NASEMSO Trauma Manager Council Survey

Email to the TMC - Greetings, all. The American College of Surgeons Committee On Trauma continues to work on the "National Trauma System". The ACSCOT is now focusing on 4 areas; Governance, Data Linkages, Research, and a Military/Civilian Workforce for readiness if this will moves forward with the military. A Governance Workgroup has convened and Dia Gainor and I have joined this workgroup representing NASEMSO. Attached is a Proposed Minimum Trauma System Criteria that we would like you to review. The ACSCOT has asked for a quick turn-around on responses; would you be able to review and share your responses to me by 8/14/17. Please review and if you have any comments please send them to me individually. I will create a log of the responses. Thank you! Carole

PROPOSED MINIMUM TRAUMA SYSTEM CRITERIA

1. The trauma system should address the full spectrum of injury, from prevention through EMS, acute care, rehabilitation, and re-integration into society, and should address the needs of special populations	**2. Statutory authority to enable development and implementation of the trauma system. Establishment of a lead agency with sufficient authority to make and enforce policy and administrative rule.**	**3. Establishment of a trauma advisory committee with broad stakeholder representation (ACEP, ASPER/Homeland Security, ACSCOT, DoD, NAEMT, NASEMSO, NCSL, and NHTSA)**	**4. Creation, adoption, and regular update of a Trauma System Plan.**	**5. Establishment of a process and criteria to designate trauma centers based on system need**	**6. Funding mechanism for basic infrastructure, to include at minimum a Trauma Program Manager and resources for data collection, storage, and analysis.**	**7. Authority to collect and analyze injury surveillance data, at minimum to include EMS and trauma registry data from all acute care facilities.**	**8. Provision for trauma system evaluation, including non-discoverability and confidentiality of data and the performance improvement process.**	**9. Establishment of a trauma information management system with capacity to generate reports on system operations, quality metrics, and injury epidemiology.**	**10. Integration with military facilities, disaster, and mass casualty networks.**
Answers from the Trauma Manager Council									
No comments here and largely agree with the statement regarding addressing the full spectrum of injury.	When a state was evaluated by the college this was one of the recommendations but without high level commitment or continued siloing of partners at the federal, state, local level this is difficult to achieve. The key word is **sufficient authority.** Who will have that authority? The Feds? The College? When at the state level we have difficulty with this.	Is this at the federal level? If so, broad stakeholder representation needs to ensure that those that are responsible for pushing this potential criteria at the state level are involved.	What kind of plan? Is this plan operational? Or merely a system information document that is updated every few years.	While such criteria does exists, very few states have that authority or the political will to take on such an issue especially when those that are making those recommendations (ACS) won't follow their own recommendations. If this is to succeed which in my view is a good idea, it will need to be pushed down from the Feds.	No comments here. Agree with statement.	I agree with this statement, however with no funding mechanism in place, this stands to be a difficult task. But would this be evaluated at a national level? Or left to states to evaluate and report on.	No comments here.	Again, will this be a national system evaluated at the national level with states/centers/EMS submitting data such as the NTDB/NEMSIS data set? While I agree with the recommendation, I do have concerns over the ownership of such data and how it may potentially be utilized.	Needs to be spelled out more. There are Federal Medical Stations, DMAT's etc. that respond to national level events/disasters and are integrated. Am not sure what their thought on this is.
Would you be able to tell us more about the governance part of the national trauma system initiative is? What is the overarching goal? What are the implications for example, of not being integrated with military facilities-- would that mean a state system wouldn't be considered a trauma system by the COT (and potentially the feds at some time in the future)? What is the definition of military facilities? Hospitals? The clinic at the national guard post? If a state system/national system/regional system does not have authority to get trauma data from all acute care facilities, is there an impact on being considered a trauma system? (This is not the case in WY, but might be in others). I think it is a great condition for having a registry, but it doesn't really say there should be statistical *support* to actually look at the data that the information management system would contain.	My state has the authority to govern the trauma system. When we last ran into some questions in regard to some ACS verification standards potentially not met, we asked the ACS if they had any ability to monitor or issue corrective action for one of our ACS verified facilities, we were told they did not provide that service. In order for the ACS to govern a National System, I would think that they would also need to provide the oversight of legal issues and corrective actions. Just how is that going to work	Perhaps add ENA and STN	Adoption of a Trauma Plan. The NE Trauma Program is required by statute to have a Trauma Plan, however, it has not been updated since 1996. When I reached to other states for copies of their plans, only a handful of states had them to share. The reason ours has not been updated is that we have not had the staff time to do it. A model guide from the ACS would be helpful.	Criteria based on need. The NE Trauma Program does not have the criteria to designate based on need in current statute or regulation. NE is currently a voluntary and inclusive system, so this would require a culture change in our state and also Dept. approval to revise legislation and regulations. The process to change rules and regulations or legislation can take several years. Recently, there has been an executive order by the Governor on Regulatory Reform so the trend has been to eliminate red tape and regulations, not to add them. We would have a hard time meeting this standard.	Would be wonderful	Already done in my state	Provision for evaluation. The NE Trauma Program does not have the staff to perform an extensive evaluation of the trauma program. In 2016, we received a grant to do a BIS evaluation with the ACS, if we would have not had the grant funding, we would have not been able to afford the evaluation. Our current funding source is not supporting the growth of the program and there is not support to seek current funding at this time through the legislative process. I do not know how our state would pay for such an evaluation if it were required and not funded by some entity other than the state, so we would be out of compliance.	Information management system. The Trauma Program currently has a portion of an FTE that supervises our registrar and runs some of our reports. We could not afford a full-time epidemiologist. I do not know how our state would fund such a system, we would be out of compliance.	Integration with the military. My state Trauma Program currently does not interface or collaborate with these entities on a regular basis. Currently, our program is organized under community and rural health. To interact with the entities here would perhaps require a Departmental reorganization of our program, which I don't foresee in the near future. We would be out of compliance.

My state does this	If we are looking at these minimum criteria from a state perspective I have no objection. My state is meeting or exceeding these criteria, except for needs based designation (which has been a very hot topic for many years without any traction). If ACS is recommending that these criteria be "managed" at a federal/national level I'm not sure it's realistic. I also hope that the Members to Engage list would be more inclusive. I just sat through an ACS site review as an invited guest and found it disturbing that nursing reviewers are not a part of the team. Interesting stuff on the horizon for sure		Not being privy to the discussion I confess I'm not completely clear on the purpose for the minimum standard. It would seem to me it's most effective to publish minimum standards when systems are just beginning. Why now? Are our systems lacking in minimum standards? Is it anticipated these standards will be substantially different from Model Trauma System Planning and Evaluation? My observation is that this is not a nascent system, many of the states have had statue and rules in place for years as were ours (albeit without the funding) which should define minimum standards. The other observation I have is the Public Health Model the 2006 Document was based on is still, in my opinion, the best approach to develop (or to be more accurate, sustain) a trauma system.			ED Injury Data	Already done in my state	Already done in my state	My sate has regulatory responsibility that does not translate well with the federal initiatives and federal conclaves
I agree with the thoughts others have already put forth about "minimum criteria" and the need for more specific definitions of some of the terminology. The 10 proposed criteria, are at first glance, a basic starting point, but I know from my perspective (which serves the rural population), I have an issue with ACS being the "lead agency with sufficient authority to make and enforce policy and administrative rule" when they are not the designating body, the States are. The ACS does not support or focus on the rural trauma system, so this will not serve states that have rural districts, like Montana. We have far more Level V trauma centers than anything else in my system, and ACS does not even recognize a Level V. To bring a rural perspective to ACS would require a huge change in their internal culture, which I do not anticipate happening anytime soon.	In all, to put all 10 of these criteria into action for each state would require MAJOR rule/regulation/statute changes for every single state on at least one of the criteria. Whether that is to designate based on need, require registry data from all acute care hospitals, integration with military facilities etc… Is that what the proposal is in order to gain a national system? Align all of us with these exact same criteria so that all the states match? A difficult task, at a minimum!			"Establishment of a process to designate based on system need"…we've had this discussion before. Most of our states do not have the ability to limit designation of centers in our rules. Again, this would only serve the larger, urban centers.				