WISCONSIN DEPARTMENT
of HEALTH SERVICES

Wisconsin Administrative Code ch. DHS 118 Appendix A Proposed Changes Log

Wisconsin Department of Health Services
Division of Public Health
Office of Preparedness and Emergency Health Care

(10/2026)

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Summary

This document compares the 2021 criteria for level III and IV trauma care facilities in Wis. Admin. Code ch. DHS 118 Appendix A to the proposed 2026 criteria for level III and IV trauma care facilities in Wis. Admin. Code ch. DHS 118 Appendix A. These proposed criteria are not considered final at this time. This log will be updated with a final version after the administrative rule making process.

Criteria totals

The following tables describe the total number of criteria by type.

2021

Level III

Type 1 = 40 criteria

Type 2 = 117 criteria

Total = 157 criteria

Level IV*

Type 1 = 25 criteria

Type 2 = 101 criteria

Total = 126 criteria

*Includes if the trauma care facility (TCF) provides optional services.

2026

Level III

Type 1 = 11 proposed criteria

Type 2 = 72 proposed criteria

Total = 83 proposed criteria

Level IV*

Type 1 = 7 proposed criteria

Type 2 = 74 proposed criteria

Total = 81 proposed criteria

*Includes if the trauma care facility (TCF) provides optional services.

Acronyms

AAAM: Association for Advancement of Automotive Medicine

ACS: American College of Surgeons

AIS: Abbreviated Injury scale

APP: Advanced practice provider

ATLS: Advanced trauma life support

CALS: Comprehensive advanced life support

CME: Continuing medical education

CT: Computed tomography

DHS: Department of Health Services

ECG: Electrocardiogram

ED: Emergency department

EMS: Emergency Medical Services

FPPE: Focused professional practice evaluation

HR: Heart rate

ICP: Intracranial pressure monitoring

ICU: Intensive care unit

ISS: Injury severity score

IV: Intravenous

MRI: Magnetic resonance imaging

MTP: Massive transfusion protocol

PHTLS: Pre-hospital trauma life support

PI: Performance improvement

PIPS: Performance improvement and patient safety

RTAC: Regional trauma advisory council

SPB: Systolic blood pressure

STAC: Statewide trauma advisory council

TCF: Trauma care facility

TMD: Trauma medical director

TPM: Trauma program manager

Proposed rule: Section 1 – Institutional administrative commitment

Proposed Criterion 1.1, Level III and IV, Type 1

A TCF's institutional governing body, hospital leadership, and medical staff shall demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of classification with written resolutions reaffirmed every three years, signed and dated within one year of classification site visit.

2021 related criteria

2(c), Level III and IV, Type 2

The TCF must be able to provide the necessary human and physical resources including the physical plant and equipment as well as policies and procedures to properly administer acute care for all ages, consistent with their level of classification.

2(d), Level III and IV, Type 2

To care for adult patients, the TCF must have emergency department policies, procedures, protocols, or guidelines.

(1) Sedation and analgesia.

(2) Medical imaging.

(3) Injury imaging.

(4) Dosing for intubation medications, code drugs, and neurologic drugs.

2(l), Level IV, Type 2

The TCF's emergency department must:

(1) Be continuously available for resuscitation.

(2) Have continuous coverage by a registered nurse.

(3) Have continuous coverage by a physician or APP/midlevel provider.

(4) Have a physician as its medical director.

5(a), Level III and IV, Type 1

The decision of a hospital to become a TCF requires the commitment of the institutional governing body and the medical staff, and this administrative commitment must be documented. The TCF must have resolutions from both the institutional governing body and the medical staff acknowledging this commitment, and these resolutions must empower the trauma PIPS program to address events that involve multiple disciplines and to evaluate all aspects of trauma care.

5(b), Level III and IV, Type 2

The TCF's administrative support must be current at the time of the site visit and must be reaffirmed every three years. The administrative support must be from the Board of

Directors, Chief Executive Officer or Chief Administrator and the medical staff or medical executive committee.

11(um), Level III, Type 1

The TCF must have the necessary equipment for the ICU to monitor and resuscitate patients. Each TCF shall determine the equipment necessary based on the types of patients admitted and treated.

Proposed Criterion 1.2, Level III and IV, Type 2

A TCF shall identify trauma professionals and dedicated hours necessary to adequately administer a trauma program consistent with the TCF's level of classification and trauma patient volumes.

2021 related criteria

2(c), Level III and IV, Type 2

The TCF must be able to provide the necessary human and physical resources including the physical plant and equipment as well as policies and procedures to properly administer acute care for all ages, consistent with their level of classification.

14(h), Level III and IV, Type 2

The TCF must demonstrate that appropriate staff resources are dedicated to the trauma registry.

Proposed rule: Section 2 – Program scope and governance

Proposed Criterion 2.1, Level III and IV, Type 2

A TCF shall participate in the regional and statewide trauma system to promote standardization, integration, and performance improvement throughout the region and state. A TCF's TPM, TMD, trauma registrar, hospital administrator or other designated trauma staff shall attend at least 50% of the TCF's primary RTAC and STAC meetings annually. No TPM, TMD, trauma registrar, hospital administrator or other designated trauma staff may represent more than three TCFs at any one RTAC or STAC meeting.

2021 related criteria

1(a), Level III and IV, Type 2

TCFs and their health care providers must be active and engaged participants in the trauma care system and promote standardization, integration, and PIPS throughout the region and state. TCFs must be involved in state and regional trauma care system planning, development and operation and actively participate in regional and statewide trauma care system meetings and committees that provide oversight. The TPM, TMD or trauma registrar must attend at least 50% of the TCF's RTAC meetings annually. The TPM, TMD or trauma registrar may not represent more than three TCFs at any one RTAC meeting.

Proposed Criterion 2.2, Level III, Type 2

A TCF shall participate in two hospital drills or disaster plan activations per calendar year that include the TCF's highest-level activations and that are designed to refine the hospital's response to mass casualty events.

2021 related criteria

18(a), Level III and IV, Type 2

The TCF must meet the disaster-related requirements of the Joint Commission or other accrediting bodies.

18(b), Level III, Type 2

A liaison from the trauma program must be a member of the TCF's disaster committee.

18(c), Level III and IV, Type 2

The TCF must participate in regional disaster management plans and exercises.

Proposed Criterion 2.3, Level IV, Type 2

A TCF shall participate in one hospital drill or disaster plan activation per calendar year that includes the TCF's highest-level activation and that is designed to refine the hospital's response to mass casualty events.

2021 related criteria

None

Proposed Criterion 2.4, Level III and IV, Type 2

A TCF trauma center shall ensure the TMD satisfies all of the following requirements:

- The TMD is a current board certified or board eligible physician that participates in the TCF's trauma call panel or that is staff of the TCF's emergency department.
- The TMD serves as the TMD of no more than two trauma programs.
- The TMD is credentialed to provide trauma care.
- The TMD holds a current Advanced Trauma Life Support (ATLS) certification.
- The TMD possesses evidence that the TMD has completed at least four hours of trauma-related continuing medical education (CME) during each calendar year, at least one hour of which shall be pediatric-specific education.

2021 related criteria

5(d), Level III and IV, Type 1

The TMD must meet one of the following set of standards:

(1) Be a current board-certified general surgeon, neurosurgeon or orthopedic surgeon and be actively involved in the care of trauma patients.

(2) Be eligible for board certification in general surgery, neurosurgery or orthopedic surgery and be actively involved in the care of trauma patients.

(3) Be approved to take trauma call through the alternate pathway requirements for general surgeons, neurosurgeons or orthopedic surgeons and be actively involved in the care of trauma patients.
(4) Be a current board certified emergency medicine physician and staff the emergency department.
(5) Be eligible for board certification as an emergency medicine physician and staff the emergency department.
(6) Be approved to take trauma call through the alternate pathway for emergency medicine physicians and staff the emergency department.

5(e), Level III and IV, Type 2

The TMD must be current in ATLS.

5(g), Level III, Type 2

The TMD may not direct more than two trauma centers.

5(h), Level III and IV, Type 2

The TMD must actively participate in the trauma multidisciplinary PIPS review committee.

Proposed Criterion 2.5, Level III, Type 2

A TCF shall ensure that if the TMD is not a general or trauma surgeon, the TCF shall ensure that a designated board certified or board eligible general or trauma surgeon serves as the lead liaison to the TCF's trauma program.

2021 related criteria

2(b)1, Level III, Type 1

The TCF must have surgical commitment.

Proposed Criterion 2.6, Level III and IV, Type 2

A TCF shall ensure the TMD is responsible for and has the authority to do all of the following:

- Transcend normal departmental hierarchies and work across departments and administrative units to address deficiencies in care.
- Develop and promote policies, procedures, protocols, and practice management guidelines relevant to the care of an injured patient across the continuum of care, in conjunction with the TPM.
- Chair or co-chair the trauma multidisciplinary committee.
- Oversee the structure and process of the trauma PIPS program.
- Have an established process for evaluation of provider participation in trauma care concerns, which may be guided by findings from the PIPS process or other professional evaluations.
- Conduct or participate in focused professional practice evaluation (FPPE) as needed.

2021 related criteria

5(c), Level III and IV, Type 2

The trauma program must involve multiple disciplines and transcend normal department hierarchies by having appropriate specialty representation from all phases of care.

5(f), Level III and IV, Type 2

The TMD must have the authority to manage all aspects of trauma care.

5(i), Level III, Type 2

The TMD, in collaboration with the TPM, must have the responsibility and authority to report any deficiencies in trauma care and any trauma team members who do not meet specified trauma call criteria to the appropriate person(s).

5(j), Level III, Type 2

The TMD must conduct, and have the authority to conduct, an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation when indicated by findings of the trauma PIPS process. The TMD must have the authority to recommend changes for the trauma panel based on performance review.

5(k), Level III and IV, Type 1

The TMD and TPM must be granted authority by the hospital governing body to lead the trauma PIPS program. This authority must be evidenced in written job descriptions for both the TMD and TPM.

Proposed Criterion 2.7, Level III and IV, Type 2

A TCF shall ensure the TPM fulfills all of the following requirements:

- Demonstrate evidence of clinical experience in the provision of acute care either as a nurse, APP, or prehospital care clinician.
- Possess evidence that the TPM has completed at least four hours of trauma-related education during each calendar year, at least one hour of which shall be pediatric-specific education.
- Have previously completed, or complete within 12 months of hire, at least one course pertaining to trauma performance improvement.

2021 related criteria

5(s), Level III and IV, Type 2

The TPM must show evidence of educational preparation, relevant clinical experience in the care of injured patients and administrative ability. The TCF may determine who meets these requirements. Evidence that a TPM meets these requirements may include a copy of the trauma coordinator job description. The TPM may be a nurse, but does not have to be.

Proposed Criterion 2.8, Level III and IV, Type 2

A TCF shall ensure the TPM is responsible for and has the authority to do all of the following:

- Transcend normal departmental hierarchies and work across departments and administrative units to address deficiencies in care.
- Develop and promote policies, procedures, protocols, and practice management guidelines relevant to care of an injured patient across the continuum of care, in conjunction with the TMD.
- Monitor performance improvement activities, including staff education.
- Chair or co-chair the trauma multidisciplinary committee.
- Oversee the structure and process of the trauma PIPS program.
- Awareness of the trauma registry.

2021 related criteria

2(n), Level III and IV, Type 2

A TMD and TPM knowledgeable and involved in trauma care must work together with guidance from the trauma multidisciplinary peer review committee to identify events, develop corrective action plans and ensure methods of monitoring, reevaluating and benchmarking.

Proposed Criterion 2.9, Level III, Type 2

A TCF shall ensure at least one staff trauma registrar shall either have previously attended or attend within 12 months of hire both an Association for the Advancement of Automotive Medicine (AAAM) abbreviated injury score (AIS) coding course and an ICD-10 coding course.

2021 related criteria

14(f), Level III, Type 2

At least one staff trauma registrar at each TCF must either have previously attended the following two courses or attend the following two courses within 12 months of being hired:

(1) The American Trauma Society's two-day, in person trauma registry course or equivalent provided by a state trauma program.

(2) The Association of the Advancement of Automotive Medicine's Abbreviated Injury Scale and Injury Scoring: Uses and Techniques course.

Proposed Criterion 2.10, Level IV, Type 2

A TCF shall ensure at least one staff trauma registrar shall either have previously attended or attend within 12 months of hire both a trauma registry course and a trauma coding-related course.

2021 related criteria
None

Proposed Criterion 2.11, Level III and IV, Type 2

A TCF shall administer an injury prevention program that prioritizes injury prevention work based on trends identified in the trauma registry and local epidemiological data. The TCF shall have a designated person with injury prevention in their job description.

2021 related criteria

14(d), Level III and IV, Type 2

A TCF must use trauma registry data to identify injury prevention priorities that are appropriate for local implementation.

17(a), Level III and IV, Type 2

The TCF must have an organized and effective approach to injury prevention and must prioritize these efforts based on local trauma registry and epidemiologic data.

17(b), Level III and IV, Type 2

The TCF must have someone in a leadership position that has injury prevention as part of his or her job description.

Proposed rule: Section 3 – Facilities and equipment resources

Proposed Criterion 3.1, Level III, Type 1

A TCF shall ensure that an operating room with adequate staff is available within 30 minutes of an emergent operating room request.

2021 related criteria

9(b), Level III and IV if the TCF provides orthopedic surgery for trauma patients, Type 1

An operating room must be adequately staffed, with at least an operating room nurse and operating room technician, and available within 30 minutes of operating room team request for emergency operations on musculoskeletal injuries.

11(g), Level III and IV if the TCF provides surgical services for trauma patients, Type 1

An operating room must be adequately staffed, with at least an operating room nurse and operating room technician, and available within 30 minutes of operating room team request.

Proposed Criterion 3.2, Level IV, Type 2

If a TCF provides any surgical services for injured patients under circumstances where the TCF takes an injured patient to the operating room emergently or urgently, the TCF

shall have a written document outlining expected response times for staff of the operating room.

2021 related criteria

9(b), Level III and IV if the TCF provides orthopedic surgery for trauma patients, Type 1

An operating room must be adequately staffed, with at least an operating room nurse and operating room technician, and available within 30 minutes of operating room team request for emergency operations on musculoskeletal injuries.

11(g), Level III and IV if the TCF provides surgical services for trauma patients, Type 1

An operating room must be adequately staffed, with at least an operating room nurse and operating room technician, and available within 30 minutes of operating room team request.

Proposed Criterion 3.3, Level III and IV, Type 2

A TCF shall have an adequate supply of red blood cells and plasma.

2021 related criteria

11(xm), Level III, Type 1

The TCF's blood bank must have an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes.

Proposed Criterion 3.4, Level III and IV, Type 2

A TCF shall have all of the following laboratory services continuously available:

- Standard analysis of blood, urine, and other body fluids.
- Blood typing and cross-matching.
- Coagulation studies.
- Blood gas and pH determinations.
- Drug and alcohol screening.

If the laboratory within the TCF is not staffed at all times, the trauma center shall have a call-back process for laboratory personnel for trauma activations such that the laboratory personnel are on-site within 30 minutes of activation.

2021 related criteria

11(wm), Level III and IV, Type 1

The TCF must have laboratory services available 24 hours per day for the standard analysis of blood, urine and other body fluids, including microsampling when appropriate.

11(x), Level III and IV, Type 1
The TCF's blood bank must be capable of blood typing and crossmatching.

11(ym), Level III, Type 1
The TCF must have coagulation studies, blood gas analysis and microbiology studies available 24 hours per day.

Proposed Criterion 3.5, Level III, Type 2

A TCF shall ensure the following services are available at all times and be accessible for patient care within the time interval specified:

- Conventional radiography—30 minutes.
- CT—30 minutes.
- Point-of-care ultrasound—15 minutes.

2021 related criteria

11(m), Level III and IV, Type 1
Conventional radiology must be available 24 hours per day. The radiology technician does not need to be in-house 24 hours per day but must respond within 30 minutes of notification.

11(mm), Level III, Type 1
CT must be available 24 hours per day. The CT technologist does not need to be in-house 24 hours per day but must respond within 30 minutes of notification.

11(nm), Level III and IV, Type 2
For TCFs with MRI capabilities, the MRI technologist may respond from outside the hospital. The trauma PIPS program must document and review arrival of the MRI technologist within one hour of being called.

Proposed Criterion 3.6, Level IV, Type 2

A TCF shall ensure the following services are available at all times and be accessible for patient care within the time interval specified:

- Conventional radiography—30 minutes.
- CT—30 minutes.
- If offered as a service, point-of-care ultrasound—15 minutes.

2021 related criteria

11(m), Level III and IV, Type 1
Conventional radiology must be available 24 hours per day. The radiology technician does not need to be in-house 24 hours per day but must respond within 30 minutes of notification.

11(nm), Level III and IV, Type 2

For TCFs with MRI capabilities, the MRI technologist may respond from outside the hospital. The trauma PIPS program must document and review arrival of the MRI technologist within one hour of being called.

Proposed Criterion 3.7, Level III and IV, Type 2

If a TCF provides neurosurgery onsite, then the TCF must have cerebral monitoring and craniotomy capabilities.

2021 related criteria

11(j), Level III and IV, Type 1

If a TCF provides neurosurgical services, the TCF must have the necessary equipment to perform a craniotomy.

11(l), Level III and IV, Type 1

The TCF's trauma PIPS program must address the need for pulse oximetry, end-tidal carbon dioxide detection, arterial pressure monitoring, patient rewarming and intracranial pressure monitoring.

11(v), Level III and IV, Type 1

If a TCF has neurosurgical coverage and admits neuro-trauma patients, intracranial pressure monitoring equipment must be available.

Proposed Criterion 3.8, Level III and IV, Type 2

A TCF shall have all of the following:

Airway Management

- Portable suction capabilities.
- Bag-valve-mask respirators with appropriately sized masks.
- Portable oxygen tanks and an oxygen supply.
- Oropharyngeal airways in a variety of sizes.
- Nasopharyngeal airways in a variety of sizes.
- Laryngoscopes with a variety of blades.
- Endotracheal tubes for adults.
- Rescue airway equipment including a laryngoscope and supraglottic airways.
- Cricothyroidotomy instruments and supplies.
- Video laryngoscopy.

Breathing equipment

- A non-invasive ventilation system.
- Thoracostomy instruments and supplies.
- A closed-chest drainage device.

- An adjunct to confirm intubation.
- A mechanical ventilator.
- A decompression needle.

Circulatory support

- Tourniquet.
- Vascular access.
- Fluid administration such as standard intravenous therapy or large-bore administration devices and catheters.
- Thermal control including a blanket warmer, fluid warmer, and warming devices.
- For level III TCFs, a rapid infuser.
- For level IV TCFs, a rapid infuser or a pressure bag with a warming element.

Monitoring

- Pulse oximetry capability.
- End tidal carbon dioxide determinations.
- Blood pressure capability.
- Heart rate capability.
- Thermometer.
- ECG capability.

Other

- Two-way radio communication capabilities with EMS.
- Defibrillation capability.
- Skeletal and cervical immobilization.
- Gastric decompression.

The TCF may have alternative equipment than what is specifically listed if they can document and demonstrate that the required clinical functions may still be met in a timely and safe manner for the patient.

2021 related criteria

2(e), Level III and IV, Type 2

The TCF must have medications and equipment readily available for emergency care.

(1) Airway control and ventilation

(2) Pulse oximetry

(3) End tidal carbon dioxide determination

(4) Suction

(5) Electrocardiogram monitoring or defibrillation

(6) Fluid administration such as standard intravenous therapy or large-bore administration devices and catheters

(7) Cricothyrotomy

(8) Thoracostomy

(9) Vascular access

(10) Decompression

(11) Gastric decompression

(12) Conventional radiology

(13) Two-way radio communication with ambulance crew or rescue

(14) Skeletal and cervical immobilization

(15) Thermal control for patients and resuscitation fluids

(16) Rapid fluid infusion

11(i), Level III and IV if the TCF provides surgical services for trauma patients, Type 1

The TCF must have the ability to perform services involving rapid infusers, thermal control equipment and resuscitation fluids, intraoperative radiologic capabilities and equipment for fracture fixation/stabilization.

Proposed Criterion 3.9, Level III and IV, Type 2

A TCF shall have all of the following pediatric equipment:

- Portable pediatric resuscitation cart or bag organized for identification of appropriately sized age- or weight-based equipment.
- Standardized chart or tool to estimate weight.
- Neonatal, infant, and child blood pressure cuffs.
- Defibrillator with pediatric capabilities.
- Pulse oximeter with pediatric capabilities.
- Continuous end-tidal CO2 monitoring device.
- 24 and 22 gauge catheter over the needle.
- Pediatric intraosseous needles.
- IV administration sets with calibrated chambers or an infusion pump.
- Endotracheal tubes: 2.5 mm uncuffed, 3.0 mm uncuffed, 3.5 mm cuffed and uncuffed, 4.0 mm cuffed, 4.5 mm cuffed, 5.0 mm cuffed, 5.5 mm cuffed, and 6.0 mm cuffed.
- Stylets for pediatric and infant sized endotracheal tubes.
- Laryngoscope blades: straight size 0, straight size 1, and straight and curved size 2.
- Supraglottic airway: size 1, 1.5, 2, and 2.5.

- Nasopharyngeal airway: infant and child size.
- Oropharyngeal airways: size 0 (50mm), size 1 (60mm), size 2 (70mm), size 3 (80mm).
- Pediatric size Magill forceps.
- Bag-mask device, self-inflating in child and infant size.
- Bag-mask masks in size pre-term, neonatal, infant, and child.
- Simple oxygen face masks in infant and child size.
- Non-rebreather masks in infant and child size.
- Nasal cannulas in infant and child size.
- Suction catheters: at least one in the 6-8 French size and at least one in the 10-12 French size.

The TCF may have alternative equipment than what is specifically listed if they can document and demonstrate that the required clinical functions may still be met in a timely and safe manner for the patient.

2021 related criteria

10(b), Level III and IV, Type 2

A TCF that stabilizes pediatric trauma patients in the emergency department must have the following medications and equipment:

(1) Mannitol or 3% saline.

(2) Intubation, code and neurologic medications.

(3) Catheter-over-the-needle device; 22 and 24 gauge.

(4) Pediatric intraosseous needles or device.

(5) Intravenous solutions including the following: normal saline and dextrose 5% normal saline.

(6) Infant and child c-collars.

(7) Cuffed endotracheal tubes: 3.5, 4.5, 5.5, and 6.5 millimeters.

(8) Laryngoscope: Straight: 1, Straight: 2, and Curved: 2.

(9) Infant and child nasopharyngeal airways.

(10) Oropharyngeal airways, sizes 0,1,2,3 and 4.

(11) Pediatric stylets for endotracheal tubes.

(12) Infant and child suction catheters.

(13) Bag-mask device, self-inflating: infant: 450 milliliters.

(14) Masks to fit bag-mask device adaptor for infants and children.

(15) Clear oxygen masks: partial non-breather infant and partial nonbreather child.

(16) Infant and child nasal cannulas.

(17) Nasogastric tubes: Infant: 8 French size and child: 10 French size.

(18) Laryngeal mask airway: sizes 1.5, 2, 2.5, and 3.

(19) Chest tubes: Infant: 10 or 12 French size and Child: one in the 16-24 French size range.

Proposed rule: Section 4 – Personnel and services

Proposed Criterion 4.1, Level III, Type 1

A TCF shall have general or trauma surgery capability at all times.

2021 related criteria

6(a), Level III, Type 1

The TCF must have continuous general surgery capability.

Proposed Criterion 4.2, Level III and IV, Type 2

A TCF with general or trauma surgeons caring for injured patients shall ensure that the general or trauma surgeons have (a) completed ATLS at least once, (b) have privileges in general surgery, (c) hold current board certification or board eligibility in general surgery, or (d) have been approved through the alternate pathway. Any physician on the alternate pathway shall satisfy all of the following: (1) Possess a current ATLS certification; (2) Complete 24 hours of trauma continuing medical education within the classification cycle; (3) Provide written notification to the TMD that the physician is following alternate pathway requirements; and (4) Possess a license to practice medicine and surgery under ch. 448, Stats., and approvals for full and unrestricted emergency medicine privileges by the hospital's credentialing committee.

2021 related criteria

6(b), Level III and IV if the TCF provides general surgical services for trauma patients, Type 2

General surgeons must meet one of the following set of standards in order to take trauma call:

(1) Be board certified by the American Board of Surgery.

(2) Be eligible for board certification by the American Board of Surgery according to current criteria.

(3) Meet the general surgery alternate pathway requirements in 6.(c);

or

(4) Have completed an Accreditation Council for Graduate Medical Education or Canadian residency and be recognized by a major professional organization.

Note: An example of recognition by a major professional organization is being a fellow of the ACS.

6(c), Level III and IV if the TCF provides general surgical services for trauma patients, Type 2

The alternate pathway requirements for general surgeons are:

(1) Completion of a residency training program in general surgery, with the time period consistent with years of training in the United States. The completion of a residency training program must be evidenced by a certified letter from the program director.

(2) Current certification as a provider or instructor of the ATLS program.

(3) Completion of 36 hours of trauma continuing medical education within the last three years.

(4) Attendance at educational meetings and at least 50% of all trauma PIPS meetings in the past three years.

(5) Membership or attendance at local and regional or national meetings during the past three years.

(6) Provision of a list of patients treated in the last three years with accompanying Injury Severity Score and outcome data.

(7) Completion of a performance improvement assessment by the TMD demonstrating that the morbidity and mortality results for patients treated by the surgeon compare favorably with comparable patients treated by other members of the call panel.

(8) License to practice medicine and approval for full and unrestricted surgical privileges by the facility's credentialing committee.

6(d), Level III and IV if the TCF provides general surgical services for trauma patients, Type 2

Trauma surgeons in a TCF must have privileges in general surgery.

6(f), Level III and IV if the TCF provides general surgical services for trauma patients, Type 2

All general surgeons on the trauma team must have successfully completed the ATLS course at least once.

Proposed Criterion 4.3, Level IV, Type 2

A TCF with any general or trauma surgical commitment shall have a guideline that outlines roles and responsibilities regarding participation of general or trauma surgeons in care of an injured patient.

2021 related criteria

None

Proposed Criterion 4.4, Level III, Type 2

A TCF shall have a documented backup call schedule or a backup plan, including expeditious transfer for when the general or trauma surgeon is encumbered.

2021 related criteria

2(h), Level III, Type 2

The TCF must have continuous general surgical coverage. The TCF must have a back-up plan in place for when a surgeon is not available. The back-up plan may include activation of a back-up surgeon or transfer of the patient. A surgeon may be on-call at more than one TCF but each TCF must have a back-up plan. The TCF must monitor all the times that a surgeon is unable to respond through the trauma PIPS program.

Proposed Criterion 4.5, Level IV, Type 2

A TCF with any general or trauma surgical commitment shall ensure there is a document accessible to all relevant TCF employees that describes surgical coverage availability and contingency plans for gaps in coverage, such as a backup call schedule or backup plan such as expeditious transfer.

2021 related criteria

None

Proposed Criterion 4.6, Level III and IV, Type 2

A TCF with general or trauma surgeons shall ensure the attending surgeon is present in the operating room for all operations and the TCF shall document the presence of the attending surgeon.

2021 related criteria

6(e), Level III and IV if the TCF provides general surgical services for trauma patients, Type 2

The attending surgeon must be present in the operating room for all operations and the TCF must document the presence of the attending surgeon.

Proposed Criterion 4.7, Level III and IV, Type 2

A TCF shall ensure the TCF's emergency department director is a board-certified or board-eligible physician and has a collaborative relationship with the trauma program.

2021 related criteria

2(1)(4), Level IV, Type 2

The TCF's emergency department must:

(1) Be continuously available for resuscitation.

(2) Have continuous coverage by a registered nurse.

(3) Have continuous coverage by a physician or APP/midlevel provider.

(4) Have a physician as its medical director.

7(a), Level III, Type 1

The TCF's emergency department must have a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients.

Proposed Criterion 4.8, Level III and IV, Type 2

A TCF shall ensure physicians involved in the care of injured patients in the emergency department shall be (a) board-certified or board-eligible in emergency medicine and have completed ATLS at least once, (b) be board-certified or board-eligible in a specialty other than emergency medicine and be current in ATLS, or (c) have been approved through the alternate pathway. Any physician on the alternate pathway shall satisfy all of the following: (1) Possess a current ATLS certification; (2) Complete 24 hours of trauma continuing medical education within the classification cycle; (3) Provide written notification to the TMD that the physician is following alternate pathway requirements; and (4) Possess a license to practice medicine and surgery under ch. 448, Stats., and approvals for full and unrestricted emergency medicine privileges by the hospital's credentialing committee.

2021 related criteria

2(m), Level IV, Type 2

Physicians licensed to practice medicine who treat trauma patients in the ED must be current in ATLS unless the physician is board-certified in emergency medicine. APPs/midlevel providers who participate in the initial evaluation of trauma patients must be current in ATLS. This may be fulfilled by the Comprehensive Advanced Life Support program if the program includes the mobile trauma module skills station and the provider is re-verified every four years. The Rural Trauma Team Development Course does not fulfill this requirement.

7(d), Level III and IV, Type 2

Emergency medicine physicians must meet one of the following set of standards in order to take trauma call:

(1) Be board certified in emergency medicine.

(2) Be eligible for board certification by the appropriate emergency medicine board according to current criteria.

(3) Be board certified in a specialty other than emergency medicine recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

(4) Meet the emergency medicine alternate pathway requirements; or

(5) Have completed an Accreditation Council for Graduate Medical Education or Canadian residency and be recognized by a major professional organization.

Note: An example of recognition by a major professional organization is being a fellow of the ACS.

7(f), Level III and IV, Type 2

Emergency medicine physicians on the emergency department schedule must be regularly involved in the care of injured patients.

7(e), Level III and IV, Type 2

The alternate pathway requirements for emergency medicine physicians are:

(1) Completion of a residency training program in emergency medicine, with the time period consistent with years of training in the United States. The completion of a residency training program must be evidenced by a certified letter from the program director.

(2) Current certification as a provider or instructor of the ATLS program.

(3) Completion of 36 hours of trauma continuing medical education within the last three years.

(4) Attendance at educational meetings and at least 50% of all trauma PIPS meetings in the past three years.

(5) Membership or attendance at local and regional or national meetings during the past three years.

(6) Provision of a list of patients treated in the last three years with accompanying Injury Severity Score and outcome data.

(7) Completion of a performance improvement assessment by the TMD demonstrating that the morbidity and mortality results for patients treated by the emergency medicine physician compare favorably with comparable patients treated by other members of the call panel.

(8) License to practice medicine and approval for full and unrestricted emergency medicine privileges by the facility's credentialing committee.

7(j), Level III and IV, Type 2

Physicians who are licensed to practice medicine who treat trauma patients in the emergency department must be current in ATLS unless the physician is board-certified in emergency medicine. APPs/midlevel providers who participate in the initial evaluation of trauma patients must be current in ATLS. For Level IV TCFs, this may be fulfilled by the Comprehensive Advanced Life Support program if the program includes the mobile trauma module skills station and the provider is re-verified every four years. The Rural Trauma Team Development Course does not fulfill this requirement.

7(k), Level III and IV, Type 2

All board-certified emergency medicine physicians or those eligible for certification by an appropriate emergency medicine board according to current requirements must have successfully completed the ATLS course at least once.

Proposed Criterion 4.9, Level III and IV, Type 1

A TCF shall ensure there is 24-hour emergency coverage by a physician or an APP, as per hospital, local, and state guidelines. The TCF shall have a written plan for addressing

intra-facility emergencies without adverse effect on the care of patients in the emergency department.

2021 related criteria

2(k), Level IV, Type 2

The TCF must have 24-hour emergency coverage by a physician or APP/midlevel provider.

7(b), Level III, Type 2

When it is necessary for the physician to leave the emergency department for short periods to address in-house emergencies, these cases and their frequency must be reviewed by the trauma PIPS program for timeliness of response and appropriateness of care and to ensure that this practice does not adversely affect the care of patients in the emergency department.

11(r), Level III, Type 1

The TCF must have physician coverage of the ICU available within 30 minutes and have a formal plan in place for emergency coverage. A TCF must track physician response time as part of the trauma PIPS program. Physician coverage of the ICU does not replace the primary surgeon but instead ensures that the patient's immediate needs are met while the primary surgeon is being contacted.

Proposed Criterion 4.10, Level III and IV, Type 2

A TCF with neurosurgical services onsite shall ensure that neurosurgeons caring for an injured patient have privileges in neurosurgery and hold current board certification or board eligibility in neurosurgery.

2021 related criteria

8(h), Level III if the TCF provides neurosurgery for trauma patients and IV if the TCF provides neurosurgery for trauma patients, Type 2

Neurosurgeons must meet one of the following set of standards in order to take trauma call:

(1) Be board certified by an appropriate neurosurgical board.

(2) Be eligible for board certification by an appropriate neurosurgical board.

(3) Meet the neurosurgery alternate pathway requirements; or

(4) Have completed an Accreditation Council for Graduate Medical Education or Canadian residency and be recognized by a major professional organization.

Note: An example of recognition by a major professional organization is being a fellow of the ACS.

8(i), Level III if the TCF provides neurosurgery for trauma patients and IV if the TCF provides neurosurgery for trauma patients, Type 2

The alternate pathway requirements for neurosurgeons are:

(1) Completion of a residency training program in neurosurgery, with the time period consistent with years of training in the United States. The completion of a residency training program must be evidenced by a certified letter from the program director.

(2) Current certification as a provider or instructor of the ATLS program.

(3) Completion of 36 hours of trauma continuing medical education within the last three years.

(4) Attendance at educational meetings and at least 50% of all trauma PIPS meetings in the past three years.

(5) Membership or attendance at local and regional or national meetings during the past three years.

(6) Provision of a list of patients treated in the last three years with accompanying Injury Severity Score and outcome data.

(7) Completion of a performance improvement assessment by the TMD demonstrating that the morbidity and mortality results for patients treated by the surgeon compare favorably with comparable patients treated by other members of the call panel.

(8) License to practice medicine and approval for full and unrestricted surgical privileges by the facility's credentialing committee.

Proposed Criterion 4.11, Level III and IV, Type 2

A TCF with neurosurgical services onsite shall have a guideline that outlines roles and responsibilities regarding participation of neurosurgeons in the care of an injured patient. The guideline shall specify all of the following:

- Rules requiring an evaluation of the injured patient within 30 minutes of any of the following: (1) Glasgow coma scale less than 12, with intracranial hemorrhage and the presence of trauma, (2) The injured patient has a neurologic deficit as a result of potential spinal cord injury, applicable to spine surgeon, whether a neurosurgeon or orthopedic surgeon and (3) A general or trauma surgeon request.
- Criteria for when an immediate neurosurgical response is required.
- Expected response times for trauma activations and inpatient emergencies.
- Criteria for neurosurgical admission and consultation regarding the injured patient.

2021 related criteria

8(c), Level III and IV, Type 2

The TCF must have a written policy or guideline approved by the TMD that defines which types of patients require a response by neurosurgery and which type of neurosurgical injuries may remain at the TCF and which should be transferred.

Proposed Criterion 4.12, Level III and IV, Type 2

A TCF with neurosurgical services onsite shall have a documented backup call schedule or a backup plan, including expeditious transfer for when the neurosurgeon is encumbered.

2021 related criteria

8(a), Level III if the TCF provide neurosurgery for trauma patients and IV if the TCF provide neurosurgery for trauma patients, Type 2

The TCF must have a formal and published contingency plan for times in which a neurosurgeon is encumbered upon the arrival of a neuro-trauma case. The contingency plan must include:

(1) A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of a neuro-trauma patient.

(2) A requirement for direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.

(3) A review process through the trauma PIPS program to monitor the efficacy of the plan and process. The TCF, in conjunction with a higher level classification TCF, may define the non-survivable injury patient who can be kept at the facility and transmitted to palliative care.

8(b), Level III if the TCF provide neurosurgery for trauma patients and IV if the TCF provide neurosurgery for trauma patients, Type 2

If one neurosurgeon covers more than one TCF, each TCF must have a published back-up schedule. The back-up schedule may include calling a back-up neurosurgeon, guidelines for transfer or both. The trauma PIPS program must demonstrate that appropriate and timely care is provided when the back-up schedule must be used.

Proposed Criterion 4.13, Level III, Type 1

A TCF shall have continuous orthopedic surgery capability.

2021 related criteria

9(a), Level III, Type 1

The TCF must have orthopedic surgery capability.

9(d), Level III, Type 1

TCFs must have an orthopedic surgeon on call and promptly available 24 hours a day.

Proposed Criterion 4.14, Level III and IV, Type 2

A TCF with orthopedic surgeons caring for an injured patient shall ensure that the orthopedic surgeons have privileges in orthopedic surgery and hold current board certification or board eligibility in orthopedic surgery.

2021 related criteria

9(h), Level III and IV if the TCF provides orthopedic surgery for trauma patients, Type 2

Orthopedic surgeons must meet one of the following set of standards in order to take trauma call:

(1) Be board certified in orthopedic surgery.

(2) Be eligible for board certification by the appropriate orthopedic specialty board according to current criteria.

(3) Meet the orthopedic surgery alternate pathway requirements; or

(4) Have completed an Accreditation Council for Graduate Medical Education or Canadian residency and be recognized by a major professional organization.

Note: An example of recognition by a major professional organization is being a fellow of the ACS.

9(i), Level III and IV if the TCF provides orthopedic surgery for trauma patients, Type 2

The alternate pathway requirements for orthopedic surgeons are:

(1) Completion of a residency training program in orthopedic surgery, with the time period consistent with years of training in the United States. The completion of a residency training program must be evidenced by a certified letter from the program director.

(2) Current certification as a provider or instructor of the ATLS program.

(3) Completion of 36 hours of trauma continuing medical education within the last three years.

(4) Attendance at educational meetings and at least 50% of all trauma PIPS meetings in the past three years.

(5) Membership or attendance at local and regional or national meetings during the past three years.

(6) Provision of a list of patients treated in the last three years with accompanying Injury Severity Score and outcome data.

(7) Completion of a performance improvement assessment by the TMD demonstrating that the morbidity and mortality results for patients treated by the surgeon compare favorably with comparable patients treated by other members of the call panel.

(8) License to practice medicine and approval for full and unrestricted surgical privileges by the facility's credentialing committee.

Proposed Criterion 4.15, Level III, Type 2

A TCF shall have a written document that outlines roles and responsibilities regarding participation of orthopedic surgeons in care of an injured patient.

The written document shall specify all of the following:

- Rules requiring an orthopedic surgical evaluation at bedside of the injured patient within 30 minutes of any of the following: (1) hemodynamically unstable, secondary to pelvic fracture; (2) suspected extremity compartment syndrome; (3) fractures or dislocations with risk of avascular necrosis; (4) vascular compromise related to a fracture or dislocation; (5) provider request, with an attending orthopedic surgeon shall be involved in the clinical decision-making for care of these patients.

- Expected response times for trauma activations and inpatient emergencies.
- Criteria for surgical admission and consultation regarding the injured patient.

2021 related criteria

9(d), Level III, Type 2

TCFs must have an orthopedic surgeon on call and promptly available 24 hours a day.

Proposed Criterion 4.16, Level IV, Type 2

If a TCF has continuous orthopedic surgery capability and provides emergent orthopedic surgery, the TCF shall have a written document in compliance with Proposed Criterion 4.15 of this Appendix.

2021 related criteria

None

Proposed Criterion 4.17, Level IV, Type 2

If a TCF provides any orthopedic surgical services for injured patients, the TCF shall have a written document that outlines roles and responsibilities regarding participation of orthopedic surgeons in care of the injured patient.

The written document shall specify:

- Criteria for when an immediate orthopedic surgical response is required.
- Expected response times for trauma activations and inpatient emergencies.
- Criteria for surgical admission and consultation regarding the injured patient.

2021 related criteria

None

Proposed Criterion 4.18, Level III, Type 2

A TCF shall have a documented backup call schedule or a backup plan, including expeditious transfer for when the orthopedic surgeon is encumbered.

2021 related criteria

9(f), Level III and IV if the TCF provides orthopedic surgery for trauma patients, Type x

If the orthopedic surgeon is not dedicated to a single facility or is unavailable while on call, the TCF must have a published back-up schedule. The back-up schedule may include calling a back-up orthopedic surgeon or guidelines for transfer or both.

Proposed Criterion 4.19, Level IV, Type 2

A TCF with any orthopedic surgical commitment shall have an accessible document for orthopedic surgical coverage availability and contingency plan for gaps in coverage, such as a backup call schedule or backup plan such as expeditious transfer.

2021 related criteria

9(f), Level III and IV if the TCF provides orthopedic surgery for trauma patients, Type x

If the orthopedic surgeon is not dedicated to a single facility or is unavailable while on call, the TCF must have a published back-up schedule. The back-up schedule may include calling a back-up orthopedic surgeon or guidelines for transfer or both.

Proposed Criterion 4.20, Level III and IV, Type 2

A TCF who offers any surgical and anesthesia services, as defined by hospital, local, or institutional policies, shall ensure that surgical and anesthesia services are available within 30 minutes of request for operations.

2021 related criteria

11(b), Level III and IV if the TCF provides anesthesiology services for trauma patients, Type 1

Anesthesiology services, including anesthesiologists or certified registered nurse anesthetists, must be available within 30 minutes of notification and request for emergency operations, for managing airway problems, and as needed for patient care.

Proposed Criterion 4.21, Level III and IV, Type 2

A TCF who offers any surgical services shall have a written plan that outlines roles and responsibilities for when anesthesia services are included in the care of an injured patient.

2021 related criteria

11(b), Level III and IV if the TCF provides anesthesiology services for trauma patients, Type 1

Anesthesiology services, including anesthesiologists or certified registered nurse anesthetists, must be available within 30 minutes of notification and request for emergency operations, for managing airway problems, and as needed for patient care.

Proposed Criterion 4.22, Level III and IV, Type 2

A TCF shall ensure a radiologist has access to patient images and is available for imaging interpretation. The TCF shall have a process for prioritization of radiological reads for highest level trauma team activations. Final radiology reports shall accurately reflect critical communications to members of the trauma team, including changes between preliminary and final interpretations.

2021 related criteria

11(o), Level III, Type 1

Qualified radiologists must be available within 30 minutes of notification, in person or by tele-radiology, to interpret radiographs.

11(om), Level III, Type 2

Radiological diagnostic information must be communicated in a timely manner in either written or electronic form.

11(p), Level III, Type 2

Critical radiology information deemed to immediately affect patient care must be verbally communicated to the trauma team in a timely manner.

11(pm), Level III, IV if TCF provides radiological services for trauma patients, Type 2

The final radiology report must accurately reflect the chronology and context of communications with the trauma team, including changes between the preliminary and final interpretations. The TCF must have a written over-read process that defines how changes in interpretation are documented and communicated.

Proposed Criterion 4.23, Level III, Type 1

A TCF shall have continuous ICU capability.

2021 related criteria

11(a), Level III, Type 1

The TCF must have an ICU. An ICU, regardless of whether an area of the facility is actually so designated, is a department or area of a TCF that provides intensive treatment medicine, focuses on patients with severe and life-threatening illness or injuries which require constant and close monitoring and support and is staffed by highly trained doctors and nurses who specialize in caring for critically ill patients.

Proposed Criterion 4.24, Level III, Type 2

A TCF shall ensure a general or trauma surgeon on the trauma call panel is actively involved in and responsible for setting policies and making administrative decisions related to trauma ICU patients.

2021 related criteria

11(qm), Level III and IV if the TCF provides surgical and ICU services for trauma patients, Type 2

A surgeon on the trauma call panel must be actively involved in and responsible for setting policies and making administrative decisions related to trauma ICU patients. This may be a TMD who is a surgeon.

Proposed Criterion 4.25, Level III, Type 2

A TCF shall have a written plan for the general or trauma surgeon’s involvement in the care of an injured patient admitted to the ICU.

2021 related criteria

11(r), Level III, Type 1

The TCF must have physician coverage of the ICU available within 30 minutes and have a formal plan in place for emergency coverage. A TCF must track physician response time as part of the trauma PIPS program. Physician coverage of the ICU does not replace the primary surgeon but instead ensures that the patient's immediate needs are met while the primary surgeon is being contacted.

11(s), Level III, Type 1

In a TCF, the trauma surgeon must retain responsibility for and coordinate all therapeutic decisions of trauma ICU patients. Many of the daily care requirements can be collaboratively managed by a dedicated ICU team, but the trauma surgeon must be kept informed and concur with major therapeutic and management decisions made by the ICU team.

Proposed Criterion 4.26, Level IV, Type 2

If a TCF offers ICU services, the TCF shall ensure a general or trauma surgeon who is actively involved in the care of injured patients is actively involved in and responsible for setting policies and making administrative decisions related to trauma ICU patients.

2021 related criteria

11(qm), Level III and IV if the TCF provides surgical and ICU services for trauma patients, Type 2

A surgeon on the trauma call panel must be actively involved in and responsible for setting policies and making administrative decisions related to trauma ICU patients. This may be a TMD who is a surgeon.

Proposed Criterion 4.27, Level IV, Type 2

If a TCF offers ICU services and general or trauma surgeon commitment, the TCF shall have a written plan for the general or trauma surgeon's involvement in the care of injured patients admitted to the ICU.

2021 related criteria

None

Proposed Criterion 4.28, Level III, Type 2

A TCF shall ensure the patient-to-nurse ratio in the ICU is defined by a hospital written document for ICU nursing staffing and varies based on patient acuity.

2021 related criteria

11(u), Level III, Type 2

For trauma patients in the ICU, the TCF must have adequate numbers of licensed registered nurses, licensed practical nurses and other personnel to provide nursing care to all trauma patients in the ICU.

11(tm), Level III, Type 1

In the TCF, qualified critical care nurses must be available 24 hours per day to provide care for trauma patients during the ICU phase. The TCF may define who is a qualified critical care nurse based on education and competency standards.

Proposed Criterion 4.29, Level IV, Type 2

If a TCF offers ICU services, the TCF shall ensure the patient-to-nurse ratio in the ICU is defined by a hospital written document for ICU nursing staffing and varies based on patient acuity.

2021 related criteria

None

Proposed Criterion 4.30, Level III, Type 2

A TCF shall have the following allied health services available:

- Continuous respiratory therapy.
- Nutrition support.
- Speech therapy.
- Social work.
- Occupational therapy.
- Physical therapy.

2021 related criteria

11(w), Level III, Type 1

The TCF must have a respiratory therapist in-house or on call 24 hours a day.

12(a), Level III, Type 1

Physical therapy services must be provided in the TCF.

12(b), Level III, Type 2

Social services must be provided in the TCF.

Proposed Criterion 4.31, Level IV, Type 2

A TCF shall have the following allied health services capabilities available:

- Respiratory therapy.
- Social work or case management.
- Occupational therapy.
- Physical therapy.

2021 related criteria

None

Proposed Criterion 4.32, Level III and IV, Type 2

A TCF that staffs the emergency department with APPs who are or have the potential to be clinically involved with injured patients shall ensure that the staffed APPs have current ATLS certification or CALS with the trauma module.

2021 related criteria

2(m), Level IV, Type 2

Physicians licensed to practice medicine who treat trauma patients in the ED must be current in ATLS unless the physician is board-certified in emergency medicine. APPs/midlevel providers who participate in the initial evaluation of trauma patients must be current in ATLS. This may be fulfilled by the Comprehensive Advanced Life Support program if the program includes the mobile trauma module skills station and the provider is re-verified every four years. The Rural Trauma Team Development Course does not fulfill this requirement.

7(j), Level III and IV, Type 2

Physicians who are licensed to practice medicine who treat trauma patients in the emergency department must be current in ATLS unless the physician is board-certified in emergency medicine. APPs/midlevel providers who participate in the initial evaluation of trauma patients must be current in ATLS. For Level IV TCFs, this may be fulfilled by the Comprehensive Advanced Life Support program if the program includes the mobile trauma module skills station and the provider is re-verified every four years. The Rural Trauma Team Development Course does not fulfill this requirement.

11(z), Level III and IV, Type 2

APPs who participate in the initial evaluation of trauma patients must be current in ATLS, except if the APP is accepting a trauma patient as a direct admission.

Proposed rule: Section 5 – Patient care expectations and protocols

Proposed Criterion 5.1, Level III and IV, Type 2

A TCF shall have evidence-based trauma clinical practice guidelines, protocols, or algorithms that are reviewed at least every three years.

2021 related criteria

15(d), Level III and IV, Type 2

The TCF must use clinical practice guidelines, protocols and algorithms derived from evidence-based validated resources to help reduce unnecessary variation in the care they provide.

Proposed Criterion 5.2, Level III and IV, Type 2

A TCF shall have their trauma team activation criteria clearly defined, encompassing if the TCF has a tiered activation criteria. For the highest level of activation, the following criteria shall be included with a mechanism of trauma:

1. Evidence of shock or hypoperfusion indicated by either of the following:
    a. Confirmed blood pressure less than 90 mm Hg at any time in adults, and age-specific hypotension in children.

Age	SBP (mmHg)
< 1 year old	≤ 70
1-10 years old	≤ 70 + (2x age in years)

    b. Persistent tachycardia in a patient ≤14 years old.

Age	HR
< 2 years old	>180
2-5 years old	>160
6-14 years old	>140

2. Penetrating trauma to the head, neck, chest, abdomen, pelvis, or extremities proximal to the elbow or knee.
3. Glasgow coma scale score of less than nine.
4. The patient requires ongoing blood transfusion to maintain vitals.
5. The patient has respiratory compromise or is in need of an emergent airway.
6. Discretion of the emergency department provider or nurse.

2021 related criteria

5(l), Level III and IV, Type 2

The criteria for a graded activation must be clearly defined by the TCF. TCFs must have the highest level of activation. The highest level activation criteria must include the following criteria:

(1) Confirmed blood pressure less than 90 millimeters of mercury at any time in adults and delineated by age range hypotension in children.

(2) Gunshot wounds to the neck, chest, or abdomen or extremities proximal to the elbow/knee.

(3) Glasgow coma scale score less than nine with mechanism attributed to trauma.

(4) Transfer patients from other hospitals receiving blood to maintain vital signs.

(5) Intubated patients transferred from the scene or patients who have respiratory compromise or are in need of an emergency airway. This includes intubated patients who are transferred from another facility with ongoing respiratory compromise.

(6) Emergency medicine physician’s discretion.

Proposed Criterion 5.3, Level III and IV, Type 1

A TCF shall define the trauma team and have a goal to have the trauma team fully assembled within 30 minutes of trauma activation as indicated by a written document. A level III TCF shall include the general or trauma surgeon in the highest-level activation.

2021 related criteria

2(f), Level III, Type 1

It is expected that the surgeon will be in the emergency department on patient arrival with adequate notification from the field. The maximum acceptable surgeon response time, with notification from the field and tracked from patient arrival, is 30 minutes for the highest level activation. The surgeon must be activated for all highest level activations regardless of impending transfer or other scenario.

Note: for TCFs with less than six highest-level activations annually, surgeon response time may be tracked over 3 years.

2(g), Level IV, Type 1

It is expected that a physician, if available or APP/ midlevel provider will be in the emergency department on patient arrival with adequate notification from the field. The maximum acceptable response time for a physician or APP/ midlevel provider, with notification from the field and tracked from patient arrival, is 30 minutes for the highest level activation. Note: for TCFs with less than six highest-level activations annually, physician and APP/midlevel provider response time may be tracked over 3 years.

5(m), Level III and IV, Type 2

The trauma team, as defined by the TCF, must be fully assembled within 30 minutes of trauma activation.

Proposed Criterion 5.4, Level III and IV, Type 2

A TCF that defines their general or trauma surgeons shall respond to the highest-level trauma team activations by being at the patient's bedside within 30 minutes of activation at least 70% of the time. For TCFs with less than seven highest-level activations annually, general surgeon response time may be tracked over the classification cycle.

2021 related criteria

2(f), Level III, Type 1

It is expected that the surgeon will be in the emergency department on patient arrival with adequate notification from the field. The maximum acceptable surgeon response time, with notification from the field and tracked from patient arrival, is 30 minutes for the highest level activation. The surgeon must be activated for all highest level activations regardless of impending transfer or other scenario.

Note: for TCFs with less than six highest-level activations annually, surgeon response time may be tracked over 3 years.

Proposed Criterion 5.5, Level III, Type 2

A TCF shall have a written document that defines (1) acceptable general or trauma surgical response times to activations other than the highest level and (2) acceptable general or trauma surgical response times for a surgical evaluation or consultation in the emergency department and upon admission.

2021 related criteria

5(o), Level III and IV if the TCF provides surgical services for trauma patients, Type 2

An emergency medicine physician may initially evaluate the limited-tier trauma patient, but the TCF must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission.

Proposed Criterion 5.6, Level IV, Type 2

A TCF with general or trauma surgeon commitment shall have a written document that defines (1) acceptable general or trauma surgical response times to trauma team activations and (2) acceptable general or trauma surgical response times for surgical evaluation or consultation in the emergency department and upon admission.

2021 related criteria

5(o), Level III and IV if the TCF provides surgical services for trauma patients, Type 2

An emergency medicine physician may initially evaluate the limited-tier trauma patient, but the TCF must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission.

Proposed Criterion 5.7, Level III, Type 2

A TCF shall have a written document, approved by the TMD, that defines the types of injuries that may be treated at the TCF and the types of injuries for which the TCF will transfer the injured patient. For prevalent injuries that may be admitted to the TCF, the TCF shall develop an inpatient care guideline that includes which patients may receive a surgical evaluation or consultation, and who will be performing the tertiary exam.

2021 related criteria

5(r), Level III and IV if the TCF provides surgical services for trauma patients, Type 2

A TCF must have written guidelines for the care of non-surgically admitted patients. TCFs that admit more than 10% of injured patients to non-surgical services must review all non-surgical admissions through the trauma PIPS program. Care must be reviewed for appropriateness of admission, patient care, complications and outcomes. If a trauma patient is admitted by an internal medicine physician for medical comorbidities or medical management, a surgical consultation is required.

5(o), Level III and IV if the TCF provides surgical services for trauma patients, Type 2

An emergency medicine physician may initially evaluate the limited-tier trauma patient, but the TCF must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission.

Proposed Criterion 5.8, Level IV, Type 2

A TCF shall have a written document, approved by the TMD, that defines the types of injuries that may be treated at the TCF and the types of injuries for which the TCF will transfer the injured patient. For prevalent injuries that may be admitted to the TCF, the TCF shall develop an inpatient care guideline that includes which patients may receive a surgical evaluation or consultation, and who will be performing the tertiary exam. For level IV TCFs with general or trauma surgical commitment, defining which patients may receive a surgical evaluation or consultation shall be included.

2021 related criteria

2(j), Level IV, Type 2

The TCF must have collaborative treatment and transfer guidelines reflecting the TCF's capabilities. These treatment and transfer guidelines must be developed and regularly reviewed with input from higher-level TCFs in the region.

5(r), Level III and IV if the TCF provides surgical services for trauma patients, Type 2

A TCF must have written guidelines for the care of non-surgically admitted patients. TCFs that admit more than 10% of injured patients to non-surgical services must review all non-surgical admissions through the trauma PIPS program. Care must be reviewed for appropriateness of admission, patient care, complications and outcomes. If a trauma patient is admitted by an internal medicine physician for medical comorbidities or medical management, a surgical consultation is required.

5(o), Level III and IV if the TCF provides surgical services for trauma patients, Type 2

An emergency medicine physician may initially evaluate the limited-tier trauma patient, but the TCF must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission.

Proposed Criterion 5.9, Level III and IV, Type 2

A TCF shall ensure the trauma program concurrently monitors the provision of health care services provided to trauma patients admitted to their TCF.

2021 related criteria

5(q), Level III and IV if the TCF provides surgical services for trauma patients, Type 1

For TCFs that admit injured patients to individual surgeons or nonsurgical services, the TCF must have a method to identify injured patients, monitor the provision of health care services, make periodic rounds and hold discussions with individual practitioners.

These activities may be carried out by the TPM in conjunction with the TMD at a frequency commensurate with the volume of trauma admissions.

Proposed Criterion 5.10, Level III, Type 1

A TCF shall have a massive transfusion protocol (MTP) that is developed collaboratively between the trauma program and the blood bank, and reflective of what blood products are available.

2021 related criteria

11(y), Level III and IV, Type 1

TCFs must have a massive transfusion protocol that is developed collaboratively with the trauma service and blood bank.

Proposed Criterion 5.11, Level IV, Type 1

A TCF shall have a massive transfusion protocol (MTP) or an emergent blood release protocol that is developed collaboratively between the trauma program and the blood bank, and reflective of what blood products are available.

2021 related criteria

11(y), Level III and IV, Type 1

TCFs must have a massive transfusion protocol that is developed collaboratively with the trauma service and blood bank.

Proposed Criterion 5.12, Level III and IV, Type 2

A TCF shall have a written document for rapid reversal for patients on anticoagulants, which may include transfer of the patient.

2021 related criteria

None

Proposed Criterion 5.13, Level III and IV, Type 2

A TCF shall have a written document that outlines the process the TCF will follow to assess children for nonaccidental trauma, including requirements for assessment, treatment or transfer, reporting, and a list of possible indicators of abuse.

2021 related criteria

10(a)(1), Level III and IV, Type 2

A TCF that stabilizes pediatric trauma patients in the emergency department must have guidelines to assure appropriate and safe care of children. A TCF's pediatric trauma guidelines must include: (1) Child maltreatment assessment, treatment or transfer and reporting protocols including a list of indicators of possible physical abuse.

Proposed Criterion 5.14, Level III and IV, Type 2

A TCF shall, in collaboration with the emergency department and trauma program, do all of the following (1) Perform a pediatric readiness assessment during each classification

cycle (2) Develop a plan to address at least one of the identified gaps (3) Identify a pediatric point of contact.

2021 related criteria

None

Proposed Criterion 5.15, Level III and IV, Type 2

A TCF shall have all of the following pediatric documents:

- Imaging guidelines, including age and weight-based criteria based on as low as reasonably achievable radiation exposure guidelines.
- A weight and color-based system to assure appropriate sizing and dosing of resuscitation equipment and medications.
- Dosing guidelines for intubation, code, and neurologic drugs.
- Guidelines for administration of sedation.

2021 related criteria

10(a)(2-5), Level III and IV, Type 2

A TCF that stabilizes pediatric trauma patients in the emergency department must have guidelines to assure appropriate and safe care of children. A TCF's pediatric trauma guidelines must include:

(2) Imaging guidelines, including age and weight-based criteria based on as low as reasonably achievable guidelines.

(3) A system to assure appropriate sizing and dosing of resuscitation equipment and medications.

(4) Dosing guidelines for intubation, code and neurologic drugs.

(5) Guidelines for administration of sedation.

Proposed Criterion 5.16, Level III and IV, Type 2

A TCF shall have a written document designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to, and while in, the radiology department.

2021 related criteria

11(lm), Level III and IV, Type 2

A TCF must have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to, and while in, the radiology department.

Proposed Criterion 5.17, Level III and IV, Type 2

A TCF shall have a transfer plan that includes expeditious critical care transport, and consideration of pediatric and burn patients.

2021 related criteria

2(i), Level III and IV, Type 2

The TCF must have transfer plans that include a plan for expeditious critical care transport, follow-up and performance monitoring.

13(a), Level III and IV, Type 2

A TCF must have written guidelines, including transfer plans, for the care of burn patients.

Proposed Criterion 5.18, Level III and IV, Type 1

A TCF shall ensure the decision to transfer an injured patient shall be based solely on the needs of the patient, without consideration of their health plan or payor status.

2021 related criteria

4(b), Level III and IV, Type 2

The TCF's decision to transfer an injured patient to a specialty care facility in an acute situation must be based solely on the needs of the patient and not on the requirements of the patient's specific provider network or the patient's ability to pay.

Proposed Criterion 5.19, Level III and IV, Type 1

A TCF shall ensure when trauma patients are transferred, the transferring provider shall directly communicate with the receiving provider to ensure safe transition of care. This communication may occur through a transfer center.

2021 related criteria

4(a), Level III and IV, Type 2

When transferring a patient direct provider-to-provider contact is required.

4(c)(2), Level III and IV, Type 2

When a patient is being transferred out, the TCF must have a contingency plan that includes: (2) A requirement for direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.

Proposed Criterion 5.20, Level III and IV, Type 2

A TCF shall have a diversion protocol that is approved by the TMD and includes all of the following:

- Agreement of the general or trauma surgeon in the decision to divert for trauma centers that have general or trauma surgeons on call.
- A process for notification of dispatch, EMS agencies, and surrounding hospitals.
- A diversion log to record reasons for and duration of diversions that does not exceed 438 hours during the reporting period as per DHS 118.04 (6) (a) 3.

2021 related criteria

3(d), Level III and IV, Type 2

A TCF must have a diversion protocol for trauma related occurrences, which includes a system to notify dispatch and EMS agencies.

3(e), Level III, Type 2

The TMD must be involved in the development of the TCF's diversion protocol for trauma related occurrences.

3(f), Level III, Type 2

A trauma surgeon must be involved in the decision each time the TCF goes on diversion for trauma related occurrences.

3(h), Level III and IV, Type 2

When a TCF is required to divert for trauma related occurrences it must:

(1) Notify other TCFs of divert or advisory status.

(2) Maintain a divert log.

(3) Review all diverts and advisories to the trauma PIPS program.

3(g), Level III, Type 2

A TCF must not be on diversion for trauma related occurrences more than five percent of the time.

3(i), Level III and IV, Type 2

The TCF must routinely document, report and monitor their diversion hours. This documentation must include the reason for initiating the diversion policy.

Proposed Criterion 5.21, Level III and IV, Type 2

A TCF shall have a written document approved by the TMD that defines the types of neurotrauma injuries that may be treated at the TCF, and, if available, when tele-neuro services will be consulted, and under what circumstances will an injured patient be transferred or admitted. For prevalent injuries that may be admitted to the TCF, the TCF shall develop an inpatient care guideline that includes at a minimum, which patients may receive a surgical evaluation or consultation, and who will be performing the tertiary exam.

2021 related criteria

8(c), Level III and IV, Type 2

The TCF must have a written policy or guideline approved by the TMD that defines which types of patients require a response by neurosurgery and which type of neurosurgical injuries may remain at the TCF and which should be transferred.

8(d), Level III and IV, Type 2

If a TCF does not have neurosurgical coverage, all patients requiring ICP monitoring and patients with significant traumatic brain injuries should be transferred to a higher level

TCF. If the TCF does not transfer the patient with a traumatic brain injury, the scope of practice and care of the patient must be outlined in a written guideline or policy.

Proposed Criterion 5.22, Level III and IV, Type 2

If a TCF utilizes tele-neuro services for injured patients, the TCF shall have a procedure for when tele-neuro services are not available, made in conjunction with the tele-neuro provider.

2021 related criteria

None

Proposed Criterion 5.23, Level III and IV, Type 2

A TCF shall have a written document approved by the TMD that defines the types of orthopedic injuries that may be treated at the TCF and the types of orthopedic injuries for which the injured patient will be transferred. For prevalent injuries that may be admitted to the TCF, the TCF shall develop an inpatient care guideline that includes at a minimum, which patients may receive a surgical evaluation or consultation, and who will be performing the tertiary exam.

2021 related criteria

None

Proposed Criterion 5.24, Level III, Type 2

A TCF shall have a written document approved by the TMD that defines the types of injuries for which injured patients may be admitted to the ICU and the types of injuries for which injured patients shall be transferred. A TCF shall establish an inpatient care guideline for injuries that may be admitted to the TCF that at a minimum, includes all ICU patients with a traumatic injury requiring general or trauma surgical consultation and that provides the general or trauma surgeon shall retain responsibility for the trauma patient in the ICU up to the point where the general or trauma surgeon documents transfer of primary responsibility to another service.

2021 related criteria

11(rm), Level III, Type 2

The TCF's trauma PIPS program must review all ICU trauma admissions and transfers of ICU patients to ensure that appropriate patients are being selected to remain at the TCF versus being transferred to a higher level of care. The TCF must have a written guideline that defines which types of ICU patients they will admit and which they will transfer to a higher level of care.

11(s), Level III, Type 1

In a TCF, the trauma surgeon must retain responsibility for and coordinate all therapeutic decisions of trauma ICU patients. Many of the daily care requirements can be collaboratively managed by a dedicated ICU team, but the trauma surgeon must be kept informed and concur with major therapeutic and management decisions made by the ICU team.

Proposed Criterion 5.25, Level IV, Type 2

A TCF that has an ICU shall have a written document approved by the TMD that defines the types of injuries for which the TCF will admit the injured patient to the ICU or will be transferred. A TCF shall establish an inpatient care guideline for injuries that may be admitted to the TCF that at a minimum, includes all ICU patients with a traumatic injury requiring general or trauma surgical consultation and that provides the general or trauma surgeon shall retain responsibility for the trauma patient in the ICU up to the point where the general or trauma surgeon documents transfer of primary responsibility to another service.

2021 related criteria

None

Proposed Criterion 5.26, Level III and IV, Type 2

A TCF shall screen admitted trauma patients greater than 12 years old for alcohol misuse with a validated tool or routine blood alcohol content testing. The TCF shall achieve a screening rate of at least 80 percent.

2021 related criteria

17(c), Level III and IV, Type 2

Universal screening for alcohol use must be performed and documented for all injured patients over 12 years of age. This screening must be done on patients admitted or discharged from the emergency department, but not those transferred to a higher level of care.

Proposed Criterion 5.27, Level III and IV, Type 2

A TCF shall have a process for referral or intervention for patients who screen positive for alcohol misuse.

2021 related criteria

None

Proposed rule: Section 6 – Data surveillance and systems

Proposed Criterion 6.1, Level III and IV, Type 2

A TCF shall have a written data quality plan, including data validation, with demonstrated compliance with that plan. At a minimum, the plan shall require yearly review of data quality.

2021 related criteria

14(i), Level III and IV, Type 2

The TCF must have a strategy for monitoring the validity of the data entered into the trauma registry.

Proposed Criterion 6.2, Level III and IV, Type 2

A TCF shall ensure the trauma registry is concurrent, defined as having a minimum of 80 percent of patient records completed within 60 days of the patient discharge date.

2021 related criteria

14(e), Level III and IV, Type 2

A TCF's trauma registry must be concurrent. At a minimum, the TCF must enter 80% of cases within 60 days of patient discharge.

Proposed Criterion 6.3, Level III and IV, Type 2

A TCF shall submit the required data elements, defined by the Wisconsin trauma data dictionary to the Wisconsin trauma registry per s. DHS 118.09 (2) and (3) (a) and (b).

2021 related criteria

14(a), Level III and IV, Type 2

A TCF must collect and analyze trauma registry data and must submit this data to the department per s. DHS 118.09 (3) (a) & (b).

14(b), Level III and IV, Type 2

The TCF must submit the required data elements, defined by the Wisconsin Trauma Data Dictionary to the Wisconsin trauma registry. Note: The is prepared, maintained and updated by the Wisconsin Department of Health Services and is published on the Department's : https://www.dhs.wisconsin.gov/publications/p01117.pdf

Proposed Criterion 6.4, Level III and IV, Type 1

A TCF shall ensure that appropriate measures are in place to keep trauma registry data confidential. The trauma center shall protect against threats, hazards, and unauthorized uses or disclosures of trauma program data as required by the Health Insurance Portability and Accountability Act and other state and federal laws. Protocols to protect confidentiality, including providing information only to staff members who have a demonstrated need to know, shall be integrated in the administration of the trauma program.

2021 related criteria

14(g), Level III and IV, Type 2

The TCF must ensure that appropriate measures are in place to meet the confidentiality requirements of the trauma registry data. The TCF must protect against threats, hazards and unauthorized uses or disclosures of trauma program data as required by the Health Insurance Portability and Accountability Act and other state and federal laws. Protocols to protect confidentiality, including providing information only to staff members who

have a demonstrated need to know, must be integrated in the administration of the TCF's trauma program.

Proposed Criterion 6.5, Level III and IV, Type 2

A TCF shall use trauma registry data to support their injury prevention and performance improvement and patient safety efforts.

2021 related criteria

14(c), Level III and IV, Type 2

A TCF must use trauma registry data to support their trauma PIPS program.

Proposed rule: Section 7 – Performance improvement and patient safety

Proposed Criterion 7.1, Level III and IV, Type 2

A TCF shall ensure the trauma PIPS program is integrated with the hospital quality and patient safety efforts and have a clearly defined reporting structure and method for the integration of feedback.

2021 related criteria

15(c), Level III and IV, Type 2

The TCF's trauma PIPS program must integrate with the facility quality and patient safety efforts and have a clearly defined reporting structure and method for the integration of feedback.

Proposed Criterion 7.2, Level III and IV, Type 2

A TCF shall ensure the TCF has a written PIPS plan that does all of the following:

- Outlines the organizational structure of the trauma PIPS process, with a clearly defined relationship to the hospital quality and patient safety department.
- Specifies the processes for event identification, and a benchmark goal for identifying events appropriate for the volume of trauma patients.
- Includes a list of audit filters, event review, and report review that includes, at minimum, EMS, ED, and inpatient specific filters, for adult and pediatrics. The audit filters shall include response expectations and adherence to written documents throughout the criteria.
- Defines levels of review of primary, secondary, tertiary and quaternary, with a listing for each level that clarifies all of the following:
    - Which cases are to be reviewed.
    - Who performs the review.
    - When cases can be closed or be advanced to the next level.

- Specify the members and responsibilities of the trauma multidisciplinary peer review and systems or operations committee concurrent with criteria 7.5 and 7.6.
- Outlines an annual process for identification of priority areas for PI, based on audit filters, event reviews, and benchmarking reports.

2021 related criteria

2(a), Level III and IV, Type 1

The TCF must have an integrated, concurrent trauma PIPS program.

2(g), Level IV, Type 1

It is expected that a physician, if available or APP/ midlevel provider will be in the emergency department on patient arrival with adequate notification from the field. The maximum acceptable response time for a physician or APP/ midlevel provider, with notification from the field and tracked from patient arrival, is 30 minutes for the highest level activation. Note: for TCFs with less than six highest-level activations annually, physician and APP/midlevel provider response time may be tracked over 3 years.

2(o)(1-2, 8-9), Level III and IV, Type 2

The trauma multidisciplinary peer review committee must:

(1) Meet at least quarterly to ensure cases are being reviewed in a timely fashion.

(2) Review systemic and care provider issues and propose improvements to the care of the injured patient.

(8) Systematically review mortalities, significant complications and process variances associated with unanticipated outcomes and determine opportunities for improvement, as evidenced by documented meeting minutes.

(9) Review selected cases involving multiple specialties, mortality data, adverse events and problem trends.

2(p), Level III and IV, Type 2

The TCF's trauma PIPS program must have audit filters to review and improve pediatric and adult patient care.

2(r), Level III and IV, Type 2

If an adult TCF annually admits fewer than 100 injured patients younger than 15 years old, the TCF must review the care of injured children as part of the trauma PIPS program. This review must include pediatric admissions and transfers.

3(a), Level III and IV, Type 2

The TCF must participate in the training of prehospital care providers, the development and improvement of prehospital care protocols and the prehospital PIPS program. The TCF must review care and provide feedback to prehospital care providers. The TCF can participate in the training of prehospital care providers in a variety of ways including being involved in programs such as Prehospital Trauma Life Support (PHTLS), grand rounds, trauma conferences, and case reviews.

3(c), Level III, Type 2

TCFs must evaluate over and under triage rates on a quarterly basis and perform rigorous multidisciplinary performance improvement to attain a goal of less than five percent under triage. If a TCF is not meeting this goal, the TCF must explain the variance and demonstrate that they are doing performance improvement work to reach this goal.

4(c), Level III and IV, Type 2

When a patient is being transferred out, the TCF must have a contingency plan that includes:

(1) A credentialing process to allow the trauma surgeon or other physician to provide initial evaluation and stabilization of the patient.

(2) A requirement for direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.

(3) A review process through the trauma PIPS program to monitor the efficacy of the transfer process.

4(d), Level III and IV, Type 2

The TCF must review all trauma patients who are transferred out during the acute care phase and all trauma patients transferred to a higher level of care within or outside of the TCF to review the rationale for transfer, appropriateness of care, adverse outcomes and opportunities for improvement. This case review should include evaluation of transport activities and follow-up from the TCF to which the patient was transferred.

5(n), Level III and IV, Type 2

The TCF's trauma PIPS program must evaluate on an ongoing basis the potential criteria for the various levels of trauma team activation to determine which patients require the resources of the full trauma team. Variances in trauma team activation must be documented and reviewed for reasons for delay, opportunities for improvement and corrective actions.

8(e), Level III and IV, Type 1

For all neurosurgical cases, whether patients are admitted or transferred, care must be timely and appropriate.

8(g), Level III if the TCF provides neurosurgery for trauma patients and IV if the TCF provides neurosurgery for trauma patients, Type 1

For neurosurgical cases, the trauma PIPS program must:

(1) Monitor all patients admitted or transferred.

(2) Review all cases requiring backup to be called in or the patient to be diverted or transferred because of the unavailability of the neurosurgeon on call.

(3) Monitor the 30 minute response time for the neurosurgeon once consulted.

9(g), Level III and IV if the TCF provides orthopedic surgery for trauma patients, Type 1

As part of the trauma PIPS program, the TCF must review all major orthopedic trauma cases for appropriateness of the decision to transfer or admit. The TCF must define the scope of practice and indicators for patients that will be admitted.

11(e), Level III and IV if the TCF provides anesthesiology services for trauma patients, Type 2

The TCF must document the availability of anesthesia services and delays in airway control or operations in the trauma PIPS program.

11(f), Level III and IV if the TCF provides anesthesiology services for trauma patients, Type 1

When the anesthesiologist or designee is responding from outside the TCF, during the time between notification of the anesthesia provider and their arrival, a provider must be available for emergency airway management. The presence of a provider skilled in emergency airway management must be documented.

11(h), Level III and IV if the TCF provides surgical services for trauma patients, Type 2

The TCF must monitor the timeliness of starting operations and the instances when operating room personnel including anesthesia support services, post anesthesia care unit personnel are not available for greater than 30 minutes. The TCF must monitor and document through the trauma PIPS program the response times of these personnel. The TCF must identify and review operating room delays involving trauma patients or adverse outcomes for reasons for delay and opportunities for improvement.

11(n), Level III and IV if the TCF provides CT services for trauma patients, Type 2

If a CT technologist takes a call from outside the facility, the TCF's trauma PIPS program must document the CT technologist's time of arrival at the facility.

11(q), Level III and IV if the TCF provides radiological services for trauma patients, Type 2

The TCF must monitor changes in interpretation between the preliminary and final radiology reports, as well as missed injuries, through the trauma PIPS program.

11(r), Level III, Type 1

The TCF must have physician coverage of the ICU available within 30 minutes and have a formal plan in place for emergency coverage. A TCF must track physician response time as part of the trauma PIPS program. Physician coverage of the ICU does not replace the primary surgeon but instead ensures that the patient's immediate needs are met while the primary surgeon is being contacted.

11(rm), Level III, Type 2

The TCF's trauma PIPS program must review all ICU trauma admissions and transfers of ICU patients to ensure that appropriate patients are being selected to remain at the TCF versus being transferred to a higher level of care. The TCF must have a written guideline

that defines which types of ICU patients they will admit and which they will transfer to a higher level of care.

11(sm), Level III and IV, Type 2

The TCF's trauma PIPS program must document that timely and appropriate ICU care and coverage are being provided for trauma ICU patients. The TCF must continuously monitor the timely response of credentialed providers to the ICU as part of the trauma PIPS program. The TCF's trauma PIPS program must include quality indicators for the ICU including review of complications. Review of complications includes but is not limited to review of orthopedic and neurosurgical complications if the TCF provides these services.

15(a), Level III and IV, Type 2

The TCF must have a trauma PIPS program that includes a comprehensive written plan outlining the configuration and identifying both adequate personnel to implement that plan and an operational data management system.

15(c), Level III and IV, Type 2

The TCF's trauma PIPS program must integrate with the facility quality and patient safety efforts and have a clearly defined reporting structure and method for the integration of feedback.

15(e), Level III and IV, Type 2

The TCF must document, in the trauma PIPS program written plan, all process and outcome measures. At least annually, the TCF must review and update all process and outcome measures.

15(g), Level III and IV, Type

The TCF must have sufficient mechanisms available to identify events for review by the trauma PIPS program. Once an event is identified, the trauma PIPS program must be able to verify and validate that event.

Proposed Criterion 7.3, Level III and IV, Type 2

A TCF shall have documented evidence of timely event identification, effective use of audit filters, attempts at corrective actions, action plans, demonstrated loop closure, and strategies for sustained improvement measured over time.

2021 related criteria

14(j), Level III and IV, Type 2

The TCF must demonstrate that all trauma patients can be identified for review.

14(k), Level III and IV, Type 2

The TCF's trauma PIPS program must be supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement.

15(b), Level III and IV, Type 2

The TCF's loop closure including problem resolution, outcome improvements and assurance of safety must be readily identifiable through methods of monitoring, re-evaluation, benchmarking and documentation.

15(h), Level III and IV, Type

The TCF must have a process to address trauma program operational events including system process related events and, when appropriate, the analysis and proposed corrective action. The TCF must have documentation that reflects the review of operational events, and when appropriate, the analysis and proposed corrective action.

15(i), Level III and IV, Type 2

When the TCF identifies an opportunity for improvement, appropriate corrective actions to mitigate or prevent similar future adverse events must be developed, implemented and clearly documented by the trauma PIPS program.

Proposed Criterion 7.4, Level III and IV, Type 2

A TCF shall ensure a designated liaison participates in the TCF's prehospital PI process that includes, at a minimum, a process for reviewing and providing feedback to EMS agencies regarding the accuracy of triage and the provision of trauma care rendered. The TCF may assist in the development of prehospital care protocols relevant to the care of trauma patients or provide educational opportunities.

2021 related criteria

3(b), Level III and IV, Type 2

The trauma health care team, including surgeons, emergency medicine physicians, medical directors for EMS agencies and basic and advanced prehospital personnel must actively participate in the development of protocols that guide prehospital care.

7(g), Level III and IV, Type 2

A representative from the emergency department must participate in the prehospital PIPS program.

Proposed Criterion 7.5, Level III and IV, Type 2

A TCF shall satisfy the following trauma multidisciplinary peer review committee attendance thresholds:

- 75 percent of meetings for the TMD and TPM.
- 50 percent of meetings for the liaisons, or one predetermined alternate, from EMS, emergency medicine, inpatient admitting providers, and radiology.
- 50 percent of meetings for the liaisons, or one predetermined alternative, from TCFs with specialty services in general surgery, neurosurgery, orthopedic surgery, critical care medicine, or anesthesia.

A TCF shall make a reasonable effort to ensure that each member of the committee is a physician. A TCF shall invite all general or trauma surgeons responding to trauma team activation to the meeting. The trauma program shall have a process to invite the

emergency medicine and general or trauma surgeons involved in the care of the patients to specific meetings.

2021 related criteria

2(o)(7), Level III and IV, Type 2

The trauma multidisciplinary peer review committee must:

(7) Require 50% attendance of its continuous members and document attendance.

7(h), Level III and IV, Type 2

If the TMD is not an emergency medicine physician, there must be a designated emergency medicine physician liaison available to the TMD for trauma PIPS issues that occur in the emergency department. As part of the trauma PIPS program, the designated emergency medicine physician liaison must be responsible for all emergency department audits, critiques and mortality review of patients treated in the emergency department.

7(i), Level III, Type 2

Emergency medicine physicians must participate actively in the overall trauma PIPS program and the multidisciplinary trauma peer review committee.

8(f), Level III and IV, Type 1

If a TCF provides neurosurgical services, neurosurgery must be part of the trauma PIPS program.

9(c), Level III and IV if the TCF provides orthopedic surgery for trauma patients, Type 1

The TCF must have an orthopedic surgeon who is identified as the liaison to the trauma program.

9(e), Level III and IV if the TCF provides orthopedic surgery for trauma patients, Type 1

A TCF must include orthopedic surgery as part of the trauma PIPS program.

11(c), Level III and IV if the TCF provides anesthesiology services for trauma patients, Type 1

A qualified and dedicated physician anesthesiologist or certified registered nurse anesthetist or a certified anesthesia assistant must be designated as a liaison to the trauma program.

11(d), Level III and IV if the TCF provides anesthesiology services for trauma patients, Type 2

The anesthesia liaison must participate in the trauma PIPS program.

11(t), Level III, Type 2

The TCF must have a designated ICU liaison to the trauma service. The liaison must be designated based on the service that provides the majority of the care in the ICU.

Proposed Criterion 7.6, Level III and IV, Type 2

A TCF shall ensure the multidisciplinary systems or operations committee meeting attendance should be inclusive of the service lines in criteria 7.5 and expand beyond to other areas involved in caring for trauma patients or those needed to affect change such as lab, blood bank, hospital quality, or administration.

2021 related criteria

None

Proposed Criterion 7.7, Level III and IV, Type 2

A TCF shall ensure liaisons to the multidisciplinary peer review committee and the multidisciplinary systems or operations committee meeting have a process for dissemination of information resulting from these meetings to their respective service lines.

2021 related criteria

15(j), Level III and IV if the TCF provides surgical services for trauma patients, Type 2

When a general surgeon cannot attend the trauma multidisciplinary peer review meeting, the TMD must ensure that the general surgeon receives and acknowledges receipt of critical information generated at the meeting.

Proposed Criterion 7.8, Level III and IV, Type 2

A TCF shall ensure all cases of trauma-related mortality and transfer to hospice are reviewed and classified for potential opportunities for improvement.

Deaths shall be categorized as:

- Mortality with opportunity for improvement.
- Mortality without opportunity for improvement.

Any death with opportunity for improvement identified at the primary or secondary review shall be taken to the tertiary level. A mortality without opportunity for improvement may be closed at the secondary level.

2021 related criteria

2(o)(8), Level III and IV, Type 2

The trauma multidisciplinary peer review committee must:

(8) Systematically review mortalities, significant complications and process variances associated with unanticipated outcomes and determine opportunities for improvement, as evidenced by documented meeting minutes.

15(f), Level III and IV, Type 2

The TCF must systematically review all trauma-related mortalities from point of injury to death and identify mortalities with opportunities for improvement for the multidisciplinary trauma peer review committee.

Proposed Criterion 7.9, Level III and IV, Type 2

A TCF shall ensure all nonsurgical trauma admissions are reviewed by the trauma program.

As part of secondary review, the TMD shall review nonsurgical admissions that satisfy any of the following criteria:

- Deviation from admission written documents and defined surgical evaluation, consultation, and tertiary exam.
- Injury severity score (ISS) > 15 or if used, Nelson Score ≤ 5.
- Cases with an opportunity for improvement identified at primary review.

2021 related criteria

5(p), Level III and IV, Type 2

The TCF may admit injured patients to individual surgeons, but the structure of the trauma program must allow the TMD to have oversight authority for the care of these patients. The TCF must have a process for the TMD and TPM to review inpatient cases through the trauma PIPS program.

5(q), Level III and IV if the TCF provides surgical services for trauma patients, Type 1

For TCFs that admit injured patients to individual surgeons or nonsurgical services, the TCF must have a method to identify injured patients, monitor the provision of health care services, make periodic rounds and hold discussions with individual practitioners. These activities may be carried out by the TPM in conjunction with the TMD at a frequency commensurate with the volume of trauma admissions.

5(r), Level III and IV if the TCF provides surgical services for trauma patients, Type 2

A TCF must have written guidelines for the care of non-surgically admitted patients. TCFs that admit more than 10% of injured patients to non-surgical services must review all non-surgical admissions through the trauma PIPS program. Care must be reviewed for appropriateness of admission, patient care, complications and outcomes. If a trauma patient is admitted by an internal medicine physician for medical comorbidities or medical management, a surgical consultation is required.

Proposed Criterion 7.10, Level III and IV, Type 2

A TCF shall ensure that all instances of the TCF going on diversion by not accepting trauma patients are reviewed by the trauma program for appropriateness.

2021 related criteria

3(h)(3), Level III and IV, Type 2

When a TCF is required to divert for trauma related occurrences it must:

(3) Review all diverts and advisories to the trauma PIPS program.

Proposed Criterion 7.11, Level III and IV, Type 2

A TCF shall have a process for requesting or receiving information on patients transferred out during the acute care phase to a tertiary TCF relating to outcomes or opportunities for improvement.

2021 related criteria

3(a), Level III and IV, Type 2

The TCF must participate in the training of prehospital care providers, the development and improvement of prehospital care protocols and the prehospital PIPS program. The TCF must review care and provide feedback to prehospital care providers. The TCF can participate in the training of prehospital care providers in a variety of ways including being involved in programs such as Prehospital Trauma Life Support (PHTLS), grand rounds, trauma conferences, and case reviews.

Proposed rule: Section 8 – Professional education and community outreach

Proposed Criterion 8.1, Level III and IV, Type 2

A TCF shall provide public and professional trauma education.

2021 related criteria

3(a), Level III and IV, Type 2

The TCF must participate in the training of prehospital care providers, the development and improvement of prehospital care protocols and the prehospital PIPS program. The TCF must review care and provide feedback to prehospital care providers. The TCF can participate in the training of prehospital care providers in a variety of ways including being involved in programs such as Prehospital Trauma Life Support (PHTLS), grand rounds, trauma conferences, and case reviews.

16(a), Level III and IV, Type 2

The TCF must engage in public and professional education, including participation in prehospital education.

Proposed Criterion 8.2, Level III and IV, Type 2

A TCF shall provide trauma orientation to new nurses and providers caring for trauma patients. The TCF shall provide trauma-related education for nurses and providers involved in trauma care.

2021 related criteria

11(zm), Level III and IV, Type 2

A TCF must have appropriate orientation, credentialing processes and skill maintenance for APPs, as witnessed by an annual review by the TMD.

16(b), Level III and IV, Type 2

The TCF must provide trauma-related education for nurses involved in trauma care.

Proposed Criterion 8.3, Level III and IV, Type 2

A TCF with an emergency medicine residency training program shall ensure that supervision is provided by in-house attending emergency physicians at all times.

2021 related criteria

7(c), Level III and IV, Type 2

For TCFs with an emergency medicine residency training program, supervision must be provided by in-house attending emergency physicians 24 hours per day.

2021 criteria not being proposed

2(q), Level III and IV, Type 2

If an adult TCF annually admits 100 or more injured patients younger than 15 years old, the TCF must:

(1) Have trauma surgeons credentialed for pediatric trauma care by the facility's credentialing body.
(2) Have a pediatric emergency department area.
(3) Have a pediatric intensive care area.
(4) Have appropriate resuscitation equipment.
(5) Have a pediatric-specific trauma PIPS program.

11(k), Level III and IV if the TCF provides surgical services for trauma patients, Type 1

Post anesthesia services, including qualified nurses, must be available 24 hours per day to provide care for the patient if needed during the recovery phase.

11(km), Level III and IV if the TCF provides surgical services for trauma patients, Type 1

In the delivery of post anesthesia care, providers must have the necessary equipment to monitor and resuscitate patients, consistent with the process of care designated by the facility.

11(vm), Level III and IV, Type 2

Trauma patients, as defined by the Wisconsin trauma registry inclusion criteria, must not be admitted or transferred by a primary care physician without the knowledge and consent of the trauma service. The TCF's trauma PIPS program must monitor adherence to this guideline. Note: The Wisconsin trauma registry inclusion criteria are contained within the which is published on the Department's Trauma webpage: https://www.dhs.wisconsin.gov/publications/p01117.pdf