Trauma Designation 2024 Gap Assessment

157.125 (j) Trauma Designation Requirements Gap Assessment (April 19, 2023)

Requirement	Met	Not Met	Priority	Comments
(1) Facilities must have documented evidence of participation in their RAC: (A) evidence of submitting the regional data requests for the past three years; and (B) evidence the TMD and TPM are participating in the trauma system planning and regional disaster planning through the RAC.				
(2) Facilities must have evidence of quarterly trauma registry submissions to the State Trauma Registry for patients that meet the NTDB registry inclusion criteria or burns with moderate or higher risk, following the National Trauma Data Standard (NTDS) definitions.				
(3) Facilities must demonstrate trauma registry performance measures for the following: (A) data validations and correction of issues identified; and (B) measures to ensure accurate coding and ISS and that all patient profiles submitted to the State Trauma Registry have an ISS.				
(4) Facilities must maintain a written trauma operational plan for the program to include: (A) description of the scope of services available to support trauma care; (B) trauma program authority and oversight; (C) trauma population evaluated and treated by the trauma program to identify those patients routinely admitted and those patients routinely transferred out for definitive care; (D) trauma activation guidelines that meet the national recommendations; (E) trauma management guidelines based on evidence-				

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based practice; (F) trauma policies and procedures; (G) description of the trauma program staffing; (H) trauma medical staff credentialing and education requirements; (I) measures for rounding on admitted trauma patients to complete a tertiary exam and to facilitate the continuum of care through discharge or transfer; (J) data management procedures to ensure all performance improvement documents and registry documents are secured to maintain confidentiality; (K) measures to promote a safe culture; (L) documented transfer guidelines with evidence of medical and nursing staff education on trauma transfers; (M) resources available for trauma patient population inpatient areas, including the operating suite, ICU, general units, and rehabilitation services; (N) evidence of staff orientation, skills credentialing, and ongoing education for all areas providing care to injured patients that meet trauma activation guidelines, NTDB registry inclusion criteria, or burns with moderate or higher risk; (O) ancillary services available to support the injured patients who meet trauma activation guidelines, NTDB registry inclusion criteria, or burns with moderate or higher risk; (P) psychosocial support services for the trauma patient and families; (Q) trauma operations committee with defined goals and objectives, members, minutes, and attendance requirements; (R) processes to ensure all trauma designation requirements are monitored for compliance;				

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(S) trauma registry procedures; (T) injury prevention resources; (U) outreach education resources; (V) TMD and TPM participation in the RAC; (W) processes to provide emergency medical services (EMS) feedback and transfer follow-up feedback; (X) measures to support trauma research as appropriate for the level of designation; and (Y) succession planning for the TMD, TPM, and trauma registrar.				
(5) The trauma program's written operational plan and all associated documents must be approved by the trauma operations committee and forwarded to the hospital's governing body for review and approval.				
(6) The hospital's Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Chief Operating Officer (COO), and Chief Medical Officer (CMO), and the trauma administrator have documented evidence of implementing a culture of safety and measures to continually promote a safe culture.				
(7) The hospital's CEO, CNO, COO, CMO, and the trauma administrator have documented evidence of implementing trauma-informed care practices in all areas of receiving, assessing, evaluating, and caring for injured patients, and psychosocial support or wellness programs for staff.				
(8) The hospital's CEO, CNO, COO, Chief Financial Officer (CFO), and the trauma administrator are responsible for providing adequate resources to ensure the trauma program's performance improvement and patient safety processes and trauma registry maintain concurrent operations.				
(9) The hospital's CEO, CMO, trauma administrator, and TMD have measures in place to monitor the trauma				

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physicians' coverage and the trauma physicians' contract deliverables to ensure adequate trauma coverage, with backup coverage when needed, and to ensure defined requirements for education, training, timeliness of response to trauma activations, attendance to required meetings, disaster response capabilities, as well as attendance at the RAC meetings and other requirements are met.				
(10) The hospital's CEO, CNO, COO, CFO, and trauma administrator in conjunction with the TMD and TPM, have established processes to monitor and track the trauma fees and trauma patient uncompensated care, in addition to the operational cost of the trauma program, to assist with completing the uncompensated care grant application, and provide evidence of how these funds are used to improve the facility's trauma program and trauma care.				
(11) Written trauma management guidelines for the hospital that align with evidence-based practices, current national standards and hospital resources available; must be reviewed and approved a minimum of every three years by the trauma operations committee. The guidelines must include: (A) trauma activation and response time guidelines based on national recommendations; (B) trauma resuscitation and documentation guidelines; (C) consultation services response guidelines; (D) admission and transfer guidelines; (E) burn injury management guidelines; (F) management of trauma patients with a defined or suspected neurologic deficit due to spinal cord injury, including neurogenic shock; (G) management of patients with mild, moderate, and severe traumatic brain injury; (H) hemorrhage control and management of shock; (I) complex orthopedic pelvic, acetabular, or long bone				

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fractures, hemodynamically unstable pelvic fractures, fractures with the potential for vascular compromise, and partial or complete amputation of a long bone extremity; (J) screening, management, and appropriate interventions or referral for both suspected and confirmed abuse of all patient populations; (K) measures to prevent over-imaging for patients requiring transfer, and processes to share medical images with the receiving facility; (L) pain management guidelines for all populations; (M) guidelines for massive transfusion; (N) management of the acutely injured pregnant patient that is greater than 20 weeks gestation; (O) management guidelines for substance use and misuse screening and mental health screening and interventions; (P) management guidelines for trauma care of the morbidly obese patients; (Q) transfer guidelines to ensure that when the evaluating physician defines an acutely injured patient who meets trauma activation guidelines, NTDB registry inclusion criteria or burns with moderate or higher risk with a projected ISS of 11 or greater, and requires transfer, the transfer must be to a higher-level trauma facility or specialty resource facility such as a burn center, and if not transferred to a higher level of trauma facility, must be reviewed through the trauma performance improvement and patient safety process by the TMD for appropriateness of transfer. The review must include feedback from the accepting facility; (R) if greater than 15 percent of the patients meeting trauma activation guidelines are less than 15 years-of-age, the facility must have pediatric management guidelines, and if 15 percent of the patients meeting trauma activation guidelines are 65 or older, the facility must have geriatric trauma management guidelines; (S) guidelines for patient and family-centered care;				

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(T) documentation standards pertinent to the care of trauma patients in all nursing units providing care to the trauma patient; and (U) processes to measure and report adherence to these guidelines must be integrated into the trauma performance improvement and patient safety plan and aggregately reported through the trauma operations committee.				
(12) The trauma program must have provisions for the availability of all necessary equipment and services to administer the appropriate level of care and support for the injured patient meeting trauma activation guidelines, NTDB registry inclusion criteria, or burns with moderate or higher risk through the continuum of care to discharge or transfer.				
(13) Adult trauma facilities must meet and maintain the Emergency Medical Services for Children's Pediatric Readiness Criteria as evidenced by the following: (A) annual completion of the online Pediatric Readiness Survey (https://pedsready.org), including a written and monitored corrective action plan for identified improvement opportunities; (B) pediatric equipment and resources immediately available at the facility, and staff have defined and documented competency skills and training on the pediatric equipment; (C) education and training requirements for Emergency Nursing Pediatric Course (ENPC) or Pediatric Advanced Life Support (PALS) are met for the nurses responding to trauma activations; and (D) documented evidence that the trauma program has completed a minimum of one quarterly pediatric trauma resuscitation simulation with medical staff participation, including a completed critique that identifies opportunities for improvement that is integrated into the trauma performance improvement initiatives and tracked until the identified opportunities are corrected.				

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(14) Free-standing children's trauma facilities must have resources and equipment immediately available for adult trauma resuscitations, adherence to the nursing requirements for Trauma Nurse Core Course (TNCC) or Advanced Trauma Care for Nurses (ATCN), documented evidence that the trauma program has completed a minimum of one quarterly adult trauma resuscitation simulation with medical staff participation, including a completed critique that identifies opportunities for improvement that is integrated into the trauma performance improvement initiatives and tracked until the identified opportunities are corrected.				
(15) Rural Level IV trauma facilities in a county with a population of 30,000 or less may utilize telemedicine resources with an Advanced Practice Provider (APP) available to respond to the trauma patient's bedside within 15 minutes of notification, with written resuscitation and trauma management guidelines that are monitored through the trauma performance improvement and patient safety processes. (A) The APP must be current in Advance Trauma Life Support (ATLS), annually maintain an average 16 hours of trauma-related continuing medical education and demonstrate adherence to the trauma patient management guidelines and documentation standards. (B) The on-call physician must respond within 30 minutes when requested. (C) The facility must have a documented telemedicine physician credentialing process. (D) All assessments, physician orders, and interventions initiated through telemedicine must be documented in the patient's medical record.				
(16) Telemedicine in non-rural trauma facilities, if utilized, must have a documented physician credentialing process, written trauma protocols for utilization of telemedicine that include physician response times, and measures to ensure the trauma management guidelines and evidence-based practice are monitored through the trauma performance improvement and patient safety processes.				

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(A) Telemedicine cannot replace the requirement for the trauma on-call physician to respond to the trauma activations in-person, to conduct inpatient rounds, or to respond to the inpatient units when requested. (B) All telemedicine assessments, physician orders, and interventions initiated through telemedicine must be documented in the patient's medical record.				
(17) The TMD must define the role and expectations of the hospitalist or intensivist in providing care to the admitted injured patient that meets trauma activation guidelines, NTDB registry inclusion criteria, or burns with moderate or higher risk requiring admission.				
(18) The trauma program has an identified administrator or executive leader who assists with the trauma program budget, oversight of trauma contracts, trauma billing, securing transfer and transport agreements, and attends a minimum of 50 percent of the trauma operations committee meetings annually. This individual serves as a trauma liaison to the chief executive officers.				
(19) A trauma registered nurse is a participating member of the nurse staffing committee.				
(20) The facility maintains medical records that facilitate the documentation of trauma patient arrival, level of activation, physician response and team response times, EMS time-out, resuscitation, assessments, vital signs, Glasgow Coma Score (GCS), serial evaluation of needs, interventions, patient response to interventions, reassessments, and re-evaluation through all phases of care to discharge or transfer, including: (A) integration of the EMS patient care records including the EMS wristband tracking number; and (B) substance misuse screening and interventions.				
(21) The facility must have an organized, effective trauma service that is recognized in the medical staff bylaws and approved by the governing body. Medical staff credentialing must include a process for requesting and granting delineation of privileges for the TMD to oversee the providers participating in trauma call coverage, the trauma panel, and trauma management through all				

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phases of care.				
(22) The facility must identify a TMD responsible for the provision of trauma care. The TMD must be credentialed and privileged by the facility for the treatment of trauma patients through all phases of care to discharge or transfer. The TMD must have authority and oversight of the trauma program and be dedicated to only one trauma facility. The TMD must be a physician who meets the following criteria: (A) Level I, II, III and non-rural Level IV trauma facilities must have a medical director who: ● (i) is a trauma or general surgeon that is board-certified or board-eligible; ● (ii) preferably has completed a trauma fellowship; and ● (iii) demonstrates knowledge, expertise, and experience in caring for all types of trauma injuries. (B) Rural Level IV facilities that do not routinely admit patients meeting trauma activation guidelines, NTDB registry inclusion criteria or burns with moderate or higher risk to their facility may choose to have a surgeon that is board-certified or board-eligible or an emergency medicine physician that is board-certified or board-eligible, or a family medicine physician that is board-certified or board-eligible and current in ATLS to serve as the facility's TMD; (i) if the individual serving as the Level IV TMD is not a surgeon or emergency medicine physician or family medicine physician that is board-certified or board-eligible, the physician must be current in ATLS; and (ii) annually maintain 16 hours of trauma-related continuing medical education; (C) regularly and actively participates in trauma care at the trauma facility where TMD services are provided, including taking trauma call monthly or providing coverage in the emergency department for Level IV facilities utilizing an emergency medicine or family medicine physician as the TMD;				

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(D) maintains current verification in ATLS or a department-recognized equivalent course, and preferably is an ATLS instructor; (E) demonstrates effective administrative skills and oversight of the trauma performance and patient safety plan and processes, chairs the secondary level of performance reviews, chairs the trauma operations committee, chairs the trauma multidisciplinary peer review committee, and communicates and collaborates with trauma liaisons for emergency medicine, orthopedics, neurosurgery, critical care, radiology, anesthesia, rehabilitation, and other surgical and medical specialists; (F) has the responsibility for credentialing the trauma service surgeons participating in the call schedule, advanced practice providers participating in trauma care, and trauma liaisons, or appropriate physicians for the Level IV facilities, utilizing established and approved guidelines; (G) is a member of the facility's disaster planning and preparedness committee with a specific focus on mass casualty, multiple casualties, and events requiring response planning and patient flow management for potential surges in the operating suite or ICU; (H) collaborates with the trauma service surgeons participating in the call schedule, advanced practice providers, panel, trauma liaisons, TPM, trauma administrator, and nursing leaders to develop the trauma management guidelines for the trauma facility that are consistent with national evidence-based practice guidelines; (I) participates in the RAC trauma committee, disaster preparedness activities, and medical director committee as defined by the RAC bylaws; (J) has a documented job description that defines the TMD's authority and oversight of the trauma program through all phases of care; (K) has completed a trauma performance improvement and patient safety course every four years or as updated, a course on the role of the TMD, the Federal Emergency				

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Management Agency (FEMA) Independent Study (IS) 100, 200, and 700 courses, and a course on hospital preparedness, planning, and response to a disaster at least once, as defined by the ACS standards; and (L) provides or facilitates annual training for trauma surgeons, trauma liaisons, or other physicians (for Level IV facilities) on the facility's mass casualty response, patient flow coordination, and job action sheets, which may be completed through table-top simulation training or other educational measures in collaboration with the TPM, emergency department medical director, and the facility's emergency management leader.				
(23) Each designated trauma facility must have an identified TPM responsible for monitoring trauma patient care from pre-hospital management to trauma activation, inpatient admission, rounding on inpatient, transfer or discharge, throughout the continuum of care, and transfer follow-up as appropriate. The role must be only for that facility and cannot cover multiple facilities. The TPM has the following authority and responsibility to: (A) identify and address trauma performance improvement and patient safety issues through all phases of care in the trauma facility, including validating and documenting identified events and preparing them for the secondary level of review, and implementing and tracking the action plans to address opportunities for improvement or manage the personnel completing these job functions; (B) perform trauma registry data abstraction, entry, coding, and validation, injury prevention activities, outreach education activities, and participate in RAC activities; (C) organize, track, and follow-through on the trauma performance improvement and patient safety processes to ensure resolution and reporting; (D) comply with the trauma registry processes outlined in the trauma operations plan and data submission requirements to the State Trauma Registry; (E) oversee the injury prevention, outreach education, and research initiatives of the trauma program in				

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conjunction with the TMD; (F) co-chair the trauma operations committee; (G) record the minutes of the trauma multidisciplinary peer review committee discussion; (H) attend specific facility-wide meetings representing the trauma program; (I) participate in the RAC trauma committee, disaster preparedness activities, and other committees as defined by the RAC bylaws; (J) assist with the orientation and education of staff in areas providing trauma care; (K) serve as the trauma liaison with the facility risk and quality departments; (L) maintain certification in TNCC or ATCN, Emergency Nursing Pediatric Course (ENPC) or Pediatric Advanced Life Support (PALS), and complete the Association for the Advancement of Automotive Medicine (AAAM) Injury Scaling Course as it is updated, a trauma program manager course at least once, a trauma performance improvement course every four years or as updated; (M) demonstrate expertise in trauma care, and have administrative organization skills; (N) attend an alternate course on data management versus the AAAM Injury Scaling Course and have processes in place for outsourcing and continual support for the trauma registry services when functioning at a Level IV rural trauma facility with NTDB registry inclusion criteria, or burns with moderate to higher risk having an annual volume of fewer than 75 patients; (O) complete the FEMA IS 100, 200, and 300 courses and a disaster course on hospital preparedness, planning, and response with the option that Level IV facilities may choose alternate training to the IS 300 and the disaster course on hospital preparedness, planning, and response; (P) routinely collaborate with the TMD, trauma liaisons, nursing leaders, staff, and other resources to identify				

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opportunities for trauma facility improvements; (Q) routinely participate or assist with trauma care at the facility; (R) have a documented job description that defines the TPM's authority and oversight of the trauma program through all phases of care; and (S) be a full-time employee of the facility to ensure that the TPM is current with the facility's policies and procedures and available during business hours to address trauma-related issues; the hours dedicated to the trauma program are based on the number of injured patients who meet trauma activation guidelines, NTDB registry inclusion criteria, or burns with moderate to higher risk to ensure concurrent processes. (T) have an organizational structure that allows the TPM to assess and review trauma care from admission to discharge, provide recommendations to improve care through all phases of care, and a reporting structure to an administrator that has the authority to recommend and monitor facility system changes and oversees the trauma program.				
(24) Rural Level IV or Critical Access hospital (CAH) facilities that annually have 75 or less patients that meet trauma activation guidelines, NTDB registry inclusion criteria or burns with moderate to higher risk and do not admit these patients to the hospital for injury management may choose to utilize a part-time registered nurse in the TPM role, or to integrate the TPM responsibilities with the Chief Nursing Officer's position, as long as the trauma performance improvement and trauma registry processes are concurrent, and resources are available to respond to the facility for high trauma volume or high trauma acuity.				
(25) The TMD, in conjunction with the trauma liaisons, defines the criteria and credentialing guidelines for the trauma service surgeons and specialty surgeons covering trauma call. The criteria include: (A) board-certification or board-eligibility in a defined specialty; (B) adherence to trauma activations guidelines and				

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response times; (C) participation in the trauma performance improvement and patient safety plan and process; (D) compliance with ATLS and continuing medical education if not board-certified or board-eligible; (E) participation and attendance for trauma surgeons and trauma liaisons at the trauma operations committee and trauma multidisciplinary peer review committee meetings maintaining a minimum of 50 percent participation; (F) participation for trauma surgeons and trauma liaisons in outreach education and injury prevention initiatives; (G) attendance as assigned at assigned facility-wide committees such as the medical staff committee, blood utilization committee, resuscitation committee, critical care committee, pharmacy committee, or prehospital committee; (H) adherence to transfer guidelines; (I) adherence to diversion guidelines; (J) adherence to established evidence-based practice or trauma management guidelines; (K) adherence to supervision expectations; and (L) specific activation guidelines, established in collaboration with orthopedic surgery and neurosurgery, that requires a 30-minute response to orthopedic and neurosurgical trauma injuries including monitoring compliance and reporting aggregate response summaries at the operations committee.				
(26) The TMD is responsible for the trauma call schedule for the trauma and general surgeons and collaborating with trauma liaisons and other specialty services to complete their trauma call schedule to ensure trauma facility coverage and that individuals are not on-call for two facilities at the same time. Trauma or general surgeons responsible for responding to trauma activations must be dedicated to one trauma facility				

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while they are on-call. (A) In Level III facilities, if the specialty physician on trauma call is covering two facilities, there must be a documented contingency plan. The facility must have documented guidelines for on-call practices. (B) This process must be monitored through the trauma performance improvement and patient safety plan and reported through the trauma operations committee. (C) In Level IV facilities that utilize an emergency medicine physician or family medicine physician as their TMD and do not routinely admit patients that meet their trauma activation guidelines, NTDB registry inclusion criteria, or burns with moderate or higher risk to their ICU or operative suite, the TMD is responsible for assisting with scheduling physician coverage in the emergency department to ensure trauma requirements are followed.				
(27) The trauma facility should maintain a concurrent trauma performance improvement and patient safety plan. The plan must be data-driven and align with the culture of safety and just culture concepts. The plan must define variances in care or events for review, the levels of harm, levels of review, identifying opportunities for improvement, corrective action plans, and processes to monitor the action plan until the desired change is met and sustained. (A) Trauma facilities must meet the staffing standards outlined by the ACS for verification of the trauma registry and performance improvement personnel. (B) The plan must utilize standardized terminology for classifying morbidity and mortality with the terms: ● (i) morbidity or mortality without opportunity; ● (ii) morbidity or mortality with opportunity for improvement; and ● (iii) morbidity or mortality with regional opportunity for improvement. (C) The plan encompasses a review of all identified events, including system issues, delays in care, hospital events such as complications, and all trauma deaths.				

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(D) The trauma performance improvement and patient safety plan must be approved by the TMD, TPM, and the trauma operations committee and disseminated to all departments providing care to the trauma patient to ensure they are knowledgeable of their role in the plan and the data they share at the trauma operations committee. (E) The TMD must chair the secondary level of performance review, the trauma multidisciplinary peer review committee, and co-chair the trauma operations committee with the TPM. (F) The trauma performance improvement and patient safety plan must outline the roles and responsibilities of the trauma operations committee and its membership. (G) The required members of the trauma operations committee include: ● (i) TMD and TPM; ● (ii) Performance improvement personnel and lead registry staff, if utilized; ● (iii) administrator or executive leader; ● (iv) nursing managers or leaders for units that provide trauma care; ● (v) trauma surgeons, trauma liaisons, and representatives for the trauma APPs; ● (vi) ancillary departments that support the trauma program such as radiology, interventional radiology, laboratory, blood bank, respiratory therapy, pharmacy, rehabilitation services, and EMS representatives as appropriate; and ● (vii) managed care contract and billing leaders to attend the committee meeting a minimum of twice a year to review trauma finances and billing status to share current status and identified opportunities for improvements. They can attend in-person or virtually. (H) Trauma facilities that participate in benchmarking programs must share the facility's benchmark reports with the trauma operations committee to identify successes and opportunities for improvement, develop action plans for the identified opportunities, and monitor the action plan outcomes.				

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(I) The trauma program must define who will attend the trauma multidisciplinary peer review committee and have documentation that reflects their attendance, and monitor attendance to validate a minimum of 50 percent attendance. (J) The trauma performance improvement and patient safety plan must have documented evidence that all identified events have a defined level of harm, are processed through the levels of review, have opportunities for improvement identified, have a corrective action plan that is implemented, and have data that are monitored and analyzed to ensure the desired change or outcome is reached to achieve event resolution. (K) The trauma facility must complete a 12-month summary of the facility's trauma performance improvement and patient safety plan, share the report with its facility quality program, and submit the report to the department. (L) The trauma facility must document and include in its trauma performance improvement and patient safety plan the external review of the trauma verification and designation pre-review questionnaire, site survey activities, the site survey summary report, including the medical record reviews, and all communication with the department.				
(28) Trauma facilities must submit required trauma data every 90 days or quarterly to the State Trauma Registry and have documented evidence of data validation and correction of identified errors or blank fields. (A) The facility must have procedures that identify the trauma registry inclusion criteria for the Texas reporting requirements. All trauma facilities must include patients meeting NTDB registry inclusion criteria or burns with moderate or higher risk. (B) Level I, II, and III trauma facilities must submit the validated trauma registry data to the NTDB each quarter. (C) The trauma registry processes must be concurrent. Registry data abstraction, data entry, and coding must begin during the patient’s hospital admission and be				

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completed within 60 days of the patient's hospital discharge. This requirement must be met at a minimum of 80 percent. (D) The trauma registry must have sufficient personnel and technical infrastructure support to ensure concurrent data abstraction and complete data entry within the 60-day timeline. (E) The trauma program must have documented procedures for trauma registry inclusion criteria, trauma registry validation, trauma registry data submission to the State Trauma Registry and NTDB as appropriate, and documented procedures to request data from the facility's trauma registry that are approved by the TMD, TPM, and reviewed at the trauma operations committee.				
(29) The trauma facility must meet the current ACS standards for staffing requirements for the trauma registry. (A) All trauma registrars must have a documented job description with defined core functions and an organizational structure that reports to the TPM. (B) All trauma registrars must complete the AAAM Injury Scaling Course, a trauma registry course, and the current International Classification of Diseases (ICD) coding class within 12 months of starting their role as a trauma registrar. (C) Rural Level IV trauma facilities that have 75 or fewer injured patients that meet NTDB registry inclusion criteria or burns with moderate or higher risk and do not admit trauma patients for intensive care or trauma operative interventions may have the trauma registrar attend an alternate data management course or outsource their registry requirements. (D) Trauma facilities that utilize a pool of trauma registrars must have an identified trauma registrar from the pool that is assigned to the facility to ensure data requests are addressed in a timely manner. (E) The EMS wristband tracking number must be included in the registry abstraction and submission of data to the				

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State Trauma Registry.				
(30) The trauma facility must have education, certification requirements, skills competency requirements, and evidence of trauma continuing education for trauma nursing staff providing care for patient meeting trauma activation guidelines, NTDB registry inclusion criteria, or burns with moderate or higher risk that are monitored for compliance. (A) There must be documented role-specific orientation plans for new staff for all units that provide trauma care. (B) Registered nurses assigned to care for arriving patients that meet trauma activation guidelines must have current TNCC or ATCN, ENPC or PALS, and Advanced Cardiac Life Support (ACLS) certifications. Those that are new to the facility or the facility's trauma resuscitation area must meet these requirements within 12 months of their hiring date. (C) There must be documented evidence that the highest level of trauma activation established by the facility has two registered nurses with the required education, certifications, and training responding to the activation. (D) Nurses providing care to the trauma patient through the continuum of care must have documented evidence of trauma training and education for the trauma population they care for, training in trauma-informed care, and access to trauma-related continuing education.				
(31) The trauma facility must provide outreach training programs for trauma-related continuing education for staff, community trauma providers, APPs, nurses, EMS, and other staff participating in trauma care or trauma system development. (A) Level I trauma facilities must have documented evidence of outreach education to the rural facilities in their regions and contiguous region if a Level I trauma facility is not available in the contiguous region to include: ● (i) trauma management guidelines for all injuries; ● (ii) designation assistance;				

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● (iii) transfers; and ● (iv) trauma registry assistance. (B) The outreach education job functions may be integrated into the trauma program manager's job descriptions for the Level III and IV facilities. (C) Level III and IV facilities may assist with RAC educational activities or collaborate with other healthcare systems to provide outreach education.				
(32) The trauma facility must have an individual responsible for injury prevention and public education (IPPE). (A) The Level III and IV facilities may integrate the IPPE job functions into the TPM job description and IPPE activities may be integrated with RAC activities or provided in collaboration with other healthcare facilities for the Level III and IV facilities. (B) Trauma facilities must participate in all statewide IPPE initiatives such as the Stop the Bleed course and provide the appropriate documentation to demonstrate their activities.				
(33) The trauma facility must have a comprehensive facility all-hazard disaster response and business continuity plan with procedures for establishing incident command and department-specific guidelines or job action sheets that guide actions and responses. (A) All trauma program surgeons, trauma liaisons, trauma program personnel, operating suite leaders, and critical care medical directors and nursing leaders must complete a mass casualty response training on their role and potential job functions and job action sheet to ensure competency regarding measures for surge capacity and patient flow management from resuscitation to inpatient admission, operative suite, and critical care during a multiple casualty or mass casualty event. (B) The trauma program must have documented evidence of an annual mass casualty or a no-notice multiple casualty simulation training that integrates EMS and is planned by the TMD, emergency department medical director, TPM, trauma administrator, operating suite				

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leaders, critical care leaders, and facility emergency management leaders.				
(34) The trauma facility must have a process in place to provide trauma patient outcomes and feedback to EMS providers. (A) The facility must have documented guidelines to provide EMS time-out for the arriving injured patient that are a collaborative outcome between the TMD, emergency department medical director, and the EMS medical directors. (B) Trauma patient outcomes and feedback must adhere to the Health Information Portability Accountability Act (HIPAA). (C) Processes must be established and agreed to between the TMD and the EMS medical directors for the top three EMS transporting agencies to receive trauma patient outcomes, feedback, and identify opportunities for improvement for the patients they transport to the facility on a scheduled basis. (D) Trauma facilities must provide EMS feedback within 30 days of the date of arrival on trauma patients the EMS providers transported to the facility, as requested. (E) Feedback must include the first 24 hours of care, resuscitation disposition, injury diagnosis available, operative interventions, and demographic information. (F) All identified EMS opportunities for improvement are shared with the specific transporting EMS provider following HIPAA guidelines.				

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Priority 1 = Need 24 to 18 months lead time to establish new processes and monitor compliance to requirement.

Priority 2 = Need 18 months to modify current process and monitor compliance to requirement.

Priority 3 = Need 15 to 12 months update processed and monitor compliance to requirement.

Priority 4 = Current systems or processes in place require little modification and monitoring is in place.

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