Region 1 Trauma Network Application

Introduction

Regional Trauma Network Development

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

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

The application template that follows is an adaptation of the US Department of Health and Human Services (HRSA) Model Trauma System Planning and Evaluation (2006). The application has adopted or adapted 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

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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.

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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
WordenE@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: Dr. Robert Orr, MD FACEP

Address: 6920 S Cedar St Suite 8, Lansing, MI 48911

Email: boborr710@yahoo.com
tcemca@iserv.net

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

BETP
Bureau of EMS, Trauma & Preparedness

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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.

2017 – 2019 Injury Prevention Objective(s):

1. The RTN will request and review available Region 1 injury data which will be used to provide guidance on regional injury prevention plans and IP education and outreach needs. Data will be monitored quarterly.
Score:
3. The RTN monitors and evaluates injury prevention activities and programs in the region.

2. By December 2017, and upon request through December 2019, all the Region 1 Facilities will update the RTN with current injury prevention activities offered. This information will be used to update the regional injury prevention resource and regional plan. The regional plan will include specific strategies to address regionally identified (data driven) issues relating to trauma. A priority focus will be: Adult/Child passenger restraints, EMS pediatric restraints and traumatic brain injury and concussions.
Score:
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.

The Region 1 IP committee created a regional injury prevention plan, which every facility agreed to participate with. The focus was elderly fall and car seat use. During the first application period facilities focused on the availability of car seat training and/or technicians. They also agreed to have staff trained in Matter of Balance. Each hospital identified a point of contact for injury prevention, and the group worked together to create a regional injury prevention training resource tool, that can be utilized by the Regional partners looking for trainings.

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

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2017 – 2019 Communication Objective(s):

1. By June 2018 the RTC coordinate the development of an informational tool for the RTN and RTAC membership addressing the regional communication options available for use during MCI.
    a. The RTN will encourage each MCA to have a written communication plan and to communicate the plan to the hospitals by June 2019. This information will be shared during the RMCAN meetings.
    b. District 1 Healthcare Coalition leadership will be included in RTAC education sessions, to ensure understanding of preparedness plans as they relate to Trauma and Mass Casualty.

Score:

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

2. By June 2019, the RTN will confirm the inclusion of communication system redundancies information in 100% of hospital inter-facility transfer protocols
    a. Trauma staff will be educated on the hospital policies for transfer communication during system failure.

Score:

2. Inter-facility communication procedures are generally included in patient transfer protocols for each medical facility but there is no regional procedure.

During the first application period the RTN and RTAC agreed to adopt the District 1 Healthcare Coalition Communication plan as the backup communication plan. Each facility verified they were linked into D1 through their safety/disaster preparedness staff, and that there was redundancy in communication options in each hospital. The group decided to work towards having a better working knowledge of the communications planning in the Healthcare Coalition plans, as well as have the Regional MCA create a plan that the trauma staff will have input on, and that staff will be educated on. The RTAC also wanted to assure staff will have knowledge of backup methods of communication for trauma transfers, during a communication failure.

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Infrastructure

Infrastructure: 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.

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2017 – 2019 Infrastructure(s):

1. By December 2017, the RTN will review 100% of Region 1 MCA trauma protocols, in an effort to continue integrating the needs of the trauma system with the medical oversight of the overall EMS system
    a. The RTN will be available to convene upon request to address any recommended trauma protocol changes found during RPRSO reviews.
    b. The RTN will work with the Trauma Steering Committee to make the recommended changes to protocols as identified.

Score:
3. The RTN has adopted state approved regional trauma protocols.

2. By October 2017, The Trauma Steering committee, will establish meeting dates and committee goals, which includes establishing standards for annual review of Region 1 MCA trauma protocols, by the regional facility Trauma Medical Directors.

Score:
3. Trauma medical directors or designated trauma representatives participate in EMS oversight through participation in local medical control authority meetings. However, there is no formal written relationship.

During the first application period the RTN reviewed of all the Region's MCA EMS trauma protocols for content, consistency and to identify differences. They also wanted to make sure that each MCA Medical Director was familiar with any differences found. Region 1 struggled with creating a regional trauma destination protocol, but will have one submitted to the QA committee in the new application period. The Region 1 Trauma Network had both a Medical Steering Committee and a Trauma Steering Committee. The group decided we did not need both committees. The decision was made to keep the Trauma Steering Committee and include the MCA Medical Directors and Trauma Staff on the committee, to make data driven suggested changes to Trauma Protocols. This group will meet quarterly, or sooner if needed.

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Infrastructure

Infrastructure: 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)(F) 303.2	The regional trauma network plan should ensure that the number, levels, and distribution of trauma facilities are communicated to all partners and stakeholders. The RTN should develop procedures to insure that trauma patients are transported to an appropriate facility that is prepared to provide care.	0. Not known. 1. There is no regional plan to identify the number, levels, and distribution of trauma facilities. There is no regional diversion protocol. 2. There is a regional system plan and a diversion protocol but they do not identify the number, levels or distribution of trauma facilities in the region. The plan and protocol are not based on available data. ***3. There is a regional system plan and a diversion protocol that identifies the number, levels and distribution of trauma facilities. System updates using available data not routine.*** 4. There is a regional system plan and a diversion protocol that identifies the number, levels and distribution of trauma facilities based on available data. However, the regional plan and diversion protocol is not used to make decisions about trauma facility designations. 5. There is a regional system plan that identifies the number and levels of trauma facilities. The plan is used to make decisions about trauma center diversion procedures. The plan accounts for facility resources and geographic distribution, population density, injured patient volume, and transportation resource capabilities and transport times. The plan is reviewed and revised periodically.
325.132(3)(c)(ii)(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.

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2017 – 2019 Infrastructure(s):

1. By December 2017 and ongoing through December 2019, the RTN will monitor the utilization of the regional trauma triage and transport protocol and make updates based on this process.
2. By December 2018 and ongoing through December 2019, the Steering Committee membership will have reviewed regional trauma diversion data yearly

Score:

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.

1. By January 2018, The RTN will reassess Region 1 trauma assets and the trauma level verification/designation development progress.
2. As Region 1 Hospitals develop their trauma programs, through December 2019, the Trauma Program Managers will educate MCA leadership and Region 1 EMS agencies on their facility activation criteria updates, provisional, designation and verification status changes, as well as trauma patient outcomes upon agency request

Score:

4. The regional trauma plan addresses the roles, resources and responsibilities of licensed acute care facilities and specialty care facilities.

During the first application the RTAC surveyed the regional facilities for trauma assets, hospital capabilities, and intended level of verification. This helped identify what kind of patients each facility was capable of caring for, as well as where they might transfer patients needing a higher level of care. During this application period the RTAC wants to reassess the assets, and share the information to all EMS agencies in the region, along with making sure they educate EMS and Region 1 hospitals on their activation criteria, verification status changes, and the process for EMS to request trauma patient outcomes. A gap was identified with regards to having information disseminated from the RTN and regional hospitals reach more EMS agencies in a timely manner. The RTAC also wants to continue to support each facilities trauma program staff with the tools that will help them to be successful in the verification/designation process.

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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)(c)(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)(c)(ii)(E) 302.6	The region has adopted mandatory regional pre-hospital triage protocols to ensure that trauma patients are transported to an appropriate trauma center based on their injuries. The triage protocols are regularly evaluated and updated to ensure acceptable and region-defined rates of sensitivity and specificity for appropriate identification of a major trauma patient.	0. Not known. 1. There are no mandatory regional triage criteria to ensure trauma patients are transported to the most appropriate trauma facility. 2. 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)(c)(ii)(H) 303.4	When injured patients arrive at a medical facility that cannot provide the appropriate level of definitive care, there is an organized and regularly monitored system to ensure that the patients are expeditiously transferred to the appropriate, system-defined trauma facility.	0. Not known. 1. There is no existing process in the region for collecting data on and regularly reviewing the conformity of inter-facility transfers within the trauma system according to pre-established procedures. **2. There is a fragmented system within the region, usually event based, to monitor inter-facility transfer of trauma patients.** 3. The regional system for monitoring inter-facility transfers is new, the procedures are in place, but training has yet to occur. 4. The region has an organized system for monitoring inter-facility transfers. 5. The monitoring of trauma patient inter-facility transfers is integrated into the overall program of system performance improvement. When the system identifies issues for correction, a plan of action is implemented.

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2017 – 2019 Regional Performance Improvement Plan Objective(s):

1. As guided by the State of Michigan Trauma Administrative rules, the RTC will generate a yearly data report to all Region 1 stakeholders discussing the regional trauma system and performance improvements metrics outlined in the Administrative Rules. By December 2017 and ongoing through December 2019. The RTAC Education Committee will disseminate a quarterly newsletter to all stakeholders including data driven educational opportunities, trauma updates and injury prevention information.

Score:

3. Regional data reports are done on an annual basis, but are not used for decision-making and/or evaluation of system performance.

1. By December 31, 2017 the RTN in collaboration with the RPSRO and key RTAC subcommittees will work to develop and approve a prehospital triage/destination protocol for use in Region 1.
2. By June 2018, the RTN will develop a plan to educate Region 1 EMS agencies about 60 second time outs and handoff information.

Score:

3. Regional triage criteria are used by all pre-hospital providers. There is no current process in place for evaluation.

1. By June 2019 the Trauma Steering Committee will review data regarding inter-facility transfer times, transfer delays and multiple facility transfers. Utilizing this data the committee will suggestions for process improvement and education regarding trauma transfers.

Score:

2. There is a fragmented system within the region, usually event based, to monitor inter-facility transfer of trauma patients.

During the first application period Region 1 identified members for the RPSRO, and developed the process for meetings and data review. Region 1 had very minimal data in the ImageTrend data base, so did not have much data to review. The group took the opportunity to identify what audit filters will be reviewed at every meeting. Those filters include trauma diversions, surgical airways/airways with greater than 2 attempts, multiple transfers for one patient and ED LOS. The RPSRO will also continue to work on making the availability of EMS run reports more readily accessible. The RTAC decided to make 60 second timeouts a standard in the region, so will work with the education committee to develop Hospital and EMS education on this subject. This application period, the RTAC will focus on EMS and data driven performance improvement.

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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)(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.

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2017 – 2019 Regional Performance Improvement (s):

2. By June 2019 the RPSRO will meet quarterly to review:
    - Trauma related EMS and transfer patient data for process improvement opportunities
    - The RPSRO will monitor and report performance measures outlined in the Administrative Rules and in the regionally selected PI measures.
    - RTN will develop recommendations to address gaps and barriers identified by the RPRSO

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

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

Score:
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.

2. By September 2017 and ongoing through December 2019, the RTN and RTAC will continue to monitor, facilitate and evaluate participation the state trauma registry. Progress indicator will be 100 % of facilities have signed data use agreements, and data entered into ImageTrend.

Score:
2. There is limited access to the state trauma registry. Data extraction is not available to evaluate performance or improve resource allocation.

During the first application period, focus for the Region 1 Trauma Network was getting all facilities engaged in the trauma network, and helping them with their trauma programs. Of the 11 hospitals, 9 are actively pursuing trauma verification, 1 is in the process of getting staff in place to support a trauma program, and 1 will not be verifying, but has agreed to share data and information upon request. This application period the data to drive PI through our RPSRO will be available. Each facility has designated staff to participate on the RPSRO, and ACS verified facilities have TMD's identified to lead the process.

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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.

2017-2019 Continuum of Care:

1. By March 2018, the Region 1 RTAC will identify key staff to represent Rehabilitation Services at the Region 1 Trauma meetings.
2. By June 2018, the RTAC will have a Rehabilitation Committee tasked with identifying rehabilitation facilities in Region 1 and the strengths and weaknesses in regional rehabilitation services availability.

Score:

1. There are no written plans for the integration of rehabilitation services with the regional trauma system or with trauma centers.

The RTAC had a very good discussion regarding continuum of care and identified some of the difficulties faced regarding access to rehabilitation care for trauma patients. The group identified the need for rehabilitation staff to be added to the RTAC, as well as the need to survey assets within our region.

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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.

2017 – 2019 Regional Trauma Education Objective(s):

1. By September 2017 and ongoing through December 2019, the Region 1 RTC will disseminate available trauma educational opportunities to all stakeholders. This education will include trauma patient care, injury prevention opportunities and District 1 preparedness educational offerings.

Score:
2. There are regional trauma training standards for EMS personnel, nurses and physicians but there is no requirement for course attendance.

2. The Region 1 RTC will disseminate information regarding any regional or statewide protocol changes or updates to all ED/Trauma/EMS/MCA partners.

Score:
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.

The RTAC has been very active in education for our facilities. We have had educational sessions on data, building a trauma program and are currently working on a putting together a mock PI review session. Our IP coordinators have offered education to become a car seat technician, Car Fit for seniors, Matter of Balance and Think First programs. We have a TPM mailing list where they ask questions and share ideas, documents, and policies. The group has been very supportive of each other, and this has led to an open exchange of ideas and information helping our facilities to build their trauma programs.

Region 1 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.

Region 1 Trauma Network Application

- 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 1 Trauma Network Application

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

MCA	Name (Signature)	Title	Date
TCEMCA		Medical Director	3-29-17
Lenawee MCA		MD	3-29-17
Hillsdale County Medical Control	Shirley Curtis	EMS Manager	3-29-17
SCMCA	KD Awan DO	EMS Medical Director	3-29-17
W/L MCA	MD	EMS Medical Director	4/27/17
Gratiot County MCA	Megan Hasse	TPM	5/11/17
Jackson County	John C Maino II MD JOHN C. MAINO II, MD, FACEP	MEDICAL DIRECTOR JACKSON COUNTY MEDICAL CONTROL	5/15/17

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

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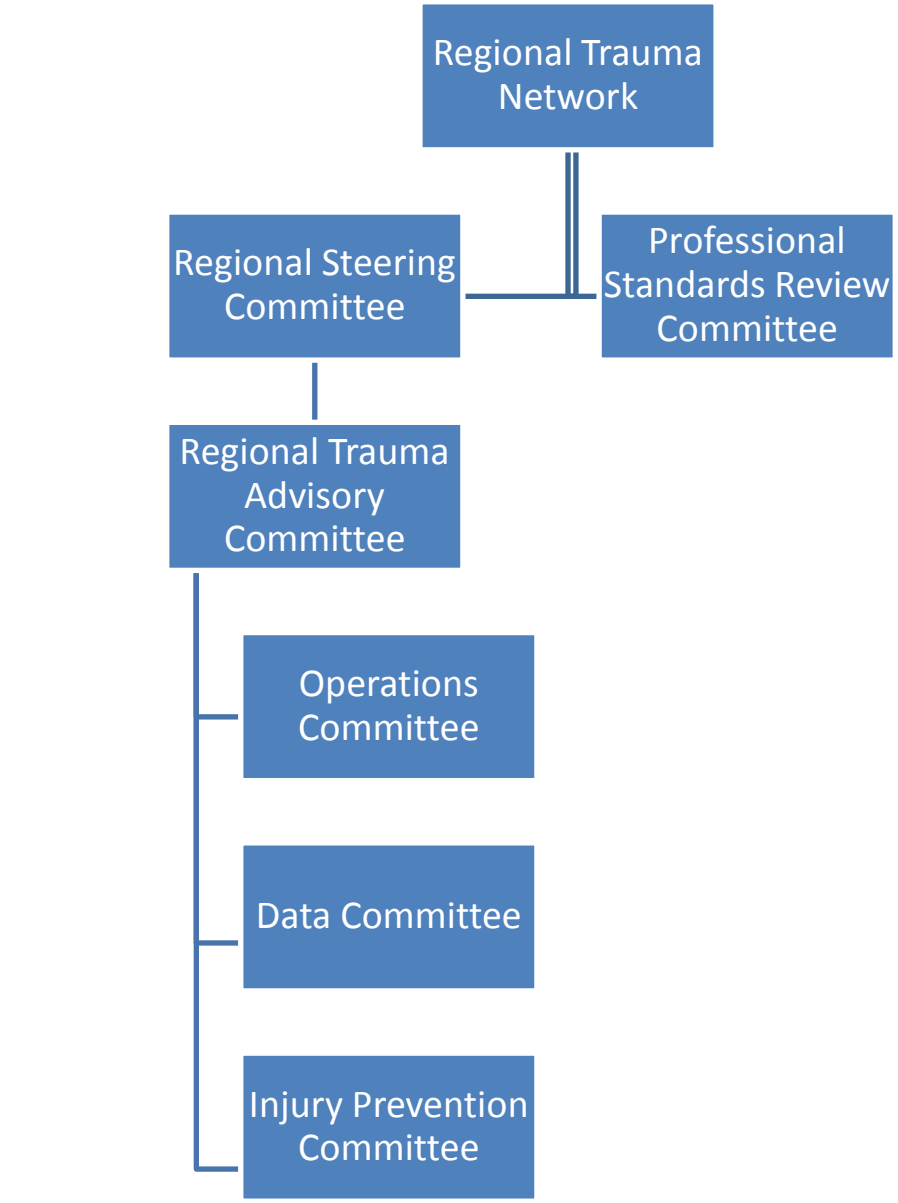
Organization Chart

Region 1 Regional Trauma Coalition



Region 1 Trauma Network Application

Region 1 Coordinator Contact Information:

Theresa Jenkins
12880 S. Bauer Rd
Eagle, MI 48822
517-243-8507

Regional Trauma Network Members:

Gratiot County MCA	Megan Hasse, RN	MCA Representative
Hillsdale County MCA	Shirley Curtis, RN	MCA Representative
Jackson County MCA	John Maino, MD	Medical Director
Lenawee County MCA	Ron DiCecco, MD	Medical Director
Livingston County MCA	Robert Domeier, MD	Medical Director
Shiawassee County MCA	Donald Edwards, DO	Medical Director
Tri County Emergency MCA	Robert K Orr, DO	Medical Director

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

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

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

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Region 1 Trauma Network Application

1. NAME AND COVERAGE AREA

A. Name

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

B. Coverage Area

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

2. PURPOSE

The purposes of the Network are as follows:

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

B. To develop a regional trauma plan and to apply to the Michigan Department of Community Health (referred to herein as the Department) for approval and recognition as the Region 1Trauma Network. The plan will address each of the following trauma system components: leadership, public information & prevention, human resources, communications, medical direction, triage, transport, trauma care facilities, inter-facility transfers, rehabilitation, and evaluation of patient care within the system.

C. To establish the Region 1 Trauma Advisory Council.

3. ORGANIZATIONAL STRUCTURE

The Network is comprised of Four (4) branches

- Region 1 Trauma Network- (referred to herein as the Regional Trauma Network)
- Region 1Trauma Advisory Council- (referred to herein as the Regional Trauma Advisory Council)
- Region 1Trauma Steering Committee – (referred to herein as Trauma Steering Committee)
- Region 1 Professional Standards Review Organization – (referred to herein as Professional Standards Review Organization)

4. REGIONAL TRAUMA NETWORK

A. Purpose

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

B. Membership

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

C. Officers

The Chairperson, Vice-Chairperson will be selected by the Regional Trauma Network.

1. **Election, Removal, Resignation and Vacancies**
   All Officers of the Network will be elected by a majority vote of the Regional Trauma Network members. Elected officers will hold office for a two (2) year term unless removed by an affirmative vote of three quarters of the Regional Trauma Network members. The term of office may be renewed at the discretion of the Regional Trauma Network. Any officer may resign at any time by delivering written notice to the Chairperson. Vacancies occurring in any office at any time will be filled by the Regional Trauma Network.
2. **Chairperson**
   The Chairperson will preside over all meetings of the Regional Trauma Network. In the event of a vacancy in the office of Chairperson, the Vice-Chairperson will automatically succeed to the office of Chairperson until a new Chairperson is elected by the Regional Trauma Network.
3. **Vice-Chairperson**
   The Vice-Chairperson will report to the Chairperson as instructed by the Chairperson, and will perform such duties and have such powers as may from time to time be assigned by the Chairperson. In the absence or disability of the Chairperson the Vice-Chairperson will perform the duties and exercise the powers of the Chairperson.

D. Staff, Contactors, and Consultants

The Regional Trauma Network will select or approve the appointment or hiring of contractors, consultants and others necessary to carry out the purposes and authority of the Network. The Regional Trauma Network will provide supervision and management of any appointed personnel.

E. Other Contract Parties

The Regional Trauma Network will establish the duties, responsibilities and compensation of other Network contract Parties. These duties, responsibilities and compensation will be established by a written contract approved by the Regional Trauma Network.

F. Duties

1. The Regional Trauma Network will see that all orders and resolutions of the Regional Trauma Network are carried into effect and will have the general powers of supervision and management of the Regional Trauma Network.
2. **Establish the Regional Trauma Advisory Council**
   The Regional Trauma Network will establish a Regional Trauma Advisory Council, and reserves the right to determine the size, member eligibility, authority and other matters relating to the composition and activities of the Regional Trauma Advisory Council. The recommended makeup of the Regional Trauma Advisory Council is outlined in the section relating to the Regional Trauma Advisory Council.
3. **Delegation of Duties**
   The Regional Trauma Network may delegate duties to the Trauma Steering Committee, Regional Trauma Advisory Council and/or Sub-Committees as needed.

G. Meetings and Rules

1. **Meeting Schedule**
   The Regional Trauma Network shall establish a regular schedule for quarterly meetings. The Chairperson may call for a special or emergency meeting of the Regional Trauma Network when deemed necessary.

2. Quorum Requirement

A quorum for the transaction of business at any meeting of the Regional Trauma Network shall require the presence of the medical directors of at least 4 of the 7 MCAs in the Network.

3. Voting

Actions of the Regional Trauma Network, other than officer elections, require a simple majority of the MCA's of the Regional Trauma Network for an action to be approved. If votes are taken with less than all the MCA Medical Directors present, the actions must be ratified by the remaining MCA Medical Directors in order to be approved.

4. Rules

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

H. Consent Resolution

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

5. TRAUMA STEERING COMMITTEE

A. Purpose

The Regional Trauma Steering Committee provides direction and supervision for the activities of the Regional Trauma Advisory Council and the Sub-Committees.

B. Membership

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

1. Member Designees, Resignation and Vacancies

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

C. Officers

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

1. Co-Chairpersons

a. Duties and Responsibilities

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

b. Requirements

The Network's Co-Chairpersons must be physicians with a current license from the State of Michigan. One must be an MCA EMS Medical Director and be board-certified in Emergency

Medicine and one must be a Trauma Medical Director and be board certified in General Surgery.

c. Terms of Service

The Co-Chairpersons will be appointed in opposite years and serve for a two year term. During the first year one Co-Chairperson will be appointed for a two year term and one for a one year term. The term of office may be renewed at the discretion of the Regional Trauma Network. A Co-Chairperson may resign at any time by delivering written notice to the Regional Trauma Network Chairperson. Vacancies occurring will be filled by the Regional Trauma Network.

D. Executive Authority

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

E. Meetings and Rules

1. **Meeting Schedule**

The Trauma Steering Committee shall establish a regular schedule for quarterly meetings. The Co-Chairpersons may call for a special or emergency meeting of the Trauma Steering Committee when deemed necessary.

2. Quorum Requirement

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

3. Voting

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

4. Rules

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

F. Consent Resolution

Action may be taken by the Trauma Steering Committee, without a meeting, by a written consent (as requested either by mail, fax or e mail) signed by a simple majority of the members of the Trauma Steering Committee if responses/votes are consistent with quorum requirements.

6. REGIONAL TRAUMA ADVISORY COUNCIL

A. Purpose

The purpose of the Regional Trauma Advisory Council under the directives of the Regional Trauma Network and Trauma Steering Committee is to provide leadership and direction in matters related to trauma system development in the Network Area.

Region 1 Trauma Network Application

B. Membership

1. Co-Chairpersons

The Co-Chairpersons of the Trauma Steering Committee will serve as Co-Chairpersons of the Regional Trauma Advisory Council.

2. Member/Alternate Designation

Members of the Regional Trauma Advisory Council shall be designated in writing by the appointing MCA, hospital, or other organization. Alternate members may be designated. Each appointing body may replace its appointed representative(s) and/or its alternate representative(s), and may fill any vacancy created by the resignation of an appointed representative(s) or alternate representative(s).

3. Members

The Regional Trauma Advisory Council will be comprised of the following eligible membership with the goal of maximizing inclusion of the Network's constituents:

a) Medical Director or designee of each MCA within the Network Area.
b) MCA administrative representative.
c) Trauma Director or designee from each verified trauma facility, each provisionally approved trauma facility and each facility actively seeking verification within the Network Area.
d) Trauma Program Manager from each verified trauma facility, each provisionally approved trauma facility and each facility actively seeking verification within the Network Area.
e) Trauma Registrar from each verified trauma facility, each provisionally approved trauma facility and each facility actively seeking verification within the Network Area.
f) Trauma Nurse Representative from each verified trauma facility, each provisionally approved trauma facility and each facility actively seeking verification within the Network Area.
g) Trauma Outreach and Prevention Coordinator from each verified trauma facility, each provisionally approved trauma facility and each facility actively seeking verification within the Network Area.
h) Emergency Department Physician representative from licensed hospitals and free standing surgical outpatient facilities (as defined in the EMS Act Section 20918.1) within the Network Area.
i) Emergency Department Nurse Representative from licensed hospitals and free standing surgical outpatient facilities (as defined in the EMS Act Section 20918.1) within the Network Area.
j) Life Support Agency, EMS Personnel and Consumer representatives as appointed by each MCA in the Network Area, to include as an example:
   - Protocol Committee/Advisory Committee Chairperson.
   - EMS Personnel Representative.
   - Life Support Agency Representative.
   - EMS Communication/EMD representative
   - Consumer representative not affiliated with the EMS or Hospital systems.

3. Member Appointment and Removal

Each appointment and replacement of a representative or alternate representative must be presented to the Regional Trauma Network or designee in writing or electronically, on the

appointing organization's letterhead signed by the administrative head of the appointing organization.

4. **Resignation**
   A resigning member of the Regional Trauma Advisory Council will have no further obligation to the Network.
5. **Membership Review**
   The Regional Trauma Advisory Council will review, at least annually, the appointments of its representatives and any alternate representatives.
6. **Additional Stakeholder Membership**
   The Regional Trauma Advisory Council, by a vote of a simple majority of its existing members, may authorize additional stakeholders within the Network Area to be represented on the Regional Trauma Advisory Council. Additional stakeholders selected may appoint one representative and one alternate representative to serve in the absence of the first appointed representative.

C. Regional Trauma Advisory Council Participation

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

D. Duties

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

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

E. Recommendation Approval

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

F. Sub-Committees

1. **Establishing Sub-Committees**
   The Regional Trauma Advisory Council may establish sub-committees as required and as it deems appropriate, unless otherwise restricted by the Trauma Steering Committee or Regional Trauma Network. Each sub-committee will elect its own chairperson(s). The Network Co-Chairperson(s) and Network Coordinator (subject to funding becoming available) will be ex-officio members of each sub-committee.
2. **Sub-Committee Chairperson(s) Attendance at Regional Trauma Advisory Council Meetings**
   Each sub-committee chairperson(s) will attend the Regional Trauma Advisory Council meetings and make a sub-committee report. If unable to attend, other arrangements for sub-committee reporting must be made by the Chairperson(s).

G. Meetings and Rules

1. Meeting Schedule

The Regional Trauma Advisory Council shall establish a regular schedule for quarterly meetings. The Co-Chairpersons may call for a special or emergency meeting of the Regional Trauma Advisory Committee when deemed necessary.

2. Voting

Actions of the Regional Trauma Advisory Committee require a simple majority of the members of the Regional Trauma Advisory Committee present at the meeting in which an action is being considered.

3. Rules

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

H. Consent Resolution

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

I. Actions Requiring Regional Trauma Advisory Council Approval

The following actions and activities will require the approval of the Regional Trauma Advisory Council:

1. The Regional Trauma Advisory Council will have the authority to approve or return for reconsideration to a sub-committee, sub-committee recommendations for allocation of funding (subject to funding becoming available).
2. The Regional Trauma Advisory Council will have the authority to approve or return for reconsideration to a sub-committee, sub-committee recommendations for Network plans.
3. The Regional Trauma Advisory Council may delegate responsibility to the sub-committee(s) as needed.
4. The adoption of any plan or recommended action by any participant in the Network, require the approval of a simple majority of the Regional Trauma Advisory Council members present at a Regional Trauma Advisory Council meeting, at which such plan or recommended action is presented. Plans and recommendations that do not receive simple majority support at a Regional Trauma Advisory Council meeting may be referred to the sub-committee for reconsideration.

7. REGIONAL PROFESSIONAL STANDARDS REVIEW ORGANIZATION

A. Purpose

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

B. Members

The Regional Professional Standards Review Organization will be comprised of the following eligible membership with the goal of maximizing inclusion of the Network's constituents:

1. MCA Medical Director
2. Trauma Medical Director
3. Trauma Surgeon
4. EMS Representation
5. Nursing Representation
6. MCA Representation

C. Members appointment and renewal

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

D. Resignation

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

E. Membership Review

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

F. Meetings and Rules

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

G. Confidentiality

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

H. Data Use Agreement

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

8. CONFLICT OF INTEREST

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

of interest. The disclosure shall become a part of the minutes of that Regional Network, Steering Committee, Advisory Council or Advisory Council Sub Committees meeting.

9. ADMINISTRATION AND APPROVAL PROCESS

A. Plan Approval Process

1. Plans and actions of the Regional Trauma Advisory Council must be approved by the Trauma Steering Committee. Final approval of all plans and actions is by the Regional Trauma Network. If approval of any plan or action is not received from the Trauma Steering Committee and each participating MCA, the plan or action will be returned to the Co-Chairpersons, with comments from the Trauma Steering Committee or each non-approving MCA identifying the reason for non-approval. Discussions on the unapproved aspect(s) of such plan or action will continue until the plan is approved by the Trauma Steering Committee and each of the Regional Trauma Network MCAs or the plan or action is withdrawn.
2. If approval is received from the Trauma Steering Committee and each participating MCA in the Regional Trauma Network, the protocols/policies/plans will be submitted to the Department for review and implementation approval. Once approved by the Department the protocols/policies/plans will be implemented.
3. The Co-Chairpersons will refer items for reconsideration to the Regional Trauma Advisory Council or Trauma Steering Committee as needed.

B. Confidentiality.

1. To the extent required by law, the Regional Trauma Network, Regional Trauma Advisory Council, Trauma Steering Committee and Sub-Committees will comply with the Michigan Open Meetings Act.
2. To the extent required by law, the Regional Trauma Network will comply with the Michigan Freedom of Information Act, Public Act 441 of 1976: MCL 15.231 et seq.and redact all personal identifiers or other information pursuant to applicable FOIA exemptions. However, all documents prepared in support of the Network are considered exempt from disclosure thereunder pursuant to MCL §15.243(y).
3. The confidentiality and protection of patient data collected as part of the creation and operation of the trauma system shall be provided and maintained through creation of a Regional Professional Standards Review Organization (PSRO), as provided in the 1967 PA 270, MCL 331.531 to 331.533. Data collected will only be used or disclosed for the purposes described in Part 209 of the Public Health Code and the Michigan Administrative Code R325.22101 through $22217. Any other uses or disclosures will be made only as required by applicable laws.
4. The Regional Trauma Advisory Council shall observe the confidentiality provisions of the Health Insurance Portability and Accountability Act under 45 CFR Part 164, data confidentiality provisions under the code, or as established by the Regional Professional Standards Review Organization (PSRO).

10. Amendments.

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

11. Indemnification.

This section left intentionally blank.