NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

2021 - 2022
NCTTRAC Regional Acute Coronary Syndrome (ACS) Plan
Summary of Significant Changes

1. System Access
   - Removal of Annex A: 9-1-1 Outage Contacts pending updates and further verification

2. Communications
   - Verbiage added to include reference to HB786 and the endorsement of telephone CPR

3. Pre-hospital Triage Criteria
   - Verbiage included regarding AHA national standards for EMS triage/transport decisions

4. Helicopter Activation
   - Verbiage included regarding AHA national standards for consideration of transporting via air medical versus long transport time via ground

5. Inter-Hospital Transfers
   - Verbiage included regarding AHA national standards for duration of time from First Medical Contact to STEMI intervention

NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

2022 Regional Acute Coronary Syndrome (ACS) System Plan

Endorsed by NCTTRAC Board of Directors
Date: August 10, 2021

Approved by NCTTRAC General Membership
Date: Pending

Supersedes Regional ACS System Plan Date:
March 23, 2020

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NCTTRAC serves the counties of Cooke, Fannin, Grayson, Denton, Wise, Parker, Palo Pinto, Ellis, Kaufman, Navarro, Collin, Hunt, Rockwall, Erath, Hood, Johnson, Somervell, Tarrant, and Dallas.

Any questions and/or suggested changes to this document should be sent to:

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APPROVAL AND IMPLEMENTATION

This plan applies to all counties within Trauma Service Area (TSA) E. TSA-E includes Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise counties.

This plan is hereby approved for implementation and supersedes all previous editions.

_____ _____

Secretary Date

RECORD OF CHANGES

The North Central Texas Trauma Regional Advisory Council ensures that necessary changes and revisions to The Regional Acute Coronary Syndrome (ACS) System Plan are prepared, coordinated, published, and distributed.

The plan will undergo updates and revisions:

- On an annual basis to incorporate significant changes that may have occurred;
- When there is a critical change in the definition of assets, systems, networks or functions that provide to reflect the implications of those changes;
- When new methodologies and/or tools are developed; and
- To incorporate new initiatives.

The Regional ACS System Plan revised copies will be dated and marked to show where changes have been made.

“Record of Changes” form is found on the following page.

RECORD OF CHANGES

This section describes changes made to this document. Use this table to record:

- Location within document (i.e. page #, section #, etc)
- Change Number, in sequence, beginning with 1
- Date the change was made to the document
- Description of the change and rationale if applicable
- Name of the person who recorded the change

Article/Section	Date of Change	Summary of Changes	Change Made by (Print Name)
All	7/7/2021	Changed dates to reflect FY22 approval	EHS Staff
Section 9.4.1	7/7/2021	Added verbiage to match AHA national standards regarding EMS triage/transport decisions	EHS Staff
Section 10.3.3	7/7/2021	Added verbiage to match AHA national standards regarding consideration of transporting via air medical vs long transport time via ground	EHS Staff
Section 12.3.4	7/7/2021	Added verbiage to match AHA national standards regarding duration of time from First Medical Contact to STEMI intervention	EHS Staff
Section 6.3.2	7/7/2021	Included reference to HB786	EHS Staff
Section 5.3.1	7/27/2021	Removal of Annex A:9-1-1 Outage Contacts	EHS Staff

Final revisions should be submitted to the NCTTRAC Emergency Healthcare Systems Department at EHS@NCTTRAC.org, telephone 817.608.0390.

Table of Contents

1. INTRODUCTION

1.1 Mission

1.1.1 The mission of the North Central Texas Trauma Regional Advisory Council (NCTTRAC) Acute Coronary Syndrome (ACS) Plan is to create a system that improves the quality of heart attack care within the region through organized efforts of prevention and acute care. Reduction in heart disease morbidity and mortality will be achieved by developing and maintaining integrated quality processes in patient care and education.

1.2 Vision

1.2.1 NCTTRAC will provide leadership in regionalized Acute Coronary Syndrome treatment by creating a broad stakeholder coalition with the responsibility and resources to develop, operate, evaluate, and integrate a cardiac system of care.

1.3 Organization

1.3.1 NCTTRAC's goal is to provide the infrastructure and leadership necessary to sustain an ACS treatment and transfer system within the designated nineteen county region known as Trauma Service Area E (TSA-E), and to improve the level of care provided to persons living or traveling through the region. Standing committees and member organizations (hospitals, first responder organizations, EMS Providers, air medical providers, emergency management, and public health), work cooperatively to ensure that quality care is provided to ACS patients by pre-hospital and hospital professionals. An additional goal of the Regional ACS System Plan is to promote cardiac awareness and education to the public and health care providers throughout the region.

1.4 Regional Plan

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

2. ACS SYSTEM OF CARE GOALS

2.1 The purpose of the Cardiac committee shall be to facilitate the collaboration and development of a regional comprehensive ACS system based on accepted standards of care. NCTTRAC will encourage participation from EMS providers, health care facilities, organizations, entities, and professional societies involved in health care. NCTTRAC will facilitate regional participation in providing quality cardiac care. NCTTRAC shall develop a plan for a regional comprehensive ACS system that:

2.1.1 Identifies and integrates resources to foster commitment and cooperation in developing a cardiac system of care.

2.1.2 Promotes EMS and hospital provider participation.

2.1.3 Establishes system coordination for access, guidelines, and referrals. These structures will establish continuity and uniformity of care among the providers of cardiac care.

2.1.4 Promotes collaboration among EMS Providers, hospitals, and members of the Committee.

2.1.5 Develops uniform cardiac system standards that address patients' needs, outcomes, and opportunities for improvement.

3. CARDIAC FACILITY CAPABILITY

3.1 Goal

3.1.1 The goal of the Committee is to ensure that there is understanding throughout the region with regard to facility capabilities for the care of the ACS patient, and this information is available for patient destination decision making.

3.1.2 EMResource is the official means of notification of these capabilities and their availability. The options for Cardiac / ACS patient care abilities fall under "Status: 24/7 STEMI" and currently include:

- Yes
- No
- Unavailable – Temporarily unable to provide STEMI care

3.1.3 Because the Texas Department of State Health Services (DSHS) does not designate ACS facilities in Texas, the Committee will encourage external credentialing organizations as the means for recognition of cardiac facilities.

4. COMMUNITY AWARENESS AND PREVENTION

4.1 Goal

4.1.1 The goal is for NCTTRAC participating hospitals to collaborate with EMS Providers to educate the public on heart disease symptom recognition, risk factors and behavior modifications. Education will also include the importance of early activation of 911 services and the role EMS plays in treatment of the ACS patient.

4.1.2 Refer to NCTTRAC Cardiac/Stroke video in the link below: https://www.youtube.com/watch?v=IJArXa-8RMs&t=10s

4.2 Committees Charged

4.2.1 Responsibilities are charged to the NCTTRAC Cardiac, EMS and Public Education/Injury Prevention Committees.

5. SYSTEM ACCESS

5.1 Goal

5.1.1 The goal for System Access within TSA-E is two-fold. First, access to emergency Cardiac care within the region must be available. Second, EMS must be available to provide quality health care to patients in TSA-E. In portions of this region, First Responder Organizations (FRO) may provide initial treatment pending EMS arrival.

5.2 Committee Charged

5.2.1 Responsibilities are charged to the NCTTRAC EMS Committee.

5.3 Objective

5.3.1 One of the primary elements of an EMS/Cardiac system is to provide access to EMS and subsequent mobilization of a medical response to the scene. Every call for emergency services should universally and automatically be accompanied by location identifying information. A regional system providing dedicated lines that allow direct routing of emergency calls is ideal. Routing is based on telephone exchange area, not municipal boundaries. Automatic Number Identification (ANI) and Automatic Location Identification (ALI) should be available. Alternative routing

allowing 911 calls to be routed to a designated alternative location is in effect. In the event 911 is out of service, 24/7 emergency phone numbers listed by county, are available for the civilian population.

5.3.2 When calls come into a 911 center, the communication system ensures that the call taker has the appropriate written protocols, as well as, having the training available to assist the caller. The caller should not have to talk to more than two telecommunications personnel and transferring of calls should be limited to less than ten seconds. In the event that the telephone or network communication is down, EMS facilities and key agencies need access to two-way radios to communicate with dispatch, hospitals, and the NCTTRAC Emergency Medical Coordination Center (EMCC).

6. COMMUNICATIONS

6.1 Goal

6.1.1 EMS communications systems must provide the means by which emergency resources can be accessed, mobilized, managed, and coordinated. An emergency assistance request and the coordination of the response require communication linkages for:

6.1.1.1 Access to EMS from the scene of the incident

6.1.1.2 Dispatch and coordination of EMS resources

6.1.1.3 Coordination with medical facilities, and

6.1.1.4 Coordination with other public safety and emergency personnel. EMS should notify the receiving cardiac facility of incoming acute cardiac patient transports in order for the facility to activate their cardiac protocol.

6.2 Committees Charged

6.2.1 Responsibilities are charged to the NCTTRAC EMS Committee and the Cardiac Committee.

6.3 Objective

6.3.1 The system of communication is an integral part of a regional plan for the care of cardiac patients. Networks should be geographically integrated and based on the functional need to enable routine and special large-scale operations for communications among EMS and other public safety agencies. Utilization of system status management technology should be considered for both areas with high demand of mobile resources and for those areas where resources may not be readily available on a routine basis but would benefit from shifting resources from one geographic area to another.

6.3.2 EMS communication center(s) should be staffed with fully trained tele communicators. The ideal tele communicator should have completed an Emergency Dispatch course, such as the Emergency Medical Dispatch: National Standard Curriculum as offered from the National Highway Traffic Safety Administration and the U.S. Department of Transportation. NCTTRAC encourages early adoption of Texas HB 786 regarding tele communicators CPR.

6.3.3 NCTTRAC encourages participation from all EMS agencies within the nineteen counties that comprise TSA-E. By enhancing participation, NCTTRAC can identify quality issues related to response times. NCTTRAC can then move toward the resolution of these issues through assessment, education, intervention, and evaluation through system process improvement (SPI) procedures.

7. MEDICAL OVERSIGHT

7.1 Goal

7.1.1 The development of a Regional System of Cardiac care requires the active participation of qualified physician providers. Physicians should be clinically qualified in their area of practice and have expertise and competence in the treatment of cardiac patients. The regional cardiac system of care will be developed under the direction of representatives of NCTTRAC medical staff throughout the region.

7.2 Committees Charged

7.2.1 Responsibilities are charged to the Medical Directors Committee.

7.3 Objective

7.3.1 The development of a regional system for cardiac care requires the active participation of qualified physician providers with expertise and competence in the treatment of cardiac patients. NCTTRAC has an established Medical Directors Committee. This committee meets quarterly to provide guidance in the development and review of hospital and prehospital assessment tools, regional plans, and treatment guidelines. The committee is comprised of the elected committee medical directors of the following committees: Air Medical, Cardiac, Emergency Department Operations, Emergency Medical Services, Pediatric, Perinatal, Regional Emergency Preparedness (Disaster), Stroke, and Trauma. Each Medical Director is responsible for participating with and providing medical oversight for their service line committee, as well as collaborating with other RAC committees and Medical Directors.

8. REGIONAL PRE-HOSPITAL MEDICAL CONTROL

8.1 Goal

8.1.1 The regional cardiac plan will assist with identification and education of regional medical control resources, standardize guidelines, and analyze accessibility of medical control resources. Additionally, it will identify and educate NCTTRAC EMS Providers and sources of medical direction.

8.2 Committees Charged

8.2.1 Responsibilities are charged to the NCTTRAC EMS Committee, the Medical Directors Committee, and the Cardiac Committee.

8.3 Objectives

8.3.1 Presently, each EMS agency has its own medical director and standard operating procedures (SOPs). Each medical director has the legal authority under Texas Administrative Code, Chapter 197 and the Texas Department of State Health Services (DSHS) Chapter 157 for developing the agency's local protocols and guidelines. TSA-E provides off-line guidelines to each EMS provider and medical director as recommended by the EMS, Trauma, and Medical Directors Committees that may be utilized and adopted. Each medical director within TSA-E assumes the responsibility for cardiac oversight as well as specific performance improvement to investigate patient outcomes for his or her EMS personnel.

8.3.2 NCTTRAC encourages coordinated medical control in our region and to that end has organized a Medical Directors Committee which meets periodically to review the protocols and guidelines for EMS Providers within TSA E. Several medical directors have multiple EMS Providers working with them to help consolidate and control the

pre-hospital care of the cardiac patients but this is not a mandatory requirement at this time. Through the efforts of the Medical Directors Committee, NCTTRAC will continue to work towards developing consistency and standardization of the guidelines used within our region.

8.4 Physician Involvement in Regional Plan Development

8.4.1 The Medical Directors Committee meets quarterly to conduct its usual business and to review and approve regional planning components, policies, and guidelines related to medical care. Each EMS Medical Director and at least one physician from each NCTTRAC hospital has the opportunity for representation on this standing working group. All physicians within TSA-E are invited to attend these meetings.

8.5 Medical Direction of Pre-hospital Care Providers

8.5.1 In accordance with DSHS guidelines, all NCTTRAC pre-hospital care providers function under medical control through a delegated physician practice. Regional EMS guidelines are available online to all EMS Providers for incorporation into local protocols. Periodic reviews and updates are completed and upon approval are distributed as necessary. These guidelines serve as a baseline and individual Medical Directors may adapt for their local community.

8.6 Regional Quality Improvement

8.6.1 The Medical Directors Committee meets quarterly to conduct business and to carry out regional quality improvement activities. (Please see System PI section for more details).

9. PRE-HOSPITAL TRIAGE CRITERIA

9.1 Goal

9.1.1 Patients will be identified, rapidly and accurately assessed, and will be transported to the closest appropriate facility.

9.2 Committees Charged

9.2.1 Responsibilities are charged to the NCTTRAC EMS Committee with input from the Cardiac Committee and oversight from the Medical Directors Committee.

9.3 Purpose

9.3.1 The pre-hospital ACS triage and transport guidelines serve to direct the regional triage of adult ACS patients (greater than or equal to 18 years) to the closest most appropriate facility. In the event EMS encounters an ACS patient under the age of 18, contact the closest pediatric hospital or Medical Control for guidance. See *Annex A: Acute Coronary Syndrome Triage and Transport Guidelines*

9.4 System Triage

9.4.1 EMS Transport decisions should be based on standard of care, local EMS Protocols, capabilities, and availabilities of local receiving hospitals. Transport decisions should consider first medical contact (FMC) by EMS provider to intervention at STEMI receiving facility less than or equal to 90 minutes based on AHA National Standards.

9.4.2 If transport time is greater than or equal to 45 minutes, the AHA National Standard is first medical contact to intervention in less than 120 minutes.

10. HELICOPTER

10.1 Activation Goal
- 10.1.1 Regional air transport resources may be appropriately utilized in order to reduce delays in providing optimal cardiac care.

10.2 Committees Charged
- 10.2.1 Responsibilities are charged to the NCTTRAC Air Medical Committee with input from the EMS and Cardiac Committees, and guidance from the Medical Directors Committee.

10.3 Decision Criteria
- 10.3.1 Helicopter activation/scene response may be considered when it can reduce transportation time or provide advanced life support.
- 10.3.2 Patients meeting criteria for helicopter dispatch should be transported to the closest, most appropriate facility.
- 10.3.3 Consider Air Medical Transport if ground transport time is greater than 30 minutes and if air medical does not prolong arrival to STEMI receiving facility. Transport decisions should consider first medical contact (FMC) by EMS provider to intervention at STEMI receiving facility less than or equal to 90 minutes based on AHA National Standards. If transport time is greater than or equal to 45 minutes, the AHA National Standard is first medical contact to intervention in less than 120 minutes.
- 10.3.4 Refer to *Annex B: Aircraft Utilization and Systems Performance Review*

11. FACILITY BYPASS

11.1 Goal
- 11.1.1 Facilities will communicate the availability of ACS patient care capability status promptly and clearly to regional EMS and other facilities through EMResource in order to ensure that cardiac patients are transported to the closest appropriate cardiac facility.

11.2 Committees Charged
- 11.2.1 Responsibilities are charged to the NCTTRAC EMS Committee, the Medical Directors Committee, and the Cardiac Committee.

11.3 System Objective
- 11.3.1 The system objective is to ensure that cardiac patients will be transported to the closest appropriate facility.
- 11.3.2 All hospitals and EMS providers have the ability to create event notifications in EMResource. These events are used to inform the emergency healthcare partners in TSA-E about any incidents or occurrences that might affect the overall emergency healthcare system in TSA-E. Proper posting on EMResource is the official and standard mechanism for notification in TSA-E. All EMS services are expected to monitor EMResource at all times for current system information. An EMS agencies should use the information within EMResource to help inform patient destination decisions to ensure that all patients receive the appropriate care quickly and effectively.
- 11.3.3 A full listing of EMResource status types, policies, and procedures in TSA-E can be found in *Annex C: TSA-E EMResource Policies & Procedures.*

12. INTER-FACILITY TRANSFERS

12.1 Goal

12.1.1 The goal for establishing and implementing inter-facility transfer criteria in NCTTRAC is to ensure that ACS patients requiring additional or specialized care and treatment beyond a facility's capability are identified and transferred to the most appropriate facility as soon as possible.

12.2 Committees Charged

12.2.1 Responsibilities are charged to the NCTTRAC Cardiac Committee with input from the Air Medical and EMS committees, and guidance from the Medical Directors Committee.

12.3 Objectives

12.3.1 To ensure that all facilities make transfer decisions based on ACC/AHA guidelines.

12.3.2 Cardiac receiving facilities are encouraged to collaborate with transferring facilities (hospitals, free standing ERs, etc.) to develop processes that meet evidence based guidelines.

12.3.3 No more than one transfer should take place in efforts to minimize the transport time for a patient that is in need of interventions not available at the sending facility. Every possible determination should be evaluated before making the decision to transport the ACS patient to help prevent the need for a double transfer.

12.3.4 Transfer decisions should consider first medical contact (FMC) by referring facility to intervention at STEMI receiving facility less than or equal to 120 minutes based on AHA National Standards. If transfer time is greater than 30 minutes, consider consult with receiving cardiologist regarding administration of lytics.

13. SYSTEM PERFORMANCE IMPROVEMENT

13.1 NCTTRAC participating organizations must have a performance improvement system for ACS patients.

13.2 Goals

13.2.1 The goal is to establish a method for monitoring and evaluating ACS system performance and the impact of system development.

13.3 Committees Charged

13.3.1 Responsibilities are charged to the NCTTRAC Cardiac Committee.

13.4 Objectives

13.4.1 Encourage participation in state / RAC cardiac data registries which reflect evidence based practices of the processes and outcomes of the NCTTRAC Cardiac system of care

13.4.2 Provide a multidisciplinary forum for cardiac care providers to evaluate cardiac patient outcomes from a system perspective and to assure the optimal delivery of cardiac care

13.4.3 Facilitate the sharing of information and performance data

13.4.4 Provide a process for medical oversight of regional cardiac operations

13.4.5 Confidentiality – All information and materials provided and/or presented during SPI meetings are strictly confidential.

1. Introduction

1.1 Texas Administrative Code, Title 25, Part 1, Chapter 157, Subchapter G, Rule §157.123 establishes the legal framework of the Emergency Medical Services (EMS) Trauma System in the State of Texas; which includes the creation of Regional Advisory Councils and their respective authority to develop an EMS/Cardiac System plan based on standard guidelines for comprehensive system development, to include pre- hospital triage criteria, diversion protocols, bypass protocols, and regional Acute Coronary Syndrome treatment guidelines. As such, the North Central Texas Trauma Regional Advisory Council (NCTTRAC) has developed, vetted, and approved the following Acute Coronary Syndrome Triage and Transport Guidelines for use by North Central Texas EMS providers licensed by the Texas Department of State Health Services (TDSHS).

2. Overview

2.1 For the Acute Coronary Syndrome (ACS) patient, as for other critically ill patients, assessment is the foundation on which all management and transportation decisions are based.

2.2 The survival of the ACS patient is dependent upon rapid recognition of ACS, management of life-threatening symptoms, and rapid transport to an appropriate facility, as outlined on Page 2 of this document. Scene times should be kept to a minimum with only the necessary interventions made to identify and/or correct immediate life threats. All secondary interventions should be performed en route to an appropriate facility or while awaiting aeromedical evacuation.

2.3 The first step in ACS assessment is the **Scene Assessment** / Scene Size-Up. As you approach the scene, assure safety for yourself and the patient while taking BSI precautions. Rapidly identify the number/type of patients and request additional resources as appropriate.

- 2.3.1 Additional resources (e.g. aeromedical evacuation, special rescue, additional ambulances) should be notified based off of dis- patch information; and requested to proceed with arrival/landing on scene during scene assessment / scene size-up.
- 2.3.2 Recognition of multi-patient incidents and mass-casualty incidents is critical. In these incidents, priority shifts from focusing all resources on the most critical patient to providing the greatest good to the greatest number of patients.

2.4 Once a brief scene assessment / scene size-up has been performed, which may include rapid triage of multiple patients, attention should focus on evaluating individual patients. Individual patients should be assessed/treated based off of initial triage priority.

2.5 The Primary Assessment begins with a simultaneous, or global, overview of the status of the patient's respiratory, circulatory, and neurological systems to identify obvious, significant problems with oxygenation, circulation, hemorrhage, or gross neurological deficit; followed by a rapid focused assessment of Airway, Breathing/Ventilation, Circulation/Bleeding, Disability, and Expose/Environment.

- 2.5.1 Make immediate interventions to correct life-threats in the order found. Progress from BLS (least invasive) to ALS (most invasive), utilizing the most appropriate intervention warranted in a given situation.
- 2.5.2 Assess the Patient's Mental Status: If unresponsive, check for a pulse. If no pulse, initiate CPR per local protocol.
- 2.5.3 Airway: While simultaneously applying C-spine precautions (if applicable), the provider should establish/ensure a patent airway by opening (e.g. jaw-thrust), clearing (e.g.

suction), assessing, and intervening (e.g. OPA/NPA, King LTD-S, ET Tube).

2.5.4 Breathing: Ensure adequate oxygenation and ventilation of the lungs utilizing appropriate oxygen-delivery devices (e.g. NC, NRB, C-PAP, BVM). Expose the chest and obtain breath sounds. Treat abnormalities according to local protocol.

2.5.5 Circulation: Observe the color,temperature, and moisture of the skin while rapidly assessing for the presence/location/ quality of pulses (e.g. carotid, femoral, radial) to estimate Blood Pressure and/or perfusion.

2.5.6 Disability: Rapidly assess Level of Consciousness, pupils, and motor /sensor y responses. If trauma suspected, utilize appropriate devices to restrict spinal motion. Observe for increased ICP and signs/symptoms of impending brain-stem herniation (e.g. unequal pupils, bradycardia, hypertension, irregular respirations).

2.5.7 Expose/Environment: Rapidly extricate/remove patients from dangerous environments (e.g. fir e, snow, pool, etc.). Re- move patients clothing in order to fully assess for injury. After assessing, cover patient to maintain body heat if appropriate.

2.6 The Secondary Assessment begins after the recognition/management of life-threatening symptoms found in the Primary Assessment. The objective of the Secondary Assessment is to gather detailed information.

2.6.1 Reassess/Confirm Airway, Breathing, and Circulation. Make appropriate interventions as necessary.

2.6.2 Obtain full/detailed vital signs utilizing available equipment.

2.6.3 Obtain a 12-lead ECG. Transmit 12-lead ECG to receiving facility if able/applicable.

2.6.4 Obtain SAMPLE and OPQRST histories if able/applicable.

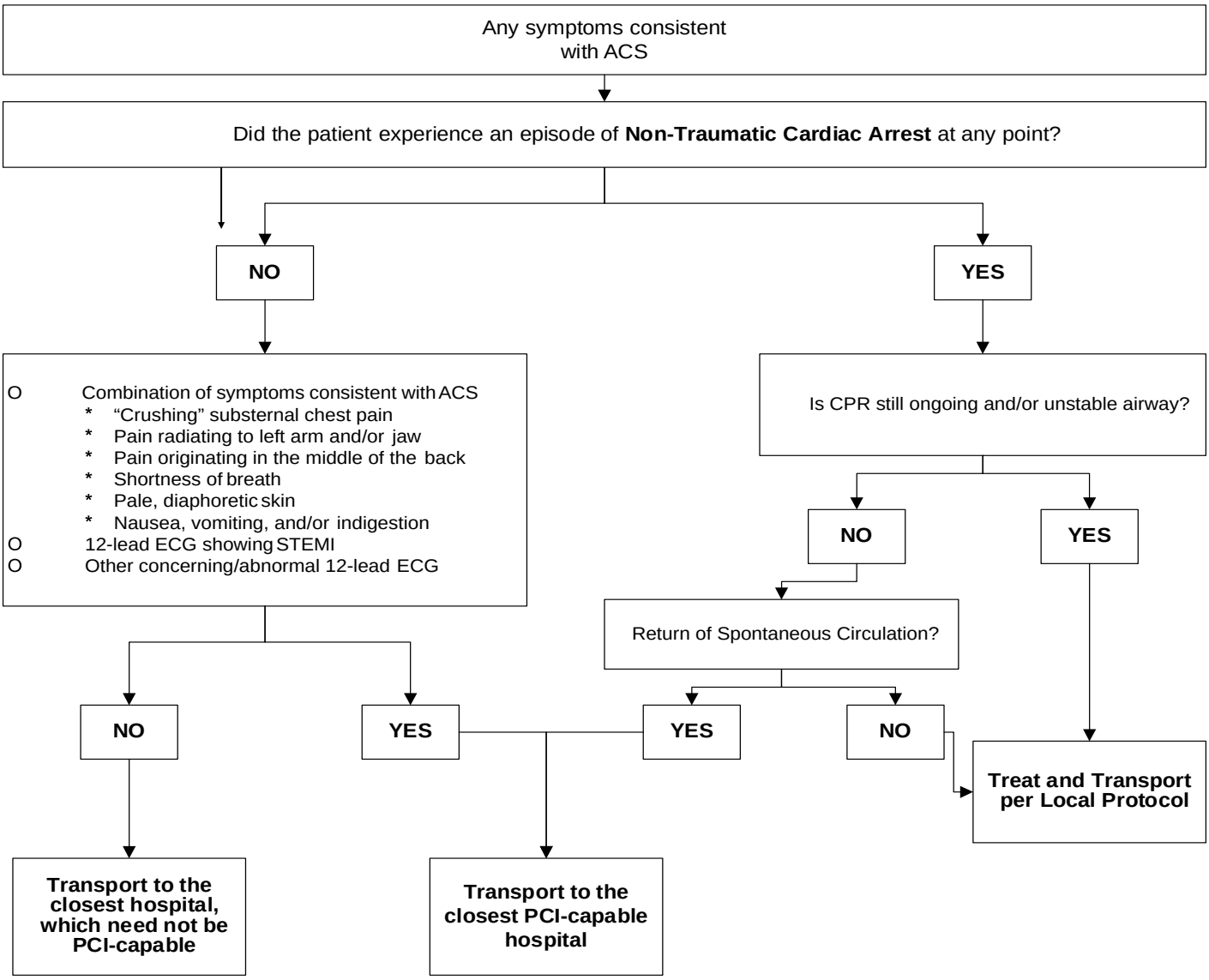
2.6.5 Obtain vascular access and administer appropriate fluid boluses to restore/maintain a radial pulse and/or SBP > 90 mmHg. Do not over-infuse fluids in ACS patients. Do not attempt to restore baseline vital signs.

2.6.6 Administer appropriate medications and other interventions per local protocol.

2.6.7 Perform a detailed head-to-toe physical examination

2.7 Continuously reassess airway, breathing, circulation, and disability. Document vital signs frequently. Make appropriate interventions as necessary.

3. Transport Algorithm



3.1 Attention should be directed at:
- 3.1.1 Early recognition of STEMI through 12-lead ECG analysis.
- 3.1.2 Early notification of receiving hospital via 12-lead ECG transmission or direct telephone call.
- 3.1.3 Early initiation of transport to appropriate PCI capable hospital.

3.2 Cardiac Arrest patients should be transported to the closest appropriate hospital after receiving high-quality CPR on-scene per protocol.

3.3 Pediatric patients should be triaged preferentially to a Pediatric Specialty Center.

3.4 Ultimately, the final transport decision rests with the individual EMS personnel directing patient care at the scene, in consultation with local protocol and/or local medical direction.

4. Special Considerations

4.1 Air Medical Evacuation**:** When requesting air medical assets, confirm the air craft's present location and estimated time of arrival (ETA) to the scene. The ETA includes start-up, lift-off, and flight time(s) to the scene.

4.1.1 If the aircraft's ETA or the total time to definitive care by air exceeds the estimated ground transport time to the closest most appropriate facility, immediate ground transport should be considered.

4.1.2 Air medical assets may be utilized to deliver higher echelons of care and/or specialty services when indicated (e.g. need for advanced airway management, surgical amputation teams).

4.1.3 The purpose of air medical evacuation is to achieve getting the critical patient to the most appropriate definitive care hospital in the shortest amount of time. The air medical helicopter to be utilized is the closest medical helicopter to the scene appropriate for the patient's needs

4.2 Cardiac Arrest: If patients are found to meet one or more the following criteria, CPR may be withheld and the patient declared dead if in accordance with local protocol.

4.2.1 Pulseless and apneic in addition to signs incompatible with life (e.g. decapitation, dependent lividity, rigor mortis, and decom- position).

4.2.2 No pupillary reflexes, no spontaneous movement, and no organized cardiac rhythm on the ECG greater than 40 complexes per minute.

4.3 Obstetrics**:** Consult Off-Line or On-Line Medical Control/Direction.

4.4 Pediatrics**:** Pediatric patients should be triaged preferentially to a Pediatric Specialty Center

4.4.1 If the term "lethargic" is used by the caregiver, the term needs to be described.

4.5 Transfer of Patient Care Info: The regional standard for Patient Care Report (PCR/ePCR) handoff communication is as follows:

4.5.1 The receiving facility should be notified of patient and patient status prior to EMS arrival.

4.5.2 At the time of transfer of patient care, at a minimum, verbal communication will occur, and a paper short-list and/or electronic draft-report will be delivered. Copies of EKG

4.5.3 A final written or electronic full care report will be available within one business day.

4.5.4 *This regional standard expounds upon the minimum requirements set-forth in TDSHS EMS Rule §157.11(m)*

1. Background

1.1 The North Central Texas Trauma Regional Advisory Council (NCTTRAC) is an organization designed to facilitate the development, implementation, and operation of a comprehensive trauma care system based on accepted standards of care to decrease morbidity and mortality. The Air Medical Committee for the North Central Texas Trauma Regional Advisory Council is a standing committee that provides recommendations and guidance for air medical operations in the Trauma Service Area - E (TSA-E). It is the mission of the Air Medical Committee to promote safe, ethical, and high-quality patient care during air medical transport for the citizens of Texas.

1.2 The purpose of a Regional Advisory Council (RAC) is to develop, implement, and monitor a regional emergency medical service trauma system plan within a TSA. A RAC is an organized group of healthcare entities and other concerned citizens who have an interest in improving and organizing trauma care within a specified Trauma Service Area. RAC membership may include hospitals, physicians, nurses, EMS providers, rehabilitation facilities, dispatchers, as well as other community groups. Regional Advisory Council objectives are to reduce the incidence of trauma through education, data collection and analysis and performance improvement. This is accomplished by providing educational programs and conducting performance improvement efforts that provide every provider guidance and motive to reduce the incidence of trauma as well as improve the outcome of trauma patients.

2. Purpose

2.1 The purpose of this document is to:

- 2.1.1 Define the system established by the TSA-E Air Medical programs to assist EMS ground providers and facilitate requesting the closest appropriate aircraft for the patient in need
- 2.1.2 Describe the review request process and specific indicators for systems performance improvement
- 2.1.3 Improve patient care, collaboration, and foster a community partnership for all stakeholders within the RAC

3. Desired Outcomes

3.1 The desired outcome is to request the closest appropriate aircraft and integrate air medical providers into the RAC System Performance Improvement (SPI) process. This provides a platform for concerns regarding air medical services to be identified, addressed, and provided a mechanism for loop closure within the Regional Advisory Council. This should occur when they are unsuccessful in being addressed among corporate entities. The intent is not to replace interworking collaboration among Air Medical and EMS services or care facilities.

- 3.1.1 Concerns regarding the air medical service(s) may include: safety, patient care, dispatching, or membership services.
- 3.1.2 The Air Medical Committee recommends that the evaluation of appropriate use of a helicopter rests with the requesting organization.
- 3.1.3 Performance improvement may include, educational initiatives, process improvement plans and/or recommendations from the NCTTRAC and/or GETAC Air Medical Committees.

4. Process to Locate, Request, Communicate, And Improve Air Medical Services

4.1 EMResource is a software system that will publish all aircraft in TSA-E, their location, and availability. You can view this in a list or map view.

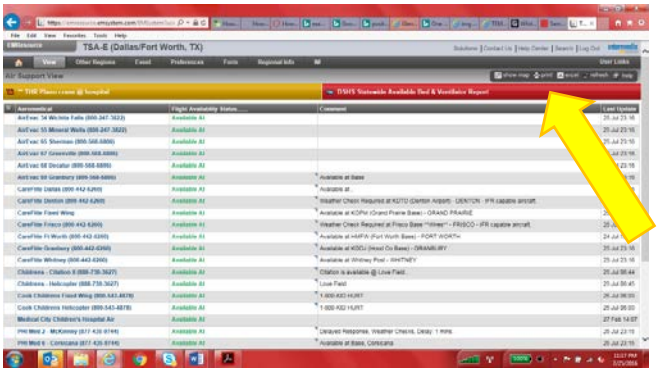
4.2 Obtain a facility or personal login by creating a support ticket with NCTTRAC
- 4.2.1 Go to https://www.ncttrac.org/
- 4.2.2 On the bottom right select Create A Helpdesk Ticket
- 4.2.3 Start a Ticket
- 4.2.4 Choose "Support – Other"
- 4.2.5 Then fill in the needed fields and state that your agency needs a log in for EMResource

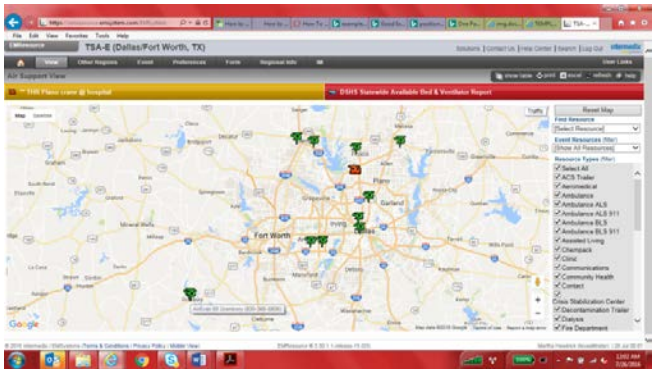
4.3 Once Log In is attained, go to https://emresource.emsystem.com/login.htm

4.4 You will see a list of area helicopters, hospitals, EMS and their status (set up a preferred view and notifications so the system is what you need).

4.5 Find the table view and list of helicopters (pictured below on the left). It will state in GREEN "Available at" if available for a call and the location (usually "at base") or RED "Unavailable" if on a flight or out of service for a Maintenance Event.

4.6 Change and set the helicopter map view as your preference (yellow arrow indicates where to change the view, the map view is pictured below on the right). It is a very quick view with the helicopters mapped in their locations (hovering over or clicking on the icon will identify the aircraft). They are colored for their availability:
- GREEN=Available
- RED=Unavailable for a patient flight





4.7 All aircraft in your area can be viewed and you will be able to identify the closest available aircraft to your location and call the appropriate provider.

4.8 Radio communication for Ground to Air, will occur utilizing the preferred contact method and channel as designated by the requesting ground agency, either at the time of the activation or through prearranged channel designation with the Air Provider. In the event of a disaster or MCI situation, the Texas Statewide Interoperability Channel Plan should be implemented. This plan states that radio communication from Ground to air, authorized by the Texas Government Code and regulated by the FCC, is to be performed on radio channel VMED 28. (see below)

Label	Receive	Transmit	Station Class	CTCSS RX /TX	Use
VMED28	155.3400	155.3400	FBT / MO	CSQ / 156.7	Tactical Channel (and for Air-to-Ground use)

4.9 Air Medical Indicators to be referred to SPI Committee if not met:
- 4.9.1 Air Medical Services will provide a launch location of the aircraft responding
- 4.9.2 Air Medical Providers participating in the NCTTRAC are operating on EMResource tracking map, updating and refreshing the aircraft current positions at least every 3 minutes.
- 4.9.3 ETE (flight time only) will not exceed 5 minutes past time given
- 4.9.4 ETA (includes lift time) will not exceed 5 minutes past time given
- 4.9.5 Air Medical Services scene times will not exceed 20 minutes (does not include specialty teams)
- 4.9.6 Air Medical Services inter-facility transfer times will not exceed 40 minutes (does not include specialty teams)
- 4.9.7 Provide air medical transport response for inter-facility trauma patients within 60 minutes of the time of the request

4.10 If an indicator falls outside of the above parameters, the event may be submitted to the NCTTRAC SPI Committee for review and it may be referred from SPI to the appropriate Committee and Individual Provider for action.

4.11 Process for requesting reviews and/or reporting concerns to the SPI Committee:
- 4.11.1 Go to https://www.ncttrac.org/
- 4.11.2 On the bottom right select Create A Helpdesk Ticket
- 4.11.3 Start a Ticket
- 4.11.4 Choose “Member – SPI Referral Form Request”
- 4.11.5 Then fill in the necessary fields. Be as specific as possible to allow for a sufficient review.

1. Introduction

1.1 Purpose

1.1.1 The TSA-E Regional EMResource Policies and Procedures document dictates EMResource use in Trauma Service Area E. It defines relevant terms, lays out how resources are organized, describes how the application is administered, defines the status types and their status options, and identifies system performance measures for both individual organizations and regional use.

1.2 Administrative Support

1.2.1 The TSA-E Regional EMResource Policies and Procedures document will be reviewed and updated annually. All revisions and review activities will be noted in the Record of Changes in the front of the document.

2. EMResource Overview

2.1 EMResource General Concept of Operations

2.1.1 EMResource serves as the primary day-to-day information sharing platform in the emergency healthcare system within Trauma Service Area E. It has 3 central functions:

2.1.1.1 Capabilities Database

2.1.1.2 Daily Status Updates

2.1.1.3 Event Notifications

2.2 Capabilities Database

2.2.1 EMResource allows healthcare facilities and EMS agencies to list their normal operating capabilities. For healthcare facilities, these typically involve clinical service provision – can this facility take burn patients, does it have inpatient psychiatric capabilities, etc. For EMS agencies, these typically involve response capabilities – can this EMS agency provide critical care transport services, can it perform swift water rescues, etc. Service capabilities are generally updated on an as-needed basis as opposed to on a regular schedule.

2.3 Daily Status Updates

2.3.1 EMResource allows hospitals to update certain statuses on a daily basis (or more frequently as needed). This ensures that EMS agencies transporting patients and other healthcare facilities looking to transfer patients can make well-informed patient destination decisions. Statuses with daily (or more frequent) update requirements are listed below.

2.3.1.1 Hospital Intake Status – hospitals report on the current status of their Emergency Department's ability to take patients. An "Open" status should be updated every 24 hours; an "Advisory" or "Advisory – Surge" status should be updated every 4 hours; a "Closed" status should be updated every 2 hours.

2.3.1.2 NEDOCS – hospitals use the National Emergency Department Overcrowding Score to provide regional partners with a quantifiable ED saturation level. The higher the NEDOCS, the busier the ED, and generally the longer that EMS will have to wait to offload a patient. NEDOCS should be updated every 6 hours.

2.3.1.3 ED Psych Holds – hospitals report the number of psych holds in their Emergency Department. This allows emergency response units transporting

psychiatric patients to make informed patient destination decisions that ensure the psychiatric patient receives treatment in a timely manner. The more ED Psych Holds, the longer it will take for that psychiatric patient to receive proper treatment.

2.3.1.4 Bed Availability Reporting – hospitals report the number of available beds in their facility according to the DSHS WholeBed categories. These numbers should be updated at least once every 24 hours.

2.3.1.5 Flight Availability Status – air medical units report on their availability and location. Air Evac, PHI, and Careflite have linked their CAD systems with EMResource to ensure that these updates occur in real time.

2.4 Event Notifications

2.4.1 EMResource allows any user to publish an event notification that sends email and text alerts to other EMResource users. These are most commonly used for events that affect the emergency healthcare system in TSA-E (such as hospital construction requiring ambulance traffic to take an alternate route), but are also used in emergencies to notify the emergency healthcare system about mass casualty incidents, region wide or statewide bed reports, or severe weather.

2.5 EMResource Funding

2.5.1 EMResource is funded at the state level through the Hospital Preparedness Program (HPP) as managed by the Department of State Health Services (DSHS). DSHS charges HPP grantees in each Trauma Service Area (TSA) with regional EMResource administrative duties (NCTTRAC is the HPP grantee for TSA-E). Additional EMResource enhancements in TSA-E are funded on a case-by-case basis, but generally the HPP is the first funding stream considered for regional EMResource enhancements.

2.6 EMResource Administration

2.6.1 EMResource is administered regionally by NCTTRAC. NCTTRAC employs one primary EMResource Regional Administrator and multiple secondary EMResource Regional Administrators. Questions about regional EMResource administration should be directed to NCTTRAC_EMCC@ncttrac.org. Regional EMResource use is overseen by the NCTTRAC Board of Directors, who may create an EMResource Workgroup as needed to tackle specific tasks. Additional EMResource oversight is provided by the Regional Emergency Preparedness Committee (REPC) and all NCTTRAC clinical committees.

2.6.2 EMResource is administered at the statewide level by the Department of State Health Services (DSHS). DSHS maintains a team of multiple EMResource Statewide Administrators who help coordinate EMResource use throughout Texas.

2.6.3 EMResource is owned by the private company Juvare. Certain administrative actions are only available to Juvare employees. Juvare employs Client Success Managers to support the EMResource Statewide Administrators and the EMResource Regional Administrator.

2.7 EMResource Access

2.7.1 Any individual who is associated with an emergency healthcare facility or organization can access EMResource using a unique username and password. Individuals who need to have an EMResource account created should follow these steps:

2.7.1.1 Go to http://support.ncttrac.org/Main/frmTickets.aspx

2.7.1.2 Click “Start Ticket”
2.7.1.3 In the “Department” drop-down menu, select “Crisis Applications – New Account Request (TSA-E/DFW Region).
2.7.1.4 Fill in the required fields and click “Submit”.

2.7.2 NCTTRAC staff will create user accounts based on the information provided in the support ticket. After an account is created, NCTTRAC staff will send an email to the individual containing their username, password, and links to basic training resources. Individuals must provide an email address that is associated with an emergency healthcare facility or organization - @gmail.com, @outlook.com, etc. will not be accepted.

2.7.3 All users must have a unique username and password and should not share that information with anyone else. The only exception to this policy is for EMS dispatch centers, who may have one generic log-in with view-only access. The password to such an account must be changed at least once per year. EMS agencies are still expected to have at least one user with permission to update statuses and create events on-staff at all times.

3. EMResource Regional Participation Standards

3.1 In order to improve EMResource utilization and ensure data validity, TSA-E has adopted the following participation standards:

3.2 Hospitals

3.2.1 Healthcare facilities must ensure that at least one person with EMResource access is on-site 24/7.

3.2.2 Hospitals must update their “Hospital Intake Status” at least once every 24 hours if the status is “Open”, once every 4 hours if the status is “Advisory” or “Advisory – Surge”, or and every 2 hours if the status is “Closed”.

3.2.3 Hospitals must update their “Psych ED Holds” number at least once every 6 hours.

3.2.4 Hospitals must update their “NEDOCS” status at least once every 6 hours.

3.2.5 Hospitals must update their Immediate Bed Availability numbers at least once every 24 hours.

3.2.6 Hospitals must update specific service line status types as needed. If a hospital sets a service line status type to “Unavailable” (or any other equivalent indicating a temporary outage or issue), the hospital must update that service line status every 4 hours.

3.2.7 Hospitals must update their EMResource point of contact information annually or as the contact information changes.

3.2.8 Hospitals must review the list of EMResource users associated with their facility and contact NCTTRAC with information on any necessary changes. Hospitals must complete this process annually or as users change over.

3.3 EMS Agencies

3.3.1 EMS Agencies must ensure that at least one person with EMResource access is on-shift 24/7.

3.3.2 EMS Agencies must have a method to monitor EMResource for hospital status information. This can include active monitoring of EMResource via computer or

mobile application, or it can include relevant status change notifications being sent to EMS Agency staff.

3.3.2.1 EMS Agencies must review their service line statuses and make any necessary changes at least annually

3.3.3 EMS Agencies must update their EMResource point of contact information annually.

3.3.4 EMS Agencies must review the list of EMResource users associated with their agency and contact NCTTRAC with information on any necessary changes. EMS Agencies must complete this process annually.

3.4 Status Update Matrix

Every 2 Hours	Every 4 Hours	Every 6 Hours	Every 24 Hours	As Needed
Hospital Intake Status: Closed	Hospital Intake Status: Advisory - Capability	NEDOCS	Hospital Intake Status: Open	Service Line Statuses
	Hospital Intake Status: Advisory – Surge	Psych ED Holds	All Bed Availability Categories	
	Service Line Statuses marked “Unavailable”			

4. EMResource Organization & Views

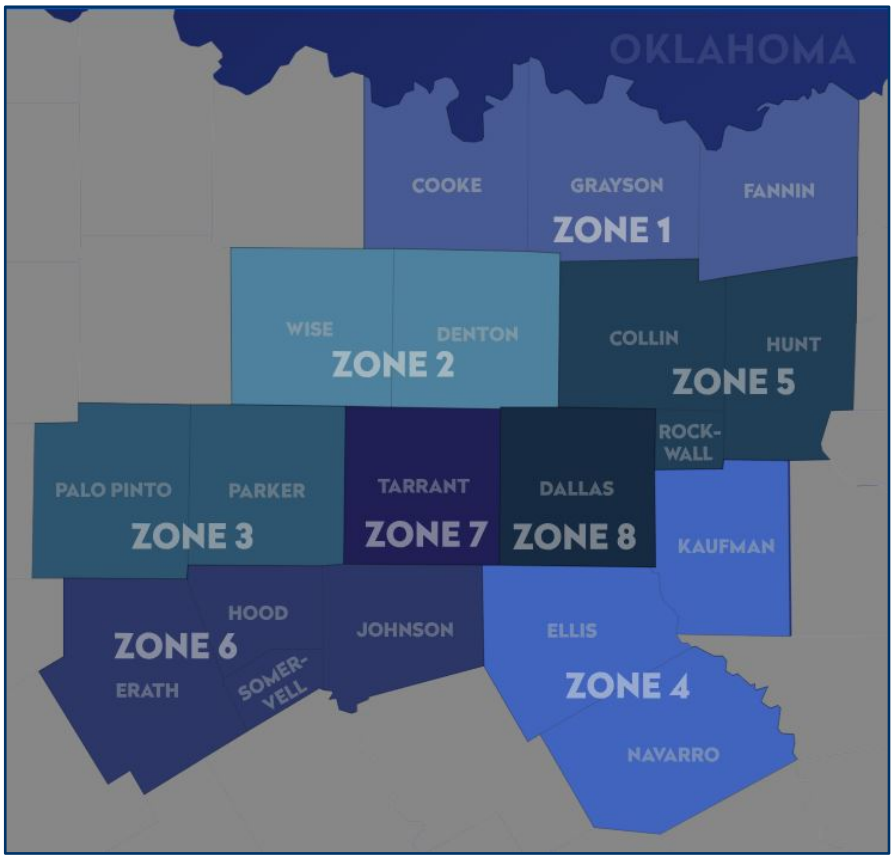
4.1 General Organization

4.1.1 All resources in EMResource are assigned a Resource Type. Resource Type is determined by a resource’s county of residence and by how a resource is licensed according to the Department of State Health Services (DSHS) Licensure Lists. DSHS Licensure Lists can be found at https://www.dshs.texas.gov/facilities/find-a-licensee.aspx for medical facilities and at https://www.dshs.texas.gov/emstraumasystems/formsresources.shtm#OpenRecords for EMS agencies/First Responder Organizations (FROs).

4.1.2 Resource Types use the following naming convention: Z# - Name County Provider Type. The # is the NCTTRAC zone that the county falls into, County is the resource’s county of residence, and the Provider Type is a resource’s provider type as licensed by DSHS.

4.1.3 For example, hospitals in Collin County are listed in Resource Type “Z5 – Collin County Hospitals”. NCTTRAC zones and their composite counties are listed on the following page.

Zone 1
-Cooke County
-Fannin County
-Grayson County
Zone 2
-Denton County
-Wise County
Zone 3
-Palo Pinto County
-Parker County
Zone 4
-Ellis County
-Kaufman County
-Navarro County
Zone 5
-Collin County
-Hunt County
-Rockwall County
Zone 6
-Erath County
-Hood County
-Johnson County
-Somervell County
Zone 7
-Tarrant County
Zone 8
-Dallas County



4.1.4 Each county has five Resource Types. For example, Dallas County has the following Resource Types: “Z8 - Dallas County Hospitals”; “Z8 – Dallas County Special Facilities”; “Z8 – Dallas County LTC”; “Z8 – Dallas County EMS”; and “Z8 – Dallas County FROs”. An explanation of how resources are divided into their county-based Resource Type can be found below.

4.1.4.1 County Hospitals

4.1.4.1.1 The “County Hospitals” Resource Types is composed of facilities that appear in the DSHS “Directory of General and Specialty Hospitals” that have both “General Hospital” and “Emergency Department” in their “Designation/Services/Accreditation” column.

4.1.4.2 County Specialty Facilities

4.1.4.2.1 The “County Specialty Facilities” Resource Types is composed of facilities that meet one or more of the following criteria:

4.1.4.2.2 Facilities that appear in the DSHS “Directory of General and Specialty Hospitals” that have the following listed in their “Designation/Services/Accreditation column”:

4.1.4.2.3 “Special Hospital” and “Mental Health Services”

4.1.4.2.4 “Comprehensive Medical Rehabilitation”

4.1.4.2.5 "Comprehensive Rehab Services" WITHOUT "General Hospital" and "Emergency Department"
4.1.4.2.6 "Long-Term Acute Care"
4.1.4.2.7 "Pediatric" WITHOUT "General Hospital" and "Emergency Department"
4.1.4.2.8 "Special Hospital"
4.1.4.2.9 Facilities that appear in the DSHS "Directories of Ambulatory Surgical Centers"
4.1.4.2.10 Facilities that appear in the DSHS "Directory of Private Psychiatric Hospitals"

4.1.4.3 County Long-Term Care Facilities
4.1.4.3.1 The "County Long-Term Care Facilities" is composed of Assisted Living Facilities (ALF), Skilled Nursing Facilities (SNF), and ICF/IID facilities.

4.1.4.4 County EMS Agencies
4.1.4.4.1 The "County EMS Agencies" Resource Types is composed of agencies that appear in the DSHS "EMS Providers Agencies" list.

4.1.4.5 County FROs
4.1.4.5.1 The "County FROs" Resource Types is composed of agencies that appear in the DSHS "EMS First Responder Organizations" list.

4.1.5 There are also Resource Types for individual vehicles or assets. These Resource Types are listed below:

4.1.5.1 Aeromedical
4.1.5.1.1 The "Aeromedical" Resource Type is composed of individual air medical units located within TSA-E. Air medical units that are based outside of TSA-E but provide services within TSA-E will also be included in the "Aeromedical" Resource Type whenever possible.

4.1.5.2 AMBUS
4.1.5.2.1 The "AMBUS" Resource Type is composed of individual AMBUS units located within TSA-E. AMBUSes are part of the Emergency Medical Task Force (EMTF) program, and AMBUS host agencies update EMResource with changes in AMBUS deployment status.

4.1.5.3 Mass Fatality Trailers
4.1.5.3.1 The "Mass Fatality Trailers" Resource Type is composed of individual Mass Fatality Trailers (MFTs) located within TSA-E that were purchased with Hospital Preparedness Program (HPP) funds. A Mass Fatality Trailer is a refrigerated trailer that can hold up to 20 deceased bodies during a Mass Fatality event.

4.1.5.4 MERC Trailers
4.1.5.4.1 The "MERC Trailers" Resource Type is composed of individual Mobile Emergency Response Communications (MERC) Trailers that were purchased with HPP funds. A MERC Trailer is a towable trailer that contains a variety of communications equipment to be used during a communications failure.

4.1.6 Resources that do not fit any of the criteria above will be assigned the Resource Type that best fits. This will be determined by the EMResource Regional Administrator with input from the EMResource Workgroup (when meeting), the Regional Emergency Preparedness Committee (REPC), and the NCTTRAC Emergency Department Operations Committee.

4.2 Region Default View

4.2.1 The Region Default view is the standard view for EMResource in TSA-E. When new users log-in, the Region Default view is the first thing they see. The Region Default view Resource Type structure is listed below.

- Aeromedical
- Z8 – Dallas County Hospitals
- Z7 – Tarrant County Hospitals
- Z6 – Erath County Hospitals
- Z6 – Hood County Hospitals
- Z6 – Johnson County Hospitals
- Z6 – Somervell County Hospitals
- Z5 – Collin County Hospitals
- Z5 – Hunt County Hospitals
- Z5 – Rockwall County Hospitals
- Z4 – Ellis County Hospitals
- Z4 – Kaufman County Hospitals
- Z4 – Navarro County Hospitals
- Z3 – Palo Pinto County Hospitals
- Z3 – Parker County Hospitals
- Z2 – Denton County Hospitals
- Z2 – Wise County Hospitals
- Z1 – Cooke County Hospitals
- Z1 – Fannin County Hospitals
- Z1 – Grayson County Hospitals

4.2.2 The Region Default view Status Types structure is listed below.

4.2.2.1 The “Aeromedical” Resource Type shows the following Status Types as columns on the Region Default view:

- Flight Availability Status
- Comments
- Last Update Time

4.2.2.2 The “County Hospitals” Resource Types show the following Status Types as columns on the Region Default view:

- Facility Type
- Hospital Intake Status
- NEDOCS
- Psych ED Holds
- Transfer Line
- Status: Trauma
- DSHS Trauma Designation
- DSHS Stroke Designation
- Status: 24/7 STEMI

- Status: OB/L&D
- Status: SAFE-Ready
- Status: Bariatric CT/MRI
- Comment

4.3 Resource Detail View

4.3.1 The Resource Detail view shows each status associated with an individual resource. It also shows basic resource information (such as name, point of contact, and address), contains a map that shows the resource's location, and has a list of all users who are associated with that resource.

4.4 Map

4.4.1 The EMResource Map view shows each resource in the system plotted on a map. Events that have been created with addresses will also appear on the map. Users can filter out which resources they want to see using the "Standard Resource Type" filters on the right side of the screen. By default, the TSA-E EMResource Map view shows Aeromedical resources. After setting their own filters, users can then save their map so that those filters appear each time that user opens the map.

4.4.2 Resource icons on the Map change colors based on that resource's current status in their Default Status Type. For example, Aeromedical resource icons will appear green if the unit is "Available At", red if the unit is "Unavailable", and yellow if the unit is "Delayed At" or "Limited Availability".

4.5 Regional Assets View

4.5.1 The Regional Assets view shows the deployment status of each deployable resource that was purchased with HPP funds. The Resource Type and Status Type structures are detailed below.

4.5.1.1 AMBUS

- Deployment Status
- 24/7 Point of Contact
- Comments
- Last Update Time

4.5.1.2 Mass Fatality Trailers

- Deployment Status
- 24/7 Point of Contact
- Comments
- Last Update Time

4.5.1.3 MERC Trailers

- Deployment Status
- 24/7 Point of Contact
- Comments
- Last Update Time

4.6 Custom Views

4.6.1 Each EMResource user has the ability to create a custom view that only applies to their individual user account. Within this custom view, users can decide what resources and what statuses they need to see and organize them in whichever way they see fit. Instructions on how to set up an individual custom view can be found in the "Basic Orientation – Custom Views" video found on the NCTTRAC website at the

following link: https://ncttrac.org/programs/healthcare-coalition-hpp/tsa-e/emcc/crisis-applications/.

4.7 Additional Views

4.7.1 Details regarding additional EMResource views can be found in Section VIII, Additional Views, at the end of this document.

5. Status Types and Definitions

5.1 Healthcare Facilities Status Types

5.1.1 Hospital Intake Status

5.1.1.1 Reflects the current status of a hospital's Emergency Department. Should be updated at least once every 24 hours if the status is "Open" and at least once every 4 hours if the status is "Advisory" or "Closed". Is also used by facilities without Emergency Departments to indicate overall facility status.

5.1.1.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.1.2.1 Open: The ED is open and accepting patients with no limitations.

5.1.1.2.2 Advisory - Capability: Hospital is advising EMS that a primary patient care service is temporarily unavailable and pre-hospital providers should consider patient needs prior to transporting to this facility. Comments are mandatory. This status option must be updated at least once every 4 hours.

5.1.1.2.3 Advisory – Surge: Hospital is advising EMS about a surge-related resource constraint so that EMS can make an informed decision regarding patient destinations. This is the status that hospitals should select if they are dealing with patient numbers that exceed their normal capability. Hospitals can still receive EMS patients. Comments are mandatory. This status option must be updated at least once every 4 hours.

5.1.1.2.4 Closed: The ED is suffering from an internal disaster/facility emergency that is preventing them from safely accepting patients. Examples may include fire, flooding, power outage, water shortage, structural damage, etc. This facility cannot accept EMS patients. This status option is not to be used for patient surge and should not be used to address internal staffing issues. Comments are mandatory. This status option must be updated at least once every 2 hours.

5.1.2 NEDOCS

5.1.2.1 The National Emergency Department Overcrowding Score (NEDOCS) is the global standard for measuring patient throughput, helping hospitals measure capacity and reduce overcrowding. This saturation score takes a variety of factors into account to calculate the final score. Update every 6 hours.

5.1.2.2 Hospitals enter the following factors to calculate their NEDOCS. These variables are defined by the NEDOCS Organization and can be found at the following link: https://www.nedocs.org/News/Article/NEDOCS-Variables-and-Definitions

5.1.2.2.1 Number of ED Patients: The total number of patients in the ED. Includes all patients who have walked in the door, but have not been discharged. Includes patients in the waiting rooms, and waiting admits in the ED.

5.1.2.2.2 Number of ED Admits: Count all admits waiting for a bed in the ED. Patients moved away from ED to inpatient holding areas should not be counted. Count all ED admits/rollovers/holdovers waiting in ED care for an inpatient bed.

5.1.2.2.3 Last Door-to-Bed Time (hours; ex 1.25): Door-to-bed time for the last patient to receive a bed. For example: if you're measuring at 1300 hrs. and the last patient to be placed in a bed was at 1255 hrs, count that patient's door – bed time. When measuring NEDOCS at 1400 hrs, count the person who received the bed last, between 1300 – 1400 hrs. If no one was placed in a bed during 1300 and 1400 hrs, count the patient who received bed at 1255 hrs. Always count the most recent patient's door-bed time. 15 minute increments; for example, enter 2.25 for 2 ¼ hours.

5.1.2.2.4 Number of Critical Care Patients in ED: Count the number of patients in 1:1 care. Includes ventilators, ICU admits, critical care patients, trauma patients, and sometimes includes psych holds. Typically a site specific variable, which should include all patients who require a one-to-one nurse care.

5.1.2.2.5 Longest ED Admit (hours; ex. 1.25): Count the longest holdover, admit waiting for an inpatient bed in the ED. If four patients are waiting for an inpatient bed, count the patient waiting longest. Time to admit starts upon decision to admit. Decision to admit typically a joint decision between ED and admitting physician. 15 minute increments; for example, enter 2.25 for 2 ¼ hours

5.1.2.2.6 Number of ED Beds: Total number of gurneys, chairs, and other treatment benches in use, or staffed. Includes hallways and chairs that are opened up. Do not include un-staffed beds, such as beds in closed areas at night, or un-staffed beds at slow times.

5.1.2.2.7 Number of Inpatient Beds (excluding PEDS and OB): Count all inpatient beds regularly staffed. Can differ from licensed IP beds, if some licensed beds virtually not staffed, or staffed in disaster. Count holding beds, including observation beds.

5.1.2.3 The final NEDOCS falls into one of 5 categories based on severity. These categories and their score ranges are listed below.

- Normal (0 – 50)
- Busy (51 – 100)
- Overcrowded (101 – 140)
- Severe (141 – 180)
- Disaster (181 or higher)

5.1.3 Phone: Emergency Department - the direct phone line to contact this facility's emergency department.

5.1.4 Phone: House Supervisor - the direct phone line to contact this facility's house supervisor.

5.1.5 Command Center Activation Status

5.1.5.1 Reflects the current activation status of a facility's command center. All activations must list a command center point of contact in the comments. Should be updated as needed.

5.1.5.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.5.2.1 Activated: This facility's command center is currently activated. You must list a command center point of contact in the comments. This status option must be updated once every 24 hours.

5.1.5.2.2 Partially Activated: This facility's command center is currently partially activated. You must list a command center point of contact in the comments. This status option must be updated once every 24 hours.

5.1.5.2.3 Not Activated: This facility's command center is currently not activated.

5.1.6 Critical Utilities Availability

5.1.6.1 Reflects the current status of a facility's critical utilities. If a utility failure occurs, specific details must be noted in the comments. Should be updated as needed.

5.1.6.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.6.2.1 Available: This facility has all critical utilities fully available and has no needs.

5.1.6.2.2 Partial Failure: This facility is experiencing a partial utilities failure. Specifics should be noted in the comments. This status option must be updated at least once every 24 hours.

5.1.6.2.3 Total Failure: This facility is experiencing a total utilities failure. Specifics should be noted in the comments. This status option must be updated at least once every 24 hours.

5.1.7 DSHS Maternal Designation

5.1.7.1 Reflects the facility's current DSHS Maternal Level of Care Designation as shown on the DSHS Level of Care Designation list. This status can only be changed by an EMResource Regional Administrator. The EMResource Regional Administrator will validate this status for all facilities on a monthly basis. Facilities should contact support@ncttrac.org if they think that their current designation status is in error.

5.1.7.2 The following status options are available:

- I: Basic
- II: Specialty
- III: Subspecialty
- IV: Comprehensive

5.1.8 DSHS Neonatal Designation

5.1.8.1 Reflects the facility's current DSHS Neonatal Designation as shown on the DSHS Neonatal Designation list. This status can only be changed by an

EMResource Regional Administrator. The EMResource Regional Administrator will validate this status for all facilities on a monthly basis. Facilities should contact support@ncttrac.org if they think that their current designation status is in error.

5.1.8.2 The following status options are available:
- I: Well Nursery
- II: Special Care Nursery
- III: Intensive Care
- IV: Adv. Intensive Care

5.1.9 DSHS Stroke Designation

5.1.9.1 Reflects the facility's current DSHS Stroke Designation as shown on the DSHS Stroke Designation list. This status can only be changed by an EMResource Regional Administrator. The EMResource Regional Administrator will validate this status for all facilities on a monthly basis. Facilities should contact support@ncttrac.org if they think that their current designation status is in error.

5.1.9.2 The following status options are available:
- I: Comprehensive
- II: Primary
- III: Support

5.1.10 DSHS Trauma Designation

5.1.10.1 Reflects the facility's current DSHS Trauma Designation as shown on the DSHS Trauma Designation list. This status can only be changed by an EMResource Regional Administrator. The EMResource Regional Administrator will validate this status for all facilities on a monthly basis. Facilities should contact support@ncttrac.org if they think that their current designation status is in error.

5.1.10.2 The following status options are available:
- I: Comprehensive
- II: Major
- III: Advanced
- IV: Basic

5.1.11 Facility Type

5.1.11.1 Shows the type of facility for each resource. Can only be updated by the EMResource Regional Administrator.

5.1.11.2 The following status options are available:
- General Hospital
- Free-Standing ED
- Psychiatric Facility
- ASC
- Long-Term Acute Care
- Rehab Facility
- Specialty Facility
- Nursing Home
- Assisted Living Facility
- ICF/IID

- Specialty – Pediatric
- Specialty – Cardiac
- Specialty – Orthopedics

5.1.12 Immediate Bed Availability Categories

5.1.12.1 Immediate bed availability categories indicate the current number of available beds of a particular type. In other words, “This is the number of this type of patient that my facility can currently take.”

5.1.12.2 Immediate Bed Availability statuses fall into four categories.

5.1.12.3 Immediate Bed Availability

5.1.12.3.1 IBA: MedSurg Monitored - The number of currently available beds to provide monitored acute care to inpatients.

5.1.12.3.2 IBA: MedSurg Non Monitored - The number of currently available beds to provide non-monitored acute care to inpatients.

5.1.12.3.3 IBA: Pedi Monitored - The number of currently available beds to provide monitored pediatric care to children.

5.1.12.3.4 IBA: Pedi Non Monitored - The number of currently available beds to provide non-monitored pediatric care to children.

5.1.12.3.5 IBA: Adult ICU Monitored - The number of currently available beds to provide monitored care, including ventilator support, for critically injured or ill patients. Specialized support or treatment equipment is available for patients with life-threatening conditions that require intensified comprehensive observation and care.

5.1.12.3.6 IBA: Adult ICU Non Monitored - The number of currently available beds to provide non-monitored care, including ventilator support, for critically injured or ill patients. Specialized support or treatment equipment is available for patients with life-threatening conditions that require intensified comprehensive observation and care.

5.1.12.3.7 IBA: PICU Monitored - The number of currently available beds to provide monitored care, including ventilator support, for critically injured patients under the age of 18 years. Specialized support or treatment equipment is available for patients with life-threatening conditions that require intensified comprehensive observation and care.

5.1.12.3.8 IBA: PICU Non Monitored - The number of currently available beds to provide non-monitored care, including ventilator support, for critically injured patients under the age of 18 years. Specialized support or treatment equipment is available for patients with life-threatening conditions that require intensified comprehensive observation and care.

5.1.12.3.9 IBA: NICU Monitored - The number of currently available beds to provide monitored care for infants requiring sustained life support, conventional ventilation, minor surgical procedures, and severe and complex illnesses.

5.1.12.3.10 IBA: NICU Non Monitored - The number of currently available beds to provide non-monitored care for infants requiring sustained life support, conventional ventilation, minor surgical procedures, and severe and complex illnesses.

5.1.12.3.11 IBA: Burn Monitored - The number of currently available beds to provide monitored care for severely burned patients.

5.1.12.3.12 IBA: Burn Non Monitored - The number of currently available beds to provide non-monitored care for severely burned patients.

5.1.12.3.13 IBA: Neg Pressure ER Beds - Number of currently available beds in the emergency room to provide care for patients where environmental factors (such as air exchanges) are controlled in an effort to minimize the transmission of infectious agents.

5.1.12.3.14 IBA: Neg Pressure Inpatient Beds - Number of currently available beds to provide inpatient care for patients where environmental factors (such as air exchanges) are controlled in an effort to minimize the transmission of infectious agents.

5.1.12.3.15 IBA: Emergency Dept. - Number of currently available beds for the provision of unscheduled outpatient services to patients in need of immediate care. Hospital emergency diagnosis and treatment of illness or injury is provided.

5.1.12.3.16 IBA: Operating Rooms - The number of currently available beds to provide care for patients in equipped and staffed operating rooms. These beds can be made available for patient care in a short period of time.

5.1.12.3.17 IBA: OB Antepartum - The number of currently available beds to provide care to antepartum patients.

5.1.12.3.18 IBA: OB L&D - The number of currently available beds to provide care through all stages of labor and delivery during childbirth.

5.1.12.3.19 IBA: OB Recovery and Postpartum - The number of currently available beds to provide care following childbirth.

5.1.12.4 Immediate Psych Bed Availability

5.1.12.4.1 Psych: Child Male (<=12) - The number of currently available beds to provide inpatient psychiatric services to male patients age 12 and under with acute mental health issues.

5.1.12.4.2 Psych: Child Female (<=12) - The number of currently available beds to provide inpatient psychiatric services to female patients age 12 and under with acute mental health issues.

5.1.12.4.3 Psych: Ado Male (13-17) - The number of currently available beds to provide inpatient psychiatric services to male patients between age 13 and 17 with acute mental health issues.

5.1.12.4.4 Psych: Ado Female (13-17) - The number of currently available beds to provide inpatient psychiatric services to female patients between age 13 and 17 with acute mental health issues.

5.1.12.4.5 Psych: Adult Male (>=18) - The number of currently available beds to provide inpatient psychiatric services to male patients age 18 and older with acute mental health issues.

5.1.12.4.6 Psych: Adult Female (>=18) - The number of currently available beds to provide inpatient psychiatric services to female patients age 18 and over with acute mental health issues.

5.1.12.4.7 Psych: Chem Dep Male - The number of currently available beds to provide inpatient psychiatric services to male patients with chemical dependencies.

5.1.12.4.8 Psych: Chem Dep Female - The number of currently available beds to provide inpatient psychiatric services to female patients with chemical dependencies.

5.1.12.4.9 Psych: Older Adult Male - The number of currently available beds to provide inpatient psychiatric services to older adult male patients with acute mental health issues.

5.1.12.4.10 Psych: Older Adult Female - The number of currently available beds to provide inpatient psychiatric services to older adult female patients with acute mental health issues.

5.1.12.4.11 Psych: Total Beds - The total number of currently available beds to provide inpatient psychiatric services to all patient demographics.

5.1.12.5 MCI Bed Availability

5.1.12.5.1 MCI Green - The facility's capacity for additional victims with minor needs.

5.1.12.5.2 MCI Yellow - The facility's capacity for additional victims with delayed needs.

5.1.12.5.3 MCI Red - The facility's capacity for additional victims with immediate needs.

5.1.12.5.4 MCI Gray - The facility's capacity for additional MCI Gray victims with urgent needs.

5.1.12.5.5 MCI Black - The facility's capacity for additional deceased victims.

5.1.12.6 Ventilator Availability

5.1.12.6.1 Adult & Pedi Vents - The number of ventilators that may be used for adult OR pediatric patients that are present in the institution but are currently not in use and could be supported by currently available staff.

5.1.12.6.2 Adult Only Vents - The number of ventilators that may be used for adult patients ONLY that are present in this institution but are currently not in use and could be supported by currently available staff.

5.1.12.6.3 Pedi Only Vents - The number of ventilators that may be used for pediatric patients ONLY that are present in the institution but are currently not in use and could be supported by currently available staff.

5.1.13 NICU Transfer Line
- 5.1.13.1 Shows the phone number to call if you need to transfer a NICU patient to this facility.
- 5.1.13.2 This is a text-entry field.

5.1.14 OB Transfer Line
- 5.1.14.1 Shows the phone number to call if you need to transfer an OB patient to this facility.
- 5.1.14.2 This is a text-entry field.

5.1.15 Psych ED Holds
- 5.1.15.1 Reflects the current number of psych holds in a facility's emergency department. Psych holds are defined as patients who have undergone a medical screening exam and mental health evaluation and are awaiting transfer or admission for inpatient psychiatric care.
- 5.1.15.2 This status is a numeric entry field.
- 5.1.15.3 The "Psych ED Holds" status should be updated at least once every 24 hours. It will be marked "Overdue" after 24 hours without an update.

5.1.16 Psych: Adult
- 5.1.16.1 Reflects the current status of a facility's ability to provide inpatient adult psychiatric services. Should be updated as needed.
- 5.1.16.2 Facilities can select from the following status options. Definitions for each status option are provided.
  - 5.1.16.2.1 Available: This facility currently has inpatient adult psychiatric availability.
  - 5.1.16.2.2 Unavailable: This facility temporarily has no inpatient adult psychiatric availability. Comments are mandatory. This status option must be updated every 4 hours.
  - 5.1.16.2.3 Not Provided: This facility does not provide inpatient adult psychiatric services.

5.1.17 Psych: Adolescent
- 5.1.17.1 Reflects the current status of a facility's ability to provide inpatient adolescent psychiatric services. Should be updated as needed.
- 5.1.17.2 Facilities can select from the following status options. Definitions for each status option are provided.
  - 5.1.17.2.1 Available: This facility currently has inpatient adolescent psychiatric availability.
  - 5.1.17.2.2 Unavailable: This facility temporarily has no inpatient adolescent psychiatric availability. Comments are mandatory. This status option must be updated every 4 hours.
  - 5.1.17.2.3 Not Provided: This facility does not provide inpatient adolescent psychiatric services.

5.1.18 Psych: Pediatric

5.1.18.1 Reflects the current status of a facility's ability to provide inpatient pediatric psychiatric services. Should be updated as needed.

5.1.18.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.18.2.1 Available: This facility currently has inpatient pediatric psychiatric availability.

5.1.18.2.2 Unavailable: This facility temporarily has no inpatient pediatric psychiatric availability. Comments are mandatory. This status option must be updated every 4 hours.

5.1.18.2.3 Not Provided: This facility does not provide inpatient pediatric psychiatric services.

5.1.19 Psych: Adult Chem. Dep.

5.1.19.1 Reflects the current status of a facility's ability to provide inpatient adult chemical dependency psychiatric services. Should be updated as needed.

5.1.19.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.19.2.1 Available: This facility currently has inpatient adult chemical dependency psychiatric availability.

5.1.19.2.2 Unavailable: This facility temporarily has no inpatient adult chemical dependency psychiatric availability. Comments are mandatory. This status option must be updated every 4 hours.

5.1.19.2.3 Not Provided: This facility does not provide inpatient adult chemical dependency psychiatric services.

5.1.20 Psych: Adolescent Chem. Dep.

5.1.20.1 Reflects the current status of a facility's ability to provide inpatient adolescent chemical dependency psychiatric services. Should be updated as needed.

5.1.20.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.20.2.1 Available: This facility currently has inpatient adolescent chemical dependency psychiatric availability.

5.1.20.2.2 Unavailable: This facility temporarily has no inpatient adolescent chemical dependency psychiatric availability. Comments are mandatory. This status option must be updated every 4 hours.

5.1.20.2.3 Not Provided: This facility does not provide inpatient adolescent chemical dependency psychiatric services.

5.1.21 Service: Neonatal Transport

5.1.21.1 Reflects the current status of a facility's ability to provide Neonatal Transport services. Should be updated as needed.

5.1.21.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.21.2.1 Available: This facility can currently provide Neonatal Transport services.

5.1.21.2.2 Unavailable: This facility is temporarily unable to provide Neonatal Transport services. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.21.2.3 Not Provided: This facility does not provide Neonatal Transport services.

5.1.22 Service: OB Transport
5.1.22.1 Reflects the current status of a facility's ability to provide OB Transport services. Should be updated as needed.
5.1.22.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.22.2.1 Available: This facility can currently provide OB Transport services.
5.1.22.2.2 Unavailable: This facility is temporarily unable to provide OB Transport services. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.22.2.3 Not Provided: This facility does not provide OB Transport services.

5.1.23 Status: 24/7 STEMI
5.1.23.1 Reflects the current status of a facility's ability to provide 24/7 STEMI services. Does not show any accreditations. Should be updated as needed.
5.1.23.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.23.2.1 Available: This facility can currently provide 24/7 STEMI services.
5.1.23.2.2 Unavailable: This facility is temporarily unable to provide 24/7 STEMI services. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.23.2.3 Not Provided: This facility does not provide 24/7 STEMI services.

5.1.24 Status: Anti-Venom
5.1.24.1 Reflects the current status of a facility's ability to provide Anti-Venom services. Should be updated as needed.
5.1.24.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.24.2.1 Available: This facility can currently provide Anti-Venom services.
5.1.24.2.2 Unavailable: This facility is temporarily unable to provide Anti-Venom services. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.24.2.3 Not Provided: This facility does not provide Anti-Venom services.

5.1.25 Status: Bariatric CT/MRI
5.1.25.1 Reflects the current status of a facility's ability to provide Bariatric CT/MRI services. Should be updated as needed.

5.1.25.2 Facilities can select from the following status options. Definitions for each status option are provided.
- 5.1.25.2.1 Available: This facility can currently provide Bariatric CT/MRI services.
- 5.1.25.2.2 Unavailable: This facility is temporarily unable to provide Bariatric CT/MRI services. Comments are mandatory. This status option must be updated at least once every 4 hours.
- 5.1.25.2.3 Not Provided: This facility does not provide Bariatric CT/MRI services.

5.1.26 Status: Burn
- 5.1.26.1 Reflects the current status of a facility's ability to provide burn services. Should be updated as needed.
- 5.1.26.2 Facilities can select from the following status options. Definitions for each status option are provided.
  - 5.1.26.2.1 Available: This facility can currently provide Burn services.
  - 5.1.26.2.2 Unavailable: This facility is temporarily unable to provide Burn services. Comments are mandatory. This status option must be updated at least once every 4 hours.
  - 5.1.26.2.3 Not Provided: This facility does not provide Burn services.

5.1.27 Status: ECMO
- 5.1.27.1 Reflects the current status of a facility's ability to provide Extracorporeal Membrane Oxygenation (ECMO) services. Should be updated as needed.
- 5.1.27.2 Facilities can select from the following status options. Definitions for each status option are provided.
  - 5.1.27.2.1 Available - Adult: This facility can currently provide Adult ECMO services.
  - 5.1.27.2.2 Available – Pedi/NICU: This facility can currently provide Pediatric and Neonatal ECMO services.
  - 5.1.27.2.3 Available – All Ages: This facility can currently provide Adult, Pediatric, and Neonatal ECMO services.
  - 5.1.27.2.4 Unavailable: This facility is temporarily unable to provide ECMO services. Comments are mandatory. This status option must be updated at least once every 4 hours.
  - 5.1.27.2.5 Not Provided: This facility does not provide ECMO services.

5.1.28 Status: Hand
- 5.1.28.1 Reflects the current status of a facility's ability to provide Hand services. Should be updated as needed.
- 5.1.28.2 Facilities can select from the following status options. Definitions for each status option are provided.
  - 5.1.28.2.1 Available: This facility can currently provide Hand services.
  - 5.1.28.2.2 Unavailable: This facility is temporarily unable to provide Hand services. Comments are mandatory. This status option must be updated at least once every 4 hours.
  - 5.1.28.2.3 Not Provided: This facility does not provide Hand services.

5.1.29 Status: Hyperbaric Chamber

5.1.29.1 Reflects the current status of a facility's ability to provide Hyperbaric Chamber services. Should be updated as needed.
5.1.29.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.29.2.1 Available: This facility can currently provide Hyperbaric Chamber services.
5.1.29.2.2 Unavailable: This facility is temporarily unable to provide Hyperbaric Chamber services. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.29.2.3 Not Provided: This facility does not provide Hyperbaric Chamber services.

5.1.30 Status: ICU
5.1.30.1 Reflects the current status of a facility's Intensive Care Unit. Should be updated as needed.
5.1.30.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.30.2.1 Available: This facility's ICU is currently fully operational.
5.1.30.2.2 Unavailable: This facility's ICU is temporarily unavailable. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.30.2.3 Not Provided: This facility does not provide ICU services.

5.1.31 Status: MedSurg
5.1.31.1 Reflects the current status of a facility's ability to provide Medical/Surgical beds. .
5.1.31.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.31.2.1 Available: This facility can currently provide Med/Surg beds.
5.1.31.2.2 Unavailable: This facility is temporarily unable to provide Med/Surge beds.
5.1.31.2.3 Not Provided: This facility does not provide Med/Surg beds.

5.1.32 Status: NICU
5.1.32.1 Reflects the current status of a facility's Neonatal Intensive Care Unit. Should be updated as needed.
5.1.32.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.32.2.1 Available: This facility's NICU is currently fully operational.
5.1.32.2.2 Unavailable: This facility's NICU is temporarily unavailable. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.32.2.3 Not Provided: This facility does not provide NICU services.

5.1.33 Status: OB/L&D
5.1.33.1 Reflects the current status of a facility's ability to provide OB/L&D services. Should be updated as needed.
5.1.33.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.33.2.1 Available: This facility can currently provide OB/L&D services.
5.1.33.2.2 Unavailable: This facility is temporarily unable to provide OB/L&D services. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.33.2.3 Not Provided: This facility does not provide OB/L&D services.

5.1.34 Status: OR
5.1.34.1 Reflects the current status of a facility's operating rooms. Should be updated as needed.
5.1.34.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.34.2.1 Available: This facility's OR(s) are currently fully operational.
5.1.34.2.2 Unavailable: This facility's OR(s) are temporarily unavailable. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.34.2.3 Not Provided: This facility does not provide OR services.

5.1.35 Status: Oral/Maxillofacial
5.1.35.1 Reflects the current status of a facility's ability to provide Oral/Maxillofacial services. Should be updated as needed.
5.1.35.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.35.2.1 Available: This facility can currently provide Oral/Maxillofacial services.
5.1.35.2.2 Unavailable: This facility is temporarily unable to provide Oral/Maxillofacial services. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.35.2.3 Not Provided: This facility does not provide Oral/Maxillofacial services.

5.1.36 Status: PICU
5.1.36.1 Reflects the current status of a facility's Pediatric Intensive Care Unit. Should be updated as needed.
5.1.36.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.36.2.1 Available: This facility's PICU is currently fully operational.
5.1.36.2.2 Unavailable: This facility's PICU is temporarily unavailable. Comments are mandatory. This status option must be updated at least once every 4 hours.
5.1.36.2.3 Not Provided: This facility does not provide PICU services.

5.1.37 Status: Replant
5.1.37.1 Reflects the current status of a facility's ability to provide Replant services. Should be updated as needed.
5.1.37.2 Facilities can select from the following status options. Definitions for each status option are provided.
5.1.37.2.1 Available: This facility can currently provide Replant services.
5.1.37.2.2 Unavailable: This facility is temporarily unable to provide Replant services. Comments are mandatory. This status option must be updated at least once every 4 hours.

5.1.37.2.3 Not Provided: This facility does not provide Replant services

5.1.38 Status: SAFE-Ready

5.1.38.1 Reflects the current status of a facility's ability to provide Sexual Assault Forensic Evidence collection services. DSHS defines a SAFE-Ready facility as "A SAFE-Ready facility uses a certified sexual assault nurse examiner or a physician with specialized training to conduct a forensic medical examination of a sexual assault survivor, or uses telemedicine to consult with a system of sexual assault forensic examiners, regardless of whether a report to law enforcement is made." Should be updated as needed.

5.1.38.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.38.2.1 Available: This facility can currently provide SAFE-Ready services.

5.1.38.2.2 Unavailable: This facility is temporarily unable to provide SAFE-Ready services. Comments are mandatory. This status option must be updated at least once every 4 hours.

5.1.38.2.3 Not Provided: This facility does not provide SAFE-Ready services.

5.1.39 Status: Stroke General Service

5.1.39.1 Reflects the current status of a facility's ability to provide general stroke services. Should be updated as needed. Does not reflect DSHS designation status.

5.1.39.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.39.2.1 Available: This facility can currently provide general stroke services.

5.1.39.2.2 Unavailable: This facility is temporarily unable to provide general stroke services. Comments are mandatory. This status option must be updated at least once every 4 hours.

5.1.39.2.3 Not Provided: This facility does not provide general stroke services.

5.1.40 Status: Stroke NeuroIR

5.1.40.1 Reflects the current status of a facility's ability to provide NeuroIR services. Can only be updated by Level I (Comprehensive) designated facilities. Should be updated as needed.

5.1.40.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.40.2.1 Available: This facility can currently provide NeuroIR services.

5.1.40.2.2 Unavailable: This facility is temporarily unable to provide NeuroIR services. Comments are mandatory. This status option must be updated at least once every 4 hours.

5.1.40.2.3 Not Provided: This facility does not provide NeuroIR services.

5.1.41 Status: Stroke NeuroSurg

5.1.41.1 Reflects the current status of a facility's ability to provide NeuroSurg services. Can only be updated by Level I (Comprehensive), Level II

(Primary), or Level III (Support) designated facilities. Should be updated as needed.

5.1.41.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.41.2.1 Available: This facility can currently provide NeuroSurg services.

5.1.41.2.2 Unavailable: This facility is temporarily unable to provide NeuroSurg services. Comments are mandatory. This status option must be updated at least once every 4 hours.

5.1.41.2.3 Not Provided: This facility does not provide NeuroSurg services.

5.1.42 Status: Trauma

5.1.42.1 Reflects the current status of a facility's ability to provide Trauma Surgery services.

5.1.42.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.42.2.1 Available: This facility can currently provide Trauma Surgery services.

5.1.42.2.2 Unavailable: This facility is temporarily unable to provide Trauma Surgery services. Comments are mandatory. This status option must be updated at least once every 4 hours.

5.1.42.2.3 Not Provided: This facility does not provide Trauma Surgery services.

5.1.43 Status: Therapeutic Hypothermia

5.1.43.1 Reflects the current status of a facility's ability to provide Therapeutic Hypothermia services. Should be updated as needed.

5.1.43.2 Facilities can select from the following status options. Definitions for each status option are provided.

5.1.43.2.1 Available - Adult: This facility can currently provide Adult Therapeutic Hypothermia services.

5.1.43.2.2 Available – NICU: This facility can currently provide Neonatal Therapeutic Hypothermia services.

5.1.43.2.3 Available – Adult/NICU: This facility can currently provide Adult and Neonatal Therapeutic Hypothermia services.

5.1.43.2.4 Unavailable: This facility is temporarily unable to provide Therapeutic Hypothermia services. Comments are mandatory. This status option must be updated at least once every 4 hours.

5.1.43.2.5 Not Provided: This facility does not provide Therapeutic Hypothermia services.

5.1.44 Transfer Line

5.1.44.1 Shows the phone number to call if you need to transfer a patient to this facility.

5.1.44.2 This is a text-entry field.

5.2 EMS/FRO Status Types

5.2.1 Agency Type

5.2.1.1 Shows the type of agency for each resource. Can only be updated by the EMResource Regional Administrator. Agencies should contact support@ncttrac.org if their agency type is in error.
5.2.1.2 The following status options are available.
5.2.1.2.1 FD EMS
5.2.1.2.2 VFD
5.2.1.2.3 Private EMS
5.2.1.2.4 Hospital EMS
5.2.1.2.5 Public EMS
5.2.1.2.6 Other

5.2.2 Dispatch Number
5.2.2.1 Shows the non-emergency phone number to contact this agency's dispatch center. Should be updated as needed.
5.2.2.2 This status is updated using a text entry field.

5.2.3 EMS Medical Director
5.2.3.1 Shows the current EMS Medical Director for the agency. Please list a contact phone number in the comments. Should be updated as needed
5.2.3.2 This status is updated using a text entry field.

5.2.4 Service: 911 EMS Response
5.2.4.1 Reflects the current status of an agency's ability to perform 911 EMS response. Should be updated as needed.
5.2.4.2 Agencies can select from the following status options. Definitions for each status option are provided.
5.2.4.2.1 Available: This agency can currently perform 911 EMS response.
5.2.4.2.2 Unavailable: This agency is temporarily unable to perform 911 EMS response. This status option must be updated at least once every 4 hours. Comments are mandatory.
5.2.4.2.3 Not Provided: This agency does not perform 911 EMS response.

5.2.5 Service: Critical Care Transport
5.2.5.1 Reflects the current status of an agency's ability to perform Critical Care Transport services. Should be updated as needed.
5.2.5.2 Agencies can select from the following status options. Definitions for each status option are provided.
5.2.5.2.1 Available: This agency can currently perform Critical Care Transport services.
5.2.5.2.2 Unavailable: This agency is temporarily unable to perform Critical Care Transport services. This status option must be updated at least once every 4 hours. Comments are mandatory.
5.2.5.2.3 Not Provided: This agency does not provide Critical Care Transport services.

5.2.6 Service: HazMat Response
5.2.6.1 Reflects the current status of an agency's ability to perform Hazardous Materials Response operations. Should be updated as needed.
5.2.6.2 Agencies can select from the following status options. Definitions for each status option are provided.

5.2.6.2.1 Available: This agency can currently perform Hazardous Materials Response operations.
5.2.6.2.2 Unavailable: This agency is temporarily unable to perform Hazardous Materials Response operations. This status option must be updated at least once every 4 hours. Comments are mandatory.
5.2.6.2.3 Not Provided: This agency does not have the capability to perform Hazardous Materials Response operations.

5.2.7 Service: HCID Response
5.2.7.1 Reflects the current status of an agency's ability to perform High Consequence Infections Disease (HCID) Response operations. Should be updated as needed.
5.2.7.2 Agencies can select from the following status options. Definitions for each status option are provided.
5.2.7.2.1 Available: This agency can currently perform HCID response operations.
5.2.7.2.2 Unavailable: This agency is temporarily unable to perform HCID response operations. This status option must be updated at least once every 4 hours. Comments are mandatory.
5.2.7.2.3 Not Provided: This agency does not have the capability to perform HCID response operations.

5.2.8 Service: High Angle Rescue
5.2.8.1 Reflects the current status of an agency's ability to perform High Angle Rescue operations. Should be updated as needed.
5.2.8.2 Agencies can select from the following status options. Definitions for each status option are provided.
5.2.8.2.1 Available: This agency can currently perform High Angle Rescue operations.
5.2.8.2.2 Unavailable: This agency is temporarily unable to perform High Angle Rescue operations. This status option must be updated at least once every 4 hours. Comments are mandatory.
5.2.8.2.3 Not Provided: This agency does not have the capability to perform High Angle Rescue operations.

5.2.9 Service: Hospital Patient Transfers
5.2.9.1 Reflects the current status of an agency's ability to perform hospital patient transfers. Should be updated as needed.
5.2.9.2 Agencies can select from the following status options. Definitions for each status option are provided.
5.2.9.2.1 Available: This agency can currently perform hospital patient transfers.
5.2.9.2.2 Unavailable: This agency is temporarily unable to perform hospital patient transfers. This status option must be updated at least once every 4 hours. Comments are mandatory.
5.2.9.2.3 Not Provided: This agency does not perform hospital patient transfers.

5.2.10 Service: Swift Water Rescue

5.2.10.1 Reflects the current status of an agency's ability to perform Swift Water Rescue operations. Should be updated as needed.

5.2.10.2 Agencies can select from the following status options. Definitions for each status option are provided.

5.2.10.2.1 Available: This agency can currently perform Swift Water Rescue operations.

5.2.10.2.2 Unavailable: This agency is temporarily unable to perform Swift Water Rescue operations. This status option must be updated at least once every 4 hours. Comments are mandatory.

5.2.10.2.3 Not Provided: This agency does not have the capability to perform Swift Water Rescue operations.

5.2.11 Service: Trench Rescue/Recovery

5.2.11.1 Reflects the current status of an agency's ability to perform Trench Rescue/Recovery operations. Should be updated as needed.

5.2.11.2 Agencies can select from the following status options. Definitions for each status option are provided.

5.2.11.2.1 Available: This agency can currently perform Trench Rescue/Recovery operations.

5.2.11.2.2 Unavailable: This agency is temporarily unable to perform Trench Rescue/Recovery operations. This status option must be updated at least once every 4 hours. Comments are mandatory.

5.2.11.2.3 Not Provided: This agency does not have the capability to perform Trench Rescue/Response operations.

5.2.12 Vehicle: Bariatric

5.2.12.1 Reflects the current status of an agency's ability to provide specialty bariatric vehicles. Non-emergency contact information for these vehicles should be listed in the comments.

5.2.12.2 Agencies can select from the following status options. Definitions for each status option are provided.

5.2.12.2.1 Available: This agency has a currently available specialty bariatric vehicle. Please list non-emergency contact information for this vehicle in the comments.

5.2.12.2.2 Unavailable: This agency's specialty bariatric vehicle is temporarily unavailable. This status option must be updated at least once every 4 hours. Comments are mandatory.

5.2.12.2.3 Not Provided: This agency does not have a specialty bariatric vehicle.

5.2.13 Vehicle: Mobile Command Center

5.2.13.1 Reflects the current status of an agency's ability to provide a mobile command center. Non-emergency contact information for this asset should be listed in the comments.

5.2.13.2 Agencies can select from the following status options. Definitions for each status option are provided.

5.2.13.2.1 Available: This agency has a currently available mobile command center. Please list non-emergency contact information for this vehicle in the comments.
5.2.13.2.2 Unavailable: This agency's mobile command center is temporarily unavailable. This status option must be updated at least once every 4 hours. Comments are mandatory.
5.2.13.2.3 Not Provided: This agency does not have a mobile command center.

5.2.14 Vehicle: Other
5.2.14.1 Lists any other specialty vehicles that an agency might have. The agency should list both the specialty vehicle and the non-emergency contact information for that vehicle.
5.2.14.2 This status is updated by a text entry field.

5.3 Other Status Types
5.3.1 24/7 Point of Contact
5.3.1.1 Shows the 24/7 Point of Contact for a deployable asset. Should be updated as needed.
5.3.1.2 This status is updated using a text entry field.
5.3.2 Deployment Status
5.3.2.1 Reflects the current deployment status of a regional deployable asset. Should be updated as needed.
5.3.2.2 Asset hosts can select from the following status options. Definitions for each status option are provided.
5.3.2.2.1 Demobilized: This asset has been demobilized from a deployment.
5.3.2.2.2 Deployed: This asset is currently deployed. Comments are mandatory.
5.3.2.2.3 In Rehab: This asset is currently in rehab from a deployment.
5.3.2.2.4 Mission Capable: This asset is currently capable of deployment.
5.3.2.2.5 On Alert: This asset is currently on alert in anticipation of a potential deployment.
5.3.2.2.6 Out of Service: This asset is currently out of service. Comments are mandatory.
5.3.2.2.7 Partially Capable: This asset is currently partially capable of deployment. Comments are mandatory.
5.3.3 Flight Availability Status
5.3.3.1 Reflects the current status of an air medical unit's availability to respond to calls. For most air medical providers, this status is automatically updated using an API from the air medical provider's CAD system into EMResource.
5.3.3.2 Air medical units can select from the following status options. Definitions for each status option are provided.
5.3.3.2.1 Delayed At: This aircraft is delayed. Enter location/time/weather in comments.
5.3.3.2.2 Unavailable: This aircraft is unavailable. Enter location/maintenance in comments.
5.3.3.2.3 Available At: This aircraft is available. Enter location in comments.
5.3.3.2.4 Limited Availability: This aircraft's availability is limited.

5.3.4 Point of Contact Verified
5.3.4.1 Shows the date that a facility/organization last verified that its Point of Contact in EMResource was correct.
5.3.4.2 This is a text entry field.

6. System Performance Improvement Metrics and Indicators

6.1 Regional
6.1.1 TSA-E uses the following Performance Metrics and Indicators to measure overall EMResource utilization success.
6.1.1.1 At least 75% of hospitals update their Hospital Intake Status at least once every 24 hours 80% of the time. Tracked monthly using EMResource reports. Report will be sent to ED Operations Committee, Trauma Committee, and NCTTRAC Zones.
6.1.1.2 At least 75% of hospitals update their NEDOCS at least once every 6 hours. Tracked monthly using EMResource reports. Report will be sent to ED Operations Committee, Trauma Committee, and NCTTRAC Zones.
6.1.1.3 At least 75% of hospitals update their Psych ED Holds at least once every 6 hours. Tracked monthly using EMResource reports. Report will be sent to ED Operations Committee, Mental Health Workgroup, and NCTTRAC Zones.
6.1.1.4 At least 75% of hospitals and special facilities update their available bed numbers at least once every 24 hours. Tracked monthly. Report will be sent to ED Operations Committee, REPC, and NCTTRAC Zones.
6.1.1.5 At least 75% of hospitals, special facilities, and EMS agencies update their EMResource point of contact at least once per year. Tracked annually using Status Type “Point of Contact Verified”.
6.1.1.6 At least 75% of hospitals, special facilities, and EMS agencies review their associated users list and send necessary changes to NCTTRAC at least once per year. Tracked annually using NCTTRAC email records.
6.1.1.7 At least 75% of EMS agencies monitor EMResource for status changes via active monitoring or status change notifications. Tracked annually via regional survey.

6.2 Hospitals
6.2.1 TSA-E uses the following Performance Metrics and Indicators to measure individual healthcare facility EMResource utilization success.
6.2.1.1 Hospital updates its Hospital Intake Status at least once every 24 hours 80% of the time. Tracked monthly using EMResource reports.
6.2.1.2 Hospital updates its NEDOCS at least once every 6 hours. Tracked monthly using EMResource reports.
6.2.1.3 Hospital updates its Psych ED Holds status at least once every 6 hours. Tracked monthly using EMResource reports.
6.2.1.4 Facility updates its available bed numbers at least once every 24 hours. Tracked monthly using EMResource reports.
6.2.1.5 Facility has at least one person with EMResource access on-site 80% of the time. Tracked annually via regional survey.
6.2.2 EMS

6.2.2.1 TSA-E uses the following Performance Metrics and Indicators to measure individual EMS Agency EMResource utilization success.
6.2.2.1.1 EMS Agency monitors EMResource for status changes via active monitoring or status change notifications. Tracked annually via regional survey.
6.2.2.1.2 EMS Agency has at least one person with EMResource access on-shift 80% of the time. Tracked annually using regional survey.

7. Accountability

7.1. NCTTRAC staff will run monthly reports on update frequency and make available to NCTTRAC Committees. Frequent non-compliance will prompt informal follow-up by NCTTRAC staff; continued non-compliance will prompt review by SPI/related committee. Further actions against non-compliant organizations to be determined by SPI/related committee and pushed to NCTTRAC Board of Directors for action.

8. Additional Views

8.1 Clinical Views
8.1.1 TSA-E: Pediatric
8.1.1.1 Shows all County – Hospitals and County – Special Facilities Resource Types
8.1.1.2 Shows the following status types:
- Hospital Intake Status
- Transfer Line
- IBA: Pedi Monitored
- IBA: Pedi Non Monitored
- IBA: PICU Monitored
- IBA: PICU Non Monitored
- Pedi Only Vents

8.1.2 TSA-E: Perinatal
8.1.2.1 Shows all County – Hospitals and County – Special Facilities Resource Types.
8.1.2.2 Shows the following status types:
- Hospital Intake Status
- DSHS Maternal Designation
- OB Transfer Line
- Service: OB Transport
- Status: OB/L&D
- IBA: OB Antepartum
- IBA: OB L&D
- IBA: OB Recovery and Postpartum
- DSHS Neonatal Designation
- NICU Transfer Line
- Service: Neonatal Transport
- Status: NICU
- Status: ECMO
- Status: Therapeutic Hypothermia

- IBA: NICU Monitored
- IBA: NICU Non Monitored

8.1.3 TSA-E: Psych

8.1.3.1 Shows all County – Hospitals and County – Special Facilities Resource Types with licensed psych beds.

8.1.3.2 Shows the following status types:

- Hospital Intake Status
- Psych ED Holds
- Psych: Pediatric
- Psych: Adolescent
- Psych: Adult
- Psych: Adolescent Chem. Dep.
- Psych: Adult Chem. Dep.
- Psych: Child Male (<=12)
- Psych: Child Female (<=12)
- Psych: Ado Male (13-17)
- Psych: Ado Female (13-17)
- Psych: Adult Male (>=18)
- Psych: Adult Female (>=18)
- Psych: Older Adult Male
- Psych: Older Adult Female
- Psych: Chem Dep Male
- Psych: Chem Dep Female
- Psych: Total Beds

8.1.4 TSA-E: Stroke

8.1.4.1 Shows all County – Hospitals and County – Special Facilities Resource Types.

8.1.4.2 Shows the following status types:

- Hospital Intake Status
- NEDOCS
- DSHS Stroke Designation
- Status: Stroke General Service
- Status: Stroke NeuroIR
- Status: Stroke NeuroSurg

8.1.5 TSA-E: Trauma

8.1.5.1 Shows all County – Hospitals and County – Special Facilities Resource Types.

8.1.5.2 Shows the following status types:

- Hospital Intake Status
- NEDOCS
- DSHS Trauma Designation
- Transfer Line
- Status: Anti-Venom
- Status: Burn
- Status: Hyperbaric Chamber
- Status: ICU

- Status: OR
- Status: Oral/Maxillofacial
- Status: Replant
- Status: Hand
- Status: ECMO
- Status: SAFE-Ready
- Status: Therapeutic Hypothermia

8.2 Zone Views

- Z8 – Dallas
- Z7 – Tarrant
- Z6 – Erath Hood Johnson S-vell
- Z5 – Collin, Hunt, Rockwall
- Z4 – Ellis, Kaufman, Navarro
- Z3 – Parker, Palo Pinto
- Z2 – Denton, Wise
- Z1 – Cooke, Fannin, Grayson

8.2.1 All zone views will contain the County – Hospitals, County – Special Facilities, County – EMS Agencies, and County – FROs located within the identified zone.

8.2.2 Individual zones will eventually have the opportunity to customize their specific zone view. Currently, all zone views have the same status types:

- Facility Type
- Hospital Intake Status
- NEDOCS
- IBA: Emergency Dept
- Psych ED Holds
- Psych: Total Beds
- Transfer Line
- MCI Green
- MCI Red
- MCI Yellow

8.3 Disaster Views

8.3.1 TSA-E: Bed Availability

8.3.1.1 Shows all County – Hospitals and County – Special Facilities Resource Types

8.3.1.2 Shows the following status types:

- IBA: MedSurg Monitored
- IBA: MedSurg Non Monitored
- IBA: Pedi Monitored
- IBA: Pedi Non Monitored
- IBA: Adult ICU Monitored
- IBA: Adult ICU Non Monitored
- IBA: PICU Monitored
- IBA: PICU Non Monitored
- IBA: NICU Monitored
- IBA: NICU Non Monitored
- IBA: Burn Monitored
- IBA: Burn Non Monitored

- IBA: Neg Pressure ER Beds
- IBA: Neg Pressure Inpatient Beds
- IBA: Emergency Dept
- IBA: Operating Rooms
- IBA: OB Antepartum
- IBA: OB L&D
- IBA: OB Recovery and Postpartum
- Adult & Pedi Vents
- Adult Only Vents
- Pedi Only Vents

8.3.2 TSA-E: Facility EM
8.3.2.1 Shows all County – Hospitals and County – Special Facilities Resource Types
8.3.2.2 Shows the following status types:
- Hospital Intake Status
- Command Center Activation Status
- Critical Utilities Availability

8.3.3 TSA-E: MCI Beds
8.3.3.1 Shows all County – Hospitals and County – Special Facilities Resource Types
8.3.3.2 Shows the following status types:
- MCI Green
- MCI Yellow
- MCI Red
- MCI Gray
- MCI Black
- DSHS Trauma Designation
- Hospital Intake Status

8.4 Resource Type Views
- TSA-E: EMS Agencies
- TSA-E: FROs
- TSA-E: LTC Facilities
- TSA-E: Specialty Facilities

8.5 Position-Specific Views
8.5.1 EMS/ED (Default View for ED Staff and EMS users)
- Hospital Intake Status
- NEDOCS
- Psych ED Holds
- Status: Trauma
- DSHS Trauma Designation
- DSHS Stroke Designation
- Status: 24/7 STEMI
- Status: OB/L&D
- Status: SAFE-Ready
- MCI: Green, Yellow, Red, Black
- Helipad

8.5.2 Transfer Centers (Default View for Transfer Center users)
8.5.2.1 Statuses to be determined

NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

20220 Regional Acute Coronary Syndrome (ACS) System Plan

Endorsed by NCTTRAC Board of Directors
Date: Pending~~February 11, 2020~~

Approved by NCTTRAC General Membership
Date: Pending~~March 23, 2020~~

Supersedes Regional ACS System Plan Date: March 23, 2020

600 Six Flags Drive
Suite 160
Arlington, TX 76011
Phone: 817-608-0390
Fax: 817-608-0399

www.NCTTRAC.org

NCTTRAC serves the counties of Cooke, Fannin, Grayson, Denton, Wise, Parker, Palo Pinto, Ellis, Kaufman, Navarro, Collin, Hunt, Rockwall, Erath, Hood, Johnson, Somervell, Tarrant, and Dallas.

Any questions and/or suggested changes to this document should be sent to:

Cardiac Committee Chair
600 Six Flags Drive, Suite 160
Arlington, TX 76011

817.608.0390
Admin@NCTTRAC.org

APPROVAL AND IMPLEMENTATION

This plan applies to all counties within Trauma Service Area (TSA) E. TSA-E includes Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise counties.

This plan is hereby approved for implementation and supersedes all previous editions.

_____ _____
Secretary Date

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RECORD OF CHANGES

The North Central Texas Trauma Regional Advisory Council ensures that necessary changes and revisions to The Regional Acute Coronary ~~System~~ Syndrome (ACS) System Plan are prepared, coordinated, published, and distributed.

The plan will undergo updates and revisions:

- On an annual basis to incorporate significant changes that may have occurred;
- When there is a critical change in the definition of assets, systems, networks or functions that provide to reflect the implications of those changes;
- When new methodologies and/or tools are developed; and
- To incorporate new initiatives.

The Regional ACS System~~ACS~~ Plan revised copies will be dated and marked to show where changes have been made.

"Record of Changes" form is found on the following page.

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RECORD OF CHANGES

This section describes changes made to this document. Use this table to record:

- Location within document (i.e. page #, section #, etc)
- Change Number, in sequence, beginning with 1
- Date the change was made to the document
- Description of the change and rationale if applicable
- Name of the person who recorded the change

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Article/Section	Date of Change	Summary of Changes	Change Made by (Print Name)
All~~3.1.2~~	~~11/13/2019~~7/7/2021	~~Verbiage changed regarding PCI capabilities to include yes/no and with/without PCI~~Changed dates to reflect FY22 approval	EHS Staff~~Debby Travis~~
Section IX, 9.4.1	7/7/2021	Added verbiage to match AHA national standards regarding EMS triage/transport decisions	EHS Staff
Section X, ~~3.1.3~~10.3.3	~~11/13/2019~~7/7/2021	~~Verbiage removed regarding designation and credentialing of cardiac facilities~~Added verbiage to match AHA national standards regarding consideration of transporting via air medical vs long transport time via ground	~~Debby Travis~~EHS Staff
Section XII, ~~7.3.1~~12.3.4	~~10/21/2019~~7/7/2021	Added verbiage to match AHA national standards regarding duration of time from First Medical Contact to STEMI intervention~~Verbiage changed regarding the Medical Director oversight to include participation from the qualified cardiac physician providers to offer guidance to the committee, as well as, aid in the development of regional plans and treatment guidelines.~~	EHS Staff
~~8.3~~	~~10/21/2019~~	~~Verbiage changed regarding the objective of the regional pre-hospital medical control to include the responsibility of medical control to live within each EMS agency. Each medical director has the legal authority to develop their agency's protocols and guidelines.~~	~~EHS Staff~~
~~9.3.1~~	~~11/13/2019~~	~~Verbiage to include triage & transport guidelines serve to direct the triage of adult ACS patients and in the event EMS encounters an ACS patient under the age of 18, they are to contact the closest pediatric hospital or Medical Control for~~	~~Debby Travis~~

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		~~guidance~~	
~~10.3~~	~~11/13/2019~~	~~The Aircraft Utilization Guidelines & Systems Performance Review attached as an Annex~~	~~EHS Staff~~
~~11.3.2~~	~~11/1/2019~~	~~Verbiage added to include EMResource as the official and standard mechanism for notification about an incidents that may affect the overall EHS system in TSA-E. It also serves as a resource for EMS to make an informed decision on patient destination.~~	~~Jacob Seil~~
~~11.3.3~~	~~11/1/2019~~	~~The EMResource policy and procedures attached as an Annex~~	~~Jacob Seil~~

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Final revisions should be submitted to the NCTTRAC Emergency Healthcare Systems Department at EHS@NCTTRAC.org, telephone 817.608.0390.

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Table of Contents

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NCTTRAC – Regional ACS System Plan

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I. INTRODUCTION

A. ~~1.1~~ Mission

1.~~1.1~~ The mission of the North Central Texas Trauma Regional Advisory Council (NCTTRAC) Acute Coronary Syndrome (ACS) Plan is to create a system that improves the quality of heart attack care within the region through organized efforts of prevention and acute care. Reduction in heart disease morbidity and mortality will be achieved by developing and maintaining integrated quality processes in patient care and education.

B. ~~1.2~~ Vision

1.~~2.1~~ NCTTRAC will provide leadership in regionalized Acute Coronary Syndrome treatment by creating a broad stakeholder coalition with the responsibility and resources to develop, operate, evaluate, and integrate a cardiac system of care.

C. ~~1.3~~ Organization

1. ~~3.1~~ NCTTRAC's goal is to provide the infrastructure and leadership necessary to sustain an ACS treatment and transfer system within the designated nineteen county region known as Trauma Service Area E (TSA-E), and to improve the level of care provided to persons living or traveling through the region. Standing committees and member organizations (hospitals, first responder organizations, EMS Providers, air medical providers, emergency management, and public health), work cooperatively to ensure that quality care is provided to ACS patients by pre-hospital and hospital professionals. An additional goal of the Regional ACS Plan is to promote cardiac awareness and education to the public and health care providers throughout the region.

D. ~~1.4~~ Regional Plan

1.~~4.1~~ This plan has been developed in accordance with generally accepted ACS guidelines and procedures for implementation of a comprehensive Emergency Medical Services (EMS) and ACS System plan. This plan does not establish a legal standard of care, but rather is intended as an aid to decision-making in ACS patient care scenarios. It is not intended to supersede the physician's prerogative to order treatment.

II. ACS SYSTEM OF CARE GOALS

2.1 The purpose of the Cardiac committee shall be to facilitate the collaboration and development of a comprehensive ACS system based on accepted standards of care. NCTTRAC will encourage participation from EMS providers, health care facilities, organizations, entities, and professional societies involved in health care. NCTTRAC will facilitate regional participation in providing quality cardiac care. NCTTRAC shall develop a plan for a regional comprehensive ACS system that:

2.1.1 Identifies and integrates resources to foster commitment and cooperation in developing a cardiac system of care.

2.1.2 Promotes EMS and hospital provider participation.

2.1.3 Establishes system coordination for access, guidelines, and referrals. These structures will establish continuity and uniformity of care among the providers of cardiac care.

2.1.4 Promotes collaboration among EMS Providers, hospitals, and members of the

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Committee.

2.1.5 Develops uniform cardiac system standards that address patients' needs, outcomes, and opportunities for improvement.

III. CARDIAC FACILITY CAPABILITY

3.1 Goal

3.1.1 The goal of the Committee is to ensure that there is understanding throughout the region with regard to facility capabilities for the care of the ACS patient, and this information is available for patient destination decision making.

3.1.2 EMResource is the official means of notification of these capabilities and their availability. The options for Cardiac / ACS patient care abilities fall under "Status: 24/7 STEMI" and currently include:

- Yes
- No
- Unavailable – Temporarily unable to provide STEMI care

3.1.3 Because the Texas Department of State Health Services (DSHS) does not designate ACS facilities in Texas, the Committee will encourage external credentialing organizations as the means for recognition of cardiac facilities.

IV. COMMUNITY AWARENESS AND PREVENTION

4.1 Goal

4.1.1 The goal is for NCTTRAC participating hospitals to collaborate with EMS Providers to educate the public on heart disease symptom recognition, risk factors and behavior modifications. Education will also include the importance of early activation of 911 services and the role EMS plays in treatment of the ACS patient.

4.1.2 Refer to NCTTRAC Cardiac/Stroke video in the link below: https://www.youtube.com/watch?v=IJArXa-8RMs&t=10s

4.2 Committees Charged

4.2.1 Responsibilities are charged to the NCTTRAC Cardiac, EMS and Public Education/Injury Prevention Committees.

V. SYSTEM ACCESS

5.1 Goal

5.1.1 The goal for System Access within TSA-E is two-fold. First, access to emergency Cardiac care within the region must be available. Second, EMS must be available to provide quality health care to patients in TSA-E. In portions of this Region, First Responder Organizations (FRO) may provide initial treatment pending EMS arrival.

5.2 Committee Charged

5.2.1 Responsibilities are charged to the NCTTRAC EMS Committee.

5.3 Objective

5.3.1 One of the primary elements of an EMS/Cardiac system is to provide access to EMS and subsequent mobilization of a medical response to the scene. Every call for emergency services should universally and automatically be accompanied by location identifying information. A regional system providing dedicated lines that allow direct

routing of emergency calls is ideal. Routing is based on telephone exchange area, not municipal boundaries. Automatic Number Identification (ANI) and Automatic Location Identification (ALI) should be available. Alternative routing allowing 911 calls to be routed to a designated alternative location is in effect. In the event 911 is out of service, 24/7 emergency phone numbers listed by county, are available for the civilian population. See Annex C: *9-1-1 Outage Contacts*

5.3.2 When calls come into a 911 center, the communication system ensures that the call taker has the appropriate written protocols, as well as, having the training available to assist the caller. The caller should not have to talk to more than two telecommunications personnel and transferring of calls should be limited to less than ten seconds. In the event that the telephone or network communication is down, EMS facilities and key agencies need access to two-way radios to communicate with dispatch, hospitals, and the NCTTRAAC Emergency Medical Coordination Center (EMCC).

VI. COMMUNICATIONS

6.1 Goal

6.1.1 EMS communications systems must provide the means by which emergency resources can be accessed, mobilized, managed, and coordinated. An emergency assistance request and the coordination of the response require communication linkages for: 1) access to EMS from the scene of the incident, 2) dispatch and coordination of EMS resources, 3) coordination with medical facilities and 4) coordination with other public safety and emergency personnel. EMS should notify the receiving cardiac facility of incoming acute cardiac patient transports in order for the facility to activate their cardiac protocol.

6.2 Committees Charged

6.2.1 Responsibilities are charged to the NCTTRAC EMS Committee and the Cardiac Committee.

6.3 Objective

6.3.1 The system of communication is an integral part of a regional plan for the care of cardiac patients. Networks should be geographically integrated and based on the functional need to enable routine and special large-scale operations for communications among EMS and other public safety agencies. Utilization of system status management technology should be considered for both areas with high demand of mobile resources and for those areas where resources may not be readily available on a routine basis but would benefit from shifting resources from one geographic area to another.

6.3.2 EMS communication center(s) should be staffed with fully trained tele communicators. The ideal tele communicator should have completed an Emergency Dispatch course, such as the Emergency Medical Dispatch: National Standard Curriculum as offered from the National Highway Traffic Safety Administration and the U.S. Department of Transportation. NCTTRAC encourages early adoption of Texas HB 786 regarding tele communicators CPR.

6.3.3 NCTTRAC encourages ~~100%~~ participation from all EMS agencies within the nineteen counties that comprise TSA-E. By enhancing participation, NCTTRAC can identify

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quality issues related to response times. NCTTRAC can then move toward the resolution of these issues through assessment, education, intervention, and evaluation through system process improvement (SPI) procedures.

VII. MEDICAL OVERSIGHT

7.1 Goal

7.1.1 The development of a Regional System of Cardiac care requires the active participation of qualified physician providers. Physicians should be clinically qualified in their area of practice and have expertise and competence in the treatment of cardiac patients. The regional cardiac system of care will be developed under the direction of representatives of NCTTRAC medical staff throughout the region.

7.2 Committees Charged

7.2.1 Responsibilities are charged to the Medical Directors Committee.

7.3 Objective

7.3.1 The development of a regional system for cardiac care requires the active participation of qualified physician providers with expertise and competence in the treatment of cardiac patients. NCTTRAC has an established Medical Directors Committee. This committee meets quarterly to provide guidance in the development and review of hospital and prehospital assessment tools, regional plans, and treatment guidelines. The committee is comprised of the elected committee medical directors of the following committees: Air Medical, Cardiac, Emergency Department Operations, Emergency Medical Services, Pediatric, Perinatal, Regional Emergency Preparedness (Disaster), Stroke, ~~System Performance Improvement,~~ and Trauma. Each Medical Director is responsible for participating with and providing medical oversight for their service line committee, as well as collaborating with other RAC committees and Medical Directors.

VIII. REGIONAL PRE-HOSPITAL MEDICAL CONTROL

8.1Goal

8.1.1 The regional cardiac plan will assist with identification and education of regional medical control resources, standardize guidelines, and analyze accessibility of medical control resources. Additionally, it will identify and educate NCTTRAC EMS Providers and sources of medical direction.

8.2 Committees Charged

8.2.1 Responsibilities are charged to the NCTTRAC EMS Committee, the Medical Directors Committee, and the Cardiac Committee.

8.3 Objectives

8.3.1 Presently, each EMS agency has its own medical director and standard operating procedures (SOPs). Each medical director has the legal authority under Texas Administrative Code, Chapter 197 and the Texas Department of State Health Services (DSHS) Chapter 157 for developing the agency's local protocols and guidelines. TSA-E provides off-line guidelines to each EMS provider and medical director as recommended by the EMS, Trauma, and Medical Directors Committees that may be utilized and adopted. Each medical director within TSA-E assumes the

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responsibility for cardiac oversight as well as specific performance improvement to investigate patient outcomes for his or her EMS personnel.

8.3.2 NCTTRAC encourages coordinated medical control in our region and to that end has organized a Medical Directors Committee which meets periodically to review the protocols and guidelines for EMS Providers within TSA E. Several medical directors have multiple EMS Providers working with them to help consolidate and control the pre-hospital care of the cardiac patients but this is not a mandatory requirement at this time. Through the efforts of the Medical Directors Committee, NCTTRAC will continue to work towards developing consistency and standardization of the guidelines used within our region.

8.4 Physician Involvement in Regional Plan Development

8.4.1 The Medical Directors Committee meets quarterly to conduct its usual business and to review and approve regional planning components, policies, and guidelines related to medical care. Each EMS Medical Director and at least one physician from each NCTTRAC hospital has the opportunity for representation on this standing working group. All physicians within TSA-E are invited to attend these meetings.

8.5 Medical Direction of Pre-hospital Care Providers

8.5.1 In accordance with DSHS guidelines, all NCTTRAC pre-hospital care providers function under medical control through a delegated physician practice. Regional EMS guidelines are available online to all EMS Providers for incorporation into local protocols. Periodic reviews and updates are completed and upon approval are distributed as necessary. These guidelines serve as a baseline and individual Medical Directors may adapt for their local community.

8.6 Regional Quality Improvement

8.6.1 The Medical Directors Committee meets quarterly to conduct business and to carry out regional quality improvement activities. (Please see System PI section for more details).

IX. PRE-HOSPITAL TRIAGE CRITERIA

9.1 Goal

9.1.1 Patients will be identified, rapidly and accurately assessed, and will be transported to the closest appropriate facility.

9.2 Committees Charged

9.2.1 Responsibilities are charged to the NCTTRAC EMS Committee with input from the Cardiac Committee and oversight from the Medical Directors Committee.

9.3 Purpose

9.3.1 The pre-hospital ACS triage and transport guidelines serve to direct the regional triage of adult ACS patients (greater than or equal to 18 years) to the closest most appropriate facility. In the event EMS encounters an ACS patient under the age of 18, contact the closest pediatric hospital or Medical Control for guidance. See Annex A: *Acute Coronary Syndrome Triage and Transport Guidelines*

9.4 System Triage

9.4.1 EMS Transport decisions should be based on standard of care, local EMS Protocols, ~~capabilities~~capabilities, and availabilities of local receiving hospitals. Transport decisions should consider first medical contact (FMC) by EMS provider to

intervention at STEMI receiving facility less than or equal to 90 minutes based on AHA National Standards.

If transport time is greater than or equal to 45 minutes, the AHA National Standard is first medical contact to intervention in less than 120 minutes.

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X. HELICOPTER

10.1 Activation Goal

10.1.1 Regional air transport resources may be appropriately utilized in order to reduce delays in providing optimal cardiac care.

10.2 Committees Charged

10.2.1 Responsibilities are charged to the NCTTRAC Air Medical Committee with input from the EMS and Cardiac Committees, and guidance from the Medical Directors Committee.

10.3 Decision Criteria

10.3.1 Helicopter activation/scene response may be considered when it can reduce transportation time or provide advanced life support.

10.3.2 Patients meeting criteria for helicopter dispatch should be transported to the closest, most appropriate facility.

10.3.3 Consider Air Medical Transport if ground transport time is greater than 30 minutes and if air medical does not prolong arrival to STEMI receiving facility. Transport decisions should consider first medical contact (FMC) by EMS provider to intervention at STEMI receiving facility less than or equal to 90 minutes based on AHA National Standards. If transport time is greater than or equal to 45 minutes, the AHA National Standard is first medical contact to intervention in less than 120 minutes.

10.3.4~~3~~ Refer to Annex B: *Aircraft Utilization and Systems Performance Review*

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XI. FACILITY BYPASS

11.1 Goal

11.1.1 Facilities will communicate the availability of ACS patient care capability status promptly and clearly to regional EMS and other facilities through EMResource in order to ensure that cardiac patients are transported to the closest appropriate cardiac facility.

11.2 Committees Charged

11.2.1 Responsibilities are charged to the NCTTRAC EMS Committee, the Medical Directors Committee, and the Cardiac Committee.

11.3 System Objective

11.3.1 The system objective is to ensure that cardiac patients will be transported to the closest appropriate facility.

11.3.2 All hospitals and EMS providers have the ability to create event notifications in EMResource. These events are used to inform the emergency healthcare partners in TSA-E about any incidents or occurrences that might affect the overall emergency healthcare system in TSA-E. Proper posting on EMResource is the official and standard mechanism for notification in TSA-E. All EMS services are expected to monitor EMResource at all times for current system information. An

EMS agencies should use the information within EMResource to help inform patient destination decisions to ensure that all patients receive the appropriate care quickly and effectively.

11.3.3 A full listing of EMResource status types, policies, and procedures in TSA-E can be found in Annex D: *TSA-E EMResource Policies & Procedures*.

XII. INTER-FACILITY TRANSFERS

12.1 Goal

12.1.1 The goal for establishing and implementing inter-facility transfer criteria in NCTTRAC is to ensure that ACS patients requiring additional or specialized care and treatment beyond a facility's capability are identified and transferred to the most appropriate facility as soon as possible.

12.2 Committees Charged

12.2.1 Responsibilities are charged to the NCTTRAC Cardiac Committee with input from the Air Medical and EMS committees, and guidance from the Medical Directors Committee.

12.3 Objectives

12.3.1 To ensure that all facilities make transfer decisions based on ACC/AHA guidelines.

12.3.2 Cardiac receiving facilities are encouraged to collaborate with transferring facilities (hospitals, free standing ERs, etc.) to develop processes that meet evidence based guidelines.

12.3.3 No more than one transfer should take place in efforts to minimize the transport time for a patient that is in need of interventions not available at the sending facility. Every possible determination should be evaluated before making the decision to transport the ACS patient to help prevent the need for a double transfer.

12.3.4 Transfer decisions should consider first medical contact (FMC) by referring facility to intervention at STEMI receiving facility less than or equal to 120 minutes based on AHA National Standards. If transfer time is greater than 30 minutes, consider consult with receiving cardiologist regarding administration of lytics.

XIII. SYSTEM PERFORMANCE IMPROVEMENT

13.1 NCTTRAC participating organizations must have a performance improvement system for ACS patients.

13.2 Goals

13.2.1 The goal is to establish a method for monitoring and evaluating ACS system performance and the impact of system development.

13.3 Committees Charged

13.3.1 Responsibilities are charged to the NCTTRAC Cardiac Committee.

13.4 Objectives

13.4.1 Encourage participation in state / RAC cardiac data registries which reflect evidence based practices of the processes and outcomes of the NCTTRAC Cardiac system of care

13.4.2 Provide a multidisciplinary forum for cardiac care providers to evaluate cardiac

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patient outcomes from a system perspective and to assure the optimal delivery of cardiac care

13.4.3 Facilitate the sharing of information and performance data

13.4.4 Provide a process for medical oversight of regional cardiac operations

13.4.5 Confidentiality – All information and materials provided and/or presented during SPI meetings are strictly confidential.

NCTTRAC
NORTH CENTRAL TEXAS TRAUMA REGIONAL ADVISORY COUNCIL

Coordination Flowchart

Plan/Program/Guideline Currently in Place?

No → **Begin with Plan/Program/Guideline Template** → **Develop Plan/Program/Guideline**

Yes

Documentation Review of:

FY22 Regional ACS System Plan

Primary **Committee/ Workgroup**
Revise Plan/Program/Guideline (Track Changes)
EHS staff to post to website and send appropriate notification

Cardiac Committee Review Date: 07/07/2021
Comments: Reviewed and approved
NCTTRAC Staff Initials CC Chair Sign Off: Krista Knowels Date: 07/07/2021

Committee Coordination

- Air Medical
- Cardiac
- ED Ops
- EMS
- Pediatric
- Perinatal
- REPC
- Stroke
- Trauma

Pediatric Committee Review Date: 07/19/2021
Comments: Electronic vote of approval
NCTTRAC Staff Initials CC Chair Sign Off: Cheryl Malone Date: 07/19/2021

ED Ops Committee Review Date: 07/19/2021
Comments: Electronic vote of approval
NCTTRAC Staff Initials CC Chair Sign Off: Don Tucker Date: 07/19/2021

Air Medical Committee Review Date: 07/19/2021
Comments: Electronic vote of approval
NCTTRAC Staff Initials CC Chair Sign Off: Jason Piecek Date: 07/19/2021

EMS Committee Review Date: 07/19/2021
Comments: Electronic vote of approval
NCTTRAC Staff Initials CC Chair Sign Off: Kevin Sandifer Date: 07/19/2021

Medical Directors Focus Group

Medical Director Focus Groups (Initial/Date)

- ☐ Air Medical MD: _____
- ☐ Cardiac MD: _____
- ☐ ED Ops MD: _____
- ☐ EMS MD: _____
- ☐ Pediatric MD: _____
- ☐ Perinatal MD: _____
- ☐ REPC MD: _____
- ☐ Stroke MD: _____
- ☐ Trauma MD: _____

Medical Directors Committee

Medical Directors Committee Review Date: 07/19/2021
Comments: Electronic vote of approval
NCTTRAC Staff Initials CC Chair Sign Off: Dr. Justin Northeim Date: 07/19/2021

Legal Counsel Review (PRN)

Signature _____
Date: _____

Finance Committee Review (PRN)

Signature _____
Date: _____

Final NCTTRAC Staff Review

NCTTRAC Staff Review Date: 07/19/2021
Comments: Reviewed and approved
Staff Initials JD Date: 07/19/2021

NCTTRAC Administration Review Date: 07/28/2021
Comments: _____
Staff Initials SB Date: 07/28/2021

NCTTRAC Executive Review Date: _____
Comments: recommend BoD endorsement for GM vote & approval
Staff Initials HJA Date: 08/03/2021

Board of Directors Endorsement/Approval

NCTTRAC Administration submit to Board of Directors Date: 08/03/2021
NCTTRAC Board of Directors Approval Date: 08/10/2021

General Membership approval (PRN)
Date: _____

→ **Final Format for Publication**
Date: _____

→ **Publish and Post on website**
Date: _____

For further Committee review continue on next page

Committees Continued

REPC Committee Review Date: 07/19/2021
Comments: Electronic vote of approval
NCTTRAC Staff Initials CG Chair Sign Off: Lance Lynch Date: 07/19/2021

Select Committee Review Date:
Comments:
NCTTRAC Staff Initials Chair Sign Off: Date:

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