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# Texas EMS/Trauma System marks 20-year anniversary

## 1992 was quite a year.

**Hurricane Andrew**, a Category 5 howling blast of wind and water, pounded Florida and muscled its way through the Tennessee River valley, taking the lives of 23 people. An earthquake in Nicaragua killed 116 people; a plane crash in China killed 141; millions of sick and injured people across the U.S. were delivered in ambulances to emergency rooms.

**And something else happened:** The Texas EMS-Trauma System was born when a determined group of visionary emergency health care professionals began thinking globally but acting locally. In January, final Texas Department of Health rules were approved for trauma facilities and regional advisory councils (RACs), marking the beginning of a 20-year journey that brought Texas into a leadership role in EMS/trauma systems.

Saving lives and families, especially in rural areas, is what initially spurred the 1989 Texas Legislature to pass into law Chapter 773 of the Health & Safety Code and the Omnibus Rural Healthcare Rescue Act which directed TDH—now the Texas Department of State Health Services (DSHS)—to develop a state-wide trauma system.

The Legislature did not initially provide funding for this historic public health initiative that, when enacted, would not only save lives but extend the productivity of working Texans. As a core group of EMS providers, trauma physicians and nurses volunteered countless hours in their “spare time” to develop and improve their regional trauma care plans through their local Regional Advisory



*Assistant Commissioner for Regulatory Services Kathy Perkins began her career with DSHS as a statistical clerk. She began working on developing the Texas EMS/Trauma System in 1991.*

Councils, they had no idea these small steps would be the foundation of today’s EMS/Trauma System. In just 20 years, the system has grown to 264 designated trauma facilities and 79 stroke facilities, a state-of-the-art Registry coming online soon, and a network



*Kathy Perkins, left, works on a grant project at the Bureau of Emergency Management in the early 1990s with Ernie Rodriguez. For several years, Perkins was the only employee in the trauma systems program. Rodriguez, who worked in EMS grants, is now director of Austin-Travis County EMS.*



*In the early days of designation, Kathy Perkins was personally involved in many of the surveys of Level II and Level III trauma facilities. She would make cold calls to hospitals to see if they were interested in participating in a trauma system.*

of 22 free-standing regional councils devoted to emergency medical care and disaster management.

Kathy Perkins, the first person hired into the trauma program, had a conversation with Texas EMS Magazine about what it was like in the beginning. – Steve Janda

**Texas EMS Magazine:** You were around from the beginning. How did you get involved?

**Kathy Perkins:** The trauma system got started in 1989 when the Omnibus Rural Healthcare Rescue Act passed in the Texas Legislature. I had a new master's in business and was a nurse and I thought I wanted to do health care administration at a hospital but I couldn't get any interviews. I was hired as a statistical clerk in the Bureau of Emergency Management on the 14th of April 1989, and the legislation passed in May. Six months later TDH posted a trauma systems specialist position and I applied. Then the trauma rules were passed in January of 1992.

**TEXAS EMS:** At that point, had they started to implement the law?

**KP:** I started in the trauma job December 1, and the first TTAC (Trauma Technical Advisory Committee) meeting was in January. There had been some behind the scenes work and lots of discussion about

how we were going to make (the law) work because there were no resources for it. There was no funding for many years for trauma systems.

**TEXAS EMS:** And the law said...

**KP:** Basically the law told us to do four things.

It told us to develop a statewide trauma system, designate trauma facilities and to establish a trauma registry. And the final thing it told us to do was evaluate trauma care in every health care facility in Texas. It was a big mandate. The only way it got passed was that it was attached to the Rural Omnibus Healthcare Act and at the time there was a push from the rural hospitals because they were having a lot of trouble getting their patients transferred to bigger cities. Not just trauma patients. We had patients dying because it sometimes took hours to get patients transferred. And we didn't have the helicopters we have now. It was just a different world.

**TEXAS EMS:** And there were no designated trauma facilities then?

**KP:** There were none in Texas, but there were some in other states. In the Vietnam and Korean wars, people realized the quicker



*In a 1989 photo from Williamson County, a helicopter transports a patient. There were no designated trauma facilities in 1989; the rules that created Trauma Regional Advisory Councils and trauma facilities were passed in 1992. Photo by Daniel Byram.*

they got injured soldiers to a surgeon, to a physician, to a hospital, the better their outcomes were. They started at that point translating that knowledge to trauma care outside the military. Some states at that time were ahead of us: Oregon, Missouri, Florida. So there was some national interest in trauma systems. And trauma facilities.

**TEXAS EMS:** So what did you do when you first got the job?

**KP:** We didn't have any money for a trauma system. I don't know what conversations had been going on (about implementation). But once they hired me, the first thing I did was start calling the emergency department directors in the hospitals I thought might be trauma centers someday. So I called people like Jorie Klein, Phyllis Blanco and Donna George. They all stepped up. Every

meeting I went to brought more people in the fold. I created a database list, and every person I talked to I asked if I could put them on my contact list, most said yes.

**TEXAS EMS:** Cold calls?

**KP:** Yes, cold calls. I'd say: "Here's what we have to do. Will you help me? The state has no money but I think it's a good thing for patients." I was a nurse but I had never worked in the emergency room and I was honest with them (about that). I told them that I would really depend on their expertise. I put in a lot of miles those first couple of years—I wish I had kept count—traveling across Texas, especially after the rules passed. What we found was even getting everyone together and talking can make a difference in patient care. When people are in the same room talking about what's good for the patient, then you don't have the same old attitudes. Just the relationship-building made a difference in patient care.

**Texas EMS:** And who developed the rules?

**KP:** We had an advisory committee, Trauma Technical Advisory Committee, that worked with the department. It took a lot of thought. Some decisions we made resulted in making our system work better in the end. One thing we realized quickly -- we could not run a statewide system from Austin. The law referenced geographical regions, so it gave us an opportunity to divide the state into regions. We felt strongly about that. The law says, too, that rules must provide specific requirements for the care of trauma patients, must ensure trauma care is fully coordinated with all hospitals and emergency medical services in the delivery area, and must reflect the geographic areas of the state considering time and distance. So we immediately began looking at the best way to break up the state.



*When this photo was taken in 1996 in Cleburne, the 22 RACs had been established, but there were still only a handful of trauma facilities designated across the state. Photo by Don Peoples.*

**TEXAS EMS:** And how did you do that?

**KP:** We first talked to the COGs (Councils of Government, regional entities) and tried to get them interested, but there wasn't any money and they were busy with other issues. But we ultimately used the boundaries of the 24 COGs. Originally, we wanted at least a Level I or Level II in every one of these regions, but we quickly realized that probably wasn't going to be possible because of the size of the state. So we had to go to a Level III, which is very different from what was happening in the rest of the country, where they were designating only Level Is and Level IIs. So we went with at least a Level III, a lead Level III is what we called it at the time. We took those 24 COGs and collapsed two where we didn't think there would be a III and created 22 Trauma Service Areas.

**TEXAS EMS:** What was the reasoning behind dividing up the state?

**KP:** That was a big discussion point. I don't think we started initially breaking the state up, but as we started discussing issues like triage, we realized what would work in Austin isn't going to work in San Angelo.

But that decision-making there also defined that Level IIIs could be an important piece in Texas, and it has turned out that way. "Lead" Level IIIs have turned out to keep 90 to 95 percent of trauma. What they may not keep is critical heads, although a lot of them do have neuro; burns; and children and specialties – plastics, reattachments, those kinds of things. We expected lead facilities to be leaders in the RAC. We expected them to get the RAC up and running, to provide outreach to all hospitals and EMS and to work to reduce transfer approvals and also to assist in getting injury prevention activities deeper into our state, not just in the urban areas.

**TEXAS EMS:** You had the boundaries for the RACs. How did you convince people to start an organization?



*Over the years, the EMS/Trauma System has been tested, as it was during this response to a horrific bus wreck outside Victoria. The Golden Crescent RAC (RAC-S) helped coordinate the emergency resources of the area. A National Traffic Safety Board investigator later told the Victoria fire chief that it was one of the best responses he'd seen. Photo by Frank Tilley.*

**KP:** There was another key element in the rules and that was that a hospital could not be designated as a trauma facility unless they had a letter of support from the Regional Advisory Council indicating they were participating. That means there had to be a RAC. There were hospitals that wanted to be designated and they could not until a RAC was in place. That was one thing that helped. I did travel the state. I set up meetings with ED staff, hospital CEOs. But it was mostly nurses and EMS people at these initial meetings. So I went out and tried to convince them it was the right thing to do. We didn't have much guidance.

But I have to be honest, what really kicked it down the road was when the state decided to tie dispro (Medicaid disproportionate share program) to designation. That happened in 1993. The state said any hospital receiving dispro funds had to be designated. So places that were lagging, like the Valley, came on board. I was once told that there would never be a trauma facility in the Valley.



*In just 20 years, the system has grown to 264 designated trauma facilities and 79 stroke facilities, a state-of-the-art Registry coming online soon, and a network of 22 free-standing regional councils devoted to emergency medical care and disaster management. Photo by Don Peoples.*

had no money. So this was a hot topic, what to include in the definition of trauma.

**TEXAS EMS:** It was you and ...

**KP:** It was just me. Along the way I got a few more staff, but it was just me for a couple of years. There was a point at which they had adopted the dispro rules. I had two boxes of applications from trauma facilities that I reviewed while I was on vacation in the motor home with my husband. There was nobody else to do it.

**TEXAS EMS:** What was your most daunting challenge in all of this?

**KP:** The regions wanted us to tell them exactly how to do it—how to set up a RAC. But, what they needed to do was create a RAC that worked for them. There was no “one” way to do it. So I’d tell them: “All the hospitals who take trauma need to be at the table. All the EMS firms need to be at the table. Anyone else you want at the table is fine with me.” Then once we got the first set of bylaws and trauma system plans in, we would share them with other developing RACs; they learned from each other. The other thing that was so hard was the trauma registry, which we’re still working on. Stakeholders wanted it but we had no money. We cobbled money together from TxDOT for years.

**TEXAS EMS:** Did you take that as a challenge?

**KP:** Yes. (laughter). But I honestly don’t know if dispro had not been tied to it, he might have been right. So we had pockets and holes where we did not have RACs. It was still 1995 before we had all the RACs in place.

**TEXAS EMS:** Twenty years ago, trauma care wasn’t really a well-known phrase.

**KP:** People didn’t really think of trauma from an injury perspective. In the presentations I made, I had a slide that said “Trauma = Injury.” We had to educate people that we were talking about an event where some kind of force caused an injury or potential injury. We also had to define what of the ICD9 codes to include in trauma. I remember we had a big discussion about rattlesnake bites. We ultimately decided they are trauma. But think about it like this: These hospitals are getting designated and have to start including data in these registries. That’s a workload issue. We had no money, they

**TEXAS EMS:** At some point, this became personal for you with your brother.

**KP:** That brought it home (when my brother was in a car wreck in West Texas). That area didn’t have the first RAC, but they had one of the first, and University Medical Center (Lubbock) was the first trauma facility, which is where they took him. When I heard the injury he had, which was a grade 4 or 5 liver fracture, I knew he would likely have died if he’d gone anywhere else. That gives me goosebumps (to think about). Yes, it was working. We’d already seen signs that it was working in the discussions and talks at the early meetings.

**TEXAS EMS:** What are you most proud of?

**KP:** I am very proud of the military connection in our system. They have brought something to our system that I don't believe any other state has done. For many years, those Level Is in San Antonio (now one Level I) took 40 percent of the civilian trauma. And I understand why they did that. They did it to train their doctors to take care of our soldiers. At one point we had four (military facilities) in the Texas EMS/Trauma System. So I'm very proud that has been taken to our soldiers in Iraq and Afghanistan.

I am proud that we had the first multi-state RAC, which was the Far West Texas and Southern New Mexico RAC, now called the Border RAC. The RAC also made a point to include input from Mexico. All around the state, trauma patients were coming into our state, not going out of our state. And I'm proud we actually got, without any money, a system built. And I think one of the premier systems in the country.

**Texas EMS:** What's next?

**KP:** How do we stay relevant? Right here in our law it talks about emergency health care systems. And I almost got booted out of a trauma systems committee because I wanted to consider changing the name to emergency health care systems. At the time, they did not want to. They said if we get away from our trauma name and bring in disaster and stroke, we'll lose. I can understand some of that, but where are we now with the addition of stroke?

I'm also very proud of the fact that if you take care of critical trauma patients and you handle incidents on a local level every day, those same resources can be brought to bear in a disaster situation. I believed that from the beginning. And

*The Texas EMS/Trauma System will soon get a new EMS/Trauma Registry, which comes online after years of stakeholder input. Data from that registry can be used to spot trends and perhaps prevent injuries. Photo by Joe Duty.*

it started to show with Tropical Storm Allison and TSA-Q. And now we've seen it again and again with hurricanes and other statewide events.

**TEXAS EMS:** Did you think that twenty years later we would have fully functioning RACs ...

**KP:** I dreamed of there being paid staff at the RACs, but I didn't know if it would ever happen. I'm proud of what has been created, that these people came together and built this system. That they came to help and have continued, so many of them, to this day.

*Next issue: Funding the Texas EMS/Trauma System*

