

Title 15: Mississippi Department of Health

Part 3: Bureau of Acute Care Systems

Subpart 1: Trauma System of Care

Chapter 1 Mississippi Trauma System of Care

Subchapter 1 General

Rule 1.1.1. Legal Authority: The Mississippi State Department of Health (the Department) is assigned the responsibility for creating, implementing and managing the statewide trauma system. The Department shall be designated as the lead agency for trauma system development. The Department shall develop and administer trauma regulations that include, but are not limited to, the Mississippi Trauma System of Care Plan, trauma system standards, trauma center designations, field triage, inter-facility trauma transfer, pediatric trauma care, burn care, trauma data collection, trauma system evaluation and management of state trauma system funding. The Department shall promulgate regulations specifying the methods and procedures by which Mississippi-licensed acute care facilities shall participate in the statewide trauma system. Those regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities. The Department shall also adopt a schedule of fees to be assessed for facilities that choose not to participate in the statewide trauma system, or which participate at a level lower than the level at which they are capable of participating. The Department shall take the necessary steps to develop, adopt and implement the Mississippi Trauma System of Care Plan and all associated trauma system regulations necessary to implement the Mississippi Trauma System. The Department shall cause the implementation of professional and lay trauma education programs. These trauma educational programs shall include clinical trauma education and injury prevention. As it is recognized that rehabilitation services are essential for traumatized individuals to be returned to active, productive lives, the Department shall coordinate the development of an inclusive trauma system, which shall incorporate licensed acute care facilities designated based on resources and staffing, with the Mississippi Department of Rehabilitation Services and all appropriate rehabilitation systems.

Source: Miss. Code Ann. § 41-59-5

Rule 1.1.2. Mississippi Trauma Advisory Committee: The Mississippi Trauma Advisory Committee (MTAC) is created as a committee of the Emergency Medical Services Advisory Council. The membership of the MTAC is comprised of the members of the Emergency Medical Services Advisory Council (EMSAC); the members of which are appointed by the Governor. The Chairman of EMSAC shall appoint EMSAC members to the MTAC. This committee shall act as the advisory body for trauma system development, and provide technical support to the Department in all areas of trauma system design, trauma standards, data collection and evaluation, continuous quality improvement, trauma

system funding, and evaluation of the trauma system and trauma care programs.

Source: Miss. Code Ann. § 41-59-7

Rule 1.1.3. Mississippi Trauma Advisory Committee Meetings: The Mississippi Trauma Advisory Committee (MTAC) shall meet at least quarterly and report to the State Board of Health at its regularly scheduled meetings on the performance of Trauma System. For attendance at such meetings, the members of the MTAC shall be reimbursed for their actual and necessary expenses including food, lodging and mileage as authorized by law, and they shall be paid per diem compensation. Source: Miss. Code Ann. § 41-59-7; Miss. Code Ann. § 25-3-41; and Miss. Code Ann. § 25-3-69.

Source: Miss. Code Ann. § 41-59-5

Rule 1.1.4. **Definitions:** For the purposes of the Mississippi Trauma System, the following abbreviations, acronyms, and terms shall be defined as listed.

1. ACEP – American College of Emergency Physicians.
2. ACLS – Advanced Cardiac Life Support.
3. ACSCOT – American College of Surgeons Committee on Trauma.
4. AIS – Abbreviated Injury Scale.
5. ALS – Advanced life support, including techniques of resuscitation, such as, intravenous access, and cardiac monitoring.
6. APLS – Advanced Pediatric Life Support.
7. ATCN – Advanced Trauma Care for Nurses. A course designed for the registered nurse interested in increasing his/her knowledge in the management of multiple trauma patient.
8. ATLS – Advanced Trauma Life Support.
9. Alpha Patient – A trauma patient meeting the criteria for an Alpha (major trauma or seriously injured) Alert/Activation (refer to Trauma Activation Criteria document maintained on the Department's website).
10. BACS – Bureau of Acute Care Systems, Mississippi State Department of Health.
11. BEMS – Bureau of Emergency Medical Services, Mississippi State Department of Health.

12. BLS – Basic life support techniques of resuscitation, including simple airway maneuvers, administration of oxygen, and intravenous access.
13. Board Certified – Physicians and oral/maxillofacial surgeons certified by appropriate specialty boards recognized by the American Board of Medical Specialties and the Advisory Board of Osteopathic Specialties and the American Dental Association.
14. Burn Fund – Mississippi Burn Care Fund established under Miss. Code Ann. § 7-9-70.
15. BTLS – Basic Trauma Life Support.
16. Bravo Patient – A trauma patient not meeting the criteria for an Alpha Alert/Activation, however, has received injuries requiring immediate attention (refer to Trauma Activation Criteria document maintained on the Department’s website).
17. CAP – Corrective Action Plan.
18. CCRN – Critical Care Registered Nurse.
19. CEN – Certified Emergency Nurse.
20. Catchment Area – Geographic area served by a designated trauma center for the purpose of trauma system planning, development and operations.
21. Department – also, “the Department” refers to the Mississippi State Department of Health
22. Designation – Formal recognition of hospitals by the Department as providers of specialized trauma services to meet the needs of the severely injured patient.
23. Diversion (trauma center) – Circumstances where a trauma center cannot accept the inter-facility transfer of injured trauma patients due to service or facility limitations. NOTE: This does not include pre-hospital/EMS.
24. E&D Chart – Essential and Desirables Chart for each trauma center designation level.
25. Emergency Department (or Emergency Room) – The area of an acute care hospital where the facility customarily receives patients in need of emergency medical evaluation and/or care.
26. EMS – Emergency Medical Services.
27. EMSAC – Emergency Medical Services Advisory Council.
28. ENA – Emergency Nurses Association.
29. Field Triage – Classification of patients according to medical need at the scene of an injury or onset of an illness.

30. GCS – Glasgow Coma Scale.
31. Immediately (or immediately available) – (a) unencumbered by conflicting duties or responsibilities; (b) responding without delay when notified; and (c) being within the specified resuscitation area of the trauma center when the patient is delivered or when notified by EMS that a patient is enroute, whichever is shorter. Specific times for each physician specialty are in the applicable trauma center level chapter.
32. Inclusive Trauma System – a trauma system incorporating every licensed acute care facility with an emergency department in order to provide a continuum of services for all injured persons who require care; in such a system, the injured patient's needs are matched to appropriate hospital resources.
33. Injury – (a) the result of an act that damages, harms, or hurts; (b) unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical or chemical energy or from the absence of essentials such as heat or oxygen.
34. Injury Prevention – efforts to forestall or prevent incidents that might result in injuries.
35. ISS – Injury Severity Score.
36. Level I Trauma Centers – Hospitals that have met the requirements for Level I as stated in Chapter 2 and are designated by the Department.
37. Level II Trauma Centers – Hospitals that have met the requirements for Level II as stated in Chapter 3 and are designated by the Department.
38. Level III Trauma Centers – Hospitals that have met the requirements for Level III as stated in Chapter 4 and are designated by the Department.
39. Level IV Trauma Centers – Hospitals that have met the requirements for Level IV as stated in Chapter 5 and are designated by the Department.
40. Medical Control – Physician direction over pre-hospital activities to ensure efficient trauma triage, transportation and care, as well as ongoing quality management.
41. Mid-level Providers/Practitioners – Physician Assistants (PA) and/or Nurse Practitioners (NP)
42. Mississippi Trauma System of Care Plan – The plan developed by the Department which sets out a comprehensive system of prevention, management and rehabilitation of major traumatic injuries. The plan is published on a three-year cycle.
43. Multidisciplinary Trauma Committee – Hospital committee composed of the trauma service Director, other physician members and other members appointed by the Trauma Medical Director that reviews trauma deaths in a hospital.

44. MTAC – Mississippi Trauma Advisory Committee.
45. Non-Designated Hospital – A licensed acute care hospital that has applied for designation as a trauma center but has not been designated by the Department.
46. Non-Participating Hospital – A licensed acute care hospital that has informed the Department that they do not desire to participate in the Trauma System, or a hospital that does not have a current designation or application for designation on file with the Department.
47. On-Call – Available to respond to the trauma center in order to provide a defined service.
48. PALS – Pediatric Advanced Life Support.
49. Pediatric Trauma Center – Hospitals that have met the requirements for Primary, Secondary, or Tertiary Pediatric Trauma Center designation as stated in Chapter 6 and has been designated by the Department.
50. PHTLS – Pre-Hospital Trauma Life Support.
51. Promptly (or promptly available) – Arrival of on-call physician specialists within the trauma receiving resuscitation area, emergency department, operating room, or other specified area of the trauma center within a maximum of 60 minutes from the time of notification to respond.
52. Performance Improvement (PI or Quality Improvement) – A method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary approach to problem solving and focuses not on individuals but on systems of patient care which might cause variations in patient outcome.
53. Rehabilitation – Services that seek to return a trauma patient to the fullest physical, psychological, social, vocational, and educational level of functioning of which he or she is capable, consistent with physiological or anatomical impairments and environmental limitations.
54. Research – Clinical or laboratory studies designed to produce new knowledge applicable to the care of injured patients.
55. Residency Program – A residency program of the trauma center or a residency program formally affiliated with the trauma center where senior residents can participate in educational rotations.
56. RTTC – Rural Trauma Team Course.
57. RTS – Revised Trauma Score, a pre-hospital/Trauma Center scoring system in which numerical values are assigned to differing levels of Glasgow Coma Scale, systolic blood pressure, and respiratory rate.

58. Senior Resident (or "senior level resident") – A physician licensed in the State of Mississippi who has completed at least two years of the residency under consideration and has the capability of initiating treatment, when the clinical situation demands, and who is in training as a member of the residency program, as defined in regulation, at a designated trauma center. Residents in general surgery shall have completed three clinical years of general surgery residency in order to be considered a senior resident.
59. Service Area (or "catchment area") – Geographic area defined by the local EMS agency as the area served by a designated trauma center.
60. SHO – State Health Officer.
61. TCTF – Trauma Care Trust Fund.
62. TMD – Trauma Medical Director; a physician designated by the trauma center to coordinate trauma care.
63. TNCC – Trauma Nursing Core Course.
64. TPM – Trauma Program Manager; a designated RN with responsibility for coordination of all activities on the trauma service and works in collaboration with the TMD.
65. TSMD – state Trauma System Medical Director.
66. Trauma Registry – a database program managed by the Department that hospitals use to track treatment of trauma victims.
67. Trauma Team – A group of health care professionals organized to provide care to the trauma patient in a coordinated and timely fashion. The composition of a trauma team is delineated by hospital policy.
68. Triage – the process of sorting injured patients on the basis of the actual or perceived degree of injury and assigning them to the most effective and efficient trauma care resources, in order to ensure optimal care and the best chance of survival.

Source: Miss. Code Ann. § 41-59-5

1. **Subchapter 2 Designation of Trauma/Burn Centers**

Rule 1.2.1. Application for Initial Trauma/Burn Center designation.

- a. To receive designation as a trauma center, or as a burn center, or as a tertiary pediatric trauma center, an applicant hospital shall submit an application to the Department. Within 60 days of receipt of the application, the Department shall provide written notification to the applicant hospital that the application has been

received by the Department; whether the Department accepts or rejects the application; if accepted, the date scheduled for an education visit; if rejected, the reasons for rejection and a deadline for submission of the corrected application to the Department.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.2. Trauma Center Education Visit:

1. Designated Level I, II, III Trauma Centers; Burn Centers; or Tertiary Pediatric Trauma Centers may request an education visit. This visit is used to assist the applicant hospital in preparation for the trauma center survey. The results of the visit will be held in confidence by the Department. The Department will work with and provide assistance to the applicant hospital to correct any deficiencies noted during the education visit. Education visits may be conducted on-site or by telephone/video conference; the applicant hospital shall request the preferred type of visit. The composition of the education team shall be determined by the Department.
2. If an applicant hospital requests a trauma center survey without having first received an education visit and the hospital fails to meet designation criteria, the survey shall be deemed an education visit. Any subsequent survey for designation as a trauma center shall be at the applicant hospital's expense.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.3. Hospital Surveys

1. The Department shall provide for the survey of the applicant hospital, provided that its application has been formally approved by the Department, on the date scheduled and indicated in the Department's acceptance letter to the applicant hospital, unless the Department provides written notification with justification of change to the applicant hospital no later than 14 days prior to the survey date; or the applicant hospital provides written request with justification for a change in the survey date to the Department no later than 30 days prior to the survey date.
2. Results of trauma center surveys will be provided by the Department in writing to the applicant hospital. Details related to the hospital's survey will be considered confidential and will not be released.
3. Surveys of Mississippi licensed hospitals and those that currently participate in the Trauma System may be conducted by national accrediting organizations, i.e., American College of Surgeons or American Burn Association. The Department must be present and receive the complete report from the accrediting organization, including any/all Corrective Action Plans (CAP). The Department shall review the report for compliance with the Mississippi Trauma System Rules and Regulations and shall make a recommendation to the State Health Officer for designation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.4. Level I, II, and III Trauma Center, Burn Center, and Tertiary Pediatric Trauma

Center On-site Surveys

1. The Department shall provide multidisciplinary teams for all on-site surveys.
2. Trauma Center survey teams shall consist of disciplines as follows:
 - Level I and II Trauma Centers: Teams shall consist of the following representative disciplines: trauma/general surgeon, emergency medicine physician, and trauma nursing. The Department may add additional team members as necessary. All members of teams for Level I and II Trauma Center inspections shall reside and practice outside the State of Mississippi.
 - Level III Trauma Centers: As a minimum, teams shall consist of the following representative disciplines: trauma/general surgeon and trauma nursing. Team members may reside in Mississippi; however, they may not practice in any hospital or reside within 60 miles of the applicant hospital. The Department may add team members as necessary.
 - Burn Centers: Teams shall consist of the following representative disciplines: surgeon with experience/credentials in burn care and trauma/burn nursing. Team members may reside in or outside of Mississippi; however, they may not practice in any hospital or reside within 60 miles of the applicant hospital. The Department may add team members as necessary.
 - Tertiary Pediatric Trauma Centers: Teams shall consist of the following representative disciplines: trauma/general surgeon with pediatric experience/credentials, emergency medicine physician with pediatric experience, and trauma nursing with pediatric experience. The Department may add team members as necessary. All team members shall reside outside of the State of Mississippi.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.5. Categories of Trauma Center Designations

1. Complete Designation: The hospital has completed all requirements for designation at the application level.
2. Complete Designation with Conditions: The hospital has completed all requirements for Complete Designation at the application level with the exception of minor (no patient or operational impact) condition(s). This designation category may be used for initial designations or an interim change in status from Complete Designation due to a temporary loss of a capacity or capability.
 - The Department, upon receipt, shall either approve or disapprove the plan within thirty (30) days. The Department may require a "Focused Survey" with an inspection team to review the hospital's CAP for complete implementation. If the Focused Survey team deems the CAP fully implemented, the hospital will receive Complete Designation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.6. Term of Trauma Center Designations:

1. The Department shall designate trauma centers for a period not to exceed three (3) years. Designations shall remain active for three years provided no substantive changes or variances have occurred. The Department may perform periodic trauma center audit/reviews at each designated trauma center. The State Health Officer (SHO) may extend trauma center designations for one (1) year.
2. After completion of a designation survey, the team conducting the survey will make a recommendation to the Department for designation. The Director of the Bureau of Acute Care Systems (BACS) will present the survey report and the team's recommendation to the state Trauma System Medical Director (TSMD). The TSMD may seek advice or further recommendation from the Mississippi Trauma Advisory Committee (MTAC) during its executive session, if the TSMD disagrees with the recommendations of the team; otherwise the TSMD may make direct recommendations to the State Health Officer.
3. The Director of BACS will prepare a memorandum detailing the recommendations of the team and signed by the TSMD for the State Health Officer and will forward the memorandum and the designation letter to the State Health Officer for signature. Once signed, the letter will be sent to the hospital receiving the survey.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.7. Trauma/Burn/Tertiary Pediatric Trauma Center Designation Renewal: Hospitals desiring renewal of designation must submit an application to the Department no later than 180 days prior to expiration of designation. The Department will acknowledge receipt of the application within 60 days to the applicant hospital and begin the designation process as provided by this regulation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.8. Loss of Required Trauma Care Capability: Any designated trauma/burn center that loses, either permanently or temporarily, physician, nursing, or other patient care specialties required by this regulation, shall report that loss to the Department utilizing the state approved reporting system. If the loss will result in diminished capability for a period longer than 30 days, the facility must also submit a Corrective Action Plan (CAP) that addresses how the facility will become compliant.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.9. Suspension of Trauma Center Designation: The State Health Officer may suspend the trauma center designation of any hospital for:

1. Documented conditions of serious threat or jeopardy to patients' health or welfare;

2. Failure to comply with laws or regulations;
3. Failure to satisfactorily meet the minimum requirements as a trauma center as defined by regulations for the designation level.
4. Failure to complete a Corrective Action Plan (CAP) within the timeframe specified by the Department.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.10. Hospitals having their designation suspended may reapply for designation after resolution of all issues related to the suspension, and completion of a new application and survey. When a hospital's designation is suspended or withheld, the hospital is responsible for paying the pro-rata fees as set forth in the "Play or Pay" section of these regulations from the date of suspension until the center is re-designated.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.11. Change of Trauma Center Designation

1. Trauma centers will be permitted to change designation if the following conditions are met in entirety:
 - a. The trauma center has been surveyed and designated by the Department, the designation is current, and the trauma center is in full compliance with the Mississippi Trauma System Rules and Regulations;
 - b. The Department's Trauma System Medical Director has reviewed the request and determines that there is no adverse impact to the Trauma System;
 - c. The Bureau of Acute Care Systems concurs with the request;
 - d. The State Health Officer (SHO) or designee issues the new designation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.12. Appeal Process.

1. A hospital shall have 30 calendar days from the date of notification of suspension of trauma center designation to appeal the decision, in writing, to the Department and to request a due process hearing.
2. The Director of the Bureau of Acute Care Systems, upon receipt of a request for a hearing, shall set a date no more than 30 calendar days from the receipt of the request for a hearing.
3. The hearing officer appointed to conduct the hearing shall be a person appointed by the Director of the Office of Health Protection. A stenographic record of the hearing shall be made by a certified reporter/stenographer. The record shall consist of all sworn testimony taken, written, documentary or other relevant evidence taken at said

hearing.

4. Within 30 calendar days of the receipt by the hearing officer of the certified record, he/she shall render findings of fact and conclusions of law contained in an order. The order so produced by the hearing officer shall be the final order of the Mississippi State Department of Health and shall be appealable to a court of competent jurisdiction.
5. If the decision of the Department is unfavorable to the hospital, the hospital may apply for trauma center designation at another level but must pay all costs associated with the survey.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.13. Partial Capability: Any trauma center that chooses to offer patient care services that are above the level of their trauma center designation, must comply with the standards for the higher level of designation, including response times for physician specialties, protocols and procedures, performance improvement processes, and equipment, training, and personnel as listed on the Essentials and Desirables (“E&D”) chart of the appropriate trauma center level. Additionally, the higher patient care must be reviewed by the hospital performance improvement committee, the statewide Performance Improvement Committee and the Department.

Source: Miss. Code Ann. § 41-59-5

2. Subchapter 3 Financial Support for the Trauma System

Rule 1.3.1. Trauma Care Trust Fund: The Trauma Care Trust Fund (TCTF) shall serve as the financial support mechanism for development of the Mississippi Trauma System. The Department shall contract with a vendor, which shall provide specific services, including but not limited to TCTF distribution to designated trauma centers and EMS agencies, administrative support and trauma education activities, which shall be further delineated in the annual contract with MSDH.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.2. Trauma Care Trust Fund Eligibility

1. Trauma Care Trust Fund (TCTF) distribution shall be provided to designated Level I, II, and III Trauma Centers, designated Burn Centers, eligible physicians and eligible licensed ambulance services through the approved vendor. Designated Level IV Trauma Centers will receive an annual stipend for satisfactory participation in the Mississippi Trauma System. To be eligible for trauma funding as provided for in these rules, EMS providers must comply with the Mississippi Guidelines for Field Triage of Injured Patients and transport patients to the most appropriate trauma center (determined through Trauma Registry data reporting and statewide Performance Improvement Committee). Eligible expenditures for EMS providers are listed in the Trauma System Audit Manual posted on the MSDH Website.

2. Level I Trauma Centers and stand-alone Tertiary Pediatric Trauma Centers located in a state contiguous to the State of Mississippi that participate in the Mississippi Trauma System and have been designated by the Department shall be eligible to receive distributions from the TCTF.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.3. Trauma Care Trust Fund Distribution Formula

1. Funds for the administration and development of the Trauma System will be budgeted from available funds from the TCTF. Examples of administrative and development costs include but are not limited to salaries and benefit costs for personnel (full-time and part-time equivalents) who expend a portion of their time in trauma care administration and/or development, travel and training costs for such personnel, use of trauma care physicians and/or other trauma professionals used in the development and/or maintenance of the trauma system, development and/or maintenance of accounting and auditing of the use and distribution of the TCTF, costs of vendors involved in administrative and educational activities, , and the costs associated with the development and/or implementation of the Trauma System (i.e., telecommunication systems, data storage and/or retrieval systems, advertising, equipment, etc.).
2. Eighty-five percent (85%) of the remaining funds from the TCTF are allocated to participating Level I, II and III Trauma Centers and Burn Centers which shall further allocate at least thirty percent (30%) of the funds received to eligible physicians.
3. Fifteen percent (15%) of the remaining funds from the TCTF are allocated to eligible licensed ambulance services that provide pre-hospital care to trauma victims.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.4. Trauma Care Trust Fund Distribution Calculation: Amounts to be disbursed from the Trauma Care Trust Fund (TCTF) shall be calculated as follows:

1. On or about July 31 and January 31 each year, or at such other times as the State Health Officer may direct, the Bureau of Acute Care Systems shall obtain a financial report showing the fund balance in the TCTF.
2. To obtain the amount to be distributed, the following amounts will be subtracted from the fund balance:
 - One half of an amount to be determined by the Department for the administrative expenses of the Department (Bureau of Acute Care Systems, Trauma System of Care) as of the date of the calculation;
 - One half of an amount not to exceed Ten Thousand Dollars (\$10,000) for each Level IV Trauma Center which has completed at least one year of satisfactory participation in the Mississippi Trauma System as of the date of the calculation (annual stipend);

- One half of an amount to be determined by the Department for MSTF administrative costs and costs of budgeted educational expenses as of the date of the calculation.
3. The amount remaining after the above administrative payments have been calculated, reserved and/or expended, shall be distributed according to the TCTF formula.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.5. Trauma Card Trust Fund Ambulance Service Distribution

1. Fifteen percent (15%) of the amount remaining after the expenses noted in Rule 1.3.4 have been determined shall be distributed to the vendor used for fund distribution. The vendor shall further distribute said funds to eligible licensed ambulance services. Eligible licensed ambulance services shall be those basic or advanced life support ambulance services licensed by the Bureau of Emergency Medical Services to provide emergency pre-hospital trauma care. In the event there is more than one eligible licensed ambulance service active in one county, funding for the ambulance services in said county shall be distributed to both services based on call volume or other appropriate criteria as determined by the Department.
2. For purposes of determining amounts to be distributed to licensed ambulance services pursuant to this rule, the following definitions shall apply:
 - Census – the most recent decennial United States Census.
 - Small Counties – those counties with a population of less than 15,000 as identified in the most recent Census.
 - Large Counties – those counties with a population greater than or equal to 15,000 as identified in the most recent Census.
 - Total Fund Balance – that portion of the TCTF that is allocated to licensed ambulance services.
 - Small County Population Percentage – the sum of Small Counties population as a percent of the total state population as reflected by the Census.
 - Per Capita Portion – the portion of a Small County’s disbursement that is calculated by multiplying that county’s Small County Population Percentage by the Total Fund Balance.
 - Dedicated Portion – the portion of a Small County’s disbursement that is calculated by subtracting an amount from the Total Fund Balance and dividing among the Small Counties so that each Small County receives an equal disbursement that is equal to or less than the Large County with the lowest population.
 - Adjusted Population – determined by adding the population from the Small Counties and subtracting that sum from the state’s total population.

- Adjusted Fund Balance – calculated by subtracting the amount dedicated for the smaller counties from the total fund balance.

3. **Per Capita Portion:**
Multiply the Small Counties Population Percentage by the Total Fund Balance.

Per Capita portion = (Small Counties Population Percentage X Total Fund Balance)
4. **Dedicated Portion:**
The Dedicated Portion is calculated by subtracting an amount from the Total Fund Balance and adding it to the Per Capita Portion so that the sum of the Per Capita Portion plus the Dedicated Portion is divided by the number of Small Counties, AND the result is less than or equal to the Disbursement received by the Large County with the population closest to or equal to 15,000.

Dedicated Portion = [(Per Capita Disbursement + Dedicated Portion) / (Number of Small Counties)]
< / = Disbursement of the Large County with lowest population

The Disbursement for small counties is calculated by adding the Per Capita and Dedicated Portions.

Disbursement (for Small Counties) = (Per Capita Portion) + (Dedicated Portion)
5. **The amount to be disbursed for each Large County is calculated as follows:**
Disbursement = (census population) / (Adjusted population) X (Adjusted Fund Balance)

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.6. Trauma Care Trust Fund Hospital Fixed Distribution

1. Eighty-five percent (85%) of the amount remaining after the expenses noted in Rule 1.3.4 have been determined shall be distributed to the vendor used for fund distribution. The vendor shall further distribute said funds to participating trauma centers as prescribed by the accounting firm.
2. Thirty percent (30%) of the amount reserved for distribution to hospitals shall be distributed according to a “Fixed Distribution,” based on the designated level of each eligible trauma center.
3. For purposes of determining amounts to be distributed to trauma centers pursuant to this rule, the following definitions shall apply:
 - Number of Facilities – the number of licensed acute care facilities designated as a Level I, Level II or Level III Trauma Centers
 - Relative Weights – Level I shall equal 100%; Level II shall equal 87.5%; Level III shall equal 62.5%
 - Calculated Weight – Equals the number of facilities designated at a

particular level of trauma center multiplied by the relative weight.

- Total Weight – equals the sum of calculated weights
 - Disbursement by Hospital Type – equals Total Hospital Fixed Fund / Total Weight X Relative Weight
 - Total Disbursement by Hospital Type – equals the sum of Disbursement by Hospital Type
4. To calculate the Hospital Fixed Distribution, the following formula is used:
- Multiply the number of facilities in each category (Level I, Level II and Level III) by the relative weights of each category. The product of this operation shall be the calculated weight of each type facility.
 - Sum the relative weights to obtain the “calculated weight.”
 - Divide the total Hospital Fixed Distribution amount by the product of the sum of the relative weights (“calculated weight”) and the relative weight assigned to that category.
 - The result is the amount to be distributed to each facility of that particular type (Level I, Level II or Level III).

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.7. Trauma Care Trust Fund Hospital Variable Distribution

1. Fifty percent (50%) of the amount reserved for distribution to hospitals shall be distributed according to a “Variable Distribution” formula.
2. Using patient data collected in the Trauma Registry, assign all trauma cases of each Level I, Level II, and Level II Trauma Center an ISS severity index and category of A, B, C, or D according to the following table:

ISS	ISS Severity Index	ISS Severity Category
1-9	1.02	A
10-15	2.02	B
16-24	3.80	C
>24	6.57	D

3. Using patient data collected in the Trauma Registry, Calculate the number of cases treated by each trauma center which fall within each ISS Severity Category.
4. Multiply the total number of ISS Severity Category A cases by the relative value

assignment of 1.02 to arrive at the total number of Category A points.

5. Multiply the total number of ISS Severity Category B cases by the relative value assignment of 2.02 to arrive at the total number of Category B points.
6. Multiply the total number of ISS Severity Category C cases by the relative value assignment of 3.80 to arrive at the total number of Category C points.
7. Multiply the total number of ISS Severity Category D cases by the relative value assignment of 6.57 to arrive at the total number of Category D points.
8. Add the points from Categories A, B, C, and D to arrive at a total number of points for each trauma center.
9. Sum the number of points from all categories and all hospitals to arrive at a total number of points for all trauma centers.
10. Take the number of points for each hospital and multiply that number by the total dollar amount for the 50 percent of the TCTF available for distribution to participating, eligible trauma centers. Take the product of that calculation and divide the resulting number by the total number of points for all trauma centers.
11. The resulting quotient is the dollar amount of the Hospital Variable Fund to be distributed to that trauma center.
12. Sum all the amounts to be distributed pursuant to the Hospital Variable Fund Calculation. The sum of all distributions should not exceed fifty percent (50%) of the eighty-five percent (85%) of the TCTF available for distribution to hospitals.

Source: Miss. Code Ann. § 41-59-75

- Rule 1.3.8. Trauma Care Trust Fund Burn Center Distribution: Five percent (5%) of the amount reserved for distribution to hospitals shall be distributed to designated burn centers within the Trauma System. If more than one burn center is operating within the system, the 5% will be distributed based on a pro-rata share of patients as determined by Trauma Registry inputs. (Note: Trauma patients counted toward burn center distribution cannot be used to determine hospital variable distribution.) If no hospital has been designated as a burn center at the time of the distribution, the 5% shall be included in the Hospital Fixed Distribution.

Source: Miss. Code Ann. § 41-59-75

- Rule 1.3.9. Play or Pay General Requirements:

1. Every Mississippi licensed acute care facility (hospital) having an organized emergency service or department shall participate in the Mississippi Statewide Trauma System. Every hospital having an organized emergency service or department shall submit data to the Trauma Registry.

2. Hospitals with the potential to serve as Level I, II, or III Trauma Centers must participate at the highest trauma designation level consistent with its capabilities as assessed by the Department.
3. Any hospital determined capable of participating as a Level IV Trauma Center may make application to be designated as a Level IV Trauma Center. A Level IV Trauma Center is required to submit data to the Trauma Registry and is eligible for \$10,000 for administrative costs as a participant in the Trauma System.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.10. Trauma Center Annual Capability Assessment:

1. Each year, all licensed acute care facilities shall complete the Trauma Center Annual Capability Assessment Survey, which is available via the Department's website. The facility will attest to the presence or absence of clinical services. Based on the facility's response, as well as other supporting evidence, the Department shall render an assessment of the facility's potential to participate in the Trauma System.
2. Each facility shall complete and return the Trauma Center Annual Capability Assessment Survey by July 31st each year.
3. On or about the first week of September an invoice and application (as applicable) will be sent by the Department to each facility in response to their respective survey.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.11. Annual Assessment Criteria: For the purposes of the annual capability assessment, if the trauma center has the resources to provide the following respective clinical services 24 hours per day, seven days per week, the trauma center will be assessed as follows:

1. Level I Trauma Center required services
 - Emergency Medicine
 - General Surgery
 - Orthopedic Surgery
 - Neurological Surgery
 - Anesthesia
 - Post Anesthesia Care Unit (PACU)

- Intensive Care Unit (ICU)
 - Surgical Residency Program
2. Level II Trauma Center required services
- Emergency Medicine
 - General Surgery
 - Orthopedic Surgery
 - Neurological Surgery
 - Anesthesia
 - Post Anesthesia Care Unit (PACU)
 - Intensive Care Unit (ICU)
3. Level III Trauma Center required services
- Emergency Medicine
 - General Surgery
 - Orthopedic Surgery
 - Anesthesia
 - Post Anesthesia Care Unit (PACU)
 - Intensive Care Unit (ICU)

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.12. Play or Pay Non-Participation Fee

1. Any hospital that chooses not to participate in the Trauma Care System as a Level I, II, or III Trauma Center, or participates at a level lower than the level at which it is capable of participating, as determined by the Department, or fails to maintain or becomes incapable of maintaining its designation as a Level I, II or III Trauma Center, or has its designation as a Level I, II, or III Trauma Center suspended by the Department, or becomes “non-designated” as a Level I, II, or III Trauma Center, shall be assessed and shall pay a non-participation fee as defined by this regulation.
 - All fees are due and payable annually before January 1 of each year. Any

event above, occurring during the calendar year shall result in the hospital owing a pro- rata portion of the fee. The fee assessed shall be pro-rated on a monthly basis. The fee shall be paid in full upon written notification from the Department.

2. The fee schedule shall be reassessed and adjusted, as necessary, by the Mississippi Trauma Advisory Committee.
3. The fee schedule is as follows:

Current Level	Projected Level	Fee for Non-Participation
Non-Designated	Level II	\$1,492,000.00
Non-Designated	Level III	\$ 758,000.00
Level III to	Level II	\$ 423,500.00
Level IV to	Level II	\$1,492,000.00
Level IV to	Level III	\$ 758,000.00

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.13. Play or Pay Appeal Process

1. Following the receipt of an invoice from the Department for a Non-Participation fee, the hospital assessed the fee may request a due process hearing on the assessment. Any such request for hearing must be filed by the assessed facility with the Director of the Bureau of Acute Care Systems, Mississippi State Department of Health, within thirty (30) days of the date of the assessment.
2. The date of the assessment is defined as the date which the assessment is placed in the United States Mail, postage pre-paid, addressed to the facility assessed, at the address furnished by the hospital to the Trauma Registry, or to the address published by the party as its usual and customary business address. The date of the postmark shall be prima facie evidence of the date of the assessment.
3. The Director of the Bureau of Acute Care Systems, upon receipt of a valid, timely request for a hearing, shall set a date no more than thirty (30) calendar days from the receipt of the request for hearing.
4. The hearing officer appointed to conduct the hearing shall be a person chosen or appointed by the Director of the Office of Health Protection. A stenographic record of the hearing shall be made by a certified reporter/stenographer. The record shall consist of all sworn testimony taken, written, documentary or other relevant evidence taken at said hearing.
5. The only issues for adjudication are:
 - The timeliness of notice of the assessment and delivery of the same;

- The trauma classification of the party; and
 - The calculation of the amount of the assessment.
6. Within thirty (30) days of the receipt by the hearing officer of the certified record, he or she shall render findings of fact and conclusions of law contained in an order. The order so produced by the hearing officer shall be the final order of the Mississippi State Department of Health and shall be appealable to a court of competent jurisdiction.
 7. If no appeal from the final order is taken within twenty (20) days of the date of the order, the party assessed shall pay on or before the twentieth (20th) day following the date of the order the entire fee assessed.

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.14. Delinquent Payments to the Trauma Care Trust Fund:

1. If a hospital fails to submit an application for designation as a trauma center and fails to pay the required fee for Non-Participation by January 1, a letter from the Department will be sent via certified mail to the administrator of the hospital informing that payment is due no later than 30 days from the delivery date of the letter, or that the a request for a due process hearing must be received at the Department no later than 30 days from the delivery date of the letter.
2. If the administrator fails to respond, or comply with the requirements of the certified letter, a letter will be sent by the Bureau of Acute Care Systems to the Bureau of Health Facilities Licensure and Certification documenting an alleged violation of the Minimum Standards for the Operation of Mississippi Hospitals, specifically that the governing body of the hospital, through its administrator, failed to take all reasonable steps to comply with all applicable federal, state and local laws and regulations. A copy of the letter will be sent to the hospital administrator via certified mail.
3. The Bureau of Health Facilities Licensure and Certification will conduct an investigation of the alleged violation(s). If a finding of Substantiated is returned, the Bureau of Acute Care Systems will recommend to Licensure and Certification that the hospital's license be revoked. A copy of this recommendation will be sent to the hospital administrator via certified mail. A copy of recommendation will also be sent to the Centers for Medicare and Medicaid Services (CMS).
4. Once the hospital has satisfied the requirements of this Sub-chapter, the Bureau of Acute Care Systems will send a letter to License and Certification recommending reinstatement of the hospital's license with/without restrictions, as appropriate. A copy of this recommendation will be sent to the hospital administrator via certified mail and to CMS.
5. If a hospital elects to participate at a level lower than the assessed capability and fails to pay the required fee for Non-participation by January 1, a letter from the Department will be sent via certified mail to the administrator of the hospital

informing that payment is due no later than 30 days from the delivery date of the letter, or that the a request for a due process hearing must be received at the Department no later than 30 days from the delivery date of the letter.

6. If the administrator fails to respond, or comply with the requirements of the certified letter, a letter will be sent by the Bureau of Acute Care Systems to the Bureau of Health Facilities Licensure and Certification documenting an alleged violation of the Minimum Standards for the Operation of Mississippi Hospitals, specifically that the governing body of the hospital, through its administrator, failed to take all reasonable steps to comply with all applicable federal, state and local laws and regulations. A copy of the letter will be sent to the hospital administrator via certified mail.
7. The Bureau of Health Facilities Licensure and Certification will conduct an investigation of the alleged violation(s) and if a finding of Substantiated is returned, the Bureau of Acute Care Systems will recommend to Licensure and Certification that the hospital's license be revoked. A copy of this recommendation will be sent to the hospital administrator via certified mail. A copy of recommendation will also be sent to CMS.
8. Once the hospital has satisfied the requirements of this Sub-chapter, the Bureau of Acute Care Systems will send a letter to License and Certification recommending reinstatement of the hospital's license with/without restrictions as appropriate. A copy of this recommendation will be sent to the hospital administrator via certified mail and to CMS.

6. **Subchapter 4 Mississippi State Trauma Registry**

Rule 1.4.1. Applicability

1. All Mississippi-licensed hospitals which have an emergency service or department shall participate in the Trauma Registry data collection process, whether or not they participate in the Trauma System. All out-of-state hospitals designated as Mississippi trauma centers shall participate in the Trauma Registry. Specialized treatment centers, either in-state or out-of-state, that have contracts with the Department to provide care to Mississippi trauma/burn patients, shall participate in the Trauma Registry.
2. All trauma data collection instruments shall include the collection of both pre-hospital and hospital patient care data and shall be integrated into the Department's data management systems. Trauma registry inclusion criteria and the data dictionary can be found on the Department's website.

Source: Miss. Code Ann. § 41-59-75

- Rule 1.4.2. Timeliness of Submissions: Trauma Registry data shall be submitted by all hospitals to the Department no later than two (2) months plus six (6) days after the end of the current month. For example, Trauma Registry data for the month of January is due no later than April 6th.

Source: Miss. Code Ann. § 41-59-75

Rule 1.4.3. Trauma Registrar staffing: Each trauma center shall have a sufficient number of trauma registrars to ensure all registry entries are submitted on time and are accurate. Registrars must complete initial training of sixteen (16) hours within six (6) months of hire/assignment. All registrars must complete eight (8) hours of registry specific continuing education annually.

Source: Miss. Code Ann §41-59-5

7. **Subchapter 5 Administrative and Educational Support**

8.

Rule 1.5.1. Administrative and Educational Support Activities

1. The Mississippi Trauma System of Care Plan provides for a mandatory trauma system that is inclusive, matching appropriate resources and responses to the needs of trauma patients. The Plan provides a mechanism for improving community health through an organized system of injury prevention, acute care and rehabilitation, which shall be fully integrated into the statewide public health system. The Plan calls for making use of a vendor or vendors for administrative and/or educational services as required for the efficacy of the program. Any vendor used for said purpose shall function under contract with MSDH.

Source: Miss. Code Ann. § 41-59-75

9. **Subchapter 6 Inter-facility Transfers of Trauma Patients**

Rule 1.6.1. Inter-facility Transfers

1. Patients may be transferred from trauma centers to other trauma centers and/or specialty referral centers provided that any such transfer is medically prudent, as determined by the transferring trauma center physician of record and is conducted by the appropriate level of emergency medical service provider.
2. Trauma centers shall develop written criteria for consultation and transfer of patients needing a higher/specialty level of care. Trauma center/specialty referral centers that repatriate trauma patients shall provide data required by the Trauma Registry to the receiving trauma center.
3. Trauma centers/specialty hospitals receiving transferred trauma patients shall provide written feedback to the transferring facility and shall participate in the state performance improvement process.

Source: Miss. Code Ann. § 41-59-75

Chapter 2 Performance Improvement and Patient Safety

Subchapter 1 Authority and Scope

- Rule 2.1.1. Each designated trauma center shall have a Performance Improvement and Patient Safety (PIPS) program. The PIPS program shall be multidisciplinary in nature with every member of the trauma team playing a role in PIPS program. The trauma center's trauma medical director (TMD) shall maintain overall accountability for the execution of the PIPS program. The trauma program shall have the authority to monitor all events that occur during a trauma-related episode of care within the organization.

Source: Miss. Code Ann. § 41-59-5

- Rule 2.1.2. A reporting structure for the trauma program and service must be defined. The trauma service routinely functions under the organization's department of surgery and reports to the medical executive committee, or equivalent. In addition, the trauma program shall report to the administrative structure of the organization.

Source: Miss. Code Ann. § 41-59-5

- Rule 2.1.3. The TMD and trauma program manager (TPM) shall maintain the trauma PIPS program with data support from the Trauma registry. Representatives from other clinical and hospital departments involved in the care of trauma patients, as well as the hospital's performance improvement/quality department, shall participate when appropriate to ensure multidisciplinary collaboration and compliance with the hospital's PIPS plan.

Source: Miss. Code Ann. § 41-59-5

- Rule 2.1.4. The TMD is responsible for the review of all physician related issues, including all mortalities and screened complications. Although the TMD remains responsible for the overall function of the trauma program, the TPM shall be responsible for the operational and logistical aspects of the trauma PIPS program. The TPM is responsible for identification of issues and their initial validation, the maintenance of the trauma PIPS database/files and protection of their confidentiality, facilitating data trends and analysis, and coordinating surveillance of protocols/guidelines/clinical paths.

Source: Miss. Code Ann. § 41-59-5

- Rule 2.1.5. There must be a process to address trauma program operational issues. Typically, this function is accomplished by a multidisciplinary trauma committee that examines trauma-related hospital operations and includes representatives from all phases of trauma care. PIPS activities may also be accomplished within this committee. The committee must be chaired by the TMD and shall be comprised of department directors and physicians representing all phases and disciplines of care provided to the injured patient. The committee shall meet routinely with a defined attendance requirement.

Source: Miss. Code Ann. § 41-59-5

- Rule 2.1.6. Mortalities, significant complications, and process variances associated with unanticipated outcomes shall undergo a systematic multidisciplinary trauma peer review to determine opportunities for improvement. This effort may be accomplished in a variety of formats but shall involve the participation and leadership of the TMD, general surgeons on the trauma call panel, and liaisons from emergency medicine, orthopedics, neurosurgery, anesthesia, critical care, and radiology. Ideally, other surgeons and other non-liaison members of other specialties involved in trauma call shall attend when a case in which they participated is being discussed. This meeting shall be held routinely with the frequency determined by the TMD based on case volume and the needs of the PIPS program. Meeting minutes and other documentation of this peer review activity shall be

confidential.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.7. Each trauma center shall define criteria for case selection for formal trauma mortality and morbidity review. Documentation of case review shall be completed by the TMD and the TPM. Corrective action plans shall be developed, and issues trended, as appropriate.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Performance Improvement and Patient Safety Plan

Rule 2.2.1. Each trauma center shall prepare a written Performance Improvement and Patient Safety (PIPS) Plan. There is no precise prescription for the PIPS plan; however, the trauma program must demonstrate a continuous process of monitoring, assessment, and management directed at improving care. A trauma PIPS plan shall practice a multi-disciplinary and multi-departmental approach to reviewing the quality of patient care across departments and divisions. The trauma PIPS program shall integrate with the hospital quality and patient safety effort and have a clearly defined reporting structure and method for provision of feedback.

Source: Miss. Code Ann. § 41-59-5

Rule 2.2.2. Each trauma center shall define a trauma population to perform data collection and analysis. Some programs may choose to define their trauma population as per Mississippi State Department of Health Trauma Registry Inclusion Criteria, while other programs may opt to monitor all injured patients treated at the facility regardless of registry inclusion.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Case Review Process

Rule 2.3.1. Identified cases shall be reviewed by the TPM and TMD, as appropriate, for determination of need for further action. The TMD provides oversight for the review process for all aspects of the multidisciplinary trauma care from the time of the injury through discharge. PIPS data shall be routinely presented to a committee within the hospital charged with trauma PIPS. The trauma program shall also interact with the organization's performance improvement/quality program referring appropriate issues for review.

Source: Miss. Code Ann. § 41-59-5

Rule 2.3.2. Levels of review can be accomplished in a variety of formats, depending on the volume of trauma patients at a given center and the structure of the trauma PIPS program in the context of the hospital's quality program. The levels of review are:

- a. First Level Review: TPM or designee performs the initial case review to verify and validate the issue. If the first level of review is completed, affirming that clinical care is appropriate and no issues are identified, the case does not require second level or

formal committee review. However, if an issue is identified, the issue shall be addressed by the TMD and/or the committee charged with trauma PIPS review. In some instances, immediate feedback and resolution may be possible at this level. Even if issue resolution occurs during this level, the issue and activities shall be documented for ongoing monitoring and trend analysis.

- b. Second Level Review: This level encompasses cases consisting of clinical care, provider care, or systems issues which require medical director expertise and judgment. The TPM and TMD may initiate further investigation, implement action without formal referral to a peer review or system committee, or decide to send it to the appropriate performance improvement/quality committee or to a hospital department for further investigation/peer review and request follow-up. If immediate feedback and resolution are obtained, the issue may be resolved. If not, the issue shall be referred for multidisciplinary committee review, including peer review or some other appropriate PIPS committee capable of further analysis and event resolution.
- c. Third Level Review: The TPM and TMD will perform an initial case review, consisting of identification of all background information, pertinent protocols (or deficiency of), and specify all individual issues to be discussed, in preparation for multidisciplinary review. Cases may be referred to the appropriate hospital department via appointed liaisons, committee, or department chair. The TMD and/or trauma committee will then review the response of the referral for follow-up planning.
- d. Fourth Level Review: The TPM, TMD, and multidisciplinary review committee perform the initial review. Cases are then referred to the appropriate body for external review with review response to the TMD and/or trauma committee for follow-up planning.

Source: Miss. Code Ann. § 41-59-5

- Rule 2.3.3. Reviewed issues shall have a determination classified in a manner consistent with the trauma center's institution-wide performance improvement program. Mutually agreed upon nomenclature shall be utilized. Based on this review process, the appropriateness and timeliness of care shall be reviewed, and opportunities for improvement (i.e. errors in judgment, technique, treatment, or communication, along with delays in assessment, diagnosis, technique, or treatment) shall be determined and documented. When an error can be attributed to a single credentialed provider, use of the departmental or institutional formal medical peer review process shall be considered.

Source: Miss. Code Ann. § 41-59-5

- Rule 2.3.4. The TMD must oversee corrective action planning at their institution. Structured plans may be created by any of the PIPS team members or trauma committees in an effort to improve sub-optimal performance identified through the PIPS process. The goal is to create forward momentum to effect demonstrable outcome change leading to subsequent loop closure. An evaluation and re-evaluation process will be part of the plan according to the institution's action plan methodology. Examples of corrective action categories are:

- a. Counseling
- b. Credentialing/privilege change
- c. Education
- d. External review
- e. Guideline, protocol, or pathway development or revision
- f. PEER review
- g. Resource addition or enhancement
- h. Trending

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Trauma Core Indicators

Rule 2.4.1. Process and outcomes measures, referred to as audit filters or indicators, require defined criteria and metrics. Trauma Core Indicators (TCI) are mandatory indicators within the Mississippi Trauma System.

Source: Miss. Code Ann. § 41-59-5

Chapter 3 Level I Trauma Centers

Subchapter 1 Hospital Organization

Rule 3.1.1. General

- 1. Level I Trauma Centers shall act as tertiary care facilities at the hub of the trauma care system. The facility must have the ability to provide leadership and total care for every aspect of injury from prevention to rehabilitation. As a tertiary facility, the Level I Trauma Center must have adequate depth of resources and personnel.
- 2. Level I Trauma Centers shall provide leadership in education, trauma prevention, research, system planning and performance improvement.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.2. Hospital Departments/Divisions/Sections

- 1. The Level I Trauma Centers must have the following departments, divisions, or sections:

- a. Emergency Medicine
- b. General Surgery
- c. Orthopedic Surgery
- d. Neurological Surgery
- e. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.3. Trauma Program

1. There shall be a written commitment on behalf of the entire facility to the organization of trauma care. The written commitment shall be in the form of a resolution at the time of application passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a trauma care program may be sufficient. The trauma program must be established and recognized by the medical staff and hospital administration. The trauma program must come under the direction of a board-certified general surgeon with special interest in trauma care. An identified hospital administrative leader must work closely with the trauma medical director to establish and maintain the components of the trauma program including appropriate financial support. The trauma program location in the organizational structure of the hospital must be such that it may interact effectively with at least equal authority with other departments providing patient care. The administrative structure must minimally include an administrator, medical director (TMD), trauma program manager (TPM), trauma registrar and appropriate support staff. Administrative support includes human resources, education activities, community outreach activities, and research. The trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care must be extended to all the involved departments.
2. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for the care of the trauma patient;
 - c. Defined trauma team and written roles and responsibilities;
 - d. Appointed Trauma Medical Director with a written job description;
 - e. Appointed Trauma Program Manager with a written job description;

- f. A written Trauma Performance Improvement plan; and
- g. Documentation of representative attendance at statewide PI meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.4. Trauma Service: The trauma service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured patient. The trauma service will vary in each organization depending on the needs of the patient and the resources available. The trauma service shall come under the organization and direction of a surgeon who is board certified with special interest in trauma care. All patients with multiple system trauma or serious injury shall be evaluated and or admitted by the trauma surgical service. The surgeon responsible for the overall care of the patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.5. Trauma Medical Director (TMD): Level I Trauma Centers shall have a physician director Board Certified in General Surgery of the trauma program. The medical director plays an important administrative role and may not direct more than one adult trauma center. The medical director will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the trauma program. The medical director must be given administrative support to implement the requirements specified by the state trauma plan. The director is responsible for working with the credentialing process of the hospital, and in consultation with the appropriate service chiefs, for recommending appointment and removal of physicians from the trauma team. He must cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients. The director in collaboration with the Trauma Program Manager (TPM) must coordinate the budgetary process for the trauma program. The director must be currently certified in Advanced Trauma Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The trauma director must be actively involved with the trauma system development. The TMD must perform an annual assessment of the general surgeons and mid-level providers assigned to the trauma service using a formal documented process.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.6. Trauma Program Manager (TPM)

1. Level I Trauma Centers must have a registered nurse working full-time in the role of Trauma Program Manager (TPM). Working in conjunction with the TMD, the TPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The

TPM is responsible for working with the trauma team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position. The TPM must obtain 16 hours of trauma related education per year.

2. The TPM or his/her designee must offer or coordinate services for trauma education. The TPM should liaison with local EMS personnel, the Department, and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.7. Trauma Team: There shall be identified members of the trauma team. Policies must be in place describing the respective role of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of the hospital and its staff. All physicians and mid-level providers (physician assistant/nurse practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board-Certified General Surgery Physicians. Composition of the trauma team for a severely injured patient includes:

1. Emergency Physician and/or mid-level providers (physician assistant/nurse practitioner)
2. General/Trauma Surgeon
3. Nurses: ED
4. Laboratory Technicians
5. Respiratory Therapist

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. Each trauma center may choose to have one or more committees as needed to accomplish the task. One committee must be multi-disciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education and outreach programs for injury prevention. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

- a. Trauma Medical Director (Chairman; must be present at greater than 50% of the meetings).
 - b. Emergency Medicine
 - c. General Surgery
 - d. Orthopedics
 - e. Neurosurgery
 - f. Anesthesia
 - g. Operating Room
 - h. Intensive Care
 - i. Respiratory Therapy
 - j. Radiology
 - k. Laboratory
 - l. Rehabilitation
 - m. Pre-hospital Care Providers
 - n. Administration
 - o. Pediatrics
 - p. Nursing
 - q. Trauma Program Manager
2. The clinical managers (or designees) of the departments involved with trauma care must play an active role with the committee.
 3. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

10. **Subchapter 2 Clinical Components**

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

hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (physician assistant/nurse practitioner) must be in the specified trauma resuscitation area upon patient arrival.
2. Trauma/General Surgery (In-house 24/hours). The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The 24-hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Activations is 20 minutes from the time notified to respond.
3. Orthopedic Surgery. It is required to have the orthopedists dedicated to the trauma center solely while on-call. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
4. Neurologic Surgery. It is required to have the neurosurgeon dedicated to the trauma center solely while on-call or a backup schedule must be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
5. It is desirable the following specialists are promptly available 24 hours/day:
 - a. Cardiac Surgery*
 - b. Cardiology
 - c. Critical Care Medicine
 - d. Hand Surgery
 - e. Infectious Disease
 - f. Micro-vascular Surgery
 - g. Nephrology
 - h. Nutritional Support

- i. Obstetrics/Gynecologic Surgery
- j. Ophthalmic Surgery
- k. Oral/Maxillofacial
- l. Pediatrics
- m. Plastic Surgery
- n. Pulmonary Medicine
- o. Radiology
- p. Thoracic Surgery*

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

- 6. Policies and procedures must exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 3.2.2. Qualifications of Surgeons on the Trauma Team

- 1. Basic to qualification for trauma care for any surgeon is board certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the Royal College of Physicians, the American Dental Association and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.
- 2. Alternate criteria in lieu of board certification are as follows:
 - a. A non-board-certified general surgeon must have completed a surgical residency program.
 - b. He/she must be licensed to practice medicine.
 - c. He/she must be approved by the hospital's credentialing committee for surgical privileges.
 - d. The surgeon must meet all criteria established by the trauma director to serve on the trauma team.

- e. The surgeons' experience in caring for the trauma patient must be tracked by the PI program.
 - f. The TMD must attest to the surgeons' experience and quality as part of the recurring granting of trauma team privileges.
 - g. The TMD, using the trauma PI program, is responsible for determining each general surgeon's ability to participate on the trauma team.
3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level I facility) and determine if the patient needs transport to a higher level of care. If transport is required, he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the Level I Trauma Center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines must be written at the local level to determine which types of patients should be admitted to the Level I Trauma Centers or which patients should be considered for transfer to a higher level of care. General surgeons taking trauma call must have eight (8) hours of trauma specific continuing medical education over three years. This can be met within the 40-hour requirement by licensure.
 4. The general surgery liaison, orthopedic liaison, and neurosurgery liaison must participate in a multi-disciplinary trauma committee and the PI process. Committee attendance at least fifty percent (50%) over a year's period of time.

Source: Miss. Code Ann. § 41-59-5

Rule 3.2.3. Qualification of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine or General Surgery is required (or current certification in ATLS).
2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:
 - a. He/she must be licensed to practice medicine
 - b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.
 - c. The physician must meet all criteria established by the trauma and emergency medical director to serve on the trauma team.
 - d. The physician's experience in caring for the trauma patient must be

tracked by the PI program.

- e. The trauma and emergency medical director must attest to the physician's experience and quality as part of the recurring granting of trauma team privileges.
 - f. ATLS must be obtained within 18 months of hire.
3. The emergency medicine liaison must participate in a multi-disciplinary trauma committee and the PI process. Committee attendance must be at least fifty percent (50%) over a year's period of time. Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board-Certified General Surgery Physicians), and it is required they be involved in at least eight (8) hours of trauma related continuing medical education (CME) every 3 years.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 3.3.1. Emergency Department

- 1. The facility must have an emergency department, division, service, or section staffed so trauma patients are assured immediate and appropriate initial care. The emergency physician and/or mid-level provider (physician assistant/nurse practitioner) must be in-house 24 hours/day and immediately available at all times. The emergency department medical director must meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and board certification in emergency medicine.
- 2. The emergency department medical director, along with the Trauma Medical Director, will establish trauma-specific credentials that must exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification and specialty board certification.
- 3. The emergency medicine physician will be responsible for activating the trauma team based on predetermined response protocols. He will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the multidisciplinary trauma committee and the trauma PI process.
- 4. There shall be an adequate number of RN's staffing the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC) or Advance Trauma Care for Nurses (ATCN) and participate in the ongoing PI

process of the trauma program. Nurses must obtain TNCC or ATCN within 18 months of assignment to the ER.

5. The list of required equipment necessary for the ED can be found on-line at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 3.3.2. Surgical Suites/Anesthesia

1. The operating room (OR) must be staffed and available in-house 24 hours/day.
2. An operating room must be adequately staffed and available within 30 minutes of time of notification. Availability of the operating room personnel and timeliness of starting operations must be continuously evaluated by the trauma performance improvement process, and measures must be implemented to ensure optimal care.
3. The OR nurses should participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.
4. The surgical nurses are an integral member of the trauma team and must participate in the ongoing PI process of the trauma program and be represented on the multidisciplinary trauma committee.
5. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.
6. The anesthesia department in a Level I trauma center must be ideally organized and run by an anesthesiologist who is highly experienced and devoted to the care of the injured patient. Anesthesiologists on the trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council for Graduate Medical Education, the American Board of Osteopathic Specialties and have board certification in anesthesia. One anesthesiologist must maintain commitment to education in trauma related anesthesia.
7. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be available within 30 minutes, and present for all operations.
8. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

9. The list of required equipment necessary for Surgery and Anesthesia can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 3.3.3. Post Anesthesia Care Unit (PACU)

1. Level I Trauma Centers must have a PACU staffed 24 hours/day and available to the postoperative trauma patient. Frequently it is advantageous to bypass the PACU and directly admit to the ICU. In this instance, the ICU may meet these requirements.
2. PACU staffing must be in sufficient numbers to meet the critical needs of the trauma patient.
3. The list of required equipment necessary for PACU can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 3.3.4. Intensive Care Unit (ICU)

1. Level I Trauma Centers must have an Intensive Care Unit (ICU) that meets the needs of the adult trauma patient.
2. The surgical director or co-director must be the TMD, or general surgeon taking trauma call. The director is responsible for the quality of care and administration of the ICU and will set policy and establish standards of care to meet the unique needs of the trauma patient.
3. The surgeon assumes and maintains responsibility for the care of the serious or multiple injured patients. A surgically directed ICU physician team is essential. The team will provide in-house physician coverage for all ICU trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialties but must be led by a qualified surgeon as determined by critical care credentials consistent with the medical staff privileging process of the institution. The trauma surgeon must maintain control over all the aspects of care, including but not limited to respiratory care, management of mechanical ventilation, and placement and use of pulmonary catheters, as well as the management of fluids, electrolytes and antimicrobials, and enteral and parenteral nutrition.
4. There must be in-house physician coverage for the ICU at all times. A physician credentialed by the facility must be available to the trauma patient in the ICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.

5. Level I Trauma Centers must provide staffing in sufficient numbers to meet the critical needs of the trauma patient. Critical care nurses must be available 24 hours per day. ICU nurses are integral part of the trauma team and as such, shall be represented on the multidisciplinary trauma committee and participate in the PI process of the trauma program at least 50% of the time.
6. The list of required equipment necessary for the ICU can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

11. **Subchapter 4 Clinical Support Services**

Rule 3.4.1. Respiratory Therapy Service: The service must be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatment for the injured patient.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.2. Radiological Service

1. A radiological service must have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological procedures. A technician must be in-house and immediately available for computerized tomography (CT) for both head and body.
2. Sonography, angiography, and MRI must be available to the trauma team and may be covered with a technician on call.
3. The radiology liaison must attend at least 50 percent of committee meetings and should educate and guide the entire trauma team in the appropriate use of radiologic services.
4. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must ensure the preliminary interpretations are promptly reported to the trauma team and the PI program must monitor all changes in interpretation.
5. Written policy must exist delineating the prioritization/availability of the CT scanner for trauma patients.
6. The trauma center must have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriate trauma providers during transportation to, and while in, the radiology department.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.3. Clinical Laboratory Service

1. Clinical laboratory service must have the following services available in-house 24 hours/day:
 - a. Access to a blood bank and adequate storage facilities. Sufficient quantities of blood and blood products must be maintained at all times. Blood typing and crossmatch capabilities must be readily available.
 - b. Standard analysis of blood, urine and other body fluids including micro-sampling when appropriate.
 - c. Blood gas and PH determinations (this function may be performed by services other than the clinical laboratory service, when applicable.)
 - d. Alcohol and drug screening.
 - e. Coagulation studies.
 - f. Microbiology
2. Trauma centers of all levels must have a massive blood transfusion protocol developed collaboratively between the trauma service and the blood bank.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.4. Acute Hemodialysis: Level I Trauma Centers must have Acute Hemodialysis services.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.5. Burn Care: There must be a written protocol to transfer the patient to a Burn Center, if appropriate burn care is not available at the Level I Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.6. Rehabilitation/Social Services

1. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.
2. The rehabilitation of the trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to the trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the Multidisciplinary Rehabilitation Team. The rehabilitation services must minimally include;

- a. Occupational Therapy
- b. Physical Therapy
- c. Speech Pathology
- d. Social Work
- e. Psychological
- f. Nutritional support

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.7. Prevention/Public Outreach

1. Level I Trauma Centers will be responsible for taking a lead role in coordination of appropriate agencies, professional groups and hospitals to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. Prevention programs must be specific to the needs of the hospital and/or geographic area. A trauma center's prevention program must include and track partnerships with other community organizations. At a minimum, Trauma Registry data must be utilized to identify injury trends and focus prevention needs.
2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at a Level I Trauma Centers must provide consultation to staff members of other level facilities. For example: Advanced Trauma Life Support (ATLS), Pre-Hospital Trauma Life Support (PHTLS), Trauma Nurse Curriculum Course (TNCC), and Transport Nurse Advanced Trauma Course (TNATC) courses can be coordinated by the trauma center.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.8. Transfer Guidelines: Level I Trauma Centers shall work in collaboration with the referral trauma facilities in the system and develop inter-facility transfer guidelines. These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.9. Education

1. Level I Trauma Centers must have an internal trauma education program including training in trauma for physicians, nurses and pre-hospital providers. Level I Trauma Centers must take a leadership role in providing educational activities. Education can be accomplished via many mechanisms (i.e. classic CME, preceptorships, fellowships, clinical rotations, telecommunications or providing locum tenens etc.).

2. Level I Trauma Centers must have a written trauma education plan.
3. The Level I Trauma Center is expected to support a surgical residency program. Additionally, there should be a senior resident rotation in at least one of the following disciplines: emergency medicine, general surgery, orthopedic surgery, neurosurgery or support a trauma fellowship. The Level I should provide ATLS courses for the system.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.10. Research

1. A trauma research program must be designed to produce new knowledge applicable to the care of the injured patient. The research may be conducted in a number of ways including traditional laboratory and clinical research, reviews of clinical series, and epidemiological or other studies. Publication of articles in peer-review journals as well as presentations of results at local, statewide and national meetings and ongoing studies approved by human and animal research review boards are expected from productive programs. The program should have an organized structure that fosters and monitors ongoing productivity.
2. The research program must be balanced to reflect a number of different interests. There must be a research committee, and identifiable Institutional Review Board process, active research protocols, surgeons involved in extramural educational presentations and adequate number of peer reviewed scientific publications. Publications should appear in peer-reviewed journals. In a three-year cycle, the minimum activity is ten publications from the physicians representing any of the four following specialties: emergency medicine, general surgery, orthopedic surgery, and neurosurgery.

12. Chapter 4 Level II Trauma Centers

Subchapter 1 Hospital Organization

Rule 4.1.1. General: A Level II Trauma Center is an acute care facility with the commitment, resources, and specialty training necessary to provide sophisticated trauma care, and provide leadership in performance improvement activities.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.2. Hospital Departments/Divisions/Sections: The Level II Trauma Center must have the following departments, divisions, or sections:

1. Emergency Medicine
2. Trauma/General Surgery
3. Orthopedic Surgery

4. Neurological Surgery
5. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.3. Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of trauma care. The written commitment shall be in the form of a resolution at the time of application passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. The trauma program must be established and recognized by the medical staff and hospital administration. The trauma program must come under the direction of a surgeon with current or previous board certification in General Surgery. An identified hospital administrative leader must work closely with the trauma medical director to establish and maintain the components of the trauma program including appropriate financial support. The trauma program location in the organizational structure of the hospital must be placed so that it may interact effectively with at least equal authority with other departments providing patient care. An administrative structure must minimally include an administrator, medical director (TMD), trauma program manager (TPM), trauma registrar and the appropriate support staff. Administrative support includes human resources, educational activities and community outreach activities. The trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care must extend to all the involved departments.
2. Compliance with the above will be evidenced by, but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for care of the trauma patient;
 - c. Defined trauma team and written roles and responsibilities;
 - d. Appointed Trauma Medical Director with a written job description;
 - e. Appointed Trauma Program Manager with a written job description;
 - f. A written Trauma Performance Improvement plan;

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.4. Trauma Service: The trauma service must be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured patient. The trauma service will vary in each organization depending on the needs of the patient and the resources available. The trauma service must come under the organization and direction of a surgeon with current or previous board certification in General Surgery. All patients with multiple system trauma or serious injury must be evaluated and or admitted by the trauma service. The surgeon responsible for the overall care of the patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.5. Trauma Medical Director (TMD): Level II Trauma Centers must have a physician director current or previous Board Certified in General Surgery of the trauma program. The trauma program medical director plays an important administrative role and may not direct more than one Trauma Center. The medical director will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the trauma program. The medical director must be given administrative support to implement the requirements specified by the State trauma plan. The director is responsible for working with the credentialing process of the hospital, and, in consultation with the appropriate service chiefs, recommending appointment and removal of physicians from the trauma team. He should cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients. The director in collaboration with the trauma program manager (TPM) should coordinate the budgetary process for the trauma program. The director must be currently certified in Advanced Trauma Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The trauma director must be actively involved with trauma system development. The TMD must perform an annual assessment of the general surgeons and mid-level providers assigned to the trauma service using a formal documented process.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.6. Trauma Program Manager (TPM)

1. Level II Trauma Centers must have a registered nurse working full-time in the role of Trauma Program Manager (TPM). Working in conjunction with the TMD, the TPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The TPM is responsible for working with the trauma team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position. The TPM must obtain 16 hours of trauma related education per year.
2. The TPM or his/her designee should offer or coordinate services for trauma education. The TPM should liaison with local EMS personnel, the Department, and other Trauma Centers.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.7. Trauma Team – the team approach is optimal in the care of the multiple injured patients. There must be identified members of the trauma team. Policies should be in place describing the respective role of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its staff. The team leader must be a qualified

general surgeon. All physicians and mid-level providers (physician assistant/nurse practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board-Certified General Surgery Physicians. Minimum composition of the trauma team for a severely injured patient shall include:

1. Emergency Physicians and/or mid-level providers (physician assistant/nurse practitioner)
2. General/Trauma Surgeon
3. Nurses
4. Laboratory Technicians
5. Respiratory Therapists

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. Each trauma center may choose to have one or more committees to accomplish the tasks necessary. One committee should be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, establishment of standards of care, education and outreach programs, and injury prevention. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Trauma Medical Director (Chairman; must be present at greater than 50% of the meetings)
 - b. Emergency Medicine
 - c. General Surgery
 - d. Orthopedics
 - e. Neurosurgery
 - f. Anesthesia
 - g. Operating Room

- h. Intensive Care
 - i. Respiratory Therapy
 - j. Radiology
 - k. Laboratory
 - l. Rehabilitation
 - m. Pre-hospital Care Providers
 - n. Administration
 - o. Pediatrics
 - p. Nursing
 - q. Trauma Program Manager
2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.
 3. The trauma center may wish to accomplish performance improvement activities at this same committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. This committee must be multidisciplinary, meet regularly, and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

13. **Subchapter 2 Clinical Components**

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

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.
2. Trauma/General Surgery. The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured

patient. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. The on-call surgeon must be dedicated to the trauma center and not on-call at any other hospital. There must be a back-up surgeon schedule published. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Activations is 45 minutes from the time notified to respond.

3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call or a backup schedule should be available. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
4. Neurologic Surgery. It is desirable to have the neurosurgeon dedicated to the trauma center solely while on-call or a backup schedule should be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
5. It is desirable the following specialists be on-call and available 24 hours/day:
 - a. Critical Care Medicine
 - b. Obstetrics/Gynecologic Surgery
 - c. Plastic Surgery
 - d. Radiology
 - e. Thoracic Surgery*

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

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

Rule 4.2.2. Qualifications of Surgeons on the Trauma Team

1. Basic to qualification for trauma care for any surgeon is current or previous Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the American Dental Association, the Royal College of Physicians and Surgeons of Canada or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.
2. Alternate criteria in lieu of board certification are as follows:
 - a. A non-board-certified general surgeon must have completed a surgical residency program.
 - b. He/she must be licensed to practice medicine.
 - c. He/she must be approved by the hospital's credentialing committee for surgical privileges.
 - d. The surgeon must meet all criteria established by the TMD to serve on the trauma team.
 - e. The surgeon's experience in caring for the trauma patient must be tracked by the PI program.
 - f. The TMD must attest to the surgeon's experience and quality as part of the recurring granting of trauma team privileges.
 - g. The TMD, using the trauma PI program, is responsible for determining each general surgeon's ability to participate on the trauma team.
3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level II facility) and determine if the patient needs transport to a higher level of care. If transport is required, he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the Level II Trauma Center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines should be written at the local level to determine which types of patients should be admitted to the Level II Trauma Center or which patients should be considered for transfer to a higher level of care.

General Surgeons taking trauma call must have eight (8) hours of trauma specific continuing education over three years. This can be met within the 40-hour requirement by licensure.

4. The orthopedic liaison and neurosurgery liaison must participate in a multi-disciplinary trauma committee and the PI process. Committee attendance must be at least fifty percent (50%) over a year's period of time.

Source: Miss. Code Ann. § 41-59-5

Rule 4.2.3. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, current or previous board certification in Emergency Medicine or General Surgery is required or current certification in ATLS.
2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:
 - a. He/she must be licensed to practice medicine.
 - b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.
 - c. The physician must meet all criteria established by the trauma and emergency medical director to serve on the trauma team.
 - d. The physician's experience in caring for the trauma patient must be tracked by the PI program.
 - e. The emergency medical director must attest to the physician's experience and quality as part of the recurring granting of trauma team privileges.
 - f. ATLS must be obtained within 18 months of hire.
3. The emergency medicine liaison must participate in a multi-disciplinary trauma committee and the PI process. Committee attendance must be at least fifty percent (50%) over a year's period of time. Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board-Certified General Surgery Physicians), and it is required they be involved in at least eight (8) hours of trauma related continuing education (CME) every 3 years.

Source: Miss. Code Ann. § 41-59-5

14. Subchapter 3 Facility Standards

Rule 4.3.1. Emergency Department

1. The facility must have an emergency department, division, service, or section staffed so trauma patients are assured immediate and appropriate initial care. The emergency physician must be in-house 24 hours/day and immediately available at all times. The emergency department medical director must meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and current or previous board certification in emergency medicine.
2. The director of the emergency department, along with the Trauma Medical Director (TMD), will establish trauma-specific credentials that should exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification, and specialty board certification.
3. The emergency medicine physician or designee will be responsible for activating the trauma team based on predetermined response protocols. He will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the multidisciplinary trauma committee and the trauma PI process.
4. There should be an adequate number of RN's staffed for the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC), or Advanced Trauma Care for Nurses (ATCN), and participate in the ongoing PI process of the trauma program. Nurses must obtain TNCC or ATCN within 18 months of assignment to the ER.
5. The list of required equipment necessary for the ED can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 4.3.2. Surgical Suites/Anesthesia

1. An operating room must be adequately staffed and available within 30 minutes of time of notification. Availability of the operating room personnel and timeliness of starting operations must be continuously evaluated by the trauma performance improvement process, and measures must be implemented to ensure optimal care.

2. If the staff is not in-house, hospital policy must be written to assure notification and prompt response.
3. The OR nurses should participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.
4. The surgical nurses are an integral member of the trauma team and must participate in the ongoing PI process of the trauma program and must be represented on the multidisciplinary trauma committee.
5. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma patient during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.
6. The anesthesia department in a Level II Trauma Center must be organized and run by an anesthesiologist who is experienced and devoted to the care of the injured patient.
7. A licensed anesthesia provider must be immediately available with a mechanism established to ensure early notification of the on-call provider. Anesthesiologists or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. Hospital policy must be established to determine when the licensed anesthesia provider must be immediately available for airway control and assisting with resuscitation. The availability of the licensed anesthesia provider and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
8. The list of required equipment for Surgery and Anesthesia can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 4.3.3. Post Anesthesia Care Unit (PACU)

1. It is essential to have a PACU staffed 24 hours/day and available to the postoperative trauma patient. If the staff is not in-house, hospital policy must be written to assure early notification and prompt response. If this availability requirement is met with a team on call from outside the hospital, the availability of the PACU nurses and compliance with this requirement must be documented.
2. PACU staffing should be in sufficient numbers to meet the critical needs of the trauma patient.

3. The list of required equipment necessary for the PACU can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 4.3.4. Intensive Care Unit (ICU)

1. Level II Trauma Centers must have an Intensive Care Unit (ICU) that meets the needs of the adult trauma patient.
2. The surgical director or co-director must be the TMD, or general surgeon taking trauma call. The director is responsible for the quality of care and administration of the ICU and will set policy and establish standards of care to meet the unique needs of the trauma patient.
3. The trauma surgeon assumes and maintains responsibility for the care of the serious or multiple injured patients. A surgically directed ICU physician team is desirable. The team will provide in-house physician coverage for all ICU trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialties but must be led by a qualified surgeon consistent with the medical staff privileging process of the institution. The trauma surgeon must maintain control over all aspects of care, including but not limited to respiratory care, management of mechanical ventilation and placement and use of pulmonary catheters, as well as management of fluids, electrolytes, antimicrobials, and enteral and parenteral nutrition.
4. There must be physician coverage for the ICU at all times. A physician credentialed by the facility must be promptly available to the trauma patient in the ICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.
5. Level II Trauma Centers must provide staffing in sufficient numbers to meet the critical needs of the trauma patient. Critical care nurses must be available 24 hours per day. ICU nurses are an integral part of the trauma team and as such, shall be represented on the multidisciplinary trauma committee and participate in the PI process of the trauma program at least 50% of the time.
6. The list of required equipment necessary for the ICU can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

15. Subchapter 4 Clinical Support Services

- Rule 4.4.1. Respiratory Therapy Service** – the service must be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatments for the injured patient.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.2. Radiological Service

1. A radiological service must have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological procedures. A technician must be in-house and immediately available for computerized tomography (CT) for both head and body.
2. Specialty procedures such as Sonography and Angiography must be available to the trauma team. It is desirable that MRI services be available to the trauma team.
3. The radiologist liaison must attend at least 50 percent of committee meetings and should educate and guide the entire trauma team in the appropriate use of radiologic services. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must ensure the preliminary interpretations are promptly reported to the trauma team and radiology services must monitor the interpretation.
4. Written policy must exist delineating the prioritization/availability of the CT scanner for trauma patients. The Trauma Center must have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to, and while in, the radiology department.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.3. Clinical Laboratory Service:

1. A clinical laboratory service must have the following services available in-house 24 hours/day:
 - a. Access to a blood bank and adequate storage facilities. Sufficient quantities of blood and blood products must be maintained at all times. Blood typing and crossmatch capabilities must be readily available.
 - b. Standard analysis of blood, urine, and other body fluids including micro sampling when appropriate.
 - c. Blood gas and pH determinations (this function may be performed by services other than the clinical laboratory service, when applicable).
 - d. Alcohol and drug screening.
 - e. Coagulation studies
 - f. Microbiology

2. Trauma Centers of all levels must have a massive blood transfusion protocol developed collaboratively between the trauma service and the blood bank.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.4. Acute Hemodialysis: There must be a written protocol to transfer the patient to a facility that provides this service if this service is not available at the Level II Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.5. Burn Care: There must be a written protocol to transfer the patient to a Burn Center, if appropriate burn care is not available at the Level II Trauma Center. Policies and procedures shall be in place to assure that the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.6. Rehabilitation/Social Services

1. The rehabilitation of the trauma patient and the continued support of the family members are an important part of the Trauma System. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to the trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the multidisciplinary rehabilitation team. The rehabilitation services must minimally include;
 - a. Occupational Therapy
 - b. Physical Therapy
 - c. Speech Pathology
 - d. Social Work
 - e. Psychological Therapy
 - f. Nutritional support

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.7. Prevention/Public Outreach

1. Level II Trauma Centers will be responsible for participating with appropriate agencies, professional groups and hospitals in their geographic area to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. Prevention programs must be specific to the needs of the geographic area. A trauma center's prevention program must include and track partnerships with other community organizations. Trauma Registry data must be utilized to identify injury trends and focus prevention needs.

2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at the Level II Trauma Center should provide consultation to staff members at other facilities in the geographic area. Advanced Trauma Life Support (ATLS), Pre-Hospital Trauma Life Support (PHTLS), Trauma Nurse Curriculum Course (TNCC), and Transport Nurse Advanced Trauma Course (TNATC) courses for example can be coordinated by the Trauma Center. Trauma physicians should provide a formal follow up to referring physicians/designee about specific patients to educate the practitioner for the benefit of further injured patients.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.8. Transfer Guidelines: Level II Trauma Centers shall work in collaboration with the referral trauma facilities in the system and develop interfacility transfer guidelines. These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.9. Education.

1. Level II Trauma Centers must have internal trauma education programs including training in trauma for physicians, nurses, ancillary staff, and prehospital providers.
2. Level II Trauma Centers must have a written trauma education plan.

16. **Chapter 5 Level III Trauma Centers**

Subchapter 1 Hospital Organization

Rule 5.1.1. General: A Level III Trauma Center is an acute care facility with the commitment, medical staff, personnel and specialty training necessary to provide initial resuscitation of the trauma patient. Generally, a Level III Trauma Center is expected to provide initial resuscitation of the trauma patient and immediate operative intervention to control hemorrhage and to assure maximal stabilization prior to referral to a higher level of care. In many instances, patients will remain in the Level III Trauma Center unless the medical needs of the patient require secondary transfer. The decision to transfer a patient is the responsibility of the

physician attending the trauma patient. All Level III Trauma Centers will work collaboratively with other trauma facilities to develop transfer protocols and a well-defined transfer sequence. The trauma center shall participate in hospital and statewide performance improvement activities.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.2. Hospital Departments/Divisions/Sections: The Level III Trauma Center must have the following departments, divisions, or sections:

1. Emergency Medicine
2. Trauma/General Surgery
3. Orthopedic Surgery
4. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.3. Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of trauma care. The written commitment shall be in the form of a resolution at the time of application passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. The trauma program must be established and recognized by the medical staff and hospital administration. The trauma program must come under the direction of a surgeon with current or previous board certification in General Surgery. An identified hospital administrative leader must work closely with the trauma medical director to establish and maintain the components of the trauma program including appropriate financial support. The trauma program location in the organizational structure of the hospital must be placed so that it may interact effectively with at least equal authority with other departments providing patient care. An administrative structure must minimally include an administrator, trauma medical director (TMD), trauma program manager (TPM), trauma registrar and other appropriate support staff. Administrative support includes human resources, educational activities and community outreach activities. The trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care must extend to all the involved departments.
2. Compliance with the above will be evidenced by but not limited to:

- a. Governing authority and medical staff letter of commitment in the form of a resolution;
- b. Written policies and procedures and guidelines for care of the trauma patient;
- c. Defined trauma team and written roles and responsibilities;
- d. Appointed Trauma Medical Director with a written job description;
- e. Appointed Trauma Program Manager with a written job description;
- f. A written Trauma Performance Improvement plan;

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.4. Trauma Service: The trauma service must be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured patient. The trauma service will vary in each organization depending on the needs of the patient and the resources available. The trauma service must come under the organization and direction of the TMD. All patients with multiple system trauma or serious injury must be evaluated and/or admitted by the trauma surgeon. The surgeon responsible for the overall care of the patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.5. Trauma Medical Director (TMD)

1. Level III Trauma Centers must have a physician director of the trauma program with current or previous Board Certification in General Surgery and may not direct more than one trauma center. The TMD plays an important administrative role. The TMD will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the trauma program. The TMD must be given administrative support to implement the requirements specified by the State trauma plan. The TMD is responsible for working with the credentialing process of the hospital and, in consultation with the appropriate service chiefs, recommending appointment and removal of physicians from the trauma team. She/he must cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients. The TMD in collaboration with the Trauma Program Manager (TPM) must coordinate the budgetary process for the trauma program
2. The TMD must be currently certified in Advanced Trauma Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The TMD, or his designee, must be actively involved with the trauma system development

at the community and state level. The TMD must perform an annual assessment of general surgeons and mid-level providers assigned to the trauma service using a formal documented process.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.6. Trauma Program Manager (TPM)

1. Level III Trauma Centers must have a registered nurse working in the role of Trauma Program Manager (TPM). Working in conjunction with the TMD, the TPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The TPM is responsible for working with the trauma team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position. The TPM must obtain/maintain 4 hours of trauma related education per year. TNCC may be used to meet this requirement.
2. The TPM or his/her designee must offer or coordinate services for trauma education. The TPM must liaison with local EMS personnel, the Department and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.7. Trauma Team – the team approach is optimal in the care of the severely or multiple injured patient. There must be identified members of the trauma team. Policies must be in place describing the roles of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its staff. All physicians and mid-level providers (physician assistant/nurse practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patient must be currently certified in Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board-Certified General Surgery Physicians. Minimum composition of the trauma team for severely injured patients includes:

1. General/Trauma Surgeons
2. Emergency Physicians and/or mid-level providers (physician assistant/nurse practitioner)
3. Nursing: ED
4. Laboratory Technicians
5. Respiratory Therapists
6. Radiology Technician

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated Trauma Center in the region. Each trauma center may choose to have one or more committees to accomplish the tasks necessary. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and injury prevention. The committee has administrative and systematic control and oversees the implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Trauma Medical Director (Chairman; must be present at greater than 50% of the meetings)
 - b. Emergency Medicine
 - c. General Surgery
 - d. Orthopedics
 - e. Anesthesia
 - f. Operating Room
 - g. Intensive Care
 - h. Respiratory Therapy
 - i. Radiology
 - j. Laboratory
 - k. Rehabilitation
 - l. Pre-hospital Care Providers
 - m. Administration
 - n. Pediatrics
 - o. Nursing
 - p. Trauma Program Manager

2. The clinical managers (or designees) of the departments involved with trauma care must play an active role with the committee.
3. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independent from department based review. The committee must be multidisciplinary, meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

17. Subchapter 2 Clinical Components

Rule 5.2.1. Required Components – Level III Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (physician assistant/nurse practitioner) must be in the specified trauma resuscitation area upon patient arrival.
2. Trauma/General Surgery. It is desirable that a backup surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the trauma center and not on-call to any other hospital while on trauma call. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is sooner. Response time for Bravo Activations is 45 minutes from the time notified to respond.
3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.
4. It is desirable the following specialist be on-call and available 24 hours/day:
 - a. Critical Care Medicine
 - b. Obstetrics/Gynecology Surgery
 - c. Critical Care Medicine

d. Thoracic Surgery*

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

5. Policies and procedures must exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 5.2.2. Qualifications of Surgeons on the Trauma Team

1. Basic to qualification for trauma care for any surgeon is current or previous Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the American Dental Association, the Royal College of Physicians and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons and orthopedic surgeons.

2. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level III facility) and determine if the patient needs transport to a higher level of care. If transport is required, he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the Level III Trauma Center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines must be written at the local level to determine which types of patients should be admitted to the Level III Trauma Center or which patients should be considered for transfer to a higher level of care. General Surgeons taking trauma call must have eight (8) hours of trauma specific continuing medical education (CME) over three years. This can be met within the 40-hour requirement by licensure.

3. The general surgery and orthopedic liaisons must participate in a multi-disciplinary trauma committee and the PI process. Committee attendance must be at least fifty percent (50%) over a year's period of time.

Source: Miss. Code Ann. § 41-59-5

Rule 5.2.3. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine and/or General Surgery is required or current certification in ATLS. ATLS must be obtained within 18 months of hire.

2. The emergency medicine liaison must participate in a multi-disciplinary trauma committee and the PI process. Committee attendance must be at least fifty percent (50%) over a year's period of time. Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board-Certified General Surgery Physicians), and it is required they be involved in at least eight (8) hours of trauma related continuing education (CME) every 3 years.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 5.3.1. Emergency Department

1. The facility must have an emergency department, division, service or section staffed so trauma patients are assured immediate and appropriate initial care. The emergency physician and/or mid-level providers must be in-house 24 hours/day, immediately available at all times, and capable of evaluating trauma patients and providing initial resuscitation. The emergency medicine physician will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The medical director for the department must participate with the multidisciplinary trauma committee and the trauma PI process. The emergency department medical director must meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and initial or current board certified in emergency medicine.
2. The medical director of the emergency department, along with the TMD, will establish trauma-specific credentials that must exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification, and specialty board certification.
3. The emergency medicine physician or designee will be responsible for activating the trauma team based on predetermined response protocols. He/she will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the multidisciplinary trauma committee and the trauma PI process.
4. There must be an adequate number of RN's staffed for the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC), or Advanced Trauma Care for Nurses (ATCN), and participate in the ongoing PI

process of the trauma program. Nurses must obtain TNCC or ATCN within 18 months of assignment to the ER.

5. The list of required equipment necessary for the ED can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 5.3.2. Surgical Suites/Anesthesia

1. An operating room must be adequately staffed and available within 30 minutes of time of notification, Availability of the operating room personnel and timeliness of starting operations must be continuously evaluated by the trauma performance improvement process, and measures must be implemented to ensure optimal care.
2. If the staff is not in-house, hospital policy must be written to assure notification and prompt response.
3. The OR nurses should participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.
4. The OR nurses are integral members of the trauma team and must participate in the ongoing PI process of the trauma program and must be represented on the multidisciplinary trauma committee.
5. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma patient during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.
6. The anesthesia department in a Level III Trauma Center must be organized and run by an anesthesiologist or physician liaison who is experienced and devoted to the care of the injured patient.
7. A licensed anesthesia provider must be immediately available with a mechanism established to ensure early notification of the on-call provider. Anesthesiologists or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. Hospital policy must be established to determine when the licensed anesthesia providers must be immediately available for airway control and assisting with resuscitation. The availability of the licensed anesthesia providers and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
8. The list of required equipment necessary for Surgery and Anesthesia can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 5.3.3. Post Anesthesia Care Unit (PACU)

1. A Level III Trauma Center must have a PACU staffed and available 24 hours/day to the postoperative trauma patient. Hospital policy must be written to assure early notification and prompt response. If this availability requirement is met with a team on call from outside the hospital, the availability of the PACU nurses and compliance with this requirement must be documented.
2. PACU staffing must be in sufficient numbers to meet the critical need of the trauma patient.
3. The list of required equipment necessary for the PACU can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 5.3.4. Intensive Care Unit (ICU)

1. Level III Trauma Centers must have an Intensive Care Unit (ICU) that meets the needs of the adult trauma patient.
2. There must be physician coverage for the ICU at all times. A physician credentialed by the facility must be promptly available to the trauma patient in the ICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.
3. The surgical director or co-director must be the TMD, or general surgeon taking trauma call. The director is responsible for the quality of care and administration of the ICU and will set policy and establish standards of care to meet the unique needs of the trauma patient.
4. The trauma surgeon assumes and maintains responsibility for the care of the serious or multiple injured patient. A surgically directed ICU physician team is desirable. The team will provide in-house physician coverage for all ICU trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialties but must be led by a qualified surgeon as determined by critical care credentials consistent with the medical staff privileging process of the institution. The trauma surgeon, in collaboration with other specialty providers, must maintain control over all aspects of care, including, but not limited to respiratory care, management of mechanical ventilation and placement and use of pulmonary catheters, as well as management of fluids, electrolytes, antimicrobials, and enteral and parenteral nutrition.
5. Level III Trauma Center must provide staffing in sufficient numbers to meet the needs of the trauma patient. Critical care nurses must be available 24 hours per day. ICU nurses are an integral part of the trauma team and as such, must be represented on the multidisciplinary trauma committee and participate in the PI process of the trauma program at least 50% of the time.

6. The list of required equipment necessary for the ICU can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

18. **Subchapter 4 Clinical Support Services**

- Rule 5.4.1. Respiratory Therapy Service – the service must be staffed with qualified personnel on-call 24 hours/day to provide the necessary treatments for the injured patient.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.2. Radiological Service

1. The radiologist is a key member of the trauma team and should be represented on the Multidisciplinary Trauma Committee. A radiological service must have a certified radiological technician who must be available in-house 24 hours/day to meet the immediate needs of the trauma patient for general radiological procedures. A technician must be immediately available for computerized tomography (CT) for both head and body. If the specialty technician is on-call from home, a mechanism must be in place to assure early notification and timely response.
2. Specialty procedures such as Sonography must be available to the trauma team and may be covered with a technician on call. If the technician is not in-house 24 hours/day for special procedures, the performance improvement process must document and monitor the procedure is promptly available. It is desirable that MRI services be available to the trauma team.
3. The radiologist liaison must attend at least 50 percent of committee meetings and should educate and guide the entire trauma team in the appropriate use of radiologic services. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must ensure the preliminary interpretations are promptly reported to the trauma team and radiology services must monitor the interpretation.
4. Written policy must exist delineating the prioritization/availability of the CT scanner for trauma patients. The Trauma Center must have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to, and while in, the radiology department.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.3. Clinical Laboratory Service

1. A clinical laboratory service must have the following services available in-house 24 hours/day:
 - a. Access to a blood bank and adequate storage facilities. Sufficient quantities of blood and blood products must be maintained at all times. Blood typing and crossmatch capabilities must be readily available.
 - b. Standard analysis of blood, urine, and other body fluids includes micro sampling when appropriate.
 - c. Blood gas and Ph determinations (this function may be performed by services other than the clinical laboratory service, when applicable).
 - d. Alcohol and drug screening
 - e. Coagulation studies.
 - f. Microbiology
2. Trauma centers of all levels must have a massive blood transfusion protocol developed collaboratively between the trauma service and the blood bank.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.4. Acute Hemodialysis: There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the Level III Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.5. Burn Care: There must be a written protocol to transfer the patient to a Burn Center, if appropriate burn care is not available at the Level III Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.6. Rehabilitation/Social Services:

1. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.
2. The rehabilitation of the trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to

the trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the multidisciplinary rehabilitation team. The rehabilitation services must minimally include:

- a. Occupational Therapy
- b. Physical Therapy
- c. Speech Pathology
- d. Social Work
- e. Psychological Therapy
- f. Nutritional Support

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.7. Prevention/Public Outreach

1. Level III Trauma Centers will be responsible for participating with appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. A trauma center's prevention program must include and track partnerships with other community organizations. Trauma Registry data must be utilized to identify injury trends and focus prevention needs.
2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at the Level III Trauma Center must provide consultation to staff members at other facilities in the region. Advanced Trauma Life Support (ATLS), Pre-Hospital Trauma Life Support (PHTLS), Trauma Nurse Curriculum Course (TNCC), and Transport Nurse Advanced Trauma Course (TNATC) courses for example can be coordinated by the Trauma Center. Trauma physicians must provide a formal follow up to referring physicians/designee about specific patients to educate the practitioner for the benefit of further injured patients.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.8. Transfer Guidelines:

1. Level III Trauma Centers shall work in collaboration with the referral trauma facilities in their region and develop inter-facility transfer guidelines. These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.9 Education

1. Level III Trauma Centers must have internal trauma education programs including training in trauma for physicians, mid-level providers, nurses, ancillary staff and pre-hospital providers.
2. Level III Trauma Centers must have a written trauma education plan.

Source: Miss. Code Ann. § 41-59-5

19. **Chapter 6 Level IV Trauma Centers**

Subchapter 1 Hospital Organization

Rule 6.1.1. General

1. Level IV Trauma Centers are generally licensed, small, rural facilities with a commitment to the resuscitation of the trauma patient and written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred. These facilities may be staffed by a physician, or a licensed mid-level practitioner (i.e., physician assistant or nurse practitioner) or Registered Nurse. The major trauma patient will be resuscitated and transferred.
2. This designation does not contemplate that Level IV Trauma Centers will have resources available for emergency surgery for the trauma patient. Specialty coverage may or may not be available, but a well-organized resuscitation team is required.
3. Level IV Trauma Centers may meet the following standards in their own facility or through a formal affiliation with another trauma center.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.2. Hospital Departments/Divisions/Sections – the Level IV Trauma Center must have the following departments, divisions, or sections: Emergency Medicine

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.3. Trauma Program/Service

1. There must be a written commitment letter from the Board of Directors and the medical staff on behalf of the entire facility which states the facility's commitment to compliance with the Mississippi Trauma System Rules and Regulations. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. A trauma program must be established and recognized by the organization.

Compliance with the above will be evidenced by:

- a. Board of Director's and medical staff letter of commitment;
- b. Written policies, procedures and guidelines for care of the trauma patient;
- c. A defined Trauma Team with written roles and responsibilities;
- d. Appointed Trauma Medical Director with a written job description;
- e. A written Trauma Performance Improvement Plan;
- f. Appointed Trauma Program Manager with a written job description;
- g. Documentation of Trauma Center representative's attendance at the Trauma Care Region meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.4. Trauma Medical Director (TMD)

1. The Level IV Trauma Center must have a physician director of the trauma program. In this instance, the physician is responsible for working with all members of the trauma team and overseeing the implementation of a trauma specific performance improvement process for the facility. Through this process, he/she should have overall responsibility for the quality of trauma care rendered at the facility. The director must be given administrative support to implement the requirements specified by the Mississippi Trauma System of Care Plan. The director should assist in the development of standards of care and assure appropriate policies and procedures are in place for the safe resuscitation and transfer of trauma patients. The physician director must have current verification in ATLS. ATLS requirements are waived for Board Certified Emergency Medicine and Board-Certified General Surgery Physicians.

The TMD must have the authority to manage all aspects of trauma care. The TMD authorizes trauma service privileges of the on-call panel, works in cooperation with the nursing administration to support the nursing needs of trauma patients, and develops treatment protocols along with the trauma team in collaboration with the peer review processes. The TMD must perform an annual assessment of the trauma panel providers.

2. Compliance with the above will be evidenced by:
 - a. Chairing and participating in the multidisciplinary trauma committee where trauma performance improvement is presented and attend a minimum of 50 percent of the committee meetings.
 - b. Administrative support can be documented in the organizational chart

which depicts the reporting relationship between the trauma program medical director and administration;

- c. Trauma specific policies, procedures and guidelines approved by the TMD

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.5. Trauma Program Manager (TPM)

1. The Trauma Center must have a person to act as a liaison to the regional evaluation process to conduct many of the administrative functions required by the trauma program. It is not anticipated that this would be a full-time role. Specifically, this person is responsible, with the TMD, for coordinating optimal patient care for all injured victims. This position will ideally serve as liaison with local EMS personnel, the Trauma Care Region, and other Trauma Centers. The TPM must obtain/maintain TNCC and/or 4 hours of trauma related education per year.
2. Compliance with the above will be evidenced by:
 - a. Attendance at and participation in the committee where trauma performance improvement is presented;
 - b. A written job description of roles and responsibilities to the trauma program which include: management of the trauma program, monitoring of clinical activities on trauma patients, providing staff with trauma related education, implementation of trauma specific performance improvement and supervision of the trauma registry;
 - c. Documentation of collaboration with TMD in the development and implementation of trauma specific policies, procedures and guidelines.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.6. Trauma Team

1. The team approach is optimal in the care of the multiple injured patients. The Trauma Center must have a written policy for notification and mobilization of an organized trauma team to the extent that one is available. The Trauma Team may vary in size and composition when responding to the trauma activation. The physician leader or mid-level provider on the trauma team is responsible for directing all phases of the resuscitation in compliance with ATLS protocol.

Suggested composition of the trauma team includes, if available:

- a. Physicians and/or mid-level providers
- b. Laboratory Technicians

- c. Nursing
 - d. Ancillary Support Staff
2. Compliance with the above will be evidenced by:
- a. A written resuscitation protocol which adheres to the principles of ATLS;
 - b. A written trauma team activation criteria policy which includes physiologic, anatomic and mechanism of injury criteria.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.7. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the system. The major focus will be on PI activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and injury prevention. The committee oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care.

Membership for the committee includes representatives (if available in the community) from:

- a. Emergency Medicine
 - b. Respiratory Therapy
 - c. Radiology
 - d. Laboratory
 - e. Rehabilitation
 - f. Pre-hospital Care Providers
 - g. Administration
 - h. Nursing
 - i. Trauma Program Manager
 - j. Trauma Medical Director (Chairman; must be present $\geq 50\%$)
2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.

3. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

20. **Subchapter 2 Clinical Components**

Rule 6.2.1. Required Components

1. The Trauma Center must maintain published on-call schedules for physicians and/or mid-level providers on-call to the facility.
2. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.

Source: Miss. Code Ann. § 41-59-5

21. **Subchapter 3 Facility Standards**

Rule 6.3.1. Emergency Department

1. The facility must have an emergency department staffed so trauma patients are assured immediate and appropriate initial care. There must be a designated physician director. It is not anticipated that a physician will be available on-call to an emergency department in a Level IV Trauma Center; however, it is a desirable characteristic of a Level IV. The on-call practitioner must respond to the emergency department based on local written criteria. A system must be developed to assure early notification of the on-call practitioner. Compliance with this criterion must be documented and monitored by the Trauma Performance Improvement process.
2. All physicians and mid-level providers (Physician Assistant/Nurse Practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board-Certified General Surgery Physicians. Rural Trauma Team Development Course (RTTDC) may be substituted for ATLS at Level IV Trauma Centers.
3. Emergency nurses staffing the trauma resuscitation area must be a current provider in TNCC, ATCN, or RTTDC within the last four years. Nurses must obtain trauma training within 18 months of assignment to the ER. Adequate numbers of nurses must be available in-house 24 hours/day, to meet the need of

the trauma patient. The nurse may perform other patient care activities within the hospital when not needed in the emergency department.

4. Compliance with the above will be evidenced by:
 - a. Published on-call list of practitioners to the Emergency Department;
 - b. Documentation of nursing staffing patterns to assure 24-hour coverage.
 - c. The list of required equipment necessary for the ED can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

22. Subchapter 4 Clinical Support Services

Rule 6.4.1. General

1. It is not anticipated that Level IV Trauma Centers have any of the following services available 24/7:
 - a. Respiratory Therapy Services
 - b. Radiology Services
 - c. Clinical Laboratory Services
 - d. Hemodialysis: There must be a written protocol to transfer the patient to a facility that provides this service if this service is not available at the Level IV Trauma Center.
2. Should any of these services be available, the facility should make them available to the trauma patient as necessary and within the capabilities of the facility.

Source: Miss. Code Ann. § 41-59-5

Rule 6.4.2. Burn Care: There must be a written protocol to transfer the patient to a Burn Center, if appropriate burn care is not available at the Level IV Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.4.3. Prevention/Public Outreach

1. The Level IV Trauma Center is responsible for working with other trauma centers and the Department to develop education and prevention programs for the public and professional staff.
2. Level IV Trauma Centers shall collaborate with Level I, II and III Trauma

Centers, Burn Centers and Tertiary/Secondary Pediatric Centers for the purpose of systemwide performance improvement.

Source: Miss. Code Ann. § 41-59-5

Rule 6.4.4. Transfer Guidelines

1. All facilities will work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to ensure the most expedient, safe transfer of the patient. All designated facilities will agree to provide service to the trauma patient regardless of their ability to pay.
2. The following trauma patient treatment guidelines must be in place, at a minimum:
 - a. Pediatrics
 - b. Burns
 - c. Surgical
 - d. Orthopedics
 - e. Neurological
3. Once the decision for transfer has been made, it is the responsibility of the referring physician to initiate resuscitation measures within the capabilities of the local hospital. The referring provider shall select a mode of transport according to the patient's needs so that the level of care is appropriate during transport.

Source: Miss. Code Ann. § 41-59-5

Rule 6.4.5. Level IV Trauma Centers must have an internal trauma education program.

Source: Miss. Code Ann. § 41-59-5

23. **Chapter 7 Pediatric Trauma Centers**

The hospital resources for adult trauma centers are described in Chapters 3, 4, 5 and 6. The traumatized pediatric patient has special requirements that go beyond the resources required for an adult Trauma Center.

All adult trauma centers in Mississippi are required to function at one of the three levels of pediatric trauma care. An adult Trauma Center does not have to function at the same or similar levels but must function at some level of pediatric trauma care. The three levels of pediatric trauma care include: tertiary, secondary, and primary.

24. **Subchapter 1 Tertiary Pediatric Trauma Centers**

Rule 7.1.1. General

1. Tertiary Pediatric Trauma Centers shall act as regional tertiary care facilities at the hub of the trauma care system for injured pediatric patients. The facility shall have the ability to provide leadership and total care for every aspect of injury from prevention to rehabilitation. The Tertiary Pediatric Trauma Center must have adequate depth of resources and personnel.
2. A standalone pediatric trauma center provides tertiary pediatric trauma care without sharing resources with another facility (i.e., CT scanner, radiology, surgeons, etc.). Only Level I Trauma Centers and standalone pediatric hospitals may qualify as a Tertiary Pediatric Trauma Center.
3. Tertiary Pediatric Trauma Centers have the responsibility of providing leadership in pediatric trauma education, trauma prevention, pediatric trauma research, system planning and performance improvement.
4. The list of required equipment for Tertiary Pediatric Trauma Centers can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.2. Hospital Departments/Divisions/Sections

1. The Tertiary Pediatric Trauma Center must have the following department, divisions, or sections:
 - a. Emergency medicine
 - b. General surgery (not required for stand-alone Pediatric Trauma Center)
 - c. Pediatric surgery
 - d. Orthopedic surgery
 - e. Neurological surgery
 - f. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.3. Pediatric Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of pediatric trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a

corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a pediatric trauma care program is sufficient. The pediatric trauma program must be established and recognized by the medical staff and hospital administration. The pediatric trauma program must come under the direction of a board-certified in General Surgery or Pediatric Surgery in Tertiary Center, current or previous board-certification in General or Pediatric Surgery in Primary and Secondary Centers with special interest in pediatric trauma care. An identified hospital administrative leader must work closely with the pediatric trauma medical director to establish and maintain the components of the pediatric trauma program including appropriate financial support. The pediatric trauma program location in the organizational structure of the hospital must be under the overall adult trauma program and must be such that it may interact effectively with at least equal authority with other departments providing pediatric patient care. The administrative structure must minimally include an administrator, pediatric medical director, trauma program manager, trauma registrar, and the appropriate support staff. These resources must be captured under the organization of the adult trauma program. The pediatric trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care must be extended to all the involved departments.

2. Compliance with the above will be evidenced by but not confined to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for care of the pediatric trauma patient;
 - c. Defined pediatric trauma team and written roles and responsibilities;
 - d. Appointed pediatric trauma medical director with a written job description;
 - e. Appointed pediatric trauma program manager with a written job description;
 - f. A written pediatric trauma performance improvement plan;
 - g. Documentation of representative attendance at statewide performance improvement meetings.

Source: Miss. Code Ann. § 41-59-5

- Rule 7.1.4. Pediatric Trauma Service: The pediatric trauma service must be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured pediatric patient. The pediatric trauma service will vary in each institution depending on the needs of the pediatric patient and the resources available. The pediatric trauma service

must come under the organization of the adult trauma program (not required for a standalone facility) and direction of a surgeon who is board certified (Tertiary Pediatric Trauma Center, current or previous board certified). All pediatric patients with multiple system trauma or serious injury must be evaluated and/or admitted by the pediatric trauma service. The surgeon responsible for the overall care of the pediatric patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.5. Pediatric Trauma Medical Director (TMD): Tertiary pediatric Trauma Centers must have a physician director Board Certified in General Surgery or Pediatric Surgery of the pediatric trauma program. This role can be filled by the TMD of the adult Trauma Center. The pediatric TMD plays an important administrative role and may not direct more than one pediatric Trauma Center. The pediatric TMD will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the pediatric trauma program. The pediatric TMD must be given administrative support to implement the requirements specified by the State trauma plan. The pediatric TMD is responsible for working with the credentialing process of the hospital, and in consultation with the appropriate service chiefs, for recommending appointment and removal of physicians from the pediatric trauma team. He/she must cooperate with nursing administration to support the nursing needs of the pediatric trauma patient and develop treatment protocols for the pediatric trauma patient. The pediatric trauma medical director, in collaboration with the trauma program manager, must coordinate the budgetary process for the trauma program. The director must be currently certified in ATLS, maintain personal involvement in care of the injured pediatric patient, maintain education in pediatric trauma care, and maintain involvement in professional organizations. The pediatric TMD must be actively involved with the trauma system development at the community, regional, and state levels. The TMD must perform an annual assessment of the general surgeons, pediatric surgeons, and mid-level providers assigned to the pediatric trauma service using a formal documented process.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.6. Pediatric Trauma Program Manager

1. Tertiary pediatric Trauma Centers must have a registered nurse working in the role of the TPM. The TPM of the adult Trauma Center may assume this additional role; however, if a pediatric TPM is utilized, the pediatric TPM is to report and be held accountable by the adult TPM. Working in conjunction with the pediatric trauma medical director, the pediatric TPM is responsible for organization of the pediatric trauma program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The pediatric TPM is responsible for working with the pediatric trauma team to assure optimal patient care. There are many requirements for data coordination, PI, education, and prevention activities incumbent upon this position. The TPM must obtain 16 hours of trauma related education per year.

2. The pediatric TPM/designee must offer or coordinate services for pediatric trauma education. The pediatric TPM must liaison with local EMS personnel, the Department and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.7. Pediatric Trauma Team: The team approach is optimal in the care of the multiple injured pediatric patient. There must be identified members of the pediatric trauma team. Policies must be in place describing the respective role of all personnel on the pediatric trauma team. The composition of the pediatric trauma

team will depend on the characteristics of the hospital and its staff. All physicians and/or mid-level providers (physician assistant/nurse practitioner) on the pediatric trauma team responsible for directing the initial resuscitation of the pediatric trauma patient must be certified in Advanced Trauma Life Support (ATLS). ATLS requirement is waived for Board Certified Emergency Medicine, Board Certified General Surgery and Board-Certified Pediatric Surgery physicians.

Composition of the trauma team for a severely injured patient includes:

1. ED physician and/or mid-level providers (Physician Assistant/Nurse Practitioner)
2. General/Pediatric surgeon
3. Nurses: ED
4. Laboratory Technicians
5. Radiology Services
6. Respiratory Therapist

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program including the pediatric trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated Trauma Center in the region. Each Trauma Center may choose to have one or more committees as needed to accomplish this task. One committee must be multidisciplinary and focus on pediatric trauma program oversight and leadership. The major focus will be on performance improvement (PI) activities, pediatric trauma policy development, communication among all pediatric trauma team members, and establishment of pediatric trauma standards of care, education, and outreach programs for pediatric injury prevention. The committee has administrative and systematic control and oversees implementation of all pediatric trauma program services, meets regularly, takes attendance, maintains minutes, and works to correct overall pediatric trauma program deficiencies to optimize pediatric patient care. Membership for the committee includes representatives from:
 - a. TMD (Chairman, must be present greater than 50% of the meetings)
 - b. Pediatric Emergency Medicine
 - c. Pediatric Surgery

- d. Pediatric Orthopedics
 - e. Pediatric Neurosurgery
 - f. Anesthesia
 - g. Operating room
 - h. Intensive care
 - i. Respiratory Therapy
 - j. Radiology
 - k. Laboratory
 - l. Pediatric Rehabilitation
 - m. Pre-hospital care providers
 - n. Administration
 - o. Pediatrics
 - p. Nursing
 - q. Trauma Program Manager
2. Clinical managers (or designees) of the departments involved with pediatric trauma care must play an active role with the committee.
 3. The pediatric trauma center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee must handle peer review independent from departmental based review. This committee must meet regularly, maintain attendance, and maintain minutes. This committee must report findings to the overall multidisciplinary trauma committee and hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.9. Required Clinical Components

1. Tertiary pediatric Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:
2. Pediatric Emergency Medicine (in-house 24 hours/day). Emergency Physician and/or mid-level provider (physician assistant/nurse practitioner) must be in the specified trauma resuscitation area upon patient arrival.

3. Trauma/General/Pediatric Surgery (in-house 24 hours/day). The surgeon covering pediatric trauma call must be unencumbered and immediately available to respond to the pediatric trauma patient. The 24-hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. The surgeon is expected to be in the ED upon arrival of the seriously injured pediatric patient. The surgeon's participation in major therapeutic decisions, presence in the ED for major resuscitation, and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. A system must be developed to assure early notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Activations is 20 minutes from patient arrival.
4. Orthopedic Surgery. It is required to have the orthopedic surgeon dedicated to the pediatric Trauma Center solely while on-call, but if not dedicated, a published back-up call schedule must be available. Response time for all trauma activations is 60 minutes from the time notified to respond.
5. Neurological Surgery. The neurosurgeons on the pediatric trauma team must be board certified. The pediatric neurosurgeon liaison to the pediatric trauma team must attend a minimum of 50% of the peer review committees annually and participate in the multidisciplinary trauma committee. It is required to have the neurosurgeon dedicated to the pediatric trauma center solely while on-call, but if not dedicated, a published back-up call schedule must be available. Response time for all trauma activations is 30 minutes from the time notified to respond.
6. It is desirable the following specialists are promptly available 24 hours/day:
 - a. Cardiac Surgery
 - b. Cardiology
 - c. Critical Care Medicine
 - d. Hand Surgery
 - e. Infectious Disease
 - f. Microvascular Surgery
 - g. Nephrology
 - h. Nutritional support

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

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

- 7. Policies and procedures must exist to notify the transferring hospital of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.10. Qualifications of Surgeons on the Trauma Team

- 1. Basic qualifications for pediatric trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board of Osteopathic Specialties, the Royal College of Physicians, the American Dental Association and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.
- 2. Alternate criteria in lieu of board certification are as follows:
 - a. A non-board-certified general surgeon must have completed a surgical residency program.
 - b. He/she must be licensed to practice medicine.

- c. He/she must be approved by the hospital's credentialing committee for surgical privileges.
 - d. The surgeon must meet all criteria established by the pediatric trauma medical director to serve on the pediatric trauma team.
 - e. The surgeon's experience in caring for the pediatric trauma patient must be tracked by the trauma PI program.
 - f. The pediatric trauma medical director must attest to the surgeon's experience and quality as part of the recurring granting of pediatric trauma team privileges.
 - g. The pediatric trauma medical director using the trauma PI program is responsible for determining each general surgeon's ability to participate on the pediatric trauma team.
3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured pediatric patient to make key decisions about the management of the pediatric trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation, and rehabilitation (as appropriate in a tertiary pediatric trauma center), and determine if the patient needs transport to a higher level of care. If transport is required, he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the tertiary pediatric Trauma Center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines must be written at the local level to determine which types of patient should be admitted to the tertiary pediatric Trauma Center or which patients should be considered for transfer to a higher level of care. General surgeons/pediatric surgeons taking trauma call must have eight (8) hours of trauma specific continuing medical education (CME) over three years. This can be met within the 40-hour requirements by licensure.
4. The pediatric surgeon liaison and general surgeon liaison (not required for stand-alone pediatric Trauma Center) must participate in a multidisciplinary trauma committee, the PI process; maintain committee attendance at least fifty percent (50%) over a year's period of time.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.11. Qualifications of Emergency Physicians

- 1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine or General/Pediatric Surgery is required or current certification in ATLS.
- 2. Alternate criteria for the non-boarded physician working in the Emergency Department are as follows:

- a. He/she must be licensed to practice medicine.
 - b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.
 - c. The physicians meet all criteria established by the pediatric trauma and emergency medicine directors to serve on the pediatric trauma team.
 - d. The physician's experience in caring for the pediatric trauma patient must be tracked by the trauma PI program.
 - e. The pediatric trauma and emergency medicine directors must attend to the physician's experience and quality as part of the recurring granting of pediatric trauma team privileges.
 - f. ATLS must be obtained within 18 months of hire.
3. The emergency medicine liaison must participate in a multidisciplinary trauma committee, the PI process; maintain committee attendance at least fifty percent (50%) over a year's period of time. General/Pediatric Surgery and Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General / Pediatric Surgery physicians), and it is required they be involved in at least eight (8) hours of trauma related CME every 3 years.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.12. Facility Standards: Emergency Medicine

1. The facility must have a dedicated pediatric emergency department so pediatric patients are assured immediate and appropriate initial care. The emergency physician must be in-house 24 hours/day and immediately available at all times. The emergency department medical director must meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and board certification in emergency medicine.
2. The director of the emergency department, along with the pediatric trauma medical director, will establish trauma-specific credentials that must exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification, and specialty board certification.
3. The emergency medicine physician will be responsible for activating the pediatric trauma team based on predetermined response protocols. He will provide trauma leadership and care for the pediatric trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established

standards and procedures to ensure immediate and appropriate care for the pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the multidisciplinary trauma committee and the trauma PI process.

4. There shall be an adequate number of RN's staffing the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC) or Advanced Trauma Care for Nurses (ATCN) and participate in the ongoing PI process of the trauma program. Nurses must obtain TNCC or ATCN within 18 months of assignment to the ER.
5. The list of required equipment necessary for the ED can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.13. Facility Standards: Surgical Suites/Anesthesia

1. The operating room (OR) must be staffed and available in-house 24 hours/day.
2. An operating room must be adequately staffed and available within 30 minutes of time of notification. Availability of the operating room personnel and timeliness of starting operations must be continuously evaluated by the trauma performance improvement process, and measures must be implemented to ensure optimal care.
3. The OR nurses must participate in the care of the pediatric trauma patient and be competent in the surgical stabilization of the major pediatric trauma patient. The Surgical nurses are an integral member of the trauma team and must participate in the ongoing PI process of the pediatric trauma program and be represented on the Multidisciplinary Trauma Committee.
4. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergency pediatric patient during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.
5. The anesthesia department in a tertiary pediatric Trauma Center must be organized and run by an anesthesiologist who has a special interest in the care of the injured pediatric patient. Anesthesiologist on the pediatric trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council of Graduate Medical Education or the American Board of Osteopathic Specialists and have board certification in anesthesia. One anesthesiologist must maintain commitment to education in trauma related anesthesia.
6. Anesthesia must be available in-house 24hours/day. Anesthesia Chief Residents or Certified Registered Nurse Anesthetist (CRNAs) who are capable of assessing

emergency situations in pediatric trauma patient and of providing indicated treatment, including initiation of surgical anesthesia may fill this requirement. When the CRNA or chief resident is used to meet this requirement, the staff Anesthesiologist on-call will be available within 30 minutes, and present for all operations.

7. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.
8. The list of required equipment necessary for Surgery and Anesthesia can be found online at the department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.14. Facility Standards: PACU

1. Tertiary pediatric Trauma Centers must have a PACU staffed 24 hours/day and available to the postoperative pediatric trauma patient. Frequently it is advantageous to bypass the PACU and directly admit to the PICU. In this instance, the Pediatric ICU may meet these requirements.
2. PACU staffing must be in sufficient number to meet the critical needs of the pediatric trauma patient.
3. The list of required equipment necessary for PACU can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.15. Facility Standards: Pediatric ICU (PICU)

1. Tertiary pediatric Trauma Centers must have a PICU that meets the needs of the pediatric trauma patient.
2. The surgical director or co-director must be the TMD or general/pediatric surgeon taking trauma call. The director is responsible for the quality of care and administration of the PICU and will set policy and establish standards of care to meet the unique needs of the pediatric trauma patient.
3. The pediatric trauma surgeon assumes and maintains responsibility for the care of the serious or multiple injured pediatric patient. A surgically directed PICU physician team is essential. The team will provide in-house physician coverage for all PICU pediatric trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialists, but must be led by a

qualified surgeon consistent with the medical staff privileging process of the institution. The pediatric trauma surgeon must maintain control over all aspects of care, including but not limited to respiratory care and management of the mechanical ventilation; placement and use of pulmonary catheters; management of fluid and electrolytes, antimicrobials, and enteral and parenteral nutrition.

4. There must be in-house physician coverage for the PICU at all times. A physician credentialed by the facility must be available to the pediatric trauma patient in the PICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.
5. Tertiary Pediatric Trauma Centers must provide staffing in sufficient numbers to meet the critical needs of the pediatric trauma patient. Critical care nurses must be available 24 hours per day. PICU nurses are an integral part of the pediatric trauma team and as such, shall be represented on the multidisciplinary trauma committee and participate in the PI process of the trauma program at least 50% of the time.
6. The list of required equipment necessary for the PICU can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.16. Clinical Support Services: Respiratory Therapy

1. The service must be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatment for the injured pediatric patient.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.17. Clinical Support Services: Radiological Services

1. A radiological service must have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological procedures. A technician must be in-house and immediately available for computerized tomography (CT) for both head and body.
2. Sonography, angiography and MRI must be available to the trauma team and may be covered with a technician on call.
3. The radiology liaison must attend at least 50% of the committee meetings and should educate and guide the entire trauma team in the appropriate use of radiologic services.
4. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must ensure the preliminary

interpretations are promptly reported to the pediatric trauma team and the trauma PI program must monitor all changes in interpretations.

5. Written policy must exist delineating the prioritization/availability of the CT scanner for pediatric trauma patients.
6. The Trauma Center must have policies designated to ensure the trauma patients who may require resuscitation and monitoring are accompanied by appropriate trauma providers during transportation to, and while in the radiology department.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.18. Clinical Support Services: Laboratory Services

1. Clinical laboratory service must have the following services available in-house 24 hours/day:
 - a. Access to blood bank and adequate storage facilities. Sufficient quantities of blood and blood products must be maintained at all times. Blood typing and crossmatch capabilities must be readily available.
 - b. Standard analysis of blood, urine and other body fluids including micro-sampling when appropriate.
 - c. Blood gas and pH determinations (this function may be performed by services other than the clinical laboratory service, when applicable).
 - d. Alcohol and drug screening
 - e. Coagulation studies
 - f. Microbiology
2. Trauma Centers of all levels must have a massive blood transfusion protocol developed collaboratively between the trauma service and blood bank.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.19. Clinical Support Services: Acute Hemodialysis

1. Tertiary pediatric Trauma Centers must have Acute Hemodialysis services.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.20. Clinical Support Services: Burn Care

1. There must be a written protocol to transfer the patient to a Burn Center, if appropriate burn care is not available at the tertiary pediatric Trauma Center.

Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.21. Clinical Support Services: Rehabilitation/Social Services

1. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program.
2. The rehabilitation of the pediatric trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the pediatric trauma patient, at the earliest stage possible after admission to the Tertiary Pediatric Trauma Center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the multidisciplinary rehabilitation team. The rehabilitation services must minimally include:
 - a. Occupational Therapy
 - b. Physical Therapy
 - c. Speech Pathology
 - d. Social Work,
 - e. Psychological
 - f. Nutritional support

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.22. Clinical Support Services: Prevention/Public Outreach

1. Tertiary pediatric Trauma Centers will be responsible for taking a lead role in coordination of appropriate agencies, professional groups, and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. Prevention program must be specific to the needs of the region. A Tertiary Pediatric Trauma Center's prevention program must include and track partnerships with other community organizations. At a minimum, trauma registry data must be utilized to identify injury trends and focus prevention needs.
2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at the Tertiary Pediatric Trauma Center must provide consultation to staff members of other level facilities. For example, ATLS, Pre-Hospital Trauma Life Support (PHTLS), TNCC, and Transport Nurse Advance Trauma Course (TNATC) courses can be coordinated by the tertiary pediatric Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.23. Clinical Support Services: Transfer Guidelines

1. Tertiary pediatric Trauma Centers shall work in collaboration with the referral facilities in the system and develop inter-facility transfer guidelines. These guidelines must address criteria to identify high-risk pediatric trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the pediatric trauma patient regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.24. Clinical Support Services: Education

1. Tertiary Pediatric Trauma Centers must have a written trauma education plan.
2. Tertiary Pediatric Trauma Centers must have internal trauma education programs including educational training in pediatric trauma for physicians, nurses, and pre-hospital providers. The Tertiary Pediatric Trauma Center must take a leadership role in providing educational activities. Education can be accomplished via many mechanisms (i.e., classic CME, preceptorships, fellowships, clinical rotations, telecommunications or providing locum tenens, etc.).
3. The Tertiary Pediatric Trauma Center is expected to support a pediatric surgical residency program. Additionally, there should be a senior resident rotation in at least one of the following disciplines: emergency medicine, general surgery, orthopedic surgery, neurosurgery or support a trauma fellowship.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.25. Clinical Support Services: Research

1. The trauma research program must be designated to produce new knowledge applicable to the care of the injured patients. The research may be conducted in a number of ways including traditional laboratory and clinical research, reviews of clinical series, and epidemiological or other studies. Publications of articles in peer-review journals as well as presentations of results in local, regional, and national meetings and ongoing studies approved by human and animal research review boards are expected from productive programs. The program should have an organized structure that fosters and monitors ongoing productivity.
2. The research program must be balanced to reflect the number of different interests. There must be a research committee, and identifiable Institutional Review Board process, active research protocols, surgeons involved in extramural educational presentations and adequate number of peer reviewed scientific

publications. Publications should appear in peer-reviewed journals. In a three-year cycle, the suggested minimum activity is ten publications (per review cycle) from the physicians representing the membership of the trauma team.

Source: Miss. Code Ann. § 41-59-5

25. **Subchapter 2 Secondary Pediatric Trauma Center**

Rule 7.2.1. General

1. A Secondary Pediatric Trauma Center is an acute care facility with the commitment, medical staff, personnel and specialty training necessary to provide care of the pediatric trauma patient. The decision to transfer a pediatric patient rest with the physician attending the pediatric trauma patient. All Secondary Pediatric Trauma Centers will work collaboratively with other trauma facilities to develop transfer protocols and a well-defined transfer sequence.
2. As a minimum, only Level III or higher adult trauma centers may qualify as a Secondary Pediatric Trauma Center.
3. Surgeons and ED physicians must be credentialed by the hospital for pediatric trauma care.
4. The list of required equipment for Secondary Pediatric Trauma Centers can be found on-line at the Department's website.

26. **Subchapter 3 Primary Pediatric Trauma Center**

Rule 7.3.1. General

1. Primary Pediatric Trauma Centers are facilities with a commitment to the initial resuscitation of the pediatric trauma patient and have written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred.
2. All designated trauma centers shall, as a minimum, be designated as a Primary Pediatric Trauma Center as a condition of designation in the Mississippi Trauma System.
3. The list of required equipment for Primary Pediatric Trauma Centers can be found online at the department's website.

Source: Miss. Code Ann. § 41-59-5

27. Chapter 8 Burn Centers

Subchapter 1 Hospital Organization

Rule 8.1.1. General

1. The burn center must be an acute care facility licensed in Mississippi or associated with a designated Level I Trauma Center in the MS Trauma System. The burn center must have a medical and an administrative commitment to the care of patients with burns. There must be a written commitment on behalf of the entire facility to the organization of burn care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. The burn center must have written guidelines for the triage, treatment, and transfer of burned patients from other facilities. The burn center must maintain an organizational chart relating personnel within the burn center and the hospital. The burn center must maintain current accreditation by the Joint Commission (TJC) or other recognized accrediting organization(s). The list of required equipment for burn centers can be found online at the Department's website.

Source: Miss. Code Ann. § 41-59-5

Rule 8.1.2. Burn Program

1. The burn center hospital must formally establish and maintain an organized burn program that is responsible for coordinating the care of burned patients. Compliance will be evidenced by, but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for care of the burn patient;
 - c. Defined burn team and written roles and responsibilities;
 - d. Appointed Burn Center Medical Director with a written job description;
 - e. Appointed Burn Center Program Manager with a written job description;
 - f. A written Burn Center Performance Improvement plan;
 - g. Documentation of representative attendance at statewide performance improvement meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 8.1.3. Burn Center Director

1. The burn center director must be a surgeon with board certification by the American Board of Surgery or American Board of Plastic Surgery; certification of special qualifications in surgical critical care is desirable. The burn center director must have completed a one-year fellowship in burn treatment or must have experience in the care of patients with acute burn injuries for two or more years during the previous five years. The burn center director must participate in continuing medical education in burn treatment (48 hours of burn/trauma related CME in a 3-year period) and must demonstrate ongoing involvement in burn-related research and community education in burn care and/or prevention.
2. Responsibilities of the burn center director must include, but not be limited to, the following:
 - a. Creation of policies and procedures within the burn center that specify the care of burned patients;
 - b. Creation of policies and protocols for use throughout the burn care system for referral care, triage, and transport of burn patients;
 - c. Communications on a regular basis with physicians and other authorities about patients who have been refused;
 - d. Direction of the burn center administrative functions, including approval of medical staff credentialing;
 - e. Direction and active participation in the burn center performance improvement program;
 - f. Liaison with adjacent and regional burn centers; and
 - g. Development and participation in internal and external continuing medical education programs in the care and prevention of burn injuries.

Source: Miss. Code Ann. § 41-59-5

Rule 8.1.4. Burn Program Manager (BPM)

1. Burn Centers must have a registered nurse, with two (2) or more years of experience as a nurse in a burn center, working full time in the role of Burn Program Manager (BPM), who is administratively responsible for the burn center. The BPM must have at least two (2) years or more of experience in acute burn care and six (6) months or more managerial experience. Working in conjunction with the Burn Center Director, the BPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of

burn care. The BPM is responsible for working with the burn team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position.

2. The BPM or his/her designee should offer or coordinate services for burn education. The BPM should liaison with local EMS personnel, the Department, trauma centers and other burn centers.
3. The BPM must participate in 16 or more hours of burn-related education (can be met by attendance at the annual meetings of the American Association for the Surgery of Trauma, ABA, or any ABA-endorsed meetings or continuing education programs, such as ABLIS or ABLIS Now) each year or 48 hours in a three-year period.
4. There must be an organizational chart relating the nurse manager to the burn service and other members of the burn team.

Source: Miss. Code Ann. § 41-59-5

Rule 8.1.5. Burn Team – the team approach is optimal in the care of the multiple injured patient. There must be identified members of the burn team. Policies should be in place describing the respective role of all personnel on the team. The composition of the team in any hospital will depend on the characteristics of the hospital and its staff. In some instances, a tiered response may be appropriate. If a tiered response is employed, written policy must be in place and the system monitored by the PI process. Composition of the burn team for an injured patient shall include:

1. Emergency Physicians and/or mid-level providers (physician assistant/nurse practitioner)
2. General/Trauma Surgeon
3. Physician Specialists
4. Anesthesiologist
5. Laboratory Technicians as dictated by clinical needs
6. Nursing: ED, OR, ICU, etc.
7. Auxiliary Support Staff
8. Respiratory Therapist
9. Security Officers

Rule 8.1.6. Multidisciplinary Burn Care Committee

1. The purpose of the committee is to provide oversight and leadership to the entire burn program. The exact format will be hospital specific and may be accomplished by collaboration with another designated burn center. Each burn center may choose to have one or more committees as needed to accomplish the task. One committee should be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education and outreach programs for injury prevention. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Attendance from the list below must be at least 50% or greater and reported at least quarterly. Membership for the committee should include representatives from:
 - a. Administration
 - b. Operating Room
 - c. Anesthesia
 - d. Burn and/or Plastic Surgery
 - e. Burn Emergency/Emergency Medicine
 - f. Pre-hospital providers
 - g. Intensive Care
 - h. Radiology
 - i. Laboratory
 - j. Rehabilitation
 - k. Respiratory Therapy
 - l. Nursing
 - m. Burn Program Manager/BPM
2. The clinical managers (or designees) of the departments involved with burn care should play an active role with the committee.
3. The burn center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee

should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 8.1.7. Policies and Procedures – the burn center must maintain an appropriate policy and procedure manual that is reviewed annually by the burn center director and the Burn Program Manager. The policy and procedure manual must contain, at a minimum, the following policies addressing the following:

1. Administration of the burn center.
2. Staffing of the burn center.
3. Criteria for admission to the burn center by the burn service.
4. Use of burn center beds by other medical or surgical services.
5. Criteria for discharge and follow-up care.
6. Availability of beds and the transfer of burn patients to other medical or surgical units within the hospital.
7. Care of patients with burns in areas of the burn center hospital other than the burn center.

Source: Miss. Code Ann. § 41-59-5

Rule 8.1.8. Personnel

1. The burn center must be granted the necessary authority to direct and coordinate all services for patients admitted to the burn service. The burn center director must make sure that medical care conforms to the burn center protocols. Privileges for physicians participating in the burn service must be determined by the medical staff credentialing process and approved by the burn center director. Qualifications for surgeons who are responsible for the care of burned patients must conform to criteria documenting appropriate training, patient care experience, continuing medical education, and commitment to teaching and research in the care of burned patients.

Source: Miss. Code Ann. § 41-59-5

28. Subchapter 2 Clinical Components

Rule 8.2.1. Trauma Evaluation

1. Patients with burns and trauma must be evaluated and/or stabilized at a trauma center before transfer to a burn center. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.

Source: Miss. Code Ann. § 41-59-5

Rule 8.2.2. Burn Service Coverage

1. The burn service must maintain an on-call schedule for attending staff surgeons who are assigned to the burn service. The staff surgeons must be promptly available on a 24-hour basis. Patients with >20%TBSA 2nd or 3rd degree burns and any patient with signs of airway injury must be seen by the attending on call for burn surgery or by the Burn ICU Physician within 2 hours of admission. All other inpatient admissions for burn injuries must be seen by the attending on call for burn surgery within 24 hours.

Source: Miss. Code Ann. § 41-59-5

Rule 8.2.3. Qualifications of Attending Staff Surgeons

1. The Burn Center Director must appoint qualified attending staff surgeons to participate in the care of patients on the burn service. Attending staff surgeons must be board-certified or board eligible with current Advanced Burn Life Support (ABLS). Certification of special qualifications in critical care is desirable. The attending staff surgeon must have demonstrated expertise in burn treatment. Attending staff surgeons must participate in continuing medical education in burn treatment. Other attending surgeons must demonstrate participation in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 8.2.4. Nursing Staff

1. There must be a patient care system in effect that is used to determine nurse staffing for each patient in the burn center. This system must be used to determine daily staffing needs. There must be a burn center orientation program that documents nursing competencies specific to the care and treatment of burn patients, including critical care, wound care, and rehabilitation. Burn center nursing staff must be provided with a minimum of two (2) burn-related continuing education opportunities

annually.

Source: Miss. Code Ann. § 41-59-5

Rule 8.2.5. Mid-Level Providers

1. Appropriate credentialed mid-level providers may be used as members of the burn team. These individuals may include, but are not limited to, physician assistants, surgical assistants, or nurse practitioners. They may augment but do not replace the physician member of the team.

Source: Miss. Code Ann. § 41-59-5

Rule 8.2.6. Burn Center Referral Criteria

1. Burn injuries that should be referred to a burn center include, but are not limited to the following:
 - a. Partial-thickness burns of greater than 10% of the total body surface area;
 - b. Burns that involve the face, hands, feet, genitalia, perineum, or major joints;
 - c. Third-degree burns;
 - d. Electrical burns, including lightning injury;
 - e. Chemical burns;
 - f. Inhalation injury;
 - g. Burn injury in patients with pre-existing medical disorders that could complicate management, prolonged recovery, or affect mortality;
 - h. Burn injury in patients who will require special social, emotional, or rehabilitative intervention;
 - i. Burns and concomitant trauma (such as fractures) when the burn injury poses the greatest risk of morbidity or mortality. If the trauma poses the greater immediate risk, the patient's condition may be stabilized initially in a Trauma Center before transfer to a burn center;
 - j. Burns in children; children with burns should be transferred to a burn center designated to treat children. In the absence of a regional designated pediatric burn center, an adult burn center

may serve as a second option for the management of pediatric burns.

Source: Miss. Code Ann. § 41-59-5

Rule 8.2.7. Specialty Services – the following specialists must be available for consultation:

29. General surgery
30. Cardiothoracic surgery
31. Neurological surgery
32. Obstetrics/gynecology
33. Ophthalmology
34. Anesthesiology
35. Pediatrics (if applicable)
36. Orthopedic surgery
37. Plastic surgery
38. Urology
39. Pulmonary
40. Radiology
41. Nephrology
42. Psychiatry
43. Cardiology
44. Gastroenterology
45. Hematology and/or Pathology
46. Neurology
47. Pathology
48. Infectious
disease

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

- Rule 8.3.1. Emergency Department – the emergency department must have written protocols mutually developed with the burn service for the care of acutely burned patients.

Source: Miss. Code Ann. § 41-59-5

- Rule 8.3.2. Surgical Suites – the burn center hospital must have operating rooms available 24 hours a day.

Source: Miss. Code Ann. § 41-59-5

- Rule 8.3.3. Allograft Use – the burn center hospital’s policies and procedures for the use of allograft tissues must be in compliance with all federal, state, and the Joint Commission/other recognized accrediting organizations’ requirements, and with standards of the American Association of Tissue Banks.

Source: Miss. Code Ann. § 41-59-5

49. Subchapter 4 Clinical Support Services

- Rule 8.4.1. Respiratory Therapy Service

1. Respiratory therapists must be available for the assessment and management of patients on the burn service on a 24-hour basis. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

- Rule 8.4.2. Renal Dialysis, Radiological Services, and Clinical Laboratory

1. Renal dialysis, radiological services (including computed tomography scanning), and clinical laboratory services must be available 24 hours per day.

Source: Miss. Code Ann. § 41-59-5

- Rule 8.4.3. Rehabilitation/Social Services

1. There must be a rehabilitation program designed for burned patients that

identifies specific goals.

2. The primary burn care therapist must have annual participation in 16 hours or more of burn-related education (can be met by attendance at the annual meetings of the American Association for the Surgery of Trauma, American Burn Association (ABA), or any ABA-endorsed meetings or continuing education programs, such as ABLA or ABLIS Now) each year or 48 hours over a three (3) year period.
3. Social service consultation must be available to the burn service. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.4. Nutritional Support

1. A dietician must be available on a daily basis for consultation.
2. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.5. Pharmacy

1. A pharmacist who has at least six (6) months of experience in critical care and the pharmacokinetics implications for patients with acute burn injuries must be available on a 24-hour basis.
2. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.6. Clinical Psychiatry

1. A psychiatrist or clinical psychologist should be available for consultation by the burn service on a 24-hour basis.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.7. Continuity of Care Program

1. The burn center must provide the following services:
 - a. Patient and family education in rehabilitation programs;
 - b. Support for family members or other significant persons;

- c. Coordinated discharge planning;
- d. Follow-up after hospital discharge;
- e. Access to community resources;
- f. Evaluation of the patient's physical, psychological, developmental, and vocational status;
- g. Planning for future rehabilitative and reconstructive needs.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.8. Weekly Patient Care Conferences

- 1. Patient care conferences must be held at least weekly to review and evaluate the status of each patient admitted to the burn center. Each clinical discipline should be represented to appropriately contribute to the treatment plan for each patient. Patient care conferences must be documented in the progress notes of each patient and/or in minutes of the conference.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.9. Infection Control Program

- 1. The burn center must have effective means of isolation that are consistent with principles of universal precautions and barrier techniques to decrease the risk of cross-infection and cross-contamination. The burn center hospital must provide ongoing review and analysis of nosocomial infection data and risk factors that relate to infection prevention and control for burn patients. This data must be available to the burn team to assess infection risk factors that relate to infection prevention and control for burn patients.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.10. Mass Casualty Plan

- 1. The burn center must have a written multiple-casualty plan for the triage and treatment of patients burned in a multiple casualty incident occurring within its service area. The multiple casualty plan must be reviewed and updated as needed, and on an annual basis by EMS representatives and the burn center director.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.11. Burn Prevention

1. The burn center will be responsible for taking a lead role in coordination of appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the burn system, access to the system, public support for the system, as well as specific prevention strategies. Prevention programs must be specific to the needs of the region. Trauma Registry data must be utilized to identify injury trends and focus prevention needs.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.12. Trauma Registry

1. All facilities designated as burn centers in Mississippi must participate in the statewide Trauma Registry for the purpose of supporting peer review and performance improvement activities at the local, regional, and state levels. Since this data relates to specific trauma patients and are used to evaluate and improve the quality of health care services, this data is confidential and will be governed by the Miss. Code Ann. §41-59-77.
2. This database must include all patients who are admitted to the burn center hospital for acute burn care treatment. Compliance with the above will be evidenced by:
 - a. Documentation of utilization of the Trauma Registry data in the trauma/burn performance improvement process.
 - b. Timely submission of Trauma Registry Data to the Department and the appropriate Trauma Region.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.13. Transfer Guidelines

1. All facilities will work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to ensure the most expedient, safe transfer of the patient. The transfer guidelines shall make certain that feedback is provided to the facilities and assure that this information becomes part of the trauma registry. All designated facilities will agree to accept and provide service to the trauma/burn patient regardless of their ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.14. Education

1. The burn center must be actively engaged in promoting Advanced Burn Life Support (ABLS) courses in its region. It is desirable for the director to be an ABLS instructor and essential that the director is current in ABLS. The unit should have one or more employees who are ABLS instructors.
2. The burn center must offer education on the current concepts in emergency and inpatient burn care treatment to pre-hospital and hospital care providers within its service area.
3. The burn center must have an internal burn education plan for the staff.

Source: Miss. Code Ann. § 41-59-5

Rule 8.4.15. Research

1. The burn center must participate in basic, clinical, and health sciences research. The medical director must demonstrate ongoing involvement in burn-related research.

Source: Miss. Code Ann. § 41-59-5

Title 15: Mississippi State Department of Health

Part 3: Bureau of Acute Care Systems

Subpart 2: STEMI System of Care

Chapter 1 Mississippi STEMI System of Care

Subchapter 1 General

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.1. Legal Authority: The Mississippi State Department of Health (Department) is assigned the responsibility for developing, implementing and managing the statewide STEMI System of Care (SOC). The Department shall be designated as the lead agency for STEMI SOC development, implementation and management. The Department shall develop and implement the Mississippi STEMI SOC Plan and STEMI SOC standards, which include but are not limited to those having to do with STEMI center designation, field triage of STEMI patients, inter-facility transfer of STEMI patients, STEMI care from initial medical contact through appropriate intervention, STEMI data collection, STEMI system evaluation and management of STEMI funding. The Department shall further promulgate specific regulations regarding the methods and procedures by which Mississippi-licensed acute care facilities shall participate in the statewide STEMI SOC. These specific regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities. The Department shall cause the implementation of professional and lay STEMI education programs including but not limited to STEMI education, CPR training and cardiac disease prevention programs.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.2. Mississippi STEMI SOC Advisory Committee: The Mississippi STEMI SOC Advisory Committee is created for the purpose of serving as an advisory body for statewide STEMI SOC development and shall provide support to the Department in all areas of STEMI SOC design, including the development and updating of SOC standards, SOC data collection and evaluation, SOC performance improvement, SOC funding, and evaluation of SOC programs.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.3. Members of the STEMI Advisory committee will be appointed by the State Health Officer for a term of three years and shall include representatives from the

following entities (membership list may be updated as needed based on participation):

- a. Cardiologist Chair
- b. Cardiologist, Cardiac Surgeon, or Emergency Medicine Vice-Chair
- c. Emergency Medicine Representatives from the Northern, Central and Southern Regions
- d. Emergency Nursing Representatives from the Northern, Central and Southern Regions
- e. Hospital Administration Representatives from the Northern, Central and Southern Regions
- f. Cardiology Representatives from the Northern, Central and Southern Regions
- g. STEMI Nursing Representatives from the Northern, Central and Southern Regions
- h. Registry Representatives from the Northern, Central and Southern Regions
- i. EMS Provider Representatives from the Northern, Central and Southern Regions
- j. EMS Administration Representatives from the Northern, Central and Southern Regions
- k. Non-transport EMS Representatives from the Northern, Central and Southern Regions
- l. Regional STEMI Coordinators from the Northern, Central and Southern Regions
- m. American Heart Association Representative
- n. Cardiac Surgeon

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.4. The Mississippi STEMI SOC Advisory Committee shall meet at least quarterly.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.5. Definitions: For the purpose of clarity and usage in the Mississippi STEMI SOC, the following abbreviations, acronyms, and terms shall be defined as follows:

1. ACC - American College of Cardiology
2. ACLS - Advanced Cardiac Life Support

3. ALS - Advanced life support, including techniques of resuscitation, such as, intravenous access, and cardiac monitoring
4. BACS – Bureau of Acute Care Systems, Mississippi State Department of Health
5. BEMS – Bureau of Emergency Medical Services, Mississippi State Department of Health
6. BLS - Basic life support techniques of resuscitation, including simple airway maneuvers, administration of oxygen, and intravenous access
7. CAP – Corrective Action Plan
8. CCRN - Critical Care Registered Nurse.
9. CEN - Certified Emergency Nurse
10. Department - Mississippi State Department of Health
11. Designation - Formal recognition of hospitals by the Department as providers of specialized STEMI services to meet the needs of patients suffering from an acute STEMI – following the rules and regulations as determined by the STEMI SOC.
12. E&D – Essential and Desirables chart for each STEMI Center designation level
13. Emergency Department (or Emergency Room) - The area of an acute care hospital that customarily receives patients in need of emergency medical evaluation and/or care
14. EMS - Emergency Medical Services H
15. EMSAC – Emergency Medical Services Advisory Council
16. ENA - Emergency Nurses Association
17. Field Triage - Classification of patients according to medical need at the scene of an injury or onset of an illness
18. Inclusive STEMI System of Care - a STEMI care system that incorporates every health care facility willing to participate in the voluntary system in order to provide a continuum of services for all patients suffering from an acute STEMI; the patient's needs are matched to the appropriate hospital resources

19. STEMI Receiving Centers - A hospital with the ability to provide 24/7/365 percutaneous coronary intervention (PCI) and provide leadership and complete care for every aspect of STEMI from prevention to rehabilitation
20. STEMI Referral Centers - An acute care hospital with the commitment, resources and specialty training necessary to diagnose, provide initial care and administer thrombolytics 24/7/365
21. Medical Control - Physician direction over pre-hospital activities to ensure efficient field triage, transportation, and care of STEMI patients
22. Mid-level Providers/Practitioners – Physician Assistant (PA) and/or Nurse Practitioners (NP)
23. Mississippi STEMI System of Care Plan - A formally organized plan developed by the Department, which sets out a comprehensive system for the prevention and management of STEMI patients
24. Non-Designated Hospital - A licensed acute care hospital that has applied for designation as a STEMI center, but has not been designated by the Department; or no longer meets the qualifications for a STEMI receiving center as determined by the STEMI SOC.
25. Non-Participating Hospital – A licensed acute care hospital that has informed the Department that they do not desire to participate in the STEMI SOC; and would NOT receive designation as a STEMI SOC receiving center / referral center.
26. Performance Improvement (PI or Quality Improvement) - A method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary approach to problem solving, and focuses not on individuals, but systems of patient care which might cause variations in patient outcome
27. Research - Clinical or laboratory studies designed to produce new knowledge applicable to the care of STEMI patients
28. Service Area (or "catchment area") - Geographic area defined by the local EMS agency as the area served by a designated STEMI Center
29. SHO – State Health Officer
30. STEMI Registry - a database program managed by the Department and used by hospitals to track STEMI patients and the care of STEMI patients

31. Triage - the process of sorting patients on the basis of the actual or perceived injury or illness and assigning them to the most effective and efficient STEMI care resources, in order to insure optimal care and the best chance of survival

Subchapter 2 Designation of STEMI Centers

Source: Miss. Code Ann. § 41-3-15

Rule 1.2.1. Application for STEMI Center Designation

- a. The decision to participate in the STEMI SOC is made jointly by the hospital administration and the medical staff and must be documented in an official letter of application for designation
- b. The Letter of Application should verify that the resolution to participate has been passed by the appropriate quorum of the governing authority of the hospital and co-signed by the director of the medical staff and contain the commitment to adhere to state STEMI System of Care protocols
- c. Each STEMI hospital must have an emergency physician and cardiologist (co-directors) responsible for oversight of the STEMI program
- d. STEMI program co-directors are responsible for developing and maintaining basic STEMI care protocols for the hospital
- e. STEMI program co-directors also have oversight responsibility for the STEMI component of the hospital PI program

Source: Miss. Code Ann. § 41-3-15

Rule 1.2.2. Application Process for Initial STEMI Center Designation

- a. The participation of acute care facilities in the STEMI SOC is voluntary; however, participating hospitals must be appropriately designated according to ability to care for STEMI patients – designation is a process of verifying that appropriate staff and resources are available
- b. To receive initial designation as a STEMI center the applicant hospital shall submit a letter of application to the Department
 - a. If currently designated as a STEMI receiving center by the American Heart Association, or another nationally recognized accrediting organization, and standards meet or exceed the regulations of this chapter, reciprocity shall be granted
- c. Within 60 days of receipt of the letter of application, the Department shall:
 - a. acknowledge receipt of the letter of application
 - b. provide the status of the application (accepted or rejected)
- d. If the application is accepted, the Department shall:
 - a. work with hospital staff to schedule the date for the designation survey visit

- b. provide materials to hospital staff for preparing for the designation survey visit
- e. If the application is rejected, the Department shall:
 - a. provide reasons for rejection
 - b. require documentation of corrective actions before accepting subsequent letters of application for designation from the applicant hospital
- f. The Department will provide results of the designation survey and any proposed CAP to the Mississippi STEMI SOC Advisory Committee
- g. The Mississippi STEMI SOC Advisory Committee Chair (or Vice-Chair if the Chair is unavailable) will make a recommendation for designation to the State Health Officer
- h. The Department will inform the applicant hospital of the status of the application within 14 days of the advisory committee recommendation.

Source: Miss. Code Ann. § 41-3-15

Rule 1.2.3. Term of STEMI Center Designations:

- a. The department shall designate STEMI Centers for a period not to exceed three (3) years. Designations shall remain active for three years provided no substantive changes or variances have occurred. The Department (and may perform periodic STEMI center audit/reviews. The State Health Officer (SHO) may extend STEMI Center designations for one (1) year.

Source: Miss. Code Ann. § 41-3-15

- Rule 1.2.4. Continuing Designation: Designated STEMI centers wishing to maintain current designation status shall submit a letter of intent to continue as currently designated no less than 90 days prior to the expiration of designation status.
- a. Any designated hospital not submitting a letter of intent to continue as currently designated will be required to reapply through the initial application process
 - b. Any Designated STEMI center that loses, either permanently or temporarily in excess of 90 days, patient care specialties required by this regulation, shall report that loss to the Department
 - c. If the loss will result in the hospital's inability to carry out the patient care activities associated with the current level of designation for a period longer than 90 days, the facility must submit a Corrective Action Plan (CAP) that addresses how and when the facility will become compliant

Source: Miss. Code Ann. § 41-3-15

- Rule 1.2.5. Suspension of STEMI Center Designation: The State Health Officer may suspend the STEMI center designation of any hospital for:
- a. Documented conditions of serious threat or jeopardy to patients' health or welfare
 - b. Failure to comply with laws or regulations
 - c. Failure to satisfactorily complete the minimum requirements as a STEMI center as defined by the regulations for the designation level
 - d. Failure to complete a Corrective Action Plan (CAP) within the timeframe specified by the Department
 - e. Hospitals having their Designation status suspended may reapply for designation after resolution of all issues related to the suspension, and completion and new application and designation survey visit

Source: Miss. Code Ann. § 41-3-15

- Rule 1.2.6. Change of STEMI Center Designation: STEMI Centers will be permitted to change their designation if the following conditions are met in their entirety:
- a. The STEMI Center has been appropriately surveyed and designated by the Department, the designation is current, and the STEMI Center is in full compliance with Department, regulations, policies, procedures, and protocols
 - b. The request to change designation has been approved by Mississippi STEMI Advisory Council
 - c. The State Health Officer (SHO) or designee issues the new designation

Subchapter 3 Financial Support for the STEMI SOC

Source: Miss. Code Ann. § 41-3-15

- Rule 1.3.1. The Mississippi State Department of Health is authorized to contract with the Mississippi Healthcare Alliance for services in the STEMI SOC. Services include but are not limited to cardiac disease education and prevention initiatives, public awareness initiatives designed for the purpose of making the public aware of the public health concern associated with cardiac disease, regional and STEMI center training in use of the STEMI registry, maintenance of the website providing lists and maps of currently designated STEMI centers, education activities of STEMI patient care providers, including EMS, ER and STEMI center personnel, CPR training and the dissemination of literature for use by STEMI providers. When

funds are used in public awareness campaigns and STEMI programs, it should be noted that the Mississippi State Department of Health is the state agency assigned the responsibility for developing, implementing and managing the STEMI System of Care (SOC).

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.2. STEMI Center Funding: There are no assigned annual fund distributions for STEMI centers.

Subchapter 4 Mississippi State STEMI Registry

Source: Miss. Code Ann. § 41-3-15

Rule 1.4.1. STEMI Data Collection and Use

- a. Participants in the statewide STEMI SOC will utilize a department approved national registry platform to collect data on STEMI patients and identify system issues, such as over and under triage
- b. All designated STEMI centers shall enter data on all STEMI patients
- c. Data collection will begin with systems and field data and continue through patient discharge/autopsy

Subchapter 5 STEMI Receiving Center Standards

Source: Miss. Code Ann. § 41-3-15

Rule 1.5.1. During the Initial Application for Designation Process and for re-designation STEMI Receiving Centers shall verify the following resources:

- a. Hospital Organization
 - i. STEMI service line or equivalent
 - ii. STEMI Care Coordinator or Service Line Director
 - iii. Departments/Sections
 - Interventional/Non-Interventional Cardiology
 - o A minimum of 2 interventional cardiologists are required at a facility to ensure 24-hour STEMI care

- Cardiac Catheterization Laboratory
 - o Must have 24/7/365 availability
- Emergency Department
- Coronary Care Unit
- Cardiovascular Surgery on-site or transfer protocols in place
 - o Transfer agreements should be placed on file with the Mississippi State Department of Health

iv. STEMI Treatment Protocols

- Protocols for triage, diagnosis (ECG < 10 minutes), and Cardiac Catheterization Laboratory activation
- A single activation telephone call should alert the STEMI team

b. Clinical Capabilities

i. Specialty availability (contact made with patient and care plan determined):

- Emergency Medicine – 10 minutes (ECG < 10 minutes)
- Interventional Cardiology – 30 minutes after notification by Emergency Department, or in accordance with hospital STEMI plan
- Cardiac Catheterization Lab – 30 minutes after activation

c. Consultant availability (on-call in accordance with hospital STEMI Plan):

- i. Cardiovascular Surgery
- ii. Pulmonary/Critical Care
- iii. Radiology
- iv. Internal Medicine/Hospital Care Services

d. Facilities and Resources

i. Emergency Department

- Personnel
- Designated Physician Director
- Emergency Medicine Specialists
- Nursing personnel with expertise (ACLS/ECG interpretation/cardiac arrhythmia monitoring/cardiac drugs) to monitor patient until admission to a hospital unit or transfer

□ Equipment

- Airway control and ventilation equipment
Oxygen/Pulse oximetry
- End-tidal CO₂ determination
- Suction devices
- 12-lead ECG capability
- Ability to obtain/interpret cardiac bio-markers
- Intravenous fluid administration equipment
- Sterile vascular (venous and arterial) access sets
- Gastric decompression equipment
- ACLS drugs

- Cardiac rhythm monitoring capability
- Bi-phasic cardiac defibrillator equipment
- Emergency temporary pacemaker capabilities (transthoracic/transvenous)
- Intubation/emergency airway management equipment
- Two-way communication capability with EMS

ii. Coronary/Intensive Care Unit

- Personnel
 - Designated Medical Director
 - Critical Care/Pulmonary Medicine/Intensivist (in-house or immediately ≤ 30 minutes] available)
 - Nursing personnel experienced in cardiovascular
- Equipment: Appropriate cardiac monitoring and respiratory support equipment

iii. Cardiac Catheterization Laboratory

- Personnel
 - o Radiologic staff with experience in cath lab operations and all aspects of diagnostic and interventional PCI, and cardiogenic shock therapies
 - o Nursing staff experienced in cath lab operations, conscious sedation, cardiac monitoring, cardiac emergencies, and cardiogenic shock therapies
- Equipment
 - o Guiding catheters, a variety of coronary guidewires, a variety of coronary stents

- o Advanced hemodynamic and ECG monitoring
- o Bi-phasic cardiac defibrillator equipment
- o Intravenous anti-thrombin and anti-platelet drugs
- o Intravenous vasoactive / vasopressor medications
- o Intravenous anti-arrhythmic medications
- o Aspiration thrombectomy catheters
- o Devices for acute hemodynamic support (i.e., IABP, Impella)
- o Temporary transvenous pacemaker
- o Intubation/emergency airway management equipment

iv. Rehabilitation

- Protocol for cardiac patients
- Full in-house service or transfer agreement with cardiac rehabilitation facility

v. Laboratory/Imaging Services

- Standard analyses of blood, urine, etc.
- Blood typing and cross-matching
- Comprehensive blood bank or access to equivalent facility
- Blood gases and pH determinations
- Comprehensive coagulation testing
- Cardiac bio-marker testing
- Computerized tomography angiography

- Echocardiography
- vi. Continuing Education: Formal programs on Acute Coronary Syndrome-STEMI for:
- Staff physicians (Cardiology/Emergency Medicine/Primary Care)
 - Nursing (Cardiac Cath Lab/ED/CCU)
 - Allied health personnel (Respiratory Therapy/ED technicians)
 - Community physicians
 - EMS
 - Documentation of education programs (at a minimum of 8 hours) provided at designation and re-designation

Source: Miss. Code Ann. § 41-3-15

Rule 1.5.2. During the Initial Application for Designation Process and for re-designation STEMI Referral_Centers shall verify the following resources

- a. Hospital Organization
- i. Departments/Sections
- Emergency Department
 - STEMI treatment protocols
 - o Each ED should maintain a standardized reperfusion STEMI care pathway that designates primary PCI as the preferred strategy if transfer to a primary PCI Center can be achieved within ACC/AHA guidelines
 - o Each ED should maintain a standardized STEMI care pathway that designates fibrinolysis in the ED (for eligible patients) when transfer to a primary PCI Center within ACC/AHA guidelines cannot be achieved

- o If reperfusion strategy is for transfer to a primary PCI Center, patients should be transported to the most appropriate PCI Center where the first door-to-balloon time is < 120 minutes

b. Clinical Capabilities

- i. Specialty availability (contact made with patient and care plan determined):

- Emergency Medicine – ECG < 10 minutes

c. Facilities and Resources

- i. Emergency Department

- Personnel

- Designated Physician Director
- Emergency Medicine Specialists (including mid-level practitioners)
- Nursing personnel with expertise (ACLS/ECG interpretation/cardiac arrhythmia monitoring/cardiac drugs) to monitor patient until admission to a hospital unit or transfer

- Equipment

- Airway control and ventilation equipment
- Oxygen/Pulse oximetry
- End-tidal CO₂ determination
- Suction devices
- 12-lead ECG capability
- Intravenous fluid administration equipment
- Gastric decompression equipment
- ACLS drugs

- Cardiac rhythm monitoring capability
 - Bi-phasic cardiac defibrillator equipment
 - Intubation/emergency airway management equipment
 - Two-way communication capability with EMS
- d. Continuing Education: Formal programs on Acute Coronary Syndrome-STEMI for:
- ED physicians/mid-level practitioners
 - Nurses
 - Allied health personnel
 - Community physicians
 - EMS
- Documentation of education programs should be provided at times of designation or re-designation

Subchapter 6 Pre-hospital Component and Field Triage

Source: Miss. Code Ann. § 41-3-15

Rule 1.6.1. The STEMI triage and transfer guidelines are based on the concept of getting the right patient to the right hospital in the shortest period of time. In order to do this some hospitals may be completely bypassed in favor of a more distant but more medically capable hospital. This rule provides a sample EMS Field Destination Guideline [see Appendix A].

Source: Miss. Code Ann. § 41-3-15

Rule 1.6.2. EMS providers shall utilize the same 10-minute recommendation for acquiring the 12-lead ECG and transmit the ECG prior to arrival at the STEMI Center

Source: Miss. Code Ann. § 41-3-15

- Rule 1.6.3. If the first medical contact to device can be anticipated by EMS to be achieved in 90 minutes or less, patient should be transferred directly to the STEMI Receiving Center, by-passing facilities not capable of providing PCI.

Subchapter 7 Inter-facility Transfers of STEMI Patients

Source: Miss. Code Ann. § 41-3-15

Rule 1.7.1. Inter-facility Transfers

1. Patients may be transferred from STEMI Referral Center to a STEMI Receiving Center and/or specialty referral centers provided that any such transfer is medically prudent, as determined by the transferring STEMI Center physician of record, and is conducted by the appropriate level of emergency medical service provider
2. STEMI Referral Center shall develop written criteria for consultation and transfer of patients needing a higher/specialty level of care with the regional STEMI Receiving Centers
3. STEMI Receiving Centers shall NOT be on diversion for true acute STEMI
4. STEMI Receiving Center shall provide written feedback to the STEMI Referral Center and shall participate in the state performance improvement process.

Subchapter 8 Performance Improvement and System Evaluation

Source: Miss. Code Ann. § 41-3-15

- Rule 1.8.1. Performance Improvement shall be an essential part of the STEMI SOC. It shall be used to analyze the proper functioning of the system and implement improvements in system operation. The PI program will be system-wide. Every designated STEMI center is required to participate in the system PI process. The appropriateness and quantity of all activities of the STEMI system must be continuously evaluated.
- a. The STEMI PI committee shall be responsible for the PI oversight of the STEMI System. Members of the STEMI PI committee will be appointed by the State Health Officer for a term of three years and shall include representatives from the following entities (membership list may be updated as needed based on participation):

- One Interventional Cardiologist practicing PCI from each of the three regions
- One Emergency Medicine physician practicing at a STEMI Receiving Center from each of the three regions
- The State EMS Medical Director or his physician designee
- The STEMI PI will be chaired by a cardiology physician and a vice-chair cardiologist or emergency medicine physician of the committee as determined annually by a majority of the committee.

Source: Miss. Code Ann. § 41-3-15

Rule 1.8.2. Specific audit filters will be established by the STEMI PI committee

- a. In general, the following performance improvement processes should be performed by each STEMI center. The results of these reviews shall be reported to the STEMI PI committee.
 - Each STEMI center assigns a PI person to oversee the process
 - Standards established
 - Determine audit filters
 - Collect data
 - Evaluate data
 - Determine PI issues present
 - Develop corrective action plan (CAP)
 - Re-evaluate to document results/effectiveness of CAP
- b. The following performance elements should be considered by each prehospital entity:
 - Accuracy of patient assessment and 12-lead ECG interpretation
 - Protocol adherence
 - Procedures initiated/completed

- Medical control interaction
 - Transport mode (air/ground)
 - Record/documentation
 - Inter-facility care/transport
- c. The following performance elements should be considered by each STEMI center:
- Outcome review
 - Complications
 - Deaths
 - Achievement of time-sensitive goals, i.e., door-to-balloon time
 - Adherence to designation level criteria
- Documentation of Local data/PI review should be provided at the time of designation or re-designation

Source: Miss. Code Ann. § 41-3-15

Rule 1.8.3. Data will be reviewed and analyzed at no less than two separate levels. Primary patient care data will be reviewed at each facility by its Multidisciplinary Committee. These committees will utilize nationally accepted patient review criteria and will also review the pre-hospital care of STEMI patients. The final level of data review will take place at the state level. Statewide data will be used for the review of statewide criteria and epidemiological purposes. The Statewide Education/Prevention program will be based on this data.

Title 15: Mississippi State Department of Health

Part 3: Bureau of Acute Care Systems

Subpart 3: Stroke System of Care

Chapter 1 Mississippi Stroke System of Care

Subchapter 1 General

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.1. Legal Authority: The Mississippi State Department of Health (Department) is assigned the responsibility for developing, implementing and managing the statewide Stroke System of Care (SOC). The Department shall be designated as the lead agency for Stroke SOC development, implementation and management. The Department shall develop and implement the Mississippi Stroke SOC Plan and Stroke SOC standards, which include but are not limited to those having to do with stroke center designation, field triage of stroke patients, drip and ship transfer of stroke patients, stroke care from initial medical contact through appropriate intervention, stroke data collection, stroke system evaluation and management of stroke funding. The Department shall further promulgate specific regulations regarding the methods and procedures by which Mississippi-licensed acute care facilities shall participate in the statewide Stroke SOC. These specific regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities. The Department shall cause the implementation of professional and lay stroke education programs including but not limited to stroke education, stroke prevention programs.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.2. Mississippi Stroke SOC Advisory Committee: The Mississippi Stroke SOC Advisory Committee is created for the purpose of serving as an advisory body for statewide Stroke SOC development and shall provide support to the Department in all areas of Stroke SOC design, including the development and updating of SOC standards, SOC data collection and evaluation, SOC performance improvement, SOC funding, and evaluation of SOC programs.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.3. Members of the Stroke Advisory committee will be appointed by the State Health Officer for a term of three years and shall include representatives from the following entities:

- a. Emergency Medicine Physician
- b. Emergency Nursing
- c. Hospital Administration

- d. Neurology
- e. Interventional Neurology/Radiology/Neurosurgery
- f. Stroke Program Coordinators
- g. Stroke Registry Personnel
- h. AHA Representative
- i. EMS Provider (ALS)
- j. EMS Administration

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.4. The Mississippi Stroke SOC Advisory Committee shall meet at least quarterly.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.5 **Definitions:** For the purpose of clarity and usage in the Mississippi Stroke SOC, the following abbreviations, acronyms, and terms shall be defined as follows:

AHA/ASA – American Heart Association/American Stroke Association

ALS - Advanced life support, including techniques of resuscitation, such as, intravenous access, and cardiac monitoring

ASLS – Advanced stroke life support

BACS – Bureau of Acute Care Systems, Mississippi State Department of Health

BEMS – Bureau of Emergency Medical Services, Mississippi State Department of Health

BLS - Basic life support techniques of resuscitation, including simple airway maneuvers, administration of oxygen, and intravenous access

CAP – Corrective Action Plan

CCRN - Critical Care Registered Nurse

CEN - Certified Emergency Nurse

CPG – Clinical Practice Guidelines

Department - Mississippi State Department of Health

Designation - Formal recognition of hospitals by the Department as providers of specialized stroke services to meet the needs of patients suffering from an acute stroke

DNV – Det Norske Veritas Healthcare. CMS approved accreditation organization

Emergency Department (or Emergency Room) - The area of an acute care hospital that customarily receives patients in need of emergency medical evaluation and/or care

EMS - Emergency Medical Services

EMSAC – Emergency Medical Services Advisory Council

ENA - Emergency Nurses Association

Field Triage - Classification of patients according to medical need at the scene of an injury or onset of an illness

GWTG – Get with the Guidelines database

Inclusive Stroke System of Care - a Stroke care system that incorporates every health care facility willing to participate in the voluntary system in order to provide a continuum of services for all patients suffering from an acute Stroke; the patient's needs are matched to the appropriate hospital resources

Level 1 – Stroke Center defined in the Stroke System of Care Plan

Level 2 – Stroke Center defined in the Stroke System of Care Plan

Level 3 – Stroke Center defined in the Stroke System of Care Plan

Level 4 – Non-Stroke Hospital defined in the Stroke System of Care Plan

Medical Control - Physician direction over pre-hospital activities to ensure efficient field triage, transportation, and care of stroke patients

Mid-level Providers/Practitioners – Physician Assistant (PA) and/or Nurse Practitioners (NP)

Mississippi Stroke System of Care Plan - A formally organized plan developed by the Department, which sets out a comprehensive system for the prevention and management of Stroke patients

Non-Designated Hospital - A licensed acute care hospital that has applied for designation as a stroke center, but has not been designated by the Department

Non-Participating Hospital – A licensed acute care hospital that has informed the Department that they do not desire to participate in the Stroke SOC

Performance Improvement (PI or Quality Improvement) - A method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary

approach to problem solving, and focuses not on individuals, but systems of patient care which might cause variations in patient outcome

Research - Clinical or laboratory studies designed to produce new knowledge applicable to the care of stroke patients

Service Area (or "catchment area") - Geographic area defined by the local EMS agency as the area served by a designated stroke Center

SHO – State Health Officer

Stroke Centers – Stroke Center defined in the Stroke System of Care Plan

Stroke Ready Hospitals – Stroke Center defined in the Stroke System of Care Plan

Stroke Registry – centralized, statewide database program managed by the Department and used by hospitals to track stroke patients and the care of stroke patients

TJC – The Joint Commission accreditation organization

Triage - the process of sorting patients on the basis of the actual or perceived injury or illness and assigning them to the most effective and efficient stroke care resources, in order to insure optimal care and the best chance of survival

Subchapter 2 Designation of Stroke Centers

Source: Miss. Code Ann. § 41-3-15

Rule 1.2.1 Application for Stroke Center Designation

- a. Hospitals may participate in the Stroke SOC on a voluntary basis, but must meet the standards defined in Appendix A of the Stroke SOC. Each hospital would determine whether they are available to receive patients or on critical care diversion
- b. The decision to participate in the Stroke SOC is made jointly by the hospital administration and the medical staff
- c. A written commitment in the form of a resolution passed by the appropriate quorum of the governing authority of the hospital, and co-signed by the director of the medical staff, signifies the facility's desire to participate in the system
- d. Level 1 and Level 2 Stroke Centers must have a neurologist director responsible for oversight of the Stroke Program (developing and maintaining basic stroke care protocols and stroke component of hospital performance improvement)

- e. Level 3 Stroke Ready Hospitals must have a physician director for oversight of the Stroke Program (developing and maintaining basic stroke care protocols)
- f. Stroke Centers and Stroke Ready Hospitals must participate in the approved national registry platform.

Source: Miss. Code Ann. § 41-3-15

Rule 1.2.2 Application Process for Initial Stroke Center Designation

- a. The participation of acute care facilities in the Stroke SOC is voluntary; however, participating hospitals must be appropriately designated according to ability to care for stroke patients – designation is a process of verifying that appropriate staff and resources are available
- b. To receive initial designation as a Stroke Center the applicant hospital shall submit a letter of application to the Department
 - a. If currently designated as a Stroke Center by The Joint Commission or another nationally accrediting organization, and standards meet or exceed the regulations of this chapter, reciprocity shall be granted
- c. Within 60 days of receipt of the letter of application, the Department shall:
 - a. acknowledges receipt of the letter application
 - b. provides the status of the application (accepted or rejected)
- d. If the application is accepted, the Department shall:
 - a. work with the hospital staff to schedule the date for the designation survey visit
 - b. provides materials to hospital staff for preparing for the designation survey visit
- e. If the application is rejected, the Department shall:
 - a. provides reasons for rejection
 - b. requires documentation of corrective actions before accepting subsequent letters of application for designation from the applicant hospital
- f. The Department shall provide results of the designation survey and any proposed CAP to the Mississippi Stroke SOC Advisory Committee
- g. The Mississippi Stroke SOC Advisory Committee will make a recommendation for designation to the State Health Officer
- h. The Department shall inform the applicant hospital of the status of the application within 30 days of the Advisory Committee meeting

Source: Miss. Code Ann. § 41-3-15

Rule 1.2.3 Term of Stroke Center Designations:

- a. The Department shall designate Stroke Centers for a period not to exceed three (3) years. Designations shall remain active for three years provided no substantive changes or variances have occurred. The Department may

perform periodic Stroke Center audits/reviews. The State Health Officer may extend Stroke Center designations for one (1) year. In cases of reciprocity the term of designation expires concurrently with the designation granted by the organization through which reciprocity was granted

Source: Miss. Code Ann. § 41-3-15

- Rule 1.2.4. Continuing Designation:
- a. Any Designated Stroke Center that loses, either permanently or temporarily, patient care specialties required by this regulation, shall report that loss to the Department
 - b. If the loss will result in the hospital's inability to carry out the patient care activities associated with the current level of designation for a period longer than 30 days, the facility must submit a Corrective Action Plan that addresses how and when the facility will become compliant
 - c. Subsequent designations for Stroke Centers designated based on reciprocity must be applied for through the same process followed for their initial designation and as prescribed in this document

Source: Miss. Code Ann. § 41-3-15

- Rule 1.2.5 Suspension of Stroke Center Designation: The State Health Officer may suspend the Stroke Center designation of any hospital for:
- a. Documented conditions of serious threat or jeopardy to patients' health or welfare
 - b. Failure to comply with laws or regulations
 - c. Failure to satisfactorily complete the minimum requirements as a Stroke Center as defined by the regulations for the designation level
 - d. Failure to complete a Corrective Action Plan within the timeframe specified by the Department
 - e. Hospitals having their Designation status suspended may reapply for designation after resolution of all issues related to the suspension, and completion and new application and designation survey visit

Source: Miss. Code Ann. § 41-3-15

- Rule 1.2.6. Change of Stroke Center Designation: Stroke Centers will be permitted to change their designation if the following conditions are met in their entirety:
- a. The Stroke Center has been appropriately surveyed and designated by an accredited organization and/or the Department, the designation is current, and the Stroke Center is in full compliance with Department, regulations, policies, procedures, and protocols
 - b. The request to change designation has been approved by Mississippi Stroke Advisory Council
 - c. The State Health Officer or designee issues the new designation

Subchapter 3 Financial Support for the Stroke SOC

Source: Miss. Code Ann. § 41-3-15

- Rule 1.3.1 The Mississippi State Department of Health is authorized to contract with the Mississippi Healthcare Alliance for services in the Stroke SOC. Services include but are not limited to stroke education and prevention initiatives, public awareness initiatives designed for the purpose of making the public aware of the public health concern associated with stroke training in use of the Stroke Registry, maintenance of the website providing lists and maps of currently designated Stroke Centers, education activities of stroke patient care providers, including EMS, ED and Stroke Center personnel, CPR training and the dissemination of literature for use by stroke providers. When funds are used in public awareness campaigns and stroke programs, it should be noted that the Mississippi State Department of Health is the state agency assigned the responsibility for developing, implementing and managing the Stroke System of Care.

Source: Miss. Code Ann. § 41-3-15

- Rule 1.3.2. Stroke Center Funding: There are no assigned annual fund distributions for Stroke Centers.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Mississippi State Stroke Registry

- Rule 1.4.1. Stroke Data Collection and Use
- a. Participants in the statewide Stroke SOC will utilize a Department approved national registry platform to collect data on Stroke patients and identify system issues, such as over and under triage
 - b. All designated Stroke Centers shall enter data on all stroke patients
 - c. Data collection will begin with systems and field data and continue through patient discharge.

Source: Miss. Code Ann. § 41-3-15

Subchapter 5 Stroke Center Standards

Source: Miss. Code Ann. § 41-3-15

- Rule 1.5.1. During the Initial Application for Designation Process – Level 1 Stroke Centers shall verify the following resources:
- a. Hospital Organization

- i. Core team of personnel, infrastructure, and expertise to diagnose and treat stroke patients who require intensive medical, surgical, and interventional vascular care. The team consists of a neurologist, neurosurgeon, and endovascular specialists
 - ii. Fully equipped Emergency Department (ED) for rapid diagnosis and treatment using standard CT imaging within 20 minutes and the ability to have results reported within 45 minutes of arrival
 - iii. Departments/Sections
 - 1. Emergency Department
 - 2. Interventional/Vascular Suite
 - 3. Laboratory
 - 4. Radiology
 - 5. Stroke Unit or Designated Beds
 - 6. Operating Room
 - iv. Stroke Treatment Protocols
 - 1. Protocols and care plans are available in the Emergency Department, acute care areas and stroke units for the acute assessment and treatment of patients with ischemic or hemorrhagic stroke
 - 2. Utilizes an evidenced based bedside dysphagia screen protocol approved by the organization
 - 3. Protocol for IV thrombolytics
 - 4. A single activation should alert the stroke team
- b. Clinical Capabilities
 - i. Specialty availability (contact made with patient and care plan determined):
 - 1. Door to Physician as defined in the AHA/ASA CPGs
 - 2. At least one designated stroke team practitioner is able to respond to the bedside as defined in the AHA/ASA CPGs
 - 3. NIHSS completed as defined in the AHA/ASA CPGs

4. Door to CT initiated as defined in the AHA/ASA CPGs
 5. Door to CT interpreted as defined in the AHA/ASA CPGs
 6. Door to Lab completed as defined in the AHA/ASA CPGs
 7. Door to EKG completed as defined in the AHA/ASA CPGs
 8. Door to CXR completed as defined in the AHA/ASA CPGs
 9. Door to Needle as defined in the AHA/ASA CPGs
 10. Door to Groin as defined in the AHA/ASA CPGs
 11. Door to Revascularization as defined in the AHA/ASA CPGs
- c. Consultant availability (on-call in accordance with hospital Stroke Plan):
- i. Neurologist
 - ii. Neurosurgeon
 - iii. Endovascular Specialist
 - iv. Pulmonary/Critical Care
 - v. Internal Medicine/Hospital Care Services
- d. Facilities and Resources
- i. Emergency Department
 1. Personnel
 - a. Emergency Physicians privileged in the diagnosis and treatment of ischemic and hemorrhagic stroke
 - b. Nursing personnel with expertise in Alteplase administration and care of the acute stroke patient until admission to a hospital unit or transfer
 2. Equipment
 - a. Airway control and ventilation equipment
Oxygen/Pulse oximetry
 - b. Suction devices

- c. 12-lead ECG capability
 - d. Intravenous fluid administration equipment
 - e. Approved thrombolytic medications for stroke treatment
 - f. Cardiac rhythm monitoring capability
 - g. Intubation/emergency airway management equipment
 - h. Two-way communication capability with EMS
- ii. Intensive Care Unit/Stroke Areas
 - 1. Personnel
 - a. Designated Stroke Medical Director
 - 2. Equipment
 - i. Appropriate cardiac monitoring and respiratory support equipment
- iii. Interventional/Vascular Suite
 - 1. Personnel
 - a. Radiologic staff with experience in interventional suite operations and all aspects of diagnostic and interventional stroke care
 - b. Nursing staff experienced in interventional suite operations, conscious sedation, cardiac monitoring, and cardiac and neurological emergencies
 - 2. Equipment
 - a. A variety of guiding, diagnostic, intermediate, aspiration and microcatheters
 - b. Cerebral guidewires and microwires
 - c. Stents, balloons and clot retrieval devices
 - d. Advanced hemodynamic and ECG monitoring
 - e. Intravenous antihypertensives, vasoactive/vasopressor medications

- f. Thrombolytic and antiplatelet medications
 - g. Distal protection devices
 - h. Intubation/emergency airway management equipment
- iv. Rehabilitation
 - 1. Protocol for stroke patients
 - 2. Complete rehabilitation services including OT, PT, and SLP available for all stroke patients within 24-48 hours
- v. Laboratory Services
 - 1. Glucose
 - 2. Blood cell count with platelet count
 - 3. Coagulation studies
 - 4. Blood chemistries
 - 5. Troponin
- vi. Continuing Education:
 - 1. Core Stroke Team – At least 8 hours of stroke education annually
 - 2. Emergency Department Staff – Minimal of two educational activities per year or as defined by the nationally accrediting organization
 - 3. EMS Personnel – Stroke program will provide educational activities to EMS personnel
 - 4. Public Educational Activities – Stroke program will provide at least two public educational activities per year or as defined by the nationally accrediting organization

Source: Miss. Code Ann. § 41-3-15

Rule 1.5.2. During the Initial Application for Designation Process – Level 2 Stroke Centers shall verify the following resources

- a. Hospital Organization

- i. Core team of personnel, infrastructure, and expertise to diagnose and treat stroke patients who require intensive medical and surgical care. The team consists of a diagnostic radiologist, neurologist, and neurosurgeon
- ii. Fully equipped Emergency Department for rapid diagnosis and treatment using standard CT imaging as defined in the AHA/ASA CPGs
- iii. Departments/Sections
 1. Emergency Department
 2. Laboratory
 3. Radiology
 4. Stroke unit or designated beds
 5. Operating Room
- iv. Stroke Treatment Protocols
 1. Protocols and care plans are available in the Emergency Department, acute care areas and stroke units for the acute assessment and treatment of patients with ischemic or hemorrhagic stroke
 2. Utilizes an evidenced based bedside dysphagia screen protocol approved by the organization.
 3. Protocol for IV thrombolytics
 4. A single activation should alert the stroke team
 5. Evaluation protocol to assess for large vessel occlusion that may benefit from intervention
 6. Transfer protocol to Level 1 Stroke Center for large vessel occlusion
 - a. Consider rapid transfer to Level 1 Stroke Center for the following:
 - i. Patients, who were previously functionally independent, with signs of large vessel occlusion (examples include aphasia, neglect, eye deviation, hemiplegia, intubated, NIHSS >6);

consider transfer at the discretion of the accepting physician

- ii. Patients with large strokes with cerebral edema for consideration of surgical decompression

b. Clinical Capabilities

- i. Specialty availability (contact made with patient and care plan determined):

- 1. Door to Physician as defined in the AHA/ASA CPGs
- 2. At least one designated stroke team practitioner is able to respond to the bedside as defined in the AHA/ASA CPGs
- 3. NIHSS completed as defined in the AHA/ASA CPGs
- 4. Door to CT initiated as defined in the AHA/ASA CPGs
- 5. Door to CT interpreted as defined in the AHA/ASA CPGs
- 6. Door to Lab completed as defined in the AHA/ASA CPGs
- 7. Door to EKG completed as defined in the AHA/ASA CPGs
- 8. Door to CXR completed as defined in the AHA/ASA CPGs
- 9. Door to Needle as defined in the AHA/ASA CPGs

- c. Consultant availability (on-call in accordance with hospital Stroke Plan):

- i. Neurologist
- ii. Neurosurgeon
- iii. Pulmonary/Critical Care
- iv. Internal Medicine/Hospital Care Services

d. Facilities and Resources

- i. Emergency Department

- 1. Personnel

- a. Emergency Physicians privileged in the diagnosis and treatment of ischemic and hemorrhagic stroke

- b. Nursing personnel with expertise in Alteplase administration and care of the acute stroke patient until admission to a hospital unit or transfer
- 2. Equipment
 - a. Airway control and ventilation equipment
Oxygen/Pulse oximetry
 - b. Suction devices
 - c. 12-lead ECG capability
 - d. Intravenous fluid administration equipment
 - e. Thrombolytic medications
 - f. Cardiac rhythm monitoring capability
 - g. Intubation/emergency airway management equipment
 - h. Two-way communication capability with EMS
- ii. Intensive Care Unit/Stroke Areas
 - 1. Personnel
 - a. Designated Stroke Medical Director
 - 2. Equipment
 - a. Appropriate cardiac monitoring and respiratory support equipment
- iii. Rehabilitation
 - 1. Protocol for stroke patients
 - 2. Complete rehabilitation services including OT, PT, and SLP available for all stroke patients within 24-48 hours
- iv. Laboratory Services
 - 1. Glucose
 - 2. Blood cell count with platelet count
 - 3. Coagulation studies

4. Blood chemistries

5. Troponin

v. Continuing Education:

1. Core Stroke Team – At least 8 hours of stroke education annually

2. Emergency Department Staff – Minimal of two educational activities per year or as defined by the nationally accrediting organization

3. EMS Personnel – Stroke program will provide educational activities to EMS personnel

4. Public Educational Activities – Stroke program will provide at least two public educational activities per year or as defined by the nationally accrediting organization

Rule 1.5.3. During the Initial Application for Designation Process – Level 3 Stroke Ready Hospital shall verify the following resources

a. Hospital Organization

i. ED Physician, other qualified physician, or physician extender available 24/7 to diagnose and initiate appropriate treatment including patient transfer to a Level 1 or Level 2 facility

ii. Rapid diagnosis and treatment using standard CT imaging as defined in the AHA/ASA CPGs

iii. Departments/Sections

1. Emergency Department

2. Laboratory

3. Radiology

iv. Stroke Treatment Protocols

1. Protocols and care plans are available in the Emergency Department for the acute assessment and treatment of patients with ischemic or hemorrhagic stroke

2. Utilizes an evidenced based bedside dysphagia screen protocol approved by the organization

3. Protocol for IV thrombolytics

4. A single activation should alert the stroke team
5. Evaluation protocol to assess for large vessel occlusion that may benefit from intervention
6. Transfer protocol to Level 1 Stroke Center for large vessel occlusion
 - a. Consider rapid transfer to Level 1 Stroke Center for the following:
 - i. Patients, who were previously functionally independent, with signs of large vessel occlusion (examples include aphasia, neglect, eye deviation, hemiplegia, intubated, NIHSS >6); consider transfer at the discretion of the accepting physician
 - ii. Patients with large strokes with cerebral edema for consideration of surgical decompression
 - b. Clinical Capabilities
 - i. Specialty availability (contact made with patient and care plan determined):
 1. Door to Physician as defined in the AHA/ASA CPGs
 2. At least one designated stroke team practitioner is able to respond to the bedside as defined in the AHA/ASA CPGs
 3. NIHSS completed as defined in the AHA/ASA CPGs
 4. Door to CT initiated as defined in the AHA/ASA CPGs
 5. Door to CT interpreted as defined in the AHA/ASA CPGs
 6. Door to Lab completed as defined in the AHA/ASA CPGs
 7. Door to EKG completed as defined in the AHA/ASA CPGs
 8. Door to CXR completed as defined in the AHA/ASA CPGs
 9. Door to Needle as defined in the AHA/ASA CPGs
 - c. Consultant availability (on-call in accordance with hospital Stroke Plan):

- i. Neurologist (on-call, tele-medicine, or transfer agreement to Level 1 or 2 Stroke Center)
 - ii. Critical Care Specialist
 - iii. Internal Medicine/Hospital Care Services
 - d. Facilities and Resources
 - i. Emergency Department
 - 1. Personnel
 - a. Emergency Physicians, other qualified physicians or physician extender privileged in the diagnosis and treatment of ischemic and hemorrhagic stroke
 - b. Nursing personnel with expertise in Alteplase administration and care of the acute stroke patient until admission to a hospital unit or transfer
 - 2. Equipment
 - a. Airway control and ventilation equipment
Oxygen/Pulse oximetry
 - b. Suction devices
 - c. 12-lead ECG capability
 - d. Intravenous fluid administration equipment
 - e. Thrombolytic medications
 - f. Cardiac rhythm monitoring capability
 - g. Intubation/emergency airway management equipment
 - h. Two-way communication capability with EMS
 - ii. Laboratory Services
 - 1. Glucose
 - 2. Blood cell count with platelet count
 - 3. Coagulation studies
 - 4. Blood chemistries

5. Troponin

iii. Continuing Education:

1. Core Stroke Team – At least 8 hours of stroke education annually
2. Emergency Department Staff – Minimal of two educational activities per year or as defined by the nationally accrediting organization

Rule 1.5.4. During the Initial Application for Designation Process – Level 4 Non Stroke Hospital shall verify the following resources

a. Hospital Organization

- i. Facility is able to access and evaluate for possible stroke, but lacks essential components to treat patients with IV thrombolytics
- ii. Transition plans must be established to facilitate rapid evaluation and transfer of patients to Level 1 or Level 2 Stroke Centers.
- iii. May be bypassed in accordance with this plan or an EMS Medical Control Plan.

Source: Miss. Code Ann. § 41-3-15

Subchapter 6 Pre-hospital Component and Field Triage

Rule 1.6.1. The Stroke triage and transfer guidelines are based on the concept of getting the right patient to the right hospital in the shortest period of time. In order to do this some hospitals may be completely bypassed, based on EMS guidelines or protocols, in favor of a more distant but more medically capable hospital.

Source: Miss. Code Ann. § 41-3-15

Subchapter 7 Inter-facility Transfers of Stroke Patients

Rule 1.7.1. Drip and Ship Transfer Protocol

1. Patients may be transferred from Level 2, 3, or 4 center to a Level 1 or 2 center provided that any such transfer is medically prudent, after implementation of time sensitive therapy, as determined by the transferring Stroke Center physician of

record, and is conducted by the appropriate level of emergency medical service provider

2. Level 2, 3 and 4 centers shall develop written criteria for consultation and transfer of patients needing a higher/specialty level of care
3. Level 1 and 2 centers shall provide feedback as requested to the Level 2, 3 or 4 center and shall participate in the state performance improvement process

Source: Miss. Code Ann. § 41-3-15

Subchapter 8 Performance Improvement and System Evaluation

Rule 1.8.1. Performance Improvement shall be an essential part of the Stroke SOC. It shall be used to analyze proper functioning of the system and implement improvements in system operation. The PI program will be system-wide. Every designated Stroke Center is required to participate in the system PI process and input the required statewide minimal dataset. The appropriateness and quantity of all activities of the Stroke system must be continuously evaluated.

- a. The Stroke PI committee shall be a subcommittee of the Stroke Advisory Committee responsible for the PI oversight of the Stroke System. Members of the Stroke PI committee shall include:
 - i. Chairperson – Neurologist participating in the Stroke System
 - ii. Each Level 1 and 2 Stroke Center will be authorized an administrative and/or clinical representative
 - iii. Level 3 hospitals may participate. The number of representatives will be determined by the permanent members of the sub-committee
 - iv. Three EMS organizations – one from a hospital-based EMS provider, a private EMS provider, and a public/government EMS provider

Source: Miss. Code Ann. § 41-3-15

Rule 1.8.2. Specific audit filters will be established by the Stroke PI committee

- a. In general, the following performance improvement processes should be performed by each Stroke Center. The results of these reviews shall be reported to the Stroke PI committee.
 - i. Each Stroke Center assigns a PI person to oversee the process

- ii. Standards established
 - iii. Determine audit filters
 - iv. Collect data
 - v. Evaluate data
 - vi. Determine PI issues present
 - vii. Develop corrective action plan
 - viii. Re-evaluate to document results/effectiveness of CAP
- b. The following performance elements should be considered by each pre-hospital entity:
- i. Quality measure regarding response times (time to dispatch, EMS response, on-scene time, and transport time) will be collected and analyzed
 - ii. Accuracy of patient assessment
 - iii. Transport protocol adherence
 - iv. Procedures initiated/completed
 - v. Medical control interaction
 - vi. Transport mode (air/ground)
 - vii. Record/documentation
 - viii. Inter-facility care/transport
- c. The following performance elements should be considered by each Stroke Center:
- i. Outcome review
 - ii. Complications
 - iii. Deaths
 - iv. Achievement of time sensitive goals (CT completed/reporting times and Door to Alteplase administration times)

- v. Core stroke quality measures established for hospital stroke care will be entered into the approved national registry platform for blinded comparison between hospitals

Source: Miss. Code Ann. § 41-3-15

Rule 1.8.3. Data will be reviewed and analyzed at no less than two separate levels. Primary patient care data will be reviewed at each facility by its Multidisciplinary Committee. These committees will utilize nationally accepted patient review criteria and will also review the pre-hospital care of stroke patients. The final level of data review will take place at the state level. Statewide data will be used for the review of statewide criteria and epidemiological purposes. The Statewide Education/Prevention program will be based on this data. Stroke registry personnel should be included on the PI Committee.

Source: Miss. Code Ann. § 41-3-15

Title 15: Mississippi Department of Health

Part 3: Bureau of Acute Care Systems

Subpart 4: Obstetrics (OB) System of Care

Chapter 1 Mississippi Obstetrics (OB) System of Care

Subchapter 1 General

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.1. 1. Legal Authority: The Mississippi State Department of Health (Department) is assigned the responsibility for developing, implementing and managing the statewide Obstetrics (OB) System of Care (SOC). The Department shall be designated as the lead agency for OB SOC development, implementation and management. The Department shall develop and implement the Mississippi OB SOC Plan and OB SOC standards, which include but are not limited to those having to do with maternal center and neonatal center designation, field triage of OB patients, inter-facility transfer of OB patients, OB care from initial medical contact through appropriate intervention, OB data collection, OB system evaluation and management of OB funding. The Department shall further promulgate specific regulations regarding the methods and procedures by which Mississippi licensed acute care facilities shall participate in the statewide OB SOC. These specific regulations shall include mechanisms

for determining the appropriate level of participation for each facility or class of facilities.

2. Purpose: The purpose of these regulations is to establish separate criteria for four maternal and four neonatal levels of care and procedures by which a perinatal facility may request approval to be a designated facility which has achieved a particular Department designated level of care.
3. These regulations are not intended to prevent any facility from providing medical services to a woman or infant.
4. No facility shall hold itself out as or advertise itself to the public as having achieved a Department designated level of care as a maternal or neonatal center unless it has been designated by the Department.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.2. Mississippi OB SOC Advisory Committee: The Mississippi OB SOC Advisory Committee is created for the purpose of serving as an advisory body for statewide OB SOC development and shall provide support to the Department in all areas of OB SOC design, including the development and updating of SOC standards, SOC data collection and evaluation, SOC performance improvement, SOC funding, and evaluation of SOC programs.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.3. Members of the OB System Advisory Committee will be appointed by the State Health Officer for a term of three years and shall include representatives from the following entities (membership list may be updated as needed based on participation):

1. Obstetrician Chair
2. Neonatologist, Co-Chair
3. Emergency Medicine Physician
4. Emergency Nurse
5. Family Medicine Physician

6. Neonatal Nursing Representatives from the Northern, Central and Southern Regions
7. Hospital Administration Representatives from the Northern, Central and Southern Regions
8. Obstetrician Representatives from the Northern, Central and Southern Regions Level 1 – IV Centers
9. Neonatologist Representatives from the Northern, Central and Southern Regions Level I – IV Centers
10. OB Nursing Representatives from the Northern, Central and Southern Regions
11. EMS Provider Representatives from the Northern, Central and Southern Regions
12. Regional OB Coordinators from the Northern, Central and Southern Regions
13. American College of Obstetricians and Gynecologists Representative

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.4. The Mississippi OB SOC Advisory Committee shall meet at least Quarterly.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.5. **Definitions:** For the purpose of clarity and usage in the Mississippi OB SOC, the following abbreviations, acronyms, and terms shall be defined as follows:

1. ACLS – Advanced Cardiovascular Life Support. A resuscitation course that was developed and is administered by the American Heart Association.
2. ALS – Advanced Life Support, including techniques of resuscitation, such as intravenous access, and cardiac monitoring.
3. ALSO – Advanced Life Support Obstetrics
4. APP – Advanced Practice Providers – clinicians—such as nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse midwives—who hold graduate-level education and advanced clinical training.

5. Available – Relating to staff who can be contacted for consultation at all times without delay.
6. Board-eligible – A physician who has completed a residency or fellowship and is eligible for board certification according to the applicable medical board.
7. CAP – Corrective Action Plan. A plan for the facility developed by the Department that describes the actions required of the facility to correct identified deficiencies to ensure the applicable designation requirements are met.
8. Department – The Mississippi State Department of Health
9. Designated facility – means a perinatal facility that has been inspected and approved by the Department pursuant to these regulations as meeting its established criteria for a particular maternal or neonatal level of care.
10. Designation – A formal recognition by the Department of a facility's maternal care capabilities and commitment for a period of three years.
11. Emergency Department (or Emergency Room) – The area of an acute care hospital that customarily receives patients in need of emergency medical evaluation and/or care
12. EMS – Emergency medical services. Services used to respond to an individual's perceived need for immediate medical care.
13. Gestational age - The age of a fetus or embryo determined by the amount of time that has elapsed since the first day of the mother's last menstrual period or the corresponding age of the gestation as estimated by a physician through a more accurate method.
14. High-risk infant- A newborn that has a greater chance of complications because of conditions that occur during fetal development, pregnancy conditions of the mother, or problems that may occur during labor or birth.
15. Immediately--Able to respond without delay, commonly referred to as STAT.

16. Inclusive OB System of Care – an OB care system that incorporates every health care facility willing to participate in the mandatory system in order to provide a continuum of services for maternal or neonatal care.
17. Infant – A child from birth to one year of age.
18. Inter-facility Transport – Transfer of a patient from one healthcare facility to another healthcare facility.
19. Lactation Consultant – A healthcare professional who specializes in the clinical management of breastfeeding.
20. Levels of Care – All hospitals providing obstetric and newborn services will be designated a perinatal level of care by MSDH, based upon its functional capabilities to provide risk-appropriate care for pregnant women and neonates. The levels of care will be divided into four levels defined in accordance with the 2012 policy statement by the American Academy of Pediatrics, (PEDIATRICS Vol. 130, No. 3, September 2012) and maternal standards set forth by the American College of Obstetricians and Gynecologists with modifications approved by MSDH. The levels are:
 - a. Level I – Basic Care
 - b. Level II – Specialty Care
 - c. Level III – Sub-specialty Care
 - d. Level IV – Regional Care
21. Mississippi OB System of Care Plan – A formally organized plan developed by the Department, which sets out a comprehensive system plan for care and management of OB patients.
22. MFM – Maternal Fetal Medicine
23. MMD – Maternal Medical Director
24. MPM – Maternal Program Manager
25. MSDH – Mississippi State Department of Health

26. NCPAP-Nasal continuous positive airway pressure.
27. Neonatal Program Oversight-A multidisciplinary process responsible for the administrative oversight of the neonatal program and having the authority for approving the defined neonatal program's policies, procedures, and guidelines for all phases of neonatal care provided by the facility, to include defining the necessary staff competencies, monitoring to ensure neonatal designation requirements are met, and the aggregate review of the neonatal Performance Improvement (PI) initiatives and outcomes. Neonatal Program Oversight may be performed through the neonatal program's performance improvement committee, multidisciplinary oversight committee, or other structured means.
28. Neonate – An infant from birth through 28 completed days after.
29. NMD – Neonatal Medical Director
30. NPM – Neonatal Program Manager
31. NRP – Neonatal Resuscitation Program - A resuscitation course developed and administered jointly by the American Heart Association and the American Academy of Pediatrics.
32. OBSMD – Obstetrics System Medical Director
33. OEMSACS – The Office of EMS and Acute Care Systems
34. On-site – At the facility and able to arrive at the patient bedside for urgent requests.
35. Performance Improvement (PI or Quality Improvement) – A method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary approach to problem solving, and focuses not on individuals, but systems of patient care which might cause variations in patient outcome.
36. Perinatal – Of, relating to, or being the period around childbirth, especially the five months before and one month after birth.
37. Postpartum – the six-week period following pregnancy or delivery.

38. Privileged Care Provider – a healthcare provider with pediatric or neonatal specific training qualified to manage the care of infants with mild to moderate critical conditions, including emergencies.
39. ROP – Retinopathy of Prematurity - is a potentially sight-threatening disorder in preterm infants caused by abnormal development of retinal blood vessels. It can range from mild, self-resolving changes to severe proliferative stages that may lead to retinal detachment and vision loss.
40. SHO – Mississippi State Health Officer
41. S.T.A.B.L.E. – an educational program for healthcare providers that focuses on the post-resuscitation and pre-transport stabilization of sick infants.
42. Urgent – Requiring action or attention within 30 minutes of notification.

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 General Requirements

- Rule 1.2.1. The Mississippi State Department of Health Office of EMS and Acute Care Systems (OEMSACS) shall review the applicant documents and approve the appropriate level of facility designation.
- Rule 1.2.2. The Department shall determine requirements for the levels of maternal designation. Facilities seeking Levels II, III, and IV maternal designation must meet Department-approved requirements validated by Department-approved surveyors.
- Rule 1.2.3. Facilities seeking Level I maternal designation must submit a self-survey and attest to meeting Department-approved requirements.
- Rule 1.2.4. Each location must be considered separately for designation, and the Department shall approve the designation level for each location based on the location's ability to demonstrate designation criteria are met.
- Rule 1.2.5. The four levels of maternal designation consist of:
 1. Level I – Basic Care – The Level I maternal designated facility must:
 - a. Surveillance and care of all patients admitted to the obstetric service, with an established triage system for identifying high-risk patients who

- should be transferred to a facility that provides specialty or sub-specialty care.
- b. Capability to begin an emergency cesarean delivery within 30 minutes of the decision to do so.
 - c. Mothers that are stable and likely to deliver before 35 weeks' gestation or have a fetus that is likely to require specialty services and mothers who themselves are likely to require specialty services should be transferred prior to delivery, when possible.
 - d. Proper detection and supportive care of known maternal conditions and unanticipated maternal-fetal problems that occur during labor and delivery.
 - e. Care of postpartum conditions.
 - f. Maintain a staff of providers certified to perform normal and operative vaginal deliveries and cesarean sections including obstetricians and family physicians with advanced training in obstetrics, providers certified to perform normal vaginal deliveries including certified nurse midwives, and registered nurses with training in labor and delivery, post-partum care or inpatient obstetrics.
2. Level II – Specialty Care – The Level II maternal designated facility must:
 - a. Perform all Level I maternal services.
 - b. Mothers that are stable and likely to deliver before 32 weeks gestation or have a neonate that is likely to require sub-specialty services, or mothers who themselves are likely to require sub-specialty services should be transferred prior to delivery, when possible.
 - c. Access to maternal fetal medicine consultation and antenatal diagnosis technology including fetal ultrasound.
 3. Level III – Subspecialty Care – The Level III maternal designated facility must:
 - a. Manage complex maternal and fetal illnesses before, during and after delivery.
 - b. Maintain access to consultation and referral to Maternal-Fetal Medicine specialists.
 4. Level IV – Comprehensive Care – The Level IV maternal designated facility must:
 - a. Provide all Level III capabilities as listed above.
 - b. Maintain a full range of surgical and medical specialists including Maternal-Fetal Medicine specialists at the site.

- c. Facilitate maternal transport and provide outreach education.

Rule 1.2.6 The four levels of neonatal designation consist of:

1. Level I – Well Care – The Level I neonatal designated facility must:
 - a. Provide neonatal resuscitation at every delivery.
 - b. Evaluate and provide postnatal care to stable term newborn infants.
 - c. Stabilize and provide care for infants born at 35-37 weeks gestation who remain physiologically stable.
 - d. Stabilize newborn infants who are ill and those born at less than 35 weeks gestation until transfer to a facility that can provide the appropriate level of care.
 - e. Maintain a staff of providers including pediatricians, family physicians, nurse practitioners with newborn training, registered nurses with newborn training, including being current with Neonatal Resuscitation Program Certification and S.T.A.B.L.E.
2. Level II – Special Care – The Level II neonatal designated facility must:
 - a. Provide all basic care services of a Level I neonatal designated facility.
 - b. Provide care for mothers and their infants of generally more than or equal to 32 weeks gestational age and birth weight more than or equal to 1500 grams who have physiologic immaturity or problems that are expected to resolve rapidly and are not anticipated to require subspecialty services on an urgent basis.
 - c. Provide care for infants' convalescent care after intensive care. Provide mechanical ventilation for brief duration (less than 24 hours) and/or continuous positive airway pressure.
 - e. Stabilize infants born before 32 weeks' gestation and weighing less than 1500 grams until transfer to a Level III or Level IV neonatal intensive care facility.
 - f. Maintain a staff of providers including pediatric hospitalists, neonatologists, and neonatal nurse practitioners.
 - g. Referral to a higher level of care for all infants when needed for pediatric surgical or medical subspecialty intervention.
 - h. Level II nurseries must have equipment (e.g., portable x-ray machine, blood gas analyzer) and personnel (e.g., physicians, specialized nurses, respiratory therapists, radiology technicians) to provide ongoing care of admitted infants as well as to address emergencies.

3. Level III – Neonatal Intensive Care – The Level III neonatal designated facility must:
- a. Provision of all Level I and Level II services.
 - b. Level III NICUs are defined by having continuously available personnel (neonatologists, neonatal nurses, and respiratory therapists) and equipment to provide life support for as long as necessary.
 - c. Provide comprehensive care for infants born less than 32 weeks gestation and weighing less than 1500 grams and infants born at all gestational ages and birth weights with critical illness.
 - d. Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists or anesthesiologists with experience in neonatal surgical care and pediatric ophthalmologists, on site or by prearranged consultative agreements.
 - e. Provide a full range of respiratory support and physiologic monitoring that may include conventional and/or high-frequency ventilation and inhaled nitric oxide.
 - f. Perform advanced imaging with interpretation on an urgent basis, including computed tomography, MRI and echocardiography.
 - g. Social and family support, including social services and pastoral care.
 - h. If geographic constraints for land transportation exist, the Level III facility should ensure availability of rotor and fixed-wing transport services to transfer infants requiring subspecialty intervention from other regions and facilities.
 - i. Consultation and transfer agreements with both lower-level referring hospitals and regional centers, including back-transport agreements.
 - j. Prompt diagnosis and appropriate referral of all conditions requiring surgical intervention. Major surgery should be performed by pediatric surgical specialists (including anesthesiologists with pediatric expertise) on-site within the hospital or at a closely related institution, ideally in close geographic proximity if possible. Level III facilities should be able to offer complete care, management, and evaluation for high-risk neonates 24 hours a day. A neonatologist should be available either in-house or on-call with the capacity to be in-house in a timely manner, 24 hours a day.
 - k. Level III facilities should maintain a sufficient volume of infants less than 1500 grams to meet professionally accepted guidelines to achieve adequate experience and expertise.

1. Enrollment in the Vermont Oxford Network to report and monitor data regarding outcomes of infants born less than 32 weeks and weighing less than 1500 grams.
- m. Participation in and evaluation of quality improvement initiatives.
4. Level IV – Advanced Neonatal Intensive Care – The Level IV neonatal designated facility must:
 - a. Provide all level III capabilities listed above.
 - b. Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions.
 - c. Maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists and pediatric anesthesiologists at the site.
 - d. Facilitate transport and provide outreach education including community taught NRP and S.T.A.B.L.E. classes.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Designation of Maternal and Neonatal Facilities

Rule 1.3.1. Designation

1. A perinatal facility seeking Department designation as a maternal or neonatal center shall submit a written application to the Department through an application process and shall provide upon request such additional information, documents, or inspections as the Department may deem necessary.
2. A perinatal facility may apply for designation or re-designation as a maternal and a neonatal center or may apply for designation or re-designation separately as a maternal center or a neonatal center.
3. Designation shall be for a period of three years. The SHO may extend a designation for one year.
4. A designated facility shall be subject to periodic review by the Department and shall permit on-site inspection and submit data to the Department as may be required by the Department to evaluate whether the designated center has maintained compliance with the requirements of these rules and regulations.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.2. Process for Initial Designation

1. The participation of acute care facilities in the OB SOC is mandatory; however, participating hospitals must be appropriately designated according to ability to care for maternal or neonatal patients – designation is a process of verifying that appropriate systems, staff, and resources are available
2. Once a completed application for maternal or neonatal center is received, the Department will work with hospital staff to schedule the date for the designation survey.
3. The Department shall provide for the survey of the applicant hospital, provided that its application has been formally approved by the Department, on the date scheduled and indicated in the Department's acceptance letter to the applicant hospital, unless the Department provides written notification with justification of change to the applicant hospital no later than 14 days prior to the survey date; or the applicant hospital provides written request with justification for a change in the survey date to the Department no later than 30 days prior to the survey date.
4. Results of facility surveys will be provided by the Department in writing to the applicant hospital. Details related to the hospital's survey will be considered confidential and will not be released
5. Maternal Centers currently verified by The Joint Commission Maternal Levels of Care Verification Program may request reciprocity for Department designation as a Maternal Center. The Department must receive the complete report from the accrediting organization, including any/all corrective action plans (CAP).
6. After completion of a designation survey, the team conducting the survey will make a recommendation to the Department for designation. The Director of the OEMSACS will present the survey report and the team's recommendation to the state OB System Medical Director (OBSMD). OBSMD may seek advice or further recommendation from the Mississippi OB System of Care Advisory Committee during its executive session, if the OBSMD disagrees with the recommendations of the team; otherwise the OBSMD may make direct recommendations to the State Health Officer.
7. The Director of OEMSACS will prepare a memorandum detailing the recommendations of the team and signed by the OBSMD for the State Health Officer and will forward the memorandum and the designation letter to the State Health Officer for signature. Once signed, the letter will be sent to the hospital receiving the survey. The Department will inform

the applicant hospital of the status of the application within 14 days of the advisory committee meeting.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.3. Re-Designation

1. Designated perinatal centers wishing to maintain current designation status shall submit a letter of intent to continue as currently designated no less than 30 days prior to the expiration of designation status.
2. Any designated perinatal center not submitting a letter of intent to continue as currently designated will be required to reapply through the initial application process.
3. Any Designated perinatal center that loses, either permanently or temporarily, patient care specialties required by this regulation, shall report that loss to the Department.
4. If the loss will result in the perinatal centers' inability to carry out the patient care activities associated with the current level of designation for a period longer than 30 days, the facility must submit a CAP that addresses how and when the facility will become compliant.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.4. Change in Designation Level for Maternal or Neonatal Centers

1. Maternal or Neonatal Centers will be permitted to change their designation if the following conditions are met in their entirety:
 - a. The Maternal or Neonatal Center has been appropriately surveyed and designated by the Department, the designation is current, and the Center is in full compliance with Department, regulations, policies, procedures, and protocols
 - b. The request to change designation has been approved by the Mississippi OB System Advisory Committee
 - c. The State Health Officer (SHO) or designee issues the new designation

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.5. Designation Criteria for OB Centers

An OB Center must meet all standards applicable to the relevant level of care established by The Joint Commission Maternal Levels of Care Verification Program as amended, restated, supplemented, or otherwise modified from time to time.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.6. Designation Criteria for Neonatal Centers

A neonatal center must meet all standards applicable to the relevant level of care established by the American Academy of Pediatrics Standards for Neonatal Levels of Care as amended, restated, supplemented, or otherwise modified from time to time.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.7. Designation Suspension/Revocation

The SHO may suspend or revoke a designation for any hospital if the Department determines:

1. Documented conditions of serious threat or jeopardy to patients' health or welfare,
2. Failure to comply with these rules and regulations.
3. Failure to satisfactorily meet the minimum requirements as a Maternal/Neonatal Center as defined by regulations for the designation level;
4. Failure to complete a Corrective Action Plan (CAP) within the timeframe specified by the Department.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.8. Appeal Process

The Department shall use the following notice and hearing procedures:

1. The Department shall provide written notice to the perinatal facility of any suspension or revocation pursuant to this regulation.
2. All suspensions or revocations by the Department are effective twenty days after the perinatal facility's receipt of the Department's notice, unless the perinatal facility makes a written request for an administrative hearing within

twenty (20) days of notification. In the event a timely request for a hearing is received, the action shall become effective upon the Department's final decision.

3. The Department shall provide an administrative hearing on the suspension or revocation if the perinatal facility's written request is delivered to and received by the Department no later than twenty days from the date the perinatal facility receives the notice of suspension or revocation.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.9. Hospitals having their designation suspended may reapply for designation only after:

1. Resolution of all issues that led to the suspension, as determined by the Department.
2. Submission of a complete new application for OB System of Care designation.
3. Successful completion of a Department-conducted survey verifying that all deficiencies have been corrected.

Upon satisfying these conditions, the facility's application for redesignation shall be processed in accordance with the standard designation timelines and procedures.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Performance Improvement and System Evaluation

Rule 1.4.1. Performance Improvement shall be an essential part of the OB System of Care. It shall be used to analyze proper functioning of the system and implement improvements in system operation. The PI program will be system-wide. Every designated perinatal center and neonatal center is required to participate in the system PI process. The appropriateness and quantity of all activities of the OB system must be continuously evaluated.

1. The OB PI Committee shall be responsible for the PI oversight of the OB System. Members of the OB PI Committee will be appointed by the State Health Officer for a term of three years and shall include representatives from the following entities (membership list may be updated as needed based on participation):
 - a. One Obstetrician from each of the three regions

- b. One Neonatologist from each of the three regions
 - c. One Emergency Medicine physician practicing at a maternal or neonatal center from each of the three regions
 - d. The State EMS Medical Director or his physician designee
2. The OB PI Committee will be chaired by an obstetrician and the vice-chair shall be a neonatologist or emergency medicine physician of the committee as determined annually by a majority of the committee.

Source: Miss. Code Ann. § 41-3-15

Rule 1.4.2. Specific Performance Measures will be established by the OB PI committee

- 1. In general, the following performance improvement processes should be performed by each maternal and neonatal center. The results of these reviews shall be reported to the OB PI committee.
 - a. Each maternal and neonatal center assigns a PI person to oversee the process
 - b. Standards and measures established
 - c. Determine audit filters
 - d. Collect data
 - e. Evaluate data
 - f. Determine PI issues present
 - g. Develop corrective action plan (CAP)
 - h. Re-evaluate to document results/effectiveness of CAP
 - i. The OB Performance Improvement Committee shall develop and maintain a comprehensive set of indicators, comprising both outcome measures and process measures, to promote optimal maternal and neonatal health. Outcome measures shall be designed to assess clinical results for mother and baby, and process measures shall evaluate adherence to evidence-based practices. Examples of desired pregnancy outcomes include, but are not limited to:

- i Ending preventable morbidity, mortality
- ii Reducing infections
- iii. Reducing unnecessary procedures that may cause harm or risk to mother and baby
- iv Increasing diagnosis of depression, substance use issues, and domestic violence during pregnancy
- v Reducing late maternal death (42 days to 1 year due to cardiac disease)
- vi Reducing postpartum hemorrhages
- vii. Administration of magnesium sulfate for seizure prophylaxis and IV antihypertensives (30-60 minutes from identification of severe hypertension >160/110)
- viii. Reducing ICU admission and readmission rates (within 30 days postpartum)
- ix. Neonatal specific: Infection
- x. Neonatal specific: intra-ventricular hemorrhage (IVH)
- xi. Neonatal specific: necrotizing enterocolitis (NEC)
- xii. Neonatal specific: hypothermia
- xiii. Additional indicators as identified by the state-wide PI Committee

Source: Miss. Code Ann. § 41-3-15

Rule 1.4.3 All designated OB and Neonatal facilities will actively engage in the process of data collection and retrieval.

Chapter 2 Maternal Program Requirements

Rule 2.1.1 Maternal Program Philosophy

Designated facilities must have a family-centered philosophy. The facility environment for perinatal care must meet the physiologic and psychosocial needs of the mothers, infants, and families. Parents must have reasonable access to their infants at all times and be encouraged to participate in the care of their infants. The OB Center must ensure parent, sibling, and neonate visitation are supported and facilitated, following appropriate safety guidelines.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.2 Maternal Program Plan

The facility must develop a written maternal operational plan for the maternal program that includes a detailed description of the scope of services and clinical resources available for all maternal patients and families. The plan will define the maternal patient population evaluated, treated, transferred, or transported by the

facility consistent with clinical guidelines based on current standards of maternal practice ensuring the health and safety of patients.

1. The written Maternal Program Plan must be reviewed and approved by Perinatal Multidisciplinary Committee and be submitted to the facility's governing body for review and approval. The governing body must ensure that the requirements of this section are implemented and enforced.
2. The written Maternal Program Plan must include, at a minimum:
 - a. Clinical guidelines based on current standards of maternal practice, and policies and procedures that are adopted, implemented, and enforced by the maternal program;
 - b. A process to ensure and validate that these clinical guidelines based on current standards of maternal practice, policies, and procedures are reviewed and revised a minimum of every three years;
 - c. Written triage, stabilization, and transfer guidelines for pregnant and postpartum patients that include consultation and transport services;
 - d. Written guidelines or protocols for prevention, early identification, early diagnosis, and therapy for conditions that place the pregnant or postpartum patient at risk for morbidity or mortality;
 - e. The role and scope of telehealth/telemedicine practices if utilized, including:
 - i. Documented and approved written policies and procedures that outline the use of telehealth/telemedicine for inpatient hospital care, or for inpatient consultation, including appropriate situations, scope of care, and documentation that is monitored through the PI Plan and process; and
 - ii. Written and approved procedures to gain informed consent from the patient or designee for the use of telehealth/telemedicine, if utilized, that are monitored for compliance;
 - f. Written guidelines for discharge planning instructions and appropriate follow up appointments for all mothers and infants;

- g. Written guidelines for the hospital disaster response, including a defined mother and infant evacuation plan and process to relocate mothers and infants to appropriate levels of care with identified resources, and this process must be evaluated annually to ensure maternal care can be sustained and adequate resources are available;
- h. Requirements for minimal credentials for all staff participating in the care of maternal patients;
- i. Provisions for providing continuing staff education, including annual competency and skills assessment that is appropriate for the patient population served;
- j. A perinatal staff registered nurse as a representative on the nurse staffing committee; and
- k. The availability of all necessary equipment and services to provide the appropriate level of care and support of the patient population served.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.3. Performance Improvement: The facility must have a documented PI Plan. The maternal program must measure, analyze, and track quality indicators and other aspects of performance that the facility adopts or develops that reflect processes of care and is outcome based.

1. The Chief Executive Officer, Chief Medical Officer (or Chief of Staff), and Chief Nursing Officer must implement a culture of safety for the facility and ensure adequate resources are allocated to support a concurrent, data-driven maternal PI Plan.
2. The facility must demonstrate that the Maternal PI Plan consistently assesses the provision of maternal care provided. The assessment will identify variances in care, the impact to the patient, and the appropriate levels of review. This process will identify opportunities for improvement and develop a plan of correction to address the variances in care or the system response. An action plan will track and analyze data through resolution or correction of the identified variance.
3. Maternal facilities must review their incidence and management of placenta accreta spectrum disorder through the PI Plan and report the incidence and outcomes through the Perinatal Multidisciplinary Committee. (see guideline)

4. The Maternal Medical Director (MMD) must have the authority to make referrals for peer review, receive feedback from the peer review process, and ensure maternal physician representation in the peer review process for maternal cases.
5. The MMD and the Maternal Program Manager (MPM) must participate in regional PI regional initiatives and submit requested data to assist with data analysis to evaluate regional outcomes as an element of their maternal PI Plan.
6. The facility must have documented evidence of maternal PI summary reports reviewed and reported by the Perinatal Multidisciplinary Committee that monitors and ensures the provision of services or procedures through telehealth and telemedicine, if utilized, is in accordance with the standard of care applicable to the provision of the same service or procedure in an in-person setting.
7. The facility must have documented evidence of maternal PI summary reports to support that aggregate maternal data are consistently reviewed to identify developing trends, opportunities for improvement, and necessary corrective actions. Summary reports must be provided through the Perinatal Multidisciplinary Committee, available for site surveyors, and submitted to the department as requested.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.4. Medical Staff. The facility must have an organized maternal program that is recognized by the facility's medical staff and approved by the facility's governing body.

1. The credentialing of the maternal medical staff must include a process for the delineation of privileges for maternal care.
2. The maternal medical staff must participate in ongoing staff and team-based education and training in the care of the maternal patient.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.5 Medical Director. There must be an identified MMD. The MMD must be credentialed by the facility for treatment of maternal patients and have their responsibilities and authority defined in a job description. The MMD is responsible for the provision of maternal care services and:

1. Examining qualifications of medical staff requesting maternal privileges and making recommendations to the appropriate committee for such privileges;

2. Assuring maternal medical staff competency in managing obstetrical emergencies, complications and resuscitation techniques;
3. Monitoring maternal patient care from transport if applicable, to admission, stabilization, operative intervention(s) if applicable, through discharge, and inclusive of the PI Plan;
4. Participating in ongoing maternal staff and team-based education and training in the care of the maternal patient;
5. Overseeing the inter-facility maternal transport;
6. Collaborating with the MPM in areas to include developing or revising policies, procedures and guidelines, assuring medical staff and personnel competency, education and training; and the PI Plan;
7. Frequently leading the maternal PI meetings with the MPM and participating in Maternal Program Oversight and other maternal meetings as appropriate;
8. Ensuring that the PI Plan is specific to maternal and fetal care, is ongoing, data-driven and outcome-based;
9. Participating as a clinically active and practicing physician in maternal care at the facility where medical director services are provided;
10. Maintaining active staff privileges as defined in the facility's medical staff bylaws; and
11. Developing collaborative relationships with other MMD(s) of designated facilities within the applicable Perinatal Care Region.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.6. Maternal Program Manager (MPM). The facility must identify an MPM who has the authority and oversight responsibilities written in his or her job description for the provision of maternal services through all phases of care, including discharge and identifying variances in care for inclusion in the PI Plan and:

1. Be a registered nurse with perinatal experience;
2. Be a clinically active and practicing registered nurse participating in maternal care at the facility where program manager services are provided;
3. Have the authority and responsibility to monitor the provision of maternal patient care services from admission, stabilization, operative intervention(s) if applicable, through discharge, and inclusive of the PI Plan;

4. Collaborate with the MMD in areas to include developing or revising policies, procedures and guidelines; assuring staff competency, education, and training and the PI Plan;
5. Frequently leads the maternal PI meetings and participates in the Perinatal Multidisciplinary Committee and other maternal meetings as appropriate; and
6. Ensure that the PI Plan is specific to maternal and fetal care, is ongoing, data-driven and outcome based, including telehealth/telemedicine utilization, when used.

Source: Miss. Code Ann. § 41-3-15

Chapter 3 Maternal Designation Level I (Basic Care)

Subchapter 1 Hospital Organization

Rule 3.1.1. The Level I maternal designated facility shall provide care for low-to moderate risk pregnancies with the ability to detect, stabilize, and initiate management of unanticipated maternal-fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility at which specialty maternal care is available.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.2. Maternal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal and maternal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a maternal care program may be sufficient. The maternal program must be established and recognized by the medical staff and hospital administration. The maternal program must come under the direction of a family medicine physician or an obstetrics and gynecology physician, with obstetrics training and experience, and with privileges in maternal care. The administrative structure must minimally include an administrator, Maternal Medical Director (MMD), Maternal Program Manager (MPM), and appropriate support staff. The Maternal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved.

2. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for the care of the maternal patient;
 - c. Defined maternal team and written roles and responsibilities;
 - d. Appointed Maternal Medical Director with a written job description;
 - e. Appointed Maternal Program Manager with a written job description;
 - f. A written Maternal Performance Improvement plan.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.3. Maternal Service: The maternal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the perinatal patient. The maternal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Maternal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.4. Maternal Medical Director (MMD): The MMD must be a board-eligible or board-certified physician with obstetrics training and experience, and with privileges in maternal care that demonstrates administrative skills and oversight of the performance improvement (PI) plan and has completed annual continuing education specific to maternal care. The MMD must cooperate with nursing administration to support the nursing needs of the perinatal patient and develop treatment protocols for the perinatal patients. A qualified provider with obstetric privileges may be responsible for the management of the program's obstetric services.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.5. Maternal Program Manager (MPM): Level I OB Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the MPM. Working in conjunction with the MMD, the MPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
 - b. Maternal Program Manager
 - c. Obstetrics and Gynecology
 - d. Certified Nurse Midwife (if applicable)
 - e. Maternal Fetal Medicine
 - f. Anesthesia
 - g. Pediatrician/Family Physician/APPs
 - h. Labor and Delivery
 - i. Nursing
 - j. Laboratory
 - k. Radiology (Ultrasound)
 - l. Respiratory Therapy
 - m. Social Services/Pastoral Care
 - n. Dietary
 - o. Lactation Specialist (or equivalent)

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.
3. The OB Center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement (PI) program.

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 Obstetric Service Provision

Rule 3.2.1. Patient-centered continuum of care shall be coordinated among all providers to ensure continuity, with prenatal assessments and care plans accessible at delivery sites and postpartum records shared with outpatient providers.

Source: Miss. Code Ann. § 41-3-15

Rule 3.2.2. High-risk pregnancy management: Early identification of high-risk pregnancies and appropriate risk-management shall occur with the consultation of Level IV, if needed. The program shall manage high-risk patients within its capabilities or initiate transfer protocols for those requiring advanced care. (see guidelines)

Source: Miss. Code Ann. § 41-3-15

Rule 3.2.4. Patient Education and Quality Improvement: The program shall provide comprehensive education regarding available perinatal services and engage in ongoing quality improvement activities, including review of outcomes from prenatal through postpartum care.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Transfer Guidelines

Rule 3.3.1 Identification and Management of Transfers: The program shall define criteria for maternal transfers to higher-level facilities and maintain prearranged relationships for immediate consultation and patient relocation. All designated facilities will agree to provide service to the maternal patient regardless of their ability to pay. Written agreements should be in place for the transfer of perinatal patients.

Source: Miss. Code Ann. § 41-3-15

Rule 3.3.2. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation and timely exchange of clinical information between transferring and receiving entities. Mechanisms for timely exchange of medical records, orders, and status updates shall be established before and after patient transfer.

Source: Miss. Code Ann. § 41-3-15

Rule 3.3.3. Stabilization and Transfer Protocols: Patients requiring transfer shall receive prompt assessment, stabilization, and initiation of the transfer process. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Clinical Components

Rule 3.4.1. Interdisciplinary Team: The Level I OB Center has an interdisciplinary team that includes individuals with expertise in and/or knowledge about the specialized care, treatment and services required for perinatal care. The interdisciplinary team includes individuals and specialized services to support the care, treatment, and services provided by the program.

The following individuals and services are represented on the team:

1. Obstetrics and Gynecology physician: The Obstetrics and Gynecology physician with obstetrics training and experience must be available for consultation, at all times. *
2. Qualified Physicians/Certified Nurse Midwife: Ensure that a qualified birthing professional with appropriate physician back-up is available to attend all deliveries or other obstetrical emergencies. *
 - a. must arrive at the patient's bedside within 30 minutes of an urgent request; and
 - b. must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated conditions.
3. Anesthesia: Anesthesia providers, such as anesthesiologists, nurse anesthetists, or anesthesiologist assistants working with an anesthesiologist for labor

** A physician with privileges to perform emergency cesarean deliveries must be readily available at all times.*

analgesia and surgical anesthesia must be readily available at all times. Anesthesia personnel with training and experience must be available at all times and arrive at the patient's bedside within thirty (30) minutes of an urgent request.

4. Nursing: Qualified labor, delivery, surgical, and recovery nursing personnel in adequate numbers to meet the needs of each patient are readily available at all times. Every birth must be attended by an appropriately trained and qualified RN with level-appropriate competencies as demonstrated by nursing competency documentation.
 - a. Nursing leadership must have level-appropriate formal training and experience in maternal care.
5. Laboratory and Blood Bank Services: Laboratory personnel must be immediately available to obtain and process appropriate samples and report urgent/emergent results. Blood bank services must be available at all times to determine blood type and Rh type, crossmatch blood and perform antibody testing. There must also be guidelines or protocols in place for:
 - a. initiation of massive blood component transfusion at all times with the process to obtain more blood and component therapy as needed;
 - b. Emergency release of blood components; and
 - c. Management of multiple blood component therapy.
6. Radiology and Ultrasound Support: Radiology and Ultrasound support services should be readily available at all times.

Note: It is anticipated that the Level I center will have limited obstetric ultrasonography with interpretation capabilities readily available at all times.
7. Respiratory and Pharmacy: Respiratory care personnel and a registered pharmacist should be readily available at all times.
8. Support Staff:
 - a. Lactation Specialists: Lactation Specialists or support staff with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.

- b. Social services, pastoral care, or bereavement services must be provided as appropriate to meet the needs of the patient population served.
- c. A dietician or nutritionist should be available with the appropriate training and experience for the population served.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.2. An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.3. Physicians providing back-up coverage must arrive at the patient's bedside within thirty (30) minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.4. Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

- 1. must operate under guidelines reviewed and approved by the MMD; and
- 2. must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:
 - a. provide back-up and consultation; and
 - b. arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.5. Level I Obstetrical Center requirements:

- 1. Surveillance and care of all patients admitted to the obstetric service, with an established triage system for identifying high-risk patients who should be transferred to a facility that provides specialty or sub-specialty care.
- 2. Capability to begin an emergency cesarean delivery within 30 minutes of the decision to do so.
- 3. Mothers that are stable and likely to deliver before 35 weeks' gestation or have a fetus that is likely to require specialty services and mothers who themselves are likely to require specialty services should be transferred prior to delivery, when possible.
- 4. Proper detection and supportive care of known maternal conditions and unanticipated maternal-fetal problems that occur during labor and delivery.

5. Care of postpartum conditions.
6. Maintain a staff of providers certified to perform normal and operative vaginal deliveries and cesarean sections including obstetricians and family physicians with advanced training in obstetrics, providers certified to perform normal vaginal deliveries including certified nurse midwives, and registered nurses with training in labor and delivery, post-partum care or inpatient obstetrics.
7. Capability to implement patient safety bundles for common causes of preventable maternal morbidity, such as management of maternal venous thromboembolism, obstetric hemorrhage, and severe maternal hypertension in pregnancy.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.6. Guideline/Protocol Development

The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

1. massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;
2. obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;
3. placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of unanticipated placenta accreta spectrum disorder cases, including postpartum care;
4. hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;
5. sepsis or systemic infection in the pregnant or postpartum patient;

6. venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;
7. shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and
8. behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.7. Perinatal Education.

1. The Level I OB Center must have internal perinatal education programs including training for physicians, nurses, ancillary staff, and prehospital providers.
2. Level I OB Centers must have a written perinatal education plan.

Source: Miss. Code Ann. § 41-3-15

Chapter 4

Maternal Designation Level II (Specialty Care)

Subchapter 1 Hospital Organization

- Rule 4.1.1. The Level II maternal designated facility shall provide Level I facility level of care plus care of appropriate moderate- to high-risk antepartum, intrapartum, and postpartum conditions.

Source: Miss. Code Ann. § 41-3-15

Rule 4.1.2. Maternal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal and maternal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with the written commitment of the hospital's chief executive officer, to the establishment of a maternal care program may be sufficient. The maternal program must be established and recognized by the medical staff and hospital administration. The maternal program must come under the direction of a

family medicine physician with obstetrics training and experience and with privileges in maternal care or an obstetrics and gynecology physician. The administrative structure must minimally include an administrator, Maternal Medical Director (MMD), Maternal Program Manager (MPM), and appropriate support staff. The Maternal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved.

2. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for the care of the maternal patient;
 - c. Defined maternal team and written roles and responsibilities;
 - d. Appointed Maternal Medical Director with a written job description;
 - e. Appointed Maternal Program Manager with a written job description;
 - f. Analysis and review of system perinatal outcome and quality data; and
 - g. A written Maternal Performance Improvement plan.

Source: Miss. Code Ann. § 41-3-15

- Rule 4.1.3. Maternal Service: The maternal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the perinatal patient. The maternal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Maternal Medical Director.

Source: Miss. Code Ann. § 41-3-15

- Rule 4.1.4. Maternal Medical Director (MMD): The MMD must be a board-eligible or board-certified physician with obstetrics training and experience, and with privileges in maternal care that demonstrates administrative skills and oversight of the performance improvement (PI) plan and has completed annual continuing

education specific to maternal care. Based upon available resources and facility determination of the most appropriate staffing, it may be acceptable for such leader to be board certified in another specialty with privileges and expertise in obstetric care including surgical skill and privileges to perform cesarean delivery. The MMD must cooperate with nursing administration to support the nursing needs of the perinatal patient and develop treatment protocols for the perinatal patients. A qualified provider with obstetric privileges may be responsible for the management of the program's obstetric services.

Source: Miss. Code Ann. § 41-3-15

Rule 4.1.5. Maternal Program Manager (MPM): Level II OB Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the MPM. Working in conjunction with the MMD, the MPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training.

Source: Miss. Code Ann. § 41-3-15

Rule 4.1.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
 - b. Maternal Program Manager
 - c. Neonatal Medical Director (if different from the MMD)
 - d. Neonatal Program Manager (if different from the MPM)

- e. Pediatrician or Neonatologist
 - f. Obstetrics and Gynecology
 - g. Certified Nurse Midwife (if applicable)
 - h. Maternal Fetal Medicine
 - i. Anesthesia
 - j. Labor and Delivery
 - k. Nursing
 - l. Laboratory
 - m. Radiology (Ultrasound)
 - n. Respiratory Therapy
 - o. Social Services/Pastoral Care
 - p. Dietary
 - q. Lactation Specialist (or equivalent)
 - r. General surgery
 - s. Internal Medicine
 - t. Family Medicine
 - u. Advanced Practice Provider
2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.
 3. The OB Center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement (PI) program.

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 Obstetric Service Provision

- Rule 4.2.1. Patient-centered continuum of care shall be coordinated among all providers to ensure continuity, with prenatal assessments and care plans accessible at delivery sites and postpartum records shared with outpatient providers.

Source: Miss. Code Ann. § 41-3-15

- Rule 4.2.2. High-risk pregnancy management: Early identification of high-risk pregnancies and appropriate risk-management shall occur. The program shall manage high-risk patients within its capabilities or initiate transfer protocols for those requiring advanced care.

Source: Miss. Code Ann. § 41-3-15

- Rule 4.2.3. Transfer Agreements and Continuity of Information: Written transfer agreements shall be maintained with higher-level referral centers. Mechanisms for timely exchange of medical records, orders, and status updates shall be established before and after patient transfer.

Source: Miss. Code Ann. § 41-3-15

- Rule 4.2.4. Patient Education and Quality Improvement: The program shall provide comprehensive education regarding available perinatal services and engage in ongoing quality improvement activities, including review of outcomes from prenatal through postpartum care.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Transfer Guidelines

- Rule 4.3.1 Identification and Management of Transfers: The program shall define criteria for maternal transfers to higher-level facilities and maintain prearranged relationships for immediate consultation and patient relocation. All designated facilities will agree to provide service to the maternal patient regardless of their ability to pay. Written agreements should be in place for the transfer of perinatal patient.

Source: Miss. Code Ann. § 41-3-15

- Rule 4.3.2. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation

and timely exchange of clinical information between transferring and receiving entities.

Source: Miss. Code Ann. § 41-3-15

Rule 4.3.3. Stabilization and Transfer Protocols: Patients requiring transfer shall receive prompt assessment, stabilization, and initiation of the transfer process. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Clinical Components

Rule 4.4.1. Interdisciplinary Team: The Level II OB Center has an interdisciplinary team that includes individuals with expertise in and/or knowledge about the specialized care, treatment and services required for perinatal care. The interdisciplinary team includes individuals and specialized services to support the care, treatment, and services provided by the program.

The following individuals and services are represented on the team:

1. Obstetrics and Gynecology physician: The Obstetrics and Gynecology physician with obstetrics training and experience must be available for consultation, at all times. *
 - a. Based on available resources and facility determination of the most appropriate staffing, it may be acceptable for a family physician with obstetric fellowship training or equivalent training and skills in obstetrics, and with surgical skill and privileges to perform cesarean delivery to meet the criteria for being readily available at all times.
2. Obstetrics: An obstetrics provider must be readily available at all times.
3. Qualified Physicians/Certified Nurse Midwife: Ensure that a qualified physician or certified nurse midwife with appropriate physician back-up is available to attend all deliveries or other obstetrical emergencies. *
 - a. Must arrive at the patient's bedside within thirty (30) minutes of an urgent request; and
 - b. Must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated conditions.

**A physician with privileges to perform emergency cesarean deliveries must be readily available at all times.*

4. Maternal-Fetal Medicine (MFM): A MFM specialist must be readily available at all times for consultation on-site. Availability may be through phone or telemedicine, if necessary.
5. Anesthesia: Qualified personnel with anesthesia privileges must be readily available at all times. Anesthesia personnel with training and experience must be available at all times and arrive at the patient's bedside within thirty (30) minutes of an urgent request.
6. Internal medicine providers, family medicine providers, and general surgeons must be readily available at all times for obstetric patients.
7. Nursing: Qualified labor, delivery, surgical, and recovery nursing personnel in adequate numbers to meet the needs of each patient are readily available at all times.
8. Laboratory and Blood Bank Services: Laboratory personnel must be immediately available to obtain and process appropriate samples and report urgent/emergent results. Blood bank services must be available at all times to determine blood type and Rh type, crossmatch blood and perform antibody testing. There must also be guidelines or protocols in place for:
 - a. Massive blood component transfusion;
 - b. Emergency release of blood components; and
 - c. Management of multiple blood component therapy.
9. Radiology Support: Radiologic services with interpretation must be readily available at all times and include:
 - a. Computed tomography scans;
 - b. Magnetic resonance imaging;
 - c. Non obstetric ultrasound imaging
 - d. Standard obstetric ultrasound imaging; and
 - e. Maternal echocardiography.

10. Respiratory and Pharmacy: Respiratory care personnel and a registered pharmacist should be readily available at all times.
11. Support Staff:
 - a. Lactation Specialists: Lactation Specialists or support staff with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.
 - b. Social services, pastoral care, or bereavement services must be provided as appropriate to meet the needs of the patient population served.
 - c. A dietician or nutritionist should be available with the appropriate training and experience for the population served.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.2. An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.3. Ensure that physicians providing back-up coverage must arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

- Rule 4.4.4. Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:
1. Must operate under guidelines reviewed and approved by the MMD; and
 2. Must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:
 - a. provide back-up and consultation; and
 - b. arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.5. Level II Obstetrical Center requirements:

1. Surveillance and care of all patients admitted to the obstetric service, with an established triage system for identifying high-risk patients who should be transferred to a facility that provides specialty or sub-specialty care.
2. Capability to begin an emergency cesarean delivery within 30 minutes of the decision to do so.
3. Proper detection and supportive care of known maternal conditions and unanticipated maternal-fetal problems that occur during labor and delivery.
4. Care of postpartum conditions.
5. Maintain a staff of providers certified to perform normal and operative vaginal deliveries and cesarean sections including obstetricians and family physicians with advanced training in obstetrics, providers certified to perform normal vaginal deliveries including certified nurse midwives, and registered nurses with training in labor and delivery, post-partum care or inpatient obstetrics.
6. Mothers that are stable and likely to deliver before 32 weeks gestation or have a neonate that is likely to require sub-specialty services, or mothers who themselves are likely to require sub-specialty services should be transferred prior to delivery, when possible.
7. Access to maternal fetal medicine consultation and antenatal diagnosis technology including fetal ultrasound.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.6. Guideline/Protocol Development

The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

1. massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;
2. obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;
3. placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of unanticipated placenta accreta spectrum disorder cases, including postpartum care;

4. hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;
5. sepsis or systemic infection in the pregnant or postpartum patient;
6. venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;
7. shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and
8. behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.7. Perinatal Education.

1. The Level II OB Center must have internal perinatal education programs including training for physicians, nurses, ancillary staff, and prehospital providers.
2. Level II OB Centers must have a written perinatal education plan.

Chapter 5

Maternal Designation Level III (Subspecialty Care)

Subchapter 1 Hospital Organization

Rule 5.1.1. The Level III maternal designated facility must provide Level II facility level of care plus provide care of more complex maternal medical conditions, obstetric complications, and fetal conditions.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.2. Maternal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal and maternal care. The written commitment shall be in the form of a resolution at the time of application passed by an appropriate quorum of the members of the governing authority. Should the business

organization be other than a corporation, a letter explaining such, together with the written commitment of the hospital's chief executive officer, to the establishment of a maternal care program may be sufficient. The maternal program must be established and recognized by the medical staff and hospital administration. The maternal program must come under the direction of a family medicine physician or an obstetrics and gynecology physician, with obstetrics training and experience, and with privileges in maternal care. The administrative structure must minimally include an administrator, Maternal Medical Director (MMD), Maternal Program Manager (MPM), and appropriate support staff. The Maternal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved. The program must provide perinatal system leadership if acting as a regional center in areas where Level IV facilities are not available.

2. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for the care of the maternal patient;
 - c. Defined maternal team and written roles and responsibilities;
 - d. Appointed Maternal Medical Director with a written job description;
 - e. Appointed Maternal Program Manager with a written job description; and
 - f. A written Maternal Performance Improvement plan.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.3. Maternal Service: The maternal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the perinatal patient. The maternal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Maternal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.4. Maternal Medical Director (MMD): The MMD must be a board-eligible or board-certified physician with obstetrics training and experience, and with privileges in maternal care or a board-certified maternal-fetal medicine (MFM) physician that demonstrates administrative skills and oversight of the performance improvement (PI) plan and has completed annual continuing education specific to maternal care. The MMD must cooperate with nursing administration to support the nursing needs of the perinatal patient and develop treatment protocols for the perinatal patients. A qualified provider with obstetric privileges may be responsible for the management of the program's obstetric services.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.5. Maternal Program Manager (MPM): Level III OB Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the MPM. Working in conjunction with the MMD, the MPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)

- b. Maternal Program Manager
- c. Neonatal Medical Director (if different from MMD)
- d. Neonatal Program Manager (if different from MPM)
- e. Pediatrician or Neonatologist
- f. Obstetrics and Gynecology *
- g. Certified Nurse Midwife (if applicable)
- h. Maternal Fetal Medicine (MFM)**
- i. Anesthesia***
- j. Labor and Delivery
- k. Nursing
- l. Laboratory
- m. Radiology (Ultrasound)
- n. Respiratory Therapy
- o. Social Services/Pastoral Care
- p. Dietary
- q. Lactation Specialist (or equivalent)
- r. General surgery
- s. Internal Medicine
- t. Family Medicine
- u. Advanced Practice Provider

v. Intensive Care Unit

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.
3. The OB Center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement (PI) program.

** The director of obstetric service shall be a board-certified OB-GYN or MFM.*

*** The director of the MFM program shall be a board-eligible or board-certified MFM physician.*

**** The director of obstetric anesthesia services shall be a board-certified anesthesiologist with obstetric anesthesia fellowship training or experience in obstetric anesthesia.*

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 Obstetric Service Provision

- Rule 5.2.1. Patient-centered continuum of care shall be coordinated among all providers to ensure continuity, with prenatal assessments and care plans accessible at delivery sites and postpartum records shared with outpatient providers.

Source: Miss. Code Ann. § 41-3-15

- Rule 5.2.2. High-risk pregnancy management: Early identification of high-risk pregnancies and appropriate risk-management shall occur. The program shall manage high-risk patients within its capabilities or initiate transfer protocols for those requiring advanced care.

Source: Miss. Code Ann. § 41-3-15

- Rule 5.2.3. Transfer agreements and continuity of information: Written transfer agreements shall be maintained with higher-level referral centers. Mechanisms for timely exchange of medical records, orders, and status updates shall be established before and after patient transfer.

Source: Miss. Code Ann. § 41-3-15

Rule 5.2.4. Patient education and quality improvement: The program shall provide comprehensive education regarding available perinatal services and engage in ongoing quality improvement activities, including review of outcomes from prenatal through postpartum care.

Source: Miss. Code Ann. § 41-3-15

Rule 5.2.5. Leadership and accountability: A designated perinatal services leader shall be appointed, who is responsible for aligning staffing, resources, policies, and procedures with the organization's verified Maternal Level of Care and for continuous program oversight.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Transfer Guidelines

Rule 5.3.1. The Level III OB Center must have the capability to accept maternal transports from lower levels of care for unanticipated high-risk pregnancies.

Source: Miss. Code Ann. § 41-3-15

Rule 5.3.2. Maternal transports from lower levels: The program shall maintain the capability to accept urgent maternal transports from lower-level facilities. Upon transfer request, the receiving team must confirm ETA, mobilize appropriate staff and resources, and prepare bed assignments to guarantee safe admission and continuity of care.

Rule 5.3.3. Identification and Management of Transfers: The program shall define criteria for maternal transfers to higher-level facilities and maintain prearranged relationships for immediate consultation and patient relocation. The program shall maintain documented mechanisms to facilitate and accept maternal transfers/transports. All designated facilities will agree to provide service to the maternal patient regardless of their ability to pay. Written agreements should be in place for the transfer of perinatal patients.

Source: Miss. Code Ann. § 41-3-15

Rule 5.3.4. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation

and timely exchange of clinical information between transferring and receiving entities to address maternal care quality issues.

Source: Miss. Code Ann. § 41-3-15

Rule 5.3.5. Stabilization and Transfer Protocols: Patients requiring transfer shall receive prompt assessment, stabilization, and initiation of the transfer process. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Clinical Components

Rule 5.4.1. Interdisciplinary Team: The Level III OB Center must have an interdisciplinary team that includes individuals with expertise in and/or knowledge about the specialized care, treatment and services required for perinatal care. The interdisciplinary team includes individuals and specialized services to support the care, treatment, and services provided by the program.

The following individuals and services are represented on the team:

1. Obstetrics and Gynecology physician: The Obstetrics and Gynecology physician with obstetrics training and experience must be available for consultation at all times.
2. Obstetrics: A board-eligible or board-certified obstetrician must be physically present on site at all times.
3. Qualified Physicians/Certified Nurse Midwife: Ensure that a qualified physician or certified nurse midwife with appropriate physician back-up is available to attend to all deliveries or other obstetrical emergencies.
 - a. Must arrive at the patient's bedside within thirty (30) minutes of an urgent request; and
 - b. Must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated conditions.
4. Maternal-Fetal Medicine (MFM): A MFM specialist with inpatient privileges must be readily available at all times, either on site, by phone, or by telemedicine. Timing of the need to be on site is directed by the urgency of the clinical situation; however the provider must be able to be on site to provide

direct care within 24 hours. The MFM specialist shall also be available at all times for consult for all pregnant or postpartum patients in the ICU.

5. Anesthesia: Board-certified anesthesiologist must be on site 24 hours a day, 7 days a week.
6. Intensive Care Unit (ICU): There must be the availability of an adult medical and surgical ICU that accepts pregnant women and women in the postpartum period. The ICU must be staffed by adult critical care providers on site 24 hours a day, 7 days a week.
7. Internal medicine providers, family medicine providers, and general surgeons must be readily available at all times for obstetric patients.
8. Nursing: Nursing leaders and qualified labor, delivery, surgical, and recovery nursing personnel who have special training and experience in the management of women with complex and critical maternal illnesses and obstetric complications in adequate numbers to meet the needs of each patient are readily available at all times.
9. Laboratory and Blood Bank Services: Laboratory personnel must be immediately available to obtain and process appropriate samples and report urgent/emergent results. Blood bank services must be available at all times to determine blood type and Rh type, crossmatch blood and perform antibody testing. There must be in-house availability of all blood components. There must also be guidelines or protocols in place for:
 - a. Massive blood component transfusion;
 - b. Emergency release of blood components; and
 - c. Management of multiple blood component therapy.
10. Radiology Support: Radiologic services with interpretation must be readily available at all times and include:
 - a. Specialized obstetric ultrasound and fetal assessment (to include Doppler studies);
 - b. Computed tomography scans;

- c. Magnetic resonance imaging;
 - d. Standard non-obstetric ultrasound imaging
 - e. Standard obstetric ultrasound imaging;
 - f. Maternal echocardiography; and
 - g. Basic interventional radiology (capable of performing uterine artery embolization).
11. Respiratory and Pharmacy: Respiratory care personnel and a registered pharmacist should be readily available at all times.
- a. Appropriate equipment and personnel physically present at all times onsite to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU.
12. Support Staff:
- a. Lactation Specialists: Lactation Specialists or support staff with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.
 - b. Social services, pastoral care, or bereavement services must be provided as appropriate to meet the needs of the patient population served.
 - c. A dietician or nutritionist should be available with the appropriate training and experience for the population served.
13. Subspecialists shall be readily available, per the facility's policy, for inpatient consultation, which include critical care, general surgery, infectious disease, hematology, cardiology, nephrology, neurology, gastroenterology, internal medicine, behavioral health, and neonatology.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.2. An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.3. Ensure that physicians providing back-up coverage must arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.4. Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

1. must operate under guidelines reviewed and approved by the MMD; and
2. must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:
 - a. provide back-up and consultation; and
 - b. arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.5. Level III Obstetrical Center requirements:

1. Manage complex maternal and fetal illnesses before, during and after delivery.
2. Maintain access to consultation and referral to Maternal-Fetal Medicine specialists.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.6. Guideline/Protocol Development

The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

1. Massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;
2. Obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;

3. Placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of unanticipated placenta accreta spectrum disorder cases, including postpartum care;
4. Hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;
5. Sepsis or systemic infection in the pregnant or postpartum patient;
6. Venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;
7. Shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and
8. Behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.7. Perinatal Education.

1. The Level III OB Center must have internal perinatal education programs including training for physicians, nurses, ancillary staff, and prehospital providers.
2. Level III OB Centers must have a written perinatal education plan.

Chapter 6

Maternal Designation Level IV (Regional Perinatal Health Care Centers)

Subchapter 1 Hospital Organization

- Rule 6.1.1.** The Level IV maternal designated facility must provide Level III facility level of care plus provide on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care.

Source: Miss. Code Ann. § 41-3-15

Rule 6.1.2. Maternal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal and maternal care. The written commitment shall be in the form of a resolution at the time of application passed by an appropriate

quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with the written commitment of the hospital's chief executive officer, to the establishment of a maternal care program may be sufficient. The maternal program must be established and recognized by the medical staff and hospital administration. The maternal program must come under the direction of a family medicine physician or an obstetrics and gynecology physician, with obstetrics training and experience, and with privileges in maternal care. The administrative structure must minimally include an administrator, Maternal Medical Director (MMD), Maternal Program Manager (MPM), and appropriate support staff. The Maternal Program must be multidisciplinary in nature and the performance improvement evaluation of this care must be extended to all the departments involved. The Level IV facility must provide perinatal system leadership, including facilitation of collaboration with facilities in the region, analysis and review of system perinatal outcome and quality data, provision of outreach education and assistance with quality improvement as needed.

2. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for the care of the maternal patient;
 - c. Defined maternal team and written roles and responsibilities;
 - d. Appointed Maternal Medical Director with a written job description;
 - e. Appointed Maternal Program Manager with a written job description; and
 - f. A written Maternal Performance Improvement plan.

Source: Miss. Code Ann. § 41-3-15

- Rule 6.1.3. Maternal Service: The maternal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the perinatal patient. The maternal service will vary in each organization depending on the needs of the patient and the resources

available. The service shall come under the organization and direction of the Maternal Medical Director.

Source: Miss. Code Ann. § 41-3-15

- Rule 6.1.4. Maternal Medical Director (MMD): The MMD must be a board-eligible or board-certified physician with obstetrics training and experience, and with privileges in maternal care or a board-eligible or board-certified maternal-fetal medicine physician that demonstrates administrative skills and oversight of the performance improvement (PI) plan and has completed annual continuing education specific to maternal care. The MMD must cooperate with nursing administration to support the nursing needs of the perinatal patient and develop treatment protocols for the perinatal patients. A qualified provider with obstetric privileges may be responsible for the management of the program's obstetric services.

Source: Miss. Code Ann. § 41-3-15

- Rule 6.1.5. Maternal Program Manager (MPM): Level IV OB Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the MPM. Working in conjunction with the MMD, the MPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training.

Source: Miss. Code Ann. § 41-3-15

- Rule 6.1.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

- a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
- b. Maternal Program Manager
- c. Neonatal Medical Director (if different from MMD)
- d. Neonatal Program Manager (if different from MPM)
- e. Pediatrician or Neonatologist
- f. Obstetrics and Gynecology*
- g. Certified Nurse Midwife (if applicable)
- h. Maternal Fetal Medicine (MFM)**
- i. Anesthesia***
- j. Labor and Delivery
- k. Nursing
- l. Laboratory
- m. Radiology (Ultrasound)
- n. Respiratory Therapy
- o. Social Services/Pastoral Care
- p. Dietary
- q. Lactation Specialist (or equivalent)
- r. General surgery
- s. Internal Medicine
- t. Advanced Practice Provider

u. Family Medicine

v. Intensive Care Unit

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.
3. The OB Center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement (PI) program.

** The director of obstetric service shall be a board-certified OB-GYN or MFM*

***The director of the MFM program shall be a board-eligible or board-certified MFM physician.*

**** The director of obstetric anesthesia services shall be a board-certified anesthesiologist with obstetric anesthesia fellowship training or experience in obstetric anesthesia.*

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 Obstetric Service Provision

Rule 6.2.1. Patient-centered continuum of care shall be coordinated among all providers to ensure continuity, with prenatal assessments and care plans accessible at delivery sites and postpartum records shared with outpatient providers.

Source: Miss. Code Ann. § 41-3-15

Rule 6.2.2. High-risk pregnancy management: Early identification of high-risk pregnancies and appropriate risk-management shall occur. The program shall manage high-risk patients within its capabilities

Source: Miss. Code Ann. § 41-3-15

Rule 6.2.4. Patient education and quality improvement: The program shall provide comprehensive education regarding available perinatal services and engage in

ongoing quality improvement activities, including review of outcomes from prenatal through postpartum care.

Source: Miss. Code Ann. § 41-3-15

- Rule 6.2.5. Leadership and accountability: A designated perinatal services leader shall be appointed, who is responsible for aligning staffing, resources, policies, and procedures with the organization's verified Maternal Level of Care and for continuous program oversight.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Transfer Guidelines

- Rule 6.3.1. The Level IV OB Center must have the capability to accept maternal transports from lower levels of care for unanticipated high-risk pregnancies.

Source: Miss. Code Ann. § 41-3-15

- Rule 6.3.2. Maternal transports from lower levels: The program shall maintain the capability to accept urgent maternal transports from lower-level facilities. Upon transfer request, the receiving team must confirm ETA, mobilize appropriate staff and resources, and prepare bed assignments to guarantee safe admission and continuity of care.

- Rule 6.3.3 Identification and Management of Transfers: The program shall maintain prearranged relationships for immediate consultation and patient relocation. The program shall maintain documented mechanisms to facilitate and accept maternal transfers/transports. All designated facilities will agree to provide service to the maternal patient regardless of their ability to pay. Written agreements should be in place for the transfer of perinatal patient.

Source: Miss. Code Ann. § 41-3-15

- Rule 6.3.4. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation and timely exchange of clinical information between transferring and receiving entities to address maternal care quality care issues. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Clinical Components

Rule 6.4.1. Interdisciplinary Team: The Level IV OB Center must have an interdisciplinary team that includes individuals with expertise in and/or knowledge about the specialized care, treatment and services required for perinatal care. The interdisciplinary team includes individuals and specialized services to support the care, treatment, and services provided by the program.

The following individuals and services are represented on the team:

1. Obstetrics and Gynecology physician: The Obstetrics and Gynecology physician with obstetrics training and experience must be available for consultation at all times.
2. Obstetrics: A board-eligible or board-certified obstetrician must be physically present on site at all times.
3. Qualified Physicians/Certified Nurse Midwife: Ensure that a qualified physician or certified nurse midwife with appropriate physician back-up is available to attend all deliveries or other obstetrical emergencies.
 - a. Must arrive at the patient's bedside within thirty (30) minutes of an urgent request; and
 - b. Must complete annual continuing education, specific to the care of pregnant and postpartum patient, including complicated conditions.
4. Maternal-Fetal Medicine (MFM): A board-certified MFM attending with full inpatient privileges must be readily available at all times, either on site, by phone, or by telemedicine for consultation and management. The need to be on site is directed by the urgency of the clinical situation; however, the provider must be able to be on site to provide direct care within 24 hours. The MFM specialist shall also be available at all times for consultation for all pregnant or postpartum patients in the ICU.
5. MFM Critical Care Team: The facility must have a MFM critical care team in place whose members have the expertise to manage highly complex, critically ill, or unstable maternal patients. This includes co-management for all pregnant or postpartum patients in the ICU.
 - a. A MFM Critical Care Team member with full obstetrical privileges shall be available at all times for on-site consultation and management, and to

arrive at the patient's bedside within thirty (30) minutes of an urgent request

- b. A board-certified MFM physician with expertise in critical care obstetrics shall lead the team.
6. Anesthesia: Board-certified anesthesiologist with obstetric anesthesia fellowship training or experience must be physically present on site 24 hours a day, 7 days a week.
 7. Medical/Surgical: On-site medical and surgical capabilities must be available for complex maternal conditions.
 8. Intensive Care Unit: There must be the availability of an on-site adult medical and surgical ICU for obstetric patients who are primarily or co-managed by an MFM team. This includes the onsite provision of medical and surgical care for complex maternal and surgical care for complex maternal conditions, supported by the availability of critical care units or ICU beds. (Co-management includes at least daily rounds by an MFM specialist physician with interaction with the ICU team and other subspecialists with daily documentation.) The ICU must be staffed by adult critical care providers on site 24 hours a day, 7 days a week. In some settings, the ICU is in adjoining or connected building, which is acceptable as long as maternal-fetal medicine care is as noted above. If the woman must be transported by ambulance to the ICU, this is not considered onsite.
 9. Internal medicine providers, family medicine providers, and general surgeons must be readily available at all times for obstetric patients.
 10. At least one of the following adult subspecialties must be readily available for consultation and treatment as needed onsite: neurosurgery, cardiac surgery, or transplant. If the facility does not have all three subspecialties available, there should be a process in place to transfer women to a facility that can provide the needed services.
 11. Nursing: The center shall have a continuous availability of adequate RNs who have experience in the care of women with complex medical illnesses and obstetric complications with close collaboration between critical care nurses and obstetric nurses with expertise in care for critically ill women.

- i. The Nursing Service Line leadership must have an advanced degree and national certification.
12. Laboratory and Blood Bank Services: Laboratory personnel must be immediately available to obtain and process appropriate samples and report urgent/emergent results. Blood bank services must be available at all times to determine blood type and Rh type, crossmatch blood and perform antibody testing. There must be in-house availability of all blood components. There must also be guidelines or protocols in place for:
- a. Massive blood component transfusion;
 - b. Emergency release of blood components; and
 - c. Management of multiple blood component therapy.
13. Radiology Support: Radiologic services with interpretation must be readily available at all times and include:
- a. Specialized obstetric ultrasound and fetal assessment (to include Doppler studies);
 - b. Computed tomography scans;
 - c. Magnetic resonance imaging;
 - d. Standard obstetric ultrasound imaging;
 - e. Maternal echocardiography; and
 - f. Advanced interventional radiology (capable of performing uterine artery embolization).
11. Respiratory and Pharmacy: Respiratory care personnel and a registered pharmacist should be readily available at all times.
12. Support Staff:
- a. Lactation Specialists: Lactation Specialists or support staff with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.

- b. Social services, pastoral care, or bereavement services must be provided as appropriate to meet the needs of the patient population served.
 - c. A dietician or nutritionist should be available with the appropriate training and experience for the population served.
13. Subspecialists shall be readily available, per the facility's policy, for inpatient consultation, which includes critical care, general surgery, infectious disease, hematology, cardiology, nephrology, neurology, gastroenterology, internal medicine, behavioral health, and neonatology.
- a. At least one of the following adult subspecialties must be available at all times, per the facility's policy, for consultation and treatment needed on site:
 - i. Neurosurgery
 - ii. Cardiac surgery
 - iii. Transplant surgery

Note: If the organization does not have all three subspecialties available, there should be a process in place to transfer women to a facility that can provide the needed services.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.2. An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.3. Ensure that physicians providing back-up coverage must arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.4. Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

1. must operate under guidelines reviewed and approved by the MMD; and
2. must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:
 - a. provide back-up and consultation; and
 - b. arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.5. Level IV OB Obstetrical Center requirements:

1. Manage complex maternal and fetal illnesses before, during and after delivery.
2. Maintain access to consultation and referral to Maternal-Fetal Medicine specialists.
3. Maintain a full range of surgical and medical specialists including Maternal-Fetal Medicine specialists at the site.
4. Facilitate maternal transport and provide outreach education.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.6. Guideline/Protocol Development

The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

1. Massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;
2. Obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;
3. Placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of both

anticipated and unanticipated placenta accreta spectrum disorder cases, including postpartum care;

4. Hypertensive disorders in pregnancy, including eclampsia and postpartum patients to promote early diagnosis and treatment to reduce morbidity and mortality;
5. Sepsis or systemic infection in the pregnant or postpartum patient;
6. Venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;
7. Shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and
8. Behavioral health disorders, including depression, substance abuse and addiction that include screening, education, consultation with appropriate personnel and referral.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.7. Perinatal Education.

1. The Level IV OB Center must have internal perinatal education programs including training for physicians, nurses, ancillary staff, and prehospital providers.
2. Level IV OB Centers must have a written perinatal education plan.

Source: Miss. Code Ann. § 41-3-15

Chapter 7 Neonatal Levels of Care

Subchapter 1 Neonatal Program Requirements

The neonatal levels of care establish a tiered framework—Level I through Level IV—to match facility resources, clinical expertise, and support services with the acuity of mothers and their newborns. Each ascending level builds on the previous one by defining progressively advanced requirements for infrastructure, staffing, specialized services, and quality-improvement activities, ensuring that every infant receives risk-appropriate, evidence-based care at the right place and time.

Rule 7.1.1. Designated neonatal facilities must have a family-centered philosophy. Parents must have reasonable access to their infants at all times and be encouraged to participate in the care of their infants. The facility environment for perinatal care must meet the physiologic, developmental, and psychosocial needs of the mothers, infants, and families.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.2 Designated neonatal facilities organized medical staff and institutional governing body must demonstrate an institutional commitment to the neonatal program and will

1. Include allocation of sufficient personnel and resources to attain optimal neonatal care;
2. Reaffirm the neonatal program at least every three (3) years; and
3. Verify the neonatal program description is current at the time of neonatal verification

Rule 7.1.3. Neonatal Program Plan. The facility must develop a written neonatal operational plan for the neonatal program that includes a detailed description of the scope of services and clinical resources available for all neonatal patients, mothers, and families. The plan must define the neonatal patient population evaluated, treated, transferred, or transported by the facility consistent with clinical guidelines based on current standards of neonatal practice ensuring the health and safety of patients. The plan must identify the resources used to develop the facility's neonatal policies and procedures for the neonatal services it provides.

1. The written Neonatal Program Plan must be reviewed and approved by Perinatal Multidisciplinary Committee and be submitted to the facility's governing body for review and approval. The governing body must ensure the requirements of this section are implemented and enforced.
2. The written Neonatal Program Plan must include, at a minimum:
 - a. Clinical guidelines based on current standards of neonatal practice, and policies and procedures that are adopted, implemented, and enforced by the neonatal program;
 - b. A process to ensure and validate these clinical guidelines based on current standards of neonatal practice, policies, and procedures, are reviewed and revised a minimum of every three years;

- c. Written triage, stabilization, and transfer guidelines for neonatal patients that include consultation and transport services;
- d. The role and scope of telehealth/telemedicine practices, if utilized, including:
 - i. documented and approved written policies and procedures that outline the use of telehealth/telemedicine for inpatient hospital care or for consultation, including appropriate situations, scope of care, and
 - ii. documentation that is monitored through the neonatal Performance Improvement (PI) Plan and process; and
 - iii. written and approved procedures to gain informed consent from the patient or designee for the use of telehealth/telemedicine, if utilized, that are monitored for variances;
- e. written guidelines for discharge planning instructions and appropriate follow-up appointments for all neonates/infants;
- f. provisions to facilitate continuity of care for high-risk neonatal patients from delivery to discharge;
- g. delineation of roles, responsibilities, and authority of the medical, nursing, and ancillary patient care directors;
- h. physician, advanced practice nurse, and/or other medical care provider staffing plan for neonatal coverage;
- i. plan for nurse staffing including provisions for flexibility and change in census and acuity;
- j. written guidelines for the hospital disaster response, including a defined neonatal evacuation plan and process to relocate mothers and infants to appropriate levels of care with identified resources, and this process must be evaluated annually to ensure neonatal care can be sustained and adequate resources are available;

- k. written minimal education and credentialing requirements for all staff participating in the care of neonatal patients, which are documented and monitored by the managers who have oversight of staff;
- l. written requirements for providing continuing staff education, including annual educational needs assessment to evaluate the ongoing educational needs of all staff participating in the care of newborns, which are documented and monitored by the managers who have oversight of staff;
- m. annual education plan for all staff participating in the care of newborns that includes didactic, education, simulation, competency, and skills validation;
- n. measures to monitor the availability of all necessary equipment and services required to provide the appropriate level of care and support for the patient population served;
- o. documented guidelines for consulting support personnel with knowledge and skills in breastfeeding and lactation, which includes expected response times, defined roles, responsibilities, and expectations;
- p. Appropriate allocations for family-centered care including providing parents with reasonable access to their infants and encouraging advocacy, shared decision-making, and participation in their child's care; and
- q. Assurance of equitable care for all neonatal patients and families and provisions for promoting an environment of cultural humility.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.4. Patient Safety and Quality Improvement. The facility must have a documented and approved Neonatal PI Plan. The Chief Executive Officer, Chief Medical Officer (or Chief of Staff), and Chief Nursing Officer must implement a culture of safety for the facility and ensure adequate resources are allocated to support a concurrent, data-driven Neonatal PI Plan.

- 1. The facility will have a system for identification and review of significant events that could indicate threats to patient safety, with a goal of learning from identified events and mitigating future risk of recurrence, including:
 - a. A list of specific triggers or safety indicators that warrant a record review, with the goal of identifying significant safety events such as errors, adverse events, near misses, complications, and mortalities;

- b. A process for systematic multidisciplinary review of selected cases or safety events, using acceptable failure mode and effect analysis tools with a goal of identifying interventions to improve systems and reduce future safety risks; and
 - c. A process for monitoring the implementation of identified interventions.
- 2. The facility will have a dashboard or equivalent that is used to summarize and track quality indicators relevant to newborn care, including:
 - a. A list of selected quality measures relevant to the facility with a process for obtaining data needed for each selected neonatal quality measure;
 - b. A platform to display performance on the selected quality measures, including a process for updating data with a frequency that allows for appropriate identification of performance concerns;
 - c. Benchmarking of performance, when possible, with internal or external benchmarks; and
 - d. A multidisciplinary forum for review of the dashboard or equivalent.
- 3. The facility will have a structured approach to quality improvement (QI) that seeks to improve care quality and outcomes. Quality outcomes include care that is safe, efficient, effective, timely, equitable, and patient centered. Approaches will include:
 - a. A clear process for determining current QI initiatives, with a goal that the unit is engaged in at least 1 to 2 such initiatives at any given time;
 - b. Identification of a multidisciplinary QI team for each initiative, with a designated team lead;
 - c. Use of structured improvement methods or framework to guide improvement efforts; and
 - d. A multidisciplinary quality committee that meets regularly to identify and review QI initiatives.
- 4. The facility will maximize efforts to standardize and improve care through the use of guidelines and policies that align with research-driven and evidence-based best practices, including:
 - a. A process for identifying topics for guideline or policy development;
 - b. A process for developing guidelines and policies that incorporate evidence-based recommendations;

- c. A platform for making guidelines and policies readily available to clinical providers; and
 - d. A process for periodic review of guidelines and policies to guarantee they remain updated, and evidence based.
- 5. The facility will have multidisciplinary involvement in quality and safety activities, including:
 - a. Involvement of all disciplines represented in the neonatal quality and safety activities as appropriate and as described above; and
 - b. For level IV facilities, involvement of subspecialty services with significant presence in the neonatal unit.
- 6. The neonatal-specific unit will coordinate with hospital quality and safety activities, including:
 - a. Structured collaboration with the obstetrics and pediatric surgery departments, if applicable, to identify and implement opportunities for shared quality and safety efforts;
 - b. Participation in hospital-level quality and safety activities to confirm alignment of neonatal quality goals with hospital priorities;
 - c. Alignment with hospital activities and reporting of quality measures to national organizations; and
 - d. Participation in efforts to guarantee everyday readiness for external assessments by regulatory organizations.
- 7. The facility will participate in larger communities of perinatal safety and quality, including:
 - a. Collaboration between transferring and receiving hospitals to examine and improve population-level quality and safety through structured activities such as transport review and sharing of clinical protocols; and
 - b. For level III and IV facilities, participation in regional, state, or national databases that allows benchmarking of performance.
- 1. The Neonatal Medical Director (NMD) must have the authority to make referrals for peer review, receive feedback from the peer review process, and ensure neonatal physician representation in the peer review process for neonatal cases.

2. The facility must have documented evidence of neonatal PI summary reports reviewed and reported by Perinatal Multidisciplinary Committee that monitor and ensure the provision of services or procedures through telehealth and telemedicine, if utilized, is in accordance with the standards of care applicable to the provision of the same service or procedure in an in-person setting.
3. The facility must have documented evidence of neonatal PI summary reports to support that aggregate neonatal data are consistently reviewed to identify developing trends, opportunities for improvement, and necessary corrective actions. Summary reports must be provided through the Perinatal Multidisciplinary Committee, available for site surveyors, and submitted to the Department as requested.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.5. Medical Staff. The facility must have an organized, effective neonatal program that is recognized by the facility's medical staff and approved by the facility's governing body.

1. The credentialing of the neonatal medical staff must include a process for the delineation of privileges for neonatal care.
2. The neonatal medical staff must participate in ongoing staff and team-based education and training in the care of the neonatal patient.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.6. Medical Director. There must be an identified NMD. The NMD must be credentialed by the facility for treatment of neonatal patients and have their responsibilities and authority defined in a job description. The NMD must maintain a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course. The NMD is responsible for the provision of neonatal care services and must:

1. Examine qualifications of medical staff and advanced practice providers requesting privileges to participate in neonatal/infant care and make recommendations to the appropriate committee for such privileges.
2. Ensure neonatal medical staff and advanced practice provider competencies in managing neonatal emergencies, complications, and resuscitation techniques;

3. Monitor neonatal patient care from transport, to admission, stabilization, and operative intervention(s), as applicable, through discharge, and review variances in care through the neonatal Performance Improvement (PI) Plan;
4. Participate in ongoing neonatal staff and team-based education and training in the care of the neonatal patient;
5. Oversee the inter-facility neonatal transport as appropriate;
6. Collaborate with the Neonatal Program Manager (NPM), maternal teams, consulting physicians, and nursing leaders and units providing neonatal care to include developing, implementing, or revising:
 - a. written policies, procedures, and guidelines for neonatal care that are implemented and monitored for variances;
 - b. the Neonatal PI Plan, specific reviews, and data initiatives;
 - c. criteria for transfer, consultation, or higher-level of care; and
 - d. medical staff, advanced practice providers, and personnel competencies, education, and training;
7. Participate as a clinically active and practicing physician in neonatal care at the facility where medical director services are provided;
8. Ensure that the Neonatal PI Plan is specific to neonatal/infant care, is ongoing, data driven, and outcome based;
9. Frequently lead the neonatal PI meetings with the NPM and participate in the Perinatal Multidisciplinary Committee and other neonatal meetings, as appropriate;
10. Maintain active staff privileges as defined in the facility's medical staff bylaws; and
11. Develop and maintain collaborative relationships with other NMDs of designated neonatal facilities within the applicable region.

12. Collaborate with the transport team to develop, revise, and implement written policies, procedures, and guidelines, for neonatal care that are implemented and monitored for variances;
13. Participate in ongoing transport staff competencies, education, and training;
14. Review and evaluate transports from initial activation of the transport team through delivery of patient, resources, quality of patient care provided, and patient outcomes; and
15. Integrate review findings into the overall Neonatal PI Plan and process.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.7. Neonatal Program Manager (NPM). The facility must identify an NPM who has the authority and oversight responsibilities written in his or her job description, for the provision of neonatal services through all phases of care, including discharge, and identifying variances in care for inclusion in the Neonatal PI Plan. The NPM must be a registered nurse with defined education, credentials, and experience for neonatal care applicable to the level of care being provided. The NPM must maintain a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course. The NPM must:

1. Ensure staff competency in resuscitation techniques;
2. Participate in ongoing staff and team-based education and training in the care of the neonatal patient;
3. Monitor utilization of telehealth/telemedicine, if used;
4. Collaborate with the NMD, maternal program, consulting physicians, and nursing leaders and units providing neonatal care to include developing, implementing, or revising:
 - a. written policies, procedures, and guidelines for neonatal care that are implemented and monitored for variances;
 - b. the Neonatal PI Plan, specific reviews, and data initiatives;
 - c. criteria for transfer, consultation, or higher-level of care; and
 - d. staff competencies, education, and training;

5. Regularly and actively participate in neonatal care at the facility where program manager services are provided;
6. Consistently review the neonatal care provided and ensure the Neonatal PI Plan is specific to neonatal/infant care, data driven, and outcome-based;
7. Frequently lead the meetings and participate in Perinatal Multidisciplinary Committee and other neonatal meetings as appropriate; and
8. Develop and maintain collaborative relationships with other NPMs of designated neonatal facilities within the applicable PCR.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.8. Transfer Guidelines

The program shall define criteria for neonatal transfers to higher-level facilities and maintain prearranged relationships for immediate consultation and patient relocation. All designated facilities will agree to provide service to the neonatal patient regardless of their ability to pay. Written agreements should be in place for the transfer of the neonatal patient.

Rule 7.1.9 Stabilization and Transfer Protocols:

Patients requiring transfer shall receive prompt assessment, stabilization, and initiation of the transfer process. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.10. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation and timely exchange of clinical information between transferring and receiving entities.

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 General Program Requirements

Rule 7.2.1 Family Centered Care Core Components The facility will:

1. Allow all parents to have reasonable access to their infants at all times;
2. Have access to the services, personnel, and equipment needed to provide the appropriate level of care for all infants;

3. Support the physiologic, developmental, and psychosocial needs of infants and their families;
4. Have a process to screen every family for social determinants, depression, and cultural needs; and
5. Refer patients and families to appropriate resources as needed.

Family centered care additional best practices

1. Implement the utilization of primary nursing.
2. Involve family in daily and multidisciplinary patient care rounds.
3. Implement and support a family advisory council.
4. Establish a process to evaluate potential health disparities of the patient population served.
5. Implement a coordinated process to assess and address the emotional needs of families.
6. Engage in shared decision-making by involving family in discharge planning, including transport discussions.
7. Provider and staff training on shared decision making and how to engage in difficult and inclusive conversations.
8. Explicit efforts to support lactation and the needs of breastfeeding individuals.

Rule 7.2.2 Lactation and Neonatal Nutrition

1. The facility will:
 - a. have personnel with the knowledge and skills to support lactation available at all times;
 - b. have pumping equipment and secure human milk storage facilities available;
 - c. have policies and procedures in place to support:
 - i. the initiation and maintenance of lactation;
 - ii. early initiation of milk expression;
 - iii. safety, preparation, storage, and use of human milk and formula;
 - iv. long-term pumping and transition to breastfeeding; and
 - v. the utilization of donor human milk, if available.
 - d. provide annual education to all direct care providers on the importance of, and support of lactation (i.e., pumping, mixing, safe storage, misappropriation, and proper identification); and
 - i. all direct care providers have didactic education, skills verification, and competency on the proper mixing of human milk and formula;

- e. establish a program for breastfeeding and lactation support, including data collection.

Rule 7.2.3 Neonatal Resuscitation

The facility must have written policies and procedures specific to the resuscitation and stabilization of newborns based on current standards of professional practice.

1. At least 1 person with the skills to perform a complete neonatal resuscitation including endotracheal intubation, establishment of vascular access, and administration of medications must be immediately available on-site 24/7
2. A full range of neonatal resuscitative equipment, supplies, and medications must be immediately available at all times.
3. If the facility provides obstetrical delivery services:
 - a. Each birth will be attended by at least 1 AAP Neonatal Resuscitation Program (NRP) trained provider whose only responsibility is the management of the newborn and initiating resuscitation.
 - b. In the event of identified antepartum and intrapartum risk factors, at least 2 NRP trained providers should be present at birth and be responsible solely for the management and resuscitation of the newborn. Additional qualified providers should be available depending on the anticipated risk, number of newborns, and the obstetrical setting.
 - c. If advanced resuscitation measures are anticipated, a fully qualified neonatal resuscitation team should be present at the time of birth.

Rule 7.2.4 Radiology

When obtaining imaging in neonatal and obstetrical patients, radiology services will incorporate the “as low as reasonably achievable” principle.

Rule 7.2.3 Policies and Procedures

The facility will have written:

1. neonatal, medical, and ancillary care guidelines, policies, and procedures that are established on evidence-based literature, and best-practice standards, that are monitored and tracked for adherence, reviewed at least every 3 years, and revised as needed;

2. a policy that mandates the escalation of concern and the urgent presence of a privileged care provider at the bedside, including a method to track adherence;
3. policies and procedures that define the criteria for neonatal team presence at a delivery and identify a method to track adherence, if applicable;
4. policies and procedures for the triage, stabilization, and transfer of obstetrical patients to the appropriate level of care, if applicable;
5. policies and procedures for consultation by telehealth and telephone, if applicable;
6. policies and procedures for intrafacility and interfacility neonatal transport;
7. policies and procedures for transfer to a higher level of neonatal care or for services not available at the facility, if applicable;
8. policies and procedures for car seat safety observation before discharge; and
9. policies and procedures for disaster response, including evacuation of obstetrical and neonatal patients to the appropriate level(s) of care.

Rule 7.2.4 Staff Privileges

The facility will have specified requirements for all privileged care providers participating in the care of neonatal patients, and have a credentialing process for delineation of privileges; a process to verify that all ancillary care services, clinical staff, and support staff have relevant neonatal training and expertise and a mechanism in place for medical, nursing, and ancillary care leadership to review and approve these credentials and track adherence.

Subchapter 3 Level I Neonatal Center (Well Care)

Rule 7.3.1. This Subchapter establishes the rules and regulations governing the organization, staffing, and delivery of neonatal care within Level I – Well Care facilities. It is intended to ensure that mothers and their newborns receive safe, effective, and timely clinical services in accordance with current standards of professional practice.

These requirements apply to all facilities designated as Level I – Well Care, which manage neonates of thirty-five (35) weeks gestational age or greater and may transiently retain infants of less than thirty-five (35) weeks gestational age. The Subchapter further mandates the implementation of a comprehensive

Performance Improvement (PI) Plan to monitor outcomes and drive continuous improvement in neonatal services.

Rule 7.3.2. General Requirements

The Level I neonatal designated facility shall:

1. provide neonatal resuscitation at every delivery;
2. evaluate and provide postnatal care to stable term newborn infants;
3. stabilize and provide care for infants born 35-37 weeks gestational age who remain physiologically stable;
4. stabilize newborn infants who are ill and those born at < 35 weeks gestational age until transfer to a higher level of care ;
5. maintain a staff of providers including pediatricians, family physicians, nurse practitioners with newborn training, registered nurses with newborn training including being current with Neonatal Resuscitation Program Certification and S.T.A.B.L.E.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.2. Neonatal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a neonatal care program may be sufficient. The neonatal program must be established and recognized by the medical staff and hospital administration.
2. The neonatal program must come under the direction of a practicing pediatrician, family medicine physician or a physician specializing in obstetrics and gynecology with experience in the care of neonates/infants and with privileges in neonatal care;
3. Neonatal Medical Director (NMD), Neonatal Program Manager (NPM), and appropriate support staff. The Neonatal Program must be multidisciplinary in

nature and the performance improvement evaluation of this care must be extended to all the departments involved.

4. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for the care of the neonatal patient;
 - c. Defined neonatal team and written roles and responsibilities;
 - d. Appointed Neonatal Medical Director with a written job description;
 - e. Appointed Neonatal Program Manager with a written job description;
 - f. Analysis and review of system perinatal outcome and quality data; and
 - g. A written Neonatal Performance Improvement (PI) plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.3. Neonatal Service: The neonatal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the neonatal patient. The neonatal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Neonatal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.4. Neonatal Medical Director (NMD). The NMD must be a physician who is a currently practicing pediatrician, family medicine physician, or physician specializing in obstetrics and gynecology with experience in the care of neonates/infants and with privileges in neonatal care. He/she must maintain a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course, while also completes annual continuing medical education specific to the care of neonates. The NMD must demonstrate effective administrative skills and oversight of the Neonatal PI Plan. The MMD may also serve as the NMD.

Rule 7.3.5. Neonatal Program Manager (NPM): Level I Neonatal Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the NPM. Working in conjunction with the NMD, the NPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as

developing or revising policies, procedures and guidelines, assuring staff competency, education, and training. The MPM may also serve as the NPM.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
 - b. Maternal Program Manager
 - c. Neonatal Medical Director (if different from the MPM)
 - d. Neonatal Program Manager (if different from the MPM)
 - e. Pediatrician or Neonatologist
 - f. Family Physician/APPs
 - g. Obstetrics and Gynecology
 - h. Certified Nurse Midwife (if applicable)
 - i. Maternal Fetal Medicine
 - j. Anesthesia
 - k. Labor and Delivery
 - l. Nursing
 - m. Laboratory
 - n. Radiology (Ultrasound)
 - o. Respiratory Therapy
 - p. Social Services/Pastoral Care

- q. Dietary
 - r. Lactation Specialist (or equivalent)
 - s. Pharmacist
2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.
 3. The Neonatal Center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital PI program.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.7. Clinical Components

The clinical components outlined below form the foundation for delivering integrated, high-quality maternal and neonatal care. They ensure seamless collaboration, timely availability of skilled providers, access to essential support services, and standardized stabilization and resuscitation protocols.

1. Maternal – Neonatal Collaboration
 - a. The neonatal program shall collaborate with the maternal program , consulting physicians, and nursing leadership to ensure that pregnant patients identified as high risk for requiring higher-level neonatal care are transferred to a higher-level facility prior to delivery, unless such transfer is deemed clinically unsafe.
 - b. The facility shall ensure the provision of appropriate, supportive, and emergency care by qualified personnel for unanticipated maternal-fetal or neonatal complications arising during labor and delivery, continuing through patient disposition.
2. On-Call Coverage The on-call physician, advanced practice nurse, or physician assistant shall:
 - a. Possess documented special competence in neonatal care, with privileges and credentials formally reviewed and approved by the NMD.
 - b. Maintain current certification in the NRP or department-approved equivalent.

- c. Complete annual continuing education specific to neonatal and infant care.
- d. Respond to an urgent request by arriving at the patient's bedside within thirty (30) minutes of notification.
- e. Ensure documented back-up coverage where the on-call provider is unavailable or covering multiple facilities, with back-up call providers likewise responding within thirty (30) minutes of an urgent request.

3. Ancillary Services:

- a. The facility shall maintain written guidelines that define the twenty-four-hour availability of anesthesia, laboratory, radiology, respiratory therapy, ultrasonography, and blood bank services.
 - i. Where preliminary interpretation of imaging studies is conducted pending formal radiologist report, such preliminary findings shall be documented in the patient's medical record.
 - ii. The facility shall monitor and compare preliminary impressions with final interpretations under the radiology PI Plan, with summary activity reports presented to the Neonatal Multidisciplinary Committee.
- b. Pharmacy services shall ensure a pharmacist is available at all times.
 - i. Where compounding of medications for neonates or infants is performed by a pharmacy technician, a pharmacist shall provide immediate and direct supervision of the compounding process.
 - ii. The pharmacist shall implement and adhere to compounding guidelines designed to ensure the accuracy and safety of the final product. Such processes shall be monitored through the pharmacy PI Plan, and summary reports shall be presented to the Neonatal Multidisciplinary Committee.

4. Stabilization and Resuscitation

- a. The facility shall develop, maintain, and enforce written policies, procedures, and guidelines for the stabilization and resuscitation of neonates, in accordance with current standards of professional practice.
- b. The facility shall ensure the availability of trained personnel capable of stabilizing distressed neonates, including those of less than thirty-five (35) weeks gestation, until safe to transfer to a higher level of care.

- c. Staffing requirements for neonatal resuscitation shall include:
 - i. Attendance by at least one individual, at the time of each birth, who holds current NRP certification (or Department-approved equivalent) and whose primary responsibility is neonatal management and resuscitation.
 - ii. On-site availability of at least one individual skilled in complete neonatal resuscitation, inclusive on endotracheal intubation, vascular access establishment, and administration of emergency medication.
 - iii. Immediate availability of additional NRP-certified personnel for:
 - 1. Multiple birth deliveries;
 - 2. Unanticipated maternal-fetal complications during labor and delivery;
 - 3. Deliveries identified or suspected to be high-risk.
 - iv. Immediate on-site availability of all necessary resuscitative equipment, supplies, and medications.
 - v. Any deviations from these requirements must be monitored through the Neonatal PI Plan, with reporting of variances to the Perinatal Multidisciplinary Committee.

5. Support Services

- a. The neonatal program shall ensure the availability of personnel with specialized knowledge and skills in breastfeeding and lactation, to provide assistance and counseling to mothers.
- b. The facility shall provide social services, spiritual care, and counseling resources, as appropriate, to address the holistic needs of the patient population served.

6. Staff Education

- a. The facility shall designate a registered nurse with neonatal or perinatal care experience to oversee and coordinate staff education and competency assessments.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Level II Neonatal Center (Special Care)

Rule 7.4.1. This Subchapter establishes the rules and regulations governing the organization, staffing, and delivery of neonatal care within facilities designated as Level II – Special Care. It is intended to ensure that mothers and their newborns receive safe, effective, and timely clinical services in accordance with current standards of professional practice.

These requirements apply to all facilities designated as Level II – Special Care, which manage neonates of thirty-two (32) weeks gestational age or greater and birth weight of at least fifteen hundred (1,500) grams, as well as those that may transiently retain more immature or lower-birth-weight infants. The Subchapter further mandates the implementation of a comprehensive Performance Improvement (PI) Plan to monitor outcomes and drive continuous improvement in neonatal services.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.2. General Requirements

The Level II neonatal designated facility shall maintain all Level I capabilities plus:

1. Provide comprehensive care for infants born ≥ 32 weeks of gestation and weighing ≥ 1500 grams who have physiologic immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis.
2. Provide care for infants convalescing after intensive care.
3. Provide mechanical ventilation for brief duration (less than 24 hours) and/or continuous positive airway pressure for a condition expected to resolve rapidly or until transfer to a higher-level facility is achieved.
4. Stabilize infants born before 32 weeks gestation and weighing less than 1500 grams until transfer to a Level III or Level IV neonatal intensive care facility.

5. Maintain a staff of providers including those listed in Basic Care plus pediatric hospitalists, neonatologists, and neonatal nurse practitioners.
6. Referral to a higher level of care for all infants when needed for pediatric surgical or medical subspecialty intervention.
7. Level II nurseries must have equipment (e.g., portable x-ray machine, blood gas analyzer) and personnel (e.g., physicians, specialized nurses, respiratory therapists, radiology technicians and laboratory technicians) to provide ongoing care of admitted infants as well as to address emergencies.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.3. Neonatal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal care. The written commitment shall be in the form of a resolution at the time of application, passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a neonatal care program may be sufficient. The neonatal program must be established and recognized by the medical staff and hospital administration.
2. The neonatal program must come under the direction of a practicing pediatrician, family medicine physician or a physician specializing in obstetrics and gynecology with experience in the care of neonates/infants and with privileges in neonatal care;
3. Neonatal Medical Director (NMD), Neonatal Program Manager (NPM), and appropriate support staff. The Neonatal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved.
4. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for the care of the neonatal patient;

- c. Defined neonatal team and written roles and responsibilities;
- d. Appointed Neonatal Medical Director with a written job description;
- h. Appointed Neonatal Program Manager with a written job description;
- i. Analysis and review of system perinatal outcome and quality data; and
- j. A written Neonatal Performance Improvement (PI) Plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.4. Neonatal Service: The neonatal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the neonatal patient. The neonatal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Neonatal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.5. Neonatal Medical Director (NMD). The NMD must be a physician who is a board-eligible/certified neonatologist or board-certified pediatrician with sufficient training and expertise to assume responsibility of care for infants who require Level II care, including endotracheal intubation, assisted ventilation, and CPAP management, or equivalent. and maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) and completes annual continuing medical education specific to neonatology. If the neonatologist or pediatrician is certified by the American Board of Pediatrics, they will meet maintenance of certification requirement.

The NMD must demonstrate effective administrative skills and oversight of the Neonatal PI Plan.

If the NMD and/or on-site provider is not a neonatologist, the privileged care provider must maintain a consultative relationship with a board certified or eligible neonatologist at a higher-level neonatal facility; and the facility must have a written policy or guideline that defines the criteria for neonatologist consultation at a higher-level neonatal facility.

Privileged Care Providers with pediatric- or neonatal-specific training qualified to manage the care of infants with mild to moderate critical conditions, including emergencies, will be continuously available, on-site or on-call and available to arrive on-site within an appropriate time frame as defined by the facility's policies and procedures.

1. If the on-site or on-call provider is not a physician, a written policy will be in place that defines the criteria for notification and time frame for on-site physician presence, and a tracking mechanism for compliance is required;
2. If an infant is maintained on a ventilator, a pediatric- or neonatal-specific privileged care provider who can manage respiratory emergencies will be immediately available on-site;
3. Continuously provided neonatal care for the last consecutive two years and has experience and training in the care of neonates/infants, including assisted endotracheal ventilation and NCPAP management;
4. Maintains a current status of successful completion of the NRP or a department-approved equivalent course; and
5. Must complete annual continuing medical education specific to the care of neonates.

The facility will establish a written policy for backup privileged care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for onsite presence, be based on allocating the appropriate number of competent medical providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.

The MMD may also serve as the NMD.

Rule 7.4.6. Neonatal Program Manager (NPM): Level II Neonatal Centers must have a registered nurse with a Bachelor of Science in Nursing with documented perinatal nursing experience and nursing certification preferred, working in the role of the NPM. Working in conjunction with the NMD, the NPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care. The NPM will:

1. demonstrate a current status of NRP completion;
2. have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require level II care;

3. be responsible for inpatient activities in the level II facility and, as appropriate, obstetrical, well newborn, and/or pediatric units;
4. coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate;
5. provide oversight of annual neonatal-specific education, which includes low-volume, high-risk procedures consistent with the care provided in the level II; and
6. foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment focused on the quality of care and patient care outcomes.

Rule 7.4.7. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
 - b. Maternal Program Manager
 - c. Neonatal Medical Director (if different from MMD)
 - d. Neonatal Program Manager (if different from MPM)
 - e. Pediatrics
 - f. Pediatric Hospitalist
 - g. Neonatology
 - h. Obstetrics and Gynecology
 - i. Certified Nurse Midwife (if applicable)

- j. Maternal Fetal Medicine
 - k. Anesthesia
 - l. Labor and Delivery
 - m. Nursing
 - n. Laboratory
 - o. Radiology (Ultrasound)
 - p. Respiratory Therapy
 - q. Pharmacy
 - r. Social Services/Pastoral Care
 - s. Dietary
 - t. Family Medicine
 - u. APPs/Neonatal Nurse Practitioner
 - v. Lactation Specialist (or equivalent)
2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.
 3. The Neonatal Center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital PI program.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.8. Clinical Components

The clinical components outlined below form the foundation for delivering integrated, high-quality maternal and neonatal care. They ensure seamless

collaboration, timely availability of skilled providers, access to essential support services, and standardized stabilization and resuscitation protocols.

1. Maternal – Neonatal Collaboration

- a. The neonatal program shall collaborate with the maternal program, consulting physicians, and nursing leadership to ensure that pregnant patients identified as high risk for requiring higher-level neonatal care are transferred to a higher-level facility prior to delivery, unless such transfer is deemed clinically unsafe.
- b. The facility shall ensure the provision of appropriate, supportive, and emergency care by qualified personnel for unanticipated maternal-fetal or neonatal complications arising during labor and delivery, continuing through patient disposition.

2. On-Call Coverage - The on-call physician, advanced practice nurse, or physician assistant shall:

- a. Possess documented special competence in neonatal care, with privileges and credentials formally reviewed and approved by the NMD.
- b. Maintain current certification in the NRP or department-approved equivalent.
- c. Complete annual continuing education specific to neonatal and infant care.
- d. Respond to an urgent request by arriving at the patient's bedside within thirty (30) minutes of notification.
- e. Ensure documented back-up coverage where the on-call provider is unavailable or covering multiple facilities, with back-up call providers likewise responding within thirty (30) minutes of an urgent request.
- f. Where neonatal surgery is performed, a surgeon privileged and credentialed to operate on neonates/infants shall be on-call and shall arrive at the patient's bedside in a timeframe consistent with current standards of professional practice. Surgeon response times shall be monitored and reviewed through the Neonatal PI Plan.

3. Ancillary Services:

- a. Anesthesia

- i. Anesthesia services shall be provided by practitioners with demonstrated pediatric experience and competence.
- b. Laboratory and Transfusion Services
 - i. Laboratory services shall ensure personnel are on-site at all times, as defined by written management guidelines, including when a neonate/infant is maintained on endotracheal ventilation. The ability to determine blood type, crossmatch, and perform antibody testing and the ability to perform analysis on small volume samples.
 - ii. Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to verify timely and direct communication of all critical value results.
 - iii. The facility's blood bank shall be capable of providing blood and blood component therapy and irradiated, leukoreduced or cytomegalovirus negative blood within the timelines established and approved transfusion guidelines.
- c. Pharmacy – Pharmacy services must ensure a registered pharmacist experienced in neonatal/pediatric pharmacology is available at all times and completes continuing education requirements specific to pediatric and neonatal pharmacology.
 - i. If a pharmacy technician compounds medications for neonates/infants, a pharmacist must provide immediate, direct supervision of the process.
 - ii. The pharmacy will have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the level II SCN; and must implement policies and procedures to verify the accuracy of each compounded product, monitor compounding activities through the pharmacy PI Plan, and present summary reports at Perinatal Multidisciplinary Committee meetings.
- d. Radiology – must adhere to the “As Low as Reasonably Achievable” (ALARA) principle for neonatal imaging and provide the following:

- i. Personnel trained in neonatal x-ray and ultrasound operation, including cranial ultrasonography, must be on-site and able to respond to urgent requests within 30 minutes.

Appropriately trained staff must remain continuously available to meet routine diagnostic imaging needs and to manage emergencies .

- ii. Interpretation of neonatal and perinatal studies must be available at all times; any preliminary reads pending final interpretation must be documented in the medical record.
- iii. The radiology PI Plan must compare preliminary and final readings, with summary reports submitted to the Perinatal Multidisciplinary Committee.

e. Respiratory Therapy

- i. The respiratory care leader will:
 - 1. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred;
 - 2. have sufficient time allocated to oversee the respiratory therapists (RTs) who provide care in the level II facility;
 - 3. provide oversight of annual simulation and skills verification, which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;
 - 4. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs; and
 - 5. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.
- ii. Respiratory care practitioners assigned to the special care nursery will
 - 1. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal or pediatric respiratory care certification preferred;
 - 2. be on-site 24/7 and immediately available when an infant is supported by assisted ventilation or CPAP;
 - 3. be able to attend deliveries and assist with resuscitation as requested;

4. demonstrate a current status of NRP completion;
 5. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the SCN; and
 6. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.
- iii. The facility shall maintain neonatal/infant blood gas monitoring capabilities to support the management of respiratory function and acid–base status in acutely ill neonates.
- f. Therapy services – A speech, occupational, or physical therapist with neonatal expertise must be engaged to meet the developmental and functional needs of the patient population.
- i. Therapy services should be individualized based on gestational age, clinical status, and family goals.
 - ii. At least one individual skilled in the evaluation and management of neonatal feeding and swallowing concerns, with neonatal therapy certification preferred.
 - iii. Therapists must document competencies in neonatal care and participate in the Neonatal PI Plan for therapeutic interventions.
- g. Nutrition
- i. Nutrition services shall be provided by a registered dietitian or a nutritionist trained in neonatal nutrition who will
 1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;
 2. establish policies and procedures to verify proper preparation and storage of human milk and formula; and
 3. have policies and procedures for dietary consultation for patients.
 - ii. The facility will:
 1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk;
 2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for

human milk, donor human milk, fortification of human milk and formula; and

3. have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

4. Stabilization and Resuscitation

- a. The facility shall develop, maintain, and enforce written policies, procedures, and guidelines for the stabilization and resuscitation of neonates, in accordance with current standards of professional practice.
- b. The facility shall ensure the availability of trained personnel capable of stabilizing distressed neonates, including those of less than thirty-five (35) weeks gestation, until safe to transfer to a higher-level of care.
- c. Staffing requirements for neonatal resuscitation shall include:
 - i. Attendance by at least one individual, at the time of each birth, who holds current NRP certification (or Department-approved equivalent) and whose primary responsibility is neonatal management and resuscitation.
 - ii. At least one additional provider with full neonatal resuscitation skills - including endotracheal intubation, vascular access establishment, and administration of emergency medication – must be immediately available on-site.
 - iii. Immediate availability of additional NRP-certified personnel for:
 1. Multiple birth deliveries;
 2. Unanticipated maternal-fetal complications during labor and delivery;
 3. Deliveries identified or suspected to be high-risk.
 - iv. Immediate on-site availability of all necessary resuscitative equipment, supplies, and medications.
 - v. Any deviations from these standards must be monitored through the Neonatal PI Plan, with reporting of variances to the Perinatal Multidisciplinary Committee.

5. Neonatal Transport

The facility will have policies and procedures in place to identify a local neonatal transport program to facilitate transport to a higher-level neonatal facility.

6. Pediatric Medical Subspecialists and Pediatric Surgical Specialists

Policies and procedures will be in place for referral to a higher level of neonatal care when pediatric medical subspecialty or pediatric surgical specialty consultation and/or intervention is needed.

7. Support Services

a. The neonatal program shall ensure the availability of personnel with specialized knowledge and skills in breastfeeding and lactation, to provide assistance and counseling to mothers. Services shall include latch assessment, milk supply evaluation, and coordination with nutrition teams. Breastfeeding support activities are reviewed periodically through the Neonatal PI Plan.

b. The facility shall provide social services, spiritual care, and counseling resources, as appropriate, to address the holistic needs of the patient population served. Referrals to community resources and follow-up support are coordinated through the neonatal team.

i. The Level II social worker will be a Master's prepared medical social worker with perinatal and/or pediatric experience.

ii. The facility will:

1. Provide 1 social worker for every 30 beds providing Level II neonatal care and/or specialty and subspecialty perinatal care

2. Have a written description that clearly identifies the responsibilities and function of the social worker and

3. Have social services available for each family member with an infant in the special care nursery as needed.

8. Retinopathy of Prematurity

If the facility back transfers infants for convalescent care, the facility must have a process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity and the ability to perform on-site

retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity, if needed.

9. Discharge Planning and Follow-Through Care

- a. The Neonatal Program must develop and implement discharge plans for infants at high risk of neurodevelopmental, medical, or psychosocial complications.
 - i. Plans include referrals to specialty care, early intervention programs, and community-based services.
 - 1. The facility will have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with appropriate developmental follow-up services; and have a written referral agreement with a developmental follow-up clinic or practice, when possible, to provide neurodevelopmental services for the neonatal population served.
 - ii. Follow-up outcomes are monitored via the Neonatal PI Plan to ensure continuity of care.

10. Nurse Education and Orientation

Level II Neonatal Centers nursing orientation will incorporate didactic education, simulation, skills verification, and competency and shall be tailored to the individual needs of the nurse based on clinical experience. The facility must document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members. Annual nursing education will address the annual needs assessment and incorporate simulation and skills verification of low-volume, high-risk procedures consistent with the types of care provided in the level II centers and include education related to serious safety events.

11. Clinical Nurse Educator

- a. be an RN, with nursing certification specific to the care environment preferred;
- b. have at least a Bachelor of Science in Nursing, Master's preferred;
- c. demonstrate a current status of NRP completion;
- d. cultivate collaborative relationships with the neonatal nurse leader and facility leadership to improve the quality of care and patient care outcomes⁵; and

- e. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level II neonatal care.⁹
- f. The facility will have a dedicated individual with sufficient time allocated to perform the roles and responsibilities of the clinical nurse educator.

The Source: Miss. Code Ann. § 41-3-15

Subchapter 5 Level III Neonatal Center (Intensive Care)

This Subchapter establishes the rules governing the organization, staffing, and delivery of intensive neonatal care within facilities designated as Level III – Neonatal Intensive Care Centers. Its purpose is to ensure that mothers and their neonates—ranging from mild to critical illness or requiring sustained life support—receive safe, effective, and timely clinical services in accordance with current professional standards.

Rule 7.5.1. General Requirements

The Level III neonatal designated facility shall maintain all Level I and II capabilities as well as the following:

1. Level III NICUs are defined by having continuously available personnel (neonatologists, neonatal nurses, and respiratory therapists) and equipment to provide life support for as long as necessary.
2. Provide comprehensive care for infants born less than 32 weeks gestation and weighing less than 1500 grams and infants born at all gestational ages and birth weights with critical illness.
3. Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists or anesthesiologists with experience in neonatal surgical care and pediatric ophthalmologists, on site or by prearranged consultative agreements.
4. Provide a full range of respiratory support and physiologic monitoring that may include conventional and/or high-frequency ventilation, inhaled nitric oxide delivery, and/or therapeutic hypothermia or have policies and procedures in place to facilitate neonatal transfer to a higher level of care.

5. Perform advanced imaging with interpretation on an urgent basis, including computed tomography, MRI and echocardiography.
6. Social and family support including social services and pastoral care.
7. If geographic constraints for land transportation exist, the Level III facility should ensure availability of rotor and fixed-wing transport services to transfer infants requiring subspecialty intervention from other regions and facilities.
8. Consultation and transfer agreements with both lower-level referring hospitals and regional centers, including back-transport agreements.
9. Prompt diagnosis and appropriate referral of all conditions requiring surgical intervention. Major surgery should be performed by pediatric surgical specialists (including anesthesiologists with pediatric expertise) on-site within the hospital or at a closely related institution, ideally in close geographic proximity if possible. Level III facilities should be able to offer complete care, management, and evaluation for high-risk neonates 24 hours a day. A neonatologist should be available either in-house or on-call with the capacity to be in-house in a timely manner, 24 hours a day.
10. Level III facilities should maintain a sufficient volume of infants less than 1500 grams to meet professionally accepted guidelines to achieve adequate experience and expertise.
11. Enrollment in the Vermont Oxford Network to report and monitor data regarding outcomes of infants born less than 32 weeks and weighing less than 1500 grams.
12. Participation in and evaluation of quality improvement initiatives.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.2. Neonatal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a

neonatal care program may be sufficient. The neonatal program must be established and recognized by the medical staff and hospital administration.

2. The neonatal program must come under the direction of a practicing pediatrician, family medicine physician or a physician specializing in obstetrics and gynecology with experience in the care of neonates/infants and with privileges in neonatal care;
3. Neonatal Medical Director (NMD), Neonatal Program Manager (NPM), and appropriate support staff. The Neonatal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved.
4. Compliance with the above will be evidenced by but not limited to:
 - a. Governing authority and medical staff letter of commitment in the form of a resolution;
 - b. Written policies and procedures and guidelines for the care of the neonatal patient;
 - c. Defined neonatal team and written roles and responsibilities;
 - d. Appointed Neonatal Medical Director with a written job description;
 - e. Appointed Neonatal Program Manager with a written job description; and
 - f. A written Neonatal Performance Improvement (PI) plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.3. Neonatal Service: The neonatal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the neonatal patient. The neonatal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Neonatal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.4. Neonatal Medical Director (NMD). The NMD must be a physician who is a board-eligible or board-certified neonatologist with neonatal or infant care

experience and maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) or Department-approved equivalent. The NMD is responsible for the oversight of neonatal transport protocols, staff competencies, safety standards and performance review. The NMD must also complete annual continuing medical education specific to the care of neonates, as well as demonstrate effective administrative skills and oversight of the Neonatal PI Plan.

Rule 7.5.5. Neonatal Program Manager (NPM): Level III Neonatal Centers must have a registered nurse with at least a Bachelor of Science in Nursing (Master's preferred) with documented neonatal nursing experience and nursing certification preferred, working in the role of the NPM. The NPM must maintain a current NRP certification or equivalent. Working in conjunction with the NMD, the NPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training. The NPM must have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require Level III NICU care, be responsible for inpatient activities in the NICU and, as appropriate, obstetric, well newborn, and/or pediatric units; and coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate. The NMD must provide oversight of annual neonatal-specific education which includes low-volume, high-risk procedures consistent with the care provided in the level III NICU and foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment to improve the quality of care and patient care outcomes

Rule 7.5.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

- a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
 - b. Maternal Program Manager
 - c. Neonatal Medical Director
 - d. Neonatal Program Manager
 - e. Pediatrics
 - f. Neonatology
 - g. Obstetrics and Gynecology
 - h. Certified Nurse Midwife (if applicable)
 - i. Maternal Fetal Medicine
 - j. Pediatric surgery / pediatric ophthalmology
 - k. Anesthesia/pediatric anesthesia
 - l. Labor and Delivery
 - m. Nursing
 - n. Laboratory
 - o. Radiology (Ultrasound)
 - p. Respiratory Therapy
 - q. Social Services/Pastoral Care
 - r. Dietary
 - s. Family Medicine
 - t. APPs/Neonatal Nurse Practitioner
 - u. Lactation Specialist (or equivalent)
2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.

3. The Neonatal Center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital PI program.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.7. Clinical Components

The clinical components outlined below form the foundation for delivering integrated, high-quality maternal and neonatal care. They ensure seamless collaboration, timely availability of skilled providers, access to essential support services, and standardized stabilization and resuscitation protocols.

1. Maternal – Neonatal Collaboration
 - a. The neonatal program shall collaborate with the maternal program, consulting physicians, and nursing leadership to ensure that pregnant patients identified as high risk for requiring higher-level neonatal care are transferred to a higher-level facility prior to delivery, unless such transfer is deemed clinically unsafe.
 - b. The facility shall ensure the provision of appropriate, supportive, and emergency care by qualified personnel for unanticipated maternal-fetal or neonatal complications arising during labor and delivery, continuing through patient disposition.
2. On-Site Clinical Coverage - The on-call physician, advanced practice nurse, or physician assistant shall:
 - a. At least one neonatal provider (pediatric hospitalist, neonatologist, neonatal nurse practitioner, or neonatal physician assistant) must be on-site at all times with documented competence and privileges reviewed by the NMD.
 - b. Neonatologists
 1. The NICU neonatologists will:
 - i. be a board eligible or certified neonatologist or equivalent
 - ii. complete annual CME specific to neonatology
 - iii. demonstrate a current status of NRP completion
 - ii. Have credentials that are reviewed by the NMD at least every two (2) years; and

- i. Preferably be on-site and immediately available 24/7, a written policy will be in place that defines the criteria for notification and timeframe, as defined by the facility's policies and procedures.
 - 3. If a neonatologist is not on-site 24/7, a written policy will be in place that defines the criteria for notification and timeframe for on-site presence, and a tracking mechanism for compliance is required.
- c. Privileged Care Providers

Privileged Care Providers with neonatal-specific training qualified to manage the care of infants with mild to complex critical conditions, including emergencies, will be on site 24/7 and:

 - i. Maintain current NRP certification or equivalent.
 - ii. Complete annual continuing education in neonatal care; and review of credentials at least every two years by the NMD.
 - iii. If no neonatologist on-site, have a board-certified neonatologist available for consultation and on-site, arrival within thirty (30) minutes of urgent requests.
 - iv. Ensure back-up neonatologist coverage (documented on-call) if covering multiple facilities, with the same 30-minute response time. The facility will establish a written policy for backup privileged care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent medical providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.
- d. Pediatric Medical Subspecialists
 - i. The facility must have on-site access to a broad range of pediatric medical subspecialties including, but not limited to: cardiology, pulmonology, infectious disease, neurology, ophthalmology, endocrinology, hematology, gastroenterology, nephrology, and genetics or metabolism.
 - ii. The pediatric medical subspecialists must be readily accessible for on-site consultation, have credentials to consult at the facility, including documented training, certification, competencies, and CME specific to

their subspecialty and document consultations in the medical record within an appropriate time frame and as defined by the facility's policies and procedures.

e. Neonatal Surgical Program – Optional for Level III

- i. Pediatric surgeons and pediatric surgical specialists will be available on-site or at another closely related NICU facility.
 1. If pediatric surgery is not offered on-site at the facility, policies and procedures will be in place with a facility that provides surgical care to facilitate transfer of an infant when needed.
- ii. Infants requiring cardiovascular surgery or extracorporeal membrane oxygenation (ECMO) will be transferred to a facility that provides these services.
 1. If pediatric surgery is accessible on-site, the surgeons will:
 - a. be available at the bedside within 1 hour of request or identified need;
 - b. have credentials to provide care at the facility, including documented training, certification, competencies, and continuing education specific to their pediatric surgery specialty;
 - c. establish a program for evaluating surgical performance by accurately tracking data, identifying trends, and implementing quality improvement initiatives to address surgical performance in a coordinated systematic approach within a culture of safety, equity, and prevention; and
 - d. report neonatal surgical and anesthesia care back to the PI Committee.

3. Ancillary Services:

- a. Anesthesia
 - i. If pediatric surgery is performed on-site, anesthesia providers with pediatric expertise must:
 1. be on the medical staff and promptly available 24/7 to respond to the bedside within 1 hour of request or identified need;
 2. serve as the primary responsible anesthesia provider for all infants <24 month of age and should serve as the primary anesthesiologist for children 5 year of age based on the American Society of Anesthesiologists (ASA) physical status classification; and
 3. be physically present for all neonatal surgical procedures for which they serve as the primary responsible anesthesia provider.

- b. Laboratory and Transfusion Services
 - i. Laboratory services shall ensure personnel are on-site at all times.
 - ii. Laboratory services will have the ability to determine blood type, crossmatch, and perform antibody testing.
 - iii. Pediatric pathology and intra-operative frozen section services must be available in the operative suite at the request of the operating surgeon.
 - iv. The facility's blood bank shall be capable of providing blood and blood component therapy and irradiated, leukoreduced or CMV-negative blood within the timelines established and approved transfusion guidelines.
 - 1. Policies and procedures will be in place to facilitate emergency access to blood and blood component therapy so that the NICU can provide hematologic interventions, if applicable.
 - v. The laboratory will have the ability to perform analysis on small volume sample and access to perinatal pathology services, if applicable.
 - 1. Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to maintain timely and direct communication of all critical value results.
- c. Pharmacy – Pharmacy services must ensure at least one registered pharmacist experienced in neonatal/pediatric pharmacology is available at all times, completes continuing education requirements specific to pediatric and neonatal pharmacology and participates in multidisciplinary care, including participation in patient care rounds.
 - i. If a pharmacy technician compounds medications for neonates/infants, a pharmacist must provide immediate, direct supervision of the process.
 - ii. The pharmacist must implement guidelines to address drug shortages, verify medications are appropriately allocated to the Level III NICU and verify the accuracy of each compounded product, monitor compounding activities through the pharmacy PI Plan,
 - iii. Total parenteral nutrition (TPN) tailored for neonates/infants must be readily available upon request.

1. The facility will have a written policy and procedure for the proper preparation and delivery of TPN.
- d. Radiology – must adhere to the “As Low as Reasonably Achievable” (ALARA) principle for neonatal imaging and include the following:
- i. Personnel trained in neonatal x-ray equipment must be on-site and available at all times to address emergencies.
 - ii. Personnel appropriately trained in ultrasound, computed tomography, including cranial ultrasound, computed tomography (CT), and magnetic resonance imaging (MRI) equipment and available on-site within a time period consistent with current standards of professional practice.
 - iii. Fluoroscopy must be available at all times.
 1. If fluoroscopy is not offered on-site at the facility, policies and procedures will be in place to facilitate transfer of an infant to a higher level of care.
 - iv. Neonatal diagnostic imaging studies and radiologists with pediatric expertise to interpret the neonatal diagnostic imaging studies, available at all times;
 - v. A radiologist with pediatric expertise to interpret images consistent with the patient condition and within a time period consistent with current standards of professional practice with monitoring of variances through the Neonatal PI Plan and process;
 - vi. Pediatric-trained radiologists must be available at all time for interpretation of neonatal and perinatal studies; any preliminary reads pending final interpretation must be documented in the medical record.
 - vii. Pediatric echocardiography with pediatric cardiology interpretation and consultation within professional timeframes.
 - viii. The radiology PI Plan must compare preliminary and final readings, with summary reports submitted to Perinatal Multidisciplinary Committee.

e. Respiratory Therapy

The respiratory care leader will:

- i. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred;
- ii. have sufficient time allocated to oversee the RTs who provide care in the level III NICU;
- iii. provide oversight of annual simulation and skills verification which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;
- iv. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs; and
- v. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.

Respiratory care practitioners assigned to the NICU will:

- i. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal and pediatric respiratory care certification preferred;
- ii. be on-site 24/7 and immediately available to supervise assisted ventilation, assist in resuscitation, and attend deliveries;
- iii. demonstrate a current status of NRP completion;
- iv. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the NICU; and
- v. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.
- vi. provide neonatal/infant blood gas monitoring capabilities to support the management of respiratory and metabolic management.

Therapy Services – The facility will provide on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family and psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served. The facility will have on-site access to the

following neonatal therapists who have dedicated time allocated to serve the NICU:

1. an occupational and/or physical therapist with neonatal expertise, and neonatal therapy certification preferred; and
2. a speech language pathologist with neonatal expertise, skilled in the evaluation and management of neonatal feeding and swallowing concerns, and neonatal therapy certification preferred.
 - i. If swallow studies are not offered on-site at the facility, policies and procedures will be in place to facilitate neonatal transfer to a higher level of care.
 - ii. The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal therapist coverage based on the specific need and volume of the neonatal population served.

f. Nutrition

- i. At least one registered dietician or nutritionist who has specialized training in neonatal nutrition will have dedicated time allotted to serve the NICU and will:
 1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;
 2. establish policies and procedures to verify proper preparation and storage of human milk and formula;
 3. participate in multidisciplinary care, including participation in patient care rounds; and
 4. have policies and procedures for dietary consultation for infants in the NICU.

Neonatal Nutrition

- ii. The facility will:
 1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk;
 2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for

human milk, donor human milk, fortification of human milk and formula; and

3. have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

g. Clinical Nurse Staffing

- i. A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.

h. Clinical Nurse Staff

i. Each clinical nurse will:

1. be an RN, with nursing certification specific to the care environment preferred;
2. demonstrate a current status of NRP completion;
3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level III NICU; and
4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.

ii. If the facility utilizes LPNs or non-licensed direct care providers to support the clinical nursing staff, the facility must:

1. have written criteria that define the LPNs' or non-licensed direct care providers' scope of neonatal care;
2. provide annual education specific to the care of the neonatal population served; and
3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.

i. Clinical Nurse Specialist

The clinical nurse specialist will:

- a. be an RN, with neonatal nursing certification and clinical nurse specialist certification preferred;
- b. have at least a Bachelor of Science in Nursing, Master's or Doctorate preferred;

- c. demonstrate a current status of NRP completion;
- d. foster continuous quality improvement in nursing care;
- e. develop and educate staff to provide evidence-based nursing care;
- f. be responsible for mentoring new staff and developing team building skills;
- g. provide leadership to multidisciplinary teams;
- h. facilitate case management of high-risk neonatal patients; and;
- i. cultivate collaborative relationships with multidisciplinary team members and facility leadership to improve the quality of care and patient care outcomes;
- j. The roles and responsibilities of the NICU clinical nurse specialist can be allocated to multiple individuals to perform this role.

4. Stabilization and Resuscitation

- a. The facility shall develop, maintain, and enforce written policies, procedures, and guidelines for the stabilization and resuscitation of neonates, in accordance with current standards of professional practice.
- b. The facility shall ensure the availability of trained personnel capable of stabilizing distressed neonates.
- c. Staffing requirements for neonatal resuscitation shall include:
 - i. Attendance by at least one individual, at the time of each birth, who holds current NRP certification (or Department-approved equivalent) and whose primary responsibility is neonatal management and resuscitation.
 - ii. At least one additional provider with full neonatal resuscitation skills - including endotracheal intubation, vascular access establishment, and administration of emergency medication – must be immediately available on-site.
 - iii. Additional personnel who maintain a current status of successful completion of the NRP or a Department-approved equivalent must be on-site and immediately available upon request for the following:
 - 1. Multiple birth deliveries;

2. Unanticipated maternal-fetal complications during labor and delivery;
3. Deliveries identified or suspected to be high-risk.
- iv. Immediate on-site availability of all necessary resuscitative equipment, supplies, and medications.
- v. Any deviations from these standards must be monitored through the Neonatal PI Plan, with reporting of variances to the Perinatal Multidisciplinary Committee.

5. Neonatal Transport

If the facility has a neonatal critical care transport program, it will have an identified director of neonatal transport services. The director of neonatal transport services can be the NMD or another physician who is a pediatrician, board-eligible or certified neonatologist, pediatric hospitalist, or pediatric medical subspecialist with expertise and experience in neonatal and infant transport. If the facility does not have its own transport program, the facility must have policies and procedures in place to identify a local neonatal transport program to facilitate transport.

Responsibilities of the director of neonatal transport services include the following:

- i. Train and supervise staff;
- ii. Provide appropriate review of all transport records;
- iii. develop and implement policies and procedures for patient care during transport;
- iv. develop guidelines for determining transport team composition and medical control and establish a mechanism to track adherence;
- v. establish policies and procedures to provide transport updates and outreach education;
- vi. establish a program for evaluating performance by tracking data, identifying trends, and implementing quality improvement initiatives to address transport performance in a coordinated systematic approach within a culture of safety, equity, and prevention; and
- vii. report neonatal transport data and neonatal-specific reviews back to the PI committee.
- viii. The director of neonatal transport services may delegate specific requirements to other person(s) or group(s) but retains the responsibility of certifying that these functions are addressed appropriately.

The facility will:

- i. establish minimum education, experience, and training requirements for all transport team members
- ii. select transport team members based on their experience and competence in the care of neonates and the transport team must collectively have the ability to provide a level of care that is similar to that of the admitting unit; and
- iii. provide annual transport education to all transport team members that incorporates equipment training, didactic education, simulation, and skills verification of low-volume, high-risk procedures consistent with the types of care provided during neonatal transport.

6. Support Services

The neonatal program shall ensure the availability of personnel with specialized knowledge and skills in breastfeeding and lactation, to provide assistance and counseling to mothers at all times. Services shall include latch assessment, milk supply evaluation, and coordination with nutrition teams. An IBCLC should be available for on-site consultation on weekdays and accessible by telehealth or telephone at all times. IBCLC personnel should be operationally reviewed on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.

a. Social Worker

- i. The NICU social worker will:
 1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.
- ii. The facility will:
 1. provide 1 social worker for every 30 beds providing level III neonatal care and/or specialty and subspecialty perinatal care;
 2. have a written description that clearly identifies the responsibilities and functions of the NICU social worker; and
 3. have social services available for each family with an infant in the NICU as needed.

b. Pastoral Care

Personnel skilled in pastoral care will be available as needed and by family request, and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.

The facility must have process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity, and the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity.

Rule 7.5.9 Discharge Planning and Follow-Through Care

1. Systems will be in place to establish preparation for NICU discharge, including post-discharge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed.

The facility must have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with appropriate developmental follow-up services; as well as provide developmental follow-up services or have written referral agreement with a developmental follow-up clinical or practice, when possible, to provide neurodevelopmental services for the neonatal population served.

- a. Follow-up outcomes are monitored via the Neonatal PI Plan to ensure continuity of care.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.10 Nursing Orientation and Education

1. Level III NICU nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.
2. The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.
3. Annual nursing education will address the annual needs assessment and incorporate simulation and skill verification of low-volume, high-risk procedures consistent with the types of care provided in the level III NICU and include education related to serious safety events.
4. Clinical Nurse Educator
 - a. The NICU clinical nurse educator will:
 - i. Be an RN, with nursing certification specific to the care environment preferred;

- ii. Have at least a Bachelor of Science in Nursing, Master's preferred;
 - iii. Demonstrate a current status of NRP completion;
 - iv. Cultivate collaborative relationships with the NPM and facility leadership to improve the quality of care and patient care outcomes; and
 - v. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level III neonatal care.
- b. The facility will have a dedicated individual with sufficient time allocated to perform the roles and responsibilities of the NICU clinical nurse educator.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.11 Neonatal Outreach

The Level III facility will provide multidisciplinary outreach education to referring facilities by assessing educational needs and evaluating clinical care and outcomes, including transport data, as part of collaboration with lower-level neonatal facilities, if applicable.

Subchapter 6 Level IV Neonatal Center (Advanced Neonatal Intensive Care)

This Subchapter establishes the rules governing the organization, staffing, and delivery of the highest-level neonatal care within facilities designated as Level IV – Advanced Neonatal Intensive Care Centers. Its purpose is to ensure that mothers and neonates with the most complex medical and surgical conditions benefit from multidisciplinary expertise, evidence-based practices, and continuous quality improvement aligned with current professional standards.

Rule 7.6.1. General Requirements: The Level IV neonatal designated facility shall maintain all Level III capabilities and shall also:

- 1. Provide care for infants of all gestational ages and birth weights, with mild to complex critical conditions or medical problems requiring sustained life support, hemodynamic support, conventional and high frequency mechanical ventilation, iNO delivery, and/or therapeutic hypothermia.
- 2. Be located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions.
- 3. Maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists and pediatric anesthesiologists at the site.

4. Have the ability to provide ECMO or policies and procedures in place to facilitate neonatal transfer to another unit or facility that provides ECMO.
5. Facilitate transport and provide outreach education including community taught NRP and S.T.A.B.L.E. classes.
6. Have sufficient experience based on patient volume and a systematic process to assess the quality of care provided, including a method to track specific quality indicators and clinical diagnoses, review aggregate data using accepted methodology, and develop action plans as needed to improve patient outcomes.

Source: *Miss. Code Ann. § 41-3-15*

Rule 7.6.2. Neonatal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a neonatal care program may be sufficient. The neonatal program must be established and recognized by the medical staff and hospital administration.
2. The neonatal program must come under the direction of neonatologist;
3. Neonatal Medical Director (NMD), Neonatal Program Manager (NPM), and appropriate support staff. The Neonatal Program must be multidisciplinary in nature and the performance improvement evaluation of this care must be extended to all the departments involved.
4. Compliance with the above will be evidenced by but not limited to:
 - i. Governing authority and medical staff letter of commitment in the form of a resolution;
 - ii. Written policies and procedures and guidelines for the care of the neonatal patient;
 - iii. Defined neonatal team and written roles and responsibilities;
 - iv. Appointed Neonatal Medical Director with a written job description;

- v. Appointed Neonatal Program Manager with a written job description;
- vi. Analysis and review of system perinatal outcome and quality data
- vii. A written Neonatal Performance Improvement (PI) plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.3. Neonatal Service: The neonatal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the neonatal patient. The neonatal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Neonatal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.4. Neonatal Medical Director (NMD). The NMD must be a physician who is a board-eligible or board-certified neonatologist with neonatal or infant care experience and maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) or Department-approved equivalent. The NMD is responsible for the validation of neonatal transport protocols, staff competencies, safety standards, and performance review. The NMD must also complete annual continuing medical education specific to the care of neonates, as well as demonstrate effective administrative skills and oversight of the Neonatal PI Plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.5. Neonatal Program Manager (NPM): Level IV Neonatal Centers must have a registered nurse with at least a Bachelor of Science in Nursing (Master's preferred) with documented perinatal nursing experience, working in the role of the NPM. The NPM must maintain a current NRP certification or equivalent. Working in conjunction with the NMD, the NPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training. The NPM must have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require Level IV NICU care, be responsible for inpatient activities in the NICU and, as appropriate, obstetrical, well newborn, and/or pediatric units; and coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate. The NMD must provide

oversight of annual neonatal-specific education which includes low-volume, high-risk procedures consistent with the care provided in the level IV NICU and foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment to improve the quality of care and patient care outcomes. In conjunction with the NMD, he/she shall conduct monthly case reviews, analyze transport outcomes and report variances through the PI process.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
 - a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
 - b. Maternal Program Manager
 - c. Neonatal Medical Director
 - d. Neonatal Program Manager
 - e. Pediatrics
 - f. Pediatric Hospitalist
 - g. Neonatology
 - h. Obstetrics and Gynecology
 - i. Certified Nurse Midwife (if applicable)

- j. Maternal Fetal Medicine
- k. Pediatric surgery / pediatric ophthalmology
- l. Anesthesia/pediatric anesthesia
- m. Family Medicine
- n. APPs/Neonatal Nurse Practitioner
- o. Labor and Delivery
- p. Nursing
- q. Laboratory
- r. Radiology (Ultrasound)
- s. Respiratory Therapy
- t. Social Services/Pastoral Care
- u. Dietary
- v. Lactation Specialist (or equivalent)
- w. Pharmacist

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.
3. The Neonatal Center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital PI program.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.7. Clinical Components

The clinical components outlined below form the foundation for delivering integrated, high-quality maternal and neonatal care. They ensure seamless collaboration, timely availability of skilled providers, access to essential support services, and standardized stabilization and resuscitation protocols.

1. Maternal – Neonatal Collaboration
 - a. The neonatal program must collaborate with the maternal program , consulting physicians, and nursing leadership to ensure that pregnant patients who are at high risk of delivering a neonate that requires specialized care are transferred to a facility with specialized care capabilities before delivery unless the transfer would be unsafe.
 - b. The facility shall ensure the provision of appropriate, supportive, and emergency care delivered by qualified personnel for unanticipated maternal-fetal or neonatal complications arising during labor and delivery, continuing through patient disposition.
2. On-Site Clinical Coverage
 - a. Neonatologists

The NICU neonatologists will:

 - i. be a board eligible or certified neonatologist or equivalent;
 - ii. Complete annual CME specific to neonatology;
 - iii. Demonstrate a current status of NRP completion;
 1. Have credentials that are reviewed by the NMD at least every two (2) years; and
 - iv. Preferably be on-site and immediately available 24/7, a written policy will be in place that defines the criteria for notification and timeframe, as defined by the facility’s policies and procedures.
 1. If a neonatologist is not on-site 24/7, a written policy will be in place that defines the criteria for notification and timeframe for on-site presence, and a tracking mechanism for compliance is required.
3. Privileged Care Providers

Privileged Care Providers with neonatal-specific training qualified to manage the care of infants with mild to complex critical conditions, including emergencies, will be on site 24/7 and:

 - i. Maintain current NRP certification or equivalent;
 - ii. Complete annual continuing education in neonatal care; and review of credentials at least every two years by the NMD.
 - iii. If no neonatologist on-site, have a board-certified neonatologist available for consultation and on-site, arrival within thirty (30) minutes of urgent requests.

- iv. Ensure back-up neonatologist coverage (documented on-call) if covering multiple facilities, with the same 30-minute response time. The facility will establish a written policy for backup privileged care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent medical providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.

4. Pediatric Medical Subspecialists

The facility must have on-site access to a broad range of pediatric medical subspecialties including, but not limited to;

- i. cardiology, pulmonology, infectious disease, neurology, ophthalmology, endocrinology, hematology, gastroenterology, nephrology, and genetics or metabolism; and
- ii. the pediatric medical subspecialists must:
 - 1. be readily accessible for in-person consultation;
 - 2. have credentials to consult at the facility, including documented training, certification, competencies, and continuing education specific to their subspecialty; and
 - 3. document consultations in the medical record within an appropriate time frame and as defined by the facility's policies and procedures.

5. Neonatal Surgical Program – Required for Level IV

Pediatric Surgeons

Pediatric surgeons and pediatric surgical specialists will:

- a. Be available at the bedside within one hour of request or identified need and be capable of performing major pediatric surgery, including surgery for complex conditions;
- b. If transplant or cardiac surgery is not offered on-site at the facility, policies and procedures will be in place to facilitate neonatal transport to a facility that provides appropriate surgical care;
- c. provide consultation to a broad range of pediatric surgical specialists including, but not limited to:
- d. general pediatric surgery, neurosurgery, urology, ophthalmology, otolaryngology, orthopedics, and plastic surgery;

- e. have credentials to provide care at the facility, including documented training, certification, competencies, and continuing education specific to their pediatric surgery specialty;
- f. establish a program for evaluating surgical performance by accurately tracking data, identifying trends, and implementing quality improvement initiatives to address surgical performance in a coordinated systematic approach within a culture of safety, equity, and prevention; and
- g. report neonatal surgical and anesthesia care back to the PI Committee.

6. Ancillary Services:

a. Anesthesia

- 1. Pediatric anesthesiologists must be on the medical staff and promptly available 24/7 to respond to the bedside within 1 hour of request or identified need;
- 2. serve as the primary responsible anesthesia provider for all infants <24 mo. of age and should serve as the primary anesthesiologist for children ≤ 5 y of age or based on the ASA physical status classification; and
- 3. be physically present for all neonatal surgical procedures for which they serve as the primary responsible anesthesia provider.

b. Laboratory and Transfusion Services

1. Laboratory services shall have:

- 1. laboratory personnel on-site 24/7;
- 2. the ability to determine blood type, crossmatch, and perform antibody testing;
- 3. a blood bank capable of providing blood component therapy and irradiated, leukoreduced or CMV-negative blood;
 - a. policies and procedures will be in place to facilitate emergent access to blood and blood component therapy so that the NICU can provide a full range of hematologic interventions;
- 4. the ability to perform neonatal blood gas monitoring;
- 5. the ability to perform analysis on small volume samples;
- 6. the capability to process biopsies and perform autopsies; and
- 7. access to perinatal pathology services, if applicable.

2. Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to maintain timely and direct communication of all critical value results.
- c. Pharmacy – Pharmacy services must ensure at least one registered pharmacist experienced in neonatal/pediatric pharmacology is available at all times, completes continuing education requirements specific to pediatric and neonatal pharmacology and participates in multidisciplinary care, including participation in patient care rounds.
 - i. If a pharmacy technician compounds medications for neonates/infants, a pharmacist must provide immediate, direct supervision of the process.

The pharmacist must implement guidelines to address drug shortages, verify medications are appropriately allocated to the Level III NICU and verify the accuracy of each compounded product, monitor compounding activities through the pharmacy PI Plan,

- ii. Total parenteral nutrition (TPN) tailored for neonates/infants must be readily available upon request.
 1. The facility will have a written policy and procedure for the proper preparation and delivery of TPN.
- c. Radiology – must adhere to the “As Low as Reasonably Achievable” (ALARA) principle for neonatal imaging and include the following:
 1. Appropriately trained radiology personnel continuously available on-site to meet routine diagnostic imaging needs and to address emergencies.
 2. Fluoroscopy available on-call 24/7;
 3. Personnel appropriately trained in the following techniques will be on-call and/or available on-site to perform advanced imaging as requested:
 - a. ultrasonography, including cranial ultrasonography,
 - b. computed tomography (CT), and
 - c. magnetic resonance imaging (MRI)

4. the ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested;
5. The facility will provide pediatric echocardiography and have the ability to consult with a pediatric cardiologist for timely echocardiography interpretation as requested.
 - a. If fluoroscopy is not offered on-site at the facility, policies and procedures will be in place to facilitate transfer of an infant to a higher level of care.
6. Neonatal diagnostic imaging studies and radiologists with pediatric expertise to interpret the neonatal diagnostic imaging studies, available at all times;
7. A radiologist with pediatric expertise to interpret images consistent with the patient condition and within a time period consistent with current standards of professional practice with monitoring of variances through the Neonatal PI Plan and process;
8. Pediatric-trained radiologists must be available at all time for interpretation of neonatal and perinatal studies; any preliminary reads pending final interpretation must be documented in the medical record.
9. Pediatric echocardiography with pediatric cardiology interpretation and consultation within professional timeframes.
10. The radiology PI Plan must compare preliminary and final readings, with summary reports submitted to Perinatal Multidisciplinary Committee.
11. Personnel trained in neonatal x-ray equipment must be on-site and available at all times.
12. Personnel appropriately trained in ultrasound, computed tomography, and cranial ultrasound equipment available on-site within a time period consistent with current standards of professional practice.
13. Fluoroscopy must be available at all times.

14. Neonatal diagnostic imaging studies and radiologists with pediatric expertise to interpret the neonatal diagnostic imaging studies, available at all times;
15. A radiologist with pediatric expertise to interpret images consistent with the patient condition and within a time period consistent with current standards of professional practice with monitoring of variances through the Neonatal PI Plan and process;
16. Pediatric-trained radiologists must be available at all times for interpretation of neonatal and perinatal studies; any preliminary reads pending final interpretation must be documented in the medical record.
17. Pediatric echocardiography with pediatric cardiology interpretation and consultation within professional timeframes.
18. The radiology PI Plan must compare preliminary and final readings, with summary reports submitted to the Perinatal Multidisciplinary Committee.

d. Respiratory Therapy

The respiratory care leader will:

- i. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred;
- ii. have sufficient time allocated to oversee the RTs who provide care in the level III NICU;
- iii. provide oversight of annual simulation and skills verification which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;
- iv. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs; and
- v. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.

Respiratory care practitioners assigned to the NICU will:

- i. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal and pediatric respiratory care certification preferred;
 - ii. be on-site 24/7 and immediately available to supervise assisted ventilation, assist in resuscitation, and attend deliveries;
 - iii. demonstrate a current status of NRP completion;
 - iv. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the NICU; and
 - v. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.
 - vi. provide neonatal/infant blood gas monitoring capabilities to support the management of respiratory and metabolic management.
- e. Therapy Services
- 1. The facility will provide on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family or psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served.
 - 2. The facility will have on-site access to the following neonatal therapists who have dedicated time allocated to serve the NICU:
 - 1. an occupational and/or physical therapist with sufficient neonatal expertise, and neonatal therapy certification preferred; and
 - 2. a speech language pathologist with neonatal expertise, skilled in the evaluation and management of neonatal feeding and swallowing concerns, and neonatal therapy certification preferred.
 - 3. The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal therapist coverage based on the specific need and volume of the neonatal population served.
- f. Dietician
- The NICU will have at least 1 full-time NICU-dedicated registered dietitian or nutritionist available on-site who has specialized training in neonatal nutrition and will:

1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;
2. establish policies and procedures to verify proper preparation and storage of human milk and formula;
3. participate in multidisciplinary care, including participation in patient care rounds; and
4. have policies and procedures for dietary consultation for infants in the NICU.

i. Neonatal Nutrition

The facility will:

1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk;
2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for human milk, donor human milk, fortification of human milk and formula; and
3. have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

ii. Lactation and Breastfeeding Support

The facility will:

1. have personnel with the knowledge and skills to support lactation available at all times;
2. have an IBCLC available for on-site consultation on weekdays and accessible by telehealth or telephone 24/7; and
3. operationally review IBCLC personnel on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.

iii. Clinical Nurse Staffing

A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.

iv. Clinical Nurse Staff

Each clinical nurse will:

1. be an RN, with nursing certification specific to the care environment preferred;
2. demonstrate a current status of NRP completion;
3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level III NICU; and
4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.

If the facility utilizes LPNs or non-licensed direct care providers to support the clinical nursing staff, the facility must:

1. have written criteria that define the LPNs' or non-licensed direct care providers' scope of neonatal care;
2. provide annual education specific to the care of the neonatal population served; and
3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.

v. Clinical Nurse Specialist

The clinical nurse specialist will :

1. be an RN, with neonatal nursing certification and clinical nurse specialist certification preferred;
2. have at least a Master of Science in Nursing, Doctorate preferred;
3. demonstrate a current status of NRP completion;
4. foster continuous quality improvement in nursing care;
5. develop and educate staff to provide evidence-based nursing care;
6. be responsible for mentoring new staff and developing team building skills;
7. provide leadership to multidisciplinary teams;
8. facilitate case management of high-risk neonatal patients; and
9. cultivate collaborative relationships with multidisciplinary team members and facility leadership to improve the quality of care and patient care outcomes.

The facility will have a dedicated full-time equivalent (FTE) allocated to perform the roles and responsibilities of the NICU clinical nurse specialist.

7. Stabilization and Resuscitation

- a. The facility shall develop, maintain, and enforce written policies, procedures, and guidelines for the stabilization and resuscitation of neonates, in accordance with current standards of professional practice.
- b. The facility shall ensure the availability of trained personnel capable of stabilizing distressed neonates.
- c. Staffing requirements for neonatal resuscitation shall include:
 1. Attendance by at least one individual, at the time of each birth, who holds current NRP certification (or Department-approved equivalent) and whose primary responsibility is neonatal management and resuscitation.
 2. At least one additional provider with full neonatal resuscitation skills - including endotracheal intubation, vascular access establishment, and administration of emergency medication – must be immediately available on-site.
 3. Additional personnel who maintain a current status of successful completion of the NRP or a Department-approved equivalent, must be on-site and immediately available upon request for the following:
 4. Multiple birth deliveries; to care for each neonate;
 5. Unanticipated maternal-fetal complications during labor and delivery;
 6. Deliveries identified or suspected to be high-risk for the pregnant patient or the neonate.
 4. Immediate on-site availability of all necessary resuscitative equipment, supplies, and medications.

5. Any deviations from these standards must be monitored through the Neonatal PI Plan, with reporting of variances to the Perinatal Multidisciplinary Committee

7. Neonatal Transport

If the facility has a neonatal critical care transport program, it will have an identified director of neonatal transport services. The director of neonatal transport services can be the NMD or another physician who is a pediatrician, board-eligible or certified neonatologist, pediatric hospitalist, or pediatric medical subspecialist with expertise and experience in neonatal and infant transport. If the facility does not have its own transport program, the facility must have policies and procedures in place to identify a local neonatal transport program to facilitate transport.

Responsibilities of the director of neonatal transport services include the following:

- i. Train and supervise staff;
- ii. Provide appropriate review of all transport records;
- iii. develop and implement policies and procedures for patient care during transport;
- iv. develop guidelines for determining transport team composition and medical control and establish a mechanism to track adherence;
- v. establish policies and procedures to provide transport updates and outreach education;
- vi. establish a program for evaluating performance by tracking data, identifying trends, and implementing quality improvement initiatives to address transport performance in a coordinated systematic approach within a culture of safety, equity, and prevention⁵; and
- vii. report neonatal transport data and neonatal-specific reviews back to the PI committee.
- viii. The director of neonatal transport services may delegate specific requirements to other person(s) or group(s) but retains the responsibility of certifying that these functions are addressed appropriately.

The facility will:

- i. establish minimum education, experience, and training requirements for all transport team members;
- ii. select transport team members based on their experience and competence in the care of neonates and the transport team must collectively have the ability to provide a level of care that is similar to that of the admitting unit; and
- iii. provide annual transport education to all transport team members that incorporates equipment training, didactic education, simulation, and skills

verification of low-volume, high-risk procedures consistent with the types of care provided during neonatal transport.

8. Support Services

- a. The neonatal program shall ensure the availability of personnel with specialized knowledge and skills in breastfeeding and lactation, to provide assistance and counseling to mothers at all times. Services shall include latch assessment, milk supply evaluation, and coordination with nutrition teams. An IBCLC should be available for on-site consultation on weekdays and accessible by telehealth or telephone at all times. IBCLC personnel should be operationally reviewed on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.

- b. Child Life Services

Child life services, or the equivalent, will be available for on-site consultation to support patient-and family-centered care by establishing and maintaining therapeutic relationships between patients, family members, multidisciplinary team members, and community resources.

- c. Social Worker

The NICU social worker will:

- 1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.

The facility will:

- 1. provide 1 social worker for every 30 beds providing level III neonatal care and/or specialty and subspecialty perinatal care;
- 2. have a written description that clearly identifies the responsibilities and functions of the NICU social worker; and
- 3. have social services available for each family with an infant in the NICU as needed.

- d. Pastoral Care

Personnel skilled in pastoral care will be available as needed and by family request, and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.

- e. Retinopathy of Prematurity

The facility must have process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having documented policies and procedures for the monitoring, treatment, and follow-up of

retinopathy of prematurity, and the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.8 Discharge Planning and Follow-Through Care

1. Systems will be in place to establish preparation for NICU discharge, including post-discharge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed.

The facility must have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with appropriate developmental follow-up services; as well as provide developmental follow-up services or have written referral agreement with a developmental follow-up clinical or practice, when possible, to provide neurodevelopmental services for the neonatal population served.

Follow-up outcomes are monitored via the Neonatal PI Plan to ensure continuity of care.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.9. Nursing Orientation and Education

1. Level IV NICU nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.
2. The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.
3. Annual nursing education will address the annual needs assessment and incorporate simulation and skill verification of low-volume, high-risk procedures consistent with the types of care provided in the Level IV NICU and include education related to serious safety events.

Clinical Nurse Educator

- a. The NICU clinical nurse educator will:

- i. Be an RN, with nursing certification specific to the care environment preferred;
 - ii. Have at least a Bachelor of Science in Nursing, Master's preferred;
 - iii. Demonstrate a current status of NRP completion;
 - iv. Cultivate collaborative relationships with the NPM and facility leadership to improve the quality of care and patient care outcomes; and
 - v. Have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level III neonatal care.
- b. The facility will have at least one dedicated FTE allocated to perform the roles and responsibilities of the NICU clinical nurse educator.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.10. Neonatal Outreach

The Level IV Neonatal Center will provide multidisciplinary outreach education to referring facilities by assessing educational needs and evaluating clinical care and outcomes, including transport data, as part of collaboration with lower-level neonatal facilities.

Source: Miss. Code Ann. § 41-3-15

Title 15 Mississippi State Department of Health

Part 3: Bureau of Acute Care Systems

Subpart 5: Mississippi Hospital Sustainability Program

Chapter 1 Mississippi Hospital Sustainability Grant Program Regulations

Subchapter 1 General

Legal Authority: In Section 1 of Senate Bill 2372, 2023 Regular Legislative Session (the “Mississippi Hospital Sustainability Grant Program”), the Mississippi Legislature designated the Mississippi State Department of Health (“MSDH”) to administer the Program for the purpose of strengthening, improving, and preserving access to hospital care services for all Mississippians and in recognition of the challenges incurred by hospitals as a result of the COVID-19 pandemic. Section 1 (4) of Senate Bill 2372, 2023 Regular Legislative Session, authorizes MSDH to adopt such reasonable rules as necessary for the administration of the program that allow for the management of this Program in compliance with applicable State and federal laws. This Program is being funded with a portion of the State of Mississippi’s American Rescue Plan Act’s (ARPA) State and Local Fiscal Recovery Fund (SLFRF) allocation. Accordingly, all programmatic rules and regulations must comply with U.S. Treasury’s regulations and guidelines regarding ARPA’s SLFRF.

Source: Senate Bill 2372, 2023 Regular Legislative Session

Rule 1.1.1 Definitions

1. “BACS” means the Bureau of Acute Care Systems, Mississippi State Department of Health.
2. “Beneficiary Agreement” means the instruments sent by the Department to Eligible Beneficiaries for certification of program requirements and binds the Eligible Beneficiary to all terms and conditions of the Program prior to release of funds.
3. “Coronavirus or COVID-19” means the Coronavirus Disease 2019.
4. “Critical Access Hospital” means a rural hospital designated by the Centers for Medicare and Medicaid Services (CMS) as a Critical Care Hospital and licensed as a Critical Care Hospital by HFLC.
5. “Department, the Department, or MSDH” means the Mississippi State Department of Health, as established by Miss. Code Ann. §43-3-1, *et seq.* (Rev. 2006).

6. “Eligible Beneficiary” means an entity defined in Section 1(iii) (a-f) of SB 2372 that has applied for funding by submitting a formal application through this Program and has demonstrated that it is in fact eligible to receive funds under SB 2372 based on the facts and data submitted with its application for funding. Entities eligible to apply include licensed hospitals in the State of Mississippi, including specialty hospitals recognized and licensed as such by HFLC. Hospitals owned and operated by the Department of Veterans Affairs and the State Department of Mental Health are NOT eligible to apply. No other entities except as expressly defined herein and in compliance with SB 2372 will be eligible to apply for funding under this Program.
7. “Emergency Department” means an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention that is available 24 hours per day seven days per week and approved by HFLC for such purpose.
8. “Frequently Asked Questions” means a listing of questions and answers related to the Program and potentially eligible expenses that can be found at <https://msdh.ms.gov/sustainabilitygrant>.
9. “HFLC” means the Bureau of Health Facilities Licensure and Certification, Mississippi State Department of Health.
10. “Licensed Bed” means the number of beds listed on the current hospital license issued by HFLC.
11. “Mississippi Hospital Sustainability Grant Program” means Senate Bill 2372, 2023 Regular Legislative Session.
12. “Operating Expenses” means an expense that a business incurs through its normal business operations.
13. “Program” means the “Mississippi Hospital Sustainability Grant Program” provided in Senate Bill 2372, 2023 Regular Legislative Session.
14. “Rural Hospital” means a licensed hospital in a Rural County Designation as determined by data from the U.S. Health Resources and Services Administration (HRSA) or a Metropolitan County Designation as listed under an exception for outlying counties that do not have any urbanized area population by HRSA and approved as such by HFLC.

15. “Specialty Services’ as used in these regulations refers to services provided at specialty licensed hospitals such as women’s health services, long-term acute care, rehabilitation or psychiatric services.

Source: Senate Bill 2372, 2023 Regular Legislative Session

Rule 1.1.2 Funding Formula for Eligible Beneficiaries

1. Eligible Beneficiaries may be eligible for funds up to a certain amount under this Program, following submission and evaluation of a formal application for funding, based upon the following initial funding criteria.
 - A. Each licensed hospital that has fewer than one hundred (100) licensed beds and that is not classified as a critical access hospital that operates an emergency department is eligible to receive up to Six Hundred Twenty-five Thousand Dollars (\$625,000) to defray the costs of providing emergency department services, if such hospital submits an application for funding with proof of negative economic impact as required by the Program Rules and Regulations. A hospital is not eligible to receive funding unless it has submitted a formal application with all required information and supporting documentation, and that application has been reviewed and deemed eligible under Program guidelines.
 - B. Each rural hospital that has fewer than one hundred (100) licensed beds and that is classified as a critical access hospital that operates an emergency department is eligible to receive up to Five Hundred Thousand Dollars (\$500,000) to defray the costs of providing emergency department services, if such hospital submits an application for funding with proof of negative economic impact as required by the Program Rules and Regulations. A hospital is not eligible to receive funding unless it has submitted a formal application with all required information and supporting documentation, and that application has been reviewed and deemed eligible under Program guidelines.
 - C. Each hospital that operates an emergency department and that has more than one hundred (100) licensed beds is eligible to receive up to One Million Dollars (\$1,000,000), if

such hospital submits an application for funding with proof of negative economic impact as required by the Program Rules and Regulations. A hospital is not eligible to receive funding unless it has submitted a formal application with all required information and supporting documentation, and that application has been reviewed and deemed eligible under Program guidelines.

D. Each hospital with fewer than two hundred (200) licensed beds with the majority of such beds being dedicated to providing specialty services such as women's health services, long-term acute care, rehabilitation, or psychiatric services is eligible to receive up to Five Hundred Thousand Dollars (\$500,000), if such hospital submits an application for funding with proof of negative economic impact as required by the Program Rules and Regulations. A hospital is not eligible to receive funding unless it has submitted a formal application with all required information and supporting documentation, and that application has been reviewed and deemed eligible under Program guidelines.

E. Each rural hospital with fewer than one hundred (100) licensed beds with no emergency department is eligible to receive up to Three Hundred Thousand Dollars (\$300,000) to defray the costs of providing access to hospital care in rural communities, if such hospital submits an application for funding with proof of negative economic impact as required by the Program Rules and Regulations. A hospital is not eligible to receive funding unless it has submitted a formal application with all required information and supporting documentation, and that application has been reviewed and deemed eligible under Program guidelines.

2. In addition to the funds listed above, each small rural hospital with fifty (50) beds or less which operated an emergency department is eligible to receive up to Two Hundred Fifty Thousand Dollars (\$250,000) to defray the costs of providing access to hospital care in rural communities, if such hospital submits an application for funding with proof of negative economic impact as required by the Program Rules and Regulations.

3. A hospital is not eligible to receive funding unless it has submitted a formal application with all required information and supporting documentation, and that application has been reviewed and deemed eligible under Program guidelines.
4. In the event funds remain available after the close of the Program's initial application period, and funding of all Eligible Beneficiaries, MSDH will work directly with the Mississippi Legislature to develop a plan for allocating any remaining program funds in compliance with federal regulations.

Source: Senate Bill 2372, 2023 Regular Legislative Session

Rule 1.1.3 Eligible Beneficiaries

Eligible Beneficiaries are those specifically outlined in SB 2372, Section 1 (iii) (a-f) as eligible to apply for funding under this program for an amount UP TO the amount outlined in the applicable portion of SB 2372, Section 1 (iii) (a-f).

In order to be considered for funding under this Program, an entity must (1) be defined as eligible to apply in SB 2372, Section 1 (iii) (a-f); (2) submit an application for funding with all required information and documentation within the initial application window; and (3) demonstrate through its application and supporting documentation that it experienced a financial harm as a result of the COVID-19 pandemic.

The Program will maintain Frequently Asked Questions on the Department website <https://msdh.ms.gov/sustainabilitygrant>.

Source: Senate Bill 2372, 2023 Regular Legislative Session

Rule 1.1.4 Required Application and Eligibility Documentation

1. The initial Program application window will open on June 1, 2023, and close at 11:59 pm CST on June 30, 2023.
2. As per the ARPA Final Rule, the use of ARPA funds must be reasonably proportional to the harm experienced. As such, applicants must submit revenue and operating expense data from the fiscal years 2017, 2018, and 2019 as compared to revenue and operating expenses for fiscal year 2022. Using the data from FYs 2017-2019, a pre-pandemic baseline will be determined. This will be compared to FY 2022 data to calculate the negative impact resulting from or exacerbated by the pandemic. FY 2021 data can be considered but only for periods beyond March 3, 2021, as required by ARPA guidelines. Data considered for FY 2021 must

be compared to the same time period from the pre-pandemic fiscal years (e.g., if the non-Federal entity operates on a calendar year basis, they may provide documentation showing data from April thru December 2021, but must show data for April thru December for FYs 2017-2019 in order to perform an accurate comparison). This data must demonstrate a clear negative impact resulting from or exacerbated by the pandemic.

3. Applicants must submit audited financial statements for FYs 2017-2019, 2021 (if applicable), and 2022 to support the revenue and operating expenses used in calculating the award. If audited or reviewed financial statements are not available, internally prepared financials may be provided but there may be additional procedures to be performed to ensure the validity of the data. This will be evaluated on a case-by-case basis.
4. Applicants will not be reimbursed for increased operating expenses that occurred before March 3, 2021.
5. Applicants will not be reimbursed for increased operating expenses previously reimbursed by any other State or Federal funding and will be required to certify that no other funding has been received in relation to the costs covered under this program. If additional funding has been received, it will be factored into the award calculation, as appropriate.
6. None of the funds issued under this program shall be used to pay employee premium payments.

Source: House Bill 271, 2023 Regular Legislative Session

Rule 1.1.5 Beneficiary Agreements

Beneficiary agreements will be sent by the Program to the attention of the Administrator listed for the Eligible Beneficiary hospital utilizing the most current address on file at HFLC for the hospital. (Hospitals should maintain accurate contact information with HFLC)

1. Prior to release of any Program funds all Eligible Beneficiaries will be required to certify, through a Beneficiary Agreement, that it understands and agrees to certain required provisions, including but not limited to, the following statements:
 - a. That the Eligible Beneficiary understands and agrees to follow and comply with the guidelines, guidance, rules, regulations and/or other criteria, as may be amended from time to time, by the United

States Department of the Treasury regarding the use of monies from the American Rescue Plan established by the ARP Act;

- b. That the Eligible Beneficiary understands and agrees to follow and comply with all provisions of the Program, including but not limited to, the Mississippi Hospital Sustainability Grant in Senate Bill 2372, 2023 Regular Legislative Session, and the Department Mississippi Hospital Sustainability Grant Program Rules and Regulations.
 - c. That, if the Eligible Beneficiary is found to be fully or partially noncompliant with any Program requirements, the Eligible Beneficiary agrees to return all or a portion any monies received from the Program to the Department, and the Eligible Beneficiary understands that it, or its legally responsible officials, may be subject to additional civil and criminal penalties.
 - d. That the Eligible Beneficiary certifies and acknowledges that by accepting reimbursement under this Program for negative economic impact as a result of the COVID-19 pandemic, it may be subject to additional monitoring, oversight, and/or auditing by the U.S. Department of Treasury's Office of the Inspector General, the Mississippi Office of the State Auditor, the Mississippi State Department of Health, or such other federal or state agencies with authority to conduct such reviews;
 - e. That the Eligible Beneficiary certifies it has not received and will not receive reimbursement for the expense in question from any other source of funds, including insurance proceeds.
 - f. The Beneficiary Agreement must be signed under penalty of perjury certifying that all responses and statements are true and correct and are not false, fraudulent, or materially misleading.
2. All supporting information requested in the Beneficiary Agreement must be provided. The failure to enter into the Beneficiary Agreement and agree to the required certifications and representations will result in the Eligible Beneficiary being disqualified from the Program.

Source: Senate Bill 2372, 2023 Regular Legislative Session

Rule 1.1.6 Return of funds

Any funds provided by the Department to a hospital as a beneficiary that are found to be fully or partially noncompliant with the requirements of the guidelines, guidance, rules, regulations and/or other criteria, as may be amended

from time to time, by the United States Department of the Treasury regarding the use of monies from the American Rescue Plan Act (ARPA) of 2021, Public Laws 117-2, Mississippi Hospital Sustainability Grant Program, or these rules and regulations shall be returned to the state.

Source: Senate Bill 2372, 2023 Regular Legislative Session

Rule 1.1.7 Appeals Process

1. An Eligible Beneficiary may appeal any award or disqualification notice received from the Department by giving written notice within ten (10) calendar days of the date of the notice of award decision. The appeal must be received by the Program at the address below by 5:00 p.m. CST of the 7th day.
2. If an appeal is not made within the seven (7) calendar day timeframe, the Eligible Beneficiary will have waived its right to appeal the decision and the original decision shall be deemed final. Appeals must be written and state with specificity the basis for the Eligible Beneficiary's disagreement with the decision. Appeals are determined solely on the written record. The appeal must attach copies of all documents, records, papers or other information to support the appeal. In addition, all appeals must be dated and contain the Eligible Beneficiary's name and the name of any authorized representative.
3. To be considered, the written appeal must be delivered by one of two methods: By United States Mail to the following address:
Mississippi State Department of Health
Mississippi Hospital Sustainability Grant Program – Appeals
Room O-434
P.O. Box 1700
Jackson, MS 39215-1700

Or by courier mail or hand delivery to the following:
Mississippi State Department of Health
Mississippi Hospital Sustainability Grant Program – Appeals
Room O-434
570 East Woodrow Wilson Avenue
Jackson, MS 39216
4. The Department will review the appeal and all supporting material to determine if the appeal can be resolved based upon the Eligible Beneficiary's submission and Program requirements. If so, a final written determination of the appeal will be issued by the Department.

5. If the appeal cannot be resolved after the initial review, the Department will forward the appeal for review by an Independent Hearing Officer (“IHO”), to be designated by the Attorney General of Mississippi. The Department will provide to the IHO the Eligible Beneficiary’s file, the appeal and all supporting material provided by the Eligible Beneficiary on appeal, all program requirements and policies, a Department explanation of the case, and Department’s recommendation (if any). The IHO will review all the written materials and issue a written recommendation to the Department. The Department will review and make a final written determination which will be issued by the Department to the Eligible Beneficiary within ten (10) days of the receipt of the IHO’s decision.
6. All appeal determinations made by the Department are final with no further administrative review and are not subject to judicial review.
7. An Eligible Beneficiary may withdraw an appeal at any time by providing written notice to the Department. Such written notice must be delivered to the Department at the addresses set forth above.
8. Program requirements established by the Department as dictated by federal and state law may not be waived or abrogated.

Source: Senate Bill 2372, 2023 Regular Legislative Session

Rule 1.1.8 Fraud Referrals

In cases in which fraud is suspected or where false or materially misleading information or documentation has been provided by an Eligible Beneficiary, a written referral will be made to the Mississippi State Auditor’s Office, the Office of the United States Attorney, or other appropriate federal or state agencies. The Department will cooperate fully in such investigations and provide all information and documentation which it has received or gathered on the Eligible Beneficiary.

Source: Senate Bill 2372, 2023 Regular Legislative Session

Rule 1.1.9 Waiver

The Mississippi Hospital Sustainability Grant Program Rules and Regulations may be amended by the Department at any time and are further subject to amendment pursuant to any change in the federal law providing for the grant funds and the regulations and guidance implemented related thereto. The Department, in its sole discretion, may temporarily waive any requirement of the Rules to the extent that the result of such waiver promotes the public purpose of the Mississippi Hospital Sustainability Grant Program created

through S.B. 2372 of the 2023 Regular Legislative Session and is not prohibited by state or federal law.

Source: Senate Bill 2372, 2023 Regular Legislative Session

Rule 1.1.10 Availability of Funds

This Program is contingent upon the availability of funds as appropriated by the Legislature and provided by the Federal government.

Source: Senate Bill 2372, 2023 Regular Legislative Session