NORTH CAROLINA EMERGENCY MEDICAL SERVICES
ADVISORY COUNCIL

Department of Health and Human Services
Division of Health Service Regulation
Office of Emergency Medical Services

Virtual Meeting

November 14, 2023
11:00 A.M.

Members Present

Kim Askew, MD
Jim Albright
Andrew Baird
Todd Baker
Robert Bednar
Barry Britt
John Grindstaff
Douglas Swanson, MD
Kimberly McDonald, MD
Roberto Portela, MD
Chuck Elledge
Pascal Udekwu, MD
R. Darrell Nelson, MD
Brian Pearce
Robert Poe
Sarah Rivenbark
Gail Shue
Kevin Staley
Jefferson Williams, MD
Matt Womble

Members Absent

William Atkinson, PhD
Jim Gusler
Viola Harris

Staff Members Present

Tom Mitchell
Susan Rogers
David Ezzell
Wally Ainsworth
Todd Messer
McKenzie Beamer
Chuck Lewis
Tripp Winslow, MD
Allen Johnson
Doug Calhoun
Heather Majernik
Dale Sutphin
Melynda Swindells
Anthony Davis
James Hood
Wayne Meredith, MD

Others Present

Adam Culbertson
Mallory DeLuca
Aimee Penebacker
Shelby Ferry
Alan Brooke
Gabrielle Gostigian
Amanda Barnette
Amy Chaney

Anneka Huegerich
Dale Hill
Josh Holloman
Jackie Holmes
Anjini Joiner
Chasidy Kearns
Brian Simonson
James Larsen
Angela Magill
Austin Jaynes
Chris Montera
Bradley Cooper
Brandon Locklear
Brendon Berry
Brian King
Candace Barker
Paul Seamann
Brian Simonson
Haven Stiles
Christopher Warr
Scott Williams
Carlie Dodson
Chip Meyers
Cody Golden
Corey Lee
Craig Garmer
Craig Mace
Danny Willner

Donovan Davis
Dustin Gardner
Elaina Caine
Eric Southern
Georgina Durst
Grant Hunsucker
Jared Byrd
Joel Faircloth
Joey Hundley
Joshua Lloyd
Joyce Pettengill
Joyce Winstead
Kara Clark
Karly Lynch
Katrina Schweisthal
Kelly Urban
Kevin Richards
Kim Messer
Kyle Ronn
Lee Westbrook
Melanie Belfi
Melissa Leeds
R.E. Merrill
Rhonda Phileman
Ross McKamey
Scott Suggs
Sharon Rhyne
Stephen Powell
Stone White
Thomas Nagel
Todd Doster
Travis Donaldson
David Barr
Debra Miller
Don Garner

(1) Purpose of the Meeting: The North Carolina EMS Advisory Council met virtually to receive reports/updates from Injury Committee, Compliance and Education, HealthCare Preparedness Program, Medical Director update and agency activity report. There was also a Trauma System Plan update presented by Dr. Wayne Meredith and Dr. Winslow reported on the Scope of Practice changes.

(2) Actions of the Council:

Dr. Kim Askew, Co-Chairman of the Council, called the meeting to order at 11:00 a.m.

a) Motion was made by Dr. Portela, seconded by Mr. Albright, and unanimously approved that:

RESOLVED: The EMS Advisory Council minutes from the August 8, 2023 meeting be approved.

b) Motion was made by the Injury Committee, seconded by Dr. Swanson and unanimously approved, that:

RESOLVED: Atrium Health Cabarrus Level III trauma center designation be renewed through August 31, 2027

Explanation: Atrium Health Cabarrus was reviewed on August 23, 2023. Many notable strengths were found and there were no deficiencies or weaknesses.

c) Motion was made by the Injury Committee, seconded by Mr. Pearce and unanimously approved, that:

RESOLVED: Atrium Health Cleveland Level III trauma center designation be renewed through August 31, 2027

Explanation: Atrium Health Cleveland was reviewed on August 30, 2023. Many notable strengths were found and there were no deficiencies.

d) Motion was made by the Injury Committee, seconded by Dr. Nelson and approved, with two abstentions Sarah Rivenbark and Robert Bednar, that:

RESOLVED: Novant Health Presbyterian Medical Center's Level II trauma center initial designation be approved through August 31, 2024

Explanation: Novant Health Presbyterian Medical Center was reviewed on August 2 and 3, 2023 in a joint review with the ACS for consideration of a Level II initial trauma center designation. Many strengths were found; however, one deficiency was found by the ACS

(3) Other Actions of the Council:

(a) Mr. John Grindstaff reported the following Injury Committee update:

- Atrium Health Cabarrus Hospital was visited on August 23, by a NCOEMS survey team and NCOEMS staff for the consideration of re-designation visit as a Level III Trauma Center. As noted in your report there were several notable strengths. There were no deficiencies found and no weaknesses noted. Some recommendations were made by the survey team. OEMS staff recommendations are that Atrium Health Cabarrus receive re-designation as a North Carolina Level III Trauma Center for a period of four years through August 31, 2027.
- Atrium Health Cleveland Hospital was visited on August 30, by a NCOEMS survey team and NCOEMS staff for the consideration of re-designation visit as a Level III Trauma Center. As noted in your report there were several notable strengths. There were no deficiencies found. Some weaknesses were identified, and recommendations were made by the survey team. OEMS staff recommendations are that Atrium Health

Cabarrus receive re-designation as a North Carolina Level III Trauma Center for a period of four years through August 31, 2027.

- Novant Health Presbyterian Hospital in Charlotte was visited on August 2 & 3, by and ACS survey team and NCOEMS staff and on August 8 by a NCOEMS survey team for the consideration of a Level II verification and designation. The purpose of 2 site visits was to satisfy current NC Rule requirements regarding the composition of survey teams. As noted in your report there were several notable strengths found by both ACS and NCOEMS survey teams. The ACS survey team found one deficiency of which documentation has already been received by the NCOEMS office showing correction of the deficiency. The NCOEMS survey team found no deficiencies. OEMS Staff recommendations are that the Novant Health Presbyterian Hospital be awarded Level II designation for a period of one year through August 31, 2024, with the ability to extend designation for a period of 2 years through August 2026, following the submission of documentation demonstrating the correction of the remaining deficiency no later than June 2024.
- Duke University Hospital has submitted documentation showing the correction of their deficiency from their November 2022 site visit. Per the previous report to this council, their designation as a Level I trauma center has been extended to the full designation period, ending on December 31, 2025. Additionally, their ACS verification has also been extended to December 1st, 2025.
- Caro Mont Regional Medical Center has submitted documentation showing the correction of their deficiencies from their November 2022 site visit. Per the previous report to this council, their designation as a Level III trauma hospital has been extended to the full designation period, ending on November 30th, 2026.
- The University of North Carolina Hospitals Chapel Hill Campus was visited on October 11 & 12, 2023. We are still waiting for the ACS report and will present recommendations at the February Advisory Council meeting.
- Upcoming site visits –Atrium Carolinas Medical Center (December), Womack Army Medical Center Focused review (December), Eastern Carolina University Hospital (January)

(b) Dr. Wayne Meredith gave an update on the North Carolina Trauma System Plan:

- Approximately a year ago, in August, began to refresh the North Carolina Trauma System Development Plan, which has not been done for many years. A task force was designed to oversee this mission-The Executive Steering Committee.
- Executive Steering Committee met every other week to review gap analysis between the states prior College of Surgeon's Trauma Center Consultation visit and a gap analysis that the Committee on Trauma had done and reviewed other state system legislation that had been done more recently to determine what that gap analysis would be.
- Nine subcommittees were created to address and work on the issues in the document that was created. The subcommittees are
    - ✓ Administrative & Leadership Committee

- ✓ Pre-Hospital Committee
- ✓ EMS Disaster Committee
- ✓ Trauma Center Committee
- ✓ Non-Trauma Center Committee
- ✓ Injury Prevention Committee
- ✓ Data and Performance Improvement Committee
- ✓ Rehabilitation Committee
- ✓ RAC Committee

- A vision statement was written for each committee, which was a task list for them to describe.
- An expansive Stakeholder list was created for each committee because, in the previous iteration of this, there was a very well informed trauma group who pulled together a document that was then taken to the subcommittees, to the Medical Care Commission and to ask for a state enabling legislation; however, it was realized after the completion of this document that Stakeholders had to be involved as much as possible.
- Presently, the committees are working on a vision statement (for details, see attached PowerPoint).
- There is a need to involve non-Trauma Centers more. The state trauma system did not contribute sufficiently to the Injury Prevention Community.
- There was a time when the trauma system was very tightly webbed to the Disaster Management and Emergency Preparedness Community, and it is felt we are not adequately serving that group any longer. We need to be a good servant to what their needs are in the State Trauma System.
- RACs (Regional Advisory Committees) are very variable and need consistency in what the RACs requirements are, what they are required to do, and job description of the RAC Coordinator and the relationships of the RACs to the Trauma System.
- The state has many Injury Prevention Programs in progress. All designated Trauma Centers must have an Injury Prevention Program. There are some collaborative efforts between Trauma Centers to do injury prevention; however, the Injury Prevention Program in each Trauma Center is it's own free-standing entity and does not coordinate well with any of the broader large Injury Prevention Coalitions in the state. It is believed the Trauma System should serve as a resource to the Injury Prevention Programs and that the RACs have the ability to be more powerful if they are coordinated, working on a common database, and working towards common goals.
- Non-Trauma Centers are not adequately engaged in the Trauma System. It has been discussed having Level IV Trauma Centers, which can increase the participation by what is now non-trauma centers. However, the expense, resources and people we would have to hire to do trauma center designations, supporting them, supporting their data structure, supporting their PI structure, it is believed that we would be better off spending those resources, if they can be obtained, to help all of the non-trauma centers to participate in the RACs and, thereby, get more from the RAC, have the RAC give more to the non-trauma centers and have the Trauma Centers give more to the non-Trauma Centers.

- Performance Improvement and Data Quality were combined to develop a systemwide Quality Improvement Process.
- Presently, the RACs are all different in terms of what they do, how they do it and how they relate to EMS. They have been asked to identify how they relate to the non-trauma centers; non-trauma centers are not participating in the Trauma System and a way for them to participate is through the RACs. A list of responsibilities of the RACs is needed to help standardize the position and responsibilities across the RACs. Define a relationship between the RAC and the Trauma System. A possibility on how to do this is to create a Trauma Regional Specialist position, such as the EMS Regional Specialist in Education, etc. The Trauma Regional Specialist would be a liaison between the RACs and EMS. The RACs could report to the Trauma System via the Traum Regional Specialist.
- The goal is to create a North Carolina Rehabilitation Society for rehabilitation professionals so they can have a society with whom we can collaborate, as a state trauma system, to improve rehabilitation resources and rehabilitation programs.
- Trauma Centers Committee is the most well developed part of our Trauma System. We have a very robust designation process, all the trauma centers meet on a regular basis to discuss issues and they work very well with OEMS and pre-hospital. However, they need to develop a mechanism to respond to continuing population changes, so it can be decided where trauma centers need to be, based on population and need availability.
- Subcommittees have been working on the issues with broad Stakeholder representation. All has come together very well and they have zeroed in on writing a document that addresses each issue. We are beginning to see first drafts and should be finished by the end of this year.
- Next step is for the Executive Committee to take these drafts, review them and possibly return some for more clarity and changes. In some situations, the Executive Committee will make those changes. There will probably be a period in which the Executive Committee will have to arrange meetings between the various committees due to lack of information. A document will then be written and distributed to all of the Stakeholders, through the committees, to receive feedback. Then all will be sorted according to which can be done in policy and approved by OEMS and the Council and which need a new state rule.

(c) Mr. Wally Ainsworth gave the following rules update:

- 25 Rules are in the process for amendment.
- We are currently in the public comment period, which ends at the close of business today. Any changes made due to the received comments will be submitted by mid-January.
- The next step in the process will be the Medical Care Commission meeting on February 9, 2024. If approved, they will be forwarded to the Rules Review Commission meeting on March 3, 2024. Once approved by the Rules Review Commission the proposed Rules will become effective April 1, 2014.

(d) Mr. Robert Poe gave the following Compliance and Education update:

Credentialing and compliance:

- For the timeframe of 8/1/2023 through 10/30/2023, the Credentialing unit issued 1480 credentials with 190 Paramedic credentials issued; that is 13% of all credentials issued.
- Data shows wait time for credentials accounts for the lag in issuing. Legal recognition is processed within 18 days for those that require fingerprinting, same day turnaround for those not needing fingerprinting. Testing turnaround is approximately 22 days if fingerprinting is necessary and same day if not.
- From August through October 2023, an average 29% of all cases heard by the Disciplinary Committee were due to violent offenses. DWI attributed to 17% and sexual related charges were at 11%. Patient care was 5% of the cases heard.

Education:

- There are currently 40 fully accredited institutions with 20 under leter of review; that's a total of 60. There's a growing trend of EMS agencies seeking accreditation.
- Non-accredited institutions have been allowed to offer AEMT programs due to no current accreditation standards. CAAHEP will begin voluntary AEMT accreditation on January 1, 2025
- Program Coordinator workshops for 2024 will be held at the Administrators Symposium in Wilmington on March 5 and 6th, at the NC EMS Expo in Greensboro on April 26th and 27th and at the Administrators summer symposium on July 30th and 31st. Attendance has been capped at 40, which is an increase from 30.
- Current courses ending on 12/31 are 21 Paramedic courses, 20 Advanced EMT courses and 119 basic EMT courses.
- Program handbook is being finalized and will be released soon; hopefully by December 1.

(e) David Ezzell gave the following HPP update:

- The Hospital Preparedness Program (HPP) five-year grant cycle is coming to an end. New application will be going out for the next five-year cycle. A new strategic plan is being developed for the next five-year cycle that will incorporate the program's vision, goals and values into the day-to-day responsibilities, while remaining nimble to changing grant guidance
- The HPP five-year strategic plan is to quantify, measure, promote capabilities, resources and the value of the HPP. People are unaware of the program until there is a need. The plan is to let them know prior to a need. There is staff and coalition partners that do things a little differently across the board and the goal is to be sure all partners are getting the same level of service. Lastly, there must be overall program sustainability by continuing to diversity the grand fund, working with the general assembly to see about possible appropriations and to research alternative resources for program income
- Insure we are being good stewards of the money received from the federal HPP grant and maximize those funds to meet the mission, goals and objectives of the North Carolina Healthcare Preparedness Program. Funding allocations for the Healthcare Coalitions is being updated with a

target date for implementation of July 1, 2024, the start of the new five-year cycle.

- Plan updates to the NCOEMS Emergency Operations have been posted on the website at HPP.nc.gov. Staff is being trained to ensure response readiness. Exercises are coming up for staff, as well as the MDH, in about two weeks.
- There will be a healthcare disaster track at the upcoming EMS Expo
- In February, there will be a Mobile Disaster Hospital "show and tell". MDH equipment will be set up to show capabilities. Invitations will be going out soon.
- HPP staff had the opportunity to meet with the HPP programs and Public Health programs across FEMA region IV last week in Asheville. It was discovered that many states have communication problems due to being territorial. However, North Carolina does not face any of these problems. Everyone works together.

(f) Dr. Tripp Winslow gave a Scope of Practice Changes presentation:

<u>Medications:</u>

- Approval was expanded to AEMT level for antibiotics, antivirals, tranexamic acid (TXA), steroid preparations, antiemetic preparations, magnesium sulfate and monoclonal bodies
- Approval was expanded to EMT and AEMT levels for nitrous oxide and calcium paste
- Approval was expanded to the EMT level for glucagen and immunizations in conjunction with Public Health

<u>Skills:</u>

- Manual defibrillation has been expanded to AEMT scope of practice
- Chest decompression has been expanded to AEMT scope of practice in patients who are in traumatic cardiac arrest only

<u>Specific Skill changes related to antipsychotics:</u>

- Paramedics and AEMTs can now administer all typical and atypical antipsychotics. They have access to oral and injectable antipsychotics.
- EMTs now have access to oral typical and atypical antipsychotics if the patient has already been prescribed those medications
- Between January 2023 and June 30, 2023 EMS in North Carolina took care of 82,525 patients with some type of behavioral or psychotic complaint. During this time, they only had to administer medications for agitation to 3,325 of those patients. This show we have good protocols and procedures in place and don't have to administer medications to everyone.
- Reason for expanding antipsychotics was for patient and provider safety. If a fast acting oral medication can be offered, rather than an injectable, it provides for increased patient autonomy, enhances therapeutic partnerships, there's less patient anxiety and it increases provider safety. It also increases safety because, in general, oral medications have a better safety profile.
- EMS also has access to long-acting antipsychotics. Long acting atypical and typical antipsychotics may only be used by Paramedics and AEMTs in specific pilot programs approved by the Medical Director of NC OEMS and by the DHHS Chief Psychiatrist in consultation with the State Health

Director. The programs will be monitored by the DHHS Chief Psychiatrist and the OEMS Medical Director.

- These standard operating procedures (SOPs) are optional; there is no OEMS deadline to act
- NCCEP is not planning any immediate updates
- Systems that choose to utilize these changes can update their local protocols
- Local education to address the new SOP will ne needed
- If implementing, systems must submit a modification packet to the OEMS for review and approval. Please contact your OEMS regional specialist

(g) Dr. Tripp Winslow gave the following Medical Director update:

- Continuing to move forward with scope of practice changes
- Continuing to monitor airway forms and Ketamine

(h) Mr. Tom Mitchell gave the following agency update:

- EMS Administrators across the state were encouraged to join the North Carolina Association of EMS Administrators and the North Caroline Association of Rescue and EMS if they had not already. The OEMS works with both of these organizations on topics related to EMS in North Carolina. They are an advocate, promote change through their legislative liaisons and keep updated on things going on in EMS at the state and national level
- After the passage of the budget by the General Assembly, HB 125 was passed and signed by the Governor on 10/2/2023. It was originally a Safe Surrender of Infants Bill that made crossover and was amended to make changes to approximately thirteen different pieces of legislation. Part of the Bill extended the flexibility for staffing of Non-Emergency Transport Providers statewide until May 11, 2024. OEMS will be meeting with these stakeholders to discuss a plan moving forward. The staffing waiver is still available to Emergency Providers, upon request

There being no further business, the meeting adjourned at 12:04 pm.

Minutes submitted by Susan Rogers

NC Trauma System Plan

Administrative, Governance & Funding Committee

- Define relationships between trauma system and state departments/divisions other than OEMS
- Define the administrative structure necessary to maintain a system-wide quality improvement process Define the structure to ensure that trauma clinical leadership is organized into a unified team to champion the direction of the system using the state trauma plan.
- Define the administrative structure and funding for providing system administration and data analysis support within the OEMS as needed to link and maintain the multiple new and existing databases.
- Define the administrative structure to ensure OEMS participation is included in appropriate components of the STAC, NCCOT meetings or other appropriate state trauma meetings to ensure interaction with trauma system leadership, and key trauma stakeholders.
- Consider the governance of trauma system, including relationship between OEMS, STAC, NCCOT, RACs, etc.

Administrative, Governance & Funding Committee (continued)

- Define the administrative structure to ensure that the trauma system engages in regular evaluation of all licensed acute care facilities that provide trauma care to trauma patients and designated trauma hospitals.
- Ensure that financial resources exist that support the planning, implementation, and ongoing management of the administrative and clinical care components of the trauma system.
- Develop suggestions to improve Regional organizational structure. Define roles, responsibilities, authority, and reporting structure.
- Define a mechanism to ensure the impact of continued population changes on the trauma centers and the trauma system, to include EMS resources, is identified and utilized in trauma system planning.
- Identify PI-related RAC activities that are at least partially state supported to augment other grant support and the in-kind contributions provided to RACs by trauma centers.
- Define the new system-wide quality improvement process with clearly defined authoritative roles within the lead agency (OEMS) and facilitative roles within the RACs.
- How does the Trauma System support hospitals in their quest to become trauma centers and how to engage Non-Trauma Centers in a Trauma system

Emergency Management Committee

- Define a structure and process whereby emergency management, disaster preparedness, and healthcare preparedness (HPP) are engaged in and collaborative with the state trauma system and trauma system PI process.
- Define a structure and process to ensure trauma system is engaged in State disaster planning process
- Collaborate with HPP and ensure disaster preparedness education to trauma centers, RACs and EMS
- Collaborate with HPP to assess and maximize any ASPR funding to enhance medical surge capabilities of TC.

Injury Prevention Committee

- Define the structure to collect data from a broad coalition of stakeholders and appropriate sources used to refine injury prevention targets specific to North Carolina.
- Coordination of prevention programs within RAC and between RACS.
- Coordination with statewide and local community health surveillance.
- Identify Data needs Identify Data that can be provided to the state on Injury Prevention work. Establish priorities and further injury prevention efforts by trauma systems.
- Increase opportunities for collaborative injury and violence prevention in priority areas.
- Implement a statewide injury and violence prevention initiative.

Non- Trauma Center Committee

- How to engage Non- Trauma Centers in a Trauma system.
- Identify how the Trauma System support hospitals in their quest to become trauma centers.
- Identify the responsibilities of NTC to RAC
- Identify the needs of NTC from the RAC.
- Identify the impact of continued population changes on the trauma centers and the trauma system, to include EMS resources, is identified and utilized in trauma system planning.
- Develop the appropriate structure for the trauma system to engage in regular evaluation of all licensed acute care facilities that provide trauma care to trauma patients and designated trauma hospitals.
- Ensure where appropriate that Non-Trauma Centers are engaged in the STAC and trauma system PI process.
- Define data needs from non-Trauma centers to support the Trauma System and the process to obtain data.

Performance Improvement, Data, Quality & Research Committee

- Develop a system-wide quality improvement process with clearly defined authoritative roles within the lead agency (OEMS) and facilitative roles within the RACs is required.
- Describe system to use data trending to plan System and RAC Performance Improvement and educational programs.
- Develop a coordinated statewide plan to conduct research to improve the overall Statewide Trauma system.
- Develop the appropriate structure for the trauma system to engage in regular evaluation of all licensed acute care facilities that provide trauma care to trauma patients.
- Engage emergency management, disaster preparedness, and healthcare preparedness in the STAC and trauma system PI process.
- Develop system in which Injury surveillance is coordinated with statewide and local community health surveillance.
- Engage rehabilitation services representatives in STAC and trauma system PI.
- Develop plan to Promote and support integrated data systems to support education, planning, injury prevention and research
- Develop plan to Promote, educate, and empower institutions and providers to reduce preventable deaths through optimized care, best practice, and development of clinical practice guidelines

Performance Improvement, Data, Quality & Research Committee (con't)

- Build a system that works toward continuous improvement through benchmarking, consultation, and adoption of best practices
- Identify source for and process for acquiring on-going, timely access to state ED and hospital data to provide a "denominator for trauma" and to assess the distribution of severe trauma patients treated within non-designated hospitals.
- Describe the data we need to perform the analysis to determine the optimal number, type, and location of trauma centers including Hospital and ED discharge, EMS data
- Define opportunities to link data across the continuum of care (injury prevention through rehab).
- Define the system administration, data management, and data analysis support within the OEMS needed to link and maintain the multiple new and existing databases.
- Define the data needed to have a system-wide quality improvement process with clearly defined authoritative roles within the lead agency (OEMS) and facilitative roles within the RACs.
- Identify the barriers and possible solutions to achieving the electronic linkage of Trauma data from a variety of sources utilizing deterministic and probabilistic methods.
- Define a mechanism to ensure the impact of continued population changes on the trauma centers and the trauma system, to include EMS resources, is identified and utilized in trauma system planning.

Pre-Hospital Committee

- Identify relationships to and participation of EMS systems in RACs including critical care transport
- Identify processes to increase collaboration between EMS and Trauma Centers
- Coordinate triage criteria and destination decision protocols to ensure transport of trauma patients to the most appropriate receiving facility within the inclusive trauma system.
- Transfer plans: Identify how to share the load equally across trauma centers within bounds of right patient, right place, right time.
- Establish triage criteria and destination decision protocols to ensure transport of trauma patients to the most appropriate receiving facility within the inclusive trauma system.
- Identify ideas to engage EMS medical directors, ACEP, EMS directors in the trauma
- Collaborate with NCCEP on statewide trauma destination guidelines standards
- Identify the impact of continued population changes on the trauma centers and the trauma system, to include EMS resources.
- Define the appropriate structure to use data trending to plan System and RAC Performance Improvement and educational programs. Work with RAC, Research, and PI/Data subcommittees.
- Identify ideas to ensure safe transportation of children in ambulances.

RAC Committee

- Identify ideas on how to engage NTCs.
- Develop RAC Coordinator position descriptions, standardized across all RACs.
- Identify ways to improve engagement with OEMS Regional Specialists – include possible Trauma regional specialist and other OEMS staff
- Define reporting pathways.
- Review the state of Oregon's RAC structure for relevant ideas.
- Consider RAC boundaries and definitions.
- Review overarching principles for defining a RAC boundary
- Develop criteria for RAC boundaries
- Consider reevaluating appropriate number of RACS
- Identify frequency and process for updating RAC membership
- If EMS RAC catchment areas are county-based, consider if all EMS agencies and hospitals within that county be in the same RAC.
- Define criteria for creating a new RAC and how it would become integrated into RAC system
- Define the performance to become or remain designated as a RAC

RAC Committee (continued)

- Develop Regional organizational structures that are defined based upon missions and roles, reporting and communication pathways.
- Develop standardized regional trauma system development plan and a plan to implement.
- Identify the impact of continued population changes on the trauma centers and the trauma system, to include EMS resources, is identified and utilized in trauma system planning.
- Develop data trending to be used to plan System and RAC Performance Improvement and educational programs.
- Identify a system-wide quality improvement process with clearly defined authoritative roles within the lead agency (OEMS) and facilitative roles within the RACs.
- Develop the appropriate structure for the trauma system to engage in regular evaluation of all licensed acute care facilities that provide trauma care to trauma patients and designated trauma hospitals. Such evaluation involves independent external reviews.

Rehabilitation Committee

- Define the structure whereby rehabilitation services representatives are engaged in STAC and trauma system PI.
- Define the standards, consistent with the ACS designating rules, within the trauma system plan for rehabilitation services including interfacility transfer of trauma patients to rehabilitation centers.
- Create a method for collection of data on trauma patients receiving rehabilitation services to be available in a timely manner to OEMS for analysis of outcomes and system needs.
- Define what adequate rehab facilities and resources are for the trauma system
- Complete resource assessment for system plan as it relates to rehab and develop process for keeping assessment up to date. Identify gaps in coverage in rehab and identify avenues within the rehab community to address those gaps.
- Consider ideas to eliminate or decrease the disparities of care in rehabilitation services

Trauma Centers Committee

- Identify a mechanism to respond to continued population changes regarding the effect on trauma centers, the trauma system, and EMS resources.
- Identify the principles by which we determine where trauma centers (Levels I-III) are designated to ensure a statewide system of appropriately located trauma hospitals, guided by an analysis of the number, type, and location of trauma patients who are now being managed by non-trauma facilities.
- Develop the appropriate structure and process for the trauma system to engage in regular evaluation of all licensed acute care facilities that provide trauma care to trauma patients