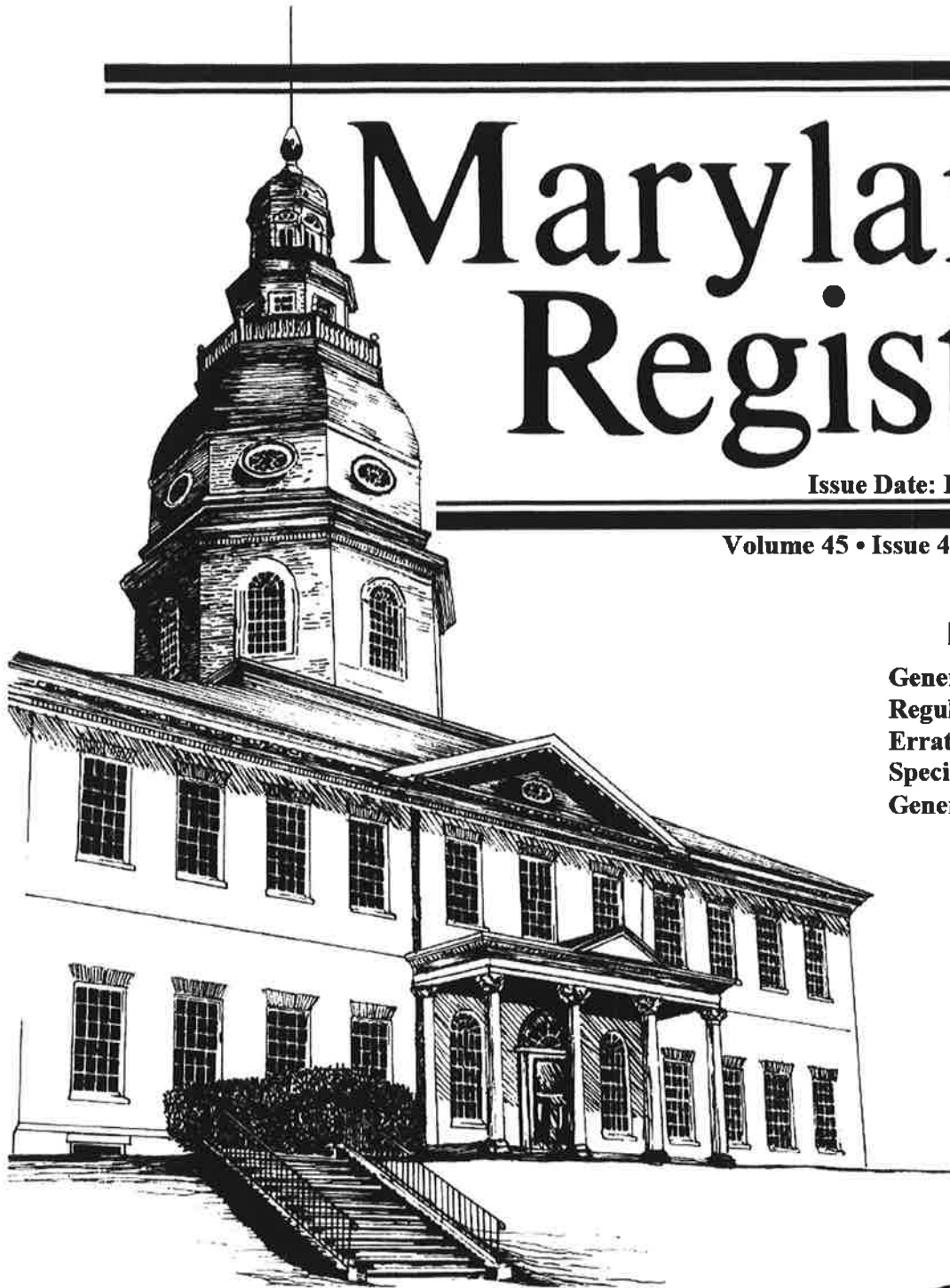

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IN THIS ISSUE

General Assembly
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Pursuant to State Government Article, §7-206, Annotated Code of Maryland, this issue contains all previously unpublished documents required to be published, and filed on or before January 29, 2018, 5 p.m.

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, I hereby certify that this issue contains all documents required to be codified as of January 29, 2018.

Gail S. Klakring
Administrator, Division of State Documents
Office of the Secretary of State



Title 30
MARYLAND INSTITUTE
FOR EMERGENCY
MEDICAL SERVICES
SYSTEMS (MIEMSS)
Subtitle 08 DESIGNATION OF
TRAUMA AND SPECIALTY
REFERRAL CENTERS

Notice of Proposed Action
 [18-044-P]

The State Emergency Medical Services Board proposes to:

(1) Amend Regulation .02 under COMAR 30.08.01 General Provisions; and

(2) Repeal existing Regulations .03—.19, adopt new Regulations .03—.22, and recodify existing Regulations .20 and .21 to be Regulations .23 and .24 under COMAR 30.08.05 Trauma Center Designation and Verification Standards.

This action was considered at the Board's regular meeting on September 12, 2017.

Statement of Purpose

The purpose of this action is to update the standards for designation of Trauma Centers in Maryland, to take effect July 1, 2018.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Carole Mays, Director, Trauma and Injury Specialty Care Program, MIEMSS, 653 West Pratt Street, Baltimore, Maryland, 21201, or call 410-706-3932, or email to cmays@miemss.org, or fax to 410-706-4768. Comments will be accepted through March 19, 2017. A public hearing has not been scheduled.

30.08.01 General Provisions

Authority: Education Article, §13-509, Annotated Code of Maryland

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

(2) "Advanced Burn Life Support [(ABLS™)] (ABLS®)" means a course developed and approved by the American Burn Association.

(2-1) "Advanced Pediatric Life Support (APLS®)" means a course developed and approved by the American Academy of

Pediatrics (AAP) and American College of Emergency Physicians (ACEP).

(2-2) "Advanced Practice Professionals (APPs)" are non-physicians that are educated at an advanced level to provide patient care in a range of settings; they include Nurse Practitioners (NPs), Nurse Anesthetists, Midwives, Clinical Nurse Specialists (CNS) and Physician Assistants (PAs).

(3) "Advanced Trauma Life Support [(ATLS™)] (ATLS®)" means a course developed and approved by the American College of Surgeons.

(4)—(11) (text unchanged)

(12) "Burn Center" means an Adult or Pediatric Burn Center in Maryland unless otherwise indicated.

(13)—(15) (text unchanged)

(16) "Bypass" means the diversionary status of a trauma or specialty referral center [which is on diversionary status] that is requested and identified in the County/Hospital Alert Tracking System (CHATS) in accordance with a MIEMSS or regional program due to a lack of staff, facilities, or equipment.

(16-1) "Continuing Education (CE)" means education provided for adults after they have left the formal education system consisting of short or part-time courses that brings participants up to date in a particular area of knowledge or skills.

(17) "Continuing [medical education] Medical Education (CME)" means training approved by the Accreditation Council of Continuing Medical Education or accredited by a state medical society recognized by [this] that Council.

(18)—(27) (text unchanged)

(27-1) "Emergent Consultation" means a physician consultation required for evaluation of known or potentially unstable injuries, injuries requiring time sensitive surgical interventions, or other reasons as determined and documented by the attending trauma, or general surgeon, or ED attending physician.

(28)—(40) (text unchanged)

(41) "Level I trauma center" means [a university-affiliated hospital with a comprehensive residency program in trauma care and trauma research which] a hospital that:

(a) [meets] Meets the Level I trauma center standards in COMAR 30.08.05[.]; and

(b) Is designated by MIEMSS and approved by the EMS Board.

(42) "Level II trauma center" means a hospital [with 24-hour, in-house, surgical coverage, with a defined trauma program and trauma services, which] that:

(a) [meets] Meets the Level II trauma center standards in COMAR 30.08.05[.]; and

(b) Is designated by MIEMSS and approved by the EMS Board.

(43)—(46) (text unchanged)

[(47) "Maryland EMS Quality Leadership Council" means the quality management council appointed by the Executive Director to coordinate, develop, and utilize resources to improve the State's emergency medical system.] "Maryland Trauma Registry Data Dictionary for Adult Patients" means the listing of data inclusion criteria, data elements and audit filters to be collected on patients with traumatic injuries treated in a Maryland Trauma Center which is incorporated by reference in COMAR 30.01.02.01(B)(2).

(48) (text unchanged)

(49) Most Critical Patients.

(a) "Most critical patients" means those patients who:

(i) Have confirmed BP < 90 mmHg at any time in adults and age-specific hypotension,

(ii) Have GSW to the head, neck, chest, or abdomen attributed to trauma,

- (iii) *Have a GCS score <9 with mechanism attributed to trauma,*
- (iv) *Are transferred from other hospitals receiving blood or vasoactives to maintain vital signs,*
- (v) *Are intubated and transferred from the scene, or*
- (vi) *Have a respiratory compromise or are in need of an emergent airway, including intubated patients who are transferred from another facility with ongoing respiratory compromise.*
- (b) *"Most critical patients" includes those patients who*
 - (i) *Are intubated and are currently stable from a respiratory standpoint,*
 - (ii) *Have a tourniquet or pelvic binder applied,*
 - (iii) *Are currently in Cardiac arrest or receiving CPR,*
 - (iv) *Have presence of motor paralysis,*
 - (v) *Have an amputation proximal to the ankle or wrist,*
 - (vi) *Have Hypoxia as evidenced by saturation <90 percent,*
 - (vii) *Have uncontrolled external hemorrhage, or*
 - (viii) *Penetrating torso injury with evisceration.*
- (50) (text unchanged)
- (51) *"Multiple [casualty] Casualty Incident (MCI)" means two or more injured people requiring emergency care simultaneously.*
- (51-1) *"National Trauma Data Bank (NTDB)" means is an American College of Surgeons (ACS) is an aggregated trauma registry of standardization of key trauma data elements for research and improving care for the surgical patient.*
- (52)—(57) (text unchanged)
- (58) *"On-call" means committed for a specific time period to be available and respond within [an agreed] the specific amount of time to provide care for a patient in the hospital.*
- (59)—(65) (text unchanged)
- (66) *"Pediatric Advanced Life Support [(PALS™)] (PALS®)" means a pediatric resuscitation course developed and approved by the American Heart Association.*
- (66-1)—(72) (text unchanged)

- (73) *"Primary Adult Resource Center (PARC)" means a comprehensive trauma program, including a dedicated trauma care facility, dedicated staff and services, and designated, specialized, advanced training and research programs, which meets the PARC standards in COMAR 30.08.05 and which, in Maryland, is [legislated to be] defined in statute as the R Adams Cowley Shock Trauma Center.*
- (74)—(75) (text unchanged)
- (76) *"Quality management [plan] (QM)" means [a written plan for] the quality management of trauma and specialty care services.*
- (77)—(92) (text unchanged)
- (92-1) *"Trauma Quality Improvement Committee (TQIC)" is a medical review committee established by MIEMSS as an advisory body for quality issue and evaluation affecting the care of trauma patients and the Maryland Trauma System. The TQIC will address issues primarily related to the system-wide delivery of trauma care across the continuum (pre-hospital care to discharge from the trauma center) identifying performance improvement activities and indicators to support resolution strategies.*
- (93) *"Trauma [resuscitation team] Resuscitation Team" means a group of trauma trained health care providers [organized to provide trauma care to the trauma patient in a coordinated and timely fashion] required to be present at the patient's bedside following trauma team activation. The minimum team requirements for all levels of activation include: Trauma Attending/General Surgeon/PGY4/APP, ED Lead Physician, ED RN's, and a Recorder/Documenter. The highest level of response requires, at a minimum, the Trauma Resuscitation Team, an Anesthesiologist or CRNA (as per institutional-specific criteria), and Respiratory Therapy.*
- (93-1) *"Trauma Service" means a group of trauma-trained physicians that are responsible for the initial resuscitation and care of the trauma patient, including Trauma/General Surgeon, Emergency Medicine, Neurosurgery, and Orthopedic Surgery.*
- (94)—(97) (text unchanged)

30.08.05 Trauma Center Designation and Verification Standards

Authority: Education Article, §13-509, Annotated Code of Maryland

.03 Organization.

	PARC	I	II	III	ED
<i>A. A hospital's board of directors, administration, and medical and nursing staffs shall demonstrate commitment to the optimal care of injured patients by:</i>					
<i>(1) Formulating a board of director's resolution stating that:</i>	E	E	E	E	E
<i>(a) The hospital agrees to meet the Trauma Center designation standards for the hospital's specific level of designation;</i>	E	E	E	E	E
<i>(b) The hospital has a commitment to the infrastructure and the financial, human, and physical resources necessary to support the hospital's specific level of designation; and</i>	E	E	E	E	E
<i>(c) The hospital has a commitment to the Quality Management (QM) process of the trauma patient; and</i>	E	E	E	E	E
<i>(2) Establishing an identifiable program whose dedication to the care of the injured is shown in:</i>					
<i>(a) Its mission statement;</i>	E	E	E	E	NA
<i>(b) The configuration of its medical, administrative, and support staffs;</i>	E	E	E	E	NA
<i>(c) The configuration of its physical plant;</i>	E	E	E	E	NA
<i>(d) Demonstrated participation and involvement in state and regional trauma system planning, development, and operations required for all designated Trauma Centers;</i>	E	E	E	E	E
<i>(e) Assurance that all trauma patients receive medical care commensurate with the level of the hospital's designation; and</i>	E	E	E	E	E
<i>(f) Demonstrated commitment to the infrastructure and financial, human, and physical resources necessary to support the hospital's level of trauma center designation through the hospital's bylaws, contracts, and budget specific to the trauma program;</i>	E	E	E	E	E

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B. A hospital shall be licensed by the Department of Health as an acute care hospital.	E	E	E	E	E
C. A hospital shall be accredited by The Joint Commission.	E	E	E	E	E
D. A hospital shall maintain current equipment and technology to support optimal trauma care for the level of the hospital's Trauma Center designation.	E	E	E	E	E
E. A hospital shall have:					
(1) A heliport or helipad positioned so there is a limited distance from the helipad to the hospital, and positioned at the closest safe location, in order to minimize effects to the patient; or	E	E	E	E	NA
(2) Access to a helicopter-landing zone near the hospital.	NA	NA	NA	NA	E
F. To administer the trauma program, a hospital shall have a trauma leadership team that includes:					
(1) A Trauma Medical Director (TMD) who:	E	E	E	E	D
(a) Has administrative oversight for the trauma program;					
(b) With the Trauma Program Manager (TPM), has the authority and is empowered by the hospital's governing body to lead the trauma program;					
(c) Has the authority and scope for administering all aspects of trauma care and is responsible for overall clinical coordination;					
(d) Is responsible for all trauma patients through the QM process;					
(e) Directs the Trauma QM Program and reports QM activity as directed by the institutional reporting structure;					
(f) Has a job description developed by the hospital to reflect the role and responsibilities as defined by COMAR;					
(g) Appears on the hospital's organizational chart where the relationship between the medical director and other hospital services are depicted and delineated; and					
(h) Participates in regional and state education, QM, and injury prevention activities;					
(2) A full-time director of patient care services, who is a registered nurse, with direct authority for all nursing and ancillary trauma patient care services, operations, and the QM associated with these services;	E	NA	NA	NA	NA
(3) An in-house resource coordinator who is available 24 hours a day and is responsible for the timely coordination of trauma patient care resources, services, patient flow and throughput;	E	E	E	E	E
(4) A TPM who is dedicated full-time to the management of the trauma program and in collaboration with the TMD and nursing management, has oversight for, monitors, and coordinates the components of the trauma program, including:	E	E	E	E	NA
(a) Patient care;					
(b) Provider education;					
(c) Public education and prevention activities;					
(d) Program management;					
(e) The hospital's participation in the Maryland State Trauma Registry;					
(f) QM for the trauma program; and					
(g) Show evidence of 16 hours of external trauma-related CE a year and over a 2-year period, half of the CE hours shall be obtained outside the hospital and be recognized by a national accrediting body;					
G. The Trauma Center shall have one or more committees that provide expert input to the hospital's management of trauma program issues that shall:					
(1) Under the leadership of the TMD and TPM or designee, provide trauma multidisciplinary peer review and include representatives from general surgery, to address clinical care issues;	E	E	E	E	NA
(2) Conduct trauma multidisciplinary peer review that includes Orthopedic surgery, Emergency Medicine, Critical Care, Anesthesia, Neurosurgery, Radiology and Nursing, to address clinical care issues;	E	E	E	E	E
(3) Monitor trauma patient care among hospital departments, medical and nursing staffs, and representative disciplines across the trauma care continuum; and	E	E	E	E	NA
(4) Collaborate with the Emergency Department (ED) Committee to address trauma care issues.	NA	E	E	E	E
H. The Trauma Resuscitation Team shall:					
(1) Be in the Trauma Resuscitation Unit on arrival for all trauma patients;	E	NA	NA	NA	NA
(2) Be in the trauma resuscitation area at the bedside within 15 minutes of being called for the highest level of activation;	NA	E	E	NA	NA
(3) Be activated by an emergency physician or nurse using clearly defined Trauma Center criteria for activation protocol;	NA	E	E	E	E
(4) Be directed by an in-house emergency physician who has experience and training in trauma resuscitation until the patient is formally transferred to the care of the trauma surgeon;	NA	E	E	E	E
(5) Be in the trauma resuscitation area at the bedside within 30 minutes of being called for the highest level of activation;	NA	NA	NA	E	D
(6) Be oriented to the trauma care system;	E	E	E	E	D

(7) Be required to complete annual continuing education and demonstrate competence for trauma care that is appropriate and specific to each member's specialty roles;	E	E	E	E	E
(8) Participate in:					
(a) Trauma Quality Management (QM); and	E	E	E	E	E
(b) Ongoing medical education or continuing education in trauma;	E	E	E	E	E
(9) Be oriented to the internal trauma patient clinical management protocols or clinical practice guidelines, and algorithms derived from evidenced-based validated resources;	E	E	E	E	E
(10) Be defined in writing, specifying the roles and responsibilities of each member; and	E	E	E	E	E
(11) Be accountable to the trauma surgeon who becomes the team leader upon arrival in the resuscitation area.	NA	E	E	E	NA
I. A hospital shall have written policies and procedures to direct the organized, safe, intra-hospital and inter-hospital transfer process of trauma patients.	E	E	E	E	E
J. A hospital shall complete transfers to in-State hospitals, or to out-of-State hospitals listed in the Maryland Emergency Medical Services Interhospital Transfer Resource Manual, in accordance with the guidelines contained in the Maryland Emergency Medical Services Interhospital Transfer Resource Manual without the need for separate transfer agreements.	E	E	E	E	E
K. A hospital shall have a written transfer agreement in place for transfer of a patient to an out-of-State hospital not listed in the Maryland Emergency Medical Services Interhospital Transfer Resource Manual, if the hospital transfers to such out-of-State hospital more than five times a year.	E	E	E	E	E
L. A hospital shall have a multidisciplinary plan of care specific to the needs of each trauma patient and address all phases of care, including discharge disposition, and rehabilitation needs.	E	E	E	E	NA

.04 Medical Staff.

	PARC	I	II	III	ED
A. Credentialing Process. Each physician and Advanced Practice Professional (APP) shall be credentialed by the hospital for the appropriate specialty, including trauma care.	E	E	E	E	E
B. Delineation or Reevaluation of Privileges:	E	E	E	E	NA
(1) The trauma physicians and APPs shall be limited to those with demonstrated skills, commitment, experiences, and interest in trauma care.	E	E	E	E	NA
(2) The trauma medical director shall serve on the medical staff as the trauma chief of service.	E	E	E	E	NA
(3) Appointment and reappointment to the trauma admitting or consulting staff shall be coordinated by the trauma medical director and based on the following criteria:	E	E	E	E	NA
(a) Maintenance of good standing in the primary specialty;	E	E	E	E	NA
(b) Evidence of the required continuing medical education in trauma, including:					
(i) For general surgeons taking trauma calls evidence of 16 hours of trauma-related CME credits a year;	E	E	E	E	NA
(ii) Over a 2-year period, half of the CME hours shall be obtained outside the hospital and be recognized by a national accrediting body;	E	E	D	D	NA
(iii) ATLSTM which may be counted in required CME credits; and	E	E	E	E	NA
(iv) Physician CME credits shall be documented in accordance with hospital policy.	E	E	E	E	NA
(c) Documented attendance at Trauma QM meetings, as those meetings are institutionally defined, of no less than monthly averaged over 12 months;	E	NA	NA	NA	NA
(d) Documented attendance at Trauma multidisciplinary meetings, Morbidity and Mortality (MandM) rounds, or hospital peer-review conference that deal with the care of injured patients; and	NA	E	E	E	NA
(e) Satisfactory performance in managing trauma patients based on performance assessment and outcome analysis.	E	E	E	E	NA

.05 Trauma Service.

	PARC	I	II	III	ED
Trauma Service requirements are as follows:					
A. The Trauma Service shall be established by the medical staff and shall be responsible for the care of injured patients.	E	E	E	E	NA
B. Privileges for physicians on the trauma service shall be determined by the medical credentialing process.	E	E	E	E	NA
C. The trauma service attending surgeon shall retain responsibility for the patient and coordinate all therapeutic decisions while the patient is on the Trauma Service.	E	E	E	E	NA
D. Injured patients may be observed by or admitted to an individual surgeon, but the structure of the program shall allow the Trauma Medical Director to have oversight authority for the care of these patients.	E	E	E	E	NA
E. The Trauma Center shall have a clearly defined response requirement for the trauma surgical evaluation of injured patients.	E	E	E	E	NA

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F. Patients with injuries having a high index of suspicion, such as a significant mechanism of injury, shall be evaluated by the trauma service in compliance with hospital protocol.	E	E	E	E	NA
G. The emergency physician may initially evaluate the trauma patient, but the Trauma Center shall have a clearly defined response requirement for the trauma surgical evaluation of those patients requiring observation or admission.	NA	E	E	E	E
H. Patients with multiple system or complex single system injuries shall be evaluated by the trauma surgery service.	E	E	E	E	NA
I. The surgeon responsible for a patient's care shall be identified.	E	E	E	E	NA
J. The hospital shall document:					
(1) Current certification as ATLS® instructors for all attending general trauma surgeons;	E	NA	NA	NA	NA
(2) Successful completion and continued certification of an ATLS® course for all general trauma surgeons;	E	E	E	D	NA
(3) Successful completion and continued certification of an ATLS® course for the TMD and all APP's who provide initial evaluation of trauma patients, treatment and care; and	E	E	E	E	E
(4) Current APLS® certification for physicians providing pediatric trauma care;	D	D	D	D	D

.06 Trauma Medical Director.

	PARC	I	II	III	ED
The Trauma Medical Director (TMD) shall:					
A. Be an expert in and committed to the care of the injured with a special interest in trauma care;	E	E	E	E	NA
B. Be board certified in general surgery or other surgical specialties;	E	E	E	E	NA
C. Be able to devote the time needed to fulfill the TMD responsibilities as delineated in COMAR;	E	E	E	D	NA
D. Have the following educational preparation and clinical experience:					
(1) Successful completion of advanced specialty training in trauma care or Trauma/Critical Care fellowship for at least 1 year;	E	E	E	D	NA
(2) Demonstrated experience at a designated Level I Trauma Center in trauma systems management, trauma research, and quality management functions; and	E	D	NA	NA	NA
(3) Documented interest in trauma center or trauma system issues as evidenced by education, publications, professional experience, and involvement in planning and prevention efforts;	E	D	D	D	NA
E. Maintain membership and active participation in local, regional, state or national trauma-related activities and trauma organizations;	E	E	E	E	NA
F. Participate in trauma educational activities such as:					
(1) Trauma/Critical Care fellowship programs;	E	D	NA	NA	NA
(2) Undergraduate medical education;	E	E	NA	NA	NA
(3) Continuing education; and	E	E	E	E	NA
(4) ATLS® courses;	E	E	E	E	NA
G. Participate in trauma research and publication efforts; and	E	E	D	D	NA
H. Demonstrate active participation in the resuscitation of multi system trauma patients, or surgery of multi system trauma patients or both.	E	E	E	E	NA

.07 Surgery Department.

	PARC	I	II	III	ED
A. General Surgery. A hospital shall have a surgery department including:					
(1) For the "most critical patients" an in-house, fellowship trained attending trauma surgeon, trauma fellow or trauma fellow equivalent/PGY5+ general surgery resident should be at the bedside upon arrival, documented at least 80 percent of the time.	E	NA	NA	NA	NA
(2) Either:					
(a) A trauma or general surgeon trained in trauma care who shall be at the bedside within 15 minutes of being called for the highest level of activation and should be at the bedside within 15 minutes with compliance demonstrated at least 80 percent of the time;	NA	E	E	NA	NA
(b) An in-house PGY4 or more senior resident who shall be at the bedside with the attending trauma or general surgeon within 15 minutes of being called for the highest level of activation and should be at the bedside within 15 minutes with compliance demonstrated at least 80 percent of the time; or	NA	E	E	NA	NA
(c) An in-house APP trained in trauma care who shall be at the bedside with the attending trauma or general surgeon within 15 minutes of being called for the highest level of activation and should be at the bedside within 15 minutes with compliance demonstrated at least 80 percent of the time;	NA	E	E	D	NA
(3) An attending trauma surgeon taking trauma call who shall be at the bedside within 30 minutes from patient arrival for the highest level of activation with the surgeons' presence with compliance demonstrated at least 80 percent of the time;	NA	NA	NA	E	NA
(4) Trauma or general surgeons who are board certified or board eligible,	E	E	E	E	NA

(5) Trauma or general surgeons who agree to actively participate in a defined continuing education program;	E	E	E	E	D
(6) Criteria and protocols for the notification and response of a trauma or general surgeon;	E	E	E	E	NA
(7) General Surgery APPs taking trauma call who have evidence of average of 16 hours a year or 32 hours in 2 years of trauma-related education; and	E	E	E	E	NA
(8) A liaison to the trauma QM program with 50 percent attendance.	E	E	E	E	NA
B. Neurosurgery. Neurosurgery requirements are as follows:					
(1) Neurosurgeons who are board certified or board eligible;	E	E	E	E	E
(2) A Board-certified or board-eligible, trauma fellowship-trained in-house neurosurgery attending or PGY2 or higher, dedicated 24 hours a day to trauma care with a Neurosurgery Attending on-call and who shall be at the patient bedside within 30 minutes after Emergent consultation has been requested by the trauma team leader for injured patients based on institution-specific criteria;	E	E	NA	NA	NA
(3) The on-call Neurosurgery Attending taking trauma call shall be at the bedside within 30 minutes after Emergent consultation has been requested by the trauma team leader for injured patients based on institution-specific criteria and with in-house physician capable of initiating stabilization and diagnostic procedures;	NA	NA	E	E	NA
(4) If a neurosurgeon taking trauma call covers more than one hospital within the same geographic area, there shall be a written contingency plan in place for times in which a neurosurgeon is unavailable upon the arrival of a Neurotrauma case;	NA	NA	E	E	E
(5) A qualified Neurosurgeon shall be regularly involved in the care of patients with neurologic injuries and shall be credentialed by the hospital with general neurosurgical privileges;	E	E	E	E	E
(6) Neurosurgery APP or PGY2 or higher with attending on-call;	NA	NA	E	E	E
(7) Neurosurgery APPs taking trauma call shall have evidence of average of 16 hours a year or 32 hours in 2 years of trauma-related education; and	E	E	E	E	NA
(8) A liaison to the trauma QM program with 50 percent attendance.	E	E	E	E	NA
D. Orthopedic Surgery. Orthopedic surgery requirements are as follows:					
(1) A Board-certified or board-eligible, trauma fellowship-trained in-house orthopedic attending or PGY2 or higher, dedicated 24 hours a day to trauma care with an Orthopedic Attending on-call and who shall be at the patient bedside within 30 minutes after Emergent consultation has been requested by the trauma team leader for injured patients based on institution-specific criteria;	E	E	NA	NA	NA
(2) Orthopedic team members shall have dedicated call at their institution or have an effective backup call system. If the on-call orthopedic surgeon is unable to respond promptly, a backup consultant on-call surgeon shall be available;	E	E	E	E	E
(3) Board-certified or board-eligible on-call attending with a 30-minute response after emergent response is requested;	NA	NA	E	E	NA
(4) Orthopedic APPs taking trauma call who have evidence of average of 16 hours a year or 32 hours in 2 years of trauma-related education; and	E	E	E	E	NA
(5) A liaison to the trauma QM program with 50 percent attendance.	E	E	E	E	NA

.08 Non-Surgical Specialty.

	PARC	I	II	III	ED
A. Anesthesia. Anesthesia requirements are as follows:					
(1) Board-certified, fellowship trained Anesthesiology Attending in-house, dedicated 24 hours a day to trauma care should be at the bedside upon arrival, and documented at least 80 percent of the time;	E	NA	NA	NA	NA
(2) Board-certified or board-eligible, in-house attending 24 hours a day;	NA	E	E	E	NA
(3) Attending anesthesiologist or CRNA taking trauma call shall be at the bedside within 15 minutes of being called with institution-specific criteria defining conditions requiring an immediate response, and present for all operations; and	NA	E	E	E	NA
(4) A liaison to the trauma QM program with 50 percent attendance.	E	E	E	E	E
B. Emergency Medicine. Emergency Medicine (EM) requirements are as follows:					
(1) Physician Director or designated Director of Trauma Services in Emergency Medicine who:					
(a) Is Board certified or board eligible in EM with evidence of active participation in daily emergency care;	NA	E	E	E	D
(b) Has administrative duties in the Emergency Department (ED);	NA	E	E	E	D
(c) Demonstrates the successful completion of the ATLS® course, at least once; and	NA	E	E	E	E
(d) Maintains ATLS® certification;	NA	E	E	E	E

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(2) <i>Emergency physician in-house 24 hours a day who is:</i>					
(a) <i>Board certified or board eligible in EM;</i>	NA	E	E	E	E
(b) <i>Board certified or board eligible in a non-EM specialty with at least 7,000 hours of emergency practice and current ATLS® certification;</i>	NA	NA	NA	E	E
(c) <i>If certified by boards other than EM and treating trauma patients in the ED, current ATLS® status; or</i>	NA	E	E	E	E
(d) <i>Has demonstrated special capabilities through commitment, continuing education, and experience;</i>	NA	NA	NA	NA	E
(3) <i>Advanced Practice Professionals (APP) providing care to the trauma patient who have current ATLS® certification; and</i>	NA	E	E	E	E
(4) <i>A liaison to the trauma QM program with 50 percent attendance.</i>	NA	E	E	E	E
C. Critical Care. Critical care requirements are as follows:					
(1) <i>Intensive care with a designated surgical director who is fellowship trained and board certified in surgery or critical care;</i>	E	E	D	NA	NA
(2) <i>A board certified surgeon who serves as director or co-director of the ICU and is actively involved in, and responsible for, setting policies and administrative decisions related to trauma ICU patients;</i>	NA	NA	E	D	NA
(3) <i>A trauma surgeon who retains responsibility for the patient and coordinates all therapeutic decisions;</i>	NA	E	E	E	NA
(4) <i>If Telemedicine is used, physician/s who have privileges in critical care and be approved by the TMD; and</i>	E	E	E	E	NA
(5) <i>A liaison to the trauma QM program with 50 percent attendance.</i>	E	E	E	E	NA

.09 Additional Surgical Specialties.

<i>The following surgical specialties shall be on call and available with a 30-minute response time:</i>	PARC	I	II	III	ED
A. <i>Cardiac;</i>	E	E	D	NA	NA
B. <i>Hand;</i>	E	E	D	D	NA
C. <i>Microvascular replant or flaps;</i>	E	E	D	D	NA
D. <i>Obstetric and gynecologic;</i>	E	E	E	E	NA
E. <i>Ophthalmic;</i>	E	E	E	D	NA
F. <i>Oral or maxillofacial;</i>	E	E	E	D	NA
G. <i>Otorhinolaryngologic;</i>	E	E	E	D	NA
H. <i>Pediatric;</i>	E	E	D	D	NA
I. <i>Plastic;</i>	E	E	E	D	NA
J. <i>Thoracic;</i>	E	E	E	E	NA
K. <i>Urologic; and</i>	E	E	E	E	NA
L. <i>Vascular.</i>	E	E	E	D	NA

.10 Additional Non-Surgical Specialties.

<i>The following non-surgical specialties shall be on-call and available 24 hours a day and shall be at the bedside within 60 minutes after Emergent consultation has been requested by the surgical trauma team leader based on institution-specific criteria:</i>	PARC	I	II	III	ED
A. <i>Cardiology;</i>	E	E	E	E	D
B. <i>Pulmonary medicine;</i>	E	E	E	E	D
C. <i>Interventional Radiology (perform complex imaging studies, or interventional procedures);</i>	E	E	E	D	NA
D. <i>Interventional Angiography; and</i>	E	E	E	D	D
E. <i>Pediatrics.</i>	E	E	D	D	NA

.11 Additional Non-Surgical Specialties.

<i>The following non-surgical specialties shall be on-call:</i>	PARC	I	II	III	ED
A. <i>Gastroenterology;</i>	E	E	E	D	NA
B. <i>Infectious Disease;</i>	E	E	E	D	NA
C. <i>Internal Medicine;</i>	E	E	E	E	D
D. <i>Nephrology;</i>	E	E	E	E	D
E. <i>Neurology;</i>	E	E	E	E	NA
F. <i>Pathology;</i>	E	E	E	E	NA
G. <i>Physiatry; and</i>	D	D	D	D	NA
H. <i>Psychiatry.</i>	E	E	E	E	D

.12 Nursing Services.

	PARC	I	II	III	ED
A. Responsibility shall be assigned within the department of nursing for trauma care. Oversight of trauma nursing care services shall be with the Department of Nursing.	NA	E	E	E	NA
B. A written plan shall exist and be approved by nursing that shall include the ability to immediately mobilize qualified staff for initial resuscitation.	E	E	E	E	E
C. There shall be a written plan for providing adequate and appropriate nursing staff to meet the acuity needs of trauma patients in each unit.	E	E	E	E	E
D. The nursing department shall participate in multidisciplinary quality management monitoring of trauma care.	E	E	E	E	E
E. There shall be an introductory education program for all nurses caring for Trauma patients that addresses the learning outcomes approved by the Maryland Trauma Quality Improvement Committee (TQIC). This introductory education program shall include 16 hours of content within 1 year of hire.	E	E	E	E	E
F. After completion of the introductory education mandated in this regulation, continuing education shall be current, meeting the following requirements:	E	E	E	E	D
(1) 8 hours of trauma-related education every year for emergency and critical care, OR, and PACU nurses caring for trauma patients; or					
(2) 4 hours of trauma-related education every year for nurses caring for trauma patients and are from other clinical areas.					

.13 Facility or Unit Capabilities.

	PARC	I	II	III	ED
A. Emergency Department. Emergency Department (ED) requirements are as follows:					
(1) A designated ED physician director and nurse manager;	NA	E	E	E	E
(2) Board-certified or board-eligible attending physician with demonstrated competence in the care of critically injured patients in-house 24 hours a day;	NA	E	E	E	D
(3) A dedicated Trauma Resuscitation Unit (TRU) with dedicated staff, equipment and supplies 24 hours a day;	E	NA	NA	NA	NA
(4) Dedicated trauma resuscitation area with dedicated staff, equipment, and supplies 24 hours a day;	NA	E	E	E	E
(5) Senior attending trauma surgeon available 24 hours a day through EMRC/SYSCOM as a resource for trauma consultation Statewide;	E	NA		NA	NA
(6) A sufficient number of registered nurses and other providers, who are competent to provide care during trauma resuscitation and present in sufficient numbers to manage projected case load, and a plan to reinforce the number of staff on immediate notice of multiple admissions;	E	E	E	E	E
(7) Defined and agreed on roles and responsibilities approved by the TMD with the overall goal to have available ED resources needed to care for patients;	NA	E	E	E	E
(8) Verification of functioning life-safety emergency equipment and supplies organized for trauma resuscitation present and immediately available 24 hours a day;	E	E	E	E	E
(9) Direct communication link to pre hospital providers and transport vehicles;	E	E	E	E	E
(10) Designated as Base Station by MIEMSS;	E	E	E	E	E
(11) Emergency Equipment located in the Resuscitation area/ED for:	E	E	E	E	E
(a) Airway control or cricothyrotomy;	E	E	E	E	E
(b) Difficult Airway Equipment;	E	E	E	E	E
(c) Thoracotomy;	E	E	E	E	E
(d) Vascular access;	E	E	E	E	E
(e) Thoracostomy/Chest decompression;	E	E	E	E	E
(f) Peritoneal Lavage;	E	E	E	E	E
(g) Bedside Ultrasound;	E	E	E	E	E
(h) Extremity Hemorrhage Control devices/Tourniquet;	E	E	E	E	E
(i) Rapid Infuser and Warmer; and	E	E	E	E	E
(j) Access to compartment measurement device;	E	E	E	E	E
(12) Policies and protocols for trauma team response and roles in ED trauma resuscitation in accordance with Regulation .11 of this chapter;	E	E	E	E	E
(13) Drugs necessary for emergency care; and	E	E	E	E	E
(14) Auto transfusion equipment and capability immediately available.	E	E	E	E	E
B. Operating Room. Operating Room (OR) requirements are as follows:					
(1) OR rooms adequately staffed with in-house personnel dedicated to trauma 24 hours a day;	E	D	NA	NA	NA
(2) OR available within 15 minutes of notification with adequate in-house staff;	E	E	E	E	NA
(3) X-ray capability including C-arm image intensifier 24 hours a day;	E	E	E	E	NA

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(4) Equipment and instrumentation appropriate for:					
(a) Neurosurgery;	E	E	E	E	NA
(b) Vascular surgery;	E	E	E	E	NA
(c) Pelvic and long-bone fracture fixation; and	E	E	E	E	NA
(d) Cardiopulmonary bypass:					
(i) Cardiopulmonary bypass;	E	E	D	NA	NA
(ii) If cardiopulmonary bypass equipment is not immediately available, a written contingency plan, including immediate patient transfer to an appropriate center with a 100 percent performance improvement review of all patients transferred;	NA	E	E	E	NA
(5) Rapid fluid infusers, blood recapturing thermal control equipment for patients and resuscitation fluids, intraoperative radiologic capabilities, equipment for fracture fixation, and equipment for bronchoscopy and gastrointestinal endoscopy;	E	E	E	E	NA
(6) Equipment for continuous monitoring of temperature, hemodynamics, and gas exchange; and	E	E	E	E	NA
(7) Endoscopes.	E	E	E	E	NA
C. Post-Anesthesia Care Unit (PACU) requirements are as follows:					
(1) Dedicated to trauma and staffed 24 hours a day;	E	NA	NA	NA	NA
(2) PACU Room/s available to trauma patients with registered nurses and other essential staff 24 hours a day; and	NA	E	E	E	NA
(3) The necessary equipment to monitor and resuscitate patients including equipment for continuous monitoring of temperature, hemodynamics, and gas exchange.	E	E	E	E	NA
D. Intensive Care Unit (ICU). Intensive care unit requirements are as follows:					
(1) Dedicated ICU for trauma with appropriately trained registered nurse staff;	E	NA	NA	NA	NA
(2) Designated ICU bed availability for trauma patients with appropriately trained trauma registered nurses in sufficient numbers based on patient acuity;	E	E	E	E	NA
(3) Written plan for triaging patients from the intensive care unit to free up beds for trauma patients when necessary or provision of alternate critical care beds for trauma patients with appropriately trained registered nurse staff;	E	E	E	E	NA
(4) The means to ensure that the trauma surgeon is kept informed and concurs with major therapeutic and management decisions made by the ICU team which can collaboratively manage many of the daily care requirements;	E	E	E	E	NA
(5) The means to ensure that trauma patients are not admitted or transferred by a primary care physician without the knowledge and consent of the trauma service;	E	E	E	E	NA
(6) The necessary equipment to monitor and resuscitate patients;	E	E	E	E	NA
(7) Support services with immediate access to clinical diagnostic services such as arterial blood gases, hematocrits, and chest X-rays available within 30 minutes;	E	E	E	E	NA
(8) A Respiratory Therapist available in the hospital 24 hours per day;	E	E	E	E	E
(9) Nutrition support services available; and	E	E	E	E	NA
(10) Acute continuous hemodialysis capability.	E	E	E	E	NA
E. Acute Spinal Cord and Head Injury Management Capability. Acute spinal cord or head injury management requirements are as follows:					
(1) Dedicated Neurotrauma units with dedicated, specialty trained nursing and support staff;	E	NA	NA	NA	NA
(2) Neuro-intensive services with intracranial pressure capabilities for trauma patients;	NA	E	D	D	NA
(3) Intracranial pressure monitoring equipment available with neurosurgical coverage;	E	E	E	E	E
(4) Dedicated services to care for spinal cord injury and patient management; and	E	NA	NA	NA	NA
(5) Orthopedics or Neurosurgery management of the spine patients with appropriate neuro monitoring consistent with current standards of care to meet the needs of the patient.	E	E	E	E	E
F. Burn Care. Burn care requirements are as follows:					
(1) Ability to provide initial resuscitation for burn patients;	E	E	E	E	E
(2) Proper equipment for the care of burned patients, prior to transfer to burn center; and	E	E	E	E	E
(3) A hospital shall complete transfers to in-State hospitals, or to out-of-State hospitals listed in the Maryland Emergency Medical Services Interhospital Transfer Resource Manual, in accordance with the guidelines contained in the Maryland Emergency Medical Services Interhospital Transfer Resource Manual without the need for separate transfer agreements.	E	E	E	E	E
(4) A hospital shall have a written transfer agreement in place for transfer of a patient to an out-of-State hospital not listed in the Maryland Emergency Medical Services Interhospital Transfer Resource Manual, if the hospital transfers to such out-of-State hospital more than five times a year.	E	E	E	E	E
G. Radiological Special Capabilities. Radiological special capabilities requirements are as follows:					
(1) Qualified radiologists and staff available within 60 minutes of consultation notification to perform complex imaging studies, or interventional procedures;	E	E	E	E	E

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(2) A Board-certified or board-eligible, in-house Radiology Attending on-call who shall provide interpretations of radiographs within 30 minutes;	E	NA	NA	NA	NA
(3) Qualified in-house Radiology or Teleradiology available 24 hours a day for the interpretations of radiographs;	NA	E	E	E	E
(4) Changes in interpretation between preliminary and final reports, as well as missed injuries, monitored through the QM program;	E	E	E	E	NA
(5) A mechanism in place to view radiographic imaging from referring hospitals;	E	D	D	D	NA
(6) In-house trauma-dedicated technicians 24 hours a day;	E	NA	NA	NA	NA
(7) In-house radiology technicians 24 hours a day;	E	E	E	E	E
(8) Dedicated computed tomography (CT) scan and angiography facilities and staff 24 hours a day;	E	NA	NA	NA	NA
(9) Interventional Angiography;	E	E	E	D	NA
(10) Sonography;	E	E	E	E	D
(11) Nuclear scanning;	E	E	E	E	NA
(12) Magnetic resonance imaging (MRI) capability available 24 hours per day;	E	E	E	D	D
(13) An MRI technologist who may respond from outside the hospital with the QM program documenting and reviewing arrival within 60 minutes of being called; and	E	E	E	D	D
(14) Computed tomography (CT):					
(a) Computed tomography (CT) in-house and available 24 hours a day;	E	E	E	E	NA
(b) In-house CT technician 24 hours a day; and	E	E	E	E	NA
(c) Back-up CT scan capabilities.	E	E	E	E	NA
H. Rehabilitation. Rehabilitation requirements are as follows:					
(1) Rehabilitation services staffed by personnel trained in rehabilitative care and properly equipped for acute care of the critically injured patient;	E	E	D	D	NA
(2) Rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services available in the critical care phase as needed;	E	E	D	D	NA
(3) Full in-house service or transfer process in place to a rehabilitation service for Long-term care or sub-acute care;	E	E	E	E	NA
(4) Ongoing continuity of care for patients with traumatic brain, musculoskeletal, and soft tissue injuries provided in affiliated rehabilitation facility by attending trauma center specialists and sub-specialists; and	E	NA	NA	NA	NA
(5) Transfer agreements to Rehabilitation hospitals, for the primary three rehabilitation hospitals the trauma center utilizes which may be a joint transfer agreement if the Trauma Center is a part of a health system that utilizes a particular rehabilitation center.	E	E	E	E	NA
I. Clinical Laboratory Service.					
(1) A clinical laboratory service shall be available 24 hours a day capable of providing:	E	E	E	E	E
(a) Standard analysis of blood, urine, and other body fluids;					
(b) Blood-typing and cross-matching;					
(c) Comprehensive blood bank or access to a central blood bank in the community and adequate storage facilities with stock minimums set by protocol for blood products;					
(d) Blood gases and pH determinations;					
(e) Coagulation studies;					
(f) Microbiology; and					
(g) Drug and alcohol screening.					
(2) The blood bank shall have an adequate in-house supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients.	E	E	E	E	E
(3) A massive transfusion protocol developed collaboratively between the trauma service and the blood bank.	E	E	E	E	E
(4) A dedicated satellite lab or Point-of-Care available near or in the trauma resuscitation area for essential lab studies.	E	E	D	D	NA
J. Equipment for Resuscitation. Equipment for resuscitation of patients of all Ages in the ED, OR, PACU, and ICU shall be immediately available and include:					
(1) Airway control and ventilation equipment, difficult airway equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, and oxygen;	E	E	E	E	E
(2) Suction devices;	E	E	E	E	E
(3) Pulse oximetry;	E	E	E	E	E
(4) Electrocardiograph-oscilloscope-defibrillator;	E	E	E	E	E
(5) Standard intravenous fluids and administration devices, including large-bore intravenous catheters;	E	E	E	E	E
(6) End-tidal CO2 determination;	E	E	E	E	E
(7) Apparatus to establish hemodynamic monitoring;	E	E	E	E	NA

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(8) Skeletal traction devices, including capabilities for cervical traction;	E	E	E	E	E
(9) Arterial catheters;	E	E	E	E	NA
(10) Thermal control equipment for patient and fluids;	E	E	E	E	E
(11) Rapid Infuser and Warmer;	E	E	E	E	E
(12) Compartmental pressure measuring device; and	E	E	E	E	D
(13) Portable ultrasound.	E	E	E	E	E

.14 Quality Management.

	PARC	I	II	III	ED
A. The ongoing Quality Management (QM) of the trauma program shall be:	E	E	E	E	E
(1) Integrated into the hospital's overall quality management program; and	E	E	E	E	E
(2) Reported to the hospital's governing body.	E	E	E	E	E
B. Trauma Centers shall have:					
(1) A QM comprehensive written plan outlining the configuration and identifying both adequate personnel to implement that plan and an operational data management system; and	E	E	E	E	E
(2) A designated QM Process Improvement (PI) position in Trauma Centers with a trauma registry volume greater than 1500 patients per year which is separate from the TPM position. This position should initiate the concurrent review process and, in conjunction with the TPM, facilitate the PI process to loop closure. This position should report directly to the TPM.	E	E	E	D	NA
C. The TMD shall have a leadership role in trauma center QM.	E	E	E	E	E
D. The following shall be included in the QM of the trauma program:					
(1) Structure to ensure that defined program outcomes and performance measures are developed and monitored regularly; to include:	E	E	E	E	E
(a) Trauma Patient Identification;	E	E	E	E	E
(b) Peer Review; and	E	E	E	E	E
(c) Audit filters;	E	E	E	E	E
(2) A hospital trauma registry with participation in the State trauma registry;	E	E	E	E	E
(3) Special audit of all trauma deaths;	E	E	E	E	E
(4) Morbidity and Mortality reviews;	E	E	E	E	E
(5) Evaluation of nursing care, medical care, utilization review, tissue review, and pre hospital care;	E	E	E	E	E
(6) Trauma center by-pass status including, if applicable, both medevac fly-by and ground unit re-route statistics; and	E	E	E	E	E
(7) Documentation of quality management available to demonstrate the multidisciplinary approach to the quality management program including and if appropriate:	E	E	E	E	E
(a) Problem Identification;					
(b) Analysis;					
(c) Action plan;					
(d) Implementation;					
(e) Reevaluation; and					
(f) Loop Closure/Resolution.					
E. The liaisons on the multidisciplinary trauma peer review committee shall attend a minimum of 50 percent of those committee meetings.	E	E	E	E	E
F. The TMD shall be involved in the development of the trauma center's bypass (diversion) protocol.	E	E	E	E	E
G. The trauma surgeon shall be involved in the decision regarding bypass (diversion) each time the center goes on bypass.	E	E	E	E	E
H. The Trauma Center shall minimize trauma bypass hours with a goal of less than 5 percent per month of the total monthly hours.	E	E	E	E	E
I. Trauma center diversion-bypass hours shall be routinely monitored, documented, and reported, including the reason for initiating the diversion policy.	E	E	E	E	E
J. Monthly Review.					
(1) At one or more appropriate forums in the hospital, the trauma program shall be reviewed monthly, including both clinical care and administration.	E	E	E	E	E
(2) When a resource is required to be within a specified period of time, the time the resource is requested and the time the resource is available shall be documented as part of the QM process and the response times shall be reviewed monthly.	E	E	E	E	E
(3) The following aspects shall be addressed:	E	E	E	E	E
(a) Trends;					
(b) All deaths;					
(c) All transfers;					
(d) Morbidities;					
(e) Problem identification and solution;					

<i>(f) Issues identified from the quality management process; and</i>					
<i>(g) Other trauma system issues.</i>					
<i>(4) Minutes shall be maintained for all meetings and shall reflect the review of operational events and, when appropriate, the analysis and proposed corrective actions.</i>	E	E	E	E	E

.15 Injury Prevention and Public Education.

	PARC	I	II	III	ED
<i>A. The trauma center shall:</i>					
<i>(1) Collaborate closely with MIEMSS in developing, monitoring, and evaluating the effectiveness of prevention and public education programs;</i>	E	E	E	E	NA
<i>(2) Conduct epidemiology research concerning injury control;</i>	E	E	NA	NA	NA
<i>(3) Collaborate with other hospitals or agencies in research; and</i>	E	E	E	E	D
<i>(4) Monitor progress of prevention programs in cooperation with State quality monitoring activities.</i>	E	E	E	E	NA
<i>B. The Trauma centers shall have:</i>					
<i>(1) An organized and effective approach to injury prevention that prioritizes those efforts based on local trauma registry and epidemiologic data;</i>	E	E	E	E	NA
<i>(2) A dedicated injury prevention coordinator in the trauma center, separate from the TPM position who, in conjunction with the TPM, facilitates outreach and injury prevention strategies specific to the population of the Trauma Center;</i>	E	NA	NA	NA	NA
<i>(3) A designated injury prevention individual in the trauma center, separate from the TPM position, who, in conjunction with the TPM, facilitates outreach and injury prevention strategies specific to the population of the Trauma Center;</i>	NA	E	E	D	NA
<i>(4) Outreach activities and program development that address one of the major causes of injury in the community;</i>	E	E	E	E	E
<i>(5) Information resources; and</i>	E	E	E	E	E
<i>(6) Collaboration with existing national, regional, state and local programs.</i>	E	E	E	E	E

.16 Trauma Research.

	PARC	I	II	III	ED
<i>A. A trauma center shall have:</i>	E	E	NA	NA	NA
<i>(1) An organized trauma research program with a designated physician director and documented research plan;</i>					
<i>(2) Regular meetings of the research group; and</i>					
<i>(3) Evidence of productivity through peer review.</i>					
<i>B. The Trauma Center shall have:</i>					
<i>(1) Proposals reviewed by an institutional review board;</i>	E	E	D	D	NA
<i>(2) Presentations at local, regional, or national meetings;</i>	E	E	D	D	NA
<i>(3) Publications in peer-reviewed journals on an average of seven per year; and</i>	E	E	D	D	NA
<i>(4) Clinical research trials designed to enhance the trauma system's ability to resuscitate, stabilize, and treat trauma patients in the most cost-effective manner.</i>	E	E	D	D	NA

.17 Education.

	PARC	I	II	III	ED
<i>A. A trauma center shall:</i>					
<i>(1) Assist MIEMSS with developing, monitoring, and evaluating the effectiveness of out-of-hospital training programs; and</i>	E	E	E	E	NA
<i>(2) Engage in public and professional education.</i>	E	E	E	E	NA
<i>B. The hospital shall offer:</i>					
<i>(1) Trauma education for:</i>	E	E	E	E	D
<i>(a) Hospital Nurses and physicians;</i>					
<i>(b) Community Nurses and Physicians;</i>					
<i>(c) Pre-hospital personnel; and</i>					
<i>(d) Allied health personnel;</i>					
<i>(2) A trauma critical care fellowship training program;</i>	E	NA	NA	NA	NA
<i>(3) A surgical residency program accredited by the Accreditation Council for Graduate Medical Education; and</i>	E	E	NA	NA	NA
<i>(4) Participation in undergraduate medical education.</i>	E	E	NA	NA	NA

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.18 Continuing Education Programs.

	PARC	I	II	III	ED
<i>A hospital shall have:</i>					
<i>A. Formal internal continuing education programs concerning the treatment and care of the trauma patients for:</i>	E	E	E	E	D
<i>(1) Physicians;</i>					
<i>(2) Nurses; and</i>					
<i>(3) Allied health personnel;</i>					
<i>B. Special training for personnel exclusively on trauma protocols and trauma care for all new physicians, nurses, and allied health personnel assigned to units where trauma care is provided; and</i>	E	E	E	E	E
<i>C. A continuing education program concerning the care and treatment of trauma patients for physicians, nurses, and allied health personnel in the region.</i>	E	E	E	E	NA

.19 Policies and Procedures.

	PARC	I	II	III	ED
<i>The following patient treatment and care documents shall be written, distributed, and monitored for quality:</i>	E	E	E	E	E
<i>A. Resuscitation policy;</i>					
<i>B. Transfusion and Massive Transfusion policy;</i>					
<i>C. Infection control plan(can utilize hospital plan);</i>					
<i>D. Trauma team activation policy;</i>					
<i>E. Physician call schedule;</i>					
<i>F. Subspecialty notification policy;</i>					
<i>G. Inter-hospital transfer policy;</i>					
<i>H. A policy providing that trauma patients may not be admitted or transferred by a primary care physician without the knowledge and consent of the trauma service, with monitoring of adherence by the QM program;</i>					
<i>I. Helicopter safety policy; and</i>					
<i>J. Organ procurement policy.</i>	E	E	E	E	E

.20 Trauma Program Manager.

	PARC	I	II	III	ED
<i>A. There shall be a Trauma Program Manager (TPM) who is a registered nurse and who is responsible for the organization of services and systems necessary for a multidisciplinary approach to providing care to the injured patient in collaboration and conjunction with the Trauma Medical Director (TMD).</i>	E	E	E	E	NA
<i>B. There shall be a defined organizational structure which delineates the roles and responsibilities of the TPM.</i>	E	E	E	E	NA
<i>C. This must be a full-time (1.0 FTE) position dedicated to the management of the trauma program.</i>	NA	E	E	E	NA
<i>D. The institution's organization shall define the structural role of the TPM to include responsibility, accountability, and authority.</i>	NA	E	E	E	NA
<i>E. The TPM shall:</i>					
<i>(1) Possess evidence of appropriate qualifications including academic and trauma-related education and clinical experience;</i>	E	E	E	E	NA
<i>(2) Have a job description developed by the hospital to reflect the role and responsibilities as defined by COMAR, and be shown on an organizational chart depicting the relationship between the TPM and other services, including the Department of Nursing;</i>	E	E	E	E	NA
<i>(3) Attend and participate in local, state and national trauma-related activities, including but are not limited to: EMS Advisory Councils, State trauma-related committees and events, National trauma-related activities and events;</i>	E	E	E	E	NA
<i>(4) Participate in trauma educational activities external to the institution's staff development programs;</i>	E	E	E	E	NA
<i>(5) As requested, participate in multidisciplinary trauma research;</i>	E	E	D	D	NA
<i>(6) Have sufficient administrative and budgetary commitment in order to support the needs of the Trauma Program inclusive of clerical and clinical nursing personnel that help fulfill needs of the concurrent performance Improvement, outreach and injury prevention;</i>	E	E	E	E	NA
<i>(7) Supervise the Trauma Registry staff and trauma clinical QM staff and have oversight for injury prevention and outreach;</i>	NA	E	E	E	NA
<i>(8) Identify an alternate supervisor to supervise the trauma registry if needed; and</i>	E	NA	NA	NA	NA
<i>(9) The TPM and/or TMD will have the oversight and approval of internal trauma-related education programs within each trauma center.</i>	E	E	E	E	NA

.21 Trauma Registry.

	PARC	I	II	III	ED
A. The Trauma Center shall maintain a Trauma Registry.	E	E	E	E	NA
B. The Trauma Registry shall include at a minimum, all of the data elements compliant with the Maryland Trauma Registry Data Dictionary for Adult Patients, including:	E	E	E	E	NA
(1) Demographic Data;	E	E	E	E	NA
(2) Pre-hospital Data;	E	E	E	E	NA
(3) Process of acute Care;	E	E	E	E	NA
(4) Clinical Data;	E	E	E	E	NA
(5) Outcome Data;	E	E	E	E	NA
(6) Final Anatomical Diagnosis;	E	E	E	E	NA
(7) Procedure Codes;	E	E	E	E	NA
(8) Quality Management Data;	E	E	E	E	NA
(9) Standard Report Utilization; and	E	E	E	E	NA
(10) Case Inclusion Criteria.	E	E	E	E	NA
C. The Trauma Registry shall support the Trauma Center with evidence of active interface with the institution and State QM process to improve the care of the injured patient across the continuum from injury prevention to outcomes measurement.	E	E	E	E	NA
D. The Trauma Registry may be under a separate department that provides support and conducts the registry data abstraction and ensures that:	E	NA	NA	NA	NA
(1) There is a reporting structure from the Trauma Registry to the TPM; and	NA	E	E	E	NA
(2) The trauma registry content staff will be under the direct supervision of the TPM/TMD.	NA	E	E	E	NA
E. The Trauma Program Manager shall have the authority, responsibility, accountability and oversight of the Trauma Registry inclusive of data submission as required by MIEMSS.	E	E	E	E	NA
F. The Trauma Registry shall have:					
(1) A staffing plan that includes workload analysis that defines personnel needs necessary to comply with the MIEMSS data submission requirements; and	E	E	E	E	NA
(2) Either:					
(a) One Trauma Registrar (1.0 FTE) dedicated to the trauma program for every 500–750 patients, subject to meeting performance standards and MIEMSS defined submissions per year; or	E	E	E	E	NA
(b) An electronic interfaced data-content mechanism.	E	D	D	D	NA
G. All discharged trauma patient records, with the minimum quarterly and annual data elements with the number of patients shall be verified no later than 6 weeks after the end of each quarter.	E	E	E	E	NA
H. All records shall be completed within 60 days of patient discharge; validation and NTDB checks shall be completed and the records shall be closed. An exception to the completeness of the MTR record is with Medical Examiner (ME) where autopsies are unavailable for registry record abstraction.	E	E	E	E	NA
I. The Trauma Registry shall have a plan to ensure Inter-rater reliability of the data entered into the MTR at the individual trauma centers. Ongoing review and evaluation shall ensure the quality, reliability and validity of the institution's MTR registry data.	E	E	E	E	NA
J. The Trauma Center shall submit data to the National Trauma Data Bank.	E	E	E	E	NA
K. Trauma Registry Staff shall have:					
(1) A job description developed by the hospital to reflect the role and responsibilities as defined by COMAR;	E	E	E	E	NA
(2) A core set of skill requirements including:	E	E	E	E	NA
(a) Anatomy and Physiology;	E	E	E	E	NA
(b) Medical Terminology; and	E	E	E	E	NA
(c) Education to be completed within 1 year of hire includes:	E	E	E	E	NA
(i). American Trauma Society Trauma Registrar Course; and	E	E	E	E	NA
(ii) Association of the Advancement of Automotive Medicine's Injury Scaling Course; and	E	E	E	E	NA
(3) Job responsibilities to include:					
(a) Ensuring assigned cases are compliant with MD Data Dictionary Inclusion Criteria or other Trauma Center self-defined criteria;	E	E	E	E	NA
(b) Compiling abstracted data for MTR case from various sources; and	E	E	E	E	NA
(c) Appropriately coding injuries, complications and procedures.	E	E	E	E	NA
L. The Trauma Registry staff liaison shall:					
(1) Attend a minimum of 50 percent all trauma multidisciplinary/peer review meetings that are held; and	E	E	E	E	NA
(2) Actively participate in the MD Trauma Quality Improvement Committee (TQIC) via attendance in person or phone as defined by the individual institution.	E	E	E	E	NA

PROPOSED ACTION ON REGULATIONS

.22 Emergency Preparedness.

	<i>PARC</i>	<i>I</i>	<i>II</i>	<i>III</i>	<i>ED</i>
<i>A. The Trauma Center shall have a hospital Emergency Preparedness/Disaster plan described in the hospital's policy and procedure manual or equivalent.</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>
<i>B. The hospital disaster plan shall have a hazards vulnerability analysis to guide the response plan.</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>
<i>C. The Hospital Incident Command System (HICS) shall be used as a management system for incident command, planning logistics, operations and finance/administrative functions.</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>
<i>D. A tiered – approach depending on the magnitude of the event and alternatives for care shall be identified.</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>
<i>E. The Trauma Center shall be represented on the hospital's Emergency Preparedness/Disaster Committee.</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>NA</i>
<i>F. The Trauma Center hospital shall:</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>
<i>(1) Participate in local, state and/or national disaster management meetings, plans and exercises; and</i>					
<i>(2) Conduct hospital drills that test the individual hospital's disaster plan at least twice a year, including actual plan activations that can substitute for drills.</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>
<i>G. A written plan for supporting Trauma Center incident debriefing shall be accessible for all staff members.</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>	<i>E</i>

PATRICIA GAINER
Acting Co-executive Director

