

PINEY WOODS  
REGIONAL ADVISORY COUNCIL  
TRAUMA SERVICE AREA G

RAC-G

TRAUMA EMS ACUTE CARE  
AND  
HOSPITAL PREPAREDNESS  
SYSTEM PLAN

2022-23

# PURPOSE OF PARTICIPATION AND INTRODUCTION

## PURPOSE OF PARTICIPATION

The purpose of developing and participating in the Piney Woods Regional Trauma, EMS, Acute Care and Hospital Preparedness System Plan is to facilitate coordination of patient care for critically injured patients, pediatric patients and patients with acute care illnesses, and disaster preparedness through RAC-G and other surrounding counties.

The Plan has been developed under the direction of the Texas Department of Health Bureau of Emergency Management's procedures and standards for implementation of a comprehensive statewide Emergency Medical Services (EMS) Trauma System as mandated in the Health and Safety Code, chapter 773, 81-90. Healthcare Volunteers, whose sole purpose is to develop a mechanism to enhance the care rendered to the patients of East Texas in RAC-G, developed and annually review the Regional Trauma, EMS, Acute Care and Hospital Preparedness System Plan.

Each patient is a unique individual and each patient's medical condition will be equally unique. Scenarios for his or her care will almost always vary because of the unique nature of each person and the conditions causing the injury or illness even in the same geographical area or institution.

These guidelines are suggestions only. It is our intention to enhance patient care and maximize the number of clinical outcomes to the best possible. The actual treatment of any patient is the responsibility of the caregivers, both before and during hospitalization. Clinical decisions must be made based on the specific medical condition of the individual, what is believed best for him or her, and the patient's choice, if known.

This document is not intended to establish a legal standard of care for treatment of any medical condition or services rendered by any emergency medical technician, hospital, physician or patient. This is an aid to decision making in general clinical scenarios. It does not constitute medical advice for or to any individual.

The purpose of participation in the RAC-G Trauma, EMS, Acute Care and Hospital Preparedness System Plan is to facilitate coordination of a regional system for trauma patient care, pediatric patient care and care of patients with acute illness such as strokes or heart attacks. Nothing contained in this plan, and no acts by a participant under the RAC-G Trauma System Plan, shall be construed as creating the relationship of a joint venture, partnership, principal/agent or employer/employee between or among any of its participants.

Every participant in the RAC-G Trauma System Plan is solely responsible for its own activities, and each shall indemnify and hold harmless all other participants in the RAC-G Trauma System Plan, including but not limited to Trauma Directors, Trauma Nurse Coordinators and Project Medical Directors that participants function under, from any loss, costs of defenses or settlement arising out of its own negligence or wrongful acts.

## INTRODUCTION AND HISTORY

Trauma Service Area-G (TSA-G) extends from the prairies of the Black Land Belt in its westernmost region to the heavily wooded eastern Pine Belt area at its eastern border. The part is an 18-county, 13,609.2 square-mile area of East Texas spanning three different natural geographic regions. A more significant percentage of TSA-G lies within the Pine Belt of eastern Texas. This area includes the counties of Marion, Harrison, Panola, Rusk, Shelby, Trinity, Gregg, Upshur, Cherokee, Freestone, Houston, and the eastern portions of Anderson, Henderson, Smith, Wood, and Camp Counties. The western parts of the latter five counties are in the Post Oak Belt, a transitional region between the highly forested Pine Belt and the Black Land Belt.

Franklin County was re-aligned to RAC-F I in 2022. RAC-F.

Rains and Van Zandt Counties also cross two different regions, with the western portion of the counties in the Black Land Belt and the eastern parts in the Post Oak Belt.

TSA-G has an abundant water supply, containing tributaries of some of the major rivers in Texas and many lakes of varying sizes. The Pine Belt region is the source for almost all of Texas' sizeable commercial timber production. A great oil field, discovered in Gregg, Rusk, and Smith Counties in 1931, has contributed heavily to the economic growth in the area, especially during the first half of the Twentieth Century. In addition to oil, gas, natural gas, lignite, clay, and coal mining, along with sand and gravel production, are active industries in the area. This area also contributes to the beef, dairy cattle, and poultry industries. Major crops produced include hay, peaches, pecans, peanuts, and sweet potatoes. Due to the number of lakes throughout the region, water sports are abundant, including swimming, fishing, and various boating activities.

The population of TSA-G as of the 2020 census is estimated at **952,927, a growth rate of 2.85%**. Except for Smith, Harrison, Henderson, and Gregg Counties, the remainder of TSA-G is primarily rural, with a population of **454,108** inhabiting a 9581.5 square-mile area.

The two largest cities in TSA-G are Tyler in Smith County, with a population of 227,727, and Longview in Gregg County, with a population of 123,367.

As of 2021, the TSA-G death rate of patients arriving at a Trauma Center is only 2.5 percent; however, the prevention of trauma-related deaths remains a priority for TSA-G.

To continue the historical record, with the Texas Department of Health's establishment of trauma facility criteria, the first meeting of trauma care professionals in Trauma Service Area G was held on October 27, 1992.

As of 2022, this RAC System has **113** Agencies classified as members, including Trauma Centers, EMS Providers, LongTermCare Facilities, Associates, and Affiliates.

As of 2022, Franklin County was re-aligned and is no longer in RAC-G.

**History:** Every effort was made to involve all EMS agencies, hospitals, surgeons, and emergency department physicians in TSA-G. A Bylaws Ad Hoc Committee was appointed, which presented a draft of TSA-G bylaws to the Steering Committee on November 18, 1992. These bylaws were presented to the entire group of trauma care professionals on December 2, 1992, and were ratified. Officers were elected in January 1993.

**Update. RAC-G BYLAWS** were reviewed in **2016-17** and Signed by Chair and Secretary of the Board of Directors of RAC-G.

**In 2017** RAC-G Bylaws were Amended and signed by Board Chair Jerri Pendarvis, Billy Perez, Treasurer, and Stacy Gregory, Secretary of the Board. (*included in Trauma Plan behind this document*).

On December 4, 1992, a request was mailed to Mr. Gene Weatherall, Chief Bureau of Emergency Management, for recognition of the Regional Advisory Council of Trauma Service Area G. The TSA-G Regional Advisory Council was officially recognized on April 23, 1993.

Franklin, Houston, Freestone, Trinity, and Shelby Counties subsequently requested realignment into Trauma Service Area G. Realignment was approved by a majority vote of the Regional Advisory Council Administrative Council, bringing the total counties in TSA-G to nineteen.

**Standing committees** were established, and on May 5, 1993, the committee members were appointed, and chairpersons were elected. On March 16, 1995, a Trauma System Planning Ad Hoc Committee was convened at the request of the Chairperson of the Regional Advisory Council. Original membership included all chairpersons of the standing Regional Advisory Council Committees and two or three other members of each committee. Meetings were held in March, May, July, and October of 1995 and in February and June of 1996.

In addition, at the April 1995 meeting of the Administrative Council of the Regional Advisory Council, the Chairman requested that any other participants interested in participating in the development of the Trauma Plan were to ask to be included. This request resulted in the final members comprising the Trauma System Planning Ad Hoc Committee.

The Trauma Service Area G Trauma Plan was completed by the Trauma System Planning Ad Hoc Committee on June 20, 1996. The plan was presented to the Administrative Council and was approved on June 26, 1996. The Regional Trauma Plan is reviewed and updated annually as needed.

The designation process has improved care for the trauma patients at each hospital and provided valuable data from a systems perspective through the regional quality improvement process and the regional trauma registry. As of 2011, there are 33 hospitals in TSA-G, twenty-one (21) of those hospitals being Designated Trauma Centers; there are also one non-designated hospital and eleven (11) Specialty Hospitals.

There are 21 EMS agencies in TSA-G. One goal of the Piney Woods Regional Advisory Council is to develop a mechanism whereby these groups can arrive at a standard set of protocols so that the level of pre-hospital care becomes constant throughout the region.

An organized regional disaster plan for TSA-G has been activated many times since its inception. We have developed a basic model to guide EMS care during any incident that exceeds any EMS system's standard operating capabilities. This plan can serve as a guideline for those EMS systems or areas of TSA-G which presently have no organized disaster preparedness plan. Our goal was to assist in standardizing the EMS response to any disaster throughout our region in coordination with other emergency response agencies (such as law enforcement and fire rescue). Our ultimate goal is to further develop this comprehensive disaster plan specific for TSA-G through the Pre-Hospital Care and Transportation Committee of the Piney Woods Regional Advisory Council (RAC-G). One of the first steps in realizing this goal was the addition of the SMART TAG System, which unifies all pre-hospital providers with the same disaster triage system. As of 2011, this system has been used in all the hospitals throughout the RAC.

Another challenge is the relationship between trauma patient flow and managed care contracts. Although the RAC-G is a volunteer organization, we hope that through our efforts, appropriate triage decisions can be made based on sound medical decisions rather than merely financial allegiance.

Finally, the RAC-G will need to address the issue of patient flow from surrounding counties outside of TSA-G into hospitals within TSA-G. While historical referral patterns should be honored, there needs to

be a mechanism whereby quality of care issues can be addressed in this group of patients from a system perspective. The tool for reviewing these patients is contact with the Trauma Coordinator at each hospital. The hospitals outside RAC-G are not required to participate in any RAC-G activities or Performance Improvement processes.

In the year 1998, the RAC-G saw the realization of some funding for the trauma system in Texas. This critical step has furthered efforts at organized trauma care in TSA-G. The long-term goal of RAC-G is to utilize these funds to achieve the most significant system impact and to monitor this impact, specifically as it relates to our death rate.

# **ORGANIZATIONAL STRUCTURE**

## EMS AGENCIES

# RAC-G TRAUMA CENTERS MAP



## **TRAUMA SERVICE AREA-G (RAC-G) Emergency Medical Services (EMS) Agencies**

The RAC-G map of EMS agencies describes EMS areas of coverage that serve all of TSA-G. These agencies range from small volunteer services to regional EMS agencies.

Virtually all of RAC-G is covered by 911 or enhanced 911. Several agencies are dispatched by the county sheriff's office, the city police department, the fire department, or some combination of these three agencies. Many do not have dispatch protocols. Approximately one-half of the dispatch agencies provide pre-arrival instructions, and a minority have computer-aided dispatch (CAD).

Approximately one-half of the EMS agencies in RAC-G respond to calls at the level of Advanced Life Support (ALS) or Mobile Intensive Care Unit (MICU) capability with paramedics. A recent TSA-G Piney Woods RAC survey indicated that the systems responding at the Basic Life Support (BLS) level are 85% Emergency Medical Technicians (EMT) and 15% Emergency Care Attendants (ECA) trained. The survey indicated that 75-80% of RAC-G systems provide continuing education for their personnel, and all but one of the services provide monthly quality assurance reviews.

One-third of the agencies work in areas with no local hospitals. Therefore, RAC-G scene-to-hospital times may range from 5 to 50 minutes. Scene-to-Level I or II Trauma Center ground times may exceed 70 minutes, and air transport times are as long as 30 minutes from some areas of RAC-G. Two-thirds of the EMS agencies have been active in the TSA-G Piney Woods RAC formation. Most of these agencies have participated in the RAC-G Pre-Hospital Care and Transportation Committee.

The Texas Department of Health EMS Program for our region has been very helpful in distributing and collecting EMS surveys for the Pre-Hospital Committee of the TSA-G Piney Woods RAC. They serve as neutral parties with authority, sharing the goal of developing standardized trauma protocols, standardized training, and practical quality improvement activities for RAC-G.

**RAC-G EMS Agencies  
2022 Spread Sheet Included in this Section**

Name	Address	City & Zip	County	Director	Phone	Level
<b>Allegiance/Lonestar Mobile Health/EMS</b>	1724 Ball Park Rd	Carthage 75935	Panola, Shelby	Monty Cartwright	936-355-9112	BLS / MICU
<b>Camp County EMS</b>	P.O. Box 866	Pittsburg 78686	Camp	Mike Reynolds	903-856-7102	MICU
<b>CHRISTUS Champion EMS</b>	604 W. Cotton	Longview 75602	Franklin, Gregg, Harrison, Marion, Panola, Rusk, Smith, Upshur, Van Zandt, Wood	Shawn Salter	903-574-5522	MICU
Crockett FD						
<b>Fairfield EMS</b>	740 W. Commerce	Fairfield 75840	Freestone	Ignacio (Billy) Perez	903-389-6511	BLS / MICU / CAP
<b>FLIGHT FOR LIFE</b>	<b>229 Airport Drive</b>	<b>Tyler TX 75704</b>	Anderson, Gregg, & Van Zandt	Chad Solomon		
<b>Grand Saline VFD</b>	<b>NO INFO</b>					
<b>Grapeland VFD</b>	P.O. Box 567	Grapeland 75844	Houston	Tim Howard	936-546-4871	BLS / MICU / CAP
<b>Groveton EMS</b>	P.O. Box 10	Groveton 75845	Trinity	David Robinson	936-642-0911	BLS / ALS
<b>Jacksonville FD / EMS</b>	911 s. Bolton.	Jacksonville 75766	Cherokee	Alicia Whetsell	903-586-7131	ALS / BLS / MICU
<b>Longview FD / EMS</b>	P.O. Box 1952	Longview 75606	Gregg, Harrison, Upshur	Hank Hester	903-239-5530	MICU
<b>Marshall / Harrison Co. Ambulance Service</b>	P.O. Box 698	Marshall 75671	Harrison	Travis Gibson	903-935-4585	BLS / MICU
<b>Mims VFD &amp; Ambulance Service</b>	12728 FM 729	Avinger 75630	Marion	Jeanne King	903-755-4112	MICU
<b>Palestine R.M.C. EMS</b>	4000 S. Loop 256	Palestine 75801	Anderson	Matthew Davis	903-731-5398	MICU CAP
<b>Teague Hospital District EMS</b>	P.O. Box 599	Teague 75860	Freestone	William Flippin	254-739-5322	(BLANK)
<b>Timpson Volunteer Ambulance Service</b>	P.O. Box 492	Timpson 75975	Shelby	Tracy Lee	936-554-0988	ALS / MICU, BLS / MICU
<b>UT Health East Texas EMS</b>	P.O. Box 387	Tyler 75710	Cherokee, Henderson, Rusk, Smith, Wood	John Smith	903-535-5800	MICU
<b>Waskom VFD EMS</b>	P.O. Box 1757	Waskom 75692	Harrison	Bob Rodocker	903-687-3328 903-352-0152	MICU



### RAC-G Flight Programs

Name	Based At	Address	City & Zip	Phone	Director
<b>Air Evac</b>	Base 53		Fairfield 75840		
<b>Flight for Life</b>	Christus Trinity Mother Frances		Tyler 75701		Shawn Salter
<b>UT Health East Texas Air 1 Central</b>	UT Health Henderson	300 Wilson Street	Henderson 75652		
<b>UT Health East Texas Air 1 North</b>	UT Health Pittsburg	2701 Hwy. 271 North	Pittsburg 75686		
<b>UT Health East Texas Air 1 West</b>	UT Health Athens	2000 South Palestine	Athens 75751		

### Resource Flight Programs Outside of RAC-G

Name	Based At	Address	City & Zip	Phone	Chief Flight Nurse
<b>Air Evac</b>	Multiple Bases				
<b>Careflite Dallas</b>		P.O. Box 225344	Dallas 75222	214-947-8450	Monty Hunsaker
<b>Hermann Life Flight</b>	Hermann Hospital	6411 Fannin Street	Houston 77004	713-704-3502	Thomas J. Flanagan
<b>LifeNet</b>					
<b>Med Trans</b>	Schumpert / Willis-Knighton	P.O. Box 21976	Shreveport Louisiana 71120	318-227-4730	Robert P. Pringle, Jr.
<b>PHI</b>					

**Pre-Hospital Resources (Updating)**

Agency	Number	Level
Camp County EMS	5	MICU
		MICU
Christus Trinity Mother Frances dba Champion EMS	60	MICU
Fairfield EMS	10/2/13	BLS /ALS/ MICU
Grand Saline VFD	3	BLS / MICU
Grapeland VFD	2	BLS / MICU
Groveton EMS	2	BLS / ALS
Hallsville Volunteer Ambulance	2	BLS / ALS
Jacksonville FD / EMS	7/20	BLS / MICU
Longview Fire / EMS	4	MICU
Marshall / Harrison County Ambulance Service	8/35	BLS /ALS/ MICU
Mims Volunteer FD & Ambulance Service	1/1	BLS / ALS
North East Texas EMS	7	BLS / MICU
Palestine Regional Medical Center EMS	6	MICU
Timpson Volunteer Ambulance Service	1	BLS / MICU
UT Health East Texas EMS	60	MICU
Waskom VFD / EMS	2	BLS / MICU
Teague Hospital District EMS	2	BLS / MICU
Flight for Life CTMF	4	HCP
In RAC-G (CTMF-Winnsboro)	1	
In Palestine	1	
Backup in Tyler Pounds Field (RAC-G)	1	
UT Health East Texas Air 1	4	HCP
(1 is Backup at Tyler Pounds Field (RAC-G)		
Air Evac (Fairfield – Freestone County)	1	HCP

**RAC-G EMS Agency  
Medical Directors**

**Updating**

Agency	Name	Address	City & Zip	Phone
<b>Camp County EMS</b>	Blair MacBeath, MD	410 Quitman Street	Pittsburg 75686	903-856-6546
<b>Champion EMS</b>	Chris Dunnahoo, MD	604 West Cotton	Longview 75602	903-553-9901
<b>Fairfield EMS</b>	J. H. Keller, MD	632 West Commerce Street	Fairfield 75840	903-389-2181
<b>Grapeland VFD / EMS</b>	Edward G. Gitshaw, MD	2900 South Loop 256	Palestine 75801	936-687-2041
<b>Jacksonville FD EMS</b>	Rodney Caldwell, MD	530 CR 3811	Troup 75789	903-372-5999
<b>Longview FD EMS</b>	Gregg Harrington, MD	P.O. Box 1952	Longview 75606	903-239-5530
<b>Marshall / Harrison County EMS</b>	Jack Cash, MD	811 South Washington	Marshall 75671	903-935-8744 Or 903-938-8209
<b>Teague Hospital District EMS</b>	Bill Halbert, MD	315 Main Street	Teague 75860	817-739-2561
<b>UT Health East Texas EMS</b>		352 South Glenwood	Tyler 75702	903-535-5200
<b>Waskom VFD / EMS</b>	Charles Black, MD	7600 G.M. Blvd.	Shreveport Louisiana ???	313-426-9404

**First Responders / EMS Agencies  
(Listed by County)  
Updating**

COUNTY	COMPONENT	DETAILS
<b>Anderson</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Palestine Regional Medical Center EMS UT Health East Texas EMS
	First Responder Agencies	79 East 84 West Bethel-Cayuga Bradford Coffee City FD Elkhart Elmwood VFD Frankston FD Lone Pine VFD Montalba Neches VFD S-AC VEMS Inc. Southside Tennessee Colony Tucker West Side VFD
<b>Camp</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Camp County EMS
	First Responder Agencies	
<b>Cherokee</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Jacksonville FD EMS UT Health East Texas EMS
	First Responder Agencies	Earl Chapel VFD Gallatin New Summerfield VFD North Cherokee County VFD Wells FD
<b>Freestone</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Fairfield EMS Teague Hospital District EMS
	First Responder Agencies	Southern Oaks VFD Streetman VFD
<b>Franklin County has been removed from the RAC-G map. In 2022.</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Champion EMS UT Health East Texas EMS
	First Responder Agencies	Mount Vernon FD North Franklin County VFD Winnsboro FD

**First Responders / EMS Agencies  
(Listed by County) – Pg 2**

COUNTY	COMPONENT	DETAILS
<b>Gregg</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Champion EMS Longview FD EMS UT Health East Texas EMS
	First Responder Agencies	Clarksville-Warren VFD Easton FD East Texas Regional Airport Elderville-Lakeport FD Kilgore FD White Oak FD Longview FD EMS Liberty City VFD
<b>Harrison</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Champion EMS Longview FD EMS Marshall-Harrison County FD EMS Hallsville EMS Hallsville FD
	First Responder Agencies	Harleton VFD Harrison County Marshall FD Waskom FD
<b>Henderson</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	UT Health East Texas EMS
	First Responder Agencies	Athens FD Baxter VFD Berryville VFD Brownsboro VFD Calendar Lake Chandler FD Eustace VFD Gun Barrel City VFD LaRue-New York FD Malakoff VFD Murchison FD Payne Springs Poynor FD Seven Points FD Shady Oaks FD South Van Zandt County Trinidad VFD Westside FD
<b>Houston</b>	9-1-1 Type	ANI Only (no location identification)
	EMS Agencies	Grapeland EMS UT Health East Texas EMS
	First Responder Agencies	Porter Springs Kennard-Ratcliff Lovelady VFD



**First Responders / EMS Agencies  
(Listed by County) – Pg 3**

COUNTY	COMPONENT	DETAILS
<b>Marion</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Champion EMS Mims Volunteer EMS
	First Responder Agencies	Mims VFD
<b>Panola</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Allegiance EMS Champion EMS UT Health East Texas EMS
	First Responder Agencies	Beckville Carthage FD Community Four FD Flatwood FD Gary FD Inter-Community FD Woods
<b>Rains</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Champion EMS Alba FD
	First Responder Agencies	Emory FD Point FD Tawakoni FD
<b>Rusk</b>	9-1-1 Type	ANI Only (no location identification)
	EMS Agencies	Champion EMS Mt Enterprise VFD UT Health East Texas EMS
	First Responder Agencies	Church Hill FD Crim Chapel FD Henderson FD Kilgore FD Laneville FD New Salem FD Shelby County VFD
<b>Smith</b>	9-1-1- Type	ANI / ALI
	EMS Agencies	Champion EMS UT Health East Texas EMS
	First Responder Agencies	Arp VFD Bullard VFD Chapel Hill VFD Civil Air Patrol Flint VFD Lindale VFD Noonday VFD Red Springs VFD Troup VFD Tyler FD Whitehouse VFD Winona VFD

**First Responders / EMS Agencies  
(Listed by County) – Pg 4**

<b>COUNTY</b>	<b>COMPONENT</b>	<b>DETAILS</b>
<b>Trinity</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Groveton EMS UT Health East Texas EMS
	First Responder Agencies	Pennington VFD Trinity PD
<b>Upshur</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Champion EMS UT Health East Texas EMS
	First Responder Agencies	Big Sandy FD East Mountain FD Gilmer FD Glenwood Acres FD Holly Lake FD
<b>Van Zandt</b>	9-1-1 Type	ANI / ALI
	EMS Agencies	Champion EMS UT Health East Texas EMS (Mabank only)
	First Responder Agencies	Ben Wheeler VFD Calendar Lake VFD Canton FD Edgewood FD Edom FD Fruitvale FD Midway FD Myrtle Springs FD Rolling Oaks FD South Van Zandt County VFD Van FD Whitton VFD
<b>Wood</b>	9-1-1 Type	ANI Only (no location identification)
	EMS Agencies	Champion EMS UT Health East Texas EMS
	First Responder Agencies	Hainesville VFD Holly Lake VFD Mineola FD Perryville VFD Quitman FD Winnsboro FD Yantis FD

**Pre-Hospital Care and Transportation  
Committee EMS Questionnaire**

**Updating**

EMS System	Written MA Agreements	Method of Dispatch	Dispatch Protocols	Bystander Instruction
Camp County EMS	Yes	EMS	Yes	Yes
Champion EMS	Yes	EMS	Yes	Yes
Champion EMS (CTMF)	Yes	EMS	Yes	Yes
Fairfield EMS	Yes	SO	No	No
Flight for Life	Yes	EMS	Yes	Yes
Grand Saline EMS	Yes	SO, F	Yes	Yes
Grapeland EMS	No	County / City	Yes	Yes
Groveton VFD				
Hallsville EMS	Yes	SO	Yes	Yes
Jacksonville FD	Yes	City PD	Yes	No
Longview FD	No	City	Yes	Yes
Marshall FD	Yes	City	Yes	Yes
Palestine R.M.C. EMS	Yes	EMS / SO / P	Yes	Yes
Teague Hospital District EMS	Yes	EMS	No	No
Timpson VFD				
UT Health East Texas Air 1	Yes	EMS	Yes	Yes
UT Health East Texas EMS	No	EMS	Yes	Yes
Waskom VFD & EMS	Yes	SO	Yes	Yes
Wills Point EMS	Yes	SO / F / P	Yes	Yes

**Pre-Hospital Care and Transportation  
Committee EMS Questionnaire**

EMS System	Computed Items	Level of Service	Monthly QI	Continuing Education
Camp County EMS	No	MICU	Yes	Yes
Champion EMS	Yes	MICU	Yes	Yes
Champion EMS (CTMF)	Yes	MICU	Yes	Yes
Fairfield EMS	Yes	BLS / MICU	Yes	Yes
Flight for Life	Yes	MICU	Yes	Yes
Good Shepherd EMS (Champion)	Yes	MICU	Yes	Yes
Grand Saline EMS	No	BLD / 1 MICU	Yes	Yes
Grapeland EMS	Yes	BLS / MICU	Yes	No
Groveton VFD				
Hallsville EMS	Yes	BLS / ALS	Yes	Yes
Jacksonville FD	Yes	ALS / MICU	Yes	No
Longview FD	Yes	MICU	Yes	Yes
Marshall FD	Yes	BLS / ALS	Yes	Yes
Palestine R.M.C. EMS	No	MICU	Yes	Yes
Teague Hospital District EMS	No	BLS / ALS	Yes	Yes
Timpson VFD				
UT Health East Texas Air 1	Yes	MICU	Yes	Yes
UT Health East Texas EMS	Yes	MICU	Yes	Yes
Waskom VFD & EMS	Yes	BLS / ALS	No	Yes
Wills Point EMS	No	BLS / MICU	No	Yes

**Pre-Hospital Care and Transportation  
Committee EMS Questionnaire, Cont.**

<b>EMS System</b>	<b>Local Hospital Available</b>	<b>Bypass Protocols In Place</b>	<b>Average Scene-Hospital Time in Minutes</b>	<b>Piney Woods RAC Participation</b>
<b>Camp County EMS</b>	Yes	Yes	5-10	Yes
<b>Champion EMS</b>	Yes	Yes	25	Yes
<b>Champion EMS (CTMF)</b>	Yes	Yes	25	Yes
<b>Fairfield EMS</b>	Yes	Yes	< 20	Yes
<b>Flight for Life</b>	Yes	Yes		Yes
<b>Good Shepherd EMS (Champion)</b>	Yes	Yes	20	Yes
<b>Grand Saline EMS</b>	Yes	Yes	4	Yes
<b>Grapeland EMS</b>	No	No	15	Yes
<b>Groveton VFD</b>				
<b>Hallsville EMS</b>	No	Yes	15	Yes
<b>Jacksonville FD</b>	Yes	Yes	5-10	Yes
<b>Longview FD</b>	Yes	Yes	8-12	Yes
<b>Marshall FD</b>	Yes	No	10	Yes
<b>Palestine R.M.C. EMS</b>	Yes	Yes	15	Yes
<b>Teague Hospital District EMS</b>	No	No	12-15	Yes
<b>Timpson VFD</b>				
<b>UT Health East Texas Air 1</b>	Yes	Yes	20	Yes
<b>UT Health East Texas EMS</b>	Yes	Yes	18	Yes
<b>Waskom VFD &amp; EMS</b>	No	Yes	20	Yes
<b>Wills Point EMS</b>	No	Yes	20	Yes

TRAUMA CENTERS AND  
SPECIALTY HOSPITALS

## Trauma Facility Designation

HOSPITAL	DESIGNATION	BEDS
Christus Good Shepherd Longview 700 East Marshall Avenue Longview, TX 75601 903-236-2000	Level III Designated	Med / Surg – 160 ICU – 33 Pedi – 19 Rehab – 25
Christus Good Shepherd Marshall P.O. Box 1599 Marshall, TX 75670 903-935-9311	Level IV Designated	Med / Surg – 79 ICU – 9 Pedi – 11 Rehab – 10
Christus Trinity Mother Frances Jacksonville 1016 South Jackson Street Jacksonville, TX 75766 903-541-4500	Level IV Designated	Med / Surg – 10 ICU – 0 Pedi – 0 Rehab – 0
Christus Trinity Mother Frances Tyler 800 East Dawson Tyler, TX 75701 903-593-8441	Level II Designated	Med / Surg – 301 ICU – 50 Pedi – 21 Rehab – 0
Christus Trinity Mother Frances Winnsboro P.O. Box 628 Winnsboro, TX 75494 903-342-5227	Level IV Designated	Med / Surg – 35 (critical access) ICU – 2 Pedi – 0 Rehab – 0
Freestone Medical Center 125 Newman Street Fairfield, TX 75840 903-389-2121	Level IV Designated	Med / Surg – 44 (licensed) ICU – 0 Pedi – 0 Rehab – 0
Longview Regional Medical Center P.O. Box 1500 Longview, TX 75607 903-758-1818	Level III Designated	Med / Surg – 98 ICU – 16 Pedi – 10 Rehab – 0
Palestine Regional Medical Center P.O. Box 4070 Palestine, TX 75802 (903) 731-8910	Level III Designated	Med / Surg – 83 ICU – 10 Pedi – 12 Rehab – 26
UT Health Athens 2000 South Palestine Athens, TX 75751 903-675-2216	Level IV Designated	Med / Surg – 75 ICU – 8 Pedi – 0 Rehab – 0
UT Health Carthage P.O. Box 409 Carthage, TX 75633 903-693-0295	Level IV Designated	Med / Surg – 45 ICU – Closed Pedi – 1 Rehab – 0
UT Health Henderson 300 Wilson Henderson, TX 75652 903-657-7541	Level IV Designated	Med / Surg – 50 ICU – 4 Pedi – 4 Rehab – 4
UT Health Jacksonville 501 South Ragsdale Jacksonville, TX 75766 903-586-3000	Level IV Designated	Med / Surg – 71 ICU – 6 Pedi – 0 Rehab – 0
UT Health Pittsburg 2701 Hwy 271 North Pittsburg, TX 75686 903-946-5000	Level IV Designated	Med / Surg – 25 ICU – 2 Pedi – 0 Rehab – 0
UT Health Quitman P.O. Box 1000 Quitman, TX 75783 903-763-4505	Level IV Designated	Med / Surg – 30 ICU – 0 Pedi – 0 Rehab – 0
UT Health Tyler 1000 South Beckham Tyler, TX 75701 903-531-8165	Level I Designated	Med / Surg – 331 ICU – 63 Pedi – 8 Rehab – 48
UT Health North Campus Tyler 11937 US Hwy 271 Tyler, TX 75708 903-877-2867	Level IV Designated	Med / Surg – 87 ICU – 12 Pedi – 0 Rehab – 8

## Specialty Hospitals

COUNTY	FACILITY(IES)
Anderson	<p><b>Palestine Regional Medical Center – Psychiatric</b>  <b>Palestine Regional Medical Center – Rehab</b>            4000 South Loop 256            Palestine, TX 75801            903-731-8910</p>
Cherokee	<p><b>Rusk State Hospital</b>            1600 Dickinson            Rusk, TX 75785            903-683-7723</p>
Gregg	<p><b>Select Specialty Hospital – Longview</b>            Christus Good Shepherd Medical Center            700 East Marshall Street            Longview, TX 75601            903-315-1106</p>
Smith	<p><b>Christus Trinity Mother Frances Health South Rehab</b>            3131 Troup Highway            Tyler, TX 75701            903-510-7012</p> <p><b>Continue Care</b>            Christus Trinity Mother Frances Hospital            800 East Dawson Street            Tyler, TX 75701            903-531-5560</p> <p><b>Baylor Scott &amp; White</b>  <b>Texas Spine and Joint Hospital</b>            1814 Roseland Boulevard            Tyler, TX 75701</p> <p><b>UT Health Tyler Behavioral Health</b>  <b>UT Health Tyler Rehab</b>  <b>UT Health Tyler Specialty</b>            1000 South Beckham            Tyler, TX 75701            903-531-8143</p>

## RAC-G Trauma Center Medical Directors

### Updating

Facility	Name	Address	City & Zip
<b>Christus Good Shepherd Medical Center – Longview</b>	Dustin McDermott MD	700 E. Marshall Ave.	Longview 75601
<b>Christus Good Shepherd Medical Center – Marshall</b>	Jennifer Chandler MD	811 S. Washington	Marshall 75766
<b>Christus Trinity Mother Frances Jacksonville</b>	Gary Smith, MD	2026 S. Jackson St.	Jacksonville 75766
<b>Christus Trinity Mother Frances Tyler</b>	Luis Fernandez, MD	615 S. Fleishel	Tyler 75701
<b>Christus Trinity Mother Frances Winnsboro</b>	Luis Haro, MD	719 W. Coke Rd.	Winnsboro 75783
<b>Freestone Medical Center</b>	Benjamin Veltri, MD	125 Newman	Fairfield 75840
<b>Houston County Medical Center</b>		1100 Loop 304 E	Crockett 75835
<b>Longview Regional Medical Center</b>	Daniel Merritt, MD	2901 N. Fourth St.	Longview 75605
<b>Palestine Regional Medical Center</b>	Robert Falconer, MD	4002 South Loop 256	Palestine 75801
<b>UT Health Athens</b>	Danny Pugh, MD	2000 S. Palestine	Athens 75751
<b>UT Health Carthage</b>	Robert Callahan, MD	P.O. Box 549	Carthage 75633
<b>UT Health Henderson</b>	Tom Curtis, MD	300 Wilson St.	Henderson 75652
<b>UT Health Jacksonville</b>	Scott Powell, MD	501 S. Ragsdale	Jacksonville 75755
<b>UT Health Pittsburg</b>	Brian Kempton, MD	2701 Hwy 271 S	Pittsburg 75686
<b>UT Health Quitman</b>	Paul Driver, MD	P.O. Box 1000	Quitman 75783
<b>UT Health Tyler</b>	Bob Creath, MD) ER Med Dir Scott Norwood MD, Trauma Medical Director	1020 E. Idel	Tyler 75701
<b>UT Health North Campus Tyler</b>		11937 US Hwy 271	Tyler 75708



## RAC-G Emergency Department Medical Directors

Facility	Name	Address	City & Zip
<b>Christus Good Shepherd Medical Center – Longview</b>	Stan Upchurch, MD	700 E. Marshall Ave.	Longview 75601
<b>Christus Good Shepherd Medical Center – Marshall</b>	Jeff Beaty, MD	811 S. Washington	Marshall 75766
<b>Christus Trinity Mother Frances Jacksonville</b>	Luis Haro, MD	2026 S. Jackson St.	Jacksonville 75766
<b>Christus Trinity Mother Frances Tyler</b>	Luis Haro, MD	615 S. Fleishel	Tyler 75701
<b>Christus Trinity Mother Frances Winnsboro</b>	Luis Haro, MD	719 W. Coke Rd.	Winnsboro 75783
<b>Freestone Medical Center</b>	Christen LeBlanc, MD	125 Newman	Fairfield 75840
<b>Houston County Medical Center</b>	N. El-Aswald, MD	1100 Loop 304 E	Crockett 75835
<b>Longview Regional Medical Center</b>	Ron Simonton, MD	2901 N. Fourth St.	Longview 75605
<b>Palestine Regional Medical Center</b>	Eric Schroder, MD	4002 South Loop 256	Palestine 75801
<b>UT Health Athens</b>	Dan Bywaters, MD	2000 S. Palestine	Athens 75751
<b>UT Health Carthage</b>	G. Reddy, MD	P.O. Box 549	Carthage 75633
<b>UT Health Henderson</b>	Thomas Curtis, MD	300 Wilson St.	Henderson 75652
<b>UT Health Jacksonville</b>	Rodney Caldwell, MD	501 S. Ragsdale	Jacksonville 75755
<b>UT Health Pittsburg</b>	Brian Kempton, MD	2701 Hwy 271 S	Pittsburg 75686
<b>UT Health Quitman</b>		P.O. Box 1000	Quitman 75783
<b>UT Health Tyler</b>	Bob Creath, MD	1000 S. Beckham	Tyler 75701
<b>UT Health North Campus Tyler</b>	Ted Gould, MD	11937 US Hwy 271	Tyler 75708

Updating

## Trauma Coordinator / HPP Coordinator / ER Doctors / TSA G

County	Hospital	Trauma Coordinator	HPP Coordinator	Medical Director
<b>Anderson</b>	Palestine Regional Medical Center	Shanna Dunn 903-731-8945 <a href="mailto:Shanna.Dunn@LPNT.net">Shanna.Dunn@LPNT.net</a>	Keith Vintila 903-731-2207 <a href="mailto:Keith.Vintila@lpnt.net">Keith.Vintila@lpnt.net</a>	Eric Schroder, MD 903-731-1153
<b>Camp</b>	UT Health Pittsburg	Rob Terry 903-946-5580 <a href="mailto:raterry1@uthet.com">raterry1@uthet.com</a>	Rob Terry 903-946-5580 <a href="mailto:raterry1@uthet.com">raterry1@uthet.com</a>	John Roland, MD 903-946-5580
<b>Cherokee</b>	Rusk State Hospital	n/a	Tim Birmingham 903-683-7723 903-948-2599 (Cell)	n/a
	CTMFH Jacksonville	Dwain Coates 903-589-7011 <a href="mailto:dwain.coates@tmfhc.org">dwain.coates@tmfhc.org</a>	Paul Duncan 903-541-4633 <a href="mailto:paul.duncan@tmfhc.org">paul.duncan@tmfhc.org</a>	Mary Price, MD 903-541-4632
	UTH Jacksonville	Heather Stanley 903-714-5267 <a href="mailto:hdstanley@uthet.com">hdstanley@uthet.com</a>	Karen Adams 903-541-5191 <a href="mailto:kadams@uthet.com">kadams@uthet.com</a>	___ Robberman, MD 903-541-5173
<b>Franklin</b>				
<b>Freestone</b>	Freestone Medical Center	Peggy Hughes 903-389-1621 <a href="mailto:phughes@freestonemc.com">phughes@freestonemc.com</a>	Peggy Hughes 903-389-1621 <a href="mailto:phughes@freestonemc.com">phughes@freestonemc.com</a>	John Burnett, MD 903-389-1661
<b>Gregg</b>	Behavior Hospital Longview	Amanda Barton, RN 903-242-3428 <a href="mailto:abarton@bh1@att.net">abarton@bh1@att.net</a>	Jerry Rollins 903-291-3456 <a href="mailto:jrollins@longviewhospital.com">jrollins@longviewhospital.com</a>	
	CTMFH Longview	Missie Banda 903-315-2861 <a href="mailto:mbanda@gsmc.org">mbanda@gsmc.org</a>	Chris Bland 903-315-5163 <a href="mailto:cbland@gsmc.org">cbland@gsmc.org</a>	Stan Upchurch, MD 903-315-2020
	CTMFH Select Specialty Hospital	Mindy Odle 903-315-1109 <a href="mailto:modle@selectmedicalcorp.com">modle@selectmedicalcorp.com</a>	Mindle Odle 903-315-1109 <a href="mailto:modle@selectmedicalcorp.com">modle@selectmedicalcorp.com</a>	n/a
	Longview Regional Medical Center	Michelle Wylie 903-242-3428 <a href="mailto:Michelle.wylie@longviewregional.com">Michelle.wylie@longviewregional.com</a>	Clayton Skinner 903-232-3795 <a href="mailto:Clayton.skinner@longviewregional.com">Clayton.skinner@longviewregional.com</a>	Gene Kelly, MD 903-242-3675
<b>Harrison</b>	CTMFH Marshall	Missy Banda 903-315-2861 <a href="mailto:mbanda@gsmc.org">mbanda@gsmc.org</a>	Brett Ulbig 903-927-6552 <a href="mailto:Brett.ulbig@gsmc.org">Brett.ulbig@gsmc.org</a>	Jeff Beaty, MD 903-315-2861
<b>Henderson</b>	UT Health Athens	Lauren Ellis 903-676-5540 <a href="mailto:lmellis@uthet.com">lmellis@uthet.com</a>	Steve Lowe 903-676-1151 <a href="mailto:slowe@uthet.com">slowe@uthet.com</a>	Dan Bywaters, MD 903-676-3155
<b>Houston</b>	Houston County Medical Center			
<b>Marion</b>				
<b>Panola</b>	UT Health Carthage	Shelbea Comer 903-694-4854 <a href="mailto:sicomer@uithet.com">sicomer@uithet.com</a>	Cindy Diffey 903-694-4871 <a href="mailto:cdiffey@uthet.com">cdiffey@uthet.com</a>	V Reddy, MD 903-694-4848
<b>Rains</b>				
<b>Rusk</b>	UT Health Henderson	Mandy Peace 903-655-5612 <a href="mailto:mspeace@uthet.com">mspeace@uthet.com</a>	Donna Stanley <a href="mailto:dkstanley1@uthet.com">dkstanley1@uthet.com</a>	Jeremy Chester, MD 903-392-1338
<b>Shelby</b>				
<b>Smith</b>	CTMFH Tyler	Terri Rowden 903- <a href="mailto:terri.rowden@tmfhc.org">terri.rowden@tmfhc.org</a>	Daryl Pritchard 903-531-5907 <a href="mailto:pritchd@tmfhc.org">pritchd@tmfhc.org</a>	Luis Haro, MD 903-531-5907
	CTMFH Continue Care Hospital Tyler	Todd Cox 903-531-4773 <a href="mailto:coxt@tmfhc.org">coxt@tmfhc.org</a>	Leigh Wilson 903-531-4979 <a href="mailto:wilson1@tmfhc.org">wilson1@tmfhc.org</a>	n/a
	CTMFH Health South	Lennis Walker 903-510-7008 <a href="mailto:lennis.walker@healthsouth.com">lennis.walker@healthsouth.com</a>	Rocky BigCrane 903-510-7012 <a href="mailto:rocky.bigcrane@healthsouth.com">rocky.bigcrane@healthsouth.com</a>	n/a

<b>Smith. Cont.</b>	Texas Spine and Joint Hospital	Deborah Pelton 903-525-3365 <a href="mailto:deborah.pelton@tsjh.org">deborah.pelton@tsjh.org</a>	Kathy Tompkins 903-525-7026 <a href="mailto:klathy.tompkins@tsjh.org">klathy.tompkins@tsjh.org</a>	n/a
	UT Health Tyler	Jo Ann Peters 903-535-6778 <a href="mailto:jpeters@uthet.com">jpeters@uthet.com</a>	Kenneth Webb 903-531-8143 <a href="mailto:kwebb@uthet.com">kwebb@uthet.com</a>	Bob Creath, MD 903-531-8143
	UT Health Tyler BHC	Jo Ann Peters 903-535-6778 <a href="mailto:jpeters@uthet.com">jpeters@uthet.com</a>	Kenneth Webb 903-531-8143 <a href="mailto:kwebb@uthet.com">kwebb@uthet.com</a>	n/a
	UT Health Tyler Rehab	Jo Ann Peters 903-535-6778 <a href="mailto:jpeters@uthet.com">jpeters@uthet.com</a>	Kenneth Webb 903-531-8143 <a href="mailto:kwebb@uthet.com">kwebb@uthet.com</a>	n/a
	UT Health Specialty	Jo Ann Peters 903-535-6778 <a href="mailto:jpeters@uthet.com">jpeters@uthet.com</a>	Kenneth Webb 903-531-8143 <a href="mailto:kwebb@uthet.com">kwebb@uthet.com</a>	n/a
	UT Health North Tyler	Marcella Bernardino <a href="mailto:Maarcella.Bernardino@uthct.edu">Maarcella.Bernardino@uthct.edu</a>	Maurice Pinsterswald 903-877-2845 <a href="mailto:Maurice.Finterwald@uthct.edu">Maurice.Finterwald@uthct.edu</a>	Jefferey Leach, MD 903-877-7260
<b>Trinity</b>				
<b>Upshur</b>				
<b>Van Zandt</b>				
<b>Wood</b>	CTMFH Winnsboro	Carol Groves <a href="mailto:carol.groves@tmfhc.org">carol.groves@tmfhc.org</a>	Stephen Stokes 903-342-3982 <a href="mailto:stephen.stokes@tmfhc.org">stephen.stokes@tmfhc.org</a>	Luis Haro, MD 903-342-3949
	UT Health Quitman	Ronna Reaves 903-763-6311 <a href="mailto:rhreaves@uthet.com">rhreaves@uthet.com</a>	Chris Norwood 903-841-7173 <a href="mailto:cnorwood@uthet.com">cnorwood@uthet.com</a>	

# PLAN REQUIREMENTS

## **PARTICIPATING COUNTIES**

Anderson	Harrison	Rains	Upshur
Camp	Henderson	Rusk	Van Zandt
Cherokee	Houston	Shelby	Wood
Freestone	Marion	Smith	
Gregg	Panola	Trinity	

## **EVIDENCE OF SYSTEM PARTICIPATION**

The first meeting of health care professionals in RAC-G was held on October 22, 1992. During that time, every effort was made to involve all EMS agencies, hospitals, surgeons, and emergency department physicians throughout RAC-G. Multiple mail-outs were sent not only to the EMS services but also to many volunteer services as well. Numerous phone calls were made to the EMS services, volunteer services (when phone numbers were available), and hospitals. Approximately two-thirds of the EMS agencies in RAC-G have been active in the RAC. Many of these agencies have participated in the RAC Pre-Hospital Care and Transportation Committee. A complete listing of all Standing Committee members is provided in the plan.

On March 16, 1995, the Trauma Systems Planning Ad Hoc Committee was convened at the request of the Chairman of the RAC. The original membership included all chairpersons of the Standing RAC Committees and several members of each Standing Committee. Meetings were held in March, May, July, and October 1995 and in February and June 1996. Participation in this committee was open to all members of the Administrative Council of the RAC and any General Assembly member who desired to participate. At April 19, 1995, and December 6, 1995, meetings of the RAC, the Chairman announced that any other participants interested in participating in the development of the trauma plan could request and become active members. This last request resulted in the final members comprising the Trauma System Planning Ad Hoc Committee.

On November 9, 1994, and again on January 10, 1995, a questionnaire was sent by the Chairman to all surgeons within RAC-G. These names were obtained through the Texas Medical Association. The questionnaire was designed to receive input from the surgeons throughout the region concerning their views of trauma center designation, regionalization of trauma care, and willingness to participate in RAC activities and trauma system planning.

The final Trauma Plan was approved by the Trauma System Planning Ad Hoc Committee on June 20, 1996, and approved by the RAC on June 26, 1996.

The Trauma Plan is updated on an annual basis.

All hospitals within the RAC-G have been active participants in the RAC.

# PLAN COMPONENTS

## SYSTEM ACCESS

Basic 9-1-1 is a communications system that provides dedicated phone lines allowing direct routing of emergency calls through a telephone company central office to a Public Safety Answering Point (PSAP). This routing is based on the specific telephone exchange area and generally not by municipal boundaries. Enhanced 9-1-1 can include Automatic Number Identification (ANI) and Automatic Location Identification (ALI). Enhanced 9-1-1 also automatically routes emergency calls to a pre-selected answering point based on the geographical location from which the call originated. ANI involves routing the local call to the telephone company central office, which then assigns the caller's telephone number to the voice, both of which are then sent to PSAP. ALI involves giving the phone number and the caller's address, which is automatically routed to the PSAP.

In RAC-G, all counties have Enhanced 9-1-1 with ANI/ALI capability, except for Houston County, which utilizes only ANI.

Since there are 20 EMS agencies and more than 125 first responder agencies in our region, there are numerous other methods for accessing emergency care throughout the region. In addition, all public phones have public access to 9-1-1.

## COMMUNICATIONS

The current Christus EMS and UT Health East Texas EMS Dispatch Systems Training and Standards for Communication Personnel requires all communications officers to maintain CPR Provider Certification and Emergency Medical Dispatch Certification. The requests are routed to EMS via the 9-1-1 system or direct line for dispatch. Other agency systems, i.e., sheriff office/PD/9-1-1, etc., are defined annually through annual data collection.

The communication network in RAC-G provides for ambulance-to-ambulance, ambulance-to-dispatch, ambulance-to-hospital and hospital-to-hospital communications consisting of several radio frequencies and telephone links (either a base site or cellular). The VHF high band FM (148-174 MHz) and the VHF low band FM (30-50 MHz) frequencies are used for communication between first responders, emergency medical services, base stations, ground units, and aircraft. Their range varies with altitude and distance. The content of these frequencies can be increased with repeaters or microwave links. The repeater receives the signal, boosts the signal, and then transmits the frequency. The UHF (450-850 MHz) frequencies can be used between communication centers and the ground units – from the ground, units to ground units, from ground units to air, and from perspective to ground units. UHF frequencies provide more significant enhancement. These frequencies are designed as Regional EMS frequencies and can be accessed by most medical facilities. UT Health East Texas utilizes an 800 MHz trunking system. Ambulances and aircraft are equipped with automatic vehicle locators (AVLs), which interface with the global dispatch system. The VHF AM (118-136 MHz) frequencies are used primarily for air-to-ground and ground-to-air communications. Communications are also maintained via land line telephone link from facility to facility and via cellular transmission from hospital to ambulance and ambulance to ambulance. Using these multiple systems, communications with public and private EMS agencies, police, fire, and hospitals are maintained.

There is a Regional Disaster Plan and a Hospital Preparedness Program for RAC-G. The Disaster Plan has been in place for several years and is based on the designation levels of all hospitals and the pre-hospital response and triage.

The communication process between hospitals and pre-hospital providers was greatly improved by using the EMS system for RAC-G. This system provides pre-hospital providers real-time communication for hospital divert status and bed capacity. The plan was a vital means of communication for our trauma service area during past hurricanes.

The process for evaluating the current EMS communications systems, their providers, and dispatch activities is accomplished by each EMS system's own performance improvement program. As shown in response to the EMS questionnaire, most of the EMS systems in RAC-G have a performance improvement process that reviews cases monthly.

The strength of the Pre-Hospital Communications Systems within RAC-G is widespread coverage via radio communications for the area through the utilization of interoperability channels MED 1, 2, and 3 and Fire 1, 2, and 3.

## **MEDICAL OVERSIGHT**

RAC-G includes both rural and urban areas. Hospitals in the area have capabilities ranging from non-designated but participating facilities to Level I, II, III, and IV Trauma Centers. There is currently no single EMS Director since there are 20 EMS agencies in the region and over 125 first responder agencies. As previously stated, one of the goals of the RAC is to establish an EMS Medical Director for RAC-G to facilitate the standardization of pre-hospital care throughout the region. Given the region's diversity and the number of EMS agencies involved, this is a long-term goal that may never be realized. There is, however, the use of the RAC's protocols, which accomplishes off-line uniformity of medical control.

There is currently a Level I and a Level II Trauma Center in Smith County. Smith County is approximately the geographic center of RAC-G (see map). A tiered patient delivery system based on the severity of injury/illness is geared toward transferring the injured/ill patient from the scene to the most appropriate level of care within a proper time frame. This goal is accomplished by applying well-established offline medical control protocols and utilizing online medical control when patient circumstances are contrary to these protocols. Adequate communication of facility diversion is also essential to prevent harmful delays in the delivery of patient care.

There are presently four air medical programs within RAC-G and several others capable of responding from outside RAC-G. The system was successfully tested during the 2019 Alto tornado incidents, with numerous agencies and helicopter services responding and transporting patients to Tyler, Lufkin, Conroe, and Houston.

Since approximately one-third of the EMS agencies provide service in areas with no local hospital, scene-to-hospital times may exceed 60 minutes. Scene-to-Level I or Level II Trauma Center ground times may exceed 70 minutes, and air transport may exceed 30 minutes from remote areas within RAC-G. There is a total of ten air-medical assets based in RAC-G.



# RAC-G CRITERIA FOR AIR MEDICAL TRANSPORT

## Air Medical Provider (AMP) Activation Guidelines

Purpose: These activation guidelines are intended to provide a framework for the RAC to develop a standardized method for ground emergency service providers to request a scene response by an AMP, to reduce delays in providing optimal care for severely ill or injured patients, and to decrease mortality and morbidity.

AMP resources should be utilized per the Regional Trauma Plan.

Guidelines for Activation and Selection of AMP:

1. The EMS provider should comply with RAC-approved triage criteria to activate AMP transport. Factors that should be considered are:
  - A. Location of incident
  - B. Number of patients
  - C. Age of patient(s)
  - D. Response time of AMP(s)

The total AMP response time (response time + scene time + transport time) will result in the delivery of the patient(s) to the most appropriate facility faster than transport by ground ambulance.
  - E. Clinical needs of the patient(s)
2. The time needed for the patient to be transported by ground ambulance poses a possible threat, or ground transport time is 30 minutes or greater:
  - A. When extrication, weather, and traffic seriously hamper access to advanced critical care.
  - B. When critical care above the level of the current provider is needed for transport.
3. Any available AMP(s) that best meets the needs of the patient(s) may be utilized.

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Other considerations: Patients meeting the criteria for AMP dispatch should be transported to the closest, most appropriate facility.

AMP Considerations:

1. The AMP should meet the RAC participation standards for RAC-G.
2. The AMP should participate as requested in RAC performance improvement activities.
3. The AMP utilized for patient treatment, and transport should be the AMP that best meets the patient's care and transport needs, including:
  - A. Performance criteria (dispatch + response time + scene time + transport time)
  - B. Clinical capabilities

C. Operational interface and safety

AMP should demonstrate safe operations at all times. Safe operations standards include safety standards such as those endorsed by the Federal Aviation Administration, the National EMS Pilots Association, the Helicopter Association International, the Association of Air Medical Services, the Commission on Accreditation of Medical Transport Systems, and the Air and Surface Transport Nurses Association.

D. Clinical and operational performance improvement (PI) practices

The following is a list of illnesses or injuries that could indicate the need for rapid transportation:

- Penetrating wound to chest, abdomen, head, neck, and groin
- Two or more long bone/pelvic fractures
- Severe burns (especially those involving more than 15% of the face or airway)
- Flail chest (with difficulty maintaining oxygenation)
- Amputation of an extremity or open fractures
- Paralysis or spinal cord injury
- Open or suspected depressed skull fracture
- Evidence of high impact and multiple patients on scene
- Falls of twenty feet or more
- Crash speed greater than 40 miles per hour
- 30-inch or more significant deformity of automobile
- Passenger compartment intrusion of 18 inches or more on the patient side of the vehicle
- Patient extrication time greater than 20 minutes and unstable vital signs
- Rollover of the vehicle with patient ejection
- Death of occupant in the same vehicle
- Pedestrian hit at 20 mph or greater
- RTS less than 10; GCS less than 8
- Airway compromise and unable to correct by ground EMS
- Persons exhibiting signs/symptoms of stroke with extended ground transportation time
- Persons showing signs/symptoms of myocardial infarction with extended ground transportation time

**If you have questions regarding whether or not to activate  
An aero-medical service, please call:**

**Air One  
1-800-255-2011**

**Flight for Life  
1-800-441-8677**

## Pre-Hospital Triage and Transport

A trauma patient can be identified as any patient experiencing a single- or multiple-system injury. More specifically, a trauma patient is any individual who experiences external blunt or penetrating forces that may damage any anatomic structure and cause an immediate threat to life, such as when the injury involves the pulmonary, cardiovascular, or central nervous system; or injuries that may affect systems in ways that are not usually life-threatening but may cause morbidity by damaging the superficial soft tissues, hollow viscera or musculoskeletal structures. Trauma imminently threatens life and limb. For our purposes, a trauma patient may be defined as a patient who presents with the following criteria (which should not be considered a complete list):

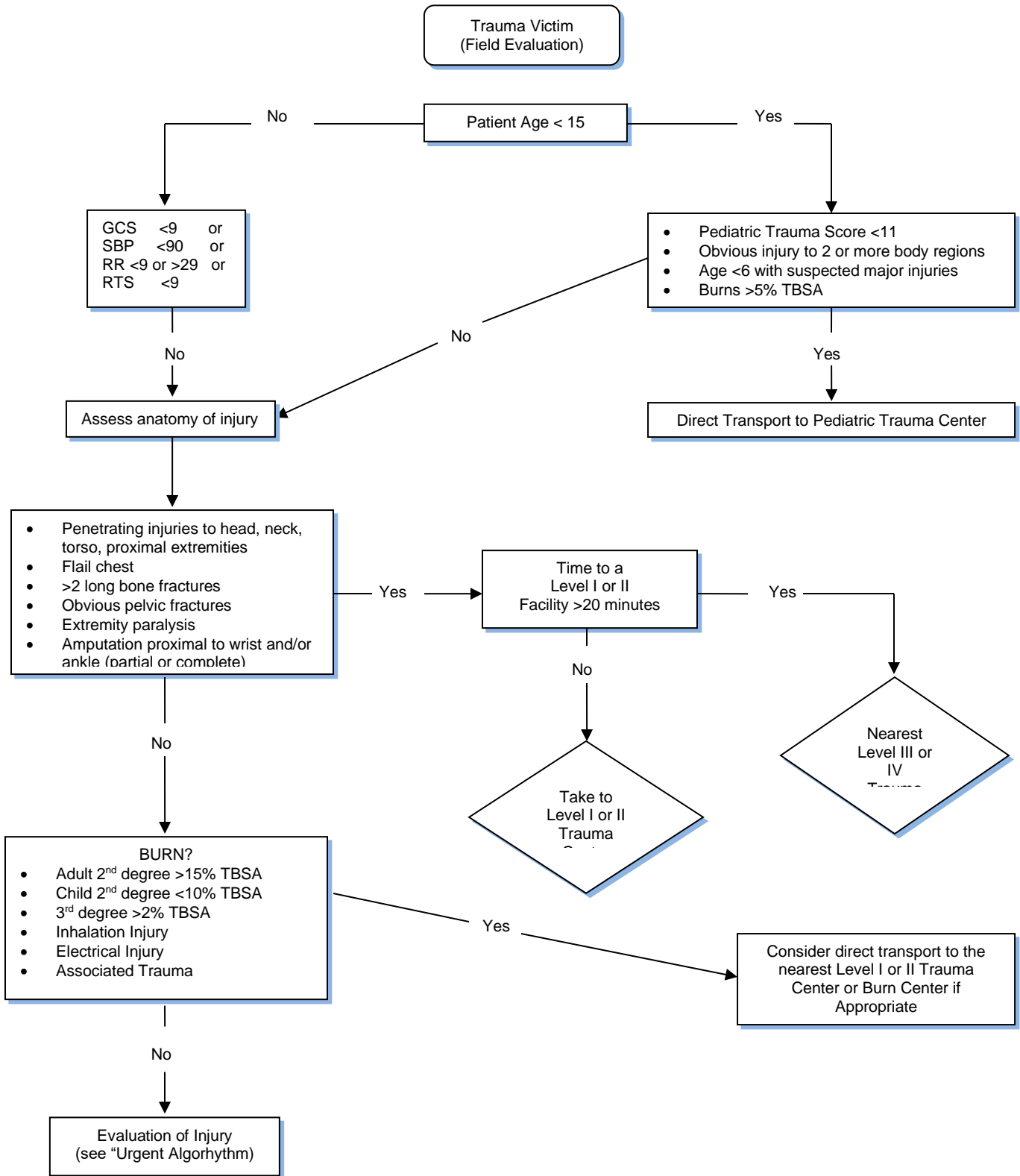
1. Glasgow Coma Score (GCS) less than or equal to 13
2. Revised Trauma Score (RTS) less than or equal to 11
3. Clinical presentation of:
  - A. Laryngeal or tracheal fracture
  - B. Tension pneumothorax
  - C. Massive hemothorax
  - D. Flail chest
  - E. Open chest wound (sucking chest wound)
  - F. Cardiac tamponade
  - G. Pelvic fracture
  - H. Two or more proximal long bone fractures
  - I. Open or suspected depressed skull fracture
4. Suspected spinal injuries as evidenced by symptoms or physical findings
5. Penetrating injury to the chest, abdomen, head, neck, or groin
6. Evidence of high-impact external forces which may cause blunt trauma:
  - A. Fall from 20 feet or more
  - B. 30-inch deformity of a portion of the motor vehicle
  - C. Ejection of the patient from the vehicle
  - D. Pedestrian hit at >20 mph by a motor vehicle
7. Limb-threatening injuries presented in the following fashion:
  - A. Injury to extremity with the absence of distal pulse
  - B. Total or partial amputation of extremity above the digits

- C. Severe crush injury with numbness or severe pain
  - D. Paresthesia or total loss of movement
8. History of motor vehicle crash requiring admission to observe for and rule out potential disruption of organ systems (i.e., pulmonary contusion, myocardial contusion, cerebral concussion, possible blunt intra-abdominal injury)

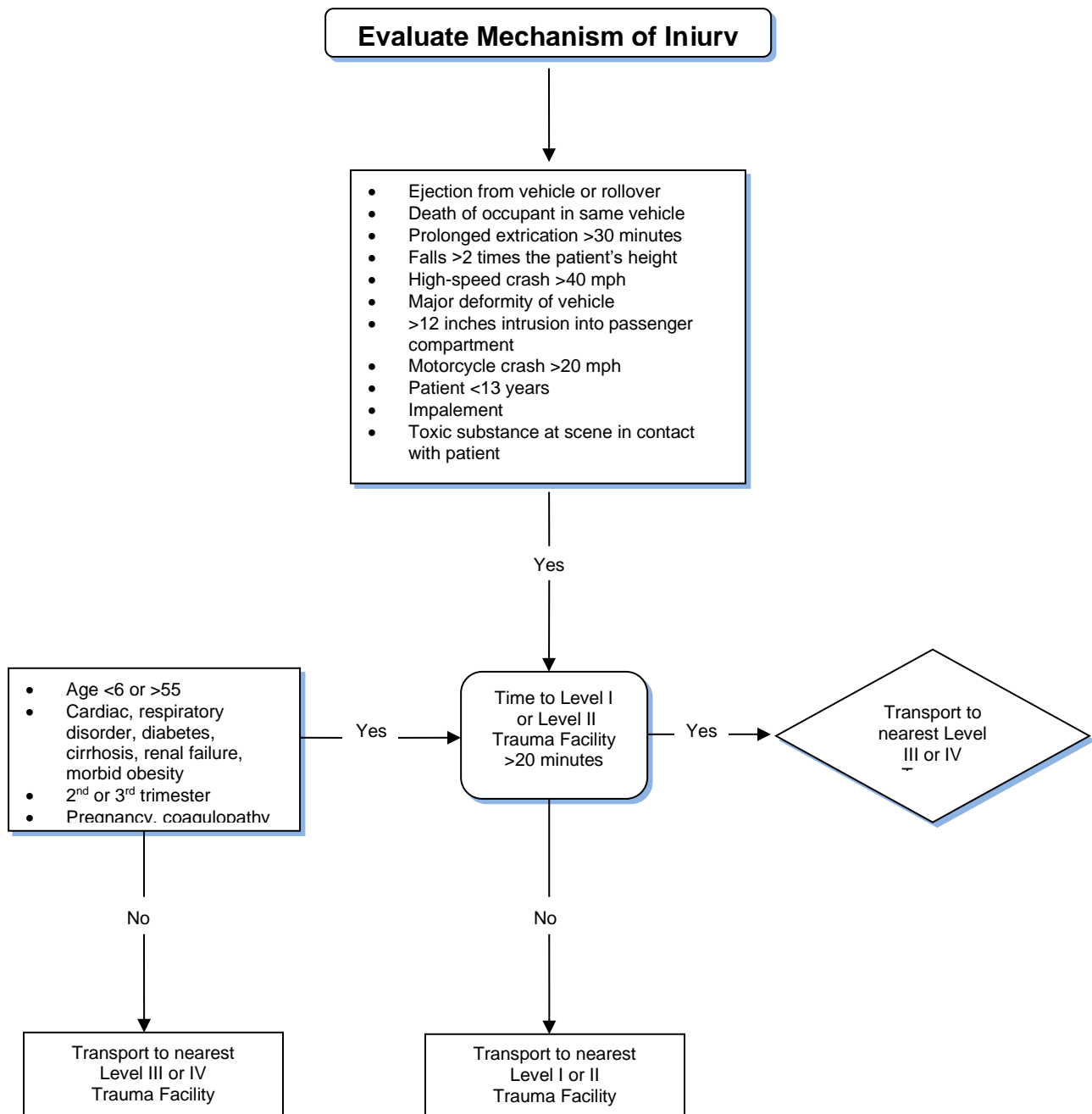
If the above criteria are met, accurate and expedient patient assessment by the first responder to the scene of the accident is critical to appropriate trauma patient triage. A Triage Decision Scheme has been developed to guide first responders regarding patient transport and destination. Vital signs, level of consciousness, mechanism of injury, and other data are assessed, and EMS Medical Control is consulted if questions remain regarding the disposition and treatment of the patient at the scene. Major trauma patients are classified as either "critical" or "urgent." The appropriate algorithm is followed to transport the patient to the most appropriate facility.

Presently, the individual EMS Medical Directors are ultimately responsible for off-line medical control in the form of patient care protocols regarding interventions by EMS personnel. On-line medical control is also the responsibility of the individual EMS Medical Director. Our goal is for the Pre-Hospital Care and Transportation Committee to ultimately become an organization that will review and consolidate these various protocols into a standard approach for all RAC-G pre-hospital personnel. Triage Decision Schemes are provided for pre-hospital personnel to assist in triaging both "critical" and "urgent" patients. A Facility Triage Action Plan is also provided.

## Triage Decision Scheme (Critical)



## Triage Decision Scheme (Urgent)



*Note: Every attempt should be made to call the ED Call Center of the receiving hospital at least 15 minutes pre-arrival*

## FACILITY TRIAGE PATIENT CRITERIA

Patient Arrives At	Critical Adult Patient	Urgent Adult Patient	Critical or Urgent Pediatric Patient
Level I	Admit	Admit	Admit to Trauma Service or transfer to Pediatric Center
Level II	Admit or stabilize and transfer to Level I	Admit or transfer to Level I	Admit to Trauma Service or transfer to Level I or Pediatric Center
Level III	Stabilize and transfer to Level I or Level II	Stabilize and admit to appropriate Service if available; otherwise, transfer to Level I or Level II	Stabilize and transfer to Level I, Level II or Pediatric Center
Level IV	Stabilize and transfer to Level I or Level II	Stabilize and transfer to Level I, Level II or Level III	Stabilize and transfer to Level I, Level II or Pediatric Center

CATEGORY I PATIENT (Critical)	CATEGORY II PATIENT (Urgent)
<p><b>CENTRAL NERVOUS SYSTEM</b></p> <ul style="list-style-type: none"> <li>Neurologic injuries producing prolonged loss of consciousness, posturing, paralysis or lateralizing signs</li> <li>Spinal injuries with or without neurologic deficit</li> <li>Open penetrating or depressed skull fractures</li> <li>CSF leak</li> <li>Deteriorization of GCS of 2 or more</li> </ul> <p><b>CHEST</b></p> <ul style="list-style-type: none"> <li>Major chest wall injury</li> <li>Suspected great vessel or cardiac injury</li> <li>Patients who may require prolonged mechanical ventilation</li> <li>Respiratory distress with a rate &gt;35 or &lt;10</li> <li>Penetrating thoracic wound</li> </ul> <p><b>PELVIS</b></p> <ul style="list-style-type: none"> <li>Pelvic ring disruption with shock requiring more than 5 units transfusion</li> <li>Evidence of continued hemorrhage</li> <li>Compound/open pelvic injury or pelvic visceral injury</li> </ul> <p><b>ABDOMEN</b></p> <ul style="list-style-type: none"> <li>Blunt abdominal trauma with hypotension</li> <li>Penetrating abdominal wound</li> </ul> <p><b>MULTIPLE SYSTEM INJURY</b></p> <ul style="list-style-type: none"> <li>Severe face injury with head injury</li> <li>Chest injury with head injury</li> <li>Abdominal or pelvic injury with head injury</li> <li>Burns with head injury</li> </ul> <p><b>SPECIALIZED PROBLEMS</b></p> <ul style="list-style-type: none"> <li>Second or third degree burns greater than 10% TBSA or involving airway</li> <li>Carbon monoxide poisoning</li> <li>Barotrauma</li> <li>Uncontrolled hemorrhage</li> <li>Severe maxillofacial or neck injuries</li> <li>Open fractures</li> <li>Second/third trimester of pregnancy</li> </ul> <p><b>SECONDARY DETERIORATION (LATE SEQUELAE)</b></p> <ul style="list-style-type: none"> <li>Patients requiring mechanical ventilation</li> <li>Sepsis</li> <li>Oxygen system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation)</li> <li>Osteomyelitis</li> </ul>	<p>Patients who are hemodynamically and physiologically stable whose injuries may include:</p> <p><b>CENTRAL NERVOUS SYSTEM</b></p> <ul style="list-style-type: none"> <li>Transient loss of consciousness</li> </ul> <p><b>CHEST</b></p> <ul style="list-style-type: none"> <li>Injuries not producing respiratory distress</li> <li>Rib fractures without flail segments</li> </ul> <p><b>ABDOMEN</b></p> <ul style="list-style-type: none"> <li>Blunt trauma not producing hypotension (should also be managed by trauma services)</li> </ul> <p><b>SPECIALIZED PROBLEMS</b></p> <ul style="list-style-type: none"> <li>Closed fractures</li> <li>Soft tissue injuries with controlled hemorrhage</li> <li>Second/third trimester of pregnancy</li> </ul>
	<p><b>CATEGORY III PATIENT</b></p> <p>Patients who are continually stable but whose injuries may include:</p> <ul style="list-style-type: none"> <li>Closed fracture without neurological deficit</li> <li>Normotensive and/or hemodynamically stable</li> <li>Soft tissue injuries of moderate degree</li> </ul>

## **FACILITY TRIAGE PATIENT CRITERIA**

Trauma patients may be placed into one of the following categories by the attending physician upon arrival in the Emergency Department based upon the severity of their injuries. Inter-hospital transfer should then be initiated as appropriate according to the RAC-G Facility Triage Decision Scheme.

### **CATEGORY I PATIENT**

#### **Central Nervous System**

- Neurological injuries producing prolonged loss of consciousness, posturing, paralysis or lateralizing signs
- Spinal injuries with or without neurological deficit
- Open, penetrating or depressed skull fractures
- CSF leak
- Deterioration of GCS of 2 or more

#### **Chest**

- Major chest wall injury
- Suspected great vessel or cardiac injury
- Patients who may require prolonged mechanical ventilation
- Respiratory distress with a rate >35 or <10
- Penetrating thoracic wound

#### **Pelvis**

- Pelvic ring disruption with shock requiring more than 5 units transfusion
- Evidence of continued hemorrhage
- Compound/open pelvic injury or pelvic visceral injury

#### **Abdomen**

- Blunt abdominal trauma with hypotension
- Penetrating abdominal wound

#### **Multiple System Injury**

- Severe face injury with head injury
- Chest injury with head injury
- Abdominal or pelvic injury with head injury
- Burns with head injury

#### **Specialized Problems**

- Second or third degree burns greater than 10% TBSA or involving airway
- Carbon monoxide poisoning
- Barotrauma
- Uncontrolled hemorrhage
- Severe maxillofacial or neck injuries
- Revised Trauma Score of 11 or less
- Open fractures
- Second/third trimester pregnancy



### **Secondary Deterioration (Late Sequelae)**

- Patients requiring mechanical ventilation
- Sepsis
- Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation)
- Osteomyelitis

### **CATEGORY II PATIENT**

Patients who are hemodynamically and physiologically stable whose injuries may include:

#### **Central Nervous System**

- Transient loss of consciousness

#### **Chest**

- Injuries not producing respiratory distress
- Rib fractures without flail segments

#### **Abdomen**

- Blunt trauma not producing hypotension (should also be managed by trauma service)

#### **Specialized Problems**

- Closed fractures
- Soft tissue injuries with controlled hemorrhage
- Second/third trimester of pregnancy
- Second degree burns to >10% TBSA

### **CATEGORY III PATIENT**

Patients who are continually stable but whose injuries may include:

- Closed fracture without neurological deficit
- Normotensive and/or hemodynamically stable
- Soft tissue injuries of moderate degree

## FACILITY TRIAGE ACTION PLAN

On-line consultation with Medical Control should be undertaken when confusion exists regarding the appropriate facility for transfer.

Patient Arrives At	Critical Adult Patient	Urgent Adult Patient	Critical or Urgent Pediatric Patient
Level I	Admit to Trauma Service or consider transfer to appropriate specialty center (i.e., burn)	Admit to Trauma Service or Surgical Subspecialty Service with Trauma consultation	Admit to Trauma Service or transfer to a Pediatric Trauma Center
Level II	Admit to Trauma Service or consider transfer to appropriate specialty center (i.e., burn)	Admit to Trauma Service or Surgical Subspecialty Service with Trauma consultation	Admit to Trauma Service or transfer to a Pediatric Trauma Center
Level III	Stabilize and transfer to a Level I or Level II Trauma Center or appropriate specialty center if needed (i.e., burn)	Stabilize and admit to appropriate Surgical Service or transfer to Level I or Level II Trauma Center or appropriate specialty center	Stabilize and transfer to Pediatric Trauma Center
Level IV	Stabilize and transfer to a Level I or Level II Trauma Center or appropriate specialty center (i.e., burn)	Stabilize and transfer to a Level I or Level II Trauma Center or appropriate specialty center	Stabilize and transfer to Level I, Level II or Pediatric Trauma Center

## TRAUMA FACILITY DIVERSION POLICY

### PURPOSE

To develop a standardized diversion policy that identifies area-specific trauma resources and assures continual access to the appropriate trauma facility for each trauma patient.

1. Each facility will develop procedures for their facility to be placed on diversion status. The RAC utilizes the EMSsystem for “real time” communication of diversion status.

Suggested reasons for facility diversion may include, but are not limited to:

- Trauma Surgeon/General Surgeon is not available
  - Internal disaster
  - Facility structure compromise
  - Exhaustion of facility and/or emergency resources
  - Specialty Surgeon (Neuro, Ortho) is not available
  - Specialty equipment (CT Scanner, MRI) is not available
  - Patient’s needs exceed facility capabilities
2. Each facility shall designate a person responsible for decisions regarding diversion status.
  3. There must be appropriate documentation of any diversion. This diversion should be reviewed in your performance improvement process and may also be reviewed in the RAC Performance Improvement Committee.
  4. Each facility is required to have a local Mass Casualty Plan and know how to activate additional resources within RAC-G if needed. The use of the EMSsystem will facilitate this process.

5. Each facility must have policies and procedures in place to open critical care beds if there is a mass casualty situation. The use of the EMSsystem allows constant real-time communication between the hospitals and pre-hospital providers.
6. Each Level I, II, III or IV facility is required to notify all EMS dispatch centers within their service area when a facility goes on and off diversion. The EMSsystem facilitates this process.

### GOAL

Trauma patients who are medically unstable, unconscious, or at high risk for multiple and severe injuries will be quickly identified and transported to an appropriate designated trauma center.

### DECISION CRITERIA

Transport protocols must ensure that patients who meet triage criteria for activation of the RAC-G Regional Trauma System Plan will be transported directly to an appropriate trauma facility rather than to the nearest hospital, except under the following circumstances:

1. If unable to establish and/or maintain an adequate airway or, in the case of traumatic cardiac arrest, the patient should be taken to the nearest trauma facility for stabilization.
2. A Level III or IV trauma facility may be appropriate if the expected scene-to-Level I or II Trauma Center time (i.e., transport time) is excessive (>20 minutes) and there is a qualified physician available at the facility's Emergency Department.
3. Medical Control may wish to order bypass in any of the above situations as appropriate, such as when a facility cannot meet hospital resource criteria or when there are patients in need of specialty care.
4. Suppose transport time to the nearest trauma facility is excessive (>20 minutes) or prolonged extrication time is expected. In that case, the EMS crew or Medical Control may consider activating air transportation resources available within the trauma service area.

### NOTE:

If there should be any question regarding whether or not to bypass a facility, on-line Medical Control should be consulted for the final decision.

# TRANSFER AGREEMENTS

## TRANSFER AGREEMENTS

Written transfer agreements are available upon request from all participating hospitals in RAC-G. Following is a synopsis of those agreements for each hospital within RAC-G.

Hospital	Multi Trauma	Head Trauma	OB Trauma	Pedi Trauma	Pedi Burn	Adult Burn	Rehab
<b>Allegiance Specialty</b>	UTH Tyler	UTH Tyler	UTH Tyler	Children's Dallas	Parkland	Parkland	UTH Tyler
<b>Christus GSMC Longview</b>	?	?	?	Children's LSU	Parkland	Parkland	?
<b>Christus GSMC Marshall</b>	?	?	?	Schumpert	LSU	LSU	?
<b>Christus TMFH Jacksonville</b>	Christus TMFH Tyler	Christus TMFH Tyler	Christus TMFH Tyler	Children's Dallas	Parkland	Parkland	Tyler Rehab
<b>Chistus TMFH Tyler</b>	Christus TMFH Tyler	Christus TMFH Tyler	Christus TMFH Tyler	Children's Dallas	Parkland	Parkland	Tyler Rehab
<b>Christus TMFH Winnsboro</b>	Christus TMFH Tyler	Christus TMFH Tyler	Christus TMFH Tyler	Children's Dallas	Parkland	Parkland	Tyler Rehab
<b>Crockett Medical Center</b>	?	?	?	Children's Dallas	Parkland	Parkland	?
<b>Freestone Medical Center</b>	?	?	?	Children's Dallas LSU	Parkland	Parkland	?
<b>Longview Regional</b>	?	?	LSU	Children's Dallas	Parkland	Parkland	?
<b>Palestine Regional</b>	UTH Tyler Christus TMFH Tyler	UTH Tyler Christus TMFH Tyler	UTH Tyler Christus TMFH Tyler	Children's Dallas	Parkland	Parkland	
<b>UTH Athens</b>	UTH Tyler	UTH Tyler	UTH Tyler	Children's Dallas	Parkland	Parkland	UTH Tyler
<b>UTH Carthage</b>	UTH Tyler	UTH Tyler	UTH Tyler	LSU	Parkland	LSU Parkland	UTH Tyler
<b>UTH Henderson</b>	UTH Tyler	UTH Tyler	UTH Tyler	Children's Dallas	Parkland	Parkland	UTH Tyler
<b>UTH Jacksonville</b>	UTH Tyler	UTH Tyler	UTH Tyler	Children's Dallas	Parkland	Parkland	UTH Tyler
<b>UTH Pittsburg</b>	UTH Tyler	UTH Tyler	UTH Tyler	Children's Dallas	Parkland	Parkland	UTH Tyler
<b>UTH Quitman</b>	UTH Tyler	UTH Tyler	UTH Tyler	Children's Dallas	Parkland	Parkland	UTH Tyler
<b>UTH Tyler</b>	UTH Tyler	UTH Tyler	UTH Tyler	Children's Dallas	Parkland	Parkland	UTH Tyler
<b>UTH North Campus Tyler</b>	UTH Tyler	UTH Tyler	UTH Tyler	Children's Dallas	Parkland	Parkland	UTH Tyler

SYSTEM PERFORMANCE  
IMPROVEMENT PLAN

# SYSTEM PERFORMANCE IMPROVEMENT PLAN

## 1. INTRODUCTION

Member organizations of the Piney Woods RAC of TSA-G agree that ongoing evaluation and re-evaluation of the Trauma Care System through a well-defined performance improvement (PI) program is the only way to improve patient care and reduce morbidity and mortality. This is especially important in predominately rural areas such as RAC-G. All member organizations agree that both facility-based and system-based performance improvement are essential. While facility-based performance improvement focuses primarily on the care rendered to individual patients, system-based performance improvement is equally important because it examines the overall function of the system, the components comprising the system from pre-hospital care to rehabilitation and the interaction of these components.

To deliver the best possible care for patients in RAC-G, facility, pre-hospital and system performance improvement programs have been developed with close cooperation among these programs.

By participating in RAC-G, all member organizations embrace the guiding principles for Trauma Systems outlined by the Texas Department of Health.

## 2. GUIDING PRINCIPLES

- A. Ongoing evaluation of the RAC-G Regional Trauma System.
- B. Mandatory participation in the performance improvement process by all member organizations – both hospitals (designated and non-designated facilities) and EMS providers.
- C. Maintain a Performance Improvement Committee with representation from all disciplines (i.e., EMS, hospital, nursing). This committee will ensure confidentiality and consistency in the performance improvement process by requiring each member to sign a statement of nondisclosure.
- D. Establishment of a performance improvement plan to systematically review patient care from a system perspective, taking into consideration the goals developed within the RAC G Trauma, EMS, Acute Care and Hospital Preparedness Plan. Patient care from a facility perspective may also be done in order to provide outside chart review.
- E. Maintenance of the Regional Trauma Registry to allow systematic review which, at a minimum, will contain the data required by the Texas Department of State Health Services EMS/Trauma Registry data dictionary for hospital and pre-hospital providers treating major trauma patients.
- F. Data submitted to the Performance Improvement Committee on a quarterly basis will be used for identification of system-wide and provider-specific educational needs and opportunities for improvement in patient care or system processes.

## 3. PHYSICIAN PEER REVIEW COMMITTEE

- A. Members of the Peer Review Committee will be any physician who is a member of RAC-G who would like to attend this committee.
- B. The Peer Review Committee Chairperson must be a physician (either Emergency Department or Surgeon) who actively participates in the care of trauma patients and is an active member of the RAC. This individual can also come from the General Assembly at large.
- C. The membership may consist of:

- a. Chairperson
- b. All Trauma Service Medical Directors from each participating hospital
- c. All Emergency Department Medical Directors from each participating hospital
- D. The term of office will be for the duration of time in which each individual remains as Medical Director for his/her respective hospital.
- E. The Peer Review Committee will review patient care and system function. Appropriate documentation will be forwarded to the referring facility for inclusion into their performance improvement program.

#### 4. DATA COLLECTION

- A. Data will be provided to the Regional Registrar on a monthly basis six weeks following the end of the month; i.e., November data will be downloaded on January 15. This is in compliance with the DSHS requirements. Those who do not submit data in a timely manner will be considered non-compliant.
- B. Performance Improvement Indicators (see Paragraph 6)
- C. The EMS Directors for each EMS System will be responsible for forwarding pre-hospital data to the regional registry for the Peer Review Committee Chairperson.
- D. In designated trauma facilities, the Trauma Nurse Coordinator will be responsible for collecting and forwarding the data to the regional registry for the Peer Review Committee Chairperson.
- E. In non-designated trauma facilities, the Trauma Nurse Coordinator or the Administrative Council representative will be responsible for collecting and forwarding the data to the Chairperson.

#### 5. RESPONSIBILITIES TO THE PERFORMANCE IMPROVEMENT PROCESS

- A. Designated Trauma Facilities
  - a. Develop an ongoing facility performance improvement program for trauma patient care.
  - b. Provide requested data for the RAC regional registry to be reported to the Peer Review Committee Chairperson in a timely manner.
  - c. Submit individual cases to the committee for discussion, educational interest and improvement of patient care.
- B. Non-Designated Facilities
  - a. Provide required data to the RAC regional registry to be reported to the Peer Review Committee Chairperson in a timely manner.
- C. EMS Providers
  - a. Provide required data to the RAC regional registry to be reported to the Peer Review Committee Chairperson in a timely manner.



D. Chairperson – Peer Review Committee

- a. Committee will meet on the day of the General Assembly on a quarterly basis.
- b. Notify committee members at least one month in advance of date, time and place for the Peer Review meeting.
- c. Maintain minutes of each meeting and provide this to the RAC Chairperson at the quarterly RAC meetings.
- d. Provide a verbal summary presentation of the data collected and PI activities at the quarterly RAC meetings.
- e. Ensure that appropriate feedback/education is provided to individual components in RAC-G in areas identified as having opportunities for improvement, and document this in the quarterly PI minutes.

E. Performance Improvement Committee Members

- a. Must be active participants in the quarterly PI meetings.
- b. **Must attend at least 75% of** the meetings unless there is a valid reason for missing a meeting.
- c. Assist in developing appropriate topics for ongoing study within the system of RAC-G.

6. RESPONSIBILITIES TO THE PERFORMANCE IMPROVEMENT PROCESS

- A. Mortality percentage based on trauma patients dead on arrival versus the unsuccessful resuscitation attempts
- B. Mechanism of Injury
- C. Femur fractures and associate complications
- D. Patient population
  - a. All patients admitted to the hospital for at least 24 hours with ICD-10 codes
  - b. Transfer to or from another hospital including patients who are transferred but are not admitted
  - c. All trauma deaths in each hospital
  - d. All patients who are dead at the scene of the injury. (This will be provided via the EMS Directors or through the Bureau of Vital Statistics – 512-458-7111.) This information is also now received at the RAC Chair Meeting in Austin.

## Statement of Non-Disclosure

As a participating member of the RAC-G Medical Oversight Peer Review Committee, I agree to abide by the following principles:

1. I agree to serve on this committee for a minimum of two (2) years.
2. I agree to maintain confidentiality in all aspects of discussions during committee meetings. Specifically, I will not discuss any aspects of individual patient care or system-related problems with any individual who is not a member of this committee.
3. I agree to attend all committee meetings unless a valid emergency develops that precludes my attendance. If this occurs, I will notify the Committee Chairperson prior to the meeting.

Name (Please Print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

JoAnn Peters, RN Trauma Committee Chair \_\_\_\_\_

Trauma Chair \_\_\_\_\_ Date \_\_\_\_\_

Dr. Y. Desai, RAC-G Medical Director \_\_\_\_\_

Physician's Committee Chair \_\_\_\_\_ Date \_\_\_\_\_

\*\* Committee Chairs need to sign prior to filing

## Medical Oversight Peer Review Committee Data Form

Name of Hospital \_\_\_\_\_ County \_\_\_\_\_

Patient Gender M F Patient Age \_\_\_\_\_

Date Seen in Emergency Department \_\_\_\_\_ ED Admit Time \_\_\_\_\_

Admit Date \_\_\_\_\_ Discharge Date \_\_\_\_\_

Mode of Arrival to Hospital

Mechanism of Injury (Circle)

Ground EMS (Name) \_\_\_\_\_

GSW or Stab Wound

Air Transport (Name) \_\_\_\_\_

Auto-Pedestrian

Private Vehicle

Fall > Height \_\_\_\_\_ feet

Police/Sheriff

Other

Other (Describe) \_\_\_\_\_

Diagnoses (List 3 of the Most Severe Injuries)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Outcome

Hospital QI Review

Lived

\_\_\_\_\_

Preventable

Died

\_\_\_\_\_

Potentially Preventable

Death Rated:

\_\_\_\_\_

Non-Preventable

Death Occurred In: \_\_\_\_\_ ER \_\_\_\_\_ OR \_\_\_\_\_ ICU \_\_\_\_\_ Floor

POS \_\_\_\_\_

ISS \_\_\_\_\_

Disposition: Home \_\_\_\_\_

Nursing Home \_\_\_\_\_

Inpatient Rehab \_\_\_\_\_

Other Hospital (Name) \_\_\_\_\_

Date of Transfer \_\_\_\_\_

Time of Transfer \_\_\_\_\_

# REHABILITATION

## REHABILITATION

### Ongoing Updating

The following facilities provide rehabilitation services to patients within RAC-G:

Christus Good Shepherd Medical Center – Longview  
Christus Good Shepherd Medical Center – Marshall  
Health South – Tyler (Christus Trinity Mother Frances)  
Palestine Regional Rehabilitation Unit – Palestine  
UT Health Rehabilitation Hospital – Tyler

All of the above facilities offer long term care of patients. Animal therapy is also provided at Tyler Rehabilitation Hospital. Bed capacity for each rehabilitation facility is listed below.

Christus Good Shepherd Medical Center – Longview	
Christus Good Shepherd Medical Center – Marshall	
Health South – Tyler (Christus Trinity Mother Frances)	63 beds
Palestine Regional Rehabilitation Unit – Palestine	17 beds
UT Health Rehabilitation Hospital – Tyler	49 beds (on 2 floors)

To initiate transfer to the facility, the referring MD, RN, case manager, family or clerk calls the facility to arrange for a screening. The number/person to call for each facility is listed below.

Christus Good Shepherd Medical Center – Longview	903-315-1926 To have liaison arrange visit/screen
Christus Good Shepherd Medical Center – Marshall	
Health South – Tyler (Christus Trinity Mother Frances)	903-731-5100 To arrange visit/screen
Palestine Regional Rehabilitation – Palestine	903-731-5100 To arrange visit/screen
UT Health Rehabilitation Hospital – Tyler	903-596-3100 To have RN consultant visit patient

Each facility conducts a screening to determine if a patient meets their criteria for admission. Criteria are based on level of function, type of injury and financial status. All facilities accept Medicare, Texas Department of Rehabilitation funding and commercial insurance. Scholarship beds will be considered on a case-by-case basis at UT Health Rehabilitation Hospital. Most commercial insurance companies require pre-certification for rehabilitation services.

PUBLIC EDUCATION AND  
INJURY PREVENTION

## **PUBLIC EDUCATION AND INJURY PREVENTION**

The following is a list of the injury prevention efforts of RAC-G:

1. Trauma Nurses Talk Tough Program  
*Currently provided to schools/programs by the Level I and II Trauma Facilities*
2. Public Service Announcements submitted to local media
3. Joint efforts with EMS for public education
4. Any trauma center or affiliate hospital may provide public education and promotion.
5. The RAC uses the newspaper and local magazines to provide injury prevention education and information.
6. Co-Sponsors with MADD East Texas Region for the "Tie One On For Safety" Campaign.
7. Injury Pay Attention East Texas quarterly prevention campaigns/Videos
8. Hospitals and EMS members offer training to bring awareness to our region, i.e., Disaster Response, Stroke, STEMI, and Trauma. The RAC makes every effort to help support these events.
9. Educational Hour is desired at each RAC-G General Assembly Quarterly Meeting.

## PROVIDER EDUCATION

This section examines the certification of Trauma and Acute Care Providers and the Regional offerings that are currently available. The RAC Clinical Education Committee provides a continuing education offering during each scheduled RAC meeting. This clinical education offering offers continuing education credit for physicians and pre-hospital providers and certificates of attendance for nurses.

1. Available courses provided by facilities with the RAC include:
  - A. Physician
    - ATLS
    - PALS
    - ACLS
  - B. Nurse
    - PALS
    - ENPC
    - ACLS
    - TNCC
    - ATCN
  - C. EMT-P
    - ACLS
    - BTLS
    - PPPC
    - PALS
  - D. EMT-I
    - BTLS Advanced
  - E. EMT
    - BTLS Basic
2. Regional Education
  - A. Trauma Case Presentations
    - Monthly at Level I and II Trauma Centers
3. Annual Symposiums
  - A. Christus Trinity Mother Frances Trauma Symposium, Stroke Symposium
  - B. Longview Regional Trauma Tools
  - C. UT Health Tyler Hot Trauma Topics
  - D. UT Health Tyler Stroke Conference



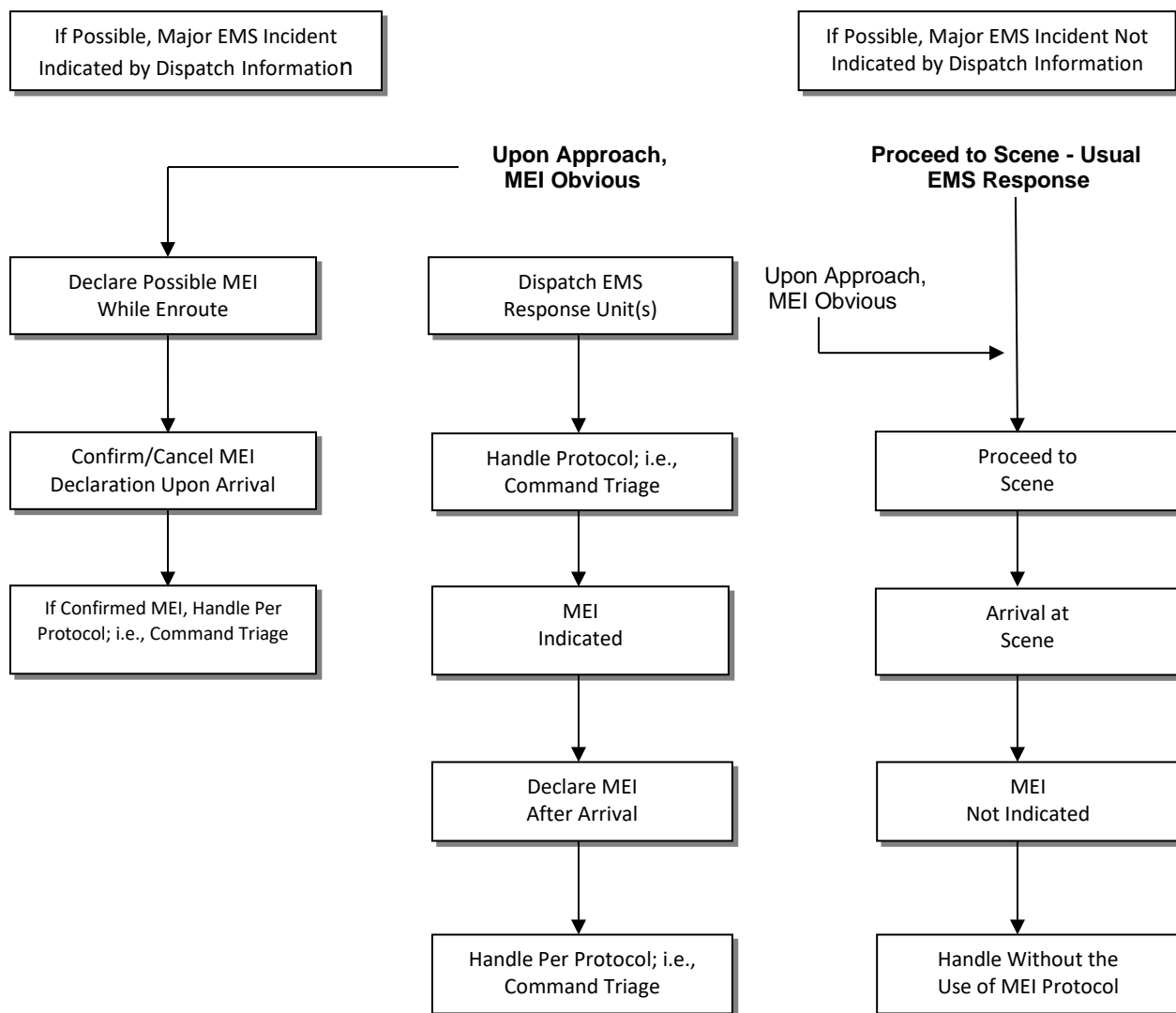
MODEL DISASTER PLAN  
FOR EMS AGENCIES

# MAJOR EMS INCIDENT (MEI EMS)

**Predesignating of Command & Triage Officers of Every Call  
If ICS in Place May Transfer Command**

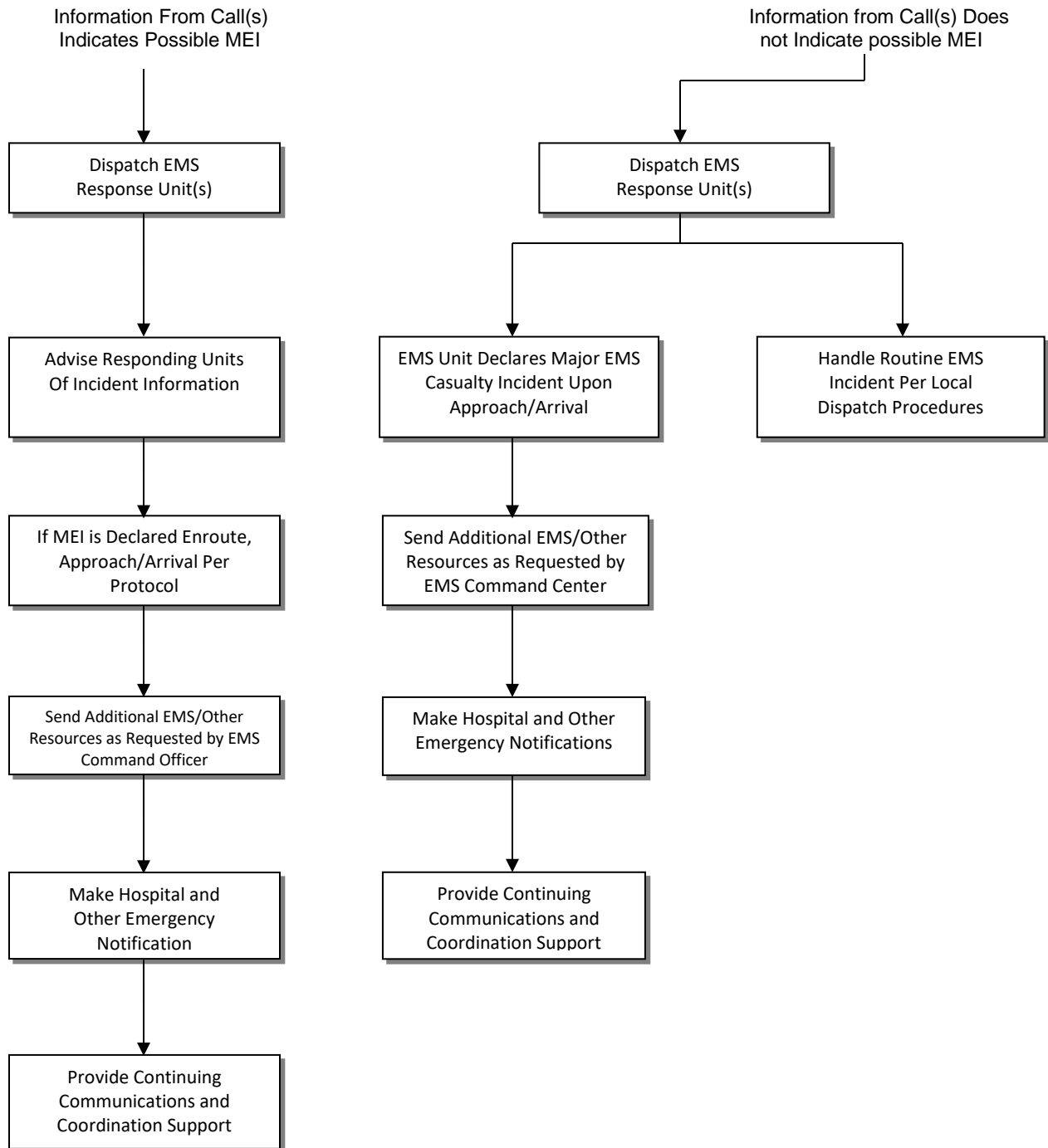
**EMS Vehicle(s) Dispatched to Scene**

**Enroute – Confirm Information with Dispatcher**



# MAJOR EMS INCIDENT (MEI DISPATCH) ALGORITHM

## EMS Dispatcher Receives Call(s) Concerning

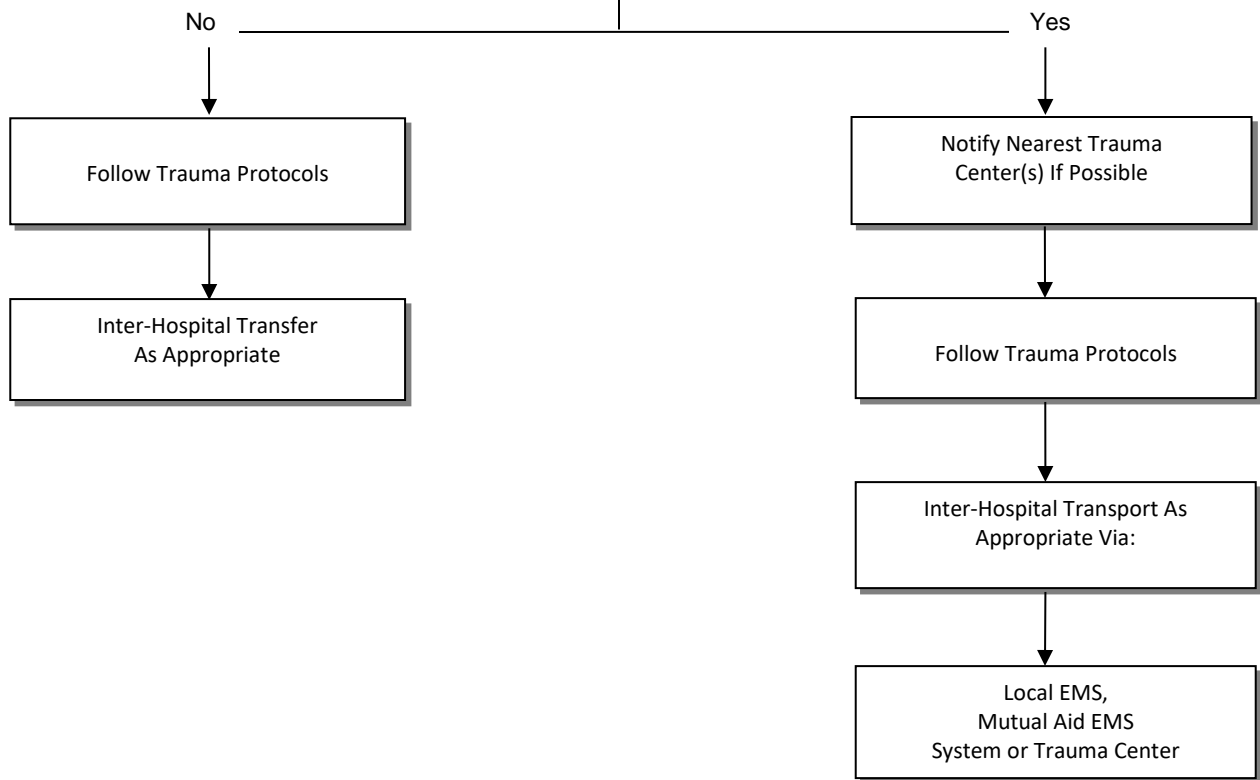


# MAJOR EMS INCIDENT HOSPITAL TRIAGE

Major EMS Incident Identified

Nearest Hospital(s) Identified  
Initiate Institutional Disaster Plan

Greater Than Current  
Resources?



TSA-G Resources Exceeded?

Yes

Utilize Resources in Bordering  
Regions (TSA'S)

## MODEL DISASTER PLAN \*

Each county and city in RAC-G maintain disaster plans. The development of a single all-encompassing plan for mass casualty or bioterrorism is finalized through the RAC. The following guidelines are provided in the meantime to standardize the EMS approach. This will lead to increased efficiency and cooperation with fire and safety providers.

The plan contained in this section is a basic model to guide EMS care during any incident exceeding the EMS system's standard operating capabilities.

Several appendices are included in this section which should help coordinate any major EMS incident. The key is to become familiar with the information in advance. The appendices in this section that impact a major EMS incident coordination are:

Appendix A: Hazardous Materials Guidelines  
Appendix B: Radioactive Materials Management

Particularly at large, major EMS incidents, it will be most effective to set up a "Command Post" in conjunction with the other emergency response agencies at the scene. In such situations, the EMS Command Officer should be at the Command Post and have an Assistant Command Officer do "footwork" at the scene. A triad Command Post (law enforcement, fire, and EMS) is preferred. The concepts described in this manual can stand alone or function within the Incident Command System (ICS).

- Portions of this plan are from the Rural Major EMS Incident; Scene Management Manual by Paul B. Anderson.

## **CONCEPT I**

### **Command and Triage Officers**

Effective and efficient management of any significant EMS incident, whether there are 6 or 60 patients, requires one person to be in charge of all EMS operations at the scene and one person to be responsible for patient triage. It takes an “EMS Command Officer” and an “EMS Triage Officer” to effectively manage any EMS incident scene. One person should not attempt to do both. Each EMS vehicle crew should pre-designate the EMS Command and Triage Officers. This will ensure that on every EMS call, there is no confusion as to who will function in these roles if that crew is the first to arrive at the scene of a significant EMS incident. All the personnel in the EMS unit should be thoroughly familiar with the significant EMS incident protocol so that each person will be able, if necessary, to function as the “EMS Command Officer,” “EMS Triage Officer,” or another critical role.

#### **TRANSFER OF COMMAND/TRIAGE**

In certain situations, it may be appropriate for EMS Command and EMS Triage responsibilities to be “transferred” to personnel arriving at the scene later. The most common situation where this occurs is if the first arriving EMS unit wishes to transfer command/triage to more experienced and/or advanced trained personnel who arrive later. Command and triage responsibilities should be assumed by EMS personnel within an EMS Agency, or they can be transferred to another EMS Agency if desired. Transfer of command should be done by radio.

#### **COMMAND AND TRIAGE RESPONSIBILITIES**

The duties of the EMS Command and Triage Officers are summarized as follows:

##### EMS Command Officer

- Performs overall scene “size-up.”
- Declares major EMS incident
- Determines need for and requests additional EMS or emergency help
- Organizes the EMS scene (incident, treatment, staging, loading and equipment bank)
- Coordinates activities with other Emergency Agencies (i.e., law enforcement and fire personnel)
- Directs all EMS activities at the scene until the incident is resolved
- Updates hospitals, makes notification, allocates patients
- In a large and/or drawn-out incident, an assistant is designated to carry out assigned duties

##### EMS Triage Officer

- Performs initial triage sweep of the scene to count the number of patients and make an initial severity determination
- Provides patient numbers and severity information to the EMS Command Officer
- Makes recommendations to EMS Command Officer concerning additional EMS resources needed
- Assigns EMS personnel to specific patient-care functions
- Continually repeats triage until all patients have been cleared from the scene
- Confers with EMS Command Officer concerning patient priority decisions, such as transport
- May assign an Assistant Triage Officer who will report back to another Triage Officer

Local protocols developed for major EMS incidents should include “checklists” that clearly identify the duties of the EMS Command and Triage Officers.

## **CONCEPT II**

### **Enroute Declaration**

An EMS unit dispatched to a situation that has the potential to be a major EMS incident should declare a possible major incident en route to the scene. A potential major incident would exist if the dispatch information indicates the possibility of:

- Multiple patients that will overtax normal mutual aid resources
- Special hazards, such as chemical or radiological incident (see Appendix A & B for HazMat and radioactive materials information)
- Difficult rescue or extrication
- EMS pre-hospital or hospital overload (system overload)

The EMS Command Officer should:

- Request the local/area EMS Dispatch/Communication Center to initiate appropriate action based on the initial information received. This may include:
  - Dispatch of additional EMS units
  - Placing appropriate EMS units on stand-by status
  - Notification of special resources that may be needed, such as rescue, extrication or hazardous materials response teams
- Notify area hospitals so that they can prepare to receive patients. Dispatch should post the event on the EMS system in order to notify all hospitals quickly.

The EMS unit that declares a possible major incident while enroute to the scene must, as soon as possible, verify that a major incident does or does not exist.

### **CONCEPT III**

#### **Scene Approach**

As the EMS vehicle approaches the scene, the crew should “size up” the situation. Initial observations should focus not only on the overall magnitude of the situation but also specifically on possible hazards, such as downed power lines, fire or hazardous materials. If any of these hazards exist, the EMS Command Officer must immediately radio the Dispatch Center to ensure that the appropriate emergency response units are sent to the scene. As the EMS vehicle approaches the scene, if it is obvious that a major EMS incident exists, the Command Officer should declare a major EMS incident and activate the Major EMS Incident Protocol upon arriving at the scene. If it is not obvious, the decision to declare or not declare a major incident may be postponed, and an actual scene assessment must be conducted before the declaration is made.

- Upon approach, if specific hazards are observed, appropriate assistance should be requested immediately.
- As the EMS vehicle approaches the scene, a parking location should be identified with SAFETY as the prime consideration.
- The EMS vehicle parking location should minimize traffic hazards, be upwind from hazardous material spills and be a safe distance from a fire, downed power lines or other hazards.
- If possible, use vehicle as protection.
- If first on the scene, identify command via radio; state “I am Command”.
- If not first on the scene, report to Incident Command for report and plan of immediate action.



## **CONCEPT IV**

### **Scene Arrival**

Upon arrival at the scene, the EMS crew should leave the vehicle to conduct a scene assessment. In order to enable the EMS Command and EMS Triage Officers to “size up” the situation, both should go together on the first triage sweep. The first sweep will usually only take a minute or two to simply count the number of patients, obtain an initial idea of the severity of the patients’ conditions and an estimate of any requirements for additional personnel and equipment. The Command and Triage Officers should briefly confer when the triage sweep is completed and make a decision to declare a major incident, if indicated. If a decision is made at this point to declare a major incident, the EMS Command Officer should contact Dispatch, declare a major incident, declare him- or herself Command and request additional resources.

The Command and Triage Officers should put on assigned vests so that they are clearly identified in their respective roles. The Command and Triage Officers should then continue to follow the Major EMS Incident Protocol.

**NOTE:** If a situation is declared a possible major EMS incident, the EMS Command Officer should, as soon as possible, either confirm that a major incident exists or cancel the declaration of a possible major EMS incident.

## **CONCEPT V**

### **EMS Communications**

The following information pertains to EMS radio communications from the scene. If the incident scene is out of radio coverage range, alternative contact methods must be used (such as the nearest telephone).

#### Dispatch/Operations Communication

The EMS unit that declares a major EMS incident should identify itself as “EMS Command”. In all subsequent radio transmission to/from this EMS unit, the term “EMS Command” should continue to be used. All EMS unit radio communications from the scene should be through the EMS “Command Officer”. No one other than the Command Officer should communicate with the dispatcher/communications center as this will only result in confusion. When the EMS personnel are present to handle the situation, the Command Officer may identify one individual to be the radio communicator. This will ensure that one person is always at the radio to hear and respond to radio communications. If a radio communicator is utilized, the EMS Command Officer still makes the decisions and directs the radio communicator.

#### Medical Communications

The EMS Command Officer is in charge of all field EMS Communications, including medical communication related to patient status, treatment and transport. To simplify and reduce the length of radio transmissions, patient information should be given by severity category as shown below.

#### Patient Severity Categories

Category	Condition
Priority 0 (Black)	Fatal
Priority I (Red)	Critical, Life-Threatening
Priority II (Yellow)	Non-Critical but Serious
Priority III (Green)	Non-Serious

Priority 0 (Black) Category patients are triaged, but patient information is not communicated. Using these severity categories as an example of medical radio communications is as follows:

“We have two trauma Priority I patients, including one with a severe head injury; three trauma Priority II patients and one trauma Priority III patient.”

This severity category system is to be used instead of taking time to give complete injury information and vital signs on every patient during a major EMS incident. If the hospital destination will be affected by the type of injury (e.g., head or chest), this information should be communicated at the appropriate time. Medical direction should be obtained as needed for individual treatment and transport decisions.

## CONCEPT VI Triage Procedures

The EMS Triage Officer should triage and categorize the patients as:

Category	Condition
Priority 0 (Black)	Fatal
Priority I (Red)	Critical, Life-Threatening
Priority II (Yellow)	Non-Critical but Serious
Priority III (Green)	Non-Serious

Patients who are dead at the scene or die at the scene are most commonly tagged with black tags. If black tags are not available, one alternative is to use red tags and put a large black "X" on the tag with a marking pen. Many techniques may be used to quickly number and categorize patients. Methods include colored ribbon, colored tape or colored tags. The key is to keep moving from patient to patient to complete the first triage sweep without delay. Initially, triage decisions are based entirely on quick observations. For example, if a patient is unconscious or obviously having respiratory difficulty, the patient would be categorized as Priority I. If another patient is conscious, talking and complaining only of pain in the ankle area, the patient initially would be categorized as Priority III.

The Command and Triage Officers do not stop to initiate treatment but may quickly direct others to do so. For example, a bystander may be asked to apply direct pressure to a bleeding wound or hold a patient's head to protect the cervical spine. The EMS Triage Officer continually repeats triage sweeps to determine if the condition of any patient has changed and to identify priorities for the movement of patients to the treatment areas and/or for transport.

As additional EMS personnel arrive at the scene, the Command Officer will assign personnel to function under the direction of the Triage Officer, who assigns them to specific patients. On subsequent triage sweeps, the Triage Officer updates the condition status of each patient based upon information provided to him/her by the EMS personnel assigned to each patient. The Triage Officer should periodically confer with the Command Officer concerning the condition and status of the patients.

In large-scale major EMS incidents, an expanded triage concept should be used which includes the designation of Assistant Triage Officers. For example, if several railroad passenger cars are overturned with injured persons in each passenger car, an Assistant Triage Officer should be appointed for each rail car. Each Assistant Triage Officer should report back to the EMS Triage Officer who, in turn, coordinates activities with the EMS Command Officer.

## **CONCEPT VII**

### **Scene Organization**

Organizing a major EMS incident scene may require the designation of specific manageable areas. If there are sufficient personnel, each area should have a Manager designated to organize the activities in the area. All area Managers report directly to the EMS Command Officer.

#### Incident Area

The Incident Area is the area involving the actual incident. If rescue extrication techniques are needed, a Rescue-Extrication Manager should be appointed to coordinate extrication activities in conjunction with the Incident Area Manager.

#### Staging Area(s)

If necessary, one or more Staging Areas should be designated for EMS vehicles to park as they arrive at the scene. This will help keep the EMS vehicles from blocking each other and allow an organized movement of vehicles as directed by the EMS Command Officer. Determine the Staging Area location while enroute to the scene. When approaching the scene, communicate to the EMS Command Officer, remain with vehicle and await orders.

#### Treatment Area(s)

The Treatment Area(s) should be organized in relation to the number of patients. With a larger number of patients, a separate Priority I Treatment Area should be identified to allow advanced or more experienced EMS personnel and equipment to be concentrated in the Priority I Treatment Area. A separate Priority II Treatment Area for serious but non-critical patients may be staffed by basic personnel. Patients categorized as Priority III require observation by at least one person to continually reassess their condition. Patients who are initially Priority III may develop complications and may need to be upgraded to Priority II or Priority I.

#### Equipment Bank Area

In certain major incident situations, an Equipment Bank Area should be established. As EMS units arrive at the Staging Area, backboards, splints, oxygen and other equipment should be removed and taken to the Equipment Bank Area. This would be communicated to incoming EMS units by the EMS Command Officer.

#### Loading Area(s)

A Loading Area(s) should be established in proximity to the Treatment Area to allow ambulance vehicles to pull up, load and leave. NOTE: Loading Area \_\_\_\_\_.

Manager = "Transportation Officer"

## **CONCEPT VIII**

### **Scene Coordination**

The EMS Command Officer is responsible for coordination of all EMS activities at the Scene, including liaison with other emergency response organizations. The EMS Command Officer must work closely with the senior law enforcement officer, senior fire officer and others. For example, the EMS Command Officer may need to request help from law enforcement to clear space in order to establish Treatment, Staging or Loading Areas. The EMS Command Officer may also request help from law enforcement to find a location for a helicopter landing zone that is safe and will not disturb patient care in the Treatment Area(s).

EMS officers, although not usually in charge of the overall scene, are in charge of all EMS functions at the scene, including determinations regarding the need for EMS resources, and all decisions affecting patient treatment and transport.

## **CONCEPT IX**

### **Scene Treatment**

Patient treatment at a major EMS incident will depend on availability of EMS resources at the scene as well as other considerations, such as distance to receiving hospitals. The EMS Command Officer and Triage Officer(s) must confer soon after arrival at the scene and make decisions (in coordination with medical direction, if practical) concerning whether or not to limit the treatment procedures at the scene. At a small-scale incident with several ambulances available, including one or more ALS units, the EMT-B's, EMT-I's and EMT-P's may be able to render Basic, Intermediate and Advanced Life Support care for the patients. However, at a large-scale incident when the number of patients is so large that the EMS personnel are overwhelmed, it may not be practical to initiate ALS skills at the scene. Considering the amount of time it would take to initiate Advanced Life Support (ALS) patient care, circumstances may dictate providing minimal advanced patient care so that more patients can be effectively treated. Therefore, even if some of the EMS personnel at the scene possess ALS capability, at a large-scale incident patient care needs.

At a major EMS incident, after the first arriving EMS unit is parked and the Command and Triage Officers have performed the initial triage sweep, the lack of additional personnel may prevent the Command and Triage individuals from limiting their roles to management duties. For example, after the first triage sweep is completed and the EMS Command Officer has radioed for additional help, it may be a period of time before responding EMS resources arrive at the scene. In this case, it would be necessary for the EMS Command and Triage Officers to render patient care until additional EMS assistance arrives. In such a situation, first responders (i.e., fire, police, etc.) may be utilized to assist with patient care until additional EMS resources arrive. In urban areas where additional EMS personnel may arrive in minutes, the Command and Triage Officers may be able to limit their functions to the Command and Triage management duties.

## **CONCEPT X**

### **Scene Hospital Coordination**

The EMS Command Officer needs to ensure that EMS communication is effectively conducted between the incident scene and the hospital(s) that will be receiving patients. The EMS Command Officer needs to work closely with the EMS Triage Officer to obtain the most current condition/severity information and communicate this information to the receiving hospital(s) for patient allocation purposes.

To assure prompt transport of patients with critical, life-threatening conditions, a local/area hospital policy should be developed for major EMS incidents. Such a policy should provide guidelines that address the area's ability to handle critically injured patients and outline how medical direction will be provided. If a geographical area has three hospitals, the policy might state that each hospital would accept two critical patients immediately from a major EMS incident scene with the most critically injured being transported to the highest level trauma center within the routine transport area. Establishing such a written transport policy for conditions allows time for medical direction to obtain information needed to make destination decisions for the other patients. This would include determining the availability of hospital beds, physicians/surgeons, surgical suites, nursing and support staffs. While hospital status information is being obtained for patient allocation purposes, the highest priority critical patients would already be Enroute from the major EMS incident scene to definitive care.

## **CONCEPT XI**

### **Hospital Triage**

RAC-G is predominately rural in nature; therefore, the major EMS Incident Plan must be careful to direct appropriate utilization of hospitals without depleting the initial in-house staff and/or overwhelming the local resources.

The hospital(s) nearest the incident will receive notification of the major EMS incident through Dispatch or field communication. The hospital(s) will activate institutional Disaster Plan(s) to ensure resources. If the anticipated patients will certainly exceed the initial hospital's resources and if time permits, the nearest Trauma Center should be contacted for back-up assistance. The nearest Trauma Center can then prepare for multiple severe patients. The Trauma Center may also wish to offer inter-hospital transport assistance at this time.

Inter-hospital transfer should be utilized as patient condition warrants based on the established Trauma Region Plan guidelines and as current resources are exceeded. If the local EMS agencies remain occupied with the initial scene, one should consider utilizing mutual-aid EMS providers for transport or requesting the accepting Trauma Center(s) to send transport teams for the patients.



## **CONCEPT XII**

### **Major EMS Incident Critiques**

All major incident exercises, as well as actual incidents, must be critiqued. The purpose of the critique should be to determine how the incident was handled and what can be learned to improve response to future incidents. All agencies involved in the exercise or actual incident must be included and a Critique Coordinator should be identified.

At the beginning of the critique, basic information including dates, times, location, type of incident and number injured should be available in handout form. The critique should address how the emergency help was summoned, dispatch agency involvement, performance of responding emergency units, command and triage performance, special resource use, mutual aid, hospital involvement and virtually all related factors. The critique should be conducted in a non-intimidating fashion and in a manner which encourages discussion so that everyone can benefit from an in-depth analysis of the event. It is also important to include Critical Incident Stress Debriefings (CISD) for all emergency personnel. CISD should be completed within 72 hours post-incident.

Major EMS incident critiques should be held within 10 days (six working days) of the date of occurrence. The critique should be documents in report form and submitted to RAC-G.

HOSPITAL PREPAREDNESS PROGRAM  
RESPONSE PLAN

## **MISSION STATEMENT**

The Mission of the Hospital Preparedness Program Committee is to promote hospital and community hazards preparedness through education, financial assistance and training while integrating state-wide preparedness activities at the local level.

## PINEY WOODS REGIONAL ADVISORY COUNCIL - TSA-G RESPONSE PLAN Revised 12/15/2022

In 2009 the Piney Woods Regional Advisory Council — RAC-G, Bioterrorism Hospital Preparedness Program Year 2 Response Plan was first developed in January 2003 in response to the national smallpox immunization program. The Smith County hospitals initially developed this plan to determine those individuals who would be immunized against smallpox. This plan was broadened to cover the entire Piney Woods Regional Advisory Council — RAC-G due to the need to regionalize the plan and due to the need to distribute 2002 hospital Bioterrorism funds in a manner that would strengthen the regional plan. With the change during YR 4 from Bioterrorism to "All Hazards" Preparedness, the response plan needed a few changes, except for converting the wording from BT to Hospital All-Hazards Preparedness. In addition to the wording change, the HRSA grants were taken over by the Assistant Secretary for Preparedness and Response (ASPR). The grant became known as the ASPR Hospital Preparedness Program.

In the 2019 pandemic surge, Coronavirus (COVID-19) had many challenges for all Hospitals, Clinics, and Long-Term Care facilities in the RAC-G Region during the COVID pandemic surge. The COVID cases were increasing dramatically daily. On March 13, 2019, President Donald Trump declared a National Emergency. Governor Greg Abbot declared a statewide public health disaster and authorizes using all resources. March 16<sup>th</sup>, 2019, businesses were restricted in capacity. Health care facilities ER departments in RAC-G and TSA-F were at saturation level with some in divert. Due to the pandemic, this plan was broadened to cover infectious diseases for the entire Piney Woods Regional Advisory Council — RAC-G to regionalize this plan.

Although East Texas contains many strong hospitals and hospital systems, none of the hospitals could individually effectively manage a true regional-wide infectious disease pandemic without financial assistance from state and federal funds. However, by working together, the regional hospitals have great combined strength. These strengths include the following:

- ✦ The Level I and II Trauma Centers at Christus Trinity Mother Frances Tyler and UT Health Tyler
- ✦ The Tuberculosis Isolation Ward at UT Health North Campus Tyler
- ✦ Negative pressure isolation room(s) at each facility
- ✦ The Public Health Laboratory of East Texas on the campus of UT Health North Campus Tyler
- ✦ A large dedicated medical community
- ✦ Several excellent ambulances and air ambulance systems
- ✦ Advanced telecommunication systems
- ✦ The Center for Pulmonary and Infectious Disease Control based at UT Health North Campus Tyler
- ✦ Vast networking with both Public Health (local and regional) and local Department of State Health Services Region 4/5 North, which encompasses most of the RAC-G region

- ✦ Establishment of a Medical Special Needs Shelter with a contract for roll-out at the University of Texas at Tyler's Patriot Gymnasium with a capacity for a 200-bed special medical shelter facility. The use of their nursing staff is part of the contract.
- ✦ Equipment for an additional 200-bed Medical Special Needs Shelter
- ✦ A network of satellite phone communications systems
- ✦ Implementation of WebEOC, a web-based emergency reporting mechanism to be used statewide
- ✦ Unified incident command structure with all trauma hospitals meeting NIMS compliance elements for disaster response
- ✦ Hospital-trained decontamination teams for 24/7 response

Following an infectious disease pandemic, patients overwhelm the emergency rooms they normally utilize. However, the hospitals with large emergency rooms in East Texas have very limited respiratory isolation capacity. Conversely, UT Health North Campus Tyler has one of the largest respiratory isolation capacities in Texas but has a small emergency department. Also, UT Health North Campus Tyler is not conveniently located for many citizens in East Texas. Likewise, East Texas has many small hospitals with no respiratory isolation capacity, and those hospitals are not equipped to handle and do not have the experience of caring for patients with contagious infectious diseases. Therefore, the following plan was developed:

Patients requiring respiratory isolation following will be sent to Trauma I and Trauma II hospitals, preferably if beds are available.

Prior to transferring any patients to the hospitals, the hospital's administration must be notified and accept the transfer.

For UT Health North Campus Tyler to open its negative pressure ward, the tuberculosis patients that reside there will need to be transferred off the ward. Many of these patients no longer require respiratory isolation so they can be transferred to another bed at UT Health North Campus Tyler. Some patients, however, will need to be transferred to an isolation room at another East Texas facility. UT Health North Campus Tyler may also need to transfer noncontagious patients to regional East Texas facilities to care for the new patients requiring isolation. The RAC-G hospitals will accept these patients as part of the regional plan.

Patients who do not require respiratory isolation following a positive diagnosis will be cared for at the hospital they present to unless that hospital cannot deliver the required care.

Trauma Level I and Trauma Level II hospitals have established off-site triage capability for potential pandemic/mass casualty events.

If the initial hospital cannot provide the needed care, the patient will be transferred to one of the larger regional hospitals if the receiving hospital has available beds and can provide the needed care. These larger regional hospitals include Christus Trinity Mother Frances Tyler, Christus Good Shepherd Longview, Longview Regional Medical Center, UT Health Tyler, and UT Health North Campus Tyler.

Once patients are no longer contagious, they will need to be transferred from UT Health North Campus Tyler back to one of the regional hospitals.

Hospitals within the East Texas area will postpone elective surgery during an infectious disease pandemic so that scarce resources such as blood products, ventilators, and pharmaceuticals can be available to the victims.

Any portable equipment purchased directly by the Piney Woods Regional Advisory Council - RAC-G will remain the property of the RAC but will be distributed to hospitals in the RAC Trauma Service Area. These hospitals will be responsible for maintaining these items and keeping them in good working order. If an infectious disease event or an event requiring UT Health North Campus Tyler to increase its respiratory isolation capacity quickly, the RAC purchased equipment can be transferred and delivered to UT Health North Campus Tyler.

Rules for the distribution of Piney Wood's PPE stockpile are contained in a separate document and will be followed during an infectious disease event.

Emergency transport ventilators purchased by RAC-G will be made available as needed during a public health emergency.

### **EMResource**

- ✚ RAC-G maintains a System Administrator for the EMResource Bed Availability and Resource Management System.
- ✚ Upon notification of a major event or regional exercise, the System Administrator will initiate an EMResource event and post it for all users.
- ✚ EMResource events and/or notifications will be specific to the hazard and users impacted.
- ✚ The System Administrator and designee will receive notifications from DSHS on State and Federal HAvBED alerts and will subsequently activate regional HAvBED events from RAC-G hospitals.

### **WebEOC**

- ✚ RAC-G maintains a System Administrator for the WebEOC Crisis Information Management System.
- ✚ Upon notification of a major event or a regional exercise, the System Administrator will initiate a WebEOC Incident and post it for all users.
- ✚ The System Administrator is designated as the secondary Administrator for WebEOC and serves as a backup to the Primary Administrator for the regional system.
- ✚ The System Administrator receives a notification on exercises and events from all local, regional, and state agencies to maintain situational awareness for incident activation.
- ✚ The System Administrator will promote system best practices and user training to all RAC

## **PINEY WOODS REGIONAL ADVISORY COUNCIL – TSA-G RESPONSE PLAN – Revised 8/5/2009**

The Piney Woods Regional Advisory Council – RAC-G, Bioterrorism Hospital Preparedness Program Year 2 Response Plan was first developed in **January 2003**, in response to the national smallpox immunization program. This plan was initially developed by the Smith County hospitals in order to determine those individuals who would be immunized against smallpox. This plan was broadened to cover the entire Piney Woods Regional Advisory Council – RAC-G due to the need to regionalize the plan and due to the need to distribute 2002 hospital Bioterrorism funds in a manner that would strengthen the regional plan. With the change during YR 4 from Bioterrorism to “All Hazards” Preparedness, the response plan needed few changes except for the conversion of the wording from BT to Hospital All Hazards Preparedness. In addition to the wording change, the HRSA grants were taken over by the Assistant Secretary for Preparedness and Response (ASPR) and the grant became known as the ASPR Hospital Preparedness Program.

Although East Texas contains many strong hospitals and hospital systems, none of the hospitals could individually effectively manage a true regional bioterrorism/all hazards event. However, by working together, the regional hospitals have great combined strength. These strengths include the following:

- The Level 1 and 2 Trauma Centers at Christus Trinity Mother Frances Tyler and UT Health Tyler
- The Tuberculosis Isolation Ward at UT Health North Campus Tyler
- Negative pressure isolation room(s) at each facility
- The Public Health Laboratory of East Texas on the campus of UT Health North Campus Tyler
- A large dedicated medical community
- Several excellent ambulance and air ambulance systems
- Advanced telecommunication systems (NETnet)
- The Center for Pulmonary and Infectious Disease Control based at UT Health North Campus Tyler
- Vast networking with both Public Health (local and regional) and local Department of State Health Services Region 4/5 North which encompasses most of the RAC-G region
- Establishment of a Medical Special Needs Shelter with contract for roll-out at the University of Texas at Tyler’s Patriot Gymnasium with a capacity for a 200-bed special medical shelter facility. Use of their nursing staff is part of the contract.
- Equipment for an additional 200-bed Medical Special Needs Shelter
- A network of satellite phone communications systems
- Implementation of WebEOC, a web-based emergency reporting mechanism to be used state-wide
- Unified incident command structure with all trauma hospitals meeting NIMS compliance elements for disaster response
- Hospital-trained decontamination teams for 24/7 response

Following a bioterrorism attack/all hazards event, patients will follow their usual behavioral pattern and present to the emergency rooms they normally utilize or to which are in closest proximity. The hospitals with large emergency rooms in East Texas, however, have very limited respiratory isolation capacity.

Conversely, UT Health North Campus Tyler has one of the largest respiratory isolation capacities in Texas, but it has a small emergency department. Also, UT Health North Campus Tyler is not conveniently located for many citizens in East Texas. Likewise, East Texas has many small hospitals with no respiratory isolation capacity, and those hospitals are not equipped to handle and do not have the experience of caring for patients with contagious infectious diseases. Therefore, the following plan was developed:

- Patients requiring respiratory isolation following a bioterrorism event will be sent to UT Health North Campus Tyler, as long as beds are available.
- Prior to transfer of any patient to UT Health North Campus, their administration must be notified and must accept the transfer.
- In order for UT Health North Campus Tyler to open its negative pressure ward, the tuberculosis patients that reside there will need to be transferred off the ward. Many of these patients no longer require respiratory isolation, so they can be transferred to another bed at UT Health North Campus Tyler. Some patients, however, will need to be transferred to an isolation room at another East Texas facility. UT Health North Campus Tyler may also need to transfer non-contagious patients to regional East Texas facilities in order to care for the new patients requiring isolation. The RAC-G hospitals will accept these patients as part of the regional plan.
- Patients that do not require respiratory isolation following a bioterrorism, chemical or all hazards event(s) will be cared for at the hospital they present to unless that hospital is unable to deliver the required level of care.
- Trauma Level 1 and Trauma Level 2 hospitals have established off-site triage capability for potential pandemic/mass casualty events.
- If the initial hospital cannot provide the needed care, the patient will be transferred to one of the larger regional hospitals if the receiving hospital has available beds and can provide the needed care. These larger regional hospitals include Christus Trinity Mother Frances Tyler, Christus Good Shepherd Longview, Longview Regional Medical Center, UT Health Tyler and UT Health North Campus Tyler.
- Once patients are no longer contagious, they will need to be transferred from UT Health North Campus Tyler back to one of the regional hospitals.
- Healthcare worker surge capacity for UT Health North Campus Tyler following a bioterrorism event will be provided by the Piney Woods Regional Advisory Council – RAC-G hospitals. The surge capacity will include physicians, nurses, respiratory therapists, pharmacists, laboratory workers and anyone else needed to provide effective care.
- Hospitals within the East Texas area will postpone elective surgery following a bioterrorism/all hazards event so that scarce resources such as blood products, ventilators and pharmaceutical can be made available to the victims.
- Following a bioterrorism/all hazards event the cost of caring for the victims will be equitably distributed among the regional hospitals.
- The portable HEPA filters purchased directly by the Piney Woods Regional Advisory Council – RAC-G will remain the property of the RAC but will be distributed to hospitals in the RAC Trauma Service Area. These hospitals will be responsible for maintaining these items and keeping them in good working order. In case of a bioterrorism/all hazards event, or an event that requires UT Health North Campus Tyler to quickly increase its respiratory isolation capacity, these HEPA filters will be delivered to UT Health North Campus Tyler. HEPA filters that hospitals buy with their own designated funds will not be at the disposal of the RAC or UT Health North Campus Tyler.



- Rules for the distribution of Piney Wood's pharmaceutical stockpile are contained in a separate document and will be followed during a bioterrorism event.
- Emergency transport ventilators purchased by RAC-G will be made available as needed during a public health emergency.
- Hospitals will keep the EMSystems computers purchased through RAC-G in good working order, updated and dedicated to EMSystems. This system will be utilized during a public health emergency to monitor the transfer of patients.

#### EMResource

- RAC-G maintains a System Administrator for the EMResource Bed Availability and Resource Management System.
- Upon notification of a significant event or regional exercise, the System Administrator will initiate an EMResource event and post it for all users.
- EMResource events and notifications will be specific to the hazard and users impacted.
- The System Administrator and designee will receive notifications from DSHS on State, and Federal HAvBED alerts and will subsequently activate regional HAvBED events from RAC-G hospitals.

#### WebEOC

- RAC-G maintains a System Administrator for the WebEOC Crisis Information Management System.
- Upon notification of a significant event or a regional exercise, the System Administrator will initiate a WebEOC Incident and post it for all users.
- The System Administrator is designated as the secondary Administrator for ETWebEOC and serves as a backup to the Primary Administrator for the regional system.
- The System Administrator receives a notification on exercises and events from all local, regional, and state agencies to maintain situational awareness for incident activation.
- The System Administrator will promote system best practices and user training to all RAC-G users.

# PEDIATRIC RESPONSE PLAN

## **PEDIATRIC MISSION STATEMENT**

The Pediatric Committee for RAC-G aims to improve the care of the pediatric population by providing education, improvement processes, equipment assistance, and information from other agencies to all members.

### GOALS

- To ensure appropriate pediatric patient care by providing education to all facilities and agencies throughout the RAC-G area.
- To assist with the timely and appropriate transfer of the pediatric patient to a Pediatric Trauma Center.

# STROKE RESPONSE PLAN

# **STROKE MISSION STATEMENT**

## OVERVIEW

The Stroke Committee of RAC-G is committed to improving the care and transportation of stroke patients by developing transport protocols and education on the most current standards of care to Emergency Departments.

## MISSION STATEMENT

To review emergency transport and treatment of the stroke patient. To do this, the Committee will identify stroke care professionals from hospitals in RAC-G. The Committee will review and define each of these hospitals' stroke care capabilities and guidelines for the transportation of the stroke patient to the appropriate hospital.

## STROKE COMMITTEE GOALS

- Development of transport protocols for the stroke patient to the facility that can give the highest level of care based on the time of onset of symptoms
- Continual education on current standards of care for the stroke patient
- Public education on all aspects of stroke and the importance of activating EMS

**TRAUMA SERVICE AREA (TSA) G  
REGIONAL STROKE PLAN  
2012**

Data from the Texas Department of Health indicated that TSA-G had one of the highest death rates from Strokes of the 22 Trauma Service Areas in Texas.

As a result, a stroke care committee was developed to develop emergent transport and treatment protocols for TSA-G.

This stroke transport plan has been developed per currently accepted guidelines.

**DESIGNATED TRAUMA CENTERS  
TSA-G**

**UPDATING LIST for 2023**

Insert Current List

## **TRAUMA SERVICE AREA-G Emergency Medical Services (EMS) Agencies**

The TSA-G map of EMS agencies describes EMS areas of coverage that serve TSA-G. These agencies range from a small volunteer service with one (ten-year-old) ground unit to a regional EMS agency with over 59 ground units and two hospital-based helicopters.

Virtually all of TSA-G is covered by 911 or enhanced 911. Several agencies are dispatched by the county sheriff's office, the city police department, the fire department, or some combination of these three agencies. Many do not have dispatch protocols. Approximately one-half of the dispatch agencies provide pre-arrival instructions, and a minority have computer-aided dispatch (CAD).

The largest regional EMS service uses dispatch personnel certified with Emergency Medical Dispatch (EMD) and a state-of-the-art CAD. A new dispatch center controls an 800 MHz trunking radio system. The system will be enhanced by AVL (Automatic Vehicle Locators). The 800 MHz system will have space available for other agencies to utilize.

Approximately one-half of the EMS agencies in Area G respond to calls at the level of Advanced Life Support (ALS) or Mobile Intensive Care Unit (MICU) capability with paramedics. A recent TSA-G Piney Woods RAC survey indicated that the systems responding at the Basic Life Support (BLS) level are 85% Emergency Medical Technicians (EMT) and 15% Emergency Care Attendants (ECA) trained. The survey indicated that 75-80% of TSA-G systems provide continuing education for their personnel, and all but one of the services provide monthly quality assurance reviews.

One-third of the agencies work in areas with no local hospitals. Therefore, TSA-G scene-to-hospital times may range from 5 to 50 minutes. Scene-to-Primary Stroke Center ground times may exceed 70 minutes, and air transport times are as long as 30 minutes from some areas of TSA-G. Two-thirds of the EMS agencies have been active in the TSA-G Piney Woods RAC formation. Most of these agencies have participated in the Piney Woods RAC Pre-Hospital Care and Transportation Committee.

The Texas Department of Health EMS Program for our region has been very helpful in distributing and collecting EMS surveys for the Pre-Hospital Committee of the TSA-G Piney Woods RAC. They serve as neutral parties with authority, sharing the goal of developing standardized trauma protocols, standardized training, and practical quality improvement activities for TSA-G.



## RAC-G Emergency Department Medical Directors

### UPDATING LIST

Facility	Name	Address	City & Zip
Christus Good Shepherd Medical Center – Longview	Dustin McDermott, MD	700 E. Marshall Ave.	Longview 75601
Christus Good Shepherd Medical Center – Marshall	Jennifer Chandler, MD	811 S. Washington	Marshall 75766
Christus Trinity Mother Frances Jacksonville	Luis Haro, MD	2026 S. Jackson St.	Jacksonville 75766
Christus Trinity Mother Frances Tyler	Luis Haro, MD	615 S. Fleishel	Tyler 75701
Christus Trinity Mother Frances Winnsboro	Luis Haro, MD	719 W. Coke Rd.	Winnsboro 75783
Freestone Medical Center	Christin LeBlanc, MD	125 Newman	Fairfield 75840
Houston County Medical Center	N. El-Aswald, MD	1100 Loop 304 E	Crockett 75835
Longview Regional Medical Center	Ron Simonton, MD	2901 N. Fourth St.	Longview 75605
Palestine Regional Medical Center	Eric Schroder, MD	4002 South Loop 256	Palestine 75801
UT Health Athens	Lane Schnell, MD	2000 S. Palestine	Athens 75751
UT Health Carthage	G. Reddy, MD	P.O. Box 549	Carthage 75633
UT Health Henderson	Thomas Curtis, MD	300 Wilson St.	Henderson 75652
UT Health Jacksonville	Rodney Caldwell, MD	501 S. Ragsdale	Jacksonville 75755
UT Health Pittsburg	Brian Kempton, MD	2701 Hwy 271 S	Pittsburg 75686
UT Health Quitman	Paul Driver, DO	P.O. Box 1000	Quitman 75783
UT Health Tyler	Bob Creath, MD	1000 S. Beckham	Tyler 75701
UT Health North Campus Tyler	Ted Gould, MD	11937 US Hwy 271	Tyler 75708

## **MEDICAL OVERSIGHT**

TSA-G includes rural and urban areas with hospital and emergency care providers with varying levels of medical capability. There is currently no single EMS director since there are 24 EMS agencies in the region and over 150 first responder agencies. As previously stated, one of the goals of the RAC is to establish an EMS Medical Director for TSA-G to facilitate the standardization of pre-hospital care throughout the region. Given the region's diversity and the number of EMS agencies involved, this is a long-term goal that may never be realized. There is, however, the use of the RAC's stroke protocols, which accomplishes off-line uniformity of medical control.

Following DSHS guidelines, all RAC-G pre-hospital care providers function under medical control. Regional EMS protocols are printed and distributed to all EMS providers for incorporation into local protocols.

## **PREHOSPITAL TRIAGE AND TRANSPORT GUIDELINES FOR STROKE PATIENTS**

The goal for the appropriate transportation of the acute stroke patient will be based on the rapid and accurate assessment of the stroke patient to include the patient's last known time normal, physical evaluation, and medical history. These items are essential for transportation to the appropriate TSA-G facility to treat the stroke patient.

## SUSPECTED STROKE

### ASSESSMENT GUIDELINES

- Cincinnati Stroke Scale
  - Facial Droop
  - Arm Drift
  - Abnormal Speech
- Complete Vital Signs
- Blood Glucose
- 12-Lead ECG
- Thrombolytic Checklist

Consider other etiologies such as:

- Hypoglycemia
- Seizure

### MINIMUM TREATMENT GUIDELINES

- Oxygen 2-4 L/min
- IV NS TKO (as per skill level)
- Monitor blood pressure
- Rapid transport to the appropriate facility as indicated
- Divert to the closest hospital for airway or patient instability
- Consider Air Medical transport for patient deterioration and decrease in transport time and if the stroke patient is in the window for thrombolytic therapy.

**TRANSPORT DECISIONS SHOULD BE BASED ON THE PATIENT'S LAST KNOWN TIME NORMAL AS APPROPRIATE.**

**CONSIDER AIR MEDICAL TRANSPORT TO DECREASE TRANSPORT TIME.**

<3 Hours	Closest Designated Stroke Center Level 1, 2 or 3
3-6 Hours	Consider the closest Primary Stroke Center Or Level 1 Designated Stroke Center
Beyond 6 Hours (Or undetermined Time of onset)	Nonemergency transport to Level 1 or 2 Stroke Center  The patient is outside the window for thrombolytics

## **PINEY WOODS REGIONAL ADVISORY COUNCIL STROKE CENTERS**

### **Ability of treating beyond 3-hour IV tPA window**

- Christus Good Shepherd Medical Center – Longview
  - (Joint Commission Certified Primary Stroke Center)
- Christus Trinity Mother Frances Tyler
  - (Joint Commission Certified Primary Stroke Center)
- Longview Regional Medical Center
  - (Joint Commission Certified Primary Stroke Center)
- UT Health Tyler
  - (Joint Commission Certified Primary Stroke Center)

### **Ability to administer IV tPA and transport to nearest Primary Stroke Center**

- UT Health Athens
- UT Health Carthage
- UT Health Henderson (???)
- UT Health Jacksonville
- UT Health Quitman
- UT Health Pittsburg
- UT Health North Campus Tyler
- Christus Good Shepherd Medical Center – Marshall (???)
- Christus Trinity Mother Frances Jacksonville
- Christus Trinity Mother Frances Winnsboro (???)
- Freestone Medical Center – Fairfield
- Palestine Regional Medical Center

The above hospitals are eligible to seek support stroke center designation from State when available.

# STEMI RESPONSE PLAN

# STEMI COMMITTEE RESPONSE PLAN

## OVERVIEW

The ST Elevation Myocardial Infarction (STEMI) Committee with the RAC-G is committed to improving the pre-hospital and hospital care of patients with symptoms of Acute Coronary Syndromes by providing quality improvement feedback to the programs and improving communication between Emergency Departments (ED) and Emergency Medical Systems (EMS), including the transmission of pre-hospital ECGs from EMS providers. Improved communication will lead to improved patient care and outcomes.

## PURPOSE OF COMMITTEE

The committee's purpose is to strengthen the relationship between the area EMS providers and the EDs they transport to and to improve the care of acute coronary syndrome patients in our community/surrounding region. The goals and project plan are fluid as acute coronary syndrome guidelines, priorities, and opportunities for improvement change.

## GOAL STATEMENTS

- Integrate EDs with EMS for emergency care assessment and community outreach, including process improvement opportunities, sharing of metrics, and case reviews.
- Integrate protocols with EMS and EDs to improve health care by all providers and improve STEMI/acute coronary syndrome patient outcomes.
- Provide educational opportunities for EMS and facilities within the RAC-G region that will improve outcomes.

## PROJECT SCOPE

The scope of this multidisciplinary committee is to improve relationships with all EMS and ED providers to improve community care by educating all systems and the community on the signs and symptoms of ACS. Educating all systems and the community may improve outcomes through rapid diagnosis and early treatment of ACS. Outcome tracking and identification of opportunities for improvement will be a part of this project.

This committee is committed to establishing processes across the RAC-G area to facilitate timely response and treatment and promote a culture of safe practice.



# APPENDICES

## **APPENDIX A**

### **HAZMAT Guidelines**

1. When approaching the scene of a hazardous material incident (known or potential), determine who's in charge. Seek the charge person out for information on how to proceed regarding the incident.
2. Identify the hazard. Get a briefing on the dangers and measures used to contain/avoid them.
3. "Stay away from the stuff." If an immediate danger to health exists, have the victims brought to you for care. Let the HAZMAT Team coordinate the removal from potentially dangerous areas. Don't become another victim.
4. Communicate the HAZMAT exposure to the accepting hospital. They, too, need to take extraordinary measures to prepare for the patient.

## APPENDIX A

### Radioactive Materials Management

The Atomic Energy Commission has established the following recommendations as safeguards in handling any disaster in which radioactive materials are involved:

If radioactive materials are involved in the incidents causing their spillage or release and if immediate actions in the involved area are necessary for the preservation of life and health, minimum contact with radioactive materials by emergency personnel may be allowed if the following precautions are observed:

1. Immediately notify the State Regional Coordinator of Emergency Services for Radiological Response.
  - a. If unable to reach the Regional Coordinator, call the State Duty Officer for Radiological Response in the Department of Public Health.
  - b. If unable to reach the above, contact the Duty Officer through the State Police.
2. If the incident involved wreckage and a person is believed to be alive and entrapped, make every effort possible to rescue the victim.
3. Several disposable caps and gowns should be kept in each disaster kit.
4. Segregate and retain those with possible contact with radioactive material until they can be examined further. Obtain the names and addresses of those involved.
5. Remove injured from the accident area with as little contact as possible and hold at a transfer point. Take any measures necessary to save a life, but carry out minimal first aid and surgical procedures until help is obtained from radiological team physicians or other physicians familiar with radiation medicine. Please DO NOT take the injured to local hospitals or doctors' offices unless it is certain that the patient is NOT contaminated with radioactivity.
6. Hospitals with radiation decontamination capabilities should be identified.
7. In the fire incident, fight fires from upwind as far as possible. Keep out of any smoke fumes or dust arising from the incident. Treat the fire as you would toxic chemicals. DO NOT handle suspected material until it has been cleared by monitoring personnel. Segregate clothing and tools used at the fire until radiological emergency teams can check them.
8. In the event of a radiological incident involving a vehicle accident, detour all traffic around the accident. If radioactive material is spilled, prevent passage through the area unless absolutely necessary. If the right of way must be cleared before AEC assistance arrives, wash spillage to the shoulders of the right of way with minimum disposal of wash water.
9. DO NOT eat, drink or smoke in the area. DO NOT use food or drinking water that may have been in contact with material from the accident.

# ATTACHMENTS