



## **ARKANSAS DEPARTMENT OF HEALTH**

### **FREQUENTLY ASKED QUESTIONS**

#### **(FAQ) REGARDING THE**

#### **ARKANSAS TRAUMA SYSTEM RULES AND REGULATIONS**

#### **PROMULGATED BY THE**

#### **ARKANSAS STATE BOARD OF HEALTH**

This document is intended to clarify and answer questions frequently asked regarding the Arkansas Trauma System Rules and Regulations (hereafter referred to as the *Rules*) set out by the Arkansas State Board of Health. It is important that hospitals and health care providers are familiar with this document as well as these FAQs.

The format of this document is as follows: section, item and/or page numbers corresponding to the page in the *Rules* are listed with the referenced questions. These are followed by the explanations/clarifications issued by the Hospital Committee of the Governor's Trauma Advisory Council, which have been reviewed and endorsed by the Arkansas Department of Health (ADH). The explanations/clarifications are not intended to change the substance of the *Rules* but rather to provide both hospitals and State-approved Trauma Surveyors the clarity to verify the compliance of a facility with the *Rules*. Individuals seeking additional explanation or clarification should address such questions in writing to the ADH Trauma Section.

## **SECTION I.            DEFINITIONS**

**Section I. (Alternate Pathway) (page 4) *Do the Alternate Criteria apply only to general surgeons?***

Yes.

**Section I. (Alternate Pathway) (page 4) *What are the criteria to satisfy the alternate pathway?***

1. Currency in ATLS (general surgery)
2. A list of patients treated during the past year with accompanying Injury Severity Score and outcome data
3. Performance improvement assessment by the trauma medical director demonstrating that the morbidity and mortality results for patients treated by the surgeon compare favorably with the morbidity and mortality results for comparable patients treated by the other members of the trauma call panel.

**(Adopted: 11/12/2015)**

**Section I. (Alpha) (page 4) *What is the updated ATCC dashboard language for Alpha?***

Alpha is now referred to as “Open” on the ATCC dashboard. The definition remains the same as defined for Alpha in the *Rules*.

**(Adopted: 11/12/2015)**

**Section I. (Bravo) (page 5) *What is the updated ATCC dashboard language for Bravo?***

Bravo is now referred to as “Delay” on the ATCC dashboard. The definition remains the same as defined for Bravo in the *Rules*.

**(Adopted: 11/12/2015)**

**Section I. (Charlie) (page 6) *What is the updated ATCC dashboard language for Charlie?***

Charlie is now referred to as “Not Provided” on the ATCC dashboard. The definition remains the same as defined for Charlie in the *Rules*.

**(Adopted: 11/12/2015)**

**Section I. (Charlie Temp) (page 6) *What is the updated ATCC dashboard language for Charlie Temp?***

Charlie Temp is now referred to as “No Capability” on the ATCC dashboard. The definition remains the same as defined for Charlie Temp in the *Rules*.

## **SECTION V.            TRIAGE REQUIREMENTS FOR TRAUMA CENTERS**

**Section V. (Standards for Level I-IV Trauma Centers) (B., 2., page 22) *What should happen in a Level III or IV facility if a patient meets “trauma activation criteria” but will likely be transferred out of the facility to a higher level of care? Do we have to activate the team for these patients?***

Yes. Facilities have an obligation to activate the trauma team for patients based on their activation protocol – NOT the likelihood of transfer. Facilities have the obligation to assess and stabilize to the limit of their available resources a patient presenting with an emergency condition. A facility shall not fail to activate the trauma team simply because the patient is likely to require transfer out. The trauma surgeon, when available, is expected to participate in the decision to transfer a patient for a higher level of care. Documentation of the surgeon's involvement is expected and will be reviewed during the site survey.

**(Updated 4/21/2015)**

**Section V. (Triage Standards for Level I-IV Trauma Centers) (C., 4., b., page 23) *Are there any exceptions to the criteria for activating the trauma team at the highest level of activation?***

The highest level of activation must require activation of the **entire trauma team** including the operating room (OR) and the general surgeon on call. The only exceptions to this are a.) Blunt force trauma with cardiac arrest (CPR in progress); b.) An isolated head injury with a GCS < 9 with a mechanism due to trauma (general surgeon response can be at the discretion of the ED physician) (for Levels I, II, and III); c.) An isolated head injury with a GCS < 13 with a mechanism due to trauma (for Level IV).

Respiratory distress attributed to trauma (if no other criteria for highest activation are met) does not require activation of the OR, but does require activation of the general surgeon on call. Activation of the general surgeon for hanging, drowning, and inhalation injury can be at the discretion of the Emergency Department (ED) physician.

## **SECTION VI. TRAUMA CENTER DESIGNATION**

**Section VI. (Purpose) (A., page 28) *Can a hospital that is „in pursuit“ of designation receive trauma patients?***

Hospitals which have submitted their Intent Application to the state and have been approved for the level they seek may represent to EMS, referring hospitals, and the community that they are in-pursuit of State Trauma Center Designation in order to begin to receive patients. They will be listed on the ATCC dashboard, will receive trauma patients, and will be required to attend TRAC meetings.

**Section VI. (Site Survey) (B., 2., page 28) *What is the cost of a site survey?***

The fees are \$2000 per surveyor plus an additional \$1000 for the lead surveyor for Levels I and II. The facilities are also responsible for airfare, car rental, and/or mileage costs for the surveyors and lodging for the surveyors and ADH staff for the two day visit. Level I facilities are required to have a —majority of the three person team come from out-of-state. Level II facilities must have —at least one of the three surveyors come from out-of-state. Typical Level I and II survey costs are \$9,000 - \$12,000. For Levels III and IV (which require fewer surveyors and less time to perform) the fee will be \$1000 per surveyor and an additional \$500 for the lead surveyor. The facilities are also responsible for airfare, car rental, and/or mileage costs for the surveyors and lodging for the surveyors and ADH staff for the one day visit. All surveyors for Level III and IV facilities may

come from in-state. The typical cost of a survey for a Level III would be \$3000 - \$5000 and a Level IV would be \$2,000 –\$3,000.

**Section VI. (Site Survey) (B., 2., page 28) *What will the report back to the hospital look like following a site survey?***

The report will contain an executive summary which will be divided into the following four sections: 1. Deficiencies (Type I or II); 2. Strengths; 3. Weaknesses (opportunities for improvement); and, 4. Recommendations. The document will then describe how the facility met or failed to meet specific criteria required in the *Rules*. The document will have the summary of the specific trauma cases reviewed by the review team and examples of the facility’s peer review and PI process.

The findings of the survey will be recorded by the state-approved site surveyors in a report. This document will go to the ADH Trauma Section’s Nurse Coordinator, who will format and distribute it to members of the TAC Hospital Designation Sub-Committee (HDS). The assigned members of the HDS will review the report submitted by the surveyors. They may, based on available information, amend the surveyor’s report with written justification for changes and then recommend any of the following to the ADH Trauma Section: designation (full or provisional); request more information from the hospital; or, denial of designation. The Trauma Section will have ultimate authority to accept, modify, or change the surveyor’s and Hospital Designation Subcommittee recommendations and will then grant (or not) the designation. The letter outlining the Trauma Section’s decision will be mailed to the hospital CEO with a copy to the TMD and TPM. The process should take approximately 8 -10 weeks to complete.

**Section VI. (Site Survey) (B., 2., a., b., & c., page 29-30) *What are the criteria for full or provisional approval? How many deficiencies are allowed? Are there minor and major deficiencies? (see B., 6., page. 33 - “Denial of Trauma Center Designation” and D., 4., page 36 - “Occasional Failure to Meet Standards”)***

The criteria will be weighted by designating them as major (Type I) or minor (Type II). The surveyors may also cite recommendations which are not criteria deficiencies; but, areas in which, in their expert opinion, the facility can improve its processes for care for injured patients.

A facility will be approved for full designation if there are no Type I deficiencies. A hospital will be approved for provisional designation with any Type II criteria deficiencies.

Any Type I deficiencies, will result in the hospital not passing a site survey and not being designated.

Hospitals receiving provisional designation are required to submit, to the ADH Trauma Section, within three months of review, a corrective action plan for a timely remediation of deficiencies within the one year provisional period. All Type II deficiencies must be corrected in the provisional year. At the conclusion of the second provisional term, if the facility has not met the ADH’s requirements, the provisional designation shall be revoked and the facility shall reapply for trauma center designation.

**Section VI. (Site Survey) (B., 2., b., page 29) *If a hospital is given provisional approval, do they get their money? Do they require a full or a focused review?***

A hospital receiving a provisional approval has all the rights and privileges of a designated Arkansas Trauma Center. The hospital will receive trauma funds during which time it is provisionally designated. The level of re-review should be recommended by the TAC Hospital Designation Subcommittee and would ultimately be at the discretion of the ADH Trauma Section. The requirements of the re-review will be delineated in the response letter to the hospital by ADH Trauma Section.

**Section VI. (Site Survey) (B., 2., d., page 30) *If a hospital is denied designation, do they get their money? Do they pay money back?***

A hospital that is not designated cannot represent itself as a trauma center. The hospital will be removed from the ATCC dashboard and will not be able to receive trauma patients by air or ground ambulance. Should the hospital decide to again seek in-pursuit of designation status, they will need to send a letter to the Trauma Section with this request along with a corrective action plan regarding the deficiencies. If the plan is approved by the ADH Trauma Section, the hospital will again attain —in-pursuit status, will be represented on the ATCC dashboard, and will be able to receive trauma patients. The earliest the hospital may be able to reapply for designation is six months after the denial or suspension/revocation. It does not have to pay money back but is not eligible for continued money unless designated at a later date.

**Section VI. (Suspension/Revocation of Designation - Occasional failure to meet standards) (D., 2- 4., page 35-36) *Who will determine if a failure to meet a standard is substantive and represents an overall diminution in quality of care and who will tell the hospital what the “reasonable” time frame is for correction? How will the ADH Trauma Section verify that the hospital has met the requirements again?***

As outlined above, the ADH Trauma Section has, with the TAC’s Hospital Designation Subcommittee, determined the level of various criteria within the *Rules*. The trauma expert surveyors will evaluate the hospital and its processes and render an opinion to the ADH Trauma Section as to the significance of a criterion deficiency based on the guidelines set out prior to the visit. The Hospital Designation Committee would, in reviewing a survey report, make recommendations to the ADH Trauma Section for remediation of any deficiencies that exist in a hospital along with a timeframe (usually within six months) for correction. This would ultimately be the decision of the ADH Trauma Section. The verification of the remediation of deficiencies will be the responsibility of the ADH Trauma Section, which may assign the task to an ad hoc review team or may require a full site survey. The plan for verification of remediation should be outlined in the original letter back to the hospital.

The *Rules* are clear that —occasional lapses in capacity are acceptable as long as they do not impact the quality of patient care and are corrected within a reasonable time frame by the hospital. The determination of impact on quality of care will be determined by the ADH Trauma Section and may require an expert opinion from outside the Section. The expectation is that —occasional lapses will not exceed 5% of the total time in a three month period that the hospital is open for trauma care. For hospitals having —occasional criteria deficiencies the expectation is that the hospital tracks through its QI process the outcome of patients during the time of occasional lack of critical capacity and that the hospital has a TRAC-sponsored plan for provision of care for such patients during the

time of lack of capacity, including transfer out of the hospital. The hospital would be obligated to report to the ADH Trauma Section times of lack of critical capacity.

**Section VI. (Complaints) (D., 5., page 36) *Who would investigate a complaint against a facility for not meeting the standards?***

The ADH Trauma Section would have this responsibility. It may delegate the investigation of the complaint to the Hospital Designation Sub-committee, but it would retain the authority to determine if a facility remained compliant with the *Rules* for designation.

**SECTION VII. TRAUMA CENTER CRITERIA**

**Section VII. (Trauma Medical Director (TMD) Trauma Medical Co-Director (TMCD)) (L1 & L2, 2., 2.1, page 39) (L3, 2., 2.2, page 60) (L4 2., 2.1 page 80) *What defines the TMD's responsibility of "actively participating in the care of injured patients"?***

If the TMD is a surgeon, active participation implies participating in the general surgery call schedule as a core physician. If the TMD is an emergency room physician, active participation implies he/she must participate in general call or be an active provider in the emergency room.

**(Adopted: 4/21/2015)**

**Section VII. (Trauma Medical Director (TMD) Trauma Medical Co-Director (TMCD)) (L1 & L2, 2., 2.2, page 39) (L3, 2., 2.3, page 60) *Does the TMD at a Level I-III facility have to be currently board-certified to meet this requirement?***

Yes, the surgeon that is the TMD/TMCD for Level I-III facilities must maintain current board-certification.

**(Adopted: 4/8/2015)**

**Section VII. (Trauma Medical Director (TMD)) (L1 & L2, 2., 2.3, page 39) *May a Level I or Level II TMD substitute attendance in a national meeting for currency in ATLS?***

Yes, the physician may attend the following: The Arkansas Trauma Update, AAST, EAST, Western Trauma, Trauma Critical Care & Acute Care Surgery Update (Mattox), and receive at least 8 hours of verifiable CME as a substitute for ATLS.

**(Updated: 6/16/2015)**

**Section VII. (Trauma Medical Director (TMD)) (L1 & L2 2., 2.7, page 40) (L3 2., 2.13, page 61) *The rule states the TMD or TMCD (L3) shall perform a written annual review of the performance of "all surgeons" on the call panel. Does this include orthopedic surgeons and neurosurgeons? Also, does the requirement for a written annual review need to include the ED physicians?***

Yes, the referenced rules require that the TMD provide a written evaluation of the surgeons on the call panel. This rule applies to all surgeons including neurosurgeons and orthopedic surgeons. In the case of neuro and orthopedics, the trauma liaison may perform these evaluations, which then must be cosigned by the TMD after review with the liaison. This rule applies to surgeons, not ED physicians.

**(Adopted: 6/16/2015)**

**Section VII. (Trauma Medical Director (TMD)) (L1 & L2 2., 2.11, page 40) (L3 2., 2.9, page 61) (L4 2., 2.8, page 81) *The rule states the TMD or TMCD (L3) shall have responsibility and authority for determining each call panel member's ability to participate on the trauma call schedule based on a periodic review. What does this encompass?***

This rule applies to surgeons as well as ED physicians. The TMD must have the ability to periodically review the performance of all physicians and remove physicians from the call schedule or from the ED staff if they do not perform acceptably.

**Section VII. (Trauma Registrar) (L1 & L2, 2., 2.21 page 41) (L3, 2., 2.22 page 62) (L4, 2., 2.18, page 81) *Can this position be shared with other departments in a facility? Can the position be shared between facilities? Can small facilities outsource this registry function to larger facilities as long as data submission is timely?***

A registrar can be shared between other departments in the facility or between facilities as long as the records are entered in a timely fashion (all records are entered within 60 days of discharge). Small facilities may outsource their registry as long as all records are entered within 60 days of discharge and the facility to which the registry is outsourced produces periodic benchmark reports back to the outsourcing (original) facility. The facility's registrar (in house or outsourced) should be available for the site survey.

**Section VII. (Trauma Program Staff) (L1 & L2, 2., 2.22, page 41) (L3, 2., 2.24, page 62) (L4, 2., 2.20, page 82) *Is there a deficiency associated with inadequate FTE's and resources for the QI program?***

A robust QI program is an area of emphasis for trauma centers. Inadequate FTE and resources dedicated to this rule will result in a deficiency. If, in the opinion of the reviewers, deficiencies exist in the QI program that are due to inadequate or inappropriate personnel support, the additional deficiency will be assessed.

**(Updated 11/12/2015)**

**Section VII. (Consultant Coverage) (L1 & L2, 2., 2.26, page 41) (L3, 2., 2.28, page 62) (L4, 2., 2.24, page 82) *What components should be included in the internal policy for consultant coverage?***

The program is to define the diagnosis or conditions for which a response is required by a consultant and what time frame is expected. The QI program is responsible then for tracking compliance with this protocol.

Example:

In hospital X, it has been agreed in the hospital's performance meeting that patients with extra-axial

hematoma (epidural, subdural) with a midline shift and a GCS < 15 should have a neurosurgeon at the bedside within one hour. The hospital had eight such patients last year and the neurosurgeon was at the bedside for six of the eight cases within the one hour expected time frame. Twice, the neurosurgeon was not paged correctly by the ED secretary. The QI process identified this problem two out of eight times and has a reasonable performance plan to address the paging issue and continues to monitor the neurosurgeon arrival time.

**Section VII. (General Surgery Participation) (L1 & L2, 3., 3.4, Page 41) (L3, 3., 3.4, page 63) (L4, 3., 3.3, page 82) *What are the requirements for ATLS for a new general surgeon?***

If a general surgeon who is new to a facility has never taken ATLS, he/she will have a one year grace period during which they must obtain ATLS certification. This period will begin commensurate with their participation on the call panel.

**Section VII (General Surgery Participation) (L1 & L2, 3., 3.7, page 42) (L3, 3., 3.7 page 63) (L4, 3., 3.6 page 82) *When the highest level of trauma is activated, the surgeon must respond to the ED promptly (LI-15 mins, LII-IV-30 mins) an aggregate of 80% of the time when on-call. How do we figure this?***

**(Updated 3/4/2016)**

***What constitutes response time?***

The response time is measured from the time the surgeon is notified until arrival in the trauma bay. It is anticipated, that with adequate notification, the surgeon will be present at the time of patient arrival.

***How is response percentage calculated?***

The hospital will have to show during the reporting period that the trauma surgeon responded promptly on an aggregate (average) of 80% of the time. The formula for this calculation is as follows:

$$\frac{\text{Number of times a surgeon responded in 30minutes (15mins for Level I) during reporting period}}{\text{Total number of activations during reporting period}} = \text{Aggregate response time}$$

**Section VII. (Participation) (L3, 3., 3.15-3.17, pages 64-65) (L4, 3., 3.1-3.11, pages 82-83) *If our facility offers services that are not required of our level of designation, what are the requirements we would need to meet?***

A trauma center providing a surgical capability above those required by the designation level must meet all the requirements for the additional capability at a center of the higher level. For example a Level 4 facility with part time general surgery must meet all the general surgical requirements in regard to arrival time (when alpha/open on the dashboard), QI, meeting attendance and CME of a Level 3 facility. The same is true of a Level 3 providing part time neurosurgical coverage, where the neurosurgical requirements of a Level 2 facility must be met. If a surgical specialist is on staff but is never listed on the dashboard and does not respond to the ED for evaluation of patients, this does not apply.

**Section VII. (Medical Specialty Support) (L2, 3., 3.34, page 44) (L3, 3., 3.29, page 65) *Do Level II and III facilities that have family practice coverage “on-call and promptly available” also need Internal Medicine?***

Family Medicine may substitute for Internal Medicine at Level II and III facilities.

**Section VII. (Surgical Specialty Support) (L2, 3., 3.36, page 44) *In determining the 90% compliance for surgical specialists, what should be used to calculate the denominator?***

In determining 90%, the denominator should be any patient with ICD-9 codes applicable to OMFS (oral and maxillofacial surgery) or eye injury respectively to include registry eligible or non-eligible patients. The program is responsible for tracking the patient’s progress as an outpatient to ensure that they are treated locally. This list of patients must be available to review (along with the original trauma band number) during the site survey.

**Section VII. (Orthopedic Surgery Participation) (L3, 3., 3.9, page 63-64) *In determining if a facility has met the percentage requirements for orthopedic coverage, what should be used to calculate the numerator and denominator?***

The denominator should be all registry eligible trauma patients. The numerator should be all registry eligible trauma patients that were transferred for treatment at another facility.

**Section VII. (Neurosurgical Participation) (L1 & L2, 3., 3.20, page 43) (L3, 3., 3.17, page 64) (Intensive Care Unit (ICU)) (L1 & L2, 7., 7.12, 7.13, page 49) (L3, 3., 3.17, page 64) *The neurosurgical participation and intensive care unit sections of the Rules reference that a facility must document compliance to the Brain Trauma Foundation Guidelines. With this being a 116 page document, how does a trauma center document compliance?***

The program should create a Clinical Practice Management Guideline (CPMG) based on the one demonstrated at the 2014 Trauma Leadership Conference and based on the Brain Trauma Foundation Guidelines. Also, when a QI case involves neurosurgery, this should be the definitive reference for appropriate care unless there is conflicting evidence-based treatment identified by the providers involved.

**(Updated: 6/16/2015)**

**Section VII. (CME Requirements) (L1 & L2, 3., 3.5, 3.11, 3.17, page 42; 3., 3.32, page 43; 4., 4.10, page 45; 4., 4.14, page 46) (L3, 3., 3.5, page 63; 3., 3.19, 3.15, page 64; 3., 3.27, page 65; 4., 4.8, 4.12, page 66) (L4, 3., 3.4, page 82; 3., 3.8, page 83; 4., 4.5, 4.9, page 84) *What comprises the trauma-specific internal education requirement?***

A facility may develop an internal education program related to trauma to include but not limited to educational meetings, in-services, case-based learning, educational conferences, grand rounds, internal trauma symposia, in house publications, web based education, and provision of articles from the trauma literature to be read by participants. This has to be a documented educational experience, not a routine peer case review meeting. CME awarded should be commensurate with the time spent in the activity and in line with national standards for such education. The program is responsible for monitoring the individual’s participation in the program. This can be done through maintenance of

certification questions, email read receipts, etc., by the learner.

Note: Facilities must have copies of applicable CME certificates. In the case of review courses, the facility must be able to demonstrate how many of the total hours are trauma-related. With the new *Rules* in place since September 2014, six hours is required for the first year. After September 2015, all providers will need two years of CME (12 hours). From September 2016 forward, there will be no further proration of CME requirements. For the current four-year cycle surveys, all CME since the last site survey will be accepted to fulfill the 18-hour requirement. However, if a physician is prorating the CME, it must be during the time period described above.

**Section VII (Medical Specialty Report) (L1 & L2, 3., 3.34, page 44) *Level I and II trauma centers are required to have interventional radiology on-call and promptly available at the request of the trauma service. Is it required that we utilize the interventional radiology service?***

The requirement in the *Rules* is to have interventional radiology services available, but it does not stipulate its use.

**(Updated: 6/16/2015)**

**Section VII. (Trauma Educational Certification for Physicians and Mid-Level Practitioners) (L1 & L2, 4., 4.11, page 45) (L3, 4., 4.9, page 66) (L4, 4., 4.6, page 84) *Our facility has mid-level practitioners that take care of trauma patients. Would they be required to take ATLS?***

ATLS is required of mid-level practitioners who assist in trauma resuscitation or who are involved in the evaluation of ESI Level 1-3 patients. ATLS is also required of any mid-levels who ever perform the initial evaluation of a trauma patient on behalf of a surgical specialist. This expectation will apply at all levels of trauma centers.

Note: It is the facility's responsibility to have ATLS cards or documentation from the ACS that providers have met the requirements. ATLS grants CME. The hours of the course are applicable to the CME requirement if they are earned during the appropriate time period. Being current in ATLS does not obviate the need to meet the separate CME requirement.

**Section VII. (Trauma Nursing Educational Preparation) (L1 & L2, 4., 4.12, page 45) (L3, 4., 4.10, page 66) (L4, 4., 4.7, page 84) *What are the Health Department approved Trauma Nursing Life Support courses?***

Recommended courses for trauma life support courses: TNCC, ATCN, or TNATC. If someone has an alternate course they believe should qualify, they may come before the Hospital Committee and present a justification and the curriculum for the course for consideration.

**(Adopted 4/8/2015)**

**Section VII. (Nursing Trauma Continuing Education) (L1 & L2 4., 4.14, page 46) (L3, 4., 4.12 page 66) (L4 4., 4.9 page 84) *Does the TNCC course count towards the trauma-specific nursing continuing education (CE) requirement?***

Yes, the CE hours earned from TNCC will count towards the CE requirement for nurses during the review period.

This rule requires an average of 4 hours of nursing CE annually. TNCC is on a four year cycle but provides over 16 hours of CE so a nurse who is current in TNCC will also be considered to have met the continuing education requirement. Additional education regarding trauma care is strongly encouraged.

**(Adopted 4/8/2015)**

**Section VII (Activation Criteria) (L1 & L2, 4., 4.17 page 46) (L3, 4., 4.15 page 67) (L4, 4., 4.12 page 85) *Are there any exceptions to the criteria for activating the trauma team at the highest level of activation?***

The highest level of activation must require activation of the entire trauma team including the OR and the general surgeon on call. The only exceptions to this are a.) blunt force trauma with cardiac arrest (CPR in progress); b.) an isolated head injury with a GCS < 9 with a mechanism due to trauma (general surgeon response can be at the discretion of the ED physician) (for Levels I, II, and III); c.) an isolated head injury with a GCS < 13 with a mechanism due to trauma (general surgeon response, if provided, can be at the discretion of the ED physician) (for Level IV).

Respiratory distress attributed to trauma (if no other criteria for highest activation are met) does not require activation of the OR, but does require activation of the general surgeon on call. Activation of the general surgeon for hanging, drowning, and inhalation injury can be at the discretion of the Emergency Department (ED) physician.

**Section VII (Activation Criteria) (L1 & L2, 4., 4.20 page 46) (L3, 4., 4.18 page 67) (L4, 4., 4.17 page 85) *What are the expectations for over and under triage rates?***

Nationally, under triage rates are expected to be low (around 5-10%) in order to not miss patients with significant injuries. Over triage rates are higher (around 25 – 40%) for the same reason. It would be expected that a facility would be able to track these rates and have a mechanism in place to address issues of incorrect triage.

**Section VII (Activation Criteria) (L1 & L2, 4., 4.20 page 46) (L3 4., 4.18 page 67) (L4 4., 4.17 page 85) *How do I determine my over & under-triage rates?***

One method of calculating your over-triage and under-triage rates is the Matrix Method. (See below)

	Not Major Trauma	Major Trauma	Total	Over-triage percentage = $(A/C) \times 100$
Highest Level TTA	A	B	C	
Midlevel TTA	D	E	F	Under-triage percentage= $[(E+H) / (F+I)] \times 100$
No TTA	G	H	I	

**Section VII. (Rural Trauma Team Development Course (RTTDC)) (L3 4., 4.20 page 67) (L4 4., 4.19 page 85) *What defines a rural Level 3 facility?***

This information will be provided by the ADH trauma nurse coordinators whether a facility meets the rural status so that they can plan accordingly. The determination will be based on the population of the community and the service area.

**Section VII. (Post-Anesthesia Care Unit (PACU)) (L1 & L2, 6., 6.6 page 48) *Do PACU nurses have to be in-house 24/7 at Level I – III facilities? If not, what is the expectation of response time?***

No. They do not have to be in-house but available within 45 minutes from time of notification. The ability to use the ICU for recovery of trauma patients following operation can serve in place of the requirement for PACU availability. This should be tracked and monitored through the QI program.

**Section VII. (Blood Bank/Ability to Transfuse Blood 24/7) (L1 & L2, 8., 8.11 page 50) (L3, 8., 8.10, page 71) *What must be included in a massive transfusion protocol?***

The facility is required to have a policy. The policy should state the trigger and authority to activate the plan and the specific allocation of products. The best evidence now suggests that the protocol provide for a 1:1:1 ratio of cells: platelets: plasma. Pediatric facilities are expected to have a policy that is based on these principles and is weight-based for children.

**(Adopted 4/8/2015)**

**Section VII. (Blood Bank/Ability to Transfuse Blood 24/7) (L3, 8., 8.10, page 71) *For Level III facilities, do the platelets have to be kept in the facility to satisfy the requirements for the massive transfusion protocol?***

Taking the requirements as a whole for Level 3 facilities, there must be the ability to transfuse PRBCs, FFPs, and Platelets. There must be a policy that acknowledges the need for balanced transfusion and codifying how these products will be obtained. There is no requirement that platelets be kept in the facility. The department acknowledges that in some cases platelets may not be immediately available, but there should be a process in place so they are ordered and delivered in as timely a fashion as possible. If platelets are not available prior to transfer, the sending facility should notify the receiving facility of the need to continue a balanced resuscitation by providing platelets.

**(Adopted 4/8/2015)**

**Section VII. (Blood Bank/Ability to Transfuse Blood 24/7) (L4 6., 6.6-6.7, page 87-88) *For Level IV facilities, what should be available for the rapid reversal of anticoagulants?***

The only requirement for a Level 4 facility is that they have O negative PRBC available or be able to type and cross match blood on site. There is a requirement for a protocol regarding rapid reversal of anticoagulants but this does not mandate that the facility have FFPs, platelets, or Kcentra onsite. It would be appropriate that the protocol codify that patients on anticoagulants need to have coagulation studies done STAT. In the case of head injury, the patient needs a STAT CT. These patients should be rapidly evaluated so that transfer can be facilitated in a timely fashion. If reversal agents are not

available regionally, the policy should include a process for obtaining these products.

**Section VII. (Radiological Services Available 24/7) (L1 & L2 8., 8.14, page 50) *Can radiology residents count for any or all of these requirements?***

PGY – 3 or greater can fulfill the requirement for radiology coverage as long as there are staff over-reads of all films within 24 hours. A process of notification of over-read discrepancies must be in place and monitored by the PI program. Documentation of this should be available for the site survey.

**Section VII. (Appropriate Documentation of Patient Records for Transferred Patients) (L1 & L2, 9., 9.5, 9.6, page 52) (L3, 9., 9.5, 9.6, page 72-73) (L4, 7., 7.5, 7.6, page 88-89) *When a patient is being transferred, what are the requirements for sending x-ray and EMS run sheet reports?***

Copies of the original run sheet shall be sent to the receiving hospital no later than the next business day. Readings of x-ray studies shall be sent to the receiving facility as soon as available when requested.

**Section VII. (Audit Filters) (L1 & L2 10., 10.3 page 53) (L3 10., 10.3 page 73) (L4 8., 8.3 page 89) *What are the current Arkansas State QI audit filters?***

Currently, the only mandatory State QI filter is trauma death.

**Section VII. (Trauma-Specific QI Program) (L1 & L2, 10., 10.17, page 54) (L3, 10., 10.17, page 74) (L4, 8., 8.17, page 90) *When asked to benchmark process and outcome measures against national standards, what should be used as a guide?***

For Level I and II trauma centers you should benchmark process and outcome measures against your TQIP reports. Level III and IV trauma centers will not be required to participate in national benchmarking at this time.

**(Updated: 6/16/2015)**

**Section VII. (Multiple Sections) (L1 & L2, 3., 3.15, page 42; 3., 3.20, page 43; 7., 7.13 and 8., 8.4 - 8.5, page 49; ) (L3, 3., 3.14, page 64; 3., 3.17, page 64 (if neurosurgical coverage exists); 8., 8.4 - 8.5, page 70) (L4, 3., 3.11, page 83 (if orthopedic coverage exists); 6., 6.3-6.4, page 87) *What are the requirements for the Clinical Practice Management Guidelines (CPMG)?***

Hospitals must have CPMGs in the required areas. The facility may use the CPMGs as provided during the leadership conference as is, or may modify them to suit the particular needs of the program. If modification occurs, the program must have evidence-based published data to support the changes. The facility's CPMGs must be formally adopted by the program and compliance tracked through the program's QI program. Example: The trauma program at the hospital adopts a CPMG that all patients with open fractures should have Cefazolin within one hour of arrival in the ED. The program's QI program then should be able to identify all patients with open fractures and further identify which patients did and did not get the antibiotics in the prescribed time frame. Further, the program should have ongoing improvement efforts to bring compliance with the CPMG to an acceptable threshold.

For facilities that do not have orthopedic coverage, it is strongly recommended that a limited Open

Fracture CPMG exist to include the appropriateness and timing of intravenous antibiotics for all open fractures, with compliance tracked through the program's QI program.

For facilities that do not have neurosurgical coverage, it is strongly recommended that a limited Traumatic Brain Injury CPMG exist that includes the Tier One care guidelines, with compliance tracked through the program's QI program.

**Section VII. (Trauma Multidisciplinary Review Process (L1 & L2, 10., 10.30, 10.31, 10.34, page 55) (L3, 10., 10.31, 10.32, 10.35, page 75-76) (L4, 8., 8.30, 8.31, 8.34, page 91-92) *Are there attendance requirements for the multidisciplinary meetings? Who must attend?***

Trauma Program Operations Review Committee—the program is expected to set its own requirements for attendance to the trauma program operations review committee meeting and be able to track compliance. The ADH does not mandate what this should be.

Trauma Peer Review Committee—attendance should be at least 50% by the following services (if available in the facility)—TMD/TCMD, **all** core general surgeons, liaisons from: Emergency Medicine, Orthopedics, Neurosurgery, Anesthesia, Critical Care, and Radiology.

The facility may choose to hold these two meetings together; but, minutes and sign-in sheets must be kept separately for each meeting. The minutes of all QI activity should be documented and available for review at the time of the site survey.

**Section VII. (Accuracy of the Trauma Data Submitted to the Trauma Registry) (L1 & L2, 11., 11.6, page 55) (L3, 11., 11.6, page 76) (L4, 9., 9.6, page 92) *When entering data into the registry, what defines arrival time and departure time?***

Arrival time is defined as the time the patient presenting by ambulance or helicopter physically enters the emergency department. It does not apply to arrival on the helipad, or the EMS loading dock. For patients who are ambulatory and self-present, it is the time they are triaged in the ED. Similarly, departure time is the time that the patient physically leaves the department or the time of death.

**Section VII. (Active Participation in the Regional and State QI Review Process) (L1 & L2, 11., 11.9, 11.10, page 56) (Active Participation in the Regional and State Peer Review Process) (L3, 11., 11.9, 11.10, page 76) (L4, 9., 9.9, 9.10, page 92-93) *Can a TPM / TMD attend a required regional or state peer review meeting by phone when a case involving their facility is being discussed?***

No, they must attend in person. Occasional attendance by Tandberg is acceptable with the state or regional QI Committee Chair's prior approval.

**Section VII. (Active Participation in the Regional and State QI Review Process) (L1 & L2, 11., 11.9, page 56) (L3, 11., 11.9, page 76) (L4, 9., 9.9, page 92) *If a TRAC creates a membership for their QI meetings, what are the attendance requirements for the TMD and TPM of each trauma center?***

If a TRAC creates a —membership for the QI meetings, these meetings must also be open to all

stakeholders who sign the confidentiality agreement, and the TMD/TPM or their respective designee must attend at least 50% of the regional peer review meetings.

**(Updated: 6/23/2015)**

**Section X. (Rehabilitation Facilities) (B., page 99)** *Trauma centers that provide rehabilitation services are asked to report patients with spinal cord injuries (SCI) and any person having a traumatic brain injury (TBI) shall be reported to the Arkansas Spinal Cord Commission within five business days of identification of the above by the trauma center. How is this done?*

SCI Registry referrals are made by the social worker or the trauma coordinator in each hospital. These referrals can be called in (1-800-459-1517) or the form can be completed and faxed (501-296-1787). The SCI form and instructions can be found at [www.spinalcord.ar.gov](http://www.spinalcord.ar.gov) on the homepage at the bottom.

TBI Registry referrals are initiated by the social worker or the trauma coordinator/registrar and faxed to 1-501-296-1787 or emailed to [atrp-info@arkansas.gov](mailto:atrp-info@arkansas.gov). When the patient has discharged, the trauma coordinator/registrar finalizes the form and faxes it to 1-501-296-1787 or emails it to [atrp-info@arkansas.gov](mailto:atrp-info@arkansas.gov). The brain injury form and instructions for completion can be referenced at the following website [www.atrp.ar.gov](http://www.atrp.ar.gov). Go to the —About Us page and scroll down to the section on the TBI Registry.

Both forms are available on the ADH website at [www.healthy.arkansas.gov](http://www.healthy.arkansas.gov), under the Trauma Section, —Forms andResources, —Hospital Forms.

Note: Referrals are not needed for trauma patients with SCI or TBI that expire in the Emergency Department.