

**BRAZOS VALLEY REGIONAL  
ADVISORY COUNCIL  
Trauma Service Area "N"**



**P.O. Box 2861  
Bryan, Texas 77805**

**Regional System Plan  
2008-2009**

*Accepted May 11, 1993  
Revised October, 1997  
Revised January, 1998  
Revised June, 2000  
Revised June, 2003  
Revised June, 2006  
Revised February 2009*



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## **INTRODUCTION**

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## **Overview of the Brazos Valley Regional Advisory Council**

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The Brazos Valley Regional Advisory Council (BVRAC) was established in 1992 through a grant from the \*Texas Department of Health's Regional Trauma System Development Grant Program. It is one of 22 Trauma Service Areas in Texas and consists of seven counties known as Trauma Service Area – N. BVRAC is recognized by the IRS as a 501(c) 3 non-profit organization since 1998.

During the 71<sup>st</sup> legislative session (1989), House Bill 18 was passed directing the establishment of a statewide trauma system for Texas. Specific rules and regulations related to the development of the statewide system were identified and implemented.

The state was divided into 22 Trauma Service Areas that account for the 254 counties in Texas. A Regional Advisory Council for trauma serves each Trauma Service Area. The Regional Advisory Councils were charged with developing a system plan based on standard guidelines for implementing a comprehensive trauma care system. The development of a regional plan is the ultimate responsibility of the stakeholders and participants of the Regional Advisory Councils. Some elements of the plan are required, while others may be added to best reflect the needs of the community. While the Plan may have numerous components, its heart is the dedication of the professionals who transform these guidelines into reality.

Trauma Service Area "N" as outlined in EMS/Trauma Rules consists of a seven county region, better known as the "Brazos Valley". The Brazos Valley and Trauma Service Area "N" include the counties of Brazos, Burleson, Leon, Madison, Robertson, Washington, and Grimes. Each county has representation of pre-hospital providers. Trauma Service Area "N" is a predominantly rural region with seven healthcare facilities. The Brazos Valley Regional Advisory Council strives to serve the counties in its region and support its mission:

***"It is our mission to provide the infrastructure and leadership necessary to sustain an optimal and comprehensive trauma, acute care, and emergency medical system within Brazos Valley Region."***

Since its inception, BVRAC has been active in trauma prevention and education programs as well as development and implementation of trauma patient care standards. Maintaining public education and awareness activities to increase the understanding of the trauma care system, access to trauma care and prevention of injuries, and providing coordination of acute medical services in mass casualty and disaster settings is an integral part of the mission and goals of BVRAC.

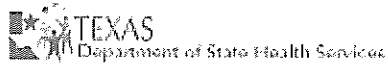
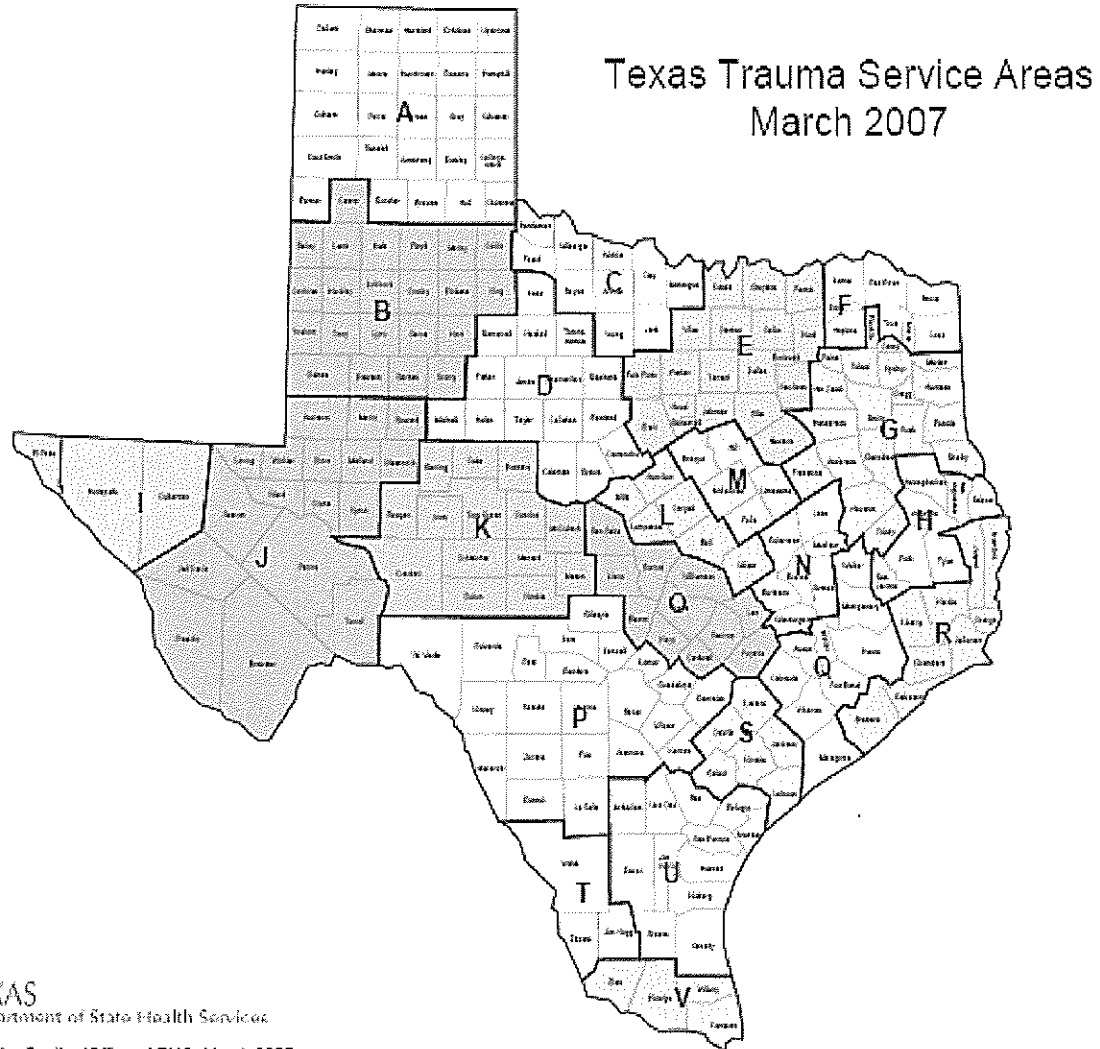
Trauma and Acute Care should be part of a seamless trauma system that provides patients with well-organized and high-quality care. Incorporation of an overall health care system requires cooperation and availability of each component of the system.

The essence of a trauma and acute care system is the ability to get the right patient to the right hospital at the right time to reduce death and disability. BVRAC members have made great strides toward this goal and continue to collaborate and strive to improve care of the trauma and acute care patient.

*(\*Texas Department of Health became Texas Department of State Health Services in 2005)*



# TEXAS TRAUMA SERVICE AREAS



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



**TRAUMA SERVICE AREA "N"**



	Population (2000)	Population (2006)	% < 5yrs old	% <18 yrs old	% >65 yrs old	Housing Units (2006)	Land Area/Miles Sq. (2000)	Persons per Sq. Mile (2000)
Brazos	152,415	159,006	7.3%	22.1%	7.7%	68,501	585.78	260.1
Burleson	16,470	16,932	6.6%	23.9%	16.6%	8,572	665.54	24.7
Madison	12,940	13,310	5.5%	20.6%	14.3%	5,016	469.65	27.5
Grimes	23,552	25,552	6.4%	22.8%	13.6%	9,878	793.60	29.7
Washington	30,373	31,912	6.5%	23.1%	17%	13,948	609.22	49.9
Robertson	16,000	16,214	6.8%	26.6%	16.2%	8,142	854.56	18.7
Leon	15,335	16,538	6%	22.2%	20%	8,659	1,072.04	14.3

Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, Census of Population and Housing, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Report.



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## BOARD OF DIRECTORS

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### EXECUTIVE COUNCIL MEMBERS

**Brenda Putz, RN - Chair**  
Texas EMS, Trauma and Acute Care Foundation  
[bk2putz@aol.com](mailto:bk2putz@aol.com)

**Wanda Wiktorik, RN - Secretary**  
Trinity Medical Center  
[wwiktorik@trinitymed.org](mailto:wwiktorik@trinitymed.org)

**Billy Rice, FP-C - Vice Chair**  
PHI Air Medical 12  
[brice@phihelico.com](mailto:brice@phihelico.com)

**Rick Moore, RN, LP - Treasurer**  
College Station Medical Center  
[rick.moore@triadhospitals.com](mailto:rick.moore@triadhospitals.com)

### COMMITTEE CHAIR MEMBERS

**Kevin Deramus, LP - Pre-Hospital Chair**  
Washington County EMS  
[kderamus@wacounty.com](mailto:kderamus@wacounty.com)

**Tina Taylor, RN - Injury Prevention Committee Chair**  
PHI Air Medical 12  
[tinataylor\\_rn@yahoo.com](mailto:tinataylor_rn@yahoo.com)

**Donna Gomez, EMT-P - Pre-Hospital Co-Chair**  
St. Joseph EMS  
[dgomez@st-joseph.org](mailto:dgomez@st-joseph.org)

**Amy Plotts, RN - Acute Care Chair**  
St. Joseph Regional Health Center  
[aplotts@mail.st-joseph.org](mailto:aplotts@mail.st-joseph.org)

**Rick Moore, RN, LP - Education Committee Chair**  
College Station Medical Center  
[rick.moore@triadhospitals.com](mailto:rick.moore@triadhospitals.com)

**Julia Jarrell, RN - Hospital Care/Mgmt. Chair**  
St. Joseph Hospital  
[jjarrell@st-joseph.org](mailto:jjarrell@st-joseph.org)

**Ginger Braly, RN - Systems QI Committee Chair**  
St. Joseph - Burleson County  
[gbraly@st-joseph.org](mailto:gbraly@st-joseph.org)

# **BVRAC BYLAWS**

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## THE BRAZOS VALLEY REGIONAL ADVISORY COUNCIL Trauma Service Area (TSA) N BYLAWS

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### Article I – Name

Brazos Valley Regional Advisory Council (BVRAC)

### Article II - Definitions

This organization shall be known as the BRAZOS VALLEY REGIONAL ADVISORY COUNCIL (BVRAC). The BVRAC Trauma Service Area includes the counties of Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington. The BVRAC Trauma Service Area is also referred to as “TSA N”.

### Article III – Mission Statement and Goals

***“It is our mission to provide the infrastructure and leadership necessary to sustain an optimal and comprehensive trauma, acute care, and emergency medical system within Brazos Valley Region.”***

#### Section 1. Goals:

- A. Advance and improve the state of healthcare for the patients within the counties of Trauma Service Area N (Brazos Valley Regional Area).
- B. Decrease morbidity and/or mortality which results from injury or illness.
- C. Encourage activities designated to promote cooperation and resolve conflicts between member organizations.
- D. Improve funding of trauma providers, acute care providers, and emergency care providers within the counties served by this Council.
- E. Maintain a Trauma and Acute Care System Plan for the RAC which is based on standard guidelines for comprehensive system development.
- F. Improve public awareness of the methods of accessing the trauma and acute care system, preventing injury, and promoting stroke and cardiac awareness.
- G. Coordinate responses to mass casualty, evacuation, and disaster events utilizing current National Incident Management System (NIMS) guidelines.



## Article IV – RAC Membership

### Section 1.

RAC membership encompasses a wide range of professionals and citizens concerned about the health and well-being of the community as it relates to trauma, acute care, emergency services and disaster preparedness. Voting membership requires that the member represent a hospital or disaster service, an individual who is involved with trauma, acute care, emergency, or disaster care, an emergency medical service, an educational agency involved in training purposes for trauma, acute care, emergency, or disaster preparedness, or a service which provides care to victims of trauma, emergency, and/or disaster. A voting member must practice and/or reside within the boundaries of TSA N.

### Section 2. Condition of Membership

- A. A member entity must complete an Agency/Individual Representation Form. The Representatives listed on this form for official representation of the agency must meet the requirements for representation as outlined in the Official Representation section of the BVRAC SOPs.
- B. No person shall be denied membership on the basis of race, sex or religious preference.
- C. A member who resigns in good standing may reapply for membership. Resignations must be submitted in writing to the Executive Committee.
- D. A member failing to actively participate in BVRAC activities as defined by the Executive Committee may be removed from the membership by a majority vote of the Executive Committee. A member who does not comply with assigned responsibilities or is charged with an act/or conviction of any felony violation of law may be relieved of duty and membership by simple majority vote of the Executive Committee. Said member may appeal this action for re-instatement in writing to the Executive Committee.
- E. Prior to removal from the membership by the Executive Committee, the Executive Director will notify said member that they are not compliant with RAC bylaws and participation requirements. If participation does not increase, a certified letter will be sent to that member organization at the last known mailing address. If the issue continues, the Executive Director will bring said member's name to the Executive Committee for removal.



### Section 3.

Agency representatives will be allowed one vote at the General Assembly meetings. The vote may only be cast by one of the two persons listed on the entity's Agency/Individual Participation Form, or designee as defined in the voting section of the BVRAC SOPs.

### Section 4. Active Participation in the RAC is defined as the following:

#### 1. EMS Provider Agencies

1. Will hold a valid state license, registration or certification through the Texas Department of State Health Services (DSHS) to maintain membership.
2. Will have pre-designated representation at no less than (4) General Assembly Meetings Annually.
3. Will have pre-designated representation at no less than (4) Pre-Hospital Committee and (4) System QI Committee Meetings annually.
4. Are strongly encouraged to attend all subcommittee meetings.
5. Will submit information into the Trauma Registry.
6. Will attend any meeting when the agency has a referral on any committee agenda.
7. Will submit required Performance Improvement data upon request.
8. Will participate in one community disaster preparedness drill per year.

#### 2. Hospital Members

1. Will have pre-designated representation at no less than (4) General Assembly Meetings Annually.
2. Will have pre-designated representation at no less than (4) Hospital Care and Management Committee Meetings and (4) Systems QI Committee Meetings annually.
3. Are strongly encouraged to attend all subcommittee meetings.
4. Will submit information into the Trauma Registry.
5. Will attend meetings when the agency has a referral on any committee agenda.
6. Will participate in 75% of scheduled preparedness activities.
7. In the event of emergency healthcare activations, will participate as required by the Health & Medical Annex of the County Emergency Operations Plans and/or the BVRAC Regional Response Plan.



3. Non-EMS/Hospital Entities
  1. Will have pre-designated representation at no less than (4) General Assembly Meetings annually.
  2. Will have pre-designated representation at no less than (4) Standing Committee Meetings annually.
4. Each agency will complete an annual Regional Needs Assessment by the 1<sup>st</sup> of June of each year.
5. Membership Dues must be paid in full by each member by the 1<sup>st</sup> of March of each year. Dues, Fees or other financial incentives do not determine the number of votes awarded to an organization/entity.

Membership dues are charged as follows:

- Hospitals - \$500.00
- 9-1-1 EMS Providers (including Air Medical) - \$250.00
- Other Members (i.e., FROs, Emergency Management, etc.) - \$50.00
- Individuals - \$25.00

6. Exceptions to the above requirements may be considered by the Board on an individual basis. An entity seeking such an exception must submit, in writing, a request for the exception and provide documentation to support the request.

## **Article V – Board of Directors**

- Section 1. The Board of Directors shall consist of the following:

### **Executive Committee**

1. Chair
2. Vice Chair
3. Secretary
4. Treasurer
5. Executive Director (ex-officio non-voting)

### **Committee Chairs**

1. Chair of the Pre-hospital Committee
2. Chair of the Hospital Care & Management Committee
3. Chair of the Physicians' Advisory Committee
4. Chair of Systems QI Committee
5. Chair of the Education Committee
6. Chair of the Injury Prevention Committee
7. Chair of the Emergency Preparedness & Response Committee
8. Chair of the Acute Care (Stroke and STEMI) Committee



### Other Members

1. Immediate Past Chair
2. Rural Member-at-Large
3. Emergency Management Member-at-Large
4. Physician-at-Large
5. Community Member-at-Large
6. Hospital Representative Member-at-Large
7. Pre-Hospital Representative Member-at-Large

Nominations for the position of Rural Member-at-Large, Emergency Management Member-at-Large, Physician-at-Large, Community-at-Large, Pre-Hospital Representative Member-at-Large and General Hospital Representative Member-at-Large will be obtained by the General Assembly and appointed by the Board.

Additionally, employees (including the Executive Director) of the RAC may not serve as a member of the Board of Directors. If an employee is appointed to a Committee Chair position, the Vice Chair of that committee will fill the Board of Director position for that committee.

#### Section 2. Quorum:

At least two (2) Executive Committee members must be present as well as two-thirds (2/3) of the filled Board of Directors positions shall constitute a quorum for the purpose of transacting any business of BVRAC.

#### Section 3. Meetings:

The Board of Directors shall be held monthly. Additional meetings will be scheduled as needed.

The Chair may call a special meeting at any time with a one (1) week advance notice to the Board of Directors. This notice may be sent by the Chair or the Executive Director electronically. A quorum is required for a special called meeting.

#### Section 4. Attendance:

Board Members must attend no less than (10) of the Board meetings per year. An alternate representative may be designated to attend a Board meeting by the member. This representative may cast that entity's vote. An alternate may attend no more than (2) of the *scheduled* board meetings per year.



Section 5. Resignation/Succession

In the event that the Chairperson resigns or is removed from office prior to the term expiration, the Vice Chair will immediately succeed the resigned/removed Chair.

A Board Member who does not comply with assigned responsibilities may be relieved of office by a majority vote of the Board. Appointment of a replacement shall be made by the Chair with a majority vote of the Board present at the meeting.

Any vacancies shall be filled for the balance of the unexpired term by the Chair with a majority vote of the Board. The Board Member who serves the unexpired term will be eligible for reappointment twice.

Section 6. Elections:

Nominations shall be held in June of each calendar year for voting in the August General Session Meeting. Terms shall begin September 1<sup>st</sup> of the same calendar year.

No chair will be limited on the number of terms that he or she may serve. In order to provide continuity of representation on the Executive Committee:

- A. The Chair is elected to a 2-year term on even numbered years. After serving the final term, the Chair will then rotate to the Immediate Past Chair position.
- B. The Vice Chair is elected to a 2-year term on even numbered years and rotates into the Chair position following completion the current Chair's final term.
- C. The Secretary and Treasurer will be elected to a 2-year term on odd numbered years..

Section 7.

The Board Members shall serve a 2-year term. In the event that there is no other person available or willing to serve, an additional term(s) may be approved by a simple majority roll-call vote of the General Assembly.

Section 8.

The Board of Directors shall be empowered to employ personnel to conduct the business of the RAC.

Section 9.

The Board shall operate in the place of a Finance/Audit Committee. Finance/Audit will remain a standing agenda item of the Board of Directors.



Section 10.

The Board of Directors shall develop and maintain policy statements that guide the functioning of the RAC. A policy shall receive final approval of the Board with a majority vote of those members present. Copies of such policy statements shall be provided to the General Assembly upon final approval of the Board of Directors at the following General Assembly meeting.

## **Article VI – Election of Officers and Board of Directors**

Section 1.

At the June meeting of each year, nominations shall be requested from floor of the General Assembly.

Section 2.

Nominations shall be provided to the General Assembly two (2) weeks prior to the August meeting each year. The election of expired term Officers and Board of Directors shall be by open ballot during the August meeting each year.

Section 3.

To qualify for the position of Vice Chair, a member must have actively functioned as a member of the Board of Directors for at least one (1) year.

## **Article VII – Duties of Board Members**

Section 1. The Chair shall:

- A. Preside at all meetings of the General Assembly, Board of Directors, and any special meetings.
- B. Facilitate development and achievement of organizational goals.
- C. Make interim appointments as needed with the approval of the Board of Directors.
- D. Sign all contracts, agreements, and other legal documents as needed after approval of the Board of Directors.
- E. Represent this organization at the Texas Department of State Health Services RAC Chair's Meeting or will identify another board member as a designee.



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- Section 2. The Vice Chair shall:
- A. Preside over RAC activities in the absence of the Chair.
  - B. Perform duties as assigned by the Chair.
  - C. Assist in preparing any necessary reports or documentation required.
- Section 3. The Secretary shall:
- A. Present the minutes of all proceedings of the Board and General Assembly meetings.
  - B. Handle all correspondence of the organization in the absence of the Executive Director.
  - C. Assist in preparing any necessary reports or documentation required.
- Section 4. The Treasurer shall:
- A. Review and certify all financial business conducted by the RAC including bank reconciliation.
  - B. Perform financial duties in the absence of the Executive Director.
  - C. Assist in preparing any necessary reports or documentation required.
- Section 5. The Executive Director shall:
- A. Maintain a record of all financial business conducted by the RAC in accordance with RAC policies/procedures and common accounting practice.
  - B. Prepare and submit financial reports to the Board and General Assembly at each of their meetings, respectively.
  - C. Ensure that Board of Directors & General Assembly meeting minutes are made available to all RAC membership and the Department of State Health Services EMS & Trauma Systems Coordination as requested.
  - D. Will make available copies of bylaws and the Trauma System Plan annually as requested.
  - E. Actively assist in seeking funding sources for the activities of the organization.



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- F. Prepare necessary reports or documentation required by government agencies or grant sponsors.
- G. Gather information from Committee Chairs, prepare and submit annual budget projections to the Board and General Assembly.
- H. Preside over meetings in which the Chair and Vice Chair are not available when a quorum is present.

Section 6. The Committee Chairs shall:

- A. Organize and conduct meetings as defined in the bylaws.
- B. Facilitate the development and achievement of goals for their committee.
- C. Provide written agendas and minutes to committee members. Provides these and sign-in sheets to the Executive Director for maintenance and provides verbal reports to the Board and General Assembly during RAC meetings.
- D. Assist in preparing any necessary reports or documentation required.

Section 7. The At Large Members Shall:

- A. Assist in preparing any necessary reports or documentation required.
- B. Facilitate the development and achievement of goals for the Board of Directors.

## Article VIII – Meetings

Section 1. Quorum

At least two (2) Executive Committee members must be present as well as representation from two-thirds (2/3) of the general membership shall constitute a quorum for a General Assembly meeting.

Section 2. Meetings

All meetings administered by the RAC are open unless otherwise stated. The RAC will operate according to the Texas Open Meetings Act. Meeting dates, times, and locations will be posted on the BVRAC Website.

The General Assembly shall meet bi-monthly.



Brazos Valley Regional Advisory Council

Any member of the Executive Council or the Executive Director may call a special meeting with a majority vote of the Board of Directors. A minimum of a two (2) week notice will be provided electronically to all members on the General Assembly email list serve.

Section 3. Attendance

See Article IV, Section 5 for the attendance requirements.

**Article IX – Committees**

Section 1. The Standing Committees and their missions are as follows:

A. Pre-hospital Committee

- To serve as a liaison for pre-hospital providers within this Region to include the monitoring of system development, coordination of activities, performance improvement, and pre-hospital training.

B. Hospital Care & Management Committee

- To serve as a liaison between health care facilities within this region to include the monitoring of system development, coordination of activities, performance improvement, and hospital training.
- To provide oversight and guidance for the Region regarding the Pediatric Objectives issued by the State of Texas.

B. Physicians Advisory Committee (a quorum constitutes a majority of serving physicians)

- To monitor the performance of identified performance improvement indicators as it relates to the quality of patient care.
- Make recommendations regarding system enhancement and/or improvements.
- Inter-local liaison committees may be formed to provide comprehensive review of issues with greater local participation. Information/inquiries may be originated at either the Physicians Advisory Committee or the other committees.

C. Education Committee

- To provide guidance for training within the Region to enhance trauma care standards in this Region.



- D. Injury Prevention Committee
  - To provide guidance within the Region for injury prevention activities.
- E. Emergency Preparedness & Response Committee
  - To coordinate preparedness and responses to acute medical mass casualty, evacuation, and disaster situations.
- F. Acute Care Committee Committee
  - To serve as a liaison to the acute care facilities and pre-hospital providers for initiatives issued by the State of Texas to include but not limited to stroke care, facility designations, public education, and training.
- G. Systems QI Committee
  - To ensure optimal care of the trauma and acute care patients in TSA-N, through critical review by members of the Brazos Valley Regional Advisory Council of cases as identified by system filters.

#### Section 2.

Each standing committee shall have an identified Chair appointed by the Board of Directors. A Vice Chair may be selected by the Committee Chair or the membership of the Committee. This process will occur in August of each year in conjunction with the election of the Board of Directors.

#### Section 3.

Each standing committee shall have at least 6 meetings per year and keep minutes of each meeting. Meeting minutes may be obtained by any RAC member from the BVRAC website or from the Executive Director. The minutes may be provided either in hard copy or electronically.

#### Section 4.

Ad Hoc Committees/Task Forces may be established and/or dissolved at the discretion of the Board. Ad Hoc Committees/Task Forces are utilized to address issues that are limited in duration or cyclic in nature.



## Article X – Fiscal Policies

### Section 1.

State mandated funds shall be allocated according to contract received by BVRAC from the Department of State Health Services. Any entity eligible according to State guidance must be classified as an active participant as stated in Article IV, Section 5, in order to receive any funding.

### Section 2.

Any grant funds received by the BVRAC will be made available to only those member entities that are active participants in BVRAC as stated in Article IV, Section 5, in order to receive any funding.

### Section 3.

Any member entity receiving funds through and/or from BVRAC must provide required reports, support documents, etc. as stated at the time the funds are received by the member entity. Failure to comply will result in ineligibility of funding through and/or from BVRAC for a period of not less than one (1) fiscal year funding cycle.

### Section 4.

Failure to comply with Article IV, Section 5 shall cause a member entity to become ineligible for funding through and/or from BVRAC for a period of not less than twelve (12) months.

### Section 5

All grant funds shall be considered "restricted". "Restricted funds" are defined as those funds that must be utilized as provided in a fully executed contract, grant application and/or award notice, or directed donation.

Any funds received that have not been "restricted" shall be considered "unrestricted" and may be utilized for any type of expenditure. "Unrestricted funds" shall include but not limited to dues, donations, etc.

### Section 6

The Brazos Valley Regional Advisory Council's fiscal and operational years shall follow the calendar year.



### Section 7

Budget preparation is achieved through needs assessments provided by the RAC committees as well as strategic direction provided by the Board. The Budget will be completed by the Executive Director and the Treasurer then presented for ratification at the August General Assembly meeting.

### Section 8

All Checks must have two signatures. These signatures may be any combination of the Executive Council and the Executive Director. No person may sign a check that is issued to him or herself. The RAC will maintain a minimum of two (2) checking accounts ("restricted" & "unrestricted") and may establish additional accounts as needed with approval of the BVRAC Executive Council.

### Section 9

Approval of expenditures must conform to the following schedule:

	<u>Amount</u>	<u>Approval Required</u>
A.	\$ 0 - \$ 2,000	Chair only
B.	\$ 2,000.01 - \$10,000	Board only
C.	\$ 10,000.01 or more	General Assembly

Any purchases and/or leases of real property, land, buildings, and vehicles shall be approved by a majority vote of the General Assembly present at the meeting.

In the absence of the Chair, expenditures from \$0 - \$2,000.00 may be approved with the agreement of the remaining BVRAC Executive Board.

### Section 10

The Executive Director shall have the authority to establish charge accounts with advance approval of the Executive Committee.

The Executive Director shall have authority to maintain and utilize RAC's secured credit card with a limit not to exceed \$ 1,000.00 (one thousand dollars). A report must be provided upon request of the Executive Committee. A report shall be provided to the Board and General Assembly as a part of the financial statements.



#### Section 11

The Chair may authorize expenditures associated with a specific grant if a budget was submitted as part of the grant application process and the grant application was approved by the Board of Directors upon completion or at notice of award.

#### Section 12

Distribution of funds will be in accordance with State and Federal regulations.

#### Section 13

Annually an external audit shall be completed in accordance with State and Federal regulations.

#### Section 14

RAC members may obtain copies of financial records, 990s, audit findings, etc. from the Executive Director or Chair. A request must be submitted in writing. The request must include what items wish to be reviewed and when the member would like to schedule a time to review requested documents. Original documents may not be removed from the RAC offices without written approval of the Chair. Some documents may not be available for copying.

### **Article XI – Alternative Dispute Resolution (ADR) Process**

#### Section 1

- A. Any provider or individual representing a provider, service, or hospital that has a dispute in connection with another provider or the RAC itself (e.g., bylaws, trauma system plan, guidelines and protocols, etc.) may formally voice its disapproval in writing. The written document will be addressed by the Chair of the RAC and/or the Executive Director.
- B. A formal protest must contain the following information: a specific statement of the situation that contains the description of each issue and a proposed solution to resolve the matter(s).
- C. A neutral or impartial group with no vested interest in the outcome of the dispute will be assembled to review the issue. This group may solicit written responses to the dispute from interested parties. If the dispute is not resolved by mutual agreement, the group will issue a written determination, within thirty (30) days of receipt of all pertinent data.



- D. Party or parties may appeal the determination by the group and ask that the issue be brought before the General Assembly for a final determination. The party or parties have no later than ten (10) working days after the determination to submit the request for secondary review. The secondary review will be limited to the original determination. The appeal must be mailed or hand-delivered in a timely manner. In the event the appeal is not timely in delivery, it will not be considered. If not considered, the party or parties will be notified in writing. The request must be submitted in writing to the following address:

BVRAC  
PO Box 2861  
Bryan, TX 76714

## **Article XII – Parliamentary Authority**

Robert’s Rule of Order shall be used as a guide for all meetings administered by the RAC.

## **Article XIII - Amendments**

### **Section 1        Bylaws**

The bylaws may be adopted, amended, or revised by an affirmative vote of two-thirds of the General Assembly present at the meeting. Proposed amendments and revisions must be submitted to an Executive Committee member or the Executive Director. All proposed bylaw revisions and/or changes will be submitted to the General Assembly Membership via United States Postal Service and/or electronically (30) days prior to action. The proposed bylaws will also be submitted to all individuals that participate in the BVRAC email list-serve.

A roll-call vote shall be taken for approval of the bylaws. The bylaws shall be reviewed/amended/revised at least once per calendar year.

### **Section 2.        Trauma System Plan**

The RAC will maintain a Trauma System Plan Workgroup that will annually update the BVRAC Regional Trauma System Plan. This Workgroup shall have membership from hospitals and pre-hospital providers and will be presided over by the Executive Director.

The Trauma System Plan shall be provided to the Department of State Health Services (DSHS) EMS & Trauma Systems Coordination by January 1<sup>st</sup> of each year. The Plan shall be approved by the Physicians Advisory Committee, the Board of Directors, and General Assembly prior to submission to the DSHS.

A majority vote of Physicians Advisory Committee, Board of Directors, and General Assembly members present shall constitute the approval of the Trauma System Plan.



Brazos Valley Regional Advisory Council

### Article XIV – Signatures

\_\_\_\_\_  
RAC Chair

\_\_\_\_\_  
Date

\_\_\_\_\_  
Executive Director

\_\_\_\_\_  
Date

## **PROVIDERS**

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## EMS PROVIDERS

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### Washington County EMS

Serving Washington County

911/Transfer

1100 East Blue Bell

Brenham, TX 77833

(979) 277-6267 - Main

(979) 277-6270 - Fax

Kevin Deramus – EMS Director

[kderamus@wacounty.com](mailto:kderamus@wacounty.com)

Medical Direction:

Dr. Henry Boehm

Dr. Robert Stark

### K&L Transport

Serving Leon County

PO BOX 422

Jewett, Texas 75846

(903) 626-4749 - Main

(903) 626-4950 - Fax

Leita Poteet – Co-Owner

[lpoteet1122@sbcglobal.net](mailto:lpoteet1122@sbcglobal.net)

Medical Direction:

Dr. Irma Aguirre

### Texas A&M EMS

Serving Texas A&M University

911

1264 TAMU

College Station, Texas 77843

(979) 845-1525 - Main

(979) 862-3450 - Fax

Matt Rushing – EMS Coordinator

[mrushing@ems.tamu.edu](mailto:mrushing@ems.tamu.edu)

Medical Direction:

Dr. Kenneth Hackney

### Guardian EMS

Serving Madison County

911/Transfer

202 E. Magnolia

Madisonville, TX 77864

(936) 349-0538 – Main

Rick Powell - Owner

Medical Direction:

Dr. Eric Wilke

### College Station Fire Dept.

Serving City of College Station

911

300 Krenek Tap

College Station, Texas 77840

(979) 764-3705 - Main

(979) 764-3403 - Fax

Billy Bradshaw – Training Captain

[bbradshaw@cstx.gov](mailto:bbradshaw@cstx.gov)

Medical Direction:

Dr. Erik Wilke

### St. Joseph EMS

Serving Burleson, Grimes, and Brazos Counties

911/Transfer

511 Sulpher Springs

Bryan, Texas 77801

(979) 775-5037 - Main

(979) 822-5564 - Fax

Donna Gomez – EMS Director

[dgomez@mail.st-joseph.org](mailto:dgomez@mail.st-joseph.org)

Medical Direction:

Dr. Charles Williams

### Legacy EMS

Brazos County

Transfer

4710 Elmo Weedon

College Station, Texas 77845

(979) 774-3700 - Main

(979) 731-1481 - Fax

Willie Saldana – Operations Captain

[wsaldana@legacyems.net](mailto:wsaldana@legacyems.net)

Medical Direction:

Dr. Jeff Erdner

### Jewett EMS

Serving Leon County

911

201 South Main

Jewett, TX 77846

(903) 626-4958

David Nobles - Administrator

Medical Direction:

Dr. Mark Hoeschele



## EMS PROVIDERS CONT.

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### **Robertson County EMS**

Serving Robertson County

911

PO Box 625

Franklin, Texas 77856

(979) 828-4911 - Main

(979) 828-3333 - Fax

Chris Lamb – EMS Director

[paramediccml@yahoo.com](mailto:paramediccml@yahoo.com)

*Medical Direction:*

Dr. Charles Williams

### **Hilltop Lakes VFD**

Serving Leon County

911

PO BOX 1474

Hilltop Lakes, Texas 77871

(936) 855-2551- Main

(936) 855-1974 - Fax

Ed Harp – EMS Director

[grayfoxrunpa@valornet.com](mailto:grayfoxrunpa@valornet.com)

*Medical Direction:*

Dr. Charles Williams

### **Bryan Fire Department**

Serving City of Bryan

911

300 W. Wm. J. Bryan

Bryan, Texas 77803

(979) 209-5972 - Main

(979) 209-5989 - Fax

Andrew Davis – EMS Chief

[adavis@bryantx.gov](mailto:adavis@bryantx.gov)

*Medical Direction:*

Dr. Charda Suresh



## **FIRST RESPONDER ORGANIZATIONS**

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### **Washington County First Responders**

*Serving Washington County*  
750 New Year Creek Lane  
Brenham, TX 77833  
(979) 277-9568 - Main  
Jon McKee – Secretary/Treasurer  
[elvira999@startel.net](mailto:elvira999@startel.net)

### **Emergency First Responders, Inc.**

*Serving Grimes County*  
PO Box 783  
Anderson, Texas 77830  
(979) 690-5352  
(979) 690-5352  
Denise Guidry - Administrator  
[dguidry@gc.emfr.org](mailto:dguidry@gc.emfr.org)  
Dr. Charles Williams, M.D. – Medical Direction

### **Burleson County First Responders**

*Serving Burleson County*  
Somerville, Texas 77879  
David Pevehouse – Administrator  
Dr. Charles Williams, M.D. – Medical Direction

### **Black Jack Volunteer Fire Department**

*Serving Robertson County*  
Franklin, TX 77856  
Raymond McCarver – Administrator  
Dr. Matthew Minson, M.D. – Medical Direction



Brazos Valley Regional Advisory Council

## AIR MEDICAL PROVIDERS

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***PHI Air Medical 12***

Serving TSA "N"

Scene/Transfer

6120 East Hwy 21

Bryan, Texas 77808

Main -

Fax -

Billy Rice – Base Supervisor

[brice@phihelico.com](mailto:brice@phihelico.com)

*Medical Direction:*

Dr. Jay Kovar



## HOSPITALS

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### ***Level III Trauma Centers***

#### **College Station Medical Center**

1604 Rock Prairie Road  
College Station, Texas 77845  
(979) 680-5314 - Main  
(979) 764-5279 - Fax  
Rick Moore – Trauma  
Coordinator  
[rick.moore@triadhospitals.com](mailto:rick.moore@triadhospitals.com)

#### **St. Joseph Regional Health Center - Bryan**

2801 Francisian Dr.  
Bryan, Texas 77802  
(979) 776-4917 - Main  
(979) 776-3950 - Fax  
Beverly Welch – E.D. Director  
[bwelch@mail.st-joseph.org](mailto:bwelch@mail.st-joseph.org)

#### **Trinity Medical Center**

700 Medical Pkwy  
Brenham, Texas 77833  
(979) 836-6173 - Main  
(979) 830-7484 - Fax  
Wanda Wiktorik – Trauma  
Coordinator  
[wwiktorik@trinitymed.org](mailto:wwiktorik@trinitymed.org)

### ***Level IV Trauma Center***

#### **Burleson St. Joseph**

1101 Woodson Ave  
Caldwell, Texas 77836  
(979) 567-3245 - Main  
Fax  
Reed Edmunson - Administrator  
[redmunson@mail.st-joseph.org](mailto:redmunson@mail.st-joseph.org)

#### **Grimes St. Joseph**

210 South Judson  
Navasota, Texas 77868  
(936) 825-6585 - Main  
Fax  
Brenda Thogerson - Trauma  
Coordinator  
[bthogerson@st-joseph.org](mailto:bthogerson@st-joseph.org)

#### **Madison St. Joseph**

100 West Cross St.  
Madisonville, Texas 77864  
(936) 348-2631 - Main  
Fax  
Julia Jerrell - Trauma  
Coordinator  
[jjarrell@mail.st-joseph.org](mailto:jjarrell@mail.st-joseph.org)

### ***Non-Designated Facilities***

#### **The Physician's Centre**

3131 University Drive E.  
Bryan, Texas 77802  
(979) 731-3100 Main  
(979) 731-3957 Fax

## HOSPITAL DATA CHART

	St. Joseph Regional Health Center	Burleson-St. Joseph	Grimes-St. Joseph	Trinity Medical Center	College Station Medical Center	Madison-St. Joseph	Physician's Center
Mailing Address	2801 Franciscan Dr. Bryan, Tx 77802	1101 Woodson Ave. Caldwell, TX 77836	P. O. Box 1390 Navasota, TX 77868	700 Medical Parkway Brenham, TX 77833	1604 Rock Prairie Road College Station, TX 77845	100 West Cross St. Madisonville, TX 77864	3131 Unversity Drive E. Bryan, Tx 77802
Phone Number	(979) 776-4917	(979) 567-3245	(979)825-9209	(979) 836-6173	(979) 764-5100	(936 348-2631	(979)731-3100
Fax Number	(979) 776-3950	(979) 567-0616	(979) 825-6007	(979) 830-7484	(979) 764-5129	(936) 348-3404	(979)731-3116
Trauma Director	Dr. Richard Alford	Dr. Robert Ostman	Dr. Luke Scamardo	Dr. Jeff Stoltenberg	Dr. Bruce Hoak	Dr. Joe Franklin	n/a
Trauma Coordinator	Vacant	Vacant	Vacant	Wanda Wiktorik	Rick Moore	Julia Jarrell	Michelle Fortune
ED Director	Dr. Bill Bass	Dr. Robert Ostman	Dr. Luke Scamardo	Wade Frazier	Dr. Eric Wilke	Dr. Grover Hubley	Gary Lambert
Facility Administrator	Jack Buckley	Reed Edmundson	Lydia Copeland	John Simms	Tom Jackson	Reed Edmundson	Michelle Fortune
EMS Phone # or frequency	(979) 776-4974 (979) 776-4975 (979) 776-4976	(979) 775-5911	(979) 825-2459	(979) 836-4520	(979) 696-1221	1-800-293-9438	(979)774-1919
	<b>Beds:</b>	<b>Beds:</b>	<b>Beds:</b>	<b>Beds:</b>	<b>Beds:</b>	<b>Beds:</b>	<b>Beds:</b>
ER	26	3	5	9	13		First Aid Station
ICU	18	0	0	5	12	0	0
Med-Surg	46 Surgical 49 Surgi/Ortho	37	25	36	66	27	16
Pediatric	22	0	0	Peds go to Med Surg	8	0	
Rehabilitation	30	0	0	0	10	0	
Total	246	37	30	60	121	48	16
Designation or Planned	Lead Level III	Designated Level IV	Designated Level IV	Designated Level III	Designated Level III	Designated Level IV	No plans for designation

## **GUIDELINES**

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## SYSTEM ACCESS

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**Objectives of System Access Component were:**

1. Identify all EMS and First Responders in each county;
2. Identify what areas each EMS and First Responder services;
3. Identify mutual aid agreements that EMS may have with other areas;
4. Identify "9-1-1" or single access telephone number availability;
5. Backup or emergency systems; and
6. Public education regarding resources and accessing help.

All information collected to meet the above objectives, was accomplished by each agency completing a Needs Assessment Survey and by attempts made by telephone. A needs survey was mailed to each agency within our TSA asking specific information from their service in regards to system access. The Pre-hospital Committee was able to compile this information and use it as a tool to set short term and long term goals for trauma system development.

Identification of EMS and First agencies, the areas they serve and any mutual aid agreements that are in place may be reviewed in Appendix D, titled "Trauma Service Area N System Access and Communication Survey". The identification of "9-1-1" service is listed below, which includes the secondary service:

COUNTY	PRIMARY SERVICE ANSWERING POINT	SECONDARY SERVICE ANSWERING POINT
Brazos	Brazos County 911 Communications Center	<ul style="list-style-type: none"> <li>• College Station Police Department</li> <li>• TAMU Police Department</li> <li>• TAMU EMS</li> </ul>
Burleson	Burleson County Sheriff's Department	<ul style="list-style-type: none"> <li>• St. Joseph EMS</li> </ul>
Grimes	Grimes County Sheriff's Department	<ul style="list-style-type: none"> <li>• St. Joseph EMS</li> </ul>
Leon	Leon County Sheriff's Department	<ul style="list-style-type: none"> <li>• Jewett EMS</li> <li>• Hilltop Lakes VFD</li> <li>• K&amp;L Transport</li> </ul>
Madison	Madison County Sheriff's Department	<ul style="list-style-type: none"> <li>• Guardian EMS</li> </ul>
Robertson	Robertson County Sheriff's Department	<ul style="list-style-type: none"> <li>• Hearne Police Department</li> <li>• Robertson County EMS</li> </ul>
Washington	City of Brenham Communication	<ul style="list-style-type: none"> <li>• Washington County EMS</li> </ul>



**Strengths of the BV-RAC System Access:**

1. Mutual aid agreements are used by all agencies within the TSA; and
2. Availability of local air medical services.

**Weaknesses of the BV-RAC System Access:**

1. Lack of an Emergency Department in Leon and Robertson County
2. Lack of participation by First Responder agencies.

**Accomplishments of the System Access Component:**

1. Education of the EMS agencies in helicopter response and availability;
2. First responder organizations are available in all counties of our TSA;
3. Identification of level of services available in the TSA;
4. Local Project Grant money obtained and distributed to first responder organizations;
5. Continuing Education hours made available to all pre-hospital providers;
6. Administrative assistance for review of system access.
7. First Responder Organizations in Leon County
8. ALS service in Leon County
9. Alternate Care Site "Disaster Trailers" located in Washington County (1), Robertson County (1), Leon County (1), and Brazos County (2).

**Long Term Goals:**

1. Improve education to the public regarding the use of 911 and back-up telephone numbers.
2. Increase participation of First Responder organizations.
3. Evaluate geographical area of TSA to increase agency participation & system access in relation to patient care and transport.

**Committee Responsible for Goals:**

All



## COMMUNICATIONS

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### **Objectives of Communication Component were:**

1. Review of dispatch procedures, dispatch training, response times and communication devices used in each county;
2. Listing of the communication devices, operating frequencies, and the effective range of each device used by the EMS services and facilities;
3. Listing of how two-way communication occurs between each EMS service and each receiving facility in the region;
4. Listing of all EMS services, with telephone numbers and frequencies, of all first responders, helicopter transport services and hospitals within the TSA; and
5. Identify dispatch call priority policies.

All information collected to meet the above objectives, was accomplished by each agency completing a Needs Assessment Survey and by attempts made by telephone. A needs survey was mailed to each agency within our TSA asking specific information from their service in regards to communication. The Pre-hospital Committee was able to compile this information and use it as a tool to set short term and long term goals for trauma system development.

### **Strengths of the BV-RAC Communication Component:**

1. The communication between services and implementation of mutual aid agreements between the EMS agencies within the region has been instrumental in the event of multi-casualty scenes that have occurred in this area.
2. Agreement of agencies with ALS capabilities to meet BLS agencies at certain points to increase the level of care for extended transports.

### **Weaknesses of the BV-RAC Communication Component:**

1. Lack of Emergency Medical Dispatch training for the dispatchers in all county Sheriff's Departments;

### **Accomplishments made in the Communication Component:**

1. Emergency Medical Dispatch training course, with plans for additional courses in the future.
2. Providing frequencies to all agencies in the TSA through the collection of the needs assessment survey and publishing it to all agencies.
3. Improvement in the communication of the rural agencies to notify helicopters to improve transport times.
4. Radio equipment funded through local project grants to first responder agencies to assist in their communication.
5. Inter-agency communications available during disaster events via VHF radios and an available mobile command unit.
6. EMD training provided to Brazos County Dispatch.



Brazos Valley Regional Advisory Council

**Long Term Goals of the BV-RAC Communication Component:**

1. Provide additional Emergency Medical Dispatch training for all dispatchers in the TSA;
2. Educate the governmental bodies within the TSA regarding the need for trained dispatchers; and
3. Review the communication procedure for multi-agency scenes, implement a common way to communicate during mutual aid.

**Committees Responsible for Goals:**

All



## **MEDICAL OVERSIGHT**

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### **Objectives of the Medical Oversight Component were:**

1. Identify all medical directors for the EMS services in the region with addresses, phone numbers and their involvement in RAC;
2. Review regional protocols in use throughout TSA-N;
3. Review regional protocols for alerting and activating helicopters in the region.

The Physician Advisory Committee in conjunction with the Pre-hospital Committee created a Needs Assessment Survey that was sent to all EMS agencies in the region to complete regarding their medical control and protocols that they currently have in place

### **Strengths of the BV-RAC in the Medical Oversight Component:**

1. BVRAC recognizes a lack of medical oversight and has action plans in place to correct.

### **Weaknesses of the BV-RAC Medical Oversight Component:**

1. Lack of physician involvement and oversight

### **Accomplishments made in the Medical Oversight Component:**

1. Standardized pre-hospital protocols were adopted that included treatment, triage, bypass, diversion, and helicopter activation.
2. Action Plans to form Physician Advisory Committee.

### **Long Term Goals of the BV-RAC Medical Oversight Component:**

1. Provide education on the standardized protocols to those agencies that do not participate in the BV-RAC.
2. Identify and improve communication with medical directors of all providers in BVRAC to ensure timely, quality care to the TSA N trauma and acute care patient.
3. Form physician advisory committee.

### **Committee(s) Responsible for Goals:**

All



## **PRE-HOSPITAL TRIAGE & BYPASS CRITERIA**

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### **GOAL:**

A goal set forth by the Brazos Valley Regional Advisory Council is to provide optimum care to the injured patient. In an effort to provide this optimum care, Pre-hospital Triage and Bypass Protocols have been established in Trauma Service Area N for Emergency Medical Service Providers and Air Medical Providers to use as a guideline to get the injured patient to the nearest appropriate facility in the least amount of time as possible.

### **GUIDELINES:**

1. If unable to establish and/or maintain an adequate airway, or in the case of a traumatic arrest, transport to the nearest acute care facility for stabilization.
  - a. Multi-system blunt or penetrating trauma with unstable vital signs (See Appendix A)
2. The following patients will be transported directly to the nearest appropriate facility:
  - a. Anatomical injury as identified in the triage algorithm attached. (See Appendix A)
  - b. High-energy event-risk for severe injury as identified in the attached triage algorithm (See Appendix A)
3. All other patients may be evaluated at the nearest Level IV facility and transferred as indicated.
4. Other patients that may be transported directly to a Level III are those patients in which the facility that is being bypassed does not provide the service that the Emergency Medical Service anticipates the patient will need. (See Appendix A)
5. If the Emergency Medical Service has any question regarding bypass, on-line medical control should be consulted.

**Guidelines and algorithm has been adopted from the American College of Surgeons and American College of Emergency Physicians**



## **DIVERSION POLICIES**

---

### **Objectives of Diversion Component were:**

1. Review all diversion policies for the facilities in the TSA;
2. Situations which require the facilities to go on diversion; and
3. Notification procedure for facilities that go on diversion.

### **Strengths of the BV-RAC Diversion Component:**

1. A guideline was created for all facilities to utilize in the event of a diversion is needed;
2. In the event that both St. Joseph and College Station Medical Center are in need of going on diversion status, both facilities will reopen accept patients; and
3. EMS agencies were educated in the diversion protocol that if it is in the best interest of the patient to not be diverted, the EMS agency will make the determination as to whether or not they will be diverted.
4. Protocol for regional diversion in place.
5. Implementation of EMSsystem as a tool for system status management.

### **Weaknesses of the BV-RAC Diversion Component:**

1. Education to EMS agencies that do not participate in RAC regarding the diversion protocol and the requirement of the agency to not be diverted if it is in the best interest of the patient.

### **Accomplishments made in the Diversion Component:**

1. The Diversion Protocol that was adopted by the BV-RAC was also forwarded to acute care facilities for utilization. (See Appendix A).
2. A phone-tree was purchased and is being utilized for the purposes of notification to all EMS and acute care facilities when any acute care facility has the need to go into a diversion status.
3. The diversion is limited to 4 hours.
4. EMSsystem used as primary diversion tool, additionally a phone tree is utilized.

### **Long Term Goals of the BV-RAC Diversion Component**

1. Include all diversions that occur within the TSA in the System QI plan for review by the System QI Committee.
2. Educate all EMS agencies, emergency department and acute care personnel regarding the use of EMSsystem and the Diversion Protocol.
3. Increase the use of EMSsystem.

### **Committee(s) Responsible for Goals:**

All



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## FACILITY TRIAGE CRITERIA

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### **Objectives of Facility Triage Criteria Component were:**

1. Classifications of patients by severity; and
2. Facility destination based upon classification of patients.
3. Utilization of air medical services for appropriate facility triage.

The above objectives were accomplished by each facility to identify the capabilities of the acute care facilities within our region. As a result of the review of each acute care facility, a portion of the Pre-hospital Triage/Bypass Protocol includes each facilities level of care within our TSA. All facilities are capable of providing stabilization, pending transfer.

### **Strengths of the BV-RAC Facility Triage Criteria Component:**

1. All except one facility within this TSA have Trauma Team Activation protocols in place.
2. Trauma coordinators participate on the Hospital Care and Management Committee to discuss any issues identified with patient referrals.
3. Trauma Coordinators network within the region and at the state level to ensure Trauma Team Activation protocols are appropriate and consistent.
4. Facility Triage is monitored through each facility's PI program.

### **Weaknesses of the BV-RAC Facility Triage Criteria Component:**

1. Inconsistency in resource availability to pre-hospital providers.
2. Consistency in transport of patients through facility triage criteria.

### **Accomplishments made in the Facility Triage Criteria Component:**

1. Regionalized trauma team activation of acute healthcare facilities;
2. Education to regional agencies of the acute healthcare agency capabilities.
3. Education to EMS agencies that participate on the RAC was accomplished;
4. Utilization of the Bypass protocol by EMS agencies after being educated of the facility capabilities; and
5. Including Facility Triage Criteria as a part of the Pre-hospital Triage/Bypass protocol.
6. EMS system used to update facility resources.

### **Long Term Goals of the BV-RAC Facility Triage Criteria Component:**

1. Educate all EMS and Emergency Department personnel in the use of trauma team activations and notification of the appropriate personnel.
2. Improve criteria for air medical service activation in the trauma team activation for those patients that have a life or limb threatening injury that would benefit from a decrease in the transport time to the facility and an increase in the level of care.
3. Develop cardiac and stroke facility triage components.
4. Ensure all patients with injuries consistent with TSA N capabilities remain within the region. Discourage transfers outside BVRAC through improved assessment and field triage capabilities.
5. Encourage direct transport from scenes to appropriate trauma centers as indicated by pre-hospital assessment and facility triage.

**Committee(s) Responsible for Goals: All**



## **INTER-HOSPITAL TRANSFERS**

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### **Objectives of Inter-hospital Transfers Component were:**

1. Evaluate any written transfer agreements currently in place by healthcare facilities;
2. Identify all healthcare facility criteria for transfer policies; and
3. Identify the necessary transfer agreements for both into the facility and out of the facility.
4. All facilities in the region will have transfer agreements in place.

### **Strengths of the BV-RAC Inter-hospital Transfers Component:**

1. Agreement that all trauma centers will accept all emergent transfers if a bed is available and an ER to ER transfer will be accomplished if appropriate.
2. Written transfer agreements are in place for all facilities participating in RAC.
3. Available transport agencies have been identified and each acute healthcare facility has been provided with contact information;
4. The 2 hour rule for completing transfer process for the major trauma patients is monitored through systems QI.

### **Weaknesses of the BV-RAC Inter-hospital Transfers Component:**

1. Lack of "800" numbers to facilitate transfers to potential Level III facilities;
2. Lack of a regional transfer center to facilitate inter-facility transfers to regional trauma centers.
3. Lack of acute care capacity in regional centers.
4. Physician dependent regional resources are inconsistent.

### **Accomplishments made in the Inter-hospital Transfers Component:**

1. All regional facilities have transfer agreements in place to tertiary facilities and for specialized services.
2. Transfers are reviewed and monitored by systems QI.

### **Long Term Goals of the BV-RAC Inter-hospital Transfers Component:**

1. Maintain written transfer agreements and monitor QI transfer fallouts.
2. Create a transfer center for transfers within our region.

### **Committee(s) Responsible for Goals:**

All



## **DESIGNATION OF TRAUMA & ACUTE CARE FACILITIES**

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### **Objectives of Plan on Designation of Trauma Facilities Component were:**

1. Identification of all area facilities by level of designate and specialty services;
2. Identify lead facility or potential lead facility for the TSA (may be shared by multiple facilities); and
3. Resources of committees in existence in region to assist facilities to maintain designation.

The Hospital Care and Management Committee members include a member from each acute healthcare facility within the TSA.

### **Strengths of the BV-RAC Plan on Designation of Trauma Facilities Component:**

1. All area facilities have been identified including their level of designation.
2. There has been ongoing communication between all facilities within the TSA regarding the designation process and assistance to all facilities, by all committee members except one facility.
3. Improvement has been identified in the expeditious movement of patients between facilities.
4. Three Level III facilities have been designated including a lead facility. Three Level IV facilities have been designated.
5. Transfer agreements exist between all facilities as indicated by resources.

### **Weaknesses of the BV-RAC Plan on Designation of Trauma Facilities Component:**

1. One facility has not been designated within the TSA, and does not seek designation.
2. Lack of a level I or II trauma center in the region.

### **Accomplishments made in the Plan on Designation of Trauma Facilities Component:**

1. Designation of all facilities that desire designation.
2. Improvements made in the communication between facilities.
3. Close communication between all healthcare facilities within the region.
4. Development of Regional Disaster Response Plan
5. Development of regionally consistent trauma activation criteria.

### **Long Term Goals of the BV-RAC Plan on Designation of Trauma Facilities Component:**

1. Maintain designation of all facilities within the region;
2. Continue to evaluate the potential increase in levels of care provided in this TSA.
3. Assist currently designated facilities as indicated to maintain designation.
4. Assist facilities in achieving appropriate stroke center designation levels.
5. Assist facilities in achieving appropriate acute care designations and accreditations based on the facilities resources.

### **Committee(s) Responsible for Goals:**

All



## **PERFORMANCE IMPROVEMENT**

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### **Objectives of System Quality Management Program Component were:**

1. Maintain regional multi-disciplinary trauma and acute care review committee;
2. Process for reviewing data filters and specific occurrences as they arise (peer review) – have clearly stated goals and objectives;
3. Feedback loop to all aspects of regional operations;
4. Medical oversight
5. Improved communication, education and quality of care for all trauma patients.
6. Improve quality of care for the trauma patient in Trauma Service Area N.

### **Strengths of the BV-RAC System Quality Management Program Component:**

1. All regional agencies upload data to the state system.
2. Quality management program has been established for ground EMS, Air Medical and Trauma & Acute Care Facilities.
3. EMS agencies, Hospitals, and Air Medical providers participate in System QI.
4. System QI review has resulted in process improvements elevating the standard of care.
5. Communication with other RAC s regarding intraregional transfers has been established.

### **Weaknesses of the BV-RAC System Quality Management Program Component**

1. Several agencies are not uploading to the state agency in a timely manner;
2. Feedback on transfer issues is not addressed as a system.
3. Some agencies are not participating regularly in the System QI Process.
4. Data collection
5. Lack of physician participation in the regional system QI.

### **Accomplishments made in the System Quality Management Program Component:**

1. EMS agencies routinely upload to the state registry; and
2. Round table discussions provide a friendly, confidential forum for discussion on issues affecting both EMS and facility patient care from a system perspective. Frank discussion results in improved patient care.
3. Increased participation from all agencies in system QI.
4. Development of a multi-disciplinary trauma and acute care review committee
5. Development of a regular meeting schedule for QI issues and loop closure.

### **Long Term Goals of the BV-RAC System Quality Management Program Component:**

1. Continue to revise and strengthen the QI Program as indicated.
2. Accomplish participation in the QI program through education and training.
3. Strengthen the hospital registry program with report capabilities
4. Development of a regional trauma registry.
5. Strengthen the hospital registry program to allow for local report capabilities.

### **Committee(s) Responsible for Goals:**

All

# **REGIONAL TREATMENT GUIDELINES**

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## INTRODUCTION

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The attached guidelines for the Brazos Valley Regional Advisory Council should be used as a minimum standard of care to treat patients with traumatic injuries. The protocols should be used in conjunction with your agency's established protocols and not in place of.

The following are general patient care guidelines for ALL patients and are not specifically listed in each protocol.

ECA	EMT	Intermediate	Paramedic
Assure scene safety	Assure scene safety	Assure scene safety	Assure scene safety
Assess CABG's	Assess CABG's	Assess CABG's	Assess CABG's
Perform Secondary Assessment	Perform Secondary Assessment	Perform Secondary Assessment	Perform Secondary Assessment
Place patient in position of comfort unless contraindicated	Place patient in position of comfort unless contraindicated	Place patient in position of comfort unless contraindicated	Place patient in position of comfort unless contraindicated



## BURNS

Exposure to heat, chemicals, electrical or inhalation believed to have caused damage to body tissues.  
**STOP THE BURNING PROCESS!!**

ECA	EMT	Intermediate	Paramedic
High flow O2 Cool and dress burns , Flush chemicals Moist sterile bandage if <10% SBA  Dry sterile bandage if > 10% SBA  <b>Transport</b>	High flow O2 Cool and dress burns , Flush chemicals Moist sterile bandage if <10% SBA  Dry sterile bandage if > 10% SBA  <b>Transport</b>	High flow O2 Intubation if indicated  Cool and dress burns , Flush chemicals  Moist sterile bandage if <10% SBA  Dry sterile bandage if > 10% SBA  IV start in unburned area if possible. % of burn area x patient weight in KG x 4 ml = total amount to infuse over 24 hours with ½ being infused in first 8 hours.  <b>Transport</b>	High flow O2 Intubation if indicated Cool and dress burns , Flush chemicals Moist sterile bandage if <10% SBA Dry sterile bandage if > 10% SBA IV start in unburned area if possible. % of burn area x patient weight in KG x 4 ml = total amount to infuse over 24 hours with ½ being infused in first 8 hours. ECG <b>Transport</b>



## EYE INJURIES

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ECA	EMT	Intermediate	Paramedic
Chemical to eyes, continuous flush with NS Open eye injury, bandage both eyes closed Abrasion and/or foreign objects—cover effected eye Impaled objects, stabilize in place, cover both eyes, <b>Transport</b>	Chemical to eyes, continuous flush with NS Open eye injury, bandage both eyes closed Abrasion and/or foreign objects—cover effected eye Impaled objects, stabilize in place, cover both eyes, <b>Transport</b>	Chemical to eyes, continuous flush with NS Open eye injury, bandage both eyes closed Abrasion and/or foreign objects—cover effected eye Impaled objects, stabilize in place, cover both eyes, <b>Transport</b>	Chemical to eyes, continuous flush with NS Open eye injury, bandage both eyes closed Abrasion and/or foreign objects—cover effected eye Impaled objects, stabilize in place, cover both eyes, <b>Transport</b>



## HEAD INJURIES

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Evidence of head trauma with one of the following present:

- Altered LOC
- Loss of consciousness
- Increase in BP, drop in pulse rate
- Irregular respirations

ECA	EMT	Intermediate	Paramedic
High flow O2 LOAD & GO Elevate backboard 30% at head <i>Transport</i>	High flow O2 LOAD & GO Elevate backboard 30% at head <i>Transport</i>	High flow O2 LOAD AND GO IV  ET intubation and/or hyperoxygenation if necessary Elevate backboard 30% at head  <i>Transport</i>	High flow O2 LOAD AND GO IV  ECG  ET intubation and/or hyperoxygenation if necessary Elevate backboard 30% at head <i>Transport</i>



## MULTI-SYSTEMS TRAUMA

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Trauma to one or more of the following:

- Head
- Neck
- Chest
- Abdomen
- Pelvis

OR multiple trauma to extremities or soft tissue with evidence of shock

ECA	EMT	Intermediate	Paramedic
High flow O2 Correct immediate threat to life if possible: Tension pneumothorax, sucking chest wound, aspirations, uncontrolled bleeding <b>Transport</b>	High flow O2 Correct immediate threat to life if possible: Tension pneumothorax, sucking chest wound, aspirations, uncontrolled bleeding  MAST for splinting purposes only  <b>Transport</b>	High flow O2 Correct immediate threat to life if possible: Tension pneumothorax, sucking chest wound, aspirations, uncontrolled bleeding  Bilateral IVs large bore titrated to 100 systolic BP - ENROUTE WHENEVER POSSIBLE MAST <b>Transport</b> Treat minor injuries and fractures as time allows	High flow O2 Correct immediate threat to life if possible: Tension pneumothorax, sucking chest wound, aspirations, uncontrolled bleeding  Bilateral IVs large bore titrated to 100 systolic BP - ENROUTE WHENEVER POSSIBLE ECG MAST <b>Transport</b>  Treat minor injuries and fractures as time allows



## MUSCULO-SKELETAL

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Isolated fractures and injuries ***WITHOUT*** multiple systems trauma or identified LOAD AND GO situation

ECA	EMT	Intermediate	Paramedic
<p>O2 Control bleeding/Splinting as indicated</p> <p><b><i>Transport</i></b></p>	<p>O2 Control bleeding/Splinting as indicated</p> <p><b><i>Transport</i></b></p>	<p>O2 Control bleeding/Splinting as indicated</p> <p>IV if long bone fracture or hypotensive or possible analgesia administration imminent.</p> <p><b><i>Transport</i></b></p>	<p>O2 Control bleeding/Splinting as indicated</p> <p>IV if long bone fracture or hypotensive or possible analgesia administration imminent. ECG if meds to be administered</p> <p><b><i>Transport</i></b></p>



## TRAUMATIC CPR

Pulseless and apneic WITH evidence of trauma or surgical problems as the sole cause of the arrest

ECA	EMT	Intermediate	Paramedic
<p>CPR Correct immediate life threatening emergencies if possible</p> <p><b>TRANSPORT NOW</b></p>	<p>CPR Correct immediate life threatening emergencies if possible</p> <p>MAST for splinting purposes only. <b>TRANSPORT NOW</b></p>	<p>CPR Correct immediate life threatening emergencies if possible (sucking chest wound, uncontrolled bleeding, hypovolemia, hypoxia)</p> <p>Intubation if it can be done quickly MAST</p> <p><b>TRANSPORT NOW</b> Bilateral IV's large bore en route (unless unavoidable prolonged scene time) Follow appropriate protocol(s) as time allows</p>	<p>CPR Correct immediate life threatening emergencies if possible (tension pneumothorax, sucking chest wound, aspiration, uncontrolled bleeding, hypovolemia, hypoxia). ECG</p> <p>Intubation if it can be done quickly MAST <b>TRANSPORT NOW</b></p> <p>Bilateral IV's large bore en route (unless unavoidable prolonged scene time) Follow appropriate protocol(s) as time allows</p>



## **REGIONAL HELICOPTER ACTIVATION PROTOCOLS**

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### **Purpose:**

The purpose of the BVRAC Air Medical Provider (AMP) Protocol is to provide guidelines for a standardized approach for ground emergency medical service providers to request a scene response by an AMP. The intent is to reduce delays in patient care and reduction in mortality and morbidity. Obviously, there cannot be a single protocol developed to meet the needs for every situation. Most emergencies can be adequately stabilized in local hospitals before a helicopter can reach the scene. However, clearly in certain situations the patient cannot be handled at a local facility (or there are no local facility in close proximity to the scene) and should be considered a candidate for Air Evacuation to the appropriate facility. The primary determinant should be to get the patient to the most appropriate facility in the shortest amount of time. Local EMS protocols should be developed in conjunction with the local health care facilities and EMS Medical Directors as to when a patient should be transported to the local facility or when the patient should be flown from the scene to a higher level of trauma center. The AMP Activation protocol should be utilized not only in isolated instances but also in close conjunction with the Facility By-pass and Triage Protocol (see policy for further).

### **Considerations:**

Several factors should be considered when evaluating the need for activating an air evacuation. There are numerous scenarios when it may be beneficial to activate an AMP. One thing that ground EMS provider should focus on is getting the patient to the most appropriate facility in the shortest amount of time. The ground EMS providers should also pay particular attention to:

- The patient meets "Major Trauma Criteria / Trauma Alert" as set by local criteria
- Number of patients will overwhelm EMS local resources or will overwhelm local hospital resources
- Patient is not easily accessible by ground EMS due to terrain or inclement weather (icy roads, bridge out, etc...)
- Ground EMS Providers must focus on two main components: Proper Clinical Care and total "Response Times" when considering to utilization of AMP's.

Total Response Times = response to the scene + scene time of Air med Crew+ transport time to facility. The goal is to choose the transport mode that will deliver the patient to the appropriate facility the fastest.

- Extended Extrication: which would allow time for the AMP to respond as the extrication was in process.
- Ground Providers should not wait on scene awaiting the arrival of helicopter transport more than 15 minutes.



### **AMP Selection Criteria:**

In order to assure BVRAC goals as set forth in the Trauma System Plan and other guidelines are followed. When choosing the appropriate AMP the ground EMS provider should look at several aspects when establishing their local protocols and these minimums should be adhered to. Each AMP providing service to the BVRAC:

- Meet the minimum participation standards as established by the BVRAC
- Participate as requested in the BVRAC performance improvement activities
- Clinical capabilities of the AMP

The AMP chosen should also best meet the patients' needs in reference to clinical care and patient transport:

- One versus two patient capable aircraft
- Response Times (response time + scene time + transport time)
- Each AMP in the BVRAC should be CAMTS accredited or "actively seeking CAMTS accreditation"
  - This is an attempt to assure minimum safety requirements are met by each AMP

### **Dispatching Information:**

The obvious normal dispatching information should be adhered to as far as:

- Name of requesting Agency
- Location of Incident (Key map / GPS)
- Ground Contact information
- Nature of call
- Number of patients
- LZ instructions

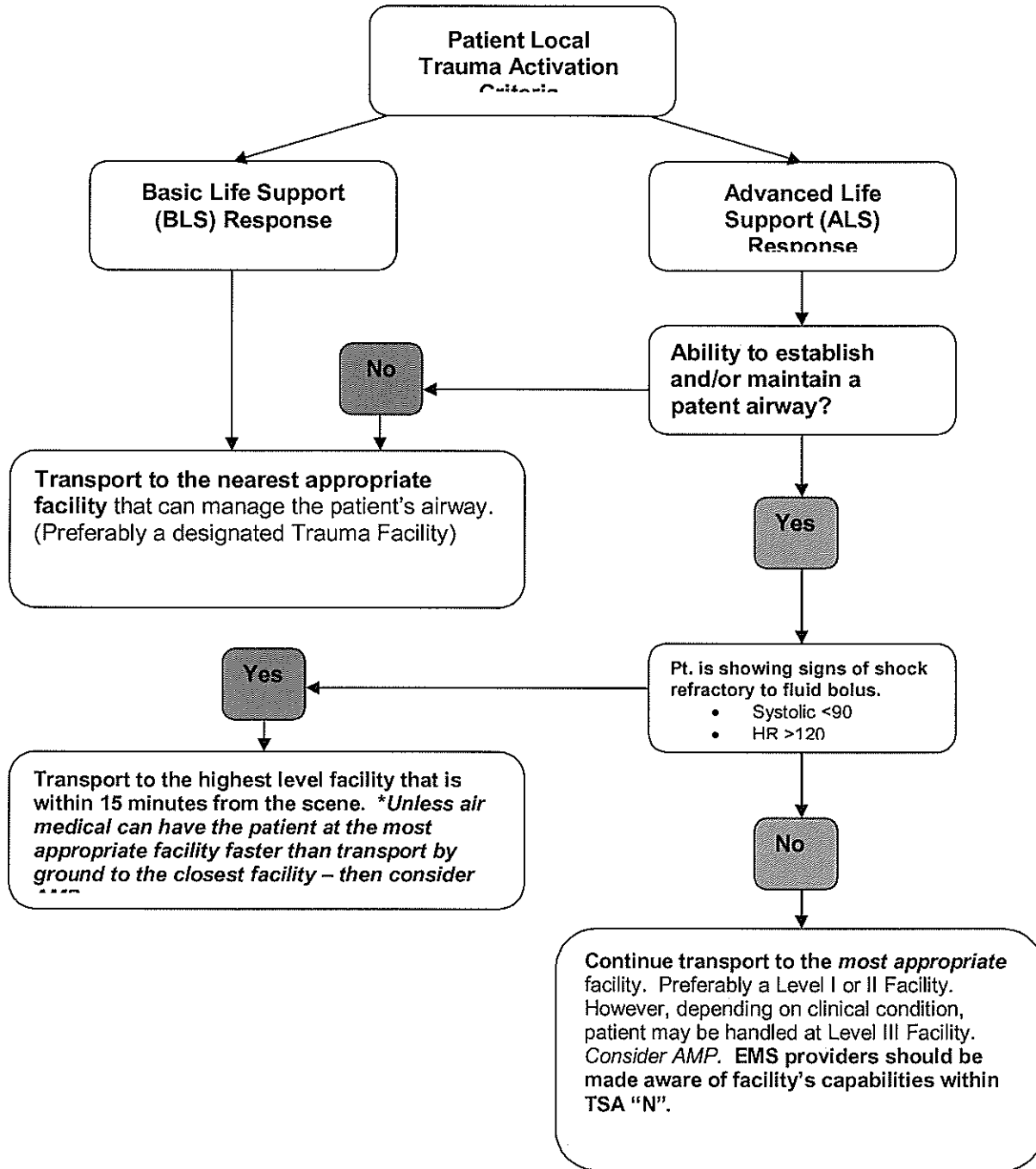
Remember the goal is to get the patient the best care as soon as possible. Access to air evacuation services should assure prompt dispatch of a helicopter when appropriate while discouraging dispatch when it's not necessary. Access should be made by persons with training in the prehospital care of injured patients, knowledge of the local air medical evacuation guidelines and when possible participants of the BVRAC (TSA) to ensure the appropriate AMP is dispatched and criteria is followed. In most situations access should be made by the local EMS agency, but trained first responders can also provide early access in some situations. In fact most registered first responders in the BVRAC are participating members.

## **APPENDICES**

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## Appendix A – Facility Bypass Protocol



When considering Air Medical Activation, remember it is the goal to get the patient to the most appropriate facility the fastest. Keep in mind the Ground EMS Transport Time versus Response Time + Scene Time + Transport Time of the Air Medical Provider (AMP). When possible, early activation of AMP may result in moving the patient to the most appropriate facility the fastest.



## Appendix B – Stroke Protocol

### SUSPECTED STROKE

#### Assessment Guidelines:

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

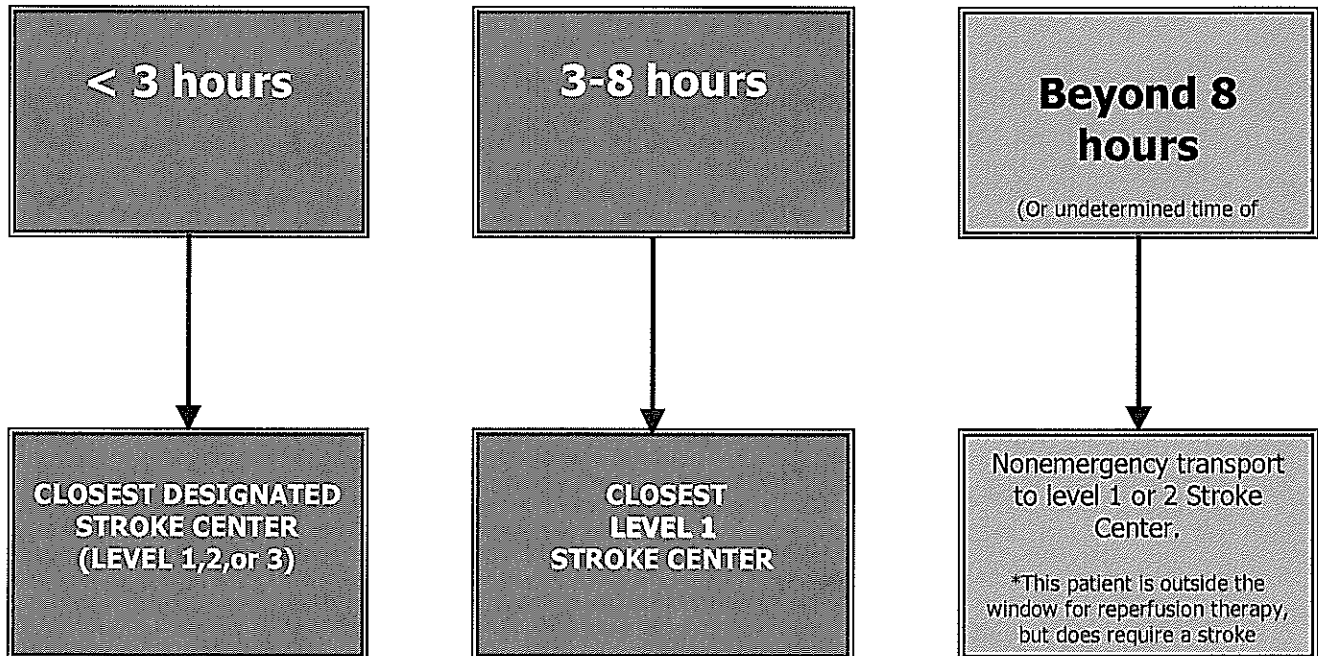
\*Consider other etiologies such as hypoglycemia and seizure.

#### Minimum Treatment Guidelines:

- Oxygen 2-4 L/min
- IV NS TKO (as per skill level)
- Consider antihypertensive agent for blood pressure above 220/110
- Rapid transport to appropriate facility as indicated.
- Divert to the closest hospital for airway or patient instability.
- Consider Air Medical transport for patient deterioration and decrease in transport time.

Transport decision should be based on time of onset as appropriate.

Consider Air Medical Transport to decrease transport time.





<b><i>Level 1 Stroke Centers</i></b> (capable of treating beyond 3 hour IV tPA window)	
<b>St. Joseph Regional Health Center</b> (Joint Commission Certified Primary Stroke Center)	Bryan

<b><i>Level 2 Stroke Centers</i></b>	
<b>College Station Medical Center</b> (currently pursuing)	College Station

<b><i>Level 3 Stroke Centers</i></b>	
<b>Madison St. Joseph</b> (currently pursuing)	Madisonville
<b>Grimes St. Joseph</b> (currently pursuing)	Navasota
<b>Burleson St. Joseph</b> (currently pursuing)	Caldwell
<b>Trinity Medical Center</b> (currently pursuing)	Brenham



**1) Level 1: Comprehensive Centers ("CSCs")**

- a. A 24/7 stroke team
- b. Personnel with expertise to include vascular neurology, neurosurgery, neuroradiology, interventional neuroradiology/endovascular physicians, critical care specialists, advanced practice nurses, rehabilitation specialists with staff to include physical, occupational, speech, and swallowing therapists, and social workers.
- c. Advanced diagnostic imaging: magnetic resonance imaging (MRI), computerized tomography angiography (CTA), digital cerebral angiography and transesophageal echocardiography.
- d. Capability to perform surgical and interventional therapies such as stenting and angioplasty of intracranial vessels, carotid endarterectomy, aneurysm clipping and coiling, endovascular ablation of AVM's and intra-arterial reperfusion.
- e. Supporting infrastructure such as 24/7 operating room support, specialized critical care support, 24/7 interventional neuroradiology/endovascular support, and stroke registry
- f. Educational and research programs

**2) Level 2: Primary Stroke Centers ("PSCs"):**

- a. 24 hour stroke team
- b. Written care protocols
- c. EMS agreements and services
- d. Trained ED personnel
- e. Dedicated stroke unit
- f. Neurosurgical , Neurological, and Medical Support Services
- g. Stroke Center Director that is a physician
- h. Neuroimaging services available 24 hours a day
- i. Lab services available 24 hours a day
- j. Outcomes and quality improvement plan
- k. Annual stroke CE requirement
- l. Public education program

**3) Level 3<sup>1</sup>: Support Stroke Facilities ("SSFs"):**

- a. Develop a plan specifying the elements of operation they do meet.
- b. Have a Level 1 or Level 2 center that agrees to collaborate with their facility and to accept their stroke patients where they lack the capacity to provide stroke treatment.
- c. Identify in the plan the Level 1 or Level 2 center that has agreed to collaborate with and accept their stroke patients for stroke treatment therapies the SSF are not capable of providing
- d. Obtain a written agreement between the Level 1 or Level 2 Stroke Center with their facility specifying the collaboration and interactions.
- e. Develop written treatment protocols which will include at a minimum:
  1. Transport or communication criteria with the collaborating/accepting Level 1 or Level 2 center.
  2. Protocols for administering thrombolytics and other approved acute stroke treatment therapies.
- f. Obtain an EMS/RAC agreement that:
  1. clearly specifies transport protocols to the SSF, including a protocol for identifying and specifying any times or circumstances in which the center cannot provide stroke treatment; and,
  2. specifies alternate transport agreements that comply with GETAC EMS Transport protocols.
- g. Document ED personnel training in stroke.
- h. Designate a stroke director (this may be an ED physician or non-Neurologist physician)
- i. Employ the NIHSS for the evaluation of acute stroke patients administered by personnel holding current certification
- j. Clearly designate and specify the availability of neurosurgical and interventional neuroradiology/endovascular services.
- k. Document access and transport plan for any unavailable neurosurgical services within 90 minutes of identified need with collaborating Level 1 or 2 Stroke Center.



**t-PA Exclusion Guidelines**

BP 185/110 or greater  
Small or resolving stroke  
Seizure at stroke onset  
Taking Coumadin  
PT > 15 sec.  
INR > 1.7  
Heparin during the past 48 hours with elevated PTT  
Platelet count < 100,000  
Acute MI  
Hypoglycemic or hyperglycemic  
Intracranial hemorrhage, neoplasm, Intracranial aneurysm  
Recent surgery  
Prior stroke within 3 months  
Gastrointestinal bleeding  
Pregnancy

**t-PA Inclusion Criteria**

Clinical Diagnosis of Stroke  
Time of onset < 3 hours



## Brazos Valley Regional Advisory Council Stroke Alert Activation Criteria

- | NO                       | YES                      | INDICATIONS:   |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Symptoms of acute stroke for less than 7 hours<br>(TIME LAST SEEN NORMAL : _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Age > 18 years  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Blood glucose >60 and <400 (BS = _____)   |

**All of the above criteria AND at least ONE of the criteria below are GREEN = STROKE ALERT ACTIVATION**

- |                          |                          |                           |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Facial droop           |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Arm drift (unilateral) |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Slurred speech         |

### t-PA Exclusion Guidelines

- BP 185/110 or greater
- Small or resolving stroke
- Seizure at stroke onset
- Taking Coumadin
- Heparin during the past 48 hours with elevated PTT
- Platelet count < 100,000
- Acute MI
- Hypoglycemic or hyperglycemic
- Intracranial hemorrhage, neoplasm, intracranial aneurysm
- Recent surgery
- Prior stroke within 3 months
- Gastrointestinal bleeding
- Pregnancy

### t-PA Inclusion Criteria

- Clinical Diagnosis of Stroke
- Time of onset < 6 hours

### Mechanical Clot Removal Criteria

- Clinical Diagnosis of Stroke
- + CT Angiogram
- Time of onset < 8 hours

**Onset  
<2hours**

Yes

- St. Joseph Regional Health Center  
 - CS Medical Center  
 - St. Joseph CS ER  
 - Grimes St. Joseph  
 - Madisonville St. Joseph  
 - Trinity Medical Center

**Onset  
2-7 hours**

Yes

- St. Joseph Regional Health Center  
 - St. Joseph CS ER

**Onset  
Beyond 7 hours**

(or undetermined time of onset)

Yes

- St. Joseph Regional Health Center  
 - St. Joseph CS ER  
 - CS Medical Center  
 - Trinity Medical Center