BIG COUNTRY REGIONAL ADVISORY COUNCIL
TRAUMA SERVICE AREA – D
REGIONAL TRAUMA PLAN
Approved 7/19/2017

PURPOSE: The purpose of BCRAC shall be to facilitate the development, implementation, and operation of a comprehensive trauma care system based on accepted standards of care to decrease morbidity and mortality resulting from trauma. BCRAC will solicit participation from health care facilities, organizations, entities and professional societies involved in health care, and community representatives within Trauma Service Area D (TSA-D) established by the Texas Department of State Health Services (DSHS). BCRAC will encourage multi-community participation in providing trauma care, work to promote the improvement of facilities and services, and cooperate with all member entities agencies and organizations in the establishment of an efficient system of care for all injured patients. BCRAC shall develop the plan for a regional comprehensive trauma system that meets as a minimum the requirements of the DSHS, and which shall address:

A. Prevention
B. Access to the system
C. Communications
D. Medical advisory activity
E. Pre-hospital triage
F. Bypass protocols
G. Diversion policies
H. Facility triage
I. Inter-hospital transfers
J. Rehabilitation access
K. Assistance in the planning and process of designation for trauma facilities, including the identification of lead facilities
L. Performance improvement program that evaluates outcome from a system perspective
M. Professional education
N. Disaster planning
O. System development status and ongoing evaluation
P. Budget/Finance
Q Strategic planning
T. Public education

BIG COUNTRY REGIONAL ADVISORY COUNCIL
TSA – D

EXECUTIVE COMMITTEE MEMBERS

OFFICERS:

H. T. Fillingim	Chair	Fisher County Hospital
Grant Madden	Vice-Chair	Sweetwater FD
Bobbie Collum	Secretary	North Runnels EMS
Marta Pagura	Treasurer	Abilene Air EVAC

HOSPITAL REPRESENTATIVES:

Anne Dominy	Abilene Regional Medical Center
Jan Harris	Stonewall County Hospital
Cindy Hale	Mitchell County Hospital
Stephanie Lebowitz	Rolling Plains Memorial Hospital
Lacy Milford	Hendrick Hospital

EMS REPRESENTATIVES:

Josie Fillingim	Fisher County Memorial Hospital EMS
Russell Thomas	Coleman County Hospital EMS
Erik Burleson	Eastland EMS
David Allman	Taylor County EMS

FIRST RESPONDER REPRESENTATIVE:

Jonathan Galinak	Eula VFD

TRAUMA SERVICE AREAS

BROWN COUNTY

North Lake Brownwood VFD - inactive
Ashley Caswell
3340 Windjammer
May, TX 76857
325-642-0326

CALLAHAN COUNTY

Citizens EMS
Margo Vinson
P. O. Box 1556
Clyde, TX 79510
325-439-1600

Cross Plains EMS
George Matthews
PO Box 597
Cross Plains, Texas 76443
325-669-4689

COLEMAN COUNTY

Heart of Texas
Wanda McIlvain
313 West Elm
Coleman, Texas 76834

COMANCHE COUNTY

Comanche County Medical Center EMS
Matt Hansen
10201 Hwy 16
Comanche, TX 76442
254-356-9110

EASTLAND COUNTY

Eastland Memorial Hospital EMS
Gene Wright
304 S. Daugherty
Eastland, TX 76448
254-631-5261

Air Evac 115 Eastland
Erik Burleson
Eastland, Texas

FISHER COUNTY

Fisher County Hospital EMS
Josie Fillingim
Drawer F
Rotan, TX
325-669-1894

JONES COUNTY

Hamlin EMS
Scott Boles
P. O. Box 400
Hamlin, TX 79520
325-576-3646

Stamford EMS
Philip Smith
301 E. Hamilton
Stamford, TX 79553
325-773-2333

KNOX COUNTY

Knox County EMS
Logan Morrow
P. O. Box 608
Knox City, TX 79529
940-203-0775

MITCHELL COUNTY

Mitchell County Hospital EMS
Jason Gruben
997 W. I-20
Colorado City, TX 79512
325-242-3202

NOLAN COUNTY

Sweetwater Fire Department
Grant Madden
900 E Broadway
Sweetwater, TX 79556
325-235-4304

SHACKELFORD COUNTY

Shackelford County Hospital District EMS
Mary Quintero
840 Gregg St.
Albany, TX 76430
254-762-3313

TAYLOR COUNTY

AirEvac 63 Abilene
Marta Pagura
1900 Pine St.
Abilene, Texas 76901
417-274-9016.

Jim Ned Volunteer Fire Dept
Jackie Cozby
P. O. Box 424
Tuscola, TX 79562
325-668-2903

North Runnels Hospital EMS
Bobbie Collom
P. O. Box 185
Winters, TX 79567
325-977-7379

Merkel EMS
Pam Orsborn
1935 CR 353
Merkel, TX 79536
325-668-3216

South Taylor EMS
David Allman
1458 CR 314
Abilene, Texas 79606
325-733-7098

THROCKMORTON COUNTY

Throckmorton EMS
Tina Hantz
802 N Minter
Throckmorton, TX 76483
940-849-2151

TRAUMA SERVICE AREA-D
REGIONAL TRAUMA PLAN

TRAUMA SERVICE AREA-D PARTICIPATION REQUIREMENTS AND HISTORY

The first meeting of Trauma Service Area-D was held in 1992 between Abilene Regional Medical Center and Hendrick Health Systems. All entities throughout the region were contacted including EMS agencies, hospitals and physicians. Representatives from Abilene Regional Medical Center and Hendrick Health Systems visited each facility within the TSA-D region. At this time administration and medical staff were encouraged to seek Trauma designation and to participate in their designated Regional Advisory Council.

Based upon the decision of the Texas Department of State Health Services, Trauma Service Area-D includes the following counties:

- Brown
- Callahan
- Coleman
- Eastland
- Fisher
- Haskell
- Jones
- Knox
- Nolan
- Shackelford
- Stephens
- Stonewall
- Taylor
- Throckmorton

The Big County Regional Advisory Council encourages each involved entity to be accountable for participation in order to remain in compliance with the standards set forth by the Texas Department of State Health Services. Active participation is required to have an effective and efficient region-wide trauma system.

Regional Advisory Council meeting notices are emailed and posted on the RAC webpage (www.bigcountryrac.org) 7 to 10 days prior to scheduled meetings.

By-laws have been incorporated and a membership list made. Most of the hospitals and EMS services have been and continue to be active participants in the Big Country Regional Advisory Council. The current requirements to be considered active and in good standing with Big Country Regional Advisory Council are as follows:

- Attendance at seventy-five (75%) percent of the regularly scheduled General Assembly meetings each fiscal year.

• Participation at the committee level in at least fifty (50%) percent of the regularly scheduled committee meetings of at least one (1) standing committee per fiscal year.
• Completion of the annual protocol affidavit to include bypass and diversion protocols.
• Completion of annual needs assessment form whether or not needs are contemplated for the fiscal year. E. Participation, as requested, in the BCRAC SQIC process.
• Submit all receipts and paperwork associated with funding to the Treasurer by the date set by the Treasurer in each funding cycle.
• Payment of all assessed dues by December 1st of each year.
• Participation in the Texas EMS Trauma Registry System, inclusive of hospitals and EMS providers, as defined by Texas Department of State Health Services.
• BCRAC participation will be recorded and kept by the Secretary, and will be based upon the State of Texas' fiscal year September 1 through August 31.
• Participation on EMSystem which is to be updated daily by the lead facilities, Hendrick Medical Center and Abilene Regional Medical Center. All other First Responders, EMS Services, and hospitals will update at least weekly, or as requested by RAC-D or EMSystem requirements.

Meeting rosters are kept. These rosters serve as the identifiable means of tracking each entities compliance with the Regional Advisory Council guidelines. Attendance records are maintained by the secretary. These sign-in rosters are mailed to the State.

Hospitals and EMS agencies within Trauma Service Area-D are encouraged and invited to participate with the Big Country Regional Advisory Council. Executive members are available to assist with designation and the re-designation process of trauma facilities as needed.

TRAUMA SERVICE AREA – D
REGIONAL ADVISORY COUNCIL

PRE-HOSPITAL TRIAGE AND TRANSPORT

INTRODUCTION

A trauma patient can be identified as a patient experiencing a severe injury which involves a single or multiple organ system. A trauma patient is an individual who experiences external blunt or a penetrating force that damages any anatomical structure causing and immediate threat to life or limb.

GOAL

Trauma patients who are medically unstable, or have multiple and/or severe injuries will be quickly identified and transported to a trauma designated hospital. Triage, transfer, bypass and diversion protocols are basic guidelines and standards for Trauma Service Area-D members. Big Country Regional Advisory Council members are encouraged to adopt these protocols and utilize them both for the regional plan and individualized entity protocols.

Triage, transfer, by-pass and diversion are terms that refer to the movement of patients according to their medical need.

Triage: Identify the trauma patients and determine their immediate need to preserve life and/or limb.

Transfer: Movement of a patient from one hospital to another based on the patients medical need.

Bypass: Movement of a trauma patient from the scene to a specific hospital not necessarily the nearest hospital based on the patient's medical need.

Diversion: Movement of a trauma patient from the scene to an alternative hospital capable of providing the most appropriate care due to the inability of the nearest hospital to provide such care.

A Trauma patient may be defined as a patient who presents with the following criteria:

1. Glasgow Coma Score less than or equal to 13.
2. Revised Trauma Score less than or equal to 11.
3. Clinical presentation of:
    a. Laryngeal or tracheal deviation
    b. Pneumothorax
    c. Hemothorax
    d. Flail chest

    e. Open chest wound
    f. Cardiac injury
    g. Pelvic fracture
    h. Long bone fracture
4. Suspected spinal cord injury.
5. Penetrating injury to head, neck, chest abdomen of groin.
6. Evidence of blunt trauma
    a. Fall from 20 feet or more
    b. MVC with victim ejected
    c. Pedestrian hit by motor vehicle
7. Injury to extremity with compromised circulation.
8. Total or partial amputation of extremity above the digits.
9. Crush injury with numbness or severe pain.
10. Paresthesia or total loss of movement.
11. Potential for disruption of organ systems.

Decision Criteria:

In the event of trauma, accurate and expedient patient assessment by the first EMS providers to the scene is the key to appropriate trauma patient care. A Triage Decision Scheme has been developed to assist EMS with appropriate patient transport and destination. After patient assessment and vital signs EMS medical control is consulted in regards to remaining questions of patient disposition and treatment. Major trauma patients are then classified as either “critical” or “urgent”. The Triage algorithm is then followed to transport the patient to the most appropriate facility.

Critical patients are hemodynamic or neurologically unstable, as well as anatomical injury patterns that place them at significant risk. Urgent patients are those that are evaluated for mechanisms of injury, high energy impact, and age or disease specific history.

FACILITY TRIAGE CRITERIA

Purpose

The purposes of the Regional Triage/Transfer Decision Scheme are:

1. to categorize patients for determination of facility transport and/or transfer
2. to specify facility action plans for transfer of patients
3. to include pediatric and bun criteria for patient transport and/or transfer

Description of Triage/Transfer Decision Scheme

The Triage/Transfer Decision Scheme was developed by the Bypass/Diversion Committee. This scheme is to serve as a model for BCRAC to incorporate trauma designated hospitals Levels I-IV. The Triage Decision Scheme is an algorithm approach to differentiating patient categories as well as a mechanism for activation of facility Trauma Team Alerts.

Patient Categories – The Triage/Transfer Decision Scheme defines patient categories as critical and urgent.

Critical patients meeting criteria of instability hemodynamicly and neurological functions, as well as specific anatomical injuries that places the patient at a high suspicion for significant risk.

Urgent categorized patients are those who are evaluated for evidence of mechanism of injury, high energy impact, and/or age and disease specific history.

Facility Triage Action Plan

The facility triage action plan is included within the Triage/Transfer Decision Scheme to assist facilities in determining where a trauma patient should be transferred. It includes the facilities that should admit the trauma patients, the facilities that should stabilize and transfer the patients, and defines the level of destination needed for facilities to receive the transfer. Guidelines for aeromedical transport are included within this to assist facilities in assuring that “the right patient, gets the right facility, in the right amount of time.”

FACILITY TRIAGE CRITERIA FOR TRANSFERS

1. The transfer of a patient may not be based on discrimination of race, religion, national origin, age, sex, physical condition of economic status.
2. Hospital administrators may negotiate and execute patient transfer agreements with other hospitals in order to facilitate the transfer of patients.
3. When a patient arrives at a hospital seeking medical treatment the patient must be evaluated by a Physician within 30 minutes of the patients’ arrival.

4. The provider on call for the Emergency Department will determine and order life support measures that are medically appropriate to stabilize the patient prior to transfer and to sustain the patient during transfer.
5. The transferring physician shall secure a receiving physician and hospital that will meet the patients' medical needs.
6. The receiving hospital will accept the patient for medical treatment and hospital care.

The transfer of patients' may occur routinely or as part of a regionalized plan for obtaining optimal care of patients at a more appropriate or specialized facility.

1. Every patient will be evaluated and a level of care will be determined. If the receiving hospital is unable to provide the patient's medical needs, the patient will be transferred.
2. All efforts within Trauma Service Area-D will be made to see that patients are transferred to trauma designated facilities.
3. All patients will be transferred to a higher level of care.
4. The patient or responsible party has the right to request a physician or hospital of their choice.
5. In the case of a regional disaster, each area will assess their damage ability to provide care. Triage and transfer will be done according to the regional disaster plan.
6. If a patient's condition requires a transfer to a higher level of care, all efforts will be made to accomplish this within 2 hours of the patients arrival at the receiving hospital.

INTER-FACILITY TRANSFERS

Trauma patients requiring specialized treatment or specialized care are identified via the Triage/Transfer Decision Scheme. Transfer to an appropriate facility is based on this criterion.

Written transfer agreements are available to the major tertiary care facilities within the region. These agreements may be broad in nature or specific, i.e. burn or pediatric.

TRAUMA SERVICE AREA-D
REGIONAL TRAUM PLAN

FACILITY TRIAGE CRITERIA AND INTER-HOSPITAL TRANSFERS

PROTOCOL FOR TRANSFER

1. Obtain order from the physician for transfer.
2. Obtain hospital acceptance from receiving hospital.
3. Complete Memorandum of Transfer (MOT)
4. Complete the Patient Request/Refusal/Consent for transfer form, this form must be signed by the patient or responsible party.
5. The transferring physician must complete a Physician Assessment and Certification Form.
6. The carbon copy of the MOT, consent for transfer form and a copy of the Physician assessment and certification form is kept by the transferring hospital.
7. The original MOT, a copy of the consent to transfer form and Physician assessment and certification form along with copies of all lab work, x-ray's, medication administration records and any other pertinent patient information is sent to the receiving hospital.
8. If the transferring physician is not available at the time of transfer, and if the patient has been evaluated by the transferring physician, the RN in charge of the patient may sign the MOT as a verbal or telephone order.

TRAUMA SERVICE AREA-D
REGIONAL TRAUM PLAN

PREHOSPITAL TRIAGE CRITERIA

A Triage/Transfer Decision Scheme has been developed by the Big Country Regional Advisory Council to assist facilities in assuring the patient destination is appropriate. It is the common goal within the BCRAC that getting "the right patient, to the right facility, in the right amount of time/"

Major trauma patients are categorized as "Critical" or "Urgent" of the Triage/Transfer Decision Scheme. During the initial assessment of trauma patients the appropriate treatment and transfer plan is initiated. Pediatric and burn patients are specifically addressed in the scheme. Patient vital signs, Glasgow Coma Scale and Revised Trauma Scores are indicators in the Triage/Transfer Decision Scheme.

Trauma centers are identified by the resources available by the institution. Triage and transport protocols are based on the hospitals capabilities. Patients who sustain major injuries require care at a higher level of care trauma facility. If the injury occurs in a rural area of the trauma service area initial stabilization may be done at a Level III or Level IV trauma center. Their clinical needs may include rapid transfer/transport to a Level I or Level II facility.

Trauma Service Area-D utilizes Enhanced 9-1-1 capabilities for accessing the EMS system. Emergency Vehicles are dispatched to the patients' proximity. Trauma facilities are notified of incoming patients via radio or cellular phone communication from ambulances and aeromedical transportation. There are 46 ground EMS services and one air medical service providing emergency care and transport to trauma centers. Ground ambulances follow treatment and transportation guidelines found in the BCRAC protocol section.
Pre-hospital protocols are reviewed on an annual basis for updates and revisions. Classes are provided to pre-hospital care personnel with information and recommended changes in patient care.
Texas Department of State Health Services, Bureau of Emergency Management are among the regulatory agencies for the emergency vehicles, trauma facilities, equipment and personnel within our trauma service area.

Within the trauma regional plan you will find a list of Trauma designated hospitals and EMS services that serve within Trauma Service Area-D.

BYPASS PROTOCOLS

Guidelines for facility, bypass protocols:

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

1. If unable to establish and/or maintain an adequate airway, or in the case of traumatic cardiac arrest, the patient should be taken to the nearest acute care facility for stabilization.
2. A general facility may be appropriate if the expected transport time to the lead facility is excessive (see #5 below).
3. A basic facility may be appropriate for immediate evaluation and stabilization if the expected transport time to a trauma facility is excessive (see #5 below).
4. Medical control may order bypass for any of the above situations, when a facility is unable to meet the hospital resource criteria or when the patient is in need of specialty care.
5. If expected transport time is excessive (25 minutes) or if a lengthy extrication time (15 minutes), consider activating air transportation resources.

NOTE: Questions regarding bypassing a facility should be directed to a medical control for a final decision.

EMS and Facility Triage Criteria for Facility Bypass should be considered. (Criteria guidelines enclosed.)

DIVERSION PROTOCOL

Guidelines for Diversion Protocol

Each facility will designate a person (ED Physician) to be responsible for decisions regarding diversion.

1. Each facility will develop a procedure on how to put their facility on diversion status. These procedures will be presented to the RAC Bypass and Diversion Committee. A facility may put on a diversion status if:
    - Trauma Surgeon is not available
    - Internal disaster
    - Specialty Surgeon (Neuro, Ortho) unavailable
    - Specialty equipment (CT scanner, MRI) unavailable

2. A record must be kept of why their facility was put on a diversion status.

3. Policies and procedures must be in place for plans to open up critical-care beds.

4. Each facility must have a local Mass Casualty protocol and knowledge of how to activate the region-wide mass casualty plan.

5. Level I and II facilities must notify Regional Trauma Communications Center of diversion status on a daily basis.

****Aside from the BCRAC approved diversion protocol each hospital is responsible for developing a diversion policy and procedure.

Criteria for the consideration of air medical transport of trauma patients:

1. The need to rapidly transport a patient to an appropriate facility for specialized care
2. Weather and /or road conditions that might delay ground transport
3. Extrication of a patient takes longer than 20 minutes
4. Utilization of ground ambulance leaves local community without adequate ambulance coverage
5. Multiple victims
6. Mechanism of injury
7. MVC with crash speed of 20 MPH or more without restraints
8. MVC with passenger compartment intrusion of 12 inches or more
9. MVC with rearward displacement of front axle
10. Gross deformity of patient's point of contact (steering wheel, dash or windshield)
11. Ejection from a moving vehicle
12. MVC with death of an occupant in same vehicle
13. Rollover MVC unrestrained occupant
14. MVC with victim ejected at 20 MPH or more
15. Pedestrian struck at 20 MPH or more
16. Patient under 12 years old struck by an automobile
17. Falls of 20 ft or more or greater than 3 time the patient height
18. Near drowning

PHYSIOLGIC AND ANATOMIC CRITERIA

1. Patients over 55y/o or under 5 y/o with multi system trauma
2. Cardiac, respiratory or any significant underlying disease process
3. Revised Trauma score of less than 12
4. Patients with a systolic B/P of less than 90
5. Heart rate of less than 60 or greater than 120
6. Respiratory rate of less than 10 or greater than 30
7. Glascow Coma Scale of less than 10
8. Potential air way compromise
9. Flail chest
10. Paralysis or suspected spinal injury
11. Loss of consciousness
12. Penetrating injury between the thigh and neck
13. Crushing injury to abdomen, chest, or head
14. Major amputation above the ankle or wrist
15. Scalping or degloving injury
16. Any impalement injury
17. 2 or more long bone fractures or a major pelvic fracture
18. OB trauma

INDICATIONS FOR BURN PATIENTS

1. Greater than 15% of body surface area burned or full thickness burn to greater than 5% body surface area
2. Major burns to face, hand, feet, or perineum
3. Major chemical burn
4. High voltage electrical burn
5. Burns associated with other trauma

TRAUMA SERVICE AREA – D
REGIONAL PLAN

CONFIDENTIAL PEER REVIEW
Big Country Regional Advisory Council CQI Data Collection

Date: _____ Month(s):_____

Reporting Hospital: _____

Average Trauma Patient Age: _____

Sex: Male ____ Female ____ (# of each)

Race: Caucasian ____ Hispanic ____ Black ____ Other ____ (# of each)

Mechanism of Injury: Blunt (MVA, Fall etc.) ____# Penetrating (GSW, Stab) ____#

Other _____#

TOTAL NUMBER: Admitted _____ Transferred _____ Deaths _____

Audit Filters	% Compliance
1. Ambulance scene time > 20 minutes Total # of patients arriving by Ambulance ____ # > 20 min ____ # < 20 min ____ Extended scene time related to: a. extrication ___ yes ___ no b. delayed patient access ___yes ___ no c. multiple victims ___ yes ___ no d. other _____	_____% compliance Average Ambulance Scene time _____
2. Trauma patients from admission until transfer, death or admit. a. serial vital signs (including temp) documented ___ yes ___ no b. serial GCS/RTS ___ yes ___ no	_____ % compliance
3. Comatose trauma patient (GCS < / = 8) leaving ED before definitive airway is established. Total # of comatose trauma Patients ____	_____ % compliance
4. Number ER patients _____ morbidity Number ER patients _____ mortality	_____ % compliance

*** Please report the total number patients that met each criterion.

TRAUMA SERVICE AREA – D
REGIONAL PLAN

CONFIDENTIAL PEER REVIEW

Reporting Hospital: _____
Date: _____

Number of Physicians staffing the Emergency Department: _____
# of Mid-Levels with ATLS: _____
# of Mid-Levels without ATLS: _____

# of Mid-Levels with ACLS: _____
# of Mid-Levels without ACLS: _____

# of Mid-Levels with PALS/ENPC:
# of Mid-Levels without PALS/ENPC:
# of Mid-Levels with TNCC:
# of Mid-Levels without TNCC:

Threshold 100% %Compliance _____

Number of RN's staffing the Emergency Department _____
# of RN's with ACLS: _____
# of RN's without ACLS: _____

# of RN's with PALS/ENPC:
# of RN's without PALS/ENPC:
# of RN's with TNCC :
# of RN's without TNCC:

Threshold 100% % Compliance_____

TRAUMA SERIVE AREA – D
REGIONAL PLAN

BREAKDOWN OF IN-FACILITY TIME PRIOR TO TRANSFER

CONFIDENTIAL PEER REVIEW

Date: _____ Month(s): _____
Reporting Hospital: _____

Review Sample: 100 % of Trauma patients transferred to another facility.

Trauma patient – arrival time at transferring hospital till departure time of transfer to another facility.

TRANSFERRED TO HIGHER LEVEL OF CARE

60 minutes or less _____
60 – 90 minutes _____
90 – 120 minutes _____
120 minutes or more _____

ARRIVAL TIME TILL TIME OF DECISION FOR TRANSFER HIGHER LEVEL OF CARE

60 minutes or less _____
60 – 90 minutes _____
90 – 120 minutes _____
120 minutes or more _____

RECEIVING HOSPITALS ACCEPTANCE TIME

60 minutes or less _____
60 – 90 minutes _____
90 – 120 minutes _____
120 minutes or more _____

CONTRBUTING FACTORS (enter total applicable patients in each category-patients maybe counted in more than once category)

TRAUMA SERVICE AREA – D
REGIONAL PLAN

CONFIDENTIAL PEER REVIEW

Date: _____ Month(s): _____

Review Sample: 100% of trauma patients arriving via EMS

EMS records attached to the Emergency Room Record.

# of Trauma patients arriving via ambulance _____
# of ER records with EMS records attached _____

%Compliance _____

Review Sample: 100% of trauma requiring trauma flow records

Utilization of the Trauma Flow Sheet

# of Trauma patients meeting criteria for trauma flow _____
# of Trauma flow utilized with pt.'s meeting criteria _____

%Compliance _____

Review Sample : 100% of trauma patients transferred

Trauma patients transferred to Trauma Designated facilities

# of Trauma patients transferred _____
# of Trauma patients transferred to Trauma Designated facilities _____