

## **Title 15: Mississippi Department of Health**

### **Part 12: Bureau of Emergency Medical Services**

#### **Subpart 32: Trauma System**

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 and includes the most current Mississippi Trauma System Regulations, as adopted by the State Board of Health, regardless of publication date.

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*

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 at <http://msdh.ms.gov/msdhsite/static/49,0,326.html>.

*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*

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*

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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.

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  - 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.
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