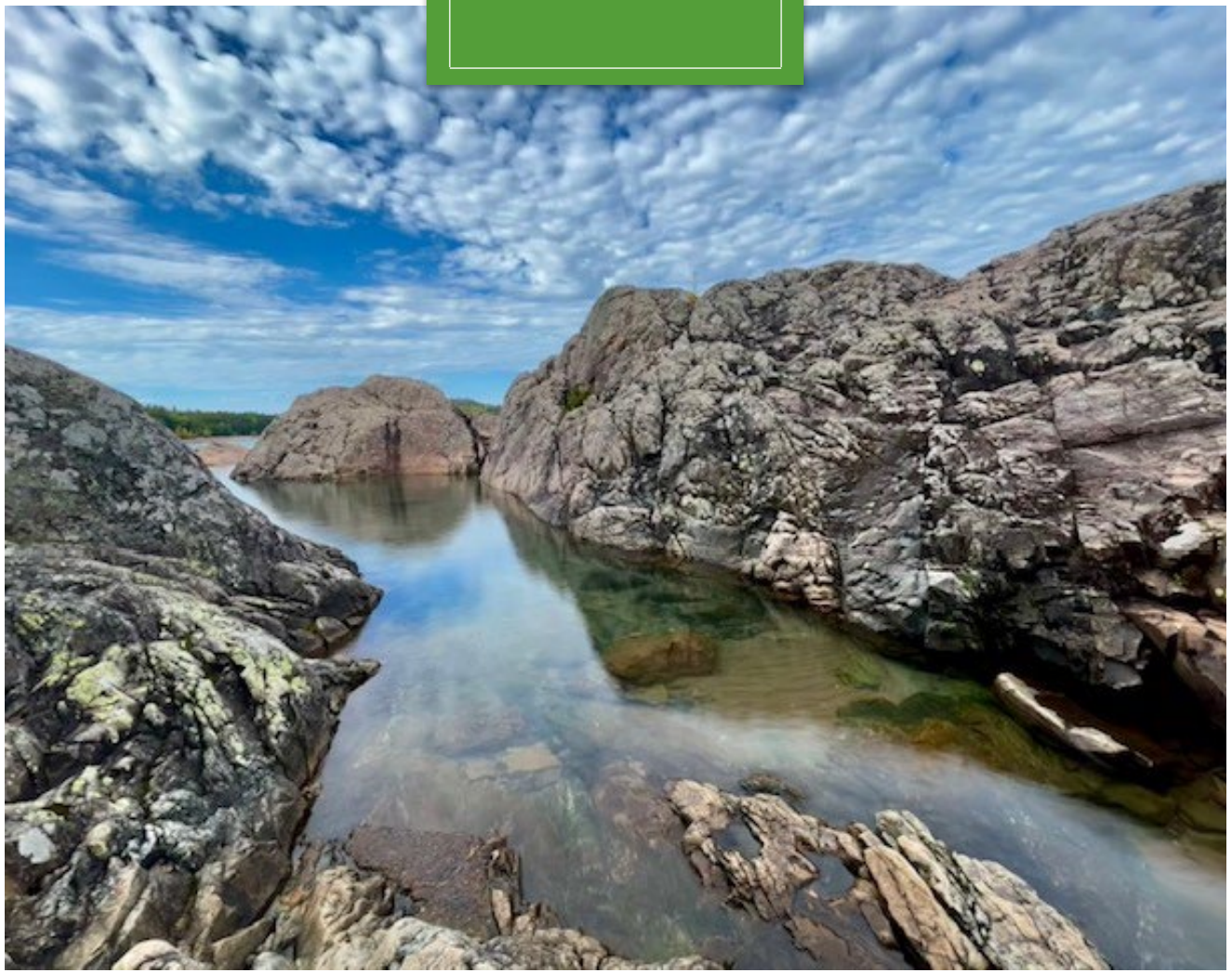


R8 TRAUMA ADVISORY COUNCIL

AUGUST 2026

AGENDA

Call to Order, Attendance

Approval Agenda, Minutes

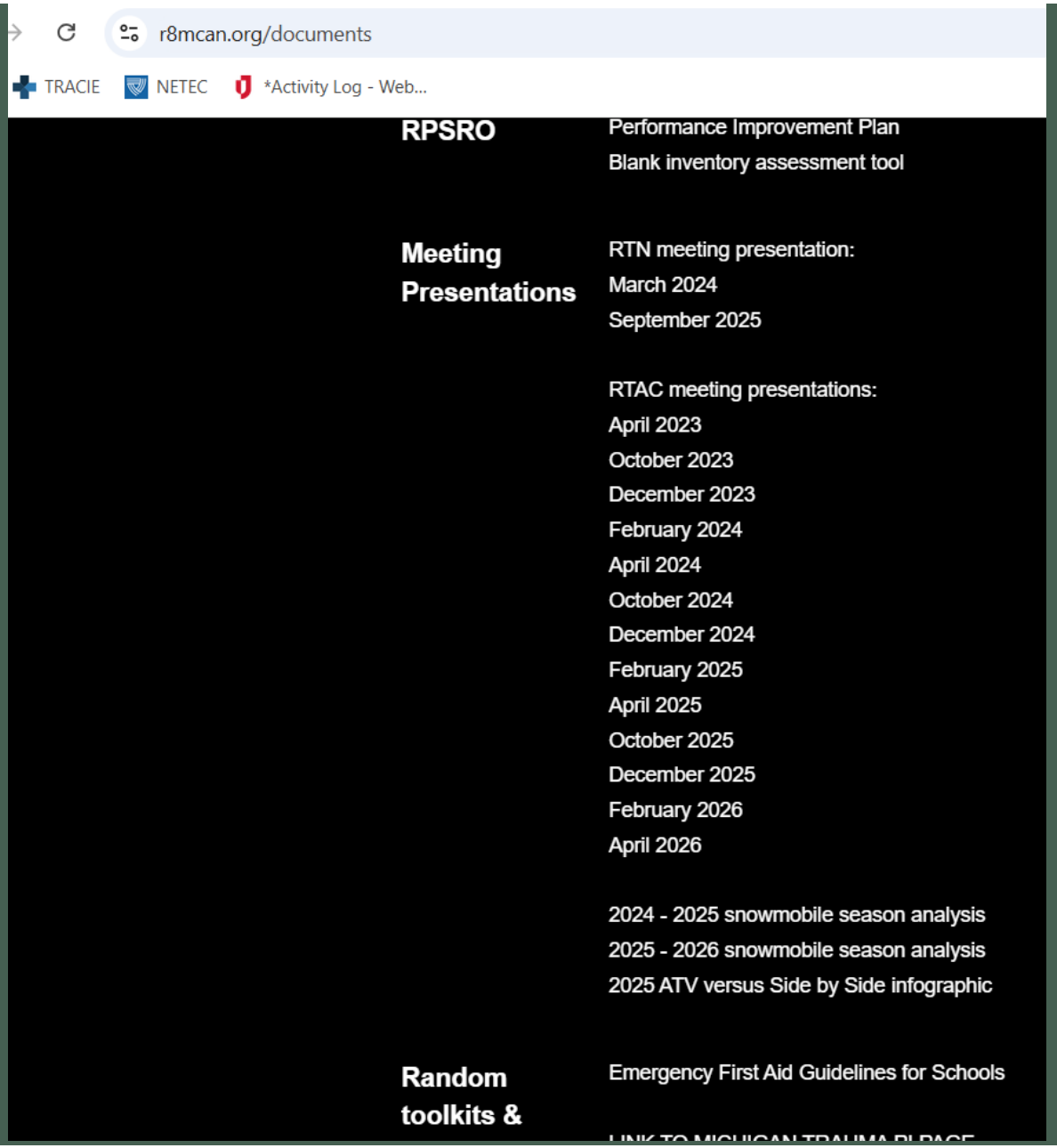
Public Comment

STATE COMMITTEE UPDATES

RURAL, MCA, PT MOVEMENT, COMMUNICATIONS

SYSTEMS OF CARE OFFICE UPDATE

R8MCAN.org


r8mcan.org/documents
TRACIE
NETEC
*Activity Log - Web...
RPSRO
Performance Improvement Plan
Blank inventory assessment tool
Meeting Presentations
RTN meeting presentation:
March 2024
September 2025
RTAC meeting presentations:
April 2023
October 2023
December 2023
February 2024
April 2024
October 2024
December 2024
February 2025
April 2025
October 2025
December 2025
February 2026
April 2026
2024 - 2025 snowmobile season analysis
2025 - 2026 snowmobile season analysis
2025 ATV versus Side by Side infographic
Random toolkits &
Emergency First Aid Guidelines for Schools

Demographics Survey

Sex Assigned at Birth and Gender

Survey Ran from 6.8.2026 – 6.29.2026 | The survey was sent to over 200 MI Trauma Registry Users requesting they complete the survey on behalf of their facility; responses represent 79 facilities in Michigan.

MDHHS
Michigan Department of Health & Human Services

Purpose of Survey

There has been considerable discussion on these required data elements nationally effective January 1, 2025, “sex assigned at birth” and “gender” including questions on how they are collected and completed per definition in the Michigan Trauma Data Dictionary. The MDHHS Systems of Care Section has discovered variability in data element capture and reporting. We have therefore gathered information on how those data points are collected, what definition is used, and what “source of truth” is considered.

MDHHS
Michigan Department of Health & Human Services

Michigan Trauma Data Dictionary Definitions

Demographics (TR1.156 - ImageTrend® data element field number) Sex Assigned at Birth Description

Element Values:

1. Male
2. Female
3. Intersex

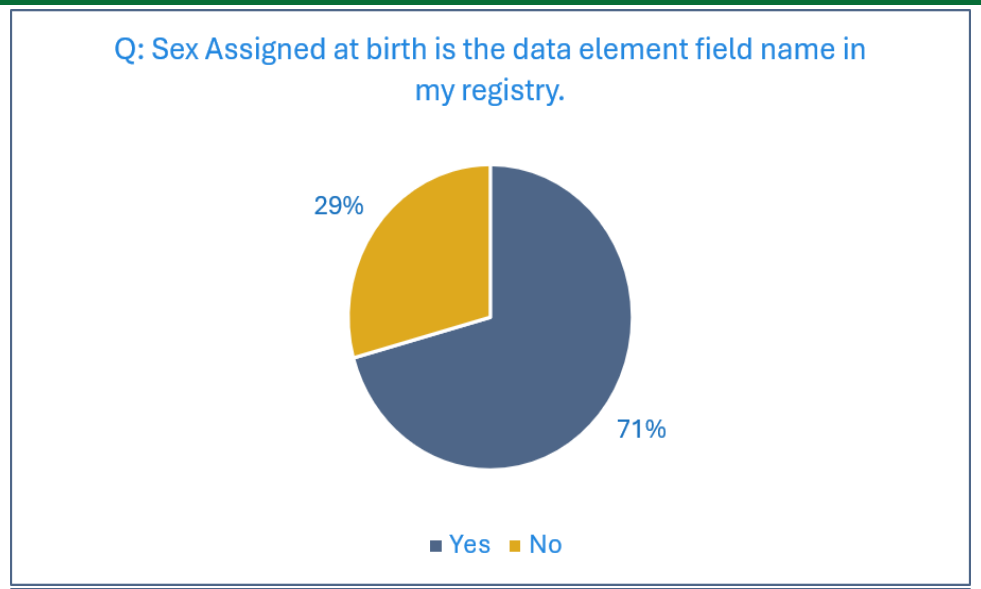
Demographics (TR1.51 - ImageTrend® data element field number) Gender

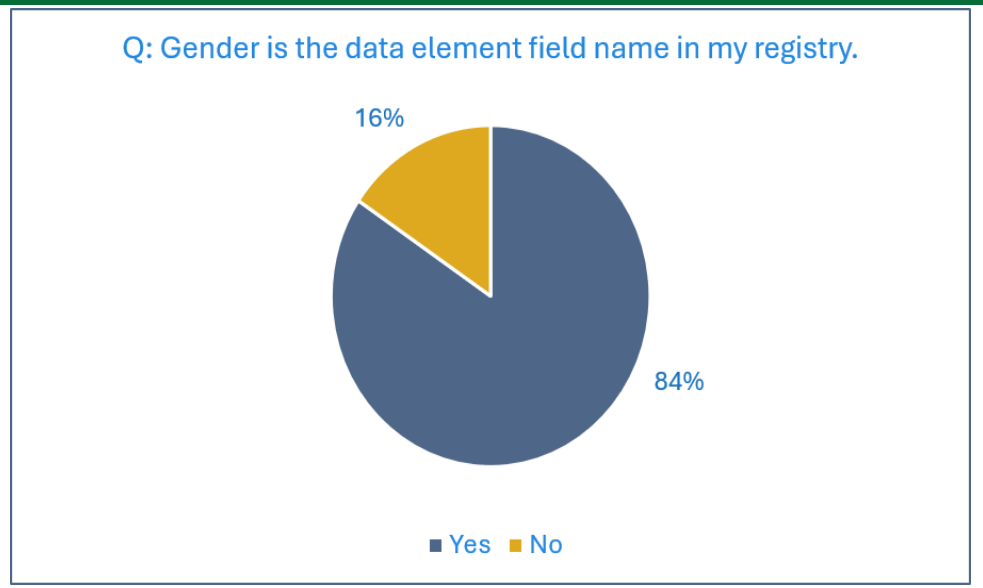
Element Values:

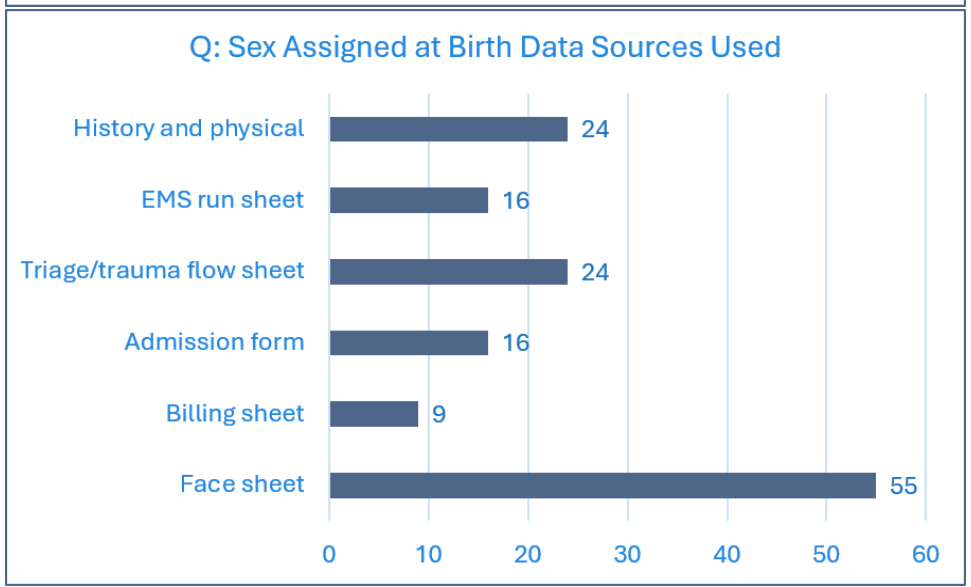
1. Man
2. Woman
3. Non-binary, genderqueer, gender nonconforming
4. Non-disclosed

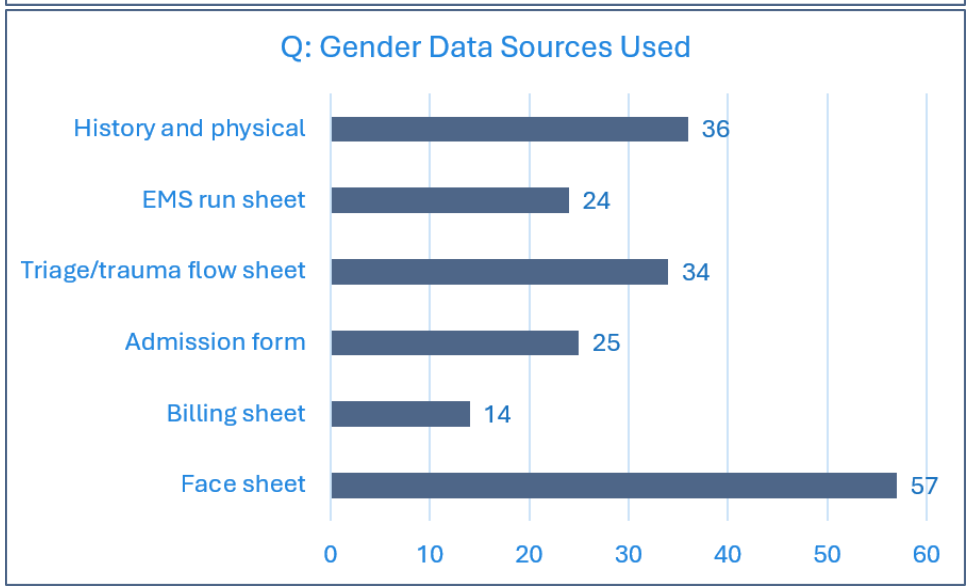
Additional Information: Patient gender should be based upon self-report or identified by a family member.

Data Elements

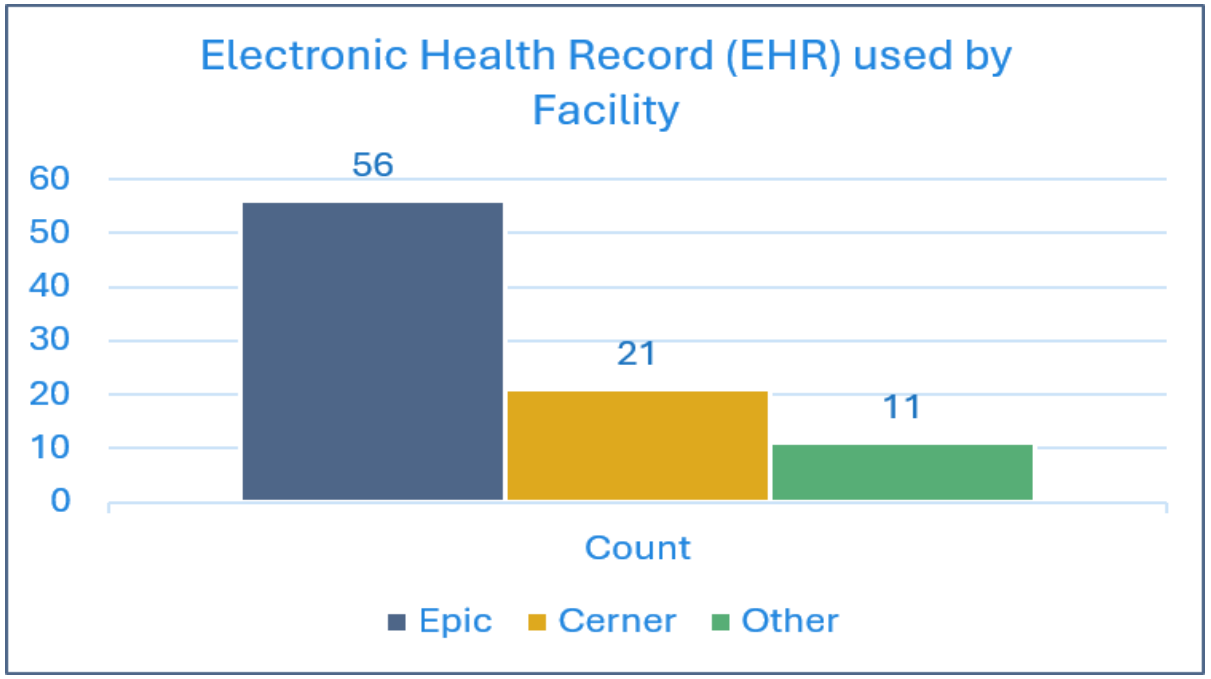


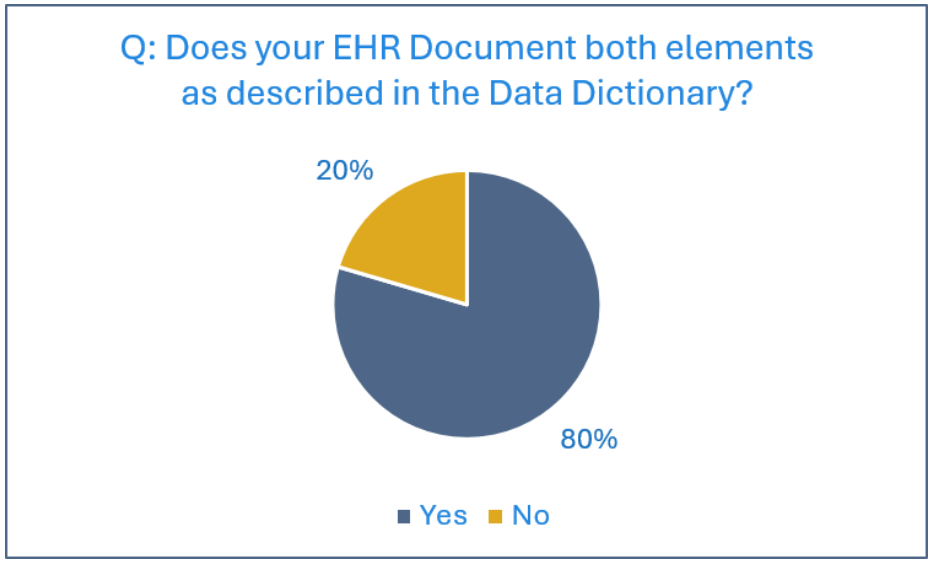


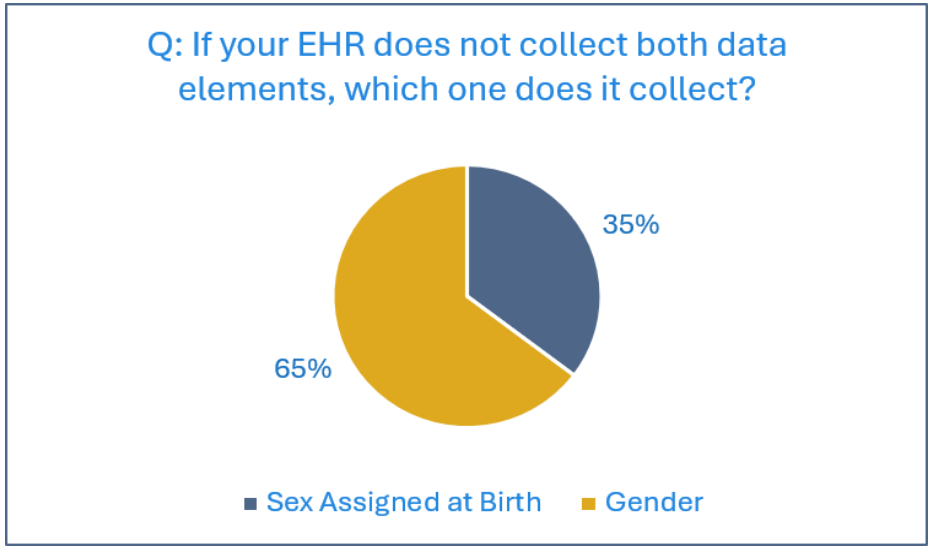




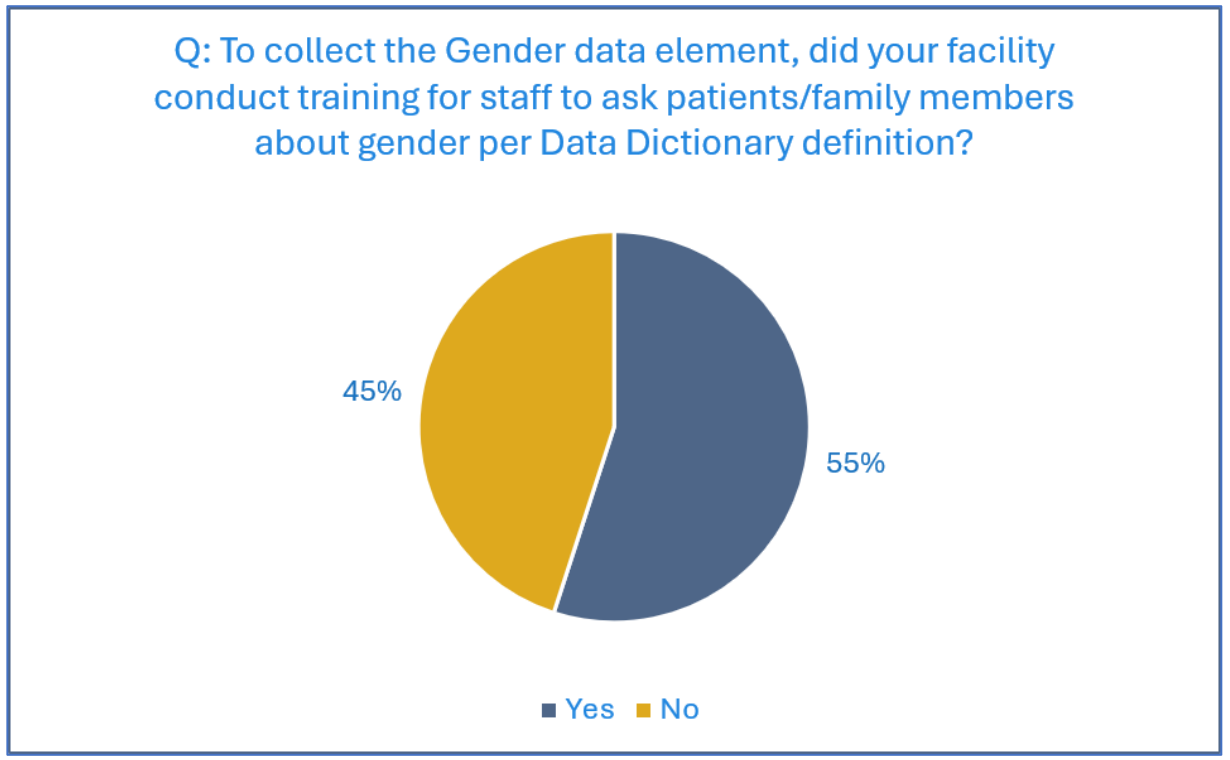
Questions Regarding Electronic Health Record (EHR)

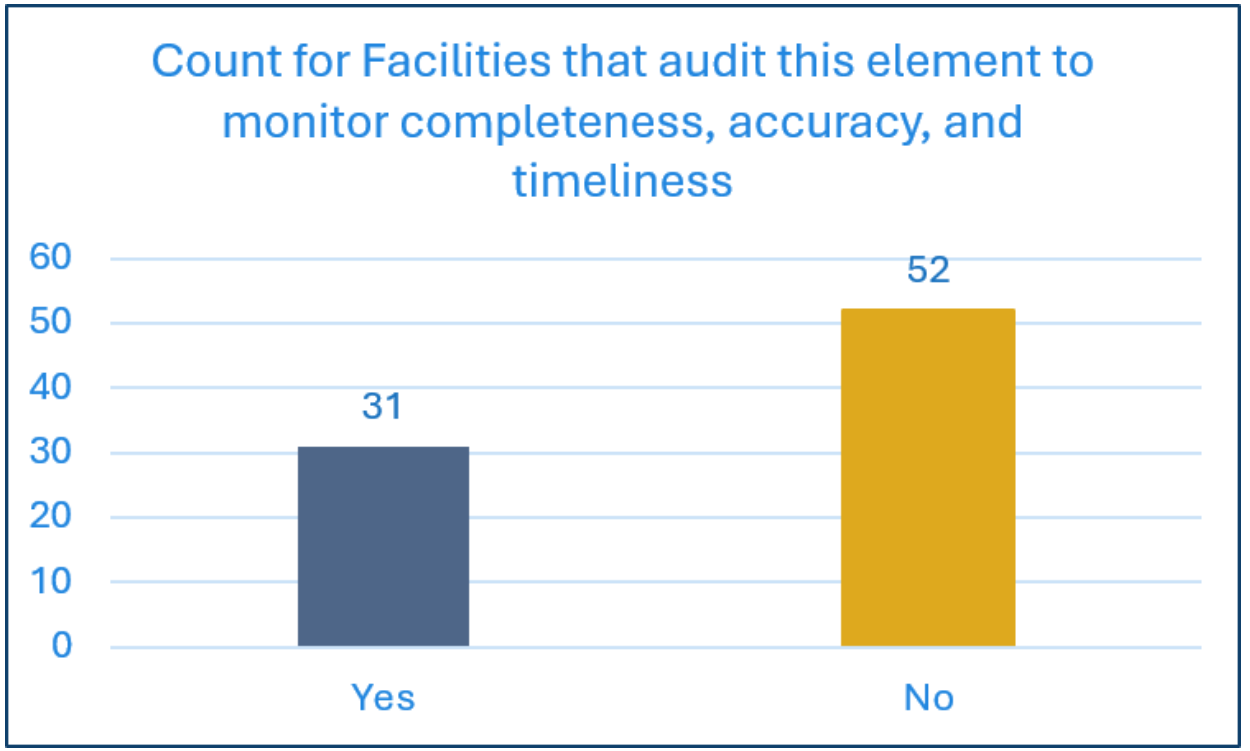






Data Quality





Challenges to collecting this element (n=80)	
Yes (More details on next slide)	31
No	49

Challenges and Opinions

- In EPIC, gender identity and sex assigned at birth are fields under demographics but are often empty "-". I typically find anything other than "Male" or "female" in the patient's history, provider notes, etc.
- "In our Epic - ""legal sex"" is documented 100% of the time and that is what we use for ""sex assigned at birth"". For gender - at our facility it is not required to ask minors their gender identity. So, we report it as Not Documented because they typically do not ask. The only time that we will report is if it is specifically documented, which is very rare."
- In V7 we also have a field "Gender Affirming Hormone Therapy"
- We will be having a registry update 6/26/26, Gender at birth could be added at that time. not 100% sure. I am assuming that the hospital staff had training.
- My data elements are "Gender" and "Gender Identity“
- Legal Sex, Gender Identity, Sex Assigned at Birth, and Sexual Orientation are entered under patient demographics/registration team. This survey is answered to the best on my understanding.
- Our medical record shows for instance “male birth sex” and “gender identity identifies as male”.
- Non-disclosed needs further explanation. Do we answer non-disclosed because the question was not asked & answered, or is it non-disclosed only when the self-reporter declines to answer?
- Difficult to ask people about what sex assigned at birth upon admission in ED. May be more appropriate in a private setting
- We have mainly geriatric patients who become offended if asked about gender
- People are not forthcoming with discussing that information.

Survey respondents from R8

Aspirus

Helen Newberry Joy Hospital

Marshfield Medical Center Dickinson

Munising Memorial Hospital

OSF St. Francis Hospital

Schoolcraft Memorial Hospital

UP Health System Marquette

UPHS Bell

Prehospital Blood Pilot Project-Three Grants

Announcement-Goal date Sept 14th

Eligibility criteria, application review panel- Aug Save the Date out

Process: application, acknowledgement form, last date for submission, application review process, award letter

OHSP approval letter- Oct 1st

Application due Nov 13th

Applications reviewed Nov 16-20

Approval letter Dec 4th

Orientation webinar Dec 7-11

Prehospital blood training program- required, CEU's

Equipment checklist and Invoice form due Aug 27th, 2027

Hospital and MCA letter

Hospital one pager

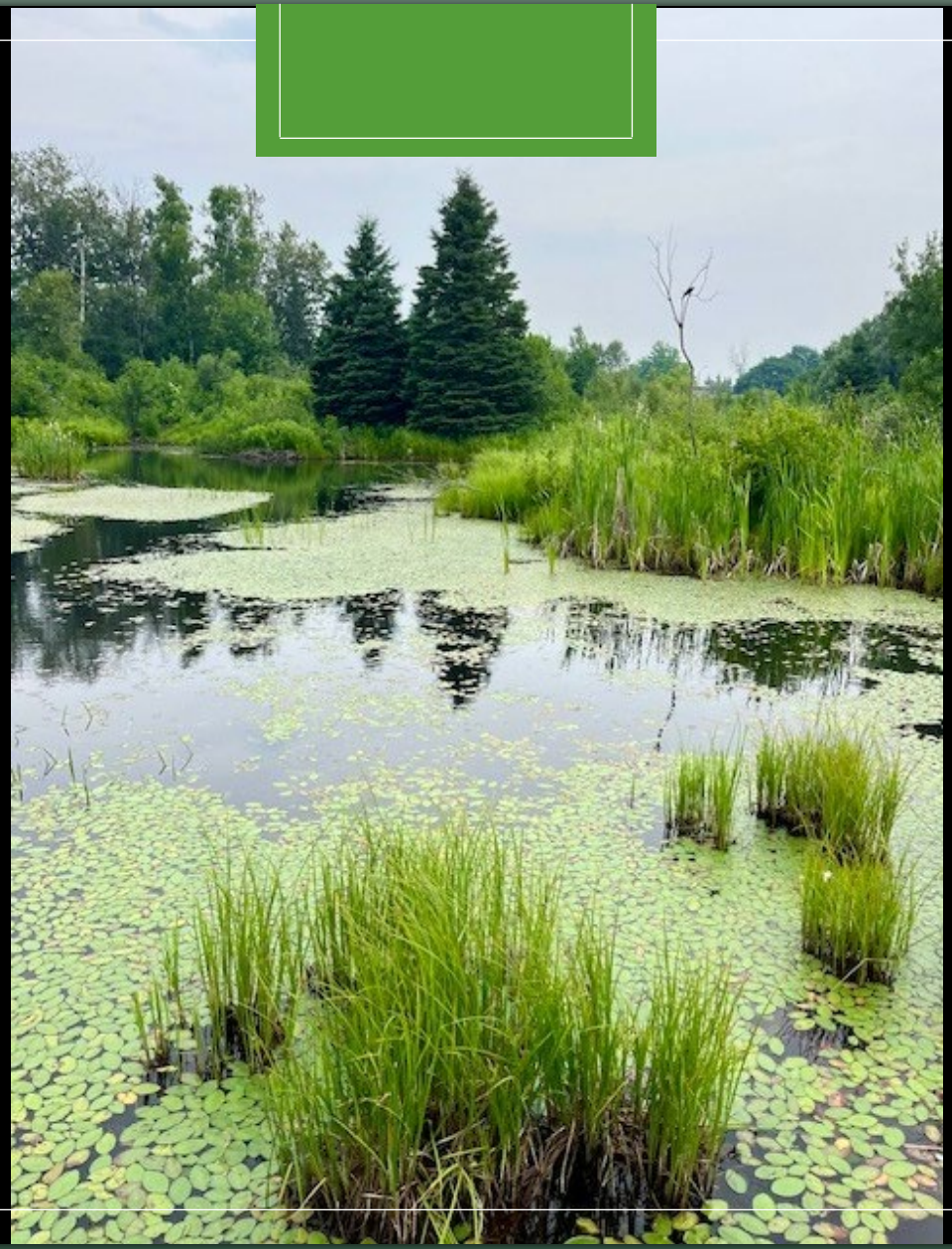
Report form final Report Aug 27th 2027

OHSP Quarterly reporting

Project Planning and Implementation 2027

- STAC term ends 2027
- Begin planning for Strategic Plan update/revision 2029
- New Adm-Media, messaging, program highlights
- Michigan Criteria launch (approach, training, messaging)
- Prehospital Blood Pilot project launch Sept 2026
- SOC workplans and assessments
- Advisory input on Level V criteria

ALWAYS PLAN AHEAD, IT WASN'T RAINING WHEN NOAH BUILT THE ARK
JANETAYLOR.NET



OLD BUSINESS

OLD BUSINESS – Decision to Transfer Awareness

SP14: By December 31, 2026, the regions will track all trauma transfers to assess the root cause of delays, overall function, and resource utilization. The following should be considered: time of decision to transfer, time of acceptance at receiving facility, time bed assigned at receiving facility, time EMS called, and time of EMS arrival for transport. Issues and challenges related to patient transfers including transfer guidelines and procedures, lack of or limited monitoring of ED dwell times, failure to report trends to the trauma RPSRO will be monitored and strategies to address will be put into place.

Roundtable discussion on what facilities have implemented since April on increasing the documentation of the decision time to transfer in the patients' medical records.

OLD BUSINESS – Broad medical and community awareness of trauma center

By December 31, 2027, identify and document at least one public-facing activity per hospital to be conducted during May (Trauma Awareness Month) to increase awareness of trauma centers and preventable injuries. Publish a regional activity list on R8MCAN.org and share through RTAC and social media channels.

By April 2025, establish public information and education components for the top three external cause codes that include the months for hospital trauma programs to distribute the information.

By April 2026, survey the hospital trauma programs on feedback they received from the messages and methods of distribution.

What feedback did you elicit from your activities?

OLD BUSINESS – 2027-2029 SOC Application status

State office had minor formatting changes, statute numbering corrections, ex-officio status added to state positions sitting on committees, and the following:

By June 30, 2027, implement a region-wide, self-imposed protocol requiring all hospital trauma programs to document transfer delays of the trauma transfer guideline red and yellow patients using the standardized definitions authored for the trauma registry. Conduct bi-annual audits to measure compliance and provide feedback to RPSRO and hospital trauma programs.	By June 30, 2027, implement a region-wide protocol requiring all hospital trauma programs to document transfer delays of the trauma transfer guideline red and yellow patients using the standardized definitions authored for the trauma registry. Conduct bi-annual audits to measure compliance and provide feedback to Regional Professional Standards Review Organization (RPSRO) and hospital trauma programs.

The application now moves to review by at least two (2) STAC members.

NEW BUSINESS

NEW BUSINESS – Trauma Team Activation Criteria

CURRENT SOM	NEW CRITERIA SOM (February 2027)
The criteria for a graded activation must be clearly defined by the trauma facility, with the highest level of activation including the six required criteria listed in Chapter 5; Table 2 of the ACS' "Resources for the Optimal Care of the Injured Patient, 2014."	In all trauma centers, the criteria for tiered activations must be clearly defined. For the highest level of activation, the following eight criteria must be included: 1. Confirmed blood pressure less than 90 mm Hg at any time in adults, and age-specific hypotension in children 2. Gunshot wounds to the neck, chest, or abdomen 3. GCS less than 9 (with mechanism attributed to trauma) 4. Transfer patients from another hospital who require ongoing blood transfusion. 5. Patients intubated in the field and directly transported to the trauma center. 6. Patients who have respiratory compromise or are in need of an emergent airway. 7. Transfer patients from another hospital with ongoing respiratory compromise (excludes patients intubated at another facility who are now stable from a respiratory standpoint) 8. Emergency physician's/Advanced Practice Provider's discretion

NEW BUSINESS – Trauma Team Activation Criteria

The trauma program may include additional criteria such as:

- Geriatric specific
- Pediatric specific
- More stringent or expanded criteria that is based on resources & data driven PI Plan

MARQUETTE

TRAUMA TEAM ACTIVATION CRITERIA

Injury > 72 hours = no trauma team activation

Level 1 Trauma Activation Criteria			
Airway	Intubated patient transported from scene		
	Compromised airway, obstruction, or need for emergent airway		
	Intubated transferred patient with ongoing respiratory compromise		
Breathing	Respiratory Rate	Age > 1 year	< 10 breaths/min
		Age < 1 year	< 30 breaths/min
	Respiratory distress (ineffective respiration effort, stridor, grunting or accessory muscle)		
Circulation	Tachycardia	**Age < 65 years**	Heart Rate over 130
		Age ≥ 65 years	Heart Rate over 120
	Hypotension	**Age 0-28 days**	SBP < 60 mmHg
		Age 1 month – 9 years	SBP < 70 mmHg + 2x age in years
		Age 10-64 years	SBP < 90 mmHg
		Age ≥ 65 years	SBP < 100 mmHg
	Any blood product prior to arrival or receiving blood products during transfer		
Disability	Glasgow Coma Scale (GCS) ≤ 11 with mechanism attributed to trauma		
Anatomic	Penetrating injuries to head, neck, torso, or extremities proximal to the elbow or knee		
	Open or depressed skull fracture		
	Paralysis or suspected spinal cord injury		
	Crushed/degloved extremity or tourniquet in place		
	Unstable pelvic fracture		
	Amputation proximal to the ankle or wrist		
Other	Emergency provider's discretion		

Level 1 Trauma Team Activation

Activation Time:

_____

If patient is
< 16 years old
Activate
PEDIATRIC TRAUMA

If patient is
>20 weeks pregnant
Activate
OB TRAUMA

Level 2 Trauma Activation Criteria			
Mechanism with obvious or suspected injury			
Disability	Glasgow Coma Scale (GCS) 12- 13 with traumatic cause		
Mechanism	**Falls**	Adult ≥ 15	> 20 feet (one story = 10 feet)
		Children ≤ 14 years	> 10 feet or 3 times the height of child
		Ground level fall, **with** evidence of direct force to the head **AND** current use of blood thinners/anticoagulated	
	MVC	Intrusion, including roof: > 12 inches occupant compartment	
		Ejection (partial or complete) from vehicle	
		Death in same passenger compartment	
		Extrication time > 20 minutes	
		Unrestrained rollover	
	Auto vs. Pedestrian / cyclist thrown, run over, or with significant impact		
	Motorcycle/ATV/Snowmobile driver or passenger crash (> 20 mph)		
	High-energy electrical injury		
	Burns > 20% TBSA (second or third degree) and /or inhalation injury		
	Suspected non-accidental trauma		
Anatomic	Flail Chest		
	2 or more long bone fractures		
Geriatric	Age 65 years or over meeting any of the Level 2 trauma activation criteria		
Other	Emergency provider's discretion		

Level 2 Trauma Team Activation

Activation Time:

_____

If patient is
< 16 years old
Activate
PEDIATRIC TRAUMA

If patient is
>20 weeks pregnant
Activate
OB TRAUMA

Trauma Consult (Level 3)
Patients not meeting activation criteria with more than 1 injury/system should have a Trauma consult.
ED provider or admitting provider to order consult.
See Trauma admission criteria for correct admitting service.

DATE:_____

PT. Name:_____

ACCT. #:_____

NEW BUSINESS – Level IV Criteria education

The STAC has requested the new SOM trauma center criteria online education be recorded and available for partners. This was reported to be achievable and when a link is established, the RTAC will receive it.

MI.GOV/TRAUMASYSTEM

- TRAUMA
- NEW MICHIGAN CRITERIA (effective February 2027)

REPORTS

REGION 8 TRAUMA NETWORK
SNOWMOBILE PATIENTS
DECEMBER 1, 2025 – MARCH 31, 2026
Data from Emergency Departments Across Region 8

TOTAL PATIENTS SEEN: 280

REGION 8 TRAUMA NETWORK

HOSPITALS SEEN AT

Aspirus Iron River	14
Aspirus Ironwood	51
Aspirus Keweenaw	11
Baraga County Memorial	12
Helen Newberry Joy	53
Marshfield Medical Dickinson	12
Munising Memorial	17
MyMI Sault	23
OSF St. Francis	3
Schoolcraft Memorial	6
UPHS Bell	1
UPHS Marquette	38
UPHS Portage	39

HOW THEY ARRIVED

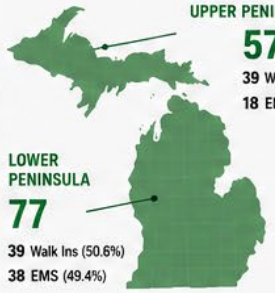
EMS	111	(39.6%)
Walk In	168	(60.0%)
Not documented	1	(0.4%)

HOME STATE OF PATIENT
(Patients from 18 states and provinces)

MI	135	GA	2
WI	40	VA	2
IL	28	not documented	2
MN	21	MO	1
OH	18	NC	1
IN	14	ONT	1
IA	5	SD	1
PA	4	TX	1
AL	2	VT	1
		KY	1

Total 280

MICHIGAN RESIDENTS
(1 city not documented)



UPPER PENINSULA
57
39 Walk Ins (68.4%)
18 EMS (31.6%)

LOWER PENINSULA
77
39 Walk Ins (50.6%)
38 EMS (49.4%)

AGE BRACKET

	Female	Male	Unknown	Total
Blank		1		1
0–9		1		1
10–19	5	16		21
20–29	9	44		53
30–39	9	26		35
40–49	10	25		35
50–59	21	49	1	71
60–69	5	41		46
70–79	2	12	1	15
80–90		2		2
TOTAL	61	217	2	280

PROTECTIVE GEAR

Helmet	237	(84.6%)
No helmet	5	(1.8%)
Unknown	29	(10.4%)
Not documented	9	(3.2%)

TRAUMA ACTIVATIONS

1	Level 1 / Full Activations	13	(4.6%)
2	Level 2 / Partial Activations	135	(48.2%)
3	Level 3 / Consultations	5	(1.8%)
	Not Activated	111	(39.6%)
	Not documented	16	(5.7%)

PATIENT GENDER

61 FEMALE
217 MALE
2 UNKNOWN

INCIDENT COUNTIES WHERE CRASH OCCURRED

Luce County, MI	44	Schoolcraft County, MI	8	Florence County, WI	3
Houghton County, MI	38	Keweenaw County, MI	7	Iron County, WI	5
Chippewa County, MI	25	Mackinac County, MI	5	Marinette County, WI	2
Gogebic County, MI	13	Delta County, MI	4	Unknown County, Idaho	1
Alger County, MI	13	Iron County, MI	3	Unknown County, Wisconsin	1
Marquette County, MI	12	not documented	63		
Ontonagon County, MI	9	Unknown	16		
Baraga County, MI	8				

TOP 5 INCIDENT COUNTIES

1. Luce (44)
2. Houghton (38)
3. Chippewa (25)
4. Gogebic (13)
5. Alger (13)

Of note is **79** had no documented location or unknown location.

DRIVER / RIDER STATUS

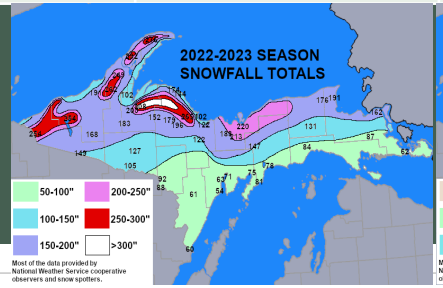
- Driver: 257 (91.8%)
- Rider: 8 (2.9%)
- Not documented or unknown: 15 (5.4%)

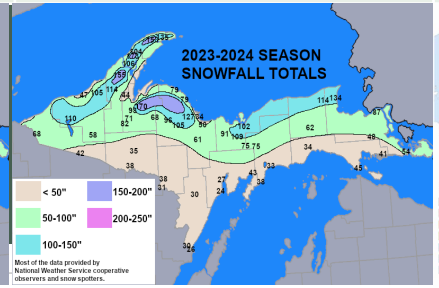
Total 280

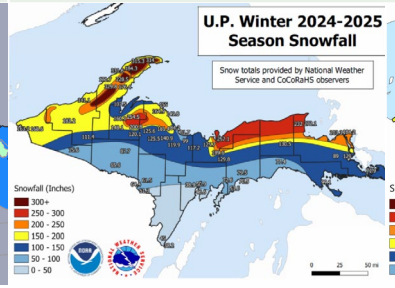
Thank you to all emergency department and trauma team members for your commitment to snowmobile injury care across the region.

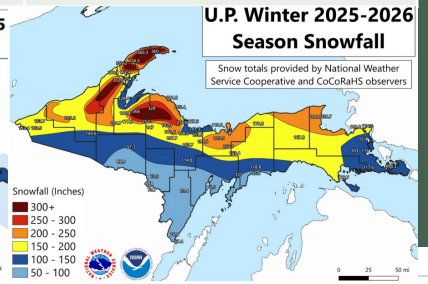
ED spreadsheets of all injured patients involved in snowmobile crashes

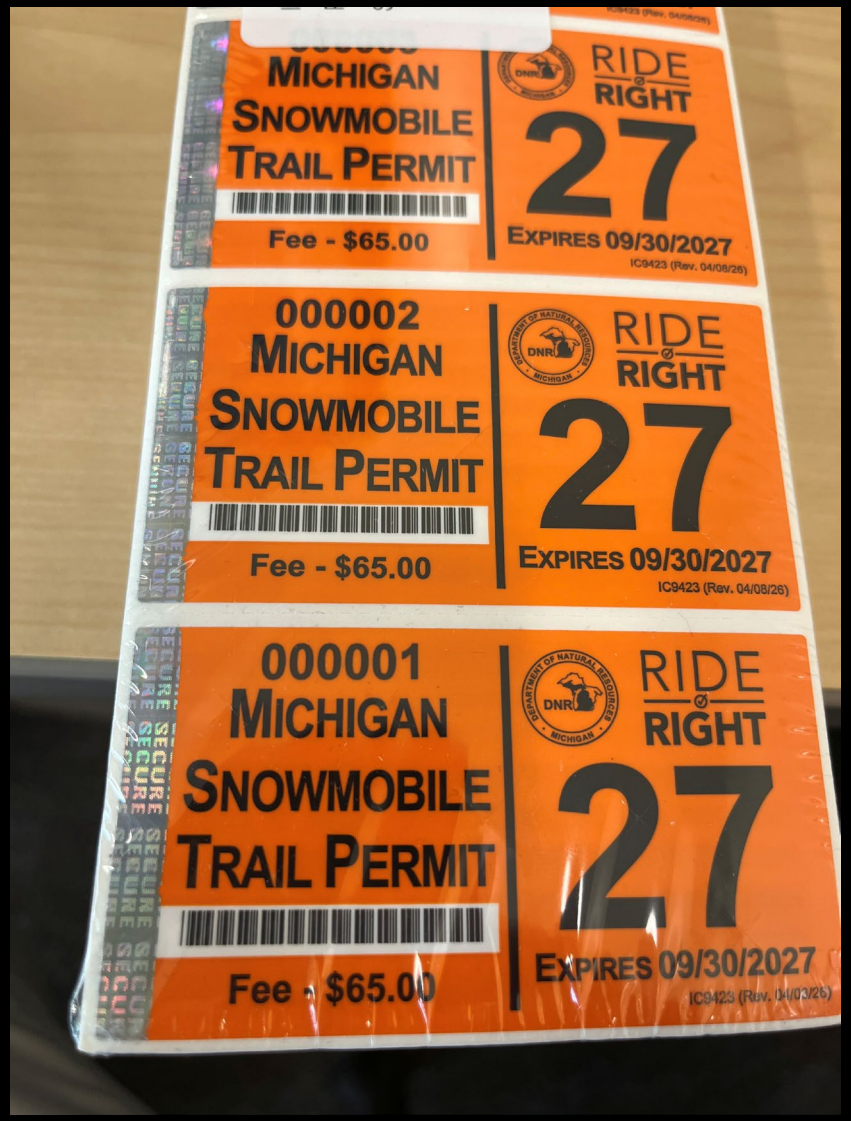
	2022-23	2023-24	2024-2025	2025-2026
AIR	10	1	1	14
AIW	22	5	52	51
AKH	9	2	8	11
AOH	17	2	--	--
BCMH	4	0	8	12
HNJH	34	4	50	53
MMCD	9	0	2	12
MMH	--	--	--	17
MMMCS	10	4	23	23
OSF	0	0	0	3
SCMH	8	0	5	6
UPHSB	3	0	4	1
UPHSM	42	2	44	38
UPHSP	21	0	47	39
TOTAL	**190**	**20**	**244**	**280**









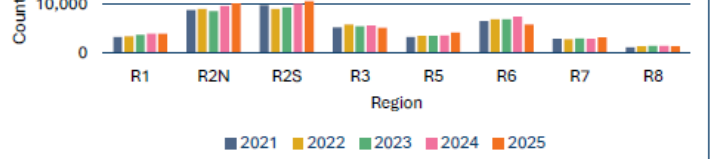


Michigan.gov/ RideRight

Michigan Trauma Registry Falls Brief Report, 2021 – 2025

Unintentional falls are the leading cause of injury and death in older adults (65 years and older) and are the top mechanism of injury for all age groups in the Michigan trauma registry.[1] Falls and related injuries can result in limits to activities, require medical treatment and can impact independence. This report provides information on incidents from the Michigan Systems of Care, trauma registry within the injury category slipping, tripping, stumbling, and falls (hereafter referred to as "falls") including selected outcomes. Total falls for all ages, 2021-2025, that met registry inclusion criteria equal 213,352. Figure 1 shows the count per trauma region by year.

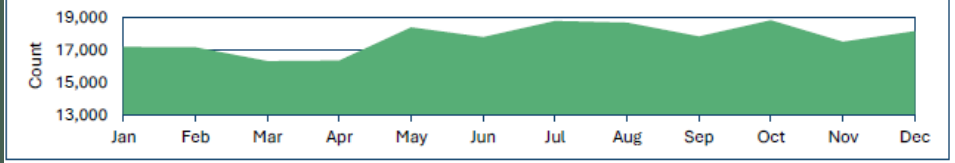
Figure 1. Falls per Year and Region, All Ages, Michigan 2021-2025



Trauma Regions

Figure 2 examines the number of falls per month for 2021-2025 combined. March had the lowest count with 16,333 and October had the highest at 18,867.

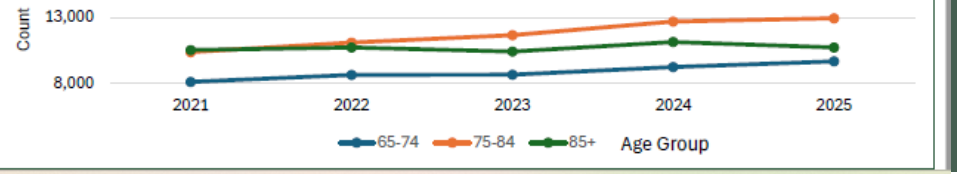
Figure 2. Falls per Month, All Ages, Michigan, 2021-2025



Older Adult Falls Information, 65 Years of Age and Older

The following information focuses on older adult falls those ages 65 and older, within the following age groups: 65-74, 75-84, 85+. The age group with the most incidents is 75-84, which had a 23% increase from 2021-2025. The 65-74 age group had an increase of 19.5%, 85+ saw a slight increase of 1.9% (Figure 3).

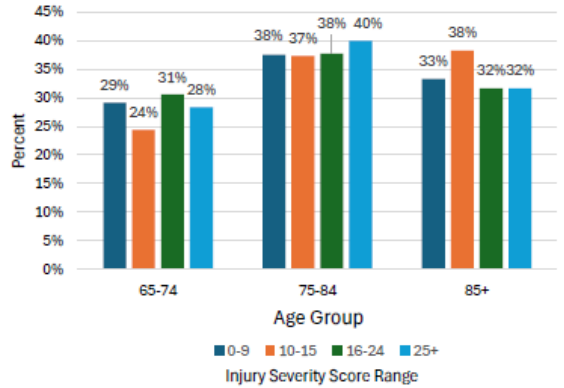
Figure 3. Falls per Year and Age Group, Older Adult Falls, Michigan, 2021-2025



Injury Severity Score

The Injury Severity Score (ISS) is used to assess the severity of a trauma incident and can be used to predict outcomes in patients. The ISS system has a range of 1-75, a higher score is associated with a higher risk of death. A range from 1-9 a minor injury; 10-15 is moderate; 16-24 is severe; and greater than 24 is very severe according to the American College of Surgeons. Figure 4 to the right illustrates ISS range by age group.

Injury Severity Score Range by Age Group, Older Adult Falls, Michigan, 2021-2025



Emergency Department & Facility Dispositions, Older Adult Falls, Michigan, 2021-2025

Table 1. Emergency Department Disposition	Age Group 65-74	75-84	85+
Deceased	24%	36%	41%
Home with/without services	47%	36%	17%
Transferred	31%	39%	30%
Admitted/floor bed	27%	37%	36%
Intensive care unit	30%	39%	32%
Telemetry	26%	38%	35%
Observation unit	30%	37%	33%
Operating room	33%	37%	30%

Selected emergency department dispositions by age group are shown here (Table 1). Dispositions are broken down by the percent in each age group. The age group with the highest percent of deceased is 85+ age group (41%).

Selected facility dispositions by age group are shown to the right (Table 2). The age group with the highest percent of deceased is 85+ (44%). Discharged to home shows the 65-74 had the highest percent (41%).

Table 2. Facility Disposition	Age Group 65-74	75-84	85+
Deceased	20%	36%	44%
Discharged to home	41%	36%	23%
Home with home health services	32%	38%	30%
Inpatient rehabilitation services	23%	39%	38%
Skilled nursing facility	21%	37%	41%

1. Facts About Falls. Centers for Disease Control and Prevention. Facts About Falls | Older Adult Fall Prevention | CDC

Region 8 Hospitals *(not for redistribution)*

Revision May 2026	Aspirus Iron River	Aspirus Ironwood	Aspirus Keweenaw	Baraga	Helen Newberry Joy	Marshfield Dickinson	Munising	MyMI Sault	OSF St Francis	Schoolcraft	UPHS Bell	UPHS Marquette	UPHS Portage
County	Iron	Gogebic	Houghton	Baraga	Luce	Dickinson	Alger	Chippewa	Delta	Schoolcraft	Marquette	Marquette	Houghton
800 MHz identifier	36AIR	27HOSP	31KMMC	07BCMH	48HNJH	22DCHS	02MMH	17WAR 17MCA (encrypt)	21OSF	77SCH	52BELL	52MGHS	31PHS
ED recorded phone line for EMS	906.265.0448	906.932.7077	906.337.6127	906.524.2547	906.293.9120	906.776.5395	906.387.0758	906.253.2711	906.786.8710	906.341.3799	906.485.2786	906.449.3131	906-483-1650
Interfacility transfer phone line for ED	906.265.0412	906.932.6220	906.337.6599	906.524.3325	906.293.9219	906.776.5555	none	906.635.4402	906.786.5707	906.341.3258	906-485-2639	844.967.1445	906.483.1112
HERN VHF for EMS/Hospital	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Adult Trauma Center Level	**None**	**IV**	**None**	**IV**	**IV**	**IV**	**None**	**IV**	**IV**	**None**	**None**	**II**	**III**
Peds Trauma Center (none)													
Burn Center/Burn Surge Center												X	X
STEMI-Receiving (PCI Capable)												X	
STEMI-Referral Center												X	X
Level-I Stroke Comprehensive													
Level-II Stroke Thrombectomy Capable													
Level-III Stroke Primary Stroke Center												X	
Level-IV Acute Stroke Ready Hospital		X				X		X					X
Obstetrical (OB) Admission						X		X	X		X	X	X
Pediatric Admission		X	X			X		X			X	X	X

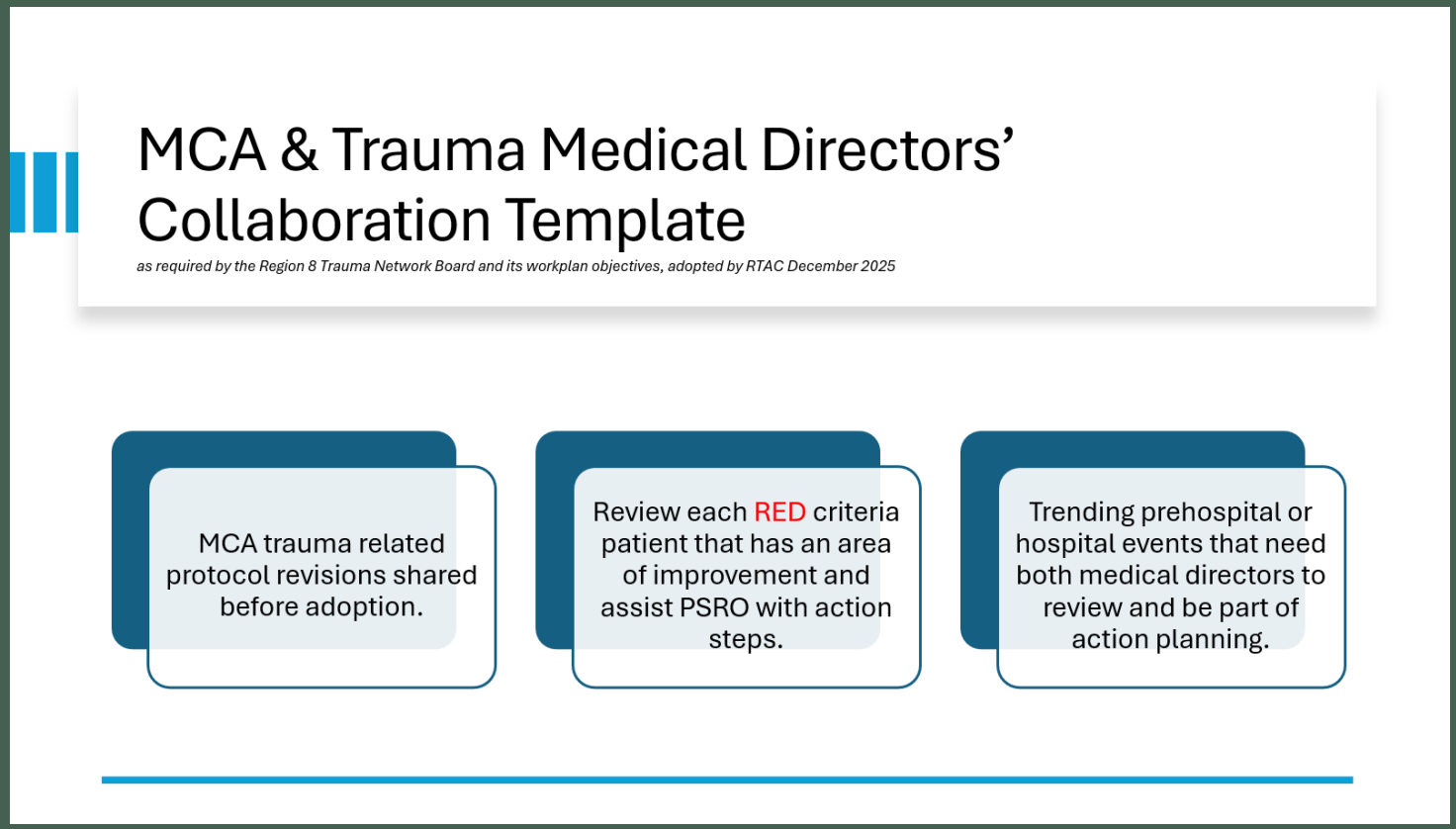
R8 Med Coord Center Emerg Activation	888-535-5806
State Burn Coordination Center	734-936-2876
Divers Alert Network 24/7	919-684-9111
Michigan Poison Center	800-222-1222
MEDDRUN CHEMPACK ACTIVATION	877-633-7786 Backup number 616-391-5330

Hospital accreditation	TJC	TJC	TJC	TJC	DNV	TJC		DNV	TJC		TJC	TJC	TJC
Blood bank affiliation	UP Regional	UP Regional	UP Regional	UP Regional	UP Regional	Community (Appleton)	UP Regional	UP Regional	Community (Appleton)	UP Regional	UP Regional	UP Regional	UP Regional
EMResource access	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
MS Teams for incidents (in progress)	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Satellite phone for incident mgt											9064646919	9064226999	9063569139

February 2026, edition LLN

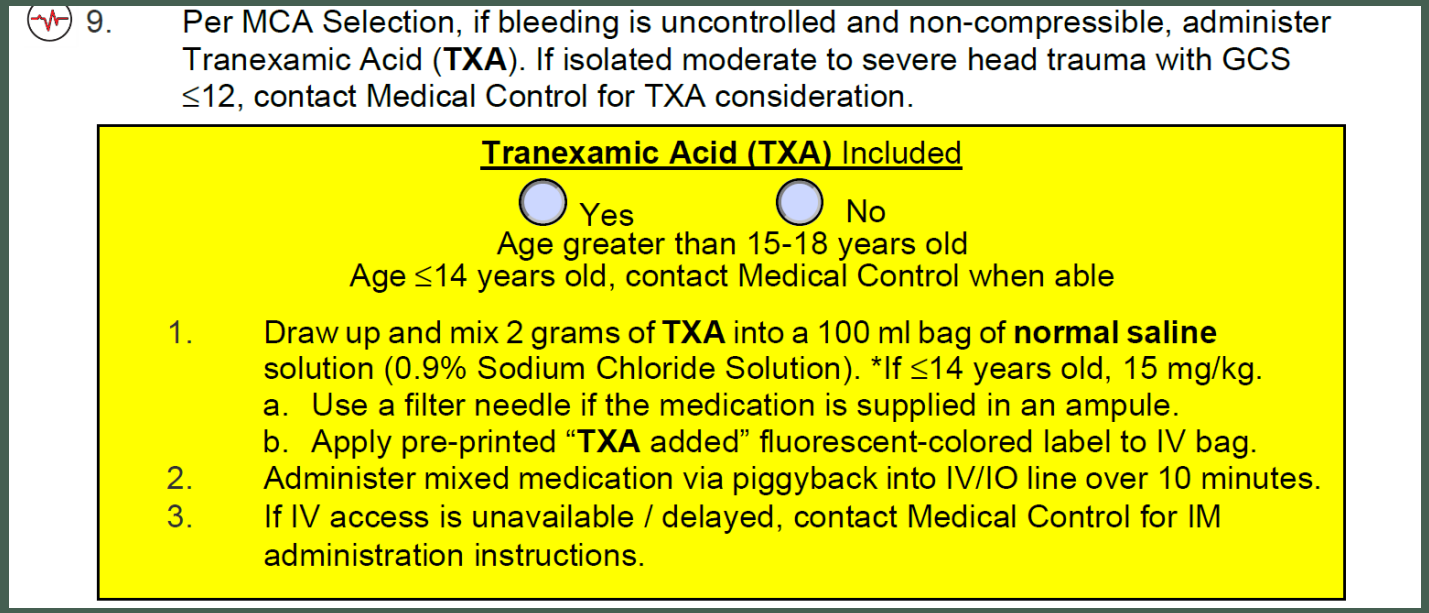
By December 2024, the RTN will author a procedure template for MCAs and hospital trauma programs to adopt that formalizes the relationship between trauma medical directors and MCA medical directors and the content to which there should be collaboration, i.e., medical directors and trauma medical directors invited to provide input on MCA PSRO reports that involved trauma care.

By February 2024, the RTN shall continue its request of Region 8 MCAs and hospital trauma programs to document their medical directors' collaboration by report at their respective meetings and evidenced in their minutes.



By September 2024, the RTN shall endorse the state approved trauma protocols.
How are the 2025 EMS protocol updates proceeding?

DRAFTED example of a 2 gram TXA modification with other language as suggested in the presentation State Medical Director Dr. Fales shared with us. The process is to work with R8MCAN on modifications.



9. Per MCA Selection, if bleeding is uncontrolled and non-compressible, administer Tranexamic Acid (**TXA**). If isolated moderate to severe head trauma with GCS ≤12, contact Medical Control for TXA consideration.

Tranexamic Acid (TXA) Included

Yes No

Age greater than 15-18 years old

Age ≤14 years old, contact Medical Control when able

1. Draw up and mix 2 grams of **TXA** into a 100 ml bag of **normal saline** solution (0.9% Sodium Chloride Solution). *If ≤14 years old, 15 mg/kg.
   a. Use a filter needle if the medication is supplied in an ampule.
   b. Apply pre-printed "**TXA** added" fluorescent-colored label to IV bag.
2. Administer mixed medication via piggyback into IV/IO line over 10 minutes.
3. If IV access is unavailable / delayed, contact Medical Control for IM administration instructions.

By December 2026, the RTN and the Region 8 Healthcare Coalition (R8HCC) will conduct a half-day workshop and four tabletop exercises (UP west, central, south, east) that incorporate a hospital being unable to accept any patients because of natural and/or manmade disaster. The results of this will provide the foundation for diversion plan development during the next workplan.
Anticipating future endeavor, no work group formed.

By December 2024, the hospitals shall review where they transfer patients, in region, and out-of-region, to ensure congruency with closest and most appropriate to determine if there are areas of opportunity for improving transfers.
Is this being done? How? Reported to each hospital trauma committee or?

RPSRO feedback

Facilities must adhere to whatever validated clinical decision rules for c-spine clearance they have adopted and that includes a proper physical exam. It has been noted that tertiary care facilities may be re-applying a c-collar to transferred patient upon arrival because the physical exam was unable to be completed on altered or intubated patients.

SP25: By December 31, 2026, there is documented evidence in the Region's Annual Report of a plan to address a minimum of one identified gap or opportunity in the following year. The RTN shall continue to establish regional benchmarks on a yearly cadence and will continue to do such through December 2026. (Examples: 120 minute door to door time for Level 1 activations that need transfer; MCA medical directors and TMDs collaboration evidenced by meeting minutes; yearly outreach to the broad medical community; regional injury prevention data collection to assist statewide campaign.)

Is there an identified gap or opportunity with documented evidence to add in 2027?

SP26: By October 31, 2025, though the regional PI process, RPSRO feedback, member organization and stakeholder feedback, and Michigan Information System (MIS) data, the education needs of trauma, stroke and STEMI providers will be identified. The level of trauma, stroke, and STEMI centers and urban versus rural centers should be considered. There is evidence that these needs are addressed in the Region's annual report and are re-assessed annually.

Do we have evidence through our RPSRO, feedback, and data to show that educational opportunities are occurring or need to be modified?

By December 2025, the RTN shall encourage the MCAs to have active, minimally quarterly, meetings of their Professional Standards Review Organizations that include MCA medical directors' and trauma medical directors' input on reports that identify patients meeting trauma triage criteria, procedures rendered, hospital capabilities, and hospital outcomes.

Is this happening?

Continuum of Care – MI Trauma Rehab Needs Assessment (statewide rehabilitation project)

By Dec. 2026, as findings occur with the statewide rehabilitation project, the RTAC shall be advised and tasked with elements required by the Department.

Continuum of Care – MI Trauma Rehab Needs Assessment Conclusions

The trauma rehabilitation needs assessment and environmental scan project aimed primarily to provide a better understanding of how Michigan statewide trauma system is working and the current state of post-acute rehabilitative service.

Phase 1 of the project has focused on the discharge planning process and shared the perspectives of discharge planners

Phase 2 of the project yielded valuable insights into patients' experiences and perspectives regarding acute care and the transition to post-discharge rehabilitation and recovery. Trauma registry analysis provided an epidemiological overview of trauma cases in Michigan. Furthermore, the analysis of Medicaid data has offered insights into the outcomes of the injuries, and post-acute care availed of by trauma patients.

Continuum of Care – MI Trauma Rehab Needs Assessment Conclusions

Survey and interviews of discharge planners

Supporting factors for successful transition of trauma patients from acute care to rehabilitative and other post-acute care on their journey towards their recovery goals.

- inter-professional relationships and communication within the hospital staff teams
- family support systems and access to healthcare and community resources

Barriers in rehabilitation transfer process identified by discharge planners included

- type and availability of medical insurance can dictate and limit
- lack of supportive services from the family and the community services
  - transportation
  - rehab providers
  - mental health services or substance use treatment

Continuum of Care – MI Trauma Rehab Needs Assessment Conclusions

Survey and interviews of patients and caregivers

A total of 10 patients participated in the survey and interviews. The participants were all over 50, with 50% retired, and 40% on Medicare. As to be expected, the patients were generally less satisfied with their post-discharge life compared to their life prior to the injury. Overall, the patients were generally satisfied with their experience at the acute care hospital; only one out of 10 participants reported a negative experience.

Immediate hospital care was efficiently executed and professionally managed by the health care staff. They reported feeling excluded from the decision-making process regarding their post-rehab recovery with lack of communication about the discharge process and post-discharge plans. They expressed a lot of concern and anxiety once they were on their own after being discharged from the facilities. They faced various challenges to be able to successfully navigate and receive rehabilitation and other follow-up care.

Continuum of Care – *(excerpt)*
MI Trauma Rehab Needs Assessment Phase 1

Factors Affecting Rehabilitation

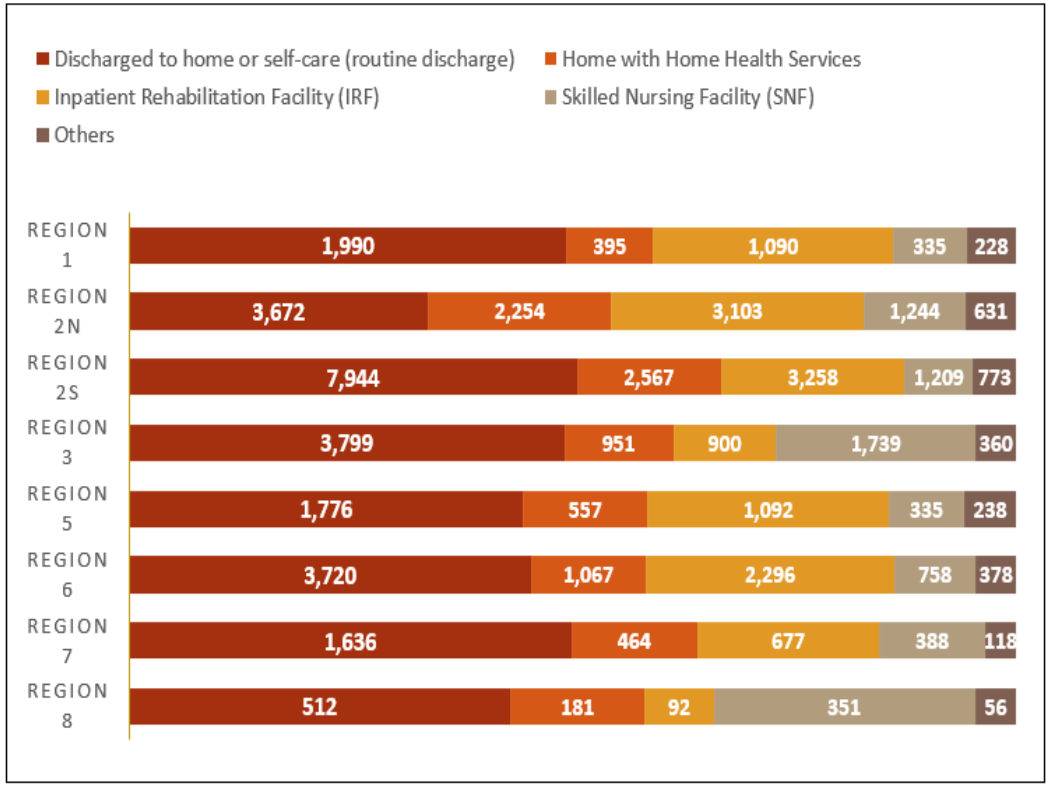
53% of the participants shared that there are certain age groups that face more challenges to get placement in rehabilitation centers. There are limited health services options available for pediatric patients, who are also not eligible for Medicare. However, some participants shared that older patients above 65 years of age are easier to get placements in rehabilitation centers.

70% of participants shared that certain types of injuries make it harder to find rehabilitation services for patients. Traumatic brain injuries (TBI) and spinal-cord injuries (SCI) are the most common types of injuries that make it harder to find rehabilitation placements. Also mentioned as injuries for which rehabilitation is harder to find were: having multiple fractures, catastrophic injuries, and those that require psychiatric consultation.

Final Thoughts and Recommendations

We asked participants, if they "had the power to address any one specific barrier to ensuring timely and appropriate transition to rehabilitation services, what would it be?" Almost all the participants shared that they would like to address the barriers regarding medical insurance and auto insurance. Insurance type can lead to both delays and denials of appropriate care. One of the participants said, *"All pediatric patients deserve to get the care they need for optimal outcome regardless of their insurance."*

After insurance, respondents highlighted issues relating to lack of community resources, insufficient medical staff, and limited transportation access as some other barriers that participants would like to address. Participants also shared the need for more availability of pediatric rehabilitation centers.



State by State Review

Our team reviewed the trauma system websites for each of the 50 states to assess how each was addressing rehabilitation in terms of planning, research, reporting requirements,

Education

Through December 2026, the RTN shall expand the recommended trauma education list to include courses for trauma registrars. The list shall continue to be published on the R8MCAN.org website > Trauma.

Recommended Trauma Education

as issued by the Region 8 Trauma Network, December 2023

PREHOSPITAL

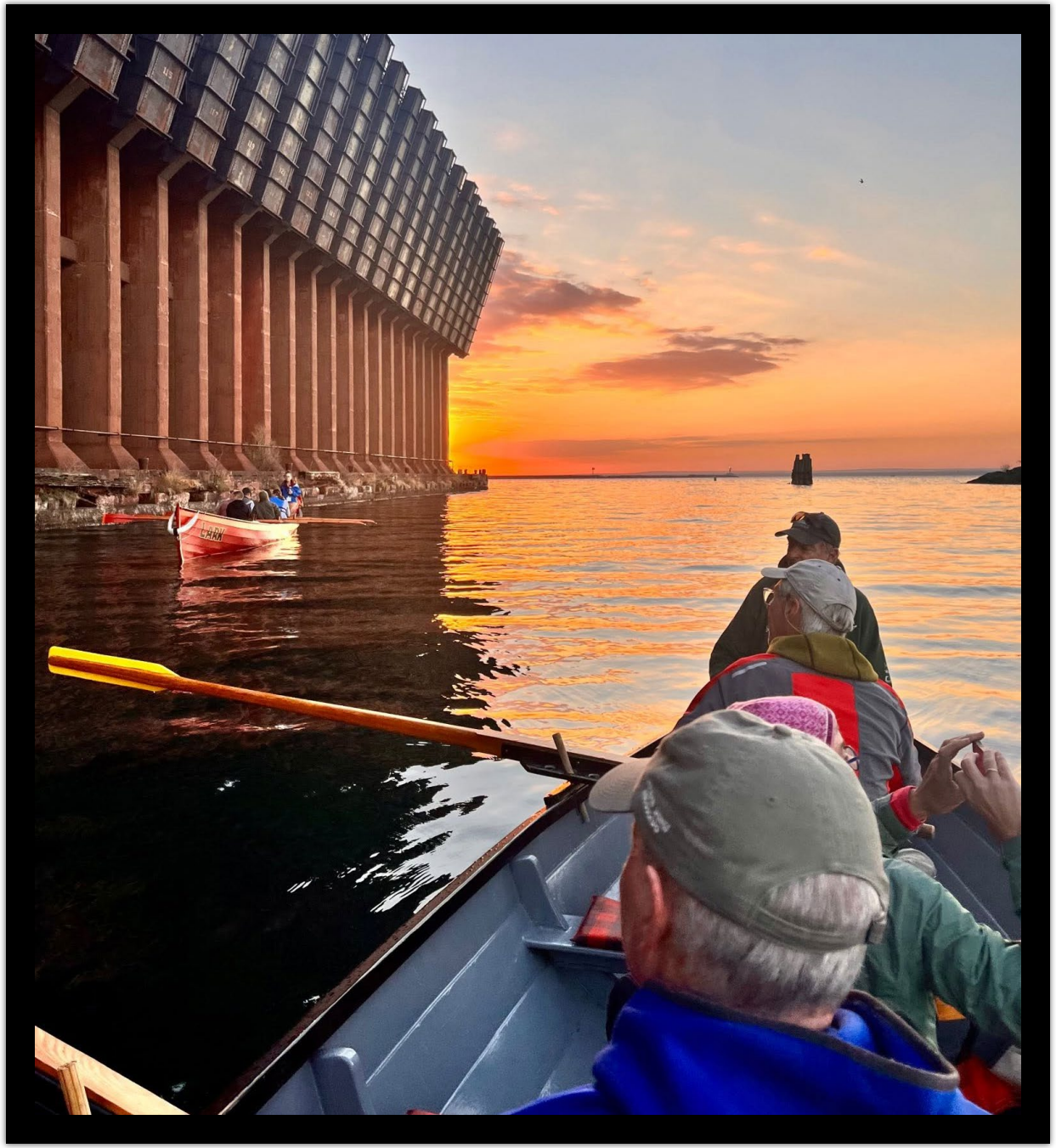
- ITLS (International Trauma Life Support)
- PHTLS (National Association of Emergency Medical Technicians)
- Geriatric EMS (National Association of Emergency Medical Technicians)
- Transport Professional Advance Trauma Course (Air & Surface Transportation Nurses Association)
- Pediatric Advanced Transport Course (Air & Surface Transportation Nurses Association)

HOSPITAL

- Advanced Trauma Life Support (American College of Surgeons)
- Emergency Nursing Pediatric Course (Emergency Nurses Association)
- Trauma Nurse Core Course (Emergency Nurses Association)
- Advanced Trauma Care for Nurses (Society of Trauma Nurses)
- Trauma Care after Resuscitation (TCAR Education Programs)
- Pediatric Trauma Across the Care Continuum (Society of Trauma Nurses)
- Rural Trauma Team Development Course (RTTDC)

TRAUMA PROGRAMS

- TOPIC / Rural TOPIC (Society for Trauma Nurses)
- ICD-10 course (American Trauma Society)
- Trauma Program Management Course (American Trauma Society)
- Trauma Registry Course (American Trauma Society)
- Abbreviated Injury Scale (Association for the Advancement of Automotive Medicine)
- Stop the Bleed (American College of Surgeons)
- Injury Prevention Professionals Course (American Trauma Society)



AGENDA

Member announcements

Public Comment

Compendiums

ADJOURNMENT

R8MCAN.ORG
MI.GOV/TRAUMASYSTEM
FB: R8TRAUMA
NELSONL7@MICHIGAN.GOV