



*PINEY WOODS
REGIONAL ADVISORY COUNCIL
TRAUMA SERVICE AREA G*

**TRAUMA EMS ACUTE CARE
AND
HOSPITAL PREPAREDNESS
SYSTEM PLAN**

2010

TABLE OF CONTENTS

PURPOSE OF PARTICIPATION AND INTRODUCTION 1

PURPOSE OF PARTICIPATION 2

INTRODUCTION AND HISTORY 3

Population by County 2006 Census (Estimate) 5

2001 Trauma-Related Death Rate per 100,000 Population 6

ORGANIZATIONAL STRUCTURE 7

EXECUTIVE COUNCIL MEMBERS 8

STANDARD COMMITTEES AND CHAIRS 9

GOVERNING DOCUMENTS 11

BYLAWS 12

ARTICLE I 12

DEFINITION: 12

ARTICLE II 12

NAME: 12

ARTICLE III 12

ARTICLE IV 12

PURPOSE: 12

ARTICLE V 13

GENERAL ASSEMBLY: 13

ARTICLE VI 13

VOTING MEMBERSHIP: 13

ARTICLE VII 15

EXECUTIVE COUNCIL: 15

ARTICLE VIII 16

DUTIES OF OFFICERS: 16

ARTICLE IX 17

ANNUAL BUDGET DEVELOPMENT PROCESS 17

ARTICLE X 17

COMMITTEES: 17

ARTICLE XI 20

AMENDMENTS: 20

ARTICLE XII 21

Development and Distribution of Bylaws 21

ARTICLE XIII 21

Alternative Dispute Resolution (ADR) Process 21

ARTICLE XIV 21

PETITION FOR MEMBERSHIP: 21

NEEDS ASSESSMENT 2008-2009 23

EMS AGENCIES 27

RAC-G Trauma Centers Map 28

Emergency Medical Services (EMS) Agencies 29

TSA-G EMS Agencies 30

Pre-Hospital Resources 32

Flight Programs 33

Resource Flight Programs Outside of TSA-G 33

TSA-G EMS Agencies Medical Directors 34

First Responders/EMS Agencies 35

Pre-Hospital Care and Transportation Committee EMS Questionnaire 40

TRAUMA CENTERS & SPECIALTY HOSPITALS 42

Texas Trauma Service Areas 43

<i>Hospital and Coordinator List</i>	44
<i>Trauma Facility Designation</i>	45
<i>Specialty Hospitals</i>	47
<i>Trauma Medical Directors</i>	48
<i>Hospital Emergency Department Directors</i>	49
<i>Trauma Nurse Coordinators</i>	50
PLAN REQUIREMENTS	52
PARTICIPATING COUNTIES.....	53
EVIDENCE OF SYSTEM PARTICIPATION	53
PLAN COMPONENTS	54
SYSTEM ACCESS.....	55
COMMUNICATIONS	55
MEDICAL OVERSIGHT	56
CRITERIA FOR AERO MEDICAL TRANSPORT	57
<i>Air Medical Activation Guidelines</i>	57
PRE-HOSPITAL TRIAGE AND TRANSPORT	59
Central Nervous System	63
Chest:.....	63
Pelvis:	63
Abdomen:	63
Multiple System Injury:.....	63
Specialized Problems:.....	63
Central Nervous System:	64
Chest:.....	64
Abdomen:	64
Specialized Problems:.....	64
FACILITY TRIAGE ACTION PLAN	65
TRAUMA FACILITY DIVERSION POLICY	65
FACILITY BYPASS.....	66
TRANSFER AGREEMENTS	67
TRANSFER AGREEMENTS.....	68
SYSTEM QUALITY IMPROVEMENT PLAN	69
SYSTEM PERFORMANCE IMPROVEMENT PLAN	70
I. INTRODUCTION	70
II. GUIDING PRINCIPLES.....	70
III. The Physician Peer Review Committee	70
IV. DATA COLLECTION	71
V. RESPONSIBILITIES TO THE PERFORMANCE IMPROVEMENT PROCESS	71
VI. AUDIT FILTERS	72
STATEMENT OF NON-DISCLOSURE	73
MEDICAL OVERSIGHT PEER REVIEW COMMITTEE DATA FORM	74
REHABILITATION	75
REHABILITATION.....	76
EDUCATION PREVENTION AND PUBLIC AWARENESS	77
PUBLIC EDUCATION AND INJURY PREVENTION	78
PROVIDER EDUCATION	78
MODEL DISASTER PLAN FOR EMS AGENCIES	80
MAJOR EMS INCIDENT (MEI EMS) MAJOR EMS INCIDENT MEI DISPATCH MAJOR EMS INCIDENT MODEL DISASTER PLAN *	81
MAJOR EMS INCIDENT MEI DISPATCH MAJOR EMS INCIDENT MODEL DISASTER PLAN *	82

MAJOR EMS INCIDENT MODEL DISASTER PLAN *	83
MODEL DISASTER PLAN *	84
<i>Concept I</i>	85
Command and Triage Officers	85
<i>Concept II</i>	86
Enroute Declaration	86
<i>Concept III</i>	87
Scene Approach	87
<i>Concept IV</i>	88
Scene Arrival	88
<i>Concept V</i>	89
EMS Communications	89
<i>Concept VI</i>	90
Triage Procedures	90
<i>Concept VII</i>	91
Scene Organization	91
<i>Concept VIII</i>	92
Scene Coordination	92
<i>Concept IX</i>	93
Scene Treatment	93
<i>Concept X</i>	94
Scene Hospital Coordination	94
<i>Concept XI</i>	95
Hospital Triage	95
<i>Concept XII</i>	96
Major EMS Incident Critiques	96
HOSPITAL PREPAREDNESS PROGRAM RESPONSE PLAN	97
HOSPITAL PREPAREDNESS PROGRAM MISSION STATEMENT	98
RESPONSE PLAN – REVISED 7/20/08	99
PEDIATRIC RESPONSE PLAN	101
PEDIATRIC MISSION STATEMENT	102
STROKE RESPONSE PLAN	103
STROKE MISSION STATEMENT	104
STEMI RESPONSE PLAN	130
STEMI COMMITTEE RESPONSE PLAN	131
APPENDICES	132
APPENDIX A	133
<i>HAZMAT Guidelines</i>	133
APPENDIX B	134
<i>Radioactive Materials Management</i>	134
ATTACHMENTS	135



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 Plan is to facilitate coordination of patient care for critically injured patients, pediatric patients, and patients with acute care illnesses 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 this Regional Trauma, EMS, Acute Care, and Hospital Preparedness 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 (TEACH) 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 TEACH 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.

Each and every participant in the RAC-G TEACH Plan is solely responsible for its own activities, and each shall indemnify and hold harmless all other participants in the RAC-G TEACH 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 Blackland Belt in its westernmost region to the heavily wooded eastern Pine Belt area at its eastern border. The region is a 19-county, 13,609.2 square-mile area of East Texas spanning three different natural geographic regions. A larger 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 portions of the latter five counties are in the Post Oak Belt, a transitional region between the highly forested Pine Belt and the Blackland Belt.

Franklin County, which is the northernmost county in TSA-G, crosses both the Post Oak Belt in the southern two-thirds of the county and the Blackland Belt in its upper one-third. Rains and Van Zandt Counties also cross two different regions, with the western portion of the counties in the Blackland Belt and the eastern portions 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' large 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 there is an abundance of water sports, including swimming, fishing and various boating activities.

The population of TSA-G is presently estimated at 893,280. With the exception of Smith, Harrison, Henderson and Gregg counties, the remainder of TSA-G is primarily rural, with a population of 379,835 inhabiting a 9581.5 square-mile area. The two largest cities in TSA-G are Tyler in Smith County, Smith County has a population of 194,635 and Longview in Gregg County, Gregg County has a population of 117,090.

Data provided by the Texas Department of Health in 1998 indicated that TSA-G had the third highest death rate from trauma of the 22 Trauma Service Areas in Texas.

Data specific to 1992 indicates that 12 of the 19 counties in TSA-G had a higher per-capita death rate than Dallas County. Fourteen of the 19 counties had an overall higher death rate when compared to the overall rate for the state of Texas (page 9). The total number of deaths due to causes listed by ICD-9 codes 800 through 999 decreased in TSA-G from 551 in 1993 to 326 in 2001, representing a 41% decrease in the number of deaths during that time. There was a desperate need for regionalization of trauma services and the development of an organized systems approach to trauma care in order to improve outcomes in Trauma Service Area G.) The Piney Woods Regional Advisory Council's long-term goal of organizing the Regional Trauma System and decreasing the mortality rate for trauma patients in TSA-G has been recognized.

In response to 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.

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.

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 Chairman 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 February and June, 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 to so request. 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.

As of the year 2006 there is one Level I, two Level II's, six Level III's and thirteen Level IV hospitals designated as trauma centers. This has not only improved care for the trauma patients at each hospital but also has provided valuable data from a systems perspective through the regional quality improvement process and the regional trauma registry. There is currently one non-designated facility in this RAC.

There are presently 24 EMS agencies and over 150 first responder 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 common set of protocols so that the level of the pre-hospital care becomes constant throughout the region.

There is an organized regional disaster plan for TSA-G that has been activated three times since its inception. We have developed a basic model to guide EMS care during any incident which exceeds normal operating capabilities of any EMS system. This plan can serve as a guideline for those EMS systems or areas of TSA-G which presently have no organized disaster preparedness plan. While each county and many cities in TSA-G have disaster plans in place, our goal was to assist in standardizing the EMS response to any disaster throughout our area 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. One of the first steps in realizing this goal was the addition of the SMART TAG System that unifies all pre-hospital providers with the same disaster triage system. In 2006 this system will also be used in all the hospitals throughout the RAC.

Another challenge is the relationship between trauma patient flow and managed care contracts. Although the Piney Woods Regional Advisory Council 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 Piney Woods Regional Advisory Council (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 mechanism for reviewing these patients is contact with the Trauma Coordinator at each hospital. The hospitals outside of RAC-G are not required to participate in any of the Piney Woods Regional Advisory Council (RAC-G) activities or the Performance Improvement process.

In the year 1998 the (RAC-G) saw the realization of some funding for the trauma system in Texas. This important 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 greatest system impact and to monitor this impact, specifically as it relates to our death rate.

Population by County 2006 Census (Estimate)

COUNTY	POPULATION	AREA (SQUARE MILES)	COUNTY SEAT
Anderson	57,064	1,070.79	Palestine
Camp	12,410	197.51	Pittsburg
Cherokee	48,513	1,052.22	Rusk
Franklin	10,367	285.66	Mt. Vernon
Freestone	18,803	877.43	Fairfield
Gregg	117,090	274.03	Longview
Harrison	63,819	898.71	Marshall
Henderson	80,222	874.24	Athens
Houston	23,044	1,230.89	Crockett
Marion	10,970	381.21	Jefferson
Panola	22,989	800.92	Carthage
Rains	11,514	232.05	Emory
Rusk	48,354	923.55	Henderson
Shelby	26,575	794.11	Center
Smith	194,635	928.38	Tyler
Trinity	14,296	692.84	Groveton
Upshur	37,923	587.64	Gilmer
Van Zandt	52,916	848.64	Canton
Wood	41,776	650.22	Quitman
TOTAL	893,280	13,691.04	

* Source – US Census Bureau

2001 Trauma-Related Death Rate per 100,000 Population

COUNTY	NUMBER OF DEATHS	DEATH RATE
Anderson	32	58.2
Camp	5	42.4
Cherokee	22	46.6
Franklin	8	83.8
Freestone	30	164.2
Gregg	87	77.3
Harrison	38	61.1
Henderson	43	57.6
Houston	11	47.2
Marion	7	63.6
Panola	22	97.3
Rains	3	30.6
Rusk	29	60.9
Shelby	17	67.2
Smith	188	105.5
Trinity	12	85.6
Upshur	11	30.6
Van Zandt	23	46.7
Wood	26	69.5
TOTAL TSA-G	614	



ORGANIZATIONAL STRUCTURE

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GOVERNING DOCUMENTS

**PINEY WOODS REGIONAL ADVISORY COUNCIL
TRAUMA SERVICE AREA-G
Bylaws**

ARTICLE I

DEFINITION:

Piney Woods Regional Advisory Council (Piney Woods RAC) is an organization of local citizens representing all health care entities within a specified Trauma Service Area. These health care entities include hospitals, physicians, nurses, EMS providers and other individuals interested in trauma and acute care. Piney Woods RAC is a formal organization chartered by the Texas Department of State Health Services, Bureau of Emergency Management to develop and implement a regional emergency medical services system plan and to oversee trauma and acute system networking. Piney Woods RAC will also develop and implement regional disaster response plans and budgets including mass casualty, natural disasters and weapons of mass destruction.

Trauma Services Area-G (TSA-G) includes the following counties as designated by the State and/or approved upon petition to the Piney Woods RAC following State approval of petition:

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

ARTICLE II

NAME:

This organization shall be known as Piney Woods Regional Advisory Council Trauma Service Area-G.

ARTICLE III

Our philosophy is to provide a comprehensive continuum of quality health care for all victims of trauma, man-made and natural, in TSA-G.

The mission and vision of Piney Woods Regional Advisory Council-TSA-G (RAC-G) is to provide effective prevention and preparedness programs so that the people of east Texas will be the least likely in the nation to be seriously injured or killed, but if injured, have the best chance for survival and maximal potential for recovery.

ARTICLE IV

PURPOSE:

- SECTION 1. Develop a trauma system plan for TSA-G which is based on standard guidelines set forth by the Texas Department of State Health Services, for comprehensive trauma and acute care system development. Submit this plan to the Texas Department of State Health Services as required by the Trauma Rules.
- SECTION 2. Assist member organizations in attaining trauma designation at the level appropriate to resources available within their immediate service area.
- SECTION 3. Provide a forum to resolve issues among members regarding trauma and acute care and encourage activities designed to promote cooperation and collaboration between member organizations.
- SECTION 4. Improve and distribute funding to trauma care providers within the counties served by this Council.

- SECTION 5. Increase public awareness of the methods to access the trauma and acute care system and injury prevention programs.
- SECTION 6. Enhance communication between pre-hospital health care providers and hospitals to facilitate the transport of patients to appropriate trauma facilities and utilization of the most efficient mode of transport.
- SECTION 7. Establish methods for expedient inter-facility transfer from lower levels to higher levels of designated trauma care and/or rehabilitation services.
- SECTION 8. Develop within the Trauma Service Area a comprehensive, standardized method of providing care through:
- A. Quality Improvement (Performance Improvement) Activities
 - B. Education and Certification Programs
 - C. Distribution of funds to enhance the care of the trauma patient
- SECTION 9. Develop a system-wide hospital preparedness plan for TSA-G which is based on standard guidelines for comprehensive disaster response plan. Submit this plan to the Texas Department of State Health Services as required by Office of Assistant Secretary of Preparedness and Response (OASPR). RAC-G will encourage multi-community participation in the preparation, response, mitigation, and recovery operations, promote the improvement of existing facilities and services, plan for future needs, and cooperate with all entities, agencies and organizations in the establishment of an efficient and effective disaster response system for all who may require such services.
- A. Provide Education and Certification Programs
 - B. Distribute funds to enhance the capacity of the regional response
 - C. Enhance regional and statewide communication
- SECTION 10. Develop a region-wide Air Medical Response Plan for TSA-G which is based on state guidelines for comprehensive air medical transport. Submit this plan to the Texas Department of State Health Services as required by EMS Provider and Licensing Rules.
- A. Provide Education and Certification Programs
 - B. Distribute funds to enhance the capacity of the regional response
 - C. Enhance regional cooperation between Air Medical Providers.

ARTICLE V

GENERAL ASSEMBLY:

- SECTION 1. Will not deny membership to any person on the basis of race, national origin, disability, gender, sexual orientation, age and/or religious preference.
- SECTION 2. Will conduct public meetings to allow discussion of issues under consideration by the Voting Membership.
- SECTION 3. Will meet quarterly.

ARTICLE VI

VOTING MEMBERSHIP:

- SECTION 1. The Voting Membership will consist of:

- A. One designated representative from each member hospital. There is one voting member or alternate.
- B. One designated representative from each member EMS provider organization, limited to one provider per system per county. There is one voting member or alternate.
- C. One selected physician from the medical staff of each member hospital. If the county does not have a member hospital, the medical community of that county may select a physician representative. There is one voting member or alternate.
- D. In the absence of a designated representative or their alternate, a proxy can be designated by written notification from the voting member of record. This notification must be faxed to the RAC office prior to the General Assembly meeting date presented at attendance registration for Piney Woods RAC meetings.

SECTION 2. Special Qualifications.

- A. Membership status for hospital will be dependent on a commitment to Piney Woods RAC participation as demonstrated by trauma facility designation or involvement in the designation process as described in 157.25 of the Trauma Rules.
- B. Membership status for Pre-hospital Providers shall be proof of valid state license.
- C. Membership status for First Responder Providers shall be proof of valid state license.
- D. Membership of Affiliate Members shall demonstrate a common interest in the goals and mission of Piney Woods RAC.

SECTION 3. The Voting Membership may delegate duties of the Piney Woods RAC for the purpose of maintaining the daily business of TSA-G.

SECTION 4. The General Assembly Voting Membership will meet at least quarterly.

SECTION 5. The meetings will be limited to business on the agenda. The agenda and meeting schedule will be mailed and/or posted on the web site (www.texas-trauma.com) at least 15 days before the scheduled meeting.

SECTION 6. Each membership hospital, EMS provider, First Responder, and Affiliate members are required to pay Annual Membership Dues. The dues amount will be posted on the website annually by September 1.

Hospitals:

- Specialty -\$350
- Less than 50 Beds - \$450
- 51-100 Beds - \$550
- 101-200 Beds - \$650
- 201 Beds plus - \$750

EMS: First Responders - \$25

- 0-25 Units - \$150
- 26-50 Units - \$250
- 51 Units plus - \$350

Associate Members: \$25

Affiliate Members: none

SECTION 7. Any dues sixty days delinquent by Voting Members will result in forfeiture of voting privileges, membership standing and financial support.

SECTION 8. **Membership Requirements.** Requirements for active membership participation in the Piney Woods RAC shall be defined as:

- A. Fifty percent (50%) required attendance at General Assembly meetings
- B. Fifty percent (50%) required attendance in a Standing Committee

- C. Compliance with register reporting requirements
- D. Active participation in the Piney Woods RAC Performance Improvement process
- E. Submission of all financial statement, invoices, and inventory that may be required by the RAC for compliance with grant requirements or sound financial practices in accordance with the timelines established by the Piney Woods RAC Executive Council.
- F. No distribution of Piney Woods RAC handled funding shall be made to an entity if that entity is not in compliance with attendance requirements. In such cases that entity shall forfeit and transfer all rights to such funds to Piney Woods RAC for redistribution of funds to appropriate eligible entities.

SECTION 9. QUORUM ESTABLISHMENT:

A two-thirds percentage of the Voting Membership is required to constitute a Quorum.

ARTICLE VII

EXECUTIVE COUNCIL:

The officers of the Executive Council will be elected from the floor of the Voting Membership for a two-year-term. There is no limit placed on the number of terms an Executive Council Member may serve as long as the officer is in compliance with the governing documents of Piney Woods Regional Advisory Council. The officers of the Executive Council will be elected by the voting membership of the General Assembly every two years. The elected officers must comply with the fifty percent attendance to all meetings and be available for GETAC Meetings.

SECTION 1. The officers of the Executive Council shall also be designated as the Board of Directors for the Piney Woods Regional Advisory Council, TSA-G, a non-profit organization.

The officers of the RAC will consist of the following:

- A. Chairperson
- B. Vice Chair
- C. Advisor (s)
- D. Secretary
- E. Treasurer
- F. Executive Director (Non-Voting Member)
- G. Committee Chairs
 - 1. The Committee Chairs of the Executive Council consists of the following:
 - a. Air Medical Committee
 - b. Hospital Preparedness Program Committee
 - c. Clinical Education Committee
 - d. Finance (Budget) Committee
 - e. Hospital Committee
 - f. Pediatric Committee
 - g. Performance Improvement Committee
 - h. Physician Peer Review/Research Committee
 - i. Pre-hospital and Transportation Committee
 - j. Public Education Committee
 - k. Stroke Committee
 - l. STEMI Committee

SECTION 2. Executive Council and Authority

- A. The officers of the Executive Council shall also be designated as the Board of Directors for the Piney Woods Regional Advisory Council, TSA-G, a non-profit organization.
- B. No healthcare system shall constitute a majority of the membership of the Executive Council.

- C. Physician representatives addressed in ARTICLE VI, SECTION 1, ITEM C will at all times be considered an independent entity
- D. Meetings will be conducted at least quarterly. Two consecutive absences shall be cause for a six-month probationary period.
 - 1. Any absence during probation is cause for dismissal from the Executive Council.
- E. Appointment of a replacement to fill a vacant office other than Committee Chair shall be made by the Executive Council subject to Voting Membership approval.
- F. The Council shall be responsible for setting the Agenda of all General Assembly Meetings
- G. The bylaws shall be reviewed at least annually with any recommended amendments forwarded to the Voting Membership for ratification.
- H. Executive Officers shall serve for a minimum term of two years. Executive Officers will be elected by the voting membership of the General Assembly every two years with no limit as to the number of terms an officer may serve as long as the officer is in compliance with the governing documents of Piney Woods Regional Advisory Council.
- I. Elections will be held at the General Membership meeting at the last meeting of the fiscal year. In the event an Executive Council position becomes vacant, the voting membership of the General Assembly will elect an officer to fill the vacant position.
- J. Each Executive Council Member shall have one vote. No votes by proxy will be accepted. Resignations from the Executive Board must be submitted in writing. The replacement process is addressed in ARTICLE VII, Section 2, ITEM E.
- K. A de facto resignation from the Executive Board automatically and immediately occurs when a Board Member changes representation to another Trauma Service Area.

SECTION 3. A two-thirds vote of the Executive Council voting membership constitutes a Quorum.

ARTICLE VIII

DUTIES OF OFFICERS:

SECTION 1: The Chair shall:

- A. Preside at meetings of the General Assembly of the organization, as well as any special called meetings
- B. Make interim appointments
- C. Review and may sign all contracts
- D. Call a special meeting when required
- E. Assure that RAC-G has representation at all required Texas Department of State Health Services meetings.

SECTION 2: The Vice Chair shall:

- A. Perform the duties as assigned by the Chair and will be eligible to serve as Chair at the end of their two-year term of internship.
- B. Perform all the duties of the Chair in his/her absence, inability to act, or refusal to act.
- C. Have all the powers and be subject to all the restrictions of the Chair when serving in his/her absence.

D. Perform all duties as assigned by the Chair or Executive Council.

SECTION 3: The Advisor (s) shall:

A. Serve as Advisor to the Chair and Chair-Elect and such duties as assigned by the Chair.

SECTION 4: The Secretary shall:

- A. Record minutes of Executive Council and General Assembly and submit prepared minutes of meetings to RAC office to be published on website within two weeks of meeting
- B. Record if a quorum is present.

SECTION 5: The Treasurer shall:

A. Present Treasurer's current account information and report to Executive Council and General Assembly meetings. The Financial Status Report is presented by the Certified Public Accountant.

SECTION 6: The Executive Director shall:

- A. The Executive Director is a salaried employee responsible to the Executive Council.
- B. The Executive Director shall direct all day to day office operations and internal affairs of the RAC TSA-G.
- C. The Executive Director shall serve on the Executive Council as an Ex-Officio member without a vote and will not be counted for a quorum of the Executive Council Meetings.

SECTION 7. OASPR Hospital Preparedness Program Manager shall:

A. Prepare Hospital Preparedness Program Data Update Form, correspondence, check disbursement, budget reports and other duties requested by Texas Department of State Health Services regarding the OASPR Hospital Preparedness Program.

ARTICLE IX

ANNUAL BUDGET DEVELOPMENT PROCESS

SECTION 1. The Annual Budget is developed by the Executive Director of the Piney Woods Regional Advisory Council-Trauma Service Area G with the guidance of the retained certified public accountant. The budget is formulated based on the previous year's spending and the Needs Assessment Forms received from the Providers within RAC-G and on the projected dollar amount allocated from federal and state contracts awarded to Piney Woods Regional Advisory Council-Trauma Service Area G. The proposed budget is then submitted for review to the Finance Committee, the Executive Board (Council) and then it is presented to the General Assembly Voting Membership for approval.

ARTICLE X

COMMITTEES:

SECTION 1. Standing Committees

A. Certain Standing Committees shall be established by the Executive Council to oversee specific areas of continuing interest. The Standing Committees are:

1. Air Medical:

a. Mission and Purpose Statement:

The goal of the Air Medical Committee is to create a culture in which to deliver consistent safe, quality air medical transport and care to the citizens of the RAC Area G community.

2. Clinical Education:

a. Mission and Purpose Statement:

The mission of the Clinical Education Committee is to provide clinically relevant education for health care providers within Piney Woods Regional Advisory Council. This education should support the endeavors of the RAC.

3. Finance :

a. Mission and Purpose Statement:

It is the mission of the Finance Committee of RAC-G to fund trauma related projects to members in good standing in order to benefit trauma patient care throughout our region.

4. Hospital:

a. Mission and Purpose Statement

1. To aid hospitals in the development and maintenance of trauma programs.
2. To assist in the review and update of the Bylaws and Trauma EMS Acute Care and Hospital Preparedness System Plan on an annual basis. Any recommended changes will be presented to the General Assembly for approval prior to distribution and implementation.

5. Hospital Preparedness Program (OASPR):

a. Mission and Purpose Statement:

To promote hospital and community all hazards preparedness through education, financial assistance and training while integrating state-wide preparedness activities at the local level.

b. Steering Committee for HPP

Mission of the RAC G Steering Committee is to assist the Hospital Preparedness Program of Piney Woods Regional Advisory Council TSA G in the regional preparedness planning efforts and maintaining compliance with the OASPR funding guidelines

6. Pediatric:

a. Mission and Purpose Statement:

To improve the care of pediatric population by providing education processes for improvement, assistance with equipment and information from other agencies to all members,

7. Performance Improvement:

a. Mission and Purpose Statement:

To ensure that trauma patients receive the highest quality care possible in RAC-G by analyzing trauma system performance and identifying opportunities for improvement

8. Physician Peer Review/Research:

a. Mission and Purpose Statement

Serve as a regional physician review committee designed to evaluate local trauma care within Trauma Service Area G and to provide input for quality of care improvement.

b. Physician Advisory – Advising the Piney Woods RAC on medical care issues, medical-legal issues and medical staff issues.

c. Physician Peer Review/Research – All phases of planning, development and implementation of an organized, integrated system for trauma care in TSA-G. Responsibilities of the committee are to revise and update Trauma System Plan on an annual basis.

d. Appointment of a replacement to fill a vacant position shall be made by the Executive Council

9. Pre-Hospital and Transportation:

a. Mission and Purpose Statement:

To provide an open venue for networking between EMS in TSA-G and to provide an arena for issues both regional and statewide open communications between hospital and pre-hospital settings. It is our intention as a committee to stand as a unified front with no single organization taking charge. It is the goal of this committee to strive to improve pre-hospital care within our trauma service area.

10. Public Information:

a. Mission and Purpose Statement:

To keep the public informed and to provide activities to promote public trauma prevention awareness and trauma prevention.

11. Stroke:

a. Mission and Purpose Statement:

1. The mission and purpose of the Stroke Care Committee is to review emergency transport and treatment of the stroke patient.
2. To identify stroke care professionals from hospitals within Trauma Service Area G and to review and define stroke care capabilities of each of these hospitals and define guidelines for the transportation of the stroke patient to the appropriate hospital.

12. STEMI Committee:

a. Mission and Purpose Statement

To improve the recognition and rapid treatment of STEMI patients throughout the facilities within Trauma Service Area G,

B. The membership composition of each Standing Committee shall be on a volunteer basis.

- C. Any qualified member of the Voting Membership shall be eligible for membership on a committee, but is restricted to serving on no more than two committees simultaneously.
- D. Each Standing Committee shall elect a Chairperson and Recorder to preside over and record committee activities.
- E. Each Standing Committee shall forward copies of all meeting minutes to the RAC Office. The Chair or designee of each committee shall present reports to the Executive Council and to the General Assembly at the quarterly RAC meetings.
- F. General Assembly non-voting members shall be eligible to attend Standing Committees.

SECTION 2. Special ADHOC Committees

- A. The Executive Council shall create Special ADHOC Committees to accomplish a specific, well-defined purpose.
- B. The Executive Council shall establish specific objectives and goals for each Special ADHOC Committee formed. Once the goals and objectives have been achieved, the Committee shall be dissolved.
- C. Each ADHOC Committee shall elect a Chairperson to preside over and record activities.
- D. Each ADHOC Committee shall forward copies of all the meeting minutes to the RAC Office, and the Committee Chair shall report to the Executive Council and to the General Assembly at the quarterly meetings.

SECTION 3. Special Committees

- A. The Voting Membership shall create Special Committees to accomplish a specific, well-defined purpose.
- B. The Voting Membership shall establish specific objectives and goals for each Special Committee formed. Once the goals and objectives have been achieved, the Special Committee shall be dissolved.
- C. Each Special Committee shall elect a Chairperson and Recorder to preside over and record activities.
- D. Each Special Committee shall forward copies of all the meeting minutes to the RAC office, and the Committee Chair shall report to the Executive Council and to the General Assembly at the quarterly meetings

SECTION 4. ROBERTS RULES OF ORDER shall be the format used to conduct all public meetings of TSA-G.

ARTICLE XI

AMENDMENTS:

SECTION 1. The Bylaws may be adopted, amended or revised by an affirmative vote of two-thirds (2/3) of the Voting Membership present at the General Assembly Meeting.

The Voting Membership may submit proposed amendments and revisions to the Executive Council for consideration and recommendation.

Copies of the proposed amendments shall be made available to the Voting Membership for review at least 30 days prior to the meeting.

ARTICLE XII

Development and Distribution of Bylaws

SECTION 1. The Piney Woods Regional Advisory Council-Trauma Service Area G governing documents known as Bylaws are reviewed on an annual basis by members of an ad hoc committee from the Hospital Standard Committee. The revisions and updates are presented in a mark-up copy form to the General Assembly Voting Membership for approval at the last meeting of the fiscal year. Clean hard copies are distributed to the providers after approval and the Bylaws are posted on RAC-G website: www.texas-trauma.com in formats that may be downloaded as needed.

ARTICLE XIII

Alternative Dispute Resolution (ADR) Process

SECTION 1. Any provider or individual representing a provider, service or hospital that has a dispute in connection with another provider or the RAC itself (e.g., By-laws, Trauma System Plan, guidelines or protocols; action(s) or inaction(s), etc.) may formally voice its disapproval in writing. The written document must be addressed to the chair person of the RAC.

SECTION 2. A formal protest must contain the following: a specific statement of the situation that contains the description of each issue and a proposed solution to resolve the matter(s).

SECTION 3. A neutral or impartial group with no vested interest in the outcome of the dispute will be assembled to review issue. This group may solicit written responses to the dispute from interested parties. If the dispute is not resolved by mutual agreement, the group will issue a written determination, within thirty (30) days of receipt of all pertinent data.

SECTION 4. Party or parties may appeal the determination by the group and ask that the dispute be brought before the General Membership of the RAC for a final determination. The party or parties have no later than five working days after the determination to submit the request for secondary review.

SECTION 5. The request must be submitted to following address:

RAC Chair
Piney Woods Regional Advisory Council
Trauma Service Area G
100 E. Ferguson Street, Suite 910
Tyler TX 75702

SECTION 6. The secondary review will be limited to the original determination. Appeal must be mailed or delivered in a timely manner. In the event the Appeal is not timely in delivery, it will not be considered. If not consider, the parties will be notified in writing.

ARTICLE XIV

PETITION FOR MEMBERSHIP:

SECTION 1. Health care entities outside TSA-G desiring to realign their county into TSA-G shall submit a written request to the Executive Council. Such request must include documentation that the county judge or the Commissioners Court has approved the realignment.

The Trauma Service Area G Governing Documents, Bylaws, were approved in regular session of the Voting Membership on August 28, 2008

Judy England, RN (Signed Original in RAC Office) August 28, 2008

Chair, Judy England, RN Date
FY 2007-09

Ann Henderson, RN (Signed Original) August 28, 2008

Ann Henderson, RN
Secretary

Updated Committees, September, 2003
Addendum added, February 11, 2004
Incorporated into Policy and Procedures April 2006
Approved updates and revisions by General Assembly August 2006
Approved updates and revisions by General Assembly August 2007
Approved updates and revisions by General Assembly August 2008

PINEY WOODS RAC-G
NEEDS ASSESSMENT 2008-2009

In order to plan for grant request and identify regional priorities current information is needed when request for monies are made to the RAC-G Finance Committee.

This document must be faxed to the RAC-G Office 903-593-5092

HOSPITAL/ EMS PROVIDER NAME: _____

ADDRESS: _____

_____ TX _____

CEO: _____

TRAUMA COORDINATOR'S NAME: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

Cell Number: _____

EMS DIRECTOR'S NAME: _____

Email Address: _____

Phone Number: _____

Fax Number: _____

Cell Number: _____

Name and Title of Person completing this form: _____

NEEDS ASSESSMENT
Page 2

EMS SERVICES:

Service Type	# of Ambulances	Staffed 24 Hours	Crew on Call	Runs per Month
BLS				
ALS				
MICU				
FIXED WING				
ROTARY CRAFT				
SPECIALTY CARE TRANSPORT				
RESERVE VEHICLES				

EMS EQUIPMENT NEEDS:

Item	# on Hand	Condition	# Requested	Priority	Match \$ Avail
Monitor/Defib					
Pulse Ox					
Backboards					
Trauma Bags					
Scoop Stretchers					
Traction Splints					
IV Fluid Warmer					
Ventilator					
Radios					
Shamu Lifts					
Pagers					
OTHER					

HOSPITALS:

Total Beds:	ICU Beds:
Trauma Beds:	Licensed Beds:
Surge Beds:	Medical/Surgical Beds:
Rehab Beds:	Negative Pressure Isolation Room:
Psychiatric Beds:	Burn Beds:
NICU Beds:	Neo-natal Beds:
Avg. Daily Census:	Pediatric Beds:

NEEDS ASSESSMENT
Page 3

HOSPITAL EQUIPMENT NEEDS:

Item	# on Hand	Condition	# Requested	Priority	Match \$ Avail
Monitor/Defib					
Pulse Ox					
AED					
BP Monitor					
Stretchers					
Crash Cart					
Pediatric Cart					
Ventilator					
Radios					
Traction Splints					
Blood Warmer					
Fluid Warmer					
Blanket Warmer					
Other					

EDUCATIONAL NEEDS ASSESSMENT (HOSPITAL/EMS)

Cert Type	# Employed by Agency	# Certified Staff	# Needing to be Trained		Matching \$ Avail
			Trained	Re-certified	
ACLS					
PALS					
ATCN					
ENPC					
TNCC					
ATLS					
PBTLS					
BTLS					
ECA/First Responder					
PEPP					
CISM					
NALS					

NEEDS ASSESSMENT
Page 4

HPP EQUIPMENT NEEDS

Monitor/Defib				
Pulse OX				
AED				
BP Monitor				
Stretchers				
Crash Cart				
Pediatric Cart				
Ventilator				
Radios				
Traction Splints				
Blood Warmer				
Blanket Warmer				
Decon- Suits				
Decon-PAPRS				
Satellite Phone				
Security Equipment				
HAM Setup				
Fluid Warmer				

HPP EDUCATIONAL NEEDS ASSESSMENT

Cert Type	# Employed by Agency	# Certified Staff	# Needing to be Trained		Matching \$ Avail
			Trained	Re-certified	
Decon Training					
CISM					
NIMS					
Mass Casualty/ Mass Fatality					

Please provide cost, description, and invoice for each item. (Attach additional pages if needed)

FAX TO RAC OFFICE: 903-593-5092 Attn: Sheryl Coffey

This needs assessment will be reviewed by the Finance Committee and the Executive Council for Regional Advisory Council Trauma Service Area G.

For questions or concerns regarding this needs assessment please call the RAC office at 903-593-4722. You may email Sheryl Coffey at sheryl.c@sbcglobal.net

Also, please note the website for the RAC: www.texas-trauma.com



EMS AGENCIES

RAC-G Trauma Centers Map

Designated Trauma Centers TSA-G



Abbreviations: ETMC - East Texas Medical Center
GSMC - Good Shepherd Medical Center
LRMC - Longview Regional Medical Center
TMFHS - Trinity Mother Frances Health System
UTHSCT - University of Texas Health Science Center at Tyler

Trauma Service Area-G (RAC-G)
Emergency Medical Services (EMS) Agencies

The RAC-G map of EMS agencies describes EMS areas of coverage which serve all of TSA-G. These agencies range from a small volunteer service to a regional EMS agency.

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 of these 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 the systems in RAC-G provide continuing education for their personnel, and all but one of the services provides 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 been participants 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 a neutral party with authority, sharing the goal of developing standardized trauma protocols, standardized training, and effective quality improvement activities for RAC-G.

RAC-G EMS Agencies

Name: Camp County EMS, Inc.
 Address: P.O. Box 866
 City: Pittsburg
 State, Zip: Texas 75686
 County: Camp
 Director: Mike Reynolds
 Telephone: (903) 856-7102
 Level of Service: MICU

Name: Champion EMS Corporate
 Address: 2201 S. Mobberly
 City: Longview
 State, Zip: TX 75607
 County: Gregg & Rusk Counties
 Director: Victor Wells
 Telephone: 903-291-2500
 Level of Service: MICU

Name: East Texas Medical Center EMS
 Address: P.O. Box 387
 City: Tyler
 State, Zip: Texas 75710
 County: Smith, Anderson, Cherokee, Franklin, Gregg, Henderson, Houston, Panola, Trinity, Upshur, Van Zandt, Wood
 Director: Anthony Myers, VP
 Telephone: (903) 535-5800
 Level of Service: MICU

Name: Fairfield EMS
 Address: 632 West Commerce
 City: Fairfield
 State, Zip: Texas 75840
 County: Freestone
 Director: Ignacio Perez
 Telephone: (903) 389-6511
 Level of Service: BLS/MICU CAP

Name: GSMC dba Champion EMS
 Address: 700 East Marshall
 City: Longview
 State, Zip: Texas 75601
 County: Gregg, Marion, Upshur, Harrison, Rusk, Panola
 Director: Tim Tennimon
 Telephone: (903) 291- 2540
 Level of Service: MICU

Name: Grand Saline VFD
 Address: P.O. Box 217
 City: Grand Saline
 State, Zip: Texas 75140
 County: Van Zandt
 Director: Gary Stilwell
 Telephone: (903) 962-4222 Emergency / (903) 962-3727 Non-Emergency
 Level of Service: BLS/MICU

Name: Grapeland VFD
 Address: P.O. Box 567
 City: Grapeland
 State, Zip: Texas 75844
 County: Houston
 Director: Chad LeBlanc
 Telephone: (936) 687-2115
 Level of Service: BLS/MICU CAP

Name: Groveton EMS, Inc.
 Address: P. O. Box 10
 City: Groveton
 State, Zip: Texas 75845
 County: Trinity
 Director: Shannon Worsham
 Telephone: (936) 642-1212
 Level of Service: BLS/ALS

Name: Hallsville Volunteer Ambulance
 Address: P.O. Box 811-H
 City: Hallsville
 State, Zip: Texas 75650
 County: Harrison
 Director: Kathy Townsend
 Telephone: (903) 668-3011
 Level of Service: BLS/ALS CAP

Name: Jacksonville Fire Department EMS
 Address: P.O. Box 360
 City: Jacksonville
 State, Zip: Texas 75766
 County: Cherokee
 Director: Paul White
 Telephone: (903) 586-4904
 Level of Service: ALS/BLS/MICU

Name: Longview Fire Department EMS
 Address: P.O. Box 1952
 City: Longview
 State, Zip: Texas 75606
 County: Gregg, Harrison, Upshur
 Director: Michael Pruitt
 Telephone: (903) 239-5534
 Level of Service: MICU

(EMS Agencies Continued)

Name: Marshall/Harrison County
Ambulance Service
Address: P.O. Box 698
City: Marshall
State, Zip: Texas 75671
County: Harrison
Director: Bob Cole
Telephone: (903) 935-4585
Level of Service: BLS/MICU

Name: Mims Vol.Fire Dept. & Amb. Serv.
Address: 12728 FM 729
City: Avinger
State, Zip: Texas 75630
County: Marion
Director: Lana Manchester
Telephone: (903) 755-4112
Level of Service: MICU

Name: North East Texas EMS
Address: P. O. Box 1743
City: Center
State, Zip: Texas 75935
County: Shelby
Director: William Harville
Telephone: (936) 598-7600
Level of Service: BLS/MICU

Name: Palestine R.M.C. EMS
Address: 4000 S Loop 256
City: Palestine 75801
County: Anderson
Director: John McMeans
Telephone: (903) 731-5398
Level of Service: MICU CAP

Name: THD Teague EMS
Address: P. O. Box 599
City: Teague
State, Zip: Texas 75860
County: Freestone
Director: Bobby Burns
Telephone: (254) 739-2536 Emergency
(254) 739-5732 Non-Emergency
Level of Service: BLS/ALS CAP

Name: Timpson Vol. Amb. Service
Address: P. O. Box 492
City: Timpson
State, Zip: Texas 75975
County: Shelby
Director: Tracy Lee
Telephone: (936) 254-2608
Level of Service: ALS/MICU,BLS/MICU

Name: Trinity Mother Frances Health Care
System (DBA Champion EMS)
Address: 421 S. Palace
City: Tyler
State, Zip: Texas 75702
County: Smith, Franklin, Rains, Rusk, Van
Zandt, Wood, Gregg,
Director: Arnie Spiers
Telephone: (903) 531-5207
Level of Service: MICU

Name: Waskom VFD EMS
Address: P.O. Box 1757
City: Waskom
State, Zip: Texas 75692
County: Harrison
Director: Bob Rodocker
Telephone: (903) 687-3328
Level of Service: BLS/ALS

Name: Wills Point EMS
Address: P.O. Box 505
City: Wills Point
State, Zip: Texas 75169
County: Van Zandt
Director: Collin Blassingame
Telephone: (903) 873-3011
Level of Service: BLS/MICU CAP

Pre-Hospital Resources

Camp County EMS.....	5 MICU
ETMC EMS.....	99* MICU
Fairfield EMS.....	2 BLS/MICU
Good Shepherd Medical Center dba Champion EM.....	18 MICU
Grand Saline VFD.....	3 BLS/MICU
Grapeland VFD.....	2 BLS/MICU
Groveton EMS, Inc.	2 BLS/ALS.
Hallsville Volunteer Ambulance.....	2 BLS/ALS
Jacksonville Fire Department/EMS.....	4 BLS/MICU
Longview Fire/EMS.....	7 MICU
Marshall/Harrison County Ambulance Serv.	6 BLS/MICU
Mims Vol. Fire Dept & Amb. Serv.	2 BLS/ALS
North East Texas EMS.....	8 BLS/MICU
Palestine R.M.C. EMS.....	6 MICU
Teague EMS.....	2 BLS/ALS
Timpson Vol. Amb. Serv.	1 BLS/MICU
Trinity Mother Frances dba Champion EMS.....	18 MICU
Waskom VFD/EMS.....	1 BLS/ALS
Wills Point EMS.....	2 BLS/MICU
Fairfield Ambulance Service.....	3 BLS/MICU
Teague Hospital District EMS.....	2 BLS/MICU
Flight for Life TMF.....	1 HCP
Air One ETMC.....	4* HCP

* ETMC unit count is for total units in the ETMC system. It is not broken down by RAC areas.

Flight Programs

AIR ONE CENTRAL
East Texas Medical Center
P.O. Box 6400
Tyler, TX 75710
(903) 531-8165
Director: Judy England

AIR ONE WEST
East Texas Medical Center Athens
2000 S. Palestine
Athens, Texas 75751
(903) 531-8165
Director: Judy England

AIR ONE NORTH
Titus County Hospital
Mt. Pleasant, Texas
(903) 531-8165
Director: Judy England

FLIGHT FOR LIFE
Trinity Mother Frances Health System
800 East Dawson
Tyler, TX 75701

Resource Flight Programs Outside of RAC-G

Med Trans
Schumpert Medical Center/Willis-Knighton Medical Center
P.O. Box 21976
Shreveport, LA 71120-1976
(318) 227-4730
Chief Flight Nurse: Robert P. Pringle, Jr.

CAREFLITE DALLAS
P.O. Box 225344
Dallas, TX 75222-5344
(214) 947-8450
Chief Flight Nurse: Monty Hunsaker

HERMANN LIFE FLIGHT
Hermann Hospital
6411 Fannin Street
Houston, TX 77004
(713) 704-3502
Chief Flight Nurse: Thomas J. Flanagan

Air Evac
LifeNet
PHI

RAC-G EMS Agencies Medical Directors

Camp County Ambulance Service, Inc.
Blair MacBeath, MD
410 Quitman Street
Pittsburg, TX 75686
(903) 856-6546

Wills Point EMS
William H. Atkinson, MD
P.O. Box 260
Wills Point, TX 75169
(903) 873-4848

ETMC EMS
William Moore, MD, FACEP
352 South Glenwood
Tyler, TX 75702
(903) 535-5200

Fairfield EMS
J. H. Keller MD
632 West Commerce Street
Fairfield, TX 75840
(903) 389-2181

GSMC dba Champion EMS
Chris Dunnahoo, M.D.
700 East Marshall
Longview, TX 75601
(903) 236-2020

Grand Saline Vol. Fire Dept.
Richard Ingram, MD
P.O. Box 297
Grand Saline, TX 75140
(903) 962-3122

Grapeland VFD/EMS
G. Edward Early, DO
2900 South Loop 256
Palestine, TX 75801
(903) 731-1156

Hallsville EMS
Gregg Harrington, MD
700 East Marshall
Longview, TX 75606
(903) 236-2020

Jacksonville Fire Department EMS
James R. Low, Jr., MD
203 Nacogdoches Street #360
Jacksonville, TX 75766
(903) 586-3505

Longview Fire Department EMS
Gregg Harrington, MD
700 East Marshall
Longview, TX 75606
(903) 236-2020

Marshall/Harrison County EMS
Jack Cash, MD
811 South Washington
Marshall, TX 75671
(903) 935-8744 or (903) 938-8209

TMF dba Champion EMS
Mark Anderson, M.D.
800 East Dawson
Tyler, TX 75701
(903) 531-4212

Teague EMS
Bill Halbert, MD
315 Main Street
Teague, TX 75860
(817) 739-2561

Waskom VFD EMS
Rex Scott
811 Washington Avenue
Marshall, TX 75670
(903) 935-8744

First Responders/EMS Agencies
(Listed By County)

<i>COUNTY</i>	<i>COMPONENT</i>	<i>DETAILS</i>
Anderson	9-1-1- Type EMS Agencies First Responder Agencies	ANI / ALI Palestine Memorial Hospital EMS EITEMS 79 East 84 West Bethel-Cayuga Bradford Coffee City FD Elkhart Elmwood VFD Frankston Fire Department Lone Pine VFD Montalba Neches VFD S-AC VEMS Inc Southside Tennessee Colony Tucker West Side VFD
Camp	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI Camp County EMS, Inc.
Cherokee	9-1-1 Types EMS Agencies First Responder Agencies	ANI / ALI ETMC EMS Jacksonville Fire Department EMS Earl Chapel VFD Gallatin New Summerfield VFD North Cherokee County VFD Wells Fire Department
Freestone	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI Fairfield EMS Teague EMS Southern Oaks VFD Streetman VFD
Franklin	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI TMF dba Champion EMS ETMC EMS – Mt. Vernon Mt. Vernon Fire Department North Franklin VFD Winnsboro FD

<i>COUNTY</i>	<i>COMPONENT</i>	<i>DETAILS</i>
Gregg	9-1-1- Type EMS Agencies	ANI / ALI Champion EMS ETMC EMS Good Shepherd Medical Center EMS dba Champion EMS Longview Fire Department EMS TMF dba Champion EMS Clarksville-Warren VFD Easton Fire Department East Texas Regional Airport Elderville-Lakeport Fire Department Kilgore Fire Department White Oak Fire Department Longview Fire Department Liberty City VFD
	First Responder Agencies	
Harrison	9-1-1 Type EMS Agencies	ANI / ALI ETMC EMS Good Shepherd Medical Center dba Champion EMS Longview Fire Department EMS Marshall-Harrison County Fire Dept. EMS Grapeland VFD Hallsville EMS Hallsville Fire Department Harleton VFD Harrison County Marshall Fire Department Waskom Fire Department
	First Responder Agencies	
Henderson	9-1-1 Types EMS Agencies First Responder Agencies	ANI / ALI ETMC EMS Athens Fire Department Baxter VFD Berryville VFD Brownsboro VFD Callendar Lake Chandler Fire Department Eustace VFD Gun Barrel City VFD LaRue-New York Fire Department Malakoff VFD Murchison Fire Department Payne Springs Poynor Fire Department Seven Points Fire Department Shady Oaks Fire Department South Van Zandt County Trinidad VFD Westside Fire Department

COUNTY	COMPONENTS	DETAILS
Houston	9-1-1 Types EMS Agencies First Responder Agencies	ANI Only (no location identification) ETMC EMS Grapeland EMS Grapeland VFD Kennard-Ratcliff Lovelady VFD
Marion	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI Good Shepherd Medical Center dba Champion EMS Mims Volunteer EMS Mims VFD
Panola	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI ETMC EMS Good Shepherd Medical Center dba Champion EMS Beckville Carthage Fire Department Community Four Fire Department Flatwood Fire Department Gary Fire Department Inter Community Fire Department Woods
Rains	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI TMF dba Champion EMS Alba Fire Department Emory Fire Department Point Fire Department Tawakani FD
Rusk	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI TMF dba Champion EMS Good Shepherd Medical Center dba Champion EMS Mt. Enterprise VFD Church Hill Fire Department Crim Chapel Fire Department Henderson Fire Department Kilgore Fire Department Laneville Fire Department New Salem Fire Department Shelby County VFD

COUNTY	COMPONENT	DETAILS
Smith	9-1-1 Types EMS Agencies	ANI / ALI ETMC EMS, ETMC Air One, TMF dba Champion EMS TMF Flight for Life
	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 Fire Department Whitehouse VFD Winona VFD
Trinity	9-1-1 Type EMS Agencies	ANI / ALI Trinity County EMS ETMC EMS
	First Responder Agencies	Pennington VFD Trinity PD,
Upshur	9-1-1 Type EMS Agencies	ANI / ALI ETMC EMS
	First Responder Agencies	GSMC dba Champion EMS Big Sandy Fire Department East Mountain Fire Department Gilmer Fire Department Glenwood Acres Fire Department Holly Lake Fire Department Union Grove Fire Department
Van Zandt	9-1-1 Type EMS Agencies	ANI / ALI ETMC EMS
	First Responder Agencies	Grand Saline VFD EMS TMF dba Champion EMS Wills Point EMS Ben Wheeler VFD Calendar Lake VFD Canton Fire Department Edgewood Fire Department Edom Fire Department Fruitvale Fire Department Midway Fire Department Myrtle Springs Fire Department Rolling Oaks Fire Department South Van Zandt County VFD Van Fire Department Whitton VFD Wills Point Fire Department

<i>COUNTY</i>	<i>COMPONENT</i>	<i>DETAILS</i>
Wood	9-1-1 Types EMS Agencies	ANI / ALI ETMC EMS TMF dba Champion EMS
	First Responder Agencies	Hawesville VFD Holly Lake VFD Mineola Fire Department Perryville VFD Quitman Fire Department Winnsboro Fire Department Yantis Fire Department

Pre-Hospital Care and Transportation Committee EMS Questionnaire

	EMS System	Written MA Agreements	Method of Dispatch	Dispatch Protocols	Bystander Instruction
1	Camp County EMS	Yes	EMS	Yes	Yes
2	ETMC EMS	No	EMS	Yes	Yes
3	Grand Saline EMS	Yes	SO, F	Yes	Yes
4	Hallsville EMS	Yes	SO	Yes	Yes
5	Flight for Life	Yes	EMS	Yes	Yes
6	Palestine MH EMS	Yes	EMS, SO, P	Yes	Yes
7	TMF dba Champion EMS	Yes	EMS	Yes	Yes
8	Waskom VFD & EMS	Yes	SO	Yes	Yes
9	Wills Point EMS	Yes	SO, F, P	Yes	Yes
10	Jacksonville FD	Yes	City PD	Yes	No
11	Teague EMS	Yes	EMS	No	No
12	Champion EMS	Yes	EMS	Yes	Yes
13	Good Shepherd EMS	Yes	EMS	Yes	Yes
14	Fairfield EMS	Yes	SO	No	No
15	Longview FD	No	City	Yes	Yes
16	Marshall Fire	Yes	City	Yes	No
17	Grapeland EMS	No	County/City	Yes	Yes
18	Air 1 – ETMC	Yes	EMS	Yes	Yes
19	Groveton VFD				
20	Timpson VFD				

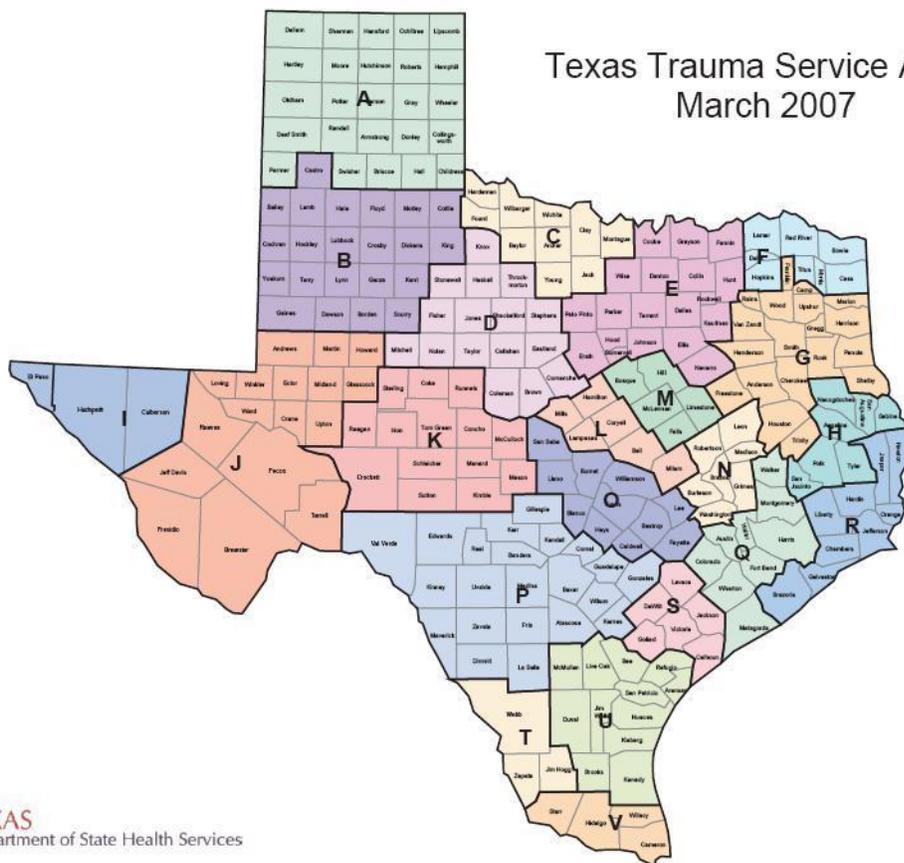
	EMS System	Computed Items	Level Of Service	Monthly QI	Continuing Education Programs
1	Camp County EMS	No	MICU	Yes	Yes
2	ETMC EMS	Yes	MICU	Yes	Yes
3	Grand Saline EMS	No	BLD/1 MICU	Yes	Yes
4	Hallsville EMS	Yes	BLS/ALS	Yes	Yes
5	Palestine MH EMS	No	MICU	Yes	Yes
6	Trinity MFH EMS	Yes	MICU	Yes	Yes
7	Waskom VFD & EMS	Yes	BLS/ALS	No	Yes
8	Wills Point EMS	No	BLS/MICU	No	Yes
9	Jacksonville FD	Yes	ALS/MICU	Yes	Yes
10	THD Teague EMS	No	BLS/ALS	Yes	Yes
11	Champion EMS	Yes	MICU	Yes	Yes
12	Good Shepherd EMS	Yes	MICU	Yes	Yes
13	Fairfield EMS	Yes	BLS/MICU	Yes	No
14	Longview FD	Yes	MICU	Yes	Yes
15	Marshall EMS	Yes	BLS/ALS	Yes	Yes
16	Grapeland EMS	Yes	BLS/MICU	Yes	No
17	Air 1 – ETMC	Yes	MICU	Yes	Yes
18	Groveton VFD				
19	Timpson VFD				
20	Flight for Life	Yes	MICU	Yes	Yes

	EMS System	Local Hospital Available	Bypass Protocols In Place	Average Scene-Hosp. Time in Min.	Piney Woods RAC Participation
1	Camp County EMS	Yes	Yes	5-10	Yes
2	ETMC EMS	Yes	Yes	18	Yes
3	Grand Saline EMS	Yes	Yes	4	Yes
4	Hallsville EMS	No	Yes	15	Yes
5	Flight for Life	Yes	Yes		Yes
6	Palestine MH EMS	Yes	Yes	15	Yes
7	TMF dba Champion EMS	Yes	Yes	25	Yes
8	GSMC/Champion EMS	Yes	Yes	25	Yes
9	Waskom VFD & EMS	No	Yes	20	Yes
10	Wills Point EMS	No	Yes	20	Yes
11	Jacksonville FD	Yes	Yes	5-10	Yes
12	Teague EMS	No	No	12-15	Yes
13	Champion EMS	Yes	Yes	20	Yes
14	Fairfield EMS	Yes	No	<45	Yes
15	Longview FD	Yes	Yes	8-12	Yes
16	Marshall EMS	Yes	No	10	Yes
17	Grapeland EMS	No	No	15	Yes
18	Air 1 – ETMC	Yes	Yes	20	Yes
19	Groveton VFD				
20	Timpson VFD				



TRAUMA CENTERS & SPECIALTY HOSPITALS

Texas Trauma Service Areas



Texas Trauma Service Areas
March 2007



Source: Health Quality Section/Office of EMS, March 2007
Created by: GIS Team, Center for Health Statistics, March 2007

Hospital and Coordinator List

LIST OF HOSPITALS/ TRAUMA COORDINATORS/ HOSPITAL PREPAREDNESS PLANNING COORDINATORS IN TSA G

Updated 9-1-08

			Licensed Beds	Surge Beds	Trauma Coordinator Contact	NPP Contact
	Hospital	Level				
Anderson	Palestine Regional Medical Center	III	112	83	Trista Brownlow, 1(303) 731-1255, Trista.Brownlow@LPNT.net	Keith Vintila, (903) 731-1022 Keith.Vintila@lpnt.net
	Palestine Regional Medical Center Psy.		35		Trista Brownlow, 1(303) 731-1255, Trista.Brownlow@LPNT.net	Keith Vintila, (903) 731-1022 Keith.Vintila@lpnt.net
	Palestine Regional Medical Ctr. REHAB		37		Trista Brownlow, 1(303) 731-1255, Trista.Brownlow@LPNT.net	Keith Vintila, (903) 731-1022 Keith.Vintila@lpnt.net
Camp	ETMC Pittsburg	IV	25	44	Ann Henderson, (903) 856-4580, ahenderson@etmc.org	Ann Henderson, (903) 856-4580, ahenderson@etmc.org
Cherokee	Rusk State Hospital	ND	?		Tim Birmingham,(903)683-7723, racqcontact@aol.com,cell 903 948-2599	Tim Birmingham, (903) 683-7723, racqcontact@aol.com
	TMFH-Jacksonville	IV	25	10	Toni Cox, (903) 589-7001, coxt1@tmfhs.org	Paul Duncan, (903) 541-4633, duncanp@tmfhs.org
	ETMC-Jacksonville	III	74	71	Patricia Chancellor(Interim) 903 541-5173, JV_CHAP@etmc.org	Karen Adams (903)541-5191, kadams@etmc.org
Franklin	ETMC - Mt. Vernon	IV	49	45	Brenda Hoover, 1(903) 537-4552, my_hoov@etmc.org	Lisa McDaniel, 1(903)537-8070, lisa.mcdaniel@etmc.org
Freestone	ETMC-Fairfield	IV	48	44	Paula Hoskins, 1(903) 389-1621, phoskinz@etmc.org	Paula Hoskins, 1(903) 389-1621, phoskinz@etmc.org
Gregg	Good Shepherd Medical Center	II	412	160	Jerri Pendarvis, (903) 315-2861,jpendarvis@gsmc.org	Chris Bland (903) 315-5163, cbland@gsmc.org
	Allegiance Specialty Hospital of Kilgore				Kate Bynum, (903) 383-4300, kbynum.ashkilgore@shmg.com	Kate Bynum, (903) 383-4300, kbynum.ashkilgore@shmg.com
	Longview Regional Medical Ctr.	III	164	98	Jay Marsolan, (903)242-3438, jay.marsolan@triadhospitals.com	Jay Marsolan, (903)242-3438, jay.marsolan@triadhospitals.com
	Select Specialty Hospital- GSMC		32		Crystie Owen, (903) 315-1103, CROwen@selectmedicalcorp.com	Crystie Owen, (903) 315-1103, CROwen@selectmedicalcorp.com
	Behavioral Hospital of Longview				Christopher Thornton (903)291-3456; cthornton@bhlongview.com	Christopher Thornton (903)291-3456; cthornton@bhlongview.com
Harrison	Good Shepherd Medical Center-Marshall	III	149	79	Rebekah McClenny	Jim Brandon (903)327-6164, Jim.Brandon@gsmcmarshall.org
Henderson	ETMC-Athens	III	117	75	Donna Smith, 1(903) 676-1100, dosmith@etmc.org (903) 676-6101 cell	Donna Smith, 1(903) 676-1100, dosmith@etmc.org (903) 676-6101 cell
Houston	ETMC - Crockett	III	49	38	Helen Dize, (936) 545-4603, hdize@etmc.org	Tom Kinzler (936)545-4235 tkinzler@etmc.org
Panola	ETMC-Carthage	IV	49	45	Irene Holte, (903) 634-4848, iholte@etmc.org	Irene Holte, (903) 634-4848, iholte@etmc.org
Rusk	Henderson Memorial	IV	96	59	Angela Riley, (903) 655-3915, ariley@hmbtx.org	Vinson Henson,(903) 655-3693, vhenson@hmbtx.org
Shelby	Shelby Regional Medical Center	IV	54	60	Jana Hagler, DON (interim) (936)598-2781 janhagler@yahoo.com	Jana Hagler, DON (interim) (936)598-2781 janhagler@yahoo.com
Smith	ETMC Tyler	I	389	252	Jo Ann Peters, (903) 535-6778, jpeters@etmc.org	Kenneth Webb, (903) 531-8143, Kwebb@etmc.org
	ETMC-Behavioral Clinic		75		Jo Ann Peters, (903) 535-6778, jpeters@etmc.org	Kenneth Webb, (903) 531-8143, Kwebb@etmc.org
	ETMC-REHAB		49		Jo Ann Peters, (903) 535-6778, jpeters@etmc.org	Kenneth Webb, (903) 531-8143, Kwebb@etmc.org
	ETMC-Specialty		36		Jo Ann Peters, (903) 535-6778, jpeters@etmc.org	Kenneth Webb, (903) 531-8143, Kwebb@etmc.org
	UTHSC-Tyler	ND	110	87	Diana Julian (903) 877-2867, diana.julian@uthct.edu	Maurice Finsterwald (903) 877-2854 Maurice.finsterwald@uthct.edu
	TMFH-Tyler	II	434	301	Janice Willette, RN (903)531-5560 willettj@tmfhs.org	Daryl Pritchard, (903) 531-5307, PRITCHD@tmfhs.org
	Continue Care Hosp.of Tyler, Inc./TMFH		51		Todd Cox (903)531-4773, coxt@tmfhs.org	Leigh Wilson (903)531-4979, wilsonl@tmfhs.org
	Texas Spine and Joint Hospital		20		Deborah Pelton (903) 525-3365, deborah.pelton@tsjh.org	Denise Hembree, (903)525-3327 denise.hembree@tsjh.org
Health South REHAB of Tyler		63		Kenneth Burris, (903) 510-7012, kenneth.burris@healthsouth.com	Kenneth Burris, (903) 510-7012, kenneth.burris@healthsouth.com	
Trinity	ETMC-Trinity	IV	30		Lynn Frye, 1(936) 662-4033, lfrye@etmc.org	Tom Kinzler 1(936)545-4235 tkinzler@etmc.org
Upshur	ETMC-Gimer	IV	37		Deborah Wells (903)841-7243 (dlwells@etmc.org)	Lynn Jett (903) 841-7242 ljett@etmc.org
VanZandt	Cozby-Germany Hospital	IV	51	49	Teresa Lovett, (903) 362-4242, tlovett@cozbygernanyhospital.com	Mary Pruitt, (903) 362-4242 x110, mpruitt@suddenlinkmail.com
Wood	ETMC-Guitman	IV	30	30		Kandy Driver (903)763-6361 kdriver@etmc.org
	Presbyterian Winnzboro	IV	50	38	Lisa Tarkington (903) 342-3970, lisatarkington@texashealth.org	Ken Russell, (903)342-3982, kennethrussell@texashealth.org
17 Counties	34 Hospitals		3,072	1668		
	TMR					Bill Bellenfant, CPA (903) 531-4556, bellenb@TMFHS.org

Trauma Facility Designation

HOSPITAL	DESIGNATION	BEDS
East Texas Medical Center 1000 South Beckham Tyler, Texas 75701 (903) 531-8165	Level I Designated	Med/Surg 385 ICU – 63 Pedi – 8 Rehab – 48
Trinity Mother Frances Hospital 800 East Dawson Tyler, Texas 75701 (903) 593-8441	Level II Designated	Med/Surg -305 ICU 50 Pedi 21 Rehab – 0
ETMC – Athens 2000 South Palestine Athens, Texas 75751 (903) 675-2216	Level III Designated	Med/Surg -87 ICU – 8 Pedi – 0 Rehab – 0
ETMC – Crockett P.O. Box 1129 Crockett, Texas 75835 (936) 544-2002	Level III Designated	Med/Surg – 15 ICU – 5 Pedi – 0 Rehab – 0
ETMC – Jacksonville 501 South Ragsdale Jacksonville, Texas 75766 (903) 586-3000	Level III Designated	Med/Surg –2 ICU – 2 Pedi – 0 Rehab – 0
ETMC – Quitman P.O. Box 1000 Quitman, Texas 75783 (903) 763-4505	Level IV Designated	Med/Surg – 28 ICU – 0 Pedi – 0 Rehab – 0
ETMC – Mt. Vernon P.O. Box 477 Mt. Vernon, Texas 75457 (903) 537-4552	Level IV Designated	Med/Surg – 30 ICU – 4 Pedi –1 Rehab – 0
ETMC – Pittsburg 414 Quitman Pittsburg, Texas 75686 (903) 856-6663	Level IV Designated	Med/Surg – 23 ICU – 2 Pedi – 0 Rehab – 0
ETMC Henderson 300 Wilson Henderson, Texas 75652 (903) 657-7541	Level IV Designated	Med/Surg – 20 ICU –4 Pedi – 4 Rehab –4
ETMC – Carthage P.O. Box 409 Carthage, Texas 75633 (903) 693-0295	Level IV Designated	Med/Surg – 19 ICU – 4 Pedi –1 Rehab – 0
Presbyterian Hospital – Winnsboro Drawer 628 Winnsboro, Texas 75494 (903) 342-5227	Level IV Designated	Med/Surg – 50 ICU – 2 Pedi – 0 Rehab – 0

HOSPITAL	DESIGNATION	BED
Cozby-Germany Hospital 707 North Waldrip Grand Saline, Texas 75140 (903) 962-4242	Level IV Designated	Med/Surg – 25 ICU – 0 Pedi – 0 Rehab – 0
ETMC – Fairfield 125 Newman Street Marshall, Texas 75670 (903) 389-2121	Level IV Designated	Med/Surg –48 ICU 0 Pedi – 0 Rehab – 0
ETMC – Clarksville (not in RAC G) Hwy. 82 W Clarksville, Texas 75426 (903) 427-3851	Level IV Designated	Med/Surg – 292 ICU – 0 Pedi – 0 Rehab – 0
ETMC – Trinity P.O. Box 471 Trinity, Texas 75862 (936) 594-3541	Level IV Designated	Med/Surg – 21 ICU – 0 Pedi – 1 Rehab – 0
Shelby Regional Medical Center 602 Hurst Street Center, Texas 75935 (936) 598-2781	Level IV Designated	Med/Surg –0 ICU – 0 Pedi – 0 Rehab – 0
Trinity Mother Frances-Jacksonville 1016 South Jackson Street Jacksonville, Texas 75766 (903) 541-4500	Level IV Designated	Med/Surg – 20 ICU – 0 Pedi – 0 Rehab – 0
Palestine Regional Hospital P.O. Box 4070 Palestine, Texas 75802 (903) 731-8910	Level III Designated	Med/Surg –89 ICU – 10 Pedi – 12 Rehab –26
Good Shepherd Medical Center 700 East Marshall Avenue Longview, Texas 75601 (903) 236-2000	Level II Designated	Med/Surg – 215 ICU – 33 Pedi –19 Rehab – 25
Longview Regional Medical Center P.O. Box 1500 Longview, Texas 75607 (903) 758-1818	Level III Designated	Med/Surg –78 ICU – 16 Pedi – 10 Rehab – 0
Good Shepherd Medical Center Marshall P.O. Box 1599 Marshall, Texas 76570 (903) 935-9311	Level III Designated	Med/Surg –30 ICU –9 Pedi – 11 Rehab – 10
University of Texas Health Science Ctr Tyler 11937 US Hwy 271 Tyler, Texas 75708 (903) 877-2867	Non-Designated	Med/Surg – 12 ICU – 3 Pedi – 0 Rehab – 8
ETMC Gilmer 712 N. Wood Gilmer, Texas 75644 903-841-7100	Level IV Designated	Med/Surg –34 ICU – 3 Pedi – 0

Specialty Hospitals

Anderson County: **Palestine Regional Medical Center – Psychiatric**
Palestine Regional Medical Center - Rehab
4000 Loop 256 (75801) P.O. Box 4070
Palestine, TX 75802
(903) 731-8910

Cherokee County: **Rusk State Hospital**
1600 Dickinson
Rusk, TX 75785
(903) 683-7723

Gregg County: **Select Specialty Hospital- Longview**
Good Shepherd Medical Center
700 E. Marshall Street
Longview TX 75601
(903) 315-1106

Allegiance Specialty Hospital of Kilgore
1612 South Henderson Boulevard
Kilgore, TX 75652
(903) 984-3505

Smith County: **ETMC Behavioral**
ETMC Rehab
ETMC Specialty
1000 So. Beckham
Tyler TX 75701
(903) 531-8143

Continue Care
Trinity Mother Frances Hospital Systems
800 E. Dawson Street
Tyler TX 75701
(903) 531-5560

Health South Rehabilitation
3131 Troup Highway
Tyler TX 75701
(903) 510-7012

Texas Spine and Joint Hospital
1814 Roseland
Tyler TX 75701
(903)525-3380

Trauma Medical Directors

Cozby-Germany Hospital

Shafi Khalid, MD
707 North Waltrip
Grand Saline, Texas 75140

East Texas Medical Center – Tyler

Scott Norwood, MD
1020 East Idel
Tyler, Texas 75701

ETMC – Athens

Danny Pugh, MD
2000 South Palestine
Athens, Texas 75751

ETMC – Carthage

Robert Callahan, MD
P.O. Box 549
Carthage, Texas 75633

ETMC – Crockett

Pat Walker, MD
P.O. Box 1129
Crockett, Texas 75835

ETMC – Fairfield

Benjamin Veltri, MD
125 Newman
Fairfield, Texas 75840

ETMC – Gilmer

Greta Parks, M.D.
712 N. Wood
Gilmer, TX 75644

ETMC – Jacksonville

Scott Powell, MD
501 South Ragsdale
Jacksonville, Texas 75755

ETMC – Pittsburg

Brian Kempton, MD
414 Quitman Street
Pittsburg, Texas 75686

ETMC – Mt. Vernon

Charles Barton, MD
P.O. Box 477
Mt. Vernon, Texas 75467

ETMC – Quitman

Paul Driver, M.D.
P.O. Box 1000
Quitman, Texas 75783

ETMC – Trinity

El-Aswad, MD
P.O. Box 471
Trinity, Texas 75862

Good Shepherd Medical Center

Todd Waltrip, MD
700 E. Marshall Avenue
Longview, Texas 75601

ETMC Henderson

Tom Curtis, MD
300 Wilson Street
Henderson, Texas 75652

Longview Regional Medical Center

Daniel Merritt, MD
2901 N. Fourth Street
Longview, Texas 75605

Good Shepherd Medical Center Marshall

Charles Kilpatrick, MD
811 South Washington
Marshall, Texas 75766

Palestine Regional Hospital

Robert Falconer, MD
4002 South Loop 256
Palestine, Texas 75801

Presbyterian Hospital – Winnsboro

Alberto de la Cruz, MD
P.O. Box 628
Winnsboro, Texas 75783

Shelby Regional Medical Center

Chuck Gutiezzes, MD
P.O. Box 1749
Center, Texas 75935

Trinity Mother Frances Hospital

Luis Fernandez, MD
615 South Fleishel
Tyler, Texas 75701

Trinity Mother Frances Hospital – Jacksonville

Gary Smith, MD
2026 S. Jackson Street
Jacksonville, Texas 75766

Hospital Emergency Department Directors

Cozby Germany Hospital

Richard Ingram, MD
801 North Waldrip
Grand Saline, Texas 75410

ETMC – Athens

Dan Bywaters, MD
P.O. Box 3412
Athens, Texas 75751

ETMC – Carthage

G. Reddy, MD
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Carthage, Texas 75633

ETMC – Crockett

N. El-Aswad, MD
P.O. Box 1129
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ETMC – Fairfield

Vacant
125 Newman Street
Fairfield, Texas 75840

ETMC – Gilmer

Greta Parks, MD
712 N. Wood
Gilmer, Texas 75644

ETMC – Jacksonville

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501 South Ragsdale
Jacksonville, Texas 75766

ETMC – Mt. Vernon

Raymond Jordon, MD
P.O. Box 477
Mt. Vernon, Texas 75457

ETMC – Pittsburg

Brian Kempton, MD
414 Quitman Street
Pittsburg, Texas 75686

ETMC – Quitman

Kimberly Vogel, MD
P.O. Box 1000
Quitman, Texas 75783

ETMC – Trinity

N. El-Aswad, MD
PO Box 471
Trinity, Texas 75862

ETMC – Tyler

Bob Creath, MD
P.O. Box 6400
Tyler, Texas 75711

Good Shepherd Medical Center

Stan Upchurch, MD
700 East Marshall
Longview, Texas 75601

ETMC Henderson

Thomas Curtis, MD
300 Wilson
Henderson, Texas 75652

Longview Regional Medical Center

Ron Simonton, MD
2901 North Fourth Street
Longview, Texas 75605

GSMC Marshall

Jeff Beaty, MD
811 South Washington
Marshall, Texas 75670

Palestine Regional Hospital

Eric Schroder, MD
2900 South Loop 256
Palestine, Texas 75801

Presbyterian Hospital – Winnsboro

Alberto de la Cruz, MD
719 West Coke Road
Winnsboro, Texas 75494

Trinity Mother Frances Health Care System

Luis Haro, M.D.
800 East Dawson
Tyler, Texas 75701

TMFH – Jacksonville

Luis Haro, M.D.
2026 S. Jackson Street
Jacksonville, Texas 75766

University of Texas Health Science Center Tyler

Ted Gould, MD.
P.O. Box 2003
Tyler, Texas 75710-2003

Trauma Nurse Coordinators

Cozby Germany Hospital

Teresa Lovett, RN
707 North Waldrip
Grand Saline, Texas 75140
(903) 962-4242

ETMC – Athens

Donna Smith, RN
2000 South Palestine
Athens, Texas 75751
(903) 676-1100

ETMC – Carthage

Irene Holte, RN
409 Cottage Road
Carthage, Texas 75633
(903) 694-4848

ETMC – Crockett

Helen Dise, RN
1100 E. Loop 304
Crockett, Texas 75835
(936) 545-4603

ETMC - Fairfield

Paula Hoskins, RN
125 Newman
Fairfield, Texas 75840
(903-389-1621)

ETMC – Gilmer

Lynn Jett, RN
712 N. Wood
Gilmer, Texas 75644
(903)841-7243

ETMC – Jacksonville

Miki Davis
501 South Ragsdale
Jacksonville, Texas 75766
(903) 541-5173

ETMC – Mt. Vernon

Brenda Hoover, RN
P.O. Box 477
Mt. Vernon, Texas 75457
(903) 537-4552

ETMC – Pittsburg

Ann Henderson, RN
414 Quitman Street
Pittsburg, Texas 75686
(903) 856-4580

ETMC – Quitman

Lisa McDaniel
117 N. Winnsboro Hwy.
Quitman, Texas 75783
(903) 763-6370

ETMC – Trinity

Jesse Baker
P.O. Box 471
Trinity, Texas 75862
(936) 662-4033

ETMC Tyler

JoAnn Peters
PO Box 6400
Tyler, Texas 75711
(903)535-6778

Good Shepherd Medical Center

Jerri Pendarvis, RN,CEN
700 East Marshall Avenue
Longview, Texas 75601
(903) 315-2861

ETMC Henderson

Angela Riley, RN
300 Wilson Street
Henderson, Texas 75652
(903) 655-3915

Longview Regional Medical Center

Jay Marsolan
2901 N. Fourth St.
Longview, Texas 75605
(903-232-3498)

Good Shepherd Medical Center - Marshall

Rebekah McClenny, RN
811 S. Washington
Marshall, Texas 75671
(903) 927-6790

Palestine Regional Medical Center

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2900 Loop 256
Palestine, Texas 75801
(903) 731-1255

Presbyterian Hospital – Winnsboro

Lisa Tarkington, CNO
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Shelby Regional Medical Center

Steve Stewart, RN
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(936)598-1743

Trinity Mother Frances – Jacksonville

Ben Beathard, RN
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Jacksonville, Texas 75766
(903)589-7001

Trinity Mother Frances Health Care System

Janice Willette, RN
800 East Dawson
Tyler, Texas 75701
(903) 531-5560

UT Health Science Center – Tyler

Diana Julian, RN
11937 US Hwy 271
Tyler, Texas 75708
(903) 877-2867



PLAN REQUIREMENTS

Participating Counties

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

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. Multiple 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 been participants 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 System 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 of 1995 and in February and June of 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 the 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 so request and become an active member. 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 obtain 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/or Automatic Location Identification (ALI). Enhanced 9-1-1 also automatically routes emergency calls to a pre-selected answering point based upon 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 assigning not only the phone number but also the address of the caller. This is automatically routed to the PSAP.

In RAC-G, all counties have Enhanced 9-1-1 with ANI/ALI capability, with the exception of 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 medical care throughout the region. In addition, all public phones have public access to 9-1-1.

Communications

The current Trinity Mother Frances Hospital Dispatch System Training and Standards for Communication Personnel requires all communications officers to maintain CPR Provider Certification, Texas Emergency Medical Technician Certification and Emergency Medical Dispatch Certification.

East Texas Medical Center EMS utilizes primarily EMT's (Emergency Medical Technicians) for dispatch. These EMT's are also Certified Emergency Medical Dispatchers. Not all EMS Systems in TSA-G utilize medical personnel for dispatch. Many systems have calls routed through various other agencies, such as the fire department, sheriff's office or local hospitals.

Champion EMS utilizes Certified Emergency Medical Dispatchers. The system is routed to EMS via the 911 system or direct line for dispatch.

The communication network in RAC-G providing for ambulance-to-ambulance, ambulance-to-dispatch, ambulance-to-hospital and hospital-to-hospital communications consist of several radio frequencies and the use of 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 the altitude and distance. The range of these frequencies can be increased with the use of 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 ground units to ground units, from ground units to air and from air to ground units. UHF frequencies provide greater enhancement. These frequencies are designed as Regional EMS frequencies and are capable of being accessed by most medical facilities. ETMC utilizes an 800 MHz trunking system. Ambulances and aircraft are equipped with automatic vehicle locators (AVL's) 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. By using these multiple systems, communications with public and private EMS agencies, police, fire and hospitals are maintained.

Each agency and their vehicles also maintain a listing of their mutual aid responders for ready reference, although written mutual aid agreements are not formally maintained by all of the EMS Systems

There is a Regional Disaster Plan as well as 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 as well as the pre-hospital response and triage.

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

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

The strength of the Pre-Hospital Communications systems within RAC-G is that there 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 in order to facilitate standardization of pre-hospital care throughout the region. Given the diversity of the region and the number of EMS agencies involved, this is a long-term goal which may never be realized. There is, however, use of the RAC's protocols, which accomplishes off-line uniformity of medical control.

Currently, there is a Level I and a Level II Trauma Center located in Smith County, and a Level II located in Gregg County. Smith County is approximately the geographic center of RAC-G (see map). A tiered patient delivery system based upon severity of injury/illness is geared toward transfer of the injured/ill patient from the scene to the most appropriate level of care within an appropriate time frame. This goal is accomplished through application of well-established off-line medical control protocols and utilization of on-line medical control when patient circumstances are contrary to these protocols. Proper communication of facility diversion is also essential to prevent harmful delays in the delivery of patient care.

There are presently two air rescue systems within RAC-G and several others which are capable of responding from the surrounding regions. The system was quite successfully tested during the 2002 Terrell bus wreck on Interstate 20, with numerous agencies and helicopter services responding and transporting patients to both Dallas and Tyler.

Since approximately one-third of the EMS Agencies provides service in areas with no local hospital, scene-to-hospital times range anywhere from 5-50 minutes. Scene-to-Level I or Level II Trauma Center ground times may exceed 70 minutes, and air transport times may be as long as 30 minutes from areas of RAC-G. The East Texas Medical Center Flight Program, Air One, currently has one EC135 helicopter and two BO105 helicopters. They have one stationed in Mt. Pleasant, one in Athens, and the EC135 in Tyler, the geographic center of Trauma Service Area-G. Trinity Mother Frances Hospital Flight for Life has one based in Tyler also.

**Criteria for Aero Medical Transport
Air One and Flight for Life**

Regional Advisory Council (RAC)

Air Medical Activation Guidelines

Purpose: These Air Medical Provider (AMP) 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 in accordance with 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 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 possible threat or ground transport time is 30 minutes or greater. When extrication, weather and traffic seriously hamper the access of ACLS care. Should critical care be needed before and during transport.
3. Any available AMP(s) that best meets the needs of the patient(s) may be utilized.

Other Considerations: Patients meeting 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, Helicopter Association International, Association of Air Medical Services, 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 illness or injuries which could indicate the need for rapid transportation:

Penetrating injury to chest, abdomen, head, neck and/or 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 multi patients on scene
Falls of twenty feet or more
Crash speed greater than 40 miles per hour

30-inch or greater deformity of automobile
Passenger compartment intrusion of 18 inches or more on patient side of vehicle
Patient extrication time greater than 20 minutes and unstable vital signs
Rollover of vehicle with patient ejection
Death of occupant in same vehicle
Pedestrian hit at 20 mph or greater
RTS less than 10; GCS less than 8
Penetrating injuries to the head, neck, chest, abdomen or groin
Airway compromise and unable to correct by ground EMS
Persons exhibiting signs/symptoms of stroke with extended ground transportation time
Persons exhibiting 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

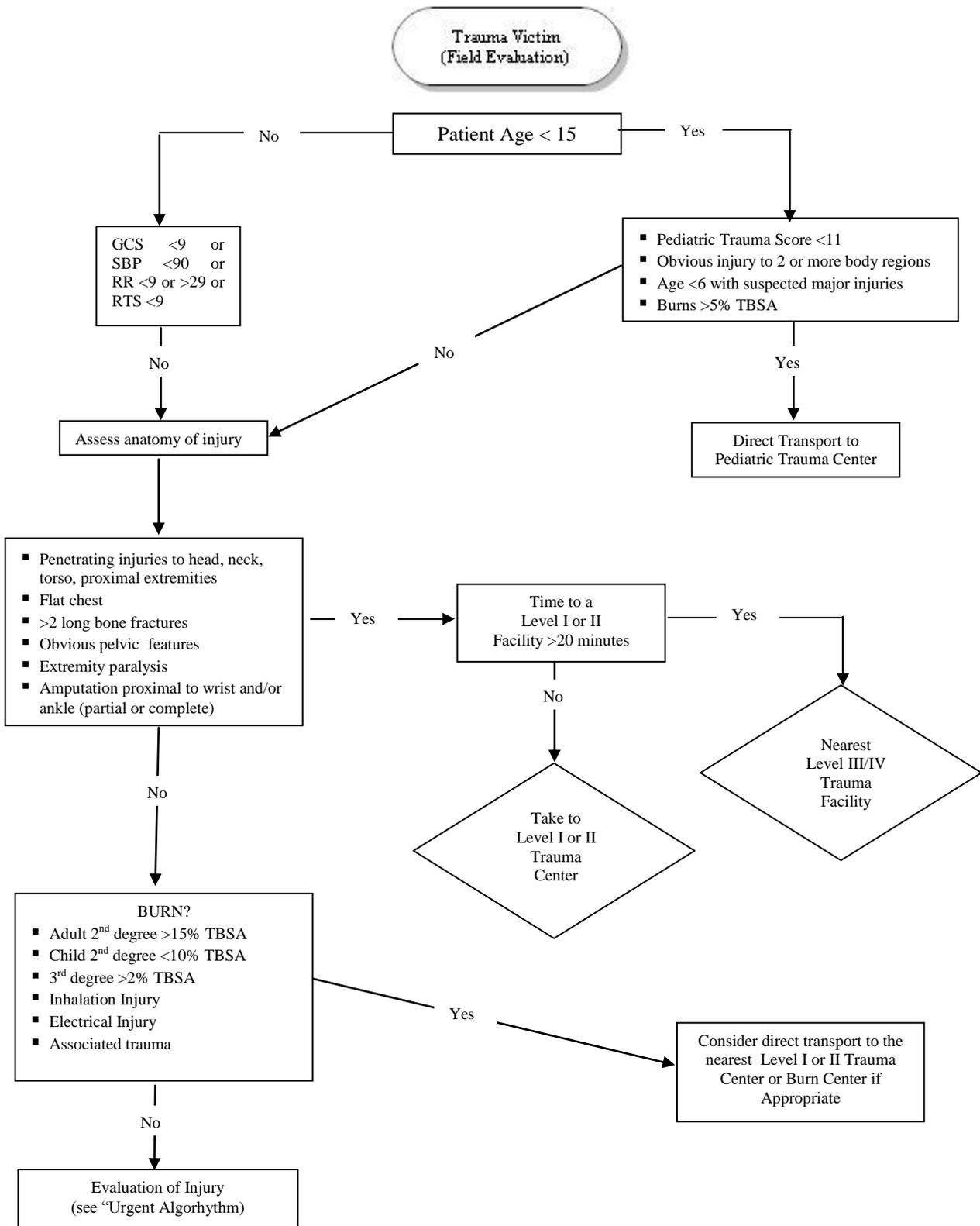
A trauma patient can be identified as any patient experiencing a single or multiple system injury. More specifically, a trauma patient is any individual who experiences external blunt or penetrating forces that may damage any anatomic structure and cause an immediate threat to life, as when injury involves 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 issues, hollow viscera or musculoskeletal structures. Trauma imminently threatens life and/or 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):

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

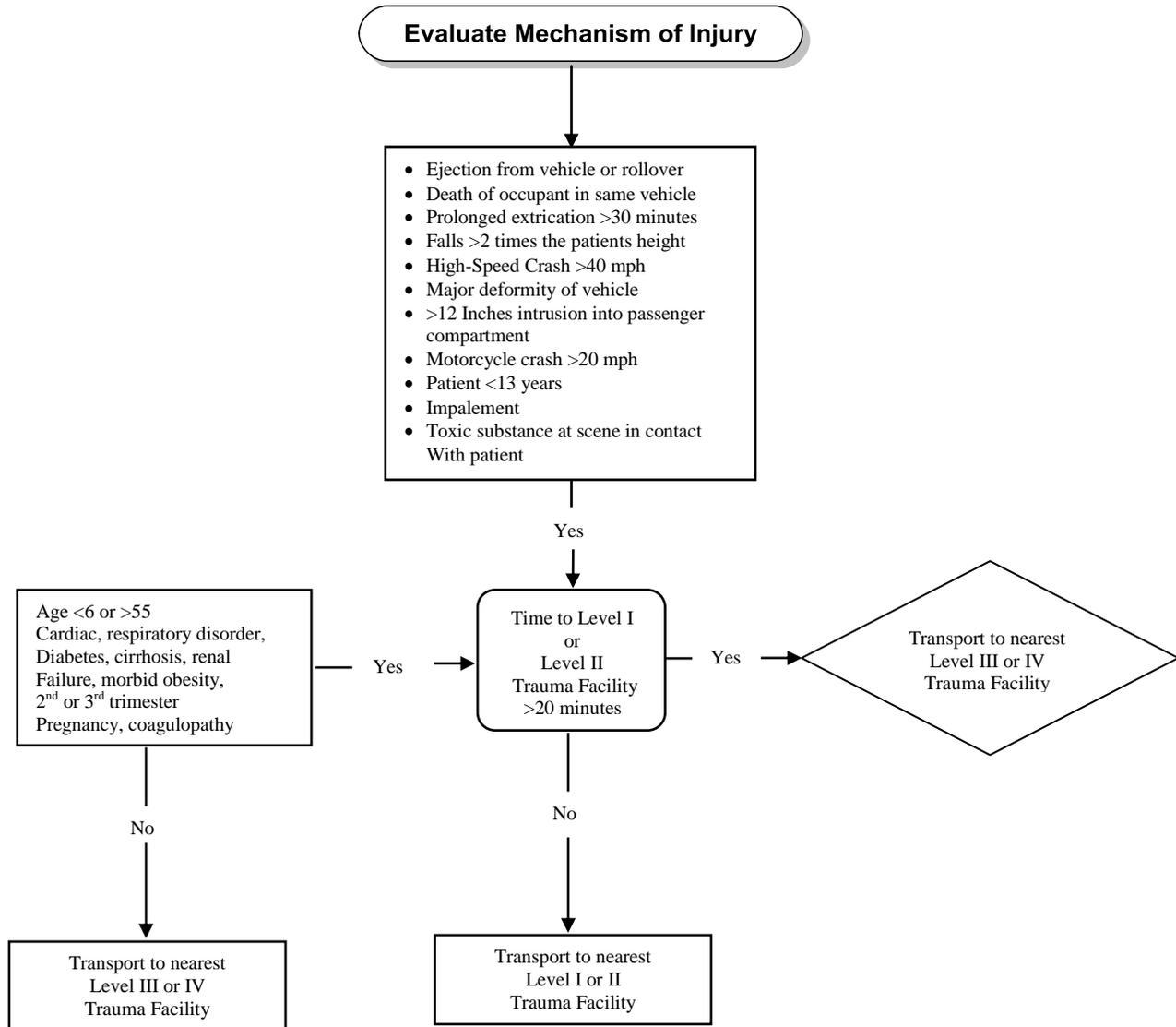
If the above criteria are met, accurate and expedient patient assessment by the first responder to the scene of the accident is key to appropriate trauma patient triage. A Triage Decision Scheme has been developed to guide first responders regarding patient transport and destination. Vital signs, level of consciousness, mechanism of injury and other data are assessed and EMS Medical Control is consulted if questions remain regarding disposition and treatment of the patient at the scene. Major trauma patients are then 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. It is our goal for the Pre-Hospital Care and Transportation Committee to ultimately become an organization that will be able to 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 the triage of 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 II	Stabilization and Admit to appropriate Service if Available, otherwise, transfer to Level I or II Trauma Center	Stabilize and Transfer to Level I, II, or Pediatric Center
Level IV	Stabilize and Transfer to Level I or II	Stabilize and Transfer to Level I, Level II, or Level III	Stabilize and Transfer to Level I, II, or Pediatric Center

CATEGORY I PATIENT: (Critical)	CATEGORY II PATIENT: (Urgent)
<p>* CENTRAL NERVOUS SYSTEM:</p> <ul style="list-style-type: none"> — Neurologic Injuries producing prolonged loss of consciousness, posturing, paralysis, or Internalizing signs — Spinal Injuries with or without neurological deficit — Open Penetrating or depressed skull fractures — CSF leak — Deterioration of GCS of 2 or more <p>* CHEST:</p> <ul style="list-style-type: none"> — 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 <p>* PELVIS:</p> <ul style="list-style-type: none"> — Pelvic ring disruption with shock requiring more than 5 units transfusion — Evidence of continued hemorrhage — Compound/open pelvic injury or pelvic visceral injury <p>* ABDOMEN:</p> <ul style="list-style-type: none"> — Blunt abdominal trauma with hypotension — Penetrating abdominal wound <p>* MULTIPLE SYSTEM INJURY:</p> <ul style="list-style-type: none"> — Severe face injury with head injury — Chest injury with head injury — Abdominal or pelvic injury with head injury — Burns with head injury <p>* SPECIALIZED PROBLEMS:</p> <ul style="list-style-type: none"> — 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 <p>* SECONDARY DETERIORATION (LATE SEQUELAE):</p> <ul style="list-style-type: none"> — Patients requiring mechanical ventilation — Sepsis — Oxygen system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal, or coagulation) — Osteomyelitis 	<p>Patients who are hemodynamically and physiologically stable whose injuries may include:</p> <p>* CENTRAL NERVOUS SYSTEM:</p> <ul style="list-style-type: none"> — Transient Loss of consciousness <p>* CHEST:</p> <ul style="list-style-type: none"> — Injuries not producing respiratory distress — Rib fractures without flail segments <p>* ABDOMEN</p> <ul style="list-style-type: none"> — Blunt trauma not producing hypotension (should also be managed by trauma services) <p>* SPECIALIZED PROBLEMS:</p> <ul style="list-style-type: none"> — Closed fractures — Soft tissue injuries with controlled hemorrhage — Second/third trimester of pregnancy
	<p>CATEGORY III PATIENT:</p> <p>Patients who are continually stable but whose injuries may include:</p> <ul style="list-style-type: none"> — Closed fracture without neurological deficit — Normotensive and/or hemodynamically stable — Soft tissue injuries of moderate degree

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 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 II Trauma Center Or appropriate specialty center if needed (i.e.burn)	Patient stabilization and admit to appropriate Surgical Service or transfer to Level I or II Trauma Center or appropriate specialty center	Stabilize and transfer to Pediatric Trauma Center
Level IV	Stabilize and transfer to a Level I or II Trauma Center Or appropriate specialty center (i.e. burn)	Stabilize and transfer to a Level I or II Trauma Center or appropriate specialty center	Stabilize and transfer to Level I, 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 in the event 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.

Facility Bypass

GOAL: Trauma patients who are medically unstable, unconscious or at high risk for multiple and/or 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 is unable to meet hospital resource criteria or when there are patients in need of specialty care.
4. If expected transport time to the nearest trauma facility is excessive (>20 minutes) or if prolonged extrication time is expected, 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. The following two pages provide 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
ETMC Athens	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
ETMC Carthage	ETMC Tyler	ETMC Tyler	ETMC Tyler	LSU	Parkland	Parkland LSU	ETMC Tyler
ETMC Clarksville	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
Cozby Germany	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
ETMC Crockett	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
ETMC Fairfield	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
ETMC Gilmer	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
GSMC Longview	GSMC	GSMC	GSMC	Children's LSU	Parkland	Parkland	GSMC
Henderson ETMC	ETMC-Tyler TMFH-Tyler	ETMC-Tyler TMFH-Tyler	ETMC-Tyler TMFH-Tyler	Children's Dallas	LSU	LSU	LSU
ETMC Jacksonville	ETMC-Tyler TMFH-Tyler	ETMC-Tyler TMFH-Tyler	ETMC-Tyler TMFH-Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
Allegiance Specialty	ETMC-Tyler TMFH-Tyler GSMC	ETMC-Tyler TMFH-Tyler GSMC	ETMC-Tyler TMFH-Tyler GSMC	Children's Dallas	Parkland	Parkland	Tyler
Longview Regional	Longview Regional	Longview Regional	LSU	Children's Dallas LSU	Parkland	Parkland	Longview (In-House)
GSMC Marshall	GSMC	GSMC	LSU Schumpert	Schumpert	LSU	LSU	GSMC Longview
ETMC Mt. Vernon	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
Palestine Regional	ETMC-Tyler TMFH-Tyler	ETMC-Tyler TMFH-Tyler	ETMC-Tyler TMFH-Tyler	Children's Dallas	Parkland	Parkland	
ETMC Pittsburg	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
Presby Winnsboro	Presby Dallas	Presby Dallas	Presby Dallas	Presby Dallas	Presby Dallas	Presby Dallas	Presby Dallas
ETMC Quitman	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
Shelby Regional	ETMC Tyler	ETMC Tyler	ETMC Tyler	LSU	LSU	LSU	
ETMC Trinity	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
TMFH Jacksonville	TMFH	TMFH	TMFH	Children's Dallas	Parkland	Parkland	Tyler Rehab
TMFH Tyler	TMFH	TMFH	TMFH	Children's Dallas	Parkland	Parkland	Tyler Rehab
ETMC Tyler	ETMC Tyler	ETMC Tyler	ETMC Tyler	Children's Dallas	Parkland	Parkland	ETMC Tyler
UTHSCT Tyler	ETMC Tyler	ETMC Tyler	TMFH	Children's Dallas	Parkland	Parkland	Tyler Rehab



SYSTEM QUALITY IMPROVEMENT PLAN

System Performance Improvement Plan

I. INTRODUCTION

Member organizations of the Piney Woods RAC of TSA-G all 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 is 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.

In order 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.

II. 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.

III. The Physician Peer Review Committee

- A. Members of the Peer Review Committee will be any physician that is a member of RAC-G that 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:
 1. Chairperson
 2. All Trauma Service Medical Directors from each participating hospital.
 3. 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 their respective hospitals.
- E. The Peer Review Committee will review patient care and the system function. Appropriate documentation will be forwarded to the referring facility for inclusion into their performance improvement program.

IV. DATA COLLECTION

- A. Data for the preceding quarter will be provided to the Regional Registrar on or before the last day of the month following the preceding quarter. Those that do not submit data on a quarterly basis will be considered non-compliant.

<u>Quarter</u>	<u>Data Delivered to Chairperson By</u>
1	April 30
2	July 31
3	October 31
4	January 31

- B. Data points collected (see Data Form).
- C. Performance Improvement Indicators (see Paragraph VI).
- D. 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.
- E. In designated trauma facilities, the Trauma Nurse Coordinator will be responsible for collecting and forwarding the data on a quarterly basis to the regional registry for the Peer Review Committee Chairperson.
- F. In non-designated facilities, the Trauma Nurse Coordinator or the Administrative Council representative will be responsible for collecting and forwarding the data on a quarterly basis to the Chairperson.

V. RESPONSIBILITIES TO THE PERFORMANCE IMPROVEMENT PROCESS

A. Designated Trauma Facilities

1. Develop an ongoing facility performance improvement program for trauma patient care.
2. Provide requested data to the RAC regional registry to be reported to the Peer Review Committee Chairperson in a timely manner.
3. Submit individual cases to the committee for discussion, educational interest and improvement of patient care.

B. Non-designated Hospitals

1. Provide required data to the RAC regional registry to be reported to the Peer Review Committee Chairperson in a timely manner.

C. EMS Providers

1. Provide required data to the RAC regional registry to be reported the Peer Review Committee Chairperson in a timely manner.

D. Chairperson –Peer Review Committee

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

E. Performance Improvement Committee Members

1. Must be active participants in the quarterly PI meetings.
2. Must attend at least 50% of the meetings unless there is a valid reason for missing the meeting.

3. Assist in the development of appropriate topics for ongoing study within the system of RAC-G.

VI. AUDIT FILTERS

- A. Mortality percentage based on trauma patients dead on arrival versus the unsuccessful resuscitation attempts.
- B. Mechanism of Injury
- C. Femur fractures and associated complications.
- D. Patient population
 1. All patients admitted to the hospital for at least 24 hours with ICD-9 codes
 2. 800.0 - 959.9.
 3. Transfer to or from another hospital including patients who are transferred but are not admitted.
 4. All trauma deaths in each hospital.
 5. 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.

Print Name _____

Signature _____

Date -----

Performance Improvement Committee Chair DATE

Physician Peer Review 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 _____

Time Admitted to ED _____ AM PM

Date of Admission _____ Date of Discharge _____

Mode of Arrival to Hospital:

- Name of EMS or Ambulance Service _____

Ground EMS _____

Air Transport _____

Private Vehicle _____

Police/Sheriff _____

Other (Describe) _____

MECHANISM OF INJURY (Circle)

* GSW or Stab wound

* Motor Vehicle Crash

* Auto-Pedestrian

* Fall -> Height _____ feet

* Other

DIAGNOSES (List 3 Most Severe Injuries) ICD-9 CODES

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 (Give Name) _____

Date of Transfer _____ Time of Transfer: _____ AM PM



REHABILITATION

Rehabilitation

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

East Texas Medical Center Rehabilitation Hospital – Tyler
Palestine Regional Rehabilitation Unit – Palestine
Health South – Tyler (TMFHS)
Good Shepherd Medical Center – Longview
Good Shepherd Medical Center – Marshall

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:

East Texas Medical Center Rehabilitation Hospital	49 beds (on 2 floors)
Palestine Regional Rehabilitation Unit	97 beds
Health South – Tyler (TMFHS)	63 beds
GSMC – Longview	26
GSMC – Marshall	10

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.

East Texas Medical Center Rehabilitation	(903) 596-3100) to have RN consultant visit patient/hospital
Rehabilitation-Health South	(903) 510-7030 (Admitting) to have RN liaison visit patient/hospital
Palestine Regional Rehabilitation	(903) 731-5100 to arrange visit/screen
Good Shepherd Medical Center Longview	903-315-1926 To have liaison arrange visit/screen

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 East Texas Rehabilitation. Most commercial insurance companies require pre-certification for rehabilitation services.



EDUCATION PREVENTION AND PUBLIC AWARENESS

Public Education and Injury Prevention

The Regional Advisory Council has purchased approximately five Injury Prevention Programs which are available for every hospital in RAC-G to use in their community. RAC-G also provides printed material, such as coloring books, for any hospital to distribute while providing an injury prevention program.

RAC-G works with the MADD East Texas Region and is a major participant in their annual “Tie One On For Safety” Campaign.. RAC-G also participates in a coalition known as Pay Attention East Texas (PAET). This coalition was developed under the direction of Dr. Paul McGaha and includes representation from the Texas Department of Public Safety, DSHS, Regional Healthcare Systems, East Texas Insurance companies, MADD, ETCADA, Carter Blood Care, Texas Department of Transportation, and local police departments. The coalition develops different public awareness campaigns related to injury prevention that are taken across the East Texas area. These campaigns change on a quarterly basis.

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

- A. Trauma Nurses Talk Tough Program
Currently provided to schools/groups by the Level I and II Trauma Facilities
- B. Public Service Announcements Submitted to Local Media
- C. Joint Efforts With EMS for Public Education
 - 1. Reddy Teddy Paramedic Program
 - 2. DWI Education Program
 - 3. Safety Health Fairs
 - 4. Book covers for the schools
 - 5. Think Child Safety Program
 - 6. ENCARE Program
 - 7. Trauma Roo Program
- D. Any trauma center or affiliate hospital may provide public education and promotion.
- E. The RAC uses the newspaper and local magazines to provide injury prevention education and information.
- F. Co-Sponsored with Mothers Against Drunk Driving East Texas Region for the Tie One On For Safety Campaign.
- G. Pay Attention East Texas quarterly injury prevention campaigns.

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 provides continuing education credit for physicians and pre-hospital providers and certificates of attendance for nurses.

- A. Available Courses provided by facilities within the RAC include:
 - 1. Physician
 - a. ATLS
 - b. PALS
 - c. ACLS
 - 2. Nurse
 - a. PALS
 - b. ENPC
 - c. ACLS
 - d. TNCC
 - e. ATCN
 - 3. EMT-P
 - a. ACLS
 - b. BTLS
 - c. PPPC
 - d. PALS

4. EMT-I
 - a. BTLS Advanced
5. EMT
 - a. BTLS Basic

B. Regional Education

1. Trauma Case Presentations
 - a. Monthly at Level I and II Trauma Centers

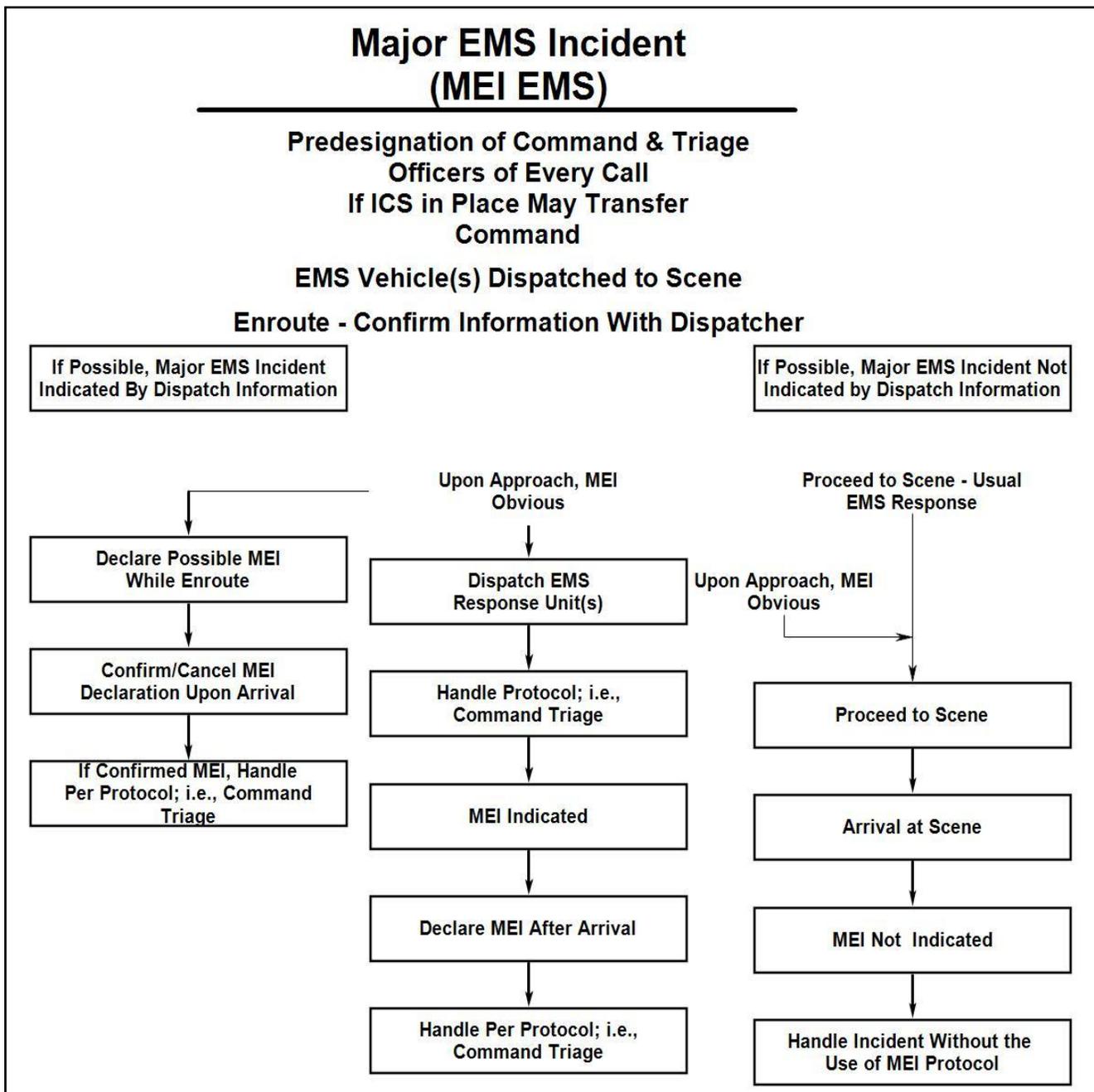
C. Annual Symposiums

1. ETMC Hot Trauma Topics
2. TMFH Trauma Symposium
3. Longview Regional Trauma Tools
4. ETMC Stroke Conference

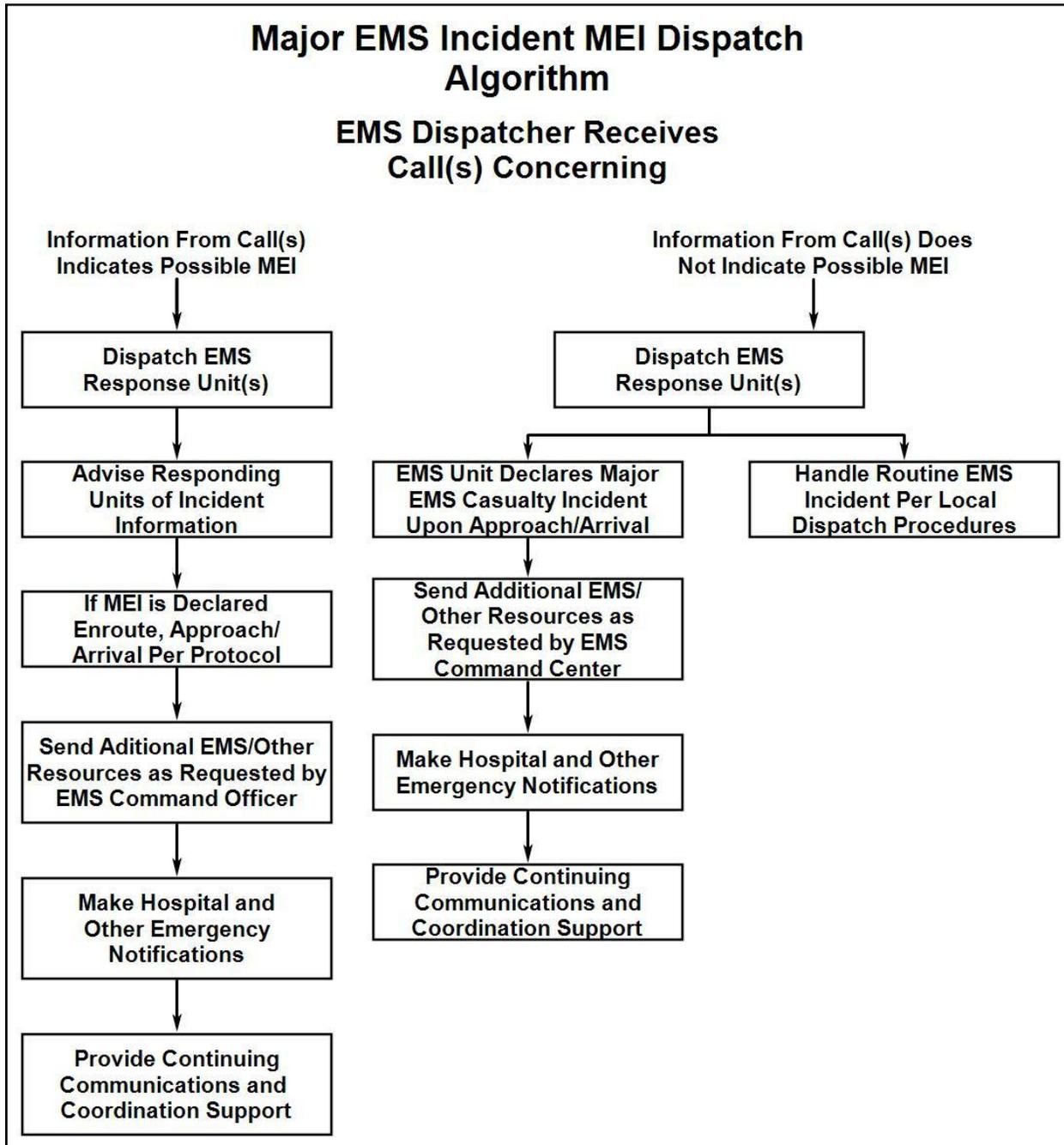


MODEL DISASTER PLAN FOR EMS AGENCIES

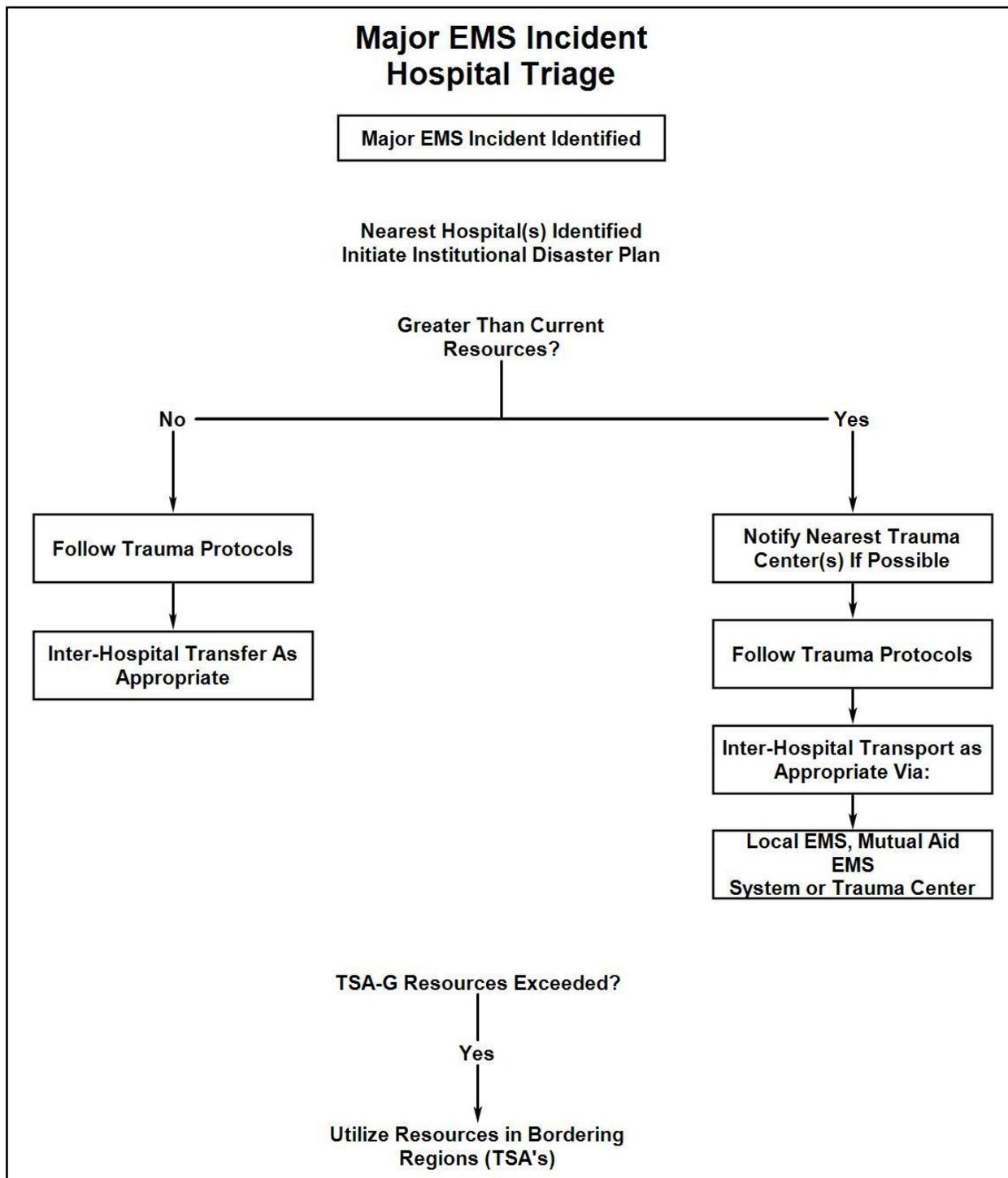
Major EMS Incident (MEI EMS)



Major EMS Incident MEI Dispatch



Major EMS Incident



Model Disaster Plan *

Each county and city in RAC -G maintains disaster plans. 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 which exceeds normal operating capabilities of the EMS system.

Several appendices are included in this section which should be helpful in coordinating any major EMS incident. The key is to become familiar with the information in advance. The appendices in this section which 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 to 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 major EMS incident, whether there are 6 or 60 patients, requires that one person be in charge of all EMS operations at the scene and that one person be responsible for patient triage. It takes both 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 major EMS incident. All the personnel in the EMS unit should be fully familiar with the major EMS incident protocol so that each person will be able, if necessary, to function as the “EMS Command Officer,” “EMS Triage Officer,” or another key 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 it 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 other 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 other 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 enroute 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:

1. Request the local/area EMS Dispatch/Communication Center to initiate appropriate action based on the initial information received. This may include:
 - a. Dispatch of additional EMS units
 - b. Placing appropriate EMS units on stand-by status
 - c. Notification of special resources that may be needed, such as rescue, extrication or hazardous materials response teams
2. 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 transmissions 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/communication 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 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:

- PRIORITY 0 (black)
- PRIORITY I (red)
- PRIORITY II (yellow)
- PRIORITY III (green)

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 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 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 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 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 Areas.

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 Officers 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 may be limited to BLS intervention due to overall 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 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 documented in report form and submitted to RAC-G.



HOSPITAL PREPAREDNESS PROGRAM RESPONSE PLAN

Hospital Preparedness Program 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 8/05/2009

The Piney Woods Regional Advisory Council –RAC-G, Bio Terrorism Hospital Preparedness Program Year 2 Response Plan was first developed in January of 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 Bio Terrorism 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 ETMC, TMFH, and GSMC
- The Tuberculosis Isolation Ward at UTHSCT
- Negative pressure isolation room(s) at each facility
- The Public Health Laboratory of East Texas on the campus of UTHSCT
- 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 UTHSCT
- 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, UTHSCT has one of the largest respiratory isolation capacities in Texas, but it has a small emergency department. Also, UTHSCT 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, or 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 UTHSCT, as long as beds are available.
- Prior to transfer of any patient to UTHSCT, UTHSCT administration must be notified and must accept the transfer.
- In order for UTHSCT 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 UTHSCT. However, some patients will need to be transferred to an isolation room at another East Texas facility. UTHSCT 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 UTHSCT, ETMC, Trinity Mother Frances, Good Shepherd Medical Center, and Longview Regional Medical Center.
- Once patients are no longer contagious they will need to be transferred from UTHSCT back to one of the regional hospitals.
- Healthcare worker surge capacity for UTHSCT 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 therapist, 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 pharmaceuticals 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 RAC, but will be distributed to hospitals in the RAC Trauma Service Area. These hospitals will be responsible in maintaining these items and keeping them in good working order. In case of a bioterrorism/all hazards event, or an event that requires UTHSCT to quickly increase its respiratory isolation capacity, these HEPA filters will be delivered to UTHSCT. HEPA filters that hospitals buy with their own designated funds will not be at the disposal of the RAC or UTHSCT.
- 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 EMS systems computers purchased through RAC -G in good working order, updated, and dedicated to EM Systems. 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 major event or regional exercise, the System Administrator will initiate an EMResource event and post 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 subsequently activate regional HAvBED events from RAC-G hospitals.
- The System Administrator will promote system best practices and user training to all RAC-G users.

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 for all users.
- The System Administrator is designated as the secondary Administrator for ETWebEOC, and serves as back-up to the Primary Administrator for the regional system.
- The System Administrator receives 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 mission of the Pediatric Committee for RAC-G is to improve the care of the pediatric population by providing education, processes for improvement, assistance with equipment, and information from other agencies to all members.

- Goals:
1. To ensure appropriate care of the pediatric patient by providing education to all facilities and agencies throughout the RAG-G area.
 2. To assist with 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 the stroke patient by developing transport protocols and education of most recent standards of care to Emergency Departments.

Mission Statement:

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

Stroke Committee Goals:

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



**PINEY WOODS REGIONAL ADVISORY
COUNCIL
TRAUMA SERVICE AREA (TSA) G
REGIONAL STROKE PLAN
2010**

Introduction

Trauma Service Area-G (TSA-G) extends from the prairies of the Blackland Belt in its westernmost region to the heavily wooded eastern Pine Belt area at its eastern border. The region is a 19-county, 13,609.2 square-mile area of East Texas spanning three different natural geographic regions. A larger 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 portions of the latter five counties are in the Post Oak Belt, a transitional region between the highly forested Pine Belt and the Blackland Belt.

Franklin County, which is the northernmost county in TSA-G, crosses both the Post Oak Belt in the southern two-thirds of the county and the Blackland Belt in its upper one-third. Rains and Van Zandt Counties also cross two different regions, with the western portion of the counties in the Blackland Belt and the eastern portions in the Post Oak Belt.

The population of TSA-G is presently estimated at 893,280. With the exception of Smith, Harrison, Henderson and Gregg counties, the remainder of TSA-G is primarily rural, with a population of 379,835 inhabiting a 9581.5 square-mile area. The two largest cities in TSA-G are Tyler in Smith County, Smith County has a population of 194,635 and Longview in Gregg County, Gregg County has a population of 117,090.

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

As a result a stroke care committee was developed with the mission of developing emergent transport and treatment protocols for TSA-G.

This stroke transport plan has been developed in accordance with current stroke accepted guidelines.

COUNTY	POPULATION	AREA (SQUARE MILES)	COUNTY SEAT
Anderson	57,064	1,070.79	Palestine
Camp	12,410	197.51	Pittsburg
Cherokee	48,513	1,052.22	Rusk
Franklin	10,367	285.66	Mt. Vernon
Freestone	18,803	877.43	Fairfield
Gregg	117,090	274.03	Longview
Harrison	63,819	898.71	Marshall
Henderson	80,222	874.24	Athens
Houston	23,044	1,230.89	Crockett
Marion	10,970	381.21	Jefferson
Panola	22,989	800.92	Carthage
Rains	11,514	232.05	Emory
Rusk	48,354	923.55	Henderson
Shelby	26,575	794.11	Center
Smith	194,635	928.38	Tyler
Trinity	14,296	692.84	Groveton
Upshur	37,923	587.64	Gilmer
Van Zandt	52,916	848.64	Canton
Wood	41,776	650.22	Quitman
TOTAL	893,280	13,691.04	

* Source – US Census Bureau

RAC-G Trauma Centers Map

Designated Trauma Centers TSA-G



Abbreviations: ETMC - East Texas Medical Center
 GSMC - Good Shepherd Medical Center
 LRMC - Longview Regional Medical Center
 TMFHS - Trinity Mother Frances Health System
 UTHSCT - University of Texas Health Science Center at Tyler

Trauma Service Area-G
Emergency Medical Services (EMS) Agencies

The TSA-G map of EMS agencies describes EMS areas of coverage which 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 of these has 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 the systems in TSA-G provide continuing education for their personnel, and all but one of the services provides 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 been participants 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 a neutral party with authority, sharing the goal of developing standardized trauma protocols, standardized training and effective quality improvement activities for TSA-G.

TSA-G EMS Agencies

Name: Camp County EMS, Inc.
Address: P.O. Box 866
City: Pittsburg
State, Zip: Texas 75686
County: Camp
Director: Mike Reynolds
Telephone: (903) 856-7102
Level of Service: MICU

Name: Champion EMS Corporate
Address: 2201 S. Mobberly
City: Longview
State, Zip: TX 75607
County: Gregg & Rusk Counties
Director: Victor Wells
Telephone: 903-291-2500
Level of Service: MICU

Name: East Texas Medical Center EMS
Address: P.O. Box 387
City: Tyler
State, Zip: Texas 75710
County: Smith, Anderson, Cherokee, Franklin, Gregg,
Henderson, Houston, Panola, Trinity, Upshur,
Van Zandt, Wood
Director: Anthony Myers, VP
Telephone: (903) 535-5800
Level of Service: MICU

Name: Fairfield EMS
Address: 632 West Commerce
City: Fairfield
State, Zip: Texas 75840
County: Freestone
Director: Steve James
Telephone: (903) 389-6511
Level of Service: BLS/MICU CAP

Name: GSMC dba Champion EMS
Address: 700 East Marshall
City: Longview
State, Zip: Texas 75601
County: Gregg, Marion, Upshur, Harrison, Rusk, Panola
Director: Brent Smith
Telephone: (903) 291-2504
Level of Service: MICU

Name: Grand Saline VFD
Address: P.O. Box 217
City: Grand Saline

State, Zip: Texas 75140
County: Van Zandt
Director: Robert Coffman, Chief
Telephone: (903) 962-4222 Emergency / (903) 962-3727 Non-Emergency
Level of Service: BLS/MICU

Name: Grapeland VFD
Address: P.O. Box 567
City: Grapeland
State, Zip: Texas 75844
County: Houston
Director: Chad LeBlanc
Telephone: (936) 687-2115
Level of Service: BLS/MICU CAP

Name: Groveton EMS, Inc.
Address: P. O. Box 10
City: Groveton
State, Zip: Texas 75845
County: Trinity
Director: Shannon Worsham
Telephone: (936) 642-1212
Level of Service: BLS/ALS

Name: Hallsville Volunteer Ambulance
Address: P.O. Box 811-H
City: Hallsville
State, Zip: Texas 75650
County: Harrison
Director: Gary Smith
Telephone: (903) 668-3011
Level of Service: BLS/ALS CAP

Name: Jacksonville Fire Department EMS
Address: P.O. Box 360
City: Jacksonville
State, Zip: Texas 75766
County: Cherokee
Director: Rodney M. Kelley, Chief
Telephone: (903) 586-4904
Level of Service: ALS/BLS/MICU

Name: Longview Fire Department EMS
Address: P.O. Box 1952
City: Longview
State, Zip: Texas 75606
County: Gregg, Harrison, Upshur
Director: Hank Hester
Telephone: (903) 239-5534
Level of Service: MICU

(EMS Agencies Continued)

Name: Marshall/Harrison County
Ambulance Service
Address: P.O. Box 698

City: Marshall
State, Zip: Texas 75671
County: Harrison
Director: Bob Cole
Telephone: (903) 935-4585
Level of Service: BLS/MICU

Name: Mims Vol.Fire Dept. & Amb. Serv.
Address: 12728 FM 729
City: Avinger
State, Zip: Texas 75630
County: Marion
Director: Lana Manchester
Telephone: (903) 755-4112
Level of Service: MICU

Name: North East Texas EMS
Address: P. O. Box 1743
City: Center
State, Zip: Texas 75935
County: Shelby
Director: William Harville
Telephone: (936) 598-7600
Level of Service:

Name: Palestine R.M.C. EMS
Address: 4000 S Loop 256
City: Palestine 75801
County: Anderson
Director: John McMeans
Telephone: (903) 731-5398
Level of Service: MICU CAP

Name: THD Teague EMS
Address: P. O. Box 599
City: Teague
State, Zip: Texas 75860
County: Freestone
Director: Bobby Burns
Telephone: (254) 739-2536 Emergency
(254) 739-5732 Non-Emergency Level of Service: BLS/ALS CAP

Name: Timpson Vol. Amb. Service
Address: P. O. Box 492
City: Timpson
State, Zip: Texas 75975
County: Shelby
Director: Tracy Lee
Telephone: (936) 254-2608
Level of Service: ALS/MICU,BLS/MICU

Name: Trinity Mother Frances Health Care System (DBA Champion EMS)
Address: 421 S. Palace
City: Tyler
State, Zip: Texas 75702
County: Smith, Franklin, Rains, Rusk, Van Zandt, Wood, Gregg, Cherokee

Director: Arnie Spiers
 Telephone: (903) 531-5207
 Level of Service: MICU

Name: Waskom VFD EMS
 Address: P.O. Box 1757
 City: Waskom
 State, Zip: Texas 75692
 County: Harrison
 Director: Pat Jenkins
 Telephone: (903) 687-3328
 Level of Service: BLS/ALS

Name: Wills Point EMS
 Address: P.O. Box 505
 City: Wills Point
 State, Zip: Texas 75169
 County: Van Zandt
 Director: Robert Tisdale
 Telephone: (903) 873-3011
 Level of Service: BLS/MICU CAP

Camp County EMS.....	6 MICU
ETMC EMS.....	84 MICU
Fairfield EMS	2 BLS/MICU
Good Shepherd Medical Center dba Champion EMS	18 MICU
Grand Saline VFD	3 BLS/MICU
Grapeland VFD	2 BLS/MICU
Groveton EMS, Inc.	2 BLS/ALS.
Hallsville Volunteer Ambulance	2 BLS/ALS
Jacksonville Fire Department/EMS	3 BLS/MICU, 2 ALS/1 Special
Longview Fire/EMS	4 MICU, 3 Reserve
Marshall/Harrison County Ambulance Serv.	6 BLS/MICU, 6 MICU
Mims Vol. Fire Dept & Amb. Serv.	3 MICU
North East Texas EMS	
Overton EMS	13 New, 5 Reserve
Palestine R.M.C. EMS	6 MICU
Teague EMS	2 BLS/ALS
Timpson Vol. Amb. Serv.	1 ALS/MICU, 1 BLS/MICU
Trinity Mother Frances dba Champion EMS.....	17 MICU, 1 Spec.
Waskom VFD/EMS.....	1 BLS/ALS
Wills Point EMS.....	2 BLS/MICU
Flight for Life TMF	1 HCP
Air One ETMC	3 HCP

Flight Programs

AIR ONE CENTRAL
East Texas Medical Center
P.O. Box 6400
Tyler, TX 75711
(903) 531-8165
Director: Terri Rowden

AIR ONE WEST
East Texas Medical Center Athens
2000 S. Palestine
Athens, Texas 75751
(903) 531-8165
Director: Terri Rowden

AIR ONE NORTH
Titus County Hospital
Mt. Pleasant, Texas
(903) 531-8165
Director: Terri Rowden

FLIGHT FOR LIFE
Trinity Mother Frances Health System
800 East Dawson
Tyler, TX 75701
(903) 531-4267
Chief Flight Nurse: Arnie Spiers

Resource Flight Programs Outside of TSA-G

LIFE AIR RESCUE
Schumpert Medical Center/Willis-Knighton Medical Center
P.O. Box 21976
Shreveport, LA 71120-1976
(318) 227-4730
Chief Flight Nurse: Robert P. Pringle, Jr.

CAREFLITE DALLAS
P.O. Box 225344
Dallas, TX 75222-5344
(214) 947-8450
Chief Flight Nurse: Monty Hunsaker

HERMANN LIFE FLIGHT
Hermann Hospital
6411 Fannin Street
Houston, TX 77004
(713) 704-3502
Chief Flight Nurse: Thomas J. Flanagan

TSA-G EMS Agencies Medical Directors

Camp County Ambulance Service, Inc.
Blair MacBeath, MD
410 Quitman Street
Pittsburg, TX 75686
(903) 856-6546

Wills Point EMS
William H. Atkinson, MD
P.O. Box 260
Wills Point, TX 75169
(903) 873-4848

ETMC EMS
William Moore, MD, FACEP
352 South Glenwood
Tyler, TX 75702
(903) 535-5200

Fairfield EMS
J. H. Keller MD
632 West Commerce Street
Fairfield, TX 75840
(903) 389-2181

GSMC dba Champion EMS
Gregg Harrington, MD
700 East Marshall
Longview, TX 75601
(903) 236-2020

Grand Saline Vol. Fire Dept.
Richard Ingram, MD
P.O. Box 297
Grand Saline, TX 75140
(903) 962-3122

Grapeland VFD/EMS
G. Edward Early, DO
2900 South Loop 256
Palestine, TX 75801
(903) 731-1156

Hallsville EMS
Gregg Harrington, MD
700 East Marshall
Longview, TX 75606
(903) 236-2020

Jacksonville Fire Department EMS
James R. Low, Jr., MD
203 Nacogdoches Street #360
Jacksonville, TX 75766
(903) 586-3505

Overton EMS
J. M. Hamilton, MD
P.O. Box 10
Overton, TX 75684
(903) 834-3115

Longview Fire Department EMS
Gregg Harrington, MD
700 East Marshall
Longview, TX 75606
(903) 236-2020

Marshall/Harrison County EMS
Jack Cash, MD
811 South Washington
Marshall, TX 75671
(903) 935-8744 or (903) 938-8209

TMF dba Champion EMS
Theodore Gould, MD
800 East Dawson
Tyler, TX 75701
(903) 531-4212

Teague EMS
Bill Halbert, MD
315 Main Street
Teague, TX 75860
(817) 739-2561

Waskom VFD EMS
Rex
811 Washington Avenue
Marshall, TX 75670
(903) 935-8744

Scott

First Responders/EMS Agencies
(Listed By County)

<i>COMPONENT</i>	<i>DETAILS</i>
9-1-1- Type EMS Agencies	ANI / ALI Palestine Memorial Hospital EMS EITEMS
First Responder Agencies	79 East 84 West Bethel-Cayuga Bradford Coffee City FD Elkhart Elmwood VFD Frankston Fire Department Lone Pine VFD Montalba Neches VFD S-AC VEMS Inc Southside Tennessee Colony Tucker West Side VFD
9-1-1 Type EMS Agencies	ANI / ALI Camp County EMS, Inc.
First Responder Agencies	
9-1-1 Types EMS Agencies	ANI / ALI EITEMS Jacksonville Fire Department EMS TMF dba Champion EMS
First Responder Agencies	Earl Chapel VFD Gallatin New Summerfield VFD North Cherokee County VFD Wells Fire Department
9-1-1 Type EMS Agencies	ANI / ALI Fairfield EMS Teague EMS
First Responder Agencies	Southern Oaks VFD Streetman VFD
9-1-1 Type EMS Agencies	ANI / ALI TMF dba Champion EMS EITEMS – Mt. Vernon
First Responder Agencies	Mt. Vernon Fire Department North Franklin VFD

COUNTY	COMPONENT	DETAILS
Gregg	9-1-1- Type EMS Agencies First Responder Agencies	ANI / ALI Champion EMS EITEMS Good Shepherd Medical Center EMS Longview Fire Department EMS TMF dba Champion EMS Clarksville-Warren VFD Easton Fire Department East Texas Regional Airport Elderville-Lakeport Fire Department Kilgore Fire Department Longview Fire Department White Oak Fire Department
Harrison	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI EITEMS Good Shepherd EMS Harleton VFD/EMS Longview Fire Department EMS Marshall-Harrison County Fire Dept. EMS Grapeland VFD Hallsville Fire Department Hallsville Volunteer Ambulance Harrison County Marshall Fire Department Waskom Fire Department
Henderson	9-1-1 Types EMS Agencies First Responder Agencies	ANI / ALI EITEMS Athens Fire Department Baxter VFD Berryville VFD Brownsboro VFD Callendar Lake Chandler Fire Department Eustace VFD Gun Barrel City VFD LaRue-New York Fire Department Malakoff VFD Murchison Fire Department Payne Springs Poynor Fire Department Seven Points Fire Department Shady Oaks Fire Department South Van Zandt County Trinidad VFD Westside Fire Department

COUNTY	COMPONENTS	DETAILS
Houston	9-1-1 Types EMS Agencies First Responder Agencies	ANI Only (no location identification) EITEMS Grapeland VFD Kennard-Ratcliff Lovelady VFD
Marion	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI Good Shepherd Medical Center dba Champion EMS Mims VFD
Panola	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI EITEMS Beckville Carthage Fire Department Community Four Fire Department Flatwood Fire Department Gary Fire Department Inter Community Fire Department Woods
Rains	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI TMF dba Champion EMS Alba Fire Department Emory Fire Department Point Fire Department Southwest Rains County
Rusk	9-1-1 Type EMS Agencies First Responder Agencies	ANI / ALI TMF dba Champion EMS Good Shepherd Medical Center EMS Mt. Enterprise VFD EMS Northeast Texas EMS Church Hill Fire Department Crim Chapel Fire Department Henderson Fire Department Kilgore Fire Department Laneville Fire Department New Salem Fire Department Shelby County VFD

COUNTY	COMPONENT	DETAILS
Smith	9-1-1 Types EMS Agencies	ANI / ALI EITEMS, ETMC Air One, TMF dba Champion EMS
	First Responder Agencies	Arp VFD Bullard VFD Chapel Hill VFD Civil Air Patrol Flint VFD Kelly Springfield Lindale VFD Noonday VFD Red Springs VFD Troup VFD Tyler Fire Department Whitehouse VFD Winona VFD
Trinity	9-1-1 Type EMS Agencies	ANI / ALI Trinity County EMS
	First Responder Agencies	Pennington VFD Trinity PD,
Upshur	9-1-1 Type EMS Agencies	ANI / ALI EITEMS
	First Responder Agencies	Big Sandy Fire Department East Mountain Fire Department Gilmer Fire Department Glenwood Acres Fire Department Holly Lake Fire Department Union Grove Fire Department
Van Zandt	9-1-1 Type EMS Agencies	ANI / ALI Ben Wheeler VFD EITEMS
	First Responder Agencies	Grand Saline VFD EMS TMF dba Champion EMS Wills Point EMS Calendar Lake VFD Canton Fire Department Edgewood Fire Department Edom Fire Department Fruitvale Fir Department Midway Fire Department Myrtle Springs Fire Department Rolling Oaks Fire Department South Van Zandt County VFD Van Fire Department Whitton VFD Wills Point Fire Department

<i>COUNTY</i>	<i>COMPONENT</i>	<i>DETAILS</i>
Wood	9-1-1 Types EMS Agencies First Responder Agencies	ANI / ALI ETMC EMS Flight for Life EMS ETEMS TMF dba Champion EMS Mineola Fire Department Quitman Fire Department Winnsboro Fire Department Yantis Fire Department

HOSPITAL	DESIGNATION	BEDS
East Texas Medical Center 1000 South Beckham Tyler, Texas 75701 (903) 531-8165	Primary Stroke Center Level I Trauma Center Designated	Med/Surg 385 ICU – 63 Pedi – 8 Rehab – 48
Trinity Mother Frances Hospital 800 East Dawson Tyler, Texas 75701 (903) 593-8441	Primary Stroke Center Level II Trauma Center Designated	Med/Surg – 269 ICU 38 Pedi 18 Rehab – 0
ETMC – Athens 2000 South Palestine Athens, Texas 75751 (903) 675-2216	Level III Trauma Designated	Med/Surg -87 ICU – 8 Pedi – 0 Rehab – 0
ETMC – Crockett P.O. Box 1129 Crockett, Texas 75835 (936) 544-2002	Level III Trauma Designated	Med/Surg – 15 ICU – 5 Pedi – 0 Rehab – 0
ETMC – Jacksonville 501 South Ragsdale Jacksonville, Texas 75766 (903) 586-3000	Level III Trauma Designated	Med/Surg –2 ICU – 2 Pedi – 0 Rehab – 0
ETMC – Quitman P.O. Box 1000 Quitman, Texas 75783 (903) 763-4505	Level IV Trauma Designated	Med/Surg – 28 ICU – 0 Pedi – 0 Rehab – 0
ETMC – Mt. Vernon P.O. Box 477 Mt. Vernon, Texas 75457 (903) 537-4552	Level IV Trauma Designated	Med/Surg – 30 ICU – 4 Pedi –1 Rehab – 0
ETMC – Pittsburg 414 Quitman Pittsburg, Texas 75686 (903) 856-6663	Level IV Trauma Designated	Med/Surg – 23 ICU – 2 Pedi – 0 Rehab – 0
Henderson Memorial Hospital 300 Wilson Henderson, Texas 75652 (903) 657-7541	Level IV Trauma Designated	Med/Surg – 20 ICU –4 Pedi – 4 Rehab –4
ETMC – Carthage	Level IV Trauma	Med/Surg – 19

P.O. Box 409 Carthage, Texas 75633 (903) 693-0295	Designated	ICU – 4 Pedi –1 Rehab – 0
Presbyterian Hospital – Winnsboro Drawer 628 Winnsboro, Texas 75494 (903) 342-5227	Level IV Trauma Designated	Med/Surg – 50 ICU – 2 Pedi – 0 Rehab – 0

HOSPITAL	DESIGNATION	BED
Cozby-Germany Hospital 707 North Waldrip Grand Saline, Texas 75140 (903) 962-4242	Level IV Designated	Med/Surg – 25 ICU – 0 Pedi – 0 Rehab – 0
ETMC – Fairfield 125 Newman Street Marshall, Texas 75670 (903) 389-2121	Level IV Designated	Med/Surg –48 ICU 0 Pedi – 0 Rehab – 0
ETMC – Clarksville (not in RAC G) Hwy. 82 W Clarksville, Texas 75426 (903) 427-3851	Level IV Designated	Med/Surg – 292 ICU – 0 Pedi – 0 Rehab – 0
ETMC – Trinity P.O. Box 471 Trinity, Texas 75862 (936) 594-3541	Level IV Designated	Med/Surg – 21 ICU – 0 Pedi – 1 Rehab – 0
Shelby Regional Medical Center 602 Hurst Street Center, Texas 75935 (936) 598-2781	Level IV Designated	Med/Surg –0 ICU – 0 Pedi – 0 Rehab – 0
Trinity Mother Frances-Jacksonville 1016 South Jackson Street Jacksonville, Texas 75766 (903) 541-4500	Level IV Designated	Med/Surg – 20 ICU – 0 Pedi – 0 Rehab – 0
Palestine Regional Hospital P.O. Box 4070 Palestine, Texas 75802 (903) 731-8910	Level III Designated	Med/Surg –89 ICU – 10 Pedi – 12 Rehab –26
Good Shepherd Medical Center 700 East Marshall Avenue Longview, Texas 75601 (903) 236-2000	Level II Designated	Med/Surg – 215 ICU – 33 Pedi –19 Rehab – 25
Longview Regional Medical Center P.O. Box 1500 Longview, Texas 75607 (903) 758-1818	Level III Designated	Med/Surg –78 ICU – 16 Pedi – 10 Rehab – 0
Good Shepherd Medical Center Marshall P.O. Box 1599 Marshall, Texas 76570 (903) 935-9311	Level III Designated	Med/Surg –30 ICU –9 Pedi – 11 Rehab – 10
University of Texas Health Science Ctr Tyler 11937 US Hwy 271 Tyler, Texas 75708	Non-Designated	Med/Surg – 12 ICU – 3 Pedi – 0 Rehab – 8

(903) 877-2867		
ETMC Gilmer 712 N. Wood Gilmer, Texas 75644 903-841-7100	Level IV Designated	Med/Surg –34 ICU – 3 Pedi – 0 Rehab – 8

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Crockett, Texas 75835

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Fairfield, Texas 75840

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Gilmer, Texas 75644

ETMC – Jacksonville
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Jacksonville, Texas 75766

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Mt. Vernon, Texas 75457

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Pittsburg, Texas 75686

ETMC – Quitman
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ETMC – Trinity
N. El-Aswad, MD

PO Box 471
Trinity, Texas 75862

ETMC – Tyler
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Tyler, Texas 75711

Good Shepherd Medical Center
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Longview, Texas 75601

Henderson Memorial Hospital
Thomas Curtis, MD
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Henderson, Texas 75652

Longview Regional Medical Center
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GSMC Marshall
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Marshall, Texas 75670

Palestine Regional Hospital
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Palestine, Texas 75801

Presbyterian Hospital – Winnsboro
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Trinity Mother Frances Health Care System
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Tyler, Texas 75701

TMFH – Jacksonville
Gary Smith, MD
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Jacksonville, Texas 75766

University of Texas Health Science Center Tyler
Ted Gould, MD
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Tyler, Texas 75710-2003

Medical Oversight

TSA-G includes both 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 in order to facilitate standardization of pre-hospital care throughout the region. Given the diversity of the region and the number of EMS agencies involved, this is a long-term goal which may never be realized. There is, however, use of the RAC's stroke protocols, which accomplishes off-line uniformity of medical control.

In accordance with 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 patients last known time normal, physical assessment, medical history. These items are essential for the transportation to the appropriate TSA-G facility for the treatment of 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
Hypoglycemia and seizure

MINIMUM TREATMENT GUIDELINES

- Oxygen 2-4 L/min
- IV NS TKO (as per skill level)
- Monitor of Blood Pressure.
- Rapid transport to 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 stroke patient is in window for thrombolytic therapy.

TRANSPORT DECISION SHOULD BE BASED ON PATIENTS 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 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.
Patient is outside the window for
thrombolytics

PINEY WOODS REGIONAL ADVISORY COUNCIL
STROKE CENTERS

Ability of treating beyond 3 hour IV tPA window

East Texas Medical Center Tyler

(Joint Commission Certified Primary Stroke Center)

Trinity Mother Francis Hospital Tyler

(Joint Commission Certified Primary Stroke Center)

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

ETMC – Athens	Athens, Texas
ETMC - Crockett	Crockett, Texas
ETMC – Jacksonville	Jacksonville, Texas
ETMC – Quitman	Quitman, Texas
ETMC – Mt. Vernon	Mt. Vernon, Texas
ETMC – Pittsburg	Pittsburg, Texas
ETMC – Henderson	Henderson, Texas
ETMC – Carthage	Carthage, Texas
ETMC – Fairfield	Fairfield, Texas
ETMC – Trinity	Trinity, Texas
Trinity Mother Francis - Jacksonville	Jacksonville, Texas
Palestine Regional Hospital	Palestine, Texas
Good Shepard Medical Center	Longview, Texas
UT Health Science Center	Tyler, Texas
ETMC – Gilmer	Gilmer, Texas
Longview Regional Medical Hospital	Longview, Texas
Good Shepard Medical Center Marshall	Marshall, Texas

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



STEMI RESPONSE PLAN

**STEMI Committee Response Plan
Ed Integration with the Pre-hospital System
And Texas Trauma System
Regional Advisory Council
For Trauma Service Area G (Piney Woods)**

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 transmission of pre-hospital ECGs from EMS providers. Improved communication will lead to improved patient care and outcomes.

Purpose of Committee:

The purpose of the committee is to strengthen the relationship between the area EMS providers and the EDs they transport to, and to improve the care of the acute coronary syndrome patient 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 to improve outcomes for the STEMI/acute coronary syndrome patient.
- 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 in order to improve community care by educating all systems and the community to the signs and symptoms of ACS. By educating all systems and the community, outcomes may be improved 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 the establishment of processes across the RAC-G area to facilitate timely response and treatment and to 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 what hazards exist and measures being used to contain/avoid it.
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 special measures to prepare for the patient.

Appendix B

Radioactive Materials Management

Recommendations for Incidents Involving Radioactive Materials

The following recommendations have been established by the Atomic Energy Commission 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, then 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 who have had possible contact with radioactive material until they can be examined further. Obtain names and addresses of those involved.
5. Remove injured from area of accident with as little contact as possible and hold at a transfer point. Take any measures necessary to save 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. **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 incidents involving fire, 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 with toxic chemicals. **DO NOT** handle suspected material until it has been cleared by monitoring personnel. Segregate clothing and tools used at the fire until they can be checked by radiological emergency teams.
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 right of way must be cleared before AEC assistance arrives, wash spillage to shoulders of 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