lead role in coordination of appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the burn system, access to the system, public support for the system, as well as specific prevention strategies. Prevention programs must be specific to the needs of the region. The trauma registry data must be utilized to identify injury trends and focus prevention needs.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.12. Trauma Registry:

1. All facilities designated as burn centers in Mississippi must participate in the statewide Trauma Registry for the purpose of supporting peer review and performance improvement activities at the local, regional, and state levels. Since this data relates to specific trauma patients and are used to evaluate and improve the quality of health care services, this data is confidential and will be governed by the Miss. Code Ann. §41-59-77.
2. This database must include all patients who are admitted to the burn center hospital for acute burn care treatment. Compliance with the above will be evidenced by:
3. Documentation of utilization of the Trauma Registry data in the trauma/burn performance improvement process.
4. Timely submission of Trauma Registry Data to the Department and the appropriate Trauma Region.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.13. Transfer Guidelines: All facilities will work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to ensure the most expedient, safe transfer of the patient. The transfer guidelines shall make certain that feedback is provided to the facilities and assure that this information becomes part of the trauma registry. All designated facilities will agree to accept and provide service to the trauma/burn patient regardless of their ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.14. Performance Improvement/Evaluation

1. The burn program must have a performance improvement program that is multidisciplinary. The burn center director must be responsible for the performance improvement program. The burn center multi-disciplinary committee, which oversees the performance improvement program, must meet at least quarterly. Sufficient documentation must be maintained to verify problems, identify opportunities for improvement, take corrective actions, and resolve problems. Morbidity and mortality conferences must be held at least monthly with physicians other than the immediate burn care team to ensure objective review of the presentations. Attendees at this conference must include specialist staff members other than those practicing in the burn center. All significant complications and deaths must be discussed. Actions recommended must also be

documented, and there must be documentation of loop closure. Records of this conference must be kept.

2. The burn center must develop an internal, specific Performance Improvement (PI) plan that minimally addresses the following key components and is fully integrated into the hospital wide program:
 - a. An organizational structure that facilitates performance improvement (Multidisciplinary Committee).
 - b. Clearly defined authority and accountability for the program.
 - c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.
 - d. Development of expectations (criteria) from evidenced based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.
 - e. Explicit definitions of outcomes derived from institutional standards.
 - f. Documentation system to monitor performance, corrective action and the result of the actions taken.
 - g. A process to delineate credentialing of all burn service physicians.
 - h. An informed peer review process utilizing a multidisciplinary method.
 - i. A method for comparing patient outcomes with computed survival probability.
 - j. Autopsy information on all deaths when available.
 - k. Review of pre-hospital care.
 - l. Review of times and reasons for burn bypass.
 - m. Review of times and reasons for burn transfers.
 - n. Audit of burn deaths.
 - o. Morbidity and Mortality review.
 - p. Feedback process with the referring hospital/physician.
3. Representatives from the burn center shall participate in the Trauma Region committees and the statewide performance improvement process.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.15. Education

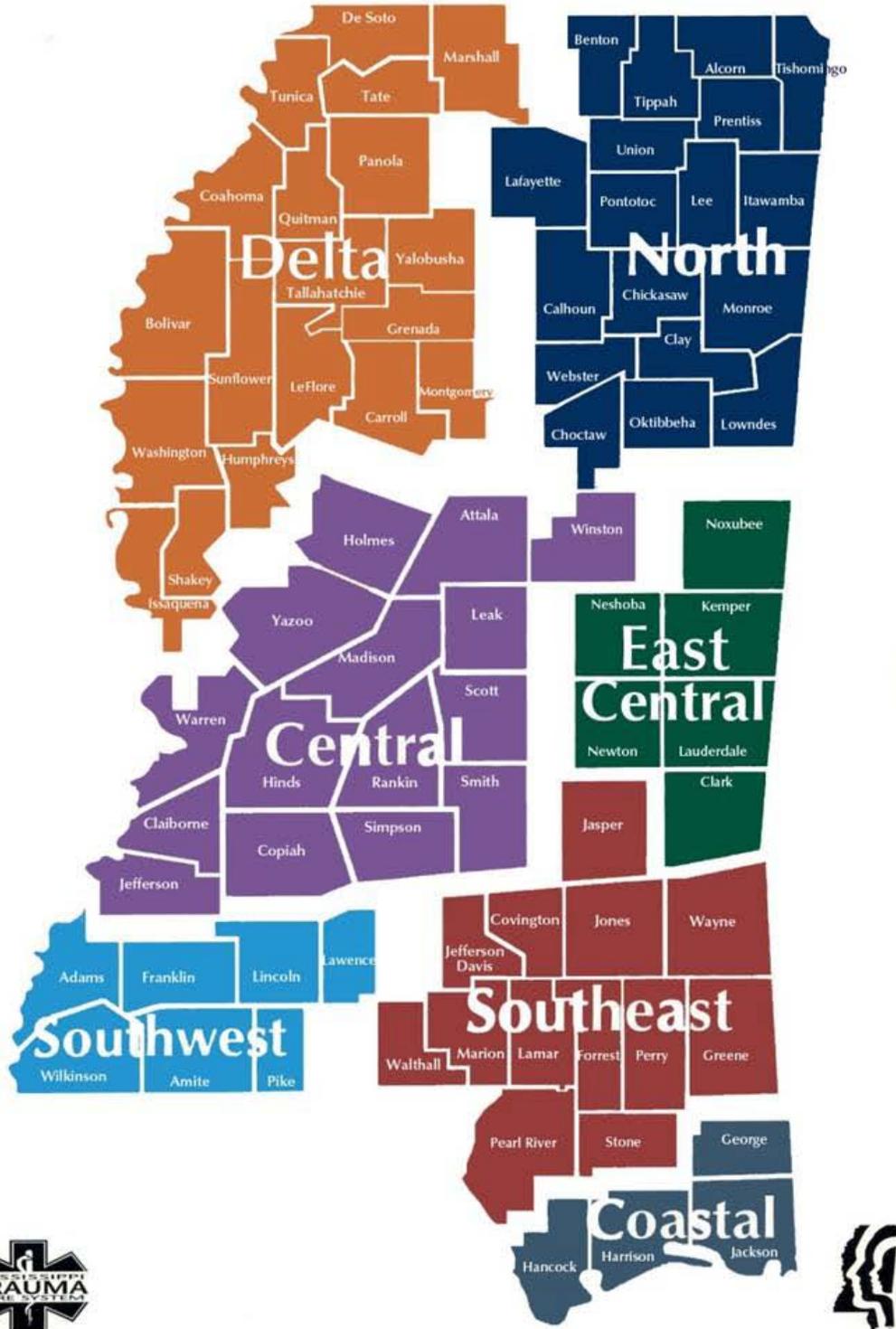
1. The burn center must be actively engaged in promoting Advanced Burn Life Support (ABLS) courses in its region. It is desirable for the director to be an ABLIS instructor and essential that the director is current in ABLIS. The unit should have one or more employees who are ABLIS instructors.
2. The burn center must offer education on the current concepts in emergency and inpatient burn care treatment to pre-hospital and hospital care providers within its service area.
3. The burn center must have an internal burn education plan for the staff.

Source: Miss. Code Ann. § 41-59-5

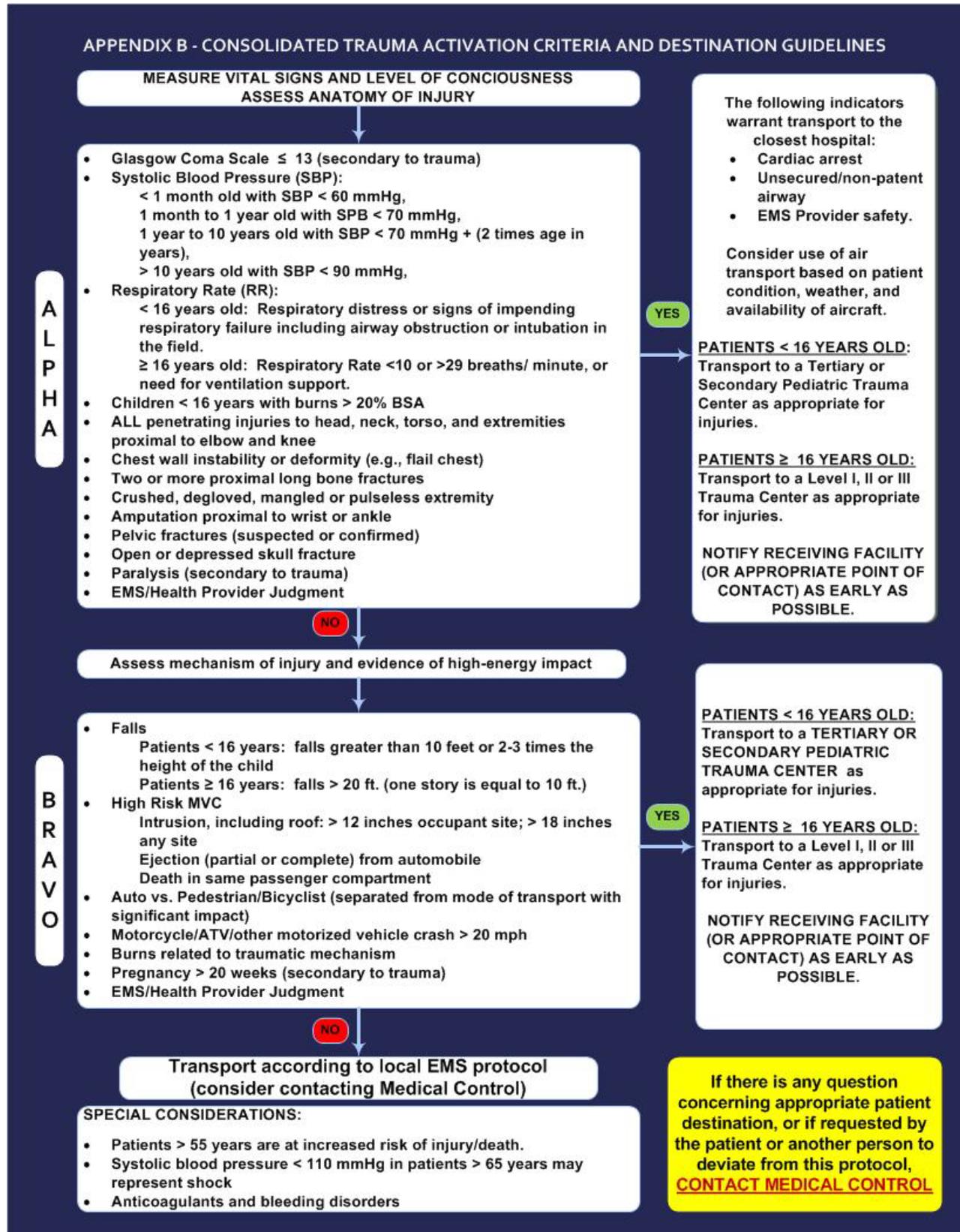
Rule 7.4.16. Research: The burn center must participate in basic, clinical, and health sciences research. The medical director must demonstrate ongoing involvement in burn-related research.

Source: Miss. Code Ann. § 41-59-5

Appendix A – Trauma Care Regions Map



Appendix B – Consolidated Trauma Activation Criteria and Destination Guidelines



Appendix B-1 – Pre-Hospital Air Medical Utilization Guidelines

CONSIDER Air medical transport when the patient condition meets established criteria **AND** the transport time to nearest appropriate hospital will be decreased by utilization of air medical resources

Patients with significant mechanism of Injury that present with any of the following:

- Glasgow Coma Scale of ≤ 13 with a normal CBG and not due to intoxication
- Systolic Blood Pressure of < 90 mmHg for ages ≥ 11 years or:
 - < 1 month SBP < 60 mm/Hg
 - 1 month to 1 yr SBP < 70 mm/Hg
 - > 1 year to 10 yr SBP < 70 mm/Hg + (2 x age in yrs)
- Respiratory rate < 10 or > 29 breaths/min; respiratory distress, impending respiratory failure, or need for ventilator support
- Need for emergent airway intervention
- Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knees
- Unstable chest wall, instability, subcutaneous emphysema
- Two or more proximal long bone fractures
- Crushed, de-gloved, or mangled extremity
- Amputation proximal to wrist or ankle
- Suspected pelvic fracture secondary to trauma
- Open or depressed skull fracture
- Paralysis secondary to trauma
- Burn $> 20\%$ BSA or with inhalation injury

Additional considerations for Air Medical utilization:

- Patient is in a geographically isolated area with reasonable suspicion the patient will require transport to a Level I or II trauma center
- Transport by ground would compromise the resources of the local EMS provider

Appendix C – Trauma Care Trust Fund Distribution Model

