WISCONSIN DEPARTMENT OF HEALTH SERVICES
PROPOSED ORDER TO ADOPT PERMANENT RULES

The Wisconsin Department of Health Services proposes an order to **revise** ss. DHS 118.03, DHS 118.04, DHS 118.08, DHS 118.09; **repeal and recreate** DHS 118 Appendix A; **relating to** trauma care.

FINDING OF EMERGENCY

RULE SUMMARY

Statutes interpreted
Section 256.25, Stats.

Statutory authority
Sections 227.11 (2) (a) and 256.25 (1r) and (2), Stats.

Explanation of agency authority
The Department of Health Services ("department") is required under s. 256.25 (1r), Stats., to develop and implement a statewide trauma care system and is required, under s. 256.25 (2), Stats., to promulgate rules to develop and implement the system. Pursuant to s. 256.25 (2), Stats., the rules promulgated by the department must include a method by which to classify all hospitals as to their respective trauma and emergency care capabilities based on standards developed by the American College of Surgeons ("ACS").

Related statute or rule
None.

Plain language analysis
The department, through the Division of Public Health, is charged with carrying out a statewide trauma care system intended to reduce death and disability resulting from traumatic injury by decreasing the incidence of trauma, providing optimal care of trauma victims and their families, and collecting and analyzing trauma-related data. Essential to this charge is the establishment of a method to classify hospitals' trauma and emergency care capabilities based on standards developed by the ACS.

The ACS is a scientific and educational association of surgeons that was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The ACS's classification criteria for trauma and emergency care capabilities are developed by the ACS Committee on Trauma ("COT") and published in a manual titled: *Resources for the Optimal Care of the Injured Patient.*

Chapter DHS 118 requires that a hospital seeking classification by the department as a Level I or II trauma center have *verification* at that level by the ACS.[1] A hospital seeking classification by

[1] The ACS does not classify trauma centers. Instead, the ACS's Verification, Review and Consultation program verifies the presence of the criteria listed in *Resources for Optimal Care of the Injured Patient.* This is accomplished through an on-site review of the hospital by a peer review team that assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.*

the department as a Level III or IV trauma center must either have verification at that level by the ACS or meet the ACS-based classification criteria specified in Chapter DHS 118 Appendix A. The classification criteria currently specified in ch. DHS 118 for Level III and IV trauma centers are based on the 2014 edition of the *Resources for Optimal Care of the Injured Patient.* A new edition of the manual was published in 2022 with updates in 2022, 2023, and 2025. Section 256.25 (2), Stats., therefore compels the department to update ch. DHS 118 to ensure the department's trauma center classification criteria are based on current ACS criteria.

No reasonable alternatives exist to rulemaking. Without proposed revisions to ch. DHS 118, the classification criteria for Wisconsin hospitals will be outdated and not in accordance with the latest recommendations from the ACS, which is inconsistent with s. 256.25 (2), Stats.

Summary of, and comparison with, existing or proposed federal regulations
There appears to be no existing or proposed federal regulations that address the activities to be regulated by the proposed rules.

Comparison with rules in adjacent states

Illinois:

Illinois statute confers on the Illinois Department of Public Health the authority and responsibility to designate applicant hospitals as Level I, Level II and Level III trauma centers. 210 Ill. Comp. Stat. 50/3.90 (b) (4). The Illinois Department of Public Health must attempt to designate trauma centers in all areas of the state and ensure that at least one Level I trauma center serves each EMS region, unless waived by the Department. Ill. Admin. Code tit. 77, § 515.2000 (a).

Illinois statute also confers on the Illinois Department of Public Health the authority and responsibility to establish the minimum standards for designation as a Level I, Level II, and Level III trauma center. 210 Ill. Comp. Stat. 50/3.90 (b) (1). The designation criteria for Level I and II trauma centers are specified in Ill. Admin. Code tit. 77, §§ 515.2030 and 515.2040 respectively. Level III criteria have not been released yet.

Iowa:
Iowa statute confers on the Iowa Department of Public Health the responsibility to adopt rules which specify hospital and emergency care facility verification criteria as well as the verification process. Iowa Code § 147A.23 2. b. Level I and II trauma care facilities must be verified by the ACS Committee on Trauma. Iowa Admin. Code r. 641-134.2 (6) a. Level III and IV trauma care facilities must be verified by the Iowa Department of Public Health in consultation with the trauma survey team, except in cases where level III centers choose to seek verification through ACS. Iowa Admin. Code r. 641-134.2 (6) b. and d. Iowa's level III verification are the criteria from the *Resources for the Optimal Care of the Injured Patient 2022,* and level IV verification are the criteria from *Resources for the Optimal Care of the Injured Patient 2014,* adopted by reference into Iowa Administrative Code. Iowa Admin. Code r. 641-134.2 (3).

Michigan:
Mich. Comp. Laws § 333.20910 (1) (l) confers on the Michigan Department of Health and Human Services the responsibility to develop, implement, and promulgate rules for the implementation and operation of a statewide trauma care system. Mich. Admin. Code r. 325.129 (1) (e) and (f) confers on the Michigan Department of Health and Human Services the responsibility to develop a statewide process for verification and designation of trauma facilities. Health care facilities seeking designation as a Level I or II trauma care facility must be verified by the ACS Committee on Trauma and comply with the additional requirements specified by the Michigan Department of Health and Human Services regarding data submission requirements, participation in regional injury prevention plans and regional performance improvement processes, and providing assistance to the Department of

Health and Human Services in the designation and verification process of other facilities. Mich. Admin. Code r. 325.130 (6).

Health care facilities seeking designation as a Level III trauma care facility may either be verified by the ACS Committee on Trauma or by the Michigan Department of Health and Human Services. Mich Admin. Code r. 325.130 (7). All Level III facilities, regardless of verification method, must comply with additional data submission requirements and participate in regional injury prevention plans and performance improvement processes. Health care facilities seeking designation as a Level IV trauma care facility must be verified by the Michigan Department of Health and Human Services. Mich. Admin. Code r. 325.130 (8). These facilities must comply with additional data submission requirements and participate in regional injury prevention plans and performance improvement processes. Mich. Admin. Code r. 325.130 (8).

Minnesota:
Minnesota Statute 144.603 (1) (2025) confers on the Commissioner of the Minnesota Department of Health the responsibility to adopt criteria to ensure that severely injured people are promptly transported and treated at trauma hospitals appropriate to the severity of injury. These criteria must be based on Minnesota's comprehensive statewide trauma system plan with the advice of the Trauma Advisory Council and using accepted standards from the ACS, the American College of Emergency Physicians, the Minnesota Office of Emergency Medical Services, the national Trauma Center Association of America, and other trauma experts. Minn. Stat. 144.603 (2) (2025).

Facilities seeking designation as a Level I or II trauma care facility must be verified by the ACS. Minn. Stat. 144.605 (3) (2025). Facilities seeking designation as a Level III trauma care facility may either be verified by the ACS or by the Minnesota Department of Health using the criteria adopted by the Commissioner. Minn. Stat. 144.605 (4) (2025). Facilities seeking designation as a Level IV trauma care facility must be verified by the Minnesota Department of Health using the criteria adopted by the Commissioner. Minn. Stat. 144.605 (5) (2025).

Summary of factual data and analytical methodologies
The department relied on the following sources to draft the proposed rule:

A. *Resources for the Optimal Care of the Injured Patient: 2014*, Committee on Trauma, American College of Surgeons (2014). This publication is on file in the Department's Division of Public Health.
B. *Resources for the Optimal Care of the Injured Patient: 2022*, Committee on Trauma, American College of Surgeons (2022). This publication is on file in the Department's Division of Public Health and available at: https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/
C. [unpublished] American College of Surgeons, *Draft Level IV Criteria, 2024*.

The department formed an Advisory Committee consisting of representatives from the following disciplines: (1) administration, (2) general surgery, (3) emergency medicine services for children or pediatrics, (4) emergency medicine physician, (5) trauma registrar, (6) two trauma program managers, and (7) pre-hospital provider. The committee representation is from all levels of trauma centers, and across all seven regional trauma advisory council (RTAC) regions. The committee members reviewed the initial draft language, and their input guided the development of the proposed rule text.

Analysis and supporting documents used to determine effect on small business
The department's analysis is based on feedback provided at the Advisory Committee meetings in which substantial discussions occurred on what is already in place and what criteria are new and will have fiscal impact.

Effect on small business
The proposed rule is anticipated to have a moderate economic impact if promulgated.

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Statement on quality of agency data
The data sources referenced and used to draft the rules and analyses are accurate, reliable, objective and are discussed in the "Summary of factual data and analytical methodologies."

Place where comments are to be submitted and deadline for submission
Comments may be submitted to the agency contact person that is listed above until the deadline given in the upcoming notice of public hearing. The notice of public hearing and deadline for submitting comments will be published in the Wisconsin Administrative Register and to the department's website, at https://www.dhs.wisconsin.gov/rules/active-rulemaking-projects.htm. Comments may also be submitted through the Wisconsin Administrative Rules Website, at: https://docs.legis.wisconsin.gov/code/chr/active.

RULE TEXT

SECTION 1. DHS 118.03 (6g), (10k), (17g), (18m) and (34g) are created to read:

DHS 118.03 **(6g)** "Classification cycle" means the three-year period between site visits.

(17g) "ICD-10" means the International Classification of Diseases, 10th Revision.

(34g) "PI" means performance improvement.

SECTION 2. DHS 118.04 (2) (b) 1. (Note) is amended to read:

Note: Wisconsin is divided into ~~9~~ 7 trauma care geographic regions. Each region has an RTAC. A trauma care region is defined by the location of the health care providers that have selected a particular RTAC for primary membership and in which the majority of each provider's trauma care and prevention occurs.

SECTION 3. DHS 118.04 (3) (b) 2. (Note) is amended to read:

Note: To request review of the Department's complaint record, contact the ~~Statewide Trauma Care Coordinator by calling 608-266-0601 or by writing to Statewide Trauma Care System Coordinator, Bureau of Local Public Health Practice and Emergency Medical Services, Room 118, 1 West Wilson St., Madison, WI 53701, or by sending a fax to 608-261-6392~~ Trauma Program at DHSTrauma@dhs.wisconsin.gov.

SECTION 4. DHS 118.04 (5) (Note) is amended to read:

Note: To request a waiver from a nonstatutory requirement under this chapter, contact the ~~statewide trauma care coordinator by calling 608-266-0601 or by writing to Statewide Trauma Care System~~

~~Coordinator, Bureau of Local Public Health Practice and Emergency Medical Services, Room 118, 1 West Wilson St., Madison, WI 53701, or by sending a fax to 608-261-6392~~ Trauma Program at DHSTrauma@dhs.wisconsin.gov.

SECTION 5. DHS 118.04 (6) (a) 1. (Note) is amended to read:

Note: For a copy of the Department's ~~assessment and classification criteria~~ application form ~~for approval as a trauma care facility, write to the Wisconsin Trauma Care System Coordinator, Division of Public Health, P.O. Box 2659, Madison WI 53701-2659 or download the form from the DHS website at: http://www.dhs.wisconsin.gov/forms/F4/F47479.doc~~ , contact the Trauma Program at DHSTrauma@dhs.wisconsin.gov.

SECTION 6. DHS 118.04 (6) (a) 3. is amended to read:

DHS 118.04 **(6)** (a) 3. The department ~~may~~ shall require a hospital to document the basis for the hospital's professed level of trauma care facility, based on current ACS requirement for level I, II and III trauma care facilities or based on the classification criteria in appendix A, through the pre-review questionnaire, for level III and IV trauma care facilities. The pre-review questionnaire shall include all Wisconsin trauma registry data from a 12-month reporting period that may not be older than 15 months at the time of submission to the department.

SECTION 7. DHS 118.04 (6) (a) 4. (intro.) and b. are amended to read:

DHS 118.04 **(6)** (a) 4. (intro.) The department may perform a site visit of a level III or IV trauma care facility to determine compliance with the trauma care facility ~~assessment and~~ classification criteria in accordance with all of the following conditions:

b. The department's site visit shall be to determine whether the facility meets the ~~assessment and~~ classification criteria in appendix A.

SECTION 7m. DHS 118.04 (6) (a) 4. a. (Note) is repealed.

SECTION 8. DHS 118.04 (6) (a) 5. d. is repealed.

SECTION 9. DHS 118.08 (2) (a) 1. a.is amended to read:

DHS 118.08 **(2)** (a) 1. a. All hospitals shall declare their current trauma care capabilities to the department within 180 days of January 1, 2005, or within one year of opening, whichever is later, according to the criteria specified in this section.

SECTION 10. DHS 118.08 (2) (a) 2. a. is amended to read:

DHS 118.08 **(2)** (a) 2. a. A hospital declaring itself as a ~~Level~~ level I or II trauma care facility shall ~~have been~~ be verified at that level by the ACS in accordance with the standards and guidelines established by the ACS and shall be classified by the department at that level. A hospital seeking to declare itself as a level I or II trauma care facility shall submit an application with their official documentation from ACS to the department for classification.

SECTION 11. DHS 118.08 (2) (a) 3. a. is amended to read:

DHS 118.08 **(2)** (a) 3. A hospital desiring department approval as a level III or IV trauma care facility shall either submit an application and documentation to the department that it has received ACS

verification at level III or IV or complete the department's ~~assessment and~~ classification ~~criteria application form~~ process as specified in s. DHS 118.04 (6) (a).

SECTION 12. DHS 118.08 (2) (a) 3. a. (Note) is repealed.

SECTION 13. DHS 118.08 (2) (a) 3. b. is repealed.

SECTION 14. DHS 118.08 (2) (a) 3. c. is amended to read:

DHS 118.08 **(2)** (a) 3. If any Type 1 Criteria or more than three Type 2 Criteria are not demonstrated at the time of the initial classification site visit ~~or at the initial site visit for any subsequent renewal of classification~~, the hospital's application may not be approved. If all Type 1 Criteria are demonstrated but one to three Type 2 Criteria are not demonstrated at the time of ~~a~~ an initial site visit, then a one-year provisional certificate of classification may be issued, and ~~another~~ focused review shall be required before the hospital's application may be approved. This second review must occur within one year from ~~the date of notification~~ the original renewal site visit and may include an onsite re-visit or a review of documents submitted by the hospital to the department. If the hospital ~~trauma care facility~~ successfully corrects the criteria deficiencies, the period of classification will be extended to three years from the date of the initial site visit. If the hospital does not correct the deficiencies, the hospital's application may not be approved.

SECTION 15. DHS 118.08 (2) (a) 5. (Note) is repealed.

SECTION 16. DHS 118.08 (2) (b) 2. a. is amended to read:

DHS 118.08 **(2)** (b) 2. a. A level III ~~or IV~~ trauma care facility shall notify the department of the facility's intent to change its level of trauma care. If the level III trauma care facility ~~meets the department's trauma care assessment and classification criteria under sub. (1), or has been~~ wishes to be recognized as a level I or II trauma care facility, the trauma care facility shall be verified by the ACS as being another level trauma care facility, ~~the department shall recognize the facility at the level desired~~ and the hospital shall be in accordance with par. (a) 2. a. If the level III trauma care facility wishes to be a level IV trauma care facility, the department shall recognize the trauma care facility as a level IV trauma care facility until completion of their classification cycle.

SECTION 16d. DHS 118.08 (2) (b) 2. am. is created to read:

DHS 118.08 **(2)** (b) 2. am. A level IV trauma care facility shall notify the department of the facility's intent to change its level of trauma care. If the level IV trauma care facility wishes to be recognized as a level I, II, or III trauma care facility, the trauma care facility shall be in accordance with par. (a) 2. a. or par. (a) 3. a., as applicable.

SECTION 16h. DHS 118.08 (2) (b) 2. b. is renumbered to DHS 118.08 (2) (b) 3. and amended to read:

DHS 118.08 **(2)** (b) 3. 'Revocations.' The department may revoke its approval of a ~~level III or IV~~ trauma care facility if the department determines the facility does not meet the criteria associated with the facility's existing classification.

SECTION 16p. DHS 118.08 (2) (b) 2. c. is repealed.

SECTION 16t. DHS 118.08 (2) (b) 2. d. is amended to read:

DHS 118.08 **(2)** (b) 2. d. If a level III or IV trauma care facility is unable to continue functioning at its current level of trauma care, the ~~facility shall notify the department no more than 30 calendar days after the facility no longer continues to function as a level III or IV trauma care facility~~ hospital shall self-

report such to the department, other regional hospitals, local emergency medical services providers, and other authorities. If the trauma care facility cannot correct its inability to meet the criteria for its level within six months of date of notification, the hospital shall reapply at another level or lose its classification status.

SECTION 17. DHS 118.08 (2) (c) 1. is amended to read:

DHS 118.08 **(2)** (c) 1. At least once every 3 years after initial classification, ~~the department shall provide all level III and IV trauma care facilities an assessment and classification criteria form~~ a trauma care facility shall submit an application at least 6 months prior to the completion of their classification cycle, then subsequently submit the forms described under s. DHS 118.04 (6) (a).

SECTION 17g. DHS 118.08 (2) (c) 2. and 3. are repealed.

SECTION 17r. DHS 118.08 (2) (c) 2m. is created to read:

DHS 118.08 **(2)** (c) 2m. If any Type 1 Criteria or more than three Type 2 Criteria are not demonstrated at the time of the renewal classification site visit, the hospital's application may not be approved. If all Type 1 Criteria are demonstrated but one to three Type 2 Criteria are not demonstrated at the time of a renewal classification site visit, then a one-year provisional certificate of classification may be issued, and focused review shall be required before the hospital's application may be approved. This second review must occur within one year from the original renewal site visit and may include an onsite re-visit or a review of documents submitted by the hospital to the department. If the trauma care facility successfully corrects the criteria deficiencies from the initial renewal site visit, the period of classification will be extended to three years from the date of the initial renewal site visit. If the trauma care facility does not correct the criteria deficiencies, the hospital's application may not be approved.

SECTION 18. DHS 118.08 (2) (d) 1. is amended to read:

DHS 118.08 **(2)** (d) 1. A hospital may not advertise in any manner or otherwise represent itself as either a trauma care facility ~~or,~~ trauma facility, trauma center, trauma hospital, or otherwise indicate it has trauma treatment capabilities unless the hospital has been classified as a level I, II, III, or IV trauma care facility by the department in accordance with this chapter.

SECTION 19. DHS 118.09 (2) (c) is amended to read:

DHS 118.09 **(2)** (c) Specify both the process and timelines for hospital ~~and ambulance service provider~~ submission of data to the department.

SECTION 20. DHS 118.09 (3) (intro.) is amended to read:

DHS 118.09 **(3)** SUBMISSION OF DATA. All hospitals~~, ambulance service providers and emergency medical responder services~~ shall submit to the department on a quarterly basis trauma data determined by the department to be required for the department's operation of the state trauma registry. The department shall prescribe all of the following:

SECTION 21. Appendix A is repealed and recreated to read:

Chapter DHS 118

Appendix A

SECTION 1 – Institutional administrative commitment

Criterion	Level	Description	Type
1.1	III and IV	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.	Type 1
1.2	III and IV	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.	Type 2

SECTION 2 – Program scope and governance

Criterion	Level	Description	Type
2.1	III and IV	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.	Type 2
2.2	III	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.	Type 2
2.3	IV	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.	Type 2
2.4	III and IV	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.	Type 2
2.5	III	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.	Type 2

2.6	III and IV	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.	Type 2
2.7	III and IV	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.	Type 2
2.8	III and IV	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.	Type 2
2.9	III	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.	Type 2

2.10	IV	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.	Type 2
2.11	III and IV	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.	Type 2

SECTION 3 – Facilities and equipment resources

Criterion	Level	Description	Type
3.1	III	A TCF shall ensure that an operating room with adequate staff is available within 30 minutes of an emergent operating room request.	Type 1
3.2	IV	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.	Type 2
3.3	III and IV	A TCF shall have an adequate supply of red blood cells and plasma.	Type 2
3.4	III and IV	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.	Type 2
3.5	III	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.	Type 2
3.6	IV	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.	Type 2
3.7	III and IV	If a TCF provides neurosurgery onsite, then the TCF must have cerebral monitoring and craniotomy capabilities.	Type 2
3.8	III and IV	A TCF shall have all of the following: *Airway Management*	Type 2

		• 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.	
3.9	III and IV	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.	Type 2

		• 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.	

SECTION 4 – Personnel and services

Criterion	Level	Description	Type
4.1	III	A TCF shall have general or trauma surgery capability at all times.	Type 1
4.2	III and IV	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.	Type 2

4.3	IV	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.	Type 2
4.4	III	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.	Type 2
4.5	IV	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.	Type 2
4.6	III and IV	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.	Type 2
4.7	III and IV	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.	Type 2
4.8	III and IV	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.	Type 2
4.9	III and IV	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.	Type 1
4.10	III and IV	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.	Type 2
4.11	III and IV	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	Type 2

		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.	
4.12	III and IV	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.	Type 2
4.13	III	A TCF shall have continuous orthopedic surgery capability.	Type 1
4.14	III and IV	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.	Type 2
4.15	III	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.	Type 2
4.16	IV	If a TCF has continuous orthopedic surgery capability and provides emergent orthopedic surgery, the TCF shall have a written document in compliance with criterion 4.15 of this Appendix.	Type 2
4.17	IV	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.	Type 2
4.18	III	A TCF shall have a documented backup call schedule or a backup plan, including expeditious transfer for when the orthopedic surgeon is encumbered.	Type 2

4.19	IV	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.	Type 2
4.20	III and IV	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.	Type 2
4.21	III and IV	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.	Type 2
4.22	III and IV	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.	Type 2
4.23	III	A TCF shall have continuous ICU capability.	Type 1
4.24	III	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.	Type 2
4.25	III	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.	Type 2
4.26	IV	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.	Type 2
4.27	IV	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.	Type 2
4.28	III	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.	Type 2
4.29	IV	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.	Type 2
4.30	III	A TCF shall have the following allied health services available: • Continuous respiratory therapy. • Nutrition support. • Speech therapy. • Social work. • Occupational therapy. • Physical therapy.	Type 2
4.31	IV	A TCF shall have the following allied health services capabilities available: • Respiratory therapy. • Social work or case management.	Type 2

		• Occupational therapy. • Physical therapy.	
4.32	III and IV	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.	Type 2

SECTION 5 – Patient care expectations and protocols

<table>
<tr><th>Criterion</th><th>Level</th><th>Description</th><th>Type</th></tr>
<tr><td>5.1</td><td>III and IV</td><td>A TCF shall have evidence-based trauma clinical practice guidelines, protocols, or algorithms that are reviewed at least every three years.</td><td>Type 2</td></tr>
<tr><td>5.2</td><td>III and IV</td><td>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.
<table>
<tr><td>Age</td><td>SPB (mmHg)</td></tr>
<tr><td>< 1 year old</td><td>≤ 70</td></tr>
<tr><td>1-10 years old</td><td>≤ 70 + (2x age in years)</td></tr>
</table>
b. Persistent tachycardia in a patient ≤14 years old.
<table>
<tr><td>Age</td><td>HR</td></tr>
<tr><td>< 2 years old</td><td>>180</td></tr>
<tr><td>2-5 years old</td><td>>160</td></tr>
<tr><td>6-14 years old</td><td>>140</td></tr>
</table>
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.</td><td>Type 2</td></tr>
<tr><td>5.3</td><td>III and IV</td><td>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.</td><td>Type 1</td></tr>
</table>

5.4	III and IV	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.	Type 2
5.5	III	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.	Type 2
5.6	IV	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.	Type 2
5.7	III	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.	Type 2
5.8	IV	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.	Type 2
5.9	III and IV	A TCF shall ensure the trauma program concurrently monitors the provision of health care services provided to trauma patients admitted to their TCF.	Type 2
5.10	III	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.	Type 1
5.11	IV	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.	Type 1
5.12	III and IV	A TCF shall have a written document for rapid reversal for patients on anticoagulants, which may include transfer of the patient.	Type 2
5.13	III and IV	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.	Type 2
5.14	III and IV	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	Type 2

		a plan to address at least one of the identified gaps (3) Identify a pediatric point of contact.	
5.15	III and IV	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.	Type 2
5.16	III and IV	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.	Type 2
5.17	III and IV	A TCF shall have a transfer plan that includes expeditious critical care transport, and consideration of pediatric and burn patients.	Type 2
5.18	III and IV	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.	Type 1
5.19	III and IV	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.	Type 1
5.20	III and IV	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.	Type 2
5.21	III and IV	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.	Type 2
5.22	III and IV	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.	Type 2
5.23	III and IV	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	Type 2

		guideline that includes at a minimum, which patients may receive a surgical evaluation or consultation, and who will be performing the tertiary exam.	
5.24	III	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.	Type 2
5.25	IV	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.	Type 2
5.26	III and IV	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.	Type 2
5.27	III and IV	A TCF shall have a process for referral or intervention for patients who screen positive for alcohol misuse.	Type 2

SECTION 6 – Data surveillance and systems

Criterion	Level	Description	Type
6.1	III and IV	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.	Type 2
6.2	III and IV	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.	Type 2
6.3	III and IV	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).	Type 2
6.4	III and IV	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	Type 1

		to know, shall be integrated in the administration of the trauma program.	
6.5	III and IV	A TCF shall use trauma registry data to support their injury prevention and performance improvement and patient safety efforts.	Type 2

SECTION 7 – Performance improvement and patient safety

Criterion	Level	Description	Type
7.1	III and IV	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.	Type 2
7.2	III and IV	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: o Which cases are to be reviewed. o Who performs the review. o 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.	Type 2
7.3	III and IV	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.	Type 2
7.4	III and IV	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.	Type 2

7.5	III and IV	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.	Type 2
7.6	III and IV	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.	Type 2
7.7	III and IV	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.	Type 2
7.8	III and IV	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.	Type 2
7.9	III and IV	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.	Type 2
7.10	III and IV	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.	Type 2
7.11	III and IV	A TCF shall have a process for requesting or receiving information on patients transferred out during the acute care	Type 2

		phase to a tertiary TCF relating to outcomes or opportunities for improvement.	

SECTION 8 – Professional education and community outreach

Criterion	Level	Description	Type
8.1	III and IV	A TCF shall provide public and professional trauma education.	Type 2
8.2	III and IV	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.	Type 2
8.3	III and IV	A TCF with an emergency medicine residency training program shall ensure that supervision is provided by in-house attending emergency physicians at all times.	Type 2

SECTION 22. EFFECTIVE DATE. This rule shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, as provided in s. 227.22 (2) (intro.), Stats.