



**BOARD OF DIRECTORS
QUARTERLY MEETING /
ANNUAL MEETING**

JULY 17, 2023



Chairman	David Persse, MD
Vice Chairman Hospital Services	Tom Flanagan
Vice Chairman Pre-Hospital Services	James Campbell
Secretary	Walter Morrow, RN, CFRN, EMT-P
Treasurer	Lon Squyres
Officer-at-Large	Brent Kaziny, MD MA
Chief Executive Officer	Lori Upton

SouthEast Texas Regional Advisory Council (Trauma Service Area Q)

Austin, Colorado, Fort Bend, Harris, Matagorda, Montgomery, Walker, Waller, and Wharton Counties

SETRAC BOARD OF DIRECTORS QUARTERLY MEETING / ANNUAL MEETING

July 17, 2023

LOCATION – SETRAC Conference Center - 1111 N. Loop West, Suite 160, Houston, TX 77008

1) CALL TO ORDER (6:30 P.M.) and ROLL CALL

**David Persse, M.D./
Walter Morrow, RN, CFRN, EMT-P**

2) WELCOME

David Persse, M.D.

3) NOMINATIONS COMMITTEE

Tom Flanagan

- a. Nominations for expiring board of director and officer positions
- b. Nomination for Walker County board of director position (unexpired term)

4) OFFICER REPORTS

- A. Chairman**
- B. Vice Chair Hospital Services**
- C. Vice Chair Pre-Hospital Services**
- D. Secretary**
- E. Member At Large**
- F. Treasurer**

**David Persse, M.D.
Tom Flanagan, BSN, MA, LP
James Campbell
Walter Morrow, RN, CFRN, EMT-P
Brent Kaziny, M.D.
Lon Squyres**

- a. Financial Reports

5) EXECUTIVE REPORT – Chief Executive Officer

- a. Preparedness and Response Report
- b. Emergency Healthcare Systems (EHS) Report

**Lori Upton, RN, BSN, MS
Lisa Spivey/Chris Collier
Suzanne Curran/Melanie Aluotto/
Clayton Ehrlich**

6) REMAINING ACTION ITEMS/BOARD CONSIDERATION

David Persse, M.D.

- A. Approval of Prior Meeting Minutes**
- B. Approval of Reports** (Financial, Leadership, Preparedness and Response, and EHS)
- C. Resolutions/Other Action Items**
 - a. Election for the Waller County representative position on the SETRAC Board of Directors
 - b. Election for expiring board of director positions
 - c. Election for expiring board officer positions

July 17, 2023 – Agenda (continued)

- d. Approval of the SETRAC Regional Trauma Plan
- e. Approval of Mechanism of Injury (MOI) Heat Maps for placement on SETRAC website
- f. Approval of the SETRAC Regional Cardiac Plan

7) GENERAL/OPEN DISCUSSION/AUDIENCE Q&A

David Persse, M.D.

8) ADJOURNMENT

David Persse, M.D.



Chairman	David Persse, MD
Vice Chair-Hospital Services	Tom Flanagan
Vice Chair-PreHospital Services	James Campbell
Secretary	Walter Morrow, RN, CFRN, EMT-P
Treasurer	Lon Squyres
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SouthEast Texas Regional Advisory Council (Trauma Service Area Q)

Austin, Colorado, Fort Bend, Harris, Matagorda, Montgomery, Walker, Waller and Wharton Counties

Board Meeting Minutes April 17, 2023

1. **CALL TO ORDER / ROLL CALL**

Tom Flanagan, Vice Chair Hospital Services, called the meeting to order at 6:35 pm on behalf of Dr. David Persse. The meeting was held in-person at the SETRAC Conference Center. Walter Morrow called roll and a quorum was established.

2. **WELCOME AND INTRODUCTION OF SPECIAL GUESTS**

Mr. Flanagan welcomed the board members and the stakeholders in attendance.

3. **NOMINATIONS COMMITTEE**

Mr. Flanagan reported that on April 18th, nominations will be open for expiring board member and officer terms. Nominations will be open for 30 days and will close on May 18th. Voting will take place during the July board meeting.

The board member terms expiring are as follows:

Houston Methodist Hospital System – Wayne Voss
Texas Children's Hospital – Dr. Brent Kaziny
Austin County – Walter Morrow
Harris County – Lon Squyres
Wharton County – Christy Gonzales
At-Large #2 – currently vacant

The officer terms expiring are as follows:

Treasurer – Lon Squyres
Vice Chairman of Pre-Hospital Services – James Campbell

Nominations are to be sent to Grace Farquhar at grace.farquhar@setrac.org.

The board discussed the consideration of bringing on a board member representing law enforcement and/or other disciplines that could be represented as well as a person with a skill set for cultivating philanthropy. Any suggestions for additional representation on the SETRAC board can be submitted to Lori Upton or Grace Farquhar for presentation to the Executive Committee.

Dudley Wait has been appointed by K.P. George (Fort Bend County Judge) as the nomination to replace Dr. Benjamin Oei as the representative for Fort Bend County.

4. OFFICER REPORTS

A. Chairman

Dr. Persse was unable to attend the meeting. There were no items to report.

B. Vice Chair Hospital Services

Mr. Flanagan had no items to report.

C. Vice Chair Pre-Hospital Services

James Campbell was unable to attend the meeting. There were no items to report.

D. Secretary

Mr. Morrow had no items to report.

E. Officer-at-Large Report

Dr. Brent Kaziny reported that a pediatric disaster tabletop exercise will be held on Thursday, April 20th, led by the ASPR Pediatric Disaster Care Center of Excellence for Region 6. Dr. Kaziny thanked SETRAC for their assistance with the exercise.

F. Treasurer Report

Lon Squyres provided an overview of the printed financial reports that were given to the board. Mr. Squyres stated that accounts are being spent as expected with no concerns.

An application for a refund for payroll taxes paid during COVID has been submitted.

5. EXECUTIVE REPORT

A written report was provided by Ms. Upton to the board. Highlights include:

- Focus is placed on the Texas Legislature regarding funding. DSHS has added an additional request for \$6.6 million for RACs to assist with cardiac, stroke, and other initiatives and \$5 million for EMTF. The senate recommended fully funding the EMTF request and providing RACs with 50% of the request (\$3.3 million).
- Several bills affecting healthcare are being followed including:
 - HB 624 and SB 1898 – concerning patient transport via fire truck.
 - HB 12 – supporting post-partum mothers by extending Medicare payments for 12 months.
 - HB 1147 – proposing lowering the age of children being trained in Stop The Bleed from 7th grade to 3rd grade and requiring an “alarm system” on STB kits.
 - SB 186-189 – concerning unpermitted boarding/group homes.
- Money is still available via Senate Bill 8 for EMS agencies that have individuals needing their initial EMT or paramedic training or for those wanting a higher degree of training.
- The following individuals have or will soon be joining the SETRAC team:

- Suzanne Curran – Director of Emergency Healthcare Services (Trauma, Pediatrics, Injury Prevention, and Stop the Bleed)
 - Melanie Aluotto – Director of Emergency Healthcare Services (Stroke, Cardiac, Perinatal)
 - Merjani “MJ” Garcia – Clinical Operations Specialist
- RAC rules have been updated as follows:
 - Neonatal rules will be approved in June.
 - Trauma rules will be open for public comment in August instead of June/July. If approved in August, the rules will not go into effect until January 2024.
 - Regarding the wristband initiative:
 - EMS rules will not change to include wristbands.
 - The only changes to the data dictionary for now are the use of UUID autogenerated numbers to cross-reference trauma and EMS patients.
 - The NEMSIS field DAgency06 will continue to be pulled for calculating EMS runs. Wristband numbers will be an optional field for now.
- An additional \$200,000 from PHEP excess funds has been received to resupply and refurbish the DPMU.
- A company has been hired to scan SETRAC records and documents, which will be retained according to the organization’s record retention policy.
- The SETRAC IT department continues to mitigate attacks on our IT system.
- **Preparedness and Response** – Lisa Spivey and Chris Collier provided the following update:
 - The annual regional functional exercise took place last week at Houston Tran star. Over 60 agencies participated. The AAR is currently being developed and will be posted to the SETRAC website once completed.
 - SETRAC assets were recently displayed in our North Corridor (Nacogdoches) and will be displayed in other corridors as well.
 - An MCI tabletop was conducted in Nacogdoches in February with 46 participants in different disciplines.
 - Work is continuing with the Behavior Threat Assessment team headed by Texas Department of Public Safety, Federal Bureau of Investigation, Houston Police Department, Harris County Sheriff’s Office, and local behavioral facilities with hospital and EMS partners.
 - Coordinators continue to work with EMS, public safety, and hospitals.
 - SETRAC assisted with the response to a tornado that struck in Deer Park in January which included successfully moving 64 patients from a nursing home.
 - Assets continue to be maintained and ready for operations with hurricane season approaching. A \$200,000 grant was received from UASI to upgrade the RCVQ.
- **Emergency Healthcare Systems** – Suzanne Curran provided the following update:
 - The Emergency Department workgroup continues to look at workplace violence and placement of mental health patients.
 - The Perinatal Committee is focusing on recognition and response to postpartum preeclampsia in the emergency department as well as best practices for breastmilk at discharge and antibiotic timeliness.
 - The regional cardiac plan is being developed by the Cardiac Care Committee. A community CPR/Stop the Bleed community event is being planned.
 - Wake up strokes and rehab utilization are being reviewed by the Stroke Committee. A boot camp for stroke coordinators is being planned for the fall.

- A meeting at SETRAC is planned for August when the trauma rules are opened for public comment. A trauma registry workshop will be held at the end of May. A revised copy of the regional trauma plan has been distributed to trauma facilities for review and input from trauma medical directors. Stop the Bleed education continues across the region.
- Injury Prevention Committee is looking at pediatric firearm and driver-pedestrian safety.
- The Pediatric Committee continues to work with the other committees and concentrating on the G7.

6. ACTION ITEMS

A. Prior Meeting Minutes

There being no further discussion or objections, the board approved the minutes as presented.

B. Reports (Officer, Finance, and Executive)

There being no further discussion or objections, the board approved the reports as presented.

The budgets for the 2023-24 fiscal year were presented to the board. The budgets were reviewed and approved by the Executive Committee prior to the meeting. There being no further discussion or objections, the board approved the minutes as presented.

C. Resolutions and/or Other Action Items

a. *Election for the Fort Bend County representative position on the SETRAC Board of Directors*

Dudley Wait was presented as the nominee for Fort Bend County. The board unanimously elected Chief Wait as a member of the SETRAC Board of Directors.

b. *Approval of revised SETRAC Bylaws*

The Section 3.3.1 of the SETRAC Bylaws have been revised to accurately reflect the change to the at-large representative positions as approved by the SETRAC Board during the quarterly meeting held on January 23, 2023.

There being no further discussion or objections, the board approved the revision to the names of the At-Large positions.

c. *Approval of elected leaders for the Pre-Hospital (EMS) Committee*

Elections were recently held for leadership of the Pre-Hospital (EMS) Committee. The list of elected leaders was presented to the board for approval.

There being no further discussion or objections, the board approved elected leaders.

d. *Approval to discontinue updating the COVID Data Report on the SETRAC website on May 11, 2023, due to the end of the COVID Public Health Emergency.*

SETRAC has maintained a report on COVID data on the SETRAC website for the general public. With the public health emergency (PHE) scheduled to end on May 11th, SETRAC would like to discontinue the report.

The board approved the request to discontinue the report shown on the SETRAC website with the ability of the report being made available again should there warrant a need to resume tracking data.

7. GENERAL / OPEN DISCUSSION

Mark Sloan made the following announcements:

- The RAC will most likely be engaged in the NCAA Football Championship at NRG in January.
- Resources may be requested/needed in Fredericksburg during the solar event in October due to an influx of visitors to the small town.
- There is a concern of fast developing storms coming off the Yucatan approaching the southeast Texas region during two-week windows of time during hurricane season, so awareness should be maintained throughout the season.

8. ADJOURNMENT

Mr. Flanagan adjourned the general board meeting at 7:20 pm.

SETRAC Board - Secretary: _____

SETRAC - June 30, 2023 YTD Expenditure Report (FY23)

(See Grant Summaries on Page 3 & 4 for Categorical breakdown of the grants)

	Grant	YTD Expenditures	Approved Budget	Variance	% Remaining	Month of Fiscal Year
*1	ASPR 23 - TSA Q	\$ 2,183,912	\$ 2,183,912	\$ -	0.0%	12/12
*2	ASPR 23 - TSA R	\$ 469,004	\$ 469,004	\$ -	0.0%	12/12
*3	ASPR 23 - TSA H	\$ 164,668	\$ 164,668	\$ -	0.0%	12/12
*4	ASPR 23 - EMTF 6	\$ 131,736	\$ 131,736	\$ -	0.0%	12/12
*5	ASPR 23 - EMTF 6 (State funds)	\$ 125,000	\$ 125,000	\$ -	0.0%	12/12
*6	RAC/EMS 2023	\$ 416,408	\$ 493,106	\$ 76,698	15.6%	10/12
*7	RAC Systems Development 2023	\$ 201,846	\$ 219,637	\$ 17,791	8.1%	10/12
*8	County Pass Thru 2023	\$ -	\$ 412,655	\$ 412,655	100.0%	10/12
*9	HFD Base Station	\$ 1,303,189	\$ 1,843,106	\$ 539,917	29.3%	9/12
	Total	\$ 4,995,763	\$ 6,042,824	\$ 1,047,061	17.3%	

*1-4 ASPR Contracts for FY23 are expending in accordance with budget.

*5 ASPR EMTF 6 (State funds) are expending in accordance with budget.

*6 FY 23 RAC EMS funds are expending in accordance with budget.

*7 FY23 RAC Development funds are expending in accordance with budget.

*8 FY 23 County Pass Thru funds for eligible EMS agencies has no expenditures for FY23 as of 6/30/23.

*9 Houston Fire Department Base Station - Reimbursement for actual payroll expenses incurred. Net Revenue is listed on Page 2.

Financial Status

Cash Status: June 30, 2023		
Frost Bank Checking	\$ 695,327.64	-This account is the main operational account.
PNC Bank Checking	\$ 158,785.33	-This account is our primary depository account for grant funds.
PayPal Account	\$ 136,822.56	-This account supports receivables for Symposium, other events
Investment Account #1	\$ -	Liquidated at \$454,564.99
Investment Account #2	\$ 505,066.20	-Monies invested in 13 week maturity, FDIC insured certificates of deposit.
Investment Account #3	\$ -	Liquidated at \$505,066.19
Investment Account #4	\$ 1,515,594.25	-Monies invested in 13 week maturity, FDIC insured certificates of deposit.
Investment Account #5	\$ 1,515,602.86	-Monies invested in 13 week maturity, FDIC insured certificates of deposit
Cash Status: June 30, 2023		
SETRAC Foundation Frost Checking	\$ 303,677.37	-This account supports Foundation business
SETRAC Foundation Inv. Acct.	\$ 1,017,345.05	-Monies invested in 28-day maturity, FDIC insured certificates of deposit
Maestro Svcs. Frost Checking Acct.	\$ 90,425.14	-This account supports Maestro Svcs operations
Chase Revenue Account	\$ 211.25	-New account opened to support streams such as Boot Camps and RHPC Symposium
SB8 Chase Checking Acct.	\$ 1,138,520.02	-This account supports SB8 Funding operations

SETRAC Operating Fund FY23 YTD September- June

Revenue (non-grant)		FY 23	Revenue (non-traditional)		FY 23
General Revenue	\$	23,744	General Revenue	\$	-
FY 2022 Dues	\$	26,594			
Deployment Revenue	\$	3,606			
STB Kits	\$	10,156			
TEEX/TXTF-1 Response Income		47278			
HFD Base Station	\$	195,395			
Total Revenue	\$	306,773			
Expenses (non-grant)					
Contract Services	\$	104,129			
Business Expenses	\$	22			
Equipment	\$	20,446			
Operational Supplies	\$	2,047			
Other	\$	127,685			
Personnel	\$	58,812			
Base Staion Expenses	\$	5,815			
Travel	\$	16,982			
Total Expenses	\$	335,938			
Net Revenue	\$	(29,165)			

Financial Summary - Categorical Budget Detail

	YTD	Budget	Variance
ASPR 23 - TSA Q			
Contract Services	\$ 4,109	\$ -	\$ (4,109)
Equipment	\$ -	\$ -	\$ -
Operational Supplies	\$ 212,337	\$ 17,146	\$ (195,191)
Other	\$ 655,828	\$ 706,940	\$ 51,112
Personnel	\$ 979,643	\$ 1,211,435	\$ 231,792
Travel	\$ 15,543	\$ 30,000	\$ 14,457
Indirect Costs	\$ 218,391	\$ 218,391	\$ -
Total	\$ 2,085,851	\$ 2,183,912	\$ 98,061
ASPR 23 - TSA R			
Contract Services	\$ 1,133	\$ -	\$ (1,133)
Equipment	\$ -	\$ -	\$ -
Operational Supplies	\$ 2,029	\$ 2,374	\$ 345
Other	\$ 78,235	\$ 83,447	\$ 5,212
Personnel	\$ 283,937	\$ 329,852	\$ 45,915
Travel	\$ 995	\$ 6,431	\$ 5,436
Indirect Costs	\$ 46,900	\$ 46,900	\$ -
Total	\$ 413,228	\$ 469,004	\$ 55,776
ASPR 23 - TSA H			
Contract Services	\$ 5,245	\$ -	\$ (5,245)
Equipment	\$ -	\$ -	\$ -
Operational Supplies	\$ 575	\$ 822	\$ 247
Other	\$ 5,361	\$ 4,413	\$ (948)
Personnel	\$ 130,375	\$ 142,367	\$ 11,992
Travel	\$ 566	\$ 601	\$ 35
Indirect Costs	\$ 16,466	\$ 16,466	\$ -
Total	\$ 158,588	\$ 164,669	\$ 6,081
ASPR 23 - EMTF 6			
Contract Services	\$ -	\$ -	\$ -
Equipment	\$ -	\$ -	\$ -
Operational Supplies	\$ -	\$ 573	\$ 573
Other	\$ 14,494	\$ 19,474	\$ 4,980
Personnel	\$ 78,137	\$ 92,085	\$ 13,948
Travel	\$ 3,826	\$ 6,431	\$ 2,605
Indirect Costs	\$ 13,173	\$ 13,173	\$ -
Total	\$ 109,630	\$ 131,736	\$ 22,106
ASPR 23 - EMTF 6 (State General Revenue)			
Other	\$ 125,000	\$ 125,000	\$ -
Total	\$ 125,000	\$ 125,000	\$ -

Financial Summary - Categorical Budget Detail

	YTD	Budget	Variance
RAC/EMS FY 23			
Operational Supplies	\$ 3,943	\$ 515	\$ (3,428)
Other	\$ 88,225	\$ 55,688	\$ (32,537)
Personnel	\$ 274,552	\$ 380,120	\$ 105,568
Indirect Costs	\$ 37,809	\$ 49,311	\$ 11,502
Travel	\$ 4,906	\$ 7,472	\$ 2,566
Total	\$ 409,435	\$ 493,106	\$ 83,671
RAC Development Funds FY23			
Operational Supplies	\$ 700	\$ 756	\$ 56
Other	\$ 35,004	\$ 55,701	\$ 20,697
Personnel	\$ 149,491	\$ 128,800	\$ (20,691)
Indirect Costs	\$ 22,438	\$ 27,411	\$ 4,973
Travel	\$ 6,671	\$ 6,969	\$ 298
Total	\$ 214,303	\$ 219,637	\$ 5,334
County Funds FY23			
Contract Services		\$ 412,655	\$ 412,655
HFD Base Station			
Personnel	\$ 1,303,189	\$ 1,843,106	\$ 539,917

Unrestricted Assets Growth

	Gen FY14	GenFY15	Gen FY16	Gen FY17	Gen FY18	Gen FY19	Gen FY20	Gen FY 21	Gen FY 22	Gen FY 23	TOTAL
Revenue (Unrestricted)	114,054.19	114,868.11	122,415.57	112,130.48	458,767.59	357,970.13	828,743.55	495,286.00	787,368.00	306,773.00	3,942,281.85
Expense (Grant Offsets)	74,408.97	110,196.24	88,944.99	190,844.81	334,373.01	469,327.17	569,818.67	176,453.00	806,477.00	335,938.00	3,324,416.40
Unrestricted Net Asset	39,645.22	4,671.87	33,470.58	(78,714.33)	124,394.58	(111,357.04)	258,924.88	318,833.00	(19,109.00)	(29,165.00)	617,865.45
Symposium 2022											31,726.75
Total Fund Balance											649,592.20

Notes:

Preparedness

Lisa Spivey-Director of Preparedness

TSA Q-West Corridor – Kat Samuel

TSA H-Gary Litton

TSA R- Jeremy Way

Training & Exercise – John Wingate & Carrie Cox

Special Populations - Fidel Calvillo

Overview:

Our Preparedness and Response team has been working extremely hard this last quarter. They have continued with increasing their trainings and meetings to in-person. Overall, the Coordinators are focusing on Coalition Development by:

- Working with the corridor chairs and facility EMCs to determine regional and corridor specific preparedness needs.
- Engaging all partners to increase corridor meeting participation, as well as radio checks.
- Offering to hospital staff on site EMResource, EMTrack and WebEOC training
- Continuing to network with hospitals, EMS, Fire, Police, Public Health, and City/County EMCs to build strong partnerships.
- Completed a Regional Hazard Vulnerability Analysis (HVA), with participation from all five corridors.
- Continue to work with our Adult Protective Services, and the boarding home issues.
- Developing relationship with EquuSearch, scheduling a meeting with their leadership.
- For 2023, began a “Back to the Basics” overview to ensure all stakeholders are familiar with the standards, the processes, the responsibilities, resources available, etc.
- Working with local partners in the planning process for the CCTA Full Scale Exercise.
- Attended the TECC Training in Nacogdoches, TX.
- STB Coordinator facilitated 12 STB classes and 2 STB Train the Trainer with a total of 210 trained and 10 new instructors trained.
- Provided multiple school districts, universities, hospitals, and EMS/Fire departments with training supplies to provide classes to staff and to public.
- To date, 920 classes have been reported and over 41,000 people have been trained in the region.
- Met with Polk County and Sabine County EMC to provide program updates.
- Met with Sabine County Judge to provide program updates.
- Currently we have 4 staff members who are CPR Instructors.
- Spring Radiological Exercise was completed, with over 100 facilities/agencies participating in the TTX, and over 65 facilities/agencies participating in the functional exercise.

Preparedness and Response

- Completed the Off the Grid Drill with over 100 facilities/agencies participating in the drill.
- Our Special Populations Coordinator continues to engage long term, home health, rehab, and FSEDs into the coalition.
 - a. Has completed five boot camps with over 140 attendees.
 - b. Provided 13 one on one visits with stakeholders.
 - c. Increased stakeholders' participation in the Off the Grid Drill in June.

Community Events/Exercises:

- Participated in the Active Shooter TTX with Houston Methodist West
- The STB workgroup provided STB training to the Houston Astros staff on Stop the Bleed Day.
- Provided resources and staff for Pride and multiple July 4th celebrations.
- Coordinated an asset display day with Nacogdoches Memorial Hospital.
- Setup an MMU for a cooling station at the Nacogdoches Blue Berry Festival.
- Participated in the Fort Bend County and Katy ISD Active Attack Full-Scale exercise.
- Participated in the National Disaster Medical System (NDMS) evacuation exercise.
- Participated in the Texas Children's Hospital G7 Functional Exercise.
- To date: 10 classes of DECON training has been conducted with 150 personnel trained.
- For Hospital Evacuation-2 facilities with 103 personnel trained.
- Technology training: EMTrack/EMResource/WebEOC classes has been conducted with over 160 trained.
- June 24, 19 patients presented to Texas Children's Hospital West due to chlorine exposure. Our Training & Exercise Coordinator, John Wingate responded to the scene and assisted with decontamination operations with staff.

Response

Chris Collier – Director of Business Operations (Interim Response Director)

EMTF 6 Coordinator - Mikal Orr

Regional Logistics and Inventory Coordinator - Kyle Erickson

Mobile Assets Coordinator – Philip Cutler

Logistics and Assets:

- RCVQ has begun refurbishment after receiving UASI Grant in the amount of \$200,000. Work completed to date: new paint job and technological updates. The truck is currently scheduled to have generator and air system replaced with a completion date of August
- Routine maintenance and service continues to keep assets at an operational state.

Preparedness and Response

- Logistics staff continue to remain busy supporting the multiple events and incidents where resources were requested.
- End of the HPP contract year spending has been completed and allowed for much needed refurbishment and upgrades to the SETRAC Fleet and response capabilities. To include repainting and flooring repairs to multiple trailers, staging area resource upgrades to fill defects from past activations, tire replacement, communications, and technology upgrades,
- DSHS allocated funding for the disaster portable morgue trailers. This funding was used to purchase expired supplies in the DPMU, repaint the 53' reefer and replace the cooling units on the 20ft trailers.

EMTF:

Training/Exercises/Meetings:

- MIST 1 – March 28-29 (Full)
- MIST 2 – April 13-14 (Full)
- MEDL – April 26-28 (2 Seats open)
- TFL/MIST Update – May 25-26 - Full
- ASMT – June 13-14
- 2nd Thursday of the Month – WebEOC trainings at 1400 & 1800 (May training will be held June 1st at same time)
- 4th Thursday of the Month – Pulsara Training (invite will be sent to appropriate team members) (May training will be held June 1st at same time)
- EMTF Workgroup Meetings – 7/25 & 9/25 in San Antonio at STRAC

New/Future Business:

- MPV 602 1.5 upgrades complete 5/15/23 – unit back in service
- EMTF-6 ListServ – any members can be on the ListServ to receive general and critical information. Please sign-up at the following address <https://list.setrac.org/mailman/listinfo/emtf6> . You may also email Mikal.Orr@setrac.org to receive the link.
- Member information – all members need to complete/update their contact information on Board #13 “EMTF Contacts” in WebEOC. The link to the EMTF WebEOC server is <https://webeoc.txemtf.org//eoc7/controlpanel.aspx>. If you do not have an EMTF WebEOC account, please email support@strac.org to request one. Please CC mikal.orr@setrac.org so that I know you have made a request for an account. If you have any questions, please contact Mikal Orr.
- SETRAC has transitioned from SmartNotice to OnSolve for event and emergency notifications. The transition is on-going. Please expect to receive emails or forms requesting updated information from agency's leadership and some individual EMTF members.

Preparedness and Response

Real World Incidents:

January 1, 2023 – July 10, 2023

Event Designation	Location	Type	Date	Assigned Resources
UASI Mobile Command Truck Rally	Regional	PR Event	1/10/2023	RCVQ
Houston Marathon	Regional	Major Event	11/14/2023 - 11/15/2023	CMOC, EOC Support, Medical Equipment Support
Deer Park Tornado	Regional	Major Incident / MCI	1/24/2023	CMOC, MPV-601, MPV-603, MPV-604, 2 AST, 2 ASTL, EOC Support, 2 MD's, 2 MIST
Baytown Chemical Exposure	Regional	MCI Hazmat	2/17/2021	MPV-601, CMOC
Liberty - Dayton Hazmat Incident	Regional	MCI Hazmat	2/25/2023	CMOC
TFS South Branch Wildfire	State	State Mission	2/27/2023 - 03/05/2023	MEDL
Severe Weather Standby	State	State Mission	3/2/2023 - 3/3/2023	MPV-603
Nacogdoches Asset Display	Regional	PR Event	3/16/2023	MMU-6103, SMU, MPV-604
NCAA Final 4	Regional	Major Event	3/31/2021 - 4/2/2023	CMOC, EOC Support, MMU-6104, MPV-602
Illegal Group Home	Regional	MCI	4/27/2023	CMOC
Manhunt - San Jacinto County	Regional	Major Incident	5/2/23	MMU-6102, 2 Liaisons, 2 Logs Staff
Shell Deer Park	Regional	Major Incident	5/5/23	CMOC, Liaison
Seabrook Bus MCI	Regional	MCI	5/11/23	MPV-601, MPV-603, CMOC
Jeep Weekend - Bolivar Peninsula	Regional	Major Event	5/18/2023 - 5/21/2023	MMU-6103, MCST, AST, Liaison
Columbus Magnolia Fest	Regional	Major Event	5/20/23	MPV-603
Surfside Boardwalk Collapse	Regional	MCI	6/2/23	MPV-603, MPV-601, CMOC
COH / HPD Gun Buy Back	Regional	Major Event	6/10/23	MMU-6105
Nacogdoches Blue Berry Fest	Regional	Major Event	6/10/2023	MMU-6103
Pride Houston	Regional	Major Event	6/24/23	MMU-6102, MPV-602, CMOC, EOC Support
Freedom Over Texas	Regional	Major Event	7/4/2022	MPV-602, MMU 6104, EOC Support, CMOC
Pearland July 4th	Regional	Major Event	7/4/2022	MMU-6101
Sugarland July 4th	Regional	Major Event	7/4/2022	MMU-6102
Tomball July 4th	Regional	Major Event	7/4/2022	MMU-6105

Information Technology

Jeremiah Williamson – Director

Jason Nolin – System Analyst

Infrastructure Development:

- Major modernization effort upgrading communications and data infrastructure components in RCVQ to support the newest technologies and applications for situation, dispatch, and incident command.
- Upgrading the communications and data infrastructure components in MCC603 to support the newest technologies and applications.
- Provisioning voice and data services in the Special Medical Unit.
- Upgrading the old cooling unit in the server room to keep server appliances operating well within environmental specifications.
- Reviewing website code and procedures to improve content updating efficiency and timeliness.
- Developing relationships with Harris County ARES to enhance alternative and off the grid communications using amature radio.

Service Continuity:

- Actively monitored and identified new cyber security threats/trends and adjusted policies accordingly.
- Reviewed, updated, and tested the rapid deployment of our backup website.
- Participating every Sunday in the Harris County ARES and the Houston Area Hospital EmComm Radio Network checks.

Security

- Underwent a week-long distributed attack between May 5-11 targeting seven email accounts at a rate of approximately 26.9 thousand sign-in attempts daily. In comparison, the typical overall organizational count of sign-ins is 100-300 daily.
- Developing an active infosec monitoring and policy management routine in response to increased activity.

Training:

- IT staff now licensed by the FCC for Amature Radio operations.
- Currently training in development of low-code applications and automation in Microsoft's Power Platform environment.



RHPC Board

Dr. Kevin Schulz – RHPC Board Chair

Toni Carnie – RHPC Co-Chair

Hazardous Vulnerability Assessment (HVA) Updates

Recent changes made to the HVA form was reviewed with the coalition members. The due date for facilities to submit their HVAs to SETRAC was July 3rd.

Healthcare Preparedness Capabilities

Long Term Care Update (C102)

SETRAC held a boot camp in Lufkin on May 23rd with good participation. The City of Houston and Harris County OEM came together to host a boot camp on June 14th, and a boot camp was held in Beaumont on June 28th.

Training and Exercise Update (C104)

Most of the spring exercises have been completed. Registration is open for CMOC-101 Training. CMOC-101 covers the basics of what it looks like to work in a real-world activation in the CMOC and allows participants both didactic and hands-on learning opportunities. The MGT-341 class is coming up and there is a waiting list for this class. A WebEOC drill was conducted at night and, after receiving feedback it has been determined that these drills are not needed for the night shift and will no longer be conducted at night.

SETRAC hosted a HAM in a Day training on Wednesday, June 7th, for individuals to prepare for and take the FCC exam to obtain their Radio Operator License. EMResource training continues to be held online; however, special classes can be scheduled by emailing requests to exercise@setrac.org.

EMTF Update (C104)

Past Activations:

1. Jeep Weekend – 5/19-5/21 (860, generator, MCI trailer, and request for 3 Voluntary ALS units)
2. 5/2/2023 – San Jacinto Search Ops Support – 4 SETRAC personnel, 860, and generator
3. 4/22/2023 - The Woodlands Ironman – SETRAC LNO on scene and HFD Strike Team on standby
4. 3/31/2023 - AST/ASTL/MPV 602 activation for Final Four to assist HFD

Training/Exercises/Meetings:

1. EMTF Training –
 - a. ASMT – June 13-14
 - b. 2nd Thursday of the Month – WebEOC trainings at 1400 & 1800
 - c. 4th Thursday of the Month – Pulsara Training (invite will be sent to appropriate team members)

RHPC Board

2. Exercises –

- a. TDEM Full-scale Hurricane Exercise – May 15-17, 2023 (opportunities to participate for TFL, MIST, AST, ASMT, MMU/RNST.
- b. UTMB Hurricane Evacuation Exercise – date TBD (opportunities to participate for TFL, MIST, AST, ASMT, MMU/RNST. Additional information and requests will be provided closer to the exercise date.)
- c. CMOC – Spring Radiological Functional Exercise April 12, 2023 (TFLs invited to attend).
- d. East Corridor MCI Triage Full-scale Exercise 4/11/2023

3. Meetings:

- a. Galveston Hurricane Evacuation Meeting
- b. UTMB/AMR – meetings to discuss RITA/IDRU teams and response.
- c. TMORT – meetings to discuss team status and prepare for training opportunities.
- d. College Football Playoff meeting

New/Future Business:

1. TDEM Conference 5/29-6/2
2. MPV 602 1.5 upgrades (Final Inspection 5/5/23)
3. EMTF-6 ListServ – any members can be on the ListServ to receive general and critical information.
4. Member information – all members need to complete/update their contact information on Board #13 “EMTF Contacts” in WebEOC.
5. A request for TFL/MIST/AST/ASMT will be distributed for participation in the TDEM Hurricane Exercise, SETRAC Radiological Surge Exercise, and the Harris Co. Full-scale Exercise.
6. SETRAC will transition from SmartNotice to OnSolve for event and emergency notifications. The transition is on-going.

Inventory Update (C104)

- The TDEM Strategic PPE Stockpile Workgroup has picked back up.
- SETRAC is actively working towards a new inventory tracking software that will streamline accountability for both the facilities and moving forward.
- SETRAC has recently supported the Iron Man Triathlon in the Woodlands, an Asset Showcase in Nacogdoches, and the Final Four NCAA Basketball Tournament
- If any agency or facility would like a tour of the SETRAC Warehouse to have a better understanding of the assets and resources we are able to provide, please contact Mr. Ericksen at kyle.ericksen@setrac.org.
- If a corridor feels that it would benefit from an Asset Showcase in their region, SETRAC would be happy to coordinate a day to provide the opportunity for partnering agencies to walk through our assets and learn more about our capabilities.
- For any training or planned event that you would like SETRAC to bring assets or resources to, please complete the “Non-Emergency Asset Request Form” on the SETRAC website and, as long as there is no real-world conflict, SETRAC will do their best to support your request.

RHPC Board

Sub-Committee Updates

RHPC Award of Excellence Committee (C101)

The Award of Excellence documents can be found on the SETRAC website and are ready to complete and submit by August 31st.

Symposium Planning (C101)

Symposium planning is underway and registration is open. The dates for the symposium are October 25th-27th at the San Luis Resort in Galveston. Call for Speakers has gone out and corridor members are encouraged to send any suggestions they may have for presentations to lori.upton@setrac.org or lisa.spivey@setrac.org.

Clinical Advisory Committee (C101)

Deferred

Corridor Updates (C101)

Downtown Corridor

The next meeting is scheduled for July 7th where the members will attend the RHPC Board meeting in lieu of the Downtown Corridor meeting. Following this meeting, the next in-person Downtown Corridor meeting is scheduled for August 4th at the City of Houston OEM.

South Corridor

The South Corridor met on May 19th at Memorial Hermann Sugar Land. The next meeting is scheduled for July 21st.

East Corridor

The East Corridor met on May 12th at Jack Hartel County Bldg. in Liberty County where Doug Kramer (National Weather Service) presented on hurricane season. The next meeting is scheduled for July 14th at Hardin County Health Services in Kountze.

North Corridor

The North Corridor met for an in-person meeting on May 10th at Woodland Heights Affinity Center in Lufkin where the members reviewed the details of the Radiological Tabletop Exercise. The next meeting is scheduled for July 12th from 2:00 to 3:30 pm at CHI St. Luke's Health Memorial Hospital in Livingston.

West Corridor

The West Corridor met on May 26th at Memorial Hermann The Woodlands where James Meaux (DSHS Region 6/5 South) presented on the closed pod process and their plans. The next meeting is scheduled for July 28th at Memorial Hermann Memorial City

Partner Updates (C101)

Public Health

- **DSHS 6/5 South** – An update was provided on the recent fungal meningitis incident deriving from epidural procedures in Mexico.

RHPC Board

- **Harris County Public Health** – HCPH is gearing up for their internal exercise on shelter assistance. There are a few open positions in the Public Health Preparedness and Response Division.
- **Houston Health Department** – The HHD TB Lab and TB Control Bureau are working to address current unexplained shortages of INH (isoniazid), rifampin, and potentially other TB drugs. This lack of availability of primary treatment drug(s) is requiring the TB Lab to coordinate sensitivity and susceptibility (resistance) testing with CDC Lab to identify appropriate courses of treatment (i.e. more lab work than usual and different drug combos than routine) for TB patients. The added drug sensitivity and susceptibility work-up is identifying more cases of multi-drug resistant TB. Additionally, the HHD TB Control Bureau is shifting more TB patients from Directly Observed Therapy (DOT) to Video Observed Therapy (VOT) due to limited resources and for efficiency gains.

OEM

- **City of Houston OEM** – The city prepared for both the Pride Parade on June 24th and Freedom Over Texas on July 4th. COH/OEM also participated in the recent TDEM exercise.
- **Harris County OEM** – Hurricane season has arrived and there has already been a named storm in the Gulf heading towards Cuba. He urged everyone to stay watchful and prepared.

EMS

- **SETRAC** – No current update.

Other Partners

No further updates.

Open Discussion/Other

Letter of Participation

Coalition members were in unanimous agreement that participation letters stating proof of participation in the regional coalition for Joint Commission surveys would be very helpful. SETRAC will begin this process at the beginning of the new fiscal year (July 1, 2023).



Trauma Committee

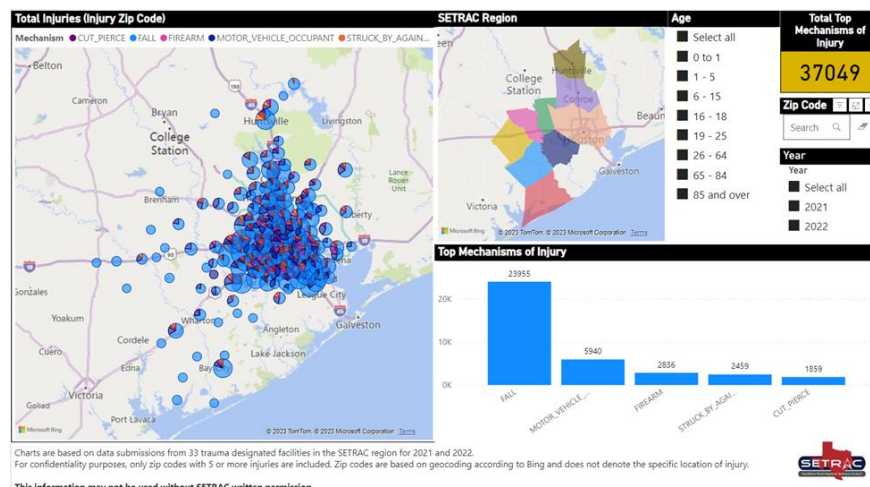
Medical Director: Dr Michelle McNutt

Chair: Dr Chad Wilson

Vice Chair: LeAnne Young and Adam Fitzhenry

The committee met in person on 7/6/2023. The next committee meeting will be held on 9/7/2023. The focus of the committee includes:

- The Regional Trauma Plan
 - Has been revised and approved through our committees
 - Seeking Board approval tonight
- Trauma Rules
 - We do not have a date at this time for the release of the new trauma rules, but once released we will send an open invitation to our stakeholders to meet and discuss. We do know that there will be a requirement for both the Trauma Program Manager and the Trauma Medical Director to meet the RAC's participation requirements.
 - Hospitals that survey under the American College of Surgeons will finish out 2023 with the Orange book rules but from January 2024 the surveys will be aligned with the Grey book rules.
- Trauma Registry Workshop
 - We had a very successful Trauma Registry Workshop with 50 people in attendance. The feedback we received from the attendees was very positive and we are planning another workshop for the end of the year.
- Trauma Data
 - The Data Subcommittee was able to finalize the data heat map and present it to the Trauma Committee. Today, we are asking for approval from the Board to post on our website.



Injury Prevention Committee

Medical Director: Dr. Lars Thestrup

Chair: Open

Vice Chairs: Kristen Beckworth and Kacey Sammons

The committee met in person on 6/8/2023. The next committee meeting will be held on 8/10/2023. The focus of the committee includes:

- Falls and Firearm Safety
 - In the fall we are planning a community event that will focus on fall prevention in the older population, but will have other educational offerings available to – for example pharmacists, dieticians, blood pressure monitoring etc.
- It's Only a White Line is now available at <https://youtu.be/XN-IJsGu1G8> . This will serve as road and car safety education across all age groups.

Pediatric Committee

The Medical Director: Dr. Brent Kaziny

Committee Chair: Dr. Nichole Davis

Vice Chairs: Andre Ruby and Eric Parmley

The committee met in person on 6/8/2023. The next committee meeting will be on 8/10/2023. The focus of the committee includes:

- Collaboration with injury prevention for firearm safety.
- Development of guidelines for care of ill or injured pediatric patients
- Recently our region had a Pediatric Disaster drill lead by the ASPR Pediatric G7 Pediatric Disaster Network



Stroke Committee

Medical Director: Dr. Sean Savitz

Chair: Dr. Chethan Venkatasubba Rao

Vice Chair: Christy Gonzales and Dr. Bryan Kharbanda

The committee met in person on 5/24/23. The next committee meeting will be held on 7/26/23. The focus of the committee includes:

- Extended Window Strokes
 - The committee has identified a trend of 70% of patients arriving to a designated stroke facility outside of the 4.5-hour window. Parameters for Extended Window Strokes have been identified as Last Known Well from 4.5 hours – 24 hours.
- Rehab Utilization
 - The committee aims to identify socio-economic indicators, to include rural vs urban, insured vs uninsured, ethnicity, etc. regarding rehab utilization
- Pre-Hospital Metrics for Stroke
 - Stakeholders have identified EMS metrics that would aide in achieving the committee goals. The metrics have been presented to the EMS Committee and are being evaluated through the EMS data workgroup.
 - The committee leaders are aware that Stroke CEO reports will be provided to EMS Medical Directors to improve care from all aspects.
- International Stroke Conference (ISC)
 - Dr. Rao aims to focus on the gaps in thrombolytics administration and thrombectomy. SETRAC is working to create a dashboard to capture eligibility versus recipient based on current and retro data obtained from the Get with the Guidelines (GWTG) registry.
 - Goal is to present on the “Evolution of Stroke Care” within our region at the 2024 ISC and highlight gaps to increase transparency and performance improvement
- 2023 Stroke Bootcamp
 - Planning this event for the January 2024, speakers and topics being confirmed
 - The bootcamp will be held for data abstractors and stroke coordinators.

Cardiac Committee

Medical Director: Dr. James McCarthy

Chair: Dr. Kevin Schulz

Vice Chairs: David Bernard and Dr. Leslie Osborn

This committee meets quarterly and met on 4/28/23. The next Committee meeting will be held on 7/28/23. The focus of the committee includes:

- Committee Goal: **Develop community education, including a regional hands-only CPR event.**
 - A hands-only CPR & STB community event is in the planning phase.
 - Zip code data from the Texas CARES registry will be used for targeted education.
 - Hybrid education model being developed.
 - Telecommunicator/911 dispatcher hands-only CPR education is in planning phase.
- Committee Goal: **Unified social media presence related to STEMI regional education.**
 - February Heart Health Month featured unified social media messaging.
- Committee Goal: **Develop Regional Cardiac Plan**
 - The Regional Cardiac Plan was approved by stakeholders on 4/28/23. The plan is awaiting Board approval. The Regional Cardiac Plan includes:
 - Data submission and meeting participation requirements to remain a member in good standing and maintain PCI status on EMResource and SETRAC's Cardiac webpage.
 - Requirement to provide case feedback to EMS.
 - Responsibilities of the Medical Director position
 - NCDR Chest Pain-MI Registry: Pending signed agreements.
 - Patient level data, not to include PHI, will be available once access is obtained.
 - Data will be used to meet the data requirements of the RAC self-assessment tool, as well as assist in formulating data driven goals.

Perinatal Committee

The Medical Director: Dr. David Weisoly

Committee Chair: Dr. Elizabeth Eason

Vice Chairs: Kendra Folh and Marty Delaney

The last meeting was held in-person at the TranStar Conference Center on 6/17/23. The next meeting will be held in person on 9/13/23. The focus of the committee includes:

- The Texas Collaborative for Healthy Mothers and Babies (TCHMB)
 - This group is focusing on recognition and response to postpartum preeclampsia in the Emergency Department (PPED). Eight hospitals from our region have enrolled in the project. The goal is to obtain baseline data and increase the treatment of patients by 50%
 - This group also focuses on improving newborn admission temperatures. RAC Q has strong participation in this project with 76% of our hospitals enrolled.
- Maternal Morbidity & Mortality Workgroup Focus:
 - The new Maternal Rules and House Bill 1164 Placenta Accreta Spectrum Disorder are in effect. Every hospital must be in compliance with the bill. The toolkit and appendices were sent out to stakeholders for awareness. Open Q&A sessions are held during this workgroup's meetings to address questions related to the maternal rules. Dr. Toy presented an educational video on Placenta Accreta Spectrum. The video will be used to assist hospitals to comply with HB 1164, maternal designation, and preparation for PASD.
 - This group is encouraging all hospitals and clinics to look at the overall treatment of patients to see if we are identifying and diagnosing the conditions as early as possible. This can aide in positively changing the racial and ethnic disparities that lead to increased mortality rate.
- Infant Morbidity & Mortality Workgroup Focus:
 - The new Neonatal Rules are in effect. Open Q&A sessions were held during this workgroup's meetings to address questions related to the neonatal rules shared with stakeholders.
 - A list of QAPI triggers is being developed that all hospitals will be encouraged to follow as a way of quality improvement and tracking. Current practices are being reviewed to ensure regional best practices are utilized.
- Perinatal Planning Workgroup Focus:
 - Neonatal Resuscitation Program (NRP): Training for EMS
 - NRP instructors throughout the region have volunteered their time to teach our EMS partners. Three classes have been held with 59 participants. 6 additional classes are scheduled through 2023. A large class for 100-200 participants is in planning phase for November 28, 2023. The goal is to reduce infant mortality through education and skills in the prehospital setting.
 - This group will begin focusing on ensuring bed reporting is accurate for disaster preparedness.

Emergency Healthcare Systems- Stroke/Cardiac/Perinatal Division

- Perinatal Quality Improvement Workgroup Focus:
 - Breastmilk at Discharge Project:
 - Project Aim: By January 1, 2024, 75% of all NICU babies will discharge on mother's own milk. According to the Q1-Q4 2022 data, the region is currently at 68.4%.
 - Project Aim: By January 1, 2024, 55% of all VLBW babies will discharge on mother's own milk. According to the Q1-Q4 2022 data, the region is currently at 52.03%.
 - Neonatal designated facilities share their best practices at each meeting.
 - Antibiotic Timeliness Project:
 - The initial project goal was to achieve $\leq 31\%$ of babies receiving antibiotics more than one hour after order or birth. The latest data reflects the region is down to 26.8%. The goal for Jan 2024 is now 20%.
 - The "Beat the Clock" initiative was adopted to decrease the percent of NICU infants receiving antibiotics in the first week of life more than 1 hour after order/birth
- Neonatal and Maternal Program Manager Collaborative:
 - This group ensures regional neonatal and maternal program managers and medical directors are abreast of the Texas Administrative Code and support through designation surveys.



Pre-Hospital/EMS

Committee Medical Director: Dr. Lesley Osborn

Committee Chair(s): Kevin Leverage, Jason Gander, Dr. Joseph Gill

SETRAC Liaison: Clayton Ehrlich

Meeting Schedule:

Past:	January 20 th , 2023
	March 17 th , 2023
	May 19 th , 2023
Upcoming:	July 21 st , 2023

* * * *

Committee Highlights:

- **EMS Workforce Development Initiative (Senate Bill 8):**

The link/webpage on the SETRAC website for more information regarding the SB8/DSHS scholarship remains active and continues to gain attraction. Since its live date we have received over 650 inquiries regarding the scholarship. To date SETRAC has distributed 77 scholarships (EMT=17, AEMT=4, Paramedic=56) for a total of \$542,743.00. We currently have 12 more potential applicants from an EMS agency that have stated intentions on applying.

- **88th Legislative EMS Update:**

The committee has continued to review proposed/passed legislation from both the House and Senate bills which all have the potential to affect EMS providers. One bill in particular will require the RAC's to develop a regional operating guideline for non-ambulance transport. SETRAC continues to monitor these changes and will update providers as changes occur.

- **EMS Wristband Initiative:**

Training and education on this implementation are currently under development to be prepared for the trial period. SETRAC has not yet implemented the EMS Wristband Initiative and our trial usage is on pause until our hospitals have the ability to capture the band and training has been completed. Once the hospitals are ready to start receiving bands, we will start a trial period while the EMS agencies adopt their own procedures. SETRAC will continue to update partners as changes occur.

- **EMS Data:**

The EMS committee is holding its first EMS Data workgroup meeting in August. Other clinical committees Stroke, Cardiac, and Trauma have developed the data points each respective committee would like to see from EMS providers. The goal of the workgroup is to see what data is commonly being collected utilizing the NEMSIS data sets to produce reports for each clinical discipline. The end goal would be to make sure we are making accurate data driven decisions on guidelines and practices.



PRE-HOSPITAL / EMS COMMITTEE REPORT

- **Regional Quality of Care:**

The EMS committee has encouraged members to attend other SETRAC committee meetings and have encouraged members of other clinical committees to attend the pre-hospital meetings (stroke, trauma, inj. prev., cardiac, etc.). Recently a few EMS agencies have made SETRAC aware that a very high call for service has been “falls”. EMS committee leadership invited the Injury Prevention/Fall Prevention workgroup to the pre-hospital meeting in July to discuss potential future initiatives that could arise from a pre-hospital standpoint.

EMS Committee Goals for 2023/2024	
Goals	Actions
<ul style="list-style-type: none">• Reengaging the EMS Whole Blood Program	<ul style="list-style-type: none">• Develop a list of providers using pre-hospital blood and creating best practices on being good stewards of whole blood.
<ul style="list-style-type: none">• EMS Data	<ul style="list-style-type: none">• Begin to collect data from EMS partners to make accurate data driven decision on best practices and regional guidelines.
<ul style="list-style-type: none">• Regional MCI Workgroup	<ul style="list-style-type: none">• To engage a group of agencies to determine/ establish common MCI nomenclature and terminology for guidelines to establish best practices for the region.
<ul style="list-style-type: none">• Engage stakeholders	<ul style="list-style-type: none">• To distribute an engagement survey for quality purposes, and to ensure the pre-hospital committee is remaining relevant to its stakeholders.

SouthEast Texas Regional Advisory Council SETRAC (TSA Q)

EMERGENCY MEDICAL SERVICES/TRAUMA SYSTEM PLAN



Established 2015
Last Revised 2023

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Introduction to SETRAC

The SouthEast Texas Regional Advisory Council (SETRAC) was organized under the authority of the Texas Department of State Health Services which was instructed by the 1989 Omnibus Rural Health Care Rescue Act. SETRAC is one of 22 Regional Advisory Councils (RAC) currently functioning within the State of Texas. SETRAC is a 501(C3) non-profit, tax-exempt organization, which is led by a Board of Directors (listed herein) and in accordance with SETRAC bylaws.

MISSION

The mission of the SouthEast Texas Regional Advisory Council is to facilitate coordination of emergency healthcare providers to ensure the most efficient, consistent, and expeditious care of each individual who experiences an acute injury, stroke or cardiac event by developing and maintaining integrated quality processes in patient care, research, education, and prevention.

VISION

The SouthEast Texas Regional Advisory Council will provide leadership within our region, state, and nation regarding the care of emergency healthcare patients and the solution to prevent mortality and morbidity.

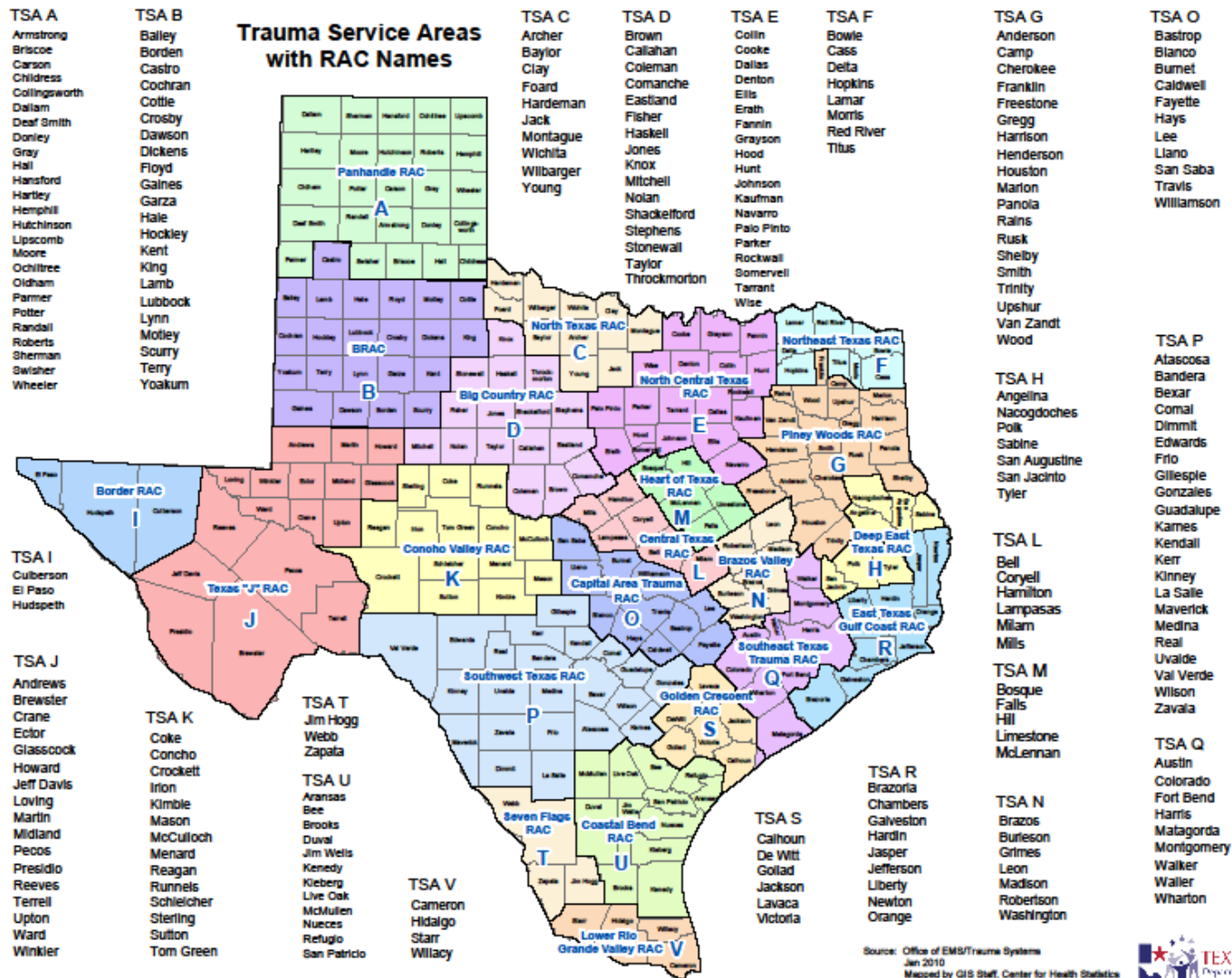
FOCUSES

- Promote external communication to our constituents through public awareness programs, educational resources, and prevention programs.
- Identify and integrate our resources as a means to obtaining commitment and cooperation.
- Identify and leverage tactics to promote EMS provider participation
- Develop a legislative agenda for procurement of funds related to emergency healthcare (direct and indirect), taking into consideration medico legal aspects, regulatory agencies, pressure groups, and current legislation.
- Establish system coordination relating to access, protocols/procedures and referrals. These structures will establish continuity and uniformity of care among the providers of emergency healthcare.
- Promote internal communication as the mechanism for system coordination which will include the EMS Providers, consumers and members of the SETRAC.
- Create system efficiency for the patient and the programs through continuous quality improvement programs which identify the patient's needs, outcome data, and help develop standard uniformity.

Revisions and Modifications

This document will be reviewed on a yearly basis by the Trauma and EMS committees. Ultimate approval of revisions and updates will reside with the SETRAC board of directors.

Trauma Service Areas with RAC Names

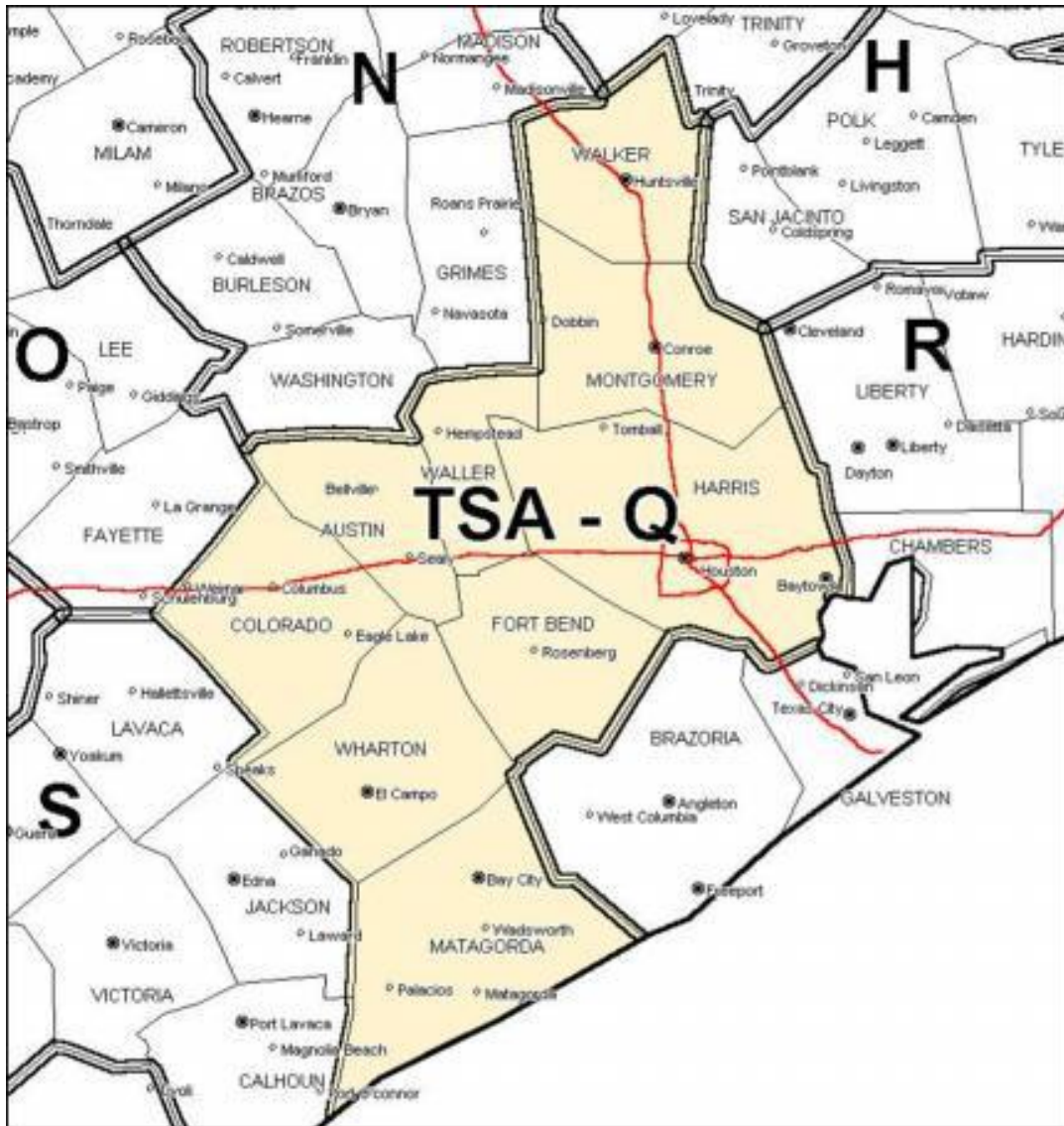


DESCRIPTION

Trauma Service Area Q is composed of nine counties, with a total land mass of 8,896 square miles. Total population of TSA-Q exceeds 6.2 million.

The variety of services available within each county, distances between acute healthcare facilities, and designated trauma centers, coupled with traffic patterns related to population density within the SETRAC region causes emergency healthcare professionals to collaborate in order to offer the highest level of appropriate care to the acutely injured, trauma patient. Transport of critically injured patients by aeromedical transport is encouraged when appropriate.

TSA-Q Counties



RAC Q accounts for 21.6% of the State of Texas population and has seen an increase in population of 6-7% as estimated by the US Census Bureau.*

County	2010 Population	2013 Population (estimate)	2017 Population (estimate)	Land Area	# of Designated Trauma Centers
Austin	28,417	28,847	29,786	647	1
Colorado	20,874	20,752	21,232	960	2
Fort Bend	585,375	652,365	764,828	861	2
Harris	4,092,459	4,336,853	4,652,980	1,703	16
Matagorda	36,702	36,592	36,840	1,100	1
Montgomery	455,746	499,137	570,934	1,042	2
Walker	67,861	68,817	72,245	784	1
Waller	43,205	45,213	51,307	513	0
Wharton	41,280	41,216	41,968	1,086	2
Total	5,371,889	5,729,792	6,242,120	8,696	27

*Population Source: U.S. Census Bureau (<http://quickfacts.census.gov/qfd/states/48000.html>) - as of 12/2018

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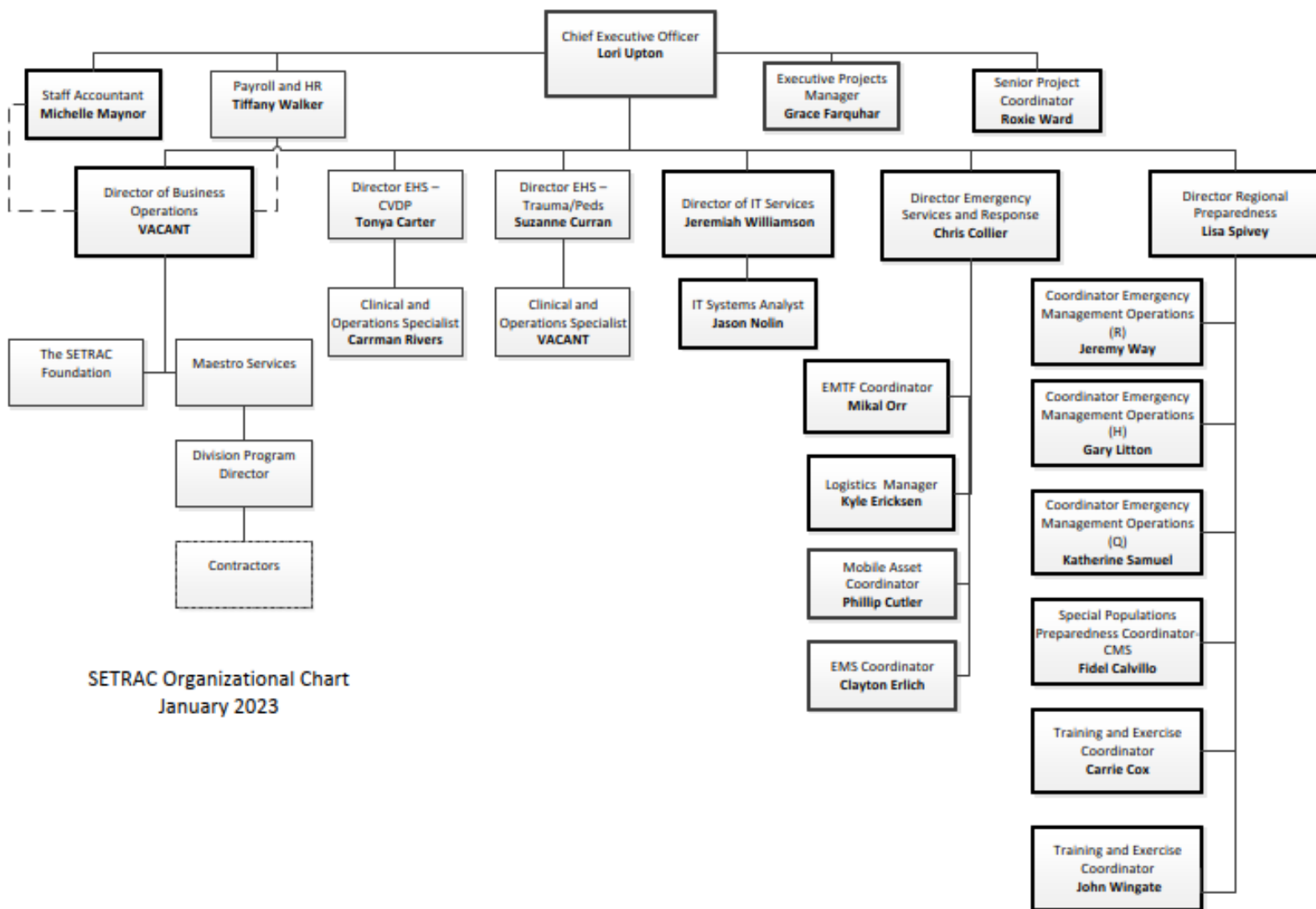
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At Large #2

Position vacant

To provide the most current information, links to websites are provided instead of a listing of facilities/EMS agencies.

[List of EMS/First Responder providers](#) - link takes you to the DSHS website

[List of Texas Trauma Designated Hospitals](#) – link takes you to the DSHS website

[List of Texas Hospitals](#) – link takes you to the Texas Hospital Association

A complete list of hospital capabilities can be found at:

<https://emresource.juware.com>

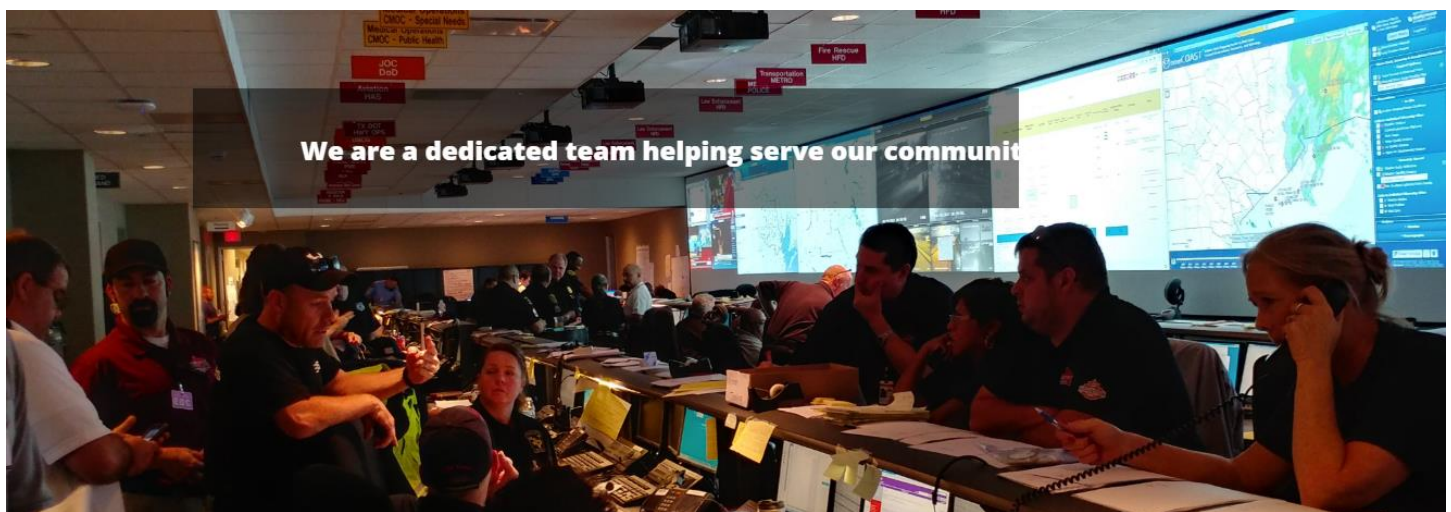
SETRAC Bylaws can be located at:

<https://www.setrac.org/wp-content/uploads/2017/08/SETRAC-Bylaws-signed-7.17.2017.pdf>

TSA-Q Web Sites

There are two main web sites within TSA-Q, one is the SETRAC website, and the other is EMResource.

SETRAC has set up a web site located at <http://www.SETRAC.org>. The web site contains information such as announcements, quarterly meeting schedule, committee information, training opportunities in the region, links to other websites, and general information about SETRAC. List servers have been set up for SETRAC and the various committees. These list servers automate the way meeting notices and important announcements are sent to participants. To subscribe, please visit our website at <http://list.setrac.org/mailman/listinfo>



The EMResource's web page <https://emresource.juware.com> displays the capacity and capability status of hospitals within our region. It is requested that the web site be updated by each entity at a minimum of once every 24 hours. This web site is also utilized to streamline resource management during disasters. To obtain access to the EMResource web site, contact the SETRAC office.

Region Default										
Pediatric Hospitals	Hospital Status	ED Status	ICU	Trauma	PCI	Stroke				
Memorial Hermann Children's (Level I)*	Open	High Volume	High Volume	Yes	Yes					
Texas Children's (Level I)*	Open	Open	Open	Yes	No					
Texas Children's Hospital - West Campus	Open	Open	Open	Non-Designated	No					
Trauma Level I	Hospital Status	ED Status	ICU	Trauma	PCI	Stroke	NeuroSurg	Ortho	Comment	
Ben Taub General*	Open	Open	Open	Yes	Yes	Comprehensive (L1)	Yes	Yes	IMU CAUTION	
Memorial Hermann*	Open	Auto-Open	High Volume	Yes	Yes	Comprehensive (L1)	Yes	Yes	Auto-changed due	
Trauma Level III	Hospital Status	ED Status	ICU	Trauma	PCI	Stroke	NeuroSurg	Ortho	Comment	
Bayshore Medical	High Volume	Auto-Open	Auto-Open	Yes	Yes	Primary (L2)	Yes	Yes	ED HOLDING...NO L & D BEDS LONG WAIT changed ...	
Clear Lake Regional Medical Center*	High Volume	Auto-Open	Auto-Open	Yes	Yes	None	Yes	Yes	Auto-changed due to expired yellow status.	
Conroe Regional Medical Center	Open	Open	Open	Yes	Yes	Primary (L2)	Yes	Yes	In Active Pursuit of Level II Trauma Center sta	
Cypress Fairbanks Medical Center*	Open	Open	Open	Yes	Yes	Primary (L2)	Yes	Yes		
Houston Northwest Medical Center*	Open	Open	Open	Yes	Yes	Primary (L2)	Yes	Yes		
I.B.I. General*	High Volume	Auto-	Auto-	Yes	No	None	No	Yes	Auto-changed due to expired red status. I Autr	

TSA-Q Participation Guidelines

Certificates of Participation

The Board shall provide for the issuance of certificates evidencing the current participation status of Members. To qualify for the certificate being requested, members must demonstrate all the requirements have been met, including payment of annual dues and the submission of data as required.

Participation for Hospitals

For hospitals with service lines represented by committees set forth in Section 5.2, each hospital must participate in 6 meetings annually. These meetings must include:

- 3 in each service line designation requested plus
- 3 other meetings that may include Board meetings, RHPC meetings, and/or meetings of the service line committees (and related subcommittees) as set forth in Section 5.2.
- Board of Director attendance at quarterly Board meetings or any special meeting will count towards Member's participation.

Participation for EMS Agencies

Attend 6 meetings annually which must include:

- At least 3 Pre-Hospital/Strategic Quality Improvement meetings plus
- 3 other meetings that may include additional Pre-Hospital/SQI meetings, Board meetings, RHPC meetings, and/or meetings of the service line committees (and related subcommittees) as set forth in Section 5.2
- Board of Director attendance at quarterly Board meetings or any special meeting will count towards Member's participation.

Additional Requirements for Trauma Centers

- At least 50% of trauma committee meetings (designee accepted)
- Submit data to SETRAC (see below)
- Encouraged to participate in subgroup meetings (ie: trauma data)
- Membership Dues

Trauma Data

- SETRAC has a regional trauma registry. All regional trauma designated hospitals submit trauma data to the regional registry at a minimum of every quarter in order to meet participation requirements for trauma designation. Trauma data elements follow National Trauma Data Bank (NTDB) and Department of State Health Services (DSHS) format. Data is aggregated and shared in Trauma Committee and Trauma Data Subcommittee meetings. For a complete list of reporting requirements, laws and rules and data elements, click on the links listed below:
- [DSHS EMS & Trauma Registries](#)
- [NTDB Dataset Dictionary](#)

SETRAC List of Committees

The primary function of the SouthEast Texas Regional Advisory Council is to provide stakeholder support through [planning](#), facilitation, operations and the provision of technical assistance to the region for [Preparedness](#), [Trauma](#), [Injury Prevention](#), [Stroke](#), [Cardiac](#), Prehospital, [Pediatric](#) and [Perinatal](#) services. As a coalition, we foster collaboration to educate our communities, and to collectively deliver appropriate care with appropriately trained providers. The following committees meet at least quarterly to discuss process improvement, gaps identified through data analysis, quality initiatives and general system of care development. Committee meeting date/time/location is listed on the SETRAC homepage: www.setrac.org.



Emergency Healthcare System Committees

SETRAC Board of Directors

Chairman
David Persse, MD

Trauma Committee

Chair
Chad Wilson, MD

Vice Chairs
LeAnne Young
Adam Fitzhenry

Stroke Committee

Chair
Chethan Rao, MD

Vice Chairs
Bryan Kharbanda, MD
Christy Gonzales

Cardiac Committee

Chair
Kevin Schulz, MD

Vice Chairs
Lesley Osborn, MD
David Bernard

Perinatal Committee

Chair
Elizabeth Eason, MD

Vice Chairs
Kendra Folh
Marty Delaney

Injury Prevention Committee

Chair
Anthony Arredondo, MD

Vice Chairs
Kristen Beckworth
Kacey Sammons

Pediatric Committee

Chair
Nichole Davis, MD

Vice Chairs
Andre Ruby
Eric Parmley

Prehospital Committee

Chair
Justin Reed

Vice Chairs
Lesley Osborn, MD
Allen Sims

TSA-Q Plan Components

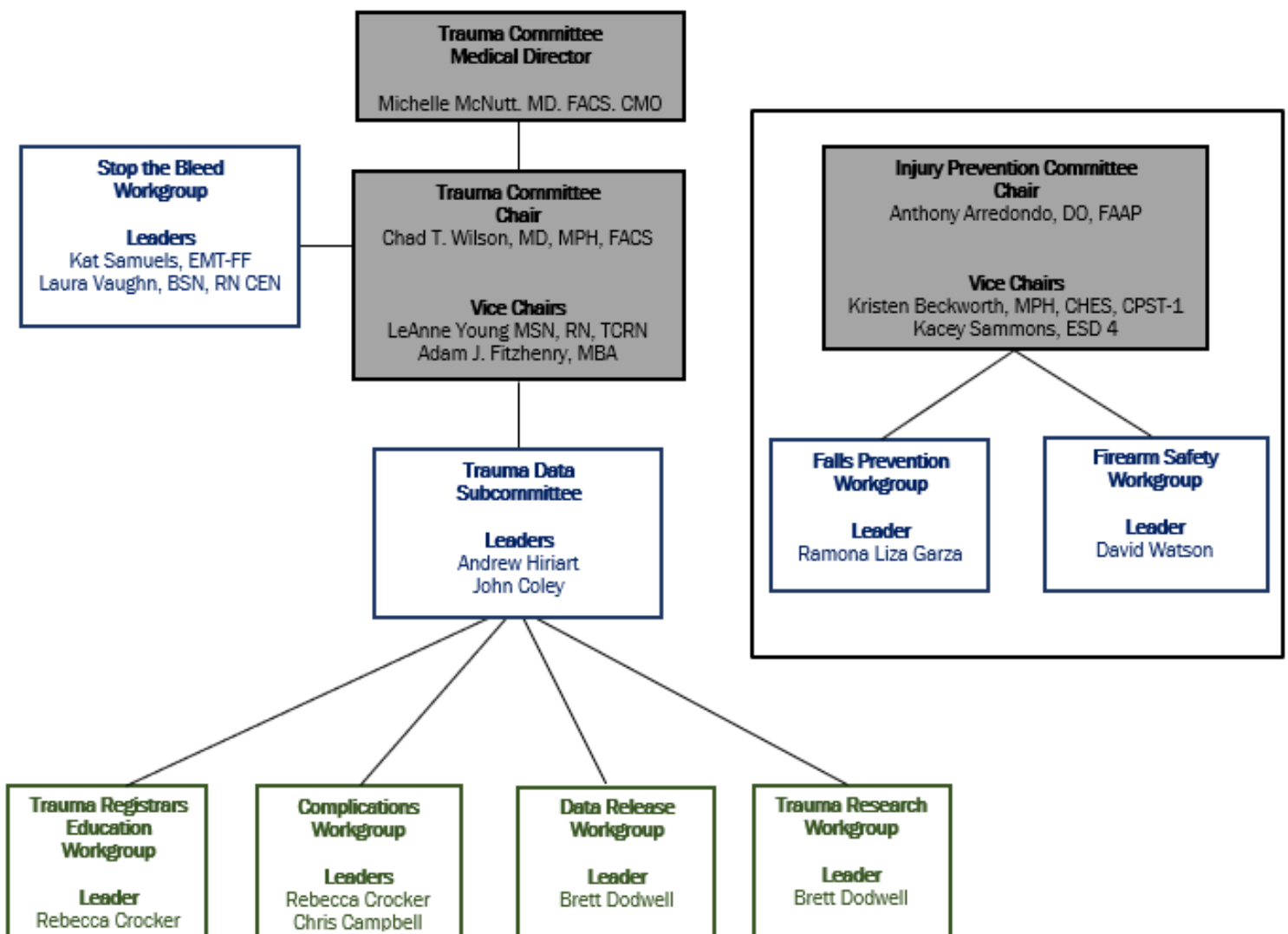
Injury Prevention

DESCRIPTION

The CDC states that violence and injury prevention require building effective partnerships to coordinate efforts across agencies, organizations, and sectors. The SouthEast Texas Regional Advisory Council (SETRAC), is the designated entity to develop and maintain the Regional Trauma/EMS Systems for TSA-Q, this provides unique opportunities to work with hospitals, EMS agencies, physicians, and other clinicians who care for these injured patients on a daily basis. We can minimize the impact of traumatic events in our 9-county region through prevention and education of our medical providers and community.



SETRAC Emergency Healthcare System Committees and Subcommittees



Access to the System

Basic 9-1-1

Basic 9-1-1 is a regional system providing dedicated trunk lines which allow direct routing of emergency calls. Routing is based on the telephone exchange area, not municipal boundaries. Automatic Number Identification (ANI) and Automatic Location Identification (ALI) are not provided with Basic 9-1-1. All areas of SETRAC have ANI, and the majority, with the exception of some rural counties have ALI.

Enhanced 9-1-1

Enhanced 9-1-1 is a system which automatically routes emergency calls to a pre-selected answering point based upon geographical location from which the call originated.

A 9-1-1 system operates by a caller dialing the digits 9-1-1, then the call is routed to the local telephone company central office or CO; at the CO, the telephone number is attached to the voice and sent to the Public Safety Answering Point (PSAP). With Automatic Location Identification and Selective Routing, the call is sent to the CO and the computer (9-1-1 Database) assigns an address to the phone number, then routes the call to the designated PSAP.

In TSA-Q, the primary emergency communication systems for public access are Basic or Enhanced 9-1-1. The emergency communication systems were implemented providing citizen's access to emergency communications to municipalities and counties (incorporated and unincorporated areas) in the TSA-Q.

ANI is a system capability that enables an automatic display of the ten-digit number of the telephone utilized to place a 9-1-1 call. ALI is a system that enables the automatic display of the calling party's name, address and other pertinent information.

Alternate Routing (AR) is a selective routing feature which allows 9-1-1 calls to be routed to a designated alternative location if all incoming 9-1-1 lines are busy or the central system (PSAP) closes down for a period of time.

Selective Routing (SR) is a telephone system that enables 9-1-1 calls from a defined geographical area to be answered at a pre-designated PSAP.

Access to the System (cont.)

Strengths

Strengths of the current 9-1-1 system include:

- Numerous counties have fully enhanced 9-1-1 systems which provide ANI and ALI information to the appropriate police, fire and EMS agencies that respond to the specific location.
- PC's that are provided to the answering point to assist in locating the caller in an ANI level of service area.
- All answering points are equipped with voice recording equipment, instant playback capabilities of previous telephone and/or radio conversations. Answering points have access to language line interpretation services, the communication devices for deaf (TDD/TTY), as well as conference call capability.
- Immediate activation of 9-1-1 with phone call and/or disconnection, even though database information is not current.

Weakness

Weakness of the current 9-1-1 system include:

- Potential average delay for database updates from time of telephone connection.
- Some areas are growing so fast that they may not yet be reflected on maps and global positional satellite (GPS) units.
- **(NOTE:** The above issues cannot be resolved by SETRAC. These problems can be resolved only by the map and GPS companies.)
- Within Harris County there are multiple EMS providers within close proximity of one another. At times this creates confusion related to the use of cell phones when calling 911. If the cell tower directs the call to a neighboring provider a delay results from the need to establish the identity of the proper provider, then transfer the call to their dispatcher. This can result in a one to three-minute delay.

Communications

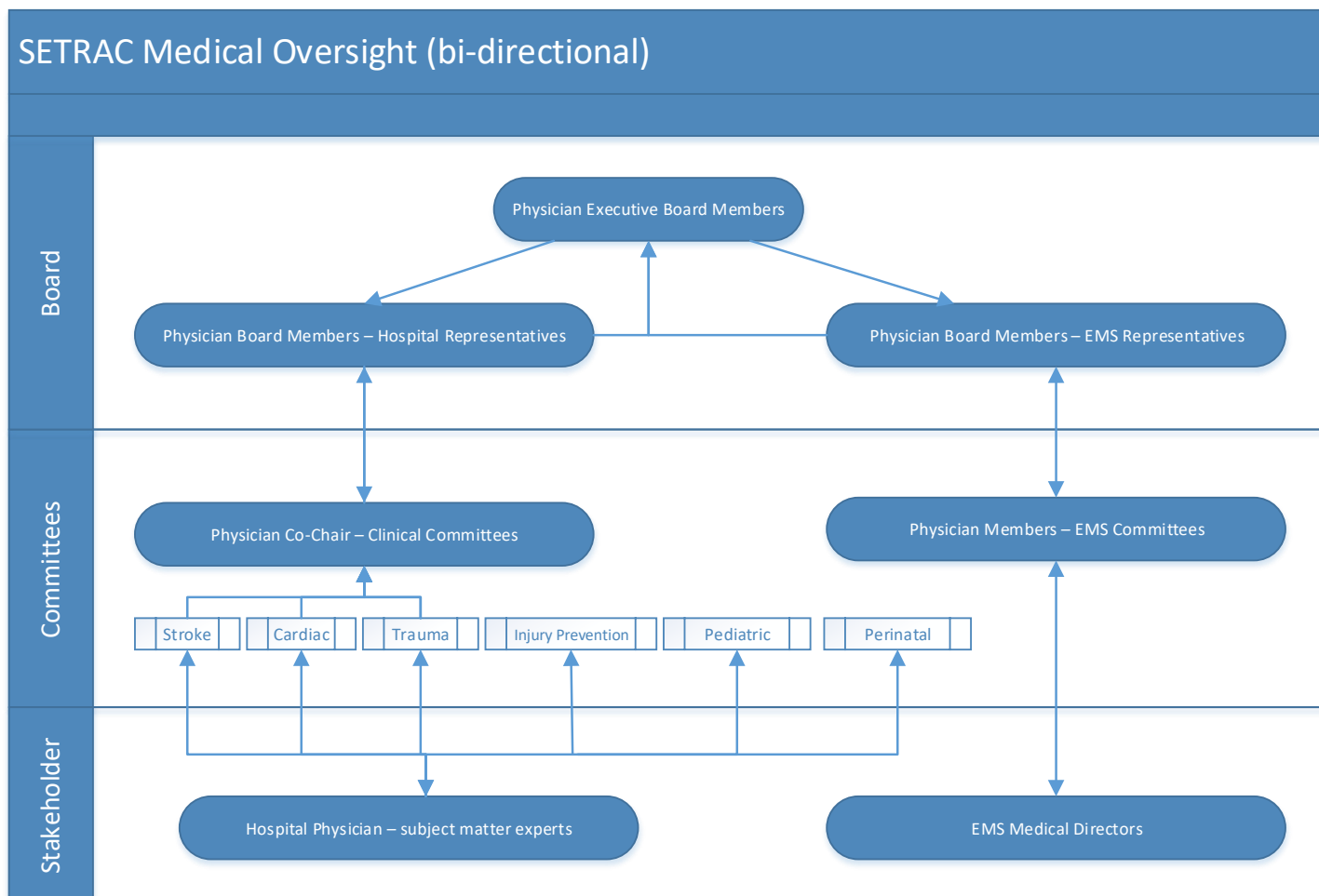
Due to the vast types of EMS and First Responder Organization agencies in TSA-Q: municipal, county, emergency service districts, non-profit, and for-profit providers, there are a variety of communications systems and dispatch methods utilized in the TSA-Q region.

Each agency has established dispatch training requirements and dispatch methods utilizing two-way radios on VHF, UHF, or 700/800mh radio system. Most providers have cellular telephones to utilize when radios are out of range and to contact hospitals for patient reports. A link to the list of agencies was provided previously in this document.

In most cases, these agencies have control stations in place that operate on their channel(s) and that are patched with control station(s) that operate on neighboring jurisdictions radio systems. This configuration allows for interoperability with most providers / users in the event of an incident or event.

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. All SETRAC clinical committees have physician, hospital, and EMS representation that lead the committees, and as needed, workgroups can be established to address specific needs. SETRAC recognizes medical oversight on all levels of the organization and those are outlined in the infographic below:



Regional Trauma Treatment Guidelines

Emergency Medical Service (EMS) professionals are most often the first healthcare providers to reach a traumatically injured patient, and based on their patient assessment and geographical location, will determine which hospital would provide the most appropriate level of care required by the patient. The triage decisions made by EMS professionals can impact the ability of the trauma patient to survive the injury, and to what quality of life they will recover to.

The SETRAC Trauma Committee, Pediatric Committee, and EMS Committee developed the SETRAC Pre-Hospital Adult and Pediatric Trauma Transport Guidelines. The purpose of these regional Pre-Hospital Trauma Transport Guidelines are to assist clinicians in determining the closest, most appropriate facility that can provide the highest level of trauma care for the traumatically injured patient, this provides patients the best chance at a full recovery after their traumatic event.

1. SETRAC Pre-Hospital Adult Trauma Transport Guidelines
 - a. Includes pre-hospital triage, treatment and by-pass guidelines
2. SETRAC Pre-Hospital Pediatric Transport Guidelines
 - a. Includes pre-hospital triage, treatment and by-pass guidelines
 - b. Addresses pre-hospital triage and scoring of pediatric patients

TRAUMA TRIAGE GUIDELINE

STEP 01



PHYSIOLOGICAL

Primary Survey and Level of Consciousness



CARDIAC
ARREST

Mental Status
Airway
Circulatory

Altered / LOC / Amnesia / Coma
Assisted or Intubated
Tourniquet and/or Hypotension*
*Pediatrics - Systolic BP < 70 mmHg + Age x 2

NO

YES

Assess anatomy
of injury.

Transport directly to Level I/II if it is
< 45 minutes by ground or air
transport time.

If Pediatric, prefer Pedi Level I Trauma
Center. Adult acceptable.

Patient meeting criteria but who are
too unstable to reach appropriate
destination, follow bullet (2) guidance

Witnessed by EMS

Pediatric - If <20 min by
Air or Ground, transport to
Pediatric Lvl I / II (adult acceptable)

Adult If <20 min by
Air or Ground, transport
to Lvl I / II

If >20 min by Air or Ground,
transport to closest Trauma
Center

1. Transport time is defined as
time from depart scene to time
arrive at destination. For Air
consider air response and
scene time with transport time.

2. If a provider cannot
oxygenate/ventilate or the
patient is too unstable for
transport to a Level I/II center,
the provider must transport to
the highest and closest Trauma
Center available;
Pediatric as applicable.

STEP 02



MAJOR INJURY

- All penetrating injuries to head, neck, torso, and
extremities proximal to elbow or knee
- Chest wall instability; e.g. flail segment
- Pelvic instability
- Two or more proximal long-bone fractures

- Major soft tissue injury, flap, avulsion, burn, or
amputation
- Multiple long bone fx and/or any one open long
bone fx
- Open or depressed skull fracture
- Paralysis

NO

YES

Assess MOI

Transport directly to Level I/II if it is
< 45 minutes by ground or air
transport time.

If Pediatric, prefer Pedi Level I Trauma
Center. Adult acceptable.

Patient meeting criteria but who are
too unstable to reach appropriate
destination, follow bullet (2) guidance

1. Transport time is defined as
time from depart scene to time
arrive at destination. For Air
consider air response and
scene time with transport time.

2. If a provider cannot
oxygenate/ventilate or the
patient is too unstable for
transport to a Level I/II center,
the provider should transport to
the highest and closest Trauma
Center available;
Pediatric as applicable.

STEP 03 MECHANISM

MOI Consideration

3. The criteria used for bypass to a Lvl I/II in Steps 3 and 4 are NOT ABSOLUTE; rather are indicators of the potential for significant injury or indicate the patient may require other support services at the Lvl I/II. Not all patients in these two categories require transport to a Lvl I/II. At minimum these patients should be transported to a Level III or IV Trauma Center. Pediatrics will require Pediatric Specific Trauma Center.

1. Falls
 - a. Greater than 10 feet or if pediatric >3x patient height
2. High Risk Auto Crash
 - a. Ejection (partial or complete) from automobile
 - b. Vehicle Telemetry data consistent with high risk injury (if available)
3. Auto vs. (pedestrian/bicyclist) Impact
4. Motorcycle crash > 20 mph
5. Death in same vehicle or extended extrication
6. Extended extrication
7. Suspicious / Non-Accidental Trauma

YES

Transport to nearest
Level III Trauma Center
Pediatric transport to Level I
Trauma Center

NO

Assess special patient or
system considerations.

STEP 04 SPECIAL CONSIDERATIONS

1. Age
 - a. Older Adults
 - i. Risk of Injury/death increases after age 55
 - ii. SBP < 110 may represent shock after age 65
 - b. Children
 - i. Should be triaged preferentially to pediatric-capable trauma center
2. Anticoagulation and bleeding disorders
3. Burns with no trauma to burn-specific center
 - a. With trauma mechanism: triage to Level I/II
4. Pregnancy > 20 weeks with MOI indicators
5. Time sensitive extremity injuries needing specialty care

YES

Transport to Level I/II. Paramedic
judgement and system status can
be used to help determine transport
destination.

NO

Transport to the closest Trauma Center.

Burn Guidelines

1. Adults (15 y.o. and older)

- a. **Minor Burns**- considered to be second-degree burns < 5% TBSA, which can be managed as an outpatient. However, if there is any concern about the need for inpatient care or about appropriate outpatient care the ER physician at the outside hospital where the patient was seen should call an ABA-verified burn center and speak to the on-call attending burn physician regarding follow-up versus transfer before discharging the patient home.
- b. **Moderate burns**- considered to be second-degree burns >5 % TBSA, but less than 10% TBSA, which may likely require transfer to a burn center for evaluation and possible admission. The ER physician at the outside hospital where the patient was seen should call the MHH-TMC transfer center and speak to the on-call attending burn physician regarding follow-up versus transfer. Patients should not be referred for burn follow-up without speaking to the on-call burn surgeon at MHH-TMC.
- c. **Major Burns**- considered to be second degree burns >10% TBSA, have any component of third degree burns, electrical burns, inhalation injury, or any other burn that meets ABA criteria for transfer to a burn center. The ER physician at the outside hospital where the patient was seen should call the MHH-TMC transfer center and speak to the on-call attending burn physician regarding immediate transfer to the burn center at MHH-TMC.
- d. **Any burns to face, hands, perineum,** electrical burns, inhalation injury, or any other burn that meets ABA criteria for transfer to a burn center.

2. Children (14 y.o. and younger)

- a. **Minor Burns**- considered to be second-degree burns < 5% TBSA, which can possibly be managed as an outpatient. However, if there is any concern about the need for inpatient care or about appropriate outpatient care, the ER physician at the outside hospital where the patient was seen should call the MHH-TMC transfer center and speak to the Pediatric ER physician regarding follow-up versus transfer before discharging the patient home. If the patient is going to be discharged home, recommend that the patient's burn wound are debrided as best as possible since this has been requested by the Pediatric Burn Surgeons.
- b. **Moderate burns**- considered to be second-degree burns >5 % TBSA, but less than 10% TBSA, which may likely require transfer to a burn center for evaluation and possible admission. The ER physician at the outside hospital where the patient was seen should call the MHH-TMC transfer center and speak to the Pediatric ER physician regarding transfer.
- c. **Major Burns**- considered to be second-degree burns >10% TBSA, have any component of third degree burns, hand, perineum, face, electrical burns, inhalation injury, or any other burn that meets ABA criteria for transfer to a burn center. The ER physician at the outside hospital where the patient was seen should call the MHH-TMC transfer center and speak to the Pediatric ER physician regarding immediate transfer to the Pediatric ER at Children's Memorial Hermann Hospital.
- d. **Burns >30% TBSA**- All pediatric burns (<16 years old) should be directly transferred to Shriners' Children's Hospital in Galveston after calling their transfer center and discussing the case with the Pediatric ER physician. It is not necessary to contact the transfer center at MHH-TMC for these patients, since it will delay appropriate transfer and care.

1. Treatment

- a. Burn patients seen at an outside hospital should have the burn wounds evaluated prior to contacting the transfer center at MHH-TMC and speaking with the Pediatric ER physician.
- b. The Pediatric ER physician will direct decisions regarding further wound care, whether the patient is being discharged home from the outside hospital or being transferred to MHH-TMC. In cases where the patient is being transferred to MHH-TMC, do not put any topical antimicrobial on the wound since this will need to be removed when the patient is evaluated by the pediatric surgery team.

- c. Do not apply saline soaked dressings or cold packs to any burn wounds because it can cause the depth of the burn to progress due to vasoconstriction of the blood vessels and/or lead to hypothermia in patients with larger burns.
- d. Not all burn patients require IV fluids. Only burn patients with burns >20% TBSA (second and/or third degree) require IV fluids; however, if there are any concerns about hypovolemia, start the patient on maintenance IV fluids.
 - a. If IV fluids need to be started, start Lactated ringers or Plasmalyte at 2 mL/kg/%TBSA with half the estimated amount being given over the first eight hours and the second half given over the ensuing 16 hours.
 - i. For children > 13 y.o., treat with adult (2mL/kg/%TBSA) resuscitation protocols.
 - ii. For children < 13 y.o. and > 30 kg, start LR at 3 mL/kg/%TBSA with half the estimated amount being given over the first eight hours and the second half given over the ensuing 16 hours.
 - iii. For infants and young children (<30 kg), start LR at 3 mL/kg/%TBSA with half the estimated amount being given over the first eight hours and the second half given over the ensuing 16 hours. In addition, they will require maintenance fluids in the form of LR (> 10kg) or D5LR (<10 kg).
 - b. Do not use the Parkland formula to determine fluid rate since it can lead to over-resuscitation.
 - c. Do **not** bolus burn patients for any reason, including hypotension, early on in resuscitation.
 - d. Place a foley in order to monitor urine output while awaiting transfer. Maintain urine output of 30-50 mL/hr for adults and children > 13 y.o. Children < 13 y.o. should have fluids titrated to maintain urine output of 1-2 mL/kg/hr.
- e. Patients who suffer burns due to chemicals should have the burn wounds decontaminated with continuous body temperature water for at least 30 minutes prior to transfer.
- f. Patients with electrical injuries should have an EKG checked to identify any arrhythmias prior to transfer.

Within our Region and in accordance with the American College of Surgeons Guidelines, a pediatric trauma patient is defined as 15 years of age or younger.

Saturation Policies (formerly “Diversions”)

The SETRAC region adopted a “No Diversion” policy in 2013. Hospitals that are experiencing high Emergency Department census or decreased inpatient bed capacity have the ability to identify these situations in EMResource.

Hospital Status:

- Open: All units/floors/bed types available; normal operating conditions
- Caution: Some areas/units of hospital unable to take patients/high census alert/some ancillary services such as CT or MRI are unavailable (please make note in comments area)
- Internal Disaster: Critical infrastructure failure
- Evacuation: Facility is evacuating
- Closed: Facility has completed evacuation or no longer in service

ED Status:

- Open: All services available and normal operating status of ED
- High Volume: Wait times are getting longer for non-urgent patients, ED census is nearing maximum, admission times increasing
- Saturation: Long wait times for most categories of patients, holding multiple admissions for > 6 hours

Trauma Status:

- No – unable to take additional trauma patients or not a designated trauma facility
- Yes – open for trauma patients and a designated facility

Acknowledgements:

- It is recognized in advance that no capacity strategy can guarantee total compliance with these guidelines and it is likely that ambulances will deliver patients to hospitals that have identified a state of saturation.
- Each facility is responsible for defining facility-specific policies and procedures for implementation of these guidelines.
- It is understood that the EMS system should not be expected to accurately screen patients transported to a facility based upon the capacity categories identified. When these questions arise, the EMS personnel should contact their on-line medical direction source, if available.

All hospitals in SETRAC have been provided with EMResource, which is an internet program that allows each hospital to update their status without the need to contact a central location. A hospital should be logged into EMResource at all times.

Communication of saturation status:

- The individual with proper authority shall log in and update EMResource appropriately.
- A hospital must indicate the applicable saturation category

Time period for diversion status:

- Saturation requests will be for 4 hours. After 4 hours, the system will “auto-open” the facility. A hospital may deactivate a saturation request at any time.

Saturation Policies (formerly “Diversion”) cont.

Authorization for over-ride of saturation request:

- The on-line medical direction source may over-ride a facility saturation request after consideration of the following:
 - Severity of the patient
 - Distance and estimated time to an alternate appropriate facility
 - Patient Request
 - Inclement weather conditions
 - Resource availability and capability of the transporting prehospital provider
 - All potential receiving facilities within a 15-minute radius of the patient location have requested saturation consideration

Communication of Internal Disaster status:

- The individual with proper authority shall log in and update EMResource appropriately.
- A hospital must indicate the condition that requires the declaration of Internal Disaster in Comments.
- The condition that requires the declaration of Internal Disaster must be an environmental or physical plant situation, such as utility outage, unsafe situation in the hospital, etc. Must specify in comments.
- SETRAC On-Call Duty Officer will contact the facility to obtain information regarding the internal disaster and whether the facility is in need of any regional resources to bring their facility back on-line.

Time period for Internal Disaster status:

- There is no time limit, but the hospital must update its status as soon as the condition that required the declaration of Internal Disaster is no longer in existence.

Regional Medical Control

The Texas Department of State Health Services under Chapter 773, Emergency Medical Services and the Texas Board of Medical Examiners under Chapter 197, Emergency Medical Service, dictate that a State of Texas Licensed Physician be designated in the role of EMS Medical Director. Each Medical Director can set and authorize EMS practice Guidelines and Protocols specific to the EMS agency or agencies that serve under their license. As a resource and a recommended standard, SETRAC and its committees can work to set recommended regional standards and best practice to each EMS agency and their designated Medical Director. SETRAC and its committees can provide resources and guidance on new and special topics, such as Infectious Disease, Preparedness and Disaster. During times of declared disasters, all agencies are subject to the policies and standards set forth by the State of Texas. These can include the Department of State Health Services, Health and Human Services and the Texas Department of Emergency Management.

Facility Triage Criteria

The process of triage allows hospitals to prioritize patients based on patient complaint, history and physical assessment findings. This process is individualized according to designation level and input from medical staff, however, guidance can be found in the American College of Surgeons (ACS) – Committee on Trauma document “[Resources for Optimal Care of the Injured Patient](#)”.

Minimum criteria for full trauma team activation as required by ACS include:

1. Confirmed blood pressure < 90 mmHg at any time in adults and age-specific hypotension in children
2. GCS < 9 with mechanism attributed to trauma
3. Transfer patients from other hospitals receiving blood to maintain vital signs
4. Intubated patients transferred from the scene
5. Patients who have respiratory compromise or are in need of an emergent airway
 - a. Includes intubated patients who are transferred from another facility with ongoing respiratory compromise
 - b. does not include patients intubated at another facility who are now stable from a respiratory stand- point
6. Emergency physician’s discretion

Additional regional criteria (approved by SETRAC Trauma Committee) for full trauma team activation at Level I and Level II trauma facilities include:

1. pre-hospital blood transfusion
2. pre-hospital tourniquet use
3. pelvic ring injury requiring stabilization device (pelvic binder or sheet)
4. gunshot wound to extremities proximal to the knee or elbow.

[SETRAC Regional Trauma Team Activation Criteria](#)

The ACS example of a tiered protocol is shown below.

Table 3 An Example of a Tiered Trauma Team Activation Protocol

FULL Trauma Team Criteria				LIMITED Trauma Team Criteria	
Persons who sustain injury with any of the following				Persons who sustain injury with any of the following	
PRIMARY SURVEY: PHYSIOLOGIC				MECHANISM OF INJURY	
Airway	Unable to adequately ventilate Intubated or assisted ventilation	Unable to adequately ventilate Intubated or assisted ventilation		<ul style="list-style-type: none">Falls: adult >20 ft; child >10 ft or 3× heightFall from any height if anticoagulated older adultHigh-risk auto crash with:<ul style="list-style-type: none">Intrusion of vehicle >12" in occupant compartment; >18" in other siteEjection (partial or complete) from automobileDeath in same passenger compartmentAuto vs. pedestrian/cyclist thrown, run over, or with significant (>20 mph) impactMotorcycle crash >20 mphHigh-energy dissipation or rapid decelerating incidents, for example:<ul style="list-style-type: none">Ejection from motorcycle, ATV, animal, and so onStriking fixed object with momentumBlast or explosionHigh-energy electrical injuryBurns >10% TBSA (second or third degree) and/or inhalation injurySuspicion of hypothermia, drowning, hangingSuspected nonaccidental traumaEMS provider judgmentBlunt abdominal injury with firm or distended abdomen or with seatbelt sign	
Breathing	Respiratory rate <10 or >29 per minute	Any sign of respiratory insufficiency (hypoxia, accessory muscle use, grunting)			
Circulation	SBP <90 mm Hg perfusion	Any sign of abnormal (capillary refill >2 secs, BP low for age)			
Deficit	GCS motor score ≤5, GCS ≤13	Age <1 y	SBP (mm Hg) <60		
		1–10 y	<70 + 2× age		
		>10 y	<90		
Deterioration of previously stable patient Transfers requiring blood transfusion					
SECONDARY SURVEY: ANATOMIC					
<ul style="list-style-type: none">Penetrating injuries to the head, neck, torso, or extremities proximal to the elbow/kneeOpen or depressed skull fractureParalysis or suspected spinal cord injuryFlail chestUnstable pelvic fractureAmputation proximal to the wrist or ankleTwo or more proximal long bone fractures (humerus or femur)Crushed, degloved, or mangled extremity					

To view the entire document, go to the American College of Surgeons webpage at: www.facs.org

Inter-Hospital Transfers

Traumatically injured patients should be transferred to a higher level of care when the medical needs of the patient require more resources than available at the initial treating facility. Research shows that it is critical to make the decision to transfer early, while continuing to stabilize and treat the patient until the transfer is completed. It is recognized that severely injured patients might not be stable prior to transfer, however, it should not be a contraindication for transfer to a higher level of care. SETRAC is also prepared to support inter-hospital transfers due to disasters that may limit facilities ability to provide services and/or the disaster results in a surge of patients. Similarly, SETRAC is prepared to support inter-hospital transfer of patients to federally designated hospitals for specific populations of patients. See also Disaster Preparedness Section.

Designation of Trauma Facilities

TSA-Q follows the Texas Administrative Code 157.125 - [Requirements for Trauma Facility Designation](#) when recognizing designated Trauma Centers in the region.

TSA-Q Disaster Preparedness

Regional Healthcare Preparedness Coalition (RHPC)

The SouthEast Texas Regional Advisory Council is a leader in healthcare emergency preparedness and response. Contracted under the Texas Department of State Health Services, SETRAC serves as the Hospital Preparedness Program (HPP) Contractor for TSA-Q, as well as TSA-R and H. additionally, SETRAC is the Lead RAC for the Region 6 EMTF program.

Through our standing Board Committee, the Regional Healthcare Preparedness Coalition (RHPC) provides coordinated planning, education, training, essential equipment and supplies, and a regional approach to healthcare response in a disaster.

This regional response is coordinated through the Catastrophic Medical Operations Center (CMOC). The CMOC serves the 25 county HPP region and provides a coordinating entity to ensure sustainment and recovery of healthcare infrastructure, staging oversight of EMS and transport assets, as well as situational awareness logistical support, and movement / tracking of medical populations, both from the community as well as from the hospitals and long term facilities in our response region.

Technological adjuncts to facilitate our planning and response efforts include: WebEOC, EmResource, EMTrack, and Everbridge. WebEOC is an integrated web-based tool that allows for information sharing, resource requests, and cross-jurisdictional awareness. EmResource is the primary tool utilized across the State of Texas for rapid incident notification, bed reporting capability, and resource/recovery need queries. EMTrack is a regional patient tracking application that integrates across the State of Texas via an interface, with the Texas Emergency Tracking Network. Everbridge is the primary notification tool utilized by EMTF 6 to provide information and query for EMTF resources.

For further information, the complete CMOC Plan, including Annexes and Appendices may be located at [CMOC Basic Plan](#).

Performance Improvement (PI) Program

PURPOSE

The purpose of the performance improvement program is to provide ongoing assessment and improvement activities designed to objectively and systematically monitor and evaluate the effectiveness of the regional trauma system through data analysis.

GOALS

- Evaluate high risk, high volume and problem prone areas related to trauma care. This can be done through stakeholder request, or through analysis of regional trauma data.
- Collaborate with other committees of SETRAC to provide educational offerings or quality improvement input when opportunities are identified through the PI process.

SCOPE

- Determining the process for ongoing assessment of the system, including trauma care, patient outcome (adult & pediatric) and compliance with TSA guidelines.
- Provide system feedback to Trauma, EMS, and Pediatric Committees.

CONFIDENTIALITY

All data will be presented in a HIPAA compliant, de-identified in the spirit of improving trauma care quality.



Regional Acute Coronary Syndrome (ACS) System Plan

Endorsed by SETRAC Board of Directors

Date: 00/00/0000

Approved by SETRAC Stakeholders

Date: 04/28/2023

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SETRAC serves the counties of Austin, Colorado, Fort Bend, Harris, Matagorda, Montgomery, Walker, Waller, and Wharton.

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I. INTRODUCTION

- **PURPOSE**

The purpose of the Acute Coronary Syndrome (ACS) Plan is to facilitate coordination of heart attack care providers to promote the most efficient, consistent, and expeditious care of each individual who experiences a heart attack.

- **MISSION**

The mission of the Southeast Texas Regional Advisory Council (SETRAC) Cardiac Committee is to reduce heart disease morbidity and mortality by developing and maintaining integrated quality processes in patient care and public education.

- **VISION**

SETRAC will provide leadership in ACS treatment within TSA Q through a stakeholder coalition supported by resources which will develop, operate, evaluate, and integrate a regionalized cardiac system of care.

- **ORGANIZATION**

SETRAC provides the infrastructure and leadership necessary to sustain an ACS treatment and transfer system within the designated nine-county region of Trauma Service Area Q (TSA Q) and works to improve the level of care provided to persons living or traveling through this region. Together, through the work of designated standing committees, SETRAC member organizations (hospitals, first responder organizations, EMS providers, air medical providers, emergency management, public health, etc.) collaborate to assure that quality care is provided to ACS patients by pre-hospital and hospital professionals. SETRAC will provide heart health awareness and education to the public and healthcare providers in each of the nine counties it serves.

- **REGIONAL PLAN**

This plan has been developed in accordance with the general accepted ACS guidelines and procedures for implementation of a comprehensive Emergency Medical Services (EMS) and ACS system plan. This plan does not establish a legal standard of care but is intended as an aid to decision-making in ACS patient care. It is not intended to supersede the physician's prerogative to order treatment.

II. ACS SYSTEM OF CARE GOALS

The purpose of the SETRAC Cardiac Care Committee is to facilitate the development, implementation, and operation of a comprehensive ACS system based on accepted, evidence-based standards of care to decrease morbidity and mortality related to ACS. SETRAC will solicit participation from health care

SETRAC Regional ACS System Plan

facilities, organizations, entities, and professional societies involved in health care. SETRAC will encourage multi-community participation in providing ACS care, work to promote improvement of facility services, and cooperate with all member entities, agencies, and organizations in the establishment of an efficient and effective system of ACS care. SETRAC will develop a plan for a regional comprehensive ACS system that will:

- Identify and integrate resources to foster commitment and collaboration in developing a regional cardiac system of care.
- Identify strategies to promote EMS provider participation in the cardiac system of care.
- Establish system coordination relating to access, protocols/ procedures, and referrals. This coordination intends to establish continuity and uniformity of care among the providers of cardiac patient care.
- Promote internal communication as the mechanism for system coordination. This communication will include stakeholders such as EMS providers, hospitals, and members of the SETRAC Cardiac Committee.
- Create system efficiency through continuous quality improvement processes to develop standardization and uniformity in approaches to cardiac patient care.

III. CARDIAC FACILITY CAPABILITIES/EXTERNAL CREDENTIALING

- To ensure that there is understanding throughout the region with regards to facility capabilities for the care of the ACS patient, and this information is available for patient destination decision making.
- EMResource is the official means of notification of these capabilities and their availability. To remain listed in EMResource as a cardiac facility, the facility must remain in good standing through the participation requirements listed below.
- Because the Texas Department of State Health Services (DSHS) does not designate ACS facilities in Texas, the committee will encourage external credentialing organizations as the means for recognition of cardiac facilities. Examples of credentialing bodies are:
 - American College of Cardiology
 - Joint Commission
 - Mission: Lifeline
 - Accreditation for Cardiovascular Excellence
- SETRAC participation requirements specific to PCI facilities include, but are not limited to:
 - Payment of dues as an accredited center.
 - Participation in SETRAC—6 annual meetings with at least 3 being cardiac committee meetings.
 - Submission of cardiac data to SETRAC on a quarterly basis.
 - Compliance with all rules established by the SETRAC Board and the Cardiac Committee (with approval by the SETRAC Board.)

NOTE: Any facility that does not meet participation requirements of the above-mentioned committees and misses two fiscal quarters of data submission will be deemed “Not participating with SETRAC” and

arrangements will need to be made on an individual basis between the facility and SETRAC in relation to any discrepancies.

IV. **HEART ATTACK AWARENESS AND PREVENTION**

Goal: The SETRAC Cardiac Care system stakeholders (SETRAC, EMS and facilities) will partner to conduct health education, public awareness and community outreach on heart health, early heart attack care, recognition of signs and symptoms of heart attack, and the emergent care of the heart attack victim.

V. **SYSTEM ACCESS**

Goal: Persons in the region will have access to emergency cardiac care. In portions of this region, First Responder Organizations (FRO) may provide initial treatment pending EMS arrival.

A primary element of an EMS/ACS system is the provision of easy and rapid access to EMS and subsequent mobilization of a medical response to the scene. Every call for emergency services should universally and automatically be accompanied by location identifying information. Routing is based on telephone exchange area, not municipal boundaries. Automatic Number Identification (ANI) and Automatic Location Identification (ALI) should be available. Alternative Routing allows 911 calls to be routed to a designated alternative location when in effect. Most areas route their calls to the county 911 in case of overload or failure.

Committee Charge

EMS Committee in collaboration with the Cardiac Care Committee will promote written protocols and proper training of dispatch personnel.

VI. **COMMUNICATIONS**

- EMS to hospital alerts
 - EMS should have the ability to alert the hospital when a STEMI is identified to activate care teams prior to the patient's arrival at the hospital.
 - Hospitals should work with local EMS to define and continually improve communications methods and procedures that describe how EMS alerts are received in the hospital and then distributed to physicians and treatment teams.
- EMS to hospital 12-leads
 - EMS should have the ability to send 12-lead ECGs from the field to the hospital.
 - EMS protocols should describe which patients should have their 12-lead ECG transmitted to the hospital.
 - STEMI Team Notification should not be dependent on 12-lead ECG transmission.
- Follow Up
 - Hospitals should provide feedback to EMS on all patients where EMS initiated a STEMI alert as well as any patient transported by EMS that was later found to have a STEMI.

VII. MEDICAL DIRECTION/OVERSIGHT

- Each EMS agency Medical Director is responsible for developing local protocols and for monitoring and improving their agencies performance.
- Local guidelines should be generally compatible with regional prehospital guidelines but may be modified at the discretion of the agency Medical Director.
- The SETRAC Cardiac Care Committee should work with the Medical Director and EMS Committees to complete a periodic review and update of prehospital guidelines.

VIII. PRE-HOSPITAL TRIAGE CRITERIA

- EMS should follow local protocols regarding triage criteria.
- Local protocols should describe when a patient should be taken preferentially to a PCI center over a non-PCI center as well as situations where air medical transport should be considered.

XII. FACILITY SATURATION

Goal: SETRAC ACS/Chest Pain facilities will communicate “facility saturation” (formerly known as “facility diversion”) status promptly and clearly to regional EMS and other facilities through EMResource to assure that cardiac patients are transported to the nearest appropriate ACS/Chest Pain facility.

Facility Saturation is used by ACS/Chest Pain System entities to assure ACS/Chest Pain patients will be transported to the nearest appropriate ACS/Chest Pain facility when the facility cannot at that time accept a patient for safe and appropriate patient care. (See ACS/Chest Pain Prehospital guidelines). These include situations which would require the facility to go on saturation, notification/ activation of saturation status, and the procedure for termination of saturation status. All facilities and pre-hospital providers should use the EMResource to notify EMS partners of saturation status.

XIII. FACILITY BYPASS

Goal: Suspected ACS/Chest Pain patients who are eligible within the timeframe for United States FDA approved cardiac therapies will be safely and rapidly transported to the nearest appropriate ACS/Chest Pain facility in accordance with published SETRAC transport guidelines.

SEE APPENDIX A: ACS/Chest Pain Prehospital Guidelines.

XIV. FACILITY TRIAGE CRITERIA

GOAL: To promote the use of National, evidence-based guidelines for the triage of ACS/Chest Pain patients

XV. INTER-HOSPITAL TRANSFERS

GOAL: To assure that those ACS/Chest Pain patients requiring additional or specialized care and treatment beyond a facility’s capability are identified and transferred to the most appropriate facility as soon as possible.

According to the federal Emergency Medical Treatment and Labor Act (EMTALA), a cardiac facility must accept any transfer of patients whose condition requires a higher level of care that cannot be provided at the initial facility.

XVI. SYSTEM QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

GOAL: To promote participation in SETRAC's data collection registry for regional performance improvement.

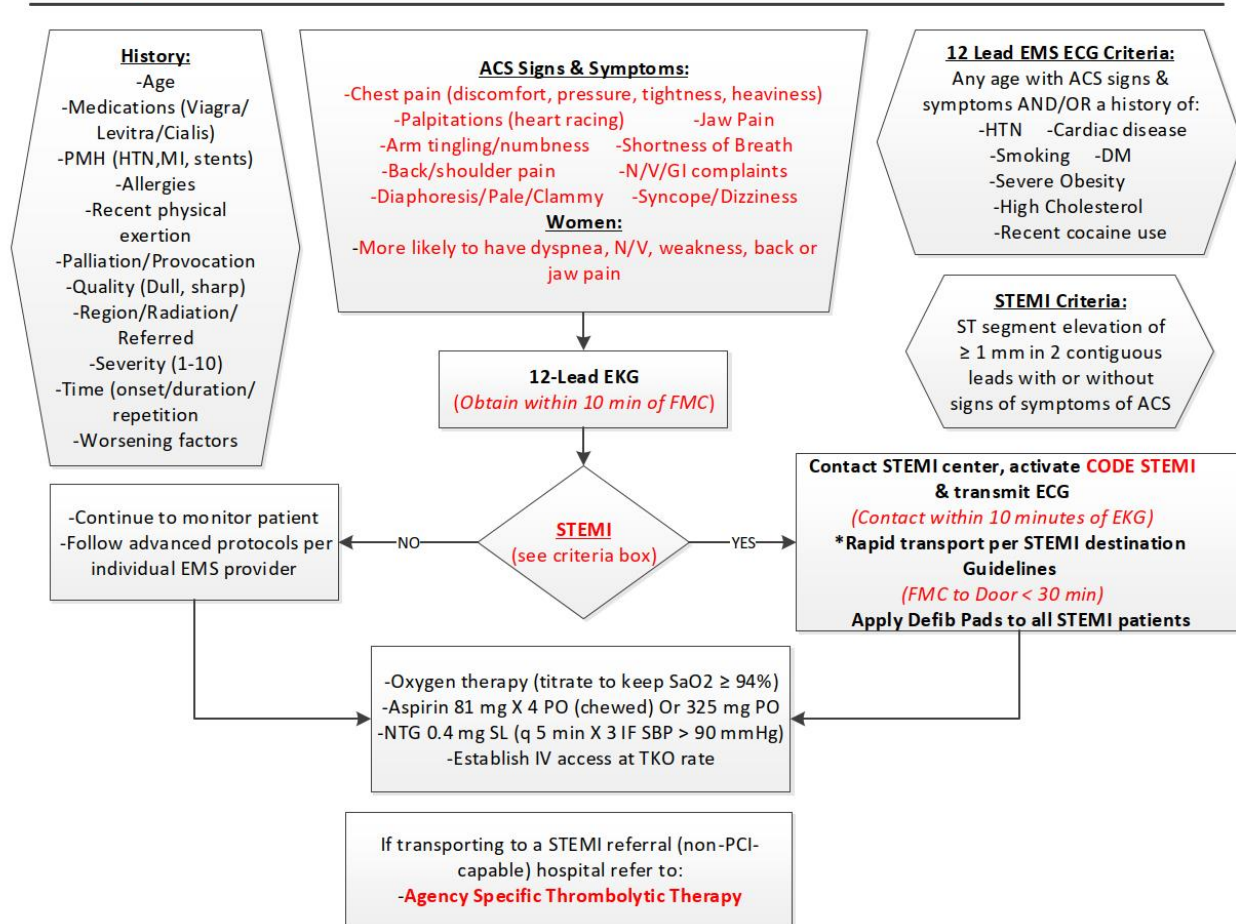
SETRAC has established a method for monitoring and evaluating ACS/Chest Pain system performance over time and assessing the impact of ACS/Chest Pain system development on the region's public health.

SETRAC has established regional cardiac data filters which reflect processes and outcomes of the SETRAC ACS/Chest Pain system of care. SETRAC also provides a multidisciplinary forum for cardiac care providers to evaluate cardiac patient outcomes from a system perspective and facilitates the sharing of information, knowledge, and scientific data.

SETRAC and our stakeholders shall conduct ongoing performance evaluation through quality indicators developed by each Committee Chair of the Board Recognized Committees, to ensure continued compliance with regional guidelines. The Medical Director for the Cardiac Committee will facilitate case reviews based on criteria established in the SETRAC QI Plan.



ACS/CHEST PAIN Prehospital Guidelines



Code STEMI Considerations:

- Establish 2nd IV if possible with NS (250-500 ml) infusing at TKO as pre-cath hydration
- Keep patient connected to monitor, place defibrillator pads & 12 lead cables when brought into ED for physician evaluation
- If possible, remain on EMS stretcher and monitor in ED
- Prepare to be escorted to CATH Lab on EMS stretcher and monitor to expedite transfer of care to CATH LAB nurse/physician.

Pearls

- Exam: Mental status, neuro, skin, neck, lung, heart, abdomen, back, extremities
- Consider STEMI imposters: LBBB, Pericarditis, Benign Early Repolarization, LV Hypertrophy, and Brugada Pattern.
- Avoid Nitroglycerin in any patient who has used Viagra (sildenafil) or Levitra (vardenafil) or Cialis (tadalafil) in the past 24 hours due to potential severe hypotension.
- Document the time of the FMC, 12-Lead ECG and STEMI activation
- Apply Defib pads to all patients for whom a STEMI alert is called; pads are not mandatory for those with ECG transmitted for consult only. Provider judgment may guide pad application in non-STEMI alert patients.

O'Gara, P. T., Kushner, F. G., Ascheim, D. D., & Casey, D. E. (2013). 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction. *Journal of the American College of Cardiology*, 61(4), 78–140. <https://doi.org/https://doi.org/10.1016/j.jacc.2012.11.019>

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