2025

RAC Self-Assessment Best Practices Resource Document

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This document contains the average score for each indicator based on how the RACs self-assessed their region. Best practice documents are included as they were submitted by individual RACs.

1. EPIDEMIOLOGY

There is a thorough description of the epidemiology of EMS, trauma, systems of care, and emergency health care incidence of EMS transport, hospital admissions, and mortality in the regional population-based data (including data specific to urban, rural, and diverse populations) to assist in defining regional priorities.

If the data is not available through the State EMS Trauma Registry, the RAC is not held accountable for this indicator.

0. Not Known

1. There is no data description of the epidemiology of EMS, trauma, systems of care, and emergency health care incidence of EMS transport, hospital admission, and mortality in the region.

2. Reported admissions and mortality data have been used to describe the statewide incidence of EMS transports, trauma, systems of care, and emergency health care deaths, aggregating all etiologies, but no regional data are available.

3. The RAC has access to the minimal data sets established to develop an epidemiology history of the regional incidence of EMS transports, hospital admissions, and mortality for trauma and other systems of care patients.

4. In addition to #3, quarterly data is aggregated in a confidential process by reporting entities and shared with the RAC membership.

5. In addition to #4, stakeholders use the data to develop strategies and prioritize needs for the rural and urban areas, including measures to address disparities or inequities in care for populations, to define key regional initiatives, prevention, and awareness programs.

AVERAGE SCORE ON THIS INDICATOR: 3.08
BEST PRACTICES: 0

2. EPIDEMIOLOGY - Surveillance

There is an established regional system of care surveillance process that can, in part, be used to support performance measures. The data available is integrated into the regional system plan.

If the data is not available through the State EMS Trauma Registry, the RAC is not held accountable for this indicator.

0. Not known

1. There are no established region-wide systems of care surveillance processes.

2. There is a regional system of care data collection process, but not all EMS providers or hospitals in the service area contribute to the database.

3. There is a regional system of care data initiative with all EMS providers and designated hospitals in the region contributing data for the incidence of EMS transports, hospital admissions, and mortality only. The data is integrated into the regional system plan.

4. In addition to #3, the hospital data is used in conjunction with the EMS data system or hospital discharge data.

5. In addition to #4, the regional data is accessible electronically and has consistent data definitions, with the established EMS wristband identifier and processes in place to support report writing. The data support prevention strategies, coalition building, public awareness, surveillance, and performance improvement with stakeholder input to define priorities and initiatives. Processes for sharing and linking data exist between EMS, public health, and the trauma and emergency health care system participants, with this data being used to monitor, investigate, and diagnose regional community health risks.

AVERAGE SCORE ON THIS INDICATOR: 2.92
BEST PRACTICES: 0

3. REGIONAL LEADERSHIP

The RAC leadership, in collaboration with its members, prepares and disseminates an annual report reflecting the activities, successes, and challenges encountered by the RAC. The regional annual report is available to RAC members and stakeholders.

0. Not known

1. No regional annual report is available.

2. Regional annual reports are developed by the RAC leadership.

3. Regional annual reports are developed in collaboration with the RAC leaders, RAC committees, and RAC members and then disseminated to the general members of the RAC. Regional annual reports include the activities of each committee (or organizational structure defined in the RAC bylaws), an overview of the regional epidemiological data collected, and an overview (which may be reflected in a map) of the services available in the region, such as the location of air medical services, EMS providers, first responder organizations (FROs), and designated facilities. The annual initiatives and goals of the RAC and their outcome are included in the report. The regional annual report is available to RAC members and stakeholders.

4. In addition to #3, the strategic accomplishments, injury and disease outcomes, and challenges encountered are included in the regional annual report, and it is available to all RAC members and stakeholders.

5. In addition to #4, the regional annual report is shared with regional coalitions, partner organizations, public health, local government entities, and the department.

AVERAGE SCORE ON THIS INDICATOR: 2.75
BEST PRACTICES: 0

4. SYSTEM PLAN

A regional EMS, trauma, systems of care, and emergency health care system plan is in place and based on an analysis of the regional demographics and regional self-assessment and provides opportunities for collaborative stakeholder participation. The regional plan reflects, at a minimum, the regional activities specific to each of the self-assessment criteria and includes the regional guidelines. The regional system plan and all associated documents are available to RAC members and stakeholders in a secure location.

0. Not known

1. A documented, outdated regional system plan exists.

2. The RAC leadership is developing/revising a regional system plan without reference to the regional demographics, resource assessments, data analyses, and regional stakeholder participation.

3. The RAC leadership, committees, and stakeholders are actively revising the regional system plan based on regional demographics, the completed self-assessment, resources available, and data analyses that align with the RAC performance criteria. The regional system plan and all associated documents are available to RAC members and stakeholders.

4. In addition to #3, the RAC identifies system priorities and timelines and integrates public health into the revisions of the regional system plan.

5. In addition to #4, the emergency preparedness plans are aligned with the regional system plan. The regional system plan and quarterly performance improvement data are shared with RAC members, stakeholders, the business community, public health, local government entities, and the department.

AVERAGE SCORE ON THIS INDICATOR: 3.13
BEST PRACTICES: 0

5. SYSTEM PLAN

The RAC trauma and emergency health care system plan clearly describes how the regional stakeholders will implement and manage the RAC performance criteria and contract requirements to ensure there is documented evidence that the performance criteria are met, and includes data analysis when appropriate. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. The regional system plan is outdated.

2. The regional system plan does not address or incorporate the RAC performance criteria or the contract requirements.

3. The regional system plan includes the elements of the RAC performance criteria and contract requirements and defines how these criteria are met, to include data related to each of the elements as appropriate. The regional system plan is available to the RAC members and stakeholders.

4. In addition to #3, the system plan objectives are monitored and analyzed quarterly and annually, then shared with regional stakeholders.

5. In addition to #4, the regional data is included in the regional annual report, reflecting the system's performance and outcomes. The regional annual report is available to RAC members, stakeholders, public health, local government entities, the business community, and the department.

AVERAGE SCORE ON THIS INDICATOR: 2.67
BEST PRACTICES: 0

6. SYSTEM PLAN

The RAC trauma and emergency health care system plan defines a process to assist in sharing the regional and state all-hazard emergency response and preparedness activities with stakeholders. Information is shared as appropriate.

0. Not known

1. There is no evidence that the regional system plan has defined processes to assist in sharing the regional and state all-hazard emergency response preparedness plans.

2. There is an established regional system plan, but there is no linkage or assistance from the region that addresses the sharing of the regional or state all-hazard emergency response and preparedness plans.

3. The regional system plan addresses the regional role in sharing the regional health care and all-hazard emergency response and preparedness plan with stakeholders. Information is shared as appropriate.

4. In addition to #3, RAC leaders foster regional stakeholder integration and participation with planning and exercising public health initiatives.

5. In addition to #4, regional stakeholders have opportunities to integrate and participate with the regional medical operation center through an inclusive process and participate in all response after-reviews.

AVERAGE SCORE ON THIS INDICATOR: 3.38
BEST PRACTICES: 2

Regional Advisory Council Best Practices

RAC G: 6. SYSTEM PLAN Piney Woods Regional Advisory Council:

Best Practice Statement 6. SYSTEM PLAN	Briefly Describe	Date Implemented :
The RAC trauma and emergency health care system plan defines a process to assist in sharing the regional and state all-hazard emergency response and preparedness activities with stakeholders. Information is shared as appropriate.	Local DSHS 4/5N (RMOC) has worked closely in the past with RAC-G exercises/drills trainings & meetings. Recently, due to budget cuts, that activity has decreased but communication remains open and meeting participation is ongoing with our virtual options.	Ongoing
Outcome Data	**Regional Performance**	**Resources Required**
Has provided a good working relationship with our local DSHS, EMCs, Hospitals, EMS, & Public Health.	Maintained line of communication with regional partners. Working together in the all-hazards	Equipment for virtual participation (cuts down on travel & hours).
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments**
The current HCC Directors work much more closely on planning efforts than in the past. Both directors have a better understanding of the "how to's" and the 'whys' in conveying the all-hazards and preparedness urgencies of their deliverables.	None except budget constraints.	
Leadership Support	**Lessons Learned**	**Current Status**
Excellent support from local DSHS leadership, Regional TDEM DDCs, and EMCs.	Its the redundant communication efforts which have provided the stakeholders and our EMTF staff excellent command/ control during response activities.	DSHS 4/5 N Leadership assists with RAC membership voter validations. DDCs & EMCs continue to work with RAC-G training & exercises. HCC F & G consistently collaborate with their Governance/Steering committees for needed training, exercise, & supplies.

Regional Advisory Council Best Practices

RAC (Letter and Name): O/CATRAC

Best Practice Statement	Briefly Describe	Date Implemented
Indicator #6 All regional stakeholders are provided equitable opportunities to engage with the Regional Medical Operations Center (RMOC) through a transparent and inclusive process. This includes the ability to integrate into response activities and to formally request and participate in After Action Reviews (AARs), ensuring that lessons learned reflect the perspectives and experiences of the entire response community.	Indicator #6 This best practice ensures that every stakeholder, such as EMS, hospitals, public health, and community partners (e.g., ISDs) have a seat at the table. It emphasizes open participation in both response operations and After Action Reviews (AARs), so that feedback is inclusive, transparent, and representative of the entire region.	Indicator #6 A regional AAR for the March 22, 2024 MCI was held on 4/1/2024. Most recently, an opportunity was sent out on 8/19/2025 regarding an MCI that occurred on 8/13/2025. The request for an AAR occurred on 8/20/2025.
Outcome Data	**Regional Performance**	**Resources Required**
Indicator #6 100% of corrective actions identified in the AAR were assigned to a responsible party within 30 days. Reduction in duplicate resource requests during MCIs compared to prior events.	Indicator #6 Demonstrated improved multi-agency coordination during the 8/13 MCI, with faster patient distribution to receiving hospitals. Documented improvements in communication flow between EMS and hospitals compared to 2024 events.	Indicator #6 Administrative support to schedule and facilitate AARs. Technology platforms (e.g., MS Teams, survey tools) for stakeholder input and virtual participation. Staff time for compiling AAR notes and tracking corrective action follow-up.
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments**
Indicator #6 Previous MCIs demonstrated inconsistent stakeholder participation. Best practices show standardized AAR invitations improve participation rates.	Indicator #6 Limited stakeholder availability due to competing operational priorities. Lack of standardized process for submitting AAR requests. Resource constraints in smaller agencies, limiting their ability to attend meetings. Variability in awareness of the RMOC role among community partners.	Indicator #6 Strong leadership support has helped ensure ongoing stakeholder engagement. Continued work is needed to strengthen community partner participation and ensure corrective actions are implemented region-wide. Future efforts may include developing a shared corrective action tracking tool across all RAC partners.
Leadership Support	**Lessons Learned**	**Current Status**
Indicator #6 EMS Medical Directors recommend regional expectations to pediatric MCI events. CATRAC Leadership to implement and ensure new expectations are followed.	Indicator #6 In prior regional AARs, we have identified that all pediatric patients involved in a bus crash will be transported to an acute care hospital for evaluation.	Indicator #6 In the most recent MCI, RMOC leadership to provide reminders to EMS Medical Directors and staff at reunification site.

7. SYSTEM PLAN

As new evidence-based guidelines are developed, the regional system disseminates the information to the stakeholders and, when needed, has the appropriate committee review the guidelines for regional integration. If regional integration is recommended, the regional committee will develop an implementation plan in collaboration with stakeholders. All stakeholders must have an opportunity to attend an educational overview of the guidelines to ensure they are knowledgeable of the new practice guidelines prior to implementation, including any elements that will be integrated into the system performance improvement process. If approved, new guidelines are shared with appropriate RAC members and stakeholders and integrated into the regional system plan.

0. Not known

1. A structured process for evaluating new evidence-based practice guidelines for implementation with the regional stakeholders does not exist.

2. A structured mechanism is in place to inform regional stakeholders of new evidence-based guidelines for implementation in the region, but it does not define how it will be integrated regionally.

3. A structured mechanism is in place to inform the regional stakeholders of new evidence-based guidelines and to define whether the guidelines should be integrated into the regional guidelines. If the recommendation is to integrate the guidelines into the region, processes for implementation of the guidelines and stakeholder education for the regional system must be provided. If approved, new guidelines are shared with RAC members and stakeholders and integrated into the system plan.

4. In addition to #3, the guidelines are integrated into the system performance improvement process.

5. In addition to #4, the plan includes the system's capabilities to collect, monitor, and analyze data for reporting purposes and to produce reports reflecting the compliance and outcomes of the guidelines. The reports are shared with the regional stakeholders and are contained in the regional annual report.

AVERAGE SCORE ON THIS INDICATOR: 3.04
BEST PRACTICES: 0

8. SYSTEM PLAN

The regional trauma and emergency health care system plan includes the capabilities and capacity for EMS and designated facilities in the RAC. This information is included in the system plan. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. The regional system plan does not address these issues.

2. The regional system plan identifies the need for capabilities or capacity for EMS or designated facilities in the region, but does not have processes in place to monitor.

3. The RAC has processes in place to monitor the capabilities and capacity for EMS and designated facilities in the RAC. This information is included in the system plan. The regional system plan is available to RAC members and stakeholders.

4. In addition to #3, the capabilities and capacity for EMS and designated facilities in all geographic areas of the region are monitored for continual operations. (Example: Pediatric transport capabilities in the very rural areas of the region are needed.)

5. In addition to #4, the regional leaders and stakeholders collectively work on strategies to advance the EMS and designated facilities' capabilities and capacity in the region with the regional stakeholders, public health, local government entities, local business community stakeholders, and the department.

AVERAGE SCORE ON THIS INDICATOR: 3.29
BEST PRACTICES: 0

9. SYSTEM INTEGRATION

There is a clearly defined, cooperative, and ongoing relationship between the regional EMS, trauma, systems of care, and emergency health care system specialty physician leaders. This is written into the system plan. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. There is little evidence of physician integration into the regional care system.

2. There is no formally established, ongoing relationship between the regional EMS, trauma, systems of care, and emergency health care system medical directors. There is no evidence of informal efforts to cooperate and communicate.

3. There are established and ongoing relationships between the regional EMS, trauma, systems of care, and other emergency health care system medical directors established through the medical advisory structure outlined in the bylaws, with minimal integration of specialty services such as neurosurgeons, neurologists, orthopedic surgeons, family medicine physicians, intensivists, hospitalists, geriatricians, pediatricians, behavioral health providers, and rehabilitation providers. Advanced practice providers are integrated into the system planning. The regional system plan is available to RAC members and stakeholders.

4. In addition to #3, some specialty physicians or services are integrated to develop specific guidelines. This medical advisory structure may be utilized to review cases referred to the performance improvement committees as necessary.

5. In addition to #4, there is integration of specialty physicians and services to assist in defining regional guidelines and evidence-based practice guidelines for patients served by the region when needed. Specialty service physicians are integrated into the development of specific guidelines for their specialty.

AVERAGE SCORE ON THIS INDICATOR: 3.04
BEST PRACTICES: 0

10. SYSTEM INTEGRATION

The regional trauma and emergency health care system plan integrates designated facilities with other acute care facilities, extended care facilities, rehabilitation facilities, and 9-1-1 EMS providers into regional committees and projects. This includes facilities for specialty care such as burn care. This element of system integration is written into the system plan. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. The regional system plan does not include the region's designated facilities or prehospital providers.

2. There is a regional system plan that integrates all designated facilities and prehospital providers, but does not include other health care stakeholders.

3. The regional system plan integrates designated facilities with other acute care facilities, extended care facilities, rehabilitation facilities, and 9-1-1 EMS providers from the urban, suburban, and rural communities into the regional committees and identified projects. This element of system integration is written into the system plan. The regional system plan is available to RAC members and stakeholders.

4. In addition to #3, the RAC outlines defined roles, responsibilities, and expectations of participation in the regional committees.

5. In addition to #4, the committee outcomes are monitored, analyzed, and shared with the regional stakeholders, public health, local government entities, local business community stakeholders, and the department.

AVERAGE SCORE ON THIS INDICATOR: 3.21
BEST PRACTICES: 1

Regional Advisory Council Best Practices

Best Practice Statement The regional trauma and emergency health care system plan integrates designated facilities with other acute care facilities, extended care facilities, rehabilitation facilities, and 9-1-1 EMS providers into regional committees and projects; facilities for specialty care such as burn care. This element of system integration is written into the system plan. The regional system plan is available to RAC members and stakeholders.	**Briefly Describe** Standing Specialty committees meet at a minimum, quarterly with some more often, pending their ongoing projects. Committees first report to the Board of Directors for additional input, then to the General Membership quarterly meeting for regional awareness and the opportunity to request assistance from other facilities/ stakeholders.	**Date Implemented** **Ongoing**
Outcome Data Some initiatives lead to formal presentations of needed improved patient care or additional input. Injury Prevention initiatives provide data for patient falls, better car seat stabalization, etc. Recent shared Trauma data lead to PI awareness.	**Regional Performance** Provides awareness for improved resources & training (symposiums), etc.	**Resources Required** **Data analysis**
Background / Comparable Data **Committee reports are given during the General Assembly meetings and an invite to evereyone to join in the specialty committee's PI/QA/patient initiatives.**	**Barriers to Implementing Best Practice** Ensuring accurate and inclusive data is available. Working with some smaller non-corporate hospitals to enhance additional data input. Our region does not have a Pediatric, nor burn center hospitals. There are protocols in place for the stabalization & transport of these specialty patients.	**Comments** RAC-G does not have a burn facility; however protocols & guidelines were written by the trauma facilities & stakeholders for stabalization & transport of these specialty victims.
Leadership Support RAC was permitted to hire a part-time data analyst who is being brought up to speed by our Level I hospital Trauma Program Director.	**Lessons Learned** We need better/more ways to engage our rural facilities in the data entry processes.	**Current Status** Getting our data analyst up to speed with the various registries/ databases.

11. BUSINESS/FINANCE

The RAC leaders provide the general membership with a financial report, which includes funds expended, planned expenditures, remaining balances of funding for RAC operations, and the funding allocated to specific projects related to the development and advancement of the regional EMS, trauma, systems of care, and emergency health care system. This must be an agenda item in the general membership meetings. Membership meetings and agendas must be posted on the RAC website.

0. Not known

1. No operational budgets or regional financial reports are shared with the RAC stakeholders.

2. The operational budget to support the regional EMS, trauma, systems of care, and emergency health care system is limited. There is no evidence of budget reports being shared with the RAC general membership.

3. The annual budget and the regional EMS, trauma, systems of care, and emergency health care system funding allocations and priorities are shared with the RAC general membership. This must be an agenda item in the general membership meeting. Membership meetings and agendas must be posted on the RAC website.

4. In addition to #3, all financial audit findings are shared with the RAC board, with appropriate action plans as necessary.

5. In addition to #4, RAC stakeholders have an opportunity to provide input and recommendations for the annual financial decisions before the final approval of the budget.

AVERAGE SCORE ON THIS INDICATOR: 4.08
BEST PRACTICES: 4

Regional Advisory Council Best Practices

RAC-G: #11. Piney Woods Regional Advisory Council, TSA- G

Best Practice Statement	Briefly Describe this is an agenda item	Date Implemented
At quarterly mtgs, the general membership a financial report, including funds expended, planned expenditures, remaining balances of funding for RAC operations, and the funding allocated to specific projects related to the development and advancement of the regional EMS, trauma, systems of care, and emergency health care system.	in the general membership meetings. and agendas are posted on the RAC website.	ongoing
Outcome Data	**Regional Performance**	**Resources Required**
Membership are aware of the admin & program funds and what is available for them/ their committees to request for their ongoing RAC initiatives/projects.	Members request funding for their regional education & training workshops/ symposiums, etc., through our RAC-G Finance committee formal process. If enough funding is available, we assist with partial funding for vital clinical equipment or communications.	None . Report is created from our QuickBooks records.
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments**
Any facility requesting funds must be in good standing/ compliance with RAC-G.	Before the "tobacco" funds were cut, RAC-G was providing as much as 40-50% of the funds to support these ongoing programs to membership. That % has been reduced to approx 30% and has been limited to regional education & training programs.	At quarterly mtgs, the general membership a financial report, including funds expended, planned expenditures, remaining balances of funding for RAC operations, and the funding allocated to specific projects related to the development and advancement of the regional EMS, trauma, systems of care, and emergency health care system.
Leadership Support	**Lessons Learned**	**Current Status**
Any requests over $5,000, if approved by the Finance Committee, must be presented to the RAC Executive Board for final approval. Awards are noted at the next General Assembly membership meeting.	To help maintain a regional approach, we sometimes have to limit the approvals to 50% of the requests to better spread the funding.	RAC-G has not had any Single-audit findings for several years due to the safeguards/guidelines in place for risk-management.

Regional Advisory Council Best Practices

RAC (Letter and Name): V - Lower Rio Grande Valley RAC

Best Practice Statement	Briefly Describe	Date Implemented
TRAC-V received a score of 5 on self assessment element #11- business/finance due to its transparency and involvement of RAC members in the financial planning process.	TRAC-V approves an annual FY budget and constantly seeks committee feedback to fund various education projects and initiatives. TRAC-V shares all financial updates at GM meetings, posts materials on its website, and presents at least 1 annual external audit report to the Board of Directors.	Since beginning of RAC activities.
Outcome Data	**Regional Performance**	**Resources Required**
Committees may submit proposals with estimates, quotes, or a general budget for review and approval by the TRAC-V Executive Director and Finance Committee to encourage committee progress and alignment with TRAC-V strategic plan.	Having this model for member engagement has allowed TRAC-V to fund projects across all committees and systems of care including education, outreach, injury prevention, and marketing items for stroke, cardiac, trauma, pre-hospital, maternal, injury prevention, and more. This allows the entire system to grow across service lines.	Participation of members, committee chairs, and board members. Funds for external audit and financial tracking tools to accurately track remaining balances per grant.
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments**
TRAC-V has always been transparent and given a financial report at General Membership meetings. Since 2020, we have included the remaining grant funds for the FY on the GM agenda and copies of the financial reports are available to members upon request.	Reliance on committee members feedback and constant communication with stakeholders. Additionally, the cost and scheduling of an external audit to report to the Board of Directors.	
Leadership Support	**Lessons Learned**	**Current Status**
The TRAC-V Board stresses the involvement and input of the general membership and its committees. TRAC-V has a process in place to request funds for a project and has set up bi-annual committee chair meetings to discuss projects and funding available.	The general membership appreciates the constant updates regarding availability of funds for education and RAC initiatives and likes to be involved in the planning process for the year.	This model of member engagement, opportunity to request funding or give feedback, audit reports, and availability of reports on RAC website or upon request is still operational and will continue to be so until other feedback is received.

Regional Advisory Council Best Practices

RAC (Letter and Name): Golden Crescent RAC "S"   Question 11

Best Practice Statement	Briefly Describe	Date Implemented
Provide accuracy and transparency in RAC financial matters.	The Golden Crescent RAC is fully committed to financial accuracy, transparency, and using the allotted funds to most good for our region.	Unknown
Outcome Data	**Regional Performance**	**Resources Required**
Financial audits by DSHS reveal no discrepancies.	We operate under a "zero sum" budget with no DSHS funds carried over year to year. A recent audit showed no discrepancies in our accounting / accounting practices. No one board member can spend funds without authorization. Checks must written by the Admin and signed by the Chair. Should the Chair write the check another board member must sign. Taxes are completed by a professional accountant.	Accounting software, knowledgeable staff to maintain financial accuracy.
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments**
None	None in our region	Finances are discussed and shown during each RAC Finance Committee meeting and General Membership Meeting. Questions are encouraged.
Leadership Support	**Lessons Learned**	**Current Status**
The Executive Board, Executive Director and our Administrative Assistant support our financial policy and vision 100%	Communication and expectations must be clear and understood by staff and regional partners.	Active

Regional Advisory Council Best Practices

RAC (Letter and Name): North Central Texas Trauma Regional Advisory Council (NCTTRAC)

Best Practice Statement	Briefly Describe	Date Implemented
NCTTRAC is committed to providing financial transparency and accountability to ensure responsible use of funds and support long-term sustainability.	NCTTRAC provides consistent financial reporting to the Board of Directors and General Membership. Staff builds the annual budget that includes input from external stakeholders approval from the Board of Directors. RAC leaders also regularly review and update financial policies to comply with federal and state regulations.	Financial reports and presentations have been consistently provided since April 2013.
Outcome Data	**Regional Performance**	**Resources Required**
N/A	For the past five years, NCTTRAC has consistently received an unmodified opinion on both its independent financial audits and federal single audits. This indicates that the organization's financial statements are presented fairly in all material respects and that it remains in full compliance with federal grant requirements, including internal controls over compliance for major federal programs.	Sage Intact Software and general knowledge of Code of Federal Regulations (CFR), Texas Grant Management Standards (TxGMS) and Generally Accepted Accounting Principles (GAAP).
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments**
Historically, NCTTRAC has operated with a single finance staff member. With increased funding, there was an opportunity build a dedicated finance team. This expansion contributed to strong internal controls, ensure accurate accounting, and enable the use of robust accounting software capable of providing detailed financial reports—tracking income, expenses, and budget variances across multiple contracts.	Limited resources can lead to staffing constraints, improper accounting systems and weak internal controls. Complex legal or grant requirements can make compliance difficult.	N/A
Leadership Support	**Lessons Learned**	**Current Status**
RAC leadership enforces written financial management policies, including budgeting, reporting, auditing, and conflict of interest protocols. They also require timely and accurate financial reports as well as demonstrate commitment to ethical management.	Transparency builds trust. Openly sharing financial information with stakeholders creates confidence and credibility. Strong internal controls are essential. Without proper checks and balances, the risk of mismanagement or fraud increases significantly.	NCTTRAC will continue to link financial plans with regional goals and budget based on infrastructure and development needs. Transparency and oversight will be maintained.

12. EMS/PREHOSPITAL

The regional trauma and emergency health care system plan defines an EMS Medical Director Committee or medical advisory process that is actively involved with the local and state advisory council initiatives focusing on the development, implementation, and ongoing evaluation of the EMS system guidelines. These guidelines include but are not limited to prehospital triage criteria to establish appropriate destination and transport criteria for patients with acute trauma, systems of care, or other time-sensitive disease processes; which resources to dispatch, such as Advanced Life Support (ALS) versus Basic Life Support (BLS) and First Responder Organizations (FRO); air- ground coordination; early notification of the receiving health care facility; pre- arrival instructions; EMS-Time Out guidelines; facility patient feedback to EMS; and other EMS regional procedures. These are elements of the regional trauma and emergency health care system plan. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. There are no regional trauma, systems of care, and emergency health care system-recommended prehospital guidelines.

2. Regional trauma, systems of care, and emergency health care system guidelines have been developed, but without regard to the national standards.

3. Regional trauma, systems of care, and emergency health care system guidelines have been developed and adopted and are congruent with national standards, but there is no evidence of a coordinated implementation process with the regional EMS providers and other stakeholders. The EMS guidelines are an element of the regional system plan. The regional system plan is available to RAC members and stakeholders.

4. In addition to #3, a documented regional implementation plan includes the regional EMS providers and other stakeholders with minimal outcome data.

5. In addition to #4, these guidelines are integrated with the regional system performance improvement process to evaluate compliance with the guidelines and outcome data.

AVERAGE SCORE ON THIS INDICATOR: 3.26
BEST PRACTICES: 0

13. EMS/PREHOSPITAL

There are recommended regional prehospital triage criteria to establish appropriate destination and transport of patients with acute trauma, systems of care, or other time-sensitive disease processes. The regional EMS Medical Director Committee or medical advisory process, EMS providers, and designated facilities regularly evaluate prehospital triage criteria to identify system gaps.
The regional prehospital triage criteria are included in the EMS guidelines of the regional trauma and emergency health care system plan. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. There are no recommended regional prehospital triage criteria to ensure that patients with acute trauma, systems of care, or other time-sensitive disease processes are transported to the appropriate facility.

2. There are differing regional prehospital triage criteria for acute trauma, systems of care, and other time-sensitive disease processes used by EMS providers. The appropriateness of prehospital triage criteria and subsequent transportation is not evaluated.

3. Regional prehospital triage criteria for patients with acute trauma, systems of care, and other time-sensitive disease processes are developed, approved by the EMS/FRO Medical Director Committee or medical advisory process, and implemented for a system approach. These prehospital guidelines are included in the regional system plan. The regional system plan is available to RAC members and stakeholders.

4. In addition to #3, the prehospital triage criteria are utilized by EMS providers and monitored through the regional system performance improvement process.

5. In addition to #4, the effectiveness of the triage criteria is evaluated through outcomes and transfer activities. These reports are generated quarterly and reviewed by the Medical Director Committee or the medical advisory process.

AVERAGE SCORE ON THIS INDICATOR: 3.17
BEST PRACTICES: 0

14. DEFINITIVE CARE FACILITIES

The regional EMS, trauma, systems of care, and emergency health care system identify and track the number, levels, and geographic location of designated facilities. This information is included in the regional trauma and emergency health care system plan. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. There is no regional system plan to identify and track the number, levels, and distribution of trauma centers for the region.

2. The regional system plan does not identify or track the number, levels, or distribution of designated facilities for the region.

3. The regional system plan identifies the number, level of designation, and distribution of designated facilities within the region and integrates this information into the regional system plan. This information is included in the regional system plan. The regional system plan is available to RAC members and stakeholders.

4. In addition to #3, the region identifies areas with limited resources for care.

5. In addition to #4, the regional system plan has provisions to assist the areas with limited resources in managing or transferring acute patients, and this is monitored through the regional system performance improvement process.

AVERAGE SCORE ON THIS INDICATOR: 3.5
BEST PRACTICES: 0

15. SYSTEM COORDINATION and PATIENT FLOW

Regional guidelines and processes to expedite interfacility transfers of patients with acute trauma or systems of care events, individuals with life-threatening or limb-threatening injuries or disease, and other time-sensitive disease processes are included in the regional trauma and emergency health care system plan. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. Regional processes to expedite interfacility transfers of acute patients are not in place.

2. The interfacility transfer guidelines and processes are defined by each facility, but no regional process is established.

3. Regional guidelines for interfacility transfer to expedite patients with acute trauma or systems of care events, individuals with time-sensitive disease processes, and life-threatening or limb-threatening injuries or diseases are written and integrated into the regional system plan. The system plan is available to RAC members and stakeholders.

4. In addition to #3, these guidelines and processes are monitored through the regional system performance improvement process.

5. In addition to #4, the region has implemented a transfer coordinating center and measures to facilitate the sharing of patient images and patient records from the transferring facility to the receiving facility to expedite the accepting team's decision-making. This may include telehealth and telemedicine capabilities. Software to track the transport agency's location and estimated time of arrival at the transferring facility is in place and integrated into the transfer decision scheme. These guidelines are monitored through the regional system performance improvement process to evaluate transfer timeliness and appropriateness and to monitor the "out of RAC" transfers. Performance improvement reports are shared quarterly with RAC members and stakeholders. The Medical Director Committee/medical advisory process reviews all transfer delays.

AVERAGE SCORE ON THIS INDICATOR: 3.17
BEST PRACTICES: 0

16. SYSTEM COORDINATION and PATIENT FLOW

Specific regional populations that may have defined needs are identified for trauma, systems of care, and other time-sensitive disease processes in the regional system plan. Examples of unique populations include bariatric, homeless, behavioral health, and the non-English speaking population in all geographic areas of the region, including the rural and remote areas. The regional trauma and emergency health care system plan identifies resources for these populations. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. There has been no consideration of the specific needs of unique populations.

2. The regional stakeholders have not prioritized the specific populations and their potential needs in the regional system plan.

3. The regional stakeholders have identified specific populations and defined specific resources for these populations. This information is integrated into the regional system plan and is available to RAC members and stakeholders.

4. In addition to #3, there are measures to share the list of resources with RAC members and stakeholders.

5. In addition to #4, the list of resources is updated annually.

AVERAGE SCORE ON THIS INDICATOR: 2.92
BEST PRACTICES: 0

17. PREVENTION and OUTREACH

Written injury and disease prevention and outreach guidelines that utilize evidence-based practices are implemented. Implementation includes collaboration with other agencies and community partners. The specific prevention and outreach programs are data-driven and aimed at high-risk injuries that produce the "top five" injury reasons for trauma facility admission or trauma deaths for the region's systems of care and time-sensitive diseases guided by regional data, with consideration to shared risk and protective factors. Specific goals with measurable objectives are incorporated into the prevention and outreach guidelines and monitored quarterly. This information is disseminated to regional stakeholders. Outcome data of the prevention and outreach guidelines are included in the regional annual report.

0. Not known

1. There is no written plan for a coordinated injury and disease prevention program.

2. There are multiple injury and disease prevention programs that may conflict with resources available or with the goals of the regional system plan, or there is a lack of regional coordination.

3. The regional system plan includes written guidelines for specific coordinated injury and time-sensitive disease prevention and outreach programs based on regional data with defined goals and measurable outcomes. The outcomes of the prevention and outreach guidelines are included in the regional annual report. The regional annual report is available to RAC members and stakeholders.

4. In addition to #3, the written injury and time-sensitive disease prevention and outreach guidelines are implemented with regional and community stakeholder participation. These programs have regional support and may be integrated with established coalitions.

5. In addition to #4, these prevention and outreach guidelines have documented evaluation processes to define their effectiveness. Through the regional annual report, the prevention and outreach outcomes are shared with regional stakeholders, public health, local government entities, the business community stakeholders, and the department. If coalitions are not in place for high-risk injuries or time-sensitive diseases, the RAC may consider developing a coalition to integrate with the community partners and other interested stakeholders.

AVERAGE SCORE ON THIS INDICATOR: 3.17
BEST PRACTICES: 0

18. PREVENTION and OUTREACH

The region conducts at least one interdisciplinary EMS, trauma, systems of care, or acute emergency health care conference or educational case review annually, designed to engage regional stakeholders, disseminate evidence-based practices, and focus on the system approach to patient care and improving regional outcomes. Information on this conference or case presentation must be shared with appropriate regional stakeholders. Regional participant attendance is documented. This information is included in the regional annual report. The regional annual report is available to RAC members and stakeholders.

0. Not known

1. There are no multidisciplinary conferences or educational case reviews conducted in the region.

2. The region provides infrequent multidisciplinary educational opportunities.

3. A regional multidisciplinary conference or educational case review for EMS, trauma, systems of care, or time-sensitive disease process opportunities is scheduled at least annually, with attendance monitored and reviewed. This information is included in the regional annual report. The regional annual report is available to RAC members and stakeholders.

4. In addition to #3, educational opportunities are defined through the self-assessment, stakeholder requests, or system performance improvement process, and attendance is monitored.

5. In addition to #4, these educational programs are inclusive to all regional health care stakeholders. Continuing education and continuing medical education credits are provided. If the RAC cannot support the educational opportunities, it is partnering with other RACs or organizations to provide educational opportunities or disseminate upcoming educational programs.

AVERAGE SCORE ON THIS INDICATOR: 3.75
BEST PRACTICES: 5

Regional Advisory Council Best Practices

RAC (Letter and Name): Golden Crescent RAC TSA S   Question 18 Prevention & Outreach

Best Practice Statement	Briefly Describe	Date Implemented
The RAC conducts an annual conference as well as nursing and EMS courses responsive to the needs of hospital and pre-hospital stakeholders in an effort to enhance the continuing education needs of the region.	GCRAC has aligned with the MidCoast Hurricane Conference each April to provide quality breakout sessions for nursing, EMS, and allied healthcare personnel.	The annual MCHC annual has been offered since 2000. Summer CE courses have been offered the past 8 years.
Outcome Data	**Regional Performance**	**Resources Required**
The annual conference is attended by at least 3 area hospital personnel and at least 7 EMS Provider personnel. TNCC and NAEMT courses offered during the same time each year yield 25-35 attendees. Evaluations for these offerings are typically excellent.	Communication and marketing for these educational offerings begins well in advance of the conference/course. The GCRAC Education Committee issues RFPs to prospective presenters both local and national.	In providing the conference with MCHC, resources are abundant from manpower to the conference building.
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments**
Each entity provides their own education resources but the conference and courses are able to bring organizations together for networking while achieving common goals in advancing knowledge and technology.	The attendance could be better. The primary barrier is staffing issues due to shortages. The conference has evolved into a two-day conference with tracks for nursing, EMS and allied health. This may make it possible for more healthcare providers to attend one day or both.	The conference preparation begins each fall with regular updates in both the planning meetings and the RAC meetings.
Leadership Support	**Lessons Learned**	**Current Status**
The MCHC is well supported locally from the county Judge, Emergency Management, area hospitals and EMS. Primary and subcommittees provide the manpower for various aspects.	The conference was previously a stand-alone offering but has evolved into a multi-faceted conference for law enforcement, emergency management, nursing, EMS/Fire, and Allied Health. This alone allows for a diverse, multidisciplinary conference with a variety of partners.	The MCHC will be offered in April 2026 and the summer courses planning for 2026 will include the new Obstetrics Life Support course.

Regional Advisory Council Best Practices

RAC (Letter and Name): E - North Central Texas Trauma Regional Advisory

Best Practice Statement	Briefly Describe	Date Implemented
NCTTRAC provides educational opportunities to enhance the knowledge, skills, and best practices of emergency healthcare professionals in order to promote a system of quality care in North Central Texas. Course fees are discounted 50% for NCTTRAC Members servicing the TSA-E counties.	NCTTRAC staff provides educational events to members based on member feedback/requests and designation rule requirements. CE hours are available via recorded instructional videos hosted on our Learning Management System for members to earn at their convenience.	March 2014 when the Professional Development Manager position was created and staffed.
Outcome Data	**Regional Performance**	**Resources Required**
An upward trend across both value and increased attendance, highlights the continued demand for the courses and its effectiveness in engaging a broader audience, both within the region and across the state.	Targeted clinical education enhances our member's operations. Examples include the highly sought-after NEMSMA Field Training Officer courses and the Association for the Advancement of Automotive Medicine Abbreviated Injury Scale (AIS15), which are both offered annually in support of our EMS partners and Trauma facility designation requirements.	Event management software plays a key role in registration utilized for events as well as overall association management. Graphic design tools to support the development of event materials. Additionally, a learning management system is used to manage CE tracking, with plans to expand into an on-demand library in the future. NCTTRAC is able to provide EMS continuing education hours as a DSHS licensed CE Provider; and nursing continuing education hours as an approved CE Provider by the California Board of Registered Nursing.
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments**
The Clinical Education program has witnessed higher attendee numbers across every fiscal year reflecting the program's expanding reach and value to participants. An example of this can be shown below on the cost share and attendee numbers for the previous fiscal years: FY23: Value $5,650 / 186 Attend. FY24: Value $73,940 / 560 Attend.	Unable to provide Continuing Medical Education (CME).	
Leadership Support	**Lessons Learned**	**Current Status**
In addition to committee members providing feedback and insight into regional education needs (e.g., designation-specific required certifications and/or trainings), NCTTRAC committee leadership has assisted in developing region-specific outreach education and performance improvements through targeted CE webinars. Committee Chairs and Medical Directors regularly volunteer to present on regional best practices, driving initiatives and advancing regional projects.	Experience has shown that cost-sharing, increased advertising, and program performance improvements leads to increased interest and attendance while also maintaining and extending programmatic funds.	Currently developing an LMS CE Library for membership that will allow on-demand access to previously recorded education events.

Regional Advisory Council Best Practices

RAC (Letter and Name): O/CATRAC

Best Practice Statement	Briefly Describe	Date Implemented
Indicator #18 The RAC ensures inclusive access to high-quality educational opportunities for all regional healthcare stakeholders through its annual Educational Symposium, led by the CATRAC Education and Injury Prevention Committee. Continuing Education (CE) and Continuing Nursing Education (CNE) credits are offered for EMS and nursing to promote professional development and system-wide competency. When the RAC is unable to independently provide these opportunities, it actively partners with accredited organizations, ensuring that stakeholders consistently have access to relevant and accredited training.	Indicator #18 This best practice highlights the RAC's commitment to inclusive, accredited educational opportunities for EMS, nursing, and other healthcare stakeholders. Through the annual CATRAC Educational Symposium, developed and led by the Education and Injury Prevention Committee, continuing education credits are consistently provided. CATRAC ensures that professional organizations have ongoing access to quality training.	Indicator #18 The first CATRAC Education Symposium was held on July 26, 2024. The second Symposium is scheduled for September 5, 2025.
Outcome Data	**Regional Performance**	**Resources Required**
Indicator #18 In our first Educational Symposium, 7.5 medical CE credits were administered to 20 EMS providers by Blanco County ESD 2. 36 nursing CEs were administered by TETAF.	Indicator #18 Strengthened regional collaboration by hosting participants representing EMS agencies, hospitals, and community partners. Increased availability of CE/CNE opportunities in the region, reducing reliance on external conferences. Enhanced provider competency in emergency healthcare systems through targeted education sessions.	Indicator #18 Administrative support for symposium planning, registration, and CE coordination. Financial resources for venue, catering, speaker honorariums, and educational materials. Partnerships with accrediting bodies (e.g., TETAF, Banco County ESD 2) to issue CE/CME credits. Committee volunteer hours for event design and support.
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments**
Indicator #18 Prior to 2024, EMS and nursing providers in the region had limited access to affordable CE/CME opportunities. Registrants for the 2025 symposium show an increase in participation by 62.5% thus far. National best practices emphasize multidisciplinary education to strengthen system preparedness and patient outcomes.	Indicator #18 Limited staff time to coordinate large-scale educational events. Financial constraints for venue and speaker costs. Competing schedules of healthcare providers, limiting attendance. Variability in accreditation requirements between disciplines.	Indicator #18 Positive participant feedback highlighted the symposium's relevance and accessibility. Continued partnerships with Texas organizations will help sustain offerings and broaden reach. Consideration should be given to hybrid (in-person + virtual) formats to increase access for rural providers.
Leadership Support	**Lessons Learned**	**Current Status**
Indicator #18 CATRAC leadership facilitate the Education and Injury Prevention Committee by allocating staff resources and budget to the annual symposium. EMS Medical Directors and hospital leadership actively encourage participation and contribute expertise as speakers.	Indicator #18 Early coordination with CE/CNE accrediting partners is essential to avoid delays in issuing credits. Including diverse clinical topics (trauma, pediatrics, cardiac, maternal health) increases engagement across disciplines. Feedback surveys provide valuable insights for improving session content and logistics.	Indicator #18 The inaugural symposium was successfully held in July 2024 with CE/CNE credits administered. The 2025 symposium is set to occur September 5, with goals to expand nursing and physician participation. Ongoing partnerships with TETAF and other RACs continue to strengthen regional educational offerings.

Regional Advisory Council Best Practices

RAC U Coastal Bend Regional Advisory Council: 18

Best Practice Statement	Briefly Describe	Date Implemented
To provide inclusive, high-quality educational opportunities for all regional healthcare stakeholders that disseminate evidence-based practices, promote interdisciplinary collaboration, and strengthen the system approach to patient care, ultimately improving regional outcomes. Objectives include offering continuing education credits, leveraging partnerships with other RACs or organizations as needed, and engaging stakeholders in the planning and content of educational programs.	Prior to this practice, educational opportunities in the region were limited and often siloed, reducing awareness of best practices and system-based approaches to patient care. This affected EMS providers, hospital staff, trauma teams, and other regional healthcare stakeholders. The RAC now conducts at least one interdisciplinary educational conference or case review annually, with content informed by self-assessment, stakeholder requests, and system performance improvement initiatives. Attendance is monitored, continuing education/medical education credits are provided, and materials are shared with all regional stakeholders. If the RAC cannot independently provide these opportunities, it collaborates with other RACs or organizations to ensure stakeholders have access to relevant educational programs.	2019
Outcome Data • Continuing education and medical education credits are awarded, enhancing professional development. • Collaborative learning has led to measurable improvements in regional performance metrics, such as response times and adherence to clinical guidelines.	**Regional Performance** Outcomes fully aligned with the goal of promoting interdisciplinary education and evidence-based practices. Unexpected benefits included stronger relationships between EMS, hospitals, and specialty care providers, fostering improved communication and coordination in patient care.	• **Resources Required** Staff to organize conferences, track attendance, and manage CE/CME credits. • Budget for speakers, materials, and venue or virtual platforms. • Collaboration with partner RACs or organizations when necessary to provide specialized educational content.

Background / Comparable Data Prior to implementation, educational programs were sporadic and inconsistent across the region. Since establishing inclusive, structured programs, stakeholders report higher engagement, improved knowledge transfer, and better system-wide coordination in clinical and operational practices.	• **Barriers to Implementing Best Practice** Scheduling conflicts for stakeholders across multiple counties. • Overcome through hybrid/virtual options and advanced scheduling to maximize participation. • Limited funding for specialized content occasionally requires partnerships with other organizations.	**Comments** This is a best practice because it ensures equitable access to high-quality educational opportunities for all regional healthcare stakeholders, enhances professional development, and strengthens system-wide performance through collaborative learning.
Leadership Support Leadership actively supports planning, funding, and promotion of these programs. Their engagement ensures alignment with regional goals, encourages participation, and reinforces the importance of interdisciplinary education and collaboration.	**Lessons Learned** • Early engagement of stakeholders in planning increases attendance and relevance of content. • Hybrid delivery options increase accessibility for rural or resource-limited facilities. • Collaboration with other RACs or organizations enhances program breadth and quality.	**Current Status** Fully implemented and ongoing, with annual reviews to assess impact, update content, and expand stakeholder participation.

Regional Advisory Council Best Practices

RAC (Letter and Name): RAC P Southwest Texas Regional Advisory Council (STRAC)

Best Practice Statement	Briefly Describe	Date Implemented
	The Southwest Texas Regional Advisory Council has developed and sustained a highly coordinated, technology-supported, and data-driven interfacility transfer system for patients with trauma, time-sensitive disease processes, and other emergent conditions. This system is operated through a centralized coordination center—MEDCOM—which manages all trauma transfers, special-case triage, and system healthcare load balancing. The result is a highly efficient, equitable, and clinically sound regional transfer process that strives to consistently meets performance benchmarks and fosters strong collaboration among all stakeholders.	Unknown
Outcome Data	**Regional Performance**	**Resources Required** - A centralized coordination center or point - Facility collaboration and coordination - Basic tech tools (image sharing, tracking, documentation) - Routine stakeholder performance reviews - Funding - Personnel
Background / Comparable Data	**Barriers to Implementing Best Practice** Funding Personnel	**Comments** See attached
Leadership Support	**Lessons Learned**	**Current Status**

Best Practice Documentation: System Coordination and Patient Flow

Interfacility Transfers and Regional System Coordination

Overview

The Southwest Texas Regional Advisory Council has developed and sustained a highly coordinated, technology-supported, and data-driven interfacility transfer system for patients with trauma, time-sensitive disease processes, and other emergent conditions. This system is operated through a centralized coordination center—MEDCOM—which manages all trauma transfers, special-case triage, and system healthcare load balancing. The result is a highly efficient, equitable, and clinically sound regional transfer process that strives to consistently meets performance benchmarks and fosters strong collaboration among all stakeholders.

Centralized Trauma Transfer Center: MEDCOM

MEDCOM is the region's 24/7 transfer coordination center for trauma and emergency medical cases.
- Leadership: Overseen by the MEDCOM Division Director, with day-to-day operations managed by Watch Commanders (experienced nurses and/or paramedics) who oversee the MEDCOM Coordinators.
- Core Responsibilities:
  • Facilitate all trauma patient and emergent interfacility transfers
  • Triage and assist with transfer placement
  • Monitor and balance the regional system's load across trauma centers
  • Coordinate H.E.L.P. (Hospital Executive Leadership Protocol) calls for complex patients

Technology Infrastructure

To ensure efficiency, transparency, and speed in transfers, MEDCOM uses the following tools:
- Image Sharing: PowerShare (University Hospital), LifeImage (BAMC) coordinated by MEDCOM
- Telemedicine & Tracking: Pulsara
- Data Collection: Datapath (in-house software for data collection for QA/QI purposes)
Note: These systems are not currently integrated but serve distinct operational needs effectively.

Transfer Process Flow

1. Identification: A patient arrives at a referring facility and is identified as exceeding local capabilities. (TSA-P uses Trauma Alert criteria (Red/Blue Criteria) to help rapid identification of patients who may need a trauma center)
2. Initiation: The facility calls MEDCOM, which uses trauma surgeon-defined criteria to determine auto-acceptance eligibility.
3. Auto-Acceptance & Load Balancing: If criteria are met, MEDCOM auto-accepts on behalf of the receiving trauma center, applying a 50/50 split between the two Level 1 Trauma Centers.
4. Consultation Pathway: If the patient does not meet auto-accept criteria, the referring physician is connected to a trauma surgeon to discuss and ensure the patient needs transfer.
5. Alternate Placement: If not eligible for a Level I center, they may be routed to a lower-level Trauma 3 facility.
6. Transport Tracking: Transport is tracked via Datapath until the patient arrives.

Special Protocol: H.E.L.P. Calls

The Hospital Executive Leadership Protocol (H.E.L.P.) is activated for complex patients denied by all local systems. Watch Commanders triage the case, and if urgent, arranges a call with local health system CEOs to find placement. MEDCOM handles 2–4 H.E.L.P. calls monthly, with almost all resulting in successful transfers within the region.

Performance Improvement & Monitoring

MEDCOM monitors:
- Decision time (arrival to MEDCOM called)
- Transfer Time (Time from acceptance to departure)
- H.E.L.P. call trends
- Trauma transfer declines
- Out-of-RAC transfers
Monthly PI meetings include trauma surgery chiefs, EMS Directors, and Trauma Program Managers. An advisory group also meets monthly to review data and transfer process.

Load Balancing Trauma System

Transfers are rotated 50/50 between University Hospital and BAMC. Pediatric trauma goes to University, adult burns to BAMC-ISR. Diversions are logged and tracked using EMResource. MEDCOM monitors real-time data dashboards and documents any split imbalance due to diversion.

Key Success Factors

- Centralized coordination
- Auto-acceptance based on trauma center defined criteria
- Real-time load balancing of the healthcare system
- Effective use of technology (Pulsara, PowerShare, LifeImage)
- Continuous quality review

Scalability & Recommendations for Other Regions

To replicate this best practice, other RACs need:
- A centralized coordination center or point
- Facility collaboration and coordination
- Basic tech tools (image sharing, tracking, documentation)
- Routine stakeholder performance reviews

19. REHABILITATION

The regional system has integrated rehabilitation resource capabilities into the regional trauma and emergency health care system plan. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. The regional stakeholders have not integrated rehabilitation resources into the regional system plan.

2. The regional system plan has integrated rehabilitation programs, but rehabilitation specialists are not participating in the regional activities. They only participate in the designated facilities.

3. The regional system plan has integrated rehabilitation program capabilities into the regional system plan and provided opportunities for rehabilitation facilities to participate in regional committees or activities. The regional system plan is available to RAC members and stakeholders.

4. In addition to #3, a regional rehabilitation specialist(s) is participating on a RAC committee(s).

5. In addition to #4, there is evidence of a well-integrated system plan to include rehabilitation facilities in the regional system planning efforts. Rehabilitation facilities provide data on patient discharge functional outcomes for the regional annual report and participate in the regional system performance improvement process.

AVERAGE SCORE ON THIS INDICATOR: 2.42
BEST PRACTICES: 0

20. EMERGENCY RESPONSE

The RAC leaders and stakeholders assist with sharing and disseminating local, regional, and state emergency response and preparedness initiatives and priorities within the RAC. Stakeholders are integrated into the emergency response training and educational opportunities.

0. Not known

1. There is no evidence of a working relationship or the sharing of data between the RAC leadership, members, stakeholders, and other partners.

2. The RAC leadership collaborates with hospital preparedness stakeholders, including the department and the Health Care Coalition, other emergency services functions (ESF) agencies, and partners, but RAC members are not updated on planning, preparedness, and activities.

3. The RAC leaders disseminate planning and preparedness information and share the data and equipment tracking needs with the regional members and stakeholders in collaboration with the identified Health Care Coalition.

4. In addition to #3, the RAC leaders share information regarding public health surveillance data, public health threats, and emergency response needs with the regional stakeholders in collaboration with the Health Care Coalition.

5. In addition to #4, the RAC leaders and stakeholders continually assess resources, capabilities, and solutions to respond to the identified regional hazards and share the status of needs with the regional stakeholders, public health, local government entities, the business community stakeholders, the Health Care Coalition, and the department.

AVERAGE SCORE ON THIS INDICATOR: 3.58
BEST PRACTICES: 2

Regional Advisory Council Best Practices

RAC U Coastal Bend Regional Advisory Council: #20.

Best Practice Statement	Briefly Describe	Date Implemented
To ensure a fully integrated and collaborative approach to emergency preparedness and response across the region. Objectives include continuous assessment of resources and capabilities, active stakeholder participation in planning and training, and transparent communication of needs and threats to support a resilient and coordinated response to regional hazards.	Hospitals, EMS agencies, public health entities, and local governments often operated in silos, leading to gaps in preparedness and delayed responses. To address this, the RAC actively collaborates with the Health Care Coalition, public health, local government, and other Emergency Services Functions (ESF) agencies to share data, identify threats, assess capabilities, and develop coordinated solutions. The RAC hosts regular meetings, organizes multi-agency training and exercises, and ensures real-time information sharing through established communication platforms.	2017 (Post Hurricane Harvey).
Outcome Data	**Regional Performance**	**Resources Required**
• 100% acute hospital participation of RAC stakeholders in at least one regional exercise annually. • Quarterly resource and capability assessments completed through the Coalition and distributed to stakeholders. • Increased coordination across sectors during actual events (e.g., hurricanes, mass casualty incidents), resulting in faster deployment of needed assets.	The outcomes have exceeded initial goals by fostering a culture of proactive preparedness rather than reactive response. Stakeholders report improved trust and operational alignment.	• Dedicated RAC/HPP staff to manage assessments, coordination, and communications. • Technology platforms for real-time data sharing and virtual meetings. • Ongoing funding for training, exercises, and equipment maintenance through the Coastal Bend Healthcare Preparedness Coalition budget.

Regional Advisory Council Best Practices

Background / Comparable Data	Barriers to Implementing Best Practice	Comments
Prior to implementing a regional emergency preparedness and response system, resources and partners operated in silos, resulting in gaps and inefficiencies during critical incidents. Since adopting this integrated approach, coordination has been streamlined—ensuring resources are deployed more efficiently, responses are faster, and operations are better organized, as evidenced by after-action reviews from recent events.	Initial challenges included engaging all stakeholders equally, as some agencies lacked resources to participate fully. Addressed by providing flexible training opportunities (virtual options, varying times) and demonstrating value through tangible improvements.	This is a best practice because it creates a unified approach to emergency preparedness that leverages the strengths of diverse partners, reduces duplication of effort, and ensures the region is better equipped to respond to any hazard.
Leadership Support	**Lessons Learned**	**Current Status**
Leadership played a crucial role by prioritizing collaboration and actively attending coalition meetings, engaging with the existing network of partners and processes to reinforce the importance of integration and sustained regional collaboration.	- Continuous communication and inclusion of all partners are essential for sustainability. - Joint planning and exercises reveal gaps before real emergencies occur, saving time and resources when crises strike. - Flexibility in engagement methods increases participation and buy-in.	Fully implemented and ongoing, with continuous monitoring, stakeholder engagement, and positive results from both planned exercises and real-world events.

Regional Advisory Council Best Practices

RAC (Letter and Name): RAC-P Southwest Texas Regional Advisory Council (STRAC)

Best Practice Statement	Briefly Describe	Date Implemented
Question 20: The RAC leaders develop and maintain a regional all-hazards emergency operations plan for health care coalition partners. The plan is coordinated with the regional system plan and other jurisdictional plans. The plan is reviewed and updated at least every two years. 4. In addition to #3, the plan is exercised at least once every two years, and after-action reports (AARs) with improvement plans are developed and shared with coalition partners. 5. In addition to #4, the plan is exercised annually with coalition partners, and improvement plans are implemented and re-evaluated in follow-up exercises.	The Southwest Texas Regional Advisory Council maintains a comprehensive regional all-hazards emergency operations plan for healthcare coalition partners, which is fully coordinated with the Regional System Plan, local jurisdictional plans, and relevant emergency management frameworks. The plan is reviewed and updated on a rolling basis and formally at least every two years to incorporate lessons learned, capability assessments, and hazard-specific annex updates. The plan integrates planning for hospitals, EMS, OEM, public health, law enforcement, and specialty response teams across TSA-P's twenty-two counties. The San Antonio RMOC's location is embedded within the San Antonio/Bexar County Emergency Operations Center, ensuring direct collaboration with local and regional emergency management agencies during both planned and unplanned incidents. The plan is exercised annually through discussion-based and operational exercises, including large-scale regional full-scale exercises such as SAMCEE and the Decon Rodeo, as well as hazard-specific drills focused on burns, pediatrics, decontamination, and radiological incidents. After each exercise, STRAC produces after-action reports with detailed improvement plans that are shared with coalition partners and tracked through corrective action processes. Follow-up exercises validate improvements. Continuous stakeholder engagement through the EMS and Hospital Disaster Group, quarterly RMOC training, and hazard-specific working groups ensures the plan remains relevant, interoperable, and operationally ready for immediate response and long-term recovery scenarios.	Unknown
Outcome Data	**Regional Performance** See Description	**Resources Required** Personnel Decon Equipment
Background / Comparable Data None	**Barriers to Implementing Best Practice** Time Personnel	**Comments**
Leadership Support	**Lessons Learned**	**Current Status** This is an annual event.

21. EMERGENCY RESPONSE

The RAC leaders share information with regional stakeholders to assist in completing a resource assessment of the system's capabilities and capacity to surge for mass casualty incidents (MCIs) in an all-hazards approach. This information is documented in a regional internal document.

0. Not known

1. A resource assessment of the regional system's capabilities and capacity to expand its resources to respond to MCIs in an all-hazards approach has not been completed.

2. The RAC leaders, members, and stakeholders completed a limited assessment of the system's capabilities and capacity to expand resources to respond to an all-hazards MCI in limited areas of the RAC.

3. The RAC leaders, members, and stakeholders completed an assessment of the system's capabilities and capacity to expand resources to respond to an all-hazards MCI for all areas of the region within the last 24 months. This is documented in a regional internal document and shared with the department at the same time the regional system plan is shared with the department.

4. In addition to #3, an assessment of the system's capabilities includes medical reserve personnel, additional equipment, age-specific resources, caches, communication interoperability, and overall management structure to ensure integration with the local government entities, the emergency management district, and Emergency Medical Task Force (EMTF).

5. In addition to #4, the RAC disseminates educational information to ensure stakeholders are trained and prepared to respond to no-notice events, as well as events with notification.

AVERAGE SCORE ON THIS INDICATOR: 3.21
BEST PRACTICES: 2

Regional Advisory Council Best Practices

RAC U Coastal Bend Regional Advisory Council: #21.

Best Practice Statement	Briefly Describe	Date Implemented
To ensure the region is fully prepared to respond to mass casualty incidents (MCIs) through comprehensive, ongoing resource assessments, integration with key partners, and regular stakeholder education. Objectives include identifying current capabilities, addressing gaps, coordinating surge capacity across all hazards, and ensuring stakeholders are trained to respond to both no-notice and planned events.	Prior to this practice, the region lacked a coordinated approach to assessing and sharing information about its ability to respond to large-scale emergencies. Resources and capabilities were siloed, leading to delays in mobilization and an inability to quickly scale during major incidents.	2015 (2 years after the creation of Healthcare Coalitions).
Outcome Data • Identified and addressed critical resource gaps (e.g., pediatric surge caches, communication redundancies). • Over 90% of regional stakeholders have participated in at least one training on MCI surge capacity in the last year. • Improved coordination during real events (e.g., multi-vehicle crashes, severe weather incidents) as documented in after-action reviews.	**Regional Performance** Outcomes fully aligned with the goal of building a resilient, surge-capable system. Stakeholders reported increased confidence in regional readiness, and response times to MCIs improved by 40%. Unexpectedly, the process also fostered stronger partnerships with local businesses and non-traditional partners, expanding the region's resource network beyond traditional EMS and healthcare entities through the Coastal Bend Healthcare Preparedness Coalition.	**Resources Required**. • Access to interoperable communication systems and real-time data platforms. • Funding for cache development, training, and exercises through EMTF and Coastal Bend Healthcare Preparedness Coalition • Ongoing engagement with Coastal Bend Healthcare Preparedness Coalition, EMTF, public health, and emergency management partners. • Maintain updated point of contact list of partner agencies.

Background / Comparable Data	Barriers to Implementing Best Practice	Comments
Previously, the lack of coordinated assessments led to inefficiencies and delayed responses during MCIs. Since implementation, coordinated resource tracking and training have streamlined operations, demonstrated by faster deployment of needed assets and positive evaluations in state-level drills.	• Initial difficulty in gathering comprehensive data from all partners. • Overcome by building trust, providing standardized templates, and demonstrating how shared information improves outcomes.	This is a best practice because it creates a unified, data-driven foundation for emergency preparedness, ensuring the region can respond effectively and efficiently to MCIs of any scale.
Leadership Support Leadership has been essential in driving this process forward by prioritizing regional collaboration, actively participating in coalition activities, and reinforcing the importance of ongoing training and assessment across all partners. It is also imperative	• **Lessons Learned** Engaging stakeholders early and demonstrating the value of their input fosters participation. • Ongoing training ensures that plans are actionable, not just theoretical. • Collaboration with non-traditional partners (private sector, schools, community organizations) significantly enhances surge capacity.	**Current Status** Fully implemented, continually updated, and validated through regular exercises and real-world response performance.

Regional Advisory Council Best Practices

RAC (Letter and Name): RAC P Southwest Texas Regional Advisory Council (STRAC)

Best Practice Statement

3. The RAC leaders, members, and stakeholders completed an assessment of the system's capabilities and capacity to expand resources to respond to an all-hazards MCI for all areas of the region within the last twenty-four months. This is documented in a regional internal document and shared with the department at the same time the regional system plan is shared with the department. 4. In addition to #3, an assessment of the system's capabilities includes medical reserve personnel, additional equipment, age-specific resources, caches, communication interoperability, and overall management structure to ensure integration with the local government entities, the emergency management district, and the Emergency Medical Task Force. 5. In addition to #4, the RAC disseminates educational information to ensure stakeholders are trained and prepared to respond to no-notice events, as well as events with notification.

Briefly Describe

The Southwest Texas Regional Advisory Council, through the EMS and Hospital Disaster Group and the Regional Medical Operations Center (RMOC), maintains a comprehensive all-hazards resource assessment that encompasses all twenty-two counties in TSA-P. This assessment is documented in the EHDG Response Plan, which has been reviewed and updated within the past twenty-four months, and submitted with the Regional System Plan. It incorporates hazard vulnerability analysis results, cache inventories, and gap analyses for critical response functions, detailing surge capacity, specialty care resources, and interoperability systems maintained through WebEOC, EMResource, and stakeholder engagement processes. The assessment includes medical reserve personnel through EMTF-8 Medical Incident Support Teams and the Medical Reserve Corps, as well as specialized equipment such as AMBUS units, ambulance strike teams, mobile medical units, decontamination trailers, PPE stockpiles, and a mobile surge ICU trailer. It also includes age-specific and hazard-specific resources, such as the Pediatric Annex, as well as plans for access and functional needs, and long-term care surge. Regional caches are maintained at the STRAC warehouse with integration into SNS and CHEMPAK systems through DSHS Region 8. Interoperable communications are supported through WebEOC, EMResource, Everbridge, VMED28, the STRAC1 talkgroup, and regional interoperable radio systems. Level 5 is achieved through proactive education and training programs, including quarterly RMOC training, hazard-specific workshops, full-scale mass casualty incidents, and skill-based drills. Updated annexes, operational guides, and resource directories are routinely shared with EMS, hospitals, OEMs, and public health partners to ensure readiness for both rapid-onset and planned incidents.

Date Implemented

Unknown

Outcome Data

None

Regional Performance

Resources Required

Funding
Personnel

Background / Comparable Data

None

Barriers to Implementing Best Practice

Funding
Personnel
Time

Comments

Leadership Support

Lessons Learned

Current Status

22. EMERGENCY RESPONSE

The RAC leaders and stakeholders establish and implement reliable system communications that are effectively coordinated for an all-hazards response or a major EMS incident. This information is included in a separate document from the regional system plan.

0. Not known

1. Guidelines for regional system communications in the event of an all-hazard incident are not in place.

2. Local EMS systems have written procedures for communications in the event of an all-hazards or major incident. However, there is no coordination among the local jurisdictions or regional stakeholders.

3. The RAC leaders and stakeholders develop guidelines for implementing system communications for an all-hazards response or major EMS incident that are effectively coordinated with existing systems, processes, and plans. This information is included in a separate document from the system plan. The document is shared with the department at the same time as the regional system plan is shared.

4. In addition to #3, the RAC facilitates a coordinated communications system with other jurisdictions and partners within the developed regional all-hazard response plan, following the incident management system and collaborating with the Health Care Coalition.

5. In addition to #4, the RAC develops communication system redundancies, and regional stakeholders regularly evaluate these communication procedures through simulated incident exercises. Changes or revisions in the procedures are based on the outcomes of these exercises. RAC leadership shares the after-action findings of these exercises with the regional stakeholders and the Health Care Coalition.

AVERAGE SCORE ON THIS INDICATOR: 3.375
BEST PRACTICES: 3

Regional Advisory Council Best Practices

RAC-G 22 EMERGENCY RESPONSE   Piney Woods Regional Advisory Council, TSA-G

Best Practice Statement	Briefly Describe	Date Implemented
The RAC leaders and stakeholders establish and implement reliable system communications that are effectively coordinated for an all-hazards response or a major EMS incident. This information is included in a separate document from the regional system plan.	Redundant communications systems are in place within the region and staged at HCC F and HCC G. Off-grid communications drills are performed twice a year and during exercises with regional HAMM operators at RACES.	annual and ongoing
Outcome Data	**Regional Performance**	**Resources Required**
Starlinks provide lower orbit capability with Wi-Fi calling and internet. Plumcase includes Starlink and broadband. MSAT is satellite phone communication from one unit to another. VHF Interoperability for the State of Texas is followed in our region.	Adequate with continued drills annually	Starlinks, Plumcase, MSAT, VHF, multiband radios, Pulsara
Background / Comparable Data	**Barriers to Implementing Best Practice**	**Comments** Multiple communication options have been found to be best practices RAC to RAC throughout the state. Other regions share our capability.
Leadership Support RACES, EMS Dispatch, HCC Directors, EMTF Coordination	**Lessons Learned** Getting an early start on planning drills & exercises has increased participation.	**Current Status**

Regional Advisory Council Best Practices

RAC U Coastal Bend Regional Advisory Council: #22.

Best Practice Statement	Briefly Describe	Date Implemented
To establish and maintain a reliable, redundant, and coordinated communications system that ensures seamless information sharing across all regional stakeholders during an all-hazards response or major EMS incident. Objectives include creating communication redundancies, regularly testing procedures through exercises, and incorporating lessons learned into continuous improvement of regional communication protocols.	Before implementing this practice, regional communication systems were fragmented, leading to delays and confusion during incidents requiring multi-agency coordination. This affected EMS providers, hospitals, public health, and emergency management partners. The system includes primary and redundant communication channels, defined roles for information flow, and integration with the Health Care Coalition and local jurisdictions. Regular exercises are conducted to evaluate and refine these procedures. After-action findings from these exercises are shared with stakeholders to inform continuous improvements.	2018 (Post Hurricane Harvey).
Outcome Data	**Regional Performance**	**Resources Required**
All stakeholders participate in at least one communication exercise annually. Redundant systems successfully tested in multi-agency drills, ensuring continuity of communication under various failure scenarios. After-action reports have led to procedural revisions in 100% of exercises to improve clarity and efficiency. Stakeholders report increased confidence in timely, coordinated communication during incidents.	The outcomes fully align with the goal of establishing a reliable and coordinated communications system. Exercises revealed minor gaps early, allowing proactive corrections. Unexpected benefits included stronger relationships between EMS, hospitals, and public health entities, improving overall regional collaboration beyond communication.	• Coastal Bend Preparedness Coalition staff dedicated to planning, coordinating, and evaluating exercises. • Communication equipment including radios, mobile data terminals, and backup systems. • Funding for training, exercises, and updates to communications infrastructure through the Coastal Bend Preparedness Coalition budget. • Technology platforms for real-time information sharing across agencies.

Regional Advisory Council Best Practices

Background / Comparable Data	Barriers to Implementing Best Practice	Comments
Previously, fragmented communication delayed multi-agency coordination during incidents. Implementing a standardized, tested system has significantly reduced response delays and enhanced situational awareness during exercises and real events.	Initial resistance from partners unfamiliar with standardized protocols. Overcome through education, exercises demonstrating effectiveness, and leadership engagement. Ensuring ongoing updates to the communication document requires continuous commitment.	This is a best practice because it creates a resilient, tested, and coordinated communication system that can be relied upon during all-hazards incidents. Sharing after-action findings ensures continuous improvement and stakeholder engagement.
Leadership Support Leadership actively championed the initiative by prioritizing inter-agency coordination, participating in exercises, and endorsing the development and maintenance of redundant systems. Their support reinforced the importance of adherence and ongoing evaluation.	**Lessons Learned** Redundancy in communication channels is critical to maintain functionality under stress or system failures. Regular exercises and after-action reviews are essential to identify gaps and make timely improvements. Engagement of all stakeholders from the start ensures buy-in and smoother implementation.	**Current Status** Fully implemented, continuously monitored, and updated based on exercise outcomes and stakeholder feedback. The system has proven effective in both simulated and real-world incidents.

Regional Advisory Council Best Practices

RAC (Letter and Name): RAC P Southwest Texas Regional Advisory Council (STRAC)

Best Practice Statement	Briefly Describe	Date Implemented
Question 22: 3. The RAC leaders and stakeholders develop guidelines for implementing system communications for an all-hazards response or major EMS incident that are effectively coordinated with existing systems, processes, and plans. This information is included in a separate document from the system plan. The document is shared with the department at the same time the regional system plan is shared. 4. In addition to #3, the RAC facilitates a coordinated communications system with other jurisdictions and partners within the developed regional all-hazard response plan, following the incident management system and collaborating with the Health Care Coalition. 5. In addition to #4, the RAC develops communication system redundancies, and regional stakeholders regularly evaluate these communication procedures through simulated incident exercises. Changes or revisions in the procedures are based on the outcomes of these exercises. RAC leadership shares the after-action findings of these exercises with the regional stakeholders and Health Care Coalition.	The Southwest Texas Regional Advisory Council maintains a structured regional communications framework that, while not a standalone written plan, clearly defines interoperable communication protocols for all-hazards and major EMS incidents and is integrated into the Regional System Plan and supporting operational documents. This plan aligns with NIMS and ICS principles, integrates with jurisdictional and regional response structures, and is shared with the department in conjunction with the Regional System Plan. The RAC facilitates a fully coordinated communications network that connects EMS, hospitals, OEM, public health, and other coalition members across TSA-P. MEDCOM operates as the regional communications hub, maintaining RMOC Level 4 readiness and providing real-time situational awareness through CAD feeds, live video, radio networks, and regional dashboards. Communication system redundancies include monthly drills on MSAT, HAM, and 800 MHz systems with hospitals and EMS, the use of multiple digital platforms including Pulsara, WebEOC, EMResource, Everbridge, and Active Alert for critical incident messaging, rapid coordination tools such as WAVE and GroupMe for non-HIPAA operational communication, and video and voice conferencing capabilities for incident leadership activation within minutes of onset. Radio interoperability is achieved through the use of VMED28, STRAC1, and CISA/SAFECOM-compliant configurations. Procedures are regularly tested through quarterly RMOC drills, annual full-scale mass casualty incidents, and hazard-specific simulations. After each exercise or major response, after-action findings and recommended updates are documented, shared with all stakeholders and the Health Care Coalition, and incorporated into subsequent communications revisions. This layered, exercised, and continually improved communications system ensures the RAC can sustain coordinated information flow and operational control under any incident conditions, even in degraded infrastructure environments.	Unknown

Outcome Data	Regional Performance	Resources Required
None		Funding Personnel

Background / Comparable Data	Barriers to Implementing Best Practice	Comments
None	Funding Personnel	

Leadership Support	Lessons Learned	Current Status

23. REGIONAL SYSTEM PERFORMANCE IMPROVEMENT

The regional trauma and emergency health care system plan has defined processes to support a regional system performance improvement plan that is supported by regional stakeholders through committee participation, sharing of requested data, and review of specific regional referrals. The system performance improvement plan defines the review process, including identifying opportunities for improvement. If the event has not been reviewed by a facility or EMS provider, the level of harm and level of review are defined. All regional opportunities for improvement have a defined action plan, and the action plan is implemented and monitored to reach event resolution. An annual summary of the regional performance improvement process is shared with the regional stakeholders. The retrospective regional Medical Director Committee/medical advisory process of the established patient field triage and destination, communication, treatment, and transport are integrated with the regional performance improvement process. The outcomes of the regional performance improvement process are included in the regional annual report. The regional annual report is available to RAC members and stakeholders.

0. Not known

1. The RAC does not have a defined structure or procedures to support a regional performance improvement process.

2. Elements of a regional system performance improvement process are established, but no formal procedures are established.

3. The RAC leadership and stakeholders have developed and implemented a regional system performance improvement plan that is supported by the stakeholders, committee activities, sharing of requested data, and referral of specific events for regional review. The system performance improvement plan defines the review process, level of harm, and level of review to include the identified opportunities for improvement. All regional opportunities for improvement have a defined action plan, and the action plan is implemented and monitored to reach event resolution. The outcomes of the regional performance improvement plan are included in the regional annual report. The regional annual report is available to RAC members and stakeholders.

4. In addition to #3, the regional performance improvement process reviews data and events specific to EMS field triage and destination, communication, treatment, and appropriateness of transport mode; diversion hours; out-of-RAC transfers; compliance with established regional evidence-based practice guidelines; patient outcomes; and membership participation criteria defined in the bylaws.

5. In addition to #4, annual reports of the regional performance improvement activities are developed and shared with stakeholders, public health, local government entities, community stakeholders, and the department.

AVERAGE SCORE ON THIS INDICATOR: 2.88
BEST PRACTICES: 0

24. REGIONAL SYSTEM PERFORMANCE IMPROVEMENT

The RAC system performance improvement plan has standardized guidelines for the review of EMS, trauma, and systems of care aggregate outcomes for all ages and all areas of the region that align with the State System Performance Improvement Plan. These outcomes are compared and measured against known national outcomes when available. The aggregate outcomes of the regional performance improvement plan are included in the regional annual report. The regional annual report is available to RAC members and stakeholders.

0. Not known

1. The regional system does not have processes established to engage in performance reviews of patient care aggregate outcomes data to evaluate its performance against national norms.

2. There is some standardized measurement of aggregate outcomes data for the region, but formalized processes are not in place.

3. The RAC system performance improvement plan outlines standardized processes for reviewing EMS, trauma, and systems of care outcomes and shares reports with appropriate committees. The aggregate outcomes of the regional performance improvement plan are included in the regional annual report. The regional annual report is available to RAC members and stakeholders.

4. In addition to #3, the stakeholders use these system reports to identify opportunities for regional improvement and develop action plans.

5. In addition to #4, the system improvements are monitored and reported through the regional annual performance improvement report and shared with stakeholders, public health, local government entities, community business stakeholders, and the department.

AVERAGE SCORE ON THIS INDICATOR: 2.71
BEST PRACTICES: 0

25. DATA MANAGEMENT

Data collection by the region through the State EMS and Trauma Registry, regional databases, or other data sources are utilized to develop data- driven regional goals with objectives that correlate with the regional system performance improvement plan. The data management plan and system performance improvement plan are included in the regional trauma and emergency health care system plan. The regional system plan is available to RAC members and stakeholders.

0. Not known

1. Regional data is not available through the state or a regional registry.

2. There are limited mechanisms for data collection that can be accessed to provide timely data to assist with developing regional goals.

3. The regional State EMS and Trauma Registry data, regional data, and the regional self-assessment provide information and data to assist with developing goals with defined measurable objectives that support the regional performance improvement plan. The data management plan and system performance improvement plan are included in the regional system plan. The regional system plan is available to RAC members and stakeholders.

4. In addition to #3, the data is used to evaluate the system performance changes in trends and identify improvement opportunities.

5. In addition to #4, the RAC has guidelines in place to share unidentified data with committees and regional stakeholders. These reports are included in the annual regional strategic planning.

AVERAGE SCORE ON THIS INDICATOR: 2.96
BEST PRACTICES: 0

26. REGIONAL RESEARCH & PUBLICATIONS

The regional EMS, trauma, systems of care, and emergency health care system has developed mechanisms to engage the regional general membership and other system stakeholders in systems of care regional research or performance improvement projects. This process is included in the regional trauma and emergency health care system plan. The regional system plan is available on request.

0. Not known

1. There is no evidence that regional data is available to support systems of care research projects.

2. Data is available through the RAC, but it is sporadic and lacks current data, validation of data, and a coordinated effort to support systems of care research activities.

3. The regional trauma, systems of care, and emergency health care system has developed mechanisms to engage the regional general membership and other system stakeholders in systems of care research projects. RAC leaders can demonstrate routine interface with the general medical community regarding trauma, systems of care, and EMS providers to share updates and integrate these leaders in performance improvement initiatives. This process is included in the regional system plan. The regional system plan is available to RAC members and stakeholders.

4. In addition to #3, research is a routine agenda item for the committee and general membership meetings.

5. In addition to #4, a structured process to discuss regional systems of care research ideas and projects with the general membership and other system stakeholders in the region is documented and disseminated to stakeholders. Guidelines specifically addressing abstracts, presentations, and publications of research projects funded by the RAC are documented and shared with all stakeholders. All research projects and findings are reported through the RAC committees and general membership meetings before abstracts, presentations, and/or publications are completed.

AVERAGE SCORE ON THIS INDICATOR: 2.46
BEST PRACTICES: 0