

Southwest Michigan Region 5 Trauma Network

# Application for Designation as a Regional Trauma Network

Plan Period 2014-2017

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# Introduction

## 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.*

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.

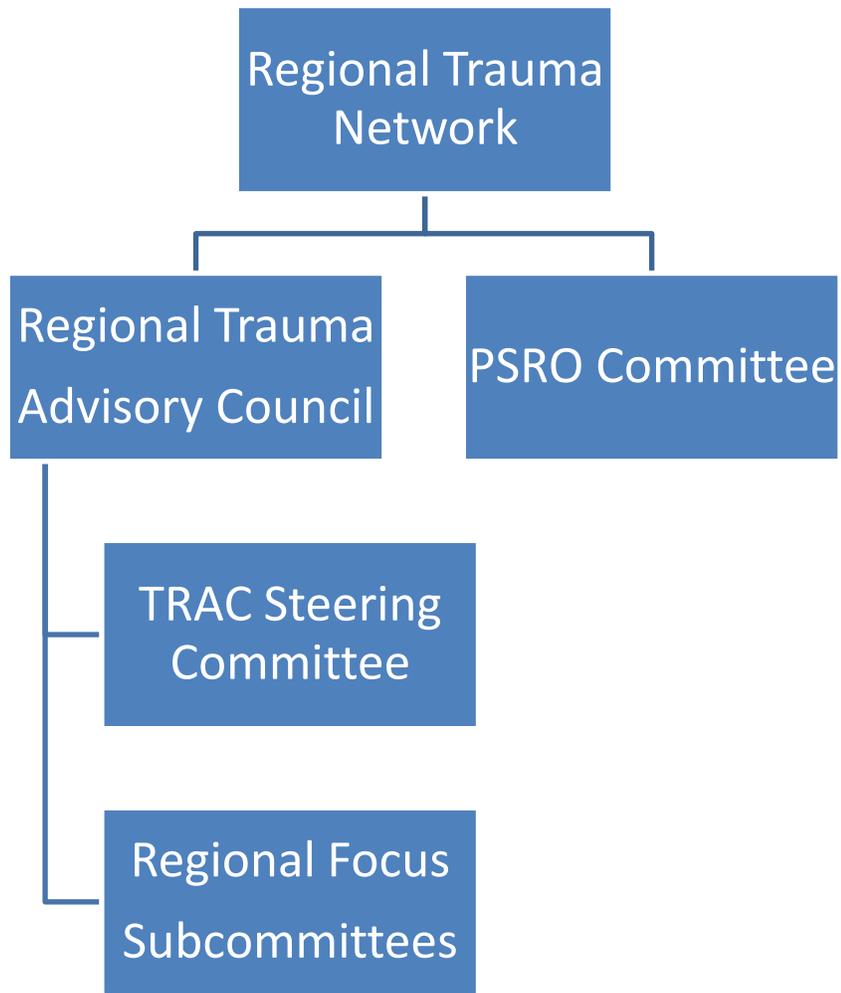
## Signatories to the Network

I have read the above and the bylaws and governance in Region 5 reflect the statements above.

MCA	Name (Signature)	Title	Date
Allegan County MCA	Ryan Seim, MD	Medical Director	
Barry County MCA	Matt Scarff, MD	Medical Director	
Berrien County MCA	Jon Beyer, DO	Medical Director	
Branch County MCA	David Fuchs, MD	Medical Director	
Calhoun County MCA	Daniel Stewart, MD	Medical Director	
Cass County MCA	Giasuddin Ahmed, MD	Medical Director	
Kalamazoo County MCA	William Fales, MD	Medical Director	
St. Joseph County MCA	Tadd Heft, MD	Medical Director	
Van Buren County MCA	Andrea Allman, DO	Medical Director	

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

## Org Chart



# Network Bylaws

## 1. NAME, COVERAGE AREA AND FIDUCIARY

### A. Name.

The name of the organization is "Southwest Michigan – Region 5 Trauma Network" (referred to herein as the "Network"), and its address is c/o KCMCA 1000 Oakland Drive, Kalamazoo, MI 49008.

### B. Coverage Area.

Network coverage area comprises the counties of Allegan, Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and VanBuren (referred to herein as the "region") or as otherwise defined by the State of Michigan as it pertains to the statewide trauma system.

## 2. PURPOSE

The purposes of the Network are as follows:

- A. To organize, coordinate and manage a Network of hospitals, medical control authorities, life support agencies, EMS personnel, physicians, nurses, and consumers to plan and implement strategies to strengthen the provision of Trauma Care Services within the region as defined and prescribed in the Michigan Statewide Trauma System Rules.
- B. To develop, implement and revise (as needed) a regional trauma plan. The plan will address each of the following trauma system components: leadership, public information & prevention, human resources, communications, medical direction, triage, transport, trauma care facilities, inter-facility transfers, rehabilitation, and evaluation of patient care within the system.

## 3. ORGANIZATIONAL STRUCTURE

The Network is comprised of three core components

- Southwest Michigan - Region 5 Trauma Network - (referred to herein as the Network) which serves as the principal governing board of the Network.
- Regional Trauma Advisory Council - (referred to herein as the RTAC) which provides the leadership and direction in matters related to trauma system development in the region.
- Various Standing and Appointed Committees.

## 4. REGIONAL TRAUMA NETWORK

### A. Purpose.

The Network will be administered and governed by the Network, with input from the Regional Trauma Advisory Council.

### B. Membership.

Membership will consist of the Medical Director, or designee, of each participating Medical Control Authority (MCA).

**C. Officers.**

The Chairperson, Vice-Chairperson and Secretary/Treasurer will be elected by the Network. The Chairperson and Vice Chairperson shall be members of the Network. The Network may elect to designate another individual to serve as Secretary/Treasurer who is not necessarily a member of the Network.

**1) Election, Removal, Resignation and Vacancies.**

All Officers of the Network will be elected by a majority vote of the Network members. Elected officers will hold office for a two (2) year term unless removed by an affirmative vote of three quarters (or more) of the Network members. The term of office will be for no more than one two-year term. 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 Network.

**2) Chairperson.**

The Chairperson will provide leadership to the Network and will preside over all meetings of the Network. In the absence of the Chairperson, the Vice-Chairperson will preside over the meetings of the Network. In the absence of both the Chairperson and Vice-Chairperson, the Chairperson will designate a member of the Network to preside over the meetings of the Network..

**3) Vice-Chairperson.**

The Vice-Chairperson will provide leadership to the Network and, in the absence of the Chairperson, will preside over the meetings of the Network. The Vice-Chairperson may perform other tasks as requested by the Chairperson in support of the Network.

**4) Secretary/Treasurer.**

The Secretary/Treasurer will serve as secretary and treasurer for the Network. The Secretary/Treasurer will record the minutes of the meetings and provide notice of the meetings. In the absence of the Secretary/Treasurer, the Chairperson may designate a member of the Network to record the minutes of the meetings.

**D. Duties.**

**1) Establish the Regional Trauma Advisory Council.**

The Network will establish a Regional Trauma Advisory Council, and reserves the right to determine the size, member eligibility, authority and other matters relating to the composition and activities of the RTAC. The makeup of the RTAC is outlined in the section relating to the RTAC. The Network will make selected appointments to the RTAC.

**2) Regional Trauma Plan**

The Network will review and approve the Regional Trauma Plan which is developed by the RTAC.

**3) Professional Standards Review Organization (PSRO) Committee**

The PSRO Committee 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 finding to the RTAC and Network. The PSRO Committee is protected under Michigan Public Health Code and the minutes of the meeting shall be kept separate and confidential. The membership of the PSRO shall be determined by the Network, who may add or remove members at its leisure. The PSRO Committee shall be chaired by the RTAC Vice-Chairperson (or in the absence of the RTAC Vice-Chairperson by a PSRO member designated by the Network Chair).

**4) Other Duties.**

The Network may perform other duties that are consistent with the Trauma Administrative Rules and other provisions of the Michigan Public Health Code.

**5) Delegation of Duties.**

The Network may delegate duties to the RTAC and/or Committees as needed.

**6) Establishing Committees.**

The RTN Chairperson may establish committees as required and as it deems appropriate. The chairperson and co-chairperson of each committee will be appointed by the RTN Chairperson and subject to approval by a simple majority of the voting members of the RTN.

**E. Meetings and Rules.**

**1) Meeting Schedule.**

The Regional Trauma Network shall establish a regular schedule for meetings. At least four (4) meetings will be scheduled per year (on a quarterly basis). The Chairperson may call for a special or emergency meeting of the Regional Trauma Network when deemed necessary or at the request of two or more Network members. Notice of a special or emergency meeting must be given by at least 2 of the 3 following methods: phone, email or fax at least twenty-four (24) hours before the meeting is held.

**2) Quorum Requirement.**

A quorum for the transaction of business at any meeting of the Regional Trauma Network shall require the presence of at least five of the members.

**3) Voting.**

Election of officers may be made by a simple majority of the members attending the meeting. Other actions of the Regional Trauma Network require a two thirds or greater supermajority vote of the members of the Network attending the meeting for an action

to be approved. Attendance may be accomplished through video or conference call capability.

**4) Rules.**

Roberts Rules of Order will govern all meetings of the Regional Trauma Network except where such rules are inconsistent with this document.

**F. Consent Resolution.**

Action may be taken by the Regional Trauma Network, without a meeting, by a written consent (as requested either by mail, fax, or e-mail) signed by all the members of the Regional Trauma Network.

## **5. REGIONAL TRAUMA ADVISORY COUNCIL (RTAC)**

**A. Purpose.**

The purpose of the RTAC is to provide leadership and direction in matters related to trauma systems development in the region, and to monitor the performance of the agencies and healthcare facilities within the region, including, but not limited to, the review of trauma deaths and preventable complications.

**B. Membership.**

**1) Voting Member/Alternate Appointment.**

Voting members of the RTAC shall be appointed in writing by the appointing MCA, hospital, or other organization or (as appropriate) by the Network. Alternate members may be designated. Each appointing body may remove and replace its appointed representative(s) and/or its alternate representative(s), and may fill any vacancy created by the resignation of an appointed representative(s) or alternate representative(s), at any time, at its discretion.

**7) Voting Members.**

The RTAC will be comprised of the following:

- a. Representative from each MCA within the Network Area.
- b. Physician representative from each verified / designated trauma facility in the region. RTAC chair and vice-chair are the voting physician representatives for their facility.
- c. Non-physician representative from each verified / designated trauma facility in the region.
- d. Representative from each provisionally approved trauma facility and each facility actively seeking verification / designation within the region.
- e. Representative from each licensed Air EMS agency located within the region.
- f. Three ground Life Support Agency representatives appointed by the Network.

- g. Three EMS personnel representatives appointed by the Network
- h. One consumer representatives appointed by the Network and not affiliated with any EMS or hospital organization.
- i. The Regional Trauma System Coordinator will serve as an ex-officio member.

**8) Voting Member Appointment and Removal Declaration.**

Each appointment and removal of a representative or alternate representative must be presented to the Network or designee in writing or electronically, on the appointing organization's letterhead (or organizational email address) signed by an authorized official of the appointing organization.

**9) Resignation.**

A resigning voting member or alternate of the RTAC will have no further obligation to the Network.

**10) Non-Voting Members.**

Non-voting members of the RTAC will be permitted. These members may come from any hospital, EMS agency, MCA, or other organization interested in trauma care or from interested individuals. Non-voting members are self-identified and subject to the approval of the Network. The Network may remove any non-voting member for cause.

**11) Membership Review.**

The RTAC will review, at least annually, the voting members, alternates, and non-voting members.

**C. Officers.**

- 1) The RTAC shall have a Chairperson, Vice-Chairperson and Secretary who shall be voting members of the RTAC.

**2) Election, Removal, Resignation and Vacancies.**

All Officers of the RTAC will be elected by a majority vote of the Network members. The positions of Chairperson and Vice-Chairperson shall rotate between the Medical Directors of the verified Level 1 and 2 Trauma Centers in the region on an annual basis. Officers will hold office for a one (1) year term unless removed by an affirmative vote of three quarters (or more) of the Network members. However, officers may be re-elected to serve additional one year terms. Any officer may resign at any time by delivering written notice to the Chairperson of the Network.

**3) Chairperson.**

The Chairperson will provide leadership to the Network and will preside over all meetings of the RTAC. In the absence of the Chairperson, the Vice-Chairperson will preside over the meetings of the RTAC. In the absence of both the Chairperson and Vice-Chairperson, the Chairperson will designate a member of the RTAC to preside over the meetings of the RTAC. If the Chairperson is not available to attend the meeting a physician designee may attend as a voting member not as an officer of the RTAC.

**4) Vice-Chairperson.**

The Vice-Chairperson will provide leadership to the Network and, in the absence of the Chairperson, will preside over the meetings of the RTAC. The Vice-Chairperson may perform other tasks as requested by the Chairperson in support of the Network. If the Vice-Chairperson is not available to attend the meeting a physician designee may attend as a voting member not as an officer of the RTAC.

**5) Secretary.**

The Secretary will serve as secretary for the RTAC. The Secretary will record the minutes of the meetings and provide notice of the meetings. In the absence of the Secretary, the RTAC Chairperson may designate a member of the RTAC to record the minutes of the meetings.

**D. Duties.**

The duties of the RTAC include, but are not limited to:

- 1) Develop, implement, and revise the Regional Trauma Plan and submit the plan for approval to the Network.
- 2) Develop, implement and monitor clinical care issues of trauma deaths and preventable complications based on recommendations from the Professional Standards Review Committee (PSRC). No patient / hospital specific data will be shared outside the PSRC.
- 3) Review / implement injury prevention activities & opportunities based on regional trauma data.
- 4) Develop & evaluate trauma triage & transfer guidelines.
- 5) Implement a trauma registry system to support the performance improvement plan for regional trauma care.
- 6) Review / support trauma related educational activities for health care providers within the region.
- 7) Make funding allocation recommendations (subject to funding becoming available) to the Network for approval.

**E. Recommendation Approval.**

Recommendations of the RTAC to the Network must be approved by a two thirds or greater supermajority of the RTAC voting members present at a meeting of the RTAC, subject to quorum requirements being met.

**F. Committees.**

**1) Establishing Committees.**

The RTAC Chairperson may establish committees as required and as it deems appropriate. Except for the RTAC Steering Committee, the chairperson and co-chairperson of each committee will be appointed by the RTAC Chairperson and subject to approval by a simple majority of the voting members of the RTAC.

**2) RTAC Steering Committee.**

An RTAC Steering Committee shall be established for the purpose of providing strategic leadership and guidance to the RTAC. The RTAC Steering Committee shall be composed of the Chairperson and Vice-Chairperson of the Network, the Chairperson and Vice-Chairperson of the RTAC, and the Chairpersons (or in the absence of the Chairperson, the Vice-Chairperson) of each RTAC Committee. The RTAC Steering Committee shall be chaired by the RTAC Chairperson (or by the RTAC Vice-Chairperson in the absence of the Chairperson or by another RTAC Steering Member designated by the RTAC Chairperson in the absence of the RTAC Chairperson and Vice-Chairperson). The RTAC Steering Committee Officers shall serve for one (1) year terms unless re-elected for an additional one year term(s).

**G. Meetings and Rules.**

**1) Meeting Schedule.**

The RTAC shall establish a regular schedule for meetings. At least four (4) meetings will be scheduled per year. The RTAC Chairperson may call for a special or emergency meeting of the RTAC when deemed necessary. The Network Chairperson may also call for a special or emergency meeting of the RTAC when deemed necessary. In the event of an emergency meeting a 24 hour notice is required using at least 2 of the 3 following three methods: phone, email or fax.

**2) Quorum Requirement.**

A quorum for the transaction of business at any meeting of the RTAC shall require the presence of at least one third of the voting members (or alternates).

**3) Voting.**

Actions of the RTAC require a two thirds or greater supermajority of the voting members (or alternates) of the RTAC present at the meeting in which an action is being considered, subject to quorum requirements being met. Members may participate by video or conference call capabilities.

**4) Rules.**

Roberts Rules of Order will govern all meetings of the Regional Trauma Advisory Council except where such rules are inconsistent with this document.

**H. Consent Resolution.**

Action may be taken by the RTAC, without a meeting, by a written consent (as requested either by mail, fax or e-mail) signed by a two-thirds or greater supermajority

of the voting members of the RTAC if responses/votes are consistent with quorum requirements.

## **6. CONFLICT OF INTEREST**

Any MCA, hospital or other organization participating in the I Network, RTAC, or RTAC Committees with a direct interest in any matter before the Regional Network, Advisory Council or Advisory Council Committees, or other conflict of interest, shall disclose the interest prior to any discussion of that matter at a Network meeting. The presiding officer of the meeting shall determine if the conflict is such that the member should refrain from discussions and/or voting on the matter. The disclosure shall become a part of the minutes of that Network, RTAC, or RTAC Committee meeting.

## **7. ADMINISTRATION AND APPROVAL PROCESS**

### **A. Books and Records.**

The officers, appointees, employees and agents of the Network shall maintain detailed and accurate books, records, and accounts of the Network's activities as determined by the Network and shall be in accordance with applicable state and federal law and regulations, including the regulations established by the Department.

### **B. Network Audit.**

The Network shall determine the need to conduct an audit of Network activities.

### **C. Plan Approval Process.**

- 1) Plans and actions of the RTAC must be approved by the Network.
- 2) If approval is received from the Network, the protocols/policies/plans will be submitted to the Department for review and implementation approval. Once approved by the Department the protocols/policies/plans will be implemented in collaboration with the regional hospitals and MCAs.

### **D. Confidentiality.**

- 1) To the extent required by law, the Network, RTAC, and Committees will comply with the Michigan Open Meetings Act.
- 2) To the extent required by law, the Regional Trauma Network will comply with the Michigan Freedom of Information Act, Public Act 441 of 1976: MCL 15.231 et seq. and redact all personal identifiers or other information pursuant to applicable FOIA exemptions. However, all documents prepared in support of the Network are considered exempt from disclosure thereunder pursuant to MCL §15.243(y).3) The confidentiality and protection of patient data collected as part of the creation and operation of the trauma system shall be provided and maintained through creation of a Regional Professional Standards Review Organization (PSRO), as provided in the 1967 PA 270, MCL 331.531 to 331.533. Data collected will only be used or disclosed for the purposes described in Part 209 of the Public Health Code and the Michigan

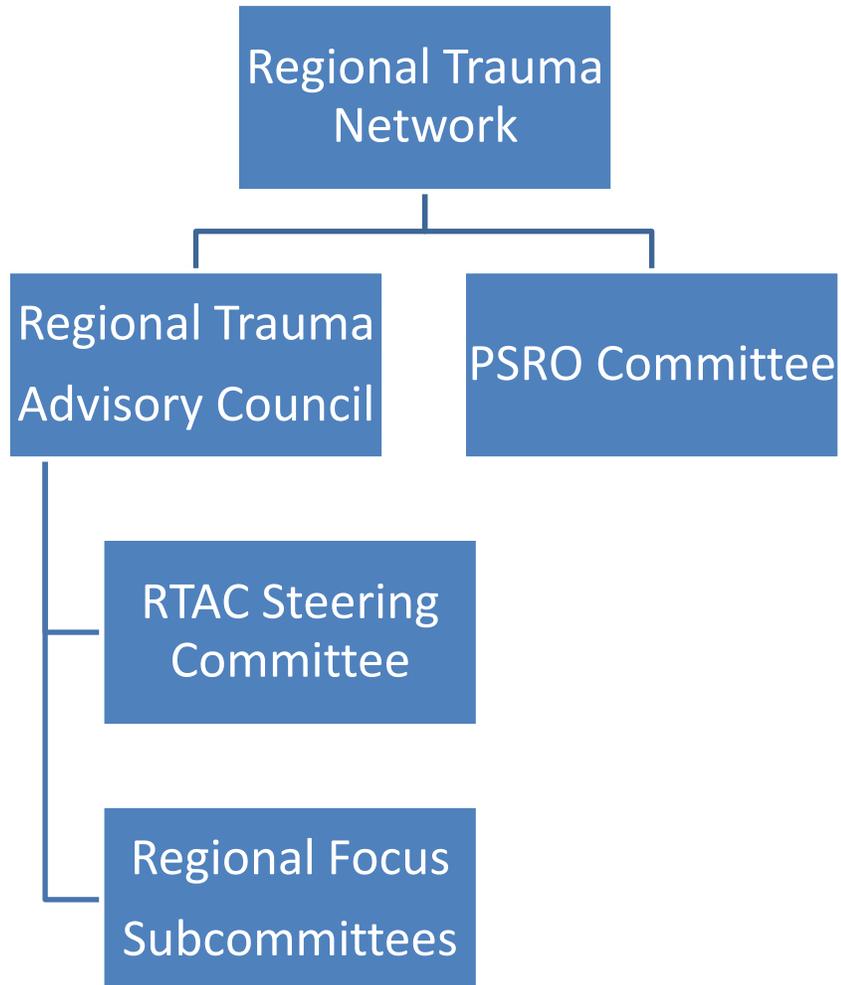
Administrative Code R325.22101 through §22217. Any other uses or disclosures will be made only as required by applicable laws.

3. The RTAC shall observe the confidentiality provisions of the Health Insurance Portability and Accountability Act under 45 CFR Part 164, data confidentiality provisions under the code, or as established by the Regional Professional Standards Review Organization (PSRO).

## **8. Adoption and Amendments**

These bylaws will be adopted by the medical control authorities of the region and may be amended or repealed by the Network, with the input from the RTAC, and subject to a two thirds or greater supermajority vote of the members of the Network. This document and all subsequent amendments are subject to approval by the Department. A notice of any amendment will be sent to each participant in the Network.

## 9. Org Chart



# Regional Trauma Network Work Plan

## 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.

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.	<ol style="list-style-type: none"> <li>0. Not known.</li> <li>1. There is no multi-disciplinary, multi-agency RTAC to provide guidance to the RTN.</li> <li>2. <b>An RTAC has not been appointed, and attempts to organize one have not been successful but are continuing.</b></li> <li>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.</li> <li>4. The RTAC is active and members regularly attend meetings. Collaboration and consensus are beginning.</li> <li>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.</li> </ol>
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.	<ol style="list-style-type: none"> <li>0. Not known.</li> <li>1. There is no defined structure (written process) for the RTN or committees.</li> <li>2. <b>There is an informal process for operations that the RTN uses when convenient, although not regularly or consistently.</b></li> <li>3. The regional governance structure and communication pathways are defined within the RTN bylaws, although the process has not been fully implemented.</li> <li>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.</li> <li>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.</li> </ol>

## System Governance Objective(s):

- 1) Appoint members to the Regional Trauma Advisory Council as prescribed in the bylaws by April 18 2014.
- 2) Clearly define governance and formal communication pathways amongst the committees in the bylaws by Jan 30 2014.

## 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.

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. <b>The RTN does not actively participate in the monitoring and evaluation of injury prevention activities and programs in the region.</b> 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. <b>There is no written plan for coordinated injury prevention programs within the region.</b> 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.

### Injury Prevention Objective(s):

- 1) The Regional Trauma Network will appoint a subcommittee of the Regional Trauma Advisory Council by April 18 2014 to develop a regional injury prevent plan
- 2) The Regional Injury Prevention Subcommittee will identify the current injury prevent plans at hospitals in the region by September 30 2014
- 3) The Regional Injury Prevention Subcommittee will identify the top 5 injury mechanisms in the region, for children and adults, by August 10, 2014
- 4) The Regional Injury Prevention Subcommittee will recommend a regional approach to the delivery of injury prevention programs by April 15 2015

## Citizen access to the trauma system

The trauma system is supported by EMS medical oversight of dispatch procedures and coordinated response resources.

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.	<ol style="list-style-type: none"> <li>0. Not known.</li> <li>1. There are no trauma specific regional EMS dispatch protocols.</li> <li>2. <b>Trauma dispatch protocols have been adopted independent of the design of the regional trauma system.</b></li> <li>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.</li> <li>4. Regional trauma specific dispatch protocols have been developed in close coordination with the RTN and are congruent with regional trauma system design.</li> <li>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.</li> </ol>
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.	<ol style="list-style-type: none"> <li>0. Not known.</li> <li>1. <b>There is no regional coordination of transportation resources. Air or ground ambulances from multiple jurisdictions can all arrive on the trauma scene unannounced.</b></li> <li>2. Each medical control authority has a priority dispatch system in place that sends appropriate transportation resources to the scene.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ol>

### System Access Objective(s):

- 1) The Regional Trauma Network will develop regional trauma specific EMS dispatch protocols by November 2014
- 2) The Regional Trauma Network will produce a white paper describing the implementation of priority medical dispatch in each medical control authority’s jurisdiction

## 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.

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.	<ol style="list-style-type: none"> <li>0. Not known.</li> <li>1. There are no written procedures for regional EMS and trauma systems communications for major EMS events or multiple jurisdiction incidents.</li> <li><b>2. Local medical control authorities have written procedures for EMS communications during major events. However, there is no coordination among the adjacent local jurisdictions.</b></li> <li>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.</li> <li>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.</li> <li>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.</li> </ol>
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.	<ol style="list-style-type: none"> <li>0. Not known.</li> <li>1. There are no specific communications plans or procedures to ensure communication among medical facilities when arranging for inter-facility patient transfers.</li> <li><b>2. Inter-facility communication procedures are generally included in patient transfer protocols for each medical facility but there is no regional procedure.</b></li> <li>3. There are uniform, regional communication procedures for arranging patient transfers, but there are no redundant procedures in the event of communication system failure.</li> <li>4. There are uniform, regional communication procedures for arranging patient transfers and there are redundant procedures in the event of communication system failure.</li> <li>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.</li> </ol>

### Communication Objective(s):

- 1) The Regional Trauma Network will develop a regional EMS major incident communications plan by August 2015
- 2) The Regional Trauma Network will describe standardized communications procedures for interfacility transfers, including contingencies for radio or telephone system failure by December 1 2014

## Medical Oversight

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

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. <b>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.</b> 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. <b>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.</b> 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.

### Medical Oversight Objective(s):

- 1) The Regional Trauma Network will develop a regional trauma system medical oversight subcommittee to include trauma medical directors by November 30 2014
- 2) The regional trauma system medical oversight subcommittee will meet regularly to evaluate program effectiveness for both on-line and off-line medical control by May of 2015

## Pre-hospital Triage Criteria

The regional trauma system is supported by system-wide pre-hospital triage criteria.

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.	<ol style="list-style-type: none"> <li>0. Not known.</li> <li>1. There are no mandatory regional triage criteria to ensure trauma patients are transported to the most appropriate trauma facility.</li> <li>2. <b>There are different triage criteria used by different providers. Appropriateness of triage protocols and subsequent transportation are not evaluated for sensitivity or specificity.</b></li> <li>3. Regional triage criteria are used by all pre-hospital providers. There is no current process in place for evaluation.</li> <li>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.</li> <li>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.</li> </ol>

### Pre-hospital Triage Criteria Objective(s):

- 1) The Regional Trauma Network will adopt a regional pre-hospital trauma triage protocol by July 1 2014
- 2) The Regional Trauma Network will work with local medical control authorities to adopt a single regional trauma triage protocol by July 1, 2015

## Trauma Diversion Policies

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

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.	<p>0. Not known.</p> <p>1. <b>There is no regional plan to identify the number, levels, and distribution of trauma facilities. There is no regional diversion protocol.</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
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.	<p>0. Not known.</p> <p>1. <b>All trauma facilities in the region are not entering data into state registry. Regional data from state trauma registry is limited.</b></p> <p>2. There is limited access to the state trauma registry. Data extraction is not available to evaluate performance or improve resource allocation.</p> <p>3. All trauma facilities in the region enter data into the state trauma registry but data are not being used to improve the system.</p> <p>4. The RTN uses the state trauma registry to routinely report on system performance and resource utilization and allocation.</p> <p>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.</p>

### Trauma Diversion Policy Objective(s):

- 1) The Regional Trauma Network will develop trauma diversion policy work group by April 1, 2014
- 2) The regional trauma diversion work group will develop a facility diversion plan by December 1, 2014
- 3) The Regional Trauma Network will review, and update as necessary, the regional trauma diversion policy annually by December 1
- 4) The Regional Trauma Network will work to insure trauma facilities are submitting data to the state registry by May 1 2015

## 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.

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).	<p>0. Not known.</p> <p>1. <b>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.</b></p> <p>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.</p> <p>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.</p> <p>4. The regional trauma plan addresses the roles, resources and responsibilities of licensed acute care facilities and specialty care facilities.</p> <p>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.</p>
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.	<p>0. Not known.</p> <p>1. <b>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.</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

### Trauma Bypass Protocol Objective(s):

- 1) The Regional Trauma Network will develop trauma bypass policy work group by April 1, 2014
- 2) The regional trauma diversion work group will develop a trauma facility bypass plan by December 1, 2014
- 3) The Regional Trauma Network will review, and update as necessary, the regional trauma pybass policy annually by December 1

## Regional Trauma Treatment Guidelines:

The regional trauma network ensures optimal patient care through the development of regional trauma treatment guidelines.

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. <b>There is a fragmented system within the region, usually event based, to monitor inter-facility transfer of trauma patients.</b> 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. <b>There are no written, quantifiable regional system performance standards or performance improvement processes.</b> 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.

## Regional Trauma Treatment Guidelines Objective(s):

- 1) The Regional Trauma Network will develop trauma transfer protocols to insure patient are expeditiously transferred to an appropriate level of care, by December 1, 2014
- 2) The Regional PSRO committee will review relevant data from any appropriate source on compliance of the transfer protocol and provide feedback starting no later than April 1, 2016.

## Regional Quality Improvement Plans

The RTN/RTAC uses system data to evaluate system performance and regularly reviews system performance reports to develop regional policy.

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. <b>The RTN does not generate trauma data reports for evaluation and improvement of system performance.</b> 2. Some general trauma system information is available to stakeholders, but it is not consistent or regular. 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.

### Regional Quality Improvement Plan Objective(s):

- 1) The Regional Trauma Network will appoint a regional PSRO group to review system performance by July 1, 2014
- 2) The regional PSRO group will develop bylaws for adoption by July 1 2015
- 3) The regional PSRO group will generate reports that are disseminated to all stakeholders no less than once per year beginning no later than January 1 2016

## Regional Trauma Objectives

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

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. <b>There are no regional trauma training guidelines for EMS personnel, nurses or physicians who routinely care for trauma patients.</b> 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. <b>The region has no process in place to inform or educate all personnel on new protocols or treatment approaches.</b> 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.

### Regional Trauma Education Objective(s):

- 1) The Regional Trauma Network will develop a plan to ensure coordinated delivery of trauma curriculum to providers across the region by April 2015
- 2) The Regional Trauma Network will develop a structured process for rolling out new treatment methods and protocols to providers by November 2015