MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

BUREAU OF EMS, TRAUMA AND PREPAREDNESS

EMS AND TRAUMA SERVICES SECTION

STATEWIDE TRAUMA SYSTEM

(By authority conferred on the department of health and human services by sections 20910, 20917a, and 2233 of 1978 PA 368, MCL 333.20910**,** 333.20917a, and 333.2233; and Executive Reorganization Order No 2015-1, MCL 400.227.)

PART 1. GENERAL PROVISIONS

R 325.125 Definitions; A to D.

Rule 1. As used in these parts:

(a) "ACS-COT" means the American College of Surgeons-Committee on Trauma.

(b) "Adult trauma patient" means an injured or potentially injured individual that is, or reasonably appears to be, 15 years of age or older.

(c) "ATLS course" means an advanced trauma life support course with an emphasis on the first hour of initial assessment and primary management of an injured patient, starting at the point in time of injury continuing through initial assessment, life-saving intervention, reevaluation, stabilization, and transfer when appropriate.

(d) "Administrative hearing" means a hearing conducted pursuant to the administrative procedures act, 1969 PA 306**,** MCL 24.201 to 24.328.

(e) "Code" means MCL 333.1101 to MCL 333.25211 and known as the Michigan public health code.

(f) "Department" means the Michigan department of health and human services, or its duly appointed successor.

(g) "Disciplinary action" means an action taken by the department against a health care facility or regional trauma network for failure to comply with the code, rules, or protocols approved by the department.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.126 Definitions; E to O.

Rule 2. As used in this part:

(a) "Health care facility" means a health care facility licensed under MCL 333.20801 and 333.21501 that operates a service for treating emergency patients, 24 hours a day, 7 days a week.

(b) "Hold itself out" means the agency, health care facility, or trauma facility advertises, announces, or charges specifically for providing trauma care as defined in the code.

(c) "Inter-facility trauma transfer" means identifying the group of trauma patients that require additional trauma resources with the goal of providing optimal care to these patients by the timely transfer of that patient to an appropriate level of care to optimize outcome.

(d) "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, within an emergency medical services system.

(e) "Medical Control Authority or "MCA" means an organization designated by the department to provide medical control as defined in the code.

(f) "Medical control authority board" means a board appointed by the participating organizations to carry out the responsibilities and functions of the medical control authority.

(g) "Medical control authority region" means the geographic area comprised of a county, group of counties, or parts of an individual county, as designated by the department.

(h) "Non-designated health care facility" means a health care facility that has chosen not to be a part of Michigan's trauma care system, or a health care facility that the department has not designated as a trauma facility.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.127 Definitions; P to T

Rule 3. As used in this part:

(a) "Pediatric trauma facility" means a facility that has obtained a level of verification as a pediatric trauma facility, as provided by the ACS-COT, as well as those requirements to be designated as a trauma facility in Michigan, as set forth in R 325.127 to R 325.138.

(b) "Pediatric trauma patient" means an injured or potentially injured individual that is, or reasonably appears to be, under 15 years of age.

(c) "Physician" means a doctor of medicine (MD) or a doctor of osteopathy (DO) who possesses a valid current license to practice medicine in the state of Michigan.

(d) "Protocol" means a patient care standard, standing orders, policy, or procedure for providing emergency medical services that is established by a medical control authority and approved by the department under MCL 333.20919.

(e) "Professional standards review organization" means 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.

(f) "Quality improvement program" means actions taken by a life support agency, medical control authority, trauma facility, or jointly between a life support agency, medical control authority, or trauma facility with a goal of continuous improvement of medical care in accordance with the code. Actions shall take place under a professional standards review organization, as provided in MCL 331.531 to 331.533.

(g) "Regional Professional Standards Review Organization or RPSRO" means a committee established by the regional trauma network for the purpose of improving the quality of trauma care within a recognized trauma region as provided in MCL 331.531 to 331.533.

(h) "Regional trauma advisory council or “RTAC" means a committee established by a regional trauma network and comprised of MCA personnel, emergency medical services (EMS) personnel, life support agency representatives, health care 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 monitor the performance of the trauma agencies and health care facilities within the region, including, but not limited to, the review of trauma deaths and preventable complications.

(i) "Regional trauma network" means an organized group comprised of the local MCAs within a region, which integrates into existing regional emergency preparedness, and is responsible for appointing a regional trauma advisory council and creating a regional trauma plan.

(j) "Regional trauma plan" means a written plan prepared by a RTAC, and submitted by the regional trauma network and approved by the department, that is based on minimum criteria established by the department.

(k) "Statewide Trauma Care Advisory Subcommittee or “STAC," as used in these rules**,** means the statewide trauma care advisory subcommittee as defined in MCL 333.20917a, 333.20908, and 333.20910, that acts as the department's subject matter experts with regard to the clinical and operational components of trauma care.

(l) "Statewide trauma care system" means a comprehensive and integrated arrangement of emergency services personnel, facilities, equipment, services, communications, medical control authorities, and organizations necessary to provide trauma care to all patients within a particular geographic region.

(m) "Statewide trauma registry" means a system for collecting data which the department manages and analyzes the data and disseminates results.

(n) "Trauma" means bodily injury caused by the application of external forces.

(o) "Trauma bypass" means to forego delivery of a patient to the nearest health care facility for another health care facility whose resources are more appropriate to the patient's injury pursuant to direction given to a pre-hospital emergency medical service by online medical direction or predetermined triage criteria as established by department-approved protocols. However, trauma care still must be provided to patients as necessary pursuant to 42 USC §1395dd or other applicable laws.

(p) "Trauma diversion” means the re-routing of a trauma patient from a trauma care facility that has 1 or more of its essential resources currently functioning at maximum capacity, or is otherwise unavailable, to an alternate trauma care facility in order to serve the best interests of the trauma patient.

(q) “Trauma facility" means a health care facility designated by the department as having met the criteria set forth in the code as being either a level I regional trauma research facility, level II regional trauma facility, level III community trauma facility, or level IV trauma support facility.

(r) "Trauma response" means a patient who has been injured or potentially injured as a result of the application of external forces and requires the utilization of the trauma care system.

(~~s~~) "Trauma team" means a team of multidisciplinary health care providers established and defined by a health care facility or emergency care facility that provides trauma care.

(t) "Triage" means classifying patients according to the severity of their medical conditions.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.128 Terms.

Rule 4. Terms defined in the code have the same meanings when used in these rules.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.129 Powers and duties of department.

Rule 5. (1) The department, with the advice of the emergency medical services coordination committee and statewide trauma care advisory subcommittee, shall do all of the following:

(a) Implement an "all-inclusive" trauma system throughout the state. This type of system allows for the care of all injured or potentially injured patients in an integrated system of health care in the pre-hospital and health care facility environments by personnel that are well trained and equipped to care for injured patients of any severity. The system allows for a health care facility to participate in the system to the extent or level that it is willing to commit the resources necessary for the appropriate management of the trauma patients and prohibits the department from limiting the number of health care facilities that seek to qualify for any given level of trauma designation under this system. It also ensures that all trauma patients are served by a system of coordinated care, based on the degree of injury and care required.

(b) Perform all of the following:

(i) Establish a statewide trauma quality improvement process using a statewide database.

(ii) Monitor the statewide trauma system.

(iii) Ensure the coordination and performance of the regional trauma networks.

(iv) Set minimum standards for system performance and trauma patient care.

(c) Develop a statewide process to establish regional trauma networks comprised of local medical control authorities in a manner that integrates into existing regional emergency preparedness, EMS, or medical control systems.

(d) Implement and maintain a statewide trauma systems plan**.**

(e) Develop a statewide process for the verification of trauma resources based on criteria as defined in the “American College of Surgeons-Resources for Optimal Care of the Injured Patient; 2014,” including any subsequent amendments and editions of this publication. This document is available online at the ACS website or from ACS, P.O. Box 92425, Chicago, IL 60675.

(f) Develop a statewide process for the designation of trauma facilities.

(g) Develop an appeals process for facilities contesting their designation.

(h) Establish state trauma recommendations and approve regional trauma triage protocols which are established and adopted by the local medical control authority.

(i) Maintain the established regional trauma networks to provide system oversight of the trauma care provided in each region of the state. Regional trauma networks shall be

comprised of collaborating local medical control authorities (MCAs) in a region. The collaborating MCAs in a region shall apply to the department for approval and recognition as a regional trauma network. The department, with the statewide trauma care advisory subcommittee and emergency medical services coordination committee, shall review the regional trauma network application for approval every 3 years. The establishment of the regional trauma networks shall not limit the transfer or transport of trauma patients between regional trauma networks.

(j) Require field triage protocols which are established and adopted by local medical control and regional trauma networks, and shall be developed based on triage criteria prescribed by the department upon the recommendation of the STAC and emergency medical services coordination committee, and following the procedures established by the department under MCL 333.20919(3).

(k) Verify the trauma care resources of designated trauma facilities or health care facilities seeking designation in this state for a 3-year period.

(l) Establish a mechanism for periodic redesignation of all health care trauma care facilities.

(m) Develop a comprehensive statewide data collection system.

(n) Formulate recommendations for the development of performance improvement plans by the regional trauma networks, consistent with those in R 325.135.

(o) Develop a process for trauma system performance improvement, which will include responsibility for monitoring compliance with standards, maintaining confidentiality, and providing periodic review of trauma facility standards. The standards as specified in R 325.129(2)(l)(e) and R 325.135 are incorporated by reference in these rules.

(p) Develop a process for the evaluation of trauma system effectiveness based on standards that are incorporated by reference in these rules, as specified in subdivision (b) of this subrule and R 325.135.

(q) Coordinate and integrate appropriate injury prevention initiatives and programs.

(r) Support the state trauma system and provide resources to carry out its responsibilities and functions.

(s) Support the training and education needs and resources of trauma care personnel throughout the state.

(2) The department may deny, suspend, or revoke designation of a trauma facility upon a finding including, but not limited to, any of the following:

(a) Failure to comply with the administrative rules and/or health care facility rules and regulations.

(b) Willful preparation or filing of false reports or records.

(c) Fraud or deceit in obtaining or maintaining designation status.

(d) Failure to meet designation criteria established in these rules.

(e) Unauthorized disclosure of medical or other confidential information.

(f) Alteration or inappropriate destruction of medical records.

(g) The facility no longer has the resources required to comply with the current level of designation conferred.

(h) The facility no longer cares for trauma patients.

(i) A department-approved trauma care verification body has determined that the facility no longer meets its trauma facility verification criteria.

(j) Identified deficiencies are not remediated in the allowable timeframe.

(3) The department shall provide notice of intent to deny, suspend, or revoke trauma facility designation and shall provide for an appeals process in accordance with the code and the sections 71 to 87 of the administrative procedures act of 1969, MCL 24.271 to 24.287.

(4) In developing a statewide trauma system, the department shall consider all of the following factors:

(a) Efficient implementation and operation.

(b) Decrease in morbidity and mortality.

(c) Cost effective implementation.

(d) Incorporation of national standards.

(e) Availability of funds for implementation.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.130. Trauma facility verification; designation and redesignation.

Rule 6. (1) A health care facility, which intends to provide trauma care, shall obtain designation as a trauma facility. A health care facility shall not self-designate itself as a trauma facility.

(2) A health care facility shall not use the word "trauma" to describe its facility, or in its advertising, unless it obtains and maintains a designation as a "trauma facility" from the department.

(3) The department shall redesignate the trauma capabilities of each health care facility on the basis of verification and designation requirements in effect at the time of redesignation.

(4) To obtain a designation as a "trauma facility," the institution shall apply to the department. An applicant health care facility has a right to an administrative hearing if denied a specific trauma facility level designation.

(5) The department shall designate the existing trauma resources of all participating health care facilities in the state, based upon the following categories:

(a) A level I regional trauma research center shall comply with the standards that are incorporated by reference and verification criteria developed by ACS-COT for Level I trauma facilities pursuant to R 325.129(l)(e), and all of the following:

(i) Comply with data submission requirements in R 325.133 and R 325.134.

(ii) Participate in coordinating and implementing regional injury prevention plans.

(iii) Provide staff assistance to the department in the designation and verification process of community trauma facilities and trauma support facilities.

(iv) Participate in the regional performance improvement process.

(b) A level II regional trauma center shall comply with the standards that are incorporated by reference and verification criteria established by the ACSCOT or level II trauma facilities, pursuant to R 325.129(l)(e), and all of the following:

(i) Comply with data submission requirements in R 325.133 and R 325.134.

(ii) Participate in coordinating and implementing regional injury prevention plans.

(iii) Provide staff assistance to the department in the designation and verification process of community trauma facilities and trauma support facilities.

(iv) Participate in the regional performance improvement process.

(c) For a level III, community trauma facility, verification criteria shall be established by the department, with the advice and recommendations of the state trauma advisory subcommittee and emergency medical services coordination committee. The standards are incorporated by reference in these rules, based upon verification criteria established by ACS-COT for level III facilities, pursuant to R 325.129(l)(e), and all of the following:

(i) Comply with data submission requirements in R 325.133 and R 325.134.

(ii) Participate in coordinating and implementing regional injury prevention plans.

(iii) Participate in the regional performance improvement process.

(d) For a Level IV trauma support facility, verification shall be completed using an "in-state" process, and criteria shall be established by the department, with the advice and recommendations of the state trauma advisory subcommittee and emergency medical services coordination committee. The verification standards incorporated by reference in these rules, are based upon criteria recommended by ACS-COT for level IV facilities, pursuant to R 325.129(l)(e) and Michigan level IV verification criteria and all of the following:

(i) Comply with data submission requirements in R 325.133 and R 325.134.

(ii) Participate in coordinating and implementing regional injury prevention plans.

(iii) Participate in the regional performance improvement process.

(e) The Michigan level III and IV verification criteria document is available from the department or online at the Michigan trauma system website.

(6) The resources of health care facilities applying for level I regional trauma research facility or level II regional trauma facility designation status shall be verified by the ACS-COT and shall do all of the following:

(a) Comply with data submission requirements in R 325.133 and R 325.134.

(b) Participate in coordinating and implementing regional injury prevention plans.

(c) Provide staff assistance to the department in the designation and verification process of community trauma facilities and trauma support facilities.

(d) Participate in the regional performance improvement process.

(7) Health care facilities seeking designation as a level III, community trauma facility shall be verified using either an in-state process established by the department, with the advice of the state trauma advisory subcommittee, or by the ACS-COT and shall do all of the following:

(a) Comply with data submission requirements in R 325.133 and R 325.134.

(b) Participate in coordinating and implementing regional injury prevention plans.

(c) Participate in the regional performance improvement process.

(8) Health care facilities seeking designation as a level IV, trauma ~~s~~support facility shall be verified using an in-state process established by the department, with the advice of the state trauma advisory subcommittee, and shall do all of the following:

(a) Comply with data submission requirements in R 325.133 and R 325.134.

(b) Participate in coordinating and implementing regional injury prevention plans.

(c) Participate in the regional performance improvement process.

(9) Health care facilities wishing to be redesignated as a level I regional trauma research facility must independently obtain ACS-COT verification at that level, and shall comply with the standards that are incorporated by reference pursuant to R 325.129(l)(e), and all of the following:

(a) Comply with data submission requirements in R 325.133 and R 325.134.

(b) Participate in coordinating and implementing regional injury prevention plans.

(c) Provide staff assistance to the department in the designation and verification process of community trauma facilities and trauma support facilities.

(d) Participate in the regional performance improvement process.

(10) Health care facilities wishing to be redesignated as a Level II regional trauma facility must independently obtain ACS-COT verification at that level, and shall comply with the standards that are incorporated by reference pursuant to R 325.129(l)(e), and all of the following:

(a) Comply with data submission requirements as set forth in R 325.133 and R 325.134.

(b) Participate in coordinating and implementing regional injury prevention plans.

(c) Provide staff assistance to the department in the designation and verification process of community trauma facilities and trauma support facilities.

(d) Participate in the regional performance improvement process.

(11) Health care facilities wishing to be re-designated as a level III community trauma facility must obtain verification at that level using either in-state resources, or the ACS-COT, and shall comply with the standards that are incorporated by reference pursuant to R 325.129(l)(e), and all of the following:

(a) Comply with data submission requirements in R 325.133 and R 325.134.

(b) Participate in coordinating and implementing regional injury prevention plans.

(c) Participate in the regional performance improvement process.

(12) Health care facilities wishing to be redesignated as a level IV trauma support facility must obtain verification at that level using an in-state process. Level IV verification criteria shall be established by the department, with the advice and recommendations of the state trauma advisory subcommittee and emergency medical services coordination committee. The verification standards incorporated by reference in these rules are based upon criteria recommended by ACS-COT for level IV facilities, pursuant to R 325.129(l)(e), R 325.130, and Michigan level IV verification criteria, including all of the following:

(a) Comply with data submission requirements in R 325.133 and R 324.134.

(b) Participate in coordinating and implementing regional injury prevention plans.

(c) Participate in the regional performance improvement process.

(13) The department may, with the advice and recommendations of the state trauma advisory committee and emergency medical services coordination committee, modify the criteria or establish additional levels of trauma care resources as appropriate to maintain an effective state trauma system**,** and protect the public welfare, except that the department shall not establish any criteria for the purpose of limiting the number of health care facilities that qualify for a particular trauma level under these rules.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.131 Triage and transport.

Rule 7. (1) The department, with the advice and recommendations of the state trauma advisory subcommittee and emergency medical services coordination committee, shall develop recommendations, based on standards that are incorporated by reference in these rules, pursuant to R 325.129(l)(e), R 325.136, R 325.137, and

R 325.138 for protocols which are established and adopted by local medical control, for the triage, transport, and inter-facility transfer of adult and pediatric trauma patients to appropriate trauma care facilities.

(2) The standards that are incorporated by reference in these rules, pursuant to R 325.129(l)(e), R 325.136, R 325.137, and R 325.138 for the triage, transport, and the inter-facility transfer of trauma patients**,** provide recommended minimum standards of care for protocols which are established and adopted by local medical control that must be utilized during transport of trauma patients. On an annual basis, or as needed, the department shall review and update these recommended minimum standards with the advice and recommendations of the state trauma advisory subcommittee and emergency medical services coordination committee.

(3) The department, with the advice and recommendations of the state trauma advisory subcommittee and emergency medical services coordination committee, shall create regional trauma networks that shall have the responsibility for developing triage and transport procedures within that geographical area. Both of the following apply:

(a) Each regional trauma network shall be created within the emergency preparedness region currently established within the state.

(b) Each trauma region may create its own triage and transport criteria and protocols, destination criteria and protocols, and inter-facility transfer criteria and protocols, which are established and adopted by local medical control, so long as they meet or exceed the standards that are incorporated by reference in these rules, pursuant to R 325.129(l)(e), R 325.129(1)(k), R 325.136, R 325.137, and R 325.138, and that they are reviewed by the quality assurance task force and approved by the department. This may include coordination of triage and transport criteria and protocols, which are established and adopted by local medical control, across geographic regions if in the best interest of providing optimal trauma care to patients.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.132 Trauma regions.

Rule 8. (1) The department, with the advice and recommendations of the state trauma advisory subcommittee and emergency medical services coordination committee, shall support the establishment and operational activities of the trauma regions through the commitment of resources.

(2) Each region shall establish a regional trauma network as prescribed and defined by R 325.125 to R 325.135.

(3) All MCAs within a region must participate in the regional trauma network, and life support agencies that care for trauma patients shall be offered membership on the regional trauma advisory council. Regional trauma advisory councils shall be operated in a manner that maximizes inclusion of their constituents. All of the following must apply:

(a) At least quarterly, a regional trauma network shall submit evidence of ongoing activity, such as meeting notices and minutes, to the department. Annually, the regional trauma advisory council shall file a report with the department which describes progress toward system development, demonstrates on-going activity, and includes evidence that members of the regional trauma advisory council are currently involved in trauma care.

(b) The regional trauma network shall develop a system regional trauma plan. The plan is subject to review of the STAC and emergency medical services coordination committee and approval by the department.

(c) The department shall review the plan to assure that it contains at a minimum, all of the following:

(i) All counties within the regional trauma advisory council have been included unless a specific county, or portion thereof, has been aligned within an adjacent network, and all health care entities and MCAs, life support agencies have been given an opportunity to participate in the planning process.

(ii) All of the following components have been addressed:

(A) Injury prevention.

(B) Communications.

(C) Regional performance improvement.

(D) Trauma education.

(E) Infrastructure.

(F) Continuum of care.

(4) Each regional trauma network shall appoint a RPSRO as defined in R 325.127(g).

(5) Each regional trauma advisory council shall develop performance improvement plans that are based on standards that are incorporated by reference in these rules, pursuant to R 325.129(l)(e), R 325.129(1)(k), and R 325.135, and shall be reviewed annually by the state trauma advisory subcommittee and emergency medical services coordination committee for recommendations to the department.

(6) Recommendations, which are developed and proposed for implementation by a regional trauma advisory council, shall meet or exceed those that have been established by the department with the advice and recommendations of the state trauma advisory subcommittee and emergency medical services coordination committee, as based on standards that are incorporated by reference in these rules, pursuant to R 325.129(l)(e) and R 325.129(1)(k).

(7) The department shall recognize the regional trauma network once it approves a completed regional trauma plan. The regional trauma network approval process shall consist of the following phases:

(a) The first phase is the application phase, which begins with the submission to the department of a completed regional plan for the regional trauma network.

(b) The second phase is the review phase, which begins with the receipt of the regional plan, and ends with a department recommendation to approve the regional trauma network.

(c) The third phase is the final phase, with the department making a final decision regarding the regional trauma network plan. This phase also includes an appeal procedure for the denial of an approval of application in accordance with the department's administrative hearings requirements.

(8) If the application phase results in a recommendation to the department for approval by the statewide trauma advisory subcommittee and the emergency medical services coordination committee, and the department approves, then the department shall notify the regional trauma network applicant of the recommended action within 90 days from receipt by the department.

(9) Upon approval, a regional trauma advisory council shall implement the plan to include the following:

(a) Education of all entities about the plan components.

(b) On-going review of resources, process, and outcome data.

(10) The regional trauma network approval is in effect for 3 years.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.133. Data collection.

Rule 9. (1) The department, with the advice and recommendations of the state trauma advisory subcommittee and emergency medical services coordination committee, shall develop and maintain a statewide trauma data registry. The department shall do all of the following:

(a) Adopt the national trauma data standard elements and definitions as a minimum set of elements for data collection, with the addition of elements as recommended by the STAC. The following standards are incorporated by reference in these rules, as identified in the National Trauma Data Standard: Data Dictionary, 2016 Admissions, including subsequent amendments and editions. A link to the document is available online at the Michigan trauma systems website. A copy may be obtained at no cost by writing to the Bureau of EMS, Trauma and Preparedness.

(b) Implement a plan for data including the following:

(i) Notify partners of data dictionary changes and new iterations annually.

(ii) Define the data validation process for designated trauma facility data submissions to the statewide trauma registry.

(iii) Participate in state data collaboration activities.

(iv) Establish and maintain processes for the following:

(A) Data related to trauma incidents shall be submitted to the statewide trauma registry according to the data submission timelines.

(B) Monitor national standards, regional issues, facility, and RPSROs to determine the need for additional data metrics needed for system function.

(C) For those trauma incidents that met the inclusion criteria identified for data submission, the following data elements shall be submitted to the department:

(1) All national trauma data standard data elements.

(2) All data elements recommended by the STAC.

(v) Develop annual reports using regional and state data defined by the STAC which assesses the state trauma system and regional trauma networks.

(vi) Evaluate and import additional data from existing databases as needed.

(vii) Support and evaluate probabilistic and deterministic data linkages.

(2) The department shall support the data collection and analysis process.

(3) Both of the following apply to health care facility participation in data submission:

(a) All designated facilities shall participate in data submission.

(b) Participation as appropriate in the RPSRO, as provided in 1967 PA 270, MCL 331.531 to 331.533.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.134 Statewide trauma registry.

Rule 10. (1) The purpose of the trauma registry is to collect and analyze trauma system data to evaluate the delivery of adult and pediatric trauma care, develop injury prevention strategies for all ages, and provide resources for research and education.

(2) The department shall coordinate data collected by the trauma care facilities and emergency medical service providers. The department shall develop and publish a data submission manual that specifies all of the following:

(a) Data elements and definitions. The standards that are incorporated by reference pursuant to R 325.133(1)(a), and all of the following:

(i) Definitions of what constitutes a reportable trauma case.

(ii) Method of submitting data to the department.

(iii) Timetables for data submission.

(iv) Data submission format.

(v) Protections for individual record confidentiality.

(b) Notification of trauma care facilities of the required registry data sets and update the facilities and providers, as necessary, when the registry data set changes.

(c) Specification of both the process and timelines for health care facility submission of data to the department.

(3) All health care facilities shall submit to the department trauma data determined by the department to be required for the department's operation of the state trauma registry. The department shall prescribe and provide both of the following:

(a) Standard reporting mechanisms to be used by all health care facilities.

(b) The form and content of records to be kept and the information to be reported to the department.

(4) The department and regional trauma advisory councils shall use the trauma registry data to identify and evaluate regional trauma care and to prepare reports and analyses as requested by regional trauma advisory councils, the state trauma advisory subcommittee, or the emergency medical services coordination committee.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.135 Regional performance improvement.

Rule 11. (1) Each trauma care region shall be required to develop and implement a regional trauma performance improvement program. This program shall include the standards that are incorporated by reference pursuant to R 325.129(1)(e), R 325.129(1)(k), and R 325.130(6)(d), and shall include the development of an annual process for reporting to the department a review of all region-wide policies, procedures, and protocols.

(2) Each regional trauma network is responsible for monitoring, assessing, and evaluating its regional trauma system to improve trauma care, reduce death and disability, surveillance of injury, and implementation of injury prevention activities.

(3) Each regional trauma network shall appoint a RPSRO.

(4) Deviations from protocols, which are established and adopted by local medical control and approved by the department for trauma patients, shall be addressed

through a documented trauma performance improvement process established by a professional standards review organization.

(5) Each 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.

(6) The performance improvement process shall include the following standards that are incorporated by reference in these rules, pursuant to R 325.129(l)(e), R 325.129(1)(k), and R 325.130(6)(d) and include all of the following system components to be evaluated for both pediatrics and adults:

(a) Components of the regional trauma plan.

(b) Triage criteria and effectiveness.

(c) Trauma center diversion.

(d) Data driven provision of care defined by available data metrics supported by the region, the statewide trauma advisory subcommittee, and the department.

(7) Each trauma care region shall be responsible for the ongoing evaluation of its trauma care system. Accordingly, each region shall be responsible for the ongoing receipt of information from the regional trauma system constituents on the implementation of various components of that region's trauma system, and shall include the standards that are incorporated by reference pursuant to R 325.129(1)(e), R 325. 129(A)(12), and R 325.130(6)(d), and include all of the following system components to be evaluated:

(a) Components of the regional trauma plan.

(b) Triage criteria and effectiveness.

(c) Trauma center diversion.

(d) Data analytics as defined by the department with the advice of the statewide trauma advisory subcommittee.

(8) Based upon information received by the region in the evaluation process, the region shall annually prepare a report containing results of the evaluation and a performance improvement plan. The report shall be made available to all regional trauma system constituents. The region shall ensure that all trauma facilities participate in this annual evaluation process, and encourage all other hospitals that treat trauma patients to participate in the annual evaluation process. The region shall not release specific information related to an individual patient or practitioner. Aggregate system performance information and evaluation will be available for review.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.136 Destination protocols.

Rule 12. Local MCAs shall develop and submit trauma destination protocols to the EMS and trauma section for review by the quality assurance task force, pursuant to MCL 333.20916. Upon review and approval by the department**,** the MCA must formally adopt and implement the protocol. The following factors will be used in evaluating those destination protocols:

(a) Trauma patients shall not be transported to a facility not participating in the state trauma system unless there is no other reasonable alternative available.

(b) Trauma patients shall be transported to the closest appropriate trauma facility as identified in regional and local medical control protocols.

(c) If a level I or level II trauma facility is not within a reasonable distance from the scene, the trauma patient shall be transported to the closest appropriate trauma facility.

(d) Each region shall make appropriate determinations for destination based on what is best for the patient.

(e) In areas of the state close to state borders, the most appropriate facility may be out of the state. If possible, transport trauma patients within state borders. Local protocols shall address this issue.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.137 Trauma patient inter-facility transfer protocols.

Rule 13. (1) All designated trauma centers shall maintain inter-facility transfer protocols for trauma patients that are consistent with regional and local medical control protocol and that are compliant with the emergency medical treatment and labor act, 42 USC 1395dd.

(2) All level III and level IV designated hospitals will develop and implement formal policies based on published guidelines for the transfer of trauma patients who need care at level I or level II trauma facilities.

(3) Trauma patients will be transported to a hospital that is designated as a trauma facility.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.

R 325.138 Criteria for transfer protocols; criteria.

Rule 14. Designated trauma centers shall contact the department for current trauma patient transfer guidelines.

History: 2007 AACS; 2017 MR 10, Eff. May 31, 2017.