Region 1 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 (formally known as 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.

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 Peer 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.
Region 1 Trauma Network Application

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 reflect progress in system development.

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.

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

<table>
<thead>
<tr>
<th>Score</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>The scorer does not know enough about the indicator to evaluate it effectively.</td>
</tr>
<tr>
<td>1</td>
<td>There is no detailed analysis of injury mortality.</td>
</tr>
<tr>
<td>2</td>
<td>Death certificate data have been used to describe the incidence of trauma deaths aggregating all etiologies, but no E-code reporting is available.</td>
</tr>
<tr>
<td>3</td>
<td>Death certificate data, by E-code, are reported on a statewide basis, but are not reported regionally.</td>
</tr>
<tr>
<td>4</td>
<td>Death certificate data, by E-code, are reported on a statewide and regional basis. These data are compared to national benchmarks, if available.</td>
</tr>
<tr>
<td>5</td>
<td>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.</td>
</tr>
</tbody>
</table>

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.
- 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.
Region 1 Trauma Network Application

- 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.

Completed applications can be submitted electronically:
To: wordene@michigan.gov
Subject line: Region 1 Trauma Network Application

OR

Mailed to:
Michigan Department of Community Health Bureau of Legal Affairs
Crime Victims, EMS and Trauma Division
Trauma Section
Capitol View Bld., 6th Floor
201 Townsend Street
Lansing MI 48913
Attention: Eileen Worden, State Trauma Manager

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:
Name:
Address:
Email:
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.
Region 1 Trauma Network Application

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.

<table>
<thead>
<tr>
<th>Rule HRSA #</th>
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</table>
| 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.
Region 1 Trauma Network Application
2013 - 2014 System Governance Objective(s):

1. By March 2014, Meeting schedules will be determined, posted in a central location and disseminated to the membership. The database of members will be routinely updated and posted in a central location.

Score:

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.

2. The RTN leadership will maintain 100% of the RTN and RTAC meeting minutes and attendance records, including individual committees, and include this information in end of year report submissions. Meeting agendas, minutes and action items will be disseminated to both groups. There will be regular opportunities for the RTN, RTAC and Subcommittees to interact and/or report on work being done. This information will be used to describe progress in the annual report.

Score:

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
### Region 1 Trauma Network Application

**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.

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<tr>
<td>325.132[3][c][ii][A] 306.2</td>
<td>The RTN is active within the region in the monitoring and evaluation of community-based injury prevention activities and programs.</td>
<td>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.</td>
</tr>
<tr>
<td>325.132[3][c][ii][A] 203.5</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving injury prevention in the next calendar year.
Region 1 Trauma Network Application

2013 – 2014 Injury Prevention Objective(s):

1. The RTN will request and review available Region 1 injury data which will be used to provide guidance on regional injury prevention plans, data will be monitored quarterly.

Score:

1. The RTN does not actively participate in the monitoring and evaluation of injury prevention activities and programs in the region.

2. By June 2014, all ACS verified facilities in the region will have shared their current trauma related injury prevention plans with the RTN. These plans will be used to inform the development of a regional specific injury prevention plan. The regional plan will include specific strategies to address regionally identified (data driven) issues relating to trauma. A priority focus will be: MVC/Child Passenger Safety and Falls/Driver Safety in the elderly population.

By August 2014, The RTAC will assign a subcommittee, tasked with developing a strategic plan to address region wide injury prevention initiatives, including the priority focus of MVC/Child Passenger Safety and Falls/Driver Safety in the elderly population. These strategies will be incorporated into regional planning through June 2016.

Score:

1. There is no written plan for coordinated injury prevention programs within the region.
## Region 1 Trauma Network Application

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

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| 325.132(3)[c][iii](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.                                                                                                                                                                                                                                         | 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][iii](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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 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. |       |

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.
Region 1 Trauma Network Application

2013–2014 System Access Objective(s):

1. By December 2013, all Region 1 MCA trauma protocols will be reviewed by the RTN to determine if criteria of destination for trauma patients have been met. The RTN will review these protocols yearly for adherence to state guidelines through 2016.

   By January 2014 The RTN will develop a plan and tools to:
   a. Develop the definition of high acuity trauma patients to be reviewed
   b. Develop a process to obtain Hospital and EMS Agency data for evaluation by the MCA’s regarding EMS related trauma calls.
   c. Develop a process to request and receive feedback from destination hospitals regarding care of high acuity trauma patients quarterly. This data will be used for regional process improvement.

Score:

2. Trauma dispatch protocols have been adopted independent of the design of the regional trauma system.

2. By June 2014, The RTN will have conducted a communication inventory for all agencies and reviewed all of the MCA’s communication protocols for:

   - Inclusion of communication channel usage by the MCA and it’s corresponding hospitals for both daily communication and all hazards response communications
   - Validation from each Region 1 EMS Agency and Hospital, that their facility is maintaining the HERN

The RTN will review these protocols yearly for adherence to state guidelines.

Score:

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.
### Region 1 Trauma Network Application

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

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</table>
| 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. These procedures 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.
Region 1 Trauma Network Application

2013 – 2014 Communication Objective(s):

1. By June 2014 the RTN will review 100% of Region 1 MCA Disaster Protocols for the inclusion of Mass Casualty communications and coordinated regional response.

By June 2014, the RTN will have confirmation that 100% of regional Hospitals have access and regularly test the statewide 800 mhz system for disasters by June 2014. This will be confirmed through the District 1 Healthcare Coalition records and monthly radio tests.

The RTN will review these protocols yearly for adherence to state guidelines.

Score:

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.

2. By June 2014 the RTN will confirm the availability of communication system redundancies in 100% of Region 1 hospitals to allow for arranging inter-facility transfers. This will be confirmed through the District 1 Healthcare Coalition records and monthly radio tests.

Score:

1. There are no specific communications plans or procedures to ensure communication among medical facilities when arranging for inter-facility patient transfers.
**Region 1 Trauma Network Application**

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

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</table>
| 325.132(3)(c)(i)(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)(i)(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.
Region 1 Trauma Network Application

2013 – 2014 Medical Oversight Objective(s):

1. By June 2014. The RTN will develop a Medical Oversight committee, which will meet annually to review 100% of Region 1 MCA triage, transport and care protocols. The group will also be available to convene upon request to address any recommended changes found during PRSO review. This group will make recommended changes to protocols as identified.

Score:

3. EMS and trauma medical directors collaborate in the development of protocols for pre-hospital providers providing care to trauma patients. There is an informal process for this according to all 7 medical directors in Region 1.

2. By June 2014. The RTN will develop a Medical Oversight committee, which will meet annually to review 100% of Region 1 MCA triage, transport and care protocols. The group will also be available to convene upon request to address any recommended changes found during PRSO review. This group will make recommended changes to protocols as identified.

Score:

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.
Region 1 Trauma Network Application

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

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<thead>
<tr>
<th>Rule</th>
<th>Indicator</th>
<th>Score</th>
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<tbody>
<tr>
<td>HRSA #</td>
<td></td>
<td>0. Not known.</td>
</tr>
<tr>
<td>325.132(3)(c)(ii)(E) 302.6</td>
<td>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.</td>
<td>1. There are no mandatory regional triage criteria to ensure trauma patients are transported to the most appropriate trauma facility. 2. There are different triage criteria used by different providers. Appropriateness of triage protocols and subsequent transportation are not evaluated for sensitivity or specificity. 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.</td>
</tr>
</tbody>
</table>

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):

1. By June 2014, the RTN will review 100% of Region 1 MCA protocols for inclusion of pre-hospital triage guidelines which are consistent with the state system protocol. The RTN will review these protocols yearly for adherence to state guidelines.

Score:

2. There are different triage criteria used by different providers. Appropriateness of triage protocols and subsequent transportation are not evaluated for sensitivity or specificity.
Region 1 Trauma Network Application

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

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<tr>
<td>325.132(3)<a href="iii">c</a>(F) 303.2</td>
<td>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.</td>
<td>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.</td>
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<tr>
<td>325.132(3)<a href="iii">c</a>(F) 205.3</td>
<td>The state trauma registry is used to identify and evaluate regional trauma care and improve the allocation of resources.</td>
<td>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.</td>
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</table>

Include at least one specific, measurable, attainable, relevant and time-bound objective for improving trauma diversion policies in the next calendar year.
Region 1 Trauma Network Application

2013 – 2014 Trauma Diversion Policy Objective(s):

1. **By June 2016, The RTN will develop an ongoing process to continually assess Region 1 trauma assets and the trauma level verification/designation.**

   The data from this survey will be used to develop the framework for a regional trauma diversion plan which will be revised and updated regularly as Region 1 hospitals obtain verification and designation status.

**Score:**

1. There is no regional plan to identify the number, levels, and distribution of trauma facilities. There is no regional diversion protocol.

2. **By June 2016 The RTN and RTAC will have a plan to monitor, facilitate and evaluate participation the state trauma registry. Progress indicator will be 100 % of facilities have signed data use agreements.**

**Score:**

1. All trauma facilities in the region are not entering data into state registry. Regional data from state trauma registry is limited.
**Region 1 Trauma Network Application**

**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.

<table>
<thead>
<tr>
<th>Rule HRSA #</th>
<th>Indicator</th>
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<tbody>
<tr>
<td>325.132(3)(c)(ii)(G) 303.1</td>
<td>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).</td>
<td>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.</td>
</tr>
</tbody>
</table>

| 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 1 Trauma Network Application

2013 – 2014 Trauma Bypass Protocol Objective(s):

1. The RTN will develop a regional trauma plan, based on ACS recommendations that define the roles, resources and responsibilities of all acute care facilities treating trauma, and of facilities that provide care to specialty populations by June 2014. The RTN will assess the plan annually and make changes as the need arises.

Score:

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. The RTN will review 100% of Region 1 MCA Trauma Triage Protocols for inclusion of the bypassing of a trauma care facility based on acuity, or the specialty care needs of the patient by June 2014. The RTN will review these protocols yearly for adherence to state guidelines.

Score:

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.
## Region 1 Trauma Network Application

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

<table>
<thead>
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</table>
| 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.
Region 1 Trauma Network Application

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

1. By June 2016 The RTN will develop a process to collect pre-hospital and inter-facility transfer data to determine gaps in the information that Region 1 trauma centers have identified as consistently missing or difficult to obtain (through Image Trend or individual facility EMR’s). This data will be used to create processes to assist in capturing the needed data to ensure timely trauma care. The RTN to take the lead in facilitating an effort to identify gaps, missing data that contributes to delays lack of effective communication, and then develop tools or process to address and evaluate collectively.

Score:

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. By June 2014.

- The PSRO will develop a process for the Region 1 MCA’s to assure trauma related EMS and transfer patient records are reviewed for quality.
- 100% of Region 1 hospitals will review defined high acuity trauma patients brought in by EMS at the request of the PSRO. The PSRO will have a process in place to monitor and report performance measures outlined in Administrative Rules
- RTN will develop recommendations to address gaps and barriers identified by PRSO

Score:

1. There are no written, quantifiable regional system performance standards or performance improvement processes.
Region 1 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.

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<thead>
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<tbody>
<tr>
<td>325.132(3)(c)(ii)(l) 206.1</td>
<td>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.</td>
<td>0. Not known. 1. The RTN does not generate trauma data reports for evaluation and improvement of system performance. 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.</td>
</tr>
</tbody>
</table>

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):

The RTN will generate a yearly data report to all Region 1 stakeholders discussing the regional trauma system and performance improvements metrics outlined in the Administrative Rules. The RTC for Region 1 will disseminate a quarterly newsletter to all stakeholders with educational opportunities, trauma updates and meetings.

Score:

2. Some general trauma system information is available to stakeholders, but it is not consistent or regular.
**Region 1 Trauma Network Application**

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

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>325.132(3)<a href="ii">c</a>(J) 310.(3)(4)(6)</td>
<td>The regional trauma network establishes and ensures that appropriate levels of EMS, nursing and physician trauma training courses are provided on a regular basis.</td>
<td>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.</td>
</tr>
</tbody>
</table>

| 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 structured process in place to routinely 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.
Region 1 Trauma Network Application

2013 – 2014 Regional Trauma Education Objective(s):

1. The Region 1 RTC will disseminate a quarterly newsletter with available trauma educational opportunities to all stakeholders. The RTN will review trauma education requirements for EMS providers in Region 1, and will make suggestions for change based on ACS recommendations by June 2016.

Score:

1. There are no regional trauma training guidelines for EMS personnel, nurses or physicians who routinely care for trauma patients.

2. The Region 1 RTC will include any Regional or Statewide protocol changes or updates into the quarterly newsletter sent to all ED/Trauma/EMS/MCA partners.

Score:

1. The region has no process in place to inform or educate all personnel on new protocols or treatment approaches.
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 Application
August 28, 2013
Regional Trauma Network Leadership and Governance

I have read the above and the bylaws and governance in Region 1 South reflect the statements above.

<table>
<thead>
<tr>
<th>MCA</th>
<th>Name (Signature)</th>
<th>Title</th>
<th>Date</th>
</tr>
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<tbody>
<tr>
<td>TCEMCA</td>
<td>Robert Orr, DO</td>
<td>Medical Director</td>
<td></td>
</tr>
<tr>
<td>Jackson County MCA</td>
<td>John Malno, MD</td>
<td>Medical Director</td>
<td></td>
</tr>
<tr>
<td>Shlakassee County MCA</td>
<td>Don Edwards, DO</td>
<td>Medical Director</td>
<td></td>
</tr>
<tr>
<td>Lenawee County MCA</td>
<td>Ron Derecoco, MD</td>
<td>Medical Director</td>
<td></td>
</tr>
<tr>
<td>Washtenaw County MCA</td>
<td>Robert Domeler, MD</td>
<td>Medical Director</td>
<td></td>
</tr>
<tr>
<td>Hillsdale County MCA</td>
<td>Brenda Brendel</td>
<td>MCA Representative</td>
<td></td>
</tr>
</tbody>
</table>

Please attach your organization chart and bylaws and include the original of this page with the RTN application.
Region 1
Trauma Network
Document of Organization & Governance

Region 1 Contact: Theresa Jenkins
Address: 12880 S. Bauer Rd
Eagle, MI 48822
Phone: 517-243-8507

Regional Trauma Network Members:

- Gratiot County MCA: Matthew Gulick RN, MCA Representative
- Hillsdale County MCA: Brenda Bendel, MCA Representative
- Jackson County MCA: John Maino, MD, Medical Director
- Lenawee County MCA: Ron DiCecco, MD, Medical Director
- Livingston County MCA: Robert Domeier, MD, Medical Director
- Shiawassee County MCA: Donald Edwards, DO, Medical Director
- Tri County Emergency MCA: Robert K Orr, DO, Medical Director

Mission: In effort to reduce mortality and morbidity, in Region 1 and across the State of Michigan, the Regional Trauma Network will develop a regionalized, accountable, coordinated system of care which includes well trained and well equipped trauma care providers to ensure that optimal trauma care is available and accessible to every person in the region.

Vision: The goal of implementation of an “Inclusive Trauma System” is to implement a coordinated, regionalized, accountable and highly effective system that will deliver the optimal care to any traumatically injured patient.

Values: By matching the patient to the appropriate facility and level of care, we will ensure the greatest impact and achieve the very best patient outcome and that in doing so we will work to reduce the rate of morbidity and mortality across the region and the state.
NAME AND COVERAGE AREA

A. Name.
The name of the organization is Region 1 Trauma Network (referred to herein as the "Network"), and its address is c/o TCEMCA, 6920 S. Cedar St. Lansing, MI 48911.

B. Coverage Area.
Network coverage area comprises the counties Clinton, Eaton, Ingham, Shiawassee, Gratiot, Jackson, Lenawee, Hillsdale and Livingston, (referred to herein as the "Network Area").

2. PURPOSE.
The purposes of the Network are as follows:

A. To organize, coordinate and manage a Network of hospitals, medical control authorities, EMS personnel, life support agencies, physicians, nurses, and consumers to plan and implement strategies to strengthen the provision of Trauma Care Services within the Network Area as defined and prescribed in the Michigan Statewide Trauma System Rules.

B. To develop a regional trauma plan and to apply to the Michigan Department of Community Health (referred to herein as the Department) for approval and recognition as the Region 1 Trauma Network. 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.

C. To establish the Region 1 Trauma Advisory Council.

3. ORGANIZATIONAL STRUCTURE.
The Network is comprised of Four (4) branches
- Region 1 Trauma Network- (referred to herein as the Regional Trauma Network)
- Region 1 Trauma Advisory Council- (referred to herein as the Regional Trauma Advisory Council)
- Region 1 Trauma Steering Committee – (referred to herein as Trauma Steering Committee)
- Region 1 Professional Standards Review Organization – (referred to herein as Professional Standards Review Organization)
4. REGIONAL TRAUMA NETWORK.

A. Purpose.
   The Network will be administered and governed by the Regional Trauma Network, with input from the Trauma Steering Committee and 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 will be selected by the Regional Trauma Network.

1. Election, Removal, Resignation and Vacancies.

   All Officers of the 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 three quarters 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.

2. Chairperson.

   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.

3. Vice-Chairperson.

   The Vice-Chairperson will report to the Chairperson as instructed by the Chairperson, and will perform such duties and have such powers as may from time to time be assigned by the Chairperson. In the absence or disability of the Chairperson the Vice-Chairperson will perform the duties and exercise the powers of the Chairperson.

D. Staff, Contactors, and Consultants.

   The Regional Trauma 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 Regional Trauma Network will provide supervision and management of any appointed personnel.
E. Other Contract Parties.
The Regional Trauma Network will establish the duties, responsibilities and compensation of other Network contract Parties. These duties, responsibilities and compensation will be established by a written contract approved by the Regional Trauma Network.

F. Duties.
1. The Regional Trauma Network will see that all orders and resolutions of the Regional Trauma Network are carried into effect and will have the general powers of supervision and management of the Regional Trauma Network.
2. Establish the Regional Trauma Advisory Council.
The Regional Trauma 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 Regional Trauma Advisory Council. The recommended makeup of the Regional Trauma Advisory Council is outlined in the section relating to the Regional Trauma Advisory Council.
3. Delegation of Duties.
The Regional Trauma Network may delegate duties to the Trauma Steering Committee, Regional Trauma Advisory Council and/or Sub-Committees as needed.

G. Meetings and Rules.
1. Meeting Schedule.
The Regional Trauma Network shall establish a regular schedule for quarterly meetings. The Chairperson may call for a special or emergency meeting of the Regional Trauma Network when deemed necessary.
2. Quorum Requirement.
A quorum for the transaction of business at any meeting of the Regional Trauma Network shall require the presence of the medical directors of at least 4 of the 7 MCAs in the Network.
3. Voting
Actions of the Regional Trauma Network, other than officer elections, require a simple majority of the MCA’s of the Regional Trauma Network for an action to be approved. If votes are taken with less than all the MCA Medical Directors present, the actions must be ratified by the remaining MCA Medical Directors in order to be approved.
4. Rules.
Roberts Rules of Order will govern all meetings of the Regional Trauma Network except where such rules are inconsistent with this document.
H. 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. TRAUMA STEERING COMMITTEE.
   A. Purpose.
      The Regional Trauma Steering Committee provides direction and supervision for
      the activities of the Regional Trauma Advisory Council and the Sub-Committees.

   B. Membership.
      The Trauma Steering Committee shall be comprised of the Medical Director or
      designee from each of the member Medical Control Authorities (Network MCAs)
      and the Trauma Director or designee from each verified trauma facility, each
      provisionally approved trauma facility and each facility actively seeking verification
      within the Network. Additional members may be added to the Trauma Steering
      Committee with a simple majority of the members of the Trauma Steering
      Committee.

      1. Member Designees, Resignation and Vacancies. A member designee may
         be replaced at any time by the respective MCA Medical Director or Trauma
         Medical Director. Any member of the Trauma Steering Committee may resign
         at any time by delivering written notice to the Trauma Steering Committee.
         Vacancies will be filled by the respective MCA Medical Director or Trauma
         Medical Director.

   C. Officers
      Officers of the Trauma Steering Committee will be Co-Chairpersons elected by
      the Regional Trauma Network. One Co-Chairperson will be an MCA Medical
      Director and one Co-Chairperson will be a Trauma Medical Director. Officers will
      be appointed by the Regional Trauma Network considering recommendation from
      the Trauma Steering Committee.

      1. Co-Chairpersons.
         a. Duties and Responsibilities.
            The Co-Chairpersons, will serve as Co-Chairpersons of the Trauma
            Steering Committee and Regional Trauma Advisory Council. The Co-
            Chairpersons will preside over all meetings of the Trauma Steering
            Committee and the Regional Trauma Advisory Council.

         b. Requirements.
            The Network’s Co-Chairpersons must be physicians with a current license
            from the State of Michigan. One must be an MCA EMS Medical Director
            and be board-certified in Emergency Medicine and one must be a Trauma
            Medical Director and be board certified in General Surgery.
c. Terms of Service.
The Co-Chairpersons will be appointed in opposite years and serve for a two year term. During the first year one Co-Chairperson will be appointed for a two year term and one for a one year term. The term of office may be renewed at the discretion of the Regional Trauma Network. A Co-Chairperson may resign at any time by delivering written notice to the Regional Trauma Network Chairperson. Vacancies occurring will be filled by the Regional Trauma Network.

D. Executive Authority.
The Trauma Steering Committee will have the authority to make a recommendation for an action to the Regional Trauma Network it deems necessary when a Regional Trauma Advisory Council meeting is not scheduled prior to a decision deadline. Any action taken by the Trauma Steering Committee in reliance on this authority shall be presented at the next Regional Trauma Advisory Council meeting for approval.

E. Meetings and Rules.
1. Meeting Schedule.
The Trauma Steering Committee shall establish a regular schedule for quarterly meetings. The Co-Chairpersons may call for a special or emergency meeting of the Trauma Steering Committee when deemed necessary.

2. Quorum Requirement.
A quorum for the transaction of business at any meeting of the Trauma Steering Committee shall require the presence of representatives from 2/3 of the verified, provisional and facilities actively seeking verification within the Network Area and representatives of at least 4 of the 7 MCAs in the Network and half of the remaining representatives.

Actions of the Trauma Steering Committee require a simple majority of the members of the Trauma Steering Committee present at the meeting in which an action is being considered, subject to quorum requirements being met.

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

F. Consent Resolution.
Action may be taken by the Trauma Steering Committee, without a meeting, by a written consent (as requested either by mail, fax or email) signed by a simple majority of the members of the Trauma Steering Committee if responses/votes are consistent with quorum requirements.
6. REGIONAL TRAUMA ADVISORY COUNCIL.
   A. Purpose.
      The purpose of the Regional Trauma Advisory Council under the directives of the
      Regional Trauma Network and Trauma Steering Committee is to provide
      leadership and direction in matters related to trauma system development in the
      Network Area.
   
   B. Membership.
      1. Co-Chairpersons.
         The Co-Chairpersons of the Trauma Steering Committee will serve as Co-
         Chairpersons of the Regional Trauma Advisory Council.
      2. Member/Alternate Designation.
         Members of the Regional Trauma Advisory Council shall be designated in
         writing by the appointing MCA, hospital, or other organization. Alternate
         members may be designated. Each appointing body may 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).
         Members.
         The Regional Trauma Advisory Council will be comprised of the following
         eligible membership with the goal of maximizing inclusion of the Network’s
         constituents:
         a) Medical Director or designee of each MCA within the Network Area.
         b) MCA administrative representative.
         c) Trauma Director or designee from each verified trauma facility, each
            provisionally approved trauma facility and each facility actively seeking
            verification within the Network Area.
         d) Trauma Program Manager from each verified trauma facility, each
            provisionally approved trauma facility and each facility actively seeking
            verification within the Network Area.
         e) Trauma Registrar from each verified trauma facility, each provisionally
            approved trauma facility and each facility actively seeking verification within
            the Network Area.
         f) Trauma Nurse Representative from each verified trauma facility, each
            provisionally approved trauma facility and each facility actively seeking
            verification within the Network Area.
         g) Trauma Outreach and Prevention Coordinator from each verified trauma
            facility, each provisionally approved trauma facility and each facility actively
            seeking verification within the Network Area.
h) Emergency Department Physician representative from licensed hospitals and free standing surgical outpatient facilities (as defined in the EMS Act Section 20918.1) within the Network Area.

i) Emergency Department Nurse representative from licensed hospitals and free standing surgical outpatient facilities (as defined in the EMS Act Section 20918.1) within the Network Area.

j) Life Support Agency, EMS Personnel and Consumer representatives as appointed by each MCA in the Network Area, to include as an example:
   - Protocol Committee/Advisory Committee Chairperson.
   - EMS Personnel Representative.
   - Life Support Agency Representative.
   - EMS Communication/EMD representative
   - Consumer representative not affiliated with the EMS or Hospital systems.

3. Member Appointment and Removal.
   Each appointment and replacement of a representative or alternate representative must be presented to the Regional Trauma Network or designee in writing or electronically, on the appointing organization's letterhead signed by the administrative head of the appointing organization.

4. Resignation.
   A resigning member of the Regional Trauma Advisory Council will have no further obligation to the Network.

5. Membership Review.
   The Regional Trauma Advisory Council will review, at least annually, the appointments of its representatives and any alternate representatives.

6. Additional Stakeholder Membership.
   The Regional Trauma Advisory Council, by a vote of a simple majority of its existing members, may authorize additional stakeholders within the Network Area to be represented on the Regional Trauma Advisory Council. Additional stakeholders selected may appoint one representative and one alternate representative to serve in the absence of the first appointed representative.

C. Regional Trauma Advisory Council Participation.
   Each MCA, hospital, or other organization granted the right to appoint a representative(s) to the Regional Trauma Advisory Council must be a participating member of the Network. Any MCA, hospital, or other organization entitled to appoint a representative(s) to the Regional Trauma Advisory Council who fails to appoint a representative will be deemed to have elected not to participate in the Network and will not be entitled to receive any funding from the Network (subject to funding becoming available).
D. Duties.

The duties of the Regional Trauma Advisory Council include, but are not limited to:

1) Develop and make recommendations to the Trauma Steering Committee and Regional Trauma Network regarding the Regional Trauma Network's Trauma System Plan.
2) Review of trauma deaths and preventable complications.
3) Make funding allocation recommendations (subject to funding becoming available).

E. Recommendation Approval.

Recommendations of the Regional Trauma Advisory Council to the Regional Trauma Steering Committee must be approved by a simple majority of those present at the meeting of the Regional Trauma Advisory Council members present at a meeting of the Regional Trauma Advisory Council.

F. Sub-Committees.

1. Establishing Sub-Committees.

The Regional Trauma Advisory Council may establish sub-committees as required and as it deems appropriate, unless otherwise restricted by the Trauma Steering Committee or Regional Trauma Network. Each sub-committee will elect its own chairperson(s). The Network Co-Chairperson(s) and Network Coordinator (subject to funding becoming available) will be ex-officio members of each sub-committee.

2. Sub-Committee Chairperson(s) Attendance at Regional Trauma Advisory Council Meetings.

Each sub-committee chairperson(s) will attend the Regional Trauma Advisory Council meetings and make a sub-committee report. If unable to attend, other arrangements for sub-committee reporting must be made by the Chairperson(s).

G. Meetings and Rules.

1. Meeting Schedule.

The Regional Trauma Advisory Council shall establish a regular schedule for quarterly meetings. The Co-Chairpersons may call for a special or emergency meeting of the Regional Trauma Advisory Committee when deemed necessary.
2. Voting.  
Actions of the Regional Trauma Advisory Committee require a simple majority of the members of the Regional Trauma Advisory Committee present at the meeting in which an action is being considered.

3. 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 Regional Trauma Advisory Council, without a meeting, by a written consent (as requested either by mail, fax or e-mail) signed by a simple majority of the members of the Regional Trauma Advisory Council.

I. Actions Requiring Regional Trauma Advisory Council Approval.  
The following actions and activities will require the approval of the Regional Trauma Advisory Council:

1. The Regional Trauma Advisory Council will have the authority to approve or return for reconsideration to a sub-committee, sub-committee recommendations for allocation of funding (subject to funding becoming available).

2. The Regional Trauma Advisory Council will have the authority to approve or return for reconsideration to a sub-committee, sub-committee recommendations for Network plans.

3. The Regional Trauma Advisory Council may delegate responsibility to the sub-committee(s) as needed.

4. The adoption of any plan or recommended action by any participant in the Network, require the approval of a simple majority of the Regional Trauma Advisory Council members present at a Regional Trauma Advisory Council meeting, at which such plan or recommended action is presented. Plans and recommendations that do not receive simple majority support at a Regional Trauma Advisory Council meeting may be referred to the sub-committee for reconsideration.

7. REGIONAL PROFESSIONAL STANDARDS REVIEW ORGANIZATION

A. Purpose  
The purpose of the Regional Professional Standards Review Organization (RPSRO) is to reduce death and disability and correct local and regional injury problems through a documented performance improvement process. Rule 325.132(4) requires that each regional trauma network appoint an RPSRO to addresses the standards referenced in the administrative rules pursuant to
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R 325.129(2)(1) and to include both adult and pediatric patients. The RPSRO is defined in R 325.127(e) as a committee established by a life support agency or a medical control authority for the purpose of improving the quality of medical care, as provided in MCL 331.531.

B. Members
The Regional Professional Standards Review Organization will be comprised of the following eligible membership with the goal of maximizing inclusion of the Network’s constituents:
1. MCA Medical Director
2. Trauma Medical Director
3. Trauma Surgeon
4. EMS Representation
5. Nursing Representation
6. MCA Representation

C. Members appointment and renewal
Each appointment or replacement of a representative or alternate representative must be presented to the Regional Trauma Network or designee in writing or electronically, on the appointing organization’s letterhead signed by the administrative head of the appointing organization.

D. Resignation
A resigning member of the Regional Professional Standards Review Organization will have no further obligation to the committee.

E. Membership Review
The Regional Trauma Network will review, at least annually, the appointments of the Professional Standards Review Committee and any alternate representatives.

F. Meetings and Rules
The membership of the Regional Professional Standards Review Organization will meet and review performance improvement requests made of the Regional Trauma Network.

G. Confidentiality
All performance improvement reviews done by the Regional Professional Standards Review Organization are confidential, including information required for the review and findings of the committee. Reports and system process improvement recommendations will be reviewed by the RTN Co-Chairs and will be presented to the Regional Trauma Network and Regional Trauma Advisory Committees with confidential information redacted. Patient
confidentially will be subject to HIPPA guidelines. Any information or recommendations from this committee will have all identifying patient and facility information redacted. These meetings will not be subject to the open meeting act.

H. Data Use Agreement
All members of the Regional Professional Standards Review Committee will be required to sign a data use agreement.

8. CONFLICT OF INTEREST.
Any MCA, hospital or other organization participating in the Regional Network, Steering Committee, Advisory Council or Advisory Council Sub Committees with an interest in any matter before the Regional Network, Steering Committee, Advisory Council or Advisory Council Sub Committees, or other conflict of interest, shall disclose the interest prior to any discussion of that matter at a Regional Network, Steering Committee, Advisory Council or Advisory Council Sub Committees meeting. The representative of such MCA, hospital or other organization shall refrain from participation in the Regional Network, Steering Committee, Advisory Council or Advisory Council Sub Committees action relating to such matter or conflict of interest. The disclosure shall become a part of the minutes of that Regional Network, Steering Committee, Advisory Council or Advisory Council Sub Committees meeting.

9. ADMINISTRATION AND APPROVAL PROCESS
A. Plan Approval Process.
1. Plans and actions of the Regional Trauma Advisory Council must be approved by the Trauma Steering Committee. Final approval of all plans and actions is by the Regional Trauma Network. If approval of any plan or action is not received from the Trauma Steering Committee and each participating MCA, the plan or action will be returned to the Co-Chairpersons, with comments from the Trauma Steering Committee or each non-approving MCA identifying the reason for non-approval. Discussions on the unapproved aspect(s) of such plan or action will continue until the plan is approved by the Trauma Steering Committee and each of the Regional Trauma Network MCAs or the plan or action is withdrawn.
2. If approval is received from the Trauma Steering Committee and each participating MCA in the Regional Trauma 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.
3. The Co-Chairpersons will refer items for reconsideration to the Regional Trauma Advisory Council or Trauma Steering Committee as needed.
B. Confidentiality.

1. To the extent required by law, the Regional Trauma Network, Regional Trauma Advisory Council, Trauma Steering Committee and Sub-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.

4. The Regional Trauma Advisory Council 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).

10. Amendments.

This document may be amended or repealed by the Regional Trauma Network with the input from the Trauma Steering Committee, Regional Trauma Advisory Council and Network Fiduciary (subject to funding becoming available). A notice of any amendment will be sent to each participant in the Network.

11. Indemnification.

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Region 1 Regional Trauma Coalition

Regional Trauma Network

Regional Steering Committee

Regional Trauma Advisory Committee

Protocol Committee

Education Committee

Injury Prevention Committee

Professional Standards Review Committee