Region 8 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 the HRSA indicators in order to initiate a regional evaluation of current trauma system status.

Application

Section 1 – Governance: Documentation that the organizational 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 Professional Standards Review Organization (PSRO), can assess the current status of the region's trauma system and by which the STAC and 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 system development plan.

The 6 required components of the Regional Trauma Network Plan are:

1) Injury prevention
2) Communications
3) Infrastructure
4) Regional performance improvement
5) Continuum of care
6) Trauma education

Region 8 Trauma Network Application

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 6 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 6 *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 6 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:

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

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

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

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

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

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

- The benchmarks focus on process measures, not outcomes. The assumption is that meeting these process measures will result in improved outcomes.
- The evaluation method relies on the qualitative judgments of the region's evaluators.
- The regions are cautioned not to draw conclusions from the numerical "score". Because the scale points are not discrete points on an ordered scale it is not possible to state that a 4 is twice as good as a 2. The score only denotes relative progress in achieving the benchmark.
- The benchmarks and indicators are not comprehensive. As the document evolves these are expected to change.

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

Michigan has had limited opportunity to fully address these indicators in a systemic fashion, so each regional trauma network should expect their average indicator scores to be within the range of 1-3. The expectation for this 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 should be emailed to:

Eileen Worden, State Trauma Manager
eworden@michigan.gov

Please insert "Region ___ Application" in the subject line of the email.

After the application has been reviewed and approved by the Statewide Trauma Advisory Subcommittee and the Emergency Medical Services Coordination Committee, The Michigan Department of Health and Human Services Director will send a letter to the Regional Trauma Network representative listed below recognizing the Regional Trauma Network.

Please provide the following:

Regional Trauma Network representative: Pat Hirt

Address: 500 Osborn Blvd, Sault Ste Marie, MI 49783

Email: phirt@wmhos.org

For questions please contact your Regional Trauma Coordinator or State Trauma Manager, Eileen Worden wordene@michigan.gov (517) 241-3020.

Region 8 Trauma Network Application
Injury Prevention

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

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

Region 8 Trauma Network Application
Injury Prevention Objectives

By March 2017, the RTAC will develop an injury prevention program database by surveying regional injury prevention stakeholders including: hospitals, senior provider networks, Medical Control Authorities, UP Traffic Safety Council, and others. Database shall contain: program type, audience, locations and contact persons.

By December 2019, the RTN will have approved a Regional Injury Prevention Plan that addresses at a minimum, the trauma registry identified top 3 injuries in the region; a needs assessment; program identification, reach, and impact. The plan will include recommendations and action steps to address injury prevention in the region for sustainability, shall will include the acute care facilities in the region. The plan shall be reviewed annually by the RTAC.

Region 8 Trauma Network Application
Communications

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

Rule HRSA #	Indicator	Score
325.132(3)(c)(ii)(C) 02.10	There are established procedures for EMS and trauma system communications for major EMS events or multiple jurisdiction incidents that are effectively coordinated with the overall regional response plans.	0. Not known. 1. There are no written procedures for regional EMS and trauma systems communications for major EMS events or multiple jurisdiction incidents. **(2.) Local medical control authorities have written procedures for EMS communications during major events. However, there is no coordination among the adjacent local jurisdictions.** 3. There are written regional EMS communications procedures for major EMS events. These procedures do not involve other jurisdictions and are not coordinated with the overall regional response plans or incident management system. 4. There are written regional EMS communications procedures for major EMS events and multiple jurisdiction incidents that are coordinated with adjacent jurisdictions, with the overall regional response plan and with the incident management system. 5. There are written regional EMS communications procedures for major EMS events and multiple jurisdiction incidents that are coordinated with the overall regional response plan and with the incident management system. There are one or more system redundancies. These procedures are regularly tested in simulated incident drills, and changes are made in the procedures based on drill results, if needed.
325.132(3)(c)(ii)(C) 302.9	There is a procedure for communications among medical facilities when arranging for inter-facility transfers including contingencies for radio or telephone system failure.	0. Not known. 1. There are no specific communications plans or procedures to ensure communication among medical facilities when arranging for inter-facility patient transfers. **(2.) Inter-facility communication procedures are generally included in patient transfer protocols for each medical facility but there is no regional procedure.** 3. There are uniform, regional communication procedures for arranging patient transfers, but there are no redundant procedures in the event of communication system failure. 4. There are uniform, regional communication procedures for arranging patient transfers and there are redundant procedures in the event of communication system failure. 5. There are uniform, regional communication procedures for arranging patient transfers and there are redundant procedures in the event of communication system failure. The effectiveness of these procedures is regularly reviewed and changes made based on the performance review, if needed.

Region 8 Trauma Network Application
Communication Objectives

By April 2017, the RTAC will have developed a communications assessment tool to identify gaps and capabilities: primary, secondary, tertiary between prehospital (ground/air) and hospital; primary, secondary, tertiary between hospital to hospital for transfers; existing COM-L plans for large incidents. Partners will complete assessment tool by July 2017.

By September 2017, the RTAC will have reviewed the gathered assessment information in database format, in addition to any reasons for variation in the region (geographic coverage areas, funding, logistics for radio reprogramming, etc.), and meet with the Regional Healthcare Coalition to draft a regional EMS communications procedure and a regional inter-facility communications procedure by March 2018.

By May 2018, meet with the Regional 911 Authority to start the process of writing a region-wide large scale incident communications procedure with completion expected March 2019 and implementation completion December 2019.

Region 8 Trauma Network Application
Infrastructure

Description: The regional trauma infrastructure consists of membership, governance, medical oversight, policies, procedures and protocols that support the regional trauma system

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

Region 8 Trauma Network Application
Infrastructure cont.

Rule HRSA #	Indicator	Score
325.132(3)©(ii)(F) 303.2	The regional trauma network plan should ensure that the number, levels, and distribution of trauma facilities are communicated to all partners and stakeholders. The RTN should develop procedures to insure that trauma patients are transported to an appropriate facility that is prepared to provide care.	0. Not known. (1.) **There is no regional plan to identify the number, levels, and distribution of trauma facilities. There is no regional diversion protocol.** 2. There is a regional system plan and a diversion protocol but they do not identify the number, levels or distribution of trauma facilities in the region. The plan and protocol are not based on available data. 3. There is a regional system plan and a diversion protocol that identifies the number, levels and distribution of trauma facilities. System updates using available data not routine. 4. There is a regional system plan and a diversion protocol that identifies the number, levels and distribution of trauma facilities based on available data. However, the regional plan and diversion protocol is not used to make decisions about trauma facility designations. 5. There is a regional system plan that identifies the number and levels of trauma facilities. The plan is used to make decisions about trauma center diversion procedures. The plan accounts for facility resources and geographic distribution, population density, injured patient volume, and transportation resource capabilities and transport times. The plan is reviewed and revised periodically.
325.132(3)©(ii)(G) 303.1	The regional trauma plan has clearly defined the roles, resources and responsibilities of all acute care facilities treating trauma, and of facilities that provide care to specialty populations (burns, pediatrics, other).	0. Not known. (1.) **There is no regional plan that outlines roles, resources and responsibilities of all acute care facilities treating trauma and/or of facilities providing care to specialty populations.** 2. There is a regional trauma system plan, but it does not address the roles, resources and responsibilities of licensed acute care facilities and/or specialty care facilities. 3. The regional trauma plan addresses the roles, resources and responsibilities of licensed acute care facilities (hospitals) only, not spinal cord injury, pediatrics, burns or others. 4. The regional trauma plan addresses the roles, resources and responsibilities of licensed acute care facilities and specialty care facilities. 5. The regional trauma plan clearly defines the roles, resources and responsibilities of all acute care facilities treating trauma within the region. Specialty care services are addressed within the plan, and appropriate policies and procedures are implemented and tracked.

By August 2017, the RTN will organize and facilitate initial and then ongoing meetings of MCA Medical Directors and their hospital(s) trauma medical directors. The initial meeting will provide orientation to the EMS system of protocol adoption (with a focus on trauma specific protocols), training and oversight, as evidenced by member roster, agenda and minutes.

By July 2018, the RTN shall adopt the RPSRO as the venue for the MCA Medical Directors and the Trauma Medical Directors to meet and coordinate the regional trauma system as evidenced by meeting minutes and the amendment to the bylaws, written description of roles and responsibilities.

By August 2017, the RTAC will develop and implement a survey of hospitals specific to roles, resources and responsibilities providing care including specialty populations, to include out of region. This living document will be communicated to stakeholders on an agreed upon time frame. This data will be used in the development of the regional system plan.

By March 2020, as an ongoing activity of regional trauma system planning, the number and levels of trauma facilities are communicated regularly to the MCAs who incorporate this information into local MCA triage and destination protocols. These local protocols account for trauma facility resources, geography and transport time. Online medical direction ensures proper destination guidance in the event of trauma diversion. The RPRSO will perform annual audits of all trauma center diversion to assure the appropriate use of diversion and accuracy of the trauma center resource.

Region 8 Trauma Network Application
Regional Performance Improvement

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

Rule HRSA #	Indicator	Score
325.132(3)©(ii)(I) 206.1	The RTN generates data reports to evaluate and improve system performance.	0. Not known. 1. The RTN does not generate trauma data reports for evaluation and improvement of system performance. **(2.) 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.
325.132(3)©(ii)© 302.6	The region has adopted mandatory regional pre-hospital triage protocols to ensure that trauma patients are transported to an appropriate trauma center based on their injuries. The triage protocols are regularly evaluated and updated to ensure acceptable and region-defined rates of sensitivity and specificity for appropriate identification of a major trauma patient.	0. Not known. 1. There are no mandatory regional triage criteria to ensure trauma patients are transported to the most appropriate trauma facility. 2. 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.
325.132(3)©(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.

Region 8 Trauma Network Application
Regional Performance Improvement cont.

Rule HRSA #	Indicator	Score
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.
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.
325.132(3)(c)(ii)(F) 205.3	The RTN data in the state trauma registry is used to identify and evaluate regional trauma care and improve the use of resources.	0. Not known. 1. All trauma facilities in the region are not entering data into state registry. Regional data from state trauma registry is limited. 2. There is limited access to the state trauma registry. Data extraction is not available to evaluate performance or improve resource allocation. **(3.) All trauma facilities in the region enter data into the state trauma registry but data are not being used to improve the system.** 4. The RTN uses the state trauma registry to routinely report on system performance and resource utilization and allocation. 5. State trauma registry reports are used extensively to improve regional trauma care and efficiently allocate trauma resources. The RTN uses these reports to determine deficiencies and allocate resources to areas of greatest need. System performance compliance with standards are assessed and reported.

By September 2017, the RPRSO will develop a plan to routinely monitor ongoing data submission to the registry that addresses, timeliness, participation and incident numbers.

By April 2017, the RPSRO will review quarterly data reports to monitor and evaluate system functioning (i.e., age, ISS score, mechanism of injury, destination, length of stay emergency department, transfer, admission) as evidenced by meeting agenda, minutes and report.

Annually, the RPSRO will develop and share and annual data reports and/or recommendations with RTN to inform decision making and evaluate system performance.

By December 2017, RTAC and the Regional Trauma Coordinator will work with partners, including the Regional MCA Network, to support the adoption of EMS System protocol for trauma triage and destination.

By December 2019, RTAC and partners will develop and implement a process to evaluate implementation of the EMS trauma triage and destination protocol.

The RPSRO, with approval by the RTN, will by November 2019, develop a plan that includes methods to monitor and address issues related to inter-facility transfers and their expeditiousness and appropriate utilization.

By August 2019, the RTN will adopt a written, quantifiable regional system performance standards based upon points of measurement in EMS, methods to monitor and address issues in inter-facility transfers, and injury programming evaluation and improvement.

By December 2019, the RPRSO will support the development of a bypass protocol for the region that addresses resources.

Region 8 Trauma Network Application
Continuum of Care

Description: Resources, including rehabilitation are integrated into a resource efficient, inclusive network that meets standards and provides optimal care for the injured.

Rule HRSA #	Indicator	Score
325.132(3)(c)(i)(F) 308.1	The regional work plan addresses the integration and participation of rehabilitation services within the continuum of care for trauma patients.	0. Not known **1. There are no written plans for the integration of rehabilitation services with the regional trauma system or with trauma centers.** 2. The regional trauma system plan has addressed the participation of rehabilitation services, but the integration of those facilities for trauma patients has not been fully realized. 3. The regional trauma system plan has addressed the participation of rehabilitation services and has begun integration of rehabilitation services through the routine use of rehabilitation services expertise. 4. The trauma system plan incorporates rehabilitation services throughout the continuum of care through the use of written agreements. Trauma centers are actively including rehabilitation services and their programs in trauma patient care plans. 5. There is evidence to show a well-integrated program of rehabilitation is available for all trauma patients. Rehabilitation programs are included in the regional trauma system plan, and the trauma centers are working closely with rehabilitation centers and services to ensure quality outcomes for trauma patients.

The RTAC will by October 2018 develop and conduct a survey of rehabilitation services available in the region, and also include services routinely used outside the region. This shall be evidenced by the publication of the survey tool and results.

By January 2019, the RTAC will use survey findings and provide recommendations to the RTN on integration of rehabilitation services within the Regional Trauma Plan, including possible role for rehabilitation content expert(s) in the network.

Region 8 Trauma Network Application
Trauma Education

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

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

Region 8 Trauma Network Application
Trauma Education Objectives

By February 2018, the RTAC and Regional MCA Network will develop and conduct a survey of partners and stakeholders regarding trauma education as evidenced by survey tool and results.

By September 2018, the RTN, with support of partners and stakeholders, will establish a mechanism to inform trauma professionals about trauma education and EMS protocols. Evidence of this shall be by the inclusion of this information on the Regional Healthcare website from the Regional Healthcare Coalition, meeting minutes reflecting role of RTN as clearinghouse for ongoing trauma education and plan for ongoing dissemination of the education initiatives.

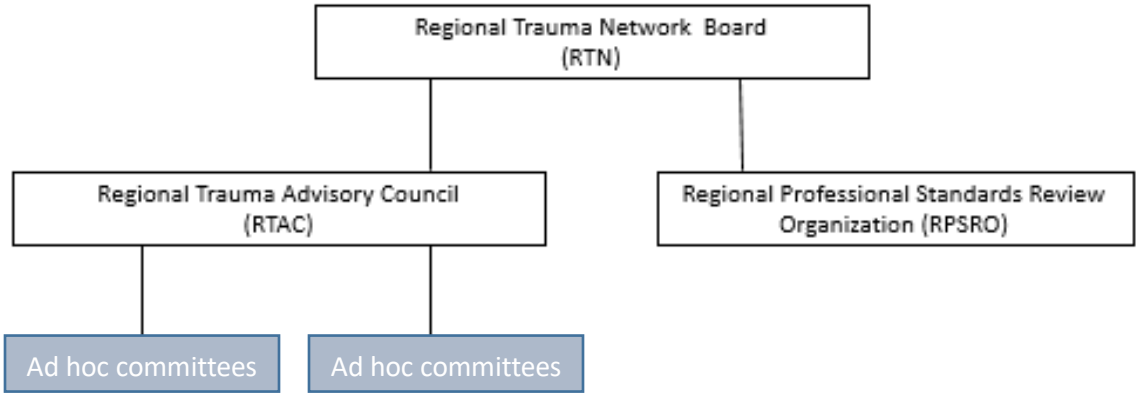
By January 2019, the RTN in partnership with the RTAC and stakeholders will develop a structured process to address trauma education including new treatments, protocols and regional training requirement and subsequently publish such document.

Region 8 Trauma Network Application

Regional Trauma Network Application Checklist

Ensure that all items on the checklist below are included in the application package.

- ☐ **Signature page of the RTN Leadership and Governance document**: Signed by Regional Trauma Network Leadership
- ☐ **RTN organizational chart:**



- ☐ **Bylaws**: Include a copy of the Regional Trauma Network bylaws with the application.
  Ensure that the following components of regional governance have been included in the submitted **bylaws**:
  - ☐ Documentation that all MCAs in the region are represented on the RTN (see Governance page)
  - ☐ The bylaws include meeting frequency (at least quarterly)
  - ☐ The bylaws describe RTN/RTAC/RPSRO membership (roles), provisions for alternates (if
  - ☐ applicable), voting privileges, and removal
  - ☐ A Regional Trauma Advisory Council has been appointed and includes:
    - ☐ MCA representatives
    - ☐ Life Support Agency representatives
    - ☐ Hospital representatives
    - ☐ EMS Physician representatives
    - ☐ Trauma Surgeon representatives
    - ☐ Trauma Program Manager representatives
    - ☐ EMS personnel
    - ☐ Nurses
    - ☐ Consumer
  - ☐ The Regional Professional Standards Review Organization has been appointed

- ☐ **RTN Work plan:**
  - ☐ Each indicator in the assessment has been scored (circle or check).
  - ☐ At least one SMART objective is written for each of the indicators.

Region 8 Trauma Network Application

Background

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

Michigan Administrative Rules

Rule 325.126 Definitions; E to O Rule 2
(m) "Medical Control" means the supervision and coordination of emergency medical services through a medical control authority, as prescribed, adopted, and enforced through department approved protocols
(n) "Medical Control Authority" (MCA) means an organization designated by the participating organizations to carry out the responsibilities and function of the medical control authority.
A Medical Control Authority in Michigan is a hospital or group of hospitals that operate a service that treats patients 24 hours a day 7 days a week. Medical Control Authorities must develop bylaws, appoint an MCA Board, an Advisory Body, and Professional Standards Review Organization (PSRO), collect data, appoint a Medical Director, establish written protocols for pre-hospital care, and are responsible for the execution of those protocols. Protocols adopted by the MCA and approved by the department have the force and effect of law. The MCA Medical Director is responsible for the supervision, coordination, and implementation and requires compliance with protocols. The Medical Control Authority may include a group of hospitals in a county or region operating under one agency staffed by personnel from out the hospital setting. Hospitals in the MCA may agree to confer their oversight responsibilities to an executive director. There are currently 61 MCA's in Michigan.

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

Rule 325.129 Powers and duties of the department Rule 5
(k)Establish regional trauma networks, consistent with current emergency preparedness regions, to provide system oversight of the trauma care provided in each region of the state. Regional trauma networks shall be comprised of collaborating local Medical Control Authorities (MCA's) in a region.
The Regional Trauma Network (RTN) therefore is:

- Comprised of one member from **each Medical Control Authority**.
- This member is responsible for representing their MCA and therefore able to make decisions and commitments on behalf of their MCA to collectively further the work and mission of the Regional Trauma Network to establish and maintain a regionalized, coordinated and accountable trauma system.
- In order for the system to function efficiently, all-inclusive and fully representative, all MCA's must participate in the work of the RTN.

- Ceding responsibility to another MCA for the trauma system in that region effectively removes that MCA from decision making and providing input into trauma care in the region.
- The Regional Trauma Network is the governing body of the Regional Trauma Network, ultimately responsible for decisions, policy, procedure and any subcommittee work related to trauma in the region including the work of the Regional Trauma Advisory Council.
- The Regional Trauma Network files an application with the Department ensuring that the elements described in the Administrative Rules are in place.
- The identified Regional Trauma Coordinators are first line contact for the department and will facilitate communication to 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.

Region 8 Trauma Network Application

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

MCA	Name (Signature)	Title	Date
Baraga County	Mary L	CEO	6-15-17
Chippewa County	Patricia A Hirt	TPM WMH	6/15/17
Delta County	EFBigsby	Delta County MCA Director	6/14/17
Dickinson County		UMD	
Gogebic Ontonagon Iron Counties		RN	6-14-17
Houghton Keweenaw Counties		Trauma Representative	6-19-17
Luce County	Shelly Reeves	Trauma Program Medical Control Coord.	6/19/17
Marquette Alger Counties	Alyson M. Sundberg	Director	6/19/2017
Schoolcraft County		LPN/Paramedic IC Schoolcraft MCA	6/20/17

Please attach your organization chart and bylaws and include the original of this page with the RTN application. *Organizational chart is page 19 of this document with Pat Hirt as RTN Chair, Marlys Folly as RTAC Chair and Dr. Larry Lewis as RSPRO Chair.*

Region 8 Trauma 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. Co-Chairperson
   a. Call to order and chair meetings
   b. Appoint committees
2. 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 and disperses to membership in a timely manner, or delegates to staff.

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. – REGIONAL TRAUMA ADVISORY COUNCIL

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. The review will include affirmation of each voting member attending 4 out of 6 meetings during the year being reviewed. In the event of a voting member attending less than 4 out of the 6 RTAC meetings a letter shall be written and sent to the voting member and to the MCA being represented by that voting member. The letter will request the MCA to designated and identify a person to represent the MCA and replace the member that has failed to attend 4 or more RTAC meetings in a year.

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 R8TN, 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 R8TN.

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, or have this delegated to staff.

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:
   a. Injury prevention
   b. Communications
   c. Infrastructure
   d. Regional performance improvement
   e. Continuum of care
   f. Trauma education
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 (RPSRO)

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 addresses 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 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 and REVIEW

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.

Region 8 Trauma Network Application

Organizational Chart