SOUTHWEST TEXAS
REGIONAL ADVISORY COUNCIL
for
TRAUMA SERVICE AREA-P

Regional Trauma System Plan
2014

Revised October 3, 2014

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Overview of Trauma Service Area P

Description

Trauma Service Area P is composed of twenty two counties, with a total land mass of 26,770 square miles. Total population of TSA- P exceeds 2.4 million. There are three (3) urban counties (more than 50,000 population); fifteen (15) rural counties (less than 50, 000 population with more than six persons per square mile), and four (4) frontier counties (population with less than six persons per square mile).

Seven of the counties in TSA-P do not have hospitals and are dependent upon adjacent counties for acute care/inpatient care. All counties in TSA-P have EMS/First Responder agencies, with level of service ranging from Basic Life Support (BLS) to Mobile Intensive Care Unit (MICU) capabilities.

The large land mass of TSA-P, and the distances between rural facilities and the comprehensive trauma centers in San Antonio present a challenge for transfer of the acutely injured patient. Wherever feasible and appropriate, transport of critical patients identified by STRAC patient criteria (Trauma Alert, Heart Alert, Stroke Alert or similar) by air medical transportation resources is encouraged. The development of MEDCOM, which coordinates inter-hospital transfers, has decreased the bureaucratic obstacles for transfer and decreased acceptance time to approximately nine to ten minutes from first request by the transferring facility.

Table 1 summarizes the EMS agencies and number of designated acute care facilities per county
available for care of the trauma patient.

County Profiles

Table 1: TSA-P County Profiles and Trauma Care Resources

County	Land Mass (Square Miles)	Total Population	County Type (pop per sq mi)	EMS /First Responder Agencies	Designated Acute Care Facilities
Atascosa	1,232	38,628	Rural (27)	3	0
Bandera	792	17,645	Rural (16)	1	N/A
Bexar	1,246	1,392,931	Urban (1,051)	27	10
Comal	562	78,021	Urban (119)	4	0
Dimmitt	1,331	10,248	Rural (7.8)	3	1
Edwards	2,120	2,162	Frontier (1.27)	1	N/A
Frio	1,133	16.252	Rural (13.7)	1	1
Gillespie	1,061	20,814	Rural (18.4)	2	0
Gonzales	1,068	18,628	Rural (16.4)	1	1
Guadalupe	711	89,023	Urban (101)	5	1
Karnes	750	15,446	Rural (16.7)	1	0
Kendall	663	23,743	Rural (28.9)	1	N/A
Kerr	1,106	43,653	Rural (37)	1	0
Kinney	1,364	3,379	Frontier (2.4)	1	N/A
LaSalle	1,489	5,866	Frontier (4.0)	1	N/A
Maverick	1,280	47,297	Rural (34.3)	2	1
Medina	1,328	39,304	Rural (24.5)	3	1
Real	700	3,047	Frontier (3.8)	2	N/A
Uvalde	1,557	25,926	Rural (15.9)	3	1
Val Verde	3,171	44,856	Rural (13.6)	1	1
Wilson	807	32,408	Rural (32)	5	0
Zavala	1,299	11,600	Rural (9.2)	1	N/A
Total	**26,770**	**1,827,953**		**70**	**18**

TSA-P EMS Summary by County

EMS Agency	Address	City	Zip	Contact Person	Phone#	E-mail Address
A-1 First Response EMS	1700 South Saint Marys Street	San Antonio	78210			
Acadian Ambulance Service	3922 IH 35 North Building 3	San Antonio	78227	Troy Mayer	512-433-9545	jmayer@acadian.com
Air Evac LifeTeam	304 South 5th Street	Carrizo Springs	78834	Julie Lewis	512-395-7460	lewisjulie@air-evac.com
Air Medical	402 E. Ramsey	San Antonio	78216	Brock Miller	210-525-9900	brock@air-medical.com
Akin Ambulance	P.O. Box 1780	Seguin	78155	Scott Akin	830-534-3474	s.akin@akinambulance.com
Alamo Area Ambulance	306 Getty	Uvalde	78801	Guillermo Balderas	830-275-9688	w_balderas@yahoo.com
Alamo Heights Fire/EMS	6116 Broadway	San Antonio	78209	Buddy Kuhn, Chief	210-824-1281 210-415-5588 (24hrs)	bkuhn@alamoheightstx.gov
Amb-Trans Ambulance Service	538 W. Woodlawn	San Antonio	78212	Maurice Shaner	210-734-7552	maury@ambtrans.com
Ambulance Billing Systems	5368 Fredericksburg Road Suite 310	San Antonio	78229	Bradley Leach/Robert Montoya	210-375-1700	steve@ambulancebills.com
American Medical Responses, Inc	11911 Radium	San Antonio	78216	Jason Dailey	210-599-9208 ext 57129	jason.dailey@emsc.net/marti.williams@amr.net
American Metropolitan Amb. Co.	1804 W. Martin Street	San Antonio	78207	Pablo Salazar	210-344-7002	amacems@aol.com
Americana Ambulance	4127 E. Southcross	San Antonio	78222	Jaime D. Rios	210-590-1911	jaimedrios@americanaambulance.com
Amistad Ambulance Transports	3912 East Highway 90	Del Rio	78840	Arnold Chacon	830-298-9796	arnold954@yaho.com
Anderson Transport Services	P.O. Box 311801	New Braunfels	78131	Rick Anderson	830-214-6781	rick@andersonambulance.com

EMS Agency	Address	City	Zip	Contact Person	Phone#	E-mail Address
Angel Care Ambulance Service	122 S. 2nd St. Ste. B	Kenedy	78119	Jason Miller	(210) 273-4174	jasonmmiller@ymail.com
Apollo Ambulance Service Inc	107 Turner Lane	Floresville	78114	Jesse Davis	830-393-8555	apolloamb@yahoo.com
Atascosa County EMS	915 Main St.	Jourdanton	78026	Jimmy Day	830-769-2702	ACES@intersatx.net
Austin- Travis County EMS	15 Waller 2nd Floor EMS	Austin	78702	Mark Montgomery	mark.montgomery@austintexas.gov	210-268-7594
Bandera County EMS	P.O. Box 5	Bandera	78003	Cindy Martin	830-796-4282	c.martin@78003.com
Blanco Vol Amb Corps	P.O. Box 632, 607 Chandler	Blanco	78606	Mike West	830-833-5239/830-554-0800 (cell)	mwest@blancoems.com
Border EMS	902 Orange	McAllen	78501	James Unwin	830-876-9778	
Bulverde-Spring Branch EMS	P.O. Box 38	Spring Branch	78070	Mark Southwell	830-228-4501/830-228-4503 fax	Mark.Southwell@bsbems.org
Camino Real Ambulance				Gracie Perez	830-876-0066	perez_gracie@yahoo.com
Canyon Lake Fire/ EMS	P.O. Box 2140	Canyon Lake	78130	Shawn Wherry	830-907-2922/830-743-2337	chief500@gvtc.com
Comal County Emergency Services	P.O. Box 2140	Canyon Lake	78133	Rita Shellenberger		
Community EMS, Inc.	3006 Avenue G	Hondo	78861	Kerry Copland, Michael Haynie	830-288-6434	ems.community@gmail.com
Converse EMS	107 Station Street	Converse	78109	Raymond Christian	210-658-8900	fdasstchief@conversetx.net
Cotulla EMS	P.O. Box 65	Cotulla	78014	Brenda Jennings	830-879-3331	cotullaems@sbcglobal.net
Courtesy EMS	550 Earl Garrett # 114	Kerrville	78028	Scott Evans	830-257-0546/830-428-8206(cell)	courtesyems@hotmail.com

EMS Agency	Address	City	Zip	Contact Person	Phone#	E-mail Address
Crystal City EMS	101 East Dimmit St.	Crystal City	78839	Chad Schafer EMT-B	830-374-3401 (cell)/(830) 448-9678	fireman8109@gmail.com
Del Rio Ambulance				Alfonso Zertuche	830-719-2495/830-734-6725	
Devine VFD	202 E. Herring Ave	Devine	78016	Patrick Dubose	830-665-4246 / Cell 210-288-0943	dvfdchief@hotmail.com
District 7 Fire Rescue				Chris Willis		cwillis@d7fr.org
Eagle Creek EMS	11382 FM 775	Floresville	78114	Christy Merendon	830-480-2303	cmerendon2003@yahoo.com
Eagle Med	2080 Airport Dr. Hangar M	San Marcos	78666	Tim Welch	(830) 431-3046	tim.welch@flyeaglemed.com
Eagle Pass Ambulance LLC	2320 Del Rio Boulevard	El Paso	78852	Felipe Zavala	830-773-0787	epambullb@yahoo.com
Eagle Pass Fire/EMS	2558 El Indio Hwy	Eagle Pass	78852	Jesus M. Rodriguez	830-757-4231	jrodriguez@eaglepassstx.us
Edwards County EMS	P.O. Box 185	Rocksprings	78880	Diane Rogers/ Paula Epperson	210-260-3403	edcoems@swtexas.net
Emerald Ambulance	12703 Mountain Air Suite 106	San Antonio	78249	Raymond Sotelo, Jr.	210-694-4508	
Esterella Medical Masters	700 S. Zarzamora, Ste LL3	San Antonio	78207		210-434-2488	
Evening Star Ambulance	909 Main Street	Jourdanton	78026		830-769-3238	
Express Care Ambulance	5707 Grey Rock	San Antonio	78228	Tina D. De los Santos	210-669-6548	tinadlopez1972@yahoo.com
First Medical Response of Texas	3720 Gattis School Rd #800, P.O. Box 264	Round Rock	78664	Edwin Reyes	2104658911	firstmedicalresponse@austin.rr.com
Fredericksburg EMS	126 West Main	Fredericksburg	78624	David Jung	830-990-2055/830-889-5848	djung@fbgtx.org

EMS Agency	Address	City	Zip	Contact Person	Phone#	E-mail Address
Frio Canyon EMS	P.O. Box 803	Leakey	78873	Donna Cone	830-232-5299	fcems@hctc.net;jaguilar.frioco@sbcglobal.net
Gemini Ambulance Service Inc.	2897 NE Loop 410	San Antonio	78217		210-494-1069	
Geronimo Vol. Fire Dept.	P.O. Box 51	Geronimo	78115	Keith Lohse	830-606-0549	
Gonzales County EMS	P.O. Box 62	Gonzales	78629	Jim Russell or Robert McCauley	830-672-7675	gcems@gvec.net
Grey Forest FD				Mark Montgomery		
Harper Fire & EMS				Catherine Kuhlmann		
Helotes Fire/EMS	12951 Bandera Road	Helotes	78023	Walton Daugherty, Chief	210-695-3572-Keith Eldard	KEldard@Helotes-TX.gov
Hollywood Park Fire/EMS	2 Mecca Dr.	San Antonio	78232	John Butrico, Chief	210 494-3111 ext: 231	jbutrico@hollywoodpark-tx.gov
Karnes County EMS	200 E. Calvert Street	Karnes City	78118	John Smart	830-299-1611	smart900@sbcglobal.net
Kendall County EMS	1175 N. Main	Boerne	78006	Jeff Fincke	830-249-3721	Jeff276@gvtc.com
Kerrville Fire/EMS	87 Coronado Street Suite 200	Kerrville	78028	Eric W. Maloney	830-257-5333	eric.maloney@kerrvilltx.gov
Kinney County EMS/ Fire	P.O. Box 1499	Brackettville	78832	Tim Ward/Jim Titchenell	830-563-2384 (Gilbert)	kcauditor@sbcglobal.net/jim.kcfr@hotmail.com
Kirby EMS	5560 Duffek Dr.	Kirby	78219	Laird Bretz	210-661-2612	lbretz@cityofkirby.org
La Vernia EMS	P.O. Box 308	La Vernia	78121	Marian Rye	830-779-1709 or 830-779-2159	lvems@ranchwireless.com
Lackland EMS				Andrew Thompson	210-275-9811	andrew.thompson.10@us.af.mil
Lake Dunlap Area VFD	915 Potthast	New Braunfels	78130	Scott Wiley, Chief	830-626-8497 or 830-237-1424 cell	maverickambulance@yahoo.com

EMS Agency	Address	City	Zip	Contact Person	Phone#	E-mail Address
Leon Valley Fire/EMS	6400 El Verde Road	San Antonio	78238	Billy Lawson	210-684-3219	b.lawson@leonvalleytexas.gov
Lone Star Ambulance	1388 Williams	Eagle Pass	78852	Louis Gonzales	830-968-3740	
Maverick Ambulance	1320 E Garrison St	Eagle Pass	78852	Adrian Davila	830-752-1126;830-513-4890	maverickambulance@att.net
MCA-Med Care Ambulance	P.O. Box 625	Adkins	78101	Mitchell Shaner	210-337-7772	Medcareambulance@prodigy.net
Medical Reliance	7231 Poss Road	San Antonio	78240	Edgar Martinez	210-734-5275	
Medical Transports of South Texas	2662 Encino Park Drive	Eagle Pass	78852	Arturo Mery/Nelda Trevino	830-752-6075/ 210-725-5440/877-244-0620	mtstsa@yahoo.com
Medina Valley EMS (closed for now)	P.O. Box 1367	Castroville	78009	Mike Farris	210-260-3403	mvems@sbcglobal.net
Methodist Aircare/Reachair Medical Services	1139 E. Sonterra Blvd. Suite 115	San Antonio	78258	Lee Fernandez	210-842-3469	lee_fernandez@reachair.com
Metro Ambulance Service, Inc.	P.O. Box 912	Schertz	78154	Susan Baldwin-Beck	210-945-2022	sbeck@txdirect.net
NC Ambulance Service	8026 Vantage Dr. Ste 102	San Antonio	78230		210-641-2900	
New Berlin Vol Fire Dept.	3820 FM 539	LaVernia	78121	Kurt Strey	830-914-4980	
New Braunfels Fire/EMS	P.O. Box 311747	New Braunfels	78131	Mark Eliot	830-221-4264	MEliot@nbtexas.org
North Star Ambulance				Jack Howley		
Nueces Canyon EMS	P.O. Box 460	Camp Wood	78833	Stephen Stephens	830-279-6908	sstephensmedic@yahoo.com/ncems@swtexas.com
Pulse Ambulance Service	P.O. Box 681225	San Antonio	78250	Nancy Hungerford	210-647-1453	

EMS Agency	Address	City	Zip	Contact Person	Phone#	E-mail Address
Sabinal EMS	PO BOX 104	Sabinal	78881	Javier Flores	830-988-2233/Javier cell 830-261-6373	sabinalems@yahoo.com
Sacred Heart Medical Services (Frio County EMS)	PO BOX 3847	Victoria	77904	Bo Reger	361-579-9727	breger@shmedical.org
San Antonio AirLife	7500 US Highway 90 West, Suite 220	San Antonio	78227	Shawn Salter	210-233-5804	shawn.salter@txairlife.com
San Antonio Fire Dept /EMS	115 Auditorium Circle	San Antonio	78205	Joe Hemann, Capt	210) 207-7525	josephhemann@sanantonio.gov
San Marcos Hays County EMS	1305 IH-35 North/ PO Box 641	San Marcos	78667	Christopher Alexander, EMS Director	512-353-5115 ext 202	calexander@smhcems.org
Schertz EMS	1404-B Schertz Parkway	Schertz	78154	Dudley Wait	210-658-6678	dwait@schertz.com
Seguin Fire/EMS	110 Elm Street	Seguin	78155	Dale Skinner	830-401-2311	dskinner@seguintexas.gov
Shavano Park EMS/FD	15604 NW Military HWY	San Antonio	78231	Mike Naughton	210-492-1111	mnaughton@shavanopark.org
ShurMed	11382 FM 775	Floresville	78114	Shirley Schriber	210-478-0790	code03shur@aol.com / 210-478-0790
Sisterdale Vol. Fire Dept.	1207 Sisterdale Rd.	Sisterdale	78006	Shannon Stockton, EMT-P	830-324-6737	
Sonterra Medical Response	202 N. Loop 1604 W. Ste 119	San Antonio	78232	Brent Drost	210-852-5034	dbadmedman3@aol.com
Southerncross Ambulance Service	P.O. Box 311295	New Braunfels	78131	Calixto J Rivera/ Joyce Whinery	830-629-2920	southerncross-ops@scatx.us/ crivera@scatx.us
Southwest EMS (brought out by Acadian)	4926 Research	San Antonio	78240	Mike West	210-877-1348	
Specialty Care EMS	3700 Fredericksburg Suite 117	San Antonio	78201	Evand Balque	210-236-9055	Evand L. Balque <ebalque@gmail.com>

EMS Agency	Address	City	Zip	Contact Person	Phone#	E-mail Address
STAR Ambulance				Jack Howley		
Star Ambulance Del Rio				Jack Howley	830-734-7908	jhowley@stx.rr.com
STARFlight	7800 Old Manor Road	Austin	78724	Casey Ping	512 854-6460	casey.ping@ci.austin.tx.us
Stockdale EMS	P.O. Box 341	Stockdale	78160	David Rice	830-391-3448	ricedw@live.com
STRAC EMS	123 Front St	San Antonio	78209	Eric Epley	210-822-5379	eric@strac.org
Superior Care Ambulance	200 NW Military Hwy #5	San Antonio	78213	Aaron Castro	210-852-0550	aaron.castro@superiormts.com
Terrell Hills Fire Department	5100 N. New Braunfels Ave.	San Antonio	78209	Billy Knupp/Justin Seibert	210-824-7401	bknupp@terrell-hills.com/jseibert@terrell-hills.co
Tx Regional EMS, Inc	1601 N. Second St	Pleasanton	78064	Dennis Kelley	830-569-5755	aggimedic@yahoo.com
United Ambulance	PO BOX 762698	San Antonio	78245	Jason Peterek	210--259-1919	unitedambulance@sbcglobal.net
United Medical Transports	P.O. Box 4091	Eagle Pass	78853	Marco Antonio Perales	830-757-4067	
University Hospital EMS	4502 Medical Drive, MS 15-2	San Antonio	78229	Rodrigo Rodriguez	210-358-3858	rodrigo.rodriguez@uhs-sa.com
Utopia EMS	P.O. Box 393	Utopia	78884	Rhonda Garofano	830-591-3847, 830-966-2435	utopiaems@gmail.com
Uvalde EMS	P.O. Box 64	Uvalde	78802	Stephen Stephens	830-278-6583/830-275-1624 cell	uems911@yahoo.com/sstephensmedic@yahoo.com
Val Verde EMS	801 Bedell	Del Rio	78840	Ramon Castro	830-703-1701/830-703-1700	ramon.castro@vvrmc.org
Wilson County WCVAA-EMS	1402 Hospital Blvd/ P.O. Box 595	Floresville	78114	Mary Hernandez, EMS Director	(830) 393-3120	wcvaa@txun.net
Wimberley EMS	220 Twilight Trail	Wimberley	78676			

TSA – P Hospital Contacts

TSA-P Regional Trauma Coordinator/VIP Contact List

(Revised 07.2014)

Organization/Address	Name	Telephone	Fax	E-mail address
Baptist Health System 520 Madison Oak Dr San Antonio, TX 78258	David Heitzman RN Director (BMC, MTBH)	210-259-1356 (cell)	210-297-0488	dxheitzm@baptisthealthsystem.com
	Dora Gonzales	210-297-4410		djgonzal@baptisthealthsystem.com
	Andrea Adams, RN TPM NEB	210-204-4127 (cell)		adadams@baptisthealthsystem.com
	Kathleen Moser	210-297-4411		kmmoser@baptisthealthsystem.com
	Ruben Saenz TPM - NCBH	210-601-4771	210-297-0488	rdsaenz@baptisthealthsystem.com
Brooke Army Medical Center/SAMMC MCHE-SDI 3851 Roger Brooke Drive Fort Sam Houston, TX 78234	Sherri Demmer, RN BSN (Trauma Educ/Injury Prev Coord)		210-916-1677	sherrilee.a.demmer.civ@mail.mil
	Gina Pickard, RN (TPM)	210-916-0324	210-916-6358	gina.pickard@amedd.army.mil
	Allison Foshee (TPC)	210-916-9198	210-916-9148	Allison.foshee@amedd.army.mil
	Bonnie Jackson (Burn Ctr Pro. Man)	210-916-0722		bonnie.ann.jackson@us.army.mil
	Michael Shiels (Burn Center Coor)	210-916-0726		Michael.Shiels@us.army.mil
CHRISTUS Santa Rosa New Braunfels 598 N. Union New Braunfels, TX 78130	Kathy Garner, RN, CSR NB, Trauma Program Manager	830-606-2159		kathy.garner@christushealth.org
CHRISTUS Medical Center 2827 Babcock Rd San Antonio, TX	Crissy Kidd, RN, Trauma Program Manager	210-705-6042		crissy.kidd@christushealth.org
CHRISTUS Westover Hills 11212 State Hwy 151 San Antonio, TX 78251	Brian Gonyou, RN, MSHS, Trauma Program Manager	210-703-8518 (office)	210-703-8511	brian.gonyou@christushealth.org
CHoSA 333 N. Santa Rose St San Antonio, TX	Sandra Williams, RN, CHoSA, Trauma Program Manager	210-704-4994		sandra.williams2@christushealth.org
Connally Memorial Med Center 499 10th Street Floresville, TX 78114	Martha Buford, Trauma Coordinator	512-944-8819		mbuford@connallymmc.org
Dimmit Regional Hospital 704 Hospital Drive Carrizo Springs, TX 78834	Ann Margaret Gonzales (TNC)	830-876-2424 x 306 cell 830-255-0064	830-876-0157	amgonzales_rn@yahoo.com
STRAC (office) 7500 Hwy 90 West Suite 200 San Antonio, TX 78227	Eric Epley, STRAC Executive Director EHDG (emerg. Prepardness)	210-822-5379 (office)	210-233-5851	eric.epley@strac.org

Organization/Address	Name	Telephone	Fax	E-mail address
	Preston Love, RN Clinical Informatics Director	210-233-5833 210-378-9611 (cell)	same	preston.love@strac.org
	Monica Jones STRAC Office Director	210-233-5852 210-336-8876 (cell)	same	monica.jones@strac.org
	Brandi Wright, BA, CSTR Clinical Informatics Registry Specialist	210-233-5914 (office) 210-831-9911 (cell)	same	brandi.wright@strac.org
	STRAC EMS Runsheet Request STRAC Help Desk STRAC Main number STRAC Website www.strac.org	210-233-5888 210-233-5850	210-233-5851	tabletpcr@strac.org
Fort Duncan Regional Med Center 333 N Foster-Maldanado Blvd Eagle Pass, TX 78852	Raul Casares, RN, Emergency Room Director *(Nelson Dungo from Uvalde (see below) is working here for Trauma as well)	956-337-2174		Raul.casares@uhsinc.com
Frio Regional Hospital 200 S IH-35 Pearsall, TX 78061	Lori Keck RN (TNC) Becky Waldrum RN	830-334-3617 ext 139	830-334-9803	frioer@trhta.net beckywaldrum@trhta.net
Gonzales Memorial Hospital PO Box 587 Gonzales, TX 78629	Tod Freeman, RN Nicole Kubenka (Registrar)	830-672-7581 830-672-7581 Ext. 206	830-672-1341	tfim@hotmail.com nkubenka@gonzalesehealthcare.com
Guadalupe Regional Med Center 1215 East Court St Seguin, TX 78155	Amy Anderson, RN (TNC)	830-401-7855	830-372-4651	aanderson@grmedcenter.com
Health South (RIOSA)	Joyce Howard RN	210-691-0737 ext 7311	210-558-1297	joycehoward@healthsouth.com
Hill Country Memorial Hosp PO Box 835 Fredericksburg, TX 78624	Karen Groff, FNP, ED Director	830-997-1279 (office) 830-997-1276 (ED)	830-997-1420	kgroff@hillcountrymemorial.prg
	Dana Wilson, ER Coordinator, Registrar	830-990-8764		dwilson@hillcountrymemorial.org
	Genise Jackson, RN, TC and Stroke Coordinator	(830) 997-1304		gjackson@hillcountrymemorial.org
Medina Regional Hospital 3100 Avenue E Hondo, TX 78861	Gena Chernak, RN	830-426-7780	830-426-7964	gchernak@medinahospital.net
	Michael T Riggs, RN TNC	830-426-7723		trigs@medinahospital.net
Methodist Healthcare System 8109 Fredericksburg Rd San Antonio, TX 78229	Chillon Montgomery,RN, Trauma Director/EM	210-575-0552	210-575-0557	Carla.montgomery@mhshealth.org

Organization/Address	Name	Telephone	Fax	E-mail address
	Andrea Wade, RN, PI Coordinator	210-575-0553		Andrea.Wade@MHShealth.com
	Brandy Martinez, RN, PI Coordinator	210-575-0555		Brandy.martinez@mhshealth.com
	Jennifer Sjogren, RN, PI Coordinator	210-575-0551		Jennifer.sjogren@mshhealth.com
	Christina Willis, RN, PI Coordinator	210-575-0554		Christina.willis@mhshealth.com
The Nix Hospital 414 Navarro Suite 1002 San Antonio, TX 78205	Evelyn Peralta, RN, ED Nursing Director	210-842-5102		Eperalta-gutierrez@nixhealth.com
Nix Community General 230 W. Miller St. Dilley, TX, 78017	Amy L. Lieck, RN, Chief Nursing Officer	830-965-2003	830-965-2017	alieck@nixhealth.com
Otto Kaiser Memorial Hospital 3349 S. Hwy 181 Kennedy, Texas 78119	Kathy Lamza, RN, ED Manager. TNC Tara Elliott, RN, Clinical Information Analyst	830-583-3401 ext 401 830-583-4554	830-583-4564	kathy.billings@okmh.org tara.elliott@okmh.org
Sid Peterson Memorial Hospital 710 Water Street Kerrville, TX 78028	Sharon Keith RN (TNC) Nick Clark, RN	830-258-7482 830-258-7741	830-258-7690	s.keith@petersonrmc.com nclark@petersonrmc.com
Southwest General Hospital 7400 Barlite San Antonio, TX 78224	Renee McClogan RN< CEM, NREMT-B Trauma/Stroke Coordinator	210-921-8629		RMcColgan@iasishealthcare.com
South TX Regional Med. Center PO Box 189 Jourdanton, TX 78026 1905 Hwy. 97E Jourdanton, TX 78026	Kim Geger, RN, ED Director	830-769-5368	830-769-5206	Kimberly-Reger@chs.net
	Rita Castillo RN (Chief Quality Officer)	830-769-5220	830-769-5240	Rita_Castillo@chs.net
	Audrey McCleary, RN Trauma Coordinator/Chest Pain Coordinator	830-769-3515 x 4300		Audrey_McCleary@chs.net
STRAC IP Chair	Susan Douglas, RN	210-358-4272		Susan.douglass@uhs-sa.com
Texsan Heart Hospital	Ann Griffin ED Director	210-736-8031		Ann.griffin@TexSanHeart.com
University Hospital 4502 Medical Drive Mailstop 14-1 San Antonio, Texas 78229	Tracy Cotner-Pouncy RN, Director of Trauma Services	210-743-2857		tracy.cotner-pouncy@uhs-sa.com
	Jenny Oliver, RN, BSN, Asst. Director Trauma Services	210-743-2858	210-702-6287	Jenny.oliver@uhs-sa.com
	Susan Douglass RN Adm. Dir, child health and safety	210-358-4272 210-215-5540(cell)	210-358-1887	Susan.Douglass@uhs-sa.com

Organization/Address	Name	Telephone	Fax	E-mail address
	Dawn Belscamper, BSN,RN, Asst. Director Trauma Services and PI Coordinator	210-743-2859	210-3584811	Dawn.belscamper@uhs-sa.com
	Debbie Hutton, RHIT, CSTR, registrar	210-358-2639	210-358-4811	deborah.hutton@uhs-sa.com
	Rose Bolenbaucher, MSN, RN, Trauma Education	210-743-2862		RoseMarie.Bolenbaucher@uhs-sa.com
UT Health Science Center 7703 Floyd Curl Dr. MC 7740 San Antonio, TX 78229				
Uvalde Memorial Hospital 1025 Garner Field Rd. Uvalde, TX. 78801	Nelson Dungo, RN (TC) *(Some wk at Fort Duncan as well)	830 278-6255 ext.1158		n.dungo@umhtx.org
	Julia Rodriguez, RN, BSN, ED Director	830-278-6251 ext 1335		j.rodriguez@umhtx.org
Val Verde Regional Med Ct 801 North Bedell Avenue Del Rio, Texas 78840	Lety Ortiz RN (ED Director)	830-778-3659	803-778 3634	Letty.ortiz@vvrmc.org
	Antonio Moscaya, BSN RN, ED/Trauma Nurse Coordinator	O: 830-778-3688 C: 830-313-4151 F: 830-778-3634		antonio.moscaya@vvrmc.org

TSA-P Hospital Summary by County

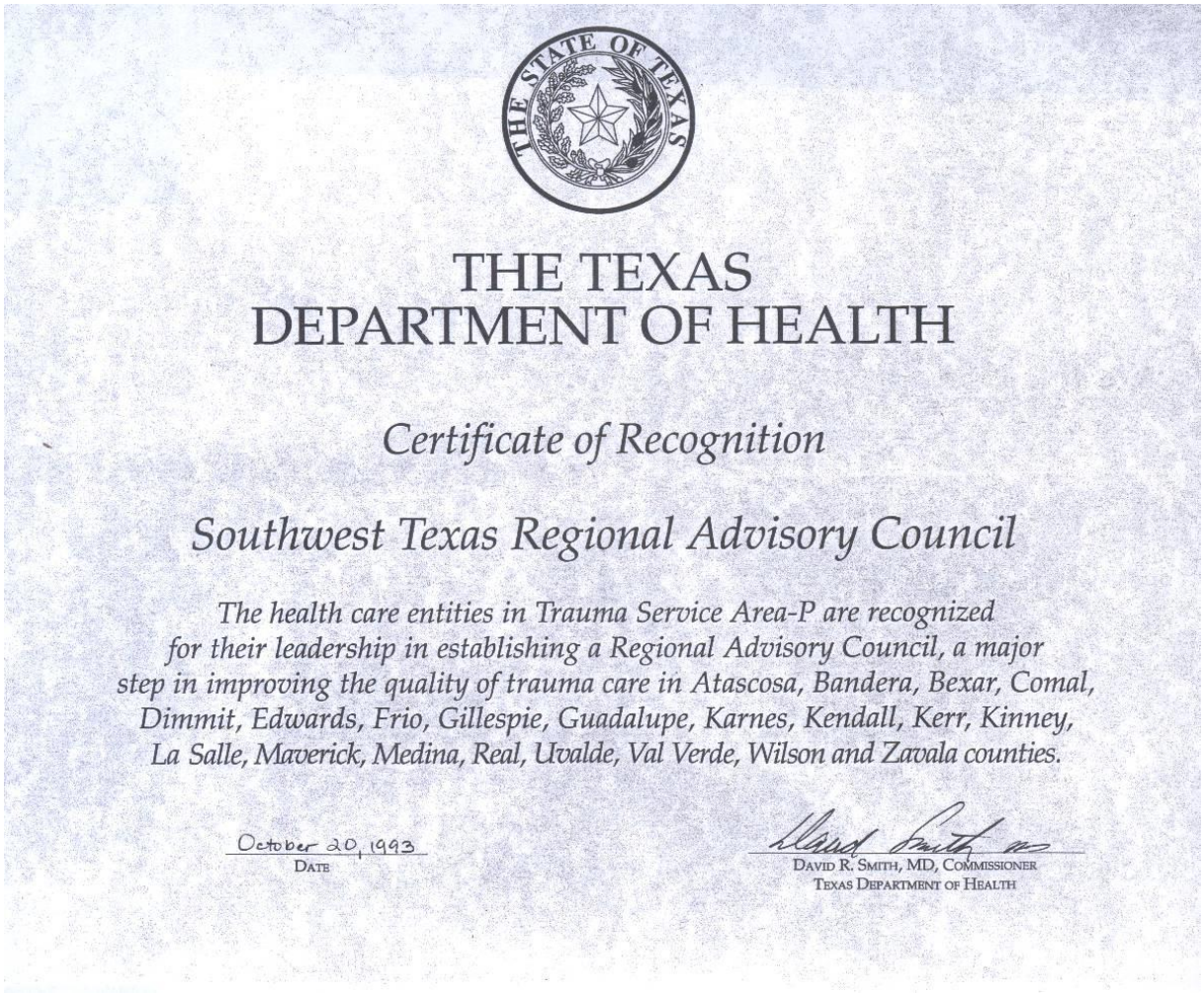
County	Hospital	City	Urban or Rural	Trauma Level
General Hospitals				
Bexar	Baptist Medical Center	San Antonio	Urban	4
Bexar	San Antonio Military Medical Center	Ft. Sam Houston	Urban	1
Bexar	Children's Hospital of San Antonio	San Antonio	Urban	ND
Bexar	Christus Santa Rosa City Centre	San Antonio	Urban	3
Bexar	Christus Santa Rosa – Alamo Heights	San Antonio	Urban	4
Bexar	Christus Santa Rosa Medical Center	San Antonio	Urban	4
Comal	Christus Santa Rosa McKenna	New Braunfels	Rural	4
Bexar	Christus Santa Rosa -Westover Hills	San Antonio	Rural	ND
La Salle	Community General Hospital	Dilley	Rural	4
Wilson	Connally Memorial Medical Center	Floresville	Rural	4
Dimmit	Dimmit County Memorial Hospital	Carrizo Springs	Rural	4
Frio	Frio Regional Hospital	Pearsall	Rural	4
Maverick	Ft. Duncan Medical Center	Eagle Pass	Rural	4
Gonzales	Gonzales Healthcare System	Gonzales	Rural	4
Guadalupe	Guadalupe Regional Medical Center	Seguin	Rural	4
Gillespie	Hill Country Memorial Hospital	Fredericksburg	Rural	4
Kerr	Kerrville VA Medical Center	Kerrville	Rural	ND
Medina	Medina Regional Hospital	Hondo	Rural	4
Bexar	Methodist Ambulatory Surgery Center	San Antonio	Urban	ND
Bexar	Methodist Children’s Hospital	San Antonio	Urban	3
Bexar	Methodist Hospital	San Antonio	Urban	3

County	Hospital	City	Urban or Rural	Trauma Level
Bexar	Methodist Specialty and Transplant Hospital	San Antonio	Urban	4
Bexar	Metropolitan Methodist Hospital	San Antonio	Urban	4
Bexar	Methodist Hospital Stone Oak	San Antonio	Urban	ND
Bexar	Methodist Texsan	San Antonio	Urban	ND
Bexar	Nix Health Care System	San Antonio	Urban	ND
Bexar	North Central Baptist Hospital	San Antonio	Urban	4
Bexar	Northeast Baptist Hospital	San Antonio	Urban	4
Bexar	Northeast Methodist Hospital	San Antonio	Urban	4
Karnes	Otto Kaiser Memorial Hospital	Kenedy	Rural	ND
Kerr	Peterson Regional Hospital	Kerrville	Rural	ND
Jourdanton	South Texas Regional Medical Center	Jourdanton	Rural	4
Bexar	South Texas Veterans Health Care Center	San Antonio	Urban	ND
Bexar	Mission Trails Baptist Hospital	San Antonio	Urban	4
Bexar	Southwest General Hospital	San Antonio	Urban	4
Bexar	South Texas Spine & Surgical Hospital	San Antonio	Urban	ND
Bexar	St. Luke's Baptist Hospital	San Antonio	Urban	4
Bexar	University Hospital	San Antonio	Urban	1
Uvalde	Uvalde Memorial Hospital	Uvalde	Rural	4
Val Verde	Val Verde Regional Medical Center	Del Rio	Rural	4
Specialty Hospitals				
Bexar	The Compass Hospital of San Antonio	San Antonio	Urban	ND
Bexar	Healthsouth RIOSA	San Antonio	Urban	ND
Bexar	Foundations Surgical Hospital	San Antonio	Urban	ND
Bexar	Innova Hospital San Antonio	San Antonio	Urban	ND

County	**Hospital**	**City**	**Urban or Rural**	**Trauma Level**
Kerr	Kerrville State Hospital	Kerrville	Rural	4
Bexar	Kindred Hospital	San Antonio	Urban	ND
Bexar	La Hacienda Treatment Center	Hunt	Rural	ND
Bexar	Laurel Ridge Treatment Center	San Antonio	Urban	ND
Bexar	LifeCare Hospitals of San Antonio	San Antonio	Urban	ND
Bexar	Promise Specialty Hospital (SW General)	San Antonio	Urban	ND
Bexar	San Antonio State Hospital	San Antonio	Urban	ND
Bexar	San Antonio Warm Springs Rehab Hospital	San Antonio	Urban	ND
Bexar	Select Specialty Hospital of San Antonio (BMC)	San Antonio	Urban	ND
Bexar	Texas Center for Infectious Diseases	San Antonio	Urban	ND

Southwest Texas Regional Advisory Council (STRAC)

Certificate of Recognition



THE TEXAS
DEPARTMENT OF HEALTH

Certificate of Recognition

Southwest Texas Regional Advisory Council

The health care entities in Trauma Service Area-P are recognized for their leadership in establishing a Regional Advisory Council, a major step in improving the quality of trauma care in Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Kinney, La Salle, Maverick, Medina, Real, Uvalde, Val Verde, Wilson and Zavala counties.

October 20, 1993
DATE

DAVID R. SMITH, MD, COMMISSIONER
TEXAS DEPARTMENT OF HEALTH

Articles of Incorporation

The State of Texas

SECRETARY OF STATE

IT IS HEREBY CERTIFIED that the attached is/are true and correct copies of the following described document(s) on file in this office:

SOUTHWEST TEXAS REGIONAL ADVISORY COUNCIL
FILE NO. 1484663-1

ARTICLES OF INCORPORATION **MARCH 30, 1998**

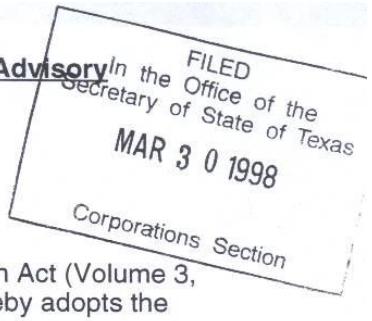
THE STATE OF TEXAS

IN TESTIMONY WHEREOF, I have hereunto signed my name officially and caused to be impressed hereon the Seal of State at my office in the City of Austin, on June 28, 1999.

DLM

Elton Bomer
Secretary of State

Articles of Incorporation for the Southwest Texas Regional Advisory Council



FILED in the Office of the Secretary of State of Texas
March 26, 1997
Corporations Section

Pursuant to article 1396-3.02 of the Texas Non-Profit Corporation Act (Volume 3, Vernon's Texas Civil Statutes) the undersigned incorporator hereby adopts the following Articles of Incorporation.

Article 1. Name

The name of this corporation is the the Southwest Texas Regional Advisory Council.

Article 2. Registered Agent

The name and address of the registered agent and registered office of this corporation is:

Ronald M. Stewart, M.D.
4502 Medical Drive
San Antonio, Texas 78229
United States of America

Article 3. Non-profit Purpose

This corporation is non-profit, and its purpose is to promote the public health by improving injury prevention, education, and injury related research. This corporation is organized exclusively for one or more of the purposes as specified in Section 501(c)(3) of the Internal Revenue Code, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code, or corresponding section of any future federal tax code.

Article 4. Initial Directors

The number of initial directors of this corporation shall be three and the names and addresses of the initial directors are as follows:

Ronald M. Stewart, M.D.
Department of Surgery
University of Texas Health Science Center at San Antonio
Room 237F
7703 Floyd Curl Drive
San Antonio, Texas 78284
United States of America

Pennie Koopman
8620 N. New Braunfels, Suite 420
San Antonio, Texas 78217

Kathy Fletcher
801 Bedell Ave.
Del Rio, Texas 78840

Article 5. Incorporator

The name and address of the incorporator of this corporation is:

Ronald M. Stewart, M.D.
6214 Ashford Point
San Antonio, Texas 78240
United States of America

Article 6. Duration

The period of the duration of this corporation is perpetual.

Article 7. Members

The classes, rights, privileges, qualifications, and obligations of members of this corporation, if any, are as stated in the bylaws of this corporation.

Article 8. Dissolution

Upon the dissolution of this corporation, its assets remaining after payment or provision for payment, of all debts and liabilities of this corporation shall be distributed for one or more exempt purposes within the meaning of Section 501(c (3) of the Internal Revenue Code or shall be distributed to the federalgovernment, or to a state or local government.

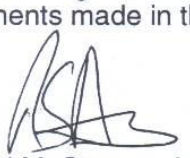
Article 9. Tax Exemption Provisions

No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation except as otherwise provided by Section 501(h) of the Internal Revenue Code, and this corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of, or in opposition to, any candidate for public office.

No part of the net earnings of this corporation shall inure to the benefit of, or be distributable to, its members, directors, officers, or other private persons, except that this corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in these Articles.

Notwithstanding any other provision of these Articles, this corporation shall not carry on any other activities not permitted to be carried on (1) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code or (2) be a corporation contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code.

The undersigned incorporators hereby declare under penalty of perjury that the statements made in the foregoing Articles of Incorporation are true.



Ronald M. Stewart, M.D.
Incorporator - Southwest Texas Regional Advisory Council

BYLAWS
Of the
SOUTHWEST TEXAS REGIONAL ADVISORY COUNCIL
FOR TRAUMA SERVICE AREA-P
July 14, 2014

These Bylaws govern the operations of the Southwest Texas Regional Advisory Council (STRAC), which is a 501(c)3 non-profit organization functioning according to Department of State Health Services (DSHS) Rules 157.123 , and organized in accordance with the Texas Non-Profit Corporation Act. This Regional Advisory Council (RAC) is an organization of local citizens and member organizations representing all licensed health care entities within Trauma Service Area "P" (TSA-P).

ARTICLE 1

Mission

To reduce death/disability related to trauma, disaster and acute illness through implementation of a well-planned and coordinated regional emergency response system.

Vision

We will be the model regional trauma, disaster and emergency healthcare system in the United States that results in the lowest risk-adjusted mortality for emergency healthcare conditions.

ARTICLE 2

Definitions

2.1 Trauma Service Area – P: TSA-P includes the Texas counties of:
Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Gonzales, Guadalupe, Karnes, Kendall, Kerr, Kinney, LaSalle, Maverick, Medina, Real, Uvalde, Val Verde, Wilson and Zavala.

2.2 Membership: Refer to Articles 4 and 5.

2.3 Other: All other definitions are in accordance with those set forth by DSHS Rules 157.2.

2.4 Executive Committee: the Board of Directors for the Southwest Texas Regional Advisory Council, a 501(c)3 Organization, incorporated in the State of Texas.

2.5 Fiscal Year: September 1 – August 31

ARTICLE 3

Functions

3.1 Develop and continually update a trauma system plan for TSA-P and submit to the Department of State Health Services as required by the most current Texas Trauma Rules.

3.2 Determine methods for, and requirements governing, efficient and expedient inter-facility transfers that are most appropriate for the patient's needs for trauma care and/or rehabilitative services. These methods shall include, but not be limited to, the definition and determination of criteria for triage and criteria for patient transfer.

3.3 Provide a forum for communication between parties of the trauma care system to enhance networking and coordination of patient care issues.

3.4 Provide the public with information regarding trauma care and injury prevention.
- 3.4.1 Support 9-1-1 and public access to trauma care.
- 3.4.2 Support programs designed to facilitate prevention of trauma and to educate the public as to its importance.

3.5 Develop and implement guidelines designed to enhance the quality of trauma care provided within TSA-P.
- 3.5.1 Assist member organizations in attaining/maintaining trauma designation or EMS licensure at the level appropriate to their available resources.
- 3.5.2 Specify and conduct performance improvement activities.

3.6 Provide a forum to resolve disputes, provide voluntary non-binding mediation, and enhance collaboration among STRAC members/participants.

3.7 Endorse programs and adopt measures that will improve funding of trauma care services.

3.8 Provide software solutions and services that improve and/or enhance Trauma, EMS, Disaster and other Acute Care Services

3.9 In concert with Members, conduct research related to Trauma, EMS, Disaster and other Acute Care Services

3.10 Develop and continually update a regional disaster plan for EMS and hospitals within TSA-P, as required by the most current Texas Trauma Rules and legislative mandates. Regional disaster planning and development is coordinated with appropriate state and local agencies.

3.11 Collaborate with local public health authorities to facilitate the integration of acute health care (clinical medicine) and public health initiatives.

ARTICLE 4

Membership and Dues

4.1 Membership Qualifications and Definitions

4.1.1 General or Individual Member: A person or organization that resides, or provides trauma or acute care in, TSA-P and meets at least one of the following criteria:

4.1.1.1 An Emergency Medical Services provider or representative

4.1.1.2 A health care professional involved in trauma or acute care

4.1.1.3 An employee or representative of a trauma or acute care facility

4.1.1.4 A local government or council of governments representative

4.1.1.5 An individual or organization whose primary function or role is public safety and/or emergency management, injury prevention or rehabilitation.

4.1.2 Member Organization: Any Texas licensed EMS provider or Texas licensed hospital deemed to meet Medicare conditions of participation in Trauma Service Area P.

4.1.3 Member Organization Representative (MOR): An individual designated by the Member Organization to participate in STRAC activities. The Member Organization must submit the name of their representative in writing to the STRAC office. This submission will remain effective until STRAC is otherwise notified by the Member Organization. The MOR is authorized to vote on behalf of their Member Organization in any STRAC decisions.

4.1.3.1 Hospital submissions for MOR must be signed by the hospital executive who has the ultimate authority for the trauma program (level of Vice-President or above).

4.1.3.2 EMS submissions for MOR must be signed by the EMS Chief or Director.

4.1.3.3 Freestanding Emergency Centers meeting the requirements above shall have one MOR per parent organization.

4.1.4 Active Participant: A member organization that meets the requirements of "active participation," as defined by the current trauma plan (Definitions of active participation are agreed upon by STRAC member organizations).

4.1.5 Voting Member: A member organization that is considered an "active participant," as determined by the most recent active participant report submitted to DSHS.

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4.1.6 STRAC administrative staff is accorded privileges and responsibilities of voting member organizations, but are not afforded voting rights, nor have dues requirements

4.2 The Executive Committee will certify active participation in the STRAC, as defined in the trauma system plan.

4.3 The Voting Membership may set and change the amount of any dues or fees payable to the STRAC by its members. Dues are payable on the first day of the Fiscal Year.

ARTICLE 5

Voting Membership

5.1 Voting Member: A member organization that is considered an "active participant," as determined by the most recent active participant report submitted to DSHS.

5.2 Each member organization is allowed only one vote, regardless of number of individuals present from their organization. A list of voting member organizations is maintained by the STRAC office.

5.3 All other STRAC members are non-voting members.

5.4 Regular and routine business of the STRAC meetings is accomplished by voting members, in accordance with Robert's Rules of Order. The Vice-Chair shall monitor parliamentary procedure.

5.5 For the purpose of conducting official business of the STRAC, a quorum is defined as any voting members present, and at least two Executive Committee members.

ARTICLE 6

Executive Committee

6.1 The Executive Committee shall consist of the:

- Chair
- Immediate Past-Chair
- Chair Emeritus
- Vice-Chair
- Secretary
- Treasurer
- Executive Director
- one trauma designated level 4 Rural Hospital
- one trauma designated Hospital at large (Not already represented on executive committee)
- one Suburban EMS
- one Rural EMS
- one EMS at large (Not already represented on executive committee)
- one Air Medical Provider representative.

The following entities will have standing appointments to the Executive Committee:

- Baptist Health System
- San Antonio Military Medical Center
- Christus Santa Rosa Healthcare
- Methodist Healthcare

- University Hospital
- San Antonio EMS
- Bexar County EMS
- San Antonio EMS Medical Director

The Chair Emeritus and Executive Director positions are non-voting members of the Executive Committee. If a standing member is elected to an officer position on the Executive Committee, the standing hospital or agency may appoint another representative to participate in the executive committee, but that agency only has one vote. A quorum of the Executive Committee shall be defined as a simple majority of the voting executive committee members.

6.2 Executive Committee responsibilities:

6.2.1 The Executive Committee, as elected representatives of the membership, is responsible for all business and activities of the organization.

6.2.2 Oversees all committees.

6.2.3 Ensures that all RAC funds are obligated in accordance with state and federal regulations.

6.2.4 Appoints replacement officers as needed.

6.2.5 Authorizes, through the chair or designee, , all agreements and contracts. Reviews all open contracts at Executive Committee meetings.

6.2.6 Assigns and delegates responsibilities to officers, committees, and staff to accomplish functions/obligations of the RAC.

6.2.7 Monitors and reviews financial status of the organization.

6.2.8 Plans strategic fiscal management

6.2.9 Authorizes proper staffing plan of RAC Office

6.2.10 Oversight of adherence to bylaws and the trauma system plan

6:3 Executive Committee Member requirements

6.3.1 An Executive Committee Member is required to attend at least 75% of all executive committee meetings.

6.3.2 An Executive Committee Member who does not meet the attendance requirements may be removed from the committee at the discretion of the committee.

6.3.3 Absences resulting from military or other institutionally assigned deployments are exempt from 6.3.1 requirements.

6.3.4 Executive Committee Members must be currently employed/contracted by (or actively volunteer with) a voting Member Organization

6:4 The Executive Committee will meet a minimum of 4 times per year.

6.5 At least one Director At-Large must be from an EMS agency; at least one Director At-Large must be from a hospital. The third Director At-Large can be from either an EMS agency or hospital.

6.6 Director At-Large Terms of Office

6.6.1 Director At-Large, EMS - two year term, elected in even years.

6.6.2 Director At-Large, Hospital - two year term, elected in odd years.

6.6.3 Director At–Large, EMS/Hospital - two year term, elected in odd years.

ARTICLE 7

Officers and Elected Executive Committee Members

7.1 Officers and elected executive committee members are elected by a simple majority of the voting membership, with terms to commence immediately following the Annual membership meeting.

7.1.1. Officers: Chair, Vice Chair, Secretary, and Treasurer

7.1.2 Elected Executive Committee Members: Trauma Designated Level 4 Rural Hospital; Trauma Designated at Large Hospital, Suburban EMS, Rural EMS, EMS at Large, Air Medical Provider

7.2 Officers Terms of Office

7.2.1 Chair – two-year term, elected in even years.

7.2.2 Vice Chair – two-year term, elected in odd years.

7.2.3 Secretary – two-year term, elected in even years.

7.2.4 Treasurer – two-year term, elected in odd years.

ARTICLE 8

Election of Officers

8.1 The Chair shall appoint a Nominating Committee, to consist of at least three members of the voting membership. The Nominating Committee shall ensure the availability of the officer candidates and propose a slate of nominations for consideration by voting members. The list of nominees must be submitted to the STRAC office at least sixty (60) days prior to the annual meeting.

8.1.1 Nominations shall also be accepted from any STRAC members, if submitted to the STRAC office at least sixty (60) days prior to annual meeting.

8.1.2 Candidates must be employed by (or actively volunteer with) a voting member organization.

8.1.3 Candidates must express a desire to serve.

8.2 Election of officers shall occur prior to the annual meeting. Ballots are distributed to all voting member organization representatives**.** Election of officers is determined by simple majority of ballots returned**.**

8.3 Officers assume their respective positions immediately following their installation as officers by the Chair, Vice-Chair, or Executive Director, which occurs at the annual meeting.

8.4 The Chair and Secretary are responsible for the election process.

8.6 An officer who does not comply with assigned responsibilities may be removed by a two-thirds (2/3) vote of the voting members present at a STRAC meeting**;** the Chair cannot vote. A replacement officer is appointed by the Executive Committee.

8.7 In the event an office is vacated by resignation or other cause, a replacement officer is appointed by the Executive Committee.

ARTICLE 9

Duties of Officers

9.1 The Chair is the executive officer of the STRAC. Responsibilities of the Chair:
- 9.1.1 Sets the agenda and presides at all meetings of STRAC.
- 9.1.2 Appoints all committee chairs.
- 9.1.3 Makes interim appointments as necessary, with approval of the Executive Committee.
- 9.1.4 Signs agreements and contracts
- 9.1.5 Calls special meetings when necessary.
- 9.1.6 Ensures that the STRAC is represented at all appropriate state and regional meetings.
- 9.1.7 Ensures that voting member organizations are informed of all appropriate state and legislative activities.
- 9.1.8 Performs other tasks as deemed necessary by the Executive Committee.

9.2 Responsibilities of the Vice-Chair:
- 9.2.1 Performs the duties of Chair in the absence of the Chair.
- 9.2.2 Performs duties assigned by the Chair, the Executive Committee, or voting member organizations.

9.3 Responsibilities of the Secretary:
- 9.3.1 Ensures dissemination of all notices required by the Bylaws.
- 9.3.2 Ensures a meeting attendance roster for member organizations.
- 9.3.3 Ensures a database of current names and mailing addresses for all member organizations.
- 9.3.4 Responsible for minutes of all proceedings of the Executive Committee and for STRAC membership meetings.
- 9.3.5 Manages the correspondence of the organization.

9.4 Responsibilities of the Treasurer:
- 9.4.1 Oversees all funds and assets of the STRAC, as provided in the Bylaws, or as directed by the Executive Committee.
- 9.4.2 Monitors monies due and payable to the STRAC.
- 9.4.3 Supervises the preparation of the annual budget with assistance from STRAC staff, and presents to Executive Committee for approval.
  - 9.4.3.1 After Executive Committee approval, presents draft budget to voting membership for final approval.
  - 9.4.3.2 Provides membership with a variance report that compares budgeted income and expenses with actual income and expenses. 9.4.4 Monitors the financial records of the STRAC and arranges for an independent annual audit, as directed by the Executive Committee.
- 9.4.5 Chairs the Finance Committee.

ARTICLE 10

Meetings

10.1 The Annual General Meeting occurs each fall, and is open to all members. A meeting notice is mailed and electronically distributed to all member organizations at least thirty (30) calendar days prior to the meeting.

10.2 Regular membership meetings, to include the Annual General Meeting, are held six times a year. Voting member organizations are notified of these meetings in writing, at least thirty (30) calendar days before the meeting. In case of Disaster or Emergency, meetings may be cancelled or rescheduled to another date.

10.2.1 All regular membership meetings are held within TSA-P.

10.2.2 The final agenda item of the Annual Meeting shall set the meeting times and locations for the coming fiscal year.

10.3 Special Meetings of the General Membership meetings may be called by the Chair, or at the request of any five (5) representatives of voting Member Organizations. Written notice is provided to Member Organizations and Executive Committee members at least seven (7) calendar days in advance, and shall state the date, time, location and purpose of the meeting. At least one-third (1/3) of the Executive Committee will be present at special meetings.

10.4 Emergency meetings of the Executive Committee may be called by the Chair, and actions are addressed at the next meeting of the general membership. Executive Committee members are notified of the date, time, location and purpose of the emergency meetings. A simple majority of the Executive Committee members is required at emergency meetings.

10.5 For the purpose of conducting official business of the STRAC, a quorum is defined as any voting members present, and at least two Executive Committee members. If the Chair and Vice Chair are absent during a Main STRAC meeting, it is up to the Executive Committee to appoint the Executive Director of STRAC or an executive committee member to conduct the meeting.

ARTICLE 11

Standing Committees

11.1 Structure, Composition and Areas of Emphasis

11.1.1 Standing committees are broadly representative of the general membership, specific to the focus of the committee. Standing committee membership is limited to representatives of voting member organizations. Committee meeting attendance is limited to standing committee members, voting Member Organization representatives, and guests invited at the discretion of the standing committee chair.

11.1.2 The Chair or Executive Committee may assign additional focus areas to standing committees as necessary.

11.1.3 Standing committee charges, focus areas, and structure are defined in the Trauma System Plan.
11.1.4 Standing committee chairs are appointed annually by the STRAC Chair.
11.1.5 Standing committee chairs may be removed at the discretion of the Executive Committee. A replacement chair is appointed by the Executive Committee
11.1.6 Standing Committee chairs must be currently employed by (or actively volunteer with) a voting member organization

11.2 STRAC Standing Committees:
11.2.1 Injury Prevention Committee
11.2.2 Pre-Hospital Care Committee
11.2.3 Performance Improvement Committee
11.2.3.1 Performance improvement process follows the guidelines detailed in Section 161.031 – 161.032 and Section 773.092(e) of the Texas Health and Safety Code, which detail the confidentiality afforded activities of this type.
11.2.4 EMS/Hospital Disaster Group (EHDG)
11.2.5 Trauma Coordinator's Committee
11.2.6 Regional Registry Committee
11.2.7 Field Data Collection Steering Committee
11.2.8 Education Committee
11.2.9 Air Medical Provider Advisory Group (AMPAG)
11.2.10 Regional Stroke Systems Committee
11.2.11 Regional Cardiac Systems Committee
11.2.12 Regional ED Operations Committee
11.2.13 Regional EMS Medical Directors
11.2.14 Finance Committee
11.2.15 Research Committee
11.2.16 MEDCOM Advisory Group
11.2.17 The San Antonio Federated Identity management governance group
11.2.18 CEO Advisory Board

11.2.19 Regional Injury Prevention Consortium
11.2.20 Emergency Medical Task Force 8
11.2.21 Alamo Regional Healthcare Coalition

ARTICLE 12

Transactions of the STRAC

12.1 Contracts: The Executive Committee may authorize any agent of the STRAC to enter into a contract, or to execute and deliver any instrument in the name of, and on behalf of, the STRAC. The Executive committee periodically will review all open contracts at Executive committee meetings.

12.2 Banking: All funds of the STRAC are deposited to the credit of the STRAC in banks, trust companies, or other depositories selected by the Executive Committee.

12.3 Gifts: The Executive Committee may accept on behalf of the STRAC, or may make contributions to charitable organizations, gifts that are not prohibited by any laws, articles, or regulations in the State of Texas.

12.4 Conflicts of Interest: The STRAC shall not make any loan to any member or officer of the STRAC, and shall not transact personal business with any Executive Committee member or officer.

12.5 Officers and Members shall conduct themselves and represent STRAC professionally and in accordance with the STRAC Bylaws , and shall NOT:

12.5.1 Act with the intention of harming the STRAC or its operations.

12.5.2 Act in any manner that would make it impossible or unnecessarily difficult to carry on the intended or ordinary business of the STRAC.

12.5.3 Receive an improper personal benefit from operation of, or participation, in STRAC.

12.5.4 Use the assets of the STRAC, directly or indirectly, for any purpose other than carrying on the business of the STRAC.

12.5.5 Wrongfully transfer or dispose of STRAC property

12.5.6 Use the name of the STRAC or any trademark or trade name adopted by the STRAC, except on behalf of the STRAC in the ordinary course of the STRAC business.

12.5.7 Disclose any of the STRAC business practices, trade secrets, or any other information (not generally known to the community) to any person not authorized to receive it.

ARTICLE 13

Books and Records

13.1 The STRAC shall keep correct and complete books and records of account. These documents may be inspected and/or copied for any designated representative of a voting member organization. Such requests to review, inspect, or receive copies of the books and records of the STRAC must be made in writing to the Executive Committee, with reasonable notice, and during normal business hours.

13.2 The Executive Committee may establish reasonable fees for copying STRAC books and records.

13.3 STRAC will assess the needs of its membership through the standing committees, work groups and other evaluation assessment tools.

ARTICLE 14

Proxies

14.1 A designated person wishing to vote by proxy for a voting member organization must present a written statement to the STRAC office (or to a STRAC staff member) on the organization's letterhead. The statement must be signed by the member organization representative (or higher authority within the organization), and must confirm the individual's authorization to cast

a vote on behalf of the member organization. Rule 14.1 does not apply to elected positions on the executive committee.

ARTICLE 15
Additional Responsibilities

15.1 STRAC is prepared to support additional non-trauma related missions mandated or requested by State or Federal Authorities including, but not limited to, the Department of the State Health Services, Emergency Support Function-8, or other Department of Homeland Security functions. This support may include coordination or supplying of services and/or administrative support/oversight for these endeavors, at the direction of the Executive Committee. These missions may include, but are not limited to, terrorism preparedness and response initiatives, stroke/cardiac system designation or other emergency healthcare system-related initiatives**.**

ARTICLE 16

Bylaws

16.1 The Bylaws may be altered, amended, or repealed and new bylaws adopted by a two-thirds (2/3) majority of voting members present after a first reading at a prior STRAC general membership meeting.

16.2 The Bylaws are construed in accordance with the laws of the State of Texas.

16.3 If any bylaw is held to be invalid, illegal, or unenforceable in any respect, the invalidity, illegality, or enforceability shall not affect any other provision, and the Bylaws are construed as if the invalid, illegal, or unenforceable provision had not been included in the bylaw.

16.4 The Bylaws are binding upon the Executive Committee and the general membership.

16.5 An annual review of the Bylaws is conducted by an Ad Hoc Bylaws committee to address changes within STRAC, and to maintain compliance with DSHS legislation. Suggested amendments may be presented during any general membership meeting. A two-third (2/3) majority of voting members present is required for approval

CERTIFICATION OF SECRETARY

I certify that I am the duly elected and acting Secretary of the Southwest Texas Trauma Regional Advisory Council and that the foregoing Bylaws constitute the Bylaws of the STRAC. These Bylaws were duly adopted at a meeting of the general members of the STRAC.

DATED THIS _____ DAY of _____, 20__

_____

(Signature)

_____

(Printed Name) Secretary of the STRAC

List of Current Officers, 2013- 2015

Chair Ronald Stewart, MD
Chairman, Department of Surgery
UTHSCSA
7703 Floyd Curl Drive
San Antonio, Texas 78284
Office: 210-567-3623
Fax: 210-567-6890
Term ends: Sept, 2015

Emeritus Chair Charles Bauer, MD
Department of Surgery,
UTHSCSA
7703 Floyd Curl Drive
San Antonio, Texas 78284
Page: 210-756-2458
No term expiration

Vice Chair Brian Eastridge
Director of Trauma UTHSCSA
7703 Floyd Curl Drive
San Antonio, TX 78229
Office: (210) 567-
Term ends: Sept 2016

Secretary Melissa Low
Level III Trauma Director
Methodist Healthcare System
8109 Fredericksburg Rd
San Antonio, TX
Office: (210) 885-8178
Term ends Sept 2015

Treasurer Dudley Wait
Director, Schertz EMS
1400 Schertz Parkway
Schertz, TX 78154
Office: 210-658-6678
Fax: 210-945-0310
Term ends: Sept, 2016

Trauma Designated At Large (Hospital)
Vicky Torres
Trauma Coordinator
SW General
7400 Barlite Blvd
San Antonio, TX 78224
Office: 210-921-8629
Term ends: Sept, 2016

Trauma Designated Level IVRural
Clover Johnson, RN
Trauma Coordinator Val Verde
Regional Medical Center
801 Bedell
Del Rio, TX 78840
Office: 830-788-3688
Term ends: Sept 2015

At-Large (EMS) Mechelle Salmon
Bulverde Spring Branch EMS
Director of EMS Services
PO BOX 38
Spring Branch, TX 78070
Office: (210) 559-4732
Term ends: Sept 2015

Rural EMS David Jung
Fredericksburg EMS
EMS Director
126 W. Main
Fredericksburg, TX 78624
Term ends Sept 2016

Suburban EMS Mark Eliot
New Braunfels Fire Dept
EMS Director
PO BOX 311747
New Braunfels, TX 78131
Term ends Sept 2015

Air Medical Provider Shawn Salter
San Antonio, Airlife President
7500 US Hwy 90, Ste 220
San Antonio, TX 78227
210-233-5812
Term ends Sept 2016

Standing Appointments
Baptist Health System
San Antonio Military Medical Center
Christus Santa Rosa Healthcare
Methodist Health System
University Healthcare
San Antonio EMS
Bexar County EMS
EMS Medical Director

Elections are held annually before the October Annual Meeting, between the August and October meetings. See Bylaws for further details.

List of Committees

(All standing committee chair appointments expire at the STRAC annual meeting in October)

Education
Chair Sherrilee Demmer,RN, BSN ((San Antonio Military Medical Center)

Field Data Collection Steering Committee (STRAC Clinical Informatics Trauma Data Project)
Chair Preston Love, RN, BSN, MS (STRAC Division Director)

Pre-Hospital Care
Chair Dudley Wait, LP (Schertz EMS Director)

MEDCOM Advisory Group
Chair Ronald Stewart, MD (University Hospital)

Trauma System Performance Improvement
Chair Brian Eastridge, MD (San Antonio Military Medical Center)
Co-Chair Chillon Montgomery, RN, BSN (Methodist Healthcare System)

EMS/Hospital Disaster Group (EHDG)
Chair Eric Epley, EMT-P (STRAC Executive Director)
Co-Chair Mark Montgomery (STRAC EP&R Division Director)

Trauma Coordinators Forum
Chair Gina Pickard, RN (San Antonio Military Medical Center)
Co-Chair Debbie Hutton (University Health Systems)

Regional Registry
Chair Preston Love, RN, BSN, MS (STRAC Division Director)
Co-Chair Debbie Hutton (University Health Systems)

Injury Prevention
Chair Brandy Martinez (Methodist Healthcare)
Sandie Williams (Christus Santa Rosa)

CEO Advisory Board
Chair Ronald Stewart, MD (University Hospital)

Regional Stroke Systems Committee
Chair Dr. Dicky Huey
Co-Chair Eric Epley, EMT-P (STRAC Executive Director)

Regional Cardiac Systems Committee
Chair Dudley Wait, LP (Schertz EMS Director)
Co-Chair Eric Epley, EMT-P (STRAC Executive Director

EMS Medical Directors Committee
Chair Emily Kidd, MD (Interim San Antonio EMS Medical Director)

Air Medical Providers Group
Chair Eric Epley (Executive Director, STRAC)

Regional ED Operations Committee
Chair Wright Hartsell, MD (Methodist Health System)
Co-Chair Kristin Juarez(Baptist Healthcare System)

STRAC Finance Committee
Chair Ronald Stewart, MD (University Hospital)
Co-Chair Bill Waechter, CEO (Baptist Healthcare System)
Co-Chair Dudley Wait, LP (Schertz EMS Director)

STRAC Research Committee
Chair Ronald Stewart, MD (University Hospital**)**
Co-Chair Brian Eastridge, MD (University Hospital)

The San Antonio Federated Identity Management Governance Group
Chair Eric Epley (Executive Director STRAC**)**

Regional Injury Prevention Consortium
Chair Eric Epley (Executive Director, STRAC)

Emergency Medical Task Force 8
Chair Mark Montgomery (EP&R Division Director STRAC)

Alamo Regional Healthcare Coalition
Chair Eric Epley (Executive Director, STRAC)
Co-Chair Mark Montgomery (EP&R Divisions Director, STRAC)

Related Committees

Governor's EMS and Trauma Advisory Council (GETAC)
Regional Emergency Medical Preparedness Steering Committee (REMPSC)
AACOG Regional Emergency Preparedness Advisory Committee (REPAC)
Texas EMS, Trauma and Acute Care Foundation (TETAF)

STRAC Member Participation Requirements & Dues Structure

STRAC's membership consists of all aspects of the trauma patient care continuum. However, EMS and hospital members have regulatory requirements to fulfill by maintaining "active participation" on the RAC. All members are encouraged to be active participants, but the STRAC reports the active participation of EMS providers, hospitals and first responder organizations to the Texas Dept. of State Health Services (DSHS) for funding eligibility and other regulatory functions. STRAC's fiscal year is identical to the DSHS fiscal year, which begins September 1 and ends August 31. The first meeting is the annual meeting each October.

EMS agency active participation requirements:

1. Attend at least 50% of general STRAC meetings (3 of 6) annually.
2. Participate, at a minimum in at least 50% of EMS committee meetings annually. (In Addition, Air Medical Providers shall participate in at least 50% of Air Medical Advisory Group Committee)
3. Pay annual dues of $150 per licensed ambulance* (Dues may be waived if written request is submitted)
   *EMS agencies receive a $50/ambulance dues discount for participation in the data project
4. Must comply with applicable memoranda of understanding or letters of attestation and STRAC Clinical Guidelines, triage criteria and participate in the appropriate data collection processes..

Hospital active participation requirements:

1. Attend at least 50% of general STRAC meetings (3 of 6) annually.
2. Participate at a minimum in at least 50% of appropriate committee(s annually.
   a. EMS/Hospital Disaster Group (All Hospitals)
   b. Regional Trauma System Committee (All Trauma-designated hospitals)
   c. Regional Cardiac Systems(All designated PCI centers)
   d. Regional Stroke Systems,(All designated Stroke centers)
3. Pay annual dues of $15/licensed bed*.
   *Hospitals receive a $3/licensed bed dues discount for participation in the data project
4. Designated Trauma/Stroke/PCI centers must comply with applicable memorandum of understanding, letters of attestation, STRAC Clinical Guidelines , triage criteria and participate in the appropriate data collections process for the service line(s).

First Responder & Other Organization active participation requirements:

1. Attend at least 33% of general STRAC meetings (2 of 6) annually.
2. Pay annual dues of $50. (Dues may be waived if written request is submitted)
3. Must comply with applicable memoranda of understanding, letters of attestation and STRAC clinical guidelines and triage criteria.

Noncompliance of requirements

Agencies that do not meet STRAC Active Participation requirements will not be listed on the Active Participation report each year to DSHS and are not allowed to vote in STRAC proceedings. Further, members who are not active participants may not be eligible to participate in various regional projects like the STRAC-ID badge system.

Prior to the beginning of each Fiscal year STRAC Executive Committee will consider Dues increases based upon the most recent 12-month Consumer Price Index to a maximum of 3%. In consideration of any unforeseen circumstances, the STRAC Executive Committee may request a meeting to discuss the potential need for any increase above the annual CPI based increase. All Dues Changes require a full Executive Committee and STRAC member vote.

System Access

There are a number of systems available for access to emergency care. Basic 911 is a system providing dedicated trunk lines that allow direct routing of emergency calls. Enhanced 911 is a system which automatically routes emergency calls to a pre-selected answering point based upon geographical location from which the call originated. Automatic Number Identification (ANI) and (Automatic Location Identification (ALI) are available only with Enhanced 911.

Bexar Metro 911 has authority for the counties surrounding San Antonio (Bexar, Comal, Guadalupe) and provides both monetary and technical assistance to each area's PSAP (Public Safety Answering Point). Bexar Metro 911 also provides educational offerings to area elementary schools on the proper use of the 911 system.

Back up systems for the civilian population to 911 include regular phone numbers listed in the front of phone books, but realistically if 911 is inoperable, the entire telephone system is likely to be down. There is currently no back up to the telephone system for access to EMS if the telephone system is down.

Within Trauma Service Area P, all residents have access to the EMS system utilizing 911. Table 2 summarizes system access throughout the region by county.

Communications

There are a variety of methods for dispatching emergency medical services within TSA-P. Each county has its own dispatch center, usually the county law enforcement agency. There is no centralized dispatch center for the region.
Few of the agencies in TSA-P currently have formal EMD dispatchers in place, more commonly the callback number is given to the EMS unit responding, and who then makes a cell phone call to the residence in an effort to give some type of pre-arrival instructions. While certainly not ideal, this informal method of EMD has resulted in positive outcomes. Another problem facing EMS agencies within STRAC is the lack of rapid and consistent communication pathways to mutual aid agencies, on-line medical control and MEDCOM. For some agencies, they have places in their coverage area where there are NO communications capabilities at all, requiring the EMS agency to utilize the hard-line telephone system to communicate with their dispatch center. This lack of consistent and comprehensive communications system throughout the region creates difficulties for other STRAC related projects, such as regionalized medical control.

Plan: The advantages of having a regional EMS communications center capable of assisting all EMS agencies with Emergency Medical Dispatch functions, on-line medical control, assisting with disaster, mutual aid, and air medical response and providing assistance with hospital diversion and bed availability is being explored by the Medcom Advisory Board that oversees the MEDCOM program. Long term plans to this end include on-going discussions in the Pre-hospital Committee, EMS Hospital Disaster Group (EHDG) and the Education Committee. Further discussion about appropriate expansion of the MEDCOM program will be held with the Medcom Advisory Board, which oversees the Trauma MEDCOM.

EMSystem or a similar capability should continue to be utilized to communicate ER diversion and other critical information. EMsystem is managed by STRAC and provides data to the Diversion Task Force for evaluation/review.

WebEOC is utilized in times of crisis and has been highly valuable in tracking assets, personnel and exchanging information real-time among hospitals, the Regional Medical Operations Center, the EOC, and the State of Texas. Future plans include training all EMS agencies and hospitals to utilize WebEOC. WebEOC is a joint project between the STRAC and the City of San Antonio's Office of Emergency Management. WebEOC is managed by STRAC, with oversight/input from the Emergency Management Coordinator for the City.

Physician Medical Oversight

Medical oversight is defined as the assistance given to the RAC in system planning by a physician or group of physicians designated by the RAC to provide technical assistance. Input from the medical community is critical to the success of the RAC. Physician participation by Trauma Surgery and Emergency Medicine specialists remains high in all aspects of the STRAC.

Within TSA-P, the following committees have physician oversight:

Trauma Performance Improvement Committee
Medcom Advisory Group
Executive Committee
Strategic Planning Committee (Ad Hoc)
Trauma Plan Review Committee (Ad Hoc)
Bylaws Review Committee (Ad Hoc)
Regional Cardiac Systems Committee
Regional Stroke Systems Committee
Regional Stroke Performance Improvement Committee
Regional Cardiac Performance Improvement Committee

Pre-Hospital Trauma Triage and Bypass Algorithm

Hospital bypass is defined as **transporting the patient to the nearest hospital that has the appropriate level of care for the patient's suspected severity of injury.** The goal of the TSA-P regional trauma system plan is to deliver the right patient to the right facility in the right amount of time. To accomplish this, a "Bypass" of the nearest facility in favor of transport to a facility with the appropriate resources may be required. Bypass reduces the amount of time from injury to definitive care at a Level I Trauma Center by eliminating inter-hospital transfer issues.

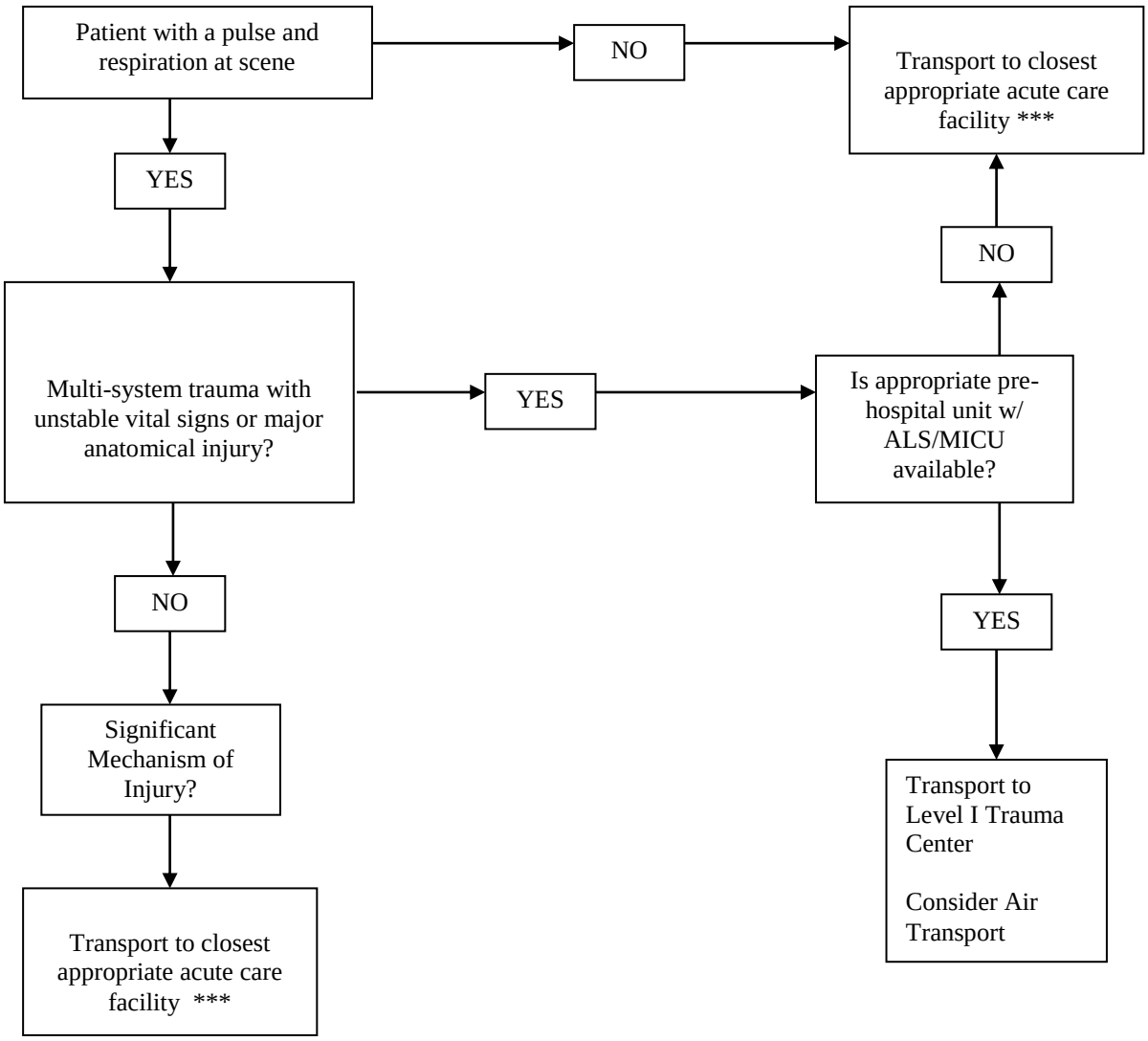
The STRAC supports the Bypass of "nearest" hospital in favor of a Level I Trauma Center for those patients who are deemed to have severe injury or the potential for same. There are, however, special circumstances where Bypass may not be the optimal choice, such as areas where on-scene advanced life support is not available and the patient requires ALS procedures.

When a patient is without pulse or breath at the scene, and CPR is initiated, transport to the nearest acute care facility is again the most prudent action.

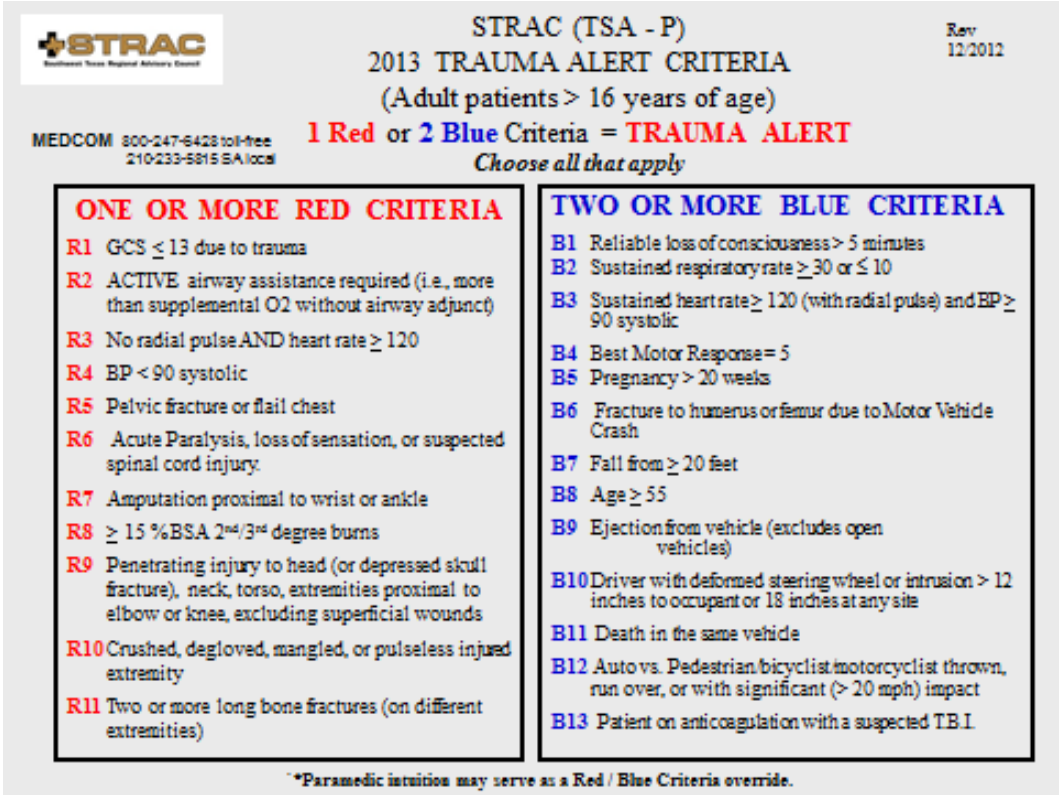
The STRAC recommends the use of the Pre hospital Trauma Triage and Bypass Algorithm developed for TSA-P and based on materials published by the American College of Surgeons and approved by the Texas Department of State Health Services. Emergency care providers at the scene should utilize the Triage Algorithm, in conjunction with on-line medical control to evaluate the level of care required by the injured person and to determine the patient's initial transport destination. If on-line medical control is not available, then the agency's Standard Operating Procedures (SOPs) and/or protocols should reflect decision-making based on the Triage Algorithm.

The purpose of the Hospital Bypass Guideline is to assist field personnel with selection of the appropriate destination (see next page).

Pre-Hospital Trauma Triage and Bypass Algorithm
Southwest Texas Regional Advisory Council
Trauma Service Area-P



*** Indicates that the STRAC highly encourages these transports to go to a designated trauma facility if at all possible.



STRAC (TSA - P)
2013 TRAUMA ALERT CRITERIA
(Adult patients > 16 years of age)
1 Red or 2 Blue Criteria = TRAUMA ALERT
Choose all that apply

Rev 12/2012

MEDCOM 800-247-6428 toll-free
210-233-5815 SA local

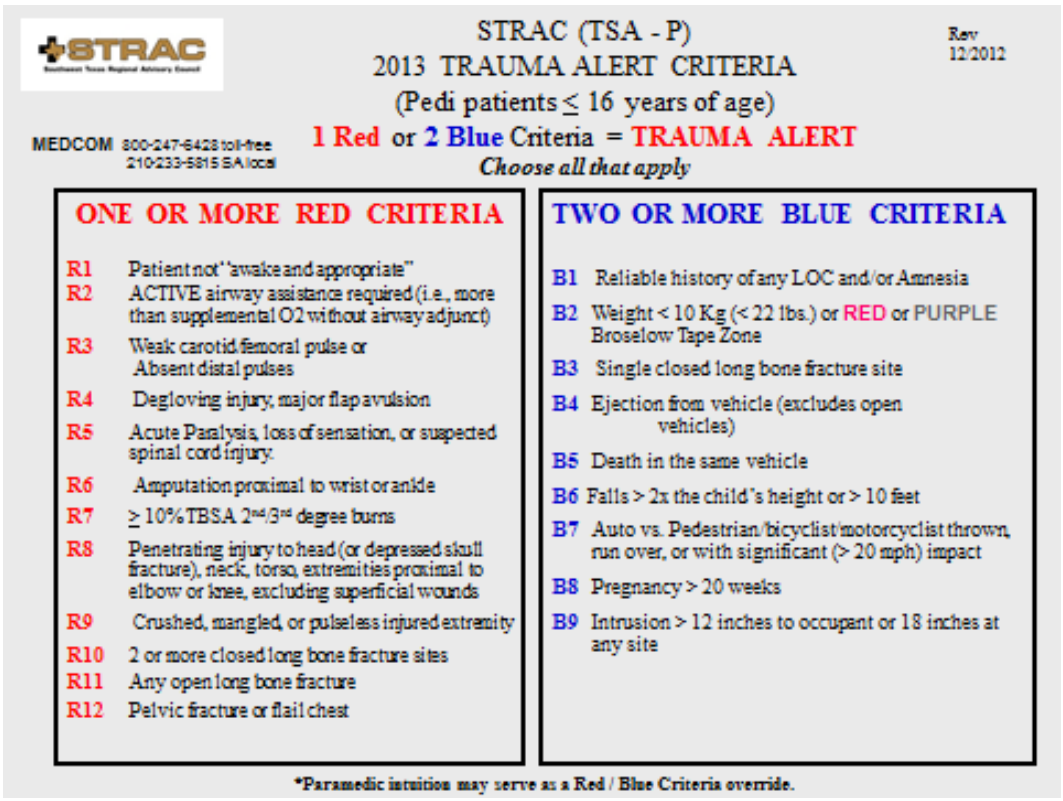
ONE OR MORE RED CRITERIA

- R1 GCS ≤ 13 due to trauma
- R2 ACTIVE airway assistance required (i.e., more than supplemental O2 without airway adjunct)
- R3 No radial pulse AND heart rate ≥ 120
- R4 BP < 90 systolic
- R5 Pelvic fracture or flail chest
- R6 Acute Paralysis, loss of sensation, or suspected spinal cord injury.
- R7 Amputation proximal to wrist or ankle
- R8 ≥ 15 %BSA 2nd/3rd degree burns
- R9 Penetrating injury to head (or depressed skull fracture), neck, torso, extremities proximal to elbow or knee, excluding superficial wounds
- R10 Crushed, degloved, mangled, or pulseless injured extremity
- R11 Two or more long bone fractures (on different extremities)

TWO OR MORE BLUE CRITERIA

- B1 Reliable loss of consciousness > 5 minutes
- B2 Sustained respiratory rate ≥ 30 or ≤ 10
- B3 Sustained heart rate ≥ 120 (with radial pulse) and BP ≥ 90 systolic
- B4 Best Motor Response = 5
- B5 Pregnancy > 20 weeks
- B6 Fracture to humerus or femur due to Motor Vehicle Crash
- B7 Fall from ≥ 20 feet
- B8 Age ≥ 55
- B9 Ejection from vehicle (excludes open vehicles)
- B10 Driver with deformed steering wheel or intrusion > 12 inches to occupant or 18 inches at any site
- B11 Death in the same vehicle
- B12 Auto vs. Pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (> 20 mph) impact
- B13 Patient on anticoagulation with a suspected T.B.I.

***Paramedic intuition may serve as a Red / Blue Criteria override.**



STRAC (TSA - P)
2013 TRAUMA ALERT CRITERIA
(Pedi patients ≤ 16 years of age)
1 Red or 2 Blue Criteria = TRAUMA ALERT
Choose all that apply

Rev 12/2012

MEDCOM 800-247-6428 toll-free
210-233-5815 SA local

ONE OR MORE RED CRITERIA

- R1 Patient not "awake and appropriate"
- R2 ACTIVE airway assistance required (i.e., more than supplemental O2 without airway adjunct)
- R3 Weak carotid/femoral pulse or Absent distal pulses
- R4 Degloving injury, major flap avulsion
- R5 Acute Paralysis, loss of sensation, or suspected spinal cord injury.
- R6 Amputation proximal to wrist or ankle
- R7 ≥ 10% TBSA 2nd/3rd degree burns
- R8 Penetrating injury to head (or depressed skull fracture), neck, torso, extremities proximal to elbow or knee, excluding superficial wounds
- R9 Crushed, mangled, or pulseless injured extremity
- R10 2 or more closed long bone fracture sites
- R11 Any open long bone fracture
- R12 Pelvic fracture or flail chest

TWO OR MORE BLUE CRITERIA

- B1 Reliable history of any LOC and/or Amnesia
- B2 Weight < 10 Kg (< 22 lbs.) or RED or PURPLE Broselow Tape Zone
- B3 Single closed long bone fracture site
- B4 Ejection from vehicle (excludes open vehicles)
- B5 Death in the same vehicle
- B6 Falls > 2x the child's height or > 10 feet
- B7 Auto vs. Pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (> 20 mph) impact
- B8 Pregnancy > 20 weeks
- B9 Intrusion > 12 inches to occupant or 18 inches at any site

***Paramedic intuition may serve as a Red / Blue Criteria override.**

Trauma Diversion

Trauma diversion is defined **as routing EMS agencies to other facilities due to a temporary inability to provide care for trauma patients**. Each hospital is responsible for developing its own written diversion policy and procedures, to include:

1. Criteria for diversion;
2. Person responsible for decision making about diversion;
3. Internal policy for utilization of EMSystem that is consistent with the Diversion Memorandum of Understanding.
4. Record keeping and performance improvement review of each diversion.

Plan: The STRAC Regional ED Operation's committee maintains oversight of the diversion MOU(pg39) that outlines the regional policies and procedures for ED diversion
At a minimum, each STRAC member hospital should have a current Regional ED Ops Diversion MOU on file and have the STRAC Trauma Diversion Policy in place as well. (See next page.)

STRAC

Southwest Texas Regional Advisory Council

STRAC EMERGENCY DEPARTMENT DIVERSION MEMORANDUM OF UNDERSTANDING

September 2011; Revision: July, 2014

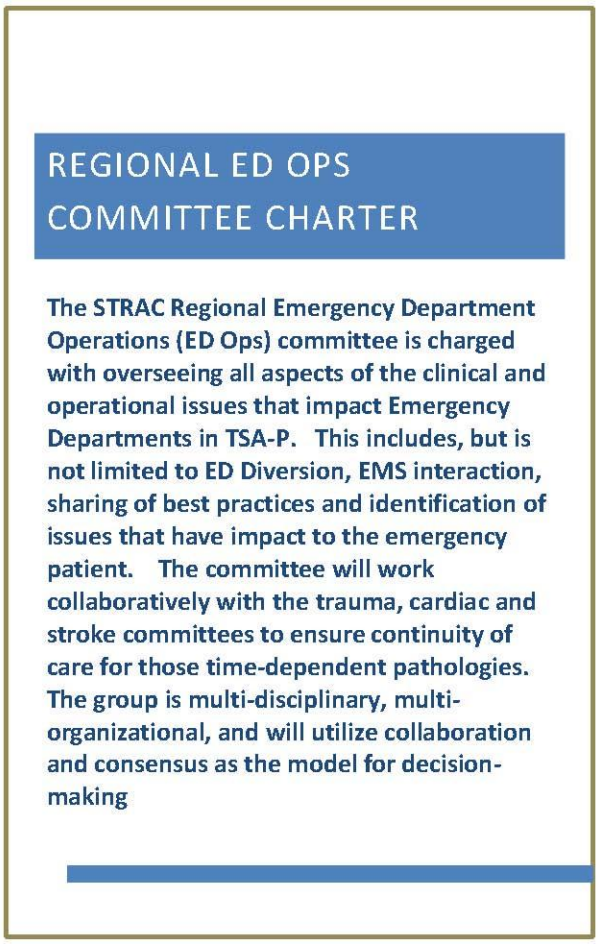
STRAC Emergency Department Diversion
Memorandum of Understanding

DEVELOPED BY THE REGIONAL EMERGENCY DEPARTMENT OPERATIONS COMMITTEE

BACKGROUND

Emergency Department Diversion has affected the San Antonio and South Texas emergency healthcare system for over a decade. In late 2000, a task force of stakeholders was assembled to better understand the causes and impact of diverting EMS ambulances from one emergency department to another. The San Antonio Diversion Task Force (DTF) started the difficult task for developing an agreement that would address all stakeholder concerns. Diversion is a process of temporarily routing EMS patients away from overwhelmed Emergency Departments so that the EMS patients do not receive delayed care or suffer potentially poor outcomes.

In 2010 the diversion task force efforts were transitioned to the STRAC Regional Emergency Department Operations Committee (ED Ops). Regional ED Ops is chaired by an emergency physician and co-chaired by ED nurse directors from the area hospitals. Membership includes emergency physicians, ED nurse directors/managers, EMS operations/command staff, EMS Medical Directors and STRAC administrative staff. Committee membership is open and meets monthly. (check www.strac.org/calendar for meeting information)



Collection of diversion data and notification of diversion status is done through the Intermedix product, EMResource (www.emsystem.com). EMResource is the largest application for ER diversion issues in the US and is deployed as a statewide solution in Texas.

EMResource also provides the ability to gather critical information during Mass Casualty Incidents (MCIs) and other high-profile events. Critical communications with hospitals and EMS via email, pager, cell phone and other pertinent notifications is paramount to successful crisis response.

The Regional ED Ops committee developed this Memorandum of Understanding to outline the agreement for Emergency Departments and EMS agencies to collaboratively work through the issue of diversion. All stakeholders recognize the complexity of diversion and its potential impact to quality patient care if all parties do not develop, implement, and follow the MOU rules that guide each organization's behavior. This is a living document and will be evaluated annually by the Regional ED ops committee for effectiveness. *The signatories to the MOU are attesting their organization will follow and enforce the rules, roles and responsibilities for their organizations as delineated in this MOU.*

ABBREVIATIONS/DEFINITIONS:

1. **AOC** – Administrator on Call
2. **Diversion Override** – The changing of a hospital's status from Divert to Diversion Override as per the Diversion Override/MCI plan. (See attached)
3. **EMResource** – the website formerly known as EMSystem, which is the 24/7 portal to diversion and MCI information in the STRAC region. EMResource is maintained by Intermedix, Inc.
4. **EMS Agency** – means 911 EMS providers in TSA-P, although in general, it refers to the EMS agencies in the Metro San Antonio area, which is defined as Bexar County and the counties contiguous to Bexar County.
5. **HEART ALERT** – Patients that meet the HEART ALERT criteria. In general, this is a STEMI patient. HEART ALERTS are routed to PCI centers. . (see file library at www.strac.org for complete HEART ALERT information)
6. **Hospitals** – Any hospital in TSA-P
7. **MCI** – Mass Casualty Incident
8. **MEDCOM** – Regional medical communications center that handles trauma transfer requests, MCI activation, dispatch of STRAC Emergency Operations and EMTF assets and other regional issues as assigned. MEDCOM's primary # is 210-233-5815
9. **Patient Parking** – The practice of holding patients on the transport EMS agencies' stretchers while awaiting a bed to place the patient in. This practice is considered patient parking even if the ED is processing and assuming care for the patient while they are on the EMS stretcher. The Patient parking time stops when Transfer of Care (TOC) occurs after the patient is transferred off the EMS stretcher and patient report between the paramedic and an emergency department nurse occurs.
10. **Primary POC** – The EMS agency or hospital Point of Contact (POC) that is routinely available to handle diversion concerns on a daily basis. Examples would be Emergency Physicians, ED Directors, EMS shift commanders, etc.
11. **Priority 123** – the system adopted to identify the criticality of EMS patients. Priority 1 patients are most critical, Priority 2 patients are potentially critical and Priority 3 patients are stable. (see file library at www.strac.org for complete Priority 123 information)
12. **Senior Administrative POC** – The agency or hospital Point of Contact (POC) that is ultimately responsible for overseeing the organization's response to diversion issues and has the authority to speak on behalf of the organization. The Senior Administrative POC will handle concerns that cannot be resolved by the Primary POC. Examples would be System Directors, COOs, CEOs, EMS Chiefs, EMS Medical Directors, etc.
13. **STRAC** – Southwest Texas Regional Advisory Council
14. **STROKE ALERT** – Patients that meet the STROKE ALERT criteria. STROKE ALERTS are routed to Stroke Centers. (see file library at www.strac.org for complete STROKE ALERT information)
15. **TRAUMA ALERT** – patients that meet Red/Blue TRAUMA ALERT criteria. TRAUMA ALERTS are routed to Trauma Centers. . (see file library at www.strac.org for complete TRAUMA ALERT-Red/Blue criteria information)
16. **TSA-P** – Trauma Service Area – P. TSA-P is the 22 county region in and around San Antonio designated by the Department of State Health Services. (See attached map)

ORGANIZATIONS AGREE TO THE FOLLOWING RULES/RESPONSIBILITES:

1. Hospitals will utilize the EMResource website to adjust their diversion status. Each hospital Emergency Department and EMS agency will have a functioning computer terminal with Internet access, configured with a recent version of an internet browser, located in a prominent position in the department/center at all times. It is recommended that computers with network-type Internet connections also have backup internet connection in case of network failure.
2. Each facility will ensure the EMResource website is active and functioning properly daily.
3. Each facility and agency will ensure, at a minimum, the agency POCs have EMResource accounts and have correct pager/phone/email information in EMResource to ensure quick notification and activation is feasible. Additional personnel are encouraged to be added to allow redundancy to the notification system.
4. Each facility and agency will participate, as directed, with the MCI drills when they are conducted. This includes quick entry of Red/Yellow/Green bed availability and other critical information necessary for command decision-making.
5. Hospitals and EMS agencies agree to ensure their personnel are knowledgeable with the Diversion MOU and any policies & procedures and appendices.
6. All Parties (hospitals and EMS agencies) recognize and agree that diversion status is a request from the hospital to the EMS agency. EMS agencies may transport patients that have special medical circumstances to a facility on diversion if the EMS crew believes that it may be in the patient's overall best interest. Examples of special medical circumstances include but are not limited to patients discharged within 72 hours from the diverted facility, transplant patients, patients with recent surgery at the diverted facility, obstetrical patients, etc. Further, there are patients that do not have special medical circumstances but insist on being transported to a diverted facility due to personal preference, physician direction, health plan guidance, or other non-medical reasons. Before transporting either of these patients (special medical circumstances and/or patients insisting to be transported to a facility on diversion), the EMS agency will inform the patient that hospitals make diversion decisions based on patient safety and real time capabilities and that EMS agencies use this information in determining the best transport location for each patient. The EMS crew will follow their agency's policies and procedures when transporting to a diverted facility for any reason. The reason for diversion over-ride will be reported as a courtesy to the receiving Emergency Department.
7. Each hospital and EMS agency will have a Primary Point of Contact (Primary POC) that is rapidly available to address immediate concerns related to diversion. Each hospital and EMS agency will also designate a Senior Administrative POC that will serve as the POC for escalated complaints or other communications. The POCs should be roles, not specific people. (See definitions section for further information on POCs) MEDCOM will maintain an up-to-date list of Primary POCs and Senior Administrative POCs and their contact numbers. This list will be distributed to the Diversion MOU signatories as well. MEDCOM's primary # is 210-233-5815.

8. Conflicts shall be directed to the Primary POC. When complaints or conflicts occur, all parties are strongly encouraged to contact the Primary POC as soon as practical so that corrective action can be taken at the time the infraction is occurring and important details can be captured. If no resolution is found, the complainant has the option to contact the Senior Administrative POC.
9. Regional ED Ops Performance Improvement committee will assist with conflict resolution and system review. Any issues that cannot be resolved in the Regional ED Ops committee will be routed to the STRAC Executive Committee for further assistance.
10. All signatories to the Diversion MOU will support and comply with the guidelines and policies established in collaboration with STRAC.
11. Status change decisions will be made by the Primary POC or their designee in accordance with any pertinent facility guidelines. Personnel that are responsible for EMResource status changes will be assigned a unique password and will be responsible for security of that password.
12. EMS agencies will be considered "notified" within 5 minutes of any change to the EMResource Diversion website.
13. Each facility agrees that if its diversion status changes from "Open" to any of the "Divert" categories, EMS units that have left the scene of an incident en route to that facility shall complete the transport if determined necessary by the field EMS crew.
14. When in a "Divert" status each facility will update the system every 2 hrs. If the status is not updated, the facility will revert to "Open" status.
15. Hospitals contacting EMS (formally or informally) to request "Informal divert" that is not tracked in EMResource is prohibited. This includes requesting informal diversion to medic units, EMS supervisors or calls to EMS dispatch or MEDCOM.
16. Hospitals agree to divert utilizing only the EMResource divert categories.
17. All parties agree not to place inappropriate comments on the website. Only pertinent operational comments will be allowed. Inappropriate comments may be removed by MEDCOM or San Antonio EMS.
18. Hospitals not specifically on diversion to OB patients shall accept obstetrical patients (OB) > than 20 weeks gestation. ED diversion status does not apply to this subpopulation of EMS patients, unless they are specifically on divert to OB patients.
19. Psychiatric patients will be considered either medical or trauma patients with respect to diversion decisions. There is no specific psychiatric divert category on EMResource.
20. Hospitals will accept Priority 1 Override patients at any time, regardless of diversion status. Priority 1 Override patients are defined as patients in extremis, including:
    a. patients with BP<70
    b. CPR in progress
    c. patients in need of emergency airway control, and
    d. at the EMS Medical Director's direction.
21. Hospitals and EMS agree to utilize the STRAC definition of pediatric patients for transport decisions. The definition of a pediatric patient is "not yet 17 y/o, or 17 y/o with a pediatrician as their primary care physician".
22. There is no penalty for a facility to go on diversion status.

23. Hospitals agree to participate in the San Antonio Fire/EMS Diversion Override/MCI plan. This plan is an operational document for the San Antonio EMS Division and outlines actions in Mass Casualty Incident (MCI) and other system overload scenarios to include the City Ice Plan. The plan is developed in conjunction with the local EMS Medical Directors, Regional ED Ops committee members, and Southwest Texas Regional Advisory Council (STRAC). The Diversion Override/MCI Plan defines procedures to follow should it occur that an unacceptable number of facilities within a specific geographic boundary are on diversion simultaneously. The plan will specify the override of any divert status of hospitals for a specified length of time until the city emergency is determined to be over.

24. A robust reporting module for diversion hours by facility is available through the EMResource website to each hospital, San Antonio EMS and STRAC. The Regional ED Ops committee may review citywide data regularly as the situation dictates.

25. Patient parking will be discouraged. Hospitals will make every attempt to have patients off of the EMS stretcher and receive patient report to accomplish "Transfer of Care" (TOC) within twenty (20) minutes of the patient's arrival. Hospitals will also work to communicate the status of beds and timeframes for moving patients to all EMS units waiting in the ED. If off-loading delays >20 minutes occur, the EMS Dispatch will contact the hospital Primary POC. If no resolution is reached, the EMS Agency reserves the right to take appropriate action(s) as they deem necessary. Actions could include escalating the complaint process and/or placing the facility on Divert.

26. Department of Defense facilities retain the option to abstain from this Memorandum of Understanding during time of war or other national security concern or at any time at the DoD's discretion.

TERM

This memorandum of understanding is in effect on the date on which it is signed and remains in effect for a period of three (3) years or if written notification is received revoking the Memorandum of Understanding with the STRAC. All parties reserve the right to terminate this MOU at any time, with or without cause. Thirty (30) day written notification is required for termination of the MOU.

ORGANIZATION: _____

(*Insert Hospital or EMS Agency Name here)*

PRIMARY POC: _____

(This is a role, not a person. Example ED shift supervisor)

PRIMARY POC CONTACT NUMBER: _____

SENIOR ADMINISTRATIVE POC: _____

(This is a role, not a person. Example would be AOD, or COO)

SENIOR ADMINISTRATIVE POC CONTACT NUMBER: _____

CEO SIGNATURE: _____

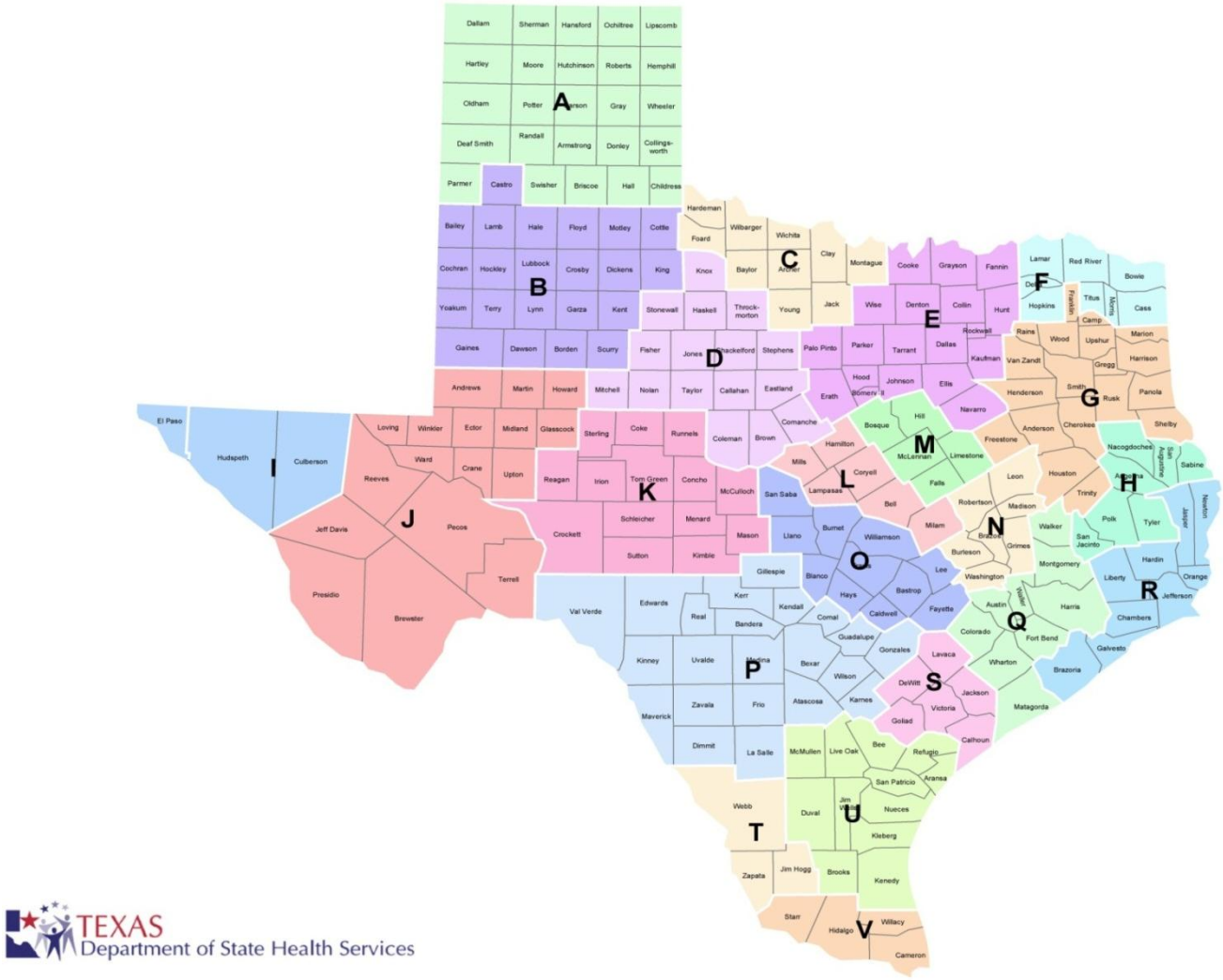
CEO NAME: _____

Date: _____

Regional ED Operations Committee Members:

Agency	Representative(s)
Acadian Ambulance Service	Steven Cope, Butch Oberhoff, Troy Bonnette
Audie Murphy VA Hospital	Doug Boyer
Baptist Health System	Rudy Elizondo, Dr. Byron Freemyer, Gina Grnach, David Heitzman, Tammy Holland, Ruben Saenz, Dr. Tim Taylor, Amy Schopperth
Center for Health Care Services	Dr. Jason Miller
Christus Santa Rosa Healthcare System	Bernadette Martinez, Carl McAndrews, Joe Pendon, Sandie Williams, Kenneth Wamer
Methodist Healthcare System	Lisa Cole, Pamela Dwyer, Dr. Wright Hartsell, Dr. Michael Huott, Susan Sewell, Sue Ellen Trevino, Pam Turner, Daniel Medina, Robert Batkins, Carla Moreno, Kara Green
Nix Healthcare System	Angela Diehl, Joanne Sundin, Rose Lopez, Dr. Gregory Roth
San Antonio AirLIFE	Josh Howell, Shawn Salter, Matt Harrison, Melisa Hoeffner
San Antonio Fire / EMS	Chief Yvette Granato, Joseph Hemann, Dr. Emily Kidd, Dr. Craig Cooley, Jesse Renteria, Jesse Vera
San Antonio Metropolitan Health Department	Sheila Folschinsky, Roger Sanchez, Roger Pollock
San Antonio Military Medical Center	Dr. Robert Gerhardt, Dr. Jeremy Cannon,
Schertz EMS	Jason Mabbit, Dudley Wait
South Texas Regional Medical Center	
Southwest General Hospital	Richard Hall, Bill Rodriguez, Daniel St. Armand
STRAC	Eric Epley, Monica Jones, Preston Love, Diana Chorn, Michelle Montgomery, Mark Montgomery, Brandi Wright
University Hospital	Dr. Sally Taylor, Dr. Mark Sparkman, Rudy Jackson, Pablo Rojas
University of Texas Health Science Center, San Antonio	Dr. Charles Bauer, Dr. David Wampler, Joe Lindstrom, Joan Polk

Texas Trauma Service Areas:



STRAC
TRAUMA DIVERSION POLICY

1. The purpose of the trauma diversion policy is to establish the criteria by which a trauma facility in Trauma Service Area P (TSA-P) may recommend that injured patients are temporarily diverted away from their emergency department to other regional facilities.

2. Each hospital participating in STRAC must keep an up to date Diversion Task Force Memorandum of Understanding (MOU) on file at STRAC. Further, to comply with DSHS requirements, each hospital must maintain an internal policy/plan for trauma diversion. At a minimum, the policy/plan must address the following issues:

   A. Events Triggering Diversion
   B. Person responsible to activate diversion
   C. Utilization of EMSystem for establishing diversion
   D. Record keeping.

3. The following guidelines are established as the minimum criteria to be included in all diversion policies. Each trauma facility is strongly encouraged to modify and enhance these guidelines to best define the practice for their care area.

   A. Events Triggering Diversion:
      1. Physical plant inadequacy - loss of water, power, or air-conditioning; environmental contamination
      2. Emergency Department Saturation: The resources of the ED have been temporarily overwhelmed (e.g., monitored beds, personnel)
      3. Equipment failure: X-ray, lab, medical gases unavailable
      4. Overwhelmed resources: shortage of appropriate physician or other professional staff manpower; other resources necessary for proper patient care in shortage
      5. Internal disasters: Fire, bomb threat, etc.

   B. Person Responsible
      1. The person or persons empowered to activate the Diversion Policy must be clearly specified by each facility. Activation of the Diversion Policy is internal to each facility and does not require approval from any outside agency.

   C. Method
      1. Each facility must specify the people, agencies and organizations to be notified when the Diversion Policy is activated. At a minimum this must include utilization of EMSystem.

   D. Record keeping
      1. The EMSystem website data is collected and reviewed by the Diversion Task Force
      2. Data may reviewed by the STRAC PI committee.

Hospital Trauma Transfer Triage Algorithm

There are two designated Comprehensive (Level I) Trauma Centers in San Antonio: University Hospital (UH), and San Antonio Military Medical Center-South . Transfers into one of these centers are coordinated through a centralized point of contact, the Regional Medical Communications Center (MEDCOM). Since its inception in July 1997, MEDCOM has decreased the transfer acceptance time to an average of nine to 10 minutes.

The procedure for accessing the Level I Trauma Centers through MEDCOM is:

Step 1: Physician at transferring hospital determines need for transfer of patient to a higher level of care. The STRAC encourages transferring physicians to complete the determination for transfer within 30 minutes of patient arrival at the initial facility by utilizing the Trauma Alert Criteria (red/blue criteria). The STRAC System Performance Improvement Committee monitors patient transfers with Trauma Alert (red/blue) criteria that exceed 30 minutes from the time the patient is admitted to the transferring ER to the time MEDCOM is called to initiate transfer of the trauma patient. .

Step 2: MEDCOM is called (1-800-247-6428 or 210-233-5815) and requests a trauma transfer process commence. Calls to MEDCOM prior to the determination that the patient will indeed need to be transferred (ie calls for "heads up") does not stop the clock. Only a valid request for transfer will do so.

Step 3: Trauma MEDCOM notifies appropriate Level I Trauma Facility of request for transfer. Level I Trauma Facilities rotate transfer acceptance. Step 4: Level I Trauma Facility accepts patient and communicates with transferring facility for report on patient. If Initial level 1 unable to accept, other level 1's will be contacted.

Step 4: Patient is transferred by most appropriate inter-hospital transport method (ground or air). If facility is more than twenty-five miles (25) or twenty-five (25) minutes transport time from the Level I Trauma facility and Trauma Alert (red/blue) criteria are present, air medical transport is recommended where available.

Plan: STRAC Trauma System Performance Improvement committee has monitored trauma transfers in TSA-P for over 10 years. Education of the transferring facilities on the indications for transfer to a Level I Trauma Center are conducted through STRAC meetings via the Trauma Coordinators and continuing to distribute posters with MEDCOM procedures and indications for transfer to a Level I Trauma Center. (See next page.)

Interhospital Transfer of Trauma Patients: Guidelines and Principles

Principle: Any injured patient should be transferred to a higher level of care when the medical needs of the patient outstrip the resources available at the initial treating facility. In general, the Trauma Alert (Red/Blue) criteria can be utilized to identify the most critical patients for transfer. However, there are other patients that may not meet Trauma Alert criteria but are still valid and appropriate trauma transfers to the Level I trauma centers.

Criteria for Consideration of Transfer to Level I Facility

Physiologic Instability

Central Nervous System
- Brain Injury
  - Penetrating injury or open fracture
  - Depressed skull fracture
  - Glasgow coma score (GCS) less than 14 or GCS deterioration
  - Lateralizing signs
- Spinal Cord Injury or vertebral injury

Chest
- Major chest wall injury or pulmonary contusion
- Wide mediastinum or other signs of great vessel injury
- Potential cardiac injury
- Multiple rib fractures

Abdomen
- Penetrating abdominal trauma
- Potential solid organ injury

Pelvis
- Unstable pelvic fracture
  - Fracture through the sacrum or sacroiliac joint
- Open pelvic fracture or perineal wound

Major extremity injury
- Decreased or absent peripheral pulse or signs of ischemia
- Open long bone fracture
- Complex soft tissue wound

Multiple system injury
- Brain injury combined with torso or extremity trauma
- Burns plus associated mechanical trauma
- Multiple long bone fractures

Access to trauma care is one of the major system goals and problems in South Texas. The Southwest Regional Advisory Council for Trauma (STRAC) has set a goal to have total transfer times of less than one hour. Utilization of MEDCOM has significantly decreased (mean 9 minutes)trauma transfer acceptance times. Total transfer times are still significantly greater than the target goal. The time required to make the decision to transfer accounts for the greatest bulk of the transfer delay. It is critical to make the decision to transfer early. Attempts to stabilize and treat the patient should be continued until the transfer is completed; however, the most severely injured patients will not be stable prior to transfer. Inability to completely stabilize a patient is not a contraindication for transfer. Our system goal is to have all interhospital transfers take less than an hour. The decision to transfer should be made early and be based upon the Trauma Alert (Red/Blue) criteria and clinical presentation.

MEDCOM: 1-800-247-6428 (local 210-233-5815)

Regional Medical Control

Regional medical control is defined as **a centralized location for receiving on-line and off-line medical orders and for regional development of treatment protocols.** As defined, there is no regional medical control in TSA-P, although treatment protocols are routinely shared informally between agencies. Further, Diversion, Trauma Alert, Heart Alert and Stroke Alert criteria and other non-medical order issues are handled through the STRAC EMS committee.

Presently, each EMS agency has its own medical director and standard operating procedures (SOPs).

Plan: There are no short term plans to create a regional medical control entity within TSA-P. However, the advantages of having a regionalized medical control system are clear. Long term plans to this end include on-going discussions in the STRAC EMS Committee and the formation of a STRAC EMS Medical Directors Committee consisting of EMS medical directors and other interested physicians throughout the region.

Table 4 summarizes the methods of medical control throughout the region. This information is currently used for disaster management planning.

Designation of Trauma Facilities

The STRAC has encouraged all hospitals within Trauma Service Area P to participate in the trauma system and seek the appropriate level of designation. As of April 2011, twenty four hospitals, or 77%, within the service area have been trauma designated. There are two Comprehensive (Level I) Trauma Facilities (all in San Antonio, Bexar County), two General (Level III) Trauma Facilities and nineteen Basic (Level IV) Trauma Facilities. There are currently no hospitals designated as major (Level II), nor have any hospitals indicated a desire to seek this level of designation. Some Basic Facilities are due for re-designation and continue to evaluate their need to upgrade their designation level. The STRAC Executive Committee has assisted in the evaluation of "under-designating" facilities.

All other hospitals within the region are in the process of designating, or have declared their intent to designate with the exception of the following hospitals: Community Hospital (Dilley), Nix (San Antonio), Peterson Regional Hospital (Kerrville), Methodist Stone Oak (San Antonio) and Christus Santa Rosa Westover Hills (San Antonio), Otto Kaiser memorial Hospital (Kenedy), .

Plan: Primary assistance for initial designation and re-designation for TSA-P hospitals comes from the Texas EMS, Trauma and Acute Care Foundation Designation Manual. Extensive resources for the designation process exist within TETAF and TTCF, as many of its members routinely assist DSHS staff with designation visits throughout the state. Continued efforts from the Trauma Coordinators Committee will attempt to change the decisions of the seven hospitals that are currently undesignated and have expressed no interest in designating.

1/30/2014; 06/10/2014 Review

Trauma System Performance Improvement Program

The Trauma System Performance Improvement Program for TSA-P

The Southwest Texas Regional Advisory Council continuously seeks to improve the performance of the trauma system within Trauma Service Area-P in order to reduce death and disability; to resolve conflicts which may be encountered in the provision of trauma care regardless of age, race, religion, sex, nationality, ability to pay, diagnosis or prognosis.

See next page for program.

SOUTHWEST TEXAS REGIONAL ADVISORY COUNCIL

PERFORMANCE IMPROVEMENT PROGRAM

MISSION AND GOAL

The Southwest Texas Regional Advisory Council (STRAC)'s ultimate **goal** is to reduce death and injury in Trauma Service Area P; to resolve conflicts and difficulties that may be encountered in the provision of trauma care, regardless of age, race, religion, sex, nationality, ability to pay, diagnosis or prognosis; to assure that all patients receive optimal level of care.

The **purpose** of continuous performance improvement (PI) is to provide ongoing improvement activities designed to objectively and systematically monitor and evaluate the quality of patient care through analysis; to identify and pursue opportunities to improve patient care; to sustain improvement over time.

The Trauma Service Area P Performance Improvement Plan is designed to achieve the following goal:

The STRAC Trauma system PI process will be used as a mechanism for identifying educational needs and opportunities for improvement in trauma patient care and system processes.

METHODOLOGY

All performance improvement activities at the local, regional and state must follow:
Health and Safety Code Chapter 773.995
Records and Proceedings Confidential
a) The proceedings and records of organized committees of hospitals, medical societies, emergency medical services providers, emergency medical services and trauma care system, or its responder organizations relating to the review, evaluation, or improvement of an emergency medical services provider, a first responder organization, an emergency medical services personnel are confidential and not subject to disclosure by court subpoena or otherwise.
b) The records and proceedings may be used by the committee and the committee members only in the exercise of proper committee functions.
c) This section does not apply to records made or maintained in the regular course of business by and emergency medical services provider, a first responder organization, or emergency medical services personnel.
Pursuant to Section 160.007 of the Texas Occupations Code, the following information relating to trauma performance improvement review is confidential and privileged.

PROCEDURES

The EMS/Trauma System Performance Improvement initiative consists of ongoing and systematic monitoring, evaluation, management and documentation of performance. This system PI process is supported by a valid and objective method of data collection and collation. The development of standard guidelines from evidence based practice, protocols, consensus of aspects of care and regulatory statues are components of the review process. Defined outcome measures and quality care indicators are tracked and monitored through this process.

Potential trauma population to be monitored

1. Any patient with ICD9-CM discharge diagnosis of 800.00-959.9; including 940-949 (burns), excluding 905-909 (late effects of injuries), 910-924 (blisters, contusions, abrasions, and insect bites), 930-939 (foreign bodies).
2. All trauma-related hospital admissions and transfers.
3. All injury-related deaths in ED or after admission
4. All MEDCOM Transfers, including non-trauma patients.

Indicators (including but not limited to):

1. Was MEDCOM contacted within 30 minutes of patient arrival to ED
2. Was intubation successful for patient with GCS of < 8 in ED
3. multi-facility transfer patients (more than 2)
4. Trauma transfers from FEC's
5. All EMS patients meeting red/blue criteria initially transported to an L4

Thresholds

The STRAC PI Committee will establish, for each indicator, a predetermined threshold when further evaluation must be triggered. The threshold value is determined based on current standards, literature, experience, or internal benchmarks. Typically, thresholds are set between 90% and 100%.

Data

Data are collected and organized for review under the direction of the STRAC PI Chairperson and the PI committee members. The primary source of system data is from the STRAC Clinical Informatics Division

Evaluation and Intervention

The STRAC PI Committee will analyze the performance data collected and determine if further investigation or information needed. The evaluation of performance includes data related to workload, level of expertise, quality of care and system variables. When areas of concern are identified, root causes will be sought and appropriate actions taken to address the situation Actions are directed to the root cause with the overall goal being to improve quality of care.

Communication

To ensure loop closure, there will be communication by the committee to the appropriate representative at facility or agency with action plan or resolution response expected. Any process changes impacting the region will be communicated to STRAC for dissemination to the region.

PROCESS

B. The process of performance improvement begins with the collection of qualitative and quantitative information at both the patient level and the systems level.
C. The review process will examine the appropriateness of care, effectiveness of care, responsiveness of the system and identify opportunities for improvement based on review.
D. There will be ongoing monitoring and evaluation of care of patients.
E. Specific clinical indicators will be used to identify potential concerns.

STRAC PI section 151099

Process indicators measure and evaluate and improve system performance. This is one component of an effective system Performance Improvement Plan. These process measures are developed from committee consensus, evidence based practice guidelines, system protocols and the regional trauma system plan. Listed are examples of process measures for consideration:

- Timeliness of EMS arrival
- On scene time <20 minutes for trauma alert
- Timeliness of air medical arrival
- Availability of resources: ambulances, AMBUS, air transport providers, medical staff, access to L1 trauma center (diversion status)
- Transfer timeliness: MEDCOM request delay is time of arrival to MEDCOM activation, less than 30 minutes
- Utilization of air medical resources
- Field triage compliance: red/blue trauma criteria
- EMS to trauma center communication
- EMS patient care record
- Utilization of warming devices (pre-hospital and trauma center)
- Number of registry records completed within 60 days of patient discharge
- Timeliness of regional registry downloads
- Availability of specialty coverage
- Availability of pediatric trauma care
- Number of trauma admissions with increased LOS due to funding / placement issues
- Number of facilities submitting data to NTDB
- Number of trauma patients with completed SBIRT screens
- Patients requiring rehabilitation will have access to rehabilitation bed
- Trauma center criteria requiring surgical specialty coverage is met decreasing the need for patient transfer
- Trauma patient transfer is facilitated through regional transfer center
- Average time on backboard is 60 minutes
- Timely completion of regional HVA
- Timely completion of regional needs assessment
- Timely completion of the annual review of the Trauma System Plan
- Access to sexual assault team
- Access to domestic violence resources
- Access to child abuse response teams
- Access to drug/alcohol / psychiatric treatment facility
- Two multidisciplinary conferences are completed annually
- EMS / Air Medical / Trauma Medical Directors participate in regional PI process
- Compliance to NEMISIS and NTBD data definitions
- Integration with blood donor center to measure blood shortages
- Integration with organ procurement organization
- Integration with police / DPS
- Integration with emergency management
- Integration with Council of Government
- Measures to ensure confidentiality
- Measures to secure and protect data
- Process for addressing complaints, grievances
- Signed agreement of participation (MOU) by all EMS, air medical and hospital facilities in region
- Completion of regional annual report

REGIONAL PROCESS PERFORMANCE REVIEW

TIER 1: Focused Measures and Criteria

Process Measures (Indicators)	Process Criteria	Compliance Target Goal %
09/2014; Under Review in Committee: Timeliness of EMS arrival on metro, rural, and frontier responses.	09/2014; Under Review in Committee: EMS providers will arrive on scene within XX minutes of dispatch based on metro, rural, and frontier.	95%
09/2014; Under Review in Committee: New: on scene time <20 for trauma alert	09/2014; Under Review in Committee: Region will define the accepted total prehospital time and monitor.	85% Compliance
09/2014; Under Review in Committee: Timeliness of air medical arrival	09/2014; Under Review in Committee: Air medical providers will arrive on scene within 35 minutes of request.	95% (weather events not included)
09/2014; Under Review in Committee: EMS will have to activate HAA for Trauma Alert patients when the transport time exceeds XX minutes.	09/2014; Under Review in Committee: EMS Dispatch Center will document request of an HAA for patients with transport time in excess of XX minutes.	95%
Availability of resources: definition of resources? Ambulances, ambus, medical staff (?); Fleeteyes tool; specify as ground/air resources; may also apply to diversion to trauma alert patients (L1 availability).	The region will have a less than 5% total incidence of trauma facility diversion quarterly.	<5%
Transfer timeliness: qualify from regional perspective (?) MEDCOM request delay (TOA to transfer request <30min)	Patients that are transferred for definitive care to a trauma center will have the transfer initiated once injuries are defined and then transfer completed within two hours.	90%
Utilization of air medical resources	Region will have defined air medical utilization standards that are reviewed every other year or with a change in the agencies available.	Reviewed and approved by membership every other year.
Field triage compliance: red/blue trauma criteria	Patients will be triaged to the appropriate trauma facility, following the regional field triage criteria.	90%
EMS to trauma center communication	EMS providers will notify the receiving trauma facility for all major and severe trauma patients (level I or II activations) prior to arrival.	90%
EMS patient care record	EMS providers will leave the standard essential documentation of the EMS patient care record at the facility with the patient.	90%
Registry records completed within 60 days of patient discharge	Trauma centers will complete the abstraction of trauma data and enter data into their facility base within 60 day of discharge.	100%

Process Measures (Indicators)	Process Criteria	Compliance Target Goal %
Timeliness of regional registry downloads	Trauma centers will complete the trauma registry profiles for trauma patients meeting the DSHS trauma registry criteria within 60 days of discharge for the hospital trauma registry and submit at a minimum quarterly downloads to the state and regional registries within 30 days of request.	100% of all trauma facilities complete quarterly downloads.
Availability of specialty coverage	The region will have provisions for specialty coverage to include neurosurgery, orthopedics, pediatrics, hand, microvascular, ENT, ophthalmology and burns.	85%
Availability of pediatric trauma care	The Trauma centers should have the minimal resources needed to stabilize and transfer pediatric trauma patients	100%
Trauma patient transfer is facilitated through regional transfer center	Each region will have provisions to coordinate communication and expedite trauma transfers.	100% of the TSAs will meet criteria
Timely completion of regional HVA; HAZARDOUS VULNERABILITY ASSESSMENT	Region completes and published annual HVA in February of each year.	100% of RACs
Timely completion of the annual review of the Trauma System Plan; July Agenda	Region reviews and revises as necessary the Trauma System Plan every year.	100% of RACs
Two multidisciplinary conferences are completed annually; SYSTEM WIDE CONFERENCE AND/OR ROUNDTABLES	Region will have two multidisciplinary conferences annually. (clinical roundtable or case presentation at main)	2 per year
EMS / Air Medical / Trauma Medical Directors participate in regional PI process	All EMS / Air Medical / Trauma Medical Directors participate in regional PI process and should attend and participate in regional PI meetings.	75%
Compliance to NEMISIS FOR EMS	Region has mechanisms in place for data analysis and trending.	100% of RACs
Integration with emergency management	Region has a defined medical operations center that can be mobilized for all full response mass casualty events.	100% of RACs
Measures to ensure confidentiality and HIPAA compliance	Region has a trauma system performance improvement committee and the members have appropriate training on confidentiality and performance improvement.	100% of RACs
Measures to secure and protect data		
Process for addressing complaints, grievances	Region has mechanisms in place to address patient complaints or filed grievances specific to EMS, air medical and trauma centers.	100% of RACs
Signed agreement of participation (MOU) by all EMS, air medical and hospital facilities in region	Region has signed mutual sharing by all EMS, air medical and hospital facilities.	100% of RACs

TIER 2: Non-Focused Measures and Criteria (variable)

Process Measures (Indicators)	Process Criteria	Compliance Target Goal %
Timeliness of trauma activation	Trauma facilities must monitor the timeliness of trauma activations and trauma surgeon response times, and report incidence of less than 80% surgeon response compliance to the highest level of trauma activation to the RAC; Quarterly	Trauma Facility will report compliance less than 80% to the RAC PI Committee.
Timeliness of surgeon response	Trauma facilities must monitor the timeliness of trauma activations and trauma surgeon response times, and report incidence of less than 80% surgeon response compliance to the highest level of trauma activation to the RAC; Quarterly	Trauma Facility will report compliance less than 80% to the RAC PI Committee.
Utilization of warming devices (pre-hospital and trauma center)	EMS providers must have provisions to prevent hypothermia.	90% of agencies will have hypothermia protocols.
Number of trauma admissions with increased LOS due to funding / placement issues	The region monitors trauma patients with increased length of stay due to lack of access to rehabilitation due to bed or funding availability. This is defined as a patient ready for discharge but cannot be discharged due to lack of funding for a rehabilitation bed or availability of a rehabilitation bed. Difficult to track	100% of the trauma facilities will participate in monitoring.
Number of facilities submitting data to NTDB	Level I and II only	25%
Trauma center criteria requiring surgical specialty coverage is met decreasing the need for patient transfer; MAY BE DIRECTED TO L3'S	Region will monitor and track trauma facility transfers due to a lack of trauma facility criteria compliance (lack of services). Multi-facility transfer or inpatient transfer (inappropriate admission) or specialty (line item)	Quarterly
Average time on backboard is 60 minutes	Time on a backboard is monitored throughout the region with collaboration of EMS, air medical and trauma facilities.	Average time is 60 minutes or less 80% of the time
Timely completion of regional needs assessment	Region completes an annual needs assessment.	100% of RACs
Access to sexual assault team	Region has provisions in place to address patients with history of sexual assault.	80% of regional trauma centers have programs in place.

Process Measures (Indicators)	Process Criteria	Compliance Target Goal %
Access to domestic violence resources	Region has provisions in place to address family / interpersonal violence.	70% of the regional trauma centers have programs in place.
Access to child abuse response teams	Regional trauma centers have provisions in place to address child abuse.	100%
Access to drug/alcohol / psychiatric treatment facility	Region has provisions in place to promote and educate individuals to provide the brief alcohol screening and intervention for all admitted trauma patients.	70% of the regional trauma centers.
NTBD FOR HOSPITAL (T2) data definitions	Level I, and II trauma centers participate in the NTDB.	95%
Integration with blood donor center to measure blood shortages	Region has provisions in place to address blood product shortages and how to secure more if needed.	95%
Integration with organ procurement organization	Region has provisions in place to address organ donor issues and procedures	100%
Integration with police / DPS	All trauma centers should have a process in place to secure help from LE needed. To include evidence collection and processes for chain of custody.	100%
Integration with Council of Government		

REGIONAL OUTCOME REVIEW PROCESS

Outcome Criteria	Compliance Target Goal %
Region reviews the trauma related mortality by field deaths, trauma facility deaths, ISS, age and mechanism of injury quarterly.	Quarterly
Region reviews the trauma related disability quarterly.	Quarterly
Region reviews the trauma center length of stay by levels of trauma facilities and ISS quarterly.	Quarterly
Region reviews the trauma center ICU length of stay by levels of trauma facilities and ISS quarterly.	Quarterly
Region will monitor and track trauma facility transfers due to a lack of trauma facility criteria compliance (lack of services). Multi-facility transfer or inpatient transfer (inappropriate admission) or specialty (line item)	Quarterly
Patients that have a GCS of 8 or less will have airway management to ensure the patient's oxygen concentration is 98% or above.	95%
Patients who have RSI in the field will have successful intubation on the first attempt.	90%

Outcome Criteria	Compliance Target Goal %
RAC will monitor the number of patients that are transferred out of the RAC for specialty care or transferred into the RAC for specialty care.	Quarterly
RAC will monitor the transfer coordination center's activity regarding the number transfer calls requested, number of patients transferred, and disposition of transfers and timeliness of transfers.	Quarterly
Region will select a minimum of two trauma related complications and monitor for incidence and outcomes annually, with quarterly reports.	Quarterly
Patients with a GCS of 12 or less will have a head CT scan within 30 minutes or arrival at the trauma center or provisions for transfer will be initiated.	95%
Region will have two multidisciplinary conferences annually. (clinical roundtable or case presentation at main)	2 per year
Region will define a dashboard report and share with all stakeholders quarterly.	Quarterly
Region will have two defined injury prevention initiatives with a defined plan, objectives, interventions, performance measures and outcome measures with quarterly updates.	Quarterly
Region has integrated the local Poison Center to define the mortality related poisons, identify street drugs, and potential threats to the region	100% of RAC's
Region has established trauma prevention / awareness coalitions to address the top five trauma hospital admission causes and their contributing factors (e.g. alcohol, falls, etc..)	100% of RAC's
Region has a defined mass casualty medical operations response plan.	100% of RAC's
Region has mechanism in place to review all partial and full response mass casualty events specific to communication, patient dispersal, and outcomes. Outcome review tools and process are standardized.	100% of RAC's
Region completes and Annual Report by March of the following year.	100% of RAC's

Rehabilitation

This plan component was added in July 1998. The STRAC continues to analyze regional rehabilitation resources.

Plan: Expected completion date of analysis is December 2012. Short-term goal has been met to provide a Rehabilitation Resources Guide for the region to assist hospitals in obtaining rehabilitation for patients. A long-term goal (January 2020) is to develop a Regional Rehabilitation Referral System that creates cooperative effort for placement and funding issues throughout the region.

Rehabilitation Resource Guide

San Antonio Rehabilitation Facilities

Hospital Based:

Downtown Baptist Hospital Rehab	111 Dallas St	297-7000	24 beds
St Luke's Baptist	7930 Floyd Curl	297-5000	24 beds
CHRISTUS/Santa Rosa City Centre	2827 Babcock	705-6100	14 beds
CHRISTUS Santa Rosa Medical Centre	2827 Babcock Road	705-6001	35 beds
Methodist Transplant Hospital	8026 Floyd Curl	575-8110	14 beds
Methodist Metro Hospital	1310 McCullough	208-2200	10 beds
NE Methodist Hospital	12412 Judson	650-4949	13 beds
NIX Hospital	414 Navarro	271-1800	16 beds
University Hospital Reeves Rehab	4502 Medical Dr.	358-4000	27 beds
Southwest General Hospital	7400 Barlite Blvd	921-2000	14 beds

Free Standing:

Compass Hospital	14743 Jones Maltsberger	402-0029	25 beds
RIOSA	9119 Cinnamon Hill	691-0737	108 beds
I.H.S. Hospital	7310 Oak Hill	308-0261	30 beds
Vencor Hospital	3636 Medical Dr	616-0616	59 beds
Warm Springs	5101 Medical Dr.	616-0100	60 beds
Lifecare	8026 Floyd Curl Dr	690-7000	34 beds
Laurel Ridge Treatment Center	17720 Corporate Woods Dr.		0
Promise of San Antonio Hospital (SW General)	7400 Barlite Blvd.		0
San Antonio State Hospital	6711 S. New Braunfels		0
Select Specialty Hospital of San Antonio (BMC)	111 Dallas Street, 4th Floor		0
Texas Center for Infectious Diseases	2303 Southeast Military Dr.		0

Rural Facilities

Guadalupe Regional	1215 East Court St.	830-379-2411	12 Beds
Connally Memorial	499 10th Street	830-393-1300	8 - Swing
South Texas Regional	1905 Hwy 97 E	830-769-3515	0 Rehab
Medina Regional	3100 Avenue E	830-426-4700	10 -Swing Bed
Frio Regional	200 S Interstate 35	830-334-3617	

Peterson Regional Medical Center	551 Hill Country Drive	830-896-4200	25 Rehab
Community General Hospital	230 W. Miller Street	830-965-2003	
Dimmit County Memorial Hospital	704 Hospital Drive	830-876-2424	0 Rehab
Ft. Duncan Medical Center	3333 N. Foster Maldonado	830-773-5321	15 Rehab
Gonzales Healthcare System	1110 Sara DeWitt Dr	830-672-7581	
Hill Country Memorial Hospital	1020 S. State Hwy 16	830-997-4353	
Kerrville VA Medical Center	3600 Memorial Blvd.	830-896-2020	12 Rehab
Otto Kaiser Memorial Hospital	3349 S. Highway 181		
Uvalde Memorial Hospital	1025 Garner Field Rd	830-278-6251	0 Rehab
Val Verde Regional Medical Center	801 Bedell	830-775-8566	

Regional Multi-Casualty Incident Plan

This plan component was added July 1998. It is updated regularly through the EMS/Hospital Disaster Group (EHDG).

There are numerous organizations that conduct disaster planning and exercises within TSA-P. The STRAC has recognized the value of integrating regional planning with the resources currently available in Bexar County.

The Committee has reviewed and prioritized disaster threats for the region.

1. Hazardous Materials and
   Weapons of Mass Destruction: Nuclear, Biological, Chemical, Radiological, Explosive
2. Aircraft Crashes
3. Natural (tornadoes and floods)

Plan: By August 2009, complete the development of the Regional Disaster Response plan that fully integrates EMS, Hospital and Public Health (ESF-8) TSA-P regional concerns and resources into the San Antonio, and AACOG/MRGCOG regional response plans. Further, ensure that any ESF-8 plans integrate into the Alamo Regional Command Center and the GDEM Disaster District plans for Region 3B

Continue the development and response of Regional EMS Strike Teams by sponsoring/organizing Strike Team Leader courses, meetings of the STL coordinators.

Continue development of MEDCOM as the Regional EMS Coordination Center for the activation of all EMS disaster resources.

Continuation of the MCI Trailer project. MCI trailers are currently placed in the following areas:

MCI 1	**Uvalde**
MCI 2	**Stockdale**
MCI 3	**Victoria**
MCI 4	**Boerne**
MCI 5	**Del Rio**
MCI 6	**Reserve**

Ensure all EMS agencies and Hospitals are fully national Incident Management System (NIMS) compliant and trained. This will be done in a variety of ways, including direct educational support, table top and functional exercises and continuing education on NIMS.

Continue to make available to the region information and training opportunities for Weapons of Mass Destruction and participate in any table-top exercises or other training events.

Continue support for the STRAC Emergency Operations Division, including the Regional Rescue Team primarily for Swiftwater Rescue purposes. One of the strong advantages of the RACs is the unique capability to bring Fire/EMS agencies from a large geographic area that otherwise would have no formal method of integration. This capability provides EMS with mutual aid type agreements through the RAC that would otherwise not exist. These agreements allow resources to be pooled, with clear advantages for Disaster response. A STRAC-sponsored regional rescue team has been developed and is a primary component of the STRAC Regional Disaster Plan.

Continue support for the Emergency Response Unit (ERU) Command/Communications Trailer. The ERU has been a highly successful project that allows communications and Incident Commanders to coexist in a 38' gooseneck command trailer. The trailer is dispatched via MEDCOM at 1-800-247-6428 and is available 24 hrs a day, 7 days a week to any public safety agency in the TSA-P.

Regional Injury Prevention and Public Education

Statement

Trauma is a preventable "disease" and a well-planned community information and prevention program is an integral part of an effective trauma system. The ultimate goal of an organized trauma system is to prevent injuries. The trauma system lead agency and care providers should organize a program to share information with the public regarding the nature of injury, the need for a trauma system, and trauma system development. The public information and prevention program should also address the need for educating the public about how to safely approach an injury scene, how to access the trauma care system, and how to provide assistance to the injured until professional help arrives. (Individual agencies provide services) In addition, problems specific to each community, as identified using the Trauma Registry data for that community, should be instituted.

The establishment of a broad based community task force with members from public and private sectors interested in trauma prevention activities can be useful in creating a systematic approach that will reduce fragmentation and intensify community efforts. Membership of the community prevention constituency includes representatives from fire and police agencies, professional health care organizations, department of motor vehicle agencies, state alcohol and drug abuse agencies, local church and civic groups, children's service agencies and acute health care facilities.

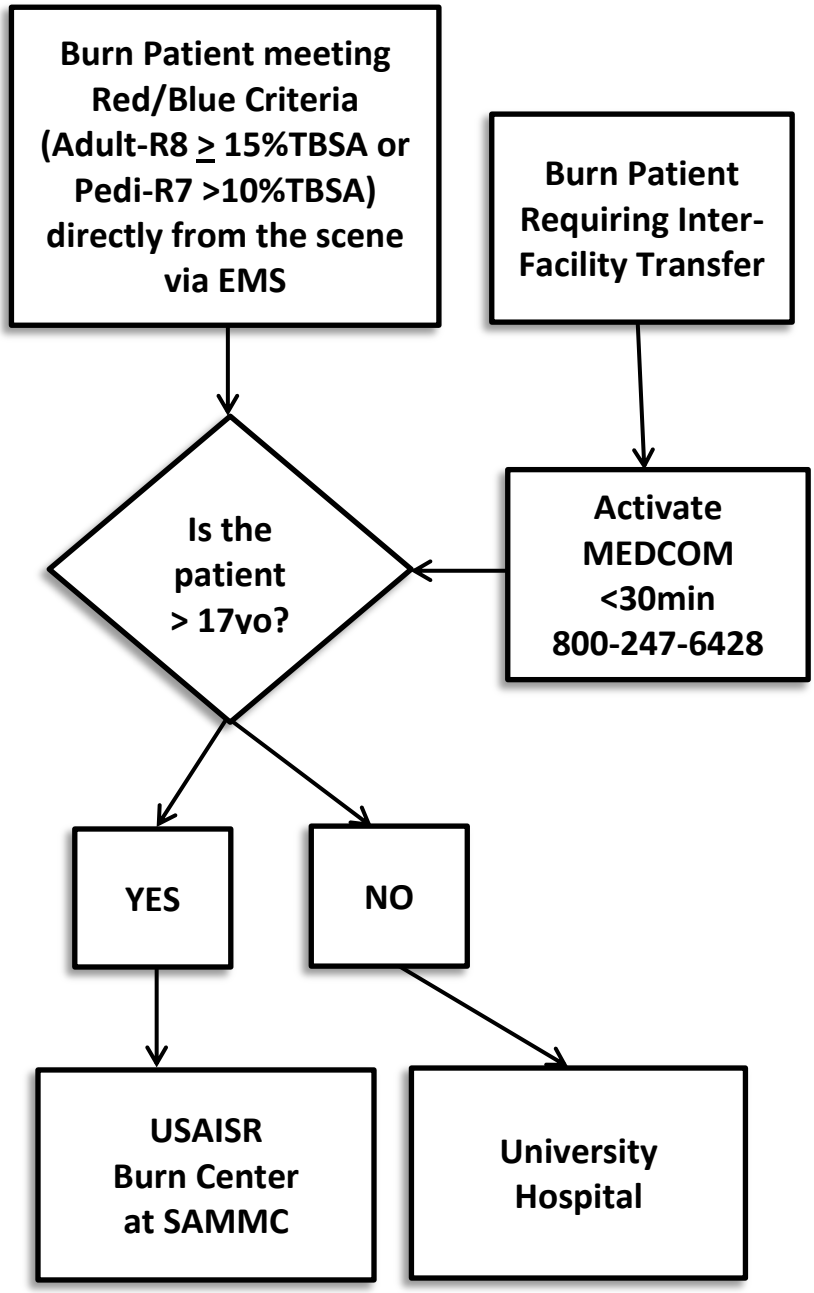
TSA-P Injury Prevention and Public Education Activities

TSA-P has been an active participant in providing injury prevention education and activities for the region. Safe Kids chapters in San Antonio and Del Rio are strong projects conducted by STRAC members and STRAC supports all efforts of the South Texas Injury Prevention Research Center. – Delete

Plan: Continue support for various projects of the Region, such as Child Seat Technician courses, inspections, Shattered Dreams project, Safe Kids, Tie one on for Safety (MADD) and Fall Prevention projects. List of projects will be updated annually.

STRAC Regional Burn Transfer and EMS Scene Transport Algorithm

Updated, July 2014



If Local Burn or Trauma Centers are unable to accept the patient, MEDCOM will assist coordination and/or provide information for other State Burn Resources.

Adult Only:
UTMB, Galveston (800) 962-3648
Christus Spohn Memorial, Corpus Christi (361) 902-4000
Hermann Hospital, Houston (713) 704-2500

Adult & Pediatric:
Parkland, Dallas (214) 590-6690
UMC, Lubbock (800) 345-9011

Pediatric Only:
Shriner's, Galveston (409) 770-6773

Regional Blood or Body Fluids Exposure Process for EMS or other Public Safety Personnel

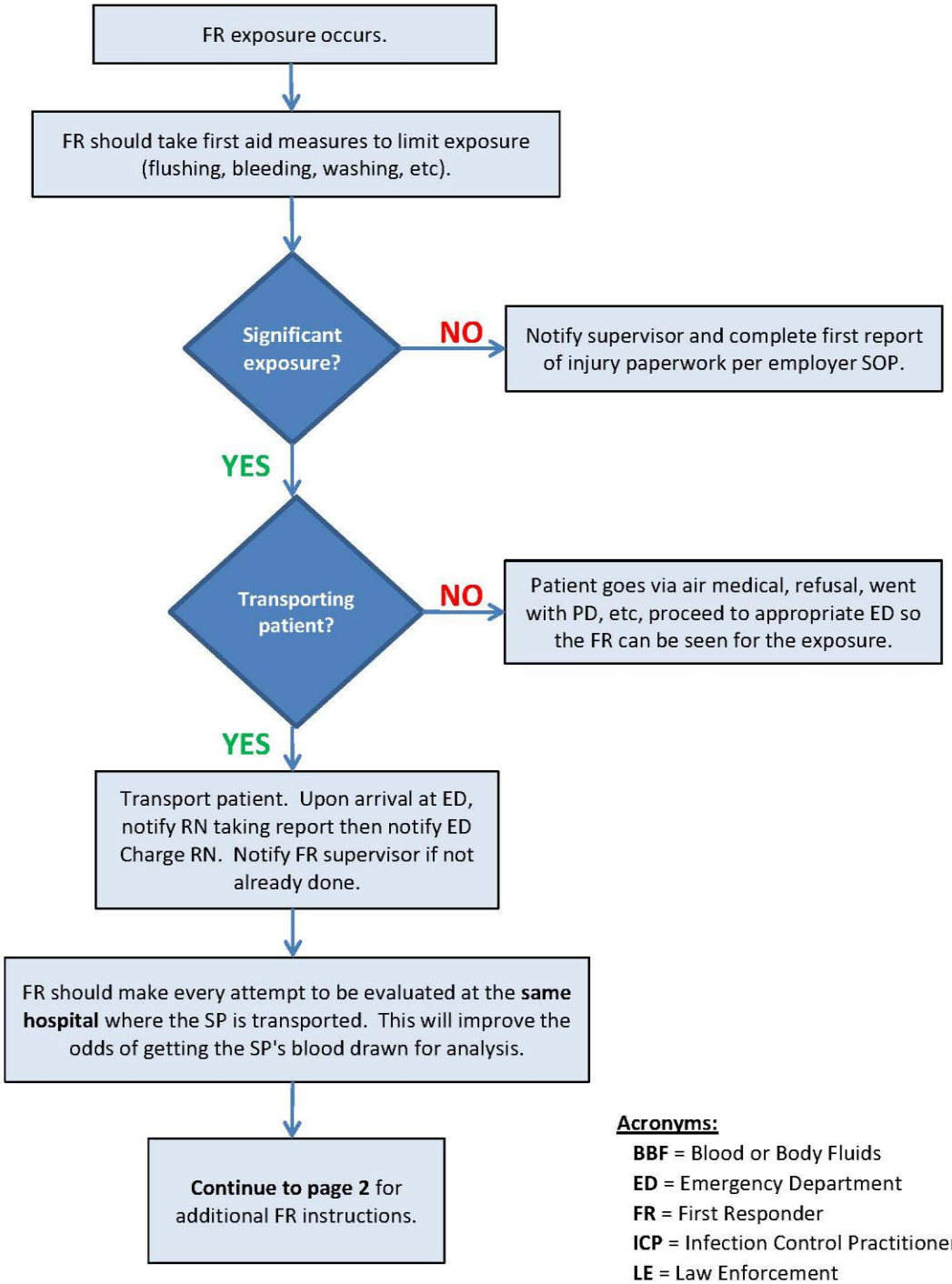
The STRAC EMS committee, in concert and collaboration with the STRAC Infection Control Committee, San Antonio Metro Health and Department of State Health Services (DSHS) Region-8, has developed this packet to provide a common, consistent method for EMS or other Public Safety/First Responder personnel to obtain proper evaluation and necessary treatment when exposed to blood and/or body fluids (BBF) in the course of their duties. For brevity, this packet refers to EMS, Public Safety, including Law Enforcement and Firefighters, Rescuers, etc., as First Responders (FR).

Process steps for the FR once exposed to Blood or Body Fluids (BBF):

1. Self-first aid must be done as soon as possible following which may include: rinse/flush thoroughly with soap and water the body part exposed to blood or body fluids, follow with anti-microbial scrubbing of the exposed area, if not contraindicated (i.e. eyes, oral cavity, etc.).
2. The FR should notify his/her supervisor and complete first report of injury paperwork per employer SOP.
3. FR should make every attempt to be evaluated at the same hospital where the source patient (SP) is transported as this will improve the odds of getting the source patient's blood drawn for analysis.
4. The FR completes the BBF Exposure packet (available on www.strac.org or EMSystem), pages 6-9.
5. The FR will provide a copy of the BBF Exposure Report (pages 6-9 of packet) to the Emergency Department Charge Nurse and retain a copy for his/her department's Infection Control Representative.
6. ***Ensure 'consent to release' documents are signed and include a named designee (supervisor).***
7. If the ***SP is in the ED***, that Emergency Department Charge Nurse receiving the exposure report shall:
   a. If the SP is in the ED, the FR should go through the normal admission process and be evaluated by the ED physician and BBF exposure is assessed for risk.
   b. Based on the risk assessment, the ED physician will consider drawing blood from the SP.
   c. Provide counseling and prophylaxis to the FR based on the SP history and/or blood draw results. If prophylaxis is selected, the FR should receive *at least* the first dose and script (minimum of 3 days), similar to hospital employees.
   d. ED Charge Nurse will fax BBF Exposure packet (pages 6-9) to the hospital ICP.
   e. ICP will fax the BBF Exposure packet (pages 6-9) to:
      1. Source patient originates from Bexar County:
         - **San Antonio Metro Health Department, Epidemiology**
           (210) 207-8876; Fax (210) 207-8807
      2. Source patient originates from *outside* Bexar County:
         - **DSHS Health Service Region 8**
           (210) 949-2121; Fax (210) 692-1457
           Note the contact number for DSHS is a 24 hour hotline voice message which will activate the on call representative within 30 minutes.

8. If the ***source patient is not in the ED,*** that Emergency Department Charge Nurse receiving the exposure report shall contact:
   a. Source patient originates from Bexar County:
      - **San Antonio Metro Health Department, Epidemiology**
        (210) 207-8876; Fax (210) 207-8807
   b. Source patient originates from *outside* Bexar County:
      - **DSHS Health Service Region #8**
        (210) 949-2121; Fax (210) 692-1457

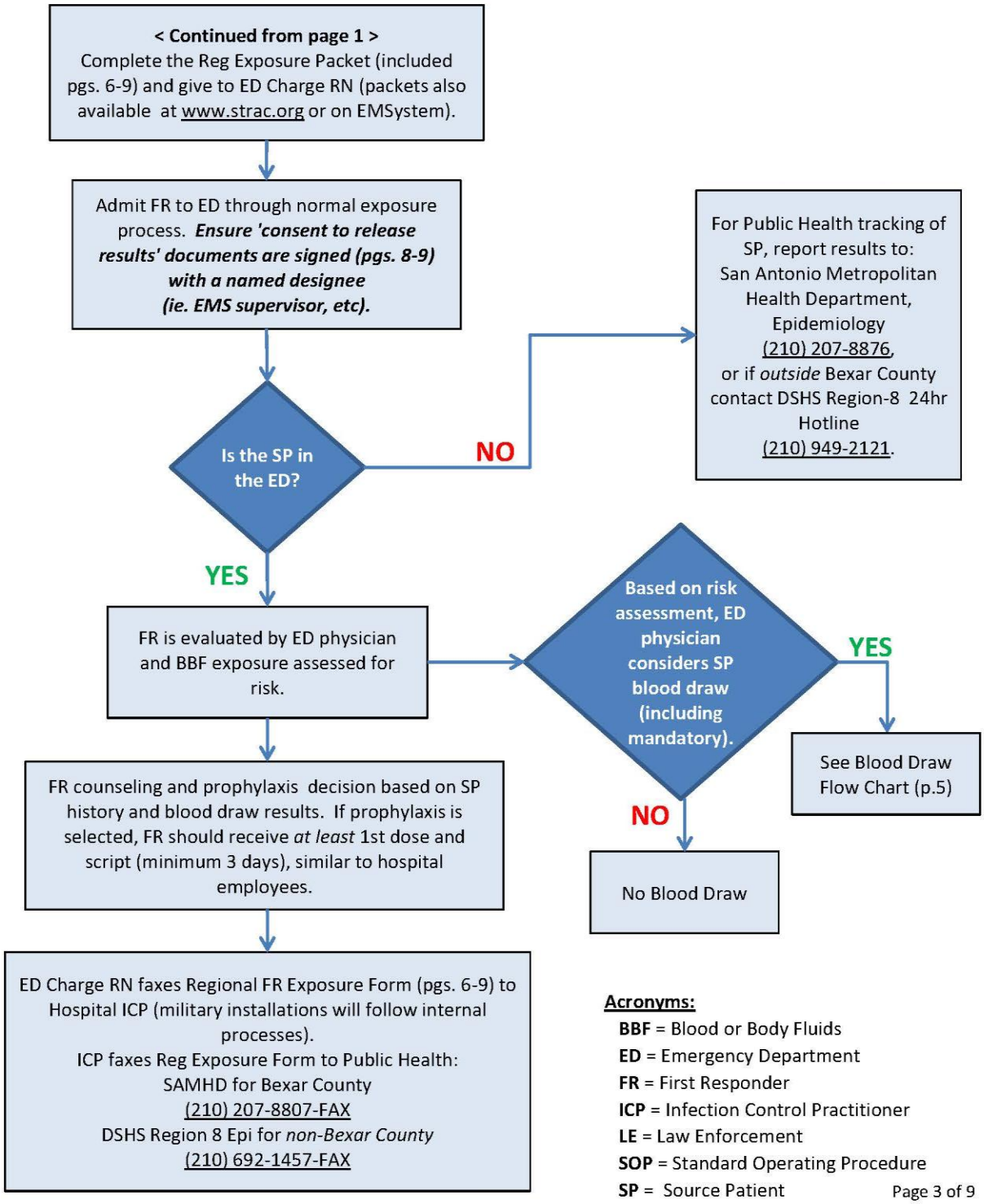
First Responder Process Blood or Body Fluids Exposure:



Acronyms:

BBF = Blood or Body Fluids
ED = Emergency Department
FR = First Responder
ICP = Infection Control Practitioner
LE = Law Enforcement
SOP = Standard Operating Procedure
SP = Source Patient

First Responder Process Blood or Body Fluids Exposure (continued from page 1):



Acronyms:

BBF = Blood or Body Fluids
ED = Emergency Department
FR = First Responder
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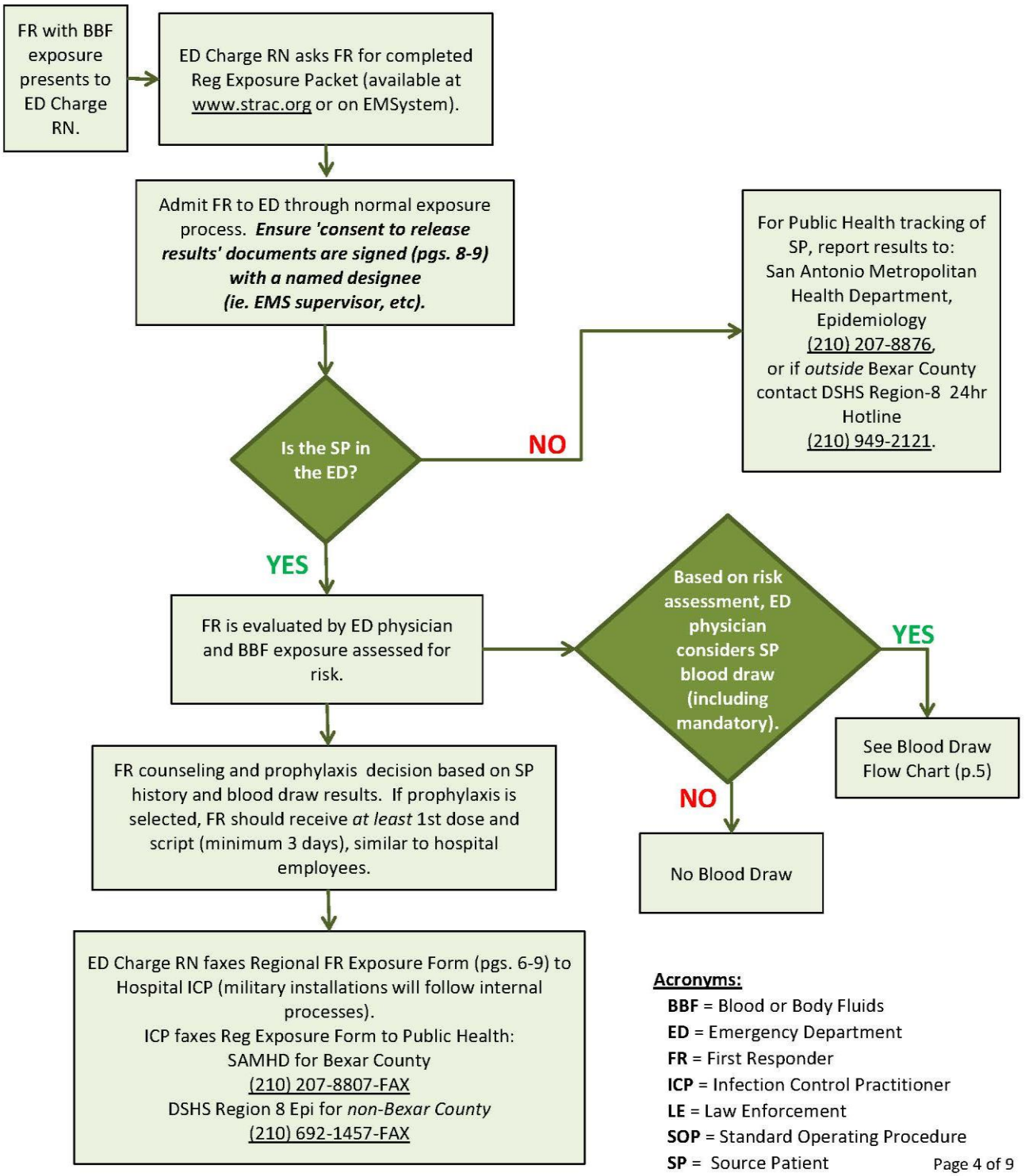
LE = Law Enforcement
SOP = Standard Operating Procedure
SP = Source Patient

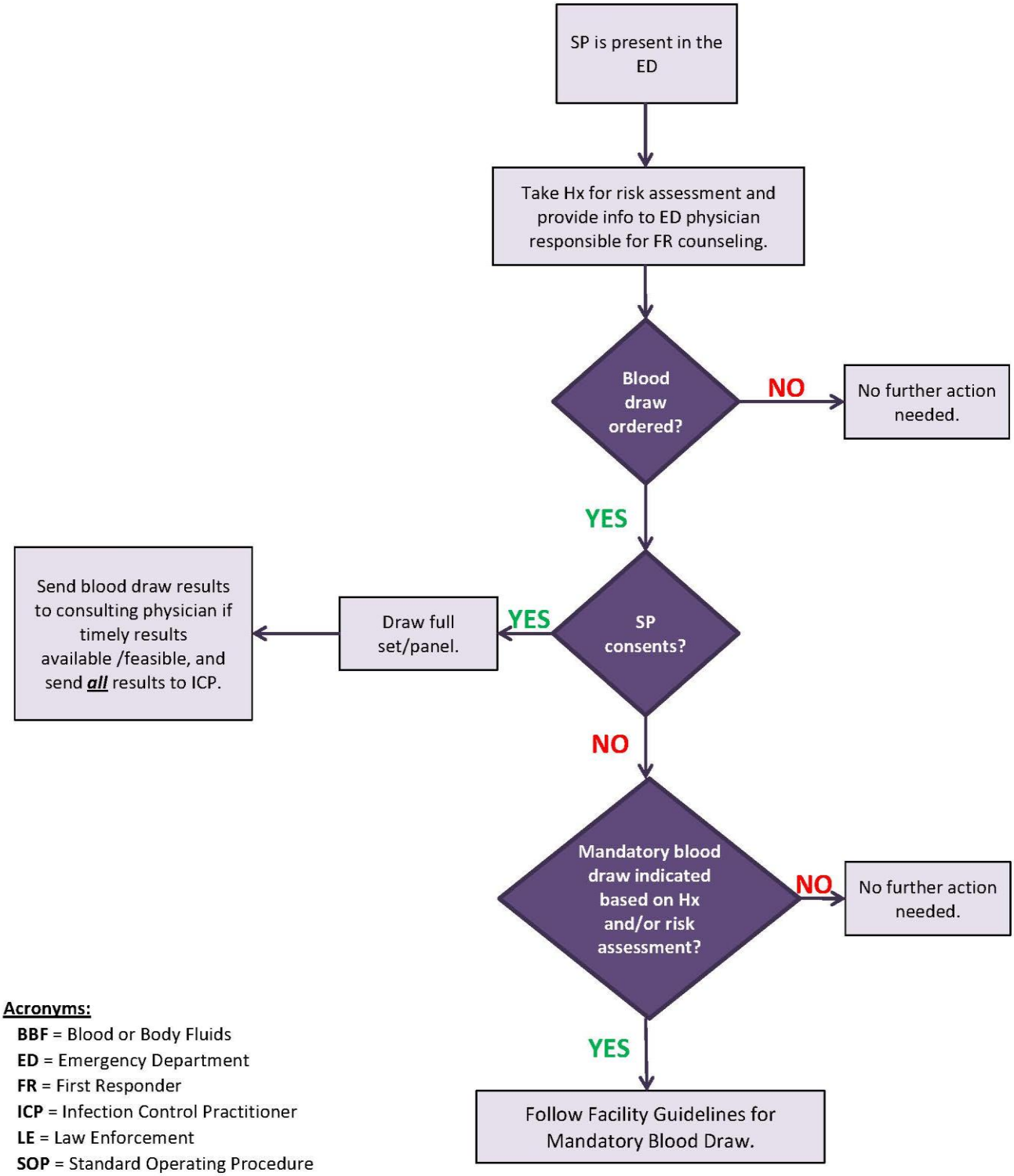
Emergency Department process for evaluation of a First Responder with On-duty Blood or Body Fluids Exposure:



Acronyms:

BBF = Blood or Body Fluids
ED = Emergency Department
FR = First Responder
ICP = Infection Control Practitioner
LE = Law Enforcement
SOP = Standard Operating Procedure
SP = Source Patient

Source Patient Blood Draw Process



Acronyms:

BBF = Blood or Body Fluids
ED = Emergency Department
FR = First Responder
ICP = Infection Control Practitioner
LE = Law Enforcement
SOP = Standard Operating Procedure
SP = Source Patient

SELF-FIRST AID MUST BE DONE AS SOON AS POSSIBLE FOLLOWING ONE OF THE ABOVE EXPOSURES. RINSE/FLUSH THOROUGHLY WITH SOAP & WATER THE BODY PART EXPOSED TO BLOOD/BODY FLUIDS

REPORT OF POSSIBLE EXPOSURE OF FIRST RESPONDER PERSONNEL

First Responder (FR) personnel who have an exposure listed in #2 below must complete this form immediately. A copy of the completed form should be given to the Emergency Department Charge Nurse where the source patient is delivered and the original returned to the Infection Control Representative of the FR agency. ITEMS 1-5 are to be completed by the FR who sustained the exposure.

PLEASE PRINT LEGIBLY

ITEMS 1-5 TO BE COMPLETED BY FIRST RESPONDER PERSONNEL

1. The exposure described in #2 below occurred during the care / management of the following patient /person (**SOURCE**):

Source Patient Name: _____ [ ] Male [ ] Female DOB ____/____/____

Transported to: _____ on Date / Time ____/____/____ @ _____AM / PM

Suspected Disease: _____Other Responders Involved? [ ] Yes [ ] No Who: _____

2. Exposure Type:
What were you exposed to:

[ ] Blood [ ] Feces [ ] Urine [ ] Saliva [ ] Vomitus [ ] Sputum [ ] Other _____

How Were You Exposed:

[ ] Coughing [ ] BVM Use [ ] Mouth to Mouth [ ] Intubation [ ] Throat Exam [ ] Needle Stick

[ ] Puncture Wound [ ] Splash [ ] Open Wound [ ] Non-intact Skin [ ] Other _____

Specifically, where were you exposed?

[ ] Face [ ] Hands [ ] Arms [ ] Legs [ ] Chest [ ] Abdomen [ ] Eyes Nose [ ] Mouth

Was personal protective equipment (PPE) utilized?

[ ] Gloves [ ] Mask [ ] Face Shield [ ] Gown [ ] Other _____

How did the exposure occur? _____

3. NAME OF EMS / PUBLIC SAFETY OFFICER EXPOSED: _____

SS#: _____-____-_____ TELEPHONE: Home: _____ Work: _____

Unit / Station # _____ Shift: _____ EMS Case / Run # _____

Last Tetanus Immunization: _____ Year of Hep. B Vaccination: _____ Measles/Rubella_____

4. EMS Service or Public Agency Name: _____

Address: _____ City/State/Zip: _____ Telephone #: _____

5. Signature of Person Reporting Exposure: _____ Date Form Completed: ____/____/_____

Provide Copy to ED Charge Nurse and retain copy for your agency's Infection Control Representative; ensure 'consent to release' documents (pages 8-9) are signed with a named designee (i.e. EMS Supervisor, etc.).

TO BE COMPLETED BY THE RECEIVING FACILITY'S INFECTION CONTROL / EPIDEMIOLOGY REPRESENTATIVE:

DISEASE IDENTIFIED _____ **Date Specimen Collected**____ /____ /_____

NO DISEASE IDENTIFIED DURING THIS HOPSPITALIZATION / STAY

RESULTS REPORTED TO: San Antonio Metropolitan Health Department 210-207-8807 (fax) on ____ / ____ / _____

RESULTS REPORTED TO: (Outside Bexar County) DSHS Health Service Region-8 210-692-1457 (fax) on ____ / ____ / ____

Name / Title of Person Completing this Section: _____

SIGNATURE: _____ **DATE:** ____ / ____ / _____

Created NOV-12; Revised AUG-14; v2

CONFIDENTIAL
HOSPITAL SHOULD CONTACT THE EPIDEMIOLOGY OF SAN ANTONIO METROPOLITANT HEALTH DEPARTMENT OR THE DSHS REGION 8 OFFICE WITH RESULTS

VISIT WWW.STRAC.ORG/DOCUMENTS FOR ADDITIONAL COPIES OF THIS FORM AND ASSOCIATED DOCUMENTS.

TEXAS ADMINISTRATIVE CODE

TITLE 25	HEALTH SERVICES
PART 1	DEPARTMENT OF STATE HEALTH SERVICES
CHAPTER 97	COMMUNICABLE DISEASES
SUBCHAPTER A	CONTROL OF COMMUNICABLE DISEASES
RULE §97.11	Notification of Emergency Medical Personnel, Fire Fighters, Peace Officers, Detention Officers, County Jailers, or Other Persons Providing Emergency Care of Possible Exposure to a Disease

(a) Purpose. The Communicable Disease Prevention and Control Act (Act), §81.048, requires a licensed hospital to notify a health authority in certain instances when an emergency medical service employee, peace officer, detention officer, county jailer, or fire fighter may have been exposed to a reportable disease during the course of duty from a person delivered to the hospital under conditions that were favorable for transmission. A hospital that gives notice of a possible exposure under this section or a local health authority that receives notice of a possible exposure under this section may give notice of the possible exposure to a person other than emergency medical service employee, a peace officer, a detention officer, a county jailer, or a fire fighter if the person demonstrates that the person was exposed to the reportable disease while providing emergency care.

(b) Disease and criteria which constitute exposure. The following diseases and conditions constitute a possible exposure to the disease for the purposes of the Act, §81.048:

(1) chickenpox; diphtheria; measles (rubeola); pertussis; pneumonic plague; SARS; smallpox; pulmonary or laryngeal tuberculosis; and any viral hemorrhagic fever, **if the worker and the patient are in the same room, vehicle, ambulance, or other enclosed space**;

(2) Haemophilus influenzae type b infection, invasive; meningitis; meningococcal infections, invasive; mumps; poliomyelitis; Q fever (pneumonia); rabies; and rubella, **if there has been an examination of the throat, oral or tracheal intubation or suctioning, or mouth-to-mouth resuscitation**;

(3) acquired immune deficiency syndrome (AIDS); anthrax; brucellosis; dengue; ehrlichiosis; hepatitis, viral; human immunodeficiency virus (HIV) infection; malaria; plague; syphilis; tularemia; typhus; any viral hemorrhagic fever; and yellow fever, **if there has been a needlestick or other penetrating puncture of the skin with a used needle or other contaminated item; a splatter or aerosol into the eye, nose, or mouth; or any significant contamination of an open wound or non-intact skin with blood or body fluids**; and

(4) amebiasis; campylobacteriosis; cholera; cryptosporidiosis; Escherichia coli O157:H7 infection; hepatitis A; salmonellosis, including typhoid fever; shigellosis; and Vibrio infections, **if fecal material is ingested**.

(5) Methicillin-resistant *Staphylococcus aureus* (MRSA) wounds, skin infections or soft tissue infections, if there has been contact of non-intact skin to these infections or drainage from these infections.

To Access Texas Administrative Code Documents Pertaining to Communicable Diseases & Exposure, Please Visit:
http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=97&rl=11
http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=97&rl=12

Workers Compensation / Health Insurance Information:

Name of Insured: _____

Address: _____ Phone:_____

Attention: _____

Name of Workers Compensation / Insurance Company: _____

Address: _____ Phone:_____

Policy #: _____ Group #: _____

Attention: _____

Source Patient Consent to Testing

Consent for Testing due to Exposure of a Health Care/Public Safety Worker

I, (PRINT: Source Patient Last Name, First Name), hereby give permission to (Hospital Name) to test my blood for Hepatitis B, Hepatitis C and the presence of the HIV antibody which is associated with Acquired Immune Deficiency Syndrome (AIDS).

I, (PRINT: Source Patient Last Name, First Name), hereby give permission to (Hospital Name) to provide all test results to (First Responder Agency), to be used solely to determine appropriate care for exposed healthcare/public safety worker.

I understand that I have been requested to have this test because a healthcare or public safety worker has been exposed to my blood or other body fluid and because the United States Centers for Disease Control and the Texas Department of State Health Services (DSHS) recommend testing of patients following such exposure.

I understand that a negative result from this test does not conclusively exclude the possibility of infection with the HIV (AIDS) virus. All positive test results will be confirmed by repeating the same test as a control for performance or laboratory error.

I understand that a positive result from this test will be reported to the Texas Department of State Health Services as required by law.

I understand that (First Responder Agency) will take precautions to protect the confidentiality of these test results. There will be no disclosure to unauthorized parties without my express written consent.

I understand that the results of this test will not be recorded in my medical record and that the results will be released only to persons or entities to which I authorize the release of my lab results.

I understand and agree that the results may be disclosed as necessary to assure appropriate follow-up testing of the health care / public safety worker exposed to my blood or other body fluids.

I have been given the opportunity to ask questions which have been answered to my satisfaction. I have read the above and have had the opportunity to discuss this information with Dr. (Physician Name). I am aware of the test's limitations and the potential consequences of positive and negative test results. My signature indicates that I give my informed consent to have the HIV, HBV and HCV screening test performed on a sample of my blood, and to provide results with designated parties.

Source Patient Last Name, First Name – PRINT LEGIBLY

Source Patient Signature

Witness

Date

Time

Place Patient MRN Sticker if Available

Update August, 2014; v2

First Responder Authorization for Release of Protected Health Information

First Responder (Patient) Name:_____ D.O.B: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

I hereby authorize _____(Hospital Name)_____**, including employees and contract physicians, to disclose protected health information to the** _____(Agency Name)_____ **Designated Infection Control Officer** _____(Last Name, First Name)_____**, and alternate(s)** _____(Last Name, First Name and Title)_____**. I authorize the release of my complete health record related to an on-duty exposure to disease that occurred on or about** _____(MM/DD/YYYY)_____**. The purpose of the disclosure is to permit the Infection Control Officer to coordinate with health care personnel and assist in post-exposure management on my behalf. This Authorization is valid for 90 days. I can revoke this authorization in writing at any time.**

The following medical records are requested in advance for compliance with State and Federal Law*

- [X] Disease Identified
- [X] Laboratory results related to exposure
- [X] Physician findings related to exposure

Treating Facility:

Facility _____
Address _____
City, State, and Zip _____
Phone _____ Fax _____

First Responder Agency:

FAX Attention To: Name, Title _____
Agency _____
Address _____
City, State, and Zip _____
Phone _____ Fax _____

Signature: _____ Date: _____

Update August, 2014; v2

Annual Plan Review Procedure

Annually the STRAC Chair, the chairs of each committee or their designees and other interested STRAC members will meet as the Plan Review Task Force to review and revise the TSA-P Trauma System Plan to reflect changes that have occurred in the system. The revised plan will be presented to the Voting Membership before the Annual General Meeting at the next scheduled STRAC meeting for review and approval at that time.

2014 Plan Review Members:

Dr. Ronald M. Stewart	University Hospital
Chillon Montgomery	Methodist Healthcare system
Eric Epley	STRAC
Dudley Wait	Schertz EMS
Monica Jones	STRAC
Preston Love	STRAC
Monica Phillips	STRAC
Tracy Cotner Pouncy	University Health Systems
Charles Bauer	UT Health Science Center
Melissa Low	Baptist Healthcare System
Leni Kirkman	University Hospital
Col Joseph Chozinski	San Antonio Medical Military Center
Jerry Rodriguez	Christus Santa Rosa Healthcare
Mechelle Salmon	Bulverde Spring Branch Fire/EMS
David Jung	Fredericksburg Fire/EMS
Dr. Brian Eastridge	University Health Systems

This plan is respectfully submitted to the Texas Department of State Health Services, Bureau of Emergency Management.

_____ _____

Ronald M. Stewart, MD Date
Chair
Southwest Texas Regional Advisory Council