

**Title 15: Mississippi Department of Health
Part 12: Bureau of Emergency Medical Services
Subpart 32: Trauma System**

- Rule 2.2.1. Required Components: Level I trauma centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:
1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
 2. Trauma/General Surgery (In-house 24/hours). The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The 24 hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. This may allow the attending surgeon to take call from outside the hospital. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured patient. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. The surgeon on-call must be dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system must be developed to assure early notification of the on-call to any other hospital while on trauma call. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 20 minutes and starts at patient arrival or EMS notification, whichever is shorter.
 3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
 4. Neurologic Surgery. It is desirable to have the neurosurgeon dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

5. Anesthesia (In-house 24 hours/day) Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

6. The following specialists must be on-call and promptly available 24 hours/day:
 - a. Cardiac Surgery*
 - b. Cardiology
 - c. Critical Care Medicine
 - d. Hand Surgery
 - e. Infectious Disease
 - f. Microvascular Surgery
 - g. Nephrology
 - h. Nutritional Support
 - i. Obstetrics/Gynecologic Surgery
 - j. Ophthalmic Surgery
 - k. Oral/Maxillofacial
 - l. Pediatrics
 - m. Plastic Surgery
 - n. Pulmonary Medicine
 - o. Radiology
 - p. Thoracic Surgery*

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified cardiac/thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

7. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.
8. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 3.2.1. Required Components: Level II Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
2. Trauma/General Surgery. The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured patient. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. It is desirable that the on-call surgeon be dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system must be developed to assure early notification of the on-call to any other hospital while on trauma call. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.
3. Orthopedic Surgery. The orthopedic surgeons on the trauma team must be board certified. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum

response time for all trauma patients is 60 minutes from the time notified to respond.

4. Neurologic Surgery. The neurosurgeons on the trauma team must be board certified. It is desirable to have the neurosurgeon dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
5. Anesthesia (In-house 24 hours/day) Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
6. The following specialists must be on-call and promptly available 24 hours/day:
 - a. Critical Care Medicine
 - b. Hand Surgery
 - c. Infectious Disease
 - d. Microvascular Surgery
 - e. Obstetrics/Gynecologic Surgery
 - f. Ophthalmic Surgery
 - g. Oral/Maxillofacial
 - h. Plastic Surgery
 - i. Radiology
 - j. Thoracic Surgery*

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is

not the case, the facility should have a board-certified thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

7. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.
8. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 4.2.1. Required Components: Level III Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
2. Trauma/General Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is sooner. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.
3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
4. Anesthesia. Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

5. The following specialists must be on-call and promptly available 24 hours/day:
Radiology
6. It is desirable (although not required) to have the following specialist available to a Level III Trauma Center:
 - a. Hand Surgery
 - b. Obstetrics/Gynecology Surgery
 - c. Ophthalmic Surgery
 - d. Oral/Maxillofacial Surgery
 - e. Plastic Surgery
 - f. Critical Care Medicine
 - g. Thoracic Surgery*
 - h. Microvascular Surgery

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available (within 30 minutes of the time notified to respond).
7. The staff specialist on-call will be notified at the discretion of the trauma surgeon and will be promptly available. The PI program will continuously monitor this availability.
8. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.1. General

1. Tertiary Pediatric Trauma Centers shall act as regional tertiary care facilities at the hub of the trauma care system for injured pediatric patients. The facility shall have the ability to provide leadership and total care for every aspect of injury from prevention to rehabilitation. The Tertiary Pediatric Trauma Center must have adequate depth of resources and personnel.
2. A stand-alone Pediatric Trauma Center provides tertiary pediatric trauma care without sharing resources with another facility (i.e., CT scanner, radiology, surgeons, etc).

Only Level I Trauma Centers and Stand-alone pediatric hospitals may qualify as a tertiary Pediatric Trauma Center.

3. The Tertiary Pediatric Trauma Centers have the responsibility of providing leadership in pediatric trauma education, trauma prevention, pediatric trauma research, and system planning.
4. The list of required equipment for Tertiary Pediatric Trauma Centers can be found on-line at <http://msdh.ms.gov/msdhsite/static/49.html>.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.9. Required Clinical Components

1. Tertiary pediatric trauma centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:
2. Pediatric Emergency Medicine (in-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival. The ED liaison on the trauma team must be board certified, maintain 48 hours of trauma related CME over a three year period, and must maintain current ATLS certification. The liaison must attend a minimum of 50% of peer review committee meetings annually and must participate in the Multidisciplinary Trauma Committee.
3. Trauma/General/Pediatric Surgery (in-house 24 hours/day). The surgeon covering pediatric trauma call must be unencumbered and immediately available to respond to the pediatric trauma patient. The 24 hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. The surgeon is expected to be in the ED upon arrival of the seriously injured pediatric patient. The surgeon's participation in major therapeutic decisions, presence in the ED for major resuscitation, and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. The surgeon on-call must be dedicated to the trauma center and not on-call at any other hospital while on trauma call. A system must be developed to assure early notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. The surgery liaison on the trauma team must be board certified, maintain 48 hours of trauma related CME over a three year period, and must maintain current ATLS certification. The liaison must attend a minimum of 50% of peer review committee meetings annually and must participate in the Multidisciplinary Trauma Committee. Response time for Alpha Alert/Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 20 minutes from patient arrival.

4. Orthopedic Surgery. The pediatric orthopedic liaison on the pediatric trauma team must be board certified, maintain 48 hours of trauma related CME over 3 years, and it is desirable to maintain current ATLS certification. The orthopedic liaison to the pediatric trauma team must attend a minimum of 50% of the peer review committees annually and participate in the Multidisciplinary Trauma Committee. It is desirable to have the orthopedic surgeon dedicated to the pediatric trauma center solely while on-call, but if not dedicated, a published back-up call schedule must be available. Response time for all trauma activations is 60 minutes from the time notified to respond.
5. Neurological Surgery. The neurosurgeons on the pediatric trauma team must be board certified. The pediatric neurosurgery liaison must maintain 48 hours of trauma related CME over 3 years, and it is desirable to maintain current ATLS certification. The pediatric neurosurgeon liaison to the pediatric trauma team must attend a minimum of 50% of the peer review committees annually and participate in the Multidisciplinary Trauma Committee. It is desirable to have the neurosurgeon dedicated to the pediatric trauma center solely while on-call, but if not dedicated, a published back-up call schedule must be available. Response time for all trauma activations is 60 minutes from the time notified to respond.
6. Anesthesia (in-house 24 hours/day). Anesthesia must be available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or certified nurse anesthetist (CRNA) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
7. The following specialists must be committed to pediatric trauma care, on-call and promptly available 24 hours/day:
 - a. Cardiac Surgery
 - b. Cardiology
 - c. Critical Care Medicine
 - d. Hand Surgery
 - e. Infectious Disease
 - f. Microvascular Surgery

- g. Nephrology
- h. Nutritional support
- i. Obstetrics/Gynecologic Surgery
- j. Ophthalmic Surgery
- k. Oral/Maxillofacial
- l. Pediatrics
- m. Pediatric Critical Care Medicine
- n. Pediatric Rehabilitation
- o. Plastic Surgery
- p. Pulmonary Medicine
- q. Radiology
- r. Thoracic Surgery*
- s. Child Life or Family Support Programs

* The trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to pediatric patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available for the injured pediatric patient (within 30 minutes of the time notified to respond).

- 8. Recognizing that early rehabilitation is imperative for the pediatric trauma patient, a physical medicine and pediatric rehabilitation specialist must be available for the pediatric trauma team.
- 9. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.1. General

- 1. A secondary pediatric trauma center is an acute care facility with the commitment, medical staff, personnel and specialty training necessary to provide initial resuscitation of the pediatric trauma patient. Pediatric patients should remain at the

- secondary pediatric trauma center only for orthopedic injuries. The decision to transfer a pediatric patient rests with the physician attending the pediatric trauma patient. All secondary pediatric trauma centers will work collaboratively with other trauma facilities to develop transfer protocols and a well-defined transfer sequence.
2. As a minimum, only Level III or higher adult trauma centers may qualify as a Secondary Pediatric Trauma Center. All pediatric trauma admissions will be reviewed by the PI process.
 3. The list of required equipment for Secondary Pediatric Trauma Centers can be found on-line at <http://msdh.ms.gov/msdhsite/static/49.html>.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.9. Required Clinical Components

1. Secondary pediatric trauma centers must have published on-call schedules and have the following medical specialists immediately available 24 hours/day to the injured pediatric patient:
 2. Pediatric Emergency Medicine (in-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
 3. Trauma/General or Pediatric Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the pediatric trauma center and not on-call to any other hospital while on pediatric trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.
 4. Orthopedic Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the pediatric trauma center and not on-call to any other hospital while on pediatric trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for all trauma activations is 60 minutes from the time notified to respond.
 5. Anesthesia. Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be available 24 hours/day. Anesthesia chief residents or certified nurse anesthetist (CRNA) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all

- operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
6. The following specialists must be on-call and promptly available:
 - a. Pediatrics
 - b. Radiology
 7. It is desirable (although not required) to have the following specialists available to the secondary pediatric trauma center:
 - a. Hand Surgery
 - b. Obstetrics/Gynecology Surgery
 - c. Ophthalmic Surgery
 - d. Oral/Maxillofacial Surgery
 - e. Plastic Surgery
 - f. Critical Care Medicine
 - g. Thoracic Surgery*

* The trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to pediatric patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available for the injured pediatric patient (within 30 minutes of the time notified to respond).
 8. The staff specialist on-call will be notified at the discretion of the trauma surgeon and will be promptly available. The PI program will continuously monitor this availability.
 9. Policies and procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.1. General: Primary pediatric trauma centers are facilities with a commitment to the resuscitation of the pediatric trauma patient and have written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred. All designated Trauma Centers shall, as a minimum, be designated as a Primary Pediatric Trauma Center as a condition of designation in the Mississippi Trauma Care System. The list of required equipment for Primary Pediatric Trauma Centers can be found on-line at <http://msdh.ms.gov/msdhsite/static/49.html>.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.1. General: The burn center must be an acute care facility licensed in Mississippi. The burn center must have a medical and an administrative commitment to the care of patients with burns. There must be a written commitment on behalf of the entire facility to the organization of burn care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. The burn center must have written guidelines for the triage, treatment, and transfer of burned patients from other facilities. The burn center must maintain an organizational chart relating personnel within the burn center and the hospital. The burn center must maintain current accreditation by the Joint Commission (TJC) or other recognized accrediting organization(s). The list of required equipment for Burn Centers can be found on-line at <http://msdh.ms.gov/msdhsite/static/49.html>.

Source: Miss. Code Ann. § 41-59-5

APPENDIX B - CONSOLIDATED TRAUMA ACTIVATION CRITERIA AND DESTINATION GUIDELINES

A
L
P
H
A

MEASURE VITAL SIGNS AND LEVEL OF CONCIIOUSNESS
ASSESS ANATOMY OF INJURY

- Glasgow Coma Scale \leq 13 (secondary to trauma)
- Systolic Blood Pressure (SBP):
 - < 1 month old with SBP < 60 mmHg,
 - 1 month to 1 year old with SPB < 70 mmHg,
 - 1 year to 10 years old with SBP < 70 mmHg + (2 times age in years),
 - > 10 years old with SBP < 90 mmHg,
- Respiratory Rate (RR):
 - < 16 years old: Respiratory distress or signs of impending respiratory failure including airway obstruction or intubation in the field.
 - \geq 16 years old: Respiratory Rate <10 or >29 breaths/ minute, or need for ventilation support.
- Children < 16 years with burns > 20% BSA
- ALL penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
- Chest wall instability or deformity (e.g., flail chest)
- Two or more proximal long bone fractures
- Crushed, degloved, mangled or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures (suspected or confirmed)
- Open or depressed skull fracture
- Paralysis (secondary to trauma)
- EMS/Health Provider Judgment

YES

The following indicators warrant transport to the closest hospital:

- Cardiac arrest
- Unsecured/non-patent airway
- EMS Provider safety.

Consider use of air transport based on patient condition, weather, and availability of aircraft.

PATIENTS < 16 YEARS OLD:
Transport to a Tertiary or Secondary Pediatric Trauma Center as appropriate for injuries.

PATIENTS \geq 16 YEARS OLD:
Transport to a Level I, II or III Trauma Center as appropriate for injuries.

NOTIFY RECEIVING FACILITY (OR APPROPRIATE POINT OF CONTACT) AS EARLY AS POSSIBLE.

NO

Assess mechanism of injury and evidence of high-energy impact

B
R
A
V
O

- Falls
 - Patients < 16 years: falls greater than 10 feet or 2-3 times the height of the child
 - Patients \geq 16 years: falls > 20 ft. (one story is equal to 10 ft.)
- High Risk MVC
 - Intrusion, including roof: > 12 inches occupant site; > 18 inches any site
 - Ejection (partial or complete) from automobile
 - Death in same passenger compartment
- Auto vs. Pedestrian/Bicyclist (separated from mode of transport with significant impact)
- Motorcycle/ATV/other motorized vehicle crash > 20 mph
- Burns related to traumatic mechanism
- Pregnancy > 20 weeks (secondary to trauma)
- EMS/Health Provider Judgment

YES

PATIENTS < 16 YEARS OLD:
Transport to a TERTIARY OR SECONDARY PEDIATRIC TRAUMA CENTER as appropriate for injuries.

PATIENTS \geq 16 YEARS OLD:
Transport to a Level I, II or III Trauma Center as appropriate for injuries.

NOTIFY RECEIVING FACILITY (OR APPROPRIATE POINT OF CONTACT) AS EARLY AS POSSIBLE.

NO

Transport according to local EMS protocol
(consider contacting Medical Control)

- SPECIAL CONSIDERATIONS:
- Patients > 55 years are at increased risk of injury/death.
 - Systolic blood pressure < 110 mmHg in patients > 65 years may represent shock
 - Anticoagulants and bleeding disorders

If there is any question concerning appropriate patient destination, or if requested by the patient or another person to deviate from this protocol, **CONTACT MEDICAL CONTROL**

Title 15: Mississippi Department of Health
Part 12: Bureau of Emergency Medical Services
Subpart 32: Trauma System

- Rule 2.2.1. Required Components: Level I trauma centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:
1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
 2. Trauma/General Surgery (In-house 24/hours). The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The 24 hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. This may allow the attending surgeon to take call from outside the hospital. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured patient. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. The surgeon on-call must be dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system must be developed to assure early notification of the on-call to any other hospital while on trauma call. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 20 minutes and starts at patient arrival or EMS notification, whichever is shorter.
 3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
 4. Neurologic Surgery. It is desirable to have the neurosurgeon dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

5. Anesthesia (In-house 24 hours/day) Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

6. The following specialists must be on-call and promptly available 24 hours/day:
 - a. Cardiac Surgery*
 - b. Cardiology
 - c. Critical Care Medicine
 - d. Hand Surgery
 - e. Infectious Disease
 - f. Microvascular Surgery
 - g. Nephrology
 - h. Nutritional Support
 - i. Obstetrics/Gynecologic Surgery
 - j. Ophthalmic Surgery
 - k. Oral/Maxillofacial
 - l. Pediatrics
 - m. Plastic Surgery
 - n. Pulmonary Medicine
 - o. Radiology
 - p. Thoracic Surgery*

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified cardiac/thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

7. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.
8. ~~Policies~~ Policies and conditions procedures should exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 3.2.1. Required Components: Level II Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
2. Trauma/General Surgery. The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured patient. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. It is desirable that the on-call surgeon be dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system must be developed to assure early notification of the on-call to any other hospital while on trauma call. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.
3. Orthopedic Surgery. The orthopedic surgeons on the trauma team must be board certified. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum

response time for all trauma patients is 60 minutes from the time notified to respond.

4. Neurologic Surgery. The neurosurgeons on the trauma team must be board certified. It is desirable to have the neurosurgeon dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
5. Anesthesia (In-house 24 hours/day) Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
6. The following specialists must be on-call and promptly available 24 hours/day:
 - a. Critical Care Medicine
 - b. Hand Surgery
 - c. Infectious Disease
 - d. Microvascular Surgery
 - e. Obstetrics/Gynecologic Surgery
 - f. Ophthalmic Surgery
 - g. Oral/Maxillofacial
 - h. Plastic Surgery
 - i. Radiology
 - j. Thoracic Surgery*

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is

not the case, the facility should have a board-certified thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

7. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.
8. ~~Policies~~ Policies and procedures should exist to notify the ~~patient's primary physician~~ transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 4.2.1. Required Components: Level III Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
2. Trauma/General Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is sooner. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.
3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
4. Anesthesia. Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

5. The following specialists must be on-call and promptly available 24 hours/day:
Radiology
6. It is desirable (although not required) to have the following specialist available to a Level III Trauma Center:
 - a. Hand Surgery
 - b. Obstetrics/Gynecology Surgery
 - c. Ophthalmic Surgery
 - d. Oral/Maxillofacial Surgery
 - e. Plastic Surgery
 - f. Critical Care Medicine
 - g. Thoracic Surgery*
 - h. Microvascular Surgery

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

7. The staff specialist on-call will be notified at the discretion of the trauma surgeon and will be promptly available. The PI program will continuously monitor this availability.
8. ~~Policies~~ Policies and procedures should exist to notify the ~~patient's primary physician~~ transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.1. General

1. Tertiary Pediatric Trauma Centers shall act as regional tertiary care facilities at the hub of the trauma care system for injured pediatric patients. The facility shall have the ability to provide leadership and total care for every aspect of injury from prevention to rehabilitation. The Tertiary Pediatric Trauma Center must have adequate depth of resources and personnel.
2. A stand-alone Pediatric Trauma Center provides tertiary pediatric trauma care without sharing resources with another facility (i.e., CT scanner, radiology, surgeons, etc).

Only Level I Trauma Centers and Stand-alone pediatric hospitals may qualify as a tertiary Pediatric Trauma Center.

3. The Tertiary Pediatric Trauma Centers have the responsibility of providing leadership in pediatric trauma education, trauma prevention, pediatric trauma research, and system planning.
4. The list of required equipment for Tertiary Pediatric Trauma Centers can be found on-line at <http://msdh.ms.gov/msdhsite/static/49.html>.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.9. Required Clinical Components

1. Tertiary pediatric trauma centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:
2. Pediatric Emergency Medicine (in-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival. The ED liaison on the trauma team must be board certified, maintain 48 hours of trauma related CME over a three year period, and must maintain current ATLS certification. The liaison must attend a minimum of 50% of peer review committee meetings annually and must participate in the Multidisciplinary Trauma Committee.
3. Trauma/General/Pediatric Surgery (in-house 24 hours/day). The surgeon covering pediatric trauma call must be unencumbered and immediately available to respond to the pediatric trauma patient. The 24 hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. The surgeon is expected to be in the ED upon arrival of the seriously injured pediatric patient. The surgeon's participation in major therapeutic decisions, presence in the ED for major resuscitation, and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. The surgeon on-call must be dedicated to the trauma center and not on-call at any other hospital while on trauma call. A system must be developed to assure early notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. The surgery liaison on the trauma team must be board certified, maintain 48 hours of trauma related CME over a three year period, and must maintain current ATLS certification. The liaison must attend a minimum of 50% of peer review committee meetings annually and must participate in the Multidisciplinary Trauma Committee. Response time for Alpha Alert/Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 20 minutes from patient arrival.

4. Orthopedic Surgery. The pediatric orthopedic liaison on the pediatric trauma team must be board certified, maintain 48 hours of trauma related CME over 3 years, and it is desirable to maintain current ATLS certification. The orthopedic liaison to the pediatric trauma team must attend a minimum of 50% of the peer review committees annually and participate in the Multidisciplinary Trauma Committee. It is desirable to have the orthopedic surgeon dedicated to the pediatric trauma center solely while on-call, but if not dedicated, a published back-up call schedule must be available. Response time for all trauma activations is 60 minutes from the time notified to respond.
5. Neurological Surgery. The neurosurgeons on the pediatric trauma team must be board certified. The pediatric neurosurgery liaison must maintain 48 hours of trauma related CME over 3 years, and it is desirable to maintain current ATLS certification. The pediatric neurosurgeon liaison to the pediatric trauma team must attend a minimum of 50% of the peer review committees annually and participate in the Multidisciplinary Trauma Committee. It is desirable to have the neurosurgeon dedicated to the pediatric trauma center solely while on-call, but if not dedicated, a published back-up call schedule must be available. Response time for all trauma activations is 60 minutes from the time notified to respond.
6. Anesthesia (in-house 24 hours/day). Anesthesia must be available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or certified nurse anesthetist (CRNA) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
7. The following specialists must be committed to pediatric trauma care, on-call and promptly available 24 hours/day:
 - a. Cardiac Surgery
 - b. Cardiology
 - c. Critical Care Medicine
 - d. Hand Surgery
 - e. Infectious Disease
 - f. Microvascular Surgery

- g. Nephrology
- h. Nutritional support
- i. Obstetrics/Gynecologic Surgery
- j. Ophthalmic Surgery
- k. Oral/Maxillofacial
- l. Pediatrics
- m. Pediatric Critical Care Medicine
- n. Pediatric Rehabilitation
- o. Plastic Surgery
- p. Pulmonary Medicine
- q. Radiology
- r. Thoracic Surgery*
- s. Child Life or Family Support Programs

* The trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to pediatric patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available for the injured pediatric patient (within 30 minutes of the time notified to respond).

- 8. Recognizing that early rehabilitation is imperative for the pediatric trauma patient, a physical medicine and pediatric rehabilitation specialist must be available for the pediatric trauma team.
- 9. Policies and procedures should exist to notify the patient's primary physician transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.1. General

- 1. A secondary pediatric trauma center is an acute care facility with the commitment, medical staff, personnel and specialty training necessary to provide initial resuscitation of the pediatric trauma patient. Pediatric patients should remain at the

secondary pediatric trauma center only for orthopedic injuries. The decision to transfer a pediatric patient rests with the physician attending the pediatric trauma patient. All secondary pediatric trauma centers will work collaboratively with other trauma facilities to develop transfer protocols and a well-defined transfer sequence.

2. As a minimum, only Level III or higher adult trauma centers may qualify as a Secondary Pediatric Trauma Center. All pediatric trauma admissions will be reviewed by the PI process.
3. The list of required equipment for Secondary Pediatric Trauma Centers can be found on-line at <http://msdh.ms.gov/msdhsite/static/49.html>.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.9. Required Clinical Components

1. Secondary pediatric trauma centers must have published on-call schedules and have the following medical specialists immediately available 24 hours/day to the injured pediatric patient:
2. Pediatric Emergency Medicine (in-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
3. Trauma/General or Pediatric Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the pediatric trauma center and not on-call to any other hospital while on pediatric trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.
4. Orthopedic Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the pediatric trauma center and not on-call to any other hospital while on pediatric trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for all trauma activations is 60 minutes from the time notified to respond.
5. Anesthesia. Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be available 24 hours/day. Anesthesia chief residents or certified nurse anesthetist (CRNA) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all

- operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
6. The following specialists must be on-call and promptly available:
 - a. Pediatrics
 - b. Radiology
 7. It is desirable (although not required) to have the following specialists available to the secondary pediatric trauma center:
 - a. Hand Surgery
 - b. Obstetrics/Gynecology Surgery
 - c. Ophthalmic Surgery
 - d. Oral/Maxillofacial Surgery
 - e. Plastic Surgery
 - f. Critical Care Medicine
 - g. Thoracic Surgery*

* The trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to pediatric patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available for the injured pediatric patient (within 30 minutes of the time notified to respond).
 8. The staff specialist on-call will be notified at the discretion of the trauma surgeon and will be promptly available. The PI program will continuously monitor this availability.
 9. Policies and procedures should exist to notify the patient's primary physician transferring hospital of the patient's condition at an appropriate time.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.1. General: Primary pediatric trauma centers are facilities with a commitment to the resuscitation of the pediatric trauma patient and have written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred. All designated Trauma Centers shall, as a minimum, be designated as a Primary Pediatric Trauma Center as a condition of designation in the Mississippi Trauma Care System. The list of required equipment for Primary Pediatric Trauma Centers can be found on-line at <http://msdh.ms.gov/msdhsite/static/49.html>.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.1. General: The burn center must be an acute care facility licensed in Mississippi. The burn center must have a medical and an administrative commitment to the care of patients with burns. There must be a written commitment on behalf of the entire facility to the organization of burn care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. The burn center must have written guidelines for the triage, treatment, and transfer of burned patients from other facilities. The burn center must maintain an organizational chart relating personnel within the burn center and the hospital. The burn center must maintain current accreditation by the Joint Commission (TJC) or other recognized accrediting organization(s). The list of required equipment for Burn Centers can be found on-line at <http://msdh.ms.gov/msdhsite/static/49.html>.

Source: Miss. Code Ann. § 41-59-5

Appendix B—Consolidated Trauma Activation Criteria and Destination Guidelines

