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EMERGENCY HEALTH SYSTEMS
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State Trauma Advisory Board Meeting Agenda

Date: April 15, 2024

Time:
10:30 a.m. Open

Location:
301 Centennial Mall South
Lincoln, NE 68509
Meadowlark Room – Lower Level

For Information Contact:
Tonja Bohling
(402) 471-8129 or
DHHS.EMSTraumaprogram@nebraska.gov

All items known at the time of distribution of this agenda are listed. A current agenda is available at the Department of Health and Human Services, Division of Public Health Office of Emergency Health Systems. If auxiliary aids or reasonable accommodations are needed for attendance at a meeting, please call Tonja Bohling at (402) 471-8129 (voice), or for persons who are deaf or hard of hearing, please call the Nebraska Relay System at 711 (TDD), prior to the meeting date. Advance notice of seven days is needed when requesting an interpreter.

2024 Board Meeting Dates:
August 16, 2024
November 18, 2024

Note: Dates are subject to change

1) Call to order, Roll Call and Declaration of a Quorum
    a. **Announcement: "This is a public meeting, and the open meetings law is posted."**
    b. **Adoption** of Agenda – April 15, 2024
2) Approval of Minutes – January 12, 2024
3) Recognition of New Board Members (Cantrell)
4) Office of Emergency Health System
    a. EMS Program (Jorgensen)
    b. Education & Training Agency Compliance (Snodgrass)
    c. Emergency Medical Services for Children (T. Wilson)
    d. Critical Incident Stress Management (Neumiller)
    e. Trauma System (Wren)
        i. Trauma Registry RFP
    f. Stroke/STEMI System (Neumiller/T. Wilson)
    g. EHS Data Systems (Steele/T. Wilson)
5) Committee Updates
    a. Region 1 Committee – Dr. Kuncir/Katie Pierce
    b. Region 2 Committee – Mackenzie Gasper
    c. Region 3 Committee – Dr. Sorrell/Renae Jacobson
    d. Region 4 Committee – Dr. Hughes/Susan Wilson
    e. Data/QA Committee (Coddington)
    f. Designation Committee (Pierce/Jacobson)
    g. Financials to Support Improvement Committee (Pierce/Coddington/Lee)
    h. Quality Trauma Care Matrix Committee (Harmon/Spohr/Dr. Sorrell)
    i. Trauma Information Highway Committee (Jacobson/Gasper/Walters/Bokelman)
    j. Legislation Outreach Committee (Dr. Hughes/Dr. Cantrell/Dr. Bauman/Dr. Kuncir/Dr. Voigt)
        i. LB 1108
    k. Statewide Education Committee (Dr. Hanna/Kirchner)
6) Trauma Program Updates (Wren/T. Wilson)
    a. OEHS Program Assessment
    b. Rural Emergency Departments – Nebraska's First Rural Emergency Hospital
7) Statewide Trauma System Medical Director/Trauma Symposium Update (Dr. Bauman)
8) Rehab Designation (Bokelman)
9) Draft Regulations (T. Wilson/Wren)
10) DHHS Block Grant Funding (Wren)
11) Next Meeting Date
12) Public Comment

JOIN THE ONLINE MEETING:
https://sonvideo.webex.com/sonvideo/j.php?MTID=m90c05b6f7f29eb58520f7f016119ed77
Meeting number (access code): 2496 763 9188
Meeting password: wWuY2NCmA75

Join by phone:
1-408-418-9388 United States Toll

MEETING MINUTES of the STATE TRAUMA ADVISORY BOARD

January 12, 2024

CALL TO ORDER/ROLL CALL/DECLARATION OF A QUORUM

The meeting of the State Trauma Advisory Board was called to order by Dr. Emily Cantrell, Board Chairperson, at 10:34 am, on Friday, January 12, 2024, virtually. The meeting was held via Zoom. Copies of the agenda were emailed in advance to the Board members, emailed to interested parties, and posted on the Department of Health and Human Services website on 01/09/2024.

The following board members were present to answer roll call:

- Mike Bailey
- Dr. Zachary Bauman
- Tami Bokelman
- Dr. Emily Cantrell
- Jill Coddington
- Mackenzie Gasper
- Marcia Harmon
- Renae Jacobson
- Kyle Kellum
- Sandra Kirchner
- Jessica Lee
- Katie Pierce
- Scott Reifschneider
- Dr. William T. Sorrell
- Mindy Walters
- Susan Wilson

The following Board members were absent: Dr. Chad Duval, Dr. Angela Hanna, Dr. Rommie Hughes, Dr. Eric Kuncir, Shana Romero, Dr. Alesha Scott, Lori Terryberry-Spohr, and Dr. David Voigt.

The following staff members from the Department were also present during all or part of the meeting:

- Tonja Bohling
- Michell Eutsler
- Alex Hartzell
- Juliann Lanphier-Willson, *DHHS Attorney*
- Diane Schoch
- Sharon Steele
- Tim Wilson
- Sherri Wren

A quorum was present, and the meeting convened.

10:37am Dr. Angela Hanna joined the meeting.

ADOPTION OF THE AGENDA

MOTION: Bailey made the motion, seconded by Sorrell, to adopt the agenda for the 1/12/2024 State Trauma Advisory Board meeting.

Voting Yes: Bailey, Bauman, Bokelman, Cantrell, Coddington, Gasper, Hanna, Harmon, Jacobson, Kellum, Kirchner, Lee, Pierce, Reifschneider, Sorrell, Walters, and S. Wilson. Voting No: None. Abstain: None. Absent: Duval, Hughes, Kuncir, Romero, Scott, Terryberry-Spohr, and Voigt. Motion carried.

APPROVAL OF THE MINUTES

MOTION: Pierce made the motion, seconded by S. Wilson, to approve the minutes of the 11/17/2023 meeting.

Voting Yes: Bailey, Bauman, Bokelman, Cantrell, Coddington, Gasper, Hanna, Harmon, Jacobson, Kellum, Kirchner, Lee, Pierce, Reifschneider, Sorrell, Walters, and S. Wilson. Voting No: None. Abstain: None. Absent: Duval, Hughes, Kuncir, Romero, Scott, Terryberry-Spohr, and Voigt. Motion carried.

AGENDA ITEM: Office of Emergency Health Systems Program Updates

Program reports are provided in the handouts, submitted for Board review prior to the meeting, and were posted in the portal.

a. EMS Program: Nothing new added – see attachment A in agenda packet.
b. Education and Training Agency Compliance: Nothing new added – see attachment A in agenda packet.
c. Emergency Medical Services for Children (EMSC) Program: Nothing new added – see attachment A in agenda packet.
d. Critical Incident Stress Management (CISM) Program: Nothing new added – see attachment A in agenda packet.
e. Trauma Program: Wren gave an update on LB 1108. This bill was introduced in this Legislative session. It is sponsored by Senator Dorn and proposes an increase to the Fifty Cents for Life Fund from $0.50 to $1.00. T. Wilson also commented, now that this legislation has been introduced, the Trauma Board's Legislative Outreach Committee can submit support or opinion to the legislative committee for that bill when it is time for a hearing. He also added the Governor is in support of this bill. There was also another bill introduced with LB1085 that could indirectly impact the Trauma Program. This bill would separate DHHS out into three divisions: Developmental Disabilities, Children & Family Services, and Public Health. The Department will keep the Board updated on this bill as it progresses.
f. Stroke/STEMI Program: Nothing new added – see attachment A in agenda packet.
g. EHS Data Systems: Nothing new added – see attachment A in agenda packet.

10:45am *Dr. Eric Kuncir joined the meeting.*

5. AGENDA ITEM: Committee Updates

a. Region 1 Committee – Pierce reported a new Trauma Program manager, Ashley Farrens, at Nebraska Medicine. The Region 1 Trauma Symposium was moved to June and added an opportunity for any discipline (student, nursing, ancillary services, etc.) at any trauma center to submit an abstract for either a poster or a very short podium presentation to share the great work they are doing related to Trauma. Pierce will send out to Wren to send out.
b. Region 2 Committee – None
c. Region 3 Committee – Jacobson reported the Region 3 Committee met in December. 2024 scheduling dates for Trauma classes were shared. One RTTDC class is scheduled and three are looking for dates. There are a couple of new TNCs in the region. No one is up for designation next year.
d. Region 4 Committee – S. Wilson reported the certification classes calendar just came out yesterday for the whole year – 5 ENPCs, 4 TNCCs, 3 ATLS. She will get those dates shared through the state calendar. Region 4 Trauma Symposium will be in September 2024. A final date will be determined on Monday and S. Wilson will get this information out and a "Save the date" to everyone as soon as it is decided.
e. QA Committee – Coddington reported they met earlier this week and came up with three goals: 1) Work on a Data Dictionary 2) investigate the Hybrid Data Dictionary 3) Registry Networking in Education. Once these goals are done, they will move into the more of the data drill down. Lunch & Learn Educations have been scheduled. The first one is on Jan 26 – Patient Inclusion for the Trauma Registry. The next one is on Feb 23 – Q&A at the start with additional topics (the topic will be sent out soon). Bryan Hospital is doing education specific to ImageTrend on March 14 from 12:00 (Noon) – 4:00pm at Bryan and April 18 from 1:00pm – 5:00 at North Platte. There are seats for 30 people. Registration is required for both trainings. The link will be sent out for registering for these classes. There is a meeting next week on the Dictionary. February 12, 2024 at 10:00am is the next QA Committee meeting.
f. Designation Committee – Jacobson reported they will be meeting on January 19, 2024. They revamped the membership to include anyone who is a reviewer. Emails were sent out to

members of the committee who were not reviewers before this change informing them of this change. They can continue to be part of this committee if they want. The Designation Committee has been tasked by the Trauma Information Committee to look at the Clarification Document as they will be adding to it at the next meeting. If anyone else has a request, just let the committee know.

g. Financials to Support Improvement Committee – Pierce update they are trying to get a report that is what everyone wants. This is a work in progress. Coddington added the Iowa report came out and they are working with Iowa on a needs assessment on how to get a similar report done for Nebraska. The Committee will look at moving this forward with grants later.
h. Quality Trauma Care Matrix Committee – Harmon reported they will be meeting on January 31, 2024. They will finalize the survey Harmon has been working on and get it out. Once this is done, they will start to look at the differences between the services where feedback is not being received to have that quality continuous.
i. Trauma Information Highway Committee – Jacobson reported this committee had meetings on Dec. 8, 2023 and Jan. 10, 2024. The current project is to look at the State Trauma Website and review and refine the things that are on there so it can serve as a hub for sharing information. The following changes were recommended and will be sent to T. Wilson: expanding the contact list for the Designated Hospitals, review of the Approved Trauma Education Form was delegated to the Designation Committee, revising the attachments that are under the Trauma Registry Resources and the TQIP Collaborative Reports, removing the old education and adding new ones, updating the board members list, sharing the Clarification Document, and expand the Pediatric Tool Kit to include rural and adult.
j. Legislation Outreach Committee – Kuncir reported they met with the EMS Board Legislative Committee, including Dr. Smith and a couple other members. From that meeting the Legislation Outreach Committee has an invitation to a sit-down breakfast on Tuesday with the Nebraska Firefighters Association. The EMS Board has had meetings with the Governor regarding increasing the Fifty Cents for Life Fund from $0.50 to $1.00. Cantrell added Mike Bailey, also on the EMS Board Legislative Committee, will be assigned to the Trauma Board Legislation Outreach Committee as well. There are opportunities to meet with lobbyists and Legislators at a breakfast next week. The Legislation Outreach Committee was reminded they have authority to speak with government officials about the Trauma System funding issues. Bauman commented on getting data to provide to Senators that shows the benefits of the Trauma System. T. Wilson responded that the Legislative Outreach Committee should determine what metrics to pull from the state registry, and the Department can pull data and add some from the registries.
k. Statewide Education Committee – Dr. Hanna reported they are working on a quarterly Statewide Educational Conference, sending invites to all the hospitals, including a cooperative case series where, on a rotating basis, cases can be presented and leaning can come from each other. Some concerns had been voice about HIPPA violations. Kirchner added the first case will come in the next month or so. The initial case series will start with a case scenario from Children's Hospital and one from Bryan. Pierce brought up the protection of PI, not HIPPA, and peer review work as a concern. T. Wilson deferred this question to Department Legal. Discussion was held. Lanphier-Willson will check with the HIPPA Compliance Team and send information back to T. Wilson. Pierce will send the statute numbers to Lanphier-Willson so she can make sure peer review work is also protected.

AGENDA ITEM: Trauma Program Update

Update given in OEHS Program Updates – Agenda Item #4.

AGENDA ITEM: Statewide Trauma System Medical Director Update

Dr. Bauman spoke on having a Statewide Symposium in 2025. The group met earlier in the week. It was suggested Wren write a grant for $60, 000-80,000 to be submitted in April, accepted/denied in June/July. It was suggested a planning committee plan for a Statewide Symposium in September or October of

2025, forgoing all regional trauma symposiums that year. Dr. Sidwell in Iowa was referred to since IA does this every other year. They have been doing this since 2019. They usually have 500-800 people attend a two-day event. There are classes offered the first day (ASID, DMAP, TNCC, ATLS, etc.) The second day they bring in keynote speakers. They have different tracks, provider track, nurse track, prehospital, etc. Registration is $75.00 with the remainder being offset with money from the state trauma department/state government. This may be offset by grant money. This would be a good opportunity to get DHHS, Senators, Legislators, etc. involved and hosted in Lincoln. It was suggested it could be held every other year and thus hold off Regional Trauma Symposiums those years and have people help on the Statewide Symposium. Iowa has about 15 people on their planning committee. If everyone agrees to proceed with a Statewide Symposium, Dr. Bauman will work with coordinating a planning committee. CME credit can be obtained through an educational institution/hospital like UNMC, Children's Hospital, Bryan Hospital, Creighton University, etc. Dr. Bauman will send out to the Board members the 2022 Iowa's State Trauma Symposium Brochure. EMS holds two EMS Statewide Conferences yearly, a three-day conference in July and a two-day conference in March. One is done by The Nebraska EMS Association. and one done by the Statewide EMS Conference; both are supplemented financially by the Department. Discussion was held.

T. Wilson will have Wren write into the grant to maintain the $60,000 amount and/or increase it from there. S. Wilson gave her support to move forward with setting up a planning committee. It was also suggested to set up a contract with one of the universities to be the lead and have them plan the Symposium and handle the CME credits. Bauman will send Board members the IA brochure to look at. Bauman will work with Wren on getting a planning committee started. Please let Dr. Bauman know if you are interested in helping on the planning committee.

AGENDA ITEM: Rehab Designation

Bokelman asked how for clarification on how designation of rehab. centers across the state works (the application process, data collection components, etc.). Wren and T. Wilson answered it is required by statute but is not being done at this time. The timeline for moving forward is unclear. There are about 13 hospitals with a rehabilitation component that fall under these requirements. Once these centers are designated there is a data collection component that is required of them. T. Wilson and Wren will do an internal strategy session and will bring a report to the next board meeting.

AGENDA ITEM: Draft Regulations

The draft regulations were sent out prior to the meeting in the agenda packet for review by the Board. The committee has been meeting regularly over the last few months to make updates and edits. These are being proposed to the board for review. The draft regulations may not be ready to move forward for board approval. Another meeting may be needed due to questions and some issues that came up. The following may need to be looked at: 1) Peer review requirement for neurosurgeon at the basic level as a requirement for the basic trauma centers and 2) Peer review requirement for an orthopedic surgeon.

Coddington reported the QA Committee met on Monday. A subgroup is working on the Data Dictionary/Hybrid Data Dictionary and looking at other states that are using a Hybrid. They did not find any other states that are doing a hybrid (state only data elements in a separate data dictionary). This will create more work for the critical access hospitals as they will have to look at two different dictionaries – the approved version at the time of propagation and the state dictionary – as they are doing the extractions. Data Dictionaries are out a couple of years and could cause access problems if there are delays in getting updates made and approved. This will be discussed more in a Data Dictionary Committee meeting on Wednesday. Making a copy of the dictionary available would be one solution.

Department Legal should weigh in on this topic as well, however the Trauma Board attorney, Teresa Hampton, retired in December. It was suggested to wait for a permanent Legal Counsel to be hire and new Legal Counsel assigned to this Board.

Wren and T. Wilson will join the next QA Committee meeting and then schedule one more Draft Regulatory meeting.

Lanphier-Willson offered to attend or find another attorney to attend the next Draft Regulation meeting.

The agenda item was tabled until the next Trauma Board meeting.

AGENDA ITEM: DHHS Block Grant Funding

Wren gave an update. There is $60,000 funding from the DHHS Block Grant for this fiscal period. Trainings have been scheduled for the Trauma Registry and planning for the TNC Day. There have been requests for Trauma Symposiums and Registry Training for Level 1 Trauma Registrars. Send requests for education for Registry or Trauma Program Managers - Leadership Management Training, especially at the Basic Level, to Wren and she will get them approved by T. Wilson. She sent out a list of specialty classes to nurses and did not get back any requests. She also inquired about interest in PCAR and TCAR classes and only received 12 or 13 responses of interest.

AGENDA ITEM: Next Meeting Date

Dr. Cantrell reminded everyone the next meeting will be in Lincoln on Monday, April 15, 2024 and it is an in-person meeting. Venue will be decided on later. It will either be held at Bryan Hospital or at the DHHS State Office Building in downtown Lincoln.

AGENDA ITEM: Public Comments

None.

CONCLUSION AND ADJOURNMENT

There being no further business, the meeting adjourned at 11:45 am by Dr. Cantrell.

Respectfully submitted,

Tonja Bohling
OEHS Administrative Technician

Attachment A

State Trauma Board Meeting, April 15, 2024
Office of Emergency Health Systems Reports

a) EMS Program (Jorgensen)

- During the first quarter of 2024, the EMS Program made 840 individual EMS contacts. (These counts do not include others assisted such as hospitals, EMS training agencies, etc.) These individual contacts are largely due to their need for technical assistance.
- The number of licensed EMS services are below:

Western	68
Central	102
Northeast	121
Southeast	130
Total	421

- We have hired Darla Hopwood as our Northeast Region EMS Specialist. Darla is located in Shelby and is an Emergency Medical Technician (EMT). We are very excited that she has joined our team.
- We are anxiously awaiting the final report from the Nebraska EMS statewide assessment that was conducted by SafeTech Solutions. Thank you to all that completed the surveys or attended a listening session.
- A Telehealth in EMS Pilot Project began in Nebraska last December. Avel eCare is the company that has been installing equipment in the back of ambulances and conducting training for those services. Currently, there are ten EMS services with 23 ambulances utilizing telehealth in the back of their ambulances. Ten more services are in the process of having equipment installed into 19 more ambulances. Those are scheduled to go live before the end of April, 2024. The EMS services are participating in a one-year project. We look forward to getting results back to quantify the benefits of an EMS telehealth system in Nebraska.
- Preventive Health and Health Services (PHHS) Block Grant: Funding cycle began on 10-1-2023 and goes through 9-30-2024. We are approved for $30,000 to fund community paramedicine training.
- EMS service periodic inspections are continuing across the state. We continue doing some initial inspections of a few services that are changing license levels or changing ownership.

b) Education and Training Agency Compliance (Snodgrass)

- Six training agency inspections to be scheduled this year.
- A contract is in place to produce a pre-course video outlining the requirements and expectations of completing an EMS initial course. This will be made available on a website link for the public.

- The Leadership Academy is scheduled for June 26-30, 2024, at Central Community College (CCC) – Columbus. Contact Wendy Snodgrass for registration information.
- The EMS Education Program is applying for Preventive Health and Health Services (PHHS) grant funds for online training program accounts, leadership training, and an EMS Instructor workshop.
- Five of the six immersive simulation sites have equipment installed. Reach out to Western Nebraska Community College (WNCC), Mid-Plains Community College, Central Community College (CCC) – Grand Island, Creighton, or Northeast Community College (NECC) to schedule time for training. These rooms are open to all healthcare professions for initial and continuing education.

Emergency Medical Services for Children Program (Wilson)

- No Report

c) Trauma System Program (Wren)

- *Trauma Center Designations:*
  - 53 Trauma Centers Designated
    - ❖ 2024 Designations:
      - ➢ Phelps Memorial Health Center, Holdrege (Basic) – Region 1
    - ❖ 2024 Upcoming Trauma Center Designation Visits:
      - ➢ Genoa Community Hospital, Genoa (Basic) – Region 1
      - ➢ Nebraska Medicine, Omaha (Comprehensive) – Region 1
      - ➢ Pawnee County Memorial Hospital, Pawnee City (Basic) – Region 2
- *Grants*:
  - Nebraska Preventive Health and Health Services Block Grant (PHHSBG): 2023-2024 Grant Award = $60,000. The funds will be used for the trauma registry, prevention, and leadership training.
- *Trauma Advisory Board Vacancies:*
  - EMS Agency Professional (Urban) – One vacancy
  - Physician practicing in emergency medicine (Rural level 3 or 4) – One vacancy
  - Region 2 Trauma Medical Director – One vacancy
- *Trauma Advisory Board Appointments:*
  - UNMC Trauma Nurse Coordinator Appointment: Ashley Farrens, MSN, MBA, RN, UNMC
- *Request for Proposal:*
  - Trauma Registry Request for Proposals are pending.
- *Trauma Registry Trainings (1:00 p.m. to 4:00 p.m.):*
  - April 18, 2024 – North Platte ***In-person only (Flyers were sent out via email to register)
  - April 19, 2024 – Zoom – Lunch and Learn – Trauma Collaborative.
  - May 3, 2024 – Zoom – Registry Basics
- *TNC Conference: (In-Person and on Zoom)*
  - June 6, 2024, 9:00 a.m. to 4:00 p.m. – North Platte.
- *Next Trauma Advisory Board Meeting (In-person):*
  - April 15, 2024, 10:30 a.m. to 2:00 p.m. – Lincoln (see website for location).

d) Stroke/STEMI System Program (Neumiller)

- *Stroke:*
  - This year the focus of the State Stroke Task Force is on women and their unique stroke risks. Trying to help them identify female specific symptoms to help them advocate for themselves and their loved ones.
  - To achieve this goal the task force members have:

        - ❖ Manned a booth at the Lincoln Women's Exposition where they were able to connect with over 350 women that visited the booth. They handed out quick reference guides for stroke recognition and were able to really take the time to talk to women, answer questions and provide support, direction, and resources for those who asked.
        - ❖ Manned a booth at the Brain Injury Alliance Conference in Kearney. Many people stopped to ask questions and to get the resources we had on hand.
    - The stroke task force is also in the process of planning a one-day Stroke Symposium (September 20, 2024). The symposium will focus on women in stroke, post-acute and rehab considerations for women after stroke. The day will conclude with stroke survivors discussing the challenges they have faced post-stroke and how they have dealt with those.
- *STEMI:*
    - Continuing to work with law enforcement with the Helmsley AED grant.
    - Officers have used their AEDs 44 times this year resulting in 3 known saves.

e) Critical Incident Stress Management Program (Neumiller)

- March 1, 2024, Debbie Kuhn retired from the Office of Emergency Health Services (OEHS), Becka Neumiller has assumed Debbie's position as the CISM program manager and is in the process of learning the program.
- Plans are in motion for a CISM 2-day conference to be held in Kearney September 13 & 14, 2024, look for forthcoming details.

f) EHS Data Systems Program (Steele)

- The Request For Proposal (RFP) is in the process of being reviewed.
- The data elements and codes within the current Trauma Data Dictionary have been reviewed and appropriate corrections have been documented.
- Meetings with the Rehabilitation Committee have been progressing. There are three rehabilitation data elements that have been activated in Patient Registry, however, those specific data elements have not yet been placed on a form. Those three rehabilitation data elements are currently in the Trauma Data Dictionary.
- Progress on reports that are related to the Ambulance Telehealth project are being put in place. There are a few Ambulance Services in the State of Nebraska that now have Telehealth capabilities in their Ambulances.
- Sharon Steele and Tim Wilson continue to work with the QA/Data Committee.
- Mason Holmes and Sharon Steele have assisted Ambulance Service personnel by answering questions and conducting training as is needed.

Archived: Friday, March 29, 2024 10:27:03 AM
From: Renae Jacobson NE-Kearney
Sent: Friday, March 29, 2024 9:40:48 AM
To: Wren, Sherri; Bohling, Tonja; Wilson, Tim
Cc: Mackenzie Gasper; Jill Coddington -NE
Subject: State trauma board packet information
Importance: Normal

Here are the results so far from the state data survey. Please include in the meeting packet.
Thanks!

Survey Results for State Data Requests:

1. Transfer delays related to ISS/EMS availability
2. Motorcycle helmet use
3. Fall related to age, activation level and anticoagulant use.
4. Mortality
5. ED LOS
6. Patient volume/activation volume
7. Alcohol and Drug detected in Transport related trauma cases
8. Car, pickup or van occupant with ISS > 15 by restraint use
9. Hospital disposition
10. Cause of injury by age
11. Blood transfusion rates at sending hospital.
12. Shock index of all transferred patients for higher level of care.

Renae Jacobson, MSN, RN, TCRN, CCRN

TRAUMA PROGRAM MANAGER/

TRAUMA NURSE COORDINATOR

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TITLE 185 NEBRASKA STATEWIDE TRAUMA SYSTEM

CHAPTER 1 STATEWIDE TRAUMA SYSTEM

001. SCOPE AND AUTHORITY. These regulations establish the procedures and standards for a comprehensive trauma system as authorized by the Nebraska Statewide Trauma System Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 71-8201 through 71-8253.

002. DEFINITIONS. For the purposes of these regulations, the definitions in the Nebraska Statewide Trauma System Act and the following apply.

002.01 ADVANCED PRACTICE PROVIDER. A person licensed as an advanced practice registered nurse or a physician assistant.

002.02 BEST PRACTICES. A practice that upon rigorous evaluation, demonstrates success, has had an impact, and can be replicated.

002.03 COMPLETE APPLICATION. An application that contains all the information requested on the application, with attestation to its truth and completeness, and that is submitted with the required documentation.

002.04 CREDENTIALING OR CREDENTIALED. Approval of a physician as a member of a hospital's trauma team by the hospital's credentialing committee, based on a review of the individual's training and experience.

002.05 IN-HOUSE. Physically present in the facility.

002.06 INJURY PREVENTION PROGRAMS. Internal institutional and external outreach educational programs designed to increase awareness of methods for prevention or avoidance of trauma-related injuries.

002.07 MECHANISM OF INJURY. The source type and characteristic of forces that produce mechanical deformations and physiologic responses that cause an anatomic lesion or functional change in humans.

002.08 MORBIDITY. The relative incidence and consequences of disease.

002.09 MORTALITY. The statistical proportion of deaths to population.

002.10 MULTIDISCIPLINARY TRAUMA REVIEW COMMITTEE. A committee with membership from all disciplines involved in trauma care across the care continuum that meets to address and evaluate trauma care.

002.11 ON-CALL. Available by phone, cell phone, radio, electronically, or pager and able to arrive at the facility within 30 minutes.

002.12 ON-SITE REVIEW. An on-site review may be a conducted at the physical location of the facility or may be conducted electronically.

002.13 PERFORMANCE IMPROVEMENT PROGRAM. A program within the designated trauma center that analyzes mortality, morbidity, and functional status and concurrently tracks and reviews process and outcome measures that encompass out-of-hospital and hospital care for the trauma center or trauma region.

002.14 RECOGNIZED INDEPENDENT VERIFICATION OR ACCREDITATION BODY OR PUBLIC AGENCY. For purposes of this regulation and the related designation, the verification or accreditation body or public agency are:

(A) Advanced Level Trauma Center: American College of Surgeons verification as a Level II Trauma Center;
(B) Basic Level Trauma Center: American College of Surgeons verification as a Level IV Trauma Center;
(C) Comprehensive Level Trauma Center: American College of Surgeons verification as a Level I Trauma Center;
(D) General Level Trauma Center: American College of Surgeons verification as a Level III Trauma Center;
(E) Advanced Level Rehabilitation Center: Commission on Accreditation of Rehabilitation Facilities for accreditation in Comprehensive Integrated Rehabilitation Program and either Brain Injury Specialty Program or Spinal Cord Specialty Program;
(F) General Level Rehabilitation Center: Joint Commission accreditation as a rehabilitation hospital;
(G) Intermediate Level Rehabilitation Center: Commission on Accreditation of Rehabilitation Facilities accreditation in Comprehensive Integrated Rehabilitation Programs;
(H) Burn Trauma Center: American Burn Association in conjunction with American College of Surgeons verification as a Burn Center and;
(I) Pediatric Trauma Center: American College of Surgeons verification as Specialty Level Pediatric Center.

002.15 RESUSCITATION. Acts designed to assess and stabilize a patient in order to save a life or limb.

002.16 TRAUMA COORDINATOR OR MANAGER. A registered nurse or an advanced practice provider with responsibility for coordination of all activities on the trauma program and who works in collaboration with the trauma medical director.

002.17 TRAUMA PEER REVIEW COMMITTEE. A committee led by the trauma medical director that is responsible for evaluation of trauma patient care, physician performance, morbidity, and mortality issues are discussed and addressed.

002.18 TRAUMA MEDICAL DIRECTOR. A physician designated by the institution and medical staff to coordinate trauma care.

002.19 TRAUMA PROGRAM. A hospital administrative unit that oversees the care of trauma patients and coordinates other trauma-related activities.

003. DESIGNATION OF TRAUMA CENTERS. To receive a designation as a trauma center, an applicant must submit a complete application and meet the requirements for designation set out in statute and in this regulation.

003.01 INITIAL APPLICATION REQUIREMENTS. An applicant seeking designation for a facility as:

(1) An advanced level trauma center must submit a letter of verification from the American College of Surgeons indicating that the facility is currently verified as a Level II Trauma Center or meet the standards for an advanced trauma center as set out in these regulations;
(2) A basic level trauma center must submit a letter of verification from the American College of Surgeons indicating that the facility is currently verified as a Level IV Trauma Center or meet the standards for a basic trauma center as set out in these regulations;
(3) A comprehensive level trauma center must submit a letter of verification from the American College of Surgeons indicating that the facility is currently verified as a Level I Trauma Center;
(4) A general level trauma center must submit a letter of verification from the American College of Surgeons indicating that the facility is currently verified as a Level III Trauma Center or meet the standards for a general trauma center as set out in these regulations;
(5) An advanced level rehabilitation center must submit an accreditation survey letter from the Commission on Accreditation of Rehabilitation Facilities for accreditation in Comprehensive Integrated Rehabilitation Program and either Brain Injury Specialty Program or Spinal Cord Specialty Program;
(6) A general level rehabilitation center must submit an accreditation survey letter from the Joint Commission indicating it has accreditation as a rehabilitation hospital and current Nebraska trauma center designation;
(7) An intermediate level rehabilitation center must submit a letter of accreditation from the Commission on Accreditation of Rehabilitation Facilities for accreditation in Comprehensive Integrated Rehabilitation Programs;
(8) A specialty burn trauma center must submit a letter of verification indicating that the facility is currently verified as a burn center by the American Burn Association in conjunction with the American College of Surgeons; or
(9) A pediatric trauma center must submit a letter of verification from the American College of Surgeons indicating that the facility is currently verified as a Specialty Level Pediatric Center.

003.01(A) WITHOUT VERIFICATION OR ACCREDITATION. An applicant seeking designation for a facility as an advanced, basic, or general level trauma center not based on verification or accreditation must submit a complete application. An on-site review of the facility is required to determine if all standards are met for designation set out in this chapter.

003.02 ON-SITE REVIEWS. A facility must cooperate with the Department and any on-site

review team, including the following:

(1) Allowing a tour and inspection of the physical plant;
(2) Permitting equipment to be checked for appropriateness and maintenance;
(3) The examination and copying of records; and
(4) Interviewing of staff.

003.02(A) ON-SITE REVIEW TEAM. An on-site review team must have, at a minimum, a physician that specializes in trauma surgery and a nurse that specializes in trauma nursing or individuals with equivalent qualification as determined by the Department as members.

003.02(B) FEES. A comprehensive or advanced level facility must pay the Department a fee for the cost of an on-site review of the facility. Such fee shall be the actual cost of the on-site review as provided in contract(s) between the Department and each reviewer or team of reviewers.

003.03 RENEWAL OF DESIGNATION. Except as provided in this section, the procedures, standards, and requirements described in this chapter govern the renewal of designations.

003.03(A) When a designated center has made a timely application, its designation does not expire until the Department's decision is final.

003.03(B) An advanced level trauma center, a basic level trauma center, a comprehensive level trauma center, a general level trauma center or specialty level pediatric, or burn trauma center who have a verification application pending with the American College of Surgeons or American Burn Association, as applicable, may submit a completed application for renewal, prior to designation expiration, and evidence that its request for verification remains pending with the American College of Surgeons or American Burn Association. The designated center must forward the American College of Surgeon's or American Burn Association's decision and any supporting documentation to the Department.

003.03(C) An advanced level or intermediate level rehabilitation center pending with the Commission on Accreditation of Rehabilitation or general level rehabilitation center pending with the Joint Commission may submit a completed application for renewal, prior to designation expiration, and evidence that its request for accreditation remains pending with the corresponding verifying body. The designated center must forward the decision and any supporting documentation to the Department.

003.04 CAUSE FOR DENIAL, REVOCATION, OR SUSPENSION OF DESIGNATION. The Department may deny, revoke, or suspend any designation or application for designation when the facility:

(A) Is in violation of the statutes; these regulations; or failure to maintain accreditation, verification, or certification for the level of designation;
(B) Makes a false statement of material facts in its application for designation or in any record required by this regulation, or in a matter under investigation;
(C) Fails to allow the on-site review team or a Department employee to inspect any part of the facility, any records, or other documentation for purposes of inspection, investigation, or other information collection activities necessary to carry out the duties of the Department;
~~(D) Fails to comply with the requirements of the approved regional plan;~~

(E) Engages in false, fraudulent, or misleading advertising. The facility must not be fraudulent in any aspect of conducting business, which adversely affects, or which reasonably could be expected to affect adversely, the capacity of the facility to provide trauma care;
(F) Fails to maintain standards required for verification or accreditation in cases where designation was based on the facility's professional verification or accreditation pursuant to Neb. Rev. Stat. § 71- 8244; or
(G) Fails to comply with all applicable provisions of the Emergency Medical Treatment and Active Labor Act.

003.05 DUTY TO PROVIDE CURRENT INFORMATION. Any designated center as a comprehensive, advanced, general, basic, or specialty level trauma center must provide written notice to the Department of any change in the designated centers trauma medical director or trauma coordinator or manager. Such notice must be provided no later than 15 days after the change is made. If the accreditation or certification of a designated center has been sanctioned, modified, terminated, or withdrawn, the licensee must notify the Department within 15 days of receipt of notification of the action.

004. STANDARDS FOR DESIGNATION OF TRAUMA CENTERS – LEVELS OF TRAUMA CENTERS. The standards and levels of trauma center designation are set out below.

004.01 COMPREHENSIVE LEVEL TRAUMA CENTERS. A Comprehensive Level Trauma Center must have current verification from the American College of Surgeons as a Level I Trauma Center.

004.02 ADVANCED LEVEL TRAUMA CENTERS. An Advanced Level Trauma Center must have current verification from the American College of Surgeons as a Level II Trauma Center or meet the standards indicated by an X under "advanced" on the Trauma Centers Criteria Chart in this chapter.

004.03 GENERAL LEVEL TRAUMA CENTERS. A General Level Trauma Center must have current verification from the American College of Surgeons as a Level III Trauma Center or meet the standards indicated by an X under "general" on the Trauma Centers Criteria Chart in this chapter.

004.04 BASIC LEVEL TRAUMA CENTERS. A basic level trauma center must have current verification from the American College of Surgeons as a Level IV Trauma Center or meet the standards indicated by an X under "basic" on the Trauma Centers Criteria Chart in this chapter.

004.05 TRAUMA CENTERS CRITERIA CHART. The standards a facility must meet for designation are:

CATEGORIES	ADVANCED	GENERAL	BASIC
Institutional organization must include the following:			
Institutional support as evidenced by a signed board resolution; a signed medical staff resolution; hospital administrator and trauma medical director working together; and an organizational chart that places	X	X	X

the trauma program in equal authority with other departments.			
The trauma program must demonstrate its ability to influence care across all phases of trauma treatment within the hospital.	X	X	X
Trauma medical director who is a current board certified general surgeon (or general surgeon eligible for certification by the American Board of Surgery) or a general surgeon who is an American College of Surgeons Fellow with a special interest in trauma care and who participates in trauma call.	X	X	
Trauma medical director who is a physician on staff at the hospital.			X
Trauma coordinator or manager.	X	X	X
Trauma team that consists of physicians, advanced practice providers, nurses, and allied health professionals to respond to a trauma emergency in the hospital emergency department. At a minimum: a. The team is under the leadership of the trauma surgeon, general surgeon or in basic trauma centers, a physician or an advanced practice provider covering the emergency department; b. When the trauma surgeon is not in-house, the physician or advanced practice provider covering the emergency department will act as team leader until the trauma surgeon arrives in the resuscitation area; and c. A trauma team that includes a registered nurse.	X	X	X
Trauma peer review committee where the trauma medical director must attend 50% of the meetings. Meeting minutes that reflect detailed discussion, action steps, and conclusions must be maintained. At the advanced level, the committee meeting must be conducted independently from hospital or department based peer review and be incorporated into the hospital wide activities. At the general or basic level, the committee meeting may be part of	X	X	X

another hospital quality meeting but the meeting minutes must reflect a separate section devoted to trauma care.			
Multidisciplinary trauma review committee may have members from all disciplines that are involved in the care of the trauma patient, meets at least twice a year, and meets all requirements in 185 NAC 1-008 and all subsections.	X	X	X
Hospital departments, divisions, or sections must include the following:			
General surgery.	X	X	
Neurological surgery.	X		
Orthopedic surgery.	X		
Emergency medicine.	X		
Anesthesia.	X	X	
Services available in-house and immediately available 24 hours a day include:			
Emergency services physician.	X	X	
Services available within 15 minutes of patient's arrival include:			
General surgery.	X		
Has a written physician back-up call schedule for general surgery. In trauma centers with accredited residency training programs, the chief resident may serve as back up.	X		
Has a surgeon dedicated to a single hospital. This means the surgeon is not on call at another hospital at the same time.	X		
Anesthesia.	X		
Services on-call 24 hours a day include:			
General surgery.	X	X	
Primary care physician or advanced practice provider covering the emergency department. In basic trauma centers where an advanced practice provider takes first call for the emergency department, there must be written criteria stating when the on-call back up attending physicians must be contacted for unstable patients.			X
Anesthesia.		X	
Orthopedic surgery.	X		
Has an orthopedic surgeon dedicated to single hospital (meaning not on call at another hospital at the same time) or back up call. In trauma centers with accredited residency training programs, the chief	X		

resident may serve as back up.			
Neurologic surgery.	X		
Has a neurosurgeon dedicated to single hospital (meaning not on call at another hospital at the same time) or back up call in trauma centers with accredited residency training programs the chief resident may serve as back up.	X		
Obstetrics gynecologic surgery.	X		
Oral maxillofacial surgery.	X		
Ophthalmic surgery.	X		
Plastic surgery.	X		
Critical care medicine.	X		
Radiology.	X	X	X
Interventional radiology. In advanced trauma centers, an interventional radiologist must either be available within 30 minutes, 24 hours a day or a written contingency plan with 100% performance improvement program review of all patients must be in place.	X		
Thoracic surgery.	X		
General or Trauma Surgeon must meet the following:			
Board certified or eligible for board certification by an appropriate specialty board recognized by the American Board of Medical Specialists or meets all of the following alternative criteria: a. Completed an approved residency program; b. Is approved for privileges by the hospital's credentialing committee; c. Meet all criteria established by the hospital's trauma director; d. Experienced in trauma care that is tracked by a performance improvement program; and	X	X	
Has a physician representative from general or trauma surgery who attends at least 50% of the trauma peer review committee meeting held at least twice a year.	X	X	
Has a physician representative from general or trauma surgery who attends at least 50% of the trauma peer review committee meetings held at least twice a year if one is on staff and actively involved in the care of trauma patients.			X

Emergency medicine physician; primary care physician or advanced practice provider covering the emergency department must meet the following:			
Has a physician who is board certified or eligible for board certification by an appropriate specialty board recognized by the American Board of Medical Specialists or meets all of the following alternative criteria: a. Completed an approved residency program; b. Approved for privileges by the hospital's credentialing committee; c. Meet all criteria established by the hospital's trauma director; d. Is experienced in trauma care that is tracked by a performance improvement program; and	X		
Has a physician representative who attends at least 50% of the trauma peer review committee meetings held a minimum of twice a year.	X	X	X
Neurosurgery must meet the following: General level trauma centers are not required to have a neurosurgeon on staff. If one is on staff and participates in the care of trauma patients, they must meet the standards indicated by an X under "general" in the following.			
Has a neurological surgeon who is board certified or eligible for board certification by an appropriate specialty board recognized by the American Board of Medical Specialists or meets all of the following alternative criteria: a. Completed an approved residency program; b. Is approved for privileges by the hospital's credentialing committee; c. Meet all criteria established by the hospital's trauma director; d. Experienced in trauma care that is tracked by a performance improvement program; and	X	X	
A neurosurgical surgeon attends at least 50% of the trauma peer review committee meetings held a minimum of twice a year.	X		
A neurosurgical surgeon, if one is on staff and actively involved in trauma care, attends at least 50% of the trauma peer review committee meetings held a minimum of twice a year.		X	X
Orthopedic surgery must meet the following:			
Orthopedic surgeon who is board certified	X		

or eligible for board certification by an appropriate specialty board recognized by the American Board of Medical Specialists or meets all of the following alternative criteria: a. Completed an approved residency program; b. Is licensed to practice medicine and approved for privileges by the hospital's credentialing committee; c. Meet all criteria established by the hospital's trauma director; d. Experienced in trauma care that is tracked by a performance improvement program; and			
An orthopedic surgeon attends at least 50% of the trauma peer review committee meetings held a minimum of twice a year.	X		
An orthopedic surgeon, if one is on staff and actively involved in trauma care, attends at least 50% of the trauma peer review committee meetings held a minimum of twice a year.		X	X
Radiology must include the following:			
A radiologist attends at least 50% of the trauma peer review committee meetings held a minimum of twice a year.	X	X	
A radiologist, if one is on staff and actively involved in trauma care, attends at least 50% of the trauma peer review committee meetings held a minimum of twice a year.			X
Facilities, resources, and capabilities include:			
Presence of a surgeon at resuscitation. In a hospital with a general surgery accredited residency program, if a team of surgeons initiates evaluation and treatment of the trauma patient, that team of surgeons may include a surgical resident from the hospital's residency program, if the resident has reached a seniority level of post graduate year (PGY) 4 or higher. If the surgical resident is a member of the evaluation and treatment team, the attending surgeon may take call from outside the hospital if the hospital establishes local criteria defining what requires the attending surgeon's immediate presence.	X		
Emergency department must meet the following:			

Trauma team activation criteria that includes physiologic, anatomic, and mechanism of injury with written protocol defining activation process including required personnel, expected response times and defined activation level(s) for the facility.	X	X	X
Trauma team activation criteria for the highest level of activation, *at minimum,* must include the following nine criteria: a. Confirmed blood pressure less than 90 mm Hg at any time in adults, and age-specific hypotension in children b. Gunshot wounds to the neck, chest, or abdomen c. GCS less than 9 (with mechanism attributed to trauma) d. Transfer patients from another hospital who require ongoing blood transfusion e. Patients intubated in the field and directly transported to the trauma center f. Patients who have respiratory compromise or are in need of an emergent airway g. Transfer patients from another hospital with ongoing respiratory compromise (excludes patients intubated at another facility who are now stable from a respiratory standpoint) h. Emergency physician's discretion. i. Facility specific criteria			
Heliport or landing zone located close enough to permit the facility to receive or transfer patients by air.	X	X	X
Have a designated physician director for the emergency department.	X	X	X
Emergency department includes equipment for patient resuscitation of all ages:			
Airway control and ventilation equipment including airway control and ventilation equipment; bag valve mask and reservoir; oropharyngeal airway devices; laryngoscope and blades; endotracheal	X	X	X

tubes; supraglottic airway device; or alternate airway device and portable video laryngoscope.			
anSuction equipment and devices.	X	X	X
Drugs necessary for Rapid Sequence Intubation.	X	X	X
Pulse oximetry.	X	X	X
Electrocardiograph-oscilloscope-defibrillator.	X	X	X
Qualitative end-tidal carbon dioxide.	X	X	
Quantitative or qualitative end-tidal carbon dioxide.			X
Large bore, long intravenous catheter for needle decompression (minimum 14 gauge, 3.25 inch).	X	X	X
Standard IV fluids and administration sets.	X	X	X
Large bore intravenous catheters.	X	X	X
Intraosseous needle or kit.	X	X	X
Cricothyroidotomy kit or equipment for surgical airway.	X	X	X
Thoracostomy tray.	X	X	X
Hemorrhage control tourniquets.	X	X	X
Traction splints (in basic trauma centers, traction splints may be shared with local emergency medical service with a written plan for obtaining equipment).	X	X	X
Pelvic binder (in basic trauma centers, pelvic binders may be shared with local emergency medical service with a written plan for obtaining equipment).	X	X	X
Pediatric resuscitation tape.	X	X	X
Thermal control for patient.	X	X	X
Equipment for communication with Emergency medical services.	X	X	X
Device capable of detecting severe hypothermia.	X	X	X
Thermal control for fluids and blood.	X	X	
Rapid infuser system in general trauma centers, the rapid infuser may be shared with the operating room.	X	X	
Ultrasound.	X	X	
Central venous pressure monitoring equipment.	X	X	
Reversal agents for anti-coagulant and anti-platelet medications.	X		
Central line insertion.	X		
Thoracotomy equipment.	X		
Arterial catheters.	X		
Internal paddles.	X		

Cervical traction devices.	X		
Operating room must include: Basic trauma centers are not required to have an operating room. If available and used in the care of trauma patients, they must meet the standards indicated by an X under "basic".			
Personnel available within 15 minutes, 24 hours a day seven days a week.	X		
Personnel available within 30 minutes, including the General Surgeon response for highest level activations, 24 hours a day seven days a week.		X	X
Age specific equipment.	X	X	
Thermal control for patient.	X	X	X
Thermal control for fluids and blood.	X	X	X
X-Ray capability including c-arm image intensifier.	X		
Endoscopes and bronchoscope	X	X	
Craniotomy instruments.	X		
Equipment for long bone and pelvic fixation.	X		
Rapid infuser system (in general trauma centers, the rapid infuser may be shared with the emergency department).	X	X	X
Post anesthetic recovery room (Critical Care Unit is acceptable) must include: Basic trauma centers are not required to have post anesthetic recovery rooms. If available and used in the care of trauma patients, they must meet the standards indicated by an X under "basic".			
Registered nurses available 24 hours a day, seven days a week.	X	X	
Monitoring equipment.	X	X	X
Pulse oximetry.	X	X	X
Thermal control.	X	X	X
Critical Care Unit for injured patients must include the following equipment for monitoring and resuscitation: Basic Trauma Centers are not required to have a Critical Care Unit. If available and used in the care of trauma patients, they must meet the standards indicated by an X under "basic.			
Airway control and ventilation equipment including bag valve mask with reservoir; oropharyngeal airway devices; laryngoscope and blades; endotracheal tubes; airway suction equipment; supraglottic airway device; or alternate airway device and portable video laryngoscope.	X	X	X
Ventilator.	X	X	
Suction equipment and devices.	X	X	X
Pulse oximetry.	X	X	X
Electrocardiograph-oscilloscope-defibrillator.	X	X	X
Qualitative end-tidal carbon dioxide.	X	X	X
Designated surgical director or surgical	X	X	

co-director.			
Intracranial pressure monitoring equipment.	X		
Pediatric patients treated in an adult center **(Patients estimated to be less than 16 years of age that are admitted to an observation or inpatient bed that is designated for adult patients.)** Advanced, basic, and general level facilities are not required to have a formal Pediatric Critical Care Unit; however, if pediatrics patients are treated on-site they must meet the standards indicated by an X in the applicable category.			
Trauma surgeons must be credentialed in pediatric care and have pediatric advance life support certification. Criteria must include Pediatric Advanced Life Support certification.	X	X	
Equipment in all patient care areas for monitoring and resuscitation of pediatric patients must include:			
Pediatric airway control and ventilation equipment: including bag valve mask with reservoir; oropharyngeal airway devices; laryngoscope and blades; endotracheal tubes; airway suction equipment; supraglottic airway device; or alternate airway device and portable video laryngoscope.	X	X	X
Electrocardiograph-oscilloscope-defibrillator.	X	X	X
Pulse oximetry.	X	X	X
Thermal control.	X	X	X
The hospital must have a pediatric critical care unit or a written plan for the transfer of pediatric trauma patients.	X	X	X
A trauma center that has a dedicated Pediatric Critical Care Unit on-site must have equipment for monitoring and resuscitation for pediatric patients of all ages that include:			
Airway control and ventilation equipment including bag valve mask with reservoir; oropharyngeal airway devices; laryngoscope and blades; endotracheal tubes; airway suction equipment; supraglottic airway device; or alternate airway device and portable video laryngoscope.	X	X	
Ventilator.	X	X	
Suction equipment and devices.	X	X	
Drugs necessary for Rapid Sequence Intubation.	X	X	
Pulse oximetry.	X	X	
Electrocardiograph-oscilloscope-defibrillator.	X	X	
Qualitative end-tidal carbon dioxide.	X	X	
Thermal control.	X	X	

Intracranial pressure monitoring equipment.	X		
Respiratory therapy service must be:			
Available in-house 24 hours a day, seven days a week.	X		
On-Call 24 hours a day, seven days a week.		X	
Radiological services-available 24 hours every day and includes:			
In-house radiology technician.	X		
Angiography.	X		
Ultrasound.	X	X	
Computerized tomography.	X	X	
In-house computerized tomography technician.	X		
Magnetic Resonance Imaging.	X		
On-call radiology.		X	X
Clinical laboratory service available 24 hours every day and includes:			
Standard analyses of blood, urine, and other body fluids including point of care testing and micro sampling.	X	X	X
Blood typing and cross matching.	X	X	
Coagulation studies.	X	X	
Packed red blood cells, frozen fresh plasma, platelets, and cryoprecipitate rapidly available for massive transfusion.	X		
Packed red blood cells, frozen fresh plasma, and rapidly available for massive transfusion.		X	
Two or more units of O Negative blood available or rapidly released in an alternate system.			X
Massive transfusion policy.	X	X	
Laboratory technologist available in-house 24 hours a day seven days a week.	X	X	
Laboratory technologist available within 30 minutes of patient's arrival.			X
Blood gases and Potential of Hydrogen (PH) determinations.	X	X	
Microbiology.	X	X	
Acute hemodialysis includes:			
The hospital must have acute hemodialysis in-house. A written plan must be in place to transfer the patient if hemodialysis is not immediately available.	X		
The hospital must have a written plan for the transfer of trauma patients to receive		X	X

acute hemodialysis if not in-house.			
Burn care includes:			
The hospital must have a written plan for the transfer of burn patients to receive burn care if not in-house.	X	X	X
Acute spinal cord and head injury management includes:			
The hospital must provide management of acute spinal cord and head injury care in-house. A written plan must be in place to transfer the patient if these services are not immediately available.	X		
The hospital must have a written plan for the transfer of patients with acute spinal cord and head injury to receive care for acute spinal cord and head injury if not in-house.		X	X
If head injury patients are managed in-house, the equipment and a surgeon credentialed by the hospital to perform a craniotomy or craniectomy and intracranial pressure monitoring must be available.		X	
If spinal cord injured patients are managed in-house, a surgeon credentialed by the hospital to perform operative spinal stabilization and the necessary equipment to treat and monitor spinal cord injuries must be available.		X	
Rehabilitation service includes:			
Hospitals must provide for in-patient acute rehabilitation or have a written plan for the transfer of trauma patients to rehabilitation services if not provided in house.	X	X	X
Hospitals must provide for in-patient physical therapy.	X	X	
Hospitals must provide for in-patient occupational therapy.	X	X	
Hospitals must provide for in-patient speech therapy.	X	X	
Hospitals must provide for in-patient social services or have a written plan for the provision of trauma patients to social service if not provided in-house.	X	X	X
Trauma education			
32 hours of trauma continuing medical education every four years or eight hours each full year employed if employed less than four years:			

General or trauma surgeons.	X		
Emergency medicine physicians who are certified by the American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine are exempt from continuing medical education with documentation of current board certification.	X		
Emergency medicine physicians that are not board certified, primary care physician, or advanced practice provider covering the emergency department.	X		
Neurosurgeon.	X		
Orthopedic surgeon.	X		
16 hours of trauma continuing medical education every four years or four hours each full year employed if employed less than four years:			
General or trauma surgeons.		X	X
Emergency medicine physicians who are certified by the American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine are exempt from continuing medical education with documentation of current board certification.		X	X
Emergency medicine physicians that are not board certified, primary care physician, or advanced practice provider covering the emergency department.		X	X
Neurosurgeon.		X	
Orthopedic surgeon, if on staff and involved in the care of trauma patients.		X	X
Advanced Trauma Life Support certification:			
General and trauma surgeons within one year of hire.	X	X	X
Locum Tenens general and trauma surgeons upon date of hire.	X	X	X
Physicians who specialized in emergency medicine, primary or family care, and advanced practice providers providing care to trauma patients in the emergency department within one year of hire.	X	X	X
Locum Tenens physicians providing care to trauma patients in the emergency department upon date of hire.	X	X	X
The Emergency Nurses Association Trauma Nurse Core Course Certification or a Department approved equivalent: Trauma Nurse Core Course certification will not count towards any other nursing continuing trauma education requirements.			
All registered nurses covering the	X	X	X

emergency department within one year of hire.			
Upon use for all registered nurses not directly employed by the hospital	X	X	X
8 hours of trauma continuing nursing education every four years or two hours of such education for each full year employed if employed less than four years. Four of the eight hours must be in pediatric trauma or one hour of such education for each full year employed if employed less than four years:			
All registered nurses covering the emergency department.	X	X	X
16 hours of trauma continuing nursing education every four years or four hours of such education for each full year employed if employed less than four years:			
All critical care unit registered nurses.	X	X	
All registered nurses treating pediatric trauma patients in an adult critical care unit must have four hours of pediatric trauma.	X		
All registered nurses in a dedicated pediatric critical care unit on-site must have four hours of pediatric trauma.	X	X	
Disaster planning and drills must:			
Hold a minimum of two disaster drills per year to include emergency medical services. One of these may be a tabletop drill.	X	X	X
Performance improvement program must include the following Trauma performance improvement activities must include use of trauma registry reports (written by the facility or obtained from the State Registrar). The facility must track: performance improvement indicators; response times in order to identify opportunities for improvement; event identification and levels of review resulting in development of corrective action plans; methods of monitoring and reevaluation; and detailed documentation of discussions in process improvement meetings. Distribution of such information within the trauma system is required. Facilities must use the trauma registry to run statistical reports.			
Performance improvement program with written plan.	X	X	X
Pediatric-specific performance improvement indicators.	X	X	X
Submits trauma registry data as required by the Department.	X	X	X
There is a peer review process in place to review and categorize deaths.	X	X	X
Multidisciplinary trauma review committee that meets at least twice a year and meets all requirements in 185 NAC 1-008 and subsections.	X	X	X
The trauma registry data is used for: improving patient care and addressing provider and system related issues.	X	X	X
Medical, nursing, or allied health (such as	X	X	X

X-ray, lab, or radiology) participates in the multidisciplinary trauma review committee.			
Review and provide feedback to emergency medical services on patient documentation reports. This may include, but is not limited to: chart review, education and training on patient care, or hands on skills training on trauma patient care.	X	X	X
Hospital provided or sponsored programs to include:			
The hospital must provide physicians, advanced practice providers, and registered nurse's continuing education within the hospital's trauma system at least once a year.	X	X	
Provide feedback on patient care and outcomes to the referring hospital.	X	X	
Prevention activities include:			
Coordinate and participate in injury prevention programs.	X	X	X

005. STANDARDS FOR PEDIATRIC TRAUMA CENTERS. To receive the designation of "specialty level pediatric" a pediatric trauma center must have and maintain verification from the American College of Surgeons as a Pediatric Trauma Center.

006. STANDARDS FOR BURN TRAUMA CENTERS. To receive the designation of "specialty level burn", a burn trauma center must have and maintain verification from the American Burn Association as a Burn Center by the American Burn Association in conjunction with the American College of Surgeons.

007. STANDARDS FOR ADVANCED LEVEL REHABILITATION CENTERS. To receive the designation of advanced level rehabilitation center, a facility must have and maintain accreditation from the Commission on Accreditation of Rehabilitation Facilities International for hospital-based rehabilitation in Comprehensive Integrated Rehabilitation Program and Brain Injury Specialty Program or Spinal Cord System of Care.

008. STANDARDS FOR INTERMEDIATE LEVEL REHABILITATION CENTER. To receive the designation of intermediate level rehabilitation center, a facility must have and maintain accreditation from the Commission on Accreditation of Rehabilitation Facilities International for hospitals based rehabilitation in Comprehensive Integrated Rehabilitation Programs.

009. STANDARDS FOR GENERAL LEVEL REHABILITATION CENTERS. To receive the designation of general level rehabilitation center, a facility must have and maintain accreditation from the Joint Commission in rehabilitation and must be designated as a trauma center by the Department.

010. TRAUMA REGISTRY. Trauma registry requirements for designated trauma, burn and rehabilitation centers are set out below.

010.01 SUBMISSION OF REPORTING DATA. All designated facilities must provide data electronically, through the use of software approved by the Department, to the trauma registry maintained by the Department.

010.02 TIME LIMITS IN REPORTING DATA. All designated ~~facilities must report data monthly to the trauma registry. F~~facilities must report data to th registry on all individual trauma patients within three months of the patient's discharge.
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010.03 INCLUSION CRITERIA. Data must be entered in the trauma registry concerning every patient who meets the ~~2019 Nebraska Trauma Registry Data Dictionary~~ National Trauma Data Standard Data Dictionary inclusion criteria and NE supplemental dictionary at the time of promulgation. Th National Trauma Data Standard Data Dictionary and the Nebraska supplemental Trauma Registry Data Dictionary ~~is~~ are available on the Department's website or may be requested from the Department at 301 Centennial Mall South, Lincoln, NE 68509.

010.04 REPORTING ENTITIES. All levels of designated trauma, specialty, and rehabilitation centers must report data to the trauma registry. Other entities as approved by the Department may report data to the trauma registry.

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010.06 DATA ELEMENTS. Must be in a format, which complies with the 2022 National Trauma Data Standard Data Dictionary and the 2024 supplemental Nebraska Trauma Registry Data Dictionary, and contain the data elements required by the National Trauma Data Standard Data Dicionary and the supplemental Nebraska Trauma Registry Data Dictionary ~~in sections Demographic Information, Injury Information, Pre-Hospital Information, Referring Hospital Information, Emergency Department Information, Hospital Procedure Information, Comorbidity, Diagnoses Information, Outcome Information, Financial Information, Quality Assurance Information, Additional Information, and Rehabilitation Information.~~

011. PERFORMANCE IMPROVEMENT PROGRAM. The standards for a performance improvement program are set out below.

011.01 ELEMENTS OF PERFORMANCE IMPROVEMENT PROGRAM. Performance improvement program activities must have the following components and be implemented:

(A) A flexible list of performance improvement indicators spanning all age groups that are applicable to the designated center and may include indicators determined by the region or state to reduce unnecessary variations in care and prevent adverse events;
(B) Methods through which the designated center consistently monitors and evaluates the performance improvement indicators;
(C) Methods to implement a corrective action plan and re-evaluate trauma care when problems are identified to demonstrate loop closure;
(D) Methods through which the designated center identifies and remedies lapses in their quality of trauma care; and
(E) Methods to evaluate all trauma mortalities.

011.02 METHODS OF PERFORMANCE IMPROVEMENT PROGRAM. Performance improvement program must describe methods designed to ensure that the designated center:

(A) React rapidly and correctly when providing trauma care;
(B) Are informed of the development of best practices in other regions, states, and countries;
(C) Identify and remedy resource challenges in their personnel, equipment, supportive services, or organization; and
(D) Share best practices information with other facilities in their region and in the state.

012. TRAUMA REGIONS. Trauma Regions are established as set out below.

012.01 REGION 1. Region 1 consists of the following counties: Antelope, Boone, Boyd, Burt, Cass, Cedar, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Sarpy, Stanton, Thurston, Wayne, and Washington.

012.02 REGION 2. Region 2 consists of the following counties: Adams, Butler, Clay, Fillmore, Gage, Hamilton, Jefferson, Johnson, Lancaster, Merrick, Nemaha, Nuckolls, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, Webster, and York.

012.03 REGION 3. Region 3 consists of the following counties: Blaine, Brown, Buffalo, Chase, Cherry, Custer, Dawson, Dundy, Franklin, Frontier, Furnas, Garfield, Gosper, Greeley, Hall, Hayes, Harlan, Hitchcock, Hooker, Howard, Kearney, Lincoln, Logan, Loup, McPherson, Phelps, Red Willow, Rock, Sherman, Thomas, Wheeler, and Valley.

012.04 REGION 4. Region 4 consists of the following counties: Arthur, Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Grant, Keith, Kimball, Morrill, Perkins, Scottsbluff, Sheridan, and Sioux.