State Trauma Advisory Council

Operating Procedures

Last Updated September 2018

I. STATUTORY PURPOSE

a. The statewide trauma system was created by the Minnesota Legislature in 2005 (Minn. Stat 144.602 – 144.608). Minn. Stat 144.608 establishes the state Trauma Advisory Council (hereinafter STAC) to advise, consult with, and make recommendations to the Commissioner of Health (hereinafter Commissioner) on the development, maintenance, and improvement of a statewide trauma system.

b. The Commissioner shall adopt criteria to ensure that severely injured people are promptly transported and treated at trauma hospitals appropriate to the severity of injury. Minimum criteria shall address emergency medical service trauma triage and transportation guidelines as approved under section 144E.101, subdivision 14, designation of hospitals as trauma hospitals, inter-hospital transfers, a trauma registry, and a trauma system governance structure.

c. The Commissioner shall base the establishment, implementation, and modifications to the criteria on the department-published Minnesota

comprehensive statewide trauma system plan. The commissioner shall seek the advice of the STAC) in implementing and updating the criteria, using accepted and prevailing trauma transport, treatment, and referral standards of the American College of Surgeons, the American College of Emergency Physicians, the Minnesota Emergency Medical Services Regulatory Board, the national Trauma Center Association of America, and other widely recognized trauma experts.

d. The Commissioner shall adapt and modify the standards as appropriate to accommodate Minnesota's unique geography and the state's hospital and health professional distribution and shall verify that the criteria are met by each hospital voluntarily participating in the statewide trauma system.

II. MEMBERSHIP

a. The STAC shall consist of 15 members; 13 are Commissioner appointed members (i-xiii), and two positions are non-Commissioner appointed members (xiv-xv):

   i. A trauma surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

   ii. A general surgeon certified by the American Board of Surgery or the American Osteopathic Board of Surgery whose practice includes trauma and who practices in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

   iii. A neurosurgeon certified by the American Board of Neurological Surgery who practices in a level I or II trauma hospital;

   iv. A trauma program nurse manager or coordinator practicing in a level I or II trauma hospital;

   v. An emergency physician certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

   vi. Trauma program manager or coordinator who practices in a level III or IV trauma hospital;

   vii. Physician certified by the American Board of Family Medicine or the American Osteopathic Board of Family Practice whose practice includes emergency department care in a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

viii. A nurse practitioner, as defined under section 144.1501, subdivision 1, paragraph (h), or a physician assistant, as defined under section 144.1501, subdivision 1, paragraph (j), whose practice includes emergency room care in a level IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

ix. A physician certified in pediatric emergency medicine by the American Board of Pediatrics or certified in pediatric emergency medicine by the American Board of Emergency Medicine or certified by the American Osteopathic Board of Pediatrics whose practice primarily includes emergency department medical care in a level I, II, III, or IV trauma hospital, or a surgeon certified in pediatric surgery by the American Board of Surgery whose practice involves the care of pediatric trauma patients in a trauma hospital;

x. An orthopedic surgeon certified by the American Board of Orthopaedic Surgery or the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma and who practices in a level I, II, or III trauma hospital;

xi. A hospital administrator of a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

xii. A rehabilitation specialist whose practice includes rehabilitation of patients with major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under section 144.661;

xiii. An attendant or ambulance director who is an EMT, EMT-I, or paramedic within the meaning of section 144E.001 and who actively practices with a licensed ambulance service in a primary service area located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

xiv. The commissioner of public safety or the commissioner of public safety's designee;

xv. The state emergency medical services medical director appointed by the Emergency Medical Services Regulatory Board.

III. TERMS OF MEMBERSHIP

a. Unless otherwise mentioned below, the terms, compensation, and removal of members of the council are governed by section 15.059, except that the council expires June 30, 2015.

b. The Commissioner appointed members shall serve a four-year term. Seven of the terms are coterminous with the Governor's term (ending in early January) and six of the terms end one year later. The Commissioner of Public Safety (or his/her designee) has no limit, and the State EMS Medical Director's term coincides with his/her position on the EMS Regulatory Board (EMSRB) as the state EMS Medical Director.

c. STAC members can reapply at the end of their term, but are limited to two consecutive terms except as noted in III.A.

d. Commissioner appointed members should communicate their intent to resign in writing to the chair of the STAC and Minnesota Department of Health staff supporting the STAC.

e. A STAC member who misses two consecutive meetings or whose attendance falls below 50% in a one year period will be contacted by MDH staff and the STAC Chair to evaluate the members' ability to fulfill their obligation to the STAC. Excused vs. unexcused absences will be considered in this evaluation.

f. Vacancies for commissioner appointed members are filled in the same membership category. Applications are made through the Secretary of State's Office of Open Appointments.

g. STAC members will annually sign a Conflict of Interest statement.

h. STAC members will not accept per diems

IV. RESPONSIBILTIES and EXPECTATIONS OF MEMBERS

a. It is the expectation that STAC members will make every effort to:

   i. Attend all meetings

   ii. Serve on committees, work groups, and other ad hoc groups as requested by the chair

   iii. Prepare for active participation in discussions and decision-making by reviewing meeting materials

   iv. Abstain from voting where a conflict of interest may exist

   v. Refrain from writing letters or engaging in other kinds of communication in the name of the STAC, unless the Commissioner specifically authorizes such communication.

V. OFFICERS

a. Chair:

   i. The chair shall be appointed by the Commissioner to a two-year term

ii. The STAC may send recommendations to the Commissioner.

iii. The chair is eligible to serve two consecutive terms.

iv. Duties of the chair are:

1. Preside at all STAC and Executive Committee meetings;
2. At the request of the Commissioner, be the spokesperson and representative for the STAC;
3. Appoint work groups and subcommittees as needed.
4. Serve on the Executive Committee

b. Vice-Chair:

i. The Vice-Chair shall be elected by the STAC

ii. The Vice-Chair will serve one, two-year term

iii. The Vice-Chair is not eligible for a consecutive term

iv. Duties of the Vice-Chair are:

1. Preside at the STAC and Executive Committee meetings in the absence of the chair;
2. Assist the chair as requested;
3. Serve on the Executive Committee

VI. NOMINATIONS, ELECTIONS and RECOMMENDATIONS

a. Nominations, elections and recommendations for office will come from the STAC as a whole, with a majority vote of those present required.

VII. MEETINGS

a. Frequency: The STAC shall meet no less than four times in a calendar year, but may meet more frequently at the call of the chair, a majority of the council members, or the commissioner.

b. Every effort will be made to annually schedule no less than four meetings for the coming year.

c. Quorum: The presence of eight STAC members constitutes a quorum at STAC meetings.

VIII. VOTING

a. At any regular or special meeting where voting is necessary, it shall be by voice unless ballots are requested by a majority of those present.

b. The Chair will determine whether there are enough members present to allow a vote.

c. The election of the Vice-Chair can be by voice or by unsigned ballots, whichever is requested by a majority of those members present.

d. The Chair will tally and report on ballot vote results.

IX. STANDING COMMITTEES

a. Executive Committee

   i. The Executive Committee will be responsible for conducting the interim business of the STAC.

   ii. The Executive Committee will consist of the chair, vice-chair and the Rural Hospital Administrator. The Chair may call other STAC members as ad hoc members of the Executive Committee based on their availability, interest, and/or expertise in the topic of interest before the Committee.

   iii. All members of the Executive Committee must be STAC members.

b. Applicant Review Subcommittee

   i. The Applicant Review Subcommittee is responsible for reviewing and evaluating applications for designation and site visit reports, and making recommendations to the STAC for action.

   ii. The Applicant Review Subcommittee will consist of:

      1. The Level I or II Trauma Surgeon;
      2. The Rural General Surgeon;
      3. The Level III or IV Emergency Department Physician;
      4. The Rural Nurse Practitioner or Physician Assistant;
      5. The Level I or II Trauma Program Manager/Coordinator; and
      6. The Level III or IV Trauma Program Manager/Coordinator.

      Other STAC members may also serve as either permanent or ad hoc members of the subcommittee.

   iii. All members of the Applicant Review Subcommittee must be STAC members.

c. STAC-EMSRB Joint Policy Committee

   i. The Joint Policy Committee is responsible for addressing EMS-related topics that affect the coordinated operation of the trauma system.

ii. The STAC-EMSRB Joint Policy Committee will consist of three STAC members appointed by the Chair and three members of the EMSRB.

X. SUBCOMMITTEES AND WORK GROUPS

a. The STAC may develop subcommittees and workgroups. Subcommittees shall consist of council members. Workgroups may include non-council members. Non-council members shall be compensated for workgroup activities under section 15.059, subdivision 3, but shall receive expenses only.

b. Up to eight regional trauma advisory councils (RTACs) may be formed as needed. RTACs shall advise, consult with, and make recommendation to the STAC on suggested regional modifications to the statewide trauma criteria that will improve patient care and accommodate specific regional needs.

c. Each RTAC must have no more than 15 members. The commissioner, in consultation with the Emergency Medical Services Regulatory Board, shall name the council members. RTAC members may receive expenses in the same manner and amount as authorized by the plan adopted under section 43A.18, subdivision 2.

XI. RESPONSIBILITES OF THE STAC

a. Trauma Care Standards: Monitor standards of care as defined in requirements

b. Hospital Designations:

   i. Review American College of Surgeons (ACS) verification documentation from Level I, II, Level I Pediatric, Level II Pediatric, and III trauma facilities

   ii. Review non-ACS Level III applications

   iii. Review Level IV applications

   iv. Make appropriate state trauma designation recommendations to the commissioner

   v. Make other relevant designation recommendations to the commissioner based on a hospitals failure to meet the designation criteria; in the interests of patient safety; or if a hospital denies or refuses a reasonable request by the commissioner or the commissioner's designee to verify information by correspondence or through an on-site visit. These additional recommendations may include provisional designation status, change or revocation of designation, or denial of designation or re-designation.

c. System Evaluation and Improvement: Address system issues, such as:

   i. Designation process and criteria

ii. Quality of care

iii. RTAC requests

iv. Educational requirements

v. Data-supported performance measurement and improvement (PI) at the state level

vi. Registry inclusion criteria and data set

d. Funding and Grants: Provide expertise and support for the development and execution of grant opportunities

e. Legislation: Provide analysis of, and recommendations regarding relevant trauma care legislation

f. Prevention: Champion relevant public education and injury prevention initiatives

g. Emergency Preparedness: Provide leadership in connecting with state and federal emergency preparedness efforts (e.g., terrorism, pandemics, natural disasters)

XII. CHANGES TO OPERATING PROCEDURES

a. STAC members may propose amendments to these Operating Procedures during a regularly scheduled meeting of the Council.

b. STAC members will be notified of a proposed amendment at least thirty days prior to a vote on its adoption.

c. An amendment requires a favorable vote of at least two-thirds of the STAC members present for adoption.

d. An amendment will take effect immediately upon the conclusion of the meeting at which it is adopted.