

Upper Peninsula Region 8 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, and 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 of the hospital setting. Hospitals in the MCA may agree to confer their oversight responsibilities to an executive director. There are currently 62 MCAs 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 MCAs 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 (MCAs) 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 MCAs 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 it's 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 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 provide the content expertise, the experience and the front line understanding of the issues, challenges, and gaps of the regional trauma system.

Addendum to RTN membership for Region 8

March 19, 2014

Baraga Hospital and Marquette General Hospital have recently changed their RTN representative. Due to the geography and the time constraints the two new representatives have added their signature on a separate signatory form. The signatures will be combined to one form in the near future.

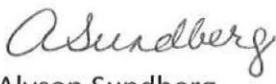
Baraga Hospital has elected Margie Hale to represent their hospital on the RTN. Gary Wadega, the previous representative for Baraga Hospital, will become an RTAC representative as well as the liaison to the RTN for RTAC.

Marquette General Hospital has elected Alyson Sundberg to represent their hospital on the RTN. Lyn Nelson, the previous representative for Marquette General Hospital, is no longer the RTN representative for Marquette General Hospital on the RTN.

Signatories to the Network

Regional Trauma Network Leadership and Governance

I have read the above the bylaws and governance in Region 8 reflects the statements above.

MCA	Name (Signature)	Title	Date
Marquette County MCA	 Alyson Sundberg	Director of Risk Mgt Compliance & EMS	3/18/2014

Regional Trauma Network Leadership and Governance

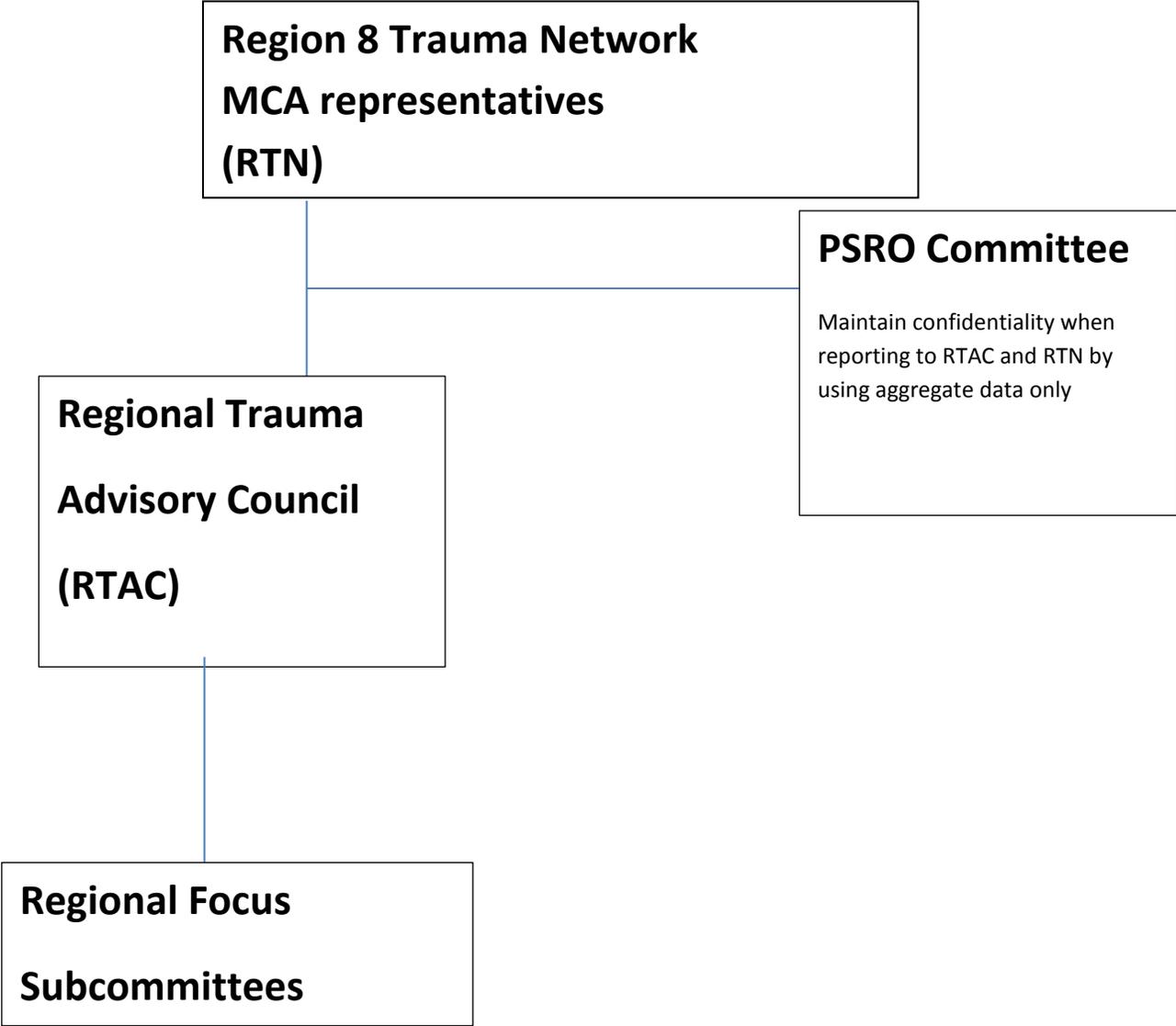
I have read the above and the bylaws and governance in Region B reflect the statements above.

MCA	Name (Signature)	Title	Date
Baraga County MCA	 Gary Wadaga	MCA Representative	10/21/2013
Delta County MCA	 Edward Bigsby	Medical Director	10/27/13
Dickinson County MCA	 Doug McDowell	Medical Director	10/27/13
Eastern UP MCA	 Pat Hill	MCA Representative	10-29-13
Gogebic-Ontonagon County MCA	 Joel Bach	MCA Representative	10-30-13
Iron County MCA	 Cindy Gurchinoff	MCA Representative	10-30-13
Keweenaw Houghton MCA	 Gerry Primeau	MCA Representative	10-30-13
Luce County MCA	 Sarah Johnson	MCA Representative	10/31/13
Marquette/Alger County MCA	 Lyn Nelson	MCA Representative	10/31/2013
Schoolcraft County MCA	 Ed Unger	MCA Representative	11/1/2013

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



Organizational Chart



Network Bylaws

ARTICLE 1. NAME, COVERAGE AREA, STRUCTURE, AND PURPOSE

SECTION 1.1 – NAME

The name of this organization shall be the Region 8 Trauma Network (herein referred to as the “R8TN”). The address is 420 West Magnetic, Marquette MI 49855.

SECTION 1.2 –COVERAGE AREA

Said geographic region is the Upper Peninsula of Michigan as designated by the State of Michigan as Region 8. Network coverage area comprises the counties of Schoolcraft, Ontonagon, Menominee, Marquette, Luce, Keweenaw, Iron, Houghton, Gogebic, Dickinson, Delta, Chippewa, Baraga, Alger (herein referred to as the “region”). Mackinac County is demographically located in region 8 but their MCA is located in region 7. Mackinac County will be included in region 7 network.

SECTION 1.3 - PURPOSES

The mission of the R8TN is to reduce morbidity and mortality in Region 8 for trauma patients.

The vision is to implement a coordinated, regionalized, accountable and effective healthcare system that will deliver optimal care to any victim of trauma.

The purpose and scope of activities of R8TN shall pertain to providing clinical oversight of trauma care in Region 8 by addressing each of the following trauma system components: leadership, public information and prevention, human resources, communications, medical direction, triage, transport, trauma care facilities, inter-facility transfers, rehabilitation, and evaluation of patient care within the system.

Section 1.4- Organizational Structure

The structure of R8TN will include the following;

1. Regional Trauma Network (herein referred to as the “RTN”) which serves as the principal governing board of the network.
2. Regional Trauma Advisory Council (herein referred to as the “RTAC”) which provides the leadership and direction in matters related to trauma system development in the region.
3. Regional Professional Standards Review Organization (herein referred to as RPSRO).
4. Various standing and appointed committees.

ARTICLE 2 MEMBERSHIP:

SECTION 2.1 – REPRESENTATION

The members of the RTN shall include:

1. The RTN will include one representative of each MCA in region 8. This is to include a minimum of one trauma medical director and one hospital administrator.

SECTION 2.2 – MEMBERSHIP APPOINTMENTS

The respective MCAs in Region 8 shall appoint one member to the RTN. This is to include a minimum of one trauma medical director and one hospital administrator.

SECTION 2.3 – DUTIES

1. **Establish the Regional Trauma Advisory Council.** The RTN 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 RTN will make selected appointments to the RTAC.
2. **Regional Trauma Plan.** The RTN will review and approve the Regional Trauma Plan which is developed by the RTAC.
3. **Professional Standards Review Organization Committee (PSRO).** 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 findings to the RTAC and RTN. 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 RTN.
4. **Other Duties.** The RTN 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 RTN may delegate duties to the RTAC and/or other committees as needed.

SECTION 2.4 – TERM OF OFFICE

All R8TN RTN members are appointed to serve a two (2) year term coinciding with the calendar year. The MCA shall appoint members prior their term expiration. Half of the board will be up for election on even number years and the other half on odd number years.

SECTION 2.5 – VACANCIES

In the event of a member vacancy, the MCA will appoint a successor who is of the same designation (see Section 2.1 – Members of the Board). Said successor shall serve until the expiration of the normal term of such member.

ARTICLE 3. OFFICERS

SECTION 3.1 – OFFICERS

Officers of this organization shall be:

1. Co-chairperson
2. Co-chairperson
3. Secretary

SECTION 3.2 – DUTIES OF OFFICERS

1. Chairperson
 - a. Call to order and chair meetings
 - b. Appoint committees
2. Co-Chairperson
 - a. Call to order and chair meetings in the absence of Chairperson.
3. Secretary
 - a. May or may not be a member of the RTN.
 - b. If he/she is not a member of the RTN, may not participate in a vote, will sign a

Statement of Confidentiality and will abide by all HIPAA requirements regarding patients, emergency medical services and provider information.

c. Keeps minutes.

d. Responsible for transmitting minutes and information to the membership in a timely manner.

SECTION 3.3 – REMOVAL OF AN OFFICER

An officer may be removed from office by a quorum, with a 30-day notice, for failing to perform the prescribed duties of the office.

SECTION 3.4 – ELECTION OF OFFICERS/TERM OF OFFICE

All officers shall be nominated and elected at the January meeting of this organization. Elected officers shall assume their duties at the next scheduled meeting. The term of office shall be one year. See 2.4.

SECTION 3.5 – VACANCIES OF AN OFFICER

In the event of an officer vacancy, a special election will be held to elect a replacement to that position. Said successor shall serve until the expiration of the normal term of such member.

ARTICLE 4. – MEETINGS

SECTION 4.1 – MEETING DATES

The R8TN will establish a regular schedule for meetings. At least four meetings will be schedule per year on a quarterly basis. Said meetings will be teleconferenced to all hospitals with teleconferencing ability as requested and will be open to hospital and emergency medical services personnel. Meeting dates of each year shall be an appendix of the bylaws.

SECTION 4.2 – CANCELLATION OF MEETINGS

A meeting may be cancelled if deemed advisable due to any reason including but not limited to lack of business or inclement weather. All Board members and interested parties will be notified by telephone, email, or in person, of all cancellation of meetings. All efforts will be made to make notifications prior to 48 hours of scheduled meeting date.

SECTION 4.3 – SPECIAL MEETINGS

The Chairperson may call a special meeting at any time, providing that members are given at least 48 hours notice. Notices of special meetings shall state the purpose of purposes of the meeting and no regular business shall be addressed at a special meeting, except that business specified in the notice.

SECTION 4.4 – ATTENDANCE

The R8TN RTN meetings are open to attendance by hospital staff, emergency medical services staff, as well as the public. All motions and business shall be conducted by current RTN members with each member casting one vote. See 4.1.

SECTION 4.5 – QUORUM FOR R8TN

A quorum for regular and special meetings is defined as one more than half with at least one (1) voting officer. Video/teleconference is acceptable as attendance.

SECTION 4.6 – PARLIMENTARY AUTHORITY

The rules contained in the current edition of Robert’s Rules of Order, Newly Revised, shall govern in all cases to which they are applicable and in which they are not inconsistent with these bylaws and any special rules of order the RTN may adopt.

ARTICLE 5 POLICIES, and PROCEDURES

SECTION 5.1 – CONFIDENTIALITY POLICY

1. To the extent required by law, the Regional Trauma Network, Regional Trauma Advisory Council and Sub-Committees will comply with the Michigan Open Meetings Act.
2. To the extent required by law, the Regional Trauma Network with 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. All documents prepared in support of the Regional Trauma 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 (RPSRO), 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 R325.22217. Any other uses or disclosures will be made only as required by applicable laws.
4. The Regional Trauma Network, Regional Trauma Advisory Council and RPSRO 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 RPSRO.

Section 5.2-Books and Records

The officers, appointees, and agents of the R8TN shall maintain detailed and accurate books, records, and accounts of the R8TN activities as determined by the RTN and shall be in accordance with applicable state and federal law and regulations, including the regulations established by the Department.

Section 5.3-Plan Approval Process

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

ARTICLE 6 – ADVISORY COUNSEL

Section 6.1-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 the trauma deaths, and preventable complications.

Section 6.2-MEMBERSHIP

1. The Regional Trauma Advisory Council (RTAC) is appointed by the Regional Trauma Network. It should be comprised of MCA personnel; life support agency representatives and EMS personnel; healthcare facility representatives, physicians and nurses; consumers. Alternate members may be designated. Each appointing body may remove and replace its' appointed representative(s) and /or its' alternate representative(s). Each appointing body may fill any vacancy created by the resignation of an appointed representative(s) or alternate representative(s), at any time, at its' discretion.
2. The RTAC will be comprised of the following:
 - Representative from each MCA with the region
 - Physician representative
 - Non-physician representative
 - Representative from ground support EMS
 - Trauma registry representative
 - Consumer representative
3. Voting member appointment and removal declaration:
Each appointment and removal of a representative or alternate representative must be presented to the RTN in writing or electronically, on the appointing organization's letterhead/email address and signed by an authorized official of the appointing organization.
4. A resigning voting member or alternate of the RTAC will have no further obligation to the R8TN.
5. Non-Voting Members
Non-voting member 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 RTN. The RTN may remove any non-voting member for cause.
6. RTN Liaison
One member of the RTAC will be a non-voting member of the RTN. This liaison will be one communication pathway between the RTN and the RTAC
7. Membership Review
The RTAC will review, at least annually, the voting members, alternates, and non-voting members of the RTAC.

Section 6.3-Quorum for RTAC

A quorum for regular and special meetings is defined as one more than half with at least one (1) voting officer. Video/teleconference is acceptable as attendance.

Section 6.4-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 RTAC members. Officers will hold office a two year term, unless removed by an affirmative vote of three quarters (or more) of the RTAC members. However, officers may be re-elected to serve additional terms. Any officer may resign at any time by delivering written notice to the Chairperson of the RTN. RTAC will advise RTN of RTAC officers.
3. Chairperson
The Chairperson will provide leadership to the RTN, and will preside over all meetings of the RTAC. In the absence of the Chairperson the Vice-Chairperson shall preside over the RTAC meetings. In the absence of both the Chairperson and the Vice-Chairperson, the Chairperson will designate a member of the RTAC to preside over the RTAC meeting.
4. Vice Chairperson
The Vice Chairperson will provide leadership to the RTAC and in the absence of the Chairperson will preside over the RTAC meetings. The Vice Chairperson may perform other tasks as requested by the Chairperson in support of the RTN.
5. Secretary
The secretary will serve as a 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 meeting

Section 6.5-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 RTN.
2. Develop, implement, and monitor the clinical care issues of trauma deaths and preventable complications based on recommendations from the Professional Standards Review Committee.
3. Implement a trauma registry system to support the performance improvement plan for regional trauma care.
4. Review and support trauma related educational activities for health care providers with the region
5. Develop RTN plan consistent with Michigan's Trauma System Plan, addressing each of the following trauma system components:
 - Injury Prevention
 - Access to the System
 - Communications
 - Medical Oversight
 - Pre-hospital Triage Criteria
 - Trauma Diversion Policies
 - Trauma Bypass Protocols
 - Regional Trauma Treatment Guidelines
6. Make funding allocations recommendations (subject to funding availability) to the RTN for approval.
7. Provide data and resources to Regional Trauma Coordinator containing information for the annual report filed with the state that will include describing progress toward the system development, demonstrating on-going activities, and evidence that members of the RTAC are involved in regional trauma care.

ARTICLE 7- REGIONAL PROFESSIONAL STANDARDS REVIEW ORGANIZATION

SECTION 7.1 – Purpose

1. The Regional Professional Standards Review Organization (RPSRO) is established by the R8TN. The purpose of the 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 address the standards referenced in the administrative rules pursuant to 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.
2. The Regional Professional Standards Review Organization (RPSRO) formulates recommendations for the development of performance improvement plans submitted to the R8TN by using the statewide comprehensive data collection system. The RPSRO shall develop a process for Regional Trauma Plan performance monitoring to ensure effectiveness and compliance from pre-hospital care to rehabilitation. The RPSRO will also evaluate and set standards for each component of the Regional Trauma Plan based on the current research.

SECTION 7.2 – RPSRO MEMBERS

The RPSRO shall be comprised of the individuals with a specialty or interest in trauma care. The RPSRO membership will consist of one MCA Trauma Medical Director, one Emergency Department Medical Director, one Trauma Center Medical Director or Trauma Surgeon, pre-hospital providers, nursing staff, and rehabilitation specialist from throughout the region. Members will be appointed by the RTN. The RTN shall establish a procedure for terms, nominations, removal and appointments of the members. The RPSRO shall elect a chairperson

1. and shall allow a designee to chair each RSPRO meeting should the chairperson be unable to attend

SECTION 7.3 – RPSRO CLOSED SESSIONS

The RPSRO is created by the Regional Trauma Network as a peer quality improvement organization and is closed under circumstances outlined with MCL 15.267 and 15.268.

SECTION 7.4 – RPSRO MEETING FREQUENCY

The RPSRO shall establish a regular schedule for meetings. Meetings will occur four times per year, minimally. The Regional Trauma Coordinator may call a special or emergency meeting of the RPSRO when deemed necessary.

SECTION 7.4.1 – RPSRO MEETINGS AND RULES

1. Meeting Notice – The Regional Trauma Coordinator shall send either email or mail notices of meetings at least thirty (30) days prior to the scheduled meeting. Notice of special meetings must be sent ten (10) days prior to the emergency meeting.
2. Quorum – At any meeting of the RPSRO, the members present shall constitute a quorum.
3. Procedure – The agenda and procedure of all meetings of the RPSRO shall be governed by Robert Rules of Order, Revised (latest edition), to the extent that such rules of order shall not be in conflict with the statutes of the State of Michigan rules.
4. The Regional Trauma Coordinator, or designee, shall act as the facilitator of the RPSRO.

SECTION 7.5 – RPSRO CONFIDENTIALITY AND DATA USE AGREEMENT

Confidentiality policy is outlined herein, Section 5.1 Data use agreement will be added to this document when State of Michigan legal authorities have completed the addendum.

SECTION 5.3.8 – RPSRO FIDUCIARY

This section left intentionally blank (subject to funding becoming available).

Confidentiality will be maintained when RPSRO reports to RTAC and RTN. Aggregate data only will be used when reporting to RTAC and RTN.

SECTION 7.6 – RPSRO CONFLICT OF INTEREST

Any RPSRO member with an interest in any matter before the RPSRO shall disclose the interest prior to any discussion of that matter at the RPSRO meeting. The disclosure shall become a part of the minutes of that RPSRO meeting.

SECTION 7.7 – RPSRO ADMINISTRATION

1. Records collection and retention - this section left intentionally blank (subject to state guidance).
2. Outcomes and recommendations of the RPSRO will be directed to the RTN for consideration and direction.

SECTION 7.8 – RPSRO INDEMNIFICATION

This section left intentionally blank (subject to state guidance).

ARTICLE 8 – AD HOC COMMITTEES

May be appointed by the R8TN chairperson to review and advise on specific concerns. Said committees shall be dissolved upon the completion of their duties.

ARTICLE 9-AMENDMENTS, REVIEW TO BY-LAWS

SECTION 9.1– AMENDMENTS

This document may be amended or repealed by the Regional Trauma Network with the input from the 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 Board and Advisory Council. An amendment to these by-laws cannot be approved at the same meeting at which it is presented.

SECTION 9.2 – REVIEW

These by-laws shall be reviewed every three (3) years.

SECTION 9.3 – VOTE

An amendment to these by-laws can only occur if it is consistent with Michigan law and with a simple majority vote of member's present.

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.

<p>325.132(3) 202.2</p>	<p>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.</p>	<p>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.</p>
<p>325.132(3)(c)(i) 202.3</p>	<p>A clearly defined and easily understood governance and communication structure is in place for regional trauma system operations.</p>	<p>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.</p>

System Governance Objective:

- By April 1, 2014 the R8TN will have appointed members to RTAC in accordance to R8TN bylaws which include a minimum representation of the following disciplines for each of the counties:
 - Medical Control Authorities
 - Life Support Agencies
 - Hospitals
 - EMS physicians
 - Trauma Surgeons
 - Trauma Program Managers
 - EMS personnel
 - Nurses
 - Consumers

- By June 2014, the region 8 RTAC membership will be active and meeting, at a minimum, quarterly as evidenced by meeting minutes and meeting schedule for 2014.
- By October 2014, procedures will be implemented to ensure recommendations, minutes, and action steps developed in subcommittees, RTAC and RTN are disseminated in an organized, accountable way to provide adequate direction, ensuring that the work plan for region 8 will move forward and will provide a venue to address issues that require immediate attention.

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.

<p>325.132(3)(c)(ii)(A) 306.2</p>	<p>The RTN is active within the region in the monitoring and evaluation of community-based injury prevention activities and programs.</p>	<p>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.</p>
<p>325.132(3)(c)(ii)(A) 203.5</p>	<p>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.</p>	<p>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.</p>

Injury Prevention Objective:

- By July 2014, the Region 8 RTAC will appoint an Injury Prevention sub-committee. The subcommittee chairperson or representative will report to RTAC scheduled meetings.

Region 8 Injury Prevention sub-committee:

- Identifying injury prevention needs:
By November 2014, the Injury Prevention subcommittee will have conducted a regional survey to obtain information from community partners on what injury prevention is currently occurring: the type, audience, locations and contact persons for the programs.
- Needs Assessment:
By December 2014, the Injury Prevention subcommittee will have developed a regional needs assessment based on data received from survey.
- Plan:
By February 2015, the Injury Prevention subcommittee will have developed a Regional Injury Prevention Plan that includes coordination of Injury Prevention programs with the leading causes of injury in Region 8. This plan will include identified presenters, audiences, delivery dates, locations and an evaluation process. The regional injury prevention plan will be re-evaluated every three years.

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

<p>325.132(3)(c)(ii)(B) 302.4</p>	<p>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.</p>	<p>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.</p>
<p>325.132(3)(c)(ii)(B) 302.8</p>	<p>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.</p>	<p>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.</p>

Citizen Access Objective:

- By July 2014, the region 8 RTAC will establish a Citizen Access and Communications subcommittee which includes dispatch representation from region 8. The subcommittee chairperson or representative will report to RTAC scheduled meetings
- By October 2014, the Region 8 trauma coordinator, along with the Citizen Access and Communications subcommittee, will introduce the Regional Trauma Plan to the Public Safety Answering Points (PSAPs) located throughout the Region, collect how dispatch centers currently communicate with one another pre, during and post incidents.
- By December 2015, create a regional minimum, standard pre-arrival instruction set/tool for pre-hospital emergency medical trauma dispatch as approved by MCA medical directors. (Note: All Region dispatch centers are currently using emergency medical dispatch based upon different software. The idea is to create a minimum, standard of what the software must include and assure the MCA medical directors are the ones signing off on the pre-arrival instructions.)

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.

<p>325.132(3)(c)(ii)(C) 302.10</p>	<p>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.</p>	<p>0. Not known. 1. There are no written procedures for regional EMS and trauma systems communications for major EMS events or multiple jurisdiction incidents. 2. Local medical control authorities have written procedures for EMS communications during major events. However, there is no coordination among the adjacent local jurisdictions. 3. There are written regional EMS communications procedures for major EMS events. These procedures do not involve other jurisdictions and are not coordinated with the overall regional response plans or incident management system. 4. There are written regional EMS communications procedures for major EMS events and multiple jurisdiction incidents that are coordinated with adjacent jurisdictions, with the overall regional response plan and with the incident management system. 5. There are written regional EMS communications procedures for major EMS events and multiple jurisdiction incidents that are coordinated with the overall regional response plan and with the incident management system. There are one or more system redundancies. These procedures are regularly tested in simulated incident drills, and changes are made in the procedures based on drill results, if needed.</p>
<p>325.132(3)(c)(ii)(C) 302.9</p>	<p>There is a procedure for communications among medical facilities when arranging for inter-facility transfers including contingencies for radio or telephone system failure.</p>	<p>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.</p>

Communications Objective:

- By July 2014, the region 8 RTAC will establish a Citizen Access and Communications subcommittee. The subcommittee chairperson or representative will report to RTAC scheduled meetings
- By October 2014, the Citizen Access and Communications subcommittee will develop an assessment tool to identify communication gaps and capabilities to include equipment (landline, satellite phones, cellular phones, VHF radios, 800MHz radios, ham radios, internet capable computers / smartphones / hotspots), geographic coverage areas, VHF templates, 800MHz templates, MEDCOM plan, existing interoperability plans, existing COM-L plans and infrastructure, EMResource, WebEOC. Share results with RTN, RTAC and partners.
- By January 2015, the Citizen Access and Communications subcommittee will have adopted a common procedure/plan for EMS and trauma system communications for major EMS events and multiple jurisdiction incidents that are coordinated with the regional disaster response plans as evidenced by RTN approval in meeting minutes.
- By January 2015, the Citizen Access and Communications subcommittee will develop, and present to RTAC, a plan for the continuation of inter-facility communication in the event of the failure with the traditional means of communication. This plan will be in approved and in place for region 8 by June 2015.

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

<p>325.132(3)(c)(ii)(D) 302.1</p>	<p>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.</p>	<p>0. Not known.</p> <p>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.</p> <p>2. EMS and trauma medical directors collaborate in the development of protocols for pre-hospital providers providing care to trauma patients.</p> <p>3. The RTN has adopted state approved regional trauma protocols.</p> <p>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.</p> <p>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.</p>
<p>325.132(3)(c)(ii)(D) 302.2</p>	<p>There is a clearly defined, cooperative, and ongoing relationship between regional trauma physician leaders and the EMS system medical directors in the region.</p>	<p>0. Not known.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

Medical Oversight Objective:

- By September 2014, region 8 RTAC will establish a Medical Oversight sub-subcommittee which will include medical control directors, and trauma medical directors, as evidenced by a formal roster. The subcommittee chairperson or representative will report to RTAC scheduled meetings
- By December 2014 the Medical Oversight sub-committee will meet with the EMS directors and the trauma medical director to discuss current EMS protocols and procedures relative to communications, pre-hospital triage, treatments and transport protocols.
- By January 2015, the Medical Oversight subcommittee will meet regularly and begin collaborating in the oversight of pre-hospital providers providing care to trauma patients as evidenced by the subcommittee meeting minutes.
- Beginning in 2015 the Medical Oversight sub-committee will meet annually to review and adopt state approved regional trauma protocols.

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

<p>325.132(3)(c)(ii)(E) 302.6</p>	<p>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.</p>	<p>0. Not known.</p> <p>1. There are no mandatory regional triage criteria to ensure trauma patients are transported to the most appropriate trauma facility.</p> <p>2. There are different triage criteria used by different providers. Appropriateness of triage protocols and subsequent transportation are not evaluated for sensitivity or specificity.</p> <p>3. Regional triage criteria are used by all pre-hospital providers. There is no current process in place for evaluation.</p> <p>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.</p> <p>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.</p>
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Pre-hospital Triage Objective:

- By February 2015, the Region 8 Medical Oversight subcommittee will develop a pre-hospital trauma triage protocol using CDC Guidelines for the Field Triage of Injured Patients.
- By April 2015, all MCAs in region 8 will have adopted and implemented the approved regional pre-hospital triage protocol to ensure that trauma patients are transported to an appropriate trauma center based on their injuries.

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

<p>325.132(3)(c)(ii)(F) 303.2</p>	<p>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>	<p>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.</p>
<p>325.132(3)(c)(ii)(F) 205.3</p>	<p>The state trauma registry is used to identify and evaluate regional trauma care and improve the allocation of resources.</p>	<p>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.</p>

Diversion Objective:

- By July 2014, the region 8 RTAC will establish a Bypass and Diversion subcommittee. The subcommittee chairperson or representative will report to RTAC scheduled meetings
- By December 2014, the Region 8 Bypass and Diversion sub-committee will develop a regional trauma diversion policy and update this policy annually.

By January 2015, all verified/designated Region 8 Trauma Centers will be submitting required trauma data into ImageTrend

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.

<p>325.132(3)(c)(ii)(G) 303.1</p>	<p>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>	<p>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.</p>
<p>325.132(3)(c)(ii)(G) 303.4</p>	<p>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>	<p>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.</p>

Bypass Objective:

- By July 2014, Region 8 RTAC will create a Bypass and Diversion sub-committee . The subcommittee chairperson or representative will report to RTAC scheduled meetings
- By December 2014 the Region 8 Bypass and Diversion sub-committee will develop a trauma facility bypass plan. This plan will be reviewed and updated as necessary. At a minimum the plan will be reviewed annually.
- By October 2014, the Region 8 Bypass and Diversion sub-committee will create a map and guide that indicates receiving facilities and the ground transportation time distances, and will provide this guide to all EMS providers and hospital emergency departments in Region 8.

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

<p>325.132(3)(c)(ii)(H) 303.4</p>	<p>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.</p>	<p>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.</p>
<p>325.132(3)(c)(ii)(H) 205.2</p>	<p>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.</p>	<p>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.</p>

Treatment Objective:

- By December 2014, the region 8 RTAC will develop trauma transfer protocols to insure patients are expeditiously transferred to an appropriate level of care.
- By December 31, 2015, the region 8 RTAC will analyze data from the state trauma registry and identify at least one goal and objective to target patient care improvement for region 8.
- By January 2016, the PSRO committee will review data on compliance of the transfer protocol and provide feedback to RTN.

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

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.	<p>0. Not known.</p> <p>1. The RTN does not generate trauma data reports for evaluation and improvement of system performance.</p> <p>2. Some general trauma system information is available to stakeholders, but it is not consistent or regular.</p> <p>3. Regional data reports are done on an annual basis, but are not used for decision-making and/or evaluation of system performance.</p> <p>4. Routine reports are generated using regional trauma data and other databases so that the system can be analyzed, standards evaluated, and performance measured.</p> <p>5. Regularly scheduled reports are generated from regional trauma data and are used by the stakeholder groups to evaluate and improve system performance effectiveness.</p>
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Quality Improvement Objective:

- By August 2014, the region 8 RTAC will establish a PSRO for region 8.
- By November 2014, the region 8 PSRO will draft a regional PSRO plan for approval and adoption by the region 8 RTN, which will include bylaws.
- By October 2014, the region 8 Data Management committee will be in place. A Committee member of the Data Management committee will attend all subcommittee meetings as necessary in order to provide needed data and receive requests for data. This member will then report back to the Data Management committee and communicate data needs.
- Chairperson for the Data Management committee will attend and be a member of the RTAC. This chairperson may also attend the RTN meetings when necessary to provide reports, data, and receive any requests for data.
- Aggregate data will be used when reporting to RTAC, RTN, and all subcommittees.
- By June 2015 and once data use agreement in place and approved/signed by stakeholders and six months of data has been submitted, regional quality goals will be developed by the RPSRO.
- By August 2015, the region 8 PSRO will develop and provide an annual trauma system performance report to the region 8 stakeholders, and will provide recommendations to RTAC.

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

<p>325.132(3)(c)(ii)(J) 310.(3)(4)(6)</p>	<p>The regional trauma network establishes and ensures that appropriate levels of EMS, nursing and physician trauma training courses are provided on a regular basis.</p>	<p>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.</p>
<p>325.132(3)(c)(ii)(J) 310.10</p>	<p>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.</p>	<p>0. Not known 1. The region has no process in place to inform or educate all personnel on new protocols or treatment approaches. 2. The region has developed a process to inform or educate all personnel on new protocols or treatment approaches but it has not been tried or tested. 3. The region has a process in place to inform or educate all personnel on new protocols or treatment approaches as system changes are identified. 4. The region has a <i>structured</i> process in place to <i>routinely</i> inform or educate all personnel on new protocols or treatment approaches. 5. The region has a structured process to educate all personnel on new protocols or treatment approaches in a timely manner, and there is a method to monitor compliance with new procedures as they are introduced.</p>

Education Objective:

- By July 2014, region 8 RTAC will establish a region 8 Education subcommittee. The subcommittee chairperson or representative will report to RTAC scheduled meetings
- By January 2015, the region 8 Education subcommittee will conduct a regional inventory of available trauma education programs (eg.ITLS,ATLS,TNCC,ENPC), along with the creation of a mechanism to share this information with regional stakeholders.
- By March 2015, the region 8 Education subcommittee will have an approved process to inform or educate all personnel on new protocols or treatment modalities to region 8 stakeholders.
- By March 2015, the region 8 Education subcommittee will begin using data-driven performance metrics to recommend regional training initiatives for EMS personnel, nurses, or physicians who routinely care for trauma patients.