BRAC MISSON:

The mission of the BRAC is to extend trauma care to the citizens of West Texas and all persons requiring trauma care in a fiscally responsible manner by working with entities and services either directly or indirectly involved in their care to improve health, of life and services while decreasing trauma related mortality and morbidity.

BRAC GOALS: The primary goals of the BRAC include but are not limited to:

1. The development of a Trauma System Plan for TSA-B, in accordance with the Texas Department of Health guidelines for comprehensive system development with submission of the plan to the Texas Department of Health as required by the Trauma Rules.
2. Decreasing morbidity and mortality resulting form trauma.
3. Assisting member organizations in attaining trauma designation at the level appropriate to resources available within their immediate service area.
4. Providing a forum to resolve conflict among members regarding trauma care and encourage activities designed to promote cooperation between member organizations.
5. Seeking ways to improve funding of trauma care providers within the counties served by TSA-B.
6. Increasing public awareness of the methods to access the trauma care system and trauma prevention.
7. Enhancing communication between healthcare providers and facilitate the transport of patients to appropriate facilities by utilization of the most effective mode of transport.
8. Developing within TSA-B, a comprehensive, standardized method of evaluating and improving care through:
    a. quality improvements activities
    b. education, injury prevention programs and certification programs
9. Re-evaluate the BRAC on a yearly basis to ensure that all appropriate entities have been invited to participate; re-evaluate the Trauma System plan and update as necessary; annual regional need assessment and annual review of bylaws.
10. Demonstrate financial accountable and fiscal stewardship with defined operational duties of leadership positions, paid positions, committee and input; responsibilities and limitations for budget creation, signing of contracts and the conducting of daily business.

FISCAL ACCOUNTABILITY AND FINANCIAL STEWARDSHIP

The Executive Board of the BRAC will develop an annual budget. Final approval of the budget will be made by the General Membership. A line item accounting of expenses will be presented at each General Membership meeting and Executive Board meeting. An annual audit will be conducted.

The annual budget will flow a standardized accounting format and will comply with DSHS requirements for reporting. The prioritized needs as identified by the need assessment and regional system planning will be supported in the budget.

A quarterly report will be provided to the Executive Board and General Membership reflecting the status of all BRAC income, expenses (line item) and status of all state contract funds.

The BRAC will develop financial goals and a timeline to support non-DSHS funds for support. The goal is to ensure that now more than 10% of administrative expenses are supported by DSHS funds.

The Executive Board will approve the annual budget, annual dues, if applicable, and a long-range budget and business plan of not less than three years duration with final acceptance through a general membership vote. The fiscal year of the organization will be September 1st through August 31st.

ANNUAL REVIEW OF TRAUMA SYSTEM PLAN AND BYLAWS

The BRAC Executive Director will make an annual review of the Trauma System plan and bylaws. This review will be submitted to DSHS and the Executive Board and general Membership of the BRAC as required.

ANNUAL REGIONAL NEEDS ASSESSMENT

An annual needs assessment will be completed by the BRAC Executive Director. This information will be submitted to DSHS for their review. The needs assessment will be distributed to all BRAC participating organizations. Data form the need assessment will provide the basis for regional planning, prioritizing and distributing of regional resources. The results of the need assessment will be presented to the Executive Committee and General membership for their review. Changes in the BRAC Trauma System Plan will be generated and determined from the results of this needs assessment.

DAY TO DAY OPERATIONS

An Executive Director will coordinate daily operations of the BRAC. This is a paid, part time contracted position without benefits. Office space will be provided for the Executive Director. A formal job description outlining roles and responsibilities is in place. A yearly evaluation will be made on the performance of the Executive Director. The Executive Board will summarize the evaluation and a review will be made with the Executive Director and Chairperson of the Executive Board.

REGIONAL CHARACTERISTICS-yearly review

The demographics of the BRAC area will be reviewed on a yearly basis. These areas will include but not be limited to:

Age-related characteristics

Service area population with percentage of persons over 65 years of age and under 12 years of age

Age-specific equipment and supply needs within the region
Rehabilitative services
Education and training needs
Disaster management including decontamination, PPE and education needs
Injury prevention needs- including community specific needs
Special injury patterns within communities
Data collection- methods to improve data collection and needs within each service area

REGIONAL DATA REPORTING

The BRAC will provide essential materials and access for regional trauma data reporting. The server will be located in an easily accessible and secure location. The BRAC Executive Director will make the coordination of PHEMS reports and hospital data. Regional reporting will be made to DSHS as outlined within their reporting criteria.

SYSTEM PLAN ACCESS

A copy of the BRAC Trauma System Plan will be given to every organization and /or entity within the TSA. The plan will also be located on the BRAC website. Changes will be distributed to each organization/entity within 30 days when changes have been made.

MEETING NOTIFICATION

Members of the Executive Board and General Membership of the BRAC will be notified not less than two weeks prior to meetings. Notification of meetings, involving possible bylaw changes must be mailed to voting members and if electronic notification is used, messages must be sent with electronic confirmation that the message has been received. Notice of special meetings of the Executive Committee may be waived by unanimous consent of the Executive Committee.

An agenda will be provided in the meeting notification information and will be available on the web site.

The Executive Director of the BRAC will post a yearly meeting listing. The information will also be posted on the BRAC Web Site.

DOCUMENTATION OF ATTENDANCE

A clear method for documentation of participation by attendance at all meetings is in place. The sign in rosters will be collected by the Executive Director and will be on file. Attendance will be submitted to DSHS. Meeting attendance requirements for financial compensation are outlined within participation section of this document.

MEETING STRUCTURE FORMAT

All meetings will adopt and utilize Robert's Rules of Order for structure and function.

BRAC COMMUNICATIONS

The Executive Director of the BRAC will establish and e-mail membership list and list of all members of the General Membership as well as a list of committee members that will be updated on an annual basis. Communications related to meetings, information/alerts, disaster management and other areas will be communicated via this mode to all e-mail participants. Those not utilizing electronic mail will have such communications sent to them directly via mail.

DSHS REVIEW

BRAC will provide the following to DSHS. The annual summary report will be compiled by the Director and submitted to DSHS as outlined below.

1. Schedule of all regular meetings and notification no less than 7 days prior to called meeting.
2. Minutes of meetings, including list of attendees and organizations they represent within 30 days for approval.
3. Any major changes in RAC. These include changing leadership, bylaws revisions and other reviews of policy and procedure.
4. Any RAC leadership changes no less than 7 days after the change. A copy of revisions to bylaws and other changes will be submitted to DSHS no less than 30 days after approval.
5. Annual report to DSHS at conclusion of fiscal year. Include: short and long term objectives for the RAC and any changes to RAC operations.
6. Any other information requested by DSHS as related to RAC activities.

EDUCATION AND TRAINING

The BRAC will develop, coordinate and schedule educational opportunities in response to RAC membership learning needs assessments. These programs will address learning and skills that are identified through the regional QI program. Educational offerings will be developed to address continuum of care, injury prevention, and programs that are consistent with systems development.

Education to all members will be offered and the Executive Director will provide documentation of this. Written documentation will be in place.

EMERGENCY/DISASTER PREPARATION

A written disaster plan will be in place for the region. Coordination of services provided by all providers will be reflected within this plan. The plan will address

availability of resources, standard planning components, threat analysis, resource assessment, and hospital/pre-hospital resources. This plan will be fully integrated with hospital and regional/city plans. Centralized coordination will be in place. These efforts will be coordinated through the Hospital Bioterrorism committee, local Emergency Preparedness groups and DSHS.

REGIONAL PERFORMANCE IMPROVEMENT

An established plan for monitoring system performance is in place. The QI committee of the RAC directs this plan. A review of mortality and morbidity within the RAC is addressed. Specific goals and objectives are in place. The plan is reviewed yearly and new indicators are put in place. The Executive Director of the BRAC keeps minutes. Sign in rosters are also in place.

A regional data collection registry will be in place. The data generated form this registry will provide and overview of the trauma issues within the TSA.

Coordination of QI activities related to skill competence or identified areas of need will be directed from the QI committee to educators and the Medical Directors.

RAC QI is multidisciplinary in nature. Confidentiality agreements are in place to ensure patient and service confidentiality.

Case reviews related to trauma are in place. The reviews are done at the regional level with EMS and at the QI Committee level. These allow for the sharing of information, review of patient outcomes. Outcomes related to trauma will be coordinated through the Injury Prevention Coalition of the South Plains. DSHS Dept. of Epidemiology and regional trauma registry data.

A feedback loop related to issues will be documented within the minutes of the QI committee. Issues directed to a specific person and/or service will be coordinated with the Medical Directors. Follow up will be generated within the minutes of the meeting for loop closure of issues. Issues related to suboptimal care provisions and standards of care will be directed through the QI committee.

A regional review of appropriateness of patients treated within facilities will be made and presented to the QI committee. This information includes data related to types of patients, patients transferred and length of stay in referring facilities. Issues related to care form tertiary care perspectives would be presented as they occur.

QI committee will incorporate pediatric issues and concerns as well as registry and injury prevention specific for this TSA.

PEDIATRIC COMMITMENT AND QUALITY OF CARE REVIEWS

It is recognized that Pediatric Trauma is the leading cause of death in children. The BRAC will include pediatric assessment, quality review and injury prevention initiatives related to pediatric trauma. Education opportunities, regional assessment and quality review may include but is not limited to:

Child Fatality Review Teams

Quality Improvement activities including car passenger safety seat inspections and installations

Timelines and appropriateness of pediatric trauma transfers

General pediatric care provided to the critically ill and injured child.

Develop and implement "accepted" standards of care related to pediatric patient care as outlined by the Pediatric Subcommittee of GETAC.

MIDLEVEL PARCTIONERS

The practice and utilization of midlevel providers in hospitals will address credentialing and will specifically outline their roles, responsibilities and care provisions, as well as, the oversight provided by designated physicians overseeing their care. The recommended guidelines form DSHS will be utilized in the credentialing and oversight role for all midlevel providers practicing within the BRAC.

INTRODUCTION

Texas Trauma Service Area (TSA) B consists of 24 with a population of 400,000+ persons. The largest of these counties in Lubbock, which serves as the geographic "hub" for the TSA. There are 17 hospitals within the TSA. Only three of these, University Medial Center (UMC), Highland Medical Center and Covenant Health System (CHS), have a bed capacity greater that 100 and are both located within the city of Lubbock. UMC is a Level I trauma facility band Covenant Medical Center (CMC) is a Level II trauma center and Highland had had a Level IV survey for verification and designation form DSHS. 14 hospitals have received Level IV trauma designation and some of have worked with the Texas Department of Health (DSHS) Bureau of Emergency Management on pilot programs.

There are 56 EMS services within TSA-B. The majority function under protocols and standards developed and implemented by the South Plains Emergency Medical Services (SPEMS) organization, while some act as independent licensed services. EMS services are represented in the Regional Advisory council (RAC) of TSA-B. The services provided by EMS range form paramedic to first responders and are a mixture of paid and volunteer services. (see attachment for list of services)

Referral patterns are from the rural facilities and region to the tertiary care centers located in Lubbock. Patient flow is via ground or air medical services. The region has one dedicated air medical services, Aerocare.

Patient referrals to tertiary care centers are through direct referrals and/or scene transports. The coordination of care and services is instrumental in the provision of safe and efficient trauma care. Rural facilities EMS providers, tertiary care centers, SPEMS and other interested agencies work in this coordination to provide optimal care to the trauma population. Inter-state communication and care provisions are being developed with New Mexico who is in the primary stages of trauma system development within their state.

A network has been developed through trauma development. This network allows for the sharing of ideas, implementation of better and improved trauma systems care and improved patient care. The tertiary care centers provide assistance to regional facilities and trauma coordinators in trauma care issues, education and preparation for trauma designation, as well as providing resources to EMS services when needed. ARAC coordinator is in place to oversee daily operations, committees, documentation, financial aspects and general duties for the TSA-B. This coordinator works with EMS services, the community and hospitals in providing guidance and oversight on the RAC.

SPECIAL CHALLENGES

TSA-B represents a classic example of the special challenges and needs in delivering trauma care to a wide and diverse region.

1. Eight contiguous counties have realigned with the TSA.
2. TSA-B is working with Region III in New Mexico on the coordination of care and services for patients entering into the Texas Trauma System
3. The wide and diverse region presents special challenges in by-pass and diversion, triage, mode of transport and other areas.

TRAUMA SYSTEM DEVELOPMENT TO DATE

The original trauma plan for TSA-B was approved by the RAC in February of 1995 and implemented within TSA-B.

Revision and updating was done in April of 1999.

A decision to separate the RAC from the SPEMS organization was made in April 2001. RAC reorganization and planning was completed in February 2003 and presented to DSHS for Their review and approval.

LIST OF RAC OFFICERS-as outlined within the articles of incorporation three persons will serve as the RAC reorganizational meeting of the BRAC. These are include:

Chair- Wendi McNabb, RN, UMC
Past Chair- Tim Berry, EMTP, Lubbock EMS
Chair Elect – Mike Deloach, EMTP, South Plains College / Littlefield EMS
Secretary- Jeannie Bennett, RN, Brownfield Regional Medical Center
Treasurer- Sharon Hunt, CEO, WJ Mangold Memorial Hospital, Lockney
EMS- Rusty Powers, EMTP, Olton EMS
EMS- Bryan Taylor, EMPT, Seminole EMS
EMS- Don Burress, EMPT, Plainview EMS
EMS- Monica McGee, EMPT, Littlefield EMS
Hospital- Linda Razar, CEO, Plains Memorial, Dimmitt
Hospital- Tammy Jones, RN, CMC, Lubbock
Hospital- Joyce Tedford, RN, Yoakum County Hospital, Denver City
Hospital- Violet Borron, RN, Plainview Covenant Hospital

Hospital- Dan Powers, CEO, Lynn Co. Hospital

STANDING COMMITTEES

Provider/Pre-hospital Education Committee
Administrators Committee
Medical Direction Committee
Trauma Coordinators/Hospital Education Committee

RAC Wide Committees

QI/Bypass and Diversion/Trauma Registry/Pediatrics
Injury Prevention
Mutual Aid/Mass Casualty/CISM

EXECUTIVE BOARD COMMITTEES

Finance Committee – elected from total membership of Executive Board
Membership/ Bylaws – elected from total membership
Nominating Committee – appointed from total membership
Grievance Committee – Ad Hoc Committee
Newsletter/Web Page Committee – elected from total membership

TSA-B HOSPITALS

HOSPITAL NAME:	**Brownfield Regional Medical Center**
Address:	705 E.Felt, Brownfield, Texas 79316
Phone:	806-637-3551
Radio Frequency Monitored:	Med 1
Trauma Designation:	Level IV
Number of Beds:	96
Designated:	January 1994
Administrator:	Mike Click
Trauma Coordinator:	Jeannie Bennett

HOSPITAL NAME:	**Cochran Memorial Hospital**
Address:	201 East Grant, Morton, Texas 79346
Phone:	806-266-5565
Radio Frequency Monitored:	Med 3
Trauma Designation:	Level IV
Number of Beds:	30
Designated:	January 1995
Administrator:	Jon Sorenson

Trauma Coordinator:

HOSPITAL NAME: **DM Cogdell Memorial Hospital**
Address: 1700 Cogdell Center, Snyder, Texas 79549
Phone: 915-573-6374
Radio Frequency Monitored: Med
Trauma Designation: Level IV
Number of Beds: 45
Designated: March 1995
Administrator:
Trauma Coordinator:

HOSPITAL NAME: **Covenant Children's Hospital**
Address: 3610 21st Street, Lubbock, Tx 79410
Phone: 806-725-1011
Radio Frequency Monitored: Med 4
Trauma Designation: Non-designated
Number of Beds: 73
Designated: Level II
Administrator: Charley Trimble
Trauma Coordinator: Cathy McMahon

HOSPITAL NAME: **Covenant Medical Center**
Address: 3615 19th Street, Lubbock, Tx 79410
Phone: 806-725-1011
Radio Frequency Monitored: Med 4
Trauma Designation: Level II
Number of Beds: 857
Designated: June 1995
Administrator: Charley Trimble
Trauma Coordinator: Cathy McMahon

HOSPITAL NAME: **Covenant Medical Center-Lakeside**
Address: 4000 24th Street, Lubbock, Tx 79410
Phone: 806-725-60000
Radio Frequency Monitored: Med 6
Trauma Designation: Non-designated
Administrator: Charley Trimble

Trauma Coordinator: Cathy McMahon

HOSPITAL NAME: Crosbyton Clinic Hospital
Address: 710 W. Main Street, Crosbyton, Tx 79322
Phone: 806-675-2382
Radio Frequency Monitored: Med 8
Trauma Designation: Non-designated
Number of Beds: 50
Designated: Non-designated
Administrator:
Trauma Coordinator: No designated trauma coordinator

HOSPITAL NAME: Highland Hospital
Address: 2412 50th Street, Lubbock, Tx 79412
Phone: 806-795-8251
Radio Frequency Monitored: Med 8
Trauma Designation: Non-designated
Number of Beds: 123
Designated: Non-designated
Administrator:
Trauma Coordinator:

HOSPITAL NAME: Lamb Healthcare Center
Address: 1500 S. Sunset, Littlefield, Tx 79339
Phone: 806-385-6411
Radio Frequency Monitored: Med 7
Trauma Designation: Level IV
Number of Beds: 40
Designated: March 1995
Administrator: Randall Young
Trauma Coordinator: Tammy Jones

HOSPITAL NAME: Levelland-Covenant Medical Center Levelland
Address: 1900 College Avenue, Levelland, Tx 79336
Phone: 806-894-4963
Radio Frequency Monitored: Med 5
Trauma Designation: Level IV
Number of Beds: 48
Designated: March 1995
Administrator: Jerry Osburn
Trauma Coordinator: Sandra Wallace

HOSPITAL NAME: Lynn County Hospital
Address: Box 1310, Tahoka, Tx 79373
Phone: 806-998-4533

Radio Frequency Monitored: Med 3
Trauma Designation: Level IV
Number of Beds: 24
Designated: March 1995
Administrator: Dan Powers
Trauma Coordinator: Donna Fields

HOSPITAL NAME: WM Mangold Memorial Hospital
Address: 320 N. Main, Lockney, Tx 79241
Phone: 806-652-3373
Radio Frequency Monitored: Med 1
Trauma Designation: Level IV
Number of Beds: 28
Designated: March 1995
Administrator: Sharon Hunt
Trauma Coordinator:

HOSPITAL NAME: Medical Arts
Address: 1600 N. Bryan Avenue, Lamesa, Tx 79331
Phone: 806-872-2183
Radio Frequency Monitored: Med 9
Trauma Designation: Level IV
Number of Beds: 40
Designated: September 1994
Administrator:
Trauma Coordinator: Jeana Amos

HOSPITAL NAME: Muleshoe Area Medical Center
Address: 708 S. 1st Street, Mulshoe, Tx 79347
Phone: 806-272-4524
Radio Frequency Monitored: Med 2
Trauma Designation: Level IV
Number of Beds: 31
Designated: 1996
Administrator: Jim Bone
Trauma Coordinator:

HOSPITAL NAME: Plains Memorial Hospital
Address: 310 W. Halsell, Dimmitt, Tx 79027
Phone: 806-647-2191
Radio Frequency Monitored: Med 2
Trauma Designation: Level IV
Number of Beds: 36
Designated: January 1995
Administrator:
Trauma Coordinator:

HOSPITAL NAME: Plainview-Covenant Hospital Plainview
Address: 2601 Dimmitt Road, Plainview, Tx 79072
Phone: 806-296-4282
Radio Frequency Monitored: Med 3
Trauma Designation: Level IV
Number of Beds: 100
Designated: March 1995
Administrator: Joe Langford
Trauma Coordinator: Violet Bourne

HOSPITAL NAME: Seminole Memorial Hospital
Address: 209 NW 8th, Seminole, TX 79360
Phone: 915-758-4901
Radio Frequency Monitored: Med 3
Trauma Designation: Level IV
Number of Beds: 49
Designated: March 1995
Administrator: Steve Beck
Trauma Coordinator: Tonya Guffey

HOSPITAL NAME: University Medical Center
Address: 602 Indiana Avenue, Lubbock, Tx 79408
Phone: 806-743-3415
Radio Frequency Monitored: Med 1-11
Trauma Designation: Level I
Number of Beds: 365
Designated: October 1993
Administrator: Jim Courtney
Trauma Coordinator: Wendi McNabb

HOSPITAL NAME: Yoakum County Hospital
Address: Box 1130, Denver City, Tx 79323
Phone: 806-592-2121
Radio Frequency Monitored: Med 7
Trauma Designation: Level IV
Number of Beds: 24
Administrator:
Trauma Coordinator: Joyce Tedford

RAC MEMBER COUNTIES

Castro Bailey	Lamb	Hale	Floyd	Motley	
Cottle	Hockley	Cochran	Crosby	Dickens	King
Yoakum	Terry	Lynn	Kent	Gaines	Dawson

7/18/06

Borden Scurry Garza Lubbock

There are also supporting counties that have re-aligned with the SPEMS organization for RAC participation.

SPEMS SUPPORTING COUNTIES

Castro	Lamb	Hale	Floydada	Motley	
Cochran	Hockley	Lubbock	Crosby	Dickens	
Yoakum	Dawson	Kent	Garza	Gaines	Howard

SYSTEM PLANNING PARICIPATION

RAC reorganization meetings were announced via the SPEMS e-mail system as well as at the quarterly RAC meetings.

Original RAC organizational meetings- RAC notices were mailed from the main SPEMS office to the following:
County judges, mayors and various elected officials; city councils and county commissioners; health care facilities- administrators and identified key personnel, financial officers, public relations, ENA members and ER nurses, physicians form various specialty areas; EMS agency director and identified key personnel; county and/or city clinics; SPEMS Executive Board members; SPEMS Committee chairs and committee members; Public service agencies- American Red Cross, Department of Public Safety, Non-profit community health and safety agencies; media organizations- regional television networks and newspaper.

At each previous RAC meeting, a general roster is placed for the attendee to sign in by name and representing facility. These rosters serve as a means of tracking participation sand representation at the RAC meetings.

Participation is defined as individuals or entities representation actively pursuing interest and involvement in the RAC. This participation includes involvement in the priorities, goals, objectives and mission statement approved by the RAC. Specific requirements for attendance defining active participation include:

1: General membership attendance of 50% of TSA-B general meetings.
2: Executive board attendance at 66% of TSA-B Executive board meetings.
3. Attend 3 QI and 2 other meetings within fiscal year. Definitions of participation, sign in for other services and other definitions related to meeting attendance are outlined within the bylaws and within this plan.
4. Annual completion of Regional Needs Assessment.
5. Each TSA-B individual member will participate in at least on Standing Committee.
6. Each member Hospital and EMS member organization will participate in Quality Management/Bypass & Diversion/Trauma Registry Committee.

REORGANIZATION PLANNING MEETINGS

Copies of Minutes and rosters are available through the SPEMS office (RAC reorganization committee functioned under the SPEMS/RAC until Approval from DSHS was obtained)

RAC COMPONENTS AND COMPONENT ISSUES

SYSTEM ACCESS

OBJECTIVES: The system Access component of the BRAC plan will:

1. Provide overview of the current 911 and enhanced 911 system in place
2. Define the communication network with in the TSA
3. Describe strengths, weaknesses, current resources, and long term objectives for system Access.

NEEDS ANAYLISIS: The SPEMS office has completed a needs assessment of current communications. This assessment addressed communication capabilities. The 911 interface is coordinated through state efforts and regional efforts.

RESOURCES: Resources currently available include 911 basic, 911 enhanced, Automatic Number Identification(ANI) and Automatic Location Identification (ALI) which are available in enhanced 911 only. All systems are enhanced 911 with different levels of service. There are dedicated trunk lines which allow direct routing of emergency calls. Routine is based on the telephone exchange area, not municipal boundaries There are no basic 911 systems within the South Plains region.

CURRENT WORK: Primary emergency communication systems for public access is Enhanced 911. The emergency communication systems were implemented providing citizens access to emergency communication to municipalities and counties (incorporated and unincorporated) in the TSA. 911 calls are routed to the local telephone company central office and then a telephone number or ANI is attached to the voice and sent to PSAP (Public Safety Answering Point). With ALI and SR, the call is sent to the telephone central office and the computer (911 Database) assigns an address to the phone number, then routes the call to the designated PSAP.

ANI is a system capability that enables an automatic display of the seven-digit number of the telephone used to place the 911 call. ALI enables automatic display of the calling party's name, address and other information.

Alternate routing (AR) is a selective routing feature, which allows 911 calls to be routed to a designated alternative location if all incoming 911 lines are busy.

Selective routing (SR) is a telephone system that enables 911 calls from a defined geographical area to be answered at a pre-designated PSAP (public Safety Answering Point).

COMMUNICATIONS NETWORK

The south Plains Association of Governments administers the South Plains 911 Emergency Communications Systems. The communications system includes the following counties:

Bailey (ALI)	Floyd (ALI)	Crosby (PC/ALI)
Hockley(ALI)	Dickens (PC/ALI)	Hale (ALI)
Motley (ALI)—	Floyd Terry (ALI)	Kent (PC/ALI)-Dickens
King (PC/ALI)-Dickens	Stonewall (PC/ALI)-Dickens	Yoakum (ALI)
Cochran (PC/ALI)	Lamb (ALI)	Garza (PC/ALI)
Lynn (PC/ALI)		

The Lubbock Communications District (LECD) administers the emergency communications system for the city of Lubbock, Lubbock County and the cities of Abernathy and Plainview.

The LECD contingency plan for the 911 systems includes redundancy of all communication links, with alternate routing capabilities for either system overflow or evacuation of any of the communication center; Each center is equipped with an emergency backup power source and ring down circuits connection each 911 answering point. Connectivity is available through the cellular network, as well as radio communication.

All coin operated telephones in the South Plains region are programmed to offer free 911 access.

Public education has been implemented to target all residents. Curriculums, videos and other public education materials are available for use in educating the public to the 911 system.

LONG TERM OBJECTIVES:

1. To provide 911 access with enhancements are financially available to the citizens, communities and services within the South Plains TSA.

COMMUNICATIONS

OBJECTIVES:

1. To provide communication access to EMS providers, hospitals and the public.
2. Define communication centers and dispatch centers for TSA-B
3. Describe educational requirements for the persons providing dispatch

NEEDS ANALYSIS:

An analysis of the communication structures was done by SPEMS in 2001. This analysis reviewed the current communication system, equipment and dispatch centers.

RESOURCES:

LUBBOCK DISPATCH CENTER: Lubbock County EMS maintains an emergency dispatch system at University Medical Center (UMC). All dispatch personnel are verified by the Texas Department of Health (DSHS) as Paramedics and/or Emergency Medical Technicians (EMT). All dispatch personnel are trained in Medical Priority for pre-arrival instructions. This dispatch center is classified as the Regional Communication Center for the RAC. A full communication manual is in place and oulines review procedures, frequency of reviews and other aspects related to ensuring quality care through this center.

Continuing education is offered at the School of Allied Health at Texas Tech University and at a variety of other locations throughout Texas.

There is formal training conducted at UMC. Medical Priority Dispatch Pre-arrival Instructions are used. APCO Institute Criteria Based Dispatch Guide Cards are also utilized.

Dedicated 800 number: 1-800-496-6644

AEROCARE DISPATCH CENTER: A dispatch center is located at the Aerocare hanger. All dispatch personnel are verified paramedics. All have a formal training program conducted at the facility with written protocols and guidelines. This dispatch center is utilized for the Covenant Health System (CHS) Air Medical transport service.

Dedicated 800 number: 1-800-9872862

CURRENT WORK:

There are ultra frequency (450-470 MHz) radio capabilities in Lubbock County and throughout the South Plains EMS region. Within the radio band, ten paired sets of frequencies are reserved for EMS communications and nave been assigned. Duplex multiplex four-channel equipment is operational for ambulance- to- dispatch, an ambulance-to- hospital and hospital-to-hospital. Aercmedical capabilities are also available.

Full regional telemetry is available. Mobile units can communicate with any equipment with a centracom hospital control console for EMS communications. Outlying communication capabilities are also available.

Lubbock police and fire department frequencies are programmed in all mobile and portable radios. Provisions made for communications with those agencies are for contacting fire crews at LIA for coordination during an EMS response at the airport. Regional EMS services have the ability to communicate with all public safety agencies via VHF/UHF frequencies.

EMS services are working with the City of Lubbock on multi-agency response.

LONG TERM OBJECTIVES:

1. Continue discussions with City of Lubbock on integration of services with multi-agency responses.
2. Upgrade communications systems to meet growing needs of the South Plains Region.

MEDICAL OVERSIGHT/MEDICAL CONTROL

OBJECTIVES:

1. To provide medical leadership for trauma care provided throughout the South Plains.
2. To describe the Quality Management process for trauma patient care review through the continuum
3. To determine medical direction and protocols for utilization by EMS services within TSA-B.

NEED ANALYSIS:

An ongoing assessment is done by the EMS services through revisions of protocols for trauma care. This direction is overseen by the Medical Director of SPEMS with assistance from the SPEMS office staff. Quality Management sets up yearly indicators for review based on statistical data and findings from meetings.

RESOURCES:

EMS MEDICAL OVERSIGHT: TSA-B is both urban and rural. The medical Director for SPEMS is Dr. Fred Hagedorn, M.D. and Assistant Medical Directors Dr. John Griswold, Craig Rhyne and Dr. Joe Sasin. All four are Board Certified and experienced in trauma care in both the prehospital and hospital arena.

Medical Direction is provided at both a regional and local level to EMS services that request this service. Protocols are reviewed and revised yearly. Education is provided on these revisions via a structured action plan.

Continuing education and EMS QI review is conducted by trained provider personnel under the direction of the Medical and Associate Medical Directors. These reviews are scheduled at least monthly in areas of the region covered by SPEMS. This includes skill performance, practice and run reviews.

EMS Medical Direction participates in continuing education and outreach programs. It also participates in protocol, bypass and diversion decisions and emergency disaster preparedness. Specific reviews are made at the regional level on scene times, QI issues, and issues specific to that service.

EMS run report data is collected and submitted through an established system to the DSHS registry department. Data sets have been developed.

Field command is defined within the Disaster/Mass Casualty portion of the EMS system. A regional plan is being addressed though cooperative efforts with EMS, hospitals, and the City of Lubbock.

HOSPITAL MEDICAL OVERSIGHT: Triage, patient delivery decisions, treatment and transfer protocols specific for hospitals are integrated into the TSA-B trauma plan. These include both pre-hospital and hospital information. These portions of each facilities trauma plan outline the role that they play in the stabilization, resuscitation, admission, and/or transfer of patients within our TSA. Each facility maintains a trauma manual, which references each of these areas.

Medical oversight for the trauma programs within each facility is defined with a Medical Director responsible for trauma. Medical oversight to regional facilities via EMS is the responsibility of the Emergency Department physician and/or regional EMS protocols.

LONG TERM OBJECTIVES:

1. Continue to provide quality EMS services to the citizens of TSA-B based on protocols, guidelines, review and quality improvement activities
2. Provide optimal care medical direction through hospitals and EMS services to ensure quality trauma care

PREHOSPITAL TRIAGE CRITERIA

OBJECTIVES:

1. To provide optimal treatment to trauma patients by ensuring that the right patient goes to the right facility in the right amount of time

2. To provide a framework for pre-hospital providers to make informed decisions related to patient presentation and ultimate disposition.
3. To describe the anatomic, physiologic, mechanism of injury and co-morbid factors in the decision making process for patient triage and disposition.

NEEDS ANALYSIS:

Pre-hospital triage criteria are reviewed in protocol review and revision a yearly basis. The standard for these is based on the "Optimal Care" Guidelines developed by the American College of Surgeons Committee on Trauma and the Emergency Physicians Medical Association.

Current resources include SPEMS protocols for all levels of pre-hospital care. These protocols are based on nationally recognized standards of care. Coordination and standardization of pre-hospital care is provided by the Texas Department of Health Bureau of Emergency Management through established regulatory mechanisms. Protocol updates are provided to all pre-hospital providers.

Aerocare has standardized care protocols and is CAAMS certified. Their protocols are reviewed and revised yearly.

CURRENT WORK:

Established pre-hospital triage decisions are contained within this document. Case reviews are done to analyze and evaluate specific patient care situations and provide recommendations to service providers.

Hospitals are notified via established radio and communications systems of incoming trauma patients.

Pediatric trauma patients are diverted to Covenant Children's Hospital.

LONG TERM OBJECTIVES:

1. To provide current up-to-date information to pre-hospital providers to triage trauma patients appropriately.
2. To continue to monitor, revise and review pre-hospital triage protocols and make changes accordingly.

DIVERSION POLICIES

OBJECTIVES:

1. To develop a hospital plan for diversion of trauma patients.

2. To ensure that communication is in place when diversion form a facility occurs.
3. To provide a written plan with review when diversion within a facility occurs.

NEEDS ANALYSIS:

A review of current practices was done with the inception of the RAC. Recent reviews related to diversion status, bed availability and ED capacity have been done. All hospitals within the TSA have a written Diversion policy, which has been submitted to the RAC.

RESOURCES:

Resources for diversion policy development were within the network of Trauma Coordinators within the State of Texas.

CURRENT WORK:

Each hospital within the TSA that is designated has a written diversion policy. The policy includes but is not limited to:

1. Designated person to place facility on diversion
2. Procedure for placing facility on diversion
3. Reasons for diversion which include:

   a. trauma surgeon no available
   b. internal disaster
   c. specialty surgeon not available
   d. specialty equipment not available

4. Record keeping related to why diversion occurred
5. Ability to opening of critical care beds
6. Mass Casualty protocol and how to activate region wide plan
7. Diversions must be reported through the RAC QI committee monthly.

LONG TERM OBJECTIVES:

1. Provide mechanism for reporting and reviewing hospital diversions with TSA-B to ensure proper patient disposition.
2. Describe role that diversions play in future planning within TSA-B.

BYPASS POLICIES

OBJECTIVES:

1. To provide guidelines for pre-hospital providers to bypass facilities

2. To describe exceptions to bypass guidelines
3. To ensure that all participating members of TSA-B are aware of bypass guidelines

NEEDS ANALYSIS:

A review of hospital capabilities was done at the inception of the RAC. This review allowed information for the development of guidelines for bypass. The RAC bypass-diversion committee developed guidelines, which are attached within the plan.

RESOURCES:

Resources utilized in the determination of bypass guidelines were the American College of Surgeons Committee on Trauma, American College of Emergency Physicians and DSHS.

CURRENT WORK:

Transport protocols must ensure that patients who meet triage criteria for activation of the regional trauma system will be transported directly to an appropriate trauma facility rather than to the nearest hospital except under the following circumstances:

1. If unable to establish and/or maintain an adequate airway, or in the case of traumatic cardiac arrest, the patient should be taken to the nearest acute facility for stabilization.
2. If expected transport time is excessive (greater than 25 minutes) or if a lengthy extrication time (greater than 15 minutes) is expected, consider contacting air medical services.
3. A rendezvous with other ground transport or air medical service may occur on hospital property or other secure area. If hospital staff provide medical assistance to patient(s) waiting rendezvous outside their facility, then the following would apply:

    a. The receiving hospital should be notified of the assistance that was provided.
    b. Assistance rendered, by whom, the patient response and reasons for assistance should be documented on the EMS run report and/or transporting service report.
    c. It is expected that the assistance rendered will not delay patient transport to a tertiary care center.
    d. The hospital must follow all provisions of the COBRA/METALA rules when providing assistance.

4. A level III or IV facility may be considered for immediate evaluation and stabilization if expected transport time to a lead facility is excessive (greater than 25 minutes)
5. Medical control may order bypass in any of the above situations as appropriate, such as when a facility is unable to meet hospital resource criteria or when there are patients in need of specialty care.

NOTE: If there is any question regarding whether to bypass a facility on-line medical control should be consulted for the final decision. RAC facility triage criteria for bypass should be considered.

CONSIDERATIONS: Criteria for consideration for air medical transport of trauma patients include but are not limited to:

1. Lengthy extrication and patient injury severity.
2. Mechanism of injury
   a. structural intrusion into patient space in vehicle
   b. patient ejection form vehicle
   c. death in same vehicle
   d. pedestrian struck at greater than 20 mph
   e. unrestrained patient with overturned vehicle
   f. motorcyclist thrown from bike at greater than 29 mph
   g. front bumper displaced to rear by more than 30 inches or front axle displaced to the rear
   h. fall greater than 20 feet in adult and more than 1.5 times the pediatric patient height
   i. penetrating injury between mid thigh and the head
   j. amputation or near amputation with possible timely reimplantation
   k. scalping or degloving injury
   l. severe hemorrhage. Patients with BP less than 90 systolic after initial volume resuscitation and those requiring ongoing blood or fluid for stabilization
   m. 2nd and 3rd degree burns greater than 15% or major burns to face, hands, feet, perineum or associated airway or inhalation injury.
   n. Patient with injury or potential injury to spinal cord, spinal column or neurologic deficit.
   o. Injuries to face or neck which might result in an unstable or potentially unstable airway and might require invasive procedure to stabilize the airway.
   p. Altered objective ranking score for trauma (i.e. RTS,TS,CRAMS, etc.)
   q. Child less than 5 with trauma injuries
   r. Age greater than 55 and multiple trauma injuries, with or without co-morbid factors such as diabetes, heart disease, etc.
   s. Respiratory rate greater than 30 or less than 10 in adult trauma patient. Heart rate greater than 120 or less than 60.

LONG TERM OBJECTIVES:

1. To provide guidelines for facility bypass
2. To provide bypass overrides related to patient stability.
3. To review facility bypass at QM level and address issues and problems related to bypass.

FACILITY TRIAGE CRITERIA

OBJECTIVES:

1. To categorize patient and determine facility transport and/or transfer
2. To specify facility action plan for determination of patient transport and/or transfer
3. To include pediatric and burn criteria for patient transport and/or transfer

NEED ANALYSIS:

Hospital capability assessments were done within facilities within TSA-B with initial RAC development and trauma center verification. These analysis reviewed physician, physical, and staffing capabilities related to each facility. The Bypass-Diversion committee of the RAC developed the triage/transfer decision scheme to serve as a model for TSA-B. It is an algorithm approach to differentiation patient categories as well as mechanism of injury for activation within facilities.

RESOURCES:

Resources utilized include physical plant review, staffing issues, and physician availability and specialty, and equipment capabilities. Resources in determination included the American College of Surgeons Committee on Trauma guidelines.

CURRENT WORK:

Patients are categorized into critical and urgent categories for this decision scheme. This assists facilities in determining which trauma patients should be transferred. It includes the facilities that should admit patients and those that should stabilize and transfer. Hospitals present transfer data at the RAC QM meeting to review types of patients being transferred as well as patients with extended lengths of stay within their facility (greater than 2 hours from arrival to disposition).

The two major facilities in Lubbock re-classify their patients into levels of activation when notified of impending trauma transfers/transports.

Interfacility transports are made to tertiary care centers for definitive and specialized care. Transfer to the appropriate facility is based on this criteria.

Written transfer agreements are in place. Regional transports into the tertiary care centers can be facilitated through the regional transfer line or Aerocare.

LONG TERM OBJECTIVES:

1. To monitor appropriateness of transfers form regional facilities
2. To review timeliness of transfers from regional facilities
3. To ensure appropriate transfers to tertiary care centers

DESIGNATION PLAN FOR FACILITIES

16 of the 20 hospitals within TSA-B are designated as trauma centers. The Trauma Coordinators Committee will allow for open dialogue related to trauma within our TSA. There is a good working relationship and openness between all trauma coordinators within the TSA. The tertiary care centers assist Level IV facilities in their redesignation process as requested. The trauma coordinators within the TSA meet to address specific trauma and care issues. This committee reports to RAC general membership at the quarterly meetings.

SYSTEM QUALITY IMPROVEMENT PROGRAM

OBJECTIVES:

1. To provide a forum to discuss care issues related to trauma.
2. To monitor specific care issues on a monthly basis related to trauma.
3. To provide a forum to direct care issues to entities involved.

NEEDS ANALYSIS:

The QM committee began as an offshoot of the Medical Direction Committee within the TSA. The QM committee has met monthly since it's inception. This committee reviewed the needs of the region and indicators are adopted yearly for RAC input, analysis and review.

RESOURCES:

Resources for the development of this committee came form a variety of sources that include DSHS, American College of Surgeons, other RACs within the state and the Texas Trauma Coordinators Forum.

CURRENT WORK:

The QM committee meets monthly and has specific indicators for review form all participants in the RAC. The committee maintains confidentiality and has a structured

action plan. Minutes are kept and data is tabulated to look at the overall issues related to trauma and trauma care within the TSA.

LONG TERM OBJECTIVES:

1. Interface regional data from entire RAC to see true trauma picture
2. Review regional data and formulate an action plan related to care and injury prevention based on this specific regional data.
3. Provide participants accurate data related to trauma in the TSA-B RAC.

TRAUMA SERVICE AREA--- B Regional Trauma Treatment Protocols

PURPOSE:

The purpose of this document is to categorize the components of regional trauma treatment protocols for designated trauma facilities. Each hospital is responsible for the completion of these protocols and standard of care. This document will serve as a listing of essential criteria that is required for each trauma service.

COMPONENTS:

The following are essential criteria for treatment as defined by the Texas Department of Health. These components are integrated into hospital quality improvement and educational activities for every designated trauma facility in TSA-B.

1. Assessment, resuscitation, and stabilization
2. Education and skill assessment
3. Appropriateness and quality care reviews
4. Participation in RAC QI process

PROTOCOL:

Every designated facility will have the following in place. These guidelines provide and overall summary of activities. The methods of implementation will be determined by each individual hospital and will be documented within their trauma service QI plan. A manual of existing and working protocols will be in place at each designated facility and readily available for nursing, medical and verification reviewer.

1. Assessment, resuscitation and stabilization of trauma patients. All persons providing medical and nursing care of trauma patients will meet established guidelines from DSHS. These may include but are not limited to:
    a. ATLS, BTLS, PHTLS, TNCC and PEPP

b. ATLS and mandated by DSHS and American College of Surgeon Guidelines
c. TNCC as mandated by DSHS

Documentation of such certifications and/or requirements will be maintained by each facility and will be available for review at the time of verification review.

Ongoing education in these areas will be provided to nurses and physicians within the region in the form of outreach educational activities, conferences, etc.

2. Education and skill assessment—Each facility will provide educational opportunities for the staff caring for trauma patients (internal and/or external). The mechanism for this will be determined by each facility. A record of these activities will be provided for review at the time of verification.

   a. treatment guidelines, policies/procedure and standards of care for trauma patients will be in place at each designated facility. These guidelines will be reviewed at the time of redesignation and will be updated to meet current standards of care per each hospitals policy.

      These will include but will not be limited to :

      1. multiple trauma patients
      2. activation criteria
      3. trauma team composition
      4. care of head injured patients
      5. care of the pediatric trauma patient
      6. hypothermia
      7. massive transfusion
      8. hospital admission and transfer criteria
      9. specific equipment/procedures related to trauma care
         a. chest tube insertion
         b. crichothyrotomy
         c. blood and fluid warmers

3. Appropriateness and quality care review

   Appropriateness and quality care reviews will be done by each designated facility. These reviews will be determined within their facility. Chart audits of nursing, physician and ancillary care will be done. The quality improvement "loop closure" mechanism will be used. The methods for this completion will be determined through a variety of mechanisms, which might include:

   a. chart audits
   b. multidisciplinary team QI meetings

c. physician and medical staff reviews
d. regional quality reviews
e. interstate quality reviews

A formal QI plan for this review and the overall review by the medical director for appropriateness and quality of care will be in place in each designated facility. This review will be viewed as protected.

4. Participation in RAC QI activities will follow established meeting requirements as determined in the TSA-B RAC plan.

PROVIDER/Pre-HOSPITAL EDUCATION COMMITTEE

PURPOSE: The purpose of the Provider/Pre-hospital Education Committee is to prove a forum and coordinated effort for all SPEMS providers for trauma care provisions within BRAC. The Provider committee will:

1. address specific issues related to pre-hospital care provided to all trauma patients within BRAC
2. discuss trauma care issues and education needs and opportunities
3. provide a forum for all pre-hospital providers to discuss, coordinate, plan and facilitate pre-hospital activities within BRAC
4. assist pre-hospital providers in improving, evaluation and determining trauma care needs
5. include oversight and direction of needed, recommended and required pre-hospital education

MISSION: To provide and make recommendations for standardization and coordination of SPEMS activities within the framework of the BRAC

STRUCTURE:

The committee make up will include representation form all SPEMS providers within BRAC. Membership is voluntary. The committee will have an elected Chair who will be responsible for notification of meetings, minutes and follow up with and through appropriate SPEMS and BRAC committee and officers.

GOALS:

Long Term:

1. Work with BRAC in coordination of trauma activities to provide pre-hospital care within established guidelines and protocols

2. Work on on-going coordination regarding communication, dispatch, medical control and educational needs of SPEMS providers.

Short Term:

1. Develop relationships within BRAC to facilities SPEMS trauma care provision
2. Make recommendations for standardization of SPEMS responsibilities and protocols within the BRAC
3. Define standard treatment protocols for trauma care and integrate into and educational program with hospital staff in their understanding and implementation
4. Define educational needs on an annual basis and provide educational opportunities for the pre-hospital providers

MEETINGS: This committee will meet at least quarterly.

ADMINISTRATOR'S COMMITTEE

PURPOSE:

The purpose of the Administrator's committee is to:

1. Assist the BRAC in addressing specific issues related to hospital care of trauma patients.
2. Address administrative concerns and issues related to trauma care.
3. Provide a method to disseminate information within the administrative.

MISSION:

The mission of the Administrator's Committee is to provide and make recommendations regarding the trauma care provided within their institutions and in coordination with other members of the BRAC, as well as to make recommendations regarding the overall operations and functions of the BRAC as a whole in an effort to assure that the BRAC operates as efficiently and effectively as possible.

STRUCTURE:

Representation on the Administrator's Committee is form all hospitals within the BRAC. AN elected chairperson will set meeting dates and times for this

committee. This committee will produce minutes of all meetings and report its activities at BRAC Executive Board and General Membership meetings, as requested by the Executive Board Chairperson.

GOALS:

Long Term

1. Provide a forum for continuing cooperative efforts related to regional trauma care.
2. Make recommendations concerning administrative factors relating to BRAC trauma capabilities.

Short Term

1. Provide comment and recommendations related to facility bypass and diversion capabilities and mass casualty capabilities
2. Assist BRAC on administrative control issues and administrative interface with SPEMS

MEETINGS:

This committee will meet at least quarterly.

MEDICAL DIRECTION COMMITTEE

PURPOSE:

The purpose of the Medical Direction Committee is to provide a forum for physicians within BRAC to discuss trauma needs, formulate action plans and plan educational activities within the BRAC.

MISSION:

The mission of the Medical Direction Committee is to provide general oversight of trauma activities within BRAC form the physician point of view while providing a mechanism for physicians to address issues directly affecting them.

STRUCTURE:

The structure of the Medical Direction Committee is physicians within BRAC providing trauma care. These include but are not limited to physicians who routinely provide trauma care. These include but are not limited to physicians who routinely provide trauma care and Medial Directors. A chair will be elected and will maintain minutes and will provide an overview of activities at the BRAC meetings.

GOALS:

Long Term:

1. Provide an open forum for physicians to address issues specifically related to them as related to trauma within the BRAC.
2. Provide the initial forum, which will interface with other physicians within the State of Texas providing trauma care.

Short Term:

1. Provide an opportunity for physicians within the BRAC to discuss current trauma care within our region
2. Determine needs of physicians within the BRAC

MEETINGS:

This committee will meet at least quarterly.

TRUAMA COORDINATORS/HOSPITAL EDUCATION COMMITTEE

PURPOSE:

The purpose of the Trauma Coordinators Committee is to address issues related to trauma care through the continuum of care and to provide dissemination of this information within their institutions and to provide educational opportunities to regional providers.

MISSION:

The mission of the Trauma Coordinators Committee is to facilitate improved understanding of trauma issues that directly effect trauma care within the BRAC as well as education. It will be orchestrated through the efforts of the trauma coordinators and other health care providers.

STRUCTURE:

Regional trauma coordinators. A chair will be elected and will maintain minutes of meetings as well as provide a report at the BRAC meetings.

GOALS:

Long Term:

1. Provide a forum within our BRAC to address trauma issues
2. Coordinate efforts, which will provide an evaluation of care, provided to trauma patients within our BRAC.

Short Term:

1. Institute a mechanism to address issues that effect the care of the trauma patient within our BRAC
2. Provide a forum, which can discuss and improve QI within our facilities

MEETINGS:

Meetings will be held at least quarterly.

QI/BYPASS-DIVERSION/REGISTRY COMMITTEE/PEDIATRICS

PURPOSE:

The purpose of this committee is to provide a forum and coordinated effort in reviewing, implementing and revising existing care provided to trauma patients within the RAC throughout the continuum of care, while reviewing age specific issues related to trauma.

MISSION:

The mission of the QI/Bypass-Diversion/Registry/Pediatric Committee is to provide evaluation of care provided to trauma patients. It will review QI issues, bypass and diversion and registry information related to trauma within our region.

STRUCTURE:

The committee make up will include representation form all EMS services, hospitals and other interested persons within TSA-B. This is an open committee. A structured QI plan is written and yearly review of information and indicators is made. Indicators are based of evidence based data related to trauma within our TSA.

GOALS:

Long Term:

1. Work to coordinate State registry data with regional information.
2. Develop indicators specific to TSA-B based on registry data from State
3. Increase EMS and hospital involvement within this committee.
4. Develop indicators that are relevant to all care providers within TSA-B.
5. Implement a regional trauma registry.

Short Term:

1. Increase participation within committee.
2. Develop QI reporting tool, which will show continuum of care.
3. Utilize current registry data to determine QI committee indicators for review.
4. Review/revise bypass and diversion plan yearly.
5. Review bypass-diversions at QI meetings
6. implement regional registry
7. Integrate pediatric specific indicators for review into the current QI structure.

MEETINGS:

Meetings are held the third Tuesday of each month at the Knipling Education Center at Covenant Medical Center.

INJURY PREVENTION

PURPOSE:

To decrease mortality and morbidity in the TSA-B region through a unified outreach approach. To Integrate injury prevention efforts through the QI committee of the RAC to prevent duplication of services and an overall view of the trauma issues and problems affecting the citizens of this region.

MISSION:

To provide education and technical assistance to the citizens of West Texas to determine injury prevention vulnerability and to establish an Injury Prevention Network in each community to decrease mortality and morbidity.

STRUCTURE:

Established stand alone Injury Prevention Coalition of the South Plains which will serve as the Injury Prevention resource for the RAC>

GOALS:

Long Term:

1. Reduce mortality and morbidity in West Texas
2. Interface with Injury Prevention networks within the Southwest
3. Develop a strong unified approach to injury prevention with all partners in the RAC

Short Term:

1. Develop injury prevention coalitions within each community of the RAC.
2. Implement region wide injury prevention activities.
3. Coordinate the RAC mission with the IPCSP mission to provide uniform education and presentations to the citizens of West Texas.

MEETINGS:

Meetings are held quarterly at the Knipling Education Center.

MUTUAL AID/MASS CASUALTY/CISM

PURPOSE:

The purpose of this committee is to establish a regional, organized approach and system for mutual aid, mass casualty response, RRAMS response and utilization and Critical Incident Stress Debriefing.

MISSION:

The mission of this committee is to proved and organized, systematic method to deal with mutual aid, mass casualty, rapid response and stress debriefing in the RAC.

STRUCTURE:

Multi-agency participation

GOALS:

Long Term:

1. Include providers outside of EMS in the regional aspects of this committee.
2. Specifically outline roles on the regional plan and it's interface with the hospitals, cities and state plans.

Short Term:

1. Provide updated information on each committee to entire RAC to solicit their input and interactions on this committee and within the organizations that support them.
2. Specifically outline the key players within each discipline and provide an overview of the responsibilities of each to the general RAC.

MEETINGS:

Meetings are held quarterly.

FINANCE COMMITTEE

PURPOSE:

The purpose of this committee is to provide leadership and oversight related to RAC expenditures and funding. This committee will provide the basic foundation for RAC financial accountability. The committee will review monthly expenditures, investments, etc.

STRUCTURE:

Elected form the total membership of the Executive Committee

GOALS:

Long Term:

1. Maintain financial stability for the RAC.
2. Oversee operational expenses and funding for the RAC.

Short Term:

1. Develop working guidelines and standard operating procedures with reporting accountability to the general membership of the RAC.
2. Develop a sound financial budget and plan for the RAC.
3. Develop improved accounting measures for RAC monies.

MEETINGS:

Meetings will be held at a minimum of quarterly. Report will be presented at all Executive and General membership meeting.

MEMBERSHIP/BYLAWS COMMITTEE

PURPOSE:

The purpose of the membership/by-laws committee is to provide a yearly review of the by-laws and submit amendments for review and approval by the Executive committee and submit to the General Membership for their review. This committee will also work to increase and improve RAC participation.

MISSION:

The mission of the Membership/by-laws committee is to provide guidance and assistance to the RAC in ensuring that the membership remains active as well as providing a forum for amendments to current by-laws to be made and adopted.

STRUCTURE:

Elected from total membership of the general membership.

GOALS:

Long Term:

1. Provide stable by-laws for RAC organization and functioning.
2. Develop time table and schedule for by-law changes.

Short Term:

1. Provide overview of new RAC by-laws to Execute Committee and general membership.
2. Assist with education of RAC entities on new by-laws.

MEETINGS:

Meet annually or as directed by Executive Committee

NOMINATING COMMITTEE

PURPOSE:

The purpose of the nomination committee is to provide the general membership with a list of persons who will be selected form the General membership with a list of persons who will be selected from the General membership to serve on the Executive Board and chair committees or other areas of the RAC.

MISSION:

The mission of the nominating committee is to provide qualified persons for presentation to the General Membership of offices and other areas of RAC.

STRUCTURE:

The nominating committee will be appointed by the Executive Committee of the RAC.

GOALS:

Long Term:

1. Provide a consistent method of selection of candidates that are qualified and interested in holding positions within the RAC.
2. Initiate a system within the RAC to solicit nominations from the general membership.

Short Term:

1. Determine committee structure, standard operation procedures and any other areas that will assist this committee in ensuring appropriate persons for their nominated positions.

MEETINGS:

Meeting will be held as called and determined by need.

GRIEVANCE COMMITTEE

PURPOSE:

The purpose of the Grievance Committee is to assist in the identification and resolution of issues related to patient care delivery within the RAC or other issues that cannot be resolved with face to face interactions.

MISSION:

The mission of the Grievance Committee is to be an impartial panel to review, render judgment and assist with implementation of solutions related to grievances submitted within the RAC.

STRUCTURE:

The committee will be comprised of general membership and Executive Committee members who have no conflicting interests in the resolution of dispute. This will serve as an Ad Hoc Committee of the Executive Board.

GOALS:

Long Term:

1. Develop system for issue resolution in an impartial and non-biased manner.
2. Implement a system for grievance resolution within the framework of the RAC.

Short Term:

1. Specify membership on committee
2. Determine membership responsibilities.
3. Develop follow through loop closure resolution form
4. Determine standard operation procedures for the committee.

MEETINGS:

Meeting as called by Executive Board.

NEWSLETTER/WEB PAGE COMMITTEE

PURPOSE:

To develop a newsletter and web page to be used within the TSA.

MISSION:

Mission of the newsletter and web page committee is to provide the entities involved on the RAC a mechanism for up to date information related to the RAC, RAC committees, education and meetings in timely manner.

STRUCTURE:

Elected from total membership of the RAC under the direction of the Executive Board.

GOALS:

Long Term:

1. Develop an interactive web page
2. Develop a tool for dissemination of information via electronic media versus conventional postal routes to decrease costs to the RAC.

Short Term:

1. Design a team to work on the newsletter and the web page.
2. Implement and develop standard operating procedures for this committee.
3. Established goals and directions for these projects.

MEETINGS:

As needed.

Meeting date reviewed or revised by the general membership:

Date Reviewed:	**Date Revised**
7/18/06	