

STATE OF WYOMING



Department of Health

Rules and Regulations for Wyoming Trauma Program

**W.S. 35-1-801
(2008 Revision)**

Chapters 1 through 4

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**State of Wyoming
Department of Health**

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WYOMING TRAUMA RULES

Chapter 1

GENERAL PROVISIONS

Section 1. Authority. These rules shall also apply to and govern the reimbursement of uncompensated trauma care to hospitals and ambulance services as outlined in House Enrolled Act 52 passed by the 2008 Budget Session. and W.S. 35-1-801, et. seq.

Section 2. Purpose and Applicability.

(a) These rules are designed to create an organized, statewide system for trauma patient care through the establishment of trauma service areas served by designated trauma center hospitals for which standards are set. The standards are formulated to be consistent with national criteria established by the American College of Surgeons and the American College of Emergency Physicians and have extended those criteria to meet the needs of Wyoming. These rules are applicable to facilities and emergency medical service providers which participate in the Wyoming Trauma Plan. They are designed to be consistent with and should be read in conjunction with the Wyoming Emergency Medical Services Act of 1977, W.S. 33-36-101, as amended, and the Standards, Rules, and Regulations for Hospitals and Related Facilities. The Department may issue manuals, bulletins, or both, to interpret the provisions of these rules and regulations. Such manuals and bulletins shall be consistent with and reflect the policies contained in these rules and regulations. The provisions contained in manuals or bulletins shall be subordinate to the provisions of these rules and regulations.

(b) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter of these rules and regulations.

Section 3. Definitions. The following definitions shall apply in the interpretation and enforcement of these rules. Where the context in which words are used in these rules indicates that such is the intent, words in the singular number shall include the plural and vice versa. Throughout these rules, gender pronouns are used interchangeably. The drafters have attempted to utilize each gender pronoun in equal numbers, in random distribution. Words in each gender shall include individuals of the other gender.

(a) “Advanced Trauma Life Support Course” or “ATLS” means the Advanced Trauma Life Support Course approved by the American College of Surgeons. When required by these rules, a physician shall maintain ATLS certification.

(b) “Acute Care Hospital” means a “hospital licensed in Wyoming pursuant to W.S. 35-2-901 through 35-2-912 and which provides acute patient care to patients with

injuries or illnesses.”

(c) “Area Trauma Hospital” or “ATH” means a designated facility that has the facilities and surgical capabilities to provide care for the majority of injured patients. Area Trauma Hospitals may serve as referral centers for Community Trauma Hospitals and Trauma Receiving Facilities. An ATH need not include a neurosurgeon on staff.

(d) “Basic Life Support” or “BLS” means treatment rendered by personnel trained to at least the Basic EMT level, including but not limited to procedures such as bandaging, splinting, basic first aid, and performing cardiopulmonary resuscitation (CPR), as defined in the Wyoming Emergency Medical Services Act of 1977, W.S. 33-36-101, or as amended.

(e) “Board” means the Wyoming State Board of Medicine established by W.S. 33-26-102 (iii).

(f) “Board Certified” means a physician who has been awarded a board diploma in a specialty recognized by the American Board of Medical Specialties, the Canadian Board, the American Osteopathic Association, or the American Board of Oral and Maxillofacial Surgery.

(g) “Board Eligible” or “Board Admissible” refers to a physician who has applied to the Board and has received a ruling that he has fulfilled the requirements to take the necessary examinations to become board certified in a specialty.

(h) “By-pass” or “Bypass” means direction given to a prehospital emergency medical services unit, by direct/on-line medical control or predetermined triage criteria, to divert past the nearest hospital and transport the patient to a facility better equipped and staffed to care for that particular patient’s needs.

(i) “Certified Critical Registered Nurse” or “CCRN” means a registered nurse who has completed the American Association of Critical-Care Nurses course of study and examination in the care of critically injured and ill patients.

(j) “Certified Registered Nurse Anesthetist” or “CRNA” means a registered nurse who has graduated from a school of nurse anesthesia accredited by the Council on Accreditation of Educational Programs of Nurse Anesthesia or its predecessor, and who has been certified as a nurse anesthetist by the Council on Certification of Nurse Anesthetists.

(k) “Community Trauma Hospital” or “CTH” refers to a designated facility that typically does not have twenty-four (24) hours per day coverage of its emergency department and shall, at a minimum, have only one (1) surgeon on staff. With these exceptions, these facilities are similar to Area Trauma Hospitals and may serve as referral centers for Trauma Receiving Facilities.

(l) “Consolidated Omnibus Budget Reconciliation Act” or “COBRA” refers to the consolidated Omnibus Budget Reconciliation Act of 1986 (Pub.L. 99-272,100 Stat.82). Adherence to COBRA is mandatory.

(m) “Continuing Education” refers to the minimum educational requirements necessary to remain certified in a medical discipline. “Continuing Nursing Education” refers to education approved or recognized by a national nurse's organization. “Continuing Medical Education” or “CME” refers to continuing education approved by the Board, Department of Health, State of Wyoming, or affiliated agencies.

(n) “Department” means the Wyoming Department of Health.

(o) “Designated Facility” refers to a health care facility that satisfies the requirements of one (1) of the four (4) categories of trauma facilities described in these rules.

(p) “Designation” refers to the process by which the Wyoming Office of Emergency Medical Services (OEMS) accepts plans submitted by Wyoming Health Care Facilities for inclusion within the Wyoming Trauma Plan, validates the plan, and assigns to the facilities the appropriate level as described in these rules.

(q) “Desirable” applies to a suggested criterion or standard which is not mandated or required for a trauma center. Compliance with this criterion or standard may be considered in the designation process.

(r) “Emergency Department” or “ED” or “Emergency Room” or “ER” means the area of a licensed health facility that customarily receives patients in need of emergency evaluation and/or care.

(s) “Emergency Medical Services” or “EMS” means the many agencies, personnel, and institutions involved in the planning, providing, and monitoring of emergency care for those suffering sudden illness or injury.

(t) “Emergency Medical Services for Children” or “EMS-C” means that portion of the emergency medical services system relating to the training of personnel and the provision of patient care to children suffering sudden illness or injury.

(u) “Emergency Medical System” means the entire system that provides care to a trauma patient through the entire spectrum of care.

(v) “Emergency Medical Technician” or “EMT” means a person who has graduated from a Division approved training program for Emergency Medical Technicians.

(w) “Emergency Medical Treatment and Active Labor Act” or “EMTALA” refers to that portion of COBRA codified at Section 1867 of the Social Security Act, and

the accompanying regulations in 42 CFR § 489.20(1), (m), (p), and (r).

(x) “Emergency physician” means a physician who provides medical coverage in an emergency room.

(y) “Emergency nurse” means a registered nurse who provides patient care or administrative services in an emergency room.

(z) “Essential” applies to a criterion or standard, compliance with which is mandated or required for designation.

(aa) “First Responder” means an individual who has completed an approved training program sponsored or approved by the OEMS in locating, providing initial basic emergency treatment, and removing individuals from imminent danger, and who is presently certified.

(bb) “Health Care Facility” means a facility as defined in W.S. 35-2-901 (a)(x).

(cc) “Health Care Provider” means a person who is licensed, certified, or otherwise authorized by the law of this state to provide health care in the ordinary course of business or practice of a profession, but does not include a person who provides services solely through the sale or dispensing of drugs or medical devices.

(dd) “Hospital” means a facility as defined in W.S. 35-2-901 (a)(xiii).

(ee) “Immediately Available” means unencumbered by conflicting duties or responsibilities, responding without delay when notified, and being within the specified area of the trauma facility when the patient arrives.

(ff) “Incident” means an admission to a hospital, both inpatient and outpatient, involving traumatic care for an individual patient within a one (1) year period to a single hospital. Admissions of the same patient for causes not directly related to an earlier admission shall be considered a separate incident.

(gg) “In House” means present at all times and immediately available to the trauma center or hospital. On call personnel are not considered in house.

(hh) “JCAHO” means the Joint Commission for Accreditation of Health Care Organizations, which is the organization responsible for accrediting Hospitals.

(ii) “Medical Control” means direction, advice, and supervision provided by medical personnel at a medical facility to prehospital personnel by radio, telephonic communications, written protocol, or direct verbal order. Medical control is also referred to as on-line medical supervision.

(jj) “Medical Director” means a licensed physician who is responsible for

supervising medical decisions. OEMS will employ a statewide medical director to provide medical oversight to the state trauma plan. Each designated facility will be required to have its own medical director.

(kk) “Mid-level practitioner” refers to a physician assistant or advanced practitioner of nursing as defined in Title 33 of the statutes.

(ll) “Monitored Bed Unit” or “MBU” refers to each area of a facility that focuses on patients who are acutely ill but with a reversible disease. These patients require skilled nursing care, close observation, monitoring and management. All patients, who in the opinion of the attending physician are critically ill, unstable or require intensive monitoring, can be admitted to a MBU.

(mm) “Multi Disciplinary Trauma Committee” means a committee within each of the designated facilities that provides oversight and leadership to the trauma program of that specific facility.

(nn) “Off-line administration” refers to establishment and monitoring of medical components of a medical system including protocols, standing orders, educational programs, and the quality and delivery of on-line medical supervision.

(oo) “On Call” means agreeing to be available to respond to the trauma center in order to provide a defined service. On call personnel shall be at the trauma center or hospital when their presence is required, in accordance with an on call roster, and either promptly available or readily available.

(pp) “On Site Survey Team” refers to a multi disciplinary group of individuals who are knowledgeable in trauma care and trauma care systems. A team will be charged with the duty to inspect and interview each hospital or facility for purposes of designation verification.

(qq) “Patient” means a sick, injured, incapacitated, or helpless individual who requires medical supervision, treatment, or monitoring.

(rr) “Pediatric Advanced Life Support” or “PALS” means a course of training available through the American Heart Association. When required by these rules, medical personnel shall maintain PALS certification.

(ss) “Peer Review Process” means the review of professional practices within a health care facility for the purpose of reducing morbidity and mortality and for the improvement of care of patients in the facility.

(tt) “Physician” means a doctor of medicine or osteopathy licensed by the Board of Medicine to practice medicine and/or surgery under state law by the board.

(uu) “Poor” means any patient at or below 300% of the federal poverty level.

(vv) “Prehospital Provider” means personnel who are certified or who are licensed and function at any level in actually delivering prehospital care.

(ww) “Promptly Available” refers to those personnel who can be attending patients at the hospital or health care facility within a maximum of thirty (30) minutes from the time they are called.

(xx) “Protocol” means a written instrument that guides the collection of data regarding the patient, provides for actions to be taken based on the collected data, and provides for a minimum level of safe practice in specific situations.

(yy) “Quality Assurance” or “QA” means the evaluation of the performance of a hospital’s or system’s response to a given standard.

(zz) “Quality Improvement” or “QI” means a quality evaluation program that is on-going, team led, and research driven. QI focuses on care and performance improvement. QI emphasizes seeking ways to improve service, deliver care, manage resources, and develop professional competence.

(aaa) “Readily Available” refers to personnel who can be attending patients at the trauma center or hospital, within a maximum of one (1) hour from the time they are called.

(bbb) “Regional Advisory Council” or “RAC” means a council consisting of representatives of the Trauma Service Area (TSA), that provides consultation, education, and quality review for the member hospitals and health care facilities.

(ccc) “Regional Trauma Center” or “RTC” means a designated facility that has the medical staff and facilities to provide advanced care to trauma patients and serves as a referral hospital for the ATH, CTH, and Trauma Receiving Facility (TRF).

(ddd) “Registered Nurse” means a person who is licensed as a registered professional nurse in the state of Wyoming.

(eee) “Site Survey” means an on site review of a facility to determine if it meets the criteria for a particular level of designation or re-designation.

(fff) “State Trauma Plan” or “Trauma Care System” means a comprehensive plan, as required by W.S. 35-1-801, designed to organize Wyoming's health care facilities to more efficiently care for trauma patients.

(ggg) “Trauma” means a physical wound or injury, including a blunt injury, penetrating injury, or burn injury caused by external force or violence.

(hhh) “Trauma Care System” or “Trauma System” means an organized approach

to providing care to trauma patients that provides personnel, facilities, and equipment for effective and coordinated trauma care.

(iii) “Trauma Care Services” or “Traumatic Care” means services to patients with at least one (1) injury diagnosis code, using the International Classification of Diseases, 9th Edition, from 800.0 through 904, 925 through 929, 940 through 959.9, and 994.7, plus at least one (1) of the following:

- (i) Hospitalization for one (1) calendar day;
- (ii) Admission to the intensive care unit or monitored bed unit;
- (iii) Cardiac or respiratory arrest on route to the hospital or emergency room;
- (iv) Dead on arrival at the facility;
- (v) Transfer from or to another acute care hospital;
- (vi) Admission directly from the emergency room to the operating room;
- (vii) Trauma team activation;
- (viii) Meets prehospital triage criteria;
- (ix) Ambulance services providing transportation to a hospital or emergency room.

(jjj) “Trauma Program Coordinator” means a registered nurse with significant experience managing trauma systems and data. This individual is employed by the OEMS to assist with the management of the Wyoming Trauma System.

(kkk) “Trauma Nurse Coordinator” means a registered nurse with specific experience in coordination of nursing of trauma patients and assumes the responsibility for or monitors the care of trauma patients throughout a hospital or facility.

(lll) “Trauma Patient” means a person who has sustained an acute injury.

(mmm) “Trauma Receiving Facility” or “TRF” means a designated facility that may include a hospital with no surgical coverage, to a small rural clinic. These facilities will provide initial resuscitation and stabilization and, as needed, will transfer critically injured patients to a higher level trauma facility.

(nnn) “Trauma Registry” means a comprehensive system established to facilitate data collection and processing from all Wyoming's designated trauma facilities. A registry is a statewide database which integrates medical and system information related to trauma patient diagnosis and the provision of trauma care by prehospital, hospital, rehabilitation centers, providers, and medical examiners. The data base is used to monitor trauma patient outcomes.

(ooo) “Trauma Service Area” or “TSA” means a geographic area designated by the OEMS for the purpose of developing a trauma system that is consistent with patient care and transport needs of the local hospitals and health care facilities.

(ppp) “Trauma Service Costs” means costs related to a facility’s provision of trauma care to patients. These may include but are not limited to trauma team activation and the provision of staff for trauma call.

(qqq) “Trauma Transport Protocols” or “TTPs” refers to a document or group of documents which describes the policies, processes, and procedures governing the dispatch of vehicles, and the triage and transport of trauma patients or pediatric trauma patients.

(rrr) “Triage” means a process used to sort patients and determine priority of need and proper place of treatment.

(sss) “Verification” means a professional process based on a facility’s performance and compliance with established guidelines. Verification involves a site survey and attempts to measure the facility’s commitment to trauma care.

(ttt) “Waiver from Designation” means a hospital or medical facility that does not hold itself out to receive trauma patients and does not maintain an emergency department.

(uuu) “Wyoming Office of Emergency Medical Services” or “OEMS” means the Wyoming Department of Health’s lead agency for emergency medical services and trauma services in the state.

(vvv) “Wyoming Trauma Coalition” or “WTC” is a group of interested health professionals and citizens established by the OEMS for the purpose of making recommendations to develop and direct the trauma system as needed.

Section 4. General Organization of Trauma Plan.

(a) OEMS shall:

(i) Collect and compile information concerning:

(A) Clinical components of the Trauma System:

(I) Public information, education, and prevention;

(II) Prehospital care;

(III) Medical direction;

(IV) Triage; and

(V) Transportation.

(B) Evaluation components of the Trauma System:

- (I) Data collection; and
- (II) Trauma center quality improvement.
- (III) Standards of care and facility standards which include the designation of hospitals or health care facilities.

(ii) Establish a system for:

- (A) Verification and designation of trauma facilities; and
- (B) A mechanism for statewide trauma system evaluation.

(b) Wyoming Trauma Coalition.

(i) The WTC shall consist of:

- (A) The Trauma Program Coordinator;
- (B) The medical director of the trauma program;
- (C) OEMS Program Manager;
- (D) A representative from the American College of Surgeons Committee on Trauma;
- (E) A representative from the Wyoming Nurses Association and/or the Wyoming Emergency Nurses Association;
- (F) A certified EMT-Basic, EMT-Intermediate, and an EMT-Paramedic;
- (G) A representative from the Wyoming Chapter of American College of Emergency Physicians;
- (H) A representative from the Wyoming Chapter of American Academy of Family Physicians;
- (I) At least one (1) medical director and one (1) trauma nurse coordinator from each of the Regional Trauma Centers and at least one (1) medical director or physician from an Area Trauma Hospital, Community Trauma Hospital, or Trauma Receiving Facility selected so as to include as many different regions of the state as possible;
- (J) A representative from the Wyoming Hospital Association;

and

(K) A representative from the Wyoming State Medical Society.

(ii) The WTC shall provide a consultation, education, and quality review role. The Committee shall review regional trauma care delivery, patient care outcomes, and compliance with the requirements of these Chapters. The Committee will provide the following:

(A) Communication with:

(I) Regional Advisory Councils (RACs) of each TSA;

(II) Participating facilities;

(III) Wyoming Department of Health;

(IV) Prehospital providers;

(V) Professional organizations; and

(VI) The general public.

(B) Education of all constituents and organizations in the delivery of trauma and emergency medical care;

(C) Public education coordination;

(D) Recommendations to RACs and participating facilities for regional trauma planning;

(E) Recommendations to RACs and participating facilities for policy development; and

(F) Injury prevention recommendations.

(iii) The WTC shall provide for quality improvement (QI) in the statewide trauma system.

(iv) The WTC shall have a written plan for implementation that will describe:

(A) Scope of trauma and emergency services offered in the regions;

(B) Ongoing assessment of performance of the regional EMS

and trauma care system, based on data supplied by the trauma registry and other sources including, but not necessarily limited to:

- (I) Trauma care delivery;
- (II) Patient care outcomes, including pediatric and adult patient outcomes;
- (III) Unexpected deaths; and
- (IV) Compliance with the requirements of W.S. 35-1-801, et. seq., and this Chapter.

(C) Identification and analysis of trends and other information, based on trauma registry data;

(D) Periodic assessment of data concerning aspects of patient care;

(E) Policies regarding confidentiality of data elements related to identification of provider's and facility's care outcomes, in accordance with applicable state and federal laws and regulations;

(F) Policies regarding confidentiality and release of patient care quality assurance committee minutes, records, and reports in accordance with applicable state and federal laws and regulations, including a requirement that each attendee of a RAC meeting is informed in writing of the confidentiality requirement. Information identifying individual patients shall not be publicly disclosed without the patient's consent or by court order;

(G) Policies regarding confidentiality of documentation of the results of inquires involving patient care issues; and

(H) Provision for feedback to the OEMS and the RAC on identified EMS and trauma system issues and concerns.

(v) It is desirable that the Committee meet on a quarterly basis, with meetings held in rotating locations or utilizing compressed video to assure easy access for Committee members.

(c) Advertising / Marketing. Only a facility which has been designated and continues to maintain designation by the Wyoming Office of Emergency Medical Services may use the terms "designated trauma center, service, unit, facility, program, hospital," or any similar terms in advertising or marketing materials, or in any other way hold itself out to the public as providing trauma treatment or services of the type offered by the designated facilities listed above and described in these rules.

Section 5: Severability. If any portion of these rules is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

Section 6: Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department including manuals, bulletins, and policy statements, which are inconsistent with this Chapter.

Section 7: Effective Date. These rules are effective when duly approved and filed by the Secretary of State.

Chapter 2

DESIGNATION PROCESS

Section 1. General Procedure.

(a) Trauma Care Facilities - Designation Process.

(i) The facility designation categories are as follows:

- (A) Regional Trauma Centers (RTCs);
- (B) Area Trauma Hospitals (ATHs);
- (C) Community Trauma Hospitals (CTHs); and
- (D) Trauma Receiving Facilities (TRFs).

(ii) The designation process shall consist of:

(A) Each facility providing information to the OEMS regarding that facility's capabilities as a trauma facility;

(B) A site survey as specified in Chapter 2, Section 1, (c);

(C) Identification of facility requirements that are not met by the facility. The OEMS shall provide advice and education to assist the facility in meeting these identified requirements; and

(D) Upon meeting the facility requirements, the OEMS shall assign a specific designation for a period of three (3) years.

(iii) The OEMS may provide consultation, advice, and/or technical assistance to facilities who request assistance in any aspect of this process. Telephone the OEMS Trauma Program Coordinator at (307) 777-7955.

(iv) The OEMS shall develop a designation criteria form for facilities seeking designation or renewal of designation as trauma care facilities. The form shall include:

(A) System standards for facility level and category of designation sought;

(B) Designation criteria form requirements;

(C) Evaluation criteria;

- (D) Goals and objectives of the facility;
- (E) Capability to provide trauma care;
- (F) Commitment to serve the trauma care needs of the state-wide system;
- (G) Compliance with goals of the state trauma plan; and
- (H) Geographic area for which the facility proposes to provide trauma care coverage.

(v) The OEMS's analysis of the submitted designation criteria form shall include a review of:

- (A) The evidence of participation in system planning;
- (B) The completeness of the form materials submitted; and
- (C) The facility's self-study for comparison with the criteria.

(vi) The facility shall:

(A) Submit designation criteria form to OEMS within ninety (90) working days of receiving the these materials from the OEMS;

(B) Within thirty (30) working days of receipt of a form from the facility, the OEMS shall review the designation criteria form for completeness and notify the facility of the result of that review;

(I) If the form is complete, the facility shall be notified in writing;

(II) If the form is incomplete, the facility shall be notified in writing of omissions or errors. The facility may refile the form when complete; and

(vii) The OEMS may grant provisional designation, for a period not exceeding one (1) year, to facilities that are currently unable to meet the standards of this Chapter of these rules, in order to ensure adequate trauma care.

(viii) The OEMS shall;

(A) Conduct a site survey of each facility in accordance with this Chapter, Section 1 (b) (ii) (B) and Section 1 (c); and

(B) Consider applications for designation, if and when applications are received, from facilities located and licensed in adjacent states in the same manner as applications received from facilities located and licensed in Wyoming.

(ix) After an evaluation to determine the current capability of each facility to meet or exceed the requirements of this Chapter for the applicable level of designation applied for, the OEMS shall designate the health care facility, based on the following guidelines:

- (A) Evaluation of the designation criteria form submitted;
- (B) Recommendations from the on site survey team;
- (C) For facilities that have been previously designated, outcomes of trauma patients during the previous designation period;
- (D) Quality of care provided to patients residing in that area;
- (E) Ability of each facility to comply with goals of the state and regional plan; and
- (F) Compliance with these rules during the previous designation period.

(x) The OEMS shall:

- (A) Notify the facility in writing of designation or denial of designation. This notification shall include a written report of the site survey; and
- (B) Notify the OEMS and RACs of the name, location, level, and category of service of facilities that have been designated.

(xi) The OEMS shall issue a renewal designation criteria form as described in this section, for all interested health care facilities, including those currently designated, no later than one hundred twenty (120) working days prior to the expiration of each facility's current designation.

(b) Site survey for designation. The OEMS shall perform a site survey of all facilities prior to designation.

(i) The OEMS shall establish multi disciplinary on site survey teams composed of individuals knowledgeable in trauma care appropriate to the level of designation requested. On site survey team members may include:

- (A) Trauma surgeons;

- (B) Emergency physicians;
- (C) Trauma nurse coordinators;
- (D) Physicians knowledgeable in pediatric trauma;
- (E) Family physicians;
- (F) Hospital or medical administrators;
- (G) OEMS personnel; and/or
- (H) Other specialties as needed for the level and category applied for.

(ii) On site survey teams for Regional Trauma Centers and Area Trauma Hospitals will, consist of a general surgeon who is an out-of-state surveyor, an emergency physician, and a trauma nurse coordinator with experience in similar trauma systems.

(iii) On site survey teams for Community Trauma Hospitals and Trauma Receiving Facilities may be composed of in state surveyors, including a general surgeon, an emergency physician, and a trauma nurse coordinator.

(iv) The on site survey team shall evaluate the appropriateness and capabilities of the facility to provide high quality trauma care services, and validate the facility's ability to meet the responsibilities, equipment, and performance standards for the level of designation sought. The evaluation shall include, but not necessarily be limited to:

(A) Reviewing medical records, staff rosters, and schedules, quality assurance committee meeting minutes, and other documents relevant to trauma care;

(B) Reviewing equipment and the physical plant; and

(C) Conducting interviews with the appropriate hospital personnel.

(v) The on site survey team shall:

(A) Make a verbal report of findings to the facility prior to leaving the facility; and

(B) Make written recommendations to the OEMS in the format

prescribed by the OEMS.

(vi) The OEMS shall review the report and recommendations to determine if the facility is substantially in compliance with the criteria. If the facility does not meet the criteria for the level of designation for which it applied, the OEMS, at its sole discretion, shall discuss designation at a lower level with the facility.

(vii) In the event there is an area in which the facility does not comply with the criteria, the OEMS shall within thirty (30) working days notify the facility, in writing, of deficiencies and recommend corrective action. The facility may submit to the OEMS a report which outlines the educational and corrective action taken. Before approving the designation, the OEMS may, at its sole discretion, elect to perform an on site inspection to confirm that the action taken brings the facility into compliance with all relevant criteria. If the OEMS elects not to perform an on site inspection and if the report substantiates action which brings the facility into compliance with all relevant criteria, the OEMS may approve the designation. If the facility disagrees that there is a need for corrective action, the facility may file a grievance according to Section 4 of these rules.

(viii) The OEMS shall require and maintain confidentiality of information, records, and reports developed pursuant to site surveys to the extent allowed by law. Members of the on site survey team shall not divulge any information obtained or included in reports submitted to the OEMS relating to the site survey, unless ordered to do so by a court of competent jurisdiction.

(ix) The facility may submit to the OEMS written objections to the report or recommendations or concerns regarding conflicts of interest pertaining to any member of the on site survey team.

(x) Applications from facilities located and licensed in adjacent states shall be treated in same manner as applications received from Wyoming facilities.

(c) A designated trauma facility shall:

(i) Notify those facilities necessary for appropriate transfer of trauma patients as soon as possible before the applicable situation, if it anticipates being unable to comply with designation standards for twenty-four (24) hours or more¹;

(ii) Immediately notify the OEMS, the WTC, and the RAC if it chooses to cease providing trauma services commensurate with its designation level. If the facility chooses to apply for a lower level of designation, it may do so at any time. This may be accomplished by initiating a new designation process as described in Section 1 of Chapter 2 of these rules. There shall be a paper review by the OEMS to determine if a full survey shall be required. This does not apply to temporary re-designation as described in Section 1 (d) (i) above.

¹ Each facility shall develop written notification protocols.

(iii) Comply with the provisions within these sections, all current state and system standards as described in this Chapter, and all policies, protocols, and procedures set forth in the system plan;

(iv) Continue its commitment to provide the resources, personnel, equipment, and response as required by its designation level;

(v) Participate in the state trauma registry as described in Section 1 of Chapter 3 of these rules; and

(vi) Have a written transfer agreement with a receiving trauma facility² (as appropriate) for the transfer of severely injured trauma patients. This transfer agreement shall include written guidelines for determining the basis for seeking consultation and arranging the transport of trauma patients. Trauma transport protocols must comply with current EMTALA and COBRA/OBRA regulations and shall include the following:

(A) The physician in the initial receiving facility shall be responsible for a decision to transfer a patient to another facility. Unless circumstances make such contact impossible, a physician or a physician-supervised mid-level practitioner in the initial receiving facility shall have direct contact with the physician at the accepting hospital before the transfer occurs;

(B) Once the decision to transfer has been made, it should be accomplished as soon as it is feasible. Resuscitation and stabilization should begin at the referring hospital, realizing that the patient's problems may be such that true stabilization may only be possible at another facility³. Transport decisions must comply with current EMTALA and COBRA/OBRA regulations;

(C) The mode of transportation used for transfer shall be determined based on time, medical interventions necessary for ongoing life support during transfer, and availability of resources. The referring and accepting physicians shall agree, prior to initiating transfer, who will assume responsibility for on-line medical control during transfer;

(D) All designated trauma services shall have written transfer agreements for the identification and transfer of patients with special care needs who meet interhospital transfer criteria; and

(E) Transfer agreements shall include the responsibility of the transferring hospital and of the receiving hospital and determine the method of assigning medical control during interhospital transfer.

² The receiving facility may be an in state facility or an out of state facility.

³ All medical advanced directives shall be adhered to.

(d) The OEMS may at any time review, inspect, evaluate, and audit all trauma patient records, trauma quality assurance committee minutes, and other documents relevant to trauma care in any designated facility at any time to verify compliance with criteria. The OEMS shall maintain confidentiality of such records as required by federal and state statutes and rules. Such inspection shall be scheduled by the OEMS when appropriate.

(e) When a health care facility is designated or loses its designation as a trauma care facility, such information is not confidential and is considered public information.

(f) Whereby the OEMS may grant a waiver from designation to hospitals and medical facilities that do not maintain an emergency department or advertize to care for trauma patients.

Section 2. Plan Development.

(a) Facilities shall have a trauma plan that is consistent with the Wyoming Trauma Plan and these rules and shall include the following:

- (i) Summary of the plan;
- (ii) Organizational structure;
- (iii) System design;
- (iv) Objectives;
- (v) Implementation schedule; and
- (vi) Fiscal impact of the system.

(b) Regional Advisory Councils:

(i) The RAC shall develop a system plan based on standard guidelines for comprehensive system development. The system plan is subject to approval by the OEMS. The OEMS shall review the plan to assure that:

(A) All counties within the region have been included unless a specific county, or portion thereof, has been included within an adjacent system;

(B) All health care entities and interested speciality centers have been given an opportunity to participate in the planning process; and

(C) The following have been addressed:

- (I) Access to the system;
- (II) Communications;
- (III) Medical oversight;
- (IV) Prehospital triage criteria;
- (V) Diversion protocols;
- (VI) Bypass protocols;
- (VII) Regional medical control;
- (VIII) Facility triage criteria;
- (IX) Inter-hospital transfers; and
- (X) A quality improvement program that evaluates the outcome from a system perspective.

(ii) The RACs shall:

- (A) Advise the OEMS concerning the statewide trauma system;
- (B) Establish trauma education and injury prevention programs.

(iii) The RAC is an entity which functions without the expectation of state or federal funding.

(iv) The RACs may request technical assistance from the OEMS.

(v) The RACs shall not require changes to referral or transport patterns for individual facilities.

(vi) The RAC shall provide a report by December 31 each year to the OEMS. This report shall describe the progress toward system development and include evidence that members of the RAC are currently involved in trauma care.

(c) Confidentiality.

(i) Data and reports concerning peer review, quality improvement, or the quality of the trauma care provided by a health care facility or a health care provider that are produced by a RAC or the WTC or provided by a health care facility to a RAC or the WTC as well as the proceedings of those committees concerning peer review and

quality improvement shall be confidential, as required by applicable federal and state laws and regulations.

(ii) A statistical report on trauma and trauma care developed by the OEMS that does not identify specific health care facilities, health care providers, or patients is not confidential and is considered public information.

Section 3. Policy Development. Health care facilities planning to implement a trauma system shall develop policies which, at a minimum, address the following:

- (a) The multi disciplinary nature of systemized trauma care;
- (b) Public information and education about the trauma system;
- (c) Marketing and advertising by trauma centers and prehospital providers as it relates to trauma care system;
- (d) Establishment of service areas for trauma hospitals;
- (e) EMS dispatching;
- (f) Communication system usage;
- (g) Transportation, including inter-trauma center transfer and transfer from a receiving hospital to a trauma center;
- (h) The integration of burn and pediatric hospitals, when applicable, into the overall Trauma Care System to ensure all trauma patients receive appropriate trauma care in the most expeditious manner possible;
- (i) Training of prehospital EMS personnel;
- (j) EMS and trauma care coordination and mutual aid between neighboring jurisdictions;
- (k) Coordination and integration of trauma care with non-medical emergency services;
- (l) Medical control and accountability, including triage and treatment protocols;
- (m) System organization and management;
- (n) Data collection and management;
- (o) Quality control and system evaluation; and

- (p) Assuring the availability of trauma team personnel.

Section 4. Denial, Revocation or Suspension of Designation and Appeals Process.

(a) OEMS shall deny an application for designation if it finds in the course of the designation process, that the applying facility:

- (i) Is unable to meet the requirements of Chapter 4 of these rules for the level of designation sought;

- (ii) Made a false statement of a material fact in its application for designation;

- (iii) Refuses to allow representatives of the OEMS to inspect any part of the facility, records, documentation, or files;

- (iv) Is unable to meet or comply with the requirements of the approved trauma plan;

- (v) Refuses to submit data to the state trauma registry as described in Chapter 3, Section 1 of these rules; or

- (vi) Has engaged in unauthorized disclosure of medical or other confidential information.

(b) OEMS shall revoke or suspend designation if any owner, officer, director, or managing employee of a designated facility:

- (i) Fails to comply with Section 5 (e) of the State of Wyoming Department of Health Standards, Rules, and Regulations for Hospitals and Related Facilities;

- (ii) Fails or refuses to comply with the provisions of this Chapter or Chapter 4 of these rules;

- (iii) Fails to provide data to the trauma registry;

- (iv) Makes a false statement of a material fact in the application for designation or in any record required by this Chapter or in a matter under investigation;

- (v) Prevents, interferes with, or attempts to impede in any way, the work of a representative of the OEMS in the lawful enforcement of this Chapter;

- (vi) Misrepresents or is fraudulent in any aspect of conducting

business, or has been unable or refuses to comply with OEMS requirements; or

(vii) Is substantially out of compliance with the requirements of this Chapter and Chapter 4 of these rules, and has been unable to or refused to comply with OEMS requirements.

(c) The OEMS shall notify a facility in writing of denial, revocation, or suspension of designation. Such notice shall include:

(i) The reasons for the action; and

(ii) Rights of the facility, which include a right to hearing, and may also include the opportunity to submit a plan of correction.

(A) The designated facility found out of compliance with Chapter 4 and this Chapter of these rules shall within thirty (30) working days, submit a plan of correction to the OEMS. The plan shall include steps the facility is to take to correct deficiencies. The OEMS shall provide assistance to the facilities that are out of compliance in order to bring the facility into compliance with these rules.

(B) When the facility submits a plan of correction, the OEMS shall approve or disapprove the plan within thirty (30) working days, unless the OEMS, at its sole discretion, elects to perform a site survey of the facility, in which case the OEMS shall approve or disapprove the plan within sixty (60) working days.

(C) Upon notification that the plan of correction is approved by OEMS, the facility shall implement that plan immediately.

(D) Upon the receipt of satisfactory evidence of correction, which may include a site survey, the OEMS may, at its sole discretion, reinstate designation status.

(E) The facility may appeal decisions of denial, suspension, or revocation of designation. Appeals will be addressed to the OEMS, Department of Health, Hathaway Building, Cheyenne, WY, 82002. Any appeal of the OEMS' decision shall be conducted in accordance with the Wyoming Administrative Procedure Act (W.S. 16-3-101 through W.S. 16-3-115).

(d) Designation shall, unless earlier evoked or suspended, expire three (3) years after the date of award unless the designee has made a timely and sufficient request for renewal of the designation.

(e) OEMS shall conduct a site survey to inspect the facilities of all applicants, during the initial designation of the trauma facility and the renewing verification of such designation, for compliance of this part and Chapter 4 of these rules. A report of inspection shall be provided to the OEMS within thirty (30) working days after the site

survey. Within thirty (30) working days of receipt of the inspection report, the OEMS may accept or reject the plan for designation based upon the findings and recommendations of such reports.

Section 5: Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department including manuals, bulletins, and policy statements, which are inconsistent with this Chapter.

Chapter 3

DESIGNATED FACILITIES' REQUIREMENTS FOR PARTICIPATION

Section 1. Data Collection. For the purpose of improving quality of trauma care, all designated facilities within the state are required to participate in use of the state trauma registry and report a portion of that data to OEMS for systems evaluation.

- (a) The OEMS shall:
 - (i) Establish a statewide data registry to collect and analyze data on the incidence, severity, and causes of trauma for the purposes of:
 - (A) Improving trauma patient care;
 - (B) Monitoring and providing information necessary to evaluate major trauma patient care and outcome;
 - (C) Assessing compliance with the standards of state trauma system operation and designation of prehospital providers, health care facilities, hospitals, and rehabilitation services;
 - (D) Providing information necessary for resource planning and management;
 - (E) Providing data for injury surveillance, analysis, and prevention programs; and
 - (F) Providing a resource for research and education.
 - (ii) Establish criteria to identify injury types to be included in the state trauma registry. These criteria shall be used by designated health care facilities.
 - (iii) Suggested sources of data for the trauma registry include but are not limited to:
 - (A) All prehospital providers;
 - (B) Medical examiners reports;
 - (C) Death Certificates;
 - (D) Wyoming Fire Incident Report System;
 - (E) Hospital discharge data;

- (F) Law enforcement agency records; and
- (G) Other sources, as available.

(iv) Establish, publish, and periodically review the required data elements to be submitted to provide information regarding injury, trauma care, and system operation, in the following categories:

- (A) Demographic;
- (B) Anatomic;
- (C) Physiologic;
- (D) Severity;
- (E) Epidemiologic;
- (F) Resource utilization;
- (G) Quality assurance;
- (H) Outcome; and
- (I) Financial.

(v) Require a case specific patient identifier which complies with the patient confidentiality requirements of these rules common to all data sources used in the trauma registry.

(vi) Provide procedures for electronic submission of data including specifications for necessary software, or provide paper forms for manual submission of data, if needed.

(vii) Provide for data quality assurance by:

(A) Developing detailed protocols for quality control, consistent with the OEMS's most current data quality guidelines;

(B) Performing validity studies to assess the completeness and accuracy of case identification and data collection; and

(C) For each provider submitting data to the registry, providing a report on completeness and accuracy of data submitted.

(viii) Evaluate requests from the WTC and RACs for collection of

voluntarily submitted additional data elements from agencies and facilities in that region.

(b) The prehospital data shall include at least the following, when applicable:

- (i) Total number of ambulance runs per year;
- (ii) Number of trauma runs per year;
- (iii) Transportation times; and
- (iv) Patient outcomes.

(c) The hospital data shall include at least the following, when applicable:

(i) Data from a trauma center or hospital:

(A) Time of arrival and description of patient treatment in:

- (I) Emergency department or trauma receiving area;
- (II) Operating room.

(B) Dates for:

- (I) Initial admission;
- (II) Intensive care; and
- (III) Discharge.

(C) Discharge data including:

- (I) Patient destination; and
- (II) Patient outcome after rehabilitation.

(ii) Data from an intermediary hospital. In the event that a patient is first transported to a receiving hospital and subsequently transferred to another facility, the applicable information from the sections above shall be available from patient care. All related records will be supplied by the hospital the patient is transferred to and sent to the transferring hospital for entry into the trauma registry.

(d) Trauma Registry- Reports. Within three (3) months after receiving trauma registry data from the individual hospitals and facilities, the OEMS shall report to the submitting facilities:

(i) Semiannually and annually on all patient data entered into the trauma registry during the six (6) month reporting period;

(ii) Semiannually, on trends, patient care outcomes, and other data, for each region and for the state, for the purpose of regional evaluation; and

(iii) Periodically on reported financial data.

(iv) Aggregate regional data semiannually to the WTC and the Regional Advisory Council excluding any confidential or identifying data.

(e) Confidentiality. Patient identifiers shall be kept in such a way to assure that patient confidentiality is maintained. The OEMS shall comply fully with all federal and state laws and regulations concerning confidentiality.

(i) Data elements related to the identification of individual patient's, provider's, and facility's care outcomes shall be confidential and the OEMS shall comply with all federal and state laws and regulations concerning confidentiality.

(ii) Persons and organizations to whom the OEMS grants access to information collected under this Chapter shall use the information for only those purposes explicitly stated in the OEMS authorization for access.

(iii) All raw data collected and maintained by the OEMS is the property of OEMS.

(f) Provider Responsibilities.

(i) All facilities shall:

(A) Use the criteria set forth by the OEMS for inclusion of patient data in the trauma registry; and

(B) Submit required registry data to the OEMS.

(ii) Data collected shall be recorded upon the registry software provided by the OEMS, using the data elements provided.

(iii) Data shall be submitted to the OEMS on a semi-annual basis:

(A) Data for patients discharged between July 1 and December 31 shall be submitted by June 30 of the following year; and

(B) Data for patient discharged between January 1 and June 30, shall be submitted by December 31 of the same year.

(iv) If the patient is further transported from one acute care hospital to another acute care hospital, a follow-up report of the care the transferred patient received and the final disposition of the patient shall be provided by the receiving hospital to the transferring hospital. The transferring hospital shall complete the trauma registry data for that patient, based upon the information it receives.

Section 2. Trauma System Evaluation. All designated facilities will be required to participate in quality initiatives within these rules.

(a) The following key components shall be addressed by the quality improvement plan designed by each facility:

- (i) Clearly stated goals and objectives;
- (ii) An organizational structure which facilitates the process of quality improvement;
- (iii) The development of standards of care;
- (iv) Established quality indicators (audit filter);
- (v) A plan to define adverse outcomes by using a code that describes the complications;
- (vi) A systematic peer review process utilizing a multi disciplinary method and involving prehospital care providers;
- (vii) A plan to incorporate autopsy information, where available, regarding all trauma patients; and
- (viii) A facility plan that includes a method for computing survival probability and comparing patient outcome.

(b) All designated trauma care services shall:

- (i) Document the trauma care quality assurance program's proceedings, findings, conclusions, recommendations, the actions taken, and the result of these actions, demonstrating that relevant findings are used to study and improve processes that affect trauma patient care;
- (ii) Evaluate the results of the trauma quality assurance program and include them with the hospital's general quality assurance program; and
- (iii) Participate in the state trauma registry as required by Section 1 of Chapter 2.

(c) A standard or protocol adopted or studied by the individual facilities may not be used by the OEMS to demonstrate negligence by a health care provider or health care facility to whom the standard or protocol applies.

Section 3: Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department including manuals, bulletins, and policy statements, which are inconsistent with this Chapter.

Chapter 4

FACILITY STANDARDS

Section 1. Regional Trauma Centers. To be designated a Regional Trauma Center (RTC), a licensed general acute care hospital shall have at least the following:

(a) Hospital Organization.

(i) Trauma Service. The trauma service shall be established and recognized by the medical staff and its bylaws and be responsible for the overall coordination and management of the system of care rendered to the injured patient. The trauma service must come under the organization and direction of a general surgeon or emergency physician who is trained, experienced, and committed to the care of the injured patient. All patients with multiple system trauma or major injury must be evaluated by the trauma service. The surgeon or emergency physician responsible for the overall care of each patient must be specifically identified.

(ii) Trauma Program Director. The director must be a board certified surgeon or a board certified emergency physician with demonstrated competency in trauma care. The director shall develop a quality improvement process and, through this process, shall be responsible for all trauma patients and administrative authority for the hospital's trauma program. The director shall be given administrative support to implement the requirements specified by the Wyoming Trauma Plan. The director shall work with the credentialing process of the hospital and participate with the credentialing committee to recommend participation on the trauma team⁴. The trauma director or his designee shall be actively involved with trauma care development at the community, state, and national level.

(iii) Trauma Team. The hospital shall have a policy describing the respective 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 staff. The team leader shall be a qualified surgeon or emergency physician who is clinically capable in all aspects of trauma care. Suggested composition of the trauma team may include:

- (A) Surgeons;
- (B) Anesthesiologists;
- (C) Emergency physicians;

⁴ It is strongly recommended that the director be an instructor in the American College of Surgeons Advanced Trauma Life Support (ATLS) course and maintain current ATLS certification or maintain certification of attendance to an American College of Emergency Physicians (ACEP) accredited trauma conference every two (2) years, maintain personal involvement in care of the injured, be educated in trauma care, and involved in professional organizations.

- (D) Laboratory technicians;
- (E) Registered nurses;
- (F) Physician specialists as dictated by clinical needs;
- (G) Prehospital care providers;
- (H) Radiology technicians;
- (I) Respiratory therapists; and
- (J) Social services/pastoral care.

(iv) **Qualifications for Surgeons on the Trauma Team.** As a general rule, all surgeons on the trauma team shall be board certified in a surgical specialty recognized by the American Board of Medical Specialties, the Canadian Board or the American Osteopathic Association. An exception to this rule is Oral and Maxillofacial Surgery. These physicians shall be board certified by the American Board of Oral and Maxillofacial Surgery⁵. The surgeons shall participate in the multi disciplinary trauma committee and the quality improvement process. All general surgeons participating on the trauma team shall be current in ATLS and be involved in continuing education specific to trauma sufficient to maintain quality patient care. This includes all residents.

(v) **Trauma Nurse Coordinator.** A RTC shall have a registered nurse working in the role of trauma nurse coordinator. Working in conjunction with the trauma director, the trauma nurse coordinator shall organize the program and all systems necessary for the multi disciplinary approach throughout the continuum of trauma care. The trauma nurse coordinator shall coordinate optimal patient care for all injured patients⁶.

(vi) **Multi Disciplinary Trauma Committee.** The purpose of the committee is to provide oversight and leadership to the entire trauma program. The major focus shall be quality improvement activities, policy development, communication among all team members, development of standards of care, education, and outreach programs and working with appropriate groups for injury prevention. The clinical managers (or designees) of the organizational areas involved with trauma care shall play

⁵ It is understood that many boards require a practice period, and that complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five (5) years after successful completion of residency, that individual is unacceptable for inclusion on the trauma team.

⁶ Recommended credentials for this position include: Certified Emergency Nurse (CEN), Trauma Nurse Core Course (TNCC) (or equivalent education), demonstrated expertise in trauma care, five (5) or more years clinical nursing experience, experience with hospital quality assurance programs including a trauma registry, experience in education program development and membership in professional organizations.

an active role with the committee. The committee shall include representatives from each of the following areas, unless the hospital has no such organizational area defined:

- (A) Administration;
- (B) Anesthesia;
- (C) Emergency Department;
- (D) Family Practice Residency Program;
- (E) Intensive Care;
- (F) General Surgery;
- (G) Laboratory;
- (H) Medical Records;
- (I) Neurosurgery;
- (J) Nursing;
- (K) Operating Room;
- (L) Orthopedics;
- (M) Pediatrics;
- (N) Prehospital care providers;
- (O) Radiology;
- (P) Rehabilitation;
- (Q) Respiratory Therapy; and
- (R) Trauma Nurse Coordinator.

(b) Clinical Components.

(i) A RTC shall have the following medical specialists available to the injured patient:

- (A) Emergency Medicine in house twenty-four (24) hours per day;

(B) Trauma/General Surgery; and

(C) Anesthesia.

(ii) The following specialists shall be on call and promptly available from inside or outside the hospital:

(A) Cardiology;

(B) Internal Medicine;

(C) Neurologic Surgery;

(D) Obstetrics/Gynecological Surgery;

(E) Ophthalmic Surgery;

(F) Oral/Maxillofacial;

(G) Plastic Surgery/ENT;

(H) Orthopedic Surgery;

(I) Pediatrics;

(J) Physical Medicine and Rehabilitation;

(K) Pulmonary/Intensive Care Medicine;

(L) Radiology;

(M) Thoracic Surgery;

(N) Urologic Surgery; and

(O) Vascular Surgery.

(iii) It is desirable to have the following specialists available to a RTC:

(A) Cardiac Surgery;

(B) Hand Surgery;

(C) Infectious Disease; and

(D) Microvascular Surgery.

(iv) The staff specialist on call shall be notified at the discretion of the trauma surgeon or emergency physician and will be promptly available. This availability will be monitored continuously by the quality improvement program. The specialist involved for consultation to the trauma patient shall be appropriately board certified and have an awareness of the unique problems of trauma patients.

(v) A general/trauma surgeon shall be qualified and have privileges to provide thoracic surgical care to patients with thoracic injuries. In instances where this is not feasible, the hospital shall apply for a waiver from the OEMS which at its sole discretion can grant such a waiver.

(vi) Policies and procedures shall be in place to notify the patient's primary physician of the patient's condition.

(c) Facility Standards.

(i) Emergency department.

(A) The hospital shall have an emergency department, division, service, or section staffed so that trauma patients are assured immediate and appropriate initial care. The emergency physician shall be in house twenty-four (24) hours per day and immediately available at all times, capable of evaluating trauma patients, providing initial resuscitation, and performing necessary surgical procedures not requiring general anesthesia.

(B) The emergency department medical director shall be board certified in emergency medicine⁷.

(C) The emergency medicine physician shall activate the trauma team based on predetermined criteria⁸. He will provide team leadership and care for the trauma patient until the arrival of the trauma surgeon in the resuscitation area. The emergency department shall 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 designee shall participate with the multi

⁷ It is highly recommended that the emergency medical physician be currently certified in ATLS or maintain certification of attendance to an ACEP accredited trauma conference every two (2) years. It is recommended that the emergency medicine physician participating with the trauma team should be board certified in a specialty recognized by the American Board of Medical Specialties, the Canadian Board, or the American Osteopathic Association. It is understood that many boards require a practice period, and the complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five (5) years after completion of a residency, that individual is unacceptable as the medical director of the emergency department.

⁸ Each facility may develop local written protocol for the activation of the trauma team.

disciplinary trauma committee and the trauma quality improvement process.

(D) General/Trauma Surgeon.

(I) A general/trauma surgeon shall be available on call twenty-four (24) hours per day to respond to the emergency department as requested. The trauma surgeon on call shall be promptly available to respond to the trauma patient. Local criteria shall be established to define conditions requiring the trauma surgeon's immediate hospital presence. The trauma surgeon's participation in major therapeutic decisions and presence in the emergency department for major resuscitation is highly recommended. The trauma surgeon's presence at operative procedures is mandatory. A system shall be developed to assure early notification of the on call surgeon and compliance with this criteria and their appropriateness must be monitored by the hospital's trauma quality improvement process. The surgeon shall maintain current certification in ATLS.

(II) The surgeon shall, in conjunction with the emergency physician, make key decisions about management of the trauma patient's care and determine if the patient needs transport to a higher level of care. If transfer is required, either the surgeon or emergency physician shall be accountable to coordinate the process with the receiving physician at the receiving facility. Generally, if an injured patient requiring surgery is to be admitted to the RTC, the surgeon shall be the admitting physician and will coordinate the patient care while hospitalized. Guidelines shall be written at the local level to determine which types of patients should be admitted to the RTC and which patients should be considered for transfer to a higher level of care.

(E) Nursing Personnel.

(I) Emergency nurses shall have special expertise in trauma care⁹.

(II) There shall be a minimum of two (2) registered nurses available in house twenty-four (24) hours per day to staff the emergency department to meet the needs of the trauma patient.

(ii) Surgical Suites. The surgical team is not required to be in house twenty-four (24) hours per day. This requirement may be met by a technician or nurse who is capable of responding to the trauma resuscitation area, anticipating the operative needs of the patient, initiating the call process for on call staff, and preparing the operating room for the patient. A team shall be on call with a well-defined mechanism/criteria for notification.

(A) Nursing Personnel. Surgical nurses shall participate in the

⁹ It is highly recommended that emergency nurses demonstrate successful completion of TNCC (or equivalent education), evidence of continuing education in trauma nursing, and participation in the ongoing quality improvement process of the trauma program.

care of the trauma patient and be competent in the surgical stabilization of the major trauma patient. Surgical nurses shall be trained in principles of resuscitation, mechanism of injury theory, multiple systems trauma, and knowledge of surgical instrumentation. The surgical nurses are integral members of the trauma team and shall participate in the ongoing quality improvement process of the trauma program and shall be represented on the multi disciplinary trauma committee.

(B) Policies and Procedures. Policies and procedures shall be in place for the following:

(I) Prioritized room availability for the emergency trauma patient during a busy operating schedule;

(II) Notification of on call surgical teams for both single and multiple patient admission;

(III) Managing death in the operating room and facilitating the organ procurement process;

(IV) Preservation of evidence;

(V) Patient monitoring by a registered nurse while the patient is in transport to the radiology suite or intensive care unit (ICU) from the operating room; and

(VI) In hospital access of blood and blood products to the operating room.

(C) Anesthesia. Anesthesia shall be promptly available with a mechanism established to ensure early notification of the on call anesthesiologist. Local criteria shall be established to determine when the anesthesiologist shall be immediately available for airway emergencies and operative management. The anesthesiologist participating on the trauma team shall be appropriately board certified or board eligible, have the necessary educational background in the care of the trauma patient, and participate in the multi disciplinary trauma committee and the quality improvement process.

(iii) Intensive Care Unit. The RTC shall have an ICU which meets the requirements of licensure in the state of Wyoming. Additionally the ICU shall have:

(A) Medical Director. The medical director for the ICU is responsible for the quality care and administration of the ICU. The trauma program director or his designee will work collaboratively with the ICU medical director to set policy and establish standards of care to meet the unique needs of the trauma patient.

(B) Physician Coverage. Trauma patients admitted to the ICU

shall be admitted under the care of a general surgeon or a qualified board certified physician who is knowledgeable about the care of ICU patients. Guidelines may be written for the rare exception to this rule (e.g., isolated head injury that the neurosurgeon agrees to manage). In addition to overall responsibility for patient care by the primary surgeon or ICU physician, there shall be in house physician coverage for intensive care at all times. This coverage may be provided by a physician who is approved by the director of the ICU. This coverage is for emergencies only (e.g., an unexpected extubation of an ICU patient) and is to ensure the patient's immediate needs are met while the identified surgeon or physician is contacted.

(C) Nursing Personnel. RTCs shall provide staffing in sufficient numbers to meet the critical needs of the trauma patient. Critical care nurses shall show evidence of completion of a structured in-service program which includes didactic and clinical content related to the care of the trauma patient¹⁰. ICU nurses are an integral part of the trauma team and as such, shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(iv) Post Anesthesia Recovery Room (PAR room). A RTC shall have a PAR room with staff on call twenty-four (24) hours per day and available to the postoperative trauma patient. PAR room staffing shall be as required for the critical needs of the trauma patient. Frequently it is advantageous to bypass the PAR room and directly admit to the ICU. In this instance, these requirements may be met by the ICU. PAR room nurses shall provide evidence of completion of a structured in-service program which includes didactic and clinical content related to the care of the trauma patient. PAR room nurses are an integral part of the trauma team and as such, shall be represented in the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(d) Clinical Support Services.

(i) A RTC shall have the following service capabilities:

(A) Radiological Service. A radiological service shall have a licensed radiological technician in house and immediately available at all times for general radiological procedures, angiography, imaging services, sonography, and computerized tomography (CT), for both head and body. If a technician is not in house twenty-four (24) hours per day for CT, angiography or sonography, the quality improvement process must document and monitor that the procedure is promptly available. A board certified radiologist shall administer the department and participate actively in the trauma quality improvement process. Written policy shall delineate the prioritization/availability of the CT scanner for trauma patients;

(B) Clinical Laboratory Service. Sufficient numbers of clinical

¹⁰ It is highly recommended that nurses in the ICU demonstrate special expertise in critical care by acquisition and maintenance of a CCRN certification.

laboratory technologists shall be promptly available at all times. A clinical laboratory service shall have the following services available twenty-four (24) hours per day:

(I) Comprehensive blood bank or access to a community central blood bank and adequate storage facilities;

(II) Standard analysis of blood, urine, and other body fluids;

(III) Blood gas and pH determinations. (This function may be performed by providers other than the clinical laboratory service, when applicable); and

(IV) Massive transfusion policy.

(C) Alcohol screening is required and drug screening is highly recommended.

(D) Social Service/Pastoral Care Support. 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 shall be readily available to trauma patients and their families. Programs shall be available to meet the unique needs of the trauma patients and their families.

(E) Rehabilitation. At the earliest stage possible after admission to the trauma center, each RTC shall address a plan for integration of rehabilitation into the acute and primary care of the trauma patient,. Designated hospitals shall identify a mechanism to initiate rehabilitation services and/or consultation upon admission as well as policies regarding coordination of the multi disciplinary rehabilitation team. Policies shall be in place to address the coordination of transfers between acute care facilities and rehabilitation facilities. Transfer agreements 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.

(F) Outreach. As a RTC, the trauma program shall develop programs for consultation with physicians in the region. Additionally, the trauma center shall provide leadership in professional education programs for prehospital care providers, nurses, and physicians in the hospitals and clinics in their region.

(G) Prevention/Public Outreach. The RTC shall take a leadership role in coordination of appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan shall take into consideration public awareness of the trauma system, access to the system, public support of the system, as well as specific prevention strategies. Substance abuse is consistently linked with traumatic injury and should be a key focus for prevention. Prevention

programs shall be specific to the needs of the region. Trauma registry data shall be utilized to identify injury trends and focus prevention needs.

(H) Transfer Protocol. RTCs shall work collaboratively with the referral trauma facilities in their region and develop interfacility transfer protocols. These guidelines shall address criteria to identify high risk trauma patients that could benefit from a higher level of trauma care. All trauma facilities shall provide services to the trauma patient regardless of their ability to pay. All transfer protocols shall be written in accordance with COBRA/OBRA and EMTALA regulations. Transfer protocols shall be written for specialty referral centers such as burn or spinal cord injury centers if the services are not available at the trauma center. The transfer agreement shall include a feedback loop so the primary provider has a good understanding of the patient outcome.

(I) Quality Improvement/Evaluation.

(I) All designated facilities shall participate in the trauma registry and submit data to OEMS as requested. The RTCs shall assist other facilities in their referral area in establishing the data collection process and, if necessary, provide data entry into the registry from abstracted patient records.

(II) Each RTC shall develop an internal quality improvement plan that, at a minimum, addresses the following key components¹¹:

(1) An organizational structure which facilitates the process of quality improvement (multi disciplinary trauma committee);

(2) Clearly stated goals and objectives of the quality improvement plan;

(3) The development of standards of care;

(4) A process to delineate privileges for all physicians participating in trauma care;

(5) Participation in the trauma statewide registry;

(6) Established quality indicators (audit filters). The plan must include, at a minimum, the recommended audit filters by the ACS and the JCAHO. The plan shall define adverse outcomes by using an explicit list of well-defined complications;

(7) A systematic informed peer review process utilizing a multi disciplinary method including prehospital care providers; and

¹¹ It is highly recommended that the plan incorporate autopsy information on all trauma patients. Complete anatomical diagnosis of injury is essential to the quality of trauma care.

(8) A method for computing survival probability and comparing patient outcomes.

(III) The RTCs shall be required to take a lead role in the statewide WTC and the RAC of their TSA.

Section 2. Area Trauma Hospitals. An Area Trauma Hospital (ATH) is an acute care facility with the commitment, medical staff, personnel, and specialty training necessary to provide primary care to the trauma patient. An ATH shall 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 be maintained in the ATH unless the medical needs of the patient require a higher level of care. The decisions to transfer a patient rests with the physician attending the trauma patient. All ATHs shall work collaboratively with the Regional Trauma Centers, Community Trauma Hospitals and Trauma Receiving Facilities to develop transfer protocols and a well-defined transfer sequence.

(a) Hospital Organization.

(i) Trauma Program. The trauma program shall be established and recognized by the medical staff and hospital administration. The trauma program shall come under the overall organization and direction of a general surgeon or emergency physician who is trained, experienced, and committed to the care of the injured patient.

(ii) Trauma Program Director. The director must be a board certified surgeon or a board certified emergency physician with demonstrated competency in trauma care. The director shall develop a quality improvement process and through this process, shall be responsible for all trauma patients and administrative authority for the hospital's trauma program. The director must be given administrative support to implement the requirements specified by the Wyoming Trauma Plan. The director shall work with the credentialing process of the hospital and participate with the credentialing committee to recommend participation on the trauma team.¹²

(iii) Trauma Team. The hospital shall have a policy describing the respective 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 staff. The team leader shall be a qualified physician who is clinically capable in all aspects of trauma resuscitation. Suggested composition of the trauma team may include:

(A) Surgeons, General, and Orthopedic;

¹² It is strongly recommended that the director be an instructor in the American College of Surgeons Advanced Trauma Life Support (ATLS) course, maintain current ATLS certification or maintain certification of attendance to an ACEP accredited trauma conference every two (2) years, and maintain personal involvement in care of the injured, education in trauma care, and involvement in professional organizations.

- (B) Anesthesiologists;
- (C) Emergency physicians;
- (D) Family physicians;
- (E) Laboratory technicians;
- (F) Registered nurses;
- (G) Physician specialists as dictated by clinical needs;
- (H) Prehospital care providers;
- (I) Radiology technicians;
- (J) Respiratory therapists; and
- (K) Social services/pastoral care.

(iv) **Qualifications for Surgeons on the Trauma Team.** As a general rule, all surgeons on the trauma team should be board certified in a surgical specialty recognized by the American Board of Medical Specialties, the Canadian Board or the American Osteopathic Association. An exception to this rule is Oral and Maxillofacial Surgery. These physicians should be board certified by the American Board of Oral and Maxillofacial Surgery.¹³ The surgeons shall participate in the multi disciplinary trauma committee and the quality improvement process. All general surgeons participating on the trauma team should be current in ATLS and be involved in continuing education specific to trauma sufficient to maintain quality patient care. This includes all residents.

(v) **Trauma Nurse Coordinator.** An ATH shall have a registered nurse working in the role of a trauma nurse coordinator. Working in conjunction with the trauma program director, the trauma nurse coordinator shall organize the program and all systems necessary for the multi disciplinary approach throughout the continuum of trauma care. The trauma nurse coordinator is responsible for coordinating optimal patient care for all injured patients.¹⁴

¹³ It is understood that many boards require a practice period, and that complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five (5) years after successful completion of residency, that individual is ordinarily unacceptable for inclusion on the trauma team.

¹⁴ Recommended credentials for this person include: Trauma Nurse Core Course (TNCC) (or equivalent education), Certified Emergency Nurse (CEN), demonstrated expertise in trauma care, five (5) or more years clinical nursing experience, experience with hospital quality assurance programs including a trauma registry, experience in education program development, and membership in professional organizations.

(vi) Multi Disciplinary Trauma Committee. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The major focus shall be quality improvement activities, policy development, communication among all team members, development of standards of care, education and outreach programs and work with appropriate groups for injury prevention. The clinical managers (or designees) of the organizational areas involved with trauma care shall play an active role with the committee. The committee shall include representatives from each of the following areas, unless the hospital has no such organizational area defined:

- (A) Administration;
- (B) Anesthesia;
- (C) Emergency Department;
- (D) General Surgery;
- (E) Intensive Care;
- (F) Laboratory;
- (G) Medical Records;
- (H) Nursing;
- (I) Operating Room;
- (J) Orthopedics;
- (K) Pediatrics;
- (L) Prehospital care providers;
- (M) Radiology;
- (N) Rehabilitation;
- (O) Respiratory Therapy; and
- (P) Trauma Nurse Coordinator.

(b) Clinical Components.

(i) An ATH shall have the following medical specialists available to the injured patient:

- day;
- (A) Emergency Medicine in house twenty-four (24) hours per
 - (B) Trauma/General Surgery.
 - (C) Anesthesia.
 - (D) Orthopedic Surgery;

(ii) The following specialists shall be on call and promptly available:

- (A) Internal Medicine; and
- (B) Radiology.

ATH: (iii) It is desirable to have the following specialists available to an

- (A) Obstetrics/Gynecological Surgery;
- (B) Pediatrics; and
- (C) Urologic Surgery.

(iv) The staff specialist on call shall be notified at the discretion of the trauma surgeon or the emergency physician and shall be promptly available. This availability shall be monitored continuously by the quality improvement program. The specialist involved for consultation to the trauma patient shall be appropriately board certified and have an awareness of the unique problems of trauma patients.

(v) A general/trauma surgeon shall be qualified and have privileges to provide thoracic surgical care to patients with thoracic injuries. In instances where this is not feasible, the hospital shall apply for a waiver from the OEMS, who at its sole discretion can grant such a waiver.

(vi) Policies and procedures shall be in place to notify the patient's primary physician of the patient's condition.

(c) Facility Standards.

(i) Emergency Department.

(A) The hospital shall have an emergency department, division, service or section staffed so that trauma patients are assured immediate and appropriate initial care. ATHs shall have a physician in the emergency department twenty-four (24)

hours per day capable of evaluating trauma patients and providing initial resuscitation and performing necessary surgical procedures not requiring general anesthesia.

(B) The emergency department shall have a designated medical director who is board certified in a specialty recognized by the American Board of Medical Specialties, the Canadian Board or the American Osteopathic Association.¹⁵ This requirement may be satisfied by a physician not currently board certified but meeting the requirements of the hospital for appointment as an emergency department medical director. This exception is only valid for those non-qualifying medical directors at the time these requirements become effective.

(C) All physicians covering the emergency department shall show commitment to trauma care by maintaining competency in resuscitation, airway management, central venous access, cervical immobilization and long bone fracture stabilization of the adult and pediatric trauma patient. This includes all residents.¹⁶

(D) The emergency medicine physician shall activate the trauma team based on predetermined criteria.¹⁷ The emergency department shall have established policies and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The physicians participating on the trauma team shall participate in CME activities related to trauma care, the multi disciplinary trauma committee and the trauma quality improvement process.

(E) General/Trauma Surgeon.

(I) A general/trauma surgeon shall be available on call twenty-four (24) hours per day to respond to the emergency department as requested. The trauma surgeon on call shall be promptly available to respond to the trauma patient. Local criteria shall be established to define conditions requiring the trauma surgeon's immediate hospital presence. The trauma surgeon's participation in major therapeutic decisions and presence in the emergency department for major resuscitation is highly recommended. The trauma surgeon's presence at operative procedures is mandatory. A system shall be developed to assure early notification of the on call surgeon and compliance with this criteria and their appropriateness must be monitored by the hospital's trauma quality improvement process. The surgeon should maintain current certification in ATLS.

(II) The surgeon shall, in conjunction with the

¹⁵ It is understood that many boards require a practice period, and the complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five (5) years after residency, that individual is ordinarily unacceptable as the medical director of the emergency department.

¹⁶ Current certification in ATLS is highly recommended or maintenance of certification of attendance to an ACEP accredited trauma conference every two (2) years.

¹⁷ Each facility may develop local written protocol for the activation of the trauma team.

emergency physician, make key decisions about management of the trauma patient's care and determine if the patient needs transport to a higher level of care. If transfer is required, either the surgeon or emergency physician shall be accountable to coordinate the process with the receiving physician at the receiving facility. Generally, if an injured patient requiring surgery is to be admitted to the ATH, the surgeon shall be the admitting physician and will coordinate the patient care while hospitalized. Guidelines shall be written at the local level to determine which types of patients should be admitted to the ATH and which patients should be considered for transfer to a higher level of care.

(F) Nursing Personnel.

(I) Emergency nurses shall have special expertise in trauma care.¹⁸

(II) Adequate numbers of registered nurses shall be available in house twenty-four (24) hours per day to staff the emergency department to meet the needs of the trauma patient.

(ii) Surgical Suites. The surgical team is not required to be in house twenty-four (24) hours per day. A team shall be on call with a well-defined mechanism for notification to expedite admission to the operating room if the patient's condition warrants. The process shall be monitored continuously by the trauma quality improvement program. Surgical nurses shall be trained in principles of resuscitation, mechanism of injury theory, multi systems trauma, and knowledge of surgical instrumentation. The surgical nurses are integral members of the trauma team and shall participate in the ongoing quality improvement process of the trauma program and shall be represented on the multi disciplinary trauma committee.

(A) Policies and Procedures. Policies and procedures shall be in place for the following:

(I) Prioritized operating room availability for the emergency trauma patient during a busy operative schedule;

(II) Notification of on call surgical teams;

(III) Managing death in the operating room and facilitating the organ procurement process;

(IV) Preservation of evidence;

(V) Patient monitoring by a registered nurse while the patient is in transport to the radiology suite or ICU from the operating room; and

¹⁸ It is highly recommended that emergency nurses demonstrate successful completion of TNCC (or equivalent education), evidence of continuing education in trauma nursing, and participation in the ongoing quality improvement process of the trauma program.

(VI) Immediate access of blood and blood products to the operating room.

(B) Anesthesia. Anesthesia shall be promptly available with a mechanism established to ensure early notification of the on call anesthesiologist. Local criteria shall be established to determine when the anesthesiologist shall be immediately available for airway emergencies and operative management of the trauma patient. Anesthesia coverage may be provided by a CRNA who is supervised by an anesthesiologist as required for the CRNA's licensure. Local conditions shall be established to determine when the CRNA must be immediately available for airway emergencies and operative management. The availability of the anesthesiologist or the CRNA and the absence of delays in airway control or operative anesthesia shall be documented and monitored by the quality improvement process. The anesthesiologist/CRNA shall have the necessary education background in the care of the trauma patient, and participate in the multi disciplinary trauma committee and the trauma quality improvement process.

(iii) Intensive Care Unit. The ATH shall have an ICU which meets the requirements for licensure in the state of Wyoming. Additionally, the ICU shall have:

(A) Medical Director. The medical director for the ICU is responsible for the quality of care and administration of the ICU. The trauma program director or his designee shall work collaboratively with the ICU medical director to set policy and establish standards of care to meet the unique needs of the trauma patient.

(B) Physician Coverage. Trauma patients admitted to the ICU shall be admitted under the care of a general surgeon or a qualified board certified physician who is knowledgeable about the care of ICU patients. Guidelines may be written for the rare exception to this rule. In addition to overall responsibility for patient care by the primary surgeon or ICU physician, there shall be in house physician coverage for the ICU at all times. This coverage may be provided by a physician who is approved by the director of the ICU. This coverage is for emergencies only (e.g., an unexpected extubation of an ICU patient) and is to ensure the patient's immediate needs are met while the identified surgeon or physician is contacted.

(C) Nursing Personnel. ATHs shall provide staffing in sufficient numbers to meet the needs of the trauma patient. Critical care nurses should show evidence of completion of a structured ICU in-service program which includes didactic and clinical content related to the care of the trauma patient. ICU nurses are an integral part of the trauma team and shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(iv) Post Anesthesia Recovery Room (PAR room). An ATH shall have a PAR room with staff on call twenty-four (24) hours per day and available to the postoperative trauma patient. PAR room staffing shall be in sufficient numbers to meet

the critical needs of the trauma patient. Frequently, it is advantageous to bypass the PAR room and directly admit to the ICU. In this instance, these requirements may be met by the ICU. PAR room nurses shall show evidence of completion of a structured in-service program which includes didactic and clinical content related to the care of the trauma patient. PAR room nurses are an integral part of the trauma team and, as such, shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(d) Clinical Support Services.

(i) An ATH shall have the following service capabilities:

(A) Radiological Service. A board certified radiologist or his designated mid-level practitioner shall be available to the facility for emergency procedures and on a routine basis to assure quality of services rendered. The radiologist is a key member of the trauma team and shall be represented on the multi disciplinary trauma committee. A licensed radiological technician shall be on call twenty-four (24) hours per day and readily available to meet the immediate needs of the trauma patient. The CT (specialty) technician may be on call from home with a mechanism in place to assure the technician is available. The quality improvement process shall verify all procedures are promptly available to the patient; and

(B) Clinical Laboratory Services. Sufficient numbers of clinical laboratory technologists shall be on call twenty-four (24) hours per day and promptly available at all times. The clinical laboratory service shall have the following services available twenty-four (24) hours per day:

(I) Comprehensive blood bank or access to a community central blood bank and adequate storage facilities;

(II) Standard analysis of blood, urine and other body fluids. Toxicology studies may be performed off site if necessary; and

(III) Blood gas and pH determinations. (This function may be performed by providers other than the clinical laboratory service, when applicable.)

(C) Alcohol screening is required and drug screening is highly recommended.

(D) Social Service/Pastoral Care Support. 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. An ATH may utilize community resources as appropriate to meet the needs of the trauma patient and their families.

(E) Rehabilitation. At the earliest stage possible after admission to the trauma center, each ATH shall address a plan for integration of rehabilitation into the acute and primary care of the trauma patient. Designated facilities shall identify a mechanism to initiate rehabilitation services and/or consultation upon admission as well as policies regarding coordination of a multi disciplinary rehabilitation team. Policies shall be in place to address the coordination of transfer between acute care facilities and rehabilitation facilities. Transfer agreements 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.

(F) Outreach. The ATH shall work collaboratively to plan, facilitate and teach professional education programs for the prehospital care providers, nurses and physicians in their own facility and in the Community Trauma Hospital (CTH) and Trauma Receiving Facilities (TRF) in their region.

(G) Prevention/Public Education. The ATH is responsible for collaborating with RTCs, CTHs, and TRFs to develop education and prevention programs for their professional staff and the public. The education and prevention programs shall include implementation strategies to assure information dissemination to all residents in the region.

(H) Transfer Protocols. The facilities shall have transfer protocols in place with receiving trauma facilities, as well as all specialty referral centers (e.g., burn, pediatrics and rehabilitation). All facilities shall work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to assure the most expedient, safe transfer of the patient. All trauma facilities shall agree to provide services to the trauma patients regardless of their ability to pay. The transfer guidelines need to assure feedback as provided to the facilities and assure this information eventually becomes part of the trauma registry. All transfer protocols shall be written in accordance with COBRA/OBRA and EMTALA regulations.

(I) Quality Improvement/Evaluation.

(I) All designated facilities will be required to participate in the trauma registry and submit data to OEMS as requested. The ATHs shall assist the CTHs and the TRFs in establishing the data collection process and, if necessary, provide data entry into the registry from abstracted patient records.

(II) Each ATH shall develop an internal quality improvement plan that, at a minimum, addresses the following key components:¹⁹

(1) An organizational structure which facilitates the process of quality improvement (multi disciplinary trauma committee);

¹⁹ It is highly recommended that the plan incorporate autopsy information on all trauma patients. Complete anatomical diagnosis of injury is essential to the quality of trauma care.

quality improvement plan;

(2) Clearly stated goals and objectives of the

(3) The development of standards of care;

(4) A process to delineate privileges for all physicians participating in trauma care;

(5) Participation in the statewide trauma registry;

(6) Established quality indicators (audit filters). The plan must include, at a minimum, the recommended audit filters by the American College of Surgeons and the JCAHO. The plan should define adverse outcomes by using an explicit list of well-defined complications;

(7) A systematic, informed peer review process utilizing a multi disciplinary method including prehospital care providers; and

(8) A method for computing survival probability and comparing patient outcomes.

(III) The ATH shall participate in the statewide WTC and the RAC of their TSA.

Section 3. Community Trauma Hospitals. Community Trauma Hospitals (CTH) are generally small, rural facilities with a commitment to the resuscitation of the trauma patient and with written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred for definitive care. The hospital is predominantly staffed with family physicians experienced and/or trained across a broad composite field of medicine including appropriate areas of acute trauma management. Frequently, these physicians are the obstetric and intensive care providers of the TSA. They commonly work in consultation with a board certified general surgeon who is committed to trauma management. A system for early notification of the physician on call shall be developed so that he can consistently be present at the time of arrival of the major trauma patient in the emergency department. This level of designation requires a general/trauma surgeon on call and promptly available to respond to the trauma patient. However, this level contemplates that there may be only one surgeon in the community and he may not be available at all times. During periods when the surgeon is not available, the hospital must notify other facilities that routinely transfer/refer patients to the CTH for emergency surgical services.²⁰ Since this level contemplates a surgeon in the community who is committed to trauma care, it is anticipated that the CTH shall provide initial resuscitation and immediate operative intervention to control hemorrhage to assure maximum stabilization prior to transfer to a

²⁰ Each facility shall develop written notification protocols.

higher level of care. In many instances, patients will be maintained in the CTH unless the medical needs of the patient require secondary transfer. The decision to transfer a patient rests with the physician attending the trauma patient. An institution intending to provide prolonged ventilatory care must assure that a physician qualified to provide ventilatory care is available at all times. If physician support is not available twenty-four (24) hours per day, transfer to a higher level of care is recommended.

(a) Hospital Organization.

(i) Trauma Program. The trauma program shall be established and recognized by the medical staff and hospital administration. The trauma program shall come under the overall organization and direction of a general surgeon or emergency physician who is trained, experienced, and committed to the care of the injured patient.

(ii) Trauma Program Director. The director must be a board certified general surgeon, a board certified emergency physician, or a board certified physician with demonstrated competency in trauma care. The director shall develop a quality improvement process and, through this process, shall be responsible for all trauma patients and administrative authority for the hospital's trauma program. The director must be given administrative support to implement the requirements specified by the Wyoming Trauma Plan.²¹

(iii) Trauma Team. The hospital shall have a policy describing the respective roles of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of development, communication among all team members, development of standards of care, education and outreach programs, and interaction with appropriate groups for injury prevention. Suggested membership for the committee include representatives (if available in the community) from:

- (A) Surgeons;
- (B) Emergency physicians;
- (C) Anesthesia;
- (D) Laboratory technician;
- (E) Physician with emergency department privileges;
- (F) Prehospital care providers;

²¹ It is strongly recommended that the director be an instructor in the American College of Surgeons Advanced Trauma Life Support (ATLS) course, and maintain current ATLS certification or maintain certification of attendance to an ACEP accredited trauma conference every two (2) years, and maintain personal involvement in care of the injured, education in trauma care, and involvement in professional organizations.

- (G) Respiratory therapist;
- (H) Family physician(s) skilled in trauma care;
- (I) Registered nurses;
- (J) Physician specialists as dictated by clinical needs;
- (K) Radiology technician; and
- (L) Social services/pastoral care.

(iv) Trauma Nurse Coordinator. A CTH shall have at least a part-time registered nurse working in the role of a trauma nurse coordinator. Working in conjunction with the trauma program director, the trauma nurse coordinator shall organize the program and all systems necessary for the multi disciplinary approach throughout the continuum of trauma care. The trauma nurse coordinator shall coordinate optimal patient care for all injured patients.²²

(v) Multi Disciplinary Trauma Committee. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The committee shall focus on quality improvement activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and interaction with appropriate groups for injury prevention. The clinical managers (or designees) of the organizational areas involved in trauma care shall play an active role with the committee. The committee shall include representatives from each of the following areas, unless the hospital has no such organizational area defined:

- (A) Administration;
- (B) Anesthesia;
- (C) Emergency department;
- (D) Family physicians;
- (E) General surgery;
- (F) Intensive Care;
- (G) Medical Records;

²² Recommended credentials for this position include: Trauma Nurse Core Curriculum (TNCC) (or equivalent education), demonstrated expertise in trauma care and five (5) or more years clinical nursing experience.

- (H) Pediatrics;
- (I) Nursing;
- (J) Prehospital care providers;
- (K) Radiology;
- (L) Rehabilitation;
- (M) Respiratory therapy; and
- (N) Trauma Nurse Coordinator.

(b) Facility Standards.

(i) Emergency Department.

(A) The hospital shall have an emergency department staffed so that trauma patients are assured immediate and appropriate initial care. CTHs may not have a physician in the emergency department twenty-four (24) hours per day. Therefore, adequately trained registered nurses shall be available to initiate basic trauma life support care. Local policy shall be written to assure early notification of the on call physician and/or surgeon to meet the trauma patient in the emergency department.

(B) The emergency department shall have a designated medical director who is board certified in a specialty recognized by the American Board of Medical Specialties, the Canadian Board or the American Osteopathic Association.²³ This requirement may be satisfied by a physician not currently board certified but meeting the requirements of the hospital for appointment as an emergency department medical director. This exception is only valid for those non-qualifying medical directors at the time these requirements become effective.²⁴ The physicians participating on the trauma team shall participate in continuing education activities related to trauma care, the multi disciplinary trauma committee and the trauma quality improvement process.

(C) Nursing Personnel.

²³ It is understood that many boards require a practice period, and the complete certification may take three (3) to five (5) years after residency. If an individual has not been certified five years after residency, that individual is ordinarily unacceptable as the medical director of the emergency department.

²⁴ All physicians covering the emergency department shall be currently certified in ATLS, or maintain certification of attendance to an ACEP accredited trauma conference every two years, and shall show commitment to trauma care by maintaining competency in resuscitation, airway management, central venous access, cervical immobilization and long bone fracture stabilization of the adult and pediatric trauma patient. This includes all residents assigned to the emergency department and responsible for the resuscitation of the trauma patient.

trauma care.²⁵ (I) Emergency nurses shall have special expertise in

(II) Adequate numbers of registered nurses must be available in house twenty-four (24) hours per day to staff the emergency department to meet the needs of the trauma patient.

(D) General/Trauma Surgeon.

(I) A general/trauma surgeon shall be available on call twenty-four (24) hours per day to respond to the emergency department as requested. This level contemplates a community where only one surgeon may reside. During those periods when the surgeon is not available, the hospital shall notify other facilities who routinely transfer/refer patients to the CTH for emergency surgical care. The trauma surgeon on call shall be promptly available to respond to the trauma patient. The surgeons should have current certification in ATLS.

(II) Local criteria shall be established to define conditions requiring the trauma surgeon's immediate hospital presence. The trauma surgeon's participation in major therapeutic decisions and consultations and presence in the emergency department for major resuscitation is highly recommended. The trauma surgeon's presence at major operative procedures is mandatory. A system shall be developed to assure early notification of the on call surgeon and compliance with this criteria and their appropriateness shall be monitored by the hospital's trauma quality improvement process.

(III) The emergency physician is expected to make key decisions about management for the trauma patient's care and determine if the patient needs transport to a higher level of care in association with the surgeon. The emergency department physician or surgeon shall coordinate the process with the receiving surgeon at the receiving facility when transfer is necessary. If the patient is admitted to the CTH, the admitting physician shall provide care and utilize surgical consultation according to the CTH guidelines for trauma patient care. Guidelines shall be written at the local level to determine which types of patients should be admitted to the CTH and which patients should be considered for transfer to a higher level of care. Telephone, teleradiology and telemedicine consultation capabilities are highly desirable for internal medicine, orthopedic surgery, obstetric/gynecological surgery and radiology. If practical, local coverage of these services is desirable. The CTH's protocol and the skill levels of the surgeon and physician staff of the CTH will determine the transfer protocols to facilitate the movement of the patient to a higher level of care.

(ii) Surgical Suites. The surgical team is not required to be in house

²⁵ It is highly recommended that emergency nurses successfully complete TNCC (or equivalent education), show evidence of continuing education in trauma nursing, and participate in the ongoing quality improvement process of the trauma program.

twenty-four (24) hours per day. A team shall be on call with a well-defined mechanism for notification to expedite admission to the operating room if the patient's condition warrants. This process shall be monitored continuously by the trauma quality improvement program. Surgical nurses shall be trained in principles of resuscitation, mechanism of injury theory, multi system trauma, and knowledge of surgical instrumentation. The surgical nurses are integral members of the trauma team and shall participate in the ongoing quality improvement process of the trauma program and shall be represented on the multi disciplinary trauma committee.

(A) Policies and Procedures. Policies and procedures shall be in place for the following:

(I) Prioritized hospital room availability for the emergency trauma patient;

(II) Notification of on call surgical teams;

(III) Managing death in the OR and facilitating the organ procurement process;

(IV) Preservation of evidence;

(V) Patient monitoring by a registered nurse while the patient is in transport to the radiology suite or ICU from the operating room; and

(VI) Immediate access of blood and blood products to the operating room.

(B) Anesthesia. Anesthesia shall be promptly available with a mechanism established to ensure early notification of the on call anesthesiologist/CRNA. Anesthesia coverage may be provided by a CRNA who is supervised by an anesthesiologist as required for the CRNA's licensure. The CTH shall document conditions when the anesthesiologist/ CRNA 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 airway control or operative anesthesia shall be documented and monitored by the quality improvement process.

(iii) Intensive Care Unit/Monitored Bed Unit (MBU).

(A) An institution intending to provide prolonged ventilatory care shall assure that a physician qualified to provide ventilatory care is available at all times. If physician support is not available twenty-four (24) hours per day, transfer to a higher level of care is recommended.

(B) The CTH shall have an ICU or MBU which meets the requirements of licensure in the state of Wyoming or the JCAHO. Additionally, the

ICU/MBU shall have:

(I) Medical Director. The medical director for the ICU/MBU is responsible for the quality of care and administration of the ICU/MBU. The trauma program director or his designee shall work collaboratively with the ICU/MBU medical director to set policy and establish standards of care to meet the unique needs of the trauma patient.

(II) Physician Coverage. Trauma patients admitted to the ICU/MBU shall be admitted under the care of the patient's physician or an attending physician with ICU/MBU admission privileges. Consultation with the general surgeon is expected. In addition to the primary physician and general surgeon, there shall be physician coverage for the ICU/MBU as specified by local criteria. The coverage shall be provided by a physician experienced and trained to recognize and manage conditions of the trauma patient as determined by the multi disciplinary trauma committee; and

(III) Nursing Personnel. CTHs shall provide staffing in sufficient numbers to meet the needs of the trauma patient. Critical care nurses shall show evidence of completion of a structured ICU in-service program which includes didactic and clinical content related to the care of the trauma patient. ICU nurses are an integral part of the trauma team and shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(iv) Post Anesthesia Recovery Room (PAR room).

(A) A CTH shall have a PAR room staff on call twenty-four (24) hours per day and available to the postoperative trauma patient. PAR room staffing shall be in sufficient numbers to meet the critical needs of the trauma patient. Frequently, it is advantageous to bypass the PAR room and directly admit to the ICU/MBU. In this instance, these requirements may be met by the ICU/MBU.

(B) PAR room nurses shall show evidence of completion of a structured in-service program which includes didactic and clinical content related to the care of the trauma patient. PAR room nurses are an integral part of the trauma team and shall be represented on the multi disciplinary trauma committee and participate in the quality improvement process of the trauma program.

(c) Clinical Support Services. In addition to licensure requirements, a CTH shall have the following service capabilities:

(i) Radiology Services. It is highly desirable for a CTH to have a board certified radiologist or his designated mid-level practitioner available to the facility for emergency procedures, and on a routine basis, to assure quality of services rendered. The radiologist is a key member of the trauma team and shall be represented on the multi disciplinary trauma committee. A licensed radiological technician shall be on call twenty-four (24) hours per day and readily available to meet the immediate needs of the

trauma patient. Twenty-four (24) hour teleradiology service is necessary if a radiologist is not available. A formal plan for emergency reading of films is necessary as backup, e.g., administrative commitment to twenty-four (24) hour available on call road transport of films to a radiologist. The CT technician may be on call from home with a mechanism in place to assure the technician is available. The quality improvement process shall verify the procedure is promptly available to the patient.

(ii) Clinical Laboratory Services.

(A) The standards for clinical laboratory services in CTHs differ very little from other designated facilities. Blood banking capability or access to community facilities shall be available. Toxicology studies may be performed off site if necessary.

(B) The clinical laboratory service shall have the following services available twenty-four (24) hours per day:

(I) Access to a community central blood bank and adequate storage facilities;

(II) Standard analysis of blood, urine and other body fluids; and

(III) Blood gas and pH determinations (this function may be performed by providers other than the clinical laboratory service, when applicable).

(C) Alcohol screening is required and drug screening is highly recommended.

(D) Sufficient numbers of clinical laboratory technologists shall be promptly available twenty-four (24) hours per day. If this requirement is fulfilled by technicians not in house, quality improvement must document and monitor the availability of testing, blood access, and the prompt recording of accurate results.

(iii) Social Service/Pastoral Care. A CTH may utilize community resources as appropriate to meet the needs of trauma patients and their families.

(iv) Rehabilitation. Each CTH shall 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. Designated facilities shall identify a mechanism to initiate rehabilitation services and/or consultation upon admission as well as policies regarding coordination of a multi disciplinary rehabilitation team. Policies shall be in place to address the coordination of transfers between acute care facilities and rehabilitation facilities. Transfer agreements 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.

(v) Outreach. The CTH shall work collaboratively to plan, facilitate and teach professional education programs for the prehospital care providers, nurses, and physicians in the CTHs and TRFs in their region.

(vi) Prevention/Public Education. The CTH shall collaborate with all other designated facilities to develop education and prevention programs for their professional staff and the public. The plan shall include implementation strategies to assure information dissemination to all residents in the region.

(vii) Transfer Protocols. CTHs shall have transfer protocols in place with receiving trauma facilities as well as all specialty referral centers (i.e., burn, pediatrics and rehabilitation). All facilities shall work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to assure the most expedient, safe transfer of the patient. All designated facilities shall agree to provide services to the trauma patient regardless of their ability to pay. The transfer guidelines need to assure feedback is provided to the facilities and assure this information eventually becomes part of the trauma registry. All transfer protocols shall be written in accordance with COBRA/OBRA and EMTALA regulations.

(viii) Quality Improvement/Evaluation.

(A) All designated facilities shall participate in the trauma registry and submit data to the OEMS as requested. The CTHs shall assist the TRFs in establishing the data collection process and, if necessary, provide data entry into the registry from abstracted patient records.

(B) Each trauma center shall develop an internal quality improvement plan that, at a minimum, addresses the following key components:²⁶

(I) An organizational structure which facilitates the process of quality improvement (multi disciplinary trauma committee);

(II) Clearly stated goals and objectives of the quality improvement plan;

(III) The development of standards of care;

(IV) A process to delineate privileges for all physicians participating in trauma care;

(V) Participation in the statewide trauma registry;

(VI) Established quality indicators (audit filters). The

²⁶ Autopsy information on all trauma patients is highly recommended. Complete anatomical diagnosis of injury is essential to the quality improvement process.

plan must include, at a minimum, the recommended audit filters by the ACS and the JCAHO. The plan should define adverse outcomes by using an explicit list of well-defined complications;

(VII) A systematic, informed peer review process utilizing a multi disciplinary method including prehospital care providers; and

(VIII) A method for computing survival probability and comparing patient outcomes.

(C) The CTH shall participate in the statewide WTC and the RAC of their TSA.

Section 4. Trauma Receiving Facilities. Trauma Receiving Facilities (TRF) are generally licensed rural facilities, clinics, or medical assistance facilities with a commitment to the resuscitation and stabilization of the trauma patient and written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred for definitive care. These facilities may not be staffed by a physician, but may be staffed by a licensed mid-level practitioner (e.g., nurse practitioner or licensed/certified physician's assistant). The major trauma patient shall be resuscitated and transferred to a higher level of care from the emergency department as appropriate. This categorization does not contemplate the availability of surgeons, operating rooms or intensive care services.

(a) Facility Organization.

(i) Trauma Program. There must be a commitment on behalf of the entire facility to the organization of trauma care. A trauma program shall be established and recognized by the institution. The trauma program shall come under the overall organization of a physician who is committed and willing to provide off-line administration of the program. In a facility staffed by physician's assistants or nurse practitioners, it most likely will be their supervising physician.

(ii) Trauma Program Director. There shall be a qualified physician director of the trauma program. In this instance, the physician shall work with all members of the trauma team to develop a quality improvement process for the facility. Through this process, he shall have overall responsibility for the quality of trauma care rendered at the facility. The director shall be given administrative support to implement the requirements specified by the Wyoming Trauma Plan. The director shall 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 should be currently certified in ATLS and participate in CME related to trauma care.

(iii) Trauma Team. The facility shall have a policy describing the role of all personnel on the trauma team. The composition of the trauma team in any facility will depend on the characteristics of the facility and its staff. The team leader shall be a

qualified physician or a qualified mid-level practitioner.²⁷ Suggested composition of the trauma team may include:

- (A) Laboratory technician;
- (B) Nurses;
- (C) Physician assistants;
- (D) Physicians;
- (E) Prehospital care providers;
- (F) Radiology technicians;
- (G) Respiratory therapists; and
- (H) Social services/pastoral care.

(iv) Trauma Nurse Coordinator. A TRF shall have a person to conduct many of the administrative functions required by the trauma program. Specifically, this person, with the physician director, shall coordinate optimal patient care for all injured patients. Many requirements for data collection and coordination, quality improvement, education and prevention activities are incumbent upon this position.

(v) Multi Disciplinary Trauma Committee.

(A) The purpose of the committee is to provide oversight and leadership to the entire trauma program. The major focus shall be quality improvement activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and work with appropriate groups for injury prevention. In a TRF, this does not need to be a separate distinct body; however, the functions of this committee may be performed in conjunction with other ongoing committees in the facility.

(B) Suggested membership for the Committee includes representatives (if available in the community) from:

- (I) Administration;
- (II) Emergency Department;

²⁷ Qualified physicians or mid-level practitioners directing the resuscitation of trauma patients shall have current ATLS certification or proof of audit of an ATLS course or maintain certification of attendance to an ACEP accredited trauma conference every two (2) years, and must show commitment to trauma care by maintaining competence in airway management, central venous access, cervical immobilization, and long bone fracture stabilization.

- (III) Medical Records;
- (IV) Pediatrics;
- (V) Prehospital care providers;
- (VI) Radiology/Laboratory;
- (VII) Rehabilitation;
- (VIII) Respiratory therapy; and
- (IX) Trauma Nurse Coordinator.

(C) The clinical managers or designees of the organizational areas involved with trauma care shall play an active role with the committee.

(b) Facility Standards.

(i) Emergency Department.

(A) The facility shall have an emergency department staffed so that trauma patients are assured immediate and appropriate initial care. It is not anticipated that a physician will be available on call to the emergency department in a TRF. This requirement may be met by a qualified mid-level practitioner on call from outside the facility.²⁸ A system shall be developed to assure early notification of the on call practitioner. Compliance with this criteria shall be documented and monitored by the quality improvement process.

(B) The TRF shall have a written policy for notification and mobilization of an organized trauma team. Additionally, written policy shall be in place for pre-activation of the transfer team from the field based on prehospital triage criteria. There shall be written transfer protocols with other trauma facilities in the region. A policy shall be in place to facilitate and expedite the transfer sequence to assure the most appropriate care is rendered. Protocols shall be in place for specialty referral for pediatrics, burn, spinal cord injuries and rehabilitation.

(C) Emergency nurses shall have special expertise in trauma care.²⁹

²⁸ Qualified physicians or mid-level practitioners directing the resuscitation of trauma patients should have current ATLS certification, or proof of audit of an ATLS course, or maintain certification of attendance of an ACEP accredited trauma conference every two (2) years, and must show commitment to trauma care by maintaining competence in airway management, central venous access, cervical immobilization, and long bone fracture stabilization.

²⁹ It is highly recommended that emergency nurses demonstrate successful completion

(D) Adequate numbers of registered nurses shall be available to meet the needs of the trauma patient.

(c) Clinical Support Services. In addition to licensure requirements, a TRF shall have the following service capabilities:

(i) Radiology Services. X-ray capabilities shall be immediately available twenty-four (24) hours per day to meet the resuscitative needs of the trauma patient. A licensed radiological technician shall be available to meet the immediate needs of the trauma patient. The technician may be on call from home with a mechanism in place to assure the technician is available. The quality improvement process shall document and monitor the process.

(ii) Clinical Laboratory Services.

(A) Clinical laboratory services shall be immediately available to the trauma patient. It is not anticipated that blood banking facilities be available; rather, access and blood storage capacities. Toxicology studies may be performed off site if necessary. The clinical laboratory shall have standard analysis of blood, urine and other body fluids services available twenty-four (24) hours per day.

(B) If this requirement is fulfilled by technicians not in house, quality improvement shall document and monitor the availability of testing, blood access and the prompt recording of accurate results.

(iii) Social Service/Pastoral Care. A TRF may utilize community resources as appropriate to meet the needs of trauma patients and their families.

(iv) Prevention/Public Education. A TRF shall work collaboratively with RTCs and ATHs to develop education and prevention programs for their professional staff and the public. The plan shall include implementation strategies to assure information dissemination to all residents in the region.

(v) Transfer Protocols. Transfer protocols shall be written with all trauma receiving facilities and appropriate specialty centers (e.g., burn, pediatrics and rehabilitation). All facilities shall work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to assure the most expedient, safe transfer of the patient. All designated facilities shall agree to provide services to trauma patients regardless of their ability to pay. The transfer guidelines need to assure feedback is provided to the facilities and assure this information eventually becomes part of the trauma registry. All transfer protocols shall be written in accordance with COBRA/OBRA and EMTALA regulations.

of TNCC (or equivalent education), evidence of continuing education in trauma nursing and participation in the ongoing quality improvement process of the trauma program.

(vi) **Quality Improvement/Evaluation.** All designated facilities shall participate in the trauma registry and submit data to OEMS. The RTCs, ATHs and CTHs shall be responsible to assist the TRFs in establishing the data collection process and, if necessary, provide data entry into the registry from abstracted patient records. Each TRF shall develop an internal quality improvement plan that addresses, at a minimum, the following key components:³⁰

(A) An organizational structure which facilitates the process of quality improvement (multi disciplinary trauma committee);

(B) Clearly stated goals and objectives of the quality improvement plan;

(C) The development of standards of care;

(D) A process to delineate privileges for all physicians participating in trauma care;

(E) Participation in the statewide trauma registry;

(F) Established quality indicators (audit filters). The plan must include, at a minimum, the recommended audit filters by the ACS and the JCAHO. The plan should define adverse outcomes by using an explicit list of well-defined complications;

(G) A systematic, informed peer review process utilizing a multi disciplinary method including prehospital care providers; and

(H) A method for computing survival probability and comparing patient outcomes.

(I) The TRFs shall participate in the statewide WTC and the RAC of their TSA.

Section 5: Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department including manuals, bulletins, and policy statements, which are inconsistent with this Chapter.

³⁰ Autopsy information on all trauma patients is highly recommended. Complete anatomical diagnosis of injury is essential to the quality improvement process.