Mississippi Trauma Care System
Level IV Trauma Center Application

Mississippi State Department of Health
Bureau of Acute Care Systems
Revised

Hospital ID:

Level of Pediatric Application:

Hospital Name:

Mailing Address:

County:

District :

Hospital Website:

Chief Administrative Officer:

Email Address:

Main Telephone Number:

Name of person completing this application and job title:

Email Address:

Telephone/Fax Number:

Date Application Submitted:

The following questions are based on the requirements set forth by Mississippi Trauma Care System Rules and Regulations, which can be found on the Department website at http://msdh.ms.gov/msdhsite/_static/resources/7361.pdf. Paragraph reference numbers are noted in parenthesis following each section of this application.

HOSPITAL ORGANIZATION (Subchapter 1)

Provide an overview of your hospital including the number of licensed beds and the average census in the past 12 months. (Tab A) Rule 6.1.1/6.1.2

Trauma Program (Tab B) Rule 6.1.3

1. Attach resolution(s) dated within the last three years supporting the trauma service by the hospital's governing body AND the medical staff.
2. Attach the organizational chart that reflects the administrative reporting structure of the trauma program.
3. Describe your involvement in regional or state level trauma care system.
   Attach documentation of trauma center representatives' attendance at district trauma meetings (provided by the Mississippi Trauma Care System Foundation. Documentation should include a bullet point list with the following information: a. How often the meetings occur; b. Attendance during the past 12 months; c. Title of the person in attendance.

Medical Director/TMD (Tab C) Rule 6.1.4

1. Attach a copy of the Trauma Medical Director's Curriculum Vitae and job description.
2. Attach documentation of current ATLS completion or Board Certification in General Surgery or Emergency Medicine.
3. Describe the Trauma Director's annual assessment of the trauma team members.

Trauma Program Manager/TPM (Tab D) Rule 6.1.5

1. Attach a copy of the Trauma Program Manager's Curriculum Vitae and job description.
2. Attach a copy of the TPM's TNCC certification.
3. Attach documentation of the TPM's 4 hours of annual trauma related education.

Trauma Team (Tab E) Rule 6.1.6

1. Attach the trauma team criteria policy which includes the trauma team activation authority and activation process with a list of the trauma team members in trauma resuscitation, and the duties/roles of each member.
2. Attach an overview of your trauma triage system and assessment to assure all multiple system trauma patients or major injury victims are evaluated and preparations for transfer to a higher level of care trauma center.
3. Attach a copy of your facility's bypass/diversion policy.

Multidisciplinary Trauma Committee / Performance Improvement (Tab F) Rule 6.1.7
Rule 2.4.1 **(Do not attach any PI minutes)**

1. Attach a copy of your PI plan.

2. Attach a composition of the hospital's committee responsible for oversight of trauma PI.
3. Describe how trauma patient care is reviewed.
4. Describe two PI issues within the last 12 months: one system related and one clinically related. Indicate the PI issue and the six-step process – Problem identification, Analysis, Preventability, Action Plan, Implementation, and Re-evaluation – or any recognized PI process that is used to resolve PI issues.
5. Attach dates and attendance records from the past 12 months of your PI committee.

CLINICAL COMPONENTS/FACILITY STANDARDS (Subchapter 2) (Subchapter 3)

Emergency Department (Tab G) Rule 6.2.1, 6.3.1

1. Attach a list of ED practitioners to include MD's and Mid-Level Providers. Provide documentation of provider's certification in ATLS / RTTDC or Board Certification in General Surgery or Emergency Medicine.
2. Attach past three month's call schedule for ED.
3. Attach a list of RN's assigned or practicing in the ED including TNCC, ATCN or RTTDC completion.
4. Attach policy stating TNCC requirement for ED nurses.

CLINICAL SUPPORT SERVICES (Subchapter 4)

Describe your hospital's resources to meet the needs of the trauma patient for the following services, if available: (Tab H) Rule 6.4.1

- Respiratory
- Radiological
- Clinical Lab
- 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 IV Trauma Center.

Prevention / Public Outreach (Tab I) Rule 6.4.3

1. Describe all trauma education programs for physicians, nurses, and pre-hospital providers, including how it is funded.
2. Describe community outreach and prevention program activities.

Transfer Guidelines (Tab J) Rule 6.4.2, 6.4.4

1. Attach trauma patient treatment guidelines or policies for the following:
   (a) Pediatrics (b) Burns (c) Surgical (d) Orthopedics (e) Neurological
2. Attach transfer guidelines regarding the transfer of the following trauma patients to higher level of care: (a) Pediatrics (b) Burns (c) Surgical
   (d) Orthopedics (e) Neurological

Education (Tab K) Rule 6.4.5

1. Attach a copy of the facility's trauma education plan/protocol to include trauma specific education for ED nurses, physicians, and mid-level providers.
2. Submit a list of educational offerings during this designation period, if

applicable.

Trauma Registry (Tab L) Rule 1.4.1/1.4.2/1.4.3

1. List the number of deaths for the last 12 months.
2. Describe the trauma deaths review process in detail at your facility.
3. Attach the name of your hospital's registrar.
4. Attach the following data for the last 12 months:
    - Number of trauma activations
    - Number of trauma patients who met trauma registry inclusion criteria
    - Number of trauma patients admitted to your hospital
    - Number of trauma patients transferred to other hospitals
    - Number of diversion/bypass occurrences

*Essential and Desirable Charts for equipment can be found on the Department website.

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SIGNATURE PAGE

1. The undersigned makes application to the Mississippi Trauma Care System for consideration of Level IV Trauma Center designation.
2. The institution represents that to the best of its ability it meets the Rules and Regulations set forth by the Mississippi Trauma Care System.
3. The institution agrees to submit to a site survey if requested by the Mississippi State Department of Health Bureau of Acute Care Systems after careful review of this application.
4. I have reviewed the information contained in the application and certify that the information is true and correct.
5. I further certify that the institution agrees to adhere to the designation program of the Mississippi Trauma Care System.

______________________________	____________________
Signature, Administrator	Date

Contact Information:
Name:
Phone:
Email:
Fax:

______________________________	____________________
Signature, Trauma Medical Director	Date

Contact Information:
Name:
Phone:
Email:
Fax:

______________________________	____________________
Signature, Trauma Program Manager	Date

Contact Information:
Name:
Phone:
Email:
Fax:

Physician Information

Name of Physician	Specify Board Certification Emergency Medicine (EM) OR General Surgery (GS)	Current ATLS OR Rural Trauma Course (yes/no)
	☐ EM ☐ GS Exp:	☐ Yes ☐ No Exp:
	☐ EM ☐ GS Exp:	☐ Yes ☐ No Exp:
	☐ EM ☐ GS Exp:	☐ Yes ☐ No Exp:
	☐ EM ☐ GS Exp:	☐ Yes ☐ No Exp:
	☐ EM ☐ GS Exp:	☐ Yes ☐ No Exp:
	☐ EM ☐ GS Exp:	☐ Yes ☐ No Exp:
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	☐ EM ☐ GS Exp:	☐ Yes ☐ No Exp:

Mid-Level Practitioner Information

Name of Practitioner	Title	Current ATLS OR Rural Trauma Course (yes/no)
		☐ Yes ☐ No Exp:
		☐ Yes ☐ No Exp:
		☐ Yes ☐ No Exp:
		☐ Yes ☐ No Exp:
		☐ Yes ☐ No Exp:
		☐ Yes ☐ No Exp:
		☐ Yes ☐ No Exp:
		☐ Yes ☐ No Exp:

TNCC Information

Name of Nurse	Current TNCC (yes/no)	Expiration Date of TNCC
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
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	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

TRAUMA BYPASS / DIVERT OCCURRENCES

Please complete if you have gone one trauma bypass/divert during the previous year

Date of Occurrence	**Time on Bypass**	**Time Off Bypass**	**Reason for Bypass**

Total number of occurrences of bypass during reporting period?
____

Total number of hours on diversion during reporting period?
____