

EAST CENTRAL
MISSISSIPPI TRAUMA
CARE REGION

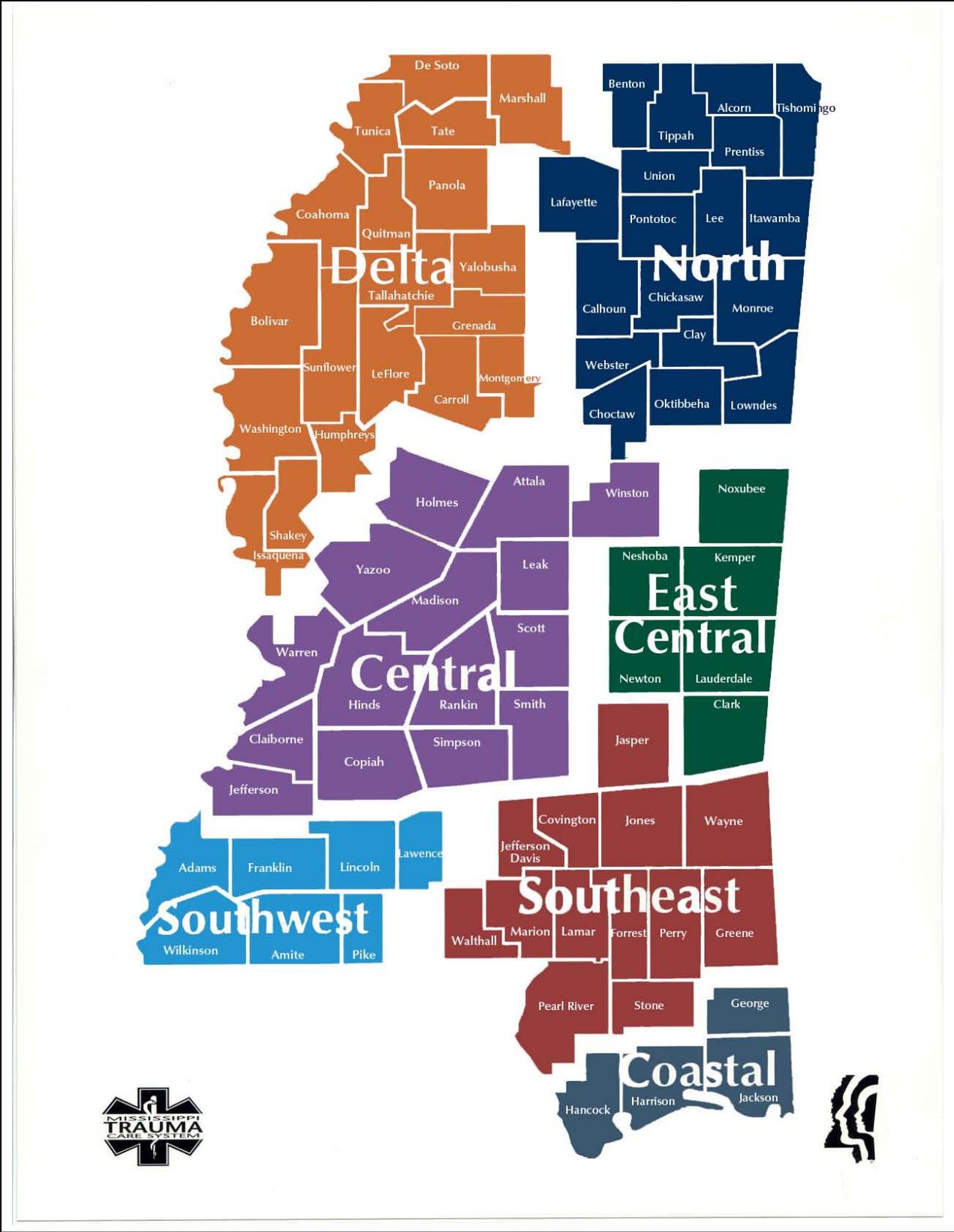
REGIONAL
TRAUMA
PLAN

2013

Revised December 2013

TABLE OF CONTENTS

MAP OF MISSISSIPPI TRAUMA CARE REGIONS	3
PLAN SUMMARY	4
OBJECTIVES	5
IMPLEMENTATION SCHEDULE	7
ADMINISTRATIVE STRUCTURE	8
REGIONAL ORGANIZATIONAL STRUCTURE	9
MEDICAL ORGANIZATION AND MANAGEMENT	10
INCLUSIVE TRAUMA SYSTEM DESIGN	11
SUGGESTED GUIDELINES FOR INTERFACILITY TRANSFER	14
INTERFACILITY TRANSFERS	15
DOCUMENTATION OF PARTICIPATION OF THE REGION HOSPITALS	16
OPERATIONAL IMPLEMENTATION OF THE POLICIES DEVELOPED	17
A. SYSTEM ORGANIZATION AND MANAGEMENT POLICY	18
B. INTRA-REGIONAL COORDINATION POLICY	19
C. TRAUMA CARE COORDINATION INTER-REGION POLICY	20
D. DATA COLLECTION AND MANAGEMENT POLICY	21
E. COORDINATION OF TRANSFERS AND TRANSPORT POLICY	22
F. INTEGRATION OF PEDIATRIC HOSPITALS POLICY	23
G. AVAILABILITY OF TRAUMA CENTER PERSONNEL/EQUIPMENT POLICY	25
H. SUGGESTED CRITERIA FOR ACTIVATION OF A TRAUMA TEAM POLICY	26
I. SYSTEM EVALUATION AND PERFORMANCE IMPROVEMENT POLICY	28
J. PROFESSIONAL AND STAFF TRAINING POLICY	29
K. PUBLIC INFORMATION AND EDUCATION POLICY	30
L. INJURY PREVENTION PROGRAMS POLICY	31
M. NON-COMPLIANCE POLICY	32
REGIONAL RESOURCE/CRITICAL CARE CAPABILITY	33
PERFORMANCE IMPROVEMENT	34
PRE-HOSPITAL TRIAGE AND TRANSPORT GUIDELINES	36
PRE-HOSPITAL PERFORMANCE IMPROVEMENT PLAN	38
PRE-HOSPITAL PATIENT CARE PROTOCOLS	40
PRE-HOSPITAL TRAUMA TRIAGE/DESTINATION GUIDELINES	41
CONSTITUTION AND BYLAWS OF EAST-CENTRAL MS TRAUMA CARE REGION	44



PLAN SUMMARY

Trauma remains the leading cause of death and disability in the first four decades of life; and with an increasingly older population, it is becoming a major problem at older ages as well. In recognition of this fact, the state of Mississippi has chosen to legislate, and provide funding for, a statewide Inclusive Trauma Care System. This System impacts all aspects of trauma care in the State as well as virtually all hospitals, both designated and non-designated. The intention, of course, is to improve the quality of trauma delivered throughout Mississippi and to establish standards of excellence for the delivery of such care.

The State of Mississippi has been divided into seven Trauma Care Regions of varying sizes and geographical distribution (see map on page 2). The East-Central Mississippi Trauma Care Region encompasses the following six counties: Clarke, Kemper, Lauderdale, Neshoba, Newton and Noxubee. Presently, eight hospitals in the region are participating in the East-Central Region: Pioneer Community Hospital-Newton in Newton, John C. Stennis Memorial Hospital in Dekalb, Neshoba County General Hospital in Philadelphia, H.C. Watkins Hospital in Quitman, Laird Hospital in Union, Noxubee General Hospital in Macon, and Anderson Regional Medical Center and Rush Foundation Hospital in Meridian. There is one non-participating hospital, Choctaw Health Center, in Philadelphia.

Currently there are four participating and one non-participating (Choctaw) ALS Emergency Medical Service Providers operating in the Region. There is also a helicopter ambulance service provided by AirCare II which is based at the Meridian Airport.

East-Central Region was organized and incorporated in January 2000. It was officially designated as the East-Central Trauma Care Region, Inc., on February 29, 2000. A Board of Directors was elected, Bylaws drafted and approved, and organizational activities begun.

The bulk of the East-Central Region is rural, consisting of six Level IV hospitals and two Level III hospitals. It follows that the resources among the member hospitals will vary considerably. The Regional Plan must, therefore, reflect this diversity, as well as the fact that resources at smaller, rural hospitals are often severely limited. An attempt has, therefore, been made to develop general guidelines and strategies for dealing with such issues as field triage, pre-hospital care, and trauma team activation. Flexibility has been written into the Plan so that individual hospitals may make their own decisions regarding issues with local or regional complicating factors. Some oversight is required, however, in order to assure a uniform and acceptable standard of practice throughout the Region. Mandatory regional policies have, therefore, been developed to provide this uniformity and oversight.

OBJECTIVES

In brief, the purpose of the East-Central Regional Trauma Plan is to provide a framework for the development of a cohesive System throughout the East-Central Region and to improve the quality of trauma care in East-Central Mississippi. To this end, the following objectives have been established:

1. Plan Development

Development of the Regional Trauma Plan is a requirement of membership and participation within the Mississippi Trauma Care System. Guidelines for regional plan content were provided by the State to assist the Region with adherence to State-established criteria. An objective of the East-Central Trauma Region is to develop our Regional Plan using those guidelines. Dr. Jack Sariago, previous East-Central Trauma Regional Chairman, drafted the initial Plan. Open discussion was conducted on the Plan by Regional Board members. Revisions were drafted, and the Plan was approved by the Board. The Plan was submitted to the State in November 2000. The State, through the work of out-of-State consultants, provided the Region with an editorial review of the Plan in May 2001. Regional Board member volunteers drafted additional revisions to the Plan. The revised Plan was approved by the Board in September 2001 and submitted to the State.

2. Commitment to Ongoing Participation and System Ownership

The long-term viability of the East-Central Trauma Region will be predicated on widespread Regional commitment to ongoing participation and a sense of member ownership. An objective of the East-Central Trauma Region is to promote and enhance Regional participation and sense of ownership. To this end, the Region has been developed by its members with input from each member, so that each member has a stake in the design and implementation of the Regional System. Our anticipated outcome of this objective is the sustained membership of all eligible hospitals within the Region. The outcome will be measured by Regional membership.

3. Inclusive Nature of the Plan with Universal Access

The East-Central Trauma Region is one of seven regions designed to provide trauma coverage for the entire State of Mississippi. By nature and design, the Regional Plan is an integral part of a whole and should be designed to be inclusive. An objective of the East-Central Trauma Region is to develop an inclusive system, both with the Region and within the State. Our anticipated outcome of this objective is to provide a trauma system that will provide a comprehensive network for trauma care accessible by every resident of the Region. The outcome will be measured by the Region's ability to coordinate an integrated system from pre-hospital emergency management services to appropriate level hospital services to post-trauma rehabilitative services if necessary.

4. Public Education

Public education has proved to be the most effective means of reducing trauma-related injuries and deaths. With the implementation of a trauma system the Region, through its trauma registry, will have the ability to track and quantify trauma-related information. This data is then used to educate the public proactively to prevent and reduce trauma-related injuries. An objective of the East-Central Trauma Region is to use trauma registry information to identify high-incident, trauma-related injuries and develop a public awareness and educational program in an effort to prevent and reduce these injuries. Our anticipated outcome is the reduction of identified and targeted trauma injuries through public education. This outcome will be measured by utilizing ongoing trauma registry reporting to evaluate the impact of Regional public education affects on targeted trauma injuries.

5. Quality Medical Care and Performance Improvement

The primary goal of any trauma system and the goal of the Mississippi Trauma Care System in particular, are to improve the outcome of acutely injured patients. An emphasis on performance improvement is essential to this end. Ongoing performance improvement on Regional trauma issues will be an integral part of Regional Board meetings. An objective of the East-Central Trauma Region is to continually strive for quality medical care through performance improvement. The anticipated outcome of this objective is enhanced quality medical care. This outcome will be measured by results reported through the performance improvement process.

6. Research and Future Plans

A Trauma Plan is dynamic and will necessarily change as a new and deeper understanding develops regarding the most efficient and appropriate method for delivering trauma care. An objective of the East-Central Trauma Region is to continually research and evaluate trauma care within the Region and improve the future of trauma care delivery. The anticipated outcome of this objective is a dynamic, not static, Trauma Plan. This outcome will be measured by the continued relevance and effectiveness of the Plan.

IMPLEMENTATION SCHEDULE

Jul 2011- June 2012	Provide community education outreach on ATV Safety , the Regional injury prevention focus for the year. Aired PSA on local network.
Jul 2012 - Jun 2013	Provide community education outreach on Distracted Driving safety, the Regional injury prevention focus for the year. Aired PSA on local network
Jul 2012 – Jun 2013	Facilitate the Healthcare Coalition Committee.
Oct – Dec 2012	Implement State adopted trauma activation and destination guidelines in the Region. Provide training and education to all Regional hospitals and EMS agencies.
Jul – Sep 2012	Review and revise Bylaws
Oct 2012	Finalize MEDCOM operations manual.
Jun 2013	Annual election of Board officers
Jan 2014	Add ENPC education to Regional training courses
Ongoing	Provide MEDCOM training and education to all Regional hospitals and EMS agencies.
Ongoing	Provide ACLS, PALS, and TNCC training courses.

ADMINISTRATIVE STRUCTURE

East Central Mississippi Care Region, Inc. is a not-for-profit Mississippi Corporation. Membership in the corporation is available to licensed hospitals participating in the statewide trauma program. The corporation is governed by a Board of Directors that consists of two appointed representatives from member hospitals, three appointed EMS representatives, and the regional EMS Advisory Council appointment. Officers are elected by the Board for the positions of Chairman, Vice-Chairman, Secretary, and Treasurer. Meetings of the Board of Directors are held bi-monthly.

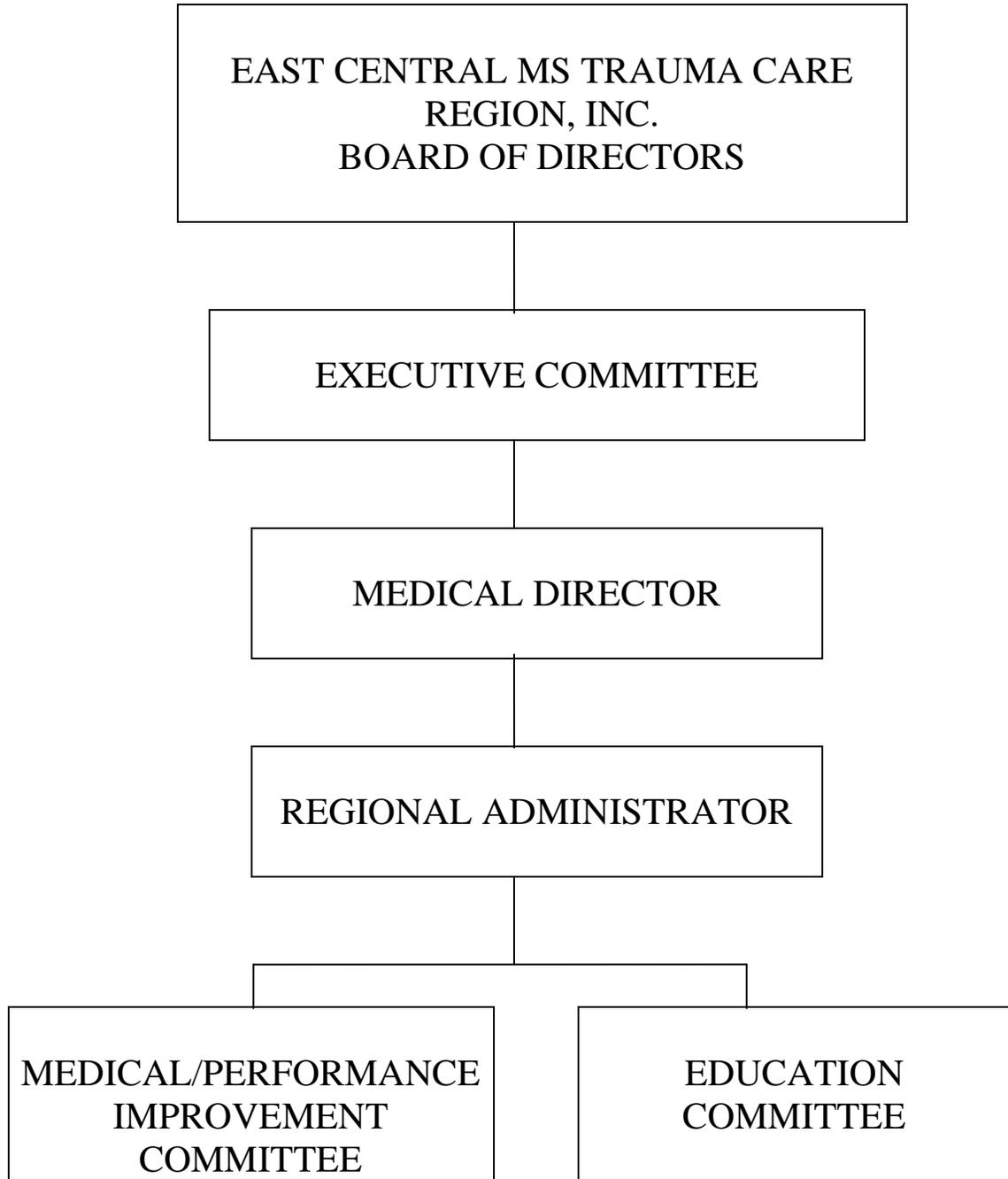
The Board supports three committees: Executive, Medical/Performance Improvement, and Education. The Executive Committee is comprised by the Board's elected officers and chaired by the Board Chairman. The Medical/Performance Improvement committee is comprised of representatives from member organizations and chaired by the regional State PI Committee appointee. The Education Committee is comprised of representatives from member organizations and chaired by a selectee of the Committee. All committees formulate recommended policies and procedures and report them to the Board of Directors at the regularly scheduled Board meetings for a ruling on the recommendations. The Board of Directors shall also appoint other non-standing committees as necessary.

The Board subcontracts for the positions of Regional Administrator and Medical Director. The Regional Administrator oversees the day-to-day operations and administrative affairs of the Region, under the direction of the Executive Committee. Responsibilities include the administrative operations of the Region, making recommendations to the Board at large, and financial management of the region. The Medical Director coordinates regional medical direction. Responsibilities include medical accountability throughout the Region and trauma system advocacy.

The business plan of the region is to establish a smooth operating organization for the system. Annual budgets are prepared and submitted to the MSDOH as regulated by the Mississippi Trauma Care System Regulations. The Regional Administrator will manage the daily administrative aspects of the organization.

EAST CENTRAL MISSISSIPPI TRAUMA CARE REGION, INC.

REGIONAL ORGANIZATIONAL STRUCTURE



MEDICAL ORGANIZATION AND MANAGEMENT

The Region's Medical Director coordinates regional medical direction. The Medical Director's role is to ensure medical accountability, act as a trauma system advocate, and provide for medical credibility throughout system development.

The Medical Director is assisted by the Medical/PI Committee, whose role is to develop, revise, and monitor all operating protocols and procedures by physicians, including reviewing pre-hospital reports for compliance with pre-established procedures. The Medical component will engage in an ongoing process of integration of the trauma medical care policies and the EMS system, overall evaluation of the trauma system and recommendation of changes. This committee will conduct continuous performance improvement geared toward improving the final outcome of injured patients. This will be dependent upon effective monitoring, integration and evaluation of all components of the patient's care. Standards will be established for pre-hospital personnel who will be held accountable to the trauma medical direction system.

INCLUSIVE TRAUMA SYSTEM DESIGN

Ours is one of a seven-system network, which addresses trauma management throughout the State of Mississippi. Our goal is an integrated network of providers, educated and certified to optimize and continually improve the outcomes and efficiency of the Region’s trauma care. Providers include hospitals, EMS, and physicians, coordinating efforts to train and treat trauma patients as quickly, effectively, and efficiently as possible.

East Central Mississippi Trauma Care Region, Inc. is composed of the following facilities:

LEVEL III	Anderson Regional Medical Center-Meridian, Ms - ARMC Rush Foundation Hospital-Meridian, Ms - RUSH
LEVEL IV	John C Stennis Memorial Hospital-DeKalb, MS - JCS HC Watkins Hospital-Quitman, MS - HCW Laird Hospital-Union, MS - LAIRD Pioneer Community Hospital-Newton -Newton, MS - PCHN Neshoba County General Hospital-Philadelphia, MS - NCGH Noxubee General Hospital-Macon, MS - NGH

Patients are triaged from the field under Destination Guidelines established by the State of MS to the most appropriate facility available, or are stabilized at the nearest facility and transferred to an appropriate facility.

All state designated trauma centers in the Region will serve both adult and pediatric patient populations for initial stabilization to the best of their resource capability and transfer when appropriate.

All facilities participating in the Region will participate in internal PI programs. The region will also perform PI activities in accordance with Mississippi Trauma Care System Regulations. The roles of providers are described in patient chronological order starting with EMS and ending with rehabilitation.

EMS and First Responders - The role of the EMS and First Responder are to render first aid and appropriate ALS care until the patient is delivered to the nearest appropriate facility. These

providers also activate the system by alerting the receiving facility to a trauma patient through their medical control.

PRE-HOSPITAL PROVIDERS

COUNTY	HOSPITAL	EMS PROVIDER	EMS PROVIDER
CLARKE	HC WATKINS	PARATECH AMBULANCE SERVICE	
KEMPER	JOHN C. STENNIS	LIFECARE	
LAUDERDALE	ANDERSON REGIONAL MEDICAL CENTER RUSH FOUNDATION HOSPITAL	METRO	
NESHOBA	CHOCTAW HEALTH CENTER NESHOBA COUNTY GENERAL HOSPITAL	NESHOBA EMS	CHC AMBUALNCE
NEWTON	PIONEER COMMUNITY HOSPITAL- NEWTON LAIRD HOSPITAL	LIFECARE	
NOXUBEE	NOXUBEE GENERAL HOSPITAL	LIFECARE	

Receiving Hospitals – Receiving hospitals are to render care appropriate to their level of certification. Patients requiring care beyond the capabilities of the hospital are to be transferred as soon as feasible through the best available means as determined by the facility’s trauma director or trauma medical control in their absence. Receiving hospitals are to utilize the appropriate transfer procedures when transferring a patient to another facility.

Rehabilitation – The region shall encourage its hospitals to utilize other facilities that have rehabilitative therapies should they not have their own and to consider reimbursement for the purchase of capital equipment used for rehabilitation. The region shall encourage the providers of rehabilitative therapies to obtain continuing education related to trauma.

Medical Professionals and Educators – Medical professionals are to provide care within the scope of their licenses or registries. Educators are to provide information to the professionals and general public in a manner that will achieve the objective relating to education.

SUGGESTED GUIDELINES FOR INTERFACILITY TRANSFER

CENTRAL NERVOUS SYSTEM	➔	<p align="center">HEAD INJURY</p> <ul style="list-style-type: none"> • Penetrating injury • Depressed skull fracture • Open injury • CSF leak • GCS 13 or less • Deterioration of GCS of 2 or more points • Lateralizing signs <p><u>SPINAL CORD INJURY</u></p>
CHEST	➔	<ul style="list-style-type: none"> • Wide superior mediastinum • Major chest wall injury • Cardiac injury • Patients who may require protracted ventilation
PELVIS/ABDOMEN	➔	<ul style="list-style-type: none"> • Pelvic ring disruption with shock, more than 5 units of blood transfused • Evidence of continued hemorrhage and compound pelvic injury or pelvic visceral injury • Suspected intra-abdominal hemorrhage or organ injury
MUSCULOSKELETAL SYSTEM	➔	<ul style="list-style-type: none"> • Fracture dislocation with loss of pulses • Open long bone fractures • Extremity ischemia • 2 or more long bone fractures
MULTIPLE SYSTEM INJURY	➔	<ul style="list-style-type: none"> • Severe face injury with head injury • Chest injury • Abdominal injury with face injury • Burns with face injury
SECONDARY DETERIORATION OF TRAUMA PATIENT	➔	<ul style="list-style-type: none"> • Patients requiring mechanical ventilation • Sepsis • Single or multiple system organ failure • Osteomyelitis

INTERFACILITY TRANSFERS

TRANSFER PATTERNS

	SURGICAL	ORTHO	NEURO	BURNS SEVERE	OPHTH	MULTIPLE INJURIES	TRAUMA LEVEL	PEDIATRIC DESIGNATION LEVEL
ARMC			*	X			III	P
JCS	X	X	X	X	X	X	IV	P
HCW	X	X	X	X	X	X	IV	P
LAIRD	SOME	X	X	X	X	X	IV	P
NRH	X	X	X	X	X	X	IV	P
NCGH	SOME	X	X	X	X	X	IV	P
PCHN	X	X	X	X	X	X	IV	P
RUSH			*	X			III	P

*Decision made on a case-to-case basis

REGIONAL TRANSFER POLICY GUIDELINES

GOALS

1. Establish a consistent mechanism to transport patients to the most appropriate facility available in a timely manner.
2. To insure all relevant data is communicated to the accepting facility.
3. To promote an orderly and timely transfer of trauma patients incorporating EMS personnel, ED staff, consulting services and accepting facilities.

PROCEDURE

1. Physician at the transferring facility will determine the need for transfer and contact the most appropriate facility available for transfer of the trauma patient.
2. The physician at the transferring facility will obtain an accepting physician.
3. The transferring physician will give the accepting physician a detailed report.
4. The transferring physician and the accepting physician will collaborate and determine the most appropriate mode of transportation for the patient and determine an ETA to the accepting facility, which will be documented on the transfer form.
5. The accepting facility may make recommendations to the transferring facility as to any treatments or procedures that must be done prior to transfer or en-route.
6. The transferring facility will follow EMTALA Guidelines for transfer.
7. The transfer team will call an updated report to the accepting facility by phone or radio when they are approximately 10 minutes from the accepting facility.
8. Feedback will be provided per state guidelines

DOCUMENTATION OF PARTICIPATION OF THE REGION
HOSPITALS

Hospitals desiring to participate in the Trauma Region have submitted letters of intent to participate. These letters have been endorsed by hospital administration and the medical staff. Copies of the letters of participation from each of the participating facilities within the Region are on file with the Region.

OPERATIONAL IMPLEMENTATION OF THE POLICIES

This section includes the policies to be used by the Board of Directors and Regional Administrator in managing the East Central Mississippi Trauma Care Region. Policies may be added or deleted as needed with the approval from the Board of Directors.

The following policies have been implemented by the Region:

- A. System Organization and Management Policy
- B. Intra-Regional Coordination Policy
- C. Trauma Care Coordination Inter-Region Policy
- D. Data Collection and Management Policy
- E. Coordination of Transfer Policy
- F. Integration of Pediatric Hospitals Policy
- G. Trauma Center Personnel/Equipment Policy
- H. Criteria for Activation of Trauma Team Policy
- I. System Evaluation Policy
- J. Professional and Staff Training Policy
- K. Public Information and Education Policy
- L. Injury Prevention Programs Policy
- M. Non-Compliance Policy

SYSTEM ORGANIZATION AND MANAGEMENT POLICY

PURPOSE:

To provide organizational structure and administrative command and control for the East Central Mississippi Trauma Care Region.

POLICY:

The Region shall develop and maintain operations for the trauma program in the geographic region delegated by the Mississippi State Department of Health.

1. The Region shall incorporate, develop and operate a Board of Directors and Regional Bylaws.
2. The East Central Mississippi Trauma Care Region, Inc. voting membership shall consist of the geographically eligible hospitals participating in the Mississippi State Trauma Care System. Participating hospitals must be designated as trauma centers by the MSDOH.
3. Additional members may participate on a non-voting status after approval of the Board of Directors.
4. The Board of Directors shall develop and maintain a Trauma Plan in accordance with the requirements established by the Mississippi Trauma Care System Regulations.
5. The Board of Directors shall hire some person or entity that shall have administrative authority over the daily operations of the Region.
6. Voting and non-voting members shall participate in the Region as specified in the Board's Bylaws and other policies.
7. Each voting member shall develop and maintain a trauma center designated by the Mississippi State Department of Health.
8. All information submitted from voting members and non-voting members to the Region shall be considered proprietary. Member organizations shall not use Region's proprietary information for individual organizational gain.

INTRA-REGIONAL COORDINATION POLICY

PURPOSE:

To establish and maintain cooperation among the agencies participating in the regional trauma plan.

POLICY:

The Region shall develop and maintain a system designed to facilitate cooperation among the agencies participating in the regional plan.

1. The system shall provide for regional trauma medical control to include criteria for activation of the trauma team. Regional trauma medical control shall be in the form of cooperation individual participant hospitals. Regional medical control shall provide for:
 - A. criteria for bypass
 - B. criteria determining a hospital's level of trauma team activation
 - C. survey to determine capabilities of region's ability to provide trauma care
2. Hospitals shall develop and provide to the Region their individual trauma plans, team activation procedures, and transfer agreements.
3. All agencies shall report to the Region their operational capabilities regarding trauma care. This is to include, but is not limited to facilities, medical specialties, and communication capabilities.

TRAUMA CARE COORDINATION INTER-REGION POLICY

PURPOSE:

The purpose of this policy is to provide the mechanism for coordinating trauma care between the Region and other trauma regions located in Mississippi.

POLICY:

The Region will facilitate the establishment and maintenance of guidelines between the participating hospitals and EMS agencies of the Region and those participating facilities and EMS agencies of neighboring and other applicable regions.

1. All participating hospitals shall establish and maintain transfer agreements as set forth in the Mississippi Trauma Care System Regulations.
2. Each EMS provider, to include hospital-based providers, shall attempt in good faith to establish mutual aid agreements with all adjacent EMS providers.
3. The Region shall maintain contact with neighboring Trauma Regions and the MSDOH to monitor the status of and changes to the Mississippi Trauma Care System and its Regions. The Region's Trauma Coordinator shall meet quarterly with the other Regional Coordinators or equivalent representatives. The Region shall incorporate Mississippi Trauma Care System changes and consider changes in other region's plans in to the Region's Performance Improvement Plan.

DATA COLLECTION AND MANAGEMENT POLICY

PURPOSE:

To provide a framework for collecting, recording, and utilizing data for purposes of trending, root cause analysis, and performance improvement.

POLICY:

The Region shall collect and report all necessary data as required by the MSDOH. The Region shall also utilize regional data collected for performance improvement and system evaluation.

COORDINATION OF TRANSFERS AND TRANSPORT POLICY

PURPOSE:

The purpose of this is to provide guidance regarding the transfer and transportation of trauma patients.

POLICY:

Trauma centers and EMS agencies shall cooperate to effectively transport a trauma patient to the appropriate trauma center.

1. The regional trauma system shall be activated through current methodology to include 911, *HP, or direct phone contact with a hospital.
2. Local ambulance provider (s) shall be dispatched to the scene under the authority of the provider's offline medical control.
3. Mississippi MEDCOM shall direct the ambulance provider (s) to the nearest appropriate trauma center and communicate any necessary information to the receiving trauma center if it is a different facility than the local receiving hospital.
4. Trauma centers shall activate their response mechanism and facilitate transfers (if needed) to the nearest appropriate higher level facility. The physician or transferring physician and the receiving physician will determine the mode of transport (air or ground).

INTEGRATION OF PEDIATRIC HOSPITALS POLICY

PURPOSE:

Provide for pediatric trauma care.

POLICY:

The Region shall integrate pediatric hospitals into the regional system.

1. All trauma centers designated by the MSDOH shall maintain transfer guidelines with a designated pediatric trauma center.
2. Each facility shall arrange for transfer according to their agreement.
3. The Region provides ENPC education to all participating Regional Trauma Centers.

SUGGESTED GUIDELINES FOR PEDIATRIC TRANSFER CRITERIA

Pediatric Trauma Patients that exhibit any of the following are appropriate patients for transfer to a children's hospital.

1. Ineffective or absent ventilator effort requiring endotracheal intubation/ventilator support.
2. Respiratory distress or failure
3. Depressed or deteriorating neurological status
4. Bradycardia not responsive to oxygenation
5. Cardiac rhythm disturbances
6. Status post cardiopulmonary arrest
7. Shock
8. Severe hypothermia
9. Injuries requiring any blood transfusion
10. Extremity injury complicated by neurovascular or compartment syndrome
11. Fracture of two or more long bones
12. Fracture of axial skeleton
13. Spinal cord injuries
14. Traumatic amputation of an extremity with potential for replantation
15. Head injury accompanied by one of the following
 - A. CSF leaks
 - B. Open head injuries (except simple scalp lacerations)
 - C. Depressed skull fractures
 - D. Decreased level of consciousness
 - E. Focal neurological signs
 - F. Basilar skull fracture
16. Significant penetrating wounds to the head, neck, thorax, abdomen, or pelvis
17. Major pelvic fractures
18. Significant blunt injury to the chest or abdomen
19. Children requiring intensive care
20. Children sustaining burns with any of the following
 - A. 2nd and 3rd degree burns of greater than 10% BSA for children less than ten years of age
 - B. 2nd and 3rd degree burns of greater than 20% BSA for children over 10 years of age

- C. 3rd degree burns of greater than 5% BSA for any age group
 - D. Signs or symptoms of inhalation injury
 - E. Respiratory distress
 - F. Facial burns or including the mouth or throat
 - G. Burns to the ears (Serious full thickness burns or burns involving the ear canal)
 - H. Deep or excessive burns of the hands, feet, genitalia, major joints, or perineum
 - I. Electrical injury/burns
21. Patient requires invasive monitoring or vasoconstrictive medications
 22. Orbital or facial fractures
 23. Diffuse abdominal tenderness

AVAILABILITY OF TRAUMA CENTER PERSONNEL AND EQUIPMENT POLICY

PURPOSE:

To ensure regulatory compliance with Mississippi Trauma Care System requirements regarding the availability of resources.

POLICY:

All participating hospitals in the Region shall comply with Mississippi Trauma Care System Regulations by maintaining a constant state of readiness with their level of certification.

1. Surgeons, orthopedic surgeons, anesthesiologists, radiologists must be either present or on-call and promptly available. Emergency Department physicians must always be present in Level I, II, and III hospitals and be available within 30 minutes in Level IV hospitals.
2. All hospitals shall have a designated trauma team consisting of physicians, specialists, nurses, and clinical ancillary personnel which should be either present or on-call and promptly available.
3. All facilities shall have a designated system for alerting and ensuring response times of staff in 30 minutes or less. Methods of activation may include, but are not limited to, cell phones, pagers, two-way radios, or maintaining on-call staff on the premises. Response times shall be documented and provided to the Region.
4. Surgeons, orthopedic surgeons, anesthesiologists, radiologists, and emergency medicine physicians must be appropriately boarded and maintain adequate CEUs and general surgeons and emergency medicine physicians additionally be certified in ATLS. CRNAs must be licensed to practice in the State of Mississippi.
5. All equipment used in trauma care shall be in working order, adequate for need and level, and meet appropriate current FDA requirements for patient care.
6. Hospitals experiencing a temporary loss of equipment capability due to failure or repair shall arrange for replacement of equipment and or proactively arrange for patient transfer or bypass as deemed necessary by that hospital's Trauma Medical Director.

SUGGESTED CRITERIA FOR ACTIVATION OF A TRAUMA TEAM **POLICY**

PURPOSE:

To provide hospitals in the Region with guidelines for the activation of their respective trauma teams.

East Central Mississippi Trauma Care Region TRAUMA ACTIVATION CRITERIA

The following shall be considered but not limited to Trauma Alpha Alert criteria:

1. Multi-system trauma with Glasgow Coma Score < 14
2. Sustained systolic BP < 90
3. Respiratory rate < 10 or > 29 breaths/min or airway obstruction
4. All penetrating injuries to the head, neck, torso, and extremities proximal to elbow and knee
5. Flail Chest
6. Traumatic paralysis
7. Multi-system trauma with open or depressed skull fracture
8. Crush injuries to the torso
9. Amputation proximal to the wrist or ankle
10. Two or more proximal long-bone fractures or pelvic fractures
11. Crushed, de-gloved, or mangled extremity
12. Burns with suspected inhalation injury or combination burns >15% BSA
13. Traumatic arrest/CPR

The following shall be considered but are not limited to Trauma Bravo Alert criteria:

1. Falls
 - Adults > 20 feet (one story is equal to 10 ft)
 - Children > 10 feet or 2-3 times the height of the child
2. High-risk auto crash
 - Intrusion: >12 inches occupant site; > 18 inches any site

- Ejection (partial or complete) from automobile
 - Death in same passenger compartment
 - Vehicle telemetry data consistent with high risk of injury
3. Auto vs. Pedestrian/Bicyclist thrown, run over, or with significant (>20 mph) impact
 4. Motorcycle crash > 20 mph
 5. Age:
 - Older Adults: Risk of injury or death increase after age 55 years
 - Children: Should be triaged preferentially to pediatric-capable trauma centers
 6. Anticoagulants and Bleeding Disorders
 7. Burns:
 - Without other trauma mechanism: Triage to burn facility
 - With trauma mechanism: Triage to trauma center
 8. Time Sensitive Extremity Injury
 9. End-Stage Renal Disease Requiring Dialysis
 10. Pregnancy > 20 weeks

*Note: Pregnant patients showing any signs of instability, severe abdominal/pelvic pain, or vaginal bleeding should be immediately upgraded to Trauma Alert status.

SYSTEM EVALUATION AND PERFORMANCE IMPROVEMENT **POLICY**

PURPOSE:

To improve performance of the system.

POLICY:

The Region shall review and evaluate the regional trauma care system to improve performance.

1. Each facility shall participate in the statewide trauma registry.
2. Each participating facility shall develop an internal PI plan that minimally addresses the following key components:
 - a. a multidisciplinary trauma committee
 - b. clearly defined authority and accountability for the program
 - c. clearly stated goals and objectives of which should be the reduction of inappropriate variation in care
 - d. development of expectations from evidence based guidelines, pathways, and protocols
 - e. explicit definitions of outcomes derived from institutional standards
 - f. documentation system to monitor performance, corrective action and the results of the actions taken
 - g. a process to delineate privileges credentialing all trauma service physicians
 - h. an informed peer review process utilizing a multidisciplinary method
 - i. a method for comparing patient outcomes with computed survival probability
 - j. autopsy information on all deaths when available
 - k. medical nursing audits
 - l. reviews of pre-hospital care and times and reasons for both trauma bypass and transfers
3. The Region shall collect and report data to the State and to participating hospitals.
4. The Region shall evaluate and review the following for effectiveness:
 - a. the components of the regional system
 - b. triage criteria and effectiveness
 - c. activation of the trauma team
 - d. notification of specialists and ancillary personnel
 - e. trauma center diversions and transfers
5. The Region shall develop a performance improvement process that identifies root causes of problems and provides for continuous improvement of the system.
6. The performance improvement process shall provide for input and feedback from patients, guardians, and provider staff.

PROFESSIONAL AND STAFF TRAINING POLICY

PURPOSE:

To provide guidelines regarding the training of participants healthcare providers in the care of the trauma patients.

POLICY:

The Region shall facilitate and maintain the provision of training opportunities for participating facilities. Individual hospitals and physicians must maintain clinical qualifications as specified by the Mississippi Trauma Care System Regulations.

1. As specified by level designation, hospital staff is defined as providers involved in the care of trauma patients.
2. The Region shall transfer any provided information regarding trauma triage guidelines and operational procedural changes associated with trauma care to all participating hospitals and EMS providers located in the region to maintain their current state or readiness. This may be through any means deemed appropriate by the Board of Directors,
3. Individual facilities are responsible for disseminating the information to their staff. The Region shall assist with the coordination and promotion of any multi-facility educational sessions on trauma care.
4. The Region shall provide training to hospital staff on its trauma policies and procedures.
5. It is desired that physicians maintain ATLS and a yearly average of 16 hours (48 over 3 years) of CMEs as specified by hospital level and clinical specialty in the Mississippi Trauma Care System Regulations. The Region shall relay any information regarding physician's educational opportunities to the participating facilities.

PUBLIC INFORMATION AND EDUCATION POLICY

PURPOSE:

To provide a format for informing and educating the general public that resides in the Region. Also, to provide regulatory oversight for the marketing and advertising by the agencies participating in the Region's Trauma Plan.

POLICY:

The Region shall develop and maintain a program of public information and education. Participating agencies shall cooperate with the Region regarding the promotion of their trauma programs.

1. The Region shall establish a network among its participating hospitals and other providers for the purpose of providing educational materials. The participating hospitals and other providers shall provide the informational and educational materials to the general public through any means deemed acceptable to the Region's Board of Directors.
2. The Region shall facilitate speakers, address public groups and serve as a resource for trauma education.
3. The Region shall assist its participating agencies in the development and provision of education to the public regarding the topics of injury prevention, safety education, and access to the system.
4. No participating agency shall use the terms "trauma center, trauma facility, trauma care provider" or similar terminology in its signs, printed material, or public advertising unless the materials meets the requirements set forth in the Mississippi Trauma Care System Regulations.
5. All marketing and promotional plans relating to the trauma program shall be submitted to the Region for review and approval prior to implementation. Such plans shall be reviewed and approved based on the following guidelines:
 - a. the information is accurate
 - b. the information does not include false claims
 - c. the information is not critical of other system participants
 - d. the information shall not include any financial inducements to any providers or third parties

INJURY PREVENTION PROGRAMS POLICY

PURPOSE:

The purpose of the policy is to provide a format for the Region's participation in injury prevention.

POLICY:

The Region shall participate in injury prevention activities.

1. The Region shall assist participating facilities with the provision of injury prevention activities.
2. The Region shall facilitate and encourage the coordination of injury prevention activities with other regions.
3. Each participating facility shall be encouraged to provide an injury prevention activity yearly.

NON-COMPLIANCE POLICY

All member hospitals, EMS agencies and eligible physicians participating in the Mississippi Trauma Care System will comply with all requests and deadlines set forth by the Mississippi State Department of Health and the Region. This policy has been enacted as a tool to promote region-wide compliance with the Mississippi Trauma Care System Rules and Regulations.

Notification of Deadlines

1. All deadlines and request from the Mississippi State Department of Health shall be forwarded to applicable organizations 10 business days of the Region's receipt of said deadlines and requests.
2. The Region shall notify applicable organizations of all Regional requests and deadlines in writing (via email or postal mail) a minimum of 15 business days prior to the deadline.

Notification of Non-Compliance

1. The Regional Administrator shall notify the organization's senior management within 10 business days after the organization is deemed non-compliant with the Mississippi Trauma Care System and East Central Mississippi Trauma Care Region deadlines and requests. Notice of non-compliance may either be emailed or mailed via certified mail to the non-compliant organization.
2. Organization's shall contact the Regional Administrator to discuss the deficiency within 10 business days after the receipt of the Region's initial notice of non-compliance.
3. If the organization does not respond to the Region's initial request within the 10 business day period, a second notice of non-compliance will be mailed via certified mail. The Region's Executive Committee and the Mississippi Department of Health shall be copied to the second notification

Habitual and/or Continued Non-Compliance

If the organization is non-compliant with the same issue for 2 consecutive quarters, the organization shall be considered to have established a pattern of non-compliance and must submit a plan of corrective action to the Region's Executive Committee for review. The plan must be submitted, in writing, to the Region within 14 calendar days of notification of the second incidence of non-compliance. The plan of correction shall 1) outline the organization's process for correcting the deficiency, 2) list the person responsible for correcting the deficiency, and 3) provide a definitive timeline for correction.

Withholding Funds

Any Mississippi Trauma Care System or East Central Mississippi Trauma Care Region funds owed to a non-compliant organization may be withheld until a pattern of compliance is established. A pattern of compliance shall be considered established after the entity has maintained compliance with all Mississippi Trauma Care System and East Central Mississippi Trauma Care Region requests and deadlines for a minimum of 1 quarter. For this purpose, any decision to withhold or distribute funding owed to a non-compliant organization shall be made by the voting membership of the Region's Board of Directors.

REGIONAL RESOURCE/CRITICAL CARE CAPABILITY

Each member hospital within the East-Central Trauma Care Region must be certified as a Trauma Center at some level. As a condition of participation within the Mississippi Trauma Care System, each hospital must meet the resource requirements established by the Regulations set forth by the State Department of Health. Therefore, each member hospital is expected to maintain capabilities consistent with their respective Trauma Center level; and oversight of these resources is provided by the State Department of Health via the certification and review process.

In addition, the East-Central Region has inventoried the resources of each individual member hospital with a concentration on the following areas: 24-hour Emergency Room, ICU, Step-down Trauma Critical Care Unit, full-time Trauma Surgeon on staff and available, anesthesia coverage, 24-hour respiratory therapy coverage, 24-hour laboratory coverage, onsite ventilator. These specific parameters were chosen to track because it was felt that the presence or absence of these resources might impact on trauma field triage and diversion, as well as on inter-facility transfer. Resource allocation is summarized in the accompanying chart.

RESOURCE ALLOCATION

	24 HR ER	ICU	FULL TIME SURGEON	ANESTHESIA	24 HR RESPIRATORY	24 HR LAB	VENTILATOR	TRAUMA LEVEL
ARMC	X	X	X	X	X	X	X	III
JCS	X				X	X		IV
HCW	X	X			X	X	X	IV
LAIRD	X				X	X	X	IV
PCHN	X				X	X		IV
NCGH	X	X	X	X	X	X	X	IV
NGH	X							IV
RUSH	X	X	X	X	X	X	X	III

PERFORMANCE IMPROVEMENT

Performance Improvement is the key to monitoring, evaluating and improving the trauma system. It involves a continuous multidisciplinary effort to measure, evaluate and improve both the process of care and the outcome. A major objective of PI is to reduce inappropriate variation in care. Trauma centers at all levels, EMS services, and the regional system itself, are expected to demonstrate a clearly defined PI program.

All Trauma Centers shall develop and have in place a performance improvement process focusing on structure, process and outcome evaluations which focus on improvement efforts to identify root causes, problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition, the process shall include:

1. A detailed audit of all trauma-related deaths, major complications and transfers (including inter-facility transfers)
2. A multidisciplinary trauma peer review committee that includes all members of the trauma team
3. Participation in the trauma system data management system
4. Each trauma center shall have a written system in place for the following:
 - Patients (children)
 - Parents of minor children who are patients
 - Legal guardian(s) of children who are patients
 - Primary caretaker(s) of children who are patients
5. The ability to follow-up on corrective actions to ensure performance improvement activities.

The system shall provide for input and feedback from these patients and guardians to hospital staff regarding the care provided. (Mississippi Trauma Care System Regulations, Section IX)

The Region is responsible for ongoing evaluation of its system. Accordingly, the Region will develop a procedure for receiving information from EMS providers, Trauma Centers and the local medical community on the implementation of various components of the Region's Trauma System, including, but not limited to:

1. components of the Regional Trauma Plan
2. triage criteria and effectiveness
3. activation of the trauma team
4. notification of specialists
5. Trauma center diversion. (MTCSR, §VIII. 8.1)

Based upon information received by the Region in the evaluation process, the Region shall annually (or as often as is necessary to insure system performance) prepare a report containing results of the evaluation and a performance improvement plan. Such report shall be made available to all EMS providers, Trauma Centers and the local medical community.

In October 2010, the Region agreed to adopt and use the State PI reports for the region as submitted.

The Region shall ensure that all Trauma Centers participate in this annual evaluation process, and encourage all other hospitals that treat trauma patients to do likewise.

Specific information related to an individual patient shall not be released. Aggregate system performance information and evaluation will be available for review. (MTCSR, §VIII. 8.2)

PRE-HOSPITAL TRAUMA TRIAGE AND TRANSPORT GUIDELINES

Purpose: To provide EMS Agencies operating within the East Central Mississippi Trauma Care Region with general guidelines for pre-hospital triage and transport of the trauma patient.

The following criteria are recommended guidelines for activation of the Regional Trauma System. These criteria were adopted by the East Central Mississippi Trauma Care Region as general guidelines for activation of the Trauma Center Trauma Team and should therefore be used as a tool in identifying the major or multiple-injury trauma patient:

- Glasgow Coma Scale. (GCS) <14
- Systolic Blood Pressure <90 mm Hg
- Respiratory Rate < 10 or >29
- Penetrating injury to the head, neck, torso, or extremities above the elbows or knees
- Flail chest
- Two or more proximal long bone fractures
- Pelvic fracture
- Limb paralysis
- Amputation proximal to the wrist or ankle
- Body surface burns > 15% (second or third degree) or burns associated with other traumatic or inhalation injury
- Trauma transfer that is intubated or receiving blood
- Children under 12 with any of the historical flats outlined below
- If none of the above applies, evaluate mechanism (Stable patient > 12 year. old)
- Ejection from vehicle
- Death in same passenger compartment
- Extrication time > 20 minutes
- Fall >20 feet for adults; pediatrics: >10 feet or 2-3 times the height of the child
- Rollover MVC
- High speed auto crash > 40 mph
- Auto deformity > 18 inches of external damage or intrusion into passenger compartment > 12 inches
- Auto vs. pedestrian or Auto vs. bicycle (> 5 mph)
- Pedestrian thrown or run over
- Motorcycle crash 20 mph

The Consolidated Trauma Activation Criteria and Destination Guidelines were adopted in November 2010 by the Region and in September 1, 2011 became our State's first standardized trauma activation criteria.

If the Paramedic/EMT has any doubt as to whether a patient is a major trauma victim, he/she should consult with Medical Control and / or the receiving trauma facility at the earliest stage possible in the patient's evaluation.

EMS agencies shall immediately notify the receiving facility of impending arrival of Trauma Patients in order that the receiving facility can determine the number and type of patients they are capable of managing at that particular time.

Trauma Center Diversion/Bypass

Any Trauma Center going on or off Diversion shall notify the area EMS Provider immediately. Prior to EMS crew departure, Patient Care Reports will be left at the receiving facility for ALL trauma patients, with documentation from time of dispatch until time of report at receiving facility.

PRE-HOSPITAL PERFORMANCE IMPROVEMENT PLAN

I. PURPOSE

The purpose of the pre-hospital record audit is to establish a method of evaluation for the pre-hospital care being delivered, and thus be able to establish benchmarks as goals for improvement. Data from agencies within the East Central Trauma Care Region will be collected, organized and evaluated and the results utilized for continued system improvement. As the Performance Improvement evaluation continues, changes will be implemented in the plan, especially in the area of goals and indicators. Feedback will be provided to EMS agencies, as this is an important aspect of quality improvement. Results of the evaluations will also be made to the State office, as well as the East Central Trauma Care Region Board of Directors.

II. POLICY

EMS agencies will be required to provide audits on a quarterly basis. Prior to each quarter, agencies will receive a request from the Regional Administrator listing specific filters (indicators) with which to assess records for the upcoming quarter. This report should be returned to the administrator within 30 days. Indicators requested will be not less than two (2) and not more than six (6) for one quarter. Additionally, there may be a random request for a specific filter if there is a need indicated, or if it is requested by the Board of Directors.

III. PROCEDURE

Attached is an appendix with a list of indicators from which the administrator will choose two (2) to six (6) per quarter. Letters will be sent out to each EMS agency in the Region at least 14 days in advance with the specific indicators for the following quarter. The audit should be completed and returned to the administrator with 30 days of the end of the quarter.

IV. CORRECTIVE ACTION

In order to reduce variations of care, once problems are identified, the EMS Agency will be asked to submit a plan to correct identified problems. The plan should include what the desired changes are, who is assigned to resolve the problem, and what action will be taken. Mississippi EMS statutes (§41-59-9, *Mississippi Code Annotated*) mandate pre-hospital providers' compliance with this Trauma Plan, including these Performance Improvement policies and procedures. Noncompliance with this policy will be considered a violation of Mississippi law and EMS Rules and Regulations and will be reported to The Division of EMS, MSDH for administrative enforcement.

V. RE-EVALUATION

Three months after the corrective action plan has been submitted, the problem identifier will be re-evaluated. The EMS agency will receive documentation of any findings, as well as any need for continued action.

VI. CONFIDENTIALITY

The East Central Trauma Care Region will abide by the laws of the State of Mississippi regarding confidentiality. Patient names or other identifying criteria will not be used in reports or audits that are distributed to the Board of Directors or the State. Any records received by the administrator shall be stored under lock and key until destroyed.

PRE-HOSPITAL PATIENT CARE PROTOCOLS

RECOMMENDED EMS Audit Indicators:

1. IV lines established where attempted
2. Intubation established where attempted
3. A scene time < 10 minutes (except in prolonged extrication)
4. Vital signs complete
5. Hospital destination appropriate
6. GCS recorded in categories
7. Pediatric Coma Score recorded in categories
8. RTS recorded
9. Emergent calls dispatched within 60 seconds
10. Length of time between Dispatch times and Arrival times for transfers out (hospital to hospital)
11. If patient in EMS care longer than 15 minutes, additional sets of VS documented
12. O2 use documented
13. Timely pre-arrival communication with receiving hospital
14. Documentation that written report left at health care facility with patient
15. Compliance with regional trauma guidelines and protocols
16. Any Bypass or Diversion orders/protocols initiated

PRE-HOSPITAL TRAUMA TRIAGE/DESTINATION GUIDELINES

STATEMENT OF INTENT

The following trauma triage guidelines are provided to assist EMS providers in determining the disposition of adult trauma patients from the field. It is understood that these are guidelines only and are to be used in conjunction with clinical judgment and communication with a medical control physician if at all possible. The Consolidated Trauma Activation Criteria and Destination Guidelines were adopted in November 2010 by the Region and in September 1, 2011 became our State's first standardized trauma activation criteria. Please see the following page for the guidelines.

APPENDIX B - CONSOLIDATED TRAUMA ACTIVATION CRITERIA AND DESTINATION GUIDELINES

ALPHA

MEASURE VITAL SIGNS AND LEVEL OF CONCIIOUSNESS
ASSESS ANATOMY OF INJURY

- Glasgow Coma Scale ≤ 13 (secondary to trauma)
- Systolic Blood Pressure (SBP):
 - < 1 month old with SBP < 60 mmHg,
 - 1 month to 1 year old with SPB < 70 mmHg,
 - 1 year to 10 years old with SBP < 70 mmHg + (2 times age in years),
 - > 10 years old with SBP < 90 mmHg,
- Respiratory Rate (RR):
 - < 16 years old: Respiratory distress or signs of impending respiratory failure including airway obstruction or intubation in the field.
 - ≥ 16 years old: Respiratory Rate <10 or >29 breaths/ minute, or need for ventilation support.
- Children < 16 years with burns > 20% BSA
- ALL penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
- Chest wall instability or deformity (e.g., flail chest)
- Two or more proximal long bone fractures
- Crushed, degloved, mangled or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures (suspected or confirmed)
- Open or depressed skull fracture
- Paralysis (secondary to trauma)
- EMS/Health Provider Judgment

The following indicators warrant transport to the closest hospital:

- Cardiac arrest
- Unsecured/non-patent airway
- EMS Provider safety.

Consider use of air transport based on patient condition, weather, and availability of aircraft.

YES

PATIENTS < 16 YEARS OLD:
Transport to a Tertiary or Secondary Pediatric Trauma Center as appropriate for injuries.

PATIENTS ≥ 16 YEARS OLD:
Transport to a Level I, II or III Trauma Center as appropriate for injuries.

NOTIFY RECEIVING FACILITY (OR APPROPRIATE POINT OF CONTACT) AS EARLY AS POSSIBLE.

NO

Assess mechanism of injury and evidence of high-energy impact

BRAVO

- Falls
 - Patients < 16 years: falls greater than 10 feet or 2-3 times the height of the child
 - Patients ≥ 16 years: falls > 20 ft. (one story is equal to 10 ft.)
- High Risk MVC
 - Intrusion, including roof: > 12 inches occupant site; > 18 inches any site
 - Ejection (partial or complete) from automobile
 - Death in same passenger compartment
- Auto vs. Pedestrian/Bicyclist (separated from mode of transport with significant impact)
- Motorcycle/ATV/other motorized vehicle crash > 20 mph
- Burns related to traumatic mechanism
- Pregnancy > 20 weeks (secondary to trauma)
- EMS/Health Provider Judgment

PATIENTS < 16 YEARS OLD:
Transport to a TERTIARY OR SECONDARY PEDIATRIC TRAUMA CENTER as appropriate for injuries.

YES

PATIENTS ≥ 16 YEARS OLD:
Transport to a Level I, II or III Trauma Center as appropriate for injuries.

NOTIFY RECEIVING FACILITY (OR APPROPRIATE POINT OF CONTACT) AS EARLY AS POSSIBLE.

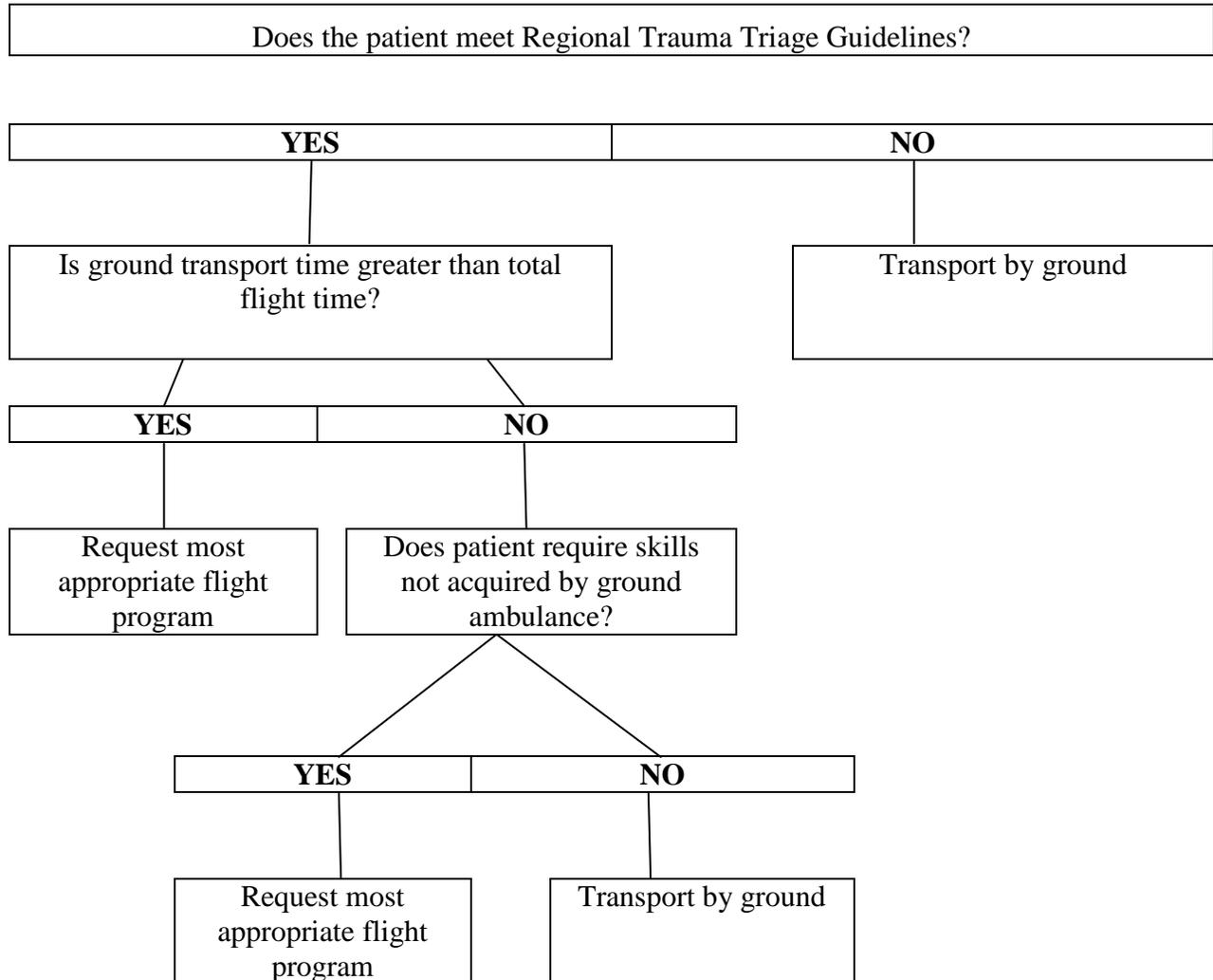
NO

Transport according to local EMS protocol (consider contacting Medical Control)

- SPECIAL CONSIDERATIONS:
- Patients > 55 years are at increased risk of injury/death.
 - Systolic blood pressure < 110 mmHg in patients > 65 years may represent shock
 - Anticoagulants and bleeding disorders

If there is any question concerning appropriate patient destination, or if requested by the patient or another person to deviate from this protocol, **CONTACT MEDICAL CONTROL**

Helicopter Decision Tree



CONSTITUTION AND BYLAWS
OF
EAST-CENTRAL MISSISSIPPI TRAUMA CARE REGION

ARTICLE I

Name

The governing body shall be known as the Board of Directors of the East-Central Mississippi Trauma Care Region (“Trauma Region”).

ARTICLE II

Purpose and Mission

The purpose and mission of the East-Central Mississippi Trauma Care Region is to provide the citizens of east-central Mississippi with a trauma care system which integrates member facilities within the region and is coordinated with the statewide Trauma System as authorized under Mississippi Code 41-59-1, which coordinates the resources of member facilities, assists member facilities with problem-solving, and distributes grant proceeds made available through the State Board of Health.

ARTICLE III

Board of Directors

Section 1. Membership The membership of the Board of Directors shall be limited to licensed Mississippi hospitals participating in the statewide Trauma System as defined in “The Mississippi Trauma Care System Regulations” established by the Mississippi Trauma Advisory Committee and the State Department of Health and representatives of State licensed pre-hospital Emergency Medical Services providers. Each participating hospital shall declare, and have certified, a Trauma Center Certification level as defined in the Regulations. The Board shall be comprised of two representatives appointed from each member hospital, and three representatives of pre-hospital Emergency Medical Services providers, appointed by the East-Central Mississippi Trauma Care Region Board of Directors. In addition, the Regional EMS Advisory Council appointment shall be an ex-officio member of the Board. Each Board member shall have a single individual vote. All appointments are made without term limits and shall be valid until replaced by another appointment. Until such time as a permanent Board of Directors is appointed, an Interim Board comprised of interested personnel from potential member hospitals will be formed to conduct business during the planning phase of establishing the Trauma Region.

Section 2. Meetings The Board of Directors shall hold regular meetings at a minimum of a quarterly basis, upon fifteen days’ notice. The regular meeting in June of each year shall be

known as the Annual Meeting. Special meetings may be held at the call of the Chairman, or, in his absence, the Vice-Chairman, or at the call of any four Directors.

Section 3. Quorum At any meeting of the Board of Directors, five Directors shall constitute a quorum for the transaction of business, but less than a quorum may adjourn a meeting to a future time. In the event of a quorum, the action of a majority of the Directors present and voting shall be necessary to bind the entire Board of Directors.

Section 4. Attendance Members of the Board of Directors will be expected to attend all meetings; however, members will be excused from attendance at meetings because of illness, out-of-town business, and other appropriate reasons. Each member may designate another physician, nurse, administrator, or other appropriate person to serve as proxy and to vote in place of the Director in his/her absence.

Section 5. Action Without Meeting The Board may take any action which may be taken at a regular or special meeting of the Board if a consent in writing, setting forth the action so taken, shall be signed and approved by all Directors. If any Director shall dissent to taking action in this manner, no action shall be taken except at a regular or scheduled meeting.

ARTICLE IV

Administration and Management

The Board of Directors may hire such administrative and medical personnel as necessary to carry out the functions of the Region. The Board may contract for such services and may authorize the Chairman to enter into contracts. The Board of Directors may establish a fee schedule for membership in the Trauma Region and/or, to the extent permitted by the Mississippi Trauma Care System Regulations, the Board of Directors may allocate a percentage of funds disbursed through the Trauma Region for expenses of the Region's administration and management.

ARTICLE V

Officers

At each Annual Meeting, the Directors shall elect a Chairman, a Vice-Chairman, a Secretary, and a Treasurer, all of whom shall hold office for a period of one year or until their successors are duly elected. The term of office shall commence on the beginning of the fiscal year, July 1.

ARTICLE VI

Duties of Officers

Section 1. The Chairman of the Board of Directors shall exercise general supervision over all affairs of the Trauma Region; preside at all meetings of the Directors; and, be an ex-officio member of all standing committees and may vote in case of tie votes by such committees.

Section 2. The Vice-Chairman of the Board of Directors shall assist the Chairman in the performance of his duties and, in the absence or inability of the Chairman, the Vice-Chairman shall perform the duties and possess the powers and authority of the Chairman.

Section 3. The Secretary shall ensure that there is accurate record of the minutes of the meetings of the Board of Directors and its standing committees; including the names of all members present at each meeting. The Secretary shall act as Chairman in the absence of the Chairman and Vice-Chairman, and when so acting, shall have all the powers and authority of the Chairman.

Section 4. The Treasurer shall be the custodian of all funds of the Trauma Region. He is responsible to see that the administrative agent of the Trauma Region maintains an accounting system in such a manner as to give a true and accurate accounting of the financial transactions of the Trauma Region, and he shall make certain that reports of such transactions are presented to the Board of Directors for the determination that all expenditures are made in accordance with state laws and to the best advantage of the Trauma Region.

Note: The use of any gender-specific term in these Bylaws is merely for brevity, and such terms shall be applicable to both genders.

ARTICLE VII

Committees

Following the Annual Meeting, the Chairman of the Board shall appoint the following standing committees whose membership may be from the Board of Directors, the medical and administrative agents or other competent individuals at member institutions as specified below:

Executive Committee. The Executive Committee shall consist of the Chairman, the Vice-Chairman, Secretary, and Treasurer and shall meet on an ad-hoc basis. In emergency situations, it shall have the power to transact all regular business of the Trauma Region within the determination of the Chairman, when a regular meeting of the Board of Directors is not feasible, provided that any action taken shall not conflict with the policies and expressed wishes of the Board of Directors at its next regularly scheduled meeting.

Additional Committees. The Chairman of the Board of Directors shall have the power to appoint such other standing or ad-hoc committees using the resources and expertise of the Board of Directors as in the Chairman's discretion may be deemed necessary and proper.

ARTICLE VIII

Conflict of Interest

Section I Purpose

The purpose of the conflicts of interest policy is to protect the Corporation's interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of an officer or director of the corporation. The policy is intended to supplement but not replace any applicable state laws governing conflicts of interest applicable to nonprofit and charitable corporations.

Section II Definitions

Interested Person

Any director, principal officer, or member of a committee with board delegated powers that have a direct or indirect financial interest, as defined below, is an interested person. If a

person is an interested person with respect to any entity in the health care system of which the Corporation is a part, he or she is an interested person with respect to all entities in the health care system.

Financial Interest

A person has a financial interest if the person has, directly or indirectly, through business, investment or family, an ownership or investment interest in any entity with which the Corporation has a transaction or arrangement, or

- a. a compensation arrangement with the Corporation or with any entity or individual with which the Corporation has a transaction or arrangement, or
- b. a potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the Corporation is negotiating a transaction or arrangement

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature.

A financial interest is not necessarily a conflict of interest. Under Section III, paragraph 2, a person who has a financial interest may have a conflict of interest only if the appropriate board or committee decides that a conflict of interest exists.

Section III Procedures

Duty to Disclose

In connection with any actual or possible conflicts of interest, an interested person must disclose the existence of his or her financial interest and must be given the opportunity to disclose all material facts to the directors and members of committees with board delegated powers considering the proposed transaction or arrangement.

Determining Whether a Conflict of Interest Exists

After disclosure of the financial interest and all material facts, and after any discussion with the interested person, he/she shall leave the board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

Procedures for Addressing the Conflict of Interest

- i) An interested person may make a presentation at the board or committee meeting, but after such presentation, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement that result in the conflict of interest.
- ii) The chairperson of the board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.
- iii) After exercising due diligence, the board or committee shall determine whether the Corporation can obtain a more advantageous transaction or arrangement with reasonable efforts from a person or entity that would not give rise to a conflict of interest.

- iv) If a more advantageous transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in the Corporation's best interest and for its own benefit and whether the transaction is fair and reasonable to the Corporation and shall make its decision as to whether to enter into the transaction or arrangement in conformity with such determination.

Violations of the Conflicts of Interest Policy

If the board or committee has reasonable cause to believe that a member has failed to disclose actual or possible conflicts of interest, it shall inform the member of the basis for such belief and afford the member an opportunity to explain the alleged failure to disclose.

If, after hearing the response of the member and making such further investigation as may be warranted in the circumstances, the board or committee determines that the member has in fact failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

Section IV Records of Proceedings

The minutes of the board and all committee with board-delegated powers shall contain:

1. the names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or possible conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the board's or committee's decision as to whether a conflict of interest in fact existed.
2. the names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection therewith

Section V Compensation

A voting member of the board of directors who receives compensation, directly or indirectly, from the Corporation for services is precluded from voting on matters pertaining to that member's compensation.

A physician who is a voting member of the board of directors and receives compensation, directly or indirectly, from the Corporation for services is precluded from discussing and voting on matters pertaining to that member's and other physicians' compensation. No physician or physician director, either individually or collectively, is prohibited from providing information to the board of directors regarding physician compensation.

A voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Corporation for services is precluded from voting on matters pertaining to that member's compensation.

Physicians who receive compensation, directly or indirectly, from the Corporation, whether as employees or independent contractors, are precluded from membership on any committee whose jurisdiction includes compensation matters. No physician, either individually or collectively, is prohibited from providing information to any committee regarding physician compensation.

Section VI Annual Statements

Each director, principal officer and member of a committee with board delegated powers shall annually sign a statement, which affirms that such person:

- a. has received a copy of the conflicts of interest policy,
- b. has read and understands the policy,
- c. has agreed to comply with the policy, and
- d. understands that the Corporation is a charitable organization and that in order to maintain its federal tax exemption it must engage primarily in activities, which accomplish one or more of its tax-exempt purposes.

Section VII Periodic Reviews

To ensure that the Corporation operates in a manner consistent with its charitable purposes and that it does not engage in activities that could jeopardize its status as an organization exempt from federal income tax, periodic reviews shall be conducted. The periodic reviews shall, at a minimum, include the following subjects:

- a. Whether compensation arrangements and benefits are reasonable and are the results of arm's-length bargaining.
- b. Whether acquisitions of physician practices and other provider services result in inurement or impermissible private benefit.
- c. Whether partnership and joint venture arrangements and arrangements with management service organizations and physician hospital organizations conform to written policies, are properly recorded, reflect reasonable payments for goods and services, further the Corporation's charitable purposes and do not result in inurement or impermissible private benefit.
- d. Whether agreement to provide health care and agreements with other health care providers, employees, and third party payers further the Corporation's charitable purposes and do not result in inurement or impermissible private benefit.

Section VIII Use of Outside Experts

In conducting the periodic reviews provided for in Section VII, the Corporation may, but need not, use outside advisors. If outside experts are used there use shall not relieve the board of its responsibility for ensuring that periodic reviews are conducted.

ARTICLE IX

Disposition of Assets upon Dissolution

Upon the dissolution of the East-Central Mississippi Trauma Care Region, all of its assets shall thereupon become the property of and inure to the benefit of the State of Mississippi, State Department of Health, and no part thereof shall inure to the benefit of any member hospital or of any individual.