

Region 2 North Trauma Network Application

Introduction

Regional Trauma Network Development

MDCH Administrative Rules R325.125 through R325.138 requires the submission of an application by the Medical Control Authorities (MCA) in a geographic region which integrates into the emergency preparedness region. Approval of the application by the Michigan Department of Community Health serves to formally recognize this entity as a Regional Trauma Network (RTN).

“Establish Regional Trauma Networks, consistent with current emergency preparedness regions, to provide system oversight of the trauma care provided in each region of the state.” R325.129 Rule 5 (k)

The application template that follows is an adaptation of the US Department of Health and Human Services (HRSA) *Model Trauma System Planning and Evaluation (2006)*. The application has adopted or adapted 20 of the HRSA indicators in order to initiate a regional evaluation of current trauma system status.

Application

Section 1 – Governance: Documentation that the regional network structure described in the administrative rules above has been addressed. The Regional Trauma Network structure and membership is considered provisional until the application is approved and the region is designated by the department.

Section 2- Work plan: Administrative Rule 325.132 requires that each regional network submit a comprehensive system development plan as a component of the application for recognition as a RTN. The following sections are devised as a means by which each RTN and its subcommittees, including the Regional Trauma Advisory Council (RTAC) and Professional Standards Review Organization (PSRO), can assess the current status of the region's trauma system and by which the State Trauma Advisory Committee (STAC) and Emergency Medical Services Coordinating Committee (EMSCC) may objectively review each application. After assessing each indicator, the RTN must write at least one SMART objective (specific, measurable, attainable, relevant, and time-bound) to address the indicator, with the understanding that progress towards a mature, fully functioning, all inclusive regional trauma system is the goal. The cumulative set of written objectives will then serve as the region's **initial** system development plan.

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The 10 required components of the Regional Trauma Network Plan are:

- 1) Injury prevention
- 2) Access to the system
- 3) Communications
- 4) Medical oversight
- 5) Pre-hospital triage criteria
- 6) Trauma diversion policies
- 7) Trauma bypass protocols
- 8) Regional trauma treatment guidelines
- 9) Regional quality improvement plans
- 10) Trauma education

Upon completion, each RTN application will have an assessed score. Scoring of the assessment provides a means for each RTN to individually track progress over time. The assessment score is meant only to assess and track the status of each individual region; assessment scores will not be used to compare and/or rank RTN status or progress against each other. Renewal applications are expected to show progress in system development reflected in additional and more mature objectives.

Application Scoring

All Regional Trauma Network applications will be submitted to the Statewide Trauma Advisory Committee (STAC) for scoring and comments. STAC will utilize the HRSA model which describes trauma system indicators and offers a scoring process: meeting the highest score (5) in every indicator would describe a mature highly functioning trauma system. Each RTN, with the advice of the RTAC, should realistically assess the current status of the region's trauma care system, using the 0-5 scoring scale, in order to arrive at a baseline score. The current score should suggest the gap between the system's current status and a desirable for subsequent assessment.

Scoring the 10 System Components

Benchmarks are global goals, expectations or outcomes that refer to the components of the trauma system plan. In scoring the trauma system, a benchmark identifies a broad system attribute.

Indicators are the tasks or outputs that characterize the benchmark. Indicators identify actions or capacities within the benchmark and are the measurable components of the benchmark.

Scoring reduces the indicator to action steps. The score offers an assessment of the current status, and subsequent scoring will mark progress over time in reaching a desirable benchmark.

Within each of the 10 *functions* there are a variety of potential benchmarks based, to the extent possible, on HRSA guidelines for model trauma system planning. For each of the 10 functions, a number of descriptive *indicators* further define the function's potential benchmark and a score for each indicator to assist in identifying efforts, progress, compliance, or any combination of these. Each indicator contains a scoring "mechanism" of ordered statements to assist in assessing progress to date.

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The following criteria are used to assess the region’s conformance to the indicator:

Score	Progress Scoring
0	Not known
1	No
2	Minimal
3	Limited
4	Substantial
5	Full

The table below is an example of how the above criteria are used to assess trauma system progress for a specific indicator.

Example of Progress Scoring

Indicator: A thorough description of the epidemiology of injury in the region exists, using both population-based data and clinical data bases.

Score	Criteria
0	The scorer does not know enough about the indicator to evaluate it effectively.
1	There is no detailed analysis of injury mortality.
2	Death certificate data have been used to describe the incidence of trauma deaths aggregating all etiologies, but no E-code reporting is available.
3	Death certificate data, by E-code, are reported on a statewide basis, but are not reported regionally.
4	Death certificate data, by E-code, are reported on a statewide and regional basis. These data are compared to national benchmarks, if available.
5	Death certificate data, by E-code, are used as part of the overall assessment of trauma care both statewide and regionally, including rural and urban preventable mortality studies.

In this example, the region should review the listed criteria and select the one that best describes its current ability to describe injury mortality, ranging from none (0) in neophyte systems to the ability to accurately describe preventable deaths (5) occurring with the trauma care system of the most mature trauma systems. A median score of 3 would indicate that there is evidence of limited, but demonstrable, progress in meeting the expectation.

Although the scoring mechanism provides a quantitative descriptor of each indicator, and the region in general, the scoring process has limitations:

- The benchmarks focus on process measures, not outcomes. The assumption is that meeting these process measures will result in improved outcomes.
- The evaluation method relies on the qualitative judgments of the region’s evaluators.

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- The regions are cautioned not to draw conclusions from the numerical “score”. Because the scale points are not discrete points on an ordered scale it is not possible to state that a 4 is twice as good as a 2. The score only denotes relative progress in achieving the benchmark.
- The benchmarks and indicators are not comprehensive. As the document evolves these are expected to change.

The application’s scoring tool is intended to help each region meet the trauma system development plan requirement of the administrative rules, and to assist the regions in identifying individual strengths and weaknesses, prioritize actions and measure progress against itself over time

Michigan has had limited opportunity to fully address these indicators in a systemic fashion, so each regional trauma network should expect their average indicator scores to be within the range of 1-3. The expectation for this initial application is that the evaluation of each region’s indicators will drive a systems approach for outlining the governance, goals, objectives, strategies and timelines that address each indicator, and that the region will build on them in a systematic, foundational way until the system maturity is reached.

Filing Instructions

The application must be completed, typed and signed. An application checklist has been included in the application packet to facilitate the process. Applications may be submitted by mail or electronically.

Electronically: <i>Gary Canfield</i>	Mail: Michigan Department of Community Health
Subject line: Region_2N___ Trauma Network Application	Bureau of Legal Affairs
To: wordene@michigan.gov	Crime Victims, EMS and Trauma Division
	Attention: Eileen Worden, State Trauma Manager
	201 Townsend Street 6 th Floor
	Capitol View Bld.
	Lansing MI 48913

Administrative Rules require that a letter be mailed to the region by the Michigan Department of Community Health within 90 days of receipt of the application. Please provide the name and address (include email) of the Regional representative who will receive the letter.

Letter recipient: **Region 2 North Trauma Network**

Name: **Gary Canfield**

Address: **19176 Hall Rd. Suite 240, Clinton Township Michigan 48038**

Email: **gary.canfield@mcemsmca.org**

For questions please contact Eileen Worden wordene@michigan.gov (517) 241-3020 or your Regional Trauma Coordinator see www.michigan.gov/ems for contact information.



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System Governance: Each region shall establish a regional trauma network. All Medical Control Authorities within a region must participate in a regional network and life support agencies shall be offered membership on the regional trauma advisory council. Regional trauma advisory committees shall maximize the inclusion of their constituents. The regional trauma network establishes a process to assess, develop and evaluate the trauma system in cooperation with the regional stakeholders in trauma care.

Current scoring status indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3) 202.2	The RTN has developed and implemented a multi-disciplinary, multi-agency Regional Trauma Advisory Council to provide overall guidance for trauma system planning and implementation. The committee meets regularly and is responsible for providing guidance to the RTN.	0. Not known. 1. There is no multi-disciplinary, multi-agency RTAC to provide guidance to the RTN. 2. An RTAC has not been appointed, and attempts to organize one have not been successful but are continuing. 3. The RTAC has been appointed, but its meetings are infrequent, and the RTN has not always sought its guidance or the RTAC is not active. Collaborative working arrangements have not been realized. 4. The RTAC is active and members regularly attend meetings. Collaboration and consensus are beginning. 5. The RTAC is active and has well defined goals and responsibilities. It meets regularly and has the support of the RTN. The RTAC routinely provides assistance and guidance to the RTN on system issues and responsibilities. The RTAC has multiple subcommittees that meet as needed to resolve specific system issues and to report back to the RTAC and RTN. There is strong evidence of consensus building among system participants.
325.132(3)(c)(i) 202.3	A clearly defined and easily understood governance and communication structure is in place for regional trauma system operations.	0. Not known. 1. There is no defined structure (written process) for the RTN or committees. 2. There is an informal process for operations that the RTN uses when convenient, although not regularly or consistently. 3. The regional governance structure and communication pathways are defined within the RTN bylaws, although the process has not been fully implemented. 4. The regional governance structure and communication pathways are defined in the bylaws, and there are policies and procedures to guide system operations. Use of this process is infrequent. 5. There are clearly defined structure and communication pathways for the region. The regional operation is articulated in the bylaws and maximizes the inclusion of the regional stakeholders in trauma care.

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving system governance in the next calendar year.

2013 - 2014 System Governance Objective(s):



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Indicator #1: *RULE HRSA #: 325.132(3)202.2*

Objectives:

- 1.) **By November, 2014 the RTAC will have implemented a regular meeting schedule and will be actively providing assistance and guidance of the RTN activities through active sub-committees.**
- 2.) **During the 2015 and 2016 application period, the RTAC and RTN will work together and use collected data, performance evaluation and assessments to identify and prioritize and address any issues that may occur in the region. Progress will be reported in the annual report and shared with the stake holders.**

Indicator #2: *Rule HRSA # 325.132(3)(c)(i)202.3*

Objectives:

- 1.) **By November, 2014 the governance structure and communication pathways will be demonstrated through organizational charts and those procedures will have been implemented in accordance with the R2N by-laws.**
- 2.) **During the 2015 and 2016 application period, the RTN with guidance from the RTAC will work to further the inclusion of all of the stakeholders in the region in the trauma care process. The RTN will accomplish this through regular meetings with the various stakeholders as evidenced through meeting minutes, agendas and attendance records submitted in the annual reports.**

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Injury Prevention: The RTN, in cooperation with other agencies and organizations, uses analytical tools to monitor the performance of population-based (regional) injury prevention programs.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(A) 306.2	The RTN is active within the region in the monitoring and evaluation of community-based injury prevention activities and programs.	0. Not known. 1. The RTN does not actively participate in the monitoring and evaluation of injury prevention activities and programs in the region. 2. The RTN does some minimal monitoring and evaluation of injury prevention activities and programs in the region. 3. The RTN monitors and evaluates injury prevention activities and programs in the region. 4. The RTN is an active participant in injury prevention programs in the region, including the evaluation of program effectiveness. 5. The RTN is integrated with injury prevention activities and programs in the region. Outreach efforts are well coordinated and duplication of effort is avoided. Ongoing evaluation is routine and data are used to make program improvements.
325.132(3)(c)(ii)(A) 203.5	The RTN has developed a written injury prevention and control plan that is coordinated with other agencies and community health programs in the region. The injury prevention program is data driven and targeted programs are developed based upon high injury risk areas. Specific goals with measurable objectives are incorporated into the injury prevention plan.	0. Not known. 1. There is no written plan for coordinated injury prevention programs within the region. 2. Although the RTN has a written injury prevention and control plan, it is not fully implemented. There are multiple injury prevention programs within the region that may compete with one another, or conflict with the goals of the regional trauma system, or both. 3. There is a written plan for coordinated injury prevention programs within the region that is linked to the regional trauma system plan, and that has goals and time-measurable objectives. 4. The regional injury prevention and control plan is being implemented in accordance with established objectives, timelines and the region is collecting data. 5. The injury prevention plan is being implemented in accordance with established timelines. Data concerning the effectiveness of the injury prevention programs are being collected and are used to validate, evaluate, and modify the program.

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Include at least one specific, measurable, attainable, relevant and time-bound objective for improving injury prevention in the next calendar year.

2013 – 2014 Injury Prevention Objective(s):

Indicator #1: *Rule HRSA # 325.132(3)(c)(ii)(A)306.2*

Objectives:

- 1.) **By November, 2014 the RTN, working with the Injury Prevention Sub-committee of the RTAC will develop the tools to identify Injury Prevention program activities within the region and begin collecting data. The data collected will include; the population served evaluations of the individual programs and the long term effects to change in Mechanism of Injury.**

Indicator #2: *Rule HRSA # 325.132(3)(c)(ii)(A)203.5*

Objectives:

- 1.) **By November, 2014 the RTN will establish an Injury Prevention sub-committee within the RTAC, to identify the injury prevention programs within the region and to develop a written plan to coordinate the injury prevention program activities. The plan will include a method of collecting data to measure the success of the individual programs and to develop additional programs that are needed and methods to improve the existing programs.**
- 2.) **During the 2015 and 2016 application period the RTN will have the written Injury Prevention plan implemented and under the direction of the RTAC Injury Prevention sub-committee continue to collect data and measurement of success of the plan by evaluation of changes in the mechanism of injury in the region.**

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Citizen access to the trauma system: The trauma system is supported by EMS medical oversight of dispatch procedures and coordinated response resources.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(B) 302.4	The trauma system EMS medical directors are actively involved with the development, implementation, and ongoing evaluation of EMS system dispatch protocols to ensure they are congruent with the trauma system design. These protocols include, but are not limited to, which resources to dispatch (ALS v BLS), air-ground coordination, early notification of the trauma facility, pre-arrival instructions, and other procedures necessary to ensure dispatched resources are consistent with the needs of injured patients.	<ul style="list-style-type: none"> 0. Not known. 1. There are no trauma specific regional EMS dispatch protocols. 2. Trauma dispatch protocols have been adopted independent of the design of the regional trauma system. 3. Regional trauma specific dispatch protocols have been adopted and are not in conflict with the trauma system design, but there has been no effort to coordinate the use of the protocols with the RTN or trauma centers. 4. Regional trauma specific dispatch protocols have been developed in close coordination with the RTN and are congruent with regional trauma system design. 5. Regional trauma specific dispatch protocols have been developed in close coordination with the RTN and are congruent with the regional trauma system design. There are established procedures to involve dispatchers and their supervisors in trauma system performance improvement and a “feedback loop” to change protocols or to update dispatcher education when appropriate.
325.132(3)(c)(ii)(B) 302.8	There are sufficient, well-coordinated air and ground ambulance resources to ensure that EMS providers arrive at the trauma scene to promptly and expeditiously transport the patient to the correct hospital by the correct transportation mode.	<ul style="list-style-type: none"> 0. Not known. 1. There is no regional coordination of transportation resources. Air or ground ambulances from multiple jurisdictions can all arrive on the trauma scene unannounced. 2. Each medical control authority has a priority dispatch system in place that sends appropriate transportation resources to the scene. 3. Each medical control authority has a priority dispatch system that ensures appropriate resources arrive on scene promptly to transport patients to the hospital. A plan for transporting trauma patients to the hospital has been completed. 4. Each medical control authority has a priority dispatch system that ensures appropriate system resources for prompt transport of trauma patients to trauma centers. A trauma transport plan has been implemented. System issues are evaluated, and corrective action plans are implemented as needed. 5. Region wide priority dispatch has been established. The dispatch system regularly assesses its ability to get the right resources to the scene and to transport patients by using the correct mode of transportation. The priority dispatch system is integrated into the overall EMS and trauma system.

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Include at least one specific, measurable, attainable, relevant and time-bound objective for improving citizen access to the trauma system in the next calendar year.

2013 – 2014 System Access Objective(s):

Indicator #1: *Rule HRSA # 325.132(3)(c)(ii)(B)302.4*

Objectives:

- 1.) **By November 2014, regional, trauma specific dispatch protocols will have been developed by sub-committees of the RTAC, presented to the state for approval and adopted by the individual MCA's to fit the trauma system design and efforts to implement the protocols with the cooperation of the RTN and trauma centers will be underway.**
- 2.) **During the 2015 and 2016 application period the RTN will have the Regional Trauma dispatch protocols implemented. Adherence to the protocols by providers will be monitored to ensure congruence with regional trauma system design. In collaboration with the MCA's protocol implementation will be evaluated and methods to address barriers and challenges will be considered.**

Indicator #2: *Rule HRSA # 325.132(3)(c)(ii)(B)302.8*

Objectives:

- 1.) **By November, 2014 the regional plan will be written by a sub-committee of the RTAC. The plan will consolidate the transport plans of the MCA's into a single regional transport plan with sub-divisions of the MCA plans. The plan will include a method to evaluate the effectiveness of the system so that any corrective actions that are deemed necessary may be implemented.**
- 2.) **During the 2015 and 2016 application period, the regional transport plan will be under continuous evaluation for effectiveness and efficiency and to ensure that the proper resources are dispatched to the scene. Over and under triage will be used as an evaluation metric to gauge the effectiveness of the protocols. Any improvements or necessary changes that are identified through evaluation of the system will be made and implemented**

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Trauma system communications: The regional trauma system is supported by a coordinated communication system linking and integrating hospitals, life support agencies, the EMS system and the Regional Trauma Network.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(C) 302.10	There are established procedures for EMS and trauma system communications for major EMS events or multiple jurisdiction incidents-that are effectively coordinated with the overall regional response plans.	0. Not known. 1. There are no written procedures for regional EMS and trauma systems communications for major EMS events or multiple jurisdiction incidents. 2. Local medical control authorities have written procedures for EMS communications during major events. However, there is no coordination among the adjacent local jurisdictions. 3. There are written regional EMS communications procedures for major EMS events. These procedures do not involve other jurisdictions and are not coordinated with the overall regional response plans or incident management system. 4. There are written regional EMS communications procedures for major EMS events and multiple jurisdiction incidents that are coordinated with adjacent jurisdictions, with the overall regional response plan and with the incident management system. 5. There are written regional EMS communications procedures for major EMS events and multiple jurisdiction incidents that are coordinated with the overall regional response plan and with the incident management system. There are one or more system redundancies. These procedures are regularly tested in simulated incident drills, and changes are made in the procedures based on drill results, if needed.
325.132(3)(c)(ii)(C) 302.9	There is a procedure for communications among medical facilities when arranging for inter-facility transfers including contingencies for radio or telephone system failure.	0. Not known. 1. There are no specific communications plans or procedures to ensure communication among medical facilities when arranging for inter-facility patient transfers. 2. Inter-facility communication procedures are generally included in patient transfer protocols for each medical facility but there is no regional procedure. 3. There are uniform, regional communication procedures for arranging patient transfers, but there are no redundant procedures in the event of communication system failure. 4. There are uniform, regional communication procedures for arranging patient transfers and there are redundant procedures in the event of communication system failure. 5. There are uniform, regional communication procedures for arranging patient transfers and there are redundant procedures in the event of communication system failure. The effectiveness of these procedures is regularly reviewed and changes made based on the performance review, if needed.

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving regional communication in the next calendar year.

2013 – 2014 Communication Objective(s):



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Indicator# 1: *Rule HRSA # 325.132(3)(c)(ii)(C)302.10*

Objectives:

- 1.) **By November 2014 a *written regional* protocol for EMS system communications that will consolidate the written plans of the Region 2 North MCA's. The plan will identify the existing procedures within the region and coordinate those plans to meet the regional requirements. Incidents that include multiple jurisdictions will be addressed within the plan and procedures will be established.**
- 2.) **During the 2015-2016 application periods, the written plan will be implemented and evaluated on a scheduled basis to identify any problems or issue. The RTAC will be providing guidance to the RTN to make corrections of any issues that are identified.**

Indicator #2: *Rule HRSA # 325.132(3)(c)(ii)(C)302.9*

Objectives:

- 1.) **By November, 2014 the RTN under the guidance of the RTAC will have identified and consolidated the existing plans for inter-facility communications and have established a written regional plan. The procedures for communication in the event of a system failure will be established and will be in the implementation process.**
- 2.) **During the 2015 and 2016 application period the RTN will under the guidance of the RTAC monitor the procedures in the written regional plan to evaluate the effectiveness of the plan developed for inter-facility transfer communications to ensure that the plan is working and any necessary corrective actions that are identified will be implemented.**

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Medical Oversight: The regional trauma system is supported by active EMS medical oversight of trauma communications, pre-hospital triage, treatment, and transport protocols.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(D) 302.1	There is well defined regional trauma system medical oversight integrating the specialty needs of the trauma system the medical oversight of the overall EMS system.	0. Not known. 1. Medical oversight of EMS providers caring for trauma patients is provided by local medical control authorities, but is outside of the purview of the regional trauma system. 2. EMS and trauma medical directors collaborate in the development of protocols for pre-hospital providers providing care to trauma patients. 3. The RTN has adopted state approved regional trauma protocols. 4. The regional trauma system has integrated medical oversight for pre-hospital providers and evaluates the effectiveness of both on-line and off-line medical control. 5. The EMS and regional trauma system fully integrate the medical oversight processes and regularly evaluate program effectiveness by correlating data with optimal outcomes. Pre-hospital EMS providers from the region are included in the development of medical oversight procedures.
325.132(3)(c)(ii)(D) 302.2	There is a clearly defined, cooperative, and ongoing relationship between regional trauma physician leaders and the EMS system medical directors in the region.	0. Not known. 1. There is no formally established, ongoing relationship between the individual trauma medical directors and the EMS system medical directors. There is no evidence of informal efforts to cooperate or communicate. 2. There is no formally established, ongoing relationship between the individual trauma medical directors and the EMS system medical directors. However, the trauma medical directors and EMS medical directors informally communicate to resolve problems and coordinate efforts. 3. Trauma medical directors or designated trauma representatives participate in EMS oversight through participation in local medical control authority meetings. However, there is no formal written relationship. 4. There is a formal, written procedure delineating the responsibilities of individual trauma center medical directors and EMS system medical directors that specifies the formal method for cooperation. However, implementation is inconsistent. 5. There is a formal, written procedure delineating the responsibilities of individual trauma center medical directors and EMS system medical directors that specifies the formal method for cooperation. There is written documentation (minutes) indicating this relationship is regularly used to coordinate efforts.

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving medical oversight in the next calendar year.

2013 – 2014 Medical Oversight Objective(s):



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Indicator #1: *Rule HRSA # 325.132(3)(c)(ii)(D)302.1*

Objectives:

- 1.) **By November 2014 the EMS and Trauma Medical Directors will have a written Regional Trauma protocols for pre-hospital provider treatment and care of trauma patients submitted for approval by the state and once approved adopted by the Regional MCA's.**
- 2.) **During the 2015 and 2016 application period the RTN with the cooperation of the regional medical oversight committee will develop a system to evaluate the protocol and work together to implement any improvements that are necessary to optimize the efficiency of patient care and transport.**

Indicator #2: *Rule HRSA # 325.132(3)(c)(ii)(D)302.2*

Objectives:

- 1.) **By November 2014 the RTN Trauma Medical Directors and/or the Trauma Representatives will have begun participating in regional medical oversight and will be developing a relationship with the local Medical Control Authorities through participation in local Medical Control Authority meetings.**

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Pre-hospital Triage Criteria: The regional trauma system is supported by system-wide pre-hospital triage criteria.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(E) 302.6	The region has adopted mandatory regional pre-hospital triage protocols to ensure that trauma patients are transported to an appropriate trauma center based on their injuries. The triage protocols are regularly evaluated and updated to ensure acceptable and region-defined rates of sensitivity and specificity for appropriate identification of a major trauma patient.	0. Not known. 1. There are no mandatory regional triage criteria to ensure trauma patients are transported to the most appropriate trauma facility. 2. <i>There are different triage criteria used by different providers. Appropriateness of triage protocols and subsequent transportation are not evaluated for sensitivity or specificity.</i> 3. Regional triage criteria are used by all pre-hospital providers. There is no current process in place for evaluation. 4. The regional triage criteria are used by all pre-hospital providers. There is region-wide evaluation of the effectiveness of the triage criteria in identifying trauma patients and in ensuring that patients are transported to the appropriate trauma facility. 5. Region participants routinely evaluate the triage criteria for effectiveness. There is linkage to performance improvement processes, and the over- and under- triage rates of the criteria are regularly reported through the RTN. Updates to the triage protocols are made as necessary to improve system performance.

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving trauma triage criteria in the next calendar year.

2013 – 2014 Trauma Triage Criteria Objective(s):

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Indicator: *Rule HRSA # 325.132(3)(c)(ii)(E)302.6*

Objectives:

- 1.) There are currently Trauma Triage Protocols written and in use in each of the MCA's in the region. By November, 2014 written evidence based Regional Trauma Triage Protocol that also meets the criteria of the individual Trauma Triage Protocols of the regional MCA's will have been developed and submitted for approval.
- 2.) During the 2015 and 2016 application period the RTN will work with the RTAC and the RTAC sub-committee to implement the approved Regional Protocol and through data collection and evaluation of the outcome of the trauma patients determine if all are triaged appropriately and transported to the appropriate facilities for optimal care.

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Trauma Diversion Policies: Diversion policies ensure that acute care facilities are integrated into an efficient system to provide optimal care for all injured patients.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(F) 303.2	The regional trauma network plan should ensure that the number, levels, and distribution of trauma facilities are communicated to all partners and stakeholders. The RTN should develop procedures to insure that trauma patients are transported to an appropriate facility that is prepared to provide care.	0. Not known. 1. There is no regional plan to identify the number, levels, and distribution of trauma facilities. There is no regional diversion protocol. 2. There is a regional system plan and a diversion protocol but they do not identify the number, levels or distribution of trauma facilities in the region. The plan and protocol are not based on available data. 3. There is a regional system plan and a diversion protocol that identifies the number, levels and distribution of trauma facilities. System updates using available data not routine. 4. There is a regional system plan and a diversion protocol that identifies the number, levels and distribution of trauma facilities based on available data. However, the regional plan and diversion protocol is not used to make decisions about trauma facility designations. 5. There is a regional system plan that identifies the number and levels of trauma facilities. The plan is used to make decisions about trauma center diversion procedures. The plan accounts for facility resources and geographic distribution, population density, injured patient volume, and transportation resource capabilities and transport times. The plan is reviewed and revised periodically.
325.132(3)(c)(ii)(F) 205.3	The state trauma registry is used to identify and evaluate regional trauma care and improve the allocation of resources.	0. Not known. 1. All trauma facilities in the region are not entering data into state registry. Regional data from state trauma registry is limited. 2. There is limited access to the state trauma registry. Data extraction is not available to evaluate performance or improve resource allocation. 3. All trauma facilities in the region enter data into the state trauma registry but data are not being used to improve the system. 4. The RTN uses the state trauma registry to routinely report on system performance and resource utilization and allocation. 5. State trauma registry reports are used extensively to improve regional trauma care and efficiently allocate trauma resources. The RTN uses these reports to determine deficiencies and allocate resources to areas of greatest need. System performance compliance with standards are assessed and reported.

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving trauma diversion policies in the next calendar year.



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2013 – 2014 Trauma Diversion Policy Objective(s):

Indicator #1: *Rule HRSA # 325.132(3)(c)(ii)(F)303.2*

Objectives:

- 1.) By November 2014 the RTN will have identified all regional facilities by their trauma levels, their system verification and designation approval and will have established a regional system plan for diversion that consolidates the information and protocols of the MCA's in the region.
- 2.) During the 2015 and 2016 application period the RTN will have a written protocol submitted for approval and through data collection will be in the evaluation process to ensure that the patients are being transported to the appropriate trauma facilities.

Indicator #2: *Rule HRSA # 325.132(3)(c)(ii)(F)205.3*

Objectives:

- 1.) By November 2014 the RTN will develop a method to monitor, support and track data entry into the state trauma registry. A plan will be developed and implemented to extract the data for use in system improvements.
- 2.) During the 2015-2016 application periods the data collection plan will be evaluated for effectiveness and corrections made as necessary to ensure that data input is meeting the requirements of the plan and actions will be taken to correct any issues that are identified.

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Trauma Bypass Protocols: The roles, resources and responsibilities of trauma care facilities are integrated into a resource efficient, inclusive network that meets standards and provides optimal care for injured patients.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(G) 303.1	The regional trauma plan has clearly defined the roles, resources and responsibilities of all acute care facilities treating trauma, and of facilities that provide care to specialty populations (spinal cord injury, burns, pediatrics, other).	0. Not known. 1. There is no regional plan that outlines roles, resources and responsibilities of all acute care facilities treating trauma and/or of facilities providing care to specialty populations. 2. There is a regional trauma system plan, but it does not address the roles, resources and responsibilities of licensed acute care facilities and/or specialty care facilities. 3. The regional trauma plan addresses the roles, resources and responsibilities of licensed acute care facilities (hospitals) only, not spinal cord injury, pediatrics, burns or others. 4. The regional trauma plan addresses the roles, resources and responsibilities of licensed acute care facilities and specialty care facilities. 5. The regional trauma plan clearly defines the roles, resources and responsibilities of all acute care facilities treating trauma within the region. Specialty care services are addressed within the plan, and appropriate policies and procedures are implemented and tracked.
325.132(3)(c)(ii)(G) 303.4	There is a regional trauma bypass protocol that provides EMS guidance for bypassing a trauma care facility for another more appropriate trauma care facility.	0. Not known. 1. There is no regional trauma bypass protocol to provide pre-hospital guidance about when to bypass an acute care facility for a more appropriate facility. 2. There is a regional bypass protocol that allows bypass of an acute care facility, but does not provide guidance for what the more appropriate facility may be. 3. There is a regional bypass protocol that provides EMS guidance for bypassing an acute care facility for a more appropriate trauma care facility and provides guidance on the levels of each facility in the region. 4. There is a regional bypass protocol that allows bypass of an acute care facility and provides guidance on what the most appropriate facility is based on the patient's injury. 5. The regional bypass protocol clearly defines the process for bypassing an acute care facility for another trauma facility more appropriate for the patient's injuries. Incidents of trauma facility bypass are tracked and reviewed regularly, and protocol revisions are made as needed.

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving trauma bypass protocols in the next calendar year.



Region 2 North Trauma Network Application

2013 – 2014 Trauma Bypass Protocol Objective(s):

Indicator #1: *Rule HRSA # 325.132(3)(c)(ii)(G)303.1*

Objectives:

- 1.) **By November 2014 the RTN, will have completed an assessment of existing regional facilities and their capabilities that clearly defines the roles, resources and responsibilities of all licensed acute and specialty care facilities that operate within the region.**

Indicator #2: *Rule HRSA # 325.132(3)(c)(ii)(G)303.4*

Objectives:

- 1.) **By November of 2014 the RTN, with assistance from the RTAC sub-committee will have developed and submitted for state approval a Regional By-Pass Protocol to guide the EMS providers operating in the region with specific criteria addressing the by-pass of a facility for a more appropriate level of trauma care facility.**
- 2.) **During the 2015 and 2016 application period the By-pass protocol will be evaluated for efficiency and effectiveness to deliver optimal patient care. Any areas that are identified as being ineffective will be addressed and modified under the direction of the RTAC and the RTAC sub-committee.**

Region 2 North Trauma Network Application

Regional Trauma Treatment Guidelines: The regional trauma network ensures optimal patient care through the development of regional trauma treatment guidelines.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(H) 303.4	When injured patients arrive at a medical facility that cannot provide the appropriate level of definitive care, there is an organized and regularly monitored system to ensure that the patients are expeditiously transferred to the appropriate, system-defined trauma facility.	0. Not known. 1. There is no existing process in the region for collecting data on and regularly reviewing the conformity of inter-facility transfers within the trauma system according to pre-established procedures. 2. There is a fragmented system within the region, usually event based, to monitor inter-facility transfer of trauma patients. 3. The regional system for monitoring inter-facility transfers is new, the procedures are in place, but training has yet to occur. 4. The region has an organized system for monitoring inter-facility transfers. 5. The monitoring of trauma patient inter-facility transfers is integrated into the overall program of system performance improvement. When the system identifies issues for correction, a plan of action is implemented.
325.132(3)(c)(ii)(H) 205.2	Collected data from a variety of sources are used to review the appropriateness of all-inclusive regional trauma performance standards, from injury prevention through rehabilitation.	0. Not known. 1. There are no written, quantifiable regional system performance standards or performance improvement processes. 2. There are written, quantifiable regional system performance standards for each component of the regional trauma system that conform to standards outlined in the Administrative Rules. 3. The RTN has adopted written, quantifiable regional system performance standards. 4. The RTN routinely uses data from multiple sources to assess compliance with regional system performance standards. 5. The RTN uses regional system compliance data to design changes or make other system refinements. There is routine and consistent feedback to all system providers to ensure that data-identified deficiencies are corrected.

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving regional trauma treatment guidelines in the next calendar year.

2013 – 2014 Regional Trauma Treatment Guidelines Objective(s):



Region 2 North Trauma Network Application

Indicator #1: *Rule HRSA # 325.132(3)(c)(ii)(H)303.4*

Objectives:

- 1.) **By November 2014 the RTN will have developed a guidance document for monitoring current inter-facility transfers of trauma patients and data will be collected to measure the frequency of transfers to ensure that the procedures are appropriate for optimal patient care.**

Indicator #2: *Rule HRSA # 325.132(3)(c)(ii)(H)205.2*

Objectives:

- 1.) **By November 2014 the RTN will have established and adopted written, quantifiable regional performance standards as subscribed in the administrative rules and collect data to address performance metrics.**

Region 2 North Trauma Network Application

Regional Quality Improvement Plans: The RTN/RTAC uses system data to evaluate system performance and regularly reviews system performance reports to develop regional policy.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(I) 206.1	No less than once per year, the RTN generates data reports that are disseminated to all trauma system stakeholders to evaluate and improve system performance.	0. Not known. 1. The RTN does not generate trauma data reports for evaluation and improvement of system performance. 2. <i>Some general trauma system information is available to stakeholders, but it is not consistent or regular.</i> 3. Regional data reports are done on an annual basis, but are not used for decision-making and/or evaluation of system performance. 4. Routine reports are generated using regional trauma data and other databases so that the system can be analyzed, standards evaluated, and performance measured. 5. Regularly scheduled reports are generated from regional trauma data and are used by the stakeholder groups to evaluate and improve system performance effectiveness.

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving regional quality improvement plans in the next calendar year.

2013 – 2014 Regional Quality Improvement Plan Objective(s):

Indicator: *Rule HRSA # 325.132(3)(c)(ii)(I)206.1*

Objectives:

- 1.) **By November 2014 the RTN will have established a system for collecting data from the trauma information systems for the purpose of evaluation and analyses of system performance for the purpose of improving the regional system of patient care.**
- 2.) **During the 2015 and 2016 application period routine data collection will occur and data will be evaluated for system performance and measures taken to improve the overall performance of the trauma system in the region.**

Region 2 North Trauma Network Application

Trauma Education: The regional trauma network ensures a competent workforce through trauma education standards.

Current scoring is indicated by bold print.

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(J) 310.(3)(4)(6)	The regional trauma network establishes and ensures that appropriate levels of EMS, nursing and physician trauma training courses are provided on a regular basis.	0. Not known. 1. There are no regional trauma training guidelines for EMS personnel, nurses or physicians who routinely care for trauma patients. 2. There are regional trauma training standards for EMS personnel, nurses and physicians but there is no requirement for course attendance. 3. There are regional trauma training requirements for EMS personnel, nurses and physicians written into the regional trauma system plan. 4. There are trauma training requirements for EMS personnel, nurses and physicians written into the regional trauma system plan and all personnel providing trauma patient care participate in trauma training. 5. All regional trauma care providers receive initial and ongoing trauma training, including updates in trauma care, continuing education and certifications, as appropriate.
325.132(3)(c)(ii)(J) 310.10	As new protocols and treatment approaches are instituted within the regional trauma system, structured processes are in place to inform or educate all personnel of those changes in a timely manner.	0. Not known 1. The region has no process in place to inform or educate all personnel on new protocols or treatment approaches. 2. The region has developed a process to inform or educate all personnel on new protocols or treatment approaches but it has not been tried or tested. 3. The region has a process in place to inform or educate all personnel on new protocols or treatment approaches as system changes are identified. 4. The region has a <i>structured</i> process in place to <i>routinely</i> inform or educate all personnel on new protocols or treatment approaches. 5. The region has a structured process to educate all personnel on new protocols or treatment approaches in a timely manner, and there is a method to monitor compliance with new procedures as they are introduced.

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving trauma education in the next calendar year.

2013 – 2014 Regional Trauma Education Objective(s):



Region 2 North Trauma Network Application

Indicator #1: *Rule HRSA # 325.132(3)(c)(ii)(J)310.(3)(4)(6)*

Objectives:

- 1.) By November 2014 the RTN, by direction of the RTAC sub-committee will have established a written plan for trauma education that addresses the requirements of the EMS personnel, nurses and physicians that work within the Regional Trauma System.
- 2.) During the 2015 and 2016 application period the RTN will monitor the training and education that is established in the system plan to evaluate compliance by participants in the system.

Indicator #2: *Rule HRSA # 325.132(3)(c)(ii)(J)310.10*

Objectives:

- 1.) By November 2014 the RTN will have developed a structured process for disseminating information to regional trauma care providers concerning new protocols and treatment approaches and the process will be in the testing stages to ensure that all providers are receiving information on changes that are occurring.
- 2.) During the 2015 and 2016 application period the RTN will monitor the process for to ensure performance and compliance with any new protocols and procedures that are established within the region. When identified any necessary corrections to the system will be implemented.

Regional Trauma Network Leadership and Governance

Background

Guidance documents from nationally recognized experts on trauma systems such as the American College of Surgeons Committee on Trauma and US Department of Health and Human Services Administration recognize the necessity of strong leadership and clearly outlined governance for effective trauma system implementation. Michigan embraced this concept in the Michigan Trauma System Plan 2004 and in the language written in the EMS and Trauma Services Section Statewide Trauma System Administrative Rules filed on October 2, 2009.

Michigan Administrative Rules

Rule 325.126 Definitions; E to O Rule 2

(m) "Medical Control" means the supervision and coordination of emergency medical services through a medical control authority, as prescribed, adopted, and enforced through department approved protocols

(n) "Medical Control Authority" (MCA) means an organization designated by the participating organizations to carry out the responsibilities and function of the medical control authority. A Medical Control Authority in Michigan is a hospital or group of hospitals that operate a service that treats patients 24 hours a day 7 days a week. Medical Control Authorities must develop bylaws, appoint an MCA Board, an Advisory Body, and Professional Standards Review Organization (PSRO), collect data, appoint a Medical Director, establish written protocols for pre-hospital care, and are responsible for the execution of those protocols. Protocols adopted by the MCA and approved by the department have the force and effect of law. The MCA Medical Director is responsible for the supervision, coordination, and implementation and requires compliance with protocols. The Medical Control Authority may include a group of hospitals in a county or region operating under one agency staffed by personnel from out the hospital setting. Hospitals in the MCA may agree to confer their oversight responsibilities to an executive director. There are currently 62 MCA's in Michigan.

Rule 325.127 Definitions; P to T Rule 3. *Regional Trauma Network (RTN): (i) "Regional trauma network" means an organized group comprised of the local MCA's within a region, which integrates into existing regional emergency preparedness, and is responsible for appointing a regional trauma advisory council and creating a regional trauma plan.*

Rule 325.129 Powers and duties of the department Rule 5

(k) Establish regional trauma networks, consistent with current emergency preparedness regions, to provide system oversight of the trauma care provided in each region of the state. Regional trauma networks shall be comprised of collaborating local Medical Control Authorities (MCA's) in a region.

Regional Trauma Network Leadership and Governance

The Regional Trauma Network (RTN) therefore is:

- Comprised of one member from **each Medical Control Authority**.
- This member is responsible for representing their MCA and therefore able to make decisions and commitments on behalf of their MCA to collectively further the work and mission of the Regional Trauma Network to establish and maintain a regionalized, coordinated and accountable trauma system.
- In order for the system to function efficiently, all inclusive and fully representative, all MCA's must participate in the work of the RTN.
- Ceding responsibility to another MCA for the trauma system in that region effectively removes that MCA from decision making and providing input into trauma care in the region.
- The Regional Trauma Network is the governing body of the Regional Trauma Network, ultimately responsible for decisions, policy, procedure and any subcommittee work related to trauma in the region including the work of the Regional Trauma Advisory Council.
- The Regional Trauma Network files an application with the Department ensuring that the elements described in the Administrative Rules are in place.
- The identified Regional Trauma Coordinators are first line contact for the department and will facilitate communication to all regional membership.
- The Regional Trauma Coordinators will work closely with the Network and its membership.

The Regional Advisory Council: Regional Trauma Advisory Council (RTAC): (h) "Regional trauma advisory council (RTAC)" means a committee established by a regional trauma network and comprised of MCA personnel, EMS personnel, life support agency representatives, healthcare facility representatives, physicians, nurses, and consumers. The functions of the RTAC are to provide leadership and direction in matters related to trauma systems development in their region, and to monitor the performance of the trauma agencies and healthcare facilities within the region, including, but not limited to, the review of trauma deaths and preventable complications.

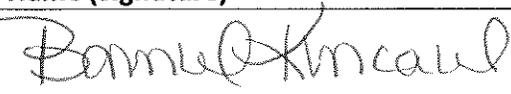
The Regional Advisory Council:

- Has Administrative Rule specified membership
- Provides the needed expertise in developing and implementing the Regional Trauma Network work plan.
- Will take the lead in executing work-plan components, advising the Network of progress, issues and challenges as well as recommended action steps.
- Monitors progress and recommendations from subcommittees and workgroups, keeps RTN updated on progress.
- The RTAC will evaluate the regional trauma system, as well as case specific issues in a PSRO format and provide updates to the RTN on progress, challenges, and make recommendations to the RTN regarding the need for policy/procedure change.
- The Regional Trauma Coordinators will work closely with the RTAC and its subcommittees and workgroups

Trauma system leadership at the local level sits with the Medical Control Authorities who make up the Regional Trauma Network. The Regional Trauma Advisory Council provides the content expertise, the experience and the front line understanding of the issues, challenges and gaps of the regional trauma system.

Regional Trauma Network Leadership and Governance

I have read the above and the bylaws and governance in Region 2 North reflect the statements above.

MCA	Name (Signature)	Title	Date
Oakland County MCA	 Bonnie Kincaid	Executive Director	10/27/13
Macomb County MCA	 Gary Canfield	Executive Director	10/27/13
St. Clair County MCA	 Ken Cummings	Executive Director	10/27/13

Please attach your organization chart and bylaws and include the original of this page with the RTN application.

REGION 2 NORTH TRAUMA NETWORK

BYLAWS

ARTICLE I

NAME, COVERAGE AREA

Section 1: NAME. The name of the Organization shall be the REGION 2 NORTH TRAUMA NETWORK (referred to herein as the "NETWORK")

Section 2: COVERAGE AREA. The Region 2 North Trauma Network area is a three (3) county region defined by the Michigan Department of Community Health which includes the following counties: Macomb, Oakland and St. Clair.

ARTICLE II

PURPOSES & ORGANIZATIONAL STRUCTURE

Section 1: PURPOSES. The purposes for which the NETWORK is formed are:

- A. To establish an all-inclusive Regional Trauma Network for the three (3) county region designated as Region 2 North by the Michigan Department of Community Health Office of EMS and Trauma Systems (referred to herein as the "DEPARTMENT") pursuant to Section 20910(I) of the Public Health Code and subsequent departmental rules R325.125-138 titled "Statewide Trauma System".
- B. To establish a coalition of Medical Control Authorities, hospitals, physicians, transporting pre-hospital life support agencies, and other stakeholders to strengthen trauma services within the NETWORK area as defined and prescribed by the DEPARTMENT in the Michigan Statewide Trauma System rules.
- C. To develop and maintain a Regional Trauma Plan through the establishment of a Regional Trauma Advisory Council addressing all aspects of trauma care services in an effort to reduce morbidity, mortality, and disability associated with trauma including; but not limited to the following:
 - a. Leadership
 - b. Public information & prevention
 - c. Human resources
 - d. Communications
 - e. Medical direction
 - f. Triage
 - g. Transport
 - h. Trauma care facilities

- i. Inter-facility transfers
- j. Rehabilitation
- k. Evaluation of trauma patient care and the trauma system

Section 2: ORGANIZATIONAL STRUCTURE. The NETWORK is comprised of three (3) major branches:

- A. Regional Trauma Network
- B. Regional Professional Standards Review Organization (referred to herein as the RPSRO)
- C. Regional Trauma Advisory Council (referred to herein as the RTAC)

ARTICLE III
REGIONAL TRAUMA NETWORK

Section 1: PURPOSE. The NETWORK will be governed and administered by the Regional Trauma Network for the purpose of approving or denying any or all components of the Regional Trauma Plan with input from the RTAC subject to the ratification of the three (3) Medical Control Authorities.

Section 2: MEMBERSHIP. Each participating Medical Control Authority (MCA) shall (acting through its own governing body) appoint one member and one alternate member, who may act in the absence of the member, to the Regional Trauma Network; there shall be as many members as there are participating MCAs in the NETWORK.

Section 3: OFFICERS. The Chairperson, Vice-Chairperson and Secretary will be selected by the Regional Trauma Network.

- A. All Officers of the Regional Trauma Network will be elected by a majority vote of the Regional Trauma Network members. Elected officers will hold office for a two (2) year term unless removed by an affirmative vote of two thirds of the Regional Trauma Network members. The term of office may be renewed at the discretion of the Regional Trauma Network. Any officer may resign at any time by delivering written notice to the Chairperson. Vacancies occurring in any office at any time will be filled by the Regional Trauma Network.
- B. The Chairperson will preside over all meetings of the Regional Trauma Network. In the event of a vacancy in the office of Chairperson, the Vice-Chairperson will automatically succeed to the office of Chairperson until a new Chairperson is elected by the Regional Trauma Network.
- C. The Secretary will record the minutes of the meetings and provide notice of the meetings. The Secretary may delegate any functional duties to the regional staff

or Fiduciary, unless the Regional Trauma Network instructs otherwise (subject to funding availability).

- Section 4: STAFF, CONTRACTORS, AND CONSULTANTS. The NETWORK will select or approve the appointment or hiring of contractors, consultants and others necessary to carry out the purposes and authority of the NETWORK. The NETWORK will provide supervision and management of any appointed personnel.
- Section 5: OPEN MEETINGS ACT. The Region 2 North Trauma Network as created under the Public Health Code, MCL 333-20910(l) and subsequent departmental rules R325.125 *et seq.*, is a public body charged with the supervision of the Regional Trauma Plan within Region 2 North and is therefore subject to the Open Meetings Act (OMA), MCL 15.261 *et seq.* Meetings may be closed under circumstances outlined within MCL 15.267 and 15.268.
- Section 6: MEETING FREQUENCY. The Regional Trauma Network shall establish a regular schedule for meetings. Meetings will occur at least quarterly (four (4) times per year). The Chairperson may call for a special or emergency meeting of the Regional Trauma Network when deemed necessary.
- Section 7: MEETING NOTICE. The Secretary of the Regional Trauma Network shall send either email or mail notices of meetings at least ten (10) days prior to the scheduled meeting. Notice of special meetings must be sent seven (7) days prior to the emergency meeting.
- Section 8: QUORUM. A quorum for the transaction of business at any meeting of the Regional Trauma Network shall require the presence of a majority of the Medical Control Authorities representing the NETWORK counties.
- Section 9: PROCEDURE. The agenda and procedure of all meetings of the Regional Trauma Network and all of its subcommittees shall be governed by Roberts Rule of Order, Revised (latest edition), and to the extent that such rules of order shall not be in conflict with the statutes of the State of Michigan or the DEPARTMENT rules.
- Section 10: VOTING AND MAJORITY VOTE. Each member of the Regional Trauma Network will receive one vote for each MCA they represent. A consensus vote of the Regional Trauma Network shall constitute an act of the Regional Trauma Network.

Section 11: AMENDMENTS TO THE BYLAWS. Amendments or changes to the Bylaws shall require a consensus vote of the NETWORK members.

ARTICLE IV
REGIONAL TRAUMA ADVISORY COUNCIL

Section 1: PURPOSE. The Regional Trauma Advisory Council (RTAC) is established to formulate the Regional Trauma Plan based on direction from the Regional Trauma Network recommendations.

Section 2: MEMBERSHIP. The RTAC shall be established by the Regional Trauma Network and shall be representative of the following categories from each county within the Region:

- One (1) - ED Physician Representative
- One (1) - Administrator Representative
- Two (2) - Advanced Life Support Agency Representative
- One (1) - Hospital Representative from each licensed hospital (as defined in EMS Act Section 20918.1)
- One (1) - Trauma Surgeon from each verified or provisionally approved (by MCA) trauma facility
- One (1) - RN Trauma Program Coordinator from each verified or provisionally approved (by MCA) trauma facility
- One (1) - Consumer Representative

The Regional Trauma Network shall establish a procedure for terms, nominations and appointments of members.

Section 3: OFFICERS. The Chairperson and Vice-Chairperson will be recommended by the members of the RTAC and ratified by the Regional Trauma Network.

- A. The Chairperson will preside over all meetings of the RTAC. In the event of a vacancy in the office of Chairperson, the Vice-Chairperson will automatically succeed to the office of Chairperson until a new Chairperson is selected by the Regional Trauma Network.

Section 4: MEETING FREQUENCY. The RTAC shall establish a regular schedule for meetings. The Chairperson may call for a special or emergency meeting of the RTAC when deemed necessary.

Section 5: MEETING NOTICE. The Chairperson of the RTAC shall send either email or mail notices of meetings at least ten (10) days prior to the scheduled meeting.

Notice of special meetings must be sent seven (7) days prior to the emergency meeting.

Section 6: QUORUM. At any meeting of the RTAC, the members present shall constitute a quorum.

Section 7: VOTING AND MAJORITY VOTE. An affirmative vote of a majority of the RTAC shall be, and constitute the act of the RTAC.

ARTICLE V

REGIONAL PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Section 1: PURPOSE. The RPSRO shall be established for the purpose of improving the quality of trauma care within the region as provided in MCL 331.531 to 331.533 and will report findings to the RTAC and the Regional Trauma Network.

Section 2: CONFIDENTIALITY OF INFORMATION. All information, records, data, and knowledge collected by or for individuals or bodies assigned professional practice review functions shall be confidential, shall be used only for carrying out of such functions, shall not be public records and shall be entitled to such non-availability for court subpoena and other benefits as may be afforded under the provisions of Act 368 of the Public Acts of 1978, Act 270 of the Public Acts of 1967 (including Section 20919(1)(g), and Administrative Rule 325.22213, as amended.

Section 3: MEMBERSHIP. The RPSRO shall be established by the Regional Trauma Network and shall be representative of the following categories from each county within the Region:

- One (1) ED Physician representative
- One (1) Trauma Surgeon representative
- One (1) Trauma Nurse representative
- Two (2) Advanced Life Support Agency representatives

The Regional Trauma Network shall establish a procedure for terms, nominations, and appointments of the members.

Section 4: OFFICERS. The Chairperson and Vice-Chairperson will be recommended by the members of the RPSRO and ratified by the Regional Trauma Network.

- A. The Chairperson will preside over all meetings of the RPSRO. In the event of a vacancy in the office of Chairperson, the Vice-Chairperson will automatically

succeed to the office of Chairperson until a new Chairperson is appointed by the NETWORK.

- Section 5: MEETING FREQUENCY. The RPSRO shall establish a regular schedule for meetings. The Chairperson may call for a special or emergency meeting of the RPSRO when deemed necessary.
- Section 6: MEETING NOTICE. The Chair of the RPSRO shall send either email or mail notices of meetings at least ten (10) days prior to the scheduled meeting. Notice of special meetings must be sent seven (7) days prior to the emergency meeting.
- Section 7: QUORUM. At any meeting of the RPSRO, the members present shall constitute a quorum.
- Section 8: VOTING AND MAJORITY VOTE. An affirmative vote of a majority of the RPSRO shall be, and constitute the act of the RPSRO.

ARTICLE VI
OTHER COMMITTEES

- Section 1: OTHER COMMITTEES. Other committees, either standing or ad hoc, may be established from time to time by the Regional Trauma Network for such purposes as the circumstances warrant. The Chairperson and members of such committees shall be appointed by the Chairperson of the Regional Trauma Network.

ARTICLE VII
AMENDMENTS

- Section 1: PROPOSAL. Proposed amendments to the Bylaws of the NETWORK may be made by the members of the Regional Trauma Network.
- Section 2: VOTING AND EFFECTIVE DATE. Proposed amendments to the Bylaws must be presented in written form to the NETWORK at least twenty (20) days in advance of the meeting in which the amendments are to be voted upon. Amendments must be approved by a consensus vote of the members or the Regional Trauma Network.

Approved by the Region 2 North Trauma Network on the 27th day of June, 2012.



Chairperson

REGION 2 NORTH REGIONAL TRAUMA NETWORK

