DEPARTMENT OF HEALTH

Level 4 Trauma Hospital Designation Criteria Recommendations

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
1.1	The board of directors, administration and medical staff shall demonstrate a commitment to provide the resources and support necessary to sustain the trauma designation. This commitment shall be renewed with each application for designation.	The board of directors, administration, and medical staff shall demonstrate a commitment to provide the resources and support necessary to sustain the trauma designation. This commitment shall be ~~renewed~~ signed and dated within one year of designation expiration ~~each application for designation~~.	The board of directors, administration, and medical staff shall demonstrate a commitment to provide the resources and support necessary to sustain the trauma designation. This commitment shall be signed and dated within one year of designation expiration.	Clarifying language
1.2	The trauma program shall be established by the facility and shall be represented on the organizational chart, which may be within an existing department (e.g., emergency or surgery).	The trauma program shall be established by the facility and ~~shall be~~ represented on the official hospital organizational chart.~~, which may be within an existing department (e.g., emergency or surgery).~~	The trauma program shall be established by the facility and shall be represented on the official hospital organizational chart.	Clarifying language
2.1	Trauma program medical director or medical advisor shall be a physician whose job description defines his or her authority, roles, and responsibilities for the leadership of the trauma program, the trauma performance improvement process and tertiary case review.	The trauma medical director (TMD) ~~or medical advisor~~ shall be a physician whose job description defines his or her authority, roles, and responsibilities for the leadership of the trauma program, the trauma performance improvement process, and tertiary case review.	The trauma medical director (TMD) shall be a physician whose job description defines his or her authority, roles, and responsibilities for the leadership of the trauma program, the trauma performance improvement process, and tertiary case review.	Clarifying language
2.2	The trauma program medical director or medical advisor must meet the same trauma training	The trauma medical director (TMD) ~~or medical advisor~~ must meet the same trauma training requirements as the Emergency Department Physician.	The trauma medical director (TMD) must meet the same trauma training requirements as the Emergency Department Physician.	Clarifying language

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	requirements as the Emergency Physician			
2.3	The trauma program medical director or medical advisor may appoint an advance practice provider to serve as a co-medical advisor.	The trauma medical director (TMD) ~~or medical advisor~~ may appoint another physician or ~~an~~ advanced practice provider (APP) to serve as a co-medical director ~~advisor~~ to assist in fulfilling the roles and responsibilities of the leadership of the trauma program, the trauma performance improvement process, and tertiary case review. If a co-medical director is appointed, the TMD must remain active in and responsible for all trauma program functions.	The trauma medical director (TMD) may appoint another physician or advanced practice provider (APP) to serve as a co-medical director to assist in fulfilling the roles and responsibilities of the leadership of the trauma program, the trauma performance improvement process, and tertiary case review. If a co-medical director is appointed, the TMD must remain active in and responsible for all trauma program functions.	Clarifying language
2.4	The advance practice provider co-medical advisor must meet the same trauma training requirement as the Emergency Advance Practice Provider.	The ~~advance practice provider~~ co-medical ~~advisor~~ director must meet the same trauma training requirement as the Emergency Department ~~advance practice~~ providers.	The co-medical director must meet the same trauma training requirement as the Emergency Department providers.	Clarifying language
3.1	The trauma manager/coordinator must be either a registered nurse or an allied health staff with emergency and trauma care experience. The manager/coordinator's job description must define his or her roles and responsibilities for the management and leadership of the trauma program and the trauma performance improvement process.	The trauma program manager~~/coordinator~~ (TPM) must be either a registered nurse or an allied health ~~staff~~ professional with emergency and trauma care experience. The ~~manager/coordinator's~~ TPM job description must define ~~his or her~~ the roles and responsibilities for the management and leadership of the trauma program and the trauma performance improvement process.	The trauma program manager (TPM) must be either a registered nurse or an allied health professional with emergency and trauma care experience. 3.1.1 The TPM job description must define the roles and responsibilities for the management and leadership of the trauma program and the trauma performance improvement process.	Clarifying language
3.2	If the trauma program manager/coordinator is not a registered nurse, a registered nurse must assist with the review of trauma care provided in all areas of	If the trauma program manager~~/coordinator~~ (TPM) is not a registered nurse, a registered nurse must assist with: ~~the~~	If the trauma program manager (TPM) is not a registered nurse, a registered nurse must assist with:	Clarifying language

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	the hospital and function as a liaison between the trauma program and the nursing staff.	3.2.1 Primary review of trauma care provided in all areas of the hospital ~~and~~ 3.2.2 Function as a liaison between the trauma program and the nursing staff	**3.2.1** Primary review of trauma care provided in all areas of the hospital **3.2.2** Function as a liaison between the trauma program and the nursing staff	
3.3		The trauma program manager (TPM) must have at least a portion of an FTE dedicated for trauma program responsibilities.	The trauma program manager (TPM) must have at least a portion of an FTE dedicated for trauma program responsibilities.	New
4.1	The hospital must have a trauma team activation policy, protocol or guideline that includes: • A list of all team members expected to respond, which may include telemedicine providers; • The response time expectation for the team members; • The physiological and clinical indicators that, when met, require the activation of the trauma team; and The person(s) authorized to activate the trauma team.	The hospital must have a trauma team activation (TTA) policy, protocol or guideline that includes: 4.1.1 A list of all team members expected to respond, which may include telemedicine providers. 4.1.2 The response time expectation for the team members, including in-house and off-site staff. 4.1.3 The physiologic~~al~~, anatomic and clinical indicators that, when met, require the activation of the trauma team. ~~and~~ 4.1.4 The person(s) authorized to activate the trauma team.	The hospital must have a trauma team activation (TTA) policy, protocol or guideline that includes: **4.1.1** A list of all team members expected to respond, which may include telemedicine providers. **4.1.2** The response time expectation for the team members, including in-house and off-site staff. **4.1.3** The physiologic, anatomic, and clinical indicators that, when met, require the activation of the trauma team. **4.1.4** The person(s) authorized to activate the trauma team.	Clarifying language
4.2	The trauma team activation indicators must be readily available in locations where a trauma patient is likely to be initially encountered.	The trauma team activation (TTA) ~~indicators~~ criteria must be readily available in locations where a trauma patient is likely to be initially encountered.	The trauma team activation (TTA) criteria must be readily available in locations where a trauma patient is likely to be initially encountered.	Clarifying language
4.3		The trauma team activation guideline, at a minimum, must include the following physiological and anatomical indicators: 4.3.1 Sustained GCS ≤10 secondary to trauma. 4.3.2 Respiratory distress, airway comprise, intubation, or respiratory rate outside of	The trauma team activation guideline, at a minimum, must include the following physiological and anatomical indicators: **4.3.1** Sustained GCS ≤10 secondary to trauma. **4.3.2** Respiratory distress, airway comprise, intubation, or respiratory rate outside of	New Minimum guidelines provide consistent TTA criteria across the state.

<table>
<tr><th>CRITERIA</th><th>CURRENT LEVEL 4 CRITERIA</th><th>CRITERIA EDITS
(current criteria with markup)</th><th>PROPOSED LEVEL 4 CRITERIA</th><th>EXPLANATION</th></tr>
<tr><td></td><td></td><td>acceptable range (see Table 1 Age Specific Respiratory)
<table>
<tr><th colspan="2">Age Specific Respiratory</th></tr>
<tr><td>Age (years)</td><td>RR (per min.)</td></tr>
<tr><td>< 1</td><td><20 or >60</td></tr>
<tr><td>1-2</td><td><10 or >50</td></tr>
<tr><td>2-5</td><td><10 or >40</td></tr>
<tr><td>6- 14</td><td><10 or >30</td></tr>
</table>
4.3.3 Penetrating injury to the head, neck, chest, abdomen, or pelvis
4.3.4 Evidence of shock/hypoperfusion indicated by:
4.3.4.1 Systolic blood pressure ≤ 90 mmHg at any time or age-specific hypotension in pediatrics (see Table 2 Age-Specific Hypotension)
<table>
<tr><th colspan="2">Age specific hypotension</th></tr>
<tr><td>Age (years)</td><td>SBP (mmHg)</td></tr>
<tr><td>< 1</td><td>≤ 70</td></tr>
<tr><td>1 – 10</td><td>≤70 + (2 x age in years)</td></tr>
</table>
4.3.4.2 Persistent tachycardia in a patient ≤14 years old (see Table 3 Age-Specific Tachycardia)
<table>
<tr><th colspan="2">Age specific tachycardia</th></tr>
<tr><td>Age (years)</td><td>HR (bpm)</td></tr>
<tr><td>< 2</td><td>>180</td></tr>
<tr><td>2-5</td><td>>160</td></tr>
<tr><td>6- 14</td><td>>140</td></tr>
</table>
4.3.4.3 Positive eFAST exam</td><td>acceptable range (see Table 1 Age Specific Respiratory)
<table>
<tr><th colspan="2">Age Specific Respiratory</th></tr>
<tr><td>Age (years)</td><td>RR (per min.)</td></tr>
<tr><td>< 1</td><td><20 or >60</td></tr>
<tr><td>1-2</td><td><10 or >50</td></tr>
<tr><td>2-5</td><td><10 or >40</td></tr>
<tr><td>6- 14</td><td><10 or >30</td></tr>
</table>
4.3.3 Penetrating injury to the head, neck, chest, abdomen, or pelvis
4.3.4 Evidence of shock/hypoperfusion indicated by:
4.3.4.1 Systolic blood pressure ≤ 90 mmHg at any time or age-specific hypotension in pediatrics (see Table 2 Age-Specific Hypotension)
<table>
<tr><th colspan="2">Age specific hypotension</th></tr>
<tr><td>Age (years)</td><td>SBP (mmHg)</td></tr>
<tr><td>< 1</td><td>≤ 70</td></tr>
<tr><td>1 – 10</td><td>≤70 + (2 x age in years)</td></tr>
</table>
4.3.4.2 Persistent tachycardia in a patient ≤14 years old (see Table 3 Age-Specific Tachycardia)
<table>
<tr><th colspan="2">Age specific tachycardia</th></tr>
<tr><td>Age (years)</td><td>HR (bpm)</td></tr>
<tr><td>< 2</td><td>>180</td></tr>
<tr><td>2-5</td><td>>160</td></tr>
<tr><td>6- 14</td><td>>140</td></tr>
</table>
4.3.4.3 Positive eFAST exam</td><td></td></tr>
</table>

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
		4.3.4.4 Provider impression of hypoperfusion (consider absent distal pulses, agitation, anxiety, confusion, delayed capillary refill, diaphoresis, pallor, persistent heart rate >120 in a patient >14 years old, tachypnea) 4.3.5 Arterial tourniquet indicated 4.3.6 Pregnancy > 20 weeks with vaginal bleeding or contractions attributed to a traumatic mechanism. 4.3.7 Burns >20% TBSA OR burns with potential need for airway management 4.3.8 Time sensitive orthopedic injuries OR severe orthopedic injury from high energy mechanism 4.3.8.1 Threatened limb: including extremity ischemia, crush injuries, concern for neurovascular compromise, amputation proximal to the wrist or ankle. **4.3.8.2** Dislocated knee or native hip **4.3.8.3** Open fracture or multiple long bone fractures 4.3.9 Suspected spinal cord injury with focal neurological deficit (i.e. numbness/tingling) 4.3.10 Discretion of emergency department (ED) provider for those patients not meeting any of the TTA criteria 4.3.10.1 Additional considerations should include: ○ Use of Anticoagulants ○ Burns with concomitant trauma ○ Significant fall: • > 15 feet • Age >65 with fall from elevation or downstairs • Age <10 with fall >2x the patient's height	**4.3.4.4** Provider impression of hypoperfusion (consider absent distal pulses, agitation, anxiety, confusion, delayed capillary refill, diaphoresis, pallor, persistent heart rate >120 in a patient >14 years old, tachypnea) **4.3.5** Arterial tourniquet indicated **4.3.6** Pregnancy > 20 weeks with vaginal bleeding or contractions attributed to a traumatic mechanism. **4.3.7** Burns >20% TBSA OR burns with potential need for airway management **4.3.8** Time sensitive orthopedic injuries OR severe orthopedic injury from high energy mechanism **4.3.8.1** Threatened limb: including extremity ischemia, crush injuries, concern for neurovascular compromise, amputation proximal to the wrist or ankle. **4.3.8.2** Dislocated knee or native hip **4.3.8.3** Open fracture or multiple long bone fractures **4.3.9** Suspected spinal cord injury with focal neurological deficit (i.e. numbness/tingling) **4.3.10** Discretion of emergency department (ED) provider for those patients not meeting any of the TTA criteria **4.3.10.1** Additional considerations should include: ○ Use of Anticoagulants ○ Burns with concomitant trauma ○ Significant fall: • > 15 feet • Age >65 with fall from elevation or downstairs	

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
			• Age <10 with fall >2x the patient's height	
5.1	If the hospital admits trauma patients as described in Section 10.2, a general surgeon must be continuously on-call and available to respond to the hospital within one hour.	If the hospital admits trauma patients as described in Section 10.2, a general surgeon must be continuously on-call and available to respond to the hospital within ~~one hour~~ 60 minutes.	If the hospital admits trauma patients as described in Section 10.2, a general surgeon must be continuously on-call and available to respond to the hospital within 60 minutes.	Clarifying language
6.1	The emergency department must be continuously covered by a physician or advanced practice provider		The emergency department must be continuously covered by a physician or advanced practice provider	No change
6.2	If the emergency department provider is off-site, an on-call schedule must identify the provider(s) covering the emergency department. When called, the provider must arrive in the emergency department within 30 minutes of the patient's arrival.	If the emergency department provider is off-site, an on-call schedule must identify the provider(s) covering the emergency department. When called, the provider must arrive ~~in the emergency department~~ at the bedside within 30 minutes of the patient's arrival.	If the emergency department provider is off-site, an on-call schedule must identify the provider(s) covering the emergency department. When called, the provider must arrive at the bedside within 30 minutes of the patient's arrival.	Clarifying language
6.3	When the primary emergency department provider is an advanced practice provider, a physician must be on-call and available for consultation by telephone (or similar means) within 30 minutes.	When the primary emergency department provider is an advanced practice provider (APP), a physician must be on-call and available for consultation by telephone (or similar means) within 30 minutes.	When the primary emergency department provider is an advanced practice provider (APP), a physician must be on-call and available for consultation by telephone (or similar means) within 30 minutes.	Clarifying language
6.4	The physician on-call for consultation must either meet the same trauma training requirements as the Emergency Physician, or practice emergency medicine or trauma surgery at a Level 1 or Level 2 trauma hospital that is verified by the American College of Surgeons.	The physician on-call for consultation must either meet the same trauma training requirements as the emergency department physician, or practice emergency medicine or trauma surgery at a Level 1 or Level 2 trauma hospital that is verified by the American College of Surgeons (ACS).	The physician on-call for consultation must either meet the same trauma training requirements as the emergency department physician, or practice emergency medicine or trauma surgery at a Level 1 or Level 2 trauma hospital that is verified by the American College of Surgeons (ACS).	Clarifying language

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
7.1	If the hospital provides emergent orthopedic surgery or admits patients for the care of surgical orthopedic injuries, a schedule of the orthopedic surgeon on-call must be maintained and accessible by emergency department and in-patient staff.	If the hospital provides emergent orthopedic surgery ~~or admits patients for the care of surgical orthopedic injuries~~, a schedule of the orthopedic surgeon on-call must be maintained and accessible by the emergency department and in-patient staff.	If the hospital provides emergent orthopedic surgery, a schedule of the orthopedic surgeon on-call must be maintained and accessible by the emergency department and in-patient staff.	Clarifying language, split 7.1 into two separate criteria (see 7.2)
7.2		If the hospital admits patients for the care of surgical orthopedic injuries, a schedule/document outlining the orthopedic surgeon coverage must be maintained and accessible by the emergency department and in-patient staff.	If the hospital admits patients for the care of surgical orthopedic injuries, a schedule/document outlining the orthopedic surgeon coverage must be maintained and accessible by the emergency department and in-patient staff.	Clarifying language, split from 7.1
8.1	There must be an in-house blood bank stocked with type-O blood.		There must be an in-house blood bank stocked with type-O blood.	No change
8.2	There must be a policy establishing a procedure for the emergent release of uncross-matched blood that ensures that uncross-matched blood can be released to the emergency department staff immediately. If the blood bank staff is off-site, the policy must include a provision to release uncross-matched blood to the emergency department staff in the absence of the blood bank staff.	There must be a policy establishing a procedure for the emergent release of uncross-matched blood that: 8.2.1 Ensures that uncross-matched blood can be released to the appropriate ~~emergency department~~ staff immediately 8.2.2 Includes a provision to release uncross-matched blood to the appropriate ~~emergency department~~ staff in the absence of the blood bank staff if they are off-site	There must be a policy establishing a procedure for the emergent release of uncross-matched blood that: 8.2.1 Ensures that uncross-matched blood can be released to the appropriate staff immediately 8.2.2 Includes a provision to release uncross-matched blood to the appropriate staff in the absence of the blood bank staff if they are off-site	Clarifying language
9.1	A radiology technician or technologist must be continuously available, either in-house or on-call.		A radiology technician or technologist must be continuously available, either in-house or on-call.	No change
9.2	If the hospital admits trauma patients as described in Section 10, a computed tomography technician or	If the hospital admits trauma patients as described in Section 10, a computed tomography (CT) technician or technologist	If the hospital admits trauma patients as described in Section 10, a computed tomography (CT) technician or technologist	Clarifying language

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	technologist must be continuously available, either in-house or on-call.	must be continuously available, either in-house or on-call.	must be continuously available, either in-house or on-call.	
9.3	A radiologist must be continuously available, either in-house or off-site.		A radiologist must be continuously available, either in-house or off-site.	No change
10.1	Trauma patients requiring admission to care for their injuries must be transferred to higher level trauma hospitals, except that patients with these conditions may be considered for admission following a trauma work-up: • Concussion • Localized subarachnoid hemorrhage or other localized intracranial hemorrhage < 8mm, a GCS motor score of 6 and not taking an anti-coagulant or anti-platelet medication. • Diminished level of consciousness attributed to a non-traumatic cause • Thoracic or lumbar transverse or spinous process fracture • Other acute spinal fracture after consultation with a spine surgeon • Orthopedic injuries in the absence of injury to another major organ system (i.e., circulatory, nervous, or respiratory) • One or two rib fractures • Pneumothorax that does not require a thoracostomy Those who refuse to be transferred	Trauma patients with the following injury patterns may be admitted to a level 4 trauma hospital. The trauma hospital should determine which of these conditions may be admitted following an initial evaluation. ~~Trauma patients requiring admission to care for their injuries must be transferred to higher level trauma hospitals, except that patients with these conditions may be considered for admission following a trauma work-up:~~ Concussion ▪ ~~Localized subarachnoid hemorrhage or other localized intracranial hemorrhage < 8mm, a GCS motor score of 6 and not taking an anti-coagulant or anti-platelet medication*~~ ▪ Subarachnoid hemorrhage involving one hemisphere no more than 3mm thick, subdural or intraparenchymal hemorrhage < 8mm thick, GCS > 13, in a patient not taking anticoagulant or antiplatelet agents (aspirin and NSAIDs are allowed)*** ▪ Diminished level of consciousness attributed to a non-traumatic cause ▪ Thoracic or lumbar transverse or spinous process fracture	Trauma patients with the following injury patterns may be admitted to a level 4 trauma hospital. The trauma hospital should determine which of these conditions may be admitted following an initial evaluation. ▪ Concussion ▪ Subarachnoid hemorrhage involving one hemisphere no more than 3mm thick, subdural or intraparenchymal hemorrhage < 8mm thick, GCS > 13, in a patient not taking anticoagulant or antiplatelet agents (aspirin and NSAIDs are allowed) * ▪ Diminished level of consciousness attributed to a non-traumatic cause ▪ Thoracic or lumbar transverse or spinous process fracture ▪ Other acute spinal fracture without neurological deficit with spine surgeon consultation ▪ Orthopedic injuries in the absence of injury to another major organ system (i.e., circulatory, nervous or respiratory) ▪ One or two rib fractures with a Practice Management Guideline in place ▪ Three or more acute rib fractures with a Practice Management Guideline in place	Clarifying language Expanded allowance to match mBIG guidelines

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
		▪ Other acute spinal fracture without neurological deficit with ~~after consultation~~ spine surgeon consultation ▪ Orthopedic injuries in the absence of injury to another major organ system (i.e., circulatory, nervous or respiratory) ▪ One or two rib fractures with a Practice Management Guideline in place ▪ Three or more acute rib fractures with a Practice Management Guideline in place after consultation** with a trauma-trained general surgeon. This consultation must be documented in the medical record ▪ Pneumothorax that does not require a thoracostomy ▪ Those who refuse to be transferred	after consultation** with a trauma-trained general surgeon. This consultation must be documented in the medical record ▪ Pneumothorax that does not require a thoracostomy ▪ Those who refuse to be transferred	Expanded number of rib fractures Requires Practice Management Guideline
10.2	If a trauma-trained general surgeon is continuously on-call, patients with the following injuries may also be considered for admission: • Pneumothorax requiring a thoracostomy • Unilateral pulmonary contusion without the need for oxygen to maintain SpO2 > 90% • Three or more rib fractures, or sternum fracture, or scapula fracture • Those who have undergone an emergent surgical procedure as part of the resuscitation that definitively treats the traumatic condition.	If a trauma trained general surgeon is continuously on-call for trauma, patients with the following injuries may also be considered for admission: ▪ Pneumothorax requiring a thoracostomy ▪ Unilateral pulmonary contusion without the need for oxygen to maintain SpO2 > 90% ▪ ~~Three or more rib fractures, or~~ Sternum fracture or scapula fracture without any acute rib fractures ▪ Those who have undergone an emergent surgical procedure as part of the resuscitation that definitively treats the traumatic condition.	If a trauma trained general surgeon is continuously on-call for trauma, patients with the following injuries may also be considered for admission: ▪ Pneumothorax requiring a thoracostomy ▪ Unilateral pulmonary contusion without the need for oxygen to maintain SpO2 > 90% ▪ Sternum fracture or scapula fracture without any acute rib fractures ▪ Those who have undergone an emergent surgical procedure as part of the resuscitation that definitively treats the traumatic condition. The general surgeon must respond to the hospital and assess the patient within 18 hours of discovery.	Clarifying language Expanded number of rib fractures and moved to 10.1

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	The general surgeon must respond to the hospital and assess the patient within 18 hours of discovery.	The general surgeon must respond to the hospital and assess the patient within 18 hours of discovery. • The consultation/admission may be accomplished by the surgeon's appointed advanced practice provider on behalf of the surgeon.	• The consultation/admission may be accomplished by the surgeon's appointed advanced practice provider on behalf of the surgeon.	
10.3	Patients may be admitted only if, in the event of deterioration, emergent transfer would result in the patient arriving at the definitive care facility within 120 minutes from the time deterioration is discovered.	~~Patients may be admitted only if, in the event of deterioration, emergent transfer would result in the patient arriving at the definitive care facility within 120 minutes from the time deterioration is discovered.~~		Removed
~~10.4~~ 10.3	The hospital must have a policy describing: • The types of trauma patients considered for admission • The specialties responsible for admitting and providing consults • The expectations for monitoring patients for deterioration Procedures to ensure that, in the event of deterioration, patients admitted for trauma care will arrive at definitive care within 120 minutes from the time deterioration is discovered.	The hospital must have a policy describing: 10.3.1 The types of trauma patients considered for admission 10.3.2 The specialties responsible for admitting and providing consults. 10.3.3 The expectations for monitoring patients for deterioration. 10.3.3.1Elements should include: 10.3.3.1.1Fluctuating or increasing heart rate 10.3.3.1.2 Fluctuating or decreasing blood pressure 10.3.3.1.3 Fluctuating or worsening level of consciousness, or mental status 10.3.3.1.4 Increasing work of breathing, shortness of breath, or tachypnea	The hospital must have a policy describing: **10.3.1** The types of trauma patients considered for admission **10.3.2** The specialties responsible for admitting and providing consults. **10.3.3** The expectations for monitoring patients for deterioration. Elements should include: **10.3.3.1** Fluctuating or increasing heart rate **10.3.3.2** Fluctuating or decreasing blood pressure **10.3.3.3** Fluctuating or worsening level of consciousness or mental status **10.3.3.4** Increasing work of breathing, shortness of breath, or tachypnea **10.3.3.5** Increasing agitation or anxiety **10.3.3.6** Diaphoresis or pallor **10.3.3.7** Indications for provider notification	Clarifying language Removed 120-minute requirement

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
		10.3.3.1.5 Increasing agitation or anxiety 10.3.3.1.6 Diaphoresis or pallor 10.3.3.2 Indicate provider notification 10.3.4 The considerations of the admission decisions, in the event of patient deterioration, must include: 10.3.4.1 weather 10.3.4.2 distance 10.3.4.3 transport resource availability 10.3.4.4 timeliness of specialty resources/definitive interventions 10.3.5 ~~Procedures to ensure that, in the event of deterioration, patients admitted for trauma care will arrive at definitive care within 120 minutes from the time deterioration is discovered.~~ The emergent transfer procedures in the inpatient setting.	**10.3.4** The considerations of the admission decisions, in the event of patient deterioration, must include: **10.3.4.1** weather **10.3.4.2** distance **10.3.4.3** transport resource availability **10.3.4.4** timeliness of specialty resources/definitive interventions **10.3.5** The emergent transfer procedures in the inpatient setting.	
11.1	The hospital must have a policy directing the internal processes to emergently transfer a trauma patient from the emergency department or an in-patient area to definitive care that lists: • The anatomical and physiological criteria that, when present, result in immediate transfer. • The criteria must include orthopedic surgical conditions and must specifically address how time-sensitive orthopedic conditions such as a threatened limb, compartment syndrome, dislocated knee and dislocated native hip (i.e., not arthroplasty)	The hospital must have a policy directing the internal processes to emergently implement the transfer of a trauma patient from the emergency department or an in-patient area to definitive care that lists: 11.1.1 The anatomic and physiologic criteria that, when present, must result in the decision to transfer. 11.1.2 The ~~criteria must include~~ orthopedic surgical conditions that, when present, must result in the decision to transfer.~~, and~~ The policy must specifically address how time-sensitive orthopedic conditions such as a threatened limb, compartment syndrome, dislocated knee, and dislocated native hip (i.e., not arthroplasty) will be managed while	The hospital must have a policy directing the internal processes to emergently implement the transfer of a trauma patient from the emergency department or an in-patient area to definitive care that lists: **11.1.1** The anatomic and physiologic criteria that, when present, must result in the decision to transfer. **11.1.2** The orthopedic surgical conditions that, when present, must result in the decision to transfer. The policy must specifically address how time-sensitive orthopedic conditions such as a threatened limb, compartment syndrome, dislocated knee, and dislocated native hip (i.e., not	Clarifying language Removed timeline

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	will be managed within one hour of discovery. • The primary and alternate ground and aeromedical transfer services along with contact information. The supplies, records, and personnel that will accompany the patient.	awaiting transport ~~within one hour of discovery.~~ 11.1.3 The primary ~~and alternate~~ ground and aeromedical transfer services to be used, ~~along~~ with contact information for each. 11.1.4 A listing of the supplies, records, and personnel ~~that will~~ accompanying the patient.	arthroplasty) will be managed while awaiting transport. **11.1.3** The primary ground and aeromedical transfer services to be used, with contact information for each. **11.1.4** A listing of the supplies, records, and personnel accompanying the patient.	Aligned with Statute language
11.2	Designated trauma hospitals may not transfer adult or pediatric patients to undesignated hospitals. Exception: Patients may be transferred to a Veterans Administration medical center.	Designated trauma hospitals may not transfer adult or pediatric patients to undesignated hospitals. Exception: Due to regulatory limitations, patients may be transferred to a Veterans Administration medical center when medically appropriate.	Designated trauma hospitals may not transfer adult or pediatric patients to undesignated hospitals. Exception: Due to regulatory limitations, patients may be transferred to a Veterans Administration medical center when medically appropriate.	Clarifying language
11.3	The hospital must have transfer agreements with trauma hospitals capable of caring for major trauma patients definitively, including agreements with at least two hospitals capable of caring for burn patients, and at least one agreement with a designated Level 1 or Level 2 Pediatric Trauma Hospital.	The hospital must have transfer agreements with trauma hospitals capable of ~~caring for major~~ providing definitive care for trauma patients ~~definitively:~~ 11.3.1 At least one with a primary referral hospital 11.3.2 At least two agreements with hospitals capable of caring for burn patients 11.3.3 At least one agreement with a designated Level 1 or Level 2 Pediatric Trauma Hospital.	The hospital must have transfer agreements with trauma hospitals capable of providing definitive care for trauma patients, including: **11.3.1** At least one agreement with a primary referral hospital **11.3.2** At least two agreements with hospitals capable of caring for burn patients **11.3.3** At least one agreement with a designated Level 1 or Level 2 Pediatric Trauma Hospital.	Clarifying language Aligned with Statute language
12.1	If the hospital admits trauma patients as described in Section 10.2, general surgeons must have successfully completed ATLS and/or CALS (including the Trauma Module) within the last four years. General Surgeons must re-take their ATLS or CALS before or during the month in which it is due.	If the hospital admits trauma patients as described in Section 10.2, general surgeons must have successfully completed ATLS and/or CALS ~~(including the Benchmark Lab or Trauma Module Course)~~ within the last four years. Providers must re-take their ATLS or CALS before or during the month in which it is due.	If the hospital admits trauma patients as described in Section 10.2, general surgeons must have successfully completed ATLS and/or CALS within the last four years. Providers must re-take their ATLS or CALS before or during the month in which it is due.	Clarifying language Change in CALS course structure in 2024

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
13.1	If the emergency physician is currently board-certified or board-eligible with an American Board of Emergency Medicine (ABEM)-approved or American Osteopathic Board of Emergency Medicine (AOBEM) certification, then the physician is required to have successfully completed an ATLS or CALS course (including the Trauma Module) once.	If the emergency department physician is currently board-certified or board-eligible with an American Board of Emergency Medicine (ABEM)-approved, ~~or~~ American Osteopathic Board of Emergency Medicine (AOBEM) certification, or is board-certified in Pediatric Emergency Medicine by the American Board of Pediatrics, then the physician is required to have successfully completed an ATLS or CALS course ~~(including the Trauma Module)~~ once.	If the emergency department physician is currently board-certified or board-eligible with an American Board of Emergency Medicine (ABEM)-approved, American Osteopathic Board of Emergency Medicine (AOBEM) certification, or is board-certified in Pediatric Emergency Medicine by the American Board of Pediatrics, then the physician is required to have successfully completed an ATLS or CALS course once.	Clarifying language Change in CALS course structure in 2024
13.2	If the emergency physician is not board-certified or board-eligible with an ABEM-approved or AOBEM certification, then the physician must have successfully completed ATLS and/or CALS (including the Trauma Module) within the last four years. Emergency physicians must re-take their ATLS or CALS before or during the month in which it is due.	If the emergency department physician is not board-certified or board-eligible with an ABEM-approved or AOBEM certification, the physician must have successfully completed ATLS and/or CALS (~~including the Trauma Module)~~ within the last four years. Emergency physicians must re-take their ATLS or CALS before or during the month in which it is due.	If the emergency department physician is not board-certified or board-eligible with an ABEM-approved or AOBEM certification, the physician must have successfully completed ATLS and/or CALS within the last four years. Emergency physicians must re-take their ATLS or CALS before or during the month in which it is due.	Clarifying language Change in CALS course structure in 2024
14.1	Advance practice providers must have successfully completed ATLS and/or CALS (including the Trauma Module Course) within the last four years. Providers must re-take their ATLS or CALS before or during the month in which it is due.	Emergency department Advanced Practice Providers (APPs) must have successfully completed ATLS and/or CALS (~~including the Benchmark Lab or Trauma Module Course)~~ within the last four years. Providers must re-take their ATLS or CALS before or during the month in which it is due. Other APPs who respond to the ED may be required to complete ATLS and/or CALS at the discretion of the hospital's trauma leadership.	Emergency department Advanced Practice Providers (APPs) must have successfully completed ATLS and/or CALS within the last four years. Providers must re-take their ATLS or CALS before or during the month in which it is due. Other APPs who respond to the ED may be required to complete ATLS and/or CALS at the discretion of the hospital's trauma leadership.	Clarifying language Change in CALS course structure in 2024
15.1	Registered nurses scheduled or expected to cover the emergency department must have successfully completed Trauma Nursing Core Course (TNCC), Comprehensive Advanced Life Support (CALS)	Registered nurses scheduled or expected to cover the emergency department must: 15.1.1 Review the hospital's trauma team activation, trauma admission, and trauma transfer policies **and**	Registered nurses scheduled or expected to cover the emergency department must: **15.1.1** Review the hospital's trauma team activation, trauma admission, and trauma transfer policies **and**	Clarifying language Trauma team activation policy review added

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	Provider Course, Advanced Trauma Care for Nurses (ATCN), or in-house training that meets the following objectives: • Identify the common mechanisms of injury associated with blunt and penetrating injuries. • Describe and demonstrate nursing trauma assessment to identify typical injuries associated with common mechanisms of injury • List appropriate interventions for injuries identified in the nursing assessment. • Associate signs and symptoms with physiological changes in the patient. • Describe the ongoing assessment to evaluate the effectiveness of interventions. • Review the hospital's trauma admission and transfer policies	15.1.2 have successfully completed Trauma Nursing Core Course (TNCC), Comprehensive Advanced Life Support (CALS) Provider Course, Advanced Trauma Care for Nurses (ATCN), or in-house training that meets the following objectives: ▪ Identify the common mechanisms of injury associated with blunt and penetrating injuries. ▪ Describe and demonstrate nursing trauma assessment to identify typical injuries associated with common mechanisms of injury ▪ List appropriate interventions for injuries identified in the nursing assessment. ▪ Associate signs and symptoms with physiological changes in the patient. ▪ Describe the ongoing assessment to evaluate the effectiveness of interventions. ~~▪ Review the hospital's trauma admission and transfer policies~~	**15.1.2** have successfully completed Trauma Nursing Core Course (TNCC), Comprehensive Advanced Life Support (CALS) Provider Course, Advanced Trauma Care for Nurses (ATCN), or in-house training that meets the following objectives: ▪ Identify the common mechanisms of injury associated with blunt and penetrating injuries. ▪ Describe and demonstrate nursing trauma assessment to identify typical injuries associated with common mechanisms of injury ▪ List appropriate interventions for injuries identified in the nursing assessment. ▪ Associate signs and symptoms with physiological changes in the patient. ▪ Describe the ongoing assessment to evaluate the effectiveness of interventions.	
15.2	If the hospital admits patients as described in Section 10 to treat an injury or to monitor the patient for deterioration, registered nurses assigned to patient floors where those patients are admitted must have successfully completed Trauma Nursing Core Course (TNCC), Comprehensive Advanced Life Support (CALS) Provider Course, Advanced Trauma Care for Nurses (ATCN), Trauma Care After Resuscitation (TCAR), Course in Advanced Trauma Nursing (CATN), or in-house training relating to the conditions treated or monitored that meets the following objectives:	If the hospital admits patients as described in Section 10 to treat an injury or to monitor the patient for deterioration, registered nurses assigned to patient floors where those patients are admitted must: 15.1.1 Review the hospital's trauma admission and trauma transfer policies **and** 15.2.2 Have successfully completed Trauma Nursing Core Course (TNCC), Comprehensive Advanced Life Support (CALS) Provider Course, Advanced Trauma Care for Nurses (ATCN), Trauma Care After Resuscitation (TCAR), Course in Advanced Trauma Nursing (CATN), or in-house training relating to the conditions treated or monitored that meets the following objectives: ▪ Identify the common mechanisms of injury associated with blunt and penetrating injuries.	If the hospital admits patients as described in Section 10 to treat an injury or to monitor the patient for deterioration, registered nurses assigned to patient floors where those patients are admitted must: **15.1.1** Review the hospital's trauma admission and trauma transfer policies **and** **15.2.2** Have successfully completed Trauma Nursing Core Course (TNCC), Comprehensive Advanced Life Support (CALS) Provider Course, Advanced Trauma Care for Nurses (ATCN), Trauma Care After Resuscitation (TCAR), Course in Advanced Trauma Nursing (CATN), or in-house training relating to the conditions treated or monitored that meets the following objectives:	Clarifying language

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	• Identify the common mechanisms of injury associated with blunt and penetrating injuries. • Describe nursing trauma assessment to identify typical injuries associated with common mechanisms of injury • List appropriate interventions for injuries identified in the nursing assessment. • Associate signs and symptoms with physiological changes in the patient. • Describe the ongoing assessment to evaluate the effectiveness of interventions. Review the hospital's trauma admission and transfer policies.	▪ Describe nursing trauma assessment to identify typical injuries associated with common mechanisms of injury ▪ List appropriate interventions for injuries identified in the nursing assessment. ▪ Associate signs and symptoms with physiological changes in the patient. ▪ Describe the ongoing assessment to evaluate the effectiveness of interventions. ~~▪ Review the hospital's trauma admission and transfer policies.~~	▪ Identify the common mechanisms of injury associated with blunt and penetrating injuries. ▪ Describe nursing trauma assessment to identify typical injuries associated with common mechanisms of injury ▪ List appropriate interventions for injuries identified in the nursing assessment. ▪ Associate signs and symptoms with physiological changes in the patient. ▪ Describe the ongoing assessment to evaluate the effectiveness of interventions.	
16.1	Licensed practical nurses scheduled or expected to cover the emergency department must have successfully completed Comprehensive Advanced Life Support (CALS) Provider Course, Advanced Trauma Care for Nurses (ATCN), an audit of Trauma Nursing Core Course (TNCC), or in-house training that meets the following objectives: • Identify the common mechanisms of injury associated with blunt and penetrating injuries • Recognize common signs and symptoms of injuries. • Identify data needed for the ongoing monitoring of a trauma patient. • Demonstrate role-specific trauma care competencies.	~~Licensed practical nurses scheduled or expected to cover the emergency department must have successfully completed Comprehensive Advanced Life Support (CALS) Provider Course, Advanced Trauma Care for Nurses (ATCN), an audit of Trauma Nursing Core Course (TNCC), or in-house training that meets the following objectives:~~ ~~• Identify the common mechanisms of injury associated with blunt and penetrating injuries~~ ~~• Recognize common signs and symptoms of injuries.~~ ~~• Identify data needed for the ongoing monitoring of a trauma patient.~~ ~~• Demonstrate role-specific trauma care competencies.~~ ~~Examine the role-specific practice parameters for trauma care as defined by the hospital. Review the hospital's trauma admission and transfer policies.~~		Removed

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	Examine the role-specific practice parameters for trauma care as defined by the hospital. Review the hospital's trauma admission and transfer policies.			
16.2	If the hospital admits patients as described in Section 10 to treat an injury or to monitor the patient for deterioration, licensed practical nurses assigned to patient floors where those patients are admitted must have successfully completed Comprehensive Advanced Life Support (CALS) Provider Course, Rural Trauma Team Development Course (RTTDC), Trauma Care After Resuscitation (TCAR), an audit of a Trauma Nursing Core Course (TNCC), or in-house training relating to the conditions treated or monitored that meets the following objectives: • Identify the common mechanisms of injury associated with blunt and penetrating injuries • Recognize common signs and symptoms of injuries. • Identify data needed for the ongoing monitoring of a trauma patient. • Describe role-specific trauma care competencies. • Examine the role-specific practice parameters for trauma care as defined by the hospital. Review the hospital's trauma admission and transfer policies.	~~If the hospital admits patients as described in Section 10 to treat an injury or to monitor the patient for deterioration, licensed practical nurses assigned to patient floors where those patients are admitted must have successfully completed Comprehensive Advanced Life Support (CALS) Provider Course, Rural Trauma Team Development Course (RTTDC), Trauma Care After Resuscitation (TCAR), an audit of a Trauma Nursing Core Course (TNCC), or in-house training relating to the conditions treated or monitored that meets the following objectives:~~ ~~• Identify the common mechanisms of injury associated with blunt and penetrating injuries~~ ~~• Recognize common signs and symptoms of injuries.~~ ~~• Identify data needed for the ongoing monitoring of a trauma patient.~~ ~~• Describe role-specific trauma care competencies.~~ ~~• Examine the role-specific practice parameters for trauma care as defined by the hospital.~~ ~~Review the hospital's trauma admission and transfer policies.~~		Removed

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
17.1	The performance improvement process must, at a minimum: • Establish methods to identify and resolve clinical care issues that are inconsistent with Advanced Trauma Life Support, Comprehensive Advanced Life Support, Trauma Nursing Core Course and Rural Trauma Team Development Course principles. • Provide for the review or surveillance of trauma cases that meet the trauma registry inclusion criteria to identify potential clinical care issues and to measure performance against the minimum thresholds. • Establish the frequency of case finding, case review and performance monitoring. • Incorporate performance-related information received from receiving hospitals about patients transferred. • Include documentation of: o Compliance with performance thresholds; o Findings from case reviews; o Actions undertaken to correct clinical care issues identified during case reviews; and o Resolution of clinical care issues	~~The performance improvement process must, at a minimum:~~ ~~• Establish methods to identify and resolve clinical care issues that are inconsistent with Advanced Trauma Life Support, Comprehensive Advanced Life Support, Trauma Nursing Core Course and Rural Trauma Team Development Course principles.~~ ~~• Provide for the review or surveillance of trauma cases that meet the trauma registry inclusion criteria to identify potential clinical care issues and to measure performance against the minimum thresholds.~~ ~~• Establish the frequency of case finding, case review and performance monitoring.~~ ~~• Incorporate performance-related information received from receiving hospitals about patients transferred.~~ ~~• Include documentation of:~~ ~~o Compliance with performance thresholds;~~ ~~o Findings from case reviews;~~ ~~o Actions undertaken to correct clinical care issues identified during case reviews; and~~ ~~o Resolution of clinical care issues~~ (included in revised 16.1 and 16.2)		Incorporated into New 16.1 and 16.2
16.1		The performance improvement process must outline (in a written document), the following elements: 16.1.1 Case Finding: the steps to identify cases that meet the trauma registry inclusion criteria	The performance improvement process must outline (in a written document), the following elements: **16.1.1** Case Finding: the steps to identify cases that meet the trauma registry inclusion criteria	New/Revised section 16 (PI Process) Requiring written document

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
		16.1.2 *Primary Review: the process to provide critical nurse level review to identify potential clinical care issues and deviations from standards of care and/or practice 16.1.3 *Secondary Review: the process to provide critical provider level review to identify potential clinical care issues and deviations from standards of care and/or practice 16.1.4 Tertiary Case Review: the established method for a provider level committee case review to identify potential clinical care issues that are identified by trauma program leaders 16.1.4.1 Define committee members and attendance expectations/requirements. 16.1.4.2 Results of tertiary case reviews that identify opportunities to improve clinical care must be communicated with the medical providers. 16.1.5 Trauma Registry: the established steps for data entry into the trauma registry 16.1.6 Performance Improvement: the method to identify and document performance related issues and steps for improvement. 16.1.7 Performance Metrics: identify where and how state and/or local metrics are monitored and tracked. * The scope of case primary and secondary review includes care provided in the prehospital setting, emergency department, in-patient units, and all areas and departments of the hospital that provide or affect trauma care, as well as performance improvement related information from a receiving hospital about transferred patients.	**16.1.2** *Primary Review: the process to provide critical nurse level review to identify potential clinical care issues and deviations from standards of care and/or practice **16.1.3** *Secondary Review: the process to provide critical provider level review to identify potential clinical care issues and deviations from standards of care and/or practice **16.1.4** Tertiary Case Review: the established method for a provider level committee case review to identify potential clinical care issues that are identified by trauma program leaders **16.1.4.1** Define committee members and attendance expectations/requirements. **16.1.4.2** Results of tertiary case reviews that identify opportunities to improve clinical care must be communicated with the medical providers. **16.1.5** Trauma Registry: the established steps for data entry into the trauma registry **16.1.6** Performance Improvement: the method to identify and document performance related issues and steps for improvement. **16.1.7** Performance Metrics: identify where and how state and/or local metrics are monitored and tracked. * The scope of case primary and secondary review includes care provided in the prehospital setting, emergency department, in-patient units, and all areas and departments of the hospital that provide or affect trauma care, as well as performance improvement related information from a receiving hospital about transferred patients.	

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
17.2	Case finding must occur, at a minimum, every two weeks and primary case review must occur within two weeks of patients' discharge	~~Case finding must occur, at a minimum, every two weeks and primary case review must occur within two weeks of patients' discharge~~ (Included in revised 16.2)		Incorporated into New 16.2
16.2		17.2 The performance improvement process must demonstrate the following elements: 17.2.1 Case Finding: 17.2.1.1 must occur, ~~at a minimum, every~~ within ~~two~~ three weeks of patients' discharge 17.2.1.2 identify trauma cases that meet the trauma registry inclusion criteria 17.2.2 Primary Review: 17.2.2.1 must occur within ~~two~~ three weeks of patients' discharge. 17.2.2.2 identify potential clinical care issues and care issues that are inconsistent with Trauma Standards of Care (e.g. Advanced Trauma Life Support [ATLS], Comprehensive Advanced Life Support [CALS], Trauma Nursing Core Course [TNCC] and Rural Trauma Team Development Course [RTTDC] principles). 17.2.2.3 the scope of case review includes care provided in the pre-hospital setting, emergency department, in-patient units, and all areas and departments of the hospital that provide or affect trauma care, as well as performance related information from a receiving hospital about transferred patients. 17.2.3 Secondary Review (if required): 17.2.3.1 must occur within ~~one month~~ six weeks of patients' discharge 17.2.3.2 identify potential clinical care issues and care issues that are inconsistent with Trauma Standards of Care (e.g. Advanced Trauma Life Support [ATLS], Comprehensive Advanced Life Support [CALS], Trauma Nursing Core Course [TNCC] and Rural Trauma Team Development Course [RTTDC] principles).	The performance improvement process must demonstrate the following elements: **16.2.1** Case Finding: **16.2.1.1** must occur within three weeks of patients' discharge **16.2.1.2** identify trauma cases that meet the trauma registry inclusion criteria **16.2.2** Primary Review: **16.2.2.1** must occur within three weeks of patients' discharge. **16.2.2.2** identify potential clinical care issues and care issues that are inconsistent with Trauma Standards of Care (e.g. Comprehensive Advanced Life Support [CALS], Trauma Nursing Core Course [TNCC] and Rural Trauma Team Development Course [RTTDC] principles). **16.2.2.3** the scope of case review includes care provided in the pre-hospital setting, emergency department, in-patient units, and all areas and departments of the hospital that provide or affect trauma care, as well as performance related information from a receiving hospital about transferred patients. **16.2.3** Secondary Review (if required): **16.2.3.1** must occur within six weeks of patients' discharge **16.2.3.2** identify potential clinical care issues and care issues that are inconsistent with Trauma Standards of Care (e.g. Advanced Trauma Life Support	New/Revised section 16 (PI Process) Extending review timelines Extending review timelines

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
		17.2.3.3 the scope of case review includes care provided in the pre-hospital setting, emergency department, in-patient units, and all areas and departments of the hospital that provide or affect trauma care, as well as performance related information from a receiving hospital about transferred patients. 17.2.4 Tertiary Case Review (if required): 17.2.4.1 tertiary case review is to be facilitated by the trauma medical director/co-TMD. 17.2.4.2 tertiary case review committee must include ED providers involved in the care of the injured patient. 17.2.4.3 learnings from tertiary case review must be provided to medical providers who are not in attendance at the meeting. 17.2.4.4 if the hospital admits trauma patients as described in Section 10.2, general surgeons and general surgery APPs must attend at least 50% of the scheduled tertiary case review meetings. 17.2.5 Performance Improvement documentation will include: 17.2.5.1 Evaluation of performance thresholds 17.2.5.2 Findings from case reviews 17.2.5.3 Actions undertaken to correct clinical care and process issues identified during case reviews 17.2.5.4 Appropriate steps towards improvement or resolution of identified issues 17.2.6 Demonstrate resolution of at least two clinical care or care process issues	[ATLS], Comprehensive Advanced Life Support [CALS], and Rural Trauma Team Development Course [RTTDC] principles). **16.2.3.3** the scope of case review includes care provided in the pre-hospital setting, emergency department, in-patient units, and all areas and departments of the hospital that provide or affect trauma care, as well as performance related information from a receiving hospital about transferred patients. **16.2.4** Tertiary Case Review (if required): **16.2.4.1** tertiary case review is to be facilitated by the trauma medical director/co-TMD. **16.2.4.2** tertiary case review committee must include ED providers involved in the care of the injured patient. **16.2.4.3** learnings from tertiary case review must be provided to medical providers who are not in attendance at the meeting. **16.2.4.4** if the hospital admits trauma patients as described in Section 10.2, general surgeons and general surgery APPs must attend at least 50% of the scheduled tertiary case review meetings. **16.2.5** Performance Improvement documentation will include: **16.2.5.1** Evaluation of performance measures **16.2.5.2** Findings from all levels of case reviews **16.2.5.3** Actions undertaken to correct clinical care and process issues identified during case reviews	Extending review timelines Clarifying surgical provider to include APPs in tertiary review attendance

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
			16.2.5.4 Appropriate steps towards improvement or resolution of identified issues **16.2.6** Demonstrate resolution of at least two clinical care or care process issues	New
17.3	Medical director review of trauma cases for clinical care issues must occur within one month of patients' discharge	~~Medical director review of trauma cases for clinical care issues must occur within one month of patients' discharge~~ (included in revised 16.2)		Incorporated into New 16.2
16.3		The hospital must establish and monitor performance improvement filters that include: 16.3.1 Case category: TTA, Transfer, Admit, Death 16.3.2 Delay in decision to transfer (>30 min) once the immediate transfer criteria/policy is met 16.3.3 Patient exceeds admission criteria and admitted locally 16.3.4 Admitted and then transferred 16.3.5 Delays in care	The hospital must establish and monitor performance improvement filters that include: **16.3.1** Case category: TTA, Transfer, Admit, Death **16.3.2** Delay in decision to transfer (>30 min) once the immediate transfer criteria/policy is met. **16.3.3** Patient exceeds admission criteria and admitted locally **16.3.4** Admitted and then transferred **16.3.5** Delays in care	New

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
		16.3.6 Deviation from trauma standards of care 16.3.7 Deviation from Practice Management Guidelines 16.3.8 At least one hospital-specific filter that focuses on improving clinical care or care processes 16.3.9 Patient admitted with 10.2 condition; general surgeon did not arrive at bedside within 18 hours	**16.3.6** Deviation from trauma standards of care **16.3.7** Deviation from Practice Management Guidelines **16.3.8** At least one hospital-specific filter that focuses on improving clinical care or care processes **16.3.9** Patient admitted with 10.2 condition; general surgeon did not arrive at bedside within 18 hours	
17.4	The hospital must establish a tertiary case review process to review potential clinical care issues identified by the trauma program leaders	~~The hospital must establish a tertiary case review process to review potential clinical care issues identified by the trauma program leaders.~~ (included in revised 16.1)		Incorporated into New 16.1
16.4		The Emergency Department must 16.4.1 Perform a Pediatric Readiness Assessment within one year of designation expiration 16.4.2 Have a plan to address at least one of the identified gaps 16.4.3 Identify a pediatric point of contact	The Emergency Department must **16.4.1** Perform a Pediatric Readiness Assessment within one year of designation expiration **16.4.2** Have a plan to address at least one of the identified gaps **16.4.3** Identify a pediatric point of contact	New self-assessment survey addressing the policies, personnel, equipment, and systems a hospital has in place to ensure it can effectively care for injured children. https://www.pedsready.org/
17.5	If the hospital admits trauma patients as described in Section 10.2, the general surgeon must attend at least 50% of the scheduled tertiary case review meetings.	~~If the hospital admits trauma patients as described in Section 10.2, the general surgeon must attend at least 50% of the scheduled tertiary case review meetings.~~ (Included in revised 16.2)		Incorporated into New 16.2.4.4
17.6	The scope of case review must include care provided in the emergency department, in-patient units, and all areas and departments of the hospital that provide or affect trauma care.	~~The scope of case review must include care provided in the emergency department, in-patient units, and all areas and departments of the hospital that provide or affect trauma care.~~ (Included in revised 16.1 and 16.2)		Incorporated into New 16.1, 16.2.2.3 and 16.2.3.3

L4 New criteria recommendations

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
17.7	Results of the trauma case reviews that identify opportunities to improve clinical care must be communicated with the medical providers.	~~Results of the trauma case reviews that identify opportunities to improve clinical care must be communicated with the medical providers.~~ (Included in revised 16.1 and 16.2)		Incorporated into 16.1.4.2 and 16.2.4.3
17.8	The trauma performance improvement process may be integrated with the hospital's quality improvement processes, but the trauma program leaders must retain oversight over the program's performance improvement initiatives. Potential clinical care issues referred to other bodies within the hospital or health system, such as peer review, or other organizations, must be made available to the trauma program leadership.	~~The trauma performance improvement process may be integrated with the hospital's quality improvement processes, but the trauma program leaders must retain oversight over the program's performance improvement initiatives. Potential clinical care issues referred to other bodies within the hospital or health system, such as peer review, or other organizations, must be made available to the trauma program leadership.~~		Removed
17.9	The trauma program must monitor imaging-interpretation turnaround times and review missed diagnoses identified from over-read reports.	~~The trauma program must monitor imaging-interpretation turnaround times and review missed diagnoses identified from over-read reports.~~		Removed
~~18.1~~ 17.1	The following performance thresholds must be maintained or exceeded: Time from patient arrival to emergency department provider arrival at hospital ≤30 minutes when the emergency department provider is off-site: 80% Trauma team activated when criteria met: 80% Time from patient arrival until transportation ordered <30 minutes when a physiological TTA criterion is met and patient transferred for trauma care; or time from when a	The following performance ~~thresholds~~ measures must be maintained or exceeded: ~~Time from patient arrival to emergency department provider arrival at hospital ≤30 minutes when the emergency department provider is off-site: 80%~~ 18.1.1 Trauma team activated when criteria met: 80% 18.1.2 Less than 30 min decision to transfer once the patient is recognized as meeting the hospital's immediate transfer criteria: 80% 18.1.3 At least one hospital-specific measure that focuses on improving clinical care and target threshold	The following performance measures must be maintained or exceeded: **17.1.1** Trauma team activated when criteria met: 80% **17.1.2** Less than 30 min decision to transfer once the patient is recognized as meeting the hospital's immediate transfer criteria: 80% **17.1.3** At least one hospital-specific measure that focuses on improving clinical care and meeting the hospital's set goal	Streamline performance measures Removed 3, updated 1, added 1 New 17.1.1 New 17.1.2 changed to decision vs. time to call New 17.1.3

L4 New criteria recommendations

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	physiological TTA criterion is discovered until transportation ordered <30 minutes when patient transferred for trauma care: 80% Airway successfully secured when sustained GCS ≤8: 90% If the hospital admits trauma patients as described in Section 10.2, the following performance threshold must also be maintained or exceeded:	~~Time from patient arrival until transportation ordered <30 minutes when a physiological TTA criterion is met and patient transferred for trauma care; or time from when a physiological TTA criterion is discovered until transportation ordered <30 minutes when patient transferred for trauma care: 80%~~ ~~Airway successfully secured when sustained GCS ≤8: 90%~~ If the hospital admits trauma patients as described in Section 10.2, the following performance ~~threshold~~ measure must also be maintained or exceeded: 18.1.4 General surgeon arrival at bedside within 18 hours as required in Section 10.2: 80% Compliance with performance thresholds is calculated based on ~~a full calendar year~~ the most recent 12 months of data. (previous 17.3)	If the hospital admits trauma patients as described in Section 10.2, the following performance measures must also be maintained or exceeded: **17.1.4** General surgeon arrival at bedside within 18 hours as required in Section 10.2: 80% Compliance with performance measures is calculated based on the most recent 12 months of data.	New 17.1.4
18.2	General surgeon arrival at bedside within 18 hours as required in Section 10.2: 80%	~~General surgeon arrival at bedside within 18 hours as required in Section 10.2: 80%~~ (revised into 17.1)		Incorporated into New 17.1.4
18.3	Compliance with performance thresholds is calculated based on a full calendar year.	~~Compliance with performance thresholds is calculated based on a full calendar year.~~ (revised into 17.1)		Incorporated into New 17.1
~~19.1~~ 18.1	The hospital must submit data as defined by the State Trauma Advisory Council within 60 days of the patients' discharge or transfer.		The hospital must submit data as defined by the State Trauma Advisory Council within 60 days of the patients' discharge or transfer.	No change
~~19.2~~ 18.2	Data imported from other sources must be submitted in a manner and format that is acceptable to MDH		Data imported from other sources must be submitted in a manner and format that is acceptable to MDH.	No change
~~20.1~~ 19.1	Emergency Department • Airway control and ventilation equipment		Emergency Department • Airway control and ventilation equipment • Arterial tourniquet	No change

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	• Arterial tourniquet • Pulse oximetry • Suction device and supplies • EKG monitor and defibrillator • Crystalloid IV fluids and administration sets • IV catheters from 14-22 Ga. • Drugs necessary for emergency trauma care • Nasal gastric & oral gastric tubes • Cervical collars • Pediatric length-based resuscitation tape or reference manual • Blanket warmer or overhead radiant heater • Warming cabinet for IV fluids or inline IV fluid warmer • Rapid IV fluid infuser system (may use pressure bag) • End-tidal CO2 detector (may be disposable) • Method to communicate with EMS • Mechanism for IV flow-rate control • Intraosseous needles and administration sets • Supplies for surgical airway & thoracostomy • Mechanism for pelvic stabilization		• Pulse oximetry • Suction device and supplies • EKG monitor and defibrillator • Crystalloid IV fluids and administration sets • IV catheters from 14-22 Ga. • Drugs necessary for emergency trauma care • Nasal gastric & oral gastric tubes • Cervical collars • Pediatric length-based resuscitation tape or reference manual • Blanket warmer or overhead radiant heater • Warming cabinet for IV fluids or inline IV fluid warmer • Rapid IV fluid infuser system (may use pressure bag) • End-tidal CO2 detector (may be disposable) • Method to communicate with EMS • Mechanism for IV flow-rate control • Intraosseous needles and administration sets • Supplies for surgical airway & thoracostomy • Mechanism for pelvic stabilization	
~~20.2~~ 19.2	Imaging Department • Airway control and ventilation equipment • Suction device and suction supplies		Imaging Department • Airway control and ventilation equipment • Suction device and suction supplies	No change
~~20.3~~ 19.3	If the hospital admits trauma patients described in Section 10, the following equipment is also required on the in-patient unit:		If the hospital admits trauma patients described in Section 10, the following equipment is also required on the in-patient unit:	No change

CRITERIA	CURRENT LEVEL 4 CRITERIA	CRITERIA EDITS (current criteria with markup)	PROPOSED LEVEL 4 CRITERIA	EXPLANATION
	• Equipment for monitoring and resuscitation		• Equipment for monitoring and resuscitation	

Modification Code Key	
Green	Decrease or eliminate
Blue	Neutral
Orange	New