NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

2022 Perinatal Care Regional System Plan

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

Approved by NCTTRAC General Membership
Date: April 13, 2021

Supersedes Perinatal Care Regional System
Plan Date: April 13, 2021

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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.

Signature on File _____
Secretary

8/11/2021 _____
Date

RECORD OF CHANGES

The North Central Texas Trauma Regional Advisory Council ensures that necessary changes and revisions to the Perinatal Care Regional 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 Perinatal Care Regional 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	7/7/21	Changed dates to reflect FY22 approval	Corrine Cooper
Section 12.1.1	7/8/2021	Changed to transported to transferred and added interfacility regarding interfacility triage criteria	Corrine Cooper
Section 6.1	7/27/2021	Removed the Appendix C-1: 9-1-1 Outage Contacts	Christina Gomez

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

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1. SCOPE

1.1 Mission

1.1.1 To improve outcomes for pregnant and postpartum women and newborns throughout Perinatal Care Region E (PCR-E), as supported by the NCTTRAC Perinatal Committee.

1.2 Vision

1.2.1 The NCTTRAC Perinatal Care Regional System Plan (PCRSP) shall involve all PCR-E perinatal stakeholders. It shall utilize data-driven evidence-based practices to improve the triple aim of perinatal care. Improvement in pregnancy, newborn and postpartum population health shall be our priority. In addition, we will strive to make perinatal care more cost effective and improve the perinatal health care experience.

1.2.2 The PCRSP builds on Texas' existing state-wide legislative mandate for perinatal hospital levels of designation and works with the Regional Advisory Council (RAC) Perinatal Care Regional Alliance (RAC-PCR Alliance) and Texas Collaborative for Healthy Mothers and Babies (TCHMB) to realize statewide coordination in the improvement of perinatal care for all Texans.

1.3 Organization

1.3.1 The NCTTRAC Perinatal Committee provides infrastructure and leadership to the nineteen-county region known as Perinatal Care Region E (PCR-E). NCTTRAC standing committees and member organizations (hospitals, first responder organizations, emergency medical services (EMS) providers, air medical providers, emergency management and public health) work collaboratively to ensure that quality care is provided to perinatal patients by pre-hospital and hospital professionals. The primary goal of the RPSP is to provide a detailed plan to reduce perinatal related morbidity and mortality via specific actions set forth by the PCR-E perinatal committee. Through this plan the perinatal committee will strive to establish uniform perinatal system standards. The organization will focus on education, prevention, prehospital management, hospital care, and long-term outcomes for perinatal patients. One of our highest organizational goals is to have patient outcome specific data inform process improvement work for all PCR-E member hospitals.

1.3.2 The Perinatal Care Regional System Plan is a guideline. The RPSP has been developed in accordance with generally accepted perinatal guidelines. (https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.) In addition, the State of Texas DSHS levels of neonatal and maternal care documents and rules will inform this guideline. (https://dshs.texas.gov/emstraumasystems/neonatal.aspx#Designation)

1.3.3 This plan does not establish a legal standard of care, but rather it is intended as an aid to decision-making in the care of perinatal patients. The Regional Perinatal System Plan is not intended to supersede the physician's or care giver's judgement.

1.4 Perinatal Care Regional System Plan (PCRSP) Goals

1.4.1 The purpose of the RPSP Committee shall be to facilitate the collaboration and advancement of a regional system of perinatal care that is based on accepted standards of care. The NCTTRAC Perinatal Committee will solicit participation from health care facilities, organizations, entities and professional societies involved in perinatal health care. The NCTTRAC Perinatal Committee will encourage regional participation in providing and outlining high quality perinatal care that is patient-focused, complies with state and national guidelines and seeks to provide perinatal patients with the most appropriate level of care. NCTTRAC Perinatal Committee shall

develop a plan for a regional system of perinatal care that:

1.4.1.1 Promotes collaboration and commitment among EMS providers, hospitals, and members of the NCTTRAC Committees

1.4.1.2 Develops uniform perinatal system standards that addresses patients' needs, outcomes and opportunities for improvement

1.4.1.3 Promotes delivery of at-risk neonates at hospitals most capable of delivering appropriate care (not solely based on level of designation)

1.4.1.4 Promotes care of the pregnant and postpartum women at hospitals most capable of delivering appropriate care (not solely based on level of state designation)

1.4.1.5 Promotes appropriate and timely structure for inter-hospital transfers. These structures will establish continuity and uniformity of care among the providers of perinatal care (strive to have a goal of 85% of very low birth weight (VLBW) infants being delivered at hospital most appropriate to deliver care).

1.4.1.6 Promotes educational opportunities to improve frontline provider's competencies and skill

1.4.1.7 Provides a review mechanism for discussing patterns of care that do not consistently comply with the RPSP goals

1.4.1.8 Provide a written report (annually) to the Texas Perinatal Advisory Council (PAC) on PCR-E stakeholder concerns (potentially through the RAC-PCR Alliance) regarding the neonatal and maternal levels of designation process.

1.4.1.9 Promote disaster preparedness planning and drills for unique aspects of the perinatal patient.

1.4.2 This plan, updated annually and approved by NCTTRAC membership, shall serve as resource guidance for providers of perinatal care across the Region.

2. REGIONAL DEMOGRAPHICS

2.1 Perinatal Care Region E (PCR-E), supported by the North Central Texas Trauma Regional Advisory Council (NCTTRAC), incorporates nineteen north central Texas non-metropolitan and metropolitan counties: Cooke, Fannin, Grayson, Wise, Denton, Palo Pinto, Parker, Ellis, Kaufman, Navarro, Collin, Hunt, Rockwall, Erath, Hood, Johnson, Somervell, Tarrant and Dallas counties. See *Annex A, Appendix A-1 for map of region*. Recent population estimates indicate that 7.97 million people reside within the 15,574.71 square miles of TSA-E, representing over 27% of the entire population of the State of Texas.

2.2 Currently, NCTTRAC is served by four Level IV Advanced Intensive Care Neonatal Facilities, eighteen Level III Intensive Care Neonatal Facilities, eighteen Level II Special Care Nursery Neonatal Facilities, and twelve Level I Well Nursery Neonatal Facilities (for a total of 52). See list of all hospitals within the region in *Annex A, Appendix A-2*. There are also approximately 130 ground and air EMS services and over 140 first responder organizations. See list of all EMS/FRO and Air Medical Providers for the region in *Annex A, Appendix A-3*.

2.2.1 https://dshs.texas.gov/emstraumasystems/neonatal.aspx

2.2.2 https://dshs.texas.gov/emstraumasystems/maternal.aspx

3. LIST OF RAC OFFICERS

3.1 A list of RAC officers, including members of the Board of Directors and the Executive Committee of the Board of Directors are available in *Annex B, Appendix B-1*. The Executive Committee of the Board of Directors consists of the Board Chair, Chair Elect, Secretary,

Treasurer, Finance Committee Chair, and Medical Directors Committee Chair.

4. STANDING COMMITTEES

4.1 Committee leadership consists of a Committee Chair, Chair Elect, and Medical Director. These positions are elected for one year terms; they are chosen by vote of the present and eligible voting members of the committee and ratified by a simple majority vote of the Board of Directors. The Chair Elect automatically ascends to the Chair position at the end of the current Chair's term. NCTTRAC standing committees are open to any individual who wants to attend, with the exception of the System Performance Improvement Subcommittee closed sessions.

4.2 A list of standing committees, with the chairperson for each, are available in *Annex B, Appendix B-2*. The list of standing committees, as well as committee's purpose, Chair terms, job descriptions, and voting participation are defined in the NCTTRAC bylaws. A copy of the bylaws is attached to this plan as *Annex B, Appendix B-3*.

5. EVIDENCE OF SYSTEM PARTICIPATION

5.1 Announcements for perinatal care region meetings and planning opportunities are sent electronically to NCTTRAC membership to allow participation from interested members and to include a broad range of participants such as physicians, nurses, EMS providers, and staff. Members have the capability to attend meetings through both audio and visual forms of technology.

5.2 Additionally, announcements are made at Committee and Board of Directors meetings for maximum visibility of members to participate. To provide evidence and track actual participation in perinatal care region planning, rosters are kept at NCTTRAC offices. Perinatal designated facilities are required to meet minimum participation guidelines per the NCTTRAC Membership and Participation SOP, as well as those requirements specifically identified in the NCTTRAC Perinatal Committee SOP.

6. SYSTEM ACCESS

6.1 All counties in the State of Texas have access to the EMS System utilizing 911 service. Additionally, all PCR-E counties received recent and robust updates including technology for cellular location. In the event 911 is out of service, 24/7 emergency phone numbers listed by county, are available for the civilian population.

6.2 The 911 capabilities for all EMS providers allow for efficient dispatch of response teams/agencies to the scene. If the telephone or network communication system is down, EMS facilities and key agencies have access to two-way radios to communicate with dispatch, hospitals, and the NCTTRAC Emergency Medical Coordination Center (EMCC).

6.3 The EMCC helps coordinate response teams for disaster and regional surge responses through PCR-E resource and crisis applications such as EMResource and WebEOC.

7. COMMUNICATION

7.1 Communication between hospitals, EMS providers, and medical control entities takes place using a variety of methods. Hospitals communicate information regarding Emergency Department saturation, Emergency Department Advisory status, bed availability numbers, and clinical service line availability by updating dedicated status types in EMResource (see the section on Diversion Policies and Bypass Protocol). Direct communication between EMS

providers, hospitals, and medical control entities generally occurs using a combination of cell phones, landline phones, and dedicated radio frequencies. Hospitals, EMS providers, and medical control entities work together to determine the best method of communication for their specific circumstances. For example, in some areas the most effective means of communication is for EMS providers to call the hospital's Emergency Department business line phone using cell phones held by individual paramedics, whereas other areas are better served by the hospital ED using a public safety radio with a dedicated channel for EMS communications.

7.2 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 facility of incoming maternal/neonatal patient transports.

7.3 NCTTRAC supports the implementation of redundant communication systems to ensure that hospitals, EMS providers, and medical control entities can still communicate with one another in the event of a primary communications method failure. In addition to administering the regional EMResource system, NCTTRAC hosts a WebEOC server with information sharing boards and patient tracking boards dedicated to EMS provider and hospital use. See *Annex C, Appendix C-1*. Using Hospital Preparedness Program (HPP) funding, NCTTRAC purchased amateur radios and VHF, UHF, and 700/800 public safety radios that can be given to hospitals and EMS providers as a means of redundant communication. NCTTRAC also purchased 2 Mobile Emergency Response Communications (MERC) trailers that can be deployed to provide temporary communications capabilities. These trailers are currently hosted by Parker County Hospital District/Lifecare EMS and Medical City North Texas. Additionally, NCTTRAC maintains multiple communications equipment caches that can be deployed in the event of a major communications failure.

7.4 Communications between multiple agencies responding to the same scene is generally dictated by the Incident Commander. Most neighboring jurisdictions share common radio frequencies or talk-groups that allow for interoperable radio communications – the exact frequencies or radio systems vary based on the jurisdiction having authority. In addition to jurisdiction-specific interoperable systems, it is recommended that EMS providers ensure their responding units are equipped with radios that have been programmed with the Texas Statewide Interoperability Channels identified in the Texas Statewide Interoperability Channel Plan.

7.5 The communication system is an integral part of a regional plan for the care of maternal and neonatal 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.

7.6 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

7.7 NCTTRAC encourages 100% participation from all EMS agencies within the nineteen counties that comprise PCR-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 performance improvement (SPI) procedures.

8. MEDICAL OVERSIGHT

8.1 The development of a regional system for perinatal care requires the active participation of qualified physician providers with expertise and competence in the treatment of perinatal patients.

8.2 NCTTRAC has an established Medical Directors Committee. This committee meets quarterly to provide guidance in the development and review of hospital and pre- hospital 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.

9. PRE-HOSPITAL TRIAGE CRITERIA

9.1 The survival of the maternal/neonatal patient is dependent upon rapid recognition/management of life-threatening injuries and rapid transport to an appropriate facility. The NCTTRAC maternal/neonatal Triage and Transport Guidelines were developed to assist emergency care providers at the scene, in conjunction with standard medical operational procedures and on-line medical control, to evaluate the level of care required by the injured or ill person and to determine the patient's initial transport destination. These guidelines align with the EMTALA Criteria found in the Guidelines for Perinatal Care, 8th ED, AAP Committee on Fetus and Newborn and ACOG Committee on Obstetric Practice a collaboration between The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The Maternal/Neonatal Triage and Transport Guidelines will be reviewed annually and revised as necessary by the EMS and Perinatal Committees with a final review and recommendation by the Medical Directors Committee and endorsement by the Board of Directors. See *Annex D: NCTTRAC Perinatal Triage and Transport Guidelines*. Regional air transport resources may be appropriately utilized in order to reduce delays in providing optimal maternal/neonatal care. Refer to *Annex F: Aircraft Utilization and Systems Performance Review*. These documents are also posted on the NCTTRAC website at www.NCTTRAC.org.

10. DIVERSION POLICIES & BYPASS PROTOCOLS

10.1 EMResource is utilized to maintain up to date information from each perinatal facility including but not limited to contact information, bed status, and open/closed status. A representative from each perinatal facility will report accurate information to EMResource at minimum every 24 hours and ensure correct contact information quarterly.

10.2 EMResource is the primary tool in PCR-E for hospitals to communicate with EMS providers about any facility issues that may be relevant to EMS patient destination decisions.

10.3 All hospitals and EMS providers can create event notifications in EMResource. These events are used to inform the emergency healthcare partners in PCR-E about any

incidents or occurrences that might affect the overall emergency healthcare system in PCR-E. For example, hospitals can create event notifications to alert EMS providers about construction that affects EMS traffic, or an EMS provider can create an event notification that alerts hospitals to an emergent mass casualty incident.

10.4 Proper posting on EMResource is considered the official and standard mechanism for notification in PCR-E. All EMS services are expected to monitor EMResource at all times for current system information. An EMS agency may call a receiving hospital for information on the status of facilities in their area if they do not have access. 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.

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

11. REGIONAL MEDICAL CONTROL

11.1 Regional Medical Control is defined as a centralized location for receiving on-line and off-line medical orders and for regional development of treatment protocols. As defined, there is no regional medical control in PCR-E.

11.2 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. PCR-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 PCR-E assumes the responsibility for maternal/neonatal oversight as well as specific performance improvement to investigate patient outcomes for his or her EMS personnel.

12. INTER-FACILITY TRANSFERS

12.1 Inter-Facility Triage Criteria

12.1.1 Patients will be interfacility triaged to the appropriate perinatal/neonatal facility, following the Perinatal Transport guidelines, with perinatal patients and/or their neonates being transferred to centers with appropriate capabilities. Each perinatal/neonatal care facility defines its internal facility triage criteria. There is not currently a regional standard for internal facility triage criteria

12.1.2 The ability of perinatal/neonatal facilities to monitor their resource capabilities is through NCTTRAC's web-based resource and crisis applications such as EMResource and WebEOC. See *Annex C, Appendix C-1*. Individual facilities are responsible for determining if a patient exceeds the facility's available resources and maintaining current capabilities. Communication of hospital capabilities to pre-hospital and hospital providers is addressed through EMResource.

12.2 Indications for Patient Transfer

12.2.1 Perinatal and neonatal patients should be transferred to a higher level of care when the medical needs of the patient outweigh the resources at the initial treating facility. The goal of patient transfer within PCR-E is to move patients to the nearest facility that is most capable of meeting the patient's medical needs. Decisions about the most appropriate facility for transport should be informed by and align with the rules set forth by the Texas State legislature regarding

maternal and neonatal levels of care designation. These rules establish the criteria that delineates the minimum service and resource requirements for each level of designation. Specific definitions of each maternal and neonatal designation level may be found on the Texas Department of State Health Services EMS &Trauma Systems website (https://dshs.texas.gov/emstraumasystems/default.shtm). Examples of patients that may be appropriate for each level include, but are not limited to the following:

12.3 Maternal

12.3.1. Level 1 Maternal:

12.3.1.1 Uncomplicated term twin gestation

12.3.1.2 Trial of labor after cesarean delivery (TOLAC)

12.3.1.3 Uncomplicated cesarean delivery

12.3.1.4 Preeclampsia at term

12.3.2 Level 2 Maternal: Any patient appropriate for level 1 care, plus higher-risk conditions such as:

12.3.2.1 Severe preeclampsia

12.3.2.2 Placenta previa with no prior uterine surgery

12.3.3 Level 3 Maternal: Any patient appropriate for level 2 care, plus higher-risk conditions such as:

12.3.3.1 Suspected placenta accreta or placenta previa with prior uterine surgery

12.3.3.2 Suspected placenta percreta

12.3.3.3 Adult respiratory syndrome or any condition requiring ventilator support

12.3.3.4 Expectant management of early severe preeclampsia at less than 34 weeks of gestation

12.3.4 Level 4 Maternal: Any patient appropriate for level 3 care, plus higher-risk conditions such as:

12.3.4.1 Severe maternal cardiac conditions

12.3.4.2 Severe pulmonary hypertension or liver failure

12.3.4.3 Pregnant women requiring neurosurgery or cardiac surgery

12.3.4.4 Pregnant women in unstable condition and in need of an organ transplant

12.4 Neonatal

12.4.1 Level 1 Neonatal: Well infants at low risk

12.4.1.1 Physiologically stable infants at 35 – 37 weeks gestation

12.4.1.2 Can stabilize infants less than 35 weeks or those who are ill until they can be transferred to a higher level of care

12.4.2 Level 2 Neonatal: Any patient appropriate for level 1 care, plus higher-risk conditions such as:

12.4.2.1 Moderately ill infants who are born at ≥32 weeks gestation or who weigh ≥1500g at birth with problems that are expected to resolve rapidly and who are not anticipated to need subspecialty-level services on an urgent basis.

12.4.3 Level 3 Neonatal: Any patient appropriate for level 2 care, plus higher-risk conditions such as:

12.4.3.1 Infants born at <32 weeks gestation

12.4.3.2 Infants weighing less than 1500 g at birth

12.4.3.3 Infants with medical or surgical conditions, regardless of gestational

age

12.4.4 Level 4 Neonatal: Any patient appropriate for level 3 care, plus higher-risk conditions such as:

12.4.4.1 Infants with complex and critical conditions requiring availability of pediatric medical and surgical specialty consultants continuously available 24 hours a day.

12.4.4.2 Infants requiring care for complex congenital cardiac malformations that require cardiopulmonary bypass, with or without ECMO

12.5 Time to Transfer

12.5.1 Access to timely and appropriate perinatal and neonatal care is a system goal in PCR-E. The focus should be to reduce time from onset of complication to definitive care. Facilities should provide initial stabilization and timely transport to the closest, most appropriate designated facility with definitive care capabilities. The time required to make the decision to transfer accounts for the greatest transfer delay. It is critical to make the decision to transfer early. Non-essential diagnostic testing and procedures will delay transfer and should be avoided.

12.5.2 Attention should be directed at life-saving stabilization. Examples of stabilization that should be undertaken prior to transport include:

12.5.2.1 Maintenance and protection of airway

12.5.2.2 Establishment of IV access

12.5.2.3 Initiating treatment for severe maternal hypertension

12.5.2.4 Maintenance of normothermia

12.5.2.5 Delivery of fetus(es) if delivery is immediately imminent or emergently required

12.5.3 Attempts to stabilize the patient should be continued until the transfer is completed; however, the most critically ill patients may not be completely stabilized prior to transfer. Inability to completely stabilize a patient is not a contraindication of transfer. If stabilization is not possible, the referring facility shall obtain written informed consent from the patient or her/his surrogate and/or written certification from the physician that the expected medical benefits of transfer outweigh the risk.

12.5.4 Inter-facility transfers should primarily occur within PCR-E however there may be occasions in which patients are transferred outside of PCR-E due to availability of resources or patient/family preference.

12.5.5 Transferring facilities shall make efforts to send medical records and radiographic studies obtained during initial management to the accepting referral center.

12.5.6 Copies of studies may be sent in hard copy or electronically through web-based programs. Exhaustive scanning frequently must be repeated at the receiving facility, often because of the quality of images, failure to transfer the images to the receiving facility, or inability to read the disc transported with the patient. This results in further delays in definitive care and avoidable exposure of the patient to ionizing radiation, and thus should also be avoided.

12.5.7 Physician to physician communication is essential between the initial facility and the accepting referral center. Physicians at accepting referral center should be available for consultation with the sending provider prior to transfer. Early communication with the receiving perinatal and/or neonatal provider can streamline the transfer process and satisfies one of the EMTALA requirements for transfer.

12.6 Method of Transfer

12.6.1 The sending physician maintains responsibility for determining the appropriate mode of transport as well as the transport team utilized. When possible and as available, perinatal/neonatal specialty care transport teams should be utilized to provide the appropriate level of care during transport.

12.7 Back Transfers/Home Transfers

12.7.1 In the event that a patient has stabilized and no longer requires the level of care and particular expertise provided by the receiving facility, efforts should be made to return the patient to the facility of origin, or the nearest facility to the patient's home community that is capable of providing the medical services needed to appropriately meet the patient's medical needs. This allows patients to be nearer to their homes and local communities in support of family-centered care models, which includes proximal access to ongoing discharge education for specialty care needs. This also promotes the availability of beds at higher level facilities for patients with more critical needs. The determination of appropriateness for back transfer should be made by the patient's physician at the higher-level facility in collaboration with the physician who will be involved in the care of the patient in the lower level facility/facility of origin.

13. PLAN FOR DESIGNATION OF POTENTIAL PERINATAL FACILITIES

13.1 The NCTTRAC Perinatal Committee will support member hospitals in seeking Texas DSHS levels of maternal and neonatal designation. The NCTTRAC Perinatal Committee will utilize the Texas Department of State Health Services (DSHS) recognized designation process for maternal and neonatal levels of care. As outlined in Texas Administrative code for requirements of maternal and neonatal levels of care (TAC, Title 25, Chapter 133, Subchapter K and J respectively) the NCTTRAC Perinatal Committee will strive to support uniform interpretation of these rules and help provide feedback to DSHS to improve the designation process. Whenever possible NCTTRAC Perinatal Committee will promote the use of a uniform data set for perinatal outcomes to improve the process of care for the patients we serve.

13.2 As required by DSHS, Perinatal facilities within the PCR-E region have an obligation to maintain NCTTRAC membership in good standing as well as meet active participation requirements.

14. SYSTEM PERFORMANCE IMPROVEMENT PROGRAM

14.1 NCTTRAC System Performance Improvement (SPI) processes are responsible for shared oversight of trauma and emergency healthcare system performance improvement activities. SPI processes are divided among nine (9) service line committees: Air Medical, Cardiac, Emergency Department Operations, Emergency Medical Services, Pediatric, Perinatal, Regional Emergency Preparedness, Stroke, and Trauma.

14.2 Generally, PCR members or staff will notify the Perinatal Committee Chair of any perinatal cases or system issues that have been reported and are in need of review. The Perinatal SPI focus group, comprised of the Perinatal Committee Chair, Chair Elect, Medical Director, and two elected committee members as approved by the committee, will review each reported case/issue in a closed session and make recommendations to the full Perinatal Committee and the Executive Committee for determinations and action plans.

14.3 Data Collection (Neonatal and Maternal data analysis)

14.3.1 Regional data will be collected and utilized to support Perinatal Committee goals and PI initiatives. Member hospitals are required by the Perinatal Committee to submit data for all Neonatal/Maternal SMART Goals which are deemed part of the PI/QI goals of the of Perinatal Committee.

14.4 Perinatal System Performance Improvement

14.4.1 The goal of Perinatal System Performance Improvement is to deepen and accelerate improvement efforts for maternal and infant health outcomes.

14.4.2 The mission of the Perinatal Quality and Performance Improvement focus group is to support the development and to enhance the quality of care for the NCTTRAC regional stakeholders. Ultimately, the focus group is responsible for making measurable improvements in maternal and infant health outcomes.

14.4.3 The Perinatal Quality and Performance Improvement focus group collaborates with the Perinatal System Performance Improvement (SPI) focus group to define committee goals and Neonatal/Maternal performance indicators for the region. The Perinatal Quality and Performance Improvement standards and performance indicators are developed from committee consensus, evidence-based practice guidelines, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists and DSHS Maternal and Neonatal Facility Designation rules/requirements. All neonatal / maternal designated centers must comply and adhere to the standards of care determined by their verifying and designating agencies.

14.4.4 The Perinatal Quality and Performance Improvement focus group monitors regional neonatal / maternal performance indicators and goals on a monthly dashboard which shall be presented to the committee and the Board of Directors. The Neonatal/Maternal performance indicators and goals are reviewed/revised annually and defined in *Appendix B-4: Perinatal Committee SOP*

14.4.5 A Perinatal Committee Quality and Performance Improvement focus group has been established by the Perinatal Committee to assist with evaluating regional data, identifying data needs, providing education, and sharing best practices.

15. REHABILITATION

15.1 Rehabilitation is the process of helping a patient adapt to a disease or disability by teaching them to focus on their existing abilities. Within a rehabilitation center, physical therapy, occupational therapy, and speech therapy can be implemented in a combined effort to increase a person's ability to function optimally within the limitations placed upon them by disease or disability.

15.2 To uphold the continuum of care from illness to health and offer a high-level of service, rehabilitation is a critical service offered within PCR-E through hospital- based programs and private organizations. A list of rehabilitation resources for the region are available in *Annex A Appendix A-4*.

15.3 Transfer protocols for rehabilitation facilities are determined by individual facilities.

16. MORBIDITY/MORTALITY REDUCTION & OUTREACH EDUCATION

16.1 Maternal and neonatal morbidity and mortality are higher than average in the state of Texas and in many situations, avoidable. Activities focused to reduce morbidity and

mortality associated with pregnancy, birth, post-partum recovery and infant care in the newborn period are integrated into the Perinatal Committee activities. Data collection on these morbidities and mortality reasons are tracked and shared with committee members in order to develop quality improvement projects.

16.2 Prevention and Awareness strategies are based on epidemiologic data that is collected through available local, regional, state and national patient data systems. Collaboration with community coalitions and partners, policy makers, and other vested stakeholders defines the interventions targeting specific populations. Intervention programs seek to create a measurable reduction of injury and increase prevention strategies (such as safe sleep initiatives, or newborn admission temperatures as examples), that have measurable outcomes in a specific timeline. Staffing and community partners are essential for success.

16.3 Outreach education is a task the Perinatal Committee as well as each individual hospital within the regional advisory council. Individual hospitals provide targeted education to other like or lower levels of maternal and neonatal designation. The Perinatal committee supports all facilities by conducting regular needs assessments and providing financial support as available and assistance in securing the requested education.

17. COALITION & PARTNERSHIP BUILDING

17.1 NCTTRAC supports collaborative partnerships with community leaders to focus on bringing in business partners and community leaders to assist with injury awareness and prevention activities.

17.2 Coalition and Partnership building is a continuous process of cultivating and maintaining relationships with stakeholders within the NCTTRAC perinatal care region. Collaboration on system development with community partnerships are key. Constituents include health care professionals, prehospital providers, insurers, payers, data experts, consumers, advocates, policy makers, perinatal center administrators, and media representatives. Coalition priorities are perinatal system development, regional system guidelines, financing initiatives and disaster preparedness, system integration, and promoting collaboration rather than competition between perinatal centers and prehospital providers. It is desired that every member of NCTTRAC participate in at least one activity or one committee.

18. DISASTER PREPAREDNESS & RESPONSE

18.1 The Perinatal Disaster preparedness and response activities will comply with the PCR-E disaster preparedness plans. The perinatal committee of PCR-E will appoint members to participate in the NCTTRAC Regional Emergency Preparedness Committee (REPC).

18.2 The goal of perinatal disaster response is to move patients out of disaster affected facilities into capable facilities if possible. If this is not possible, the disaster affected facility may ask for provider and nursing support from other member facilities or from available regional, state, and federal resources. If a facility is unable to coordinate the movement of patients and identification/requesting of resources on their own, they can contact the PCR-E Medical Coordination Center (EMCC) for assistance. The EMCC has a 24/7 Duty Phone at 817-607-7020 or can be contacted via routine email at nctrac_emcc@ncttrac.org.

18.3 Disaster preparedness and response activities among the emergency healthcare system in PCR-E are conducted at the regional level through the Health Care Coalition (HCC).

The HCC has been developed and funded as part of the federal Hospital Preparedness Program (HPP). The TSA-E HCC is composed of partner organizations from 4 core groups: hospitals, EMS, public health, and emergency management. These 4 groups work together as the HCC to promote emergency preparedness and healthcare delivery response. The HCC's purpose is to:

18.3.1 Lead collaborative regional planning, formulate strategies, and make recommendations to the NCTTRAC Board of Directors to ensure that the best possible approaches to regional HCC planning can be achieved in PCR-E.

18.3.2 Identify and assess regional needs in order to develop possible options for strengthening the overall resiliency of regional response capabilities based upon federal and state guidance and best practices (these include the Hospital Preparedness Program, Centers for Medicare and Medicaid Services, Federal Emergency Management Agency, etc.)

18.3.3 Serve to identify the regional priorities set forth by current federal and state guidelines by utilizing input from Subject Matter Experts to set strategic planning goals and initiatives.

18.4 The TSA-E HCC conducts disaster preparedness activities in accordance with the Trauma Service Area-E Health Care Coalition Regional Preparedness Strategy, which can be found in *Annex G Appendix G-1*.

18.5 Coordinated medical responses that are timely and exercised routinely can mitigate damages and save lives. The response goal of the HCC is to promote resiliency and adequate surge capacity and capability across PCR-E during a mass casualty or disaster situation. Effective response and recovery requires a coordinated effort among public and private entities. Hospitals and healthcare facilities are encouraged to be active participants in emergency preparedness efforts, including partnering with EMS, emergency management, public health, and other entities.

18.6 The TSA-E HCC regional response structure promotes jurisdictional cooperation and coordination, but recognizes the autonomy, operational authority, and unique characteristics of each jurisdiction at the facility, local, regional, and state levels. The TSA-E HCC conducts disaster response activities in accordance with the Trauma Service Area-E Health Care Coalition Regional Medical Response Strategy, which can be found in *Annex G Appendix G-1*.

18.7 Disaster Preparedness Activities

18.7.1 EMResource is utilized to maintain up to date information from each perinatal facility including but not limited to contact information, bed status, and open/closed status. A representative from each perinatal facility will report accurate information to EMResource at minimum every 24 hours and ensure correct contact information quarterly. Frequency of reporting may increase during a disaster event.

18.7.2 Perinatal facility leaders work with their facility emergency management staff to learn usage of WebEOC for disaster patient tracking. A perinatal leader should participate in their facility emergency management planning committee.

18.7.3 The perinatal committee will review EMResource reports monthly to ensure compliance. Compliance rates will be reported during monthly perinatal committee meetings.

18.7.4 The perinatal committee will participate in the annual Coalition Surge Test (or other mass patient movement-related exercises) held by the TSA-E Healthcare Coalition and the Regional Emergency Preparedness Committee (REPC).

Perinatal Committee participants will then report findings/recommendations to the Perinatal Committee.

18.7.5 A one-page check list is available for all perinatal facilities to utilize in disaster preparation and response situations. Facilities are encouraged to utilize the checklist during drills as well. See *Annex G Appendix G-2* for checklist.

18.8 Disaster Response Activities

18.8.1 Perinatal committee members participate in any RAC/local/state/national conference calls when a disaster occurs that will involve perinatal patients as available. The Pediatric and Perinatal Surge Annex is part of the Trauma Service Area E Healthcare Coalition Regional Medical Response Strategy, see *Annex G Appendix G-3*. This document describes the activities of a Pediatric/Perinatal Patient Coordination Module to guide the placement of pediatric and perinatal patients in a mass patient movement scenario. It also describes available assets, guidance, and other resources available to hospitals to respond to a Pediatric/Perinatal surge event.

18.8.2 The perinatal committee members support the regional plan set forth by the NCTTRAC.

18.9 Recovery activities

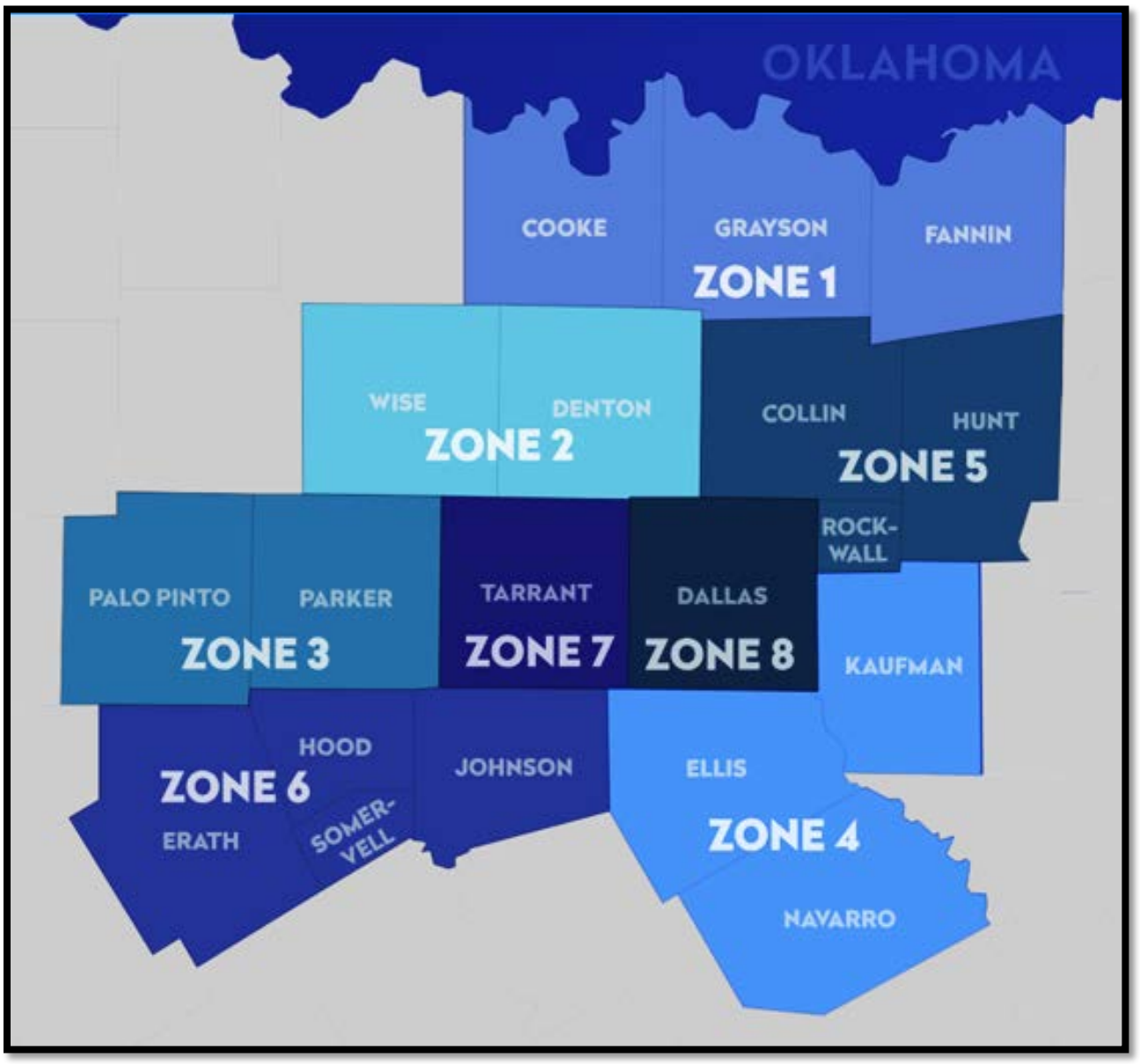
18.9.1 Perinatal facilities will make efforts to assure continuity of care for all transferred patients including follow up care, return transfers, and reunification of families.

19. RESEARCH

19.1 NCTTRAC participates in system research on an ad hoc basis. The Board of Directors is responsible for governance and release of the data for all research purposes.

Annex A
Demographics & Organizations

Appendix A-1	Map of Region
Appendix A-2	List of Hospitals
Appendix A-3	List of EMS, Air Medical & FRO Agencies
Appendix A-4	List of Rehabilitation Resources for the region



SOURCE: https://ncttrac.org/zones/
As of 7/20/2021

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
1	ACCEL REHABILITATION HOSPITAL OF PLANO	2301 MARSH LANE SUITE 200	PLANO	DENTON		
2	ATRIUM MEDICAL CENTER	2813 S MAYHILL RD	DENTON	DENTON		
3	BAYLOR EMERGENCY MEDICAL CENTER	26791 HIGHWAY 380	AUBREY	DENTON		
4	BAYLOR EMERGENCY MEDICAL CENTER	620 SOUTH MAIN SUITE 100	KELLER	TARRANT		
5	BAYLOR EMERGENCY MEDICAL CENTER	511 FM 544 SUITE 100	MURPHY	COLLIN		
6	BAYLOR EMERGENCY MEDICAL CENTER	12500 SOUTH FREEWAY SUITE 100	BURLESON	TARRANT		
7	BAYLOR EMERGENCY MEDICAL CENTER	1776 NORTH US 287 SUITE 100	MANSFIELD	TARRANT		
8	BAYLOR EMERGENCY MEDICAL CENTER	5500 COLLEYVILLE BOULEVARD	COLLEYVILLE	TARRANT		
9	BAYLOR EMERGENCY MEDICAL CENTER (ROCKWALL)	1975 ALPHA SUITE 100	ROCKWALL	ROCKWALL		
10	BAYLOR MEDICAL CENTER AT TROPHY CLUB	2850 EAST STATE HWY 114	TROPHY CLUB	DENTON		
11	BAYLOR MEDICAL CENTER AT UPTOWN	2727 EAST LEMMON AVENUE	DALLAS	DALLAS		
12	BAYLOR ORTHOPEDIC AND SPINE HOSPITAL AT ARLINGTON	707 HIGHLANDER BOULEVARD	ARLINGTON	TARRANT		
13	BAYLOR SCOTT & WHITE ALL SAINTS MEDICAL CENTER - FORT WORTH	1400 EIGHTH AVENUE	FORT WORTH	TARRANT	Level III	Level IV
14	BAYLOR SCOTT & WHITE EMERGENCY HOSPITAL - GRAND PRAIRIE	3095 KINGSWOOD BOULEVARD SUITE 100	GRAND PRAIRIE	DALLAS		
15	BAYLOR SCOTT & WHITE HEART AND VASCULAR HOSPITAL - DALLAS	621 NORTH HALL STREET	DALLAS	DALLAS		
16	BAYLOR SCOTT & WHITE INSTITUTE FOR REHABILITATION	909 NORTH WASHINGTON AVENUE	DALLAS	DALLAS		

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
17	BAYLOR SCOTT & WHITE INSTITUTE FOR REHABILITATION - FORT WORTH	6601 HARRIS PARKWAY	FORT WORTH	TARRANT		
18	BAYLOR SCOTT & WHITE INSTITUTE FOR REHABILITATION - FRISCO	2990 LEGACY DRIVE	FRISCO	COLLIN		
19	BAYLOR SCOTT & WHITE MEDICAL CENTER - CARROLLTON	4343 JOSEY LANE	CARROLLTON	DENTON		
20	BAYLOR SCOTT & WHITE MEDICAL CENTER - CENTENNIAL	12505 LEBANON ROAD	FRISCO	COLLIN	Level II	Level IV
21	BAYLOR SCOTT & WHITE MEDICAL CENTER - FRISCO	5601 WARREN PARKWAY	FRISCO	COLLIN	Level II	
22	BAYLOR SCOTT & WHITE MEDICAL CENTER - GRAPEVINE	1650 WEST COLLEGE STREET	GRAPEVINE	TARRANT	Level III	
23	BAYLOR SCOTT & WHITE MEDICAL CENTER - IRVING	1901 NORTH MACARTHUR BOULEVARD	IRVING	DALLAS	Level II	Level II
24	BAYLOR SCOTT & WHITE MEDICAL CENTER - LAKE POINTE	6800 SCENIC DRIVE	ROWLETT	ROCKWALL	Level II	
25	BAYLOR SCOTT & WHITE MEDICAL CENTER - MCKINNEY	5252 WEST UNIVERSITY DRIVE	MCKINNEY	COLLIN	Level III	
26	BAYLOR SCOTT & WHITE MEDICAL CENTER - PLANO	4700 ALLIANCE BOULEVARD	PLANO	COLLIN		
27	BAYLOR SCOTT & WHITE MEDICAL CENTER - SUNNYVALE	231 SOUTH COLLINS ROAD	SUNNYVALE	DALLAS		
28	BAYLOR SCOTT & WHITE MEDICAL CENTER AT WAXAHACHIE	2400 N I-35 E	WAXAHACHIE	ELLIS	Level I	Level II
29	BAYLOR SCOTT & WHITE SURGICAL HOSPITAL AT SHERMAN	3601 N CALAIS STREET	SHERMAN	GRAYSON		

https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
30	BAYLOR SCOTT & WHITE THE HEART HOSPITAL - DENTON	2801 SOUTH MAYHILL ROAD	DENTON	DENTON		
31	BAYLOR SCOTT & WHITE THE HEART HOSPITAL - PLANO	1100 ALLIED DRIVE	PLANO	COLLIN		
32	BAYLOR SURGICAL HOSPITAL AT FORT WORTH	1800 PARK PLACE AVENUE	FORT WORTH	TARRANT		
33	BAYLOR SURGICAL HOSPITAL AT LAS COLINAS	400 WEST INTERSTATE 635	IRVING	DALLAS		
34	BAYLOR UNIVERSITY MEDICAL CENTER	3500 GASTON AVENUE	DALLAS	DALLAS	Level III	Level IV
35	CARRUS REHABILITATION HOSPITAL	1810 WEST HIGHWAY 82 STE 100	SHERMAN	GRAYSON		
36	CARRUS SPECIALTY HOSPITAL	1810 US HWY 82 WEST STE 200	SHERMAN	GRAYSON		
37	CHILDRENS MEDICAL CENTER OF DALLAS	1935 MEDICAL DISTRICT DRIVE	DALLAS	DALLAS	Level IV	
38	CHILDRENS MEDICAL CENTER PLANO	7601 PRESTON ROAD	PLANO	COLLIN		
39	CITY HOSPITAL AT WHITE ROCK	9440 POPPY DRIVE	DALLAS	DALLAS	Level II	
40	COOK CHILDRENS MEDICAL CENTER	801 SEVENTH AVENUE	FORT WORTH	TARRANT	Level IV	
41	CRESCENT MEDICAL CENTER LANCASTER	2600 WEST PLEASANT RUN ROAD	LANCASTER	DALLAS		
42	DALLAS MEDICAL CENTER	7 MEDICAL PARKWAY	DALLAS	DALLAS		
43	DALLAS REGIONAL MEDICAL CENTER	1011 NORTH GALLOWAY AVE	MESQUITE	DALLAS	Level I	Level II
44	EMINENT MEDICAL CENTER	1351 W PRESIDENT BUSH HWY	RICHARDSON	COLLIN		
45	ENCOMPASS HEALTH REHABILITATION HOSPITAL OF ARLINGTON	3200 MATLOCK ROAD	ARLINGTON	TARRANT		
46	ENCOMPASS HEALTH REHABILITATION HOSPITAL OF CITY VIEW	6701 OAKMONT BOULEVARD	FORT WORTH	TARRANT		

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
47	ENCOMPASS HEALTH REHABILITATION HOSPITAL OF DALLAS	7930 NORTHAVEN	DALLAS	DALLAS		
48	ENCOMPASS HEALTH REHABILITATION HOSPITAL OF PLANO	2800 WEST 15TH STREET	PLANO	COLLIN		
49	ENCOMPASS HEALTH REHABILITATION HOSPITAL OF RICHARDSON	3351 WATERVIEW PARKWAY	RICHARDSON	DALLAS		
50	ENCOMPASS HEALTH REHABILITATION HOSPITAL OF THE MID-CITIES	2304 STATE HIGHWAY 121	BEDFORD	TARRANT		
51	ENNIS REGIONAL MEDICAL CENTER	2201 WEST LAMPASAS STREET	ENNIS	ELLIS		
52	FIRST BAPTIST MEDICAL CENTER	8111 MEADOW RD	DALLAS	DALLAS		
53	GLEN ROSE MEDICAL CENTER	1021 HOLDEN STREET	GLEN ROSE	SOMERVELL		
54	HUNT REGIONAL MEDICAL CENTER GREENVILLE	4215 JOE RAMSEY BOULEVARD	GREENVILLE	HUNT	Level III	Level II
55	ICARE REHABILITATION HOSPITAL	3100 PETERS COLONY ROAD	FLOWER MOUND	DENTON		
56	JOHN PETER SMITH HOSPITAL	1500 SOUTH MAIN STREET	FORT WORTH	TARRANT	Level III	Level IV
57	JPS HEALTH NETWORK - TRINITY SPRINGS NORTH	1000 ST LOUIS AVENUE	FORT WORTH	TARRANT	Level III	
58	KINDRED HOSPITAL - FORT WORTH	815 EIGHTH AVENUE	FORT WORTH	TARRANT		
59	KINDRED HOSPITAL - DALLAS	9525 GREENVILLE AVENUE	DALLAS	DALLAS		
60	KINDRED HOSPITAL DALLAS CENTRAL	8050 MEADOW ROAD	DALLAS	DALLAS		
61	KINDRED HOSPITAL-MANSFIELD	1802 HIGHWAY 157 NORTH	MANSFIELD	TARRANT		
62	KINDRED HOSPITAL-TARRANT COUNTY	1000 NORTH COOPER STREET	ARLINGTON	TARRANT		
63	KINDRED HOSPITAL-TARRANT COUNTY	7800 OAKMONT BOULEVARD	FORT WORTH	TARRANT		

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
64	LAKE GRANBURY MEDICAL CENTER	1310 PALUXY ROAD	GRANBURY	HOOD	Level I	
65	LIFECARE HOSPITALS OF DALLAS	1950 RECORD CROSSING ROAD	DALLAS	DALLAS		
66	LIFECARE HOSPITALS OF FORT WORTH	6201 OVERTON RIDGE BLVD	FORT WORTH	TARRANT		
67	LIFECARE HOSPITALS OF PLANO	6800 PRESTON ROAD	PLANO	COLLIN		
68	MAYHILL HOSPITAL	2809 MAYHILL ROAD	DENTON	DENTON		
69	MEDICAL CITY ALLIANCE	3101 NORTH TARRANT PARKWAY	FORT WORTH	TARRANT	Level III	
70	MEDICAL CITY ARLINGTON	3301 MATLOCK ROAD	ARLINGTON	TARRANT	Level III	
71	MEDICAL CITY DALLAS HOSPITAL	7777 FOREST LANE	DALLAS	DALLAS	Level IV	Level IV
72	MEDICAL CITY DENTON	3535 SOUTH I-35 EAST	DENTON	DENTON		
73	MEDICAL CITY FORT WORTH	900 EIGHTH AVENUE	FORT WORTH	TARRANT		
74	MEDICAL CITY FRISCO A MEDICAL CENTER OF PLANO FACILITY	5500 FRISCO SQUARE BLVD	FRISCO	COLLIN	Level II	
75	MEDICAL CITY LAS COLINAS	6800 NORTH MACARTHUR BOULEVARD	IRVING	DALLAS	Level II	
76	MEDICAL CITY LEWISVILLE	500 WEST MAIN STREET	LEWISVILLE	DENTON	Level III	
77	MEDICAL CITY MCKINNEY	4500 MEDICAL CENTER DRIVE	MCKINNEY	COLLIN	Level II	
78	MEDICAL CITY MCKINNEY - WYSONG CAMPUS	130 SOUTH CENTRAL EXPRESSWAY	MCKINNEY	COLLIN		
79	MEDICAL CITY NORTH HILLS	4401 BOOTH CALLOWAY ROAD	NORTH RICHLAND HILLS	TARRANT		
80	MEDICAL CITY PLANO	3901 WEST 15TH STREET	PLANO	COLLIN	Level III	Level IV
81	MEDICAL CITY WEATHERFORD	713 E ANDERSON ST	WEATHERFORD	PARKER	Level I	Level I
82	MESQUITE REHABILITATION INSTITUTE	1023 NORTH BELT LINE ROAD	MESQUITE	DALLAS		
83	MESQUITE SPECIALTY HOSPITAL	1024 NORTH GALLOWAY AVENUE	MESQUITE	DALLAS		

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
84	METHODIST DALLAS MEDICAL CENTER	1441 NORTH BECKLEY AVENUE	DALLAS	DALLAS	Level III	Level III
85	METHODIST CHARLTON MEDICAL CENTER	3500 WHEATLAND ROAD	DALLAS	DALLAS	Level II	
86	METHODIST HOSPITAL FOR SURGERY	17101 DALLAS PARKWAY	ADDISON	DALLAS		
87	METHODIST MANSFIELD MEDICAL CENTER	2700 BROAD STREET	MANSFIELD	TARRANT	Level II	
88	METHODIST MCKINNEY HOSPITAL LLC	8000 WEST ELDORADO PARKWAY	MCKINNEY	COLLIN		
89	METHODIST REHABILITATION HOSPITAL	3020 WEST WHEATLAND ROAD	DALLAS	DALLAS		
90	METHODIST RICHARDSON MEDICAL CENTER	2831 E PRESIDENT GEORGE BUSH HWY	RICHARDSON	COLLIN	Level III	Level III
91	METHODIST RICHARDSON MEDICAL CENTER CAMPUS FOR CONTINUING CARE	401 WEST CAMPBELL ROAD	RICHARDSON	DALLAS		
92	METHODIST SOUTHLAKE HOSPITAL	421 E STATE HWY 114	SOUTHLAKE	TARRANT		
93	MUENSTER MEMORIAL HOSPITAL	605 NORTH MAPLE STREET PO BOX 370	MUENSTER	COOKE		
94	NAVARRO REGIONAL HOSPITAL	3201 WEST HIGHWAY 22	CORSICANA	NAVARRO	Level I	
95	NORTH CENTRAL SURGICAL CENTER LLP	9301 NORTH CENTRAL EXPRESSWAY #100	DALLAS	DALLAS		
96	NORTH TEXAS MEDICAL CENTER	1900 HOSPITAL BOULEVARD	GAINESVILLE	COOKE	Level I	
97	OUR CHILDRENS HOUSE	1340 EMPIRE CENTRAL DRIVE	DALLAS	DALLAS		
98	PALO PINTO GENERAL HOSPITAL	400 SOUTHWEST 25TH AVENUE	MINERAL WELLS	PALO PINTO	Level I	Level I
99	PAM REHABILITATION HOSPITAL OF ALLEN	1001 RAINTREE CIRCLE	ALLEN	COLLIN		
100	PARKLAND MEMORIAL HOSPITAL	5200 - 5201 HARRY HINES BOULEVARD	DALLAS	DALLAS	Level III	Level IV
101	PINE CREEK MEDICAL CENTER	9032 HARRY HINES BOULEVARD	DALLAS	DALLAS		

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
102	PLANO SPECIALTY HOSPITAL	1621 COIT ROAD	PLANO	COLLIN		
103	PLANO SURGICAL HOSPITAL	2301 MARSH LANE SUITE 100	PLANO	DENTON		
104	PROMISE HOSPITAL OF DALLAS INC	7955 HARRY HINES BOULEVARD	DALLAS	DALLAS		
105	REBA MCENTIRE CENTER FOR REHABILITATION	1200 REBA MCENTIRE LANE	DENISON	GRAYSON		
106	SAGECREST HOSPITAL GRAPEVINE	4201 WILLIAM D TATE AVENUE	GRAPEVINE	TARRANT		
107	SAINT CAMILLUS MEDICAL CENTER	1612 HURST TOWN CENTER DR	HURST	TARRANT		
108	SELECT REHABILITATION HOSPITAL OF DENTON	2620 SCRIPTURE STREET	DENTON	DENTON		
109	SELECT SPECIALTY HOSPITAL - DALLAS	2329 PARKER RD	CARROLLTON	DALLAS		
110	SELECT SPECIALTY HOSPITAL - DALLAS (DOWNTOWN)	3500 GASTON AVENUE 3RD AND 4TH FLOORS	DALLAS	DALLAS		
111	STAR MEDICAL CENTER	4100 MAPLESHADE LANE	PLANO	COLLIN		
112	TEXAS GENERAL HOSPITAL	2709 HOSPITAL BLVD	GRAND PRAIRIE	TARRANT		
113	TEXAS HEALTH ARLINGTON MEMORIAL HOSPITAL	800 WEST RANDOL MILL ROAD	ARLINGTON	TARRANT	Level III	Level III
114	TEXAS HEALTH CENTER FOR DIAGNOSTICS & SURGERY PLANO	6020 WEST PARKER ROAD	PLANO	COLLIN		
115	TEXAS HEALTH HARRIS METHODIST HOSPITAL ALLIANCE	10864 TEXAS HEALTH TRAIL	FT WORTH	TARRANT	Level II	
116	TEXAS HEALTH HARRIS METHODIST HOSPITAL AZLE	108 DENVER TRAIL	AZLE	TARRANT		
117	TEXAS HEALTH HARRIS METHODIST HOSPITAL CLEBURNE	201 WALLS DRIVE	CLEBURNE	JOHNSON	Level I	
118	TEXAS HEALTH HARRIS METHODIST HOSPITAL FORT WORTH	1301 PENNSYLVANIA AVENUE	FORT WORTH	TARRANT	Level III	

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
119	TEXAS HEALTH HARRIS METHODIST HOSPITAL HURST-EULESS-BEDFORD	1600 HOSPITAL PARKWAY	BEDFORD	TARRANT	Level II	
120	TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHLAKE	1545 SOUTHLAKE BLVD	SOUTHLAKE	TARRANT		
121	TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHWEST FORT WORTH	6100 HARRIS PARKWAY	FORT WORTH	TARRANT	Level II	
122	TEXAS HEALTH HARRIS METHODIST HOSPITAL STEPHENVILLE	411 NORTH BELKNAP	STEPHENVILLE	ERATH	Level I	
123	TEXAS HEALTH HEART & VASCULAR HOSPITAL ARLINGTON	811 WRIGHT STREET	ARLINGTON	TARRANT		
124	TEXAS HEALTH HOSPITAL	1401 E TRINITY MILLS RD	CARROLLTON	DALLAS		
125	TEXAS HEALTH HOSPITAL CLEARFORK	5400 CLEARFORK MAIN ST	FORT WORTH	TARRANT		
126	TEXAS HEALTH HOSPITAL FRISCO	12400 DALLAS PKWY	FRISCO	COLLIN	Level I	
127	TEXAS HEALTH HUGULEY HOSPITAL	11801 SOUTH FREEWAY	BURLESON	TARRANT	Level II	Level II
128	TEXAS HEALTH PRESBYTERIAN HOSPITAL ALLEN	1105 CENTRAL EXPRESSWAY NORTH SUITE 140	ALLEN	COLLIN	Level II	
129	TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS	8200 WALNUT HILL LANE	DALLAS	DALLAS	Level III	Level IV
130	TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON	3000 I-35	DENTON	DENTON	Level III	
131	TEXAS HEALTH PRESBYTERIAN HOSPITAL FLOWER MOUND	4400 LONG PRAIRIE ROAD	FLOWER MOUND	DENTON	Level II	
132	TEXAS HEALTH PRESBYTERIAN HOSPITAL KAUFMAN	850 ED HALL DRIVE	KAUFMAN	KAUFMAN		
133	TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO	6200 WEST PARKER ROAD	PLANO	COLLIN	Level IV	

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
134	TEXAS HEALTH PRESBYTERIAN HOSPITAL ROCKWALL	3150 HORIZON ROAD	ROCKWALL	ROCKWALL	Level I	
135	TEXAS HEALTH SPECIALTY HOSPITAL FORT WORTH	1301 PENNSYLVANIA AVENUE 4TH FLOOR	FORT WORTH	TARRANT		
136	TEXAS INSTITUTE FOR SURGERY AT TEXAS HEALTH PRESBYTERIAN DALLAS	7115 GREENVILLE AVENUE	DALLAS	DALLAS		
137	TEXAS REHABILITATION HOSPITAL OF ARLINGTON	900 W ARBROOK BLVD	ARLINGTON	TARRANT		
138	TEXAS REHABILITATION HOSPITAL OF FORT WORTH	425 ALABAMA AVENUE	FORT WORTH	TARRANT		
139	TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN	2222 WELBORN STREET	DALLAS	DALLAS		
140	TEXOMA MEDICAL CENTER	5016 SOUTH US HIGHWAY 75	DENISON	GRAYSON	Level II	
141	THE COLONY ER HOSPITAL	4780 STATE HWY 121	THE COLONY	DENTON		
142	TMC BEHAVIORAL HEALTH CENTER	2601 CORNERSTONE DRIVE	SHERMAN	GRAYSON		
143	TMC BONHAM HOSPITAL	504 LIPSCOMB	BONHAM	FANNIN		
144	UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER	5323 HARRY HINES BLVD	DALLAS	DALLAS	Level III	
145	USMD HOSPITAL AT ARLINGTON	801 WEST I-20	ARLINGTON	TARRANT		
146	USMD HOSPITAL AT FORT WORTH	5900 ALTAMESA BOULEVARD	FORT WORTH	TARRANT		
147	VIBRA HOSPITAL OF RICHARDSON	401 WEST CAMPBELL ROAD SUITE 300	RICHARDSON	DALLAS		
148	VIBRA SPECIALTY HOSPITAL	2700 WALKER WAY	DESOTO	DALLAS		
149	WEATHERFORD REHABILITATION HOSPITAL LLC	703 EUREKA ST	WEATHERFORD	PARKER		

#	NAME	ADDRESS	CITY	COUNTY	NEONATAL LEVEL	MATERNAL LEVEL
150	WILSON N JONES REGIONAL MEDICAL CENTER	500 NORTH HIGHLAND AVENUE	SHERMAN	GRAYSON	Level I	
151	WISE HEALTH SURGICAL HOSPITAL	3200 NORTH TARRANT PARKWAY	FORT WORTH	TARRANT		
152	WISE HEALTH SYSTEM	609 MEDICAL CENTER DRIVE	DECATUR	WISE	Level II	
153	WISE HEALTH SYSTEM	2000 SOUTH FM 51	DECATUR	WISE		

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	Ables Springs Fire VFD FRO	30000 Fm 429	Terrell	Tx	75161	Kaufman
Ems Provider	Addison Fire Department	4798 Airport Pkwy	Addison	Tx	75001	Dallas
Ems Provider	Air Evac Ems Inc	1001 Boardwalk Springs Pl. Ste 250	O'Fallon	Mo	63368	Out Of State/Unknown
Ems Provider	Allen Fire Department Dba	310 Century Parkway	Allen	Tx	75013	Collin
First Responder	Alvord Volunteer Fire Department	Po Box 63	Alvord	Tx	76225	Wise
Ems Provider	American Medical Response Ambulance Inc Dba	Po Box 181029	Arlington	Tx	76096	Tarrant
Ems Provider	American Medical Response Ambulance Service Inc Dba	4099 McEwen Rd Ste 200	Farmers Branch	Tx	75244	Dallas
Ems Provider	American Medical Response Ambulance Service Inc Dba	2250 West Hwy 287 Business	Waxahachie	Tx	75167	Ellis
Ems Provider	American Medical Response Ambulance Service Inc Dba	3003 C Joe Ramsey Blvd	Greenville	Tx	75402	Hunt
Ems Provider	American Medical Response Ambulance Services Inc Dba	3003c Joe Ramsey Blvd.	Greenville	Tx	75401	Hunt
First Responder	Anna Fire and Rescue Inc Dba	Po Box 487	Anna	Tx	75409	Collin
Ems Provider	Argyle Volunteer Fire District Dba	Po Box 984	Argyle	Tx	76226	Denton
First Responder	Arlington Fire Department	Po Box 90231, MS 04-0260	Arlington	Tx	76004	Tarrant
Ems Provider	Arthur Lee Willis Jr Enterprises LLC Dba	2002 Academy Lane Ste 200	Farmers Branch	Tx	75234	Dallas
Ems Provider	Aubrey Area Ambulance Inc Dba	200 W Sycamore St	Aubrey	Tx	76227	Denton
Ems Provider	Azle Fire Department	Po Box 1378	Azle	Tx	76098	Parker
First Responder	Bailey Volunteer Fire Dept	Po Box 103	Bailey	Tx	75413	Fannin
Ems Provider	Bedford Fire Department	1816 Bedford Rd	Bedford	Tx	76021	Tarrant
First Responder	Bell Helicopter / Textron Dba	3255 Bell Helicopter Blvd	Fort Worth	Tx	76118	Tarrant
Ems Provider	Bells-Savoy Community Emergency Service Inc Dba	Po Box 132	Bells	Tx	75414	Grayson

License Type	Name	Mailing Address	City	State	Zip Code	County
Ems Provider	Benbrook Fire Department	528 Mercedes St	Benbrook	Tx	76126	Tarrant
First Responder	Blue Mound Vol Fire Department	301 Blue Mound Rd	Blue Mound	Tx	76131	Tarrant
First Responder	Blue Ridge Vol Fire Dept	203 W Fm 545	Blue Ridge	Tx	75424	Collin
First Responder	Blue Water Oaks VFD	Po Box 330	Alvarado	Tx	76009	Johnson
Ems Provider	Bonham Fire Department	Po Box 180446	Dallas	Tx	75218	Dallas
First Responder	Bono Volunteer Fire Department Dba	5536 Hwy 67 W	Cleburne	Tx	76033	Johnson
First Responder	Boonsville/Balsora Volunteer Fire Department Inc	280 Cr 3743	Bridgeport	Tx	76426	Wise
First Responder	Bosque Valley First Responders Organization Dba	1560 Alexander Rd.	Stephenville	Tx	76401	Erath
First Responder	Branch Volunteer Fire Department	Po Box 788	Princeton	Tx	75407	Collin
First Responder	Briar - Reno Fire Department	Po Box 1902	Azle	Tx	76098	Parker
First Responder	Briar Oaks Volunteer Fire Department Inc	515 Ward Ln	Burleson	Tx	76028	Johnson
First Responder	Bristol Volunteer Fire Department Inc	101 S Old Walnut	Ennis	Tx	75119	Ellis
First Responder	Brock-Dennis VFD Inc	1107 Fm 1189	Brock	Tx	76087	Parker
First Responder	Burleson Fire Department Fr	141 W Renfro St	Burleson	Tx	76028	Johnson
First Responder	Caddo Mills Fire & Rescue Dba	Po Box 429	Caddo Mills	Tx	75135	Hunt
First Responder	Callisburg Volunteer Fire Department Inc	116 McDaniel St	Callisburg	Tx	76240	Cooke
First Responder	Campbell Volunteer Fire Department Inc Dba	P.O. Box 73	Campbell	Tx	75422	Hunt
Ems Provider	CareFlite-Air	3110 S Great Southwest Pkwy	Grand Prairie	Tx	75052	Tarrant
Ems Provider	CareFlite-Ground	1716 Hal Avenue	Cleburne	Tx	76031	Johnson
Ems Provider	Carrollton Fire Department	1111 W Beltline Rd Ste 100	Carrollton	Tx	75006	Dallas

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	Cash Fire Department Association Inc Dba	4745 Highway 34 South	Greenville	Tx	75402	Hunt
First Responder	Celeste Volunteer Fire Department Inc Dba	Po Box 145	Celeste	Tx	75423	Hunt
First Responder	Central Community Volunteer Fire Department	4100 Old Agnes Rd	Weatherford	Tx	76088	Parker
Ems Provider	Children's Medical Center Of Dallas Dba	1935 Medical District Dr	Dallas	Tx	75235	Dallas
Ems Provider	Choice Ambulance Services LLC Dba	321 Cooper Street	Cedar Hill	Tx	75104	Dallas
First Responder	City Of Alvarado Dba	104 College Street	Alvarado	Tx	76009	Johnson
First Responder	City Of Balch Springs Dba	12500 Elam Rd	Balch Springs	Tx	75180	Dallas
Ems Provider	City Of Cedar Hill Dba	1212 W Beltline Rd	Cedar Hill	Tx	75104	Dallas
Ems Provider	City Of Celina Fire Department	1413 S Preston Rd	Celina	Tx	75009	Collin
Ems Provider	City Of Colleyville	5209 Colleyville Blvd	Colleyville	Tx	76034	Tarrant
Ems Provider	City Of Corinth Dba	3501 Fm 2181 Suite B	Corinth	Tx	76210	Denton
Ems Provider	City Of Dallas Fire-Rescue Department	1551 Baylor St. Ste. 300	Dallas	Tx	75226	Dallas
Ems Provider	City Of Dublin Dba	213 East Blackjack Street	Dublin	Tx	76446	Erath
First Responder	City Of Ennis Fire Department Dba	Po Box 220	Ennis	Tx	75120	Ellis
Ems Provider	City Of Euless Fire Department	201 N Ector Dr	Euless	Tx	76039	Tarrant
Ems Provider	City Of Everman Ems Dba	400 W Enon Ave	Everman	Tx	76140	Tarrant
First Responder	City Of Everman Fire Department Dba	404 W Enon	Everman	Tx	76140	Tarrant
First Responder	City Of Ferris FD	111 Ewing St	Ferris	Tx	75125	Ellis
First Responder	City Of Forest Hill Dba	6304 Wanda Ln	Fort Worth	Tx	76119	Tarrant
Ems Provider	City Of Grand Prairie Dba	1525 Arkansas Ln 3rd Fl	Grand Prairie	Tx	75052	Dallas
Ems Provider	City Of Grapevine Dba	1007 Ira E Woods Ave	Grapevine	Tx	76051	Tarrant

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	City Of Haltom City Fire Rescue Dba	5525 Broadway Ave	Haltom City	Tx	76117	Tarrant
Ems Provider	City Of Hurst Fire Department	2100 Precinct Line Road	Hurst	Tx	76054	Tarrant
Ems Provider	City Of Hutchins Dba	1525 E Wintergreen Rd	Hutchins	Tx	75141	Dallas
First Responder	City Of Joshua Fire Department	101 S Main St	Joshua	Tx	76058	Johnson
First Responder	City Of Kaufman Fire Department Dba	301 S Madison	Kaufman	Tx	75142	Kaufman
Ems Provider	City Of Keene Fire Rescue	201 W HiLLCrest	Keene	Tx	76059	Johnson
Ems Provider	City Of Lancaster Dba	100 Craig Shaw Memorial Pkwy	Lancaster	Tx	75134	Dallas
Ems Provider	City Of Lewisville Fire Department Dba	Po Box 299002	Lewisville	Tx	75029	Denton
Ems Provider	City Of Lucas Fire Rescue	165 Country Club Rd	Lucas	Tx	75002	Collin
Ems Provider	City Of Mansfield Fire Department Dba	1305 E Broad St	Mansfield	Tx	76063	Tarrant
First Responder	City Of Melissa Fire Department	3411 Barker Ave	Melissa	Tx	75454	Collin
Ems Provider	City Of Murphy Dba	206 N Murphy Rd	Murphy	Tx	75094	Collin
First Responder	City Of Oak Point Dba	100 Naylor Rd	Oak Point	Tx	75068	Denton
First Responder	City Of Pottsboro Dba	Po Box 1089	Pottsboro	Tx	75076	Grayson
First Responder	City Of Rockwall Fire Department Dba	385 S Goliad St	Rockwall	Tx	75087	Rockwall
Ems Provider	City Of Sachse Fire Department	3815 Sachse Rd Bldg D	Sachse	Tx	75048	Dallas
First Responder	City Of Saginaw Dba	400 South Saginaw Blvd.	Saginaw	Tx	76179	Tarrant
Ems Provider	City Of Sanger Fire Department Dba	Po Box 1729	Sanger	Tx	76266	Denton
First Responder	City Of Seagoville Dba	1717 N Hwy 175	Seagoville	Tx	75159	Dallas
Ems Provider	City Of The Colony Dba	4900 Blair Oaks Dr	The Colony	Tx	75056	Denton

License Type	Name	Mailing Address	City	State	Zip Code	County
Ems Provider	City Of Watauga Dba	7105 Whitley Road	Watauga	Tx	76148	Tarrant
Ems Provider	City Of Whitewright Ems Dba	P.O. Box 966	Whitewright	Tx	75491	Grayson
First Responder	City Of Willow Park Fire/Rescue Department Dba	101 Stagecoach Trl	Weatherford	Tx	76087	Parker
Ems Provider	City Of Wylie Fire Rescue	2000 N Hwy 78	Wylie	Tx	75098	Collin
Ems Provider	Cleburne Fire Department	114 West Wardville St	Cleburne	Tx	76033	Johnson
First Responder	Cockrell Hill Volunteer Fire Department Inc Dba	4125 W. Clarendon Dr	Cockrell Hill	Tx	75211	Dallas
First Responder	Collinsville VFD	Po Box 557	Collinsville	Tx	76233	Grayson
First Responder	Combine Fire Department Dba	125 Davis Rd	Combine	Tx	75159	Kaufman
First Responder	Commerce Emergency Corps	Po Box 8	Commerce	Tx	75428	Hunt
First Responder	Commerce Fire Department	1103 Sycamore St	Commerce	Tx	75428	Hunt
Ems Provider	Cook Children's Medical Center	124 Texas Way	Fort Worth	Tx	76106	Tarrant
Ems Provider	Cooke County Ems	301 West Church St	Gainesville	Tx	76240	Cooke
First Responder	Cool-Garner Volunteer Fire Department	2290 Garner School Rd	Weatherford	Tx	76088	Parker
Ems Provider	Coppell Fire Department	265 E Parkway Blvd	Coppell	Tx	75019	Dallas
Ems Provider	Corsicana Fire Department	200 N 12th Street	Corsicana	Tx	75110	Navarro
First Responder	Cottondale VFD Fr	Po Box 1987	Boyd	Tx	76023	Wise
First Responder	Crandall Volunteer Fire Department	106 E. Trunk St. Po Box 298	Crandall	Tx	75114	Kaufman
First Responder	Cresson Volunteer Fire Department Inc	Po Box 42	Cresson	Tx	76035	Hood
First Responder	Cross Timbers Emergency Response Team Inc	Po Box 15	Stephenville	Tx	76401	Erath
Ems Provider	Crowley Fire Department	201 E Main St	Crowley	Tx	76036	Tarrant
Ems Provider	Dale Aviation Inc Dba	1500 East Industrial Blvd	Mckinney	Tx	75069	Collin

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	Dallas County Fire Rescue Association Dba	600 Commerce St Rm-B-15	Dallas	Tx	75202	Dallas
Ems Provider	Dallas Lifecare Ems LLC Dba	3939 Us Hwy 80 E Ste 463	Mesquite	Tx	75150	Dallas
Ems Provider	Dal-Mor LLC Dba	1316 West Euless Blvd Ste 600	Euless	Tx	76040	Tarrant
First Responder	Dalworthington Gardens DPS Dba	2600 Roosevelt Dr	Dwg	Tx	76016	Tarrant
First Responder	DCBE / Acton Volunteer Fire Department Inc	6430 Smoky Hill Ct	Granbury	Tx	76049	Hood
First Responder	Decatur FD	1705 S State	Decatur	Tx	76234	Wise
Ems Provider	Denison Fire Department	700 W. Chestnut	Denison	Tx	75020	Grayson
Ems Provider	Denton County ESD No 1	Po Box 984	Argyle	Tx	76226	Denton
Ems Provider	Denton Fire Department	332 E Hickory Street	Denton	Tx	76201	Denton
Ems Provider	Desoto Fire Rescue	211 E Pleasant Run Rd	Desoto	Tx	75115	Dallas
Ems Provider	DFW Airport DPS	Po Box 610687	DFW Airport	Tx	75261	Dallas
First Responder	Dodd City Volunteer Fire Department	Po Box 202	Dodd City	Tx	75438	Fannin
First Responder	Double Oak Volunteer Fire Department Inc	1110 Cross Timbers Dr	Double Oak	Tx	75077	Denton
Ems Provider	Duncanville Fire Department	Po Box 380280	Duncanville	Tx	75138	Dallas
Ems Provider	Eagle Mountain Volunteer Fire Department	9500 Live Oak Ln	Fort Worth	Tx	76179	Tarrant
First Responder	East Wise Fire Rescue Inc	Box 69	Rhome	Tx	76078	Wise
First Responder	Ector Vol Fire Dept	Po Box 394	Ector	Tx	75439	Fannin
First Responder	Edgecliff Village Fire Rescue	1605 Edgecliff Rd	Fort Worth	Tx	76134	Tarrant
Ems Provider	Einstein Group LLC Dba	16490 Lone Star Circle	Fort Worth	Tx	76177	Tarrant
First Responder	Elmo VFD	Po Box 160	Elmo	Tx	75118	Kaufman
Ems Provider	Erath County Emergency Medical Services	830b East Road	Stephenville	Tx	76401	Erath

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	ESD 6 Volunteer Fire Department	306 Industrial Road	Waxahachie	Tx	75165	Ellis
Ems Provider	Farmers Branch Fire Department	13333 Hutton Dr	Farmers Branch	Tx	75234	Dallas
First Responder	Farmersville Volunteer Fire Department	134 N Washington St	Farmersville	Tx	75442	Collin
First Responder	Fate Department Of Public Safety	Po Box 159	Fate	Tx	75132	Rockwall
Ems Provider	Flower Mound Fire Department	3911 S Broadway	Flower Mound	Tx	75028	Denton
First Responder	Forney Fire Department	104 E Aimee Street	Forney	Tx	75126	Kaufman
First Responder	Forreston Volunteer Fire Department	Po Box 202	Forreston	Tx	76041	Ellis
First Responder	Fort Worth Fire Department	509 W. Felix Street	Fort Worth	Tx	76115	Tarrant
First Responder	Fort Worth Police Department	310 Gulf Stream Rd	Fort Worth	Tx	76106	Tarrant
Ems Provider	Frisco Fire Department	8601 Gary Burns Drive	Frisco	Tx	75034	Collin
First Responder	Frost Vol Fire Dept	Po Box 416	Frost	Tx	76641	Navarro
First Responder	Gainesville Fire Rescue Dba	201 Santa Fe Santa Fe St	Gainesville	Tx	76240	Cooke
Ems Provider	Garland Fire Department	1500 E State Hwy 66	Garland	Tx	75040	Dallas
Ems Provider	Glenn Heights Fire Dept	1938 S Hampton Rd	Glenn Heights	Tx	75154	Dallas
First Responder	Godley Fire Dept Fr	Po Box 27	Godley	Tx	76044	Johnson
First Responder	Gordonville Vol Fire Dept Dba	Po Box 453	Gordonville	Tx	76245	Grayson
Ems Provider	Granbury Hood County Ems Inc Dba	2200 Commercial Ln	Granbury	Tx	76048	Hood
First Responder	Granbury Volunteer Fire Department	Po Box 88	Granbury	Tx	76048	Hood
First Responder	Grandview Volunteer Fire Department	Po Box 505	Grandview	Tx	76050	Johnson
First Responder	Grayson County Dba	4717 Airport Drive	Denison	Tx	75020	Grayson
First Responder	Greenville Fire-Rescue	2603 Templeton Street	Greenville	Tx	75401	Hunt

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	Greenwood Rural Volunteer Fire Department Inc Dba	1418 Greenwood Cut-Off Rd.	Weatherford	Tx	76088	Parker
First Responder	Greenwood-Slidell Volunteer Fire Department	Po Box 153	Slidell	Tx	76267	Wise
First Responder	Haslet Volunteer Fire Department Dba	105 Main St	Haslet	Tx	76052	Tarrant
Ems Provider	Health Transport Inc Dba	Po Box 14274	Fort Worth	Tx	76117	Tarrant
First Responder	Heath Department Of Public Safety	200 Laurence Drive	Heath	Tx	75032	Rockwall
Ems Provider	Highland Park DPS	4700 Drexel Dr	Highland Park	Tx	75205	Dallas
Ems Provider	Highland Village Fire Department	1200 Highland Village Rd	Highland Village	Tx	75077	Denton
First Responder	Hood County Station 70 Volunteer Fire Department	3410 Hilltop Rd	Granbury	Tx	76048	Hood
First Responder	Indian Creek Volunteer Fire Department	550 Kiowa Dr. W	Gainesville	Tx	76240	Cooke
First Responder	Indian Harbor Volunteer Fire Department Dba	1414 E Apache Trl	Granbury	Tx	76048	Hood
Ems Provider	Irving Fire Department	845 W Irving Blvd	Irving	Tx	75060	Dallas
Ems Provider	JCSD Emergency Medical Group Inc Dba	14290 Gillis Road Suite A	Farmers Branch	Tx	75244	Dallas
First Responder	Johnson County ESD 1	2451 Service Dr	Cleburne	Tx	76033	Johnson
First Responder	Josephine VFD	Po Box 212	Josephine	Tx	75164	Collin
Ems Provider	Justin Community Volunteer Fire Department Inc Dba	Po Box 613	Justin	Tx	76247	Denton
Ems Provider	Keller Fire Rescue	Po Box 770	Keller	Tx	76244	Tarrant
First Responder	Kemp Community Volunteer Fire Department Inc	1307 S Elm St	Kemp	Tx	75143	Kaufman
Ems Provider	Kennedale Fire Department Dba	405 Municipal Dr	Kennedale	Tx	76060	Tarrant
Ems Provider	Krum Fire Department	400 N. First St	Krum	Tx	76249	Denton
First Responder	Ladonia Volunteer Fire Department	Paris 203 Paris St Po Box 65	Ladonia	Tx	75449	Fannin
First Responder	Lake Worth Fire Department	3805 Adam Grubb	Lake Worth	Tx	76135	Tarrant

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	Lavon Volunteer Fire Department Inc Dba	120 School Rd. Po Box 340	Lavon	Tx	75166	Collin
First Responder	Leonard Volunteer Fire Department	Po Box 1270	Leonard	Tx	75452	Fannin
First Responder	Liberty Chapel Volunteer Firefighters Inc Dba	Po Box 274	Cleburne	Tx	76033	Johnson
First Responder	Lindsay Volunteer Fire Department Dba	Po Box 143	Lindsay	Tx	76250	Cooke
First Responder	Lipan Vol Fire Dept	Po Box 211	Lipan	Tx	76462	Hood
First Responder	Lockheed Martin Aeronautics Dba	Po Box 748 Mail Zone 5905	Fort Worth	Tx	76101	Tarrant
First Responder	Locust Community Volunteer Fire Dept	Po Box 1888	Pottsboro	Tx	75076	Grayson
First Responder	Lone Camp Volunteer Fire Department Inc Dba	7236 South Fm 4	Palo Pinto	Tx	76484	Palo Pinto
First Responder	Lone Oak Texas Fire Department Inc	Po Box 353	Lone Oak	Tx	75453	Hunt
First Responder	Lowry Crossing Fire Department Inc	1407 S Bridgefarmer Rd	Mckinney	Tx	75069	Collin
First Responder	Mabank Fire Department Dba	Po Box 1233	Mabank	Tx	75147	Kaufman
Ems Provider	Mckinney Fire Department	2200 Taylor-Burk Dr	Mckinney	Tx	75071	Collin
First Responder	Mclendon Chisholm Volunteer Fire Department Inc	1371 W Fm 550	Mclendon-Chisholm	Tx	75032	Rockwall
Ems Provider	Medic Rescue Inc Dba	Po Box 2125	Rockwall	Tx	75087	Rockwall
Ems Provider	Medical Jets International LLC	Po Box 935	Forney	Tx	75126	Kaufman
Ems Provider	Med-Trans Corporation Dba	209 State Hwy 121 Bypass, Ste. 11	Lewisville	Tx	75067	Denton
First Responder	Merit Volunteer Fire Department	Po Box 262	Merit	Tx	75458	Hunt
Ems Provider	Mesquite Fire Dept	Po Box 850137	Mesquite	Tx	75185	Dallas
Ems Provider	Metropolitan Area Ems Authority Dba	2900 Alta Mere Dr	Fort Worth	Tx	76116	Tarrant

License Type	Name	Mailing Address	City	State	Zip Code	County
Ems Provider	Midlothian Fire Department	100 W Avenue F	Midlothian	Tx	76065	Ellis
First Responder	Millsap Fire / Rescue Inc	407 South Houston St.	Millsap	Tx	76066	Parker
Ems Provider	Mineral Wells Fire Ems	Po Box 460	Mineral Wells	Tx	76068	Palo Pinto
First Responder	Moss Lake Volunteer Fire Department Inc	7480 Fm 1201	Gainesville	Tx	76240	Cooke
First Responder	Muenster Volunteer Fire Department Inc	Po Box 112	Muenster	Tx	76252	Cooke
First Responder	Nevada Volunteer Fire Dept	Po Box 306	Nevada	Tx	75173	Collin
First Responder	Newark Volunteer Fire Department	Po Box 478	Newark	Tx	76071	Wise
First Responder	North Hood County VFD Dba	Po Box 203	Granbury	Tx	76048	Hood
Ems Provider	North Richland Hills Fire Department	4301 City Point Drive	North Richland Hills	Tx	76180	Tarrant
Ems Provider	Ohara Flying Service Dba	1500 Industrial Blvd Ste 118 A	Mckinney	Tx	75069	Collin
First Responder	Ovilla Fire Department	105 Cockrell Hill Road	Ovilla	Tx	75154	Ellis
First Responder	Palo Pinto County ESD 1	Po Box 460	Palo Pinto	Tx	76484	Palo Pinto
Ems Provider	Pantego Fire Department	1614 S Bowen Rd	Pantego	Tx	76013	Tarrant
First Responder	Paradise Volunteer Fire Dept	Po Box 97	Paradise	Tx	76073	Wise
First Responder	Parker County Emergency Service District 7 Dba	1418 Greenwood Cutoff Road	Weatherford	Tx	76088	Parker
First Responder	Parker County ESD 1 Dba	Po Box 323 Po Box 323	Springtown	Tx	76082	Parker
First Responder	Parker County ESD 6 Dba	6300 Granbury Hwy.	Weatherford	Tx	76087	Parker
Ems Provider	Parker County Hospital District Dba	725 State St	Weatherford	Tx	76086	Parker
First Responder	Parker Volunteer Fire Department	5700 E Parker Rd	Parker	Tx	75002	Collin
Ems Provider	Pecan Plantation VFD & Ems Inc Dba	9518 Monticello	Granbury	Tx	76049	Hood
Ems Provider	Pilot Point Fire Ems Dba	102 E Main St	Pilot Point	Tx	76258	Denton

License Type	Name	Mailing Address	City	State	Zip Code	County
Ems Provider	Plano Fire Rescue	1901 K Avenue	Plano	Tx	75074	Collin
First Responder	Ponder Volunteer Fire Department Inc	Po Box 386	Ponder	Tx	76259	Denton
Ems Provider	Possum Kingdom Lake Vol Fire And Amb Service	Po Box 345	Graford	Tx	76449	Palo Pinto
Ems Provider	Possum Kingdom Westlake Vol Ems Dba	4809 Green Acres Rd	Graham	Tx	76450	Palo Pinto
Ems Provider	Preston Volunteer Emergency Services Inc Dba	Po Box 518	Pottsboro	Tx	75076	Grayson
First Responder	Princeton Volunteer Fire Department Dba	510 Woody Drive	Princeton	Tx	75407	Collin
Ems Provider	Prosper Fire Department	1500 East First Street	Prosper	Tx	75078	Collin
First Responder	Quinlan Volunteer Fire Department Inc	Po Box 2616	Quinlan	Tx	75474	Hunt
First Responder	Randolph Volunteer Fire Department	Po Box 131	Randolph	Tx	75475	Fannin
First Responder	Red Oak Fire Rescue	547 N Methodist	Red Oak	Tx	75154	Ellis
Ems Provider	Rendon Fire Department	12330 Rendon Rd	Burleson	Tx	76028	Tarrant
First Responder	Rhome Fire Department	Po Box 228	Rhome	Tx	76078	Wise
Ems Provider	Richardson Fire Department	300 North Greenville	Richardson	Tx	75081	Dallas
Ems Provider	Richland Hills Fire Rescue	3201 Diana Drive	Richland Hills	Tx	76118	Tarrant
First Responder	Rio Vista VFD Fr	102 Depot Box 93	Rio Vista	Tx	76093	Johnson
First Responder	River Oaks Fire Department	4900 River Oaks Blvd	Fort Worth	Tx	76114	Tarrant
Ems Provider	Roanoke Fire Department	201 Fairway Dr	Roanoke	Tx	76262	Denton
Ems Provider	Rowlett Fire Department Dba	Po Box 99	Rowlett	Tx	75030	Dallas
First Responder	Royse City Fire Department	Po Box 638	Royse City	Tx	75189	Rockwall
First Responder	Runaway Bay Volunteer Fire Dept	429 Half Moon Way	Runaway Bay	Tx	76426	Wise
Ems Provider	Sacred Cross Ems Inc	P.O. Box 447	Krum	Tx	76249	Denton

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	Sansom Park Fire Rescue	5500 Buchanan St	Sansom Park	Tx	76114	Tarrant
Ems Provider	Santo Vol Fire & Ems Department Dba	Po Box 296	Santo	Tx	76472	Palo Pinto
Ems Provider	Serenity Ems LLC Dba	Po Box 550669	Dallas	Tx	75355	Dallas
Ems Provider	Sherman Fire Dept	318 S Travis	Sherman	Tx	75090	Grayson
First Responder	Sherwood Shore Voluntary Fire Dept Dba	Po Box 602	Gordonville	Tx	76245	Grayson
First Responder	Six Flags Over Texas/Hurricane Harbor Inc	Po Box 90191	Arlington	Tx	76004	Tarrant
Ems Provider	Somervell County Dba	111 Shepard Street	Glen Rose	Tx	76043	Somervell
Ems Provider	Southlake DPS	600 State St	Southlake	Tx	76092	Tarrant
First Responder	Southmayd Volunteer Fire Department	Po Box 88	Southmayd	Tx	76268	Grayson
Ems Provider	Stephenville Fire Dept	1301 Pecan Hill Dr	Stephenville	Tx	76401	Erath
Ems Provider	Sterling Ems LLC Dba	1421 E Sandy Lake Rd Suite 100	Coppell	Tx	75019	Dallas
Ems Provider	Sunnyvale Fire Rescue Department	404 Tower Pl	Sunnyvale	Tx	75182	Dallas
First Responder	Tawakoni South Volunteer Fire Department	10407 Fm 429	Quinlan	Tx	75474	Hunt
First Responder	Tawakoni Volunteer Fire Department	Po Box 2260	Quinlan	Tx	75474	Hunt
First Responder	Telephone Volunteer Fire Department Inc	Po Box 116	Telephone	Tx	75488	Fannin
First Responder	Terrell Fire Department	201 East Nash St. Po Box 310	Terrell	Tx	75160	Kaufman
First Responder	Tioga Volunteer Fire Department	Po Box 207	Tioga	Tx	76271	Grayson
First Responder	Tolar VFD Fr	Po Box 234	Tolar	Tx	76476	Hood
Ems Provider	Town Of Fairview	500 S Hwy 5	Fairview	Tx	75069	Collin
Ems Provider	Town Of Little Elm Fire Department Dba	100 W Eldorado Pkwy	Little Elm	Tx	75068	Denton
Ems Provider	Town Of Westlake Fire Ems Department	2000 Dove Road	Westlake	Tx	76262	Denton

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	Town Of Westover Hills Dba	5824 Merrymount Rd	Fort Worth	Tx	76107	Tarrant
First Responder	Trenton Volunteer Fire Dept Inc	203 N Pearl	Trenton	Tx	75490	Fannin
Ems Provider	Trophy Club Ems	295 Trophy Club Drive	Trophy Club	Tx	76262	Denton
First Responder	Union Valley VFD Fr	Po Box 525	Royse City	Tx	75189	Hunt
First Responder	University Emergency Medical Response Dba	800 W Campbell Rd Sg10	Richardson	Tx	75080	Collin
Ems Provider	University Park FD	3800 University Blvd	University Park	Tx	75205	Dallas
First Responder	Valley View Volunteer Fire Department	100 South Pecan Creek Trail	Valley View	Tx	76272	Cooke
Ems Provider	Van Alstyne Fire/Rescue	Po Box 247	Van Alstyne	Tx	75495	Grayson
First Responder	Venus VFD Fr Dba	Po Box 183	Venus	Tx	76084	Johnson
First Responder	Volunteer Fire Department Of North Shore	Po Box	Tioga	Tx	76271	Cooke
First Responder	Waxahachie Fire Department	407 Water Street	Waxahachie	Tx	75165	Ellis
First Responder	Weatherford College Dba	225 College Park Drive	Weatherford	Tx	76086	Parker
First Responder	Weatherford Fire Department Dba	202 W Oak St	Weatherford	Tx	76086	Parker
First Responder	Westminster VFD Inc Dba	Po Box 691	Westminster	Tx	75485 -0691	Collin
First Responder	Westworth Village Police Dept Dba	311 Burton Hill Rd	Westworth Village	Tx	76114	Tarrant
First Responder	White Settlement VFD	8308 Hanon	White Settlement	Tx	76108	Tarrant
First Responder	Whitesboro Fire Department	Po Box 340	Whitesboro	Tx	76273	Grayson
Ems Provider	Wilmer Fire Department	128 N Dallas Ave	Wilmer	Tx	75172	Dallas
Ems Provider	Wise County Ems	Po Box 899	Decatur	Tx	76234	Wise
First Responder	Wise County ESD 1 Dba	Po Box 828	Boyd	Tx	76023	Wise

License Type	Name	Mailing Address	City	State	Zip Code	County
First Responder	Wise County Sand Flat Fire Department Inc	Po Box 100	Chico	Tx	76431	Wise
First Responder	Wolfe City Volunteer Fire Department Inc	Po Box 134	Wolfe City	Tx	75496	Hunt

Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Cherrywood Community Home	2900 Port O Call	Plano	Collin
Intermediate Care Facility	Collin County Mhmr At Mullins	1313 Mullins	Plano	Collin
Intermediate Care Facility	Cross Bend House	3019 Cross Bend	Plano	Collin
Intermediate Care Facility	Longhorn Community Home	957 Longhorn Dr	Plano	Collin
Intermediate Care Facility	Riverbend Community Home	3700 Grifbrick	Plano	Collin
Nursing Facility	The Belmont At Twin Creeks	999 Raintree Circle	Allen	Collin
Nursing Facility	Victoria Gardens Of Allen	310 S Jupiter	Allen	Collin
Nursing Facility	Settlers Ridge Care Center	1280 Settlers Ridge Rd	Celina	Collin
Nursing Facility	Continuing Care At Highland Springs	7910 Frankford Road	Dallas	Collin
Nursing Facility	The Hillcrest Of North Dallas	18648 Hillcrest Rd	Dallas	Collin
Nursing Facility	Farmersville Health And Rehabilitation	205 Beech St	Farmersville	Collin
Nursing Facility	Lexington Medical Lodge	2000 West Audie Murphy Pkway	Farmersville	Collin
Nursing Facility	Stonemere Rehabilitation Center	11855 Lebanon Road	Frisco	Collin
Nursing Facility	Victoria Gardens Of Frisco	10700 Rolater Dr	Frisco	Collin
Nursing Facility	Baybrooke Village Care And Rehab Center	8300 Eldorado Pkwy West	Mckinney	Collin
Nursing Facility	Belterra Health & Rehab	2170 North Lake Forest Drive	Mckinney	Collin
Nursing Facility	Mckinney Healthcare And Rehabilitation Center	253 Enterprise Dr	Mckinney	Collin
Nursing Facility	North Park Health And Rehabilitation Center	1720 N Mcdonald	Mckinney	Collin
Nursing Facility	Park Manor Of Mckinney	1801 Pearson Ave	Mckinney	Collin
Nursing Facility	Accel At Willow Bend	2620 Communications Pkwy	Plano	Collin
Nursing Facility	Carrara	4501 Tradition Trail	Plano	Collin
Nursing Facility	Collinwood Care Center	3100 S Rigsbee Rd	Plano	Collin
Nursing Facility	Landmark Of Plano Rehabilitation And Nursing Center	1621 Coit Rd	Plano	Collin
Nursing Facility	Life Care Center Of Plano	3800 W Park Blvd	Plano	Collin
Nursing Facility	The Healthcare Resort Of Plano	3325 West Plano Parkway	Plano	Collin
Nursing Facility	The Legacy At Willow Bend	6101 Ohioste 500	Plano	Collin
Nursing Facility	The Park In Plano	3208 Thunderbird Ln	Plano	Collin

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	Princeton Medical Lodge	1401 W. Princeton Dr.	Princeton	Collin
Nursing Facility	San Remo	3550 Shiloh Road	Richardson	Collin
Nursing Facility	Founders Plaza Nursing & Rehab	721 S Hwy 78	Wylie	Collin
Nursing Facility	Garnet Hill Rehabilitation And Skilled Care	1420 Mccreary Rd	Wylie	Collin
Nursing Facility	Gainesville Nursing & Rehab	1900 O'neal St	Gainesville	Cooke
Nursing Facility	Pecan Tree Rehab And Healthcare Center	1900 E. California St	Gainesville	Cooke
Nursing Facility	Renaissance Care Center	1400 Black Hill Drive	Gainesville	Cooke
Nursing Facility	River Valley Health & Rehabilitation Center	1907 Refinery Rd	Gainesville	Cooke
Intermediate Care Facility	1515 Northland	1515 Northland St.	Carrollton	Dallas
Intermediate Care Facility	2100 Cedar	2100 Cedar Cir	Carrollton	Dallas
Intermediate Care Facility	2321 Greenmeadow	2321 Greenmeadow Dr.	Carrollton	Dallas
Intermediate Care Facility	6520 Braddock Place?	6520 Braddock Place	Dallas	Dallas
Intermediate Care Facility	14 Ferris Creek	9814 Ferris Creek	Dallas	Dallas
Intermediate Care Facility	23 Ferris Creek	12323 Ferris Creek Ln	Dallas	Dallas
Intermediate Care Facility	27 Ferris Creek	12327 Ferris Creek	Dallas	Dallas
Intermediate Care Facility	Ability Connection Texas Jubilee House	3108 Jubilee Tr	Dallas	Dallas
Intermediate Care Facility	Educare Community Living Corporation - Texas	14255 Haymeadow Dr	Dallas	Dallas
Intermediate Care Facility	Educare Community Living Corporation - Texas	3111 Leharve	Dallas	Dallas
Intermediate Care Facility	Educare Community Living Corporation - Texas	14163 Haymeadow Dr	Dallas	Dallas
Intermediate Care Facility	Educare Community Living Corporation - Texas	5922 Lewisburg	Dallas	Dallas
Intermediate Care Facility	Henry House	7153 Pineberry	Dallas	Dallas
Intermediate Care Facility	St. Nicholas Operations Llc	4612 Heatherbrook Dr	Dallas	Dallas
Intermediate Care Facility	Devonshire Home	1225 Devonshire	Desoto	Dallas
Intermediate Care Facility	Live Oak	812 Live Oak	Desoto	Dallas

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Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Meadow Hill Home	517 Meadow Hill	Desoto	Dallas
Intermediate Care Facility	Prairie Creek	920 Prairie Creek Dr	Desoto	Dallas
Intermediate Care Facility	Tate	525 Tate Dr	Desoto	Dallas
Intermediate Care Facility	Valley Glen	219 Valley Glen	Desoto	Dallas
Intermediate Care Facility	Educare Community Living Corporation - Texas	402 W Vinyard	Duncanville	Dallas
Intermediate Care Facility	Evergreen Hidden Court Community Home	5322 Hidden Ct	Garland	Dallas
Intermediate Care Facility	Evergreen Lighthouse Community Home	1205 Wendell Way	Garland	Dallas
Intermediate Care Facility	Evergreen Pebblecreek Community Home	530 Pebblecreek Dr	Garland	Dallas
Intermediate Care Facility	Evergreen Pyramid Community Home	706 Pyramid	Garland	Dallas
Intermediate Care Facility	Knoll Point Place Llc	3446 Knoll Point Dr	Garland	Dallas
Intermediate Care Facility	Trinity Manor	2813 Country Valley Rd	Garland	Dallas
Intermediate Care Facility	1102 Fort Scott Trail	1102 Fort Scott Trail	Grand Prairie	Dallas
Intermediate Care Facility	3502 Glenda	3502 Glenda	Grand Prairie	Dallas
Intermediate Care Facility	Amicus At Woodside	2213 Woodside Dr	Grand Prairie	Dallas
Intermediate Care Facility	Educare Community Living Corporation - Texas	4925 Embers Trail	Grand Prairie	Dallas
Intermediate Care Facility	Educare Community Living Corporation - Texas	2616 Alan A Dale	Irving	Dallas
Intermediate Care Facility	Educare Community Living Corporation - Texas	1829 Anna Dr	Irving	Dallas
Intermediate Care Facility	Educare Community Living Corporation - Texas	917 Apple Tree Ct	Irving	Dallas
Intermediate Care Facility	Fulton Community Home	2501 Crestview	Irving	Dallas
Intermediate Care Facility	Maykus Community Home	600 Maykus Ct	Irving	Dallas
Intermediate Care Facility	Rindie Community Home	1701 Rindie St	Irving	Dallas

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Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Barry Lane	234 Barry Lane	Lancaster	Dallas
Intermediate Care Facility	Willowood	731 Willowood	Lancaster	Dallas
Intermediate Care Facility	Eastbrook House	3313 Eastbrook Dr	Mesquite	Dallas
Intermediate Care Facility	Evergreen Islandview Community Home	1901 Island View	Mesquite	Dallas
Intermediate Care Facility	Evergreen Valley Creek Community Home	907 Valleycreek Dr	Mesquite	Dallas
Intermediate Care Facility	Harman House	4237 Ashwood Dr	Mesquite	Dallas
Intermediate Care Facility	1509 Versailles	1509 Versailles	Richardson	Dallas
Intermediate Care Facility	1809 Auburn	1809 Auburn	Richardson	Dallas
Intermediate Care Facility	Ability Connection Texas Ability House	615-617 Woodhaven Pl.	Richardson	Dallas
Intermediate Care Facility	Ability Connection Texas Wentworth House	642 Wentworth Dr	Richardson	Dallas
Intermediate Care Facility	Autistic Treatment Center, Inc	406 Fieldwood Drive	Richardson	Dallas
Nursing Facility	Balch Springs Nursing Home	4200 Shepherd Ln	Balch Springs	Dallas
Nursing Facility	Carrollton Health And Rehabilitation Center	1618 Kirby Rd	Carrollton	Dallas
Nursing Facility	Heritage Gardens Rehabilitation And Healthcare	2135 N Denton Dr	Carrollton	Dallas
Nursing Facility	The Madison On Marsh	2245 Marsh Ln	Carrollton	Dallas
Nursing Facility	Cedar Hill Healthcare Center	230 S Clark Rd	Cedar Hill	Dallas
Nursing Facility	Crestview Court	224 W Pleasant Run Rd	Cedar Hill	Dallas
Nursing Facility	Sandy Lake Rehabilitation And Care Center	1410 E Sandy Lake Rd	Coppell	Dallas
Nursing Facility	Adora Midtown Park	8130 Meadow Road	Dallas	Dallas
Nursing Facility	Autumn Leaves	1010 Emerald Isle Dr	Dallas	Dallas
Nursing Facility	Brentwood Place Four	3505 S Buckner Blvd Bldg 5	Dallas	Dallas
Nursing Facility	Brentwood Place One	3505 S Buckner Blvd Bldg 2	Dallas	Dallas
Nursing Facility	Brentwood Place Three	3505 S Buckner Blvd Bldg 4	Dallas	Dallas
Nursing Facility	Brentwood Place Two	3505 S Buckner Blvd Bldg 3	Dallas	Dallas

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	C C Young Memorial Home	4849 W. Lawther Dr.	Dallas	Dallas
Nursing Facility	Crystal Creek At Preston Hollow	11409 N Central Expwy	Dallas	Dallas
Nursing Facility	Diversicare Of Lake Highlands	9009 White Rock Tr	Dallas	Dallas
Nursing Facility	Golden Acres Living And Rehabilitation Center	2525 Centerville Rd	Dallas	Dallas
Nursing Facility	Healthcare Center At The Forum At Park Lane	7827 Park Lane	Dallas	Dallas
Nursing Facility	Lakewest Rehabilitation And Skilled Care	2450 Bickers St	Dallas	Dallas
Nursing Facility	Le Reve Rehabilitation & Memory Care	3309 Dilido Road	Dallas	Dallas
Nursing Facility	Monarch Pavilion Rehabilitation Suites	6825 Harry Hines Blvd	Dallas	Dallas
Nursing Facility	Onpointe Transitional Care At Texas Health Presbyterian Hospital Dalla	8200 Walnut Hill Lane Main 5	Dallas	Dallas
Nursing Facility	Pearl Nordan Care Center	1260 Abrams Rd	Dallas	Dallas
Nursing Facility	Presbyterian Village North Special Care Ctr	8600 Skyline Dr	Dallas	Dallas
Nursing Facility	Remarkable Healthcare Of Dallas	3350 Bonnie View Road	Dallas	Dallas
Nursing Facility	Senior Care Health And Rehabilitation Center - Dallas	2815 Martin Luther King Jr Blvd	Dallas	Dallas
Nursing Facility	Signature Pointe	14655 Preston Rd	Dallas	Dallas
Nursing Facility	Simpson Place	3922 Simpson Street	Dallas	Dallas
Nursing Facility	Skyline Nursing Center	3326 Burgoyne	Dallas	Dallas
Nursing Facility	South Dallas Nursing & Rehabilitation	3808 S Central Expwy	Dallas	Dallas
Nursing Facility	The Highlands Guest Care Center Llc	9009 Forest Ln	Dallas	Dallas
Nursing Facility	The Legacy Midtown Park	8280 Manderville Lane	Dallas	Dallas
Nursing Facility	The Lennwood Nursing And Rehabilitation	8017 W Virginia Dr	Dallas	Dallas
Nursing Facility	The Meadows Health And Rehabilitation Center	8383 Meadow Rd	Dallas	Dallas
Nursing Facility	The Plaza At Edgemere	8502 Edgemere	Dallas	Dallas
Nursing Facility	The Rehabilitation & Wellness Centre Of Dallas Llc	4200 Live Oak St	Dallas	Dallas
Nursing Facility	The Renaissance At Kessler Park	2428 Bahama Dr	Dallas	Dallas
Nursing Facility	The Villa At Mountain View	2918 Duncanville Rd	Dallas	Dallas
Nursing Facility	The Villages Of Dallas	550 E Ann Arbor Ave	Dallas	Dallas
Nursing Facility	Traymore Nursing Center	4315 Hopkins Ave	Dallas	Dallas
Nursing Facility	Treemont Healthcare And Rehabilitation Center	5550 Harvest Hill Rd	Dallas	Dallas
Nursing Facility	Ventana By Buckner	8301 N. Central Expressway	Dallas	Dallas
Nursing Facility	Villages Of Lake Highlands	8615 Lullwater Drive	Dallas	Dallas
Nursing Facility	Walnut Place	5515 Glen Lakes Dr	Dallas	Dallas
Nursing Facility	Desoto Ltc Partners Inc	1101 N Hampton Rd	Desoto	Dallas

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	Methodist Transitional Care Center-Desoto Llc	109 Barrows Place	Desoto	Dallas
Nursing Facility	Park Manor Health Care And Rehabilitation	207 E Parkerville Rd	Desoto	Dallas
Nursing Facility	Williamsburg Village Healthcare Campus	941 Scotland Dr	Desoto	Dallas
Nursing Facility	Duncanville Healthcare And Rehabilitation Center	419 S Cockrell Hill Rd	Duncanville	Dallas
Nursing Facility	The Laurenwood Nursing And Rehabilitation	330 W Camp Wisdom Rd	Duncanville	Dallas
Nursing Facility	Advanced Health & Rehab Center Of Garland	1201 Colonel Drive	Garland	Dallas
Nursing Facility	Garland Nursing & Rehabilitation	321 N. Shiloh Rd.	Garland	Dallas
Nursing Facility	Legend Oaks Healthcare And Rehabilitation - Garland	2625 Belt Line Road	Garland	Dallas
Nursing Facility	Pleasant Valley Healthcare And Rehabilitation Center	1525 Pleasant Valley Rd	Garland	Dallas
Nursing Facility	Senior Care Beltline	106 N Beltline Rd	Garland	Dallas
Nursing Facility	Winters Park Nursing And Rehabilitation Center	3737 N Garland Avenue	Garland	Dallas
Nursing Facility	Heritage At Turner Park Health & Rehab	820 Small St	Grand Prairie	Dallas
Nursing Facility	Ashford Hall	2021 Shoaf Dr	Irving	Dallas
Nursing Facility	Avante Rehabilitation Center	225 N Sowers Rd	Irving	Dallas
Nursing Facility	Irving Nursing And Rehabilitation	619 N. Britain Rd.	Irving	Dallas
Nursing Facility	Las Brisas Rehabilitation And Wellness Suites	3421 W Story Rd	Irving	Dallas
Nursing Facility	Northgate Plaza	2101 Northgate Dr.	Irving	Dallas
Nursing Facility	The Villages On Macarthur	3443 N Macarthur Blvd	Irving	Dallas
Nursing Facility	Lancaster Ltc Partners Inc	1515 N Elm St	Lancaster	Dallas
Nursing Facility	Millbrook Healthcare And Rehabilitation Center	1850 W Pleasant Run Rd	Lancaster	Dallas
Nursing Facility	Westridge Nursing & Rehabilitation	1241 Westridge Ave	Lancaster	Dallas
Nursing Facility	Windsor Gardens	2535 W Pleasant Run	Lancaster	Dallas
Nursing Facility	Palomino Place	3160 Gus Thomasson Road	Mequite	Dallas
Nursing Facility	Cheyenne Medical Lodge	750 Highway 352	Mesquite	Dallas
Nursing Facility	Christian Care Center	1000 Wiggins Pkwy	Mesquite	Dallas
Nursing Facility	Edgewood Rehabilitation And Care Center	1101 Windbell Dr	Mesquite	Dallas
Nursing Facility	Mesquite Tree Nursing Center	434 Paza Dr	Mesquite	Dallas
Nursing Facility	Mesquite Village Healthcare Centre	825 W. Kearney Street	Mesquite	Dallas
Nursing Facility	Town East Rehabilitation And Healthcare Center	3617 O'hare Dr	Mesquite	Dallas
Nursing Facility	Willowbend Nursing And Rehabilitation Center	2231 Highway 80 E	Mesquite	Dallas

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	Cottonwood Creek Healthcare Community	1111 W Shore Dr	Richardson	Dallas
Nursing Facility	Lindan Park Care Center Lp	1510 N Plano Rd	Richardson	Dallas
Nursing Facility	Remington Transitional Care Of Richardson	1350 E Lookout Dr	Richardson	Dallas
Nursing Facility	The Plaza At Richardson	1301 Richardson Dr	Richardson	Dallas
Nursing Facility	The Reserve At Richardson	1610 Richardson Dr	Richardson	Dallas
Nursing Facility	The Village At Richardson	1111 Rockingham Ln	Richardson	Dallas
Nursing Facility	The Manor At Seagoville	2416 Elizabeth Ln	Seagoville	Dallas
Intermediate Care Facility	Bell Community Residence	2402 Bernard	Denton	Denton
Intermediate Care Facility	Candleberry	2721 Thunderbird St	Denton	Denton
Intermediate Care Facility	Carter Community Residence	3805 Camelot	Denton	Denton
Intermediate Care Facility	Davis Community Residence	1426 Ruddell	Denton	Denton
Intermediate Care Facility	Denton State Supported Living Center	3980 State School Rd	Denton	Denton
Intermediate Care Facility	Educare Community Living Corporation - Texas	7501 Riverchase Trl	Denton	Denton
Intermediate Care Facility	Educare Community Living Corporation-Texas	3612 Big Horn Trl	Denton	Denton
Intermediate Care Facility	Newton Community Residence	3112 Cedar Hill	Denton	Denton
Intermediate Care Facility	Oakbend Community Residence	1430 N Ruddell	Denton	Denton
Intermediate Care Facility	Oakridge Group Home	2421 Oakridge	Denton	Denton
Intermediate Care Facility	Sandy Oaks I	1475 S Trinity Rd	Denton	Denton
Intermediate Care Facility	Sandy Oaks Ii	1475 S Trinity Rd	Denton	Denton
Intermediate Care Facility	Country Home	901 Cross Timbers Dr	Double Oak	Denton
Intermediate Care Facility	Laurel House	50 N Sharon Dr	Krum	Denton
Intermediate Care Facility	Pinon House	4520 Miller Road	Krum	Denton
Intermediate Care Facility	Ponderosa	9554 Rector Road	Sanger	Denton
Nursing Facility	Brookhaven Nursing And Rehabilitation Center	1855 Cheyenne	Carrollton	Denton

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	Remarkable Healthcare Of Prestonwood	4501 Plano Parkway	Carrollton	Denton
Nursing Facility	Corinth Rehabilitation Suites On The Parkway	3511 Corinth Parkway	Corinth	Denton
Nursing Facility	Cottonwood Nursing & Rehabilitation	2224n Carroll Blvd	Denton	Denton
Nursing Facility	Denton Rehabilitation And Nursing Center	2229 N Carroll Blvd	Denton	Denton
Nursing Facility	Good Samaritan Society - Denton Village	2500 Hinkle Drive	Denton	Denton
Nursing Facility	Good Samaritan Society - Lake Forest Village	3901 Montecito Drive	Denton	Denton
Nursing Facility	Senior Care At Denton Post Acute Care	2244 Brinker Rd	Denton	Denton
Nursing Facility	Vintage Health Care Center	205 N Bonnie Brae	Denton	Denton
Nursing Facility	Cross Timbers Rehabilitation And Healthcare Center	3315 Cross Timbers Rd	Flower Mound	Denton
Nursing Facility	Hollymead	4101 Long Prairie Road	Flower Mound	Denton
Nursing Facility	Prairie Estates	1350 Main St	Frisco	Denton
Nursing Facility	Rambling Oaks Courtyard Extensive Care Community	112 Barnett Blvd.	Highland Village	Denton
Nursing Facility	Longmeadow Healthcare Center	120 Meadow View Dr	Justin	Denton
Nursing Facility	Lake Village Nursing And Rehabilitation Center	169 Lake Park Rd	Lewisville	Denton
Nursing Facility	Vista Ridge Nursing & Rehabilitation Center	700 E Vista Ridge Mall Dr	Lewisville	Denton
Nursing Facility	Cedar Ridge Rehabilitation And Healthcare Center	1700 N Washington St	Pilot Point	Denton
Nursing Facility	Pilot Point Care Center	208 N Prairie St	Pilot Point	Denton
Nursing Facility	Prestonwood Rehabilitation & Nursing Center Inc	2460 Marsh Ln	Plano	Denton
Intermediate Care Facility	Auburn House	115 Auburn St	Waxahachie	Ellis
Intermediate Care Facility	Brandon Way House	209 Brandon Way	Waxahachie	Ellis
Intermediate Care Facility	Bryn Mawr House	109 Bryn Mawr	Waxahachie	Ellis

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Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Rock Springs House	206 Rock Springs	Waxahachie	Ellis
Nursing Facility	Bluebonnet Rehab At Ennis	2300 South Oak Grove Rd	Ennis	Ellis
Nursing Facility	Ennis Care Center	1200 S Hall St	Ennis	Ellis
Nursing Facility	Legend Oaks Healthcare And Rehabilitation - Ennis	1400 Medical Center Drive	Ennis	Ellis
Nursing Facility	Renaissance Rehabilitation And Healthcare Center	220 Davenport	Italy	Ellis
Nursing Facility	Midlothian Healthcare Center	900 George Hopper Road	Midlothian	Ellis
Nursing Facility	Red Oak Health And Rehabilitation Center	101 Reese Dr	Red Oak	Ellis
Nursing Facility	Focused Care Of Waxahachie	1413 W Main St	Waxahachie	Ellis
Nursing Facility	Legend Oaks Healthcare And Rehabilitation - Waxahachie	151 Country Meadows Boulevard	Waxahachie	Ellis
Nursing Facility	Pleasant Manor Healthcare And Rehabilitation	3650 S. Interstate 35 E	Waxahachie	Ellis
Intermediate Care Facility	East Rock	1485 Blackjack	Stephenville	Erath
Intermediate Care Facility	Harbin House	909 Harbin Dr	Stephenville	Erath
Intermediate Care Facility	North Rock 1	2250 Lingleville Rd	Stephenville	Erath
Intermediate Care Facility	North Rock 2	2248 Lingleville Rd	Stephenville	Erath
Intermediate Care Facility	Rock House	2254 Lingleville Rd	Stephenville	Erath
Intermediate Care Facility	Rock House 2	2326 Denman St	Stephenville	Erath
Intermediate Care Facility	Warm Springs	788 N Neblett	Stephenville	Erath
Nursing Facility	Abri At Stephenville	2601 Northwest Loop	Stephenville	Erath
Nursing Facility	Mulberry Manor	1670 Lingleville Rd	Stephenville	Erath
Nursing Facility	Stephenville Nursing And Rehabilitation	2311 West Washington	Stephenville	Erath
Intermediate Care Facility	Edwards Street House	603 Edwards St	Denison	Grayson
Intermediate Care Facility	Hyde Park House	1507 Hyde Park Ave	Denison	Grayson
Intermediate Care Facility	Lynn Street House	108 S Lynn St	Denison	Grayson

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Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Mhmr Svcs Of Texoma Alternate Living Facility Ii	1217 Desvoignes Rd	Denison	Grayson
Intermediate Care Facility	Evergreen Carriage Estates Community Home	2304 Carriage Estates Road	Sherman	Grayson
Intermediate Care Facility	Evergreen Northbrook Community Home	1732 Northbrook	Sherman	Grayson
Nursing Facility	Homestead Nursing And Rehabilitation Of Collinsville	501 N Main St	Collinsville	Grayson
Nursing Facility	Beacon Hill	3515 S. Park Avenue	Denison	Grayson
Nursing Facility	Denison Nursing And Rehabilitation Lp	601 E Hwy 69	Denison	Grayson
Nursing Facility	The Homestead Of Denison	1101 Reba Mcentire Ln	Denison	Grayson
Nursing Facility	The Terrace At Denison	1300 Memorial Dr	Denison	Grayson
Nursing Facility	Woodlands Place Rehabilitation Suites	5600 Woodlands Trail	Denison	Grayson
Nursing Facility	Cedar Hollow Rehabilitation Center	5011 North Us Hwy 75	Sherman	Grayson
Nursing Facility	Focused Care At Sherman	817 W Center	Sherman	Grayson
Nursing Facility	Texoma Healthcare Center	1000 Hwy 82 E	Sherman	Grayson
Nursing Facility	The Homestead Of Sherman	1000 Sara Swammy Dr	Sherman	Grayson
Nursing Facility	Meadowbrook Care Center	632 Windsor Way	Van Alstyne	Grayson
Nursing Facility	Whitesboro Health And Rehabilitation Center	1204 Sherman Dr	Whitesboro	Grayson
Intermediate Care Facility	Granbury House	826 N. Thorp Springs Road	Granbury	Hood
Intermediate Care Facility	6th And Mesquite	407 E Sixth St	Tolar	Hood
Nursing Facility	Granbury Care Center	301 S Park St	Granbury	Hood
Nursing Facility	Granbury Rehab & Nursing	2124 Paluxy Hwy	Granbury	Hood
Nursing Facility	Harbor Lakes Nursing & Rehab	1300 2nd St	Granbury	Hood
Nursing Facility	Trinity Nursing & Rehab Of Granbury	600 Reunion Ct.	Granbury	Hood
Intermediate Care Facility	?100 Patti J Street?	100 Patti J Street	Greenville	Hunt
Intermediate Care Facility	?2500 Terry Place?	2500 Terry Place?	Greenville	Hunt

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Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Bonnie Lea Group Home	3408 Bonnie Lea	Greenville	Hunt
Intermediate Care Facility	Sayle Street Group Home	6518 Sayle St	Greenville	Hunt
Intermediate Care Facility	Turtle Creek Family Living	505 Ermine	Greenville	Hunt
Intermediate Care Facility	Windy Hill Group Home	5307 Windy Hill Rd	Greenville	Hunt
Intermediate Care Facility	?2616 Pounds Avenue?	2616 Pounds Avenue	Tyler	Hunt
Nursing Facility	Oak Manor Of Commerce Nursing And Rehabilitation	2901 Sterling Hart Dr	Commerce	Hunt
Nursing Facility	Briarcliff Health Center Of Greenville Inc	4400 Walnut St	Greenville	Hunt
Nursing Facility	Greenville Gardens	3500 Park St	Greenville	Hunt
Nursing Facility	Greenville Health & Rehabilitation Center	4910 Wellington St	Greenville	Hunt
Nursing Facility	Legend Healthcare And Rehabilitation - Greenville	2300 Jack Finney Blvd	Greenville	Hunt
Intermediate Care Facility	Oak House	208 Alvarado Oaks Dr	Alvarado	Johnson
Intermediate Care Facility	Turkey Peak	908 Browncrest	Burleson	Johnson
Intermediate Care Facility	Community Living Concepts Inc	2764 Co Rd 310	Cleburne	Johnson
Intermediate Care Facility	Featherston	402 Featherston St	Cleburne	Johnson
Intermediate Care Facility	Highland Estates	1018 Highland Road	Cleburne	Johnson
Intermediate Care Facility	Quail Park	805 Quail Park Lane	Cleburne	Johnson
Intermediate Care Facility	Rolling Acres	2901 Fm 2280	Cleburne	Johnson
Intermediate Care Facility	Spruce House	802 Berkley	Cleburne	Johnson
Intermediate Care Facility	Bluebonnet Residential Center 1	524 N Pearson St	Godley	Johnson
Intermediate Care Facility	Community Living Concepts Inc	802 Davis St	Grandview	Johnson
Intermediate Care Facility	Community Living Concepts Inc	712 Stadium Dr	Joshua	Johnson
Intermediate Care Facility	Littlebrook Estates	105 Littlebrook Road	Joshua	Johnson
Nursing Facility	Ridgecrest Healthcare And Rehabilitation Center	561 E Ridgecrest Rd	Forney	Kaufman

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	Kaufman Healthcare Center	3001 S Houston St	Kaufman	Kaufman
Nursing Facility	Sunflower Park Health Care	1803 Highway 243 East	Kaufman	Kaufman
Nursing Facility	Kemp Care Center	1351 South Elm St.	Kemp	Kaufman
Nursing Facility	Mabank Nursing Center	110 W. Troupe	Mabank	Kaufman
Nursing Facility	Countryview Nursing & Rehabilitation	1900 N Frances St.	Terrell	Kaufman
Nursing Facility	Terrell Healthcare Center	204 W Nash	Terrell	Kaufman
Nursing Facility	Windsor Rehabilitation & Health Care Center	250 W British Flying School Blvd	Terrell	Kaufman
Intermediate Care Facility	45th Street I Community Home	1348 N 45th St	Corsicana	Navarro
Intermediate Care Facility	45th Street I I Community Home	1348 1/2 N 45th St	Corsicana	Navarro
Intermediate Care Facility	Boyd Community Home	109 Boyd Ave	Corsicana	Navarro
Intermediate Care Facility	Donaho House	1516 W 5th Ave	Corsicana	Navarro
Intermediate Care Facility	Edwards Community Home	701 W 4th Ave	Corsicana	Navarro
Intermediate Care Facility	Harmony House I V	720 Se Cr 0025	Corsicana	Navarro
Intermediate Care Facility	Harmony House Iii	509 Lakewood	Corsicana	Navarro
Intermediate Care Facility	Harmony House V I	430 Madison Ave	Corsicana	Navarro
Intermediate Care Facility	Oaklawn House	1102 Oaklawn	Corsicana	Navarro
Intermediate Care Facility	Sunset Acres House	5835 Nw Cr 2091	Corsicana	Navarro
Intermediate Care Facility	Tammy House	1312 Tammy St.	Corsicana	Navarro
Nursing Facility	Country Meadows Nursing & Rehabilitation Center	3301 W Park Row Blvd	Corsicana	Navarro
Nursing Facility	Epic Nursing & Rehabilitation	3210 W. Hwy 22	Corsicana	Navarro
Nursing Facility	Legacy West Rehabilitation And Healthcare	3300 W. 2nd Ave.	Corsicana	Navarro

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	The Village At Heritage Oaks	3002 W. 2nd Ave.	Corsicana	Navarro
Nursing Facility	Twilight Home	3001 W Fourth Ave	Corsicana	Navarro
Nursing Facility	Kerens Care Center	809 Ne 4th St.	Kerens	Navarro
Intermediate Care Facility	Newton Group Home	700 Mcmahon	Newton	Newton
Intermediate Care Facility	Northwest 23rd Street	202 Nw 23rd St	Mineral Wells	Palo Pinto
Nursing Facility	Mineral Wells Nursing & Rehabilitation	316 Sw 25th Ave	Mineral Wells	Palo Pinto
Nursing Facility	Palo Pinto Nursing Center	200 Southwest 25th Ave	Mineral Wells	Palo Pinto
Intermediate Care Facility	Elm Court	928 Elm Court	Azle	Parker
Intermediate Care Facility	Tanglewood	1613 Tanglewood	Azle	Parker
Nursing Facility	College Park Rehabilitation And Care Center	1715 Martin Dr	Weatherford	Parker
Nursing Facility	Hilltop Park Rehabilitation And Care Center	970 Hilltop Dr	Weatherford	Parker
Nursing Facility	Keeneland Nursing & Rehabilitation	700 S Bowie Dr	Weatherford	Parker
Nursing Facility	Peach Tree Place	315 W Anderson St	Weatherford	Parker
Nursing Facility	Santa Fe Health & Rehabilitation Center	1205 Santa Fe Dr	Weatherford	Parker
Nursing Facility	Senior Care At Holland Lake	1201 Holland Lake Dr	Weatherford	Parker
Nursing Facility	Weatherford Health Care Center	521 W 7th St	Weatherford	Parker
Nursing Facility	Willow Park Rehabilitation And Care Center	300 Crowne Point Blvd	Willow Park	Parker
Nursing Facility	Beacon Harbor Healthcare And Rehabilitation	6700 Heritage Parkway	Rockwall	Rockwall
Nursing Facility	Broadmoor Medical Lodge	5242 Medical Dr.	Rockwall	Rockwall
Nursing Facility	Highland Meadows	1870 John King Blvd	Rockwall	Rockwall
Nursing Facility	Rockwall Nursing Care Center	206 Storrs	Rockwall	Rockwall

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	Rowlett Health And Rehabilitation Center	9300 Lakeview Parkway	Rowlett	Rockwall
Nursing Facility	Royse City Medical Lodge	901 W. Interstate 30	Royse City	Rockwall
Nursing Facility	Cherokee Rose Nursing And Rehabilitation	203 Gibbs Blvd	Glen Rose	Somervell
Nursing Facility	Glen Rose Nursing And Rehab Center	1019 Holden St	Glen Rose	Somervell
Nursing Facility	Retama Manor Health And Rehabilitation Center/Rio Grande City	400 S Pete Diaz Jr Ave	Rio Grande City	Starr
Intermediate Care Facility	1501 Lovers Ln	1501 E Lovers Ln	Arlington	Tarrant
Intermediate Care Facility	2309 Clearwood Court	2309 Clearwood Ct	Arlington	Tarrant
Intermediate Care Facility	2410 Edinburgh	2410 Edinburgh	Arlington	Tarrant
Intermediate Care Facility	4209 Blossom Trail	4209 Blossom Tr	Arlington	Tarrant
Intermediate Care Facility	A & M Care Inc	2605 Glassboro Cir	Arlington	Tarrant
Intermediate Care Facility	Amicus At Rifleman	405 Rifleman Trail	Arlington	Tarrant
Intermediate Care Facility	Amicus At Shawn	517 Shawn Court	Arlington	Tarrant
Intermediate Care Facility	Amicus At Xavier	817 Xavier Street	Arlington	Tarrant
Intermediate Care Facility	Bosque Community Home	1919 Bosque Ln	Arlington	Tarrant
Intermediate Care Facility	California	2812 California Ln	Arlington	Tarrant
Intermediate Care Facility	Cedar Oaks Community Home	1000 Coke Rd	Arlington	Tarrant
Intermediate Care Facility	Educare Community Living Corporation - Texas	5004 Misty Wood Dr	Arlington	Tarrant
Intermediate Care Facility	Educare Community Living Corporation - Texas	2310 Sharpshire Ln	Arlington	Tarrant
Intermediate Care Facility	Educare Community Living Corporation - Texas	1824 S Fielder	Arlington	Tarrant
Intermediate Care Facility	Educare Community Living Corporation - Texas	4700 Mandalay Dr	Arlington	Tarrant
Intermediate Care Facility	Evergreen Echo Summit Community Home	6218 Echo Summit Ln	Arlington	Tarrant

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Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Evergreen Elmgrove Community Home	4211 Elmgrove	Arlington	Tarrant
Intermediate Care Facility	Evergreen Endicott Community Home	1502 Endicott	Arlington	Tarrant
Intermediate Care Facility	Evergreen Jeannette Early Community Home	329 Montana Dr	Arlington	Tarrant
Intermediate Care Facility	Evergreen Salida Community Home	911 Salida Dr	Arlington	Tarrant
Intermediate Care Facility	Evergreen Wagner Community Home	7905 Peregrine Trail	Arlington	Tarrant
Intermediate Care Facility	Fox Hill Community Home	3202 Fox Hill Dr	Arlington	Tarrant
Intermediate Care Facility	Magnolia Community Home	500 Magnolia	Arlington	Tarrant
Intermediate Care Facility	Newstart Living Center V	4503 Palomino Ct	Arlington	Tarrant
Intermediate Care Facility	Quincy House	2004 Quincy Ct	Arlington	Tarrant
Intermediate Care Facility	Racquet Club	4809 Racquet Club Drive	Arlington	Tarrant
Intermediate Care Facility	Reverchon Community Home	2121 Reverchon Dr	Arlington	Tarrant
Intermediate Care Facility	Spring Creek Community Home	4806 Spring Creek Rd	Arlington	Tarrant
Intermediate Care Facility	Denver Trail	129 Denver Trail	Azle	Tarrant
Intermediate Care Facility	James Street Community Home	708 James St	Azle	Tarrant
Intermediate Care Facility	Lakeview Community Home	1748 Spinnaker Ln	Azle	Tarrant
Intermediate Care Facility	Lamplighter Community Home	104 Lamplighter Ct	Azle	Tarrant
Intermediate Care Facility	Training Residence 6	1619 Pipeline Road	Bedford	Tarrant
Intermediate Care Facility	Walnut Community Home	3824 Walnut Dr	Bedford	Tarrant
Intermediate Care Facility	Cozby Community Home	106 Cozby St S	Benbrook	Tarrant
Intermediate Care Facility	Stella Mae	716 Stella Mae	Burleson	Tarrant
Intermediate Care Facility	Builder Road	2200 Builder Road	Crowley	Tarrant

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Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Newstart Living Center I	305 N Beverly St	Crowley	Tarrant
Intermediate Care Facility	Summer House	1925 Cattle Drive Ct	Crowley	Tarrant
Intermediate Care Facility	Amicus At Mills	512 S Mills Dr	Euless	Tarrant
Intermediate Care Facility	Chambers Creek Community Home	613 Chambers Crk	Everman	Tarrant
Intermediate Care Facility	Newstart Living Center Ii	1000 Coury Rd	Everman	Tarrant
Intermediate Care Facility	Newstart Living Center I I I	5124 Queen Ann Ct	Forest Hill	Tarrant
Intermediate Care Facility	2york	2 York Drive	Fort Worth	Tarrant
Intermediate Care Facility	Barcelona	4308 Barcelona	Fort Worth	Tarrant
Intermediate Care Facility	Cibolo House	3704 Cibolo	Fort Worth	Tarrant
Intermediate Care Facility	Country Manor Community Home	1812 Country Manor Rd	Fort Worth	Tarrant
Intermediate Care Facility	Craig Street	7504 Craig St	Fort Worth	Tarrant
Intermediate Care Facility	Educare Community Living Corporation - Texas	1433 Barron Ln	Fort Worth	Tarrant
Intermediate Care Facility	Educare Community Living Corporation - Texas	5009 Marble Falls	Fort Worth	Tarrant
Intermediate Care Facility	Fairmeadows	3309 Fairmeadows	Fort Worth	Tarrant
Intermediate Care Facility	Forest Creek	2520 Forest Creek Dr	Fort Worth	Tarrant
Intermediate Care Facility	Hastings	5320 Hastings	Fort Worth	Tarrant
Intermediate Care Facility	Huntwick	3744 Huntwick Dr	Fort Worth	Tarrant
Intermediate Care Facility	Kingswood Community Home	6717 Kingswood Dr	Fort Worth	Tarrant
Intermediate Care Facility	Longmeadow Community Home	4120 Longmeadow Way	Fort Worth	Tarrant
Intermediate Care Facility	Mountain Ridge	717 Mountain Ridge Court West	Fort Worth	Tarrant
Intermediate Care Facility	Oakland Park	4613/15 Menzer	Fort Worth	Tarrant

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Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Ohara	8321 Ohara	Fort Worth	Tarrant
Intermediate Care Facility	Poco	6505 Poco Court	Fort Worth	Tarrant
Intermediate Care Facility	Safe Care Iii	4244 River Birch	Fort Worth	Tarrant
Intermediate Care Facility	Safe Care Iv	7105 Bentley	Fort Worth	Tarrant
Intermediate Care Facility	Summer House 2	4445 Cartagena Drive	Fort Worth	Tarrant
Intermediate Care Facility	Tarrant County Dads Services West Lane	2620 Meaders	Fort Worth	Tarrant
Intermediate Care Facility	Tarrant County Mhmr Services Training Residence 2	701 Sandy Ln	Fort Worth	Tarrant
Intermediate Care Facility	Tarrant County Mhmr Services Training Residence 5	4833 Diaz	Fort Worth	Tarrant
Intermediate Care Facility	Training Residence 7	6312 Kingswood	Fort Worth	Tarrant
Intermediate Care Facility	Training Residence 8 Tarrant County Mhmr	6341 Juneau	Fort Worth	Tarrant
Intermediate Care Facility	Vinewood	1641 Vinewood	Fort Worth	Tarrant
Intermediate Care Facility	Whitman	6524 Whitman	Fort Worth	Tarrant
Intermediate Care Facility	Williams Road	1136 Williams Road	Fort Worth	Tarrant
Intermediate Care Facility	Winifred Community Home	5724 Winifred Dr	Fort Worth	Tarrant
Intermediate Care Facility	Worrell	5682 Worrell	Fort Worth	Tarrant
Intermediate Care Facility	Educare Community Living Corporation - Texas	4333 Coventry Dr	Grand Prairie	Tarrant
Intermediate Care Facility	Walnut Creek Residential Services Inc.	4611 Yale Dr.	Grand Prairie	Tarrant
Intermediate Care Facility	Brookwood Ii	649 Circle View S	Hurst	Tarrant
Intermediate Care Facility	Hurstview Community Home	540 Hurstview	Hurst	Tarrant
Intermediate Care Facility	Newstart, Inc.	201 Wisteria	Mansfield	Tarrant
Intermediate Care Facility	Brookwood I	2900 Brookwood Ln	Southlake	Tarrant

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Facility Type	Facility Name	Physical Address	City	County
Intermediate Care Facility	Brookwood I I I	2410 Taylor St	Southlake	Tarrant
Intermediate Care Facility	Safe Care I	6517 Brookside Dr	Watauga	Tarrant
Intermediate Care Facility	Safe Care Ii	8005 Lazy Brook Dr	Watauga	Tarrant
Intermediate Care Facility	Lovell House	5325 Lovell Avenue	Westover Hills	Tarrant
Intermediate Care Facility	Alyssa 1	9220 Alyssa Dr	White Settlement	Tarrant
Intermediate Care Facility	Alyssa 2	9212 Alyssa	White Settlement	Tarrant
Nursing Facility	Arbrook Plaza	401 West Arbrook Blvd	Arlington	Tarrant
Nursing Facility	Arlington Residence And Rehabilitation Center	405 Duncan Perry Rd	Arlington	Tarrant
Nursing Facility	Arlington Villas Rehabilitation And Healthcare Center	2601 W Randol Mill Rd	Arlington	Tarrant
Nursing Facility	Green Oaks Nursing & Rehab	3033 W Green Oaks Blvd	Arlington	Tarrant
Nursing Facility	Greenbrier Health Care Center	301 W. Randol Mill Rd	Arlington	Tarrant
Nursing Facility	Heritage Oaks	1112 Gibbins Rd	Arlington	Tarrant
Nursing Facility	Home For Aged Masons Clinic Nursing Center	1501 West Division	Arlington	Tarrant
Nursing Facility	Interlochen Health And Rehabilitation Center	2645 W Randol Mill Rd	Arlington	Tarrant
Nursing Facility	Matlock Place Health & Rehabilitation Center	7100 Matlock Rd	Arlington	Tarrant
Nursing Facility	Onpointe Transitional Care At Texas Health Arlington Memorial Hospital	800 W. Randol Mill Road 6th Floor	Arlington	Tarrant
Nursing Facility	Town Hall Estates Arlington Inc	824 W Mayfield Rd	Arlington	Tarrant
Nursing Facility	Azle Manor Health Care And Rehabilitation	721 Dunaway Ln	Azle	Tarrant
Nursing Facility	Bedford Wellness & Rehabilitation	2001 Forest Ridge Dr	Bedford	Tarrant
Nursing Facility	Forum Parkway Health & Rehabilitation	2112 Forum Parkway	Bedford	Tarrant
Nursing Facility	La Dora Nursing And Rehabilitation Center	1960 Bedford Rd	Bedford	Tarrant

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	Parkwood Healthcare Community	2600 Parkview Ln	Bedford	Tarrant
Nursing Facility	Benbrook Nursing & Rehabilitation Center	1000 Mckinley St	Benbrook	Tarrant
Nursing Facility	Burleson Nursing & Rehab Center, Inc. Dba Adventhealth Care Center Burleson	301 Huguley Blvd	Burleson	Tarrant
Nursing Facility	Crowley Nursing & Rehab	920 E Fm 1187	Crowley	Tarrant
Nursing Facility	Westpark Rehabilitation And Living	900 Westpark Way	Euless	Tarrant
Nursing Facility	Allegiant Wellness And Rehab	724 W. Rendon Crowley Road	Fort Worth	Tarrant
Nursing Facility	Arlington Heights Health And Rehabilitation Center	4825 Wellesley	Fort Worth	Tarrant
Nursing Facility	Bridgemoor Of Fort Worth	6301 Oakmont Blvd	Fort Worth	Tarrant
Nursing Facility	Cityview Nursing And Rehabilitation Center	5801 Bryant Irvin Rd	Fort Worth	Tarrant
Nursing Facility	Dfw Nursing & Rehab	900 W Leuda St	Fort Worth	Tarrant
Nursing Facility	Downtown Health And Rehabilitation Center	424 S Adams St	Fort Worth	Tarrant
Nursing Facility	Estates Healthcare And Rehabilitation Center	201 Sycamore School Rd	Fort Worth	Tarrant
Nursing Facility	Fort Worth Transitional Care Center	850 12th Avenue	Fort Worth	Tarrant
Nursing Facility	Ft Worth Southwest Nursing Center	5300 Alta Mesa Blvd	Fort Worth	Tarrant
Nursing Facility	Ft. Worth Wellness & Rehabilitation	2129 Skyline Dr	Fort Worth	Tarrant
Nursing Facility	Garden Terrace Alzheimers Center Of Excellence	7500 Oakmont Blvd	Fort Worth	Tarrant
Nursing Facility	Green Valley Healthcare And Rehabilitation Center	6850 Rufe Snow Dr	Fort Worth	Tarrant
Nursing Facility	Immanuels Healthcare	4515 Village Creek Rd	Fort Worth	Tarrant
Nursing Facility	James L. West Alzheimer's Center	1111 Summit Ave	Fort Worth	Tarrant
Nursing Facility	Legend Oaks Healthcare And Rehabilitation - Fort Worth	4240 Golden Triangle Boulevard	Fort Worth	Tarrant
Nursing Facility	Life Care Center Of Haltom	2936 Markum Dr	Fort Worth	Tarrant

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	Mira Vista Court	7021 Bryant Irvin Rd	Fort Worth	Tarrant
Nursing Facility	Park View Care Center	3301 View St	Fort Worth	Tarrant
Nursing Facility	Pennsylvania Nursing And Rehabilitation Center	901 Pennsylvania Ave	Fort Worth	Tarrant
Nursing Facility	Remarkable Healthcare Of Fort Worth	6649 N Riverside Dr	Fort Worth	Tarrant
Nursing Facility	Renaissance Park Multi Care Center	4252 Bryant Irvin Rd	Fort Worth	Tarrant
Nursing Facility	Richland Hills Rehabilitation And Healthcare Center	3109 Kings Ct	Fort Worth	Tarrant
Nursing Facility	Ridgmar Medical Lodge	6600 Lands End Court	Fort Worth	Tarrant
Nursing Facility	River Oaks Nursing And Rehabilitation Ltc Partners, Inc.	2416 Nw 18th Street	Fort Worth	Tarrant
Nursing Facility	Stonegate Nursing & Rehab	4201 Stonegate Blvd	Fort Worth	Tarrant
Nursing Facility	The Harrison At Heritage	4600 Heritage Trace Parkway	Fort Worth	Tarrant
Nursing Facility	The Oaks At White Settlement	8001 Western Hills Blvd	Fort Worth	Tarrant
Nursing Facility	The Stayton At Museum Way	2501 Museum Way	Fort Worth	Tarrant
Nursing Facility	Trail Lake Nursing & Rehabilitation	7100 Trail Lake Dr	Fort Worth	Tarrant
Nursing Facility	Trinity Terrace	1600 Texas St	Fort Worth	Tarrant
Nursing Facility	Village Creek Nursing & Rehabilitation Llc	3825 Village Creek Rd.	Fort Worth	Tarrant
Nursing Facility	Wedgewood Nursing Home	6621 Dan Danciger Rd	Fort Worth	Tarrant
Nursing Facility	The Watermark At Broadway Cityview	5301 Bryant Irvin Rd	Forth Worth	Tarrant
Nursing Facility	Marine Creek Nursing & Rehabilitation	3600 Angle Ave	Ft Worth	Tarrant
Nursing Facility	Arden Place Of Grapevine	1500 Autumn Dr	Grapevine	Tarrant
Nursing Facility	Grapevine Medical Lodge	1005 Ira E. Woods Parkway	Grapevine	Tarrant
Nursing Facility	The Lodge At Bear Creek	3729 Ira E Woods Avenue	Grapevine	Tarrant

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	Hurst Plaza Nursing & Rehab	215 E Plaza Blvd	Hurst	Tarrant
Nursing Facility	Oakmont Guest Care Center Llc	2712 Hurstview Dr.	Hurst	Tarrant
Nursing Facility	Heritage House At Keller Rehab & Nursing	1150 Whitley Road	Keller	Tarrant
Nursing Facility	Keller Oaks Healthcare Center	8703 Davis Boulevard	Keller	Tarrant
Nursing Facility	Pecan Manor Nursing And Rehabilitation	413 E Mansfield Cardinal	Kennedale	Tarrant
Nursing Facility	Lake Lodge Nursing & Rehabilitation	3800 Marina Dr	Lake Worth	Tarrant
Nursing Facility	Lake Worth Nursing Home	4220 Wells Dr	Lake Worth	Tarrant
Nursing Facility	Mansfield Medical Lodge	301 N Miller Rd	Mansfield	Tarrant
Nursing Facility	Mansfield Nursing & Rehabilitation Center	1402 E. Broad St.	Mansfield	Tarrant
Nursing Facility	The Pavilion At Creekwood	2100 Cannon Dr	Mansfield	Tarrant
Nursing Facility	Emerald Hills Rehabilitation And Healthcare Center	5600 Davis Blvd	North Richland Hills	Tarrant
Nursing Facility	Glenview Wellness & Rehabilitation	7625 Glenview Dr	North Richland Hills	Tarrant
Nursing Facility	Arden Place Of Richland Hills	7146 Baker Blvd.	Richland Hills	Tarrant
Nursing Facility	Discovery Village At Southlake	201 Watermere Drive	Southlake	Tarrant
Nursing Facility	The Carlyle At Stonebridge Park	170 Stonebridge Lane	Southlake	Tarrant
Nursing Facility	North Pointe Nursing & Rehabilitation	7804 Virgil Anthony Blvd	Watauga	Tarrant
Nursing Facility	West Side Campus Of Care	1950 S Las Vegas Trail	White Settlement	Tarrant
Nursing Facility	White Settlement Nursing Center	7820 Skyline Park Dr	White Settlement	Tarrant
Nursing Facility	Bridgeport Medical Lodge	2108 15th St	Bridgeport	Wise
Nursing Facility	Decatur Medical Lodge	701 W. Bennett Rd	Decatur	Wise
Nursing Facility	Heritage Place Of Decatur	605 W. Mulberry St.	Decatur	Wise

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Facility Type	Facility Name	Physical Address	City	County
Nursing Facility	The Hills Nursing & Rehabilitation	201 E Thompson St	Decatur	Wise

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Annex B
Governance

NAME	OFFICE	MEMBER ORGANIZATION
Ricky Reeves	Chair	Texas EMS Granbury
Amy Atnip	Chair Elect	Medical City Plano
Nakia Rapier	Secretary	Baylor University Medical Center
Shelly Miland	Treasurer	Texas Health Fort Worth Hospital
William Bonny	Finance Chair	Prosper Fire Department
Justin Northeim	Medical Directors Chair	Grapevine Fire Department

NAME	OFFICE / COMMITTEE	MEMBER ORGANIZATION
Jason Piecek	Air Medical Chair	PHI Air Medical
Jeff Donson	*Air Medical Chair Elect*	*Careflite Air*
Krista Knowles	Cardiac Chair	Medical City Alliance
Casey Rauschuber	*Cardiac Chair Elect*	*Wise Health System*
Donald Tucker	ED OPS Chair	Medical City Arlington
Jessica Lucio	*ED OPS Chair Elect*	*Texas Health Hospital Mansfield*
Kevin Sandifer	EMS Chair	Mansfield Fire Department
Kevin Cunningham	*EMS Chair Elect*	*Midlothian Fire Department*
William Bonny	Finance Chair Elect	Prosper Fire Department
Brandon Barth	*Finance Chair Elect*	*Flower Mound Fire Department*
John Phillips	Hospital Executive - East	Methodist Dallas Medical Center
Corey Wilson	Hospital Executive - West	Texas Health Harris Fort Worth
Justin Northeim	Medical Directors Chair	Grapevine Fire Department
VACANT	*Medical Directors Chair Elect*	
Cheryl Malone	Pediatric Chair	Medical City Dallas
Colyn Turnbow	*Pediatric Chair Elect*	*Medical City Alliance*
Pamela Gessling	Perinatal Chair	Methodist Dallas Medical Center
Regina Reynolds	*Perinatal Chair Elect*	*Parkland Health & Hospital System*
Thomas Stidham	REPC Chair	Parkland Health & Hospital System
Deborah Scott	*REPC Chair Elect*	*Texas Health Harris Methodist Hospital Fort Worth*
Robin Novakovic	Stroke Chair	UT Southwestern Medical Center
James Tatum	*Stroke Chair Elect*	*Texas Health Presbyterian Hospital Plano*
Laura Garlow	Trauma Chair	Texas Health Presbyterian Dallas
Danielle Sherar	*Trauma Chair Elect*	*JPS Health Network*

NORTH CENTRAL TEXAS TRAUMA REGIONAL ADVISORY COUNCIL, INC.
(NCTTRAC)

BYLAWS

Reviewed by the NCTTRAC Board of Directors
April 13, 2021
Approved by the NCTTRAC General Membership
September 19, 2019

Supersedes Bylaws approved September 20, 2018


NCTTRAC
NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

ANNOTATED INDEX


NCTTRAC
NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

ARTICLE I

Name

1.1 The official name of this organization shall be North Central Texas Trauma Regional Advisory Council, Inc. (NCTTRAC). For member and public education purposes, variations such as, but not limited to, North Central Texas Regional Advisory Council for Trauma, Acute, and Emergency Healthcare may be used in marketing or branding materials.

1.2 The principal place of business of NCTTRAC shall be 600 Six Flags Dr., Suite 160, Arlington, Texas 76011, in the State of Texas, unless and until determined otherwise by the NCTTRAC Board of Directors (Board).

1.3 NCTTRAC will establish and maintain a website for public access to include current information. (www.NCTTRAC.org)

ARTICLE II

Definitions

2.1 NCTTRAC is a 501(c)(3) nonprofit organization which functions according to its duly adopted charter, and federal and state law, including Texas Administrative Code Title 25 §157.2. The organization facilitates the development, implementation, and operation of comprehensive trauma, acute, and emergency healthcare systems based on accepted evidence-based standards of care principles to decrease morbidity and mortality.

2.1.1 The nineteen Texas counties comprising Trauma Service Area (TSA) - E include: Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise counties.

2.1.2 The composition of TSA-E may be changed if a county requests realignment into or out of TSA-E to another bordering TSA pursuant to requirements and approval of the Texas Department of State Health Services (DSHS).

2.1.3 NCTTRAC participants may include, but are not limited to, interested healthcare facilities, organizations, agencies, entities, advocates, and professional societies providing or involved in healthcare delivery, education, injury prevention, rehabilitation, and emergency preparedness within TSA-E.

ARTICLE III

Mission

3.1 The Mission of the North Central Texas Trauma Regional Advisory Council is to promote and coordinate a system of quality trauma, acute, and emergency healthcare and preparedness in North Central Texas.

Vision

3.2 To be recognized as a leader for promoting quality trauma, acute, and emergency healthcare and preparedness.

Philosophy

3.3 The philosophies of NCTTRAC are:

3.3.1 We prepare through research, data management, education, injury and illness prevention, and emergency management.

3.3.2 We support through the development of Regional Plans and Guidelines, resources, communications, and advocacy.

3.3.3 We respond to the needs of the regional emergency healthcare coalition and the State of Texas.

ARTICLE IV

Membership

4.1 Membership in NCTTRAC shall include Voting and Associate Members. The requirements and eligibility for membership in NCTTRAC include submission of a completed membership application, payment of applicable membership dues and Board approval. Additional membership criteria can be found in the Membership and Active Participation Standard Operating Procedure (SOP).

4.1.1 Membership Categories

4.1.1.1 Members

4.1.1.1.1 Organizations, agencies and entities providing health-related care, education, injury prevention, advocacy, rehabilitation or preparedness within TSA-E shall be eligible for voting membership in NCTTRAC.

4.1.1.1.2 Each Member shall have one vote.

4.1.1.2 Associate Members

4.1.1.2.1 Individuals or organizations not identified above shall be eligible for associate membership.

4.1.1.2.2 Associate Members are non-voting.

4.1.1.2.3 Additional information on Associate Membership is available in the NCTTRAC Sponsorship Standard Operation Procedure (SOP).

4.1.2 Final determination of Member or Associate Member status shall be approved by the Board.

4.2 NCTTRAC shall maintain equal opportunity and access to all its membership for fair representation and participation.

4.3 NCTTRAC shall assure that dues, fees or other financial incentives do not determine the number of votes awarded to a Voting Member.

4.4 In order to retain voting privileges, Members shall maintain active and consistent participation according to the Membership and Active Participation SOP.

4.5 NCTTRAC shall assess dues and fees based on a rate schedule that has been approved by the General Membership.

ARTICLE V

Officers

5.1 The officers of NCTTRAC and its Board are: Chair, Chair Elect, Secretary and Treasurer and shall be known as the Officers. The remainder of the Board will be known as Directors as specifically described in Article VII.

5.2 Nomination and Election

5.2.1 Elections for Chair Elect, Secretary, and Treasurer are routinely held at the September General Membership Meeting of each odd year.

5.2.2 Nominations for Officers are accepted in person or in writing until 21 days prior to the election.

5.2.3 Nominees must accept the nomination prior to the election.

5.2.4 Officers shall be elected at a NCTTRAC General Membership Meeting in accordance with the Voting and Elections SOP.

5.2.5 Any Officer may be removed by a majority vote of the NCTTRAC Membership.

5.3 Chair

5.3.1 Job Description

5.3.1.1 The Chair shall set the agenda and preside at all General Membership and Board Meetings and shall have the authority to call emergency or special Board Meetings in accordance with the Conducting Official Business Meetings SOP.

5.3.1.2 The Chair shall appoint a documented representative of a NCTTRAC Member in good standing as an interim officer or Committee Chair to fill any vacancy until a replacement is duly elected.

5.3.1.3 The Chair shall have the authority to appoint the Chairs of all ad-hoc committees or workgroups.

5.3.1.4 The Chair represents NCTTRAC at Governor's EMS and Trauma Advisory Council (GETAC) Meetings and other meetings as necessary.

5.3.1.5 The Chair is obligated to communicate appropriate information to whatever audience may be warranted, based on information received.

5.3.1.6 The Chair shall have check signing privileges according to the Transactions of the Organization SOP.

5.3.1.7 The Chair, as a member of the Board participates in the hiring and/or firing of the Executive Director.

5.3.2 Term of Office

5.3.2.1 The duration of the Chair term shall be two years. The Chair ascends from Chair Elect.

5.3.2.2 In the event the Chair is unable to fulfill the term, the Chair Elect shall ascend to Chair. The term of the new Chair shall be the remainder of the unfulfilled term of the previous Chair. The Executive Committee will recommend to the Board for determination if the new Chair will additionally serve the two-year term that would have been served originally.

5.4 Chair Elect

5.4.1 Job Description

5.4.1.1 The Chair Elect shall, in the absence or disability of the Chair, perform the duties and exercise the powers of the Chair, and shall perform such other duties as the Board prescribes.

5.4.1.2 The Chair Elect is a member of the Finance Committee.

5.4.1.3 The Chair Elect may represent NCTTRAC at Governor's EMS and Trauma Advisory Council (GETAC) Meetings and other meetings as necessary.

5.4.1.4 The Chair Elect is obligated to communicate appropriate information to whatever audience may be warranted, based on information received.

5.4.1.5 The Chair Elect shall have check signing privileges according to the Transactions of the Organization SOP.

5.4.1.6 The Chair Elect, as part of the Board, participates in the hiring and/or firing of the Executive Director.

5.4.1.7 The Chair Elect leads the annual bylaws and standard operating procedures review process to include review and continuation of Standing Committees/Subcommittees.

5.4.2 Term of Office

The duration of the Chair Elect term shall be two years. Nominations for Chair Elect shall come from the General Membership. The nominee for Chair Elect must be a documented representative of a NCTTRAC member organization good standing. The Chair Elect shall ascend to Chair. In the event the Chair Elect is unable to fulfill the term, there shall be an election at the next eligible General Membership Meeting to replace the Chair Elect for the remainder of the unfulfilled term.

5.5 Secretary

5.5.1 Job Description

5.5.1.1 The Secretary shall be responsible for the minutes and records of all general membership and Board Meetings.

5.5.1.2 The Secretary is responsible for voting actions and a list of designated members at each Board and General Membership Meeting to identify members in good standing for voting purposes.

5.5.1.3 The Secretary works with staff to coordinate meeting notification correspondence and support to include meeting location, date, time and agenda.

5.5.1.4 The Secretary is familiar with and refers to, for guidance, the most current edition of “Robert's Rules of Order".

5.5.1.5 The Secretary shall have check signing privileges according to the Transactions of the Organization SOP.

5.5.1.6 The Secretary may represent NCTTRAC at Governor’s EMS and Trauma Advisory Council (GETAC) Meetings and other meetings as necessary.

5.5.1.7 The Secretary is obligated to communicate appropriate information to whatever audience may be warranted, based on information received.

5.5.1.8 The Secretary, as part of the Board, participates in the hiring and/or firing of the Executive Director.

5.5.2 Term of Office

The duration of the Secretary term shall be two years. Nominations for Secretary shall come from the General Membership. The nominee for Secretary must be must be a documented representative of a NCTTRAC member organization in good standing. In the event the Secretary is unable to fulfill the term, there shall be an election at the next eligible General Membership Meeting to replace the Secretary for the remainder of the unfulfilled term.

5.6 Treasurer

5.6.1 Job Description

5.6.1.1 The Treasurer oversees the financial records of NCTTRAC.

5.6.1.2 The Treasurer is a member of the Finance Committee.

5.6.1.3 The Treasurer shall make a current financial statement available on a scheduled basis, no less than every General Membership Meeting.

5.6.1.4 The Treasurer oversees the outside annual audit review.

5.6.1.5 The Treasurer shall have check signing privileges according to the Transactions of the Organization SOP.

5.6.1.6 The Treasurer may represent NCTTRAC at Governor's EMS and Trauma Advisory Council (GETAC) Meetings and other meetings as necessary.

5.6.1.7 The Treasurer is obligated to communicate appropriate information to whatever audience may be warranted, based on information received.

5.6.1.8 The Treasurer, as part of the Board, participates in the hiring and/or firing of the Executive Director.

5.6.2 Term of Office

The duration of the Treasurer term shall be two years. Nominations for Treasurer shall come from the General Membership. The nominee for Treasurer must be must be a documented representative of a NCTTRAC member organization in good standing. In the event the Treasurer is unable to fulfill the term, there shall be an election at the next eligible General Membership Meeting to replace the Treasurer for the remainder of the unfulfilled term.

5.7 Succession of Officers

5.7.1 In the event both the Chair and Chair Elect are unable to fulfill their duties, the succession of responsibility will be first to the Secretary then to the Treasurer.

5.7.2 In the event all officers are unable to fulfill their duties, the Board shall elect a representative from the Board to fulfill the duties of the Chair.

ARTICLE VI

Executive Committee of the Board of Directors

6.1 The Executive Committee of the Board of Directors shall be known as The Executive Committee and will consist of:

6.1.1 Chair

6.1.2 Chair Elect

6.1.3 Secretary

6.1.4 Treasurer

6.1.5 Finance Committee Chair

6.1.6 Medical Directors Committee Chair

6.2 Election, Removal and Vacancies of Executive Committee members

6.2.1 Each Executive Committee Member is confirmed as a member of the Board after election by their respective committee or election by NCTTRAC Membership (as stated in Article V Section 5.2 Nominations and Elections) and ratification by the Board.

6.2.2 Each elected Executive Committee Member will hold office until whichever of the following occurs: (a) a successor is elected, (b) resignation, (c) removal from office by the Board or general membership, (d) removal from office by their respective committee, after ratification by the Board, (e) death, or (f) disability.

6.2.3 Officers, as a part of the Executive Committee, but elected by the General Membership may be removed by a 2/3rds majority vote of the NCTTRAC membership as defined in the Voting & Elections SOP.

6.3 Duties of the Executive Committee

6.3.1 Each Executive Committee Member must be a documented representative of a NCTTRAC member organization in good standing as defined in the Membership & Participation SOP.

6.3.2 The Executive Committee shall participate in Closed Session investigations of a Director removal and provide recommendations to the Board.

6.3.3 The Executive Committee will take recommendations from service line committees that have system performance improvement functions for appropriate designation/accreditation of hospitals related to initial or changes to designation/accreditation. Recommendations will be reviewed and discussed in a closed Executive Committee session to determine the best course to be taken prior to consideration and action by the full board.

6.3.4 The RAC Chair and/or an Executive Committee member recognizes their responsibility to attend DSHS meetings and identified mandatory meetings called by DSHS. Failure to comply with mandatory attendance requirements without prior DSHS approval may be cause for removal.

ARTICLE VII

Board of Directors

7.1 The Board shall consist of:

7.1.1 Chair (only votes in the event of a tie)

7.1.2 Chair Elect

7.1.3 Secretary

7.1.4 Treasurer

7.1.5 Air Medical Committee Chair / Chair Elect

7.1.6 Cardiac Committee Chair / Chair Elect

7.1.7 Emergency Department Operations Committee Chair / Chair Elect

7.1.8 EMS Committee Chair / Chair Elect

7.1.9 Finance Committee Chair / Chair Elect

7.1.10 Hospital Executive – East

7.1.11 Hospital Executive – West

7.1.12 Medical Director Committee Chair / Chair Elect

7.1.13 Pediatric Committee Chair / Chair Elect

7.1.14 Perinatal Committee Chair / Chair Elect

7.1.15 Regional Emergency Preparedness Committee Chair / Chair Elect

7.1.16 Stroke Committee Chair / Chair Elect

7.1.17 Trauma Committee Chair / Chair Elect

7.1.18 Zones Representative

7.1.19 Immediate Past Chair (ex officio, non-voting)

7.2 Election, Removal, and Vacancies of Directors

7.2.1 Each Director is confirmed as a member of the Board after election by their respective committee and ratification by the Board.

7.2.2 Any Director may be removed with or without cause at a Board Meeting by a majority vote of the Board after a Closed Executive Committee investigation and recommendation, provided that proper notice of the intention to act on the matter has been given in the notice calling the meeting.

7.2.3 Each elected Director will hold office until whichever of the following occurs: (a) a successor is elected, (b) resignation, (c) removal from office by the Board, (d) removal from office by their respective committee, after ratification by the Board, (e) death, or (f) disability.

7.3 Duties of the Board

7.3.1 The NCTTRAC Board shall act on behalf of the organization and has the principal responsibility for the organization's mission, and the legal accountability for its operations.

7.3.2 The Board shall determine NCTTRAC's mission and purpose.

7.3.2.1 The Board shall conduct periodic strategic planning to review and update the organization's mission and purpose for accuracy and validity.

7.3.2.2 Each Officer, Director and Committee Chair Elect should fully understand and support the organization's mission and the strategic plan.

7.3.3 The Board shall ensure effective organizational planning.

7.3.3.1 The Board must actively participate with staff in the overall planning process and assist in implementing organizational goals.

7.3.3.2 The Board shall set policy through the development of strong organizational plans including, but not limited to, organizational bylaws, SOPs, and the strategic plan.

7.3.4 The Board shall ensure adequate resources for NCTTRAC to fulfill its mission and shall manage those resources effectively.

7.3.4.1 The Board shall ensure that adequate financial controls are in place to safeguard its resources and preserve the tax-exempt status of the organization.

7.3.4.2 The Board shall actively participate in the development of the annual budget.

7.3.5 The Board shall ensure that NCTTRAC's programs and services are consistent with the organization's mission and shall monitor their effectiveness.

7.3.6 The Board shall ensure legal and ethical integrity and maintain accountability.

7.3.6.1 The Board shall establish pertinent organizational policies and procedures.

7.3.6.2 The Board shall adhere to provisions of the organization's Bylaws and Articles of Incorporation.

7.3.7 The Board shall oversee training of new Officers, Directors and Committee Chairs Elect and assess Board participation and performance.

7.3.7.1 New Officers, Directors and Committee Chairs Elect shall be provided with information related to their Board responsibilities as well as NCTTRAC's history, needs and challenges.

7.3.7.2 The Board shall regularly evaluate its performance in order to recognize its achievements and determine areas that need to be improved.

7.3.8 The Board shall be responsible for NCTTRAC's statement of position in matters of activism, advocacy and/or organizational endorsement. If time constraints do not allow for position development by full Board consensus the responsibility shall be delegated to the Executive Committee or Officers of the Board If time constraints are extreme.

7.3.9 Each Officer and Director shall perform his or her duties in good faith and in a manner he or she reasonably believes to be in the best interest of NCTTRAC.

7.3.9.1 Each Officer and Director shall perform his or her duties with such care as an ordinarily reasonable and prudent person in a like position with respect to a similar corporation would use under similar circumstances.

7.3.9.2 Each Officer and Director shall read and attest to the Conflict of Interest SOP at least annually.

7.3.9.3 Each Officer, Director and Standing Committee Chair Elect shall complete training related to the roles and responsibilities of the Board.

7.4 Requirements of the Board

7.4.1 Each Officer and Director must be a documented representative of a NCTTRAC member organization in good standing as defined in the Voting and Elections SOP.

7.4.2 The Officers and Directors shall participate in accordance with the Membership and Active Participation SOP.

7.4.3 All Officers, Directors and Standing Committee Chairs Elect are required to review and complete the DSHS Board Training requirement at least annually. This training and verification shall be completed within 30 days of elected or appointed participation on the Board.

7.5 Quorum

7.5.1 A quorum is defined as 50% of the voting members of the Board who are present at the call for a vote.

7.5.2 A simple majority vote of the quorum is required to take action.

7.6 Meetings

7.6.1 Meeting times and locations shall be set by the Chair and posted on the NCTTRAC website calendar.

7.6.2 The NCTTRAC Chair is responsible for approving the Board agenda and making copies available at the meeting.

7.6.3 The Secretary is responsible for ensuring that minutes are acceptable for presentation at meetings.

7.7 Directors are volunteers and not compensated, but may be reimbursed for direct expenses in accordance with the Officer / Committee Travel Reimbursement SOP.

7.8 All Officers and Directors are expected to attend all Board Meetings.

7.8.1 If an Officer or Director is absent for two consecutive regular Board Meetings, without accepted excuse, the Officer or Director will be notified by the Board Officers in writing of the consecutive absences.

7.8.1.1 Excused absence requests must be conveyed to the Executive Committee (or delegated Board Officer) for approval prior to the missed meeting.

7.8.1.2 Consensus of the Executive Committee will determine the approval of each excused absence request.

7.8.2 If, after being notified, the Officer or Director misses the next regular Board Meeting, the Chair should bring the situation to the Executive Committee's attention for discussion and resolution.

7.8.3 A cumulative attendance record less than or equal to 50% without prior approvals will be cause for removal.

7.8.4 Attendance rosters will be maintained on a rolling fiscal year calendar.

7.9 The Chair has the authority to call or postpone ad-hoc, special, and closed Board Meetings in accordance with Article VIII Section 8.2.4 within the Bylaws. In the event that a special meeting is called, notice of the purpose will be provided along with the notice of the time, date, and location as discussed in Section 8.2.4 herein.

ARTICLE VIII

Meetings

8.1 All meetings are open to the public and posted on the NCTTRAC website with exceptions for special, ad hoc, or closed meetings.

8.2 General Membership Meetings of all NCTTRAC Members are held in compliance with State contract requirements and will include, but are not limited to Board and Standing Committee/Subcommittee reports to update the Members on NCTTRAC activities.

8.2.1 Voting will be conducted in accordance with the Voting and Elections SOP.

8.2.2 The Chair has the discretion to postpone or reschedule General Membership Meetings.

8.2.2.1 Except for a catastrophic event, a minimum of twenty-four (24) hours notice shall be given.

8.2.3 Written or printed notice stating the place, day, and time of the General Membership Meeting will be delivered not less than fifteen days nor more than sixty days before the meeting. The notice will provide the meeting location and the electronic system access information. The notice will be delivered in person, by electronic transmission, or by mail. In the event that a special meeting of Members is called, notice of the purpose or purposes of the meeting will also be provided.

8.3 Board Meetings are held at least quarterly to take action on NCTTRAC's behalf.

ARTICLE IX

Committees

9.1 The Standing Committees established by NCTTRAC shall include, but are not limited to: Air Medical Committee; Cardiac Committee; Emergency Department Operations Committee; Emergency Medical Services Committee; Finance Committee; Medical Directors Committee; Pediatric Committee; Perinatal Committee; Regional Emergency Preparedness Committee; Stroke Committee; Trauma Committee. Subcommittees to the aforementioned Standing Committees may be established within these Bylaws. All Administrative Criteria applicable to standing Committees, as outlined in this article, shall also apply to Subcommittees of Standing Committees. Standing Committees and Subcommittees may be comprised of voting and nonvoting Members. In addition, non-member agencies or organizations representing key partners in the Trauma Service Area–E (TSA-E) emergency healthcare system are also encouraged to participate in Standing Committee/Subcommittee activities.

9.1.1 Standing Committee/Subcommittee Meetings, with the exception of closed sessions as defined in the Closed Meetings SOP, are open to any individual who wants to attend the meeting.

9.1.2 Standing Committees/Subcommittees shall meet at least quarterly.

9.1.3 Standing Committees shall establish and review on an annual basis a Standard Operating Procedure (SOP) that outlines committee makeup, responsibilities, goals, and products (at minimum). A Standing Committee SOP template is provided by NCTTRAC staff as a guide in addressing overarching Board of Directors expectations and considerations on a fiscal year basis.

9.1.4 The business of a Standing Committee shall be decided by a majority of the eligible votes cast as defined in the Committee SOP. The business of Subcommittees will be defined in the affiliated Standing Committee SOP.

9.1.4.1 On each Standing Committee/Subcommittee, there may be formed either a broad member representation or a documented Core Group of committee representatives that will be the deciding body for that committee's activities. Such documentation will be established in the form of a Standing Committee SOP approved by the Board.

9.1.4.1.1 The Core Group, documented as the "voting representatives of the committee" may consist of both documented representative of a NCTTRAC Member in good standing, as well as delegated representatives of identified and approved partner agencies or organizations.

9.1.4.1.2 The business of a Standing Committee/Subcommittee with an established Core Group will be directed by its Chair-derived consensus of attendees or a deliberate vote of its Core Group.

9.1.4.1.3 In the absence of an established Core Group for a Standing Committee/Subcommittee, the business of the committee will be directed by its Chair-derived consensus or deliberate vote of a documented representative of a NCTTRAC Member in good standing.

9.1.4.2 No NCTTRAC Voting Member or Core Group organization shall have more than one vote per action item in individual Standing Committee/Subcommittee Meetings.

9.1.4.3 The NCTTRAC Member's Primary Voting Representative may appoint a Standing Delegate to serve as a regular attendee to Standing Committees/Subcommittees for purposes of both subject matter representation and voting.

9.1.4.3.1 Standing Delegates shall be appointed in writing and/or email originating from the NCTTRAC Member's Primary Voting Representative.

9.1.5 The Chair of a Standing Committee/Subcommittee

9.1.5.1 The Standing Committee/Subcommittee Chair term is one year. The Chair of a Standing Committee/Subcommittee ascends from the Committee Chair Elect.

9.1.5.2 The Standing Committee/Subcommittee Chair must be a documented representative of a NCTTRAC Member organization in good standing.

9.1.5.3 The Standing Committee/Subcommittee Chair cannot hold more than one elected position with NCTTRAC at a time.

9.1.5.4 In the event the Standing Committee/Subcommittee Chair is unable to fulfill the term, the Chair Elect shall ascend to Chair. The term of the new Chair shall be the remainder of the unfulfilled term of the previous Committee Chair. The Committee will recommend if the new Chair will additionally serve the one-year term that would have been served originally for review by the Executive Committee and ratification by the Board.

9.1.6 The Chair of each Standing Committee/Subcommittee has the following responsibilities:

9.1.6.1 The Chair of each Standing Committee is a voting member of the Board.

9.1.6.2 The Chair of each Standing Committee in collaboration with NCTTRAC staff is responsible for the development of and adherence to an SOP related to committee functions and membership. Guidance on specific SOP content is provided by NCTTRAC staff as approved by the Board. All committee SOP's will be reviewed annually with the intent of final Board approval prior to the start of the NCTTRAC fiscal year.

9.1.6.3 The Chair of each Standing Committee is responsible for presenting committee and subcommittee reports to the Board on a periodic basis as approved by the Board.

9.1.6.4 The Chair of each Standing Committee/Subcommittee is responsible for representing the collective vote or consensus of the members or Core Group of the Standing Committee/Subcommittee.

9.1.6.5 The Chair of each Standing Committee/Subcommittee shall vote only in the event of a tie vote of the Standing Committee/Subcommittee.

9.1.6.6 The Chair of each Standing Committee/Subcommittee has the authority to call or postpone Standing Committee/Subcommittee Meetings.

9.1.6.7 Any workgroup not identified in the approved SOP must be established by the NCTTRAC Chair in accordance with Section 5.3 of these Bylaws.

9.1.6.8 Further clarification of responsibilities regarding conduct of meetings is found in the Conducting Official Business Meetings SOP.

9.1.7 The Chair Elect of each Standing Committee/Subcommittee is chosen by vote of the present and eligible Voting Members or Core Group as stated in 9.1.3 and approved by a simple majority vote of the Board in accordance with the Voting and Elections SOP.

9.1.7.1 The Standing Committee/Subcommittee Chair Elect term shall be one year.

9.1.7.2 Nominations for Standing Committee/Subcommittee Chair Elect shall come from its present and eligible Voting Members or Core Group.

9.1.7.3 The Standing Committee/Subcommittee Chair Elect must be a documented representative of a NCTTRAC Member in good standing.

9.1.7.4 The Standing Committee/Subcommittee Chair Elect cannot hold more than one elected position with NCTTRAC at a time.

9.1.7.5 In the event the Standing Committee/Subcommittee Chair Elect is unable to fulfill the term, there shall be an election at the next Standing Committee/Subcommittee Meeting to replace the Chair Elect for the remainder of the term.

9.1.8 The Chair Elect of each Standing Committee/Subcommittee has the following responsibilities

9.1.8.1 The Chair Elect assists the Chair with committee/subcommittee functions and assumes the Chair responsibilities for Standing Committee/Subcommittee activity and meeting management in the temporary absence of the Chair.

9.1.8.2 The Chair Elect of each Standing Committee is a voting member of the Board in the absence of the Standing Committee Chair.

9.1.8.3 The Chair Elect of each Standing Committee/Subcommittee has the authority to call or postpone Standing Committee/Subcommittee Meetings in the absence of the Standing Committee Chair.

9.1.8.4 The Chair Elect automatically ascends to the Chair position at the end of the

current Chair's term.

9.1.8.5 The Standing Committee/Subcommittee Chair Elect is chosen by vote of the present and eligible Voting Members or Core Group as stated in 9.1.3 and approved by a simple majority vote of the Board in accordance with the Voting and Elections SOP.

9.1.9 Call for removal of or complaint against any Chair of a Standing Committee/Subcommittee shall be delegated to the Executive Committee for investigation and recommendation. Recommendation shall be presented to the Board for action.

9.1.10 Purpose and responsibilities of Standing Committees/Subcommittees:

9.110.1 Air Medical Committee

9.110.1.1 Responsible for affecting and supporting safe air medical operations and high quality clinical care provided by air medical transport services in TSA-E.

9.1.10.1.2Establish standing agenda items and corresponding responsibilities (e.g. by individual appointment, workgroup, or subcommittee) to address, and document in the committee SOP, the following topics:

9.1.10.1.2.1 Professional Development

9.1.10.1.2.2 Injury / Illness Prevention and Public Education

9.1.10.1.2.3 System Performance Improvement

9.1.10.1.3Provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the Committee SOP.

9.1.10.1.4 Provide interface with other RAC committees, the Texas Association of Air Medical Service (TAAMS), and the Governor's EMS and Trauma Advisory Council (GETAC).

9.1.10.2 Cardiac Committee

9.1.10.2.1 Responsible for the development of an acute cardiac care system for TSA-E. This includes the development of guidelines for rapid transport to appropriate facilities of patients suffering ST-Elevation Myocardial Infarction (STEMI), and other acute cardiac conditions.

9.1.10.2.2Establish standing agenda items and corresponding responsibilities (e.g. by individual appointment, workgroup, or subcommittee) to address, and document in the committee SOP, the following topics:

9.1.10.2.2.1 Professional Development

9.1.10.2.2.2 Injury / Illness Prevention and Public

Education
9.1.10.2.2.3 System Performance Improvement

9.1.10.2.3 Provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the Committee SOP.

9.1.10.2.4 Provide interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).

9.1.10.3 Emergency Department Operations Committee

9.1.10.3.1 Responsible for improving Emergency Department operations in TSA-E by engaging in and supporting the development and implementation of clinical guidelines and processes; and enhancing communication, collaboration and alignment amongst the EDs, ED partners in care, and other NCTTRAC Committees in TSA-E.

9.1.10.3.2 Establish standing agenda items and corresponding responsibilities (e.g. by individual appointment, workgroup, or subcommittee) to address, and document in the committee SOP, the following topics:

9.1.10.3.2.1 Professional Development

9.1.10.3.2.2 Injury / Illness Prevention and Public Education
9.1.10.3.2.3 System Performance Improvement

9.1.10.3.3 Provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the Committee SOP

9.1.10.3.4 Provide interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).

9.1.10.4 Emergency Medical Services (EMS) Committee

9.1.10.4.1 Responsible for coordinating and improving the clinical care provided by all levels of prehospital providers within TSA-E.

9.1.10.4.2 Establish standing agenda items and corresponding responsibilities (e.g. by individual appointment, workgroup, or subcommittee) to address, and document in the committee SOP, the following topics:

9.1.10.4.2.1 Professional Development

9.1.10.4.2.2 Injury / Illness Prevention and Public

Education
9.1.10.4.2.3 System Performance Improvement

9.1.10.4.3 Provide guidance in the development and review of pre-hospital assessment tools, regional plans and treatment guidelines, Committee SOP

9.1.10.4.4 Provide interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC) and keep members informed on latest developments in prehospital transportation and care.

9.1.10.5 Finance Committee

9.1.10.5.1 Responsible for planning, monitoring, and overseeing the organization's financial resources, including, but not limited to, budgeting, financial reporting, and the creation and monitoring of internal controls and financial policies as well as oversight of the annual independent audit.

9.1.10.5.2 Provide interface with other RAC committees, professional associations, and state agencies appropriate to RAC/Member funding considerations.

9.1.10.6 Medical Director Committee

9.1.10.6.1 Responsible for recommending a minimum standard of practice for providers participating in the trauma, acute, emergency healthcare and disaster response system of TSA-E.

9.1.10.6.2 The committee will be comprised of the elected committee medical directors of the following committees: Air Medical, Cardiac, Emergency Department Operations, EMS, Pediatric, Perinatal, Regional Emergency Preparedness, Stroke, and Trauma.

9.1.10.6.3 Provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and Committee SOP.

9.1.10.6.4 Provide interface with other RAC committees, professional associations appropriate to their service lines, and the Governor's EMS and Trauma Advisory Council (GETAC).

9.1.10.7 Pediatric Committee

9.1.10.7.1 Responsible for promoting pediatric expertise through advocacy and education.

9.1.10.7.2 Establish standing agenda items and corresponding responsibilities (e.g. by individual appointment, workgroup, or subcommittee) to address, and document in the committee SOP, the following topics:

9.1.10.7.2.1 Professional Development

9.1.10.7.2.2 Injury / Illness Prevention and Public Education

9.1.10.7.2.3 System Performance Improvement

9.1.10.7.3 Serve as the resource for information regarding pediatric care, pediatric emergency preparedness, and identify needs or trends in the management of injured and acutely ill children.

9.1.10.7.4 Provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the Committee SOP

9.1.10.7.5 Provide interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).

9.1.10.8 Perinatal Committee

9.1.10.8.1 Responsible for the development of a Perinatal Region of Care (PCR) in TSA-E including the Regional Perinatal System Plan. This plan identifies all resources available in the PCRs for perinatal care including resources for emergency and disaster preparedness.

9.1.10.8.2 Establish standing agenda items and corresponding responsibilities (e.g. by individual appointment, workgroup, or subcommittee) to address, and document in the committee SOP, the following topics:

9.1.10.8.2.1 Professional Development

9.1.10.8.2.2 Injury / Illness Prevention and Public Education

9.1.10.8.2.3 System Performance Improvement

9.1.10.8.3 Provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the Committee SOP.

9.1.10.8.4 Provide interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).

9.1.10.9 Regional Emergency Preparedness Committee (REPC)

9.1.10.9.1 Responsible for jointly identifying and recommending plans and solutions that support improvements in TSA-E emergency/disaster preparedness and response between medical emergency preparedness stakeholders.

9.1.10.9.1.1 The Healthcare Coalition (HCC) Planning Subcommittee is tasked with providing subject matter expertise in regional all hazards disaster planning support.

9.1.10.9.1.2 The Emergency Medical Task Force (EMTF)–2 Subcommittee is tasked with providing subject matter expertise in regional and state planning, mobilization, recruiting, training, operations, recovery, and fiscal responsibilities.

9.1.10.9.2 Serves as the steering committee that provides recommendations and support to the NCTTRAC Board and staff regarding execution of the Texas Hospital Preparedness Program contract as administered by the Texas DSHS for EMTF-2, and TSAs C, D, and E.

9.1.10.9.3 Establish standing agenda items and corresponding responsibilities (e.g. by individual appointment, workgroup, or subcommittee) to address, and document in the committee SOP, the following topics:

9.1.10.9.3.1 Professional Development

9.1.10.9.3.2 Injury / Illness Prevention and Public Education

9.1.10.9.3.3 System Performance Improvement

9.1.10.9.4 Provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the Committee SOP

9.1.10.9.5 Provide interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).

9.1.10.10 Stroke Committee

9.1.10.10.1 Responsible for development of an acute stroke care system for TSA-E, including the development of guidelines for acute stroke care in Level I, II, and III Stroke Centers as specified in the Regional Stroke Plan.

9.1.10.10.2 Establish standing agenda items and corresponding responsibilities (e.g. by individual appointment, workgroup, or subcommittee) to address, and document in the committee SOP, the following topics:

9.1.10.10.2.1 Professional Development

9.1.10.10.2.2 Injury / Illness Prevention and Public Education

9.1.10.10.2.3 System Performance Improvement

9.1.10.10.3 Provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the Committee SOP

9.1.10.10.4 Provide interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).

9.1.10.11 Trauma Committee

9.1.10.11.1 Responsible for the oversight of the trauma system for TSA-E, including the TSA-E Regional Trauma System Plan (Plan). This Plan includes strategies to focus diverse resources in a collective strategy to reduce morbidity and mortality due to trauma.

9.1.10.11.1.1 The Professional Development Subcommittee is tasked with identifying and meeting professional development needs for all levels of providers throughout TSA-E.

9.1.10.11.1.2 The Public Education / Injury Prevention (PEIP) Subcommittee is tasked promoting injury and illness prevention and public awareness through advocacy and education.

9.1.10.11.1.3 The System Performance Improvement (SPI) Subcommittee is tasked with shared oversight of emergency healthcare system performance improvement activities with individual service line Committees of NCTTRAC.

9.1.10.11.2 Provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the Committee SOP

9.1.10.11.3 Provide interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).

9.2 Trauma Service Area –E is divided into geographic areas referred to as Zones. NCTTRAC is supportive of member efforts to organize and meet at the local level on specific issues affecting them.

9.2.1 The current Zones are:

9.2.1.1 Zone 1 – Cooke, Grayson and Fannin counties;

9.2.1.2 Zone 2 – Denton and Wise counties;

9.2.1.3 Zone 3 – Palo Pinto and Parker counties;

9.2.1.4 Zone 4 – Ellis, Kaufman and Navarro counties;

9.2.1.5 Zone 5 – Collin, Hunt and Rockwall counties;

9.2.1.6 Zone 6 – Erath, Hood, Johnson and Somervell counties;

9.2.1.7 Zone 7 – Tarrant County; and

9.2.1.8 Zone 8 – Dallas County.

9.2.2 Zone Meetings are open to any individual who wants to attend the meeting.

9.2.3 Zone Meetings shall occur at least quarterly and follow the guidance provided by the Zones Communications and Reporting SOP.

9.2.4 Each Zone Representative is chosen by vote of the present and eligible voting members of the Zone.

9.2.4.1 Nominations for each Zone Representative shall come from the Zone membership.

9.2.5 Each Zone Representative has the following responsibilities:

9.2.5.1 Serve as the primary liaison between the zone membership, the Zones Liaison, the Board, NCTTRAC Committee, and staff.

9.2.5.2 Report grassroots activity to the Zones Liaison at least quarterly.

9.2.5.3 Represent the collective vote of the members in the Zone.

9.2.5.4 Call or postpone Zone Meetings.

9.2.5.4.1 Further clarification of responsibilities regarding conduct of meetings is found in the Conducting Official Business Meetings SOP.

9.2.5.5 Ensure that timely Zone Representative elections are held as described in the Zone Communication and Reporting SOP.

9.2.6 The Zones Liaison to the Board (Zones Liaison) has the following responsibilities:

9.2.6.1 Serve as the primary liaison between each of the eight (8) Zone Representatives and the Board of Directors, NCTTRAC Committees, and staff.

9.2.6.2 Report grassroots activity to the Board of Directors and NCTTRAC's General Membership on a periodic basis as approved by the Board.

9.2.6.3 Represent the collective vote of the Zone Representatives.

9.2.7 Call for removal of, or complaint against, any Zone Representative shall be delegated to the Executive Committee for investigation and recommendation. The recommendation shall be presented to the Board for action.

9.2.8 Zone Representatives shall biannually elect one Zones Liaison to serve on the Board as a voting member. That voting member cannot simultaneously serve as an Officer or Standing Committee/Subcommittee Chair.

9.2.8.1 The Zones Liaison to the Board of Directors must be a documented representative of a NCTTRAC Member organization in good standing.

ARTICLE X

Fiscal Policies

NCTTRAC shall maintain current, true, and accurate financial records, including all income and expenditures. All records, books, and annual reports of the financial activity of NCTTRAC shall be kept at the principal office of NCTTRAC.

10.1 The fiscal year for NCTTRAC is defined as the first day of September through the last day of August of the following year.

10.2 NCTTRAC shall maintain financial records in accordance with Generally Accepted Accounting Principles (GAAP).

10.3 NCTTRAC provides financial reports in accordance with contract or grant guidance or as otherwise required by law.

10.4 NCTTRAC is a nonprofit organization under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, as recognized by the Internal Revenue Service. As such, no one individual or entity may profit from the activities of NCTTRAC.

10.5 The Finance Committee in collaboration with NCTTRAC staff prepares an annual budget. The budget is presented for approval to the Board.

10.6 The Board may accept any contribution, gift, bequest, or devise for the general purpose or for any special purpose of NCTTRAC.

10.7 NCTTRAC may be wound up and terminated by a vote of at least 2/3rds of the voting membership present and voting in accordance with the Texas Business Organizations Code (TBOC). Upon winding up and termination, any eligible existing funds of NCTTRAC shall be distributed to an appropriate organization or entity that shall utilize the funds to continue the mission of NCTTRAC.

10.8 Indemnity and Insurance

10.8.1 NCTTRAC will indemnify its Officers, Directors, employees, and agents to the fullest extent permitted by the TBOC and may, if and to the extent authorized by the Board, indemnify any other person whom it has the power to indemnify against liability, reasonable expense, or any other matter.

10.8.2 As may be provided by specific action of the Board, NCTTRAC may purchase and maintain insurance on behalf of any person who is or was an Officer, Director, employee or agent of NCTTRAC against any liability asserted against him or her and incurred by such person in such a capacity or arising out of his or her status, whether or not NCTTRAC would have the power to indemnify him or her against the liability under this Section.

10.9 Limitation of Liability – A Director of NCTTRAC shall not be liable to NCTTRAC or its Members for monetary damages arising as a result of an act or omission committed by the Director while acting within his or her capacity as a Director, except that this Section shall not eliminate or limit the liability of a Director for:

10.9.1 Breach of a Director's duty of loyalty to NCTTRAC or its Members;

10.9.2 An act or omission not in good faith that constitutes a breach of duty of the Director to NCTTRAC or that involves intentional misconduct or a knowing violation of the law;

10.9.3 A transaction from which a Director received an improper benefit, whether or not the benefit resulted from an action taken within the scope of the Director's office; or

10.9.4 An act or omission for which the liability of a Director is expressly provided for by statute.

10.10 Annual Audit – The Board shall ensure that an annual audit of NCTTRAC's financial records be performed every year by a qualified agency or individual within four months of the end of the fiscal year.

ARTICLE XI

Parliamentary Authority

11.1 The most current edition of "Robert's Rules of Order" shall be used as a general guide to parliamentary procedure for meetings.

ARTICLE XII

Amendment of Bylaws

12.1 NCTTRAC Bylaws shall be reviewed at least annually.

12.1.1 A Bylaws workgroup, led by the Chair Elect, shall be assembled for the annual review.

12.1.2 Proposed Bylaws amendments shall be presented at a General Membership Meeting by the Bylaws Workgroup in accordance with the Bylaws.

12.1.3 Copies of proposed Bylaws amendments shall be made available to Members at least 21 days prior to the meeting in which they shall be considered for adoption.

12.1.4 Bylaws amendments, as contained in the notice of such meeting, may be adopted according to the NCTTRAC SOP.

ARTICLE XIII

Signatures

13.1 These Bylaws shall be effective immediately upon approval by the General Membership and signed and dated by the Secretary unless a later effective date is specified and approved.

ARTICLE XIV

Proxies

14.1 A Voting Member can be represented by proxy.

14.1.1 Such proxy shall be originated and/or signed by the Member's documented Primary Voting Representative and filed with NCTTRAC prior to the vote as defined in the Voting and Elections SOP.

14.1.2 Such proxy shall be limited to an individual that represents the same Member organization, agency, or its parent corporation as the Voting Member's Primary Representative assigning proxy.

14.1.3 No individual shall hold more than one proxy at a time, unless granted between Members within the same corporation.

14.1.4 No such proxy shall be valid after the expiration of ninety (90) days from the date of its execution or as otherwise specified.

14.2 Voting by proxy is not available for Board Meetings.

ARTICLE XV

Financial Books and Records

15.1 NCTTRAC shall keep true and complete books and records of accounts, together with minutes of the proceedings of the Board.

15.2 The Board shall maintain current, true, and accurate financial records with full and correct entries made with respect to all financial transactions of NCTTRAC, including all income and expenditures.

15.3 All records, books, and annual reports of the financial activity of NCTTRAC shall be kept at the principle office of NCTTRAC.

ARTICLE XVI

Transactions of the Organization

16.1 The Executive Director has the authority to enter into contracts or execute and deliver any instrument in the name of and on behalf of NCTTRAC in accordance with the Transactions of the Organization SOP.

16.2 NCTTRAC shall maintain depository accounts to meet the business needs of NCTTRAC including depositing funds as authorized by the Executive Director.

16.3 Check signing authority shall be established in accordance with the Transactions of the Organization SOP.

16.4 The Board may make gifts or contributions on behalf of NCTTRAC in accordance with the Transactions of the Organization SOP.

16.5 NCTTRAC Officers and Directors shall sign a conflict of interest statement annually and update as needed.

16.5.1 Individuals are required to disclose any conflict of interest to the Board at the time that the conflict is identified.

16.6 NCTTRAC Members, officers, and staff shall conduct the business of the organization in a manner that is not otherwise prohibited by statute, by the Articles of Incorporation of NCTTRAC, or by these Bylaws.

16.7 Expenditure authority is defined by the Transactions of the Organization SOP.

CERTIFICATE BY SECRETARY

The undersigned, being the Secretary of North Central Texas Trauma Regional Advisory Council, Inc. hereby certifies that the foregoing Bylaws were duly adopted by the Members of said corporation effective on the 19th day of September, 2019.

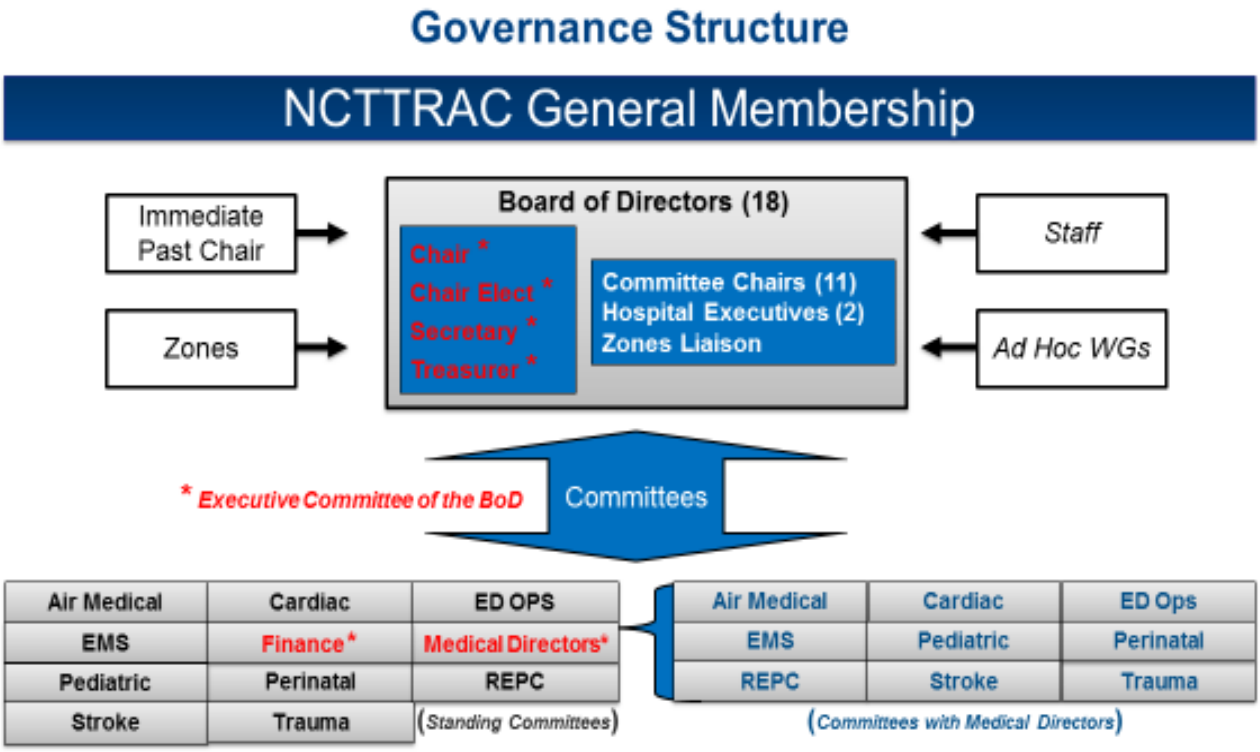
In Witness Whereof, I have signed this certification on this the 13th day of April, 2021.

Original Signed by

Signature on File

Nakia Rapier, Secretary

Attachment 1
Governance & Organization Chart



1. Committee Purpose and Responsibilities

1.1. The Perinatal Committee is responsible for the development of a Perinatal Region of Care (PCR) in Trauma Service Area (TSA)-E including the Regional Perinatal System Plan. This plan will identify all resources available in the PCRs for perinatal care including resources for emergency and disaster preparedness. The committee will provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the committee SOP. Additionally, the committee will provide interface with the other NCTTRAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).
1.2. Create and/or maintain collaborative relationships to facilitate optimal maternal and neonatal care.
1.3. Establish standardized reporting tools for data acquisition.
1.4. Develop and review system performance standards.
1.5. Review, evaluate and report hospital-based maternal and neonatal data in a de-identified manner.
1.6. Create best practices through shared quality improvement data and processes
1.7. Collaborate with other Perinatal Committees statewide.

2. Subcommittees and Work Groups

2.1. *Not Applicable*

3. Committee Chair/Chair Elect Responsibilities

3.1. Chair
- 3.1.1. The Committee Chair serves as the principal liaison between the committee and the Board of Directors with responsibilities that include, but are not limited, to:
  - 3.1.1.1. Knowledge of the Bylaws.
  - 3.1.1.2. Scheduling meetings.
  - 3.1.1.3. Meeting agenda and notes.
  - 3.1.1.4. Providing committee report to the Board of Directors.
  - 3.1.1.5. Annual review of Perinatal Plans, Guidelines, committee SOP, and SPI indicators.
  - 3.1.1.6. Provide or arrange for knowledge and dissemination of appropriate liaison group activities to committee members and the Board of Directors.
- 3.1.2. The Chair must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.
- 3.1.3. The Chair will serve a one-year term of office, beginning at the start of the Fiscal year, and be succeeded by the Chair Elect at the end of the Fiscal Year.

3.2. Chair Elect
- 3.2.1. The Committee Chair Elect assists the Chair with committee functions and assumes the Chair responsibilities for committee activity and meeting management in the temporary absence of the Chair. The Chair Elect may serve in lieu of the Perinatal Chair for Board of Directors responsibilities.
- 3.2.2. The Chair Elect must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.
- 3.2.3. The Chair Elect automatically ascends to the Chair position at the end of the current Chair's term or if the Chair position is otherwise vacated.

3.2.4. The Chair Elect position will be voted on by the Perinatal Committee annually or when the incumbent has vacated this position.

3.3 Immediate Past Chair

3.3.1 The Immediate Past Chair assists the Chair with committee functions and assumes the Chair responsibilities for committee activity and meeting management in the temporary absence of the Chair and Chair Elect.

3.3.2 The Immediate Past Chair may not serve on the NCTTRAC Board of Directors in lieu of the Committee Chair / Chair Elect.

3.3.3 The Immediate Past Chair must be a Perinatal representative of a NCTTRAC member in good standing as defined in the NCTTRAC Bylaws.

4. Committee Medical Director

4.1. The elected Perinatal Committee Medical Director is responsible for

4.1.1. Participating directly with their service line committee

4.1.2. Establishing and maintaining a standing coordination method with their service line peers

4.1.3. Maintaining availability for coordinating with other committees' Medical Directors to recommend a minimum standard of care for providers participating in the trauma, acute, emergency healthcare and disaster response systems of TSA-E

4.2. The Perinatal Committee Medical Director provides current physician insight and involvement in support of the Perinatal Committee and its responsibilities, including:

4.2.1. Identifying and assessing regional performance improvement standards, formulating strategies and making recommendations to the committee to ensure that the best possible standards of healthcare can be met within TSA-E.

4.2.2. Active partnership in the coordination and support of the following service line committee products (see appendix A for the Coordination Flow Chart):

4.2.2.1. Service Line Regional Plans

4.2.2.2. Guidelines

4.2.2.3. Texas Department of State Health Services (DSHS) Rules Reviews

4.3. The Perinatal Committee Medical Director must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.

4.4. The Perinatal Committee Medical Director position will be voted on by the Perinatal Committee annually, with each Fiscal Year, or if otherwise vacated.

4.5. The Perinatal Committee Medical Director should be prepared, with NCTTRAC staff assistance, to facilitate a peer group of perinatal medical directors (by email or meeting) in support of Perinatal Committee efforts as appropriate.

4.6. The Perinatal Committee Medical Director will be seated as a voting representative on the NCTTRAC Medical Directors Committee.

4.7. The Perinatal Medical Director represents perinatal care issues in the Medical Directors Committee.

4.8. The Perinatal Medical Director can facilitate communication via email groups among their service line physician peers, identified as a focus group.

4.9. The Perinatal Medical Director is elected by the committee. An annual review for continuation as Medical Director is based on availability and preferences of the committee.

5. Committee Representation

5.1. In accordance with NCTTRAC Bylaws Article IX, there is a voting core group identified within the Perinatal Committee. A hospital representative of a perinatal designated organization, that provides perinatal services in PCR-E and maintains NCTTRAC Membership in good standing are considered to be the voting core group.
5.2. The representatives identified as voting core group members and those with special online voting privilege in attendance of the Perinatal Committee Meeting shall be allowed to exercise their vote.
5.3. Those NCTTRAC members in good standing, may request to be considered for special online voting privilege. The voting core group must be agreed upon by the committee on a case by case bases prior to a meeting that a vote would be held.

6. Committee Attendance

6.1. Attendance is a prerequisite to meaningful participation and as such, the Perinatal Committee requires documented attendance of 75% of committee meetings by the primary or identified alternate organization/agency representative.

7. Committee Active Participation

7.1. In addition to attendance, the Perinatal Committee identifies the following to be creditable for active participation at the committee level:
7.1.1. Each member will have 100% participation in at least one of the NCTTRAC SMART goals.

8. Procedures (Meeting, Agenda and Notes)

8.1. The Perinatal Committee shall perform its responsibilities with an organized approach utilizing the following procedures:
8.1.1. The date, time and location of all scheduled meetings will be posted at least 10 days in advance on the NCTTRAC website calendar
8.1.2. The committee will meet at least quarterly
8.1.3. All meetings are held as open meetings
8.1.4. Agendas will be provided and be prepared by the committee chair
8.1.5. An attendance sheet will be provided at each meeting
8.1.6. Each meeting will have notes
8.1.7. Agenda and meeting notes will be forwarded to NCTTRAC offices and administrative staff within 20 days after the meeting for posting. The attendance will be turned in at the end of the meeting. Attendance sheets track participation, including those in virtual attendance.
8.1.8. Members may access copies of meeting agendas, minutes, and/or notes on the NCTTRAC website

9. Committee Liaisons (identify active state and local service line and coalition relations, examples below)

9.1. Governor's EMS and Trauma Advisory Council (GETAC)
9.2. Texas EMS Trauma and Acute Care Foundation (TETAF)
9.3. Perinatal Advisory Council (PAC)

9.4. Texas Collaborative for Healthy Mothers and Babies (TCHMB)

10. Standing Committee Obligations

10.1. Annual Update of Committee SOP
10.2. Annual Review of Regional Plans & Guidelines
  10.2.1. Regional Perinatal System Plan
10.3. DSHS "Essential Criteria", Rules and/or contractual deliverables, as applicable
10.4. GETAC Strategic Plan objectives and strategies, as applicable

11. Projected Committee Goals, Objectives, Strategies, Projects

11.1. Improve the access to care and quality and outcomes for pregnant women and newborns in the State through participation with NCTTRAC and state designations
11.2. One or more SMART goals will be adopted annually as established by the Perinatal Committee
11.3. NCTTRAC's "Accountability Scorecard" spreadsheet will be used to document commitments and progress with associated efforts

12. System Performance Improvement (SPI)

12.1. The Perinatal Committee will support Perinatal SPI responsibility by establishing a standing meeting agenda item and corresponding accountability (e.g. appoint individual facilitator, workgroup or subcommittee).
12.2. At minimum, the Committee will review, evaluate, and report Perinatal EMResource utilization and make recommendations to the Executive Committee of the Board of Directors for appropriate designation/accreditation of hospitals related to initial or changes to designation/accreditation as requested/required by the Department of State Health Services (DSHS).
12.3. Closed Perinatal SPI meetings support detailed reviews of Performance Improvement (PI) Indicators and referred PI events as afforded by Texas Statute and Rule.
  12.3.1. Representation:
    12.3.1.1. Perinatal Committee Chair
    12.3.1.2. Perinatal Committee Chair Elect
    12.3.1.3. Perinatal Committee Medical Director
    12.3.1.4. Two elected Perinatal Committee representatives
  12.3.2. Closed Perinatal SPI meeting participants will sign a confidentiality statement prior to the start of each closed meeting.
  12.3.3. Meeting notes, attendance rosters, and supporting documents of Closed Perinatal SPI meetings must be provided to NCTTRAC staff within 48 hours following each meeting to be secured as a confidential record of committee activities.
12.4. SPI Products
  12.4.1. Perinatal SPI Indicators
  12.4.2. Perinatal SPI Referral Form
  12.4.3. Perinatal SPI Referral Feedback Form

12.4.4. Perinatal Designation Letter of Support Review Forms

12.5. SPI Indicators - *Not Applicable*

13. Injury/Illness Prevention / Public Education

13.1. The Perinatal Committee will support Perinatal Injury/Illness Prevention and Public Education responsibility by establishing a standing meeting agenda item and corresponding accountability (e.g. appoint individual facilitator, workgroup or sub-committee).

13.2. Focus on injury prevention and education of the public health needs.

13.3. Create a broad stakeholder representation working to provide an opportunity to share resources leading to the development, operation, and evaluation of public education and injury/illness prevention efforts within Perinatal Care Region (PCR)-E.

13.4. Base decisions on current perinatal trends and data, facts and assessment of programs and presented educational opportunities.

13.5. Organize; support and/or coordinate community evidenced based education and injury/illness prevention programs.

13.6. Recommend/support prevention priorities for PCR-E according to the injury/illness, geographic location, cost, and outcome.

13.7. Serve as a resource to identify prevention programs, events and other prevention resources available in PCR-E to members and community members.

13.8. Establish Ad Hoc Task Forces, as necessary, to address specific issues.

14. Professional Development

14.1. The Committee will support Perinatal Professional Development responsibility for all levels of providers by establishing a standing meeting agenda item and corresponding accountability (e.g. appoint individual facilitator, workgroup or sub-committee).

14.2. At minimum, the Committee will:

14.2.1. Participate in the development of the Annual NCTTRAC Needs Assessment.

14.2.2. Sponsor at least two classes annually based on needs assessment results.

15. Unobligated Budget Requests

15.1. Recommendations from the Perinatal Committee, coordinated through the Finance Committee, seeking approval from the Board of Directors for financial backing and execution authority in support of related initiatives, projects, and/or education efforts within PCR-E.

Annex C
System Access & Communications

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:

1. Capabilities Database
2. Daily Status Updates
3. Event Notifications

Capabilities Database

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.

Daily Status Updates

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.

1. *Open/Closed/Advisory* – hospitals report on the current status of their Emergency Department. An "Open" status should be updated every 24 hours; an "Advisory" status should be updated every 4 hours; a "Closed" status should be updated every 4 hours.
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 4 hours.
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.
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.
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.

Event Notifications

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, statewide bed reports, or severe weather.

WebEOC is a web-based incident management software that allows users from multiple entities to communicate via information sharing boards in order to enhance the common operating picture. WebEOC is divided into incidents and boards. When a user logs in to WebEOC, they select the incident in which they are operating – each emergency or disaster requiring the use of WebEOC will have its own incident. If there is not yet a custom WebEOC incident for the current event or disaster, users should use the incident titled "!Generic Incident". NCTTRAC WebEOC Administrators will rename the "!Generic Incident" to something that describes the current event. All information entered into "!Generic Incident" will be retained in the new incident.

The NCTTRAC WebEOC server operates independently from other servers, but does share information during large-scale events with other WebEOC servers across the state. This process is called fusion - during a large-scale event, TDEM CIS will publish a fusion incident that all regional WebEOC servers can subscribe to. In TSA-E, there are five WebEOC servers: NCTTRAC, Dallas County, City of Fort Worth, City of McKinney, and City of Plano. Additionally, TDEM CIS hosts the LoneStar server, which is where the DDCs operate. Generally speaking, healthcare related information is posted on the NCTTRAC server, jurisdictional emergency management related information is posted on one of the 4 city or county servers, and EMTF related information is posted on the LoneStar server.

WebEOC has two main functions in the TSA-E HCC: narrative-based information sharing and patient tracking. Narrative-based information sharing occurs in the "Local Medical Events" and "TSA-E Medical Events" boards. HCC member organizations can create narrative-based posts in Local Medical Events to inform the HCC about events happening at their facility or within their organization. The TSA-E Medical Coordination Center uses the TSA-E Medical Events board to inform the HCC as a unit about events affecting emergency healthcare through the TSA-E region. Patient tracking occurs in the NCTTRAC Regional Patient Tracking Toolkit. A full listing and description of each WebEOC board used by the HCC can be found in the "Response Operations" section of the "Communications and Information Sharing Procedures" part of this document.

While WebEOC is always available, it is best used when it can be actively monitored. For this reason, the EMCC will notify the HCC when they should begin monitoring and posting in WebEOC. These notifications will come via an EMResource notification and the aforementioned email distribution lists.

Pending Development

Pending Development

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

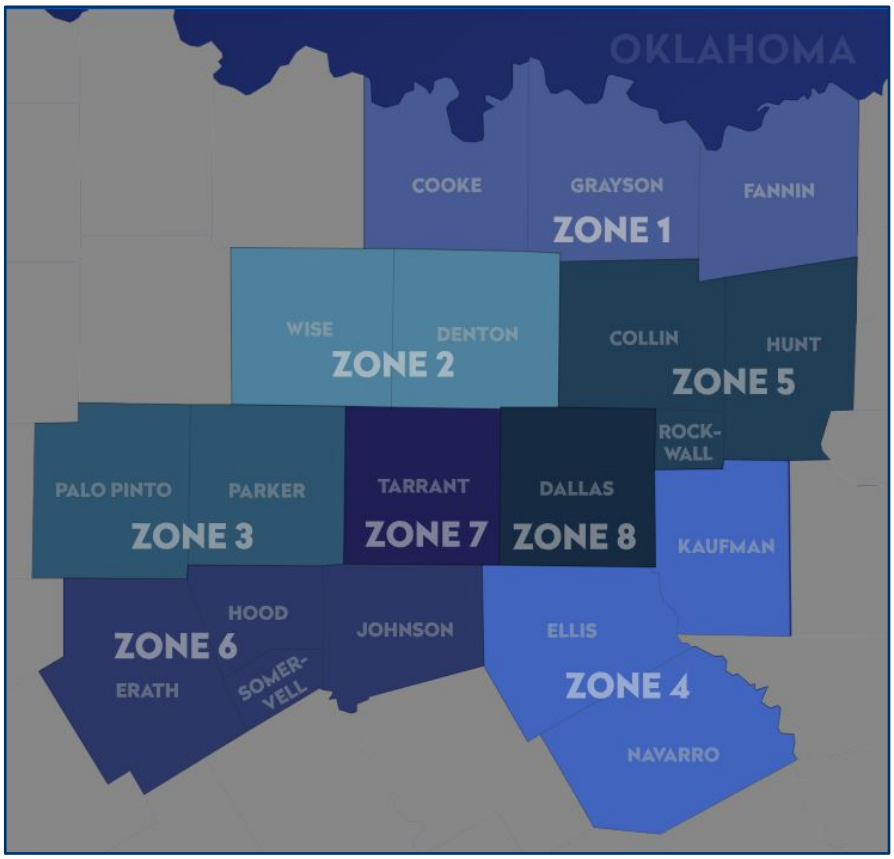
4.1 General Organization

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

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.

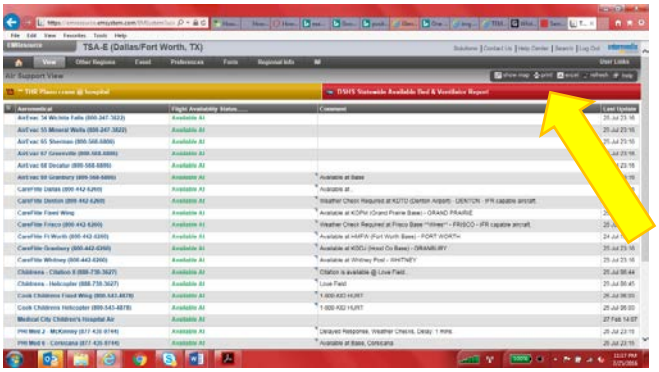
4.2 Obtain a facility or personal login by creating a support ticket with NCTTRAC
- 4.2.1 Go to https://www.ncttrac.org/
- 4.2.2 On the bottom right select Create A Helpdesk Ticket
- 4.2.3 Start a Ticket
- 4.2.4 Choose "Support – Other"
- 4.2.5 Then fill in the needed fields and state that your agency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

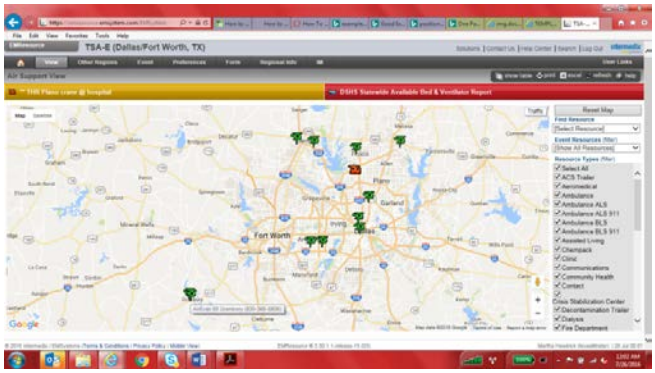
4.3 Once Log In is attained, go to https://emresource.emsystem.com/login.htm

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.

Annex G
Disaster Preparedness & Response

North Central Texas Trauma Regional Advisory Council

Trauma Service Area-E
Health Care Coalition

Regional Preparedness Strategy

NCTTRAC
600 Six Flags Dr. Suite 160
Arlington TX, 76011

RECORD OF REVIEW

TSA-E Health Care Coalition Regional Preparedness Strategy Record of Review

Review	Date	Entered By
Approved by REPC	3/29/2018	NCTTRAC Staff
Recommended by REPC	12/4/2018	NCTTRAC Staff
Approved by the NCTTRAC Board of Directors	6/11/2019	NCTTRAC Staff
NCTTRAC Staff Review	1/19/2021	NCTTRAC Staff
Approved by REPC (PENDING)	2/2/2021 (PENDING)	NCTTRAC Staff

SUMMARY OF CHANGE

TSA-E Health Care Coalition Regional Preparedness Strategy Summary of Change

Article/Section	Date of Change	Summary of Changes	Change Made by (Print Name)
All	1/19/2021	General Review & Touch-Ups	LaShanda Hernandez

DISTRIBUTION

TSA-E Health Care Coalition Regional Preparedness Strategy Record of Distribution

To Whom: Person / Agency / Organization	Method of Distribution	Date
Hospital Preparedness Program Participation Agreement Holders	Email addresses provided in Appendix A	6/14/19
EMTF Agreement Holders	Email addresses provided in Appendix A	6/14/19
Other Hospital EPC Partners	(Via Email Addresses on File)	6/14/19
Other Emergency Management Partners	(Via Email Addresses on File)	6/14/19
Other Public Health Partners	(Via Email Addresses on File)	6/14/19
Other EMS Partners	(Via Email Addresses on File)	6/14/19

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II. References

Federal

- Office of the Assistant Secretary for Preparedness and Response, 2017-2022 Health Care Preparedness and Response Capabilities
- Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Parts 403, 416, 418, 441, 460, 482, 483, 484, 485, 486, 491, and 494 (CMS Emergency Preparedness Rule)
- Robert T. Stafford Disaster Relief & Emergency Assistance Act, 42 U.S.C. 5121
- Emergency Planning and Community Right-to-Know Act, 42 USC Chapter 116
- Emergency Management and Assistance, 44 CFR
- National Incident Management System
- National Response Framework
- National Strategy for Homeland Security, October 2007

State

- Government Code, Chapter 418 (Emergency Management)
- Government Code, Chapter 421 (Homeland Security)
- Government Code, Chapter 433 (State of Emergency)
- Government Code, Chapter 791 (Inter-local Cooperation Contracts)
- State of Texas Emergency Management Plan Annex H: Public Health and Medical (August 2015)
- Texas Administrative Code, Title 25, Part 1, Chapter 133, Subchapter C, Rule 133.45 (Hospital Disaster Preparedness Requirements)
- Health & Safety Code, Chapter 778 (Emergency Management Assistance Compact)
- Executive Order of the Governor Relating to Emergency Management and Homeland Security
- Executive Order of the Governor Relating to the National Incident Management System
- Administrative Code, Title 37, Part 1, Chapter 7 (Division of Emergency Management)
- The Texas Homeland Security Strategic Plan,2015-2020
- The State of Texas Disaster Medical System Overview
- DSHS Response Operating Guidelines: Fatality Management for Catastrophic Incidents, 2013

Regional and Local

- NCTTRAC Regional Trauma System Plan (2014)
- TSA-E Regional Health Care Preparedness Coalition, TSA-E Regional High Consequence Infectious Disease (HCID) Concept of Operations (CONOPS)
- NCTTRAC HPP Statement of Work (2017 – 2022)
- Local Mass Casualty plans (city/county)

III. Introduction

A. Purpose

The Trauma Service Area E (TSA-E) Health Care Coalition (HCC) Regional Preparedness Strategy is intended to provide a guide for current and future HCC preparedness activities. The document sets out the processes by which the HCC works collectively to develop and test operational capabilities that promote communication, information sharing, resource coordination, and operational response and recovery. This document is built on information gathered from HCC membership to identify regional hazards, identify gaps in preparing and responding to those hazards, and prepare a list of action items to close those gaps.

B. Scope

The TSA-E HCC Regional Preparedness Strategy covers HCC preparedness activities for the Hospital Preparedness Program (HPP) 5-year block running from July 1, 2017 through June 30, 2022. The most recent revisions reflect planned activities from July 1, 2021 through June 30, 2022. This document applies to the Health Care Coalition in TSA-E, which covers a 19-county region in North Central Texas. Specific geographical boundaries are identified further in the document. In addition to HCC membership, the Preparedness Strategy was informed by the following regional agencies: Department of State Health Services (DSHS) Public Health Region 2/3, Disaster District Committee (DDC) 4A (Hurst), DDC 4B (Garland), DDC 22 (Sherman), North Central Texas Council of Governments (NCTCOG), and Texoma COG. This document does not supersede existing plans for individual agencies, facilities, and jurisdictions.

The TSA-E HCC engages in activities across a continuum of preparedness and response including day-to-day activities, local emergencies, regional emergencies, and statewide disasters. This document is intended to provide guidance for preparedness activities addressing any one of the identified stages of the continuum.

C. Administrative Support

The TSA-E HCC Regional Preparedness Strategy 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. General review procedures involve the following:

1. NCTTRAC staff annually reviews Preparedness Strategy to ensure consistency with other regional plans.
2. NCTTRAC staff annually reviews recent exercise and real-world incidents and incorporates identified areas of improvement into the Preparedness Strategy.
3. Revised Preparedness Strategy Draft is distributed to Health Care Coalition (HCC) members for review and comments.
4. HCC Planning Subcommittee reviews the Revised Preparedness Strategy Draft and HCC member comments. HCC Planning Subcommittee recommends approval to REPC.

5. REPC votes to recommend approval of Revised Preparedness Strategy by NCTTRAC Board of Directors.
6. NCTTRAC Board of Directors votes to approve the Revised Preparedness Strategy.

IV. Health Care Coalition Overview

A. Role of the Health Care Coalition

The TSA-E Health Care Coalition (HCC) works with all member organizations to promote emergency preparedness and health care delivery response. Its purpose is to:

- Lead collaborative regional planning, formulate strategies, and make recommendations to the NCTTRAC Board of Directors to ensure that the best possible approaches to regional Health Care Coalition planning can be achieved in TSA-E.
- Identify and assess regional needs in order to develop possible options for strengthening the overall resiliency of regional response capabilities based upon federal and state guidance and best practices (these include the Hospital Preparedness Program, Centers for Medicare & Medicaid Services, Federal Emergency Management Agency, etc.)
- Serve to identify the regional priorities set forth by current federal and state guidelines by utilizing input from Subject Matter Experts to set strategic planning goals and objectives.

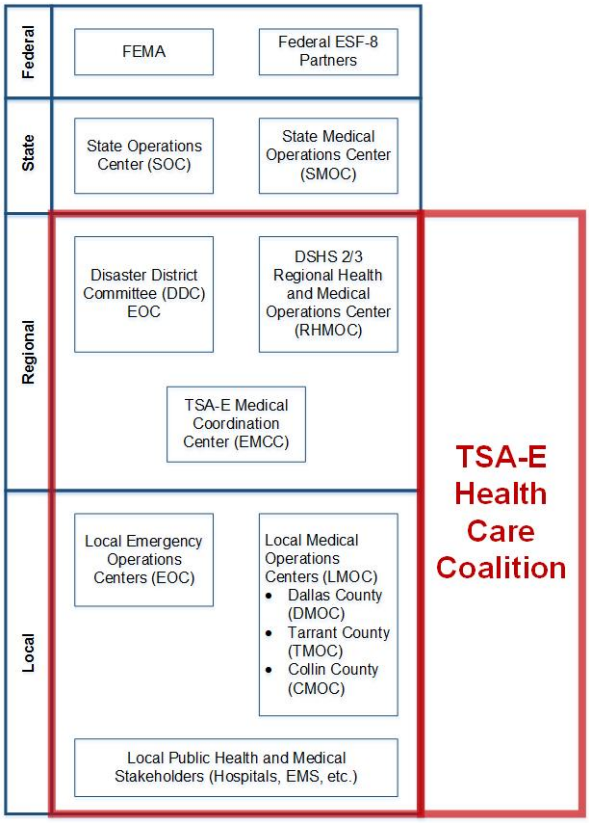
The TSA-E Health Care Coalition fulfills its purpose by focusing on the four Health Care Preparedness and Response Capabilities as identified by the Office of the Assistant Secretary for Preparedness and Response (ASPR). These four capabilities and the role of the TSA-E HCC and their fulfillment can be found below. :

- **Foundation for Health Care and Medical Readiness** - The TSA-E HCC ensures that the community's health care organizations and other stakeholders have strong relationships, identify hazards and risks, and prioritize and address gaps through planning, training, exercising, and managing resources.
- **Health Care and Medical Response Coordination** - The TSA-E HCC works with health care organizations, their jurisdictions, and DSHS Public Health Region 2/3 to plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.
- **Continuity of Health Care Service Delivery** - The TSA-E HCC supports health care organizations in the provision of uninterrupted, optimal medical care to all populations in the face of damaged or disabled health care infrastructure. Health care workers are well-trained, well-educated, and well-equipped to care for patients during emergencies. Simultaneous response and recovery operations result in a return to normal or, ideally, improved operations.
- **Medical Surge** - The TSA-E HCC supports health care organizations in the delivery of timely and efficient care to their patients even when the demand for health care services exceeds available supply. The TSA-E HCC, in collaboration with DSHS Public Health

Region 2/3, coordinates information and available resources for its members to maintain conventional surge response. When an emergency overwhelms the HCC's collective resources, the HCC supports the health care delivery system's transition to contingency and crisis surge response and promotes a timely return to conventional standards of care as soon as possible.

The response goal of the HCC is to promote resiliency and adequate surge capacity and capability across the TSA during any emergency incidents.

The TSA-E Health Care Coalition is composed of many different stakeholders. The diagram below shows the general structure of how the HCC and its stakeholders integrate with the larger ESF-8 response structure.



Individual medical facilities and other resources in an affected area have response obligations to their patients, clients, and communities. During emergencies with significant impact, both private and public sector entities may require resources beyond their capacities and these agencies must be incorporated into local emergency response activities. Both sectors must be prepared to share status information, coordinate their response and requests for support with their respective local government jurisdiction, and to use the incident command system to integrate and manage their response activity. This is accomplished on a day-to-day basis through the use of EMResource, with aggregated county-level datasets being shared via various dashboards. The TSA-E HCC supports this interaction with pre-hospital, hospital, jurisdiction emergency management, and public health authorities. Individual HCC member organization planning guidance can be found in Appendix I.

As reflected in the State of Texas Emergency Management Plan, Annex H (Public Health and Medical), all emergencies are considered a local responsibility, and legal responsibility for provision of support for emergencies is placed on the senior elected official within the affected jurisdiction. Local HCC partners such as hospitals and EMS agencies must work through these officials when resource needs cannot be met by local assets alone.

Cities and counties may elect to establish local medical operations centers (LMOCs) through which ESF-8 support is coordinated with their jurisdiction's public health and health care providers. While each LMOC operates differently depending on the city/county, these LMOCs are

generally composed of representatives from hospitals, EMS, public health, and jurisdictional emergency management. LMOCs serve as a local-level ESF-8 coordinating body for both preparedness and response activities. LMOC member organizations are often represented in TSA-E HCC meetings and activities to ensure consistency between LMOC efforts and HCC efforts. Specific information concerning the coordination between LMOCs and other HCC member organizations during an emergency response will be found in the TSA-E HCC Regional Response Strategy. The TSA-E HCC recognizes the need for a more intentional coordination effort between LMOCs and the TSA-E HCC.

DSHS Public Health Region 2/3 operates the Regional Health and Medical Operations Center (RHMOC) for TSA-E. The RHMOC serves as the regional public health and medical coordination point during regional and statewide incidents. When activated, the RHMOC houses regional public health and medical partners to ensure that regionally-based resources and mutual aid are used for public health and medical response before additional support is requested from outside the region. Generally, the RHMOC coordinates with the TSA-E Medical Coordination Center (EMCC) to share information and ensure consistency across any ESF-8 response activities. Specific information concerning the coordination between the RHMOC and the EMCC during an emergency response will be found in the TSA-E HCC Regional Response Strategy.

The HCC response is enhanced within TSA-E by partnerships with jurisdictions and health departments that have used other federal and state funding streams to develop health and medical response systems. In addition to the Hospital Preparedness Program (HPP), ESF-8 community preparedness is supported by the Public Health Emergency Preparedness program (PHEP). Within TSA-E, there are six principal PHEP participants:

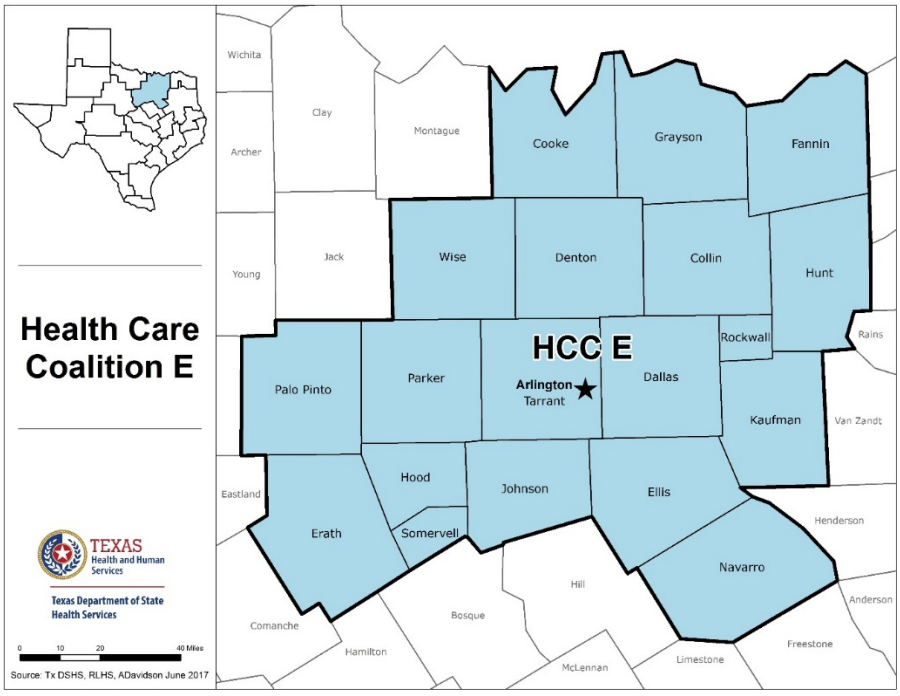
1. DSHS Public Health Region 2/3, serving Ellis, Hood, Hunt, Johnson, Kaufman, Parker, Rockwall, Somervell, and Wise counties;
2. Collin County Department of Homeland Security;
3. Dallas County Health and Human Services;
4. Denton County Health Department;
5. Grayson County Health Department;
6. Tarrant County Public Health.

A special federal initiative called the Cities Readiness Initiative (CRI) provides additional preparedness focus for counties that fall within the Dallas – Fort Worth metropolitan statistical area. The CRI works to develop, test, and maintain plans to receive and distribute life-saving medications and medical supplies from the Strategic National Stockpile to local communities following a large-scale public health emergency. Initially, the CRI was created specifically for anthrax events, but now includes other public health emergencies. Within TSA-E, this includes Collin, Denton, Dallas, Ellis, Hood, Hunt, Johnson, Kaufman, Parker, Tarrant, and Wise counties. PHEP and CRI coalition partners are responsible for development and improvement of community preparedness to respond to health threats in conjunction with HPP partners. The TSA-E HCC coordinates with its PHEP partners through mutual participation in meetings and exercises. Additionally, PHEP partners regularly attend REPC meetings and incorporate HCC representation in their own planning efforts.

B. Health Care Coalition Boundaries

The TSA-E Health Care Coalition exists within the boundaries of TSA-E, identified by the map. The following counties are included in the TSA-E Health Care Coalition:

- Collin
- Cooke
- Dallas
- Denton
- Ellis
- Erath
- Fannin
- Grayson
- Hood
- Hunt
- Johnson
- Kaufman
- Navarro
- Palo Pinto
- Parker
- Rockwall
- Somervell
- Tarrant
- Wise



The TSA-E Health Care Coalition coordinates with all ESF-8 agencies within its boundaries – this includes DSHS Public Health Region 2/3 and county Public Health Organizations. Additionally, the TSA-E HCC coordinates with adjacent Health Care Coalitions in TSA-C and TSA-D regarding Emergency Medical Task Force (EMTF) activities.

C. Health Care Coalition Members

Membership in the Health Care Coalition is clearly defined in the REPC Standard Operating Procedures (SOP) as the facilities or agencies that have satisfied one or more of the following criteria:

- Signed an HPP Letter of Agreement (LoA) and Memorandum of Sharing (MoS)
- Signed a TX EMTF Memorandum of Agreement (MoA)
- Retrieved a Certificate of Completion from the CMS Guidelines for Health Care Agency Emergency Preparedness Course (this course is hosted on the NCTTRAC Learning Management System (LMS) and is intended for non-hospital CMS agencies)
- Completed Transfer Agreement with NCTTRAC
- Other criteria as established and approved by REPC

Membership in the HCC is typically composed of (but not limited to) the following groups:

- Hospitals
- EMS Agencies
- Emergency Management Organizations
- Public Health Agencies
- Medical Societies
- Behavioral Health Services and Organizations
- VA Medical System
- Jurisdictional Emergency Management Partners
- Non-Governmental Organizations
- Outpatient Health Care Delivery Facilities
- Primary Care Providers
- Schools and Universities
- Medical Examiner Offices
- 17 CMS Provider Types

A full list of current HCC members can be found in Appendix B.

D. Organizational Structure/ Governance

The TSA-E Health Care Coalition is governed by the Regional Emergency Preparedness Committee (REPC). REPC governance is laid out in the REPC Standard Operation Procedures, which can be found in Appendix C.

REPC governance includes two main bodies: the REPC Leadership Group and the REPC Core Group. The REPC Leadership Group may convene on an ad hoc basis to represent REPC in matters necessary to maintain contractual compliance, execute deliverables, and/or endorse emergency, off-cycle purchases for regional benefit. The REPC Leadership Group comprises the following roles:

- REPC Chair
- REPC Chair Elect
- REPC Medical Director
- Immediate Past REPC Chair
- Subcommittee Chairs and Chairs Elect
- Workgroup Leads

The REPC Core Group serves as the main governing body for the TSA-E HCC and comprises representatives from hospitals, EMS, public health, emergency management, and other key partnering agencies. The REPC Core Group members hold voting authority within REPC (except where noted in the REPC SOP). The REPC Core Group meets monthly, with any ad hoc meetings occurring as needed. Specific REPC Core Group membership can be found in

Appendix C. REPC hosts a number of Subcommittees and Workgroups which work to provide recommendations to the REPC Core Group and the TSA-E Health Care Coalition at large. These Subcommittees and Workgroups are listed below:

- HCC Planning Subcommittee
- EMTF Subcommittee
- Training and Exercise Workgroup

NCTTRAC staff serves as administrative support for the TSA-E Health Care Coalition and is ultimately responsible for ensuring contractual compliance with the Hospital Preparedness Program.

All other aspects of HCC Governance and Organization can be found in the REPC SOP in Appendix C.

I. Role of Leadership within Member Organizations

Member Organization Leadership (generally defined as the organizational equivalent to a Vice President, Assistant Chief, or above) formally endorses their organization's participation in the Health Care Coalition through a signed Letter of Agreement (LoA) and Memorandum of Sharing (MoS). The LoA also sets out the general expectations of Coalition members. The HPP Letter of Agreement can be found in Appendix D.

HCC member organizations identify the internal roles of their executive leadership on an individual basis. Generally, member leadership is engaged in the individual organization's planning process and provides input, acknowledgement, and approval regarding HCC strategic and operational planning. For major projects, the HCC seeks input and buy-in from the leadership of member organizations prior to execution. This process generally includes member organization discussion with their leadership, regional surveys, and ad hoc meetings dedicated to member organizational leadership.

E. Health Care Coalition Objectives

The following list contains the TSA-E Health Care Coalition's strategic goals for both the short-term (1 year) and the long-term (3 – 5 years). The short-term goals originate in the REPC SOP (Annex C), while the long-term goals were informed by existing HPP guidance.

Short Term Goals (1 Year)

- Develop and support a robust virtual training and exercise environment through NCTTRAC Learning Management System (LMS).
- Increase the capability of EMTF with a specific focus on the development of regional Medical Incident Support Team (MIST) members.
- Develop and support an effective regional MCI Framework and Response Strategy.

Long-term Goals (3-5 Years)

- Develop and execute at least one regional or statewide Homeland Security Exercise and Evaluation Program (HSEEP) compliant functional or full-scale exercise and test/validate all four of the Health Care Preparedness and Response Capabilities by June 30, 2024.
- Collaboration between HCC partners and state, regional, and local agencies on emergency management (EM) processes.
- Review and update the Preparedness Strategy annually.
- Review and update the Response Strategy Annually
- Develop and approve an Infectious Disease Annex to the HCC Regional Medical Response Strategy prior to June 30, 2022
- Developing an HCC Continuity of Operations Plan (COOP) in BP3, review and update it annually thereafter.
- Seek alternative funding options to sustain the mission of regional disaster preparedness and response.
- Continue to highlight best practices and lessons learned in HCC meetings.
- Identify and develop capabilities to support vulnerable populations.

In addition to strategic goals, the TSA-E HCC has a number of operational objectives. These objectives will be reviewed annually by the HCC Planning Subcommittee. These are listed below.

- Protect health care personnel, current patients, visitors, and the integrity of the health care system
- Provide the best available medical care for responders, victims, and affected families
- Manage costs, regulatory compliance, and other issues so they do not compromise higher priority objectives
- Develop and use processes that enhance the integration of health care organizations into the community response
- Optimize information sharing among participating health care organizations with jurisdictional authorities to promote a common operating picture
- Enhance resource support by expediting the mutual aid process or other resource sharing arrangements among HCC partners, and by supporting the request and receipt of assistance from local, regional, state, and federal authorities
- Coordinate incident response actions for the participating health care organizations so incident objectives, strategies, and tactics are consistent for the health care response
- Develop the interface between the HCC and relevant regional authorities to establish effective support for health care system resiliency and medical surge.

F. Maintenance and Sustainability of the Health Care Coalition

The TSA-E Health Care Coalition serves a critical role in the disaster preparedness community. HCC member organizations are represented at emergency management and disaster preparedness related committees and workgroups throughout the entire geography of TSA-E. Additionally, both individual HCC member organizations and official HCC representation take part in both local and regional exercise planning efforts.

TSA-E HCC activities are funded primarily through the Hospital Preparedness Program, while individual member organizations are funded through a variety of revenue sources. The HCC seeks to share costs associated with preparedness activities with other stakeholders whenever possible. Cost-sharing strategies include (but are not limited to) partnering with other regional partners to fund multi-disciplinary regional planning efforts, training, and exercises. The HCC recognizes that the development of additional revenue streams beyond the HPP will enhance stability and sustainment of HCC preparedness activities.

The TSA-E HCC shares information regarding best practices and lessons learned in a variety of ways. REPC has a standing agenda item offering HCC members the opportunity to share lessons learned and best practices with the rest of the HCC; REPC and its associated Subcommittees and Workgroups also host educational speakers to provide special insight into a specific subject area.

A major component of maintaining the Health Care Coalition is engaging with specific partners and stakeholders within the HCC membership. Strategies for engaging specific stakeholder groups can be found below.

I. Engagement of Partners and Stakeholders: Health Care Executives

The role of executive leadership of HCC member organizations in the overall governance of the HCC is noted in part D, subsection 1, “Role of Leadership within Member Organizations”. The HCC also engages health care executives through an existing partnership with the Dallas/Fort Worth Hospital Council, a non-profit organization composed of executive leadership from hospitals throughout the region.

II. Engagement of Partners and Stakeholders: Clinicians

The HCC engages with clinicians (physicians, nurses, paramedics, etc.) on multiple levels. Clinicians represent HCC member organizations in REPC and its associated subcommittees. REPC also has a designated Medical Director on its Leadership Group. The REPC Medical Director supports additional clinical engagement with HCC activities through the establishment of expanded email groups to additional EMS and hospital-based Medical Directors. Individual HCC member organizations regularly engage clinicians within their organization and community in the development of their individual emergency preparedness plans, which inform HCC preparedness activities. For more involved clinician participation, REPC will reach out to existing NCTTRAC clinical committees for input from clinical subject matter experts.

III. Engagement of Partners and Stakeholders: Community Leaders

HCC member organizations engage community leaders on an individual level. The TSA-E HCC also engages community leaders at a regional level through regular participation in local and regional emergency preparedness committees and workgroups. NCTTRAC engages in information sharing with state and local elected officials on behalf of the HCC by demonstrating

response capabilities, hosting/supporting meeting events, and distributing annual summaries of HCC activity in the NCTTRAC Annual Report.

IV. Engagement of Partners and Stakeholders: Special Populations

The TSA-E HCC includes member organizations that represent special populations. Each member organization has the opportunity to inform HCC plans and activities. Special populations identified in federal and state guidance pediatric patients, pregnant women, seniors, individuals with access and functional needs, and individuals with behavioral health conditions. The HCC has the opportunity to address intentional engagement of special populations through representation on the REPC Core Group. To further partner engagement the HCC has established a Long-Term Care Task Force (LTC) to address vulnerabilities within long-term care facilities located in TSA-E.

G. Compliance Requirements and Legal Authorities

The TSA-E Health Care Coalition is informed and governed by several legal authorities. A full list of these legal authorities can be found in the "References" section on page 3 of this document.

NCTTRAC serves as the contractor for the Hospital Preparedness Program as administered by the DSHS. Specific requirements for both NCTTRAC as a contractor and for the TSA-E HCC are listed in the 2017 HPP Statement of Work.

The ASPR 2017-2022 Health Care Preparedness and Response Capabilities serves as the primary guide for TSA-E HCC preparedness and response activities. This document lists the four main Health Care Preparedness and Response Capabilities, identifies objectives supporting each capability, and lists activities required to complete each objective. The TSA-E HCC performs preparedness and response activities in accordance with the capabilities, objectives, and activities listed in the document.

The CMS Emergency Preparedness Rule provides federal requirements for HCC member organizations developing internal Emergency Preparedness programs and plans. The TSA-E HCC strives to address gaps identified in the individual plans of HCC member organizations. HCC member organizations are encouraged to share identified gaps with the HCC through the HCC Planning Subcommittee, the Training and Exercise Workgroup, and participation in future regional gap analyses. The HCC will then develop and implement strategies designed to address the identified gaps.

The TSA-E HCC incorporates all 17 provider types who fall under the scope of the CMS Emergency Preparedness Rule. Non-hospital CMS providers are encouraged to register as an HCC member by completing the "Guidelines for Health Care Agency Emergency Preparedness" course on the NCTTRAC Learning Management System (LMS). Individuals can access this course at the following link: http://ncttrac.litmos.com/self-signup/register/442497?type=1.

Hospitals and other agencies participating in the Hospital Preparedness Program (HPP) sign a NCTTRAC HPP Letter of Agreement (LoA) that dictates conditions of participation for both the participating agency and for NCTTRAC. These conditions of participation set out specific requirements that hospitals and other agencies must meet in order to maintain their status as an HPP sub-recipient. The LoA also lays out the responsibilities of NCTTRAC in regards to administering the HPP among its sub-recipients. The NCTTRAC HPP Letter of Agreement can be found in Appendix D.

In addition to the NCTTRAC HPP Letter of Agreement, partner agencies who host deployable regional assets purchased with HPP funds are required to sign resource-specific contracts that lay out specific requirements for the asset host. Current HPP regional assets within TSA-E with resource-specific contracts include 2 Mobile Emergency Response Communications (MERC) trailers, 4 AMBUSes, 4 Mass Fatality Trailers, and 1 Mobile Restroom Trailer. For smaller assets purchased with HPP funds, receiving agencies are required to sign a NCTTRAC Transfer Agreement which lays out the requirements for the use of the transferred items.

HCC member organizations who participate in the Emergency Medical Task Force program are required to sign a TX EMTF Memorandum of Agreement (MOA). The TX EMTF MOA lays out requirements for both the participating agency and for NCTTRAC. Additionally, the TX EMTF MOA identifies what assets a member organization could provide during an EMTF response.

The TSA-E HCC understands the process and information required to request necessary waivers and suspension of regulations. Specifically, the TSA-E HCC refers to the following documents regarding 1135 waivers made available on the CMS website:

- Authority to Waive Requirements During National Emergencies
- Requesting an 1135 Waiver

The TSA-E HCC is in the process of adopting formal Crisis Standards of Care for use throughout all HCC member organizations. The TSA-E Crisis Standards of Care are based on the results of the North Texas Mass Critical Care Task Force. The TSA-E Crisis Standards of Care policy has been approved by the NCTTRAC Board of Directors and will be included in both the TSA-E HCC Regional Response Strategy and the TSA-E Regional Trauma System Plan.

V. Health Care Coalition Risk Summary and Gap Analysis

A. Regional Hazard Vulnerability Analysis – October 2020

The Regional Hazard Vulnerability Assessment (HVA) Report is a product of the TSA-E Health Care Coalition. The Regional HVA is drawn from information reported by HCC member organizations, including (but not limited to) hospitals, EMS agencies, jurisdictional emergency managers, public health organizations, and non-hospital CMS provider agencies. The Regional HVA compiles hazard vulnerability information reported by the aforementioned partners to identify and prioritize the most significant hazards affecting the TSA-E HCC. The Regional HVA is then used to guide HCC preparedness activities. The Regional HVA is updated annually.

Note: See title link for a complete up-to-date HVA by year.

Top Ten Hazard Vulnerability Analysis Regional Results – September 2020
1) Tornado
2) Epidemic/Pandemic
3) Inclement Weather
4) IT System Outage
5) Power Outage
6) Active Shooter
7) HVAC Failure
8) Generator Failure
9) Water Disruption
10) Communication/Telephony Failure

B. Health Care Coalition Gap Analysis

The TSA-E HCC Gap Analysis identifies existing gaps between available resources and current risks. HCC preparedness activities should be focused on closing the identified gaps. The information in the TSA-E HCC Gap Analysis is drawn from the Regional HVA, After-Action Reports (AARs) from recent events and exercises, and feedback from HCC membership. The HCC acknowledges the need for a thorough regional gap analysis including the development of quantitative response goals.

Note: See title link for a complete up-to-date Gap Analysis by year.

TSA-E Healthcare Coalition Gap Analysis

Gap #1 (Previously #8):	**Regional MCI Framework is operationally vague & implementation at the local level is limited.**
HPP Capability:	Capability 2, "Health Care and Medical Response Coordination"; Capability 4, "Medical Surge".
Source:	HCC Planning Subcommittee
Associated Hazards:	Tornado, Epidemic/Pandemic, Active Shooter
Overall Current Status:	The MCI Framework was adopted regionally in 2019. Current version needs operational details and local implementation.
Overall Desired Status:	All aspects of the Regional MCI Framework are adopted at the local level and trained and exercised regularly.
MCI Framework Gap 1A:	**Timely hospital notification of mass casualty incidents (MCI).**
HPP Capability:	Capability 2, "Health Care and Medical Response Coordination"
Source:	HCC Planning Subcommittee
Associated Hazards:	Tornado, Active Shooter
Current Status:	Hospital notification of MCIs varies in both time and method. NCTTRAC will push EMResource notifications during an MCI, but often NCTTRAC is informed late in the process. EMS partners have the ability to send EMResource notifications to hospitals upon the emergence of an MCI, but they often lack on-scene resources. Hospitals often are first notified by the arrival of patients.
Desired Status:	Hospitals are notified of MCIs prior to patient arrival. This allows hospitals to implement surge procedures within their facility to better care for incoming patients.

MCI Framework Gap 1B:	**Patient destination coordination during an MCI**
HPP Capability:	Capability 2, "Health Care and Medical Response Coordination"
Source:	HCC Planning Subcommittee
Associated Hazards:	Tornado, Active Shooter, Epidemic/Pandemic
Current Status:	The responding EMS agency will decide where to send patients. Coordination with receiving hospitals regarding availability varies depending on the responding EMS agency. Hospitals closest to the scene of the MCI will likely be inundated with self-presenting patients. While there are proposed guidelines mentioned in the MCI Framework, their adoption is intermittent across the region.
Desired Status:	Regional guidelines for patient destinations during an MCI designed to alleviate patient surge on the hospitals closest to the scene. This ensures that patients receive the appropriate care as quickly as possible and prevents the transfer of the disaster from the scene to a hospital.
MCI Framework Gap 1C:	**Patient tracking in an MCI or hospital evacuation.**
HPP Capability:	Capability 2, "Health Care and Medical Response Coordination"
Source:	HCC Planning Subcommittee; NCTTRAC TSA-E 2018 Coalition Surge Test AAR
Associated Hazards:	Tornado, Active Shooter, Generator Failure, Water Disruption, Power Outage
Current Status:	The NCTTRAC Patient Tracking Toolkit in WebEOC is available to HCC members for patient tracking. However, HCC member use is sporadic, and WebEOC has some inherent limitations for patient tracking.
Desired Status:	A fully developed patient tracking concept of operations, including an effective patient tracking system utilized consistently throughout TSA-E.

Gap #2 (Previously #5):	**Regional utilization of available resources.**
HPP Capability:	Capability 2, "Health Care and Medical Response Coordination"; Capability 3, "Continuity of Health Care Service Delivery"; Capability 4, "Medical Surge".
Source:	NCTTRAC Hurricane Harvey AAR
Associated Hazards:	All
Current Status:	HCC member knowledge of available regional assets and the process to request those assets is sporadic. Sharing resources between different hospitals and hospital systems occurs on an ad hoc basis with little centralized coordination.
Desired Status:	Thorough HCC member knowledge of available regional assets. A clearly defined emergency assets request process that is exercised regularly. A clearly defined process for emergency sharing of staff, supplies, & equipment between HCC partners.
Gap #3 (Previously #9):	**Operational use of redundant communications methods is unclear.**
HPP Capability:	Capability 2, "Health Care and Medical Response Coordination"; Capability 3, "Continuity of Health Care Service Delivery"
Source:	HCC Planning Subcommittee, REPC
Associated Hazards:	Communications/Telephony Failure, It System Outage/ Power Outage
Current Status:	Existing regional redundant communications plans are high-level and provide a web of possibilities as opposed to a functional plan.
Desired Status:	Specific and intentional operational regional redundant communications guidance to include a matrix of which partners have which redundant communications capabilities.

Gap #4:	**Patient destination coordination for interfacility transfers during mass patient movement and extended patient surge events**
HPP Capability:	Capability 2, "Health Care and Medical Response Coordination"; Capability 4, "Medical Surge"
Source:	NCTTRAC Hurricane Harvey AAR; COVID-19 Experience
Associated Hazards:	All
Current Status:	Upon notification of mass patient movement into TSA-E, the EMCC will coordinate with regional hospital patient transfer centers to determine patient placement. The EMCC will load patients into the WebEOC tracking board and hospitals will utilize the same board to indicate which patients they can accept. During extended patient surge events, hospitals utilize their normal patient transfer protocols which may cause delays in transferring patients when regional bed availability is low.
Desired Status:	A fully Regional Patient Coordination Network that serves as a central coordination cell to help place patients quickly and effectively to ensure the best outcome for the patient. This will require a combination of technology and process solutions.
Gap #5 (Previously #11):	**Coordination and integration of local MOCs (DMOC, TMOC, CMOC) with the overall HCC structure is unclear.**
HPP Capability:	Capability 1, "Foundation for Health Care and Medical Readiness"; Capability 2, "Health Care and Medical Response Coordination"
Source:	NCTTRAC Executive Leadership; COVID-19 Experience
Associated Hazards:	All
Current Status:	Members of local MOCs attend HCC meetings to inform preparedness activities, but formal integration is not documented. Similarly, the processes and thresholds for escalation of an incident from local MOC level to involving the regional HCC are unclear.
Desired Status:	Formal documentation of local MOC integration and coordination with the TSA-E HCC.

Gap #6 (Previously #7):	**Lack of an operational Regional Evacuation Plan for the TSA-E HCC.**
HPP Capability:	Capability 3, "Continuity of Health Care Service Delivery"
Source:	NCTTRAC TSA-E 2018 Coalition Surge Test AAR
Associated Hazards:	Tornado, Inclement Weather, IT System Outage, HVAC Failure, Active Shooter
Current Status:	There is no current operational Regional Evacuation Plan. Each facility maintains independent Facility Evacuation Plans.
Desired Status:	Fully developed operational Regional Evacuation Plan to include thresholds for regional activation/notification, identification of roles and responsibilities for each regional partner, and standardization of the request and utilization of regional resources (e.g. WebEOC, Patient Tracking, etc). Should be trained on and exercised regularly.
Gap #7 (Previously #6):	**Inconsistent common operating picture across all HCC members during emergency events.**
HPP Capability:	Capability 2, "Health Care and Medical Response Coordination"
Source:	NCTTRAC TSA-E 2018 Coalition Surge Test AAR
Associated Hazards:	All
Current Status:	There are a variety of information sharing methods available to the HCC, but the coordinated use of those methods is inconsistent. Use of WebEOC and EMResource is sporadic and leaves information gaps.
Desired Status:	Clearly identified procedures for regional coordination of information sharing to maintain a common operating picture. These procedures should be trained on and exercised regularly.

Gap #8 (Previously #10):	**Inconsistent engagement of special populations representatives in HCC activities**
HPP Capability:	All
Source:	NCTTRAC Executive Leadership; COVID-19 Experience
Associated Hazards:	All
Current Status:	Special populations are intermittently represented in HCC activities through HCC members. While special populations are considered in HCC preparedness and response activities, they are often not formally represented. REPC recently approved a regional Long-Term Care (LTC) Task force.
Desired Status:	Regular meetings of the Regional Long-Term Care Task Force. The LTC Task Force reviews all HCC plans and initiatives to ensure special populations are appropriately addressed.

Gap #9 (Previously #13):	**After Action meetings held post-exercise/incident are not as inclusive or informative as they should be.**
HPP Capability:	Capability 1, “Foundation for Health Care and Medical Readiness”
Source:	HCC Planning Subcommittee
Associated Hazards:	All
Current Status:	After a regional incident or exercise, either NCTTRAC or the exercise host will prepare an After Action Report and hold an After Action meeting to review the report. Participation in these meetings is inconsistent.
Desired Status:	After Action Reports are developed with the full inclusion of the HCC. A formal hot wash is conducted immediately following every exercise/incident, and a formal After Action meeting is held shortly thereafter. Regional AARs are based on AARs from individual HCC partners.

VI. Health Care Coalition Workplan

A. NCTTRAC Preparedness Components

In order to meet the objectives and activities of the HCC system, NCTTRAC has developed a range of supporting capabilities and systems linking pre-hospital and hospital health care delivery agencies to other local and regional agencies. These include:

1. Operation of the TSA-E Medical Coordination Center (EMCC) including the following response support capabilities:
   - 24/7/365 Duty Phone Monitoring
   - Crisis Applications Facilitation and Support
   - Emergency Medical Task Force (EMTF) Coordination
   - Resource Request Coordination and Medical Shelter Resource Support
   - HCC Liaison Support to the DDC and Local EOCs
   - Preparations for Patient Reception/Distribution
2. Development of regional ESF-8 redundant and interoperable communications systems
3. Development of regional information systems linking local, regional, and state partners for common situational awareness. These include patient tracking and distribution, incident command awareness, and resource sharing systems
4. Procurement of regional mobile medical assets and supporting caches
5. Procurement of mass fatality supporting equipment and supplies
6. Provision of mass alerting and notification capabilities
7. Provision of administrative support of a regional volunteer management system for health and medical professionals that interfaces with the state
8. Implementation of a health care provider-to-provider mutual aid/resource sharing system
9. Coordination of the EMTF program, including the following capabilities:
   - 4 AMBUSes
   - Ambulance Strike Teams (AST)
   - Ambulance Staging Management Teams (ASMT)
   - Medical Incident Support Teams (MIST)
   - Registered Nurse Strike Teams (RNST)
   - Mobile Medical Units (MMU)
   - Infectious Disease Response Units (IDRU)
   - Wildland Fire Response Support
10. Provision of regional exercises testing ESF-8 functions and capabilities of local, regional, and state partners
11. Leadership and guidance for development of Health Care Coalition Organization (HCO) all-hazards emergency management plans including:
    - Business Continuity and Continuity of Operations plans
    - Pandemic Response Plans
    - Evacuation and Shelter–in–Place Plans
    - Alternate Care Site
    - Communications Plans

- Medical Countermeasures plans
- Fatality Management Plans
- Decontamination and Personal Protective Equipment Protocols
- Responder Force Protection

A full explanation of EMCC activities can be found in the EMCC Standard Operating Guidelines (EMCC SOG).

B. Activities and Responsibilities Matrix

The following workplan identifies specific preparedness activities to be conducted by the TSA-E Health Care Coalition.

Activity	Output	Responsible Party	Estimated Completion	Notes
Review/revise TSA-E HCC Regional Preparedness Strategy	TSA-E HCC Regional Preparedness Strategy	HCC Planning Subcommittee; NCTTRAC Staff	Completed annually	
Review/revise Regional Hazard Vulnerability Analysis	TSA-E Regional Hazard Vulnerability Analysis	Training and Exercise Workgroup; NCTTRAC Staff	Completed annually	
Review/revise TSA-E HCC Multi-Year Training and Exercise Plan (MYTEP)	TSA-E HCC MYTEP	Training and Exercise Workgroup; NCTTRAC Staff	Completed annually	Current MYTEP can be found in Appendix F.
Host/fund trainings and conduct exercises in accordance with the MYTEP.	Various trainings and exercises.	NCTTRAC Staff; Training and Exercise Workgroup.	Ongoing	Current MYTEP can be found in Appendix F.
Review/revise specific HCC operational goals	HCC Operational Goals Matrix	HCC Planning Subcommittee; REPC	Jan 2022	Before Gap Analysis. Will be reviewed and updated annually.

Activity	Output	Responsible Party	Estimated Completion	Notes
Create more awareness of the Regional Mass Casualty Framework (MCF).	Regional Mass Casualty Framework	NCTTRAC; NCTCOG; DSHS Public Health Region 2/3	June 2021	Addresses Gaps #2 and #8. Joint project between NCTTRAC, NCTCOG, and DSHS Public Health Region 2/3.
Select patient tracking system and create a TSA-E HCC Patient Tracking Concept of Operations.	Regional Patient Tracking System; TSA-E HCC Patient Tracking Con-Ops.	HCC Planning Subcommittee; REPC; NCTTRAC Staff	Dec 2021	Addresses Gap #4. Will roll into the Regional MCF and the TSA-E HCC Regional Response Strategy.
Conduct an educational visit with underperforming HCC member facilities.	NCTTRAC Staff visits to all underperforming HCC member facilities.	NCTTRAC Staff	June 2021	Addresses Gaps #5 and #6.
Providing monthly Crisis Applications Training classes to include mini session for Patient Tracking	Monthly Crisis Applications Training classes.	NCTTRAC Staff	Ongoing	Addresses Gap #6.
Develop operational Regional Evacuation Concept of Operations	TSA-E HCC Regional Evacuation Con-Ops Annex to Response Strategy	HCC Planning Subcommittee; NCTTRAC Staff	April 2022	Addresses Gap #7. Will be included in the TSA-E HCC Regional Response Strategy.

Activity	Output	Responsible Party	Estimated Completion	Notes
Review/revise TSA-E HCC Redundant Communications Concept of Operations	TSA-E HCC Redundant Communications Con-Ops.	NCTTRAC Staff; HCC Planning Subcommittee	Dec 2021	Addresses Gap #9. To be included in the TSA-E HCC Regional Response Strategy.
Develop and host a Regional Disaster Medical System course in TSA-E.	TSA-E RDMS 101	Training and Exercise Workgroup; NCTTRAC Staff	July 2021	Reference existing Joint Commission offerings. Addresses Gaps #5 and #9
Send HCC representatives to the "Health Care Coalition Response Leadership Course" in Anniston, AL	Health Care Coalition Response Leadership Course Virtually	Training and Exercise Workgroup	June 2021	
Work with all LMOCs to formalize LMOC integration and coordination with the HCC.	Formal LMOC-HCC integration & coordination summary	NCTTRAC Staff; HCC Planning Subcommittee	December 2021	Addresses Gap #11

In addition to the preparedness activities identified above, the TSA-E HCC plans, develops, and hosts a variety of regional training and exercise events. A full listing of these events can be found in the MYTEP in Appendix F.

C. Preparedness Activity Tracking

Preparedness activity tracking will be accomplished in two ways. TSA-E HCC preparedness activities will be tracked on a strategic level and reported to DSHS using the Coalition Assessment Tool (CAT). Additional information about the CAT (including the CAT Capability Planning Report Results from November 6, 2018) can be found in Appendix G. TSA-E HCC preparedness activities will be tracked internally using the Activities and Responsibilities Matrix found above. The completion of the identified activities will be tracked in the REPC Elements of the NCTTRAC Accountability Scorecard.

VII. Appendices

Appendix A: Definitions

AMBUS	Ambulance Bus
ASM	Ambulance Staging Management
ASPR	Assistant Secretary for Preparedness and Response
AST	Ambulance Strike Teams
CAT	Coalition Assessment Tool
CMS	Centers for Medicare & Medicaid Services
COG	Council of Governments
CST	Coalition Surge Test
DBH	Disaster Behavioral Health
DDC	Disaster District Chair
DHHS	Department of Health and Human Services
DSHS	Department of State Health Services
EM	Emergency Management
EMA	Emergency Management Agency
EMCC	TSA-E Medical Coordination Center
EMS	Emergency Medical Services
EMTF-2	Emergency Medical Task Force Region 2
ESF-8	Emergency Support Function-8
HCC	Health Care Coalition
HCO	Health Care Organization
HVA	Hazard Vulnerability Analysis
ICU	Intensive Care Type Unit
IDRU	Infectious Disease Response Unit
LMHA	Local Mental Health Authority
LTC	Long Term Care
MHMR	My Health My Resources
M-IST	Medical Incident Support Teams
MMU	Mobile Medical Unit
MYTEP	Multi-Year Training and Exercise Plan
NCTTRAC	North Central Texas Trauma Regional Advisory Council
NICU	Neonatal Intensive Care Type Unit
PH	Public Health
PICU	Pediatric Intensive Care Type Unit
PsySTART	Psychological Simple Triage and Rapid Treatment
REPC	Regional Emergency Preparedness Committee
RNST	Registered Nurse Strike Team
SMHA	State Mental Health Authority

SOC	State Operations Center
SOP	Standard Operating Procedure
START	Simple Triage and Rapid Treatment
TDVR	Texas Disaster Volunteer Registry
TSA	Trauma Service Area
TSA- E	Trauma Service Area E
TSA- C	Trauma Service Area C
TSA- D	Trauma Service Area D

Appendix B: HCC Member List

Organization Name	Organization Type
Abilene Regional Medical Center	Hospital
Anson General Hospital	Hospital
Baylor Heart And Vascular Center	Hospital
Baylor Institute For Rehabilitation - Dallas	Hospital
Baylor Institute For Rehabilitation - Fort Worth	Hospital
Baylor Institute For Rehabilitation - Frisco	Hospital
Baylor Medical Center At Trophy Club	Hospital
Baylor Medical Center At Uptown	Hospital
Baylor Scott & White All Saints Medical Center - Fort Worth	Hospital
Baylor Scott & White Medical Center - Carrollton	Hospital
Baylor Scott & White Medical Center - Centennial	Hospital
Baylor Scott & White Medical Center - Frisco	Hospital
Baylor Scott & White Medical Center - Garland	Hospital
Baylor Scott & White Medical Center - Grapevine	Hospital
Baylor Scott & White Medical Center - Irving	Hospital
Baylor Scott & White Medical Center - Lake Pointe	Hospital
Baylor Scott & White Medical Center - Mckinney	Hospital
Baylor Scott & White Medical Center - Plano	Hospital
Baylor Scott & White Medical Center - Sunnyvale	Hospital
Baylor Scott & White Medical Center - Waxahachie	Hospital
Baylor Scott & White Medical Center - White Rock	Hospital
Baylor Scott & White Sunnyvale	Hospital
Baylor Surgical Hospital At Fort Worth	Hospital
Baylor Surgical Hospital At Las Colinas	Hospital
Baylor University Medical Center	Hospital
Baylor Uptown	Hospital / System
Beacon Emergency Services Team, P.A.	Physician Groups & Consulting Groups
Brownwood Regional Medical Center	Hospital
BSW Health NTX Division	Hospital / System
Bubo Learning Design	Learning
Burleson Fire Dept	First Response Agency
Cannefax Consulting	Physician Groups & Consulting Groups
Carrus Specialty Hospital	Hospital
Childrens Medical Center Of Dallas	Hospital
Childrens Medical Center Plano	Hospital
Chillicothe Hospital	Hospital

Organization Name	Organization Type
City of Lancaster	EMS
City of Ovilla FD	EMS
City of Roanoke	EMS
City of Van Alstyne	EMS
Clay County Memorial Hospital	Hospital
Coleman County EMC	OEM
Coleman County Medical Center Company	Hospital
Comanche County Medical Center	Hospital
Continue Care Hendrick	Hospital
Cook Children's Medical Center	Hospital
Cook Children's Medical Center	EMS
Cook Children's Northeast Hospital	Hospital
Cooke County EMS	EMS
Coppell Fire Department	EMS
Corsair Consulting	Physician Groups & Consulting Groups
Corsicana FD	EMS
Crescent Medical Center Lancaster	Hospital
Dallas Behavioral Healthcare Hospital Llc	Hospital
Dallas County HHS	Public Health
Dallas Medical Center	Hospital
Dallas Regional Medical Center	Hospital
Denton Fire Department	EMS
Desoto Fire Rescue	EMS
Dignity Hospice	Hospice
Duncanville Fire Department	EMS
East Texas Medical Center EMS	EMS
Eastland Memorial Hospital	Hospital
Electra Memorial Hospital	Hospital
Ennis FD	EMS
Ennis Regional Medical Center	Hospital
Erath County EMS	EMS
Euless Fire Department	EMS
Euless PD	Police Department
Faith Community Hospital	Hospital
Farmers Branch Fire Department	EMS
Fisher County Hospital District	Hospital
Fisher County Hospital District	EMS
Flower Mound Fire Department	EMS
Fort Worth Fire Department	EMS
Frisco Fire Department	EMS

Organization Name	Organization Type
Garland Behavioral Hospital	Hospital
Garland Fire Department	EMS
Garnet Hill Rehabilitation and Skilled Care Center	Nursing Facility
Giatros Holdings, LLC	Physician Groups & Consulting Groups
Glen Oaks Hospital	Hospital
Glen Rose Medical Center	Hospital
Graham Regional Medical Center	Hospital
Graham Young County	EMS
Grandbury Hood County EMS (Texas EMS)	EMS
Grapevine Fire Department	EMS
Haltom City Fire Dept.	EMS
Hamlin Memorial Hospital	Hospital
Hardeman County EMS	EMS
Hardeman County Memorial Hospital	Hospital
Haskell Memorial Hospital	Hospital
HCA North Texas Division	Hospital / System
Health Transport Inc.	EMS
Healthsouth Rehabilitation Hospital Arlington	Hospital
Healthsouth Rehabilitation Hospital City View	Hospital
Healthsouth Rehabilitation Hospital Fort Worth	Hospital
Healthsouth Rehabilitation Hospital Mid-Cities	Hospital
Healthsouth Rehabilitation Hospital Plano	Hospital
Healthsouth Rehabilitation Hospital Richardson	Hospital
Heart of Texas EMS	EMS
Hendrick Medical Center	Hospital
Hendrick Medical Center Brownwood	Hospital
Highland Village Fire Department	EMS
Hunt Regional Medical Center Greenville	Hospital
Hurst Fire Department	EMS
Icare Rehabilitation Hospital	Hospital
Irving Fire Department	EMS
John Peter Smith Hospital (JPS)	Hospital / System
Jps Health Network - Trinity Springs North	Hospital
Justin Fairless DO PLLC	Physician Groups & Consulting Groups
Kindred Hospital - Fort Worth	Hospital
Kindred Hospital - Dallas	Hospital
Kindred Hospital Dallas Central	Hospital
Kindred Hospital-Mansfield	Hospital
Kindred Hospital-Tarrant County Arlington	Hospital

Organization Name	Organization Type
Kindred Hospital-Tarrant County Sw	Hospital
Knox County Hospital	Hospital
KPC Promise Hospital of Wichita Falls	Hospital
Krum Fire Department	EMS
Lake Granbury Medical Center	Hospital / System
Lewisville Fire Department	EMS
Life Care EMS	EMS
Lifecare Hospitals Of Dallas	Hospital
Lifecare Hospitals Of Fort Worth	Hospital
Lifecare Hospitals Of Plano	Hospital
Little Elm Fire Department	EMS
Lucas Fire-Rescue	EMS
Mansfield Fire Department	EMS
McKinney Fire Department	EMS
Medco ER Plano	Healthcare
Medical Air Rescue Company	EMS
Medical City Arlington	Hospital
Medical City Fort Worth	Hospital
Medical City Green Oaks Hospital	Hospital
Medical City Las Colinas	Hospital
Medical City Lewisville	Hospital
Medical City Mckinney-Wysong Campus	Hospital
Medical City Alliance	Hospital
Medical City Dallas	Hospital
Medical City Denton	Hospital
Medical City Mckinney	Hospital
Medical City North Hills	Hospital
Medical City Plano	Hospital
Medical Jets	EMS
MedStar	EMS
Mesquite Fire Department	EMS
Mesquite Rehabilitation Institute	Hospital
Mesquite Specialty Hospital	Hospital
Methodist Charlton Medical Center	Hospital
Methodist Dallas Medical Center	Hospital
Methodist Mansfield Medical Center	Hospital
Methodist Mckinney Hospital Llc	Hospital
Methodist Richardson Medical Center	Hospital
Midlothian Fire Department	EMS
Mineral Wells Fire EMS	EMS

Organization Name	Organization Type
Mitchell County EMS	EMS
Mitchell County Hospital	Hospital
Mitchell County Nursing Home	Nursing Facility
Muenster Memorial Hospital	Hospital
Navarro Regional Hospital	Hospital
Nocona General Hospital	Hospital
North Central Surgical Center Llp	Hospital
North Richland Hills Fire Department	EMS
North Texas Medical Center	Hospital
North Texas State Hospital - Vernon	Hospital
North Texas State Hospital - Wichita Falls	Hospital
Oceans Behavioral Healthcare Of Abliene	Hospital
Olney Hamilton Hospital	Hospital
Our Childrens House	Hospital
Palo Pinto General Hospital	Hospital
Parker County Emergency Management	OEM
Parker County ESD 1	Emergency Services District
Parker County ESD 6	Emergency Services District
Parkland Memorial Hospital	Hospital / System
Plano Fire Rescue	EMS
Possum Kingdom Vol Fire and Ambulance Service	EMS
Possum Kingdom Westlake Vol. EMS	EMS
Presbyterian Manor	Assisted Living, Memory Care, Retirement
Promise Hospital	Hospital
Promise Skilled Nursing Facility	Nursing Facility
Prosper Fire Department	EMS
Quest Care DFW	Physician Groups & Consulting Groups
Red Oak FD	EMS
Red River Hospital	Hospital
Richardson Fire Department	EMS
Rolling Plains Memorial Hospital	Hospital
Rowlett Fire Rescue	EMS
Sachse Fire Rescue	EMS
Sacred Cross EMS	EMS Agency
Select Rehabilitation Hospital Of Denton	Hospital
Seymour Hospital	Hospital
Sherman Fire Department	EMS
Silver Oaks Assisted Living	Small Assisted Living Facility
Somervell County FD	EMS

Organization Name	Organization Type
Songbird Lodge	Nursing Facility
South Taylor EMS	EMS
Southlake FD	EMS
Stamford Memorial Hospital	Hospital
Stephens Memorial Hospital	Hospital / System
Stephenville Fire Department	EMS
Stonewall County Ambulance Service	EMS
Stonewall Memorial Hospital	Hospital / System
Sweetwater Fire Department	EMS
Tenet Healthcare	Hospital / System
Terrell State Hospital	Hospital
Texas General Hospital	Hospital
Texas Health Hospital Frisco	Hospital
Texas Health Arlington Memorial Hospital	Hospital
Texas Health Center For Diagnostics & Surgery Plano	Hospital
Texas Health Frisco	Hospital
Texas Health Harris Methodist Hospital Alliance	Hospital
Texas Health Harris Methodist Hospital Azle	Hospital
Texas Health Harris Methodist Hospital Cleburne	Hospital
Texas Health Harris Methodist Hospital Fort Worth	Hospital
Texas Health Harris Methodist Hospital Hurst-Euless-Bedford	Hospital
Texas Health Harris Methodist Hospital Southlake	Hospital
Texas Health Harris Methodist Hospital Southwest Fort Worth	Hospital
Texas Health Harris Methodist Hospital Stephenville	Hospital
Texas Health Huguley Hospital	Hospital
Texas Health Presbyterian Hospital Allen	Hospital
Texas Health Presbyterian Hospital Dallas	Hospital
Texas Health Presbyterian Hospital Denton	Hospital
Texas Health Presbyterian Hospital Flower Mound	Hospital
Texas Health Presbyterian Hospital Kaufman	Hospital
Texas Health Presbyterian Hospital Plano	Hospital
Texas Health Presbyterian Hospital Rockwall	Hospital
Texas Health Seay Behavioral Health Hospital	Hospital
Texas Health Specialty Hospital Fort Worth	Hospital
Texas Health Springwood Hospital	Hospital
Texas Institute For Surgery At Texas Health Presbyterian Dallas	Hospital
Texas Rehabilitation Hospital Of Fort Worth	Hospital
Texas Scottish Rite Hospital For Children	Hospital
Texas Vital Care EMS	EMS
Texoma Behavioral Health Center	Hospital

Organization Name	Organization Type
Texoma Medical Center	Hospital
Texoma Medical Center Bonham Hospital	Hospital
Texoma Reba Mcentire Center For Rehabilitation	Rehab Center
The Heart Hospital Baylor Denton	Hospital
The Heart Hospital Baylor Plano	Hospital
Throckmorton County Memorial Hospital	Hospital
Total Hospice & Palliative Care	Hospice
Town of Addison Fire Department	EMS
Tradition Senior Living	Assisted Living, Memory Care, Retirement
Trans Star Ambulance	EMS
United Regional Health Care System	Hospital System
University Of North Texas Health Science Center	University
USMD Hospital At Arlington	Hospital
USMD Hospital Fort Worth	Hospital
UTSW William P Clements Hospital	Hospital
UTSW Zale Lipshy	Hospital
Vernon Fire and EMS	EMS
Vibra Specialty Hospital Of Desto	Hospital
Weatherford FD	First Response Agency
Weatherford Regional Medical Center	Hospital
Wilbarger General Hospital	Hospital
Wilson N Jones Regional Medical Center	Hospital
Wise County EMS	EMS
Wise Regional Health System	Hospital / System
Wylie Fire Rescue	EMS

Appendix C: REPC Standard Operating Procedures

The most current REPC Standard Operating Procedures can be found at the following link:

SOP 2020 2021 Regional Emergency Preparedness Committee Final

Appendix D: HPP Letter of Agreement

The most current HPP Letter of Agreement can be found at the following links:

Public Agency HPP YR 16-20 LOA 032118 Form
Private Agency HPP YR 16-20 LOA 032118 Form

Appendix E: TSA-E Regional Hazard Vulnerability Assessment Report

The most current TSA-E Regional Hazard Vulnerability Assessment Report can be found at the following link:

NCTTRAC TSA-E 2020 Hazard Vulnerability Analysis Report

Appendix F: TSA-E Training and Exercise Program

HCC-E leads the Trauma Service Area - E in the development and execution of Homeland Security Exercise Evaluation Program – compliant ESF-8 exercises that integrate participating hospitals, supporting jurisdictions, inter- and intra-regional and state partners into discussion-based and operations-based exercises. Exercises are based on regional and state hazard vulnerability assessments. Regional communications drills testing both internet-based communications and radio systems are routinely conducted. Exercises contain elements testing Hospital Preparedness Program capabilities, including interoperable communications, bed reporting, patient tracking, fatality management, hospital evacuation and / or sheltering in place, and volunteer management. All exercises test the integration of local partners with regional partners, and have incorporated resource sharing, resource requests, and information sharing through local, regional, and state partners. Exercises may be run concurrently with intra-regional partner exercises required of DSHS Public Health Region 2/3 and the Public Health Emergency Program, with Cities Readiness Initiative local and regional partners, and with other inter-regional Trauma Service Area partners. All participating agencies produce after action reports and corrective action plans for internal use, and provide input for regional development of these documents. Real life events may be used to substitute for exercise play.

The North Central Texas Trauma Regional Advisory Council's (NCTTRAC's) HCC-E Multi-Year Training and Exercise Plan (MYTEP) is the roadmap to accomplish the organizational priorities in

accomplishing the development and maintenance of the overall preparedness capabilities required to facilitate effective response to all hazards faced by NCTTRAC. This organization is pursuing a coordinated preparedness strategy that combines enhanced planning, resource acquisition, innovative training and realistic exercises to strengthen its emergency preparedness and response capabilities.

The Training and Exercise Workgroup conducts annually a Training and Exercise Planning Workshop (TEPW). This is a collaborative workshop environment for Whole Community stakeholders to engage in the revision of the Training and Exercise Plan. The TEPW also serves as a forum to coordinate training and exercise activities across organizations in order to maximize the use of resources and prevent duplication of effort throughout the region. The mission results of the coordination and development are culminated in the MYTEP, which provides a yearly guide to projected training opportunities and a five year plan for exercises in the region.

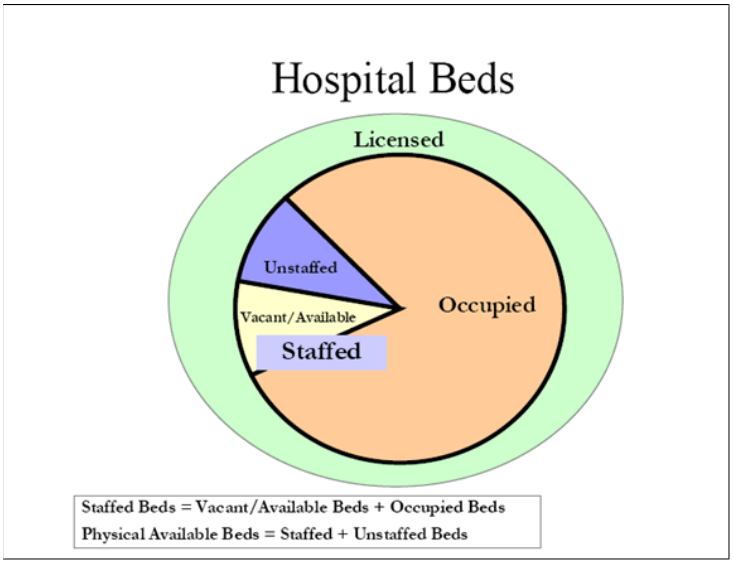
Additional information about the HCC-E Training & Exercise Program can be found at the following links:

NCTTRAC TSA-E Training & Exercise Program
HCC E Multi Year Training and Exercise Plan 2017-2022

Appendix G: Bed Availability Tracking

Due to the COVID-19 pandemic, DSHS has instituted mandatory changes to how the state tracks available beds. A general concept of bed availability is found below, and the table on the next page lists out the actual reportable fields and definitions. Bed availability is reported by hospitals in EMResource at a frequency determined by current events: during "normal" non-response times, hospitals update their bed availability once per month in response to no-notice drills. During active response events, hospitals are expected to report bed availability once per day. NCTTRAC will notify hospitals via EMResource and email notification when daily reporting is required.

The following standard definitions have been developed by the Agency for Health Care Research and Quality (AHRQ), Public Health Emergency Preparedness Program, and incorporated into the national WholeBed standard:



1. **Licensed Beds**: The maximum number of beds for which a hospital holds a license to operate. Many hospitals do not operate all of the beds for which they are licensed.
2. **Staffed Beds**: Beds that are licensed and physically available for which staff is on hand to attend to the patient who occupies the bed. Staffed beds include those that are occupied and those that are vacant.
3. **Unstaffed Beds**: Beds that are licensed and physically available and have no current staff on hand to attend to a patient who would occupy the bed.
4. **Occupied Beds**: Beds that are licensed, physically available, staffed, and occupied by a patient.
5. **Vacant/Available Beds**: Beds that are vacant and to which patients can be transported immediately. These must include supporting space, equipment, medical material, ancillary and support services, and staff to operate under normal circumstances. These beds are licensed, physically available, and have staff on hand to attend to the patient who occupies the bed.

During a Mass Casualty Incident, hospitals may be asked to report their available beds based on START triage patient categories. These categories refer to acuity of care required as opposed to specific care or age details.

Hospitals should evaluate the potential needs and resources required to manage a mass casualty incident, and project hospital bed availability 4, 24 and 72 hours into the future of an

event from the time of hospital notification. It is understood that these numbers represent a "best guess" estimate and that the actual number of beds available in 4, 24 and 72 hours will vary from these estimates, based upon the demands of the incident as well as the "routine", non-incident-related patient workload. Such beds could be made available by a number of means including:

1. The early discharge of patients
2. Cancellation of elective admissions
3. The transfer of patients to alternate care sites and facilities, and
4. The creation and opening of institutional surge beds.

Department of Health and Human Services (DHHS) evidence suggests that anywhere from 15-25% of a hospital's bed capacity could be made available by the early discharge of patients and cancellation of elective admissions. Furthermore, evidence suggests that an additional 5-20% of a hospital's bed capacity could be made available by transfer of stable patients requiring ward-type care (with the exception of oxygen administration) to a non-hospital alternate care site or facility.

Regional, state, and federal goals in the improvement of bed availability call for the provision of no less than 20% bed availability of staffed members' beds, within 4 hours of disaster inception. Coordinated mechanisms should be established by hospitals supporting this goal.

The table below shows the new bed availability categories as defined by DSHS.

Data Field	Definition
Available Staffed Adult ICU	Number of staffed available adult ICU beds capable of supporting critically ill patients, including patients with or without ventilator support. Do not include occupied beds.
Available Staffed Telemetry Beds	Number of staffed available telemetry beds. Do not include occupied beds. Do not double count beds that were reported as available in other categories.
Available Staffed MedSurg	Number of staffed available adult MedSurg beds capable of treating adult patients who do not require intensive care. Do not include occupied beds.
Available Staffed Burn Beds	Number of staffed available burn beds (approved by the American Burn Association or self-designated). These beds should not be included in other ICU bed counts. Do not include occupied beds.
Available Staffed Pediatric Beds	Number of staffed available pediatric MedSurg beds capable of treating pediatric patients who do not require intensive care. Do not include occupied beds.
Available Staffed PICU Beds	Number of staffed available pediatric ICU beds capable of supporting critically ill pediatric patients, including patients with or without ventilator support. Do not include occupied beds.
Available Staffed Psychiatry Beds	Number of staffed available beds on a psychiatric unit. Do not include occupied beds.
Data Field	**Definition**
Available Staffed Neg Pressure Isolation	Number of staffed available beds available to provide respiratory isolation through negative pressure airflow. Do not include these beds in other bed availability categories. Do not include occupied beds.
Available Staffed ED Beds	Number of staffed available beds in the Emergency Department. Do not include occupied beds.
Available Staffed Outpatient Beds	Number of staffed available outpatient beds. Do not include occupied beds.
Available Staffed Observation Beds	Number of staffed available observation beds. Do not include occupied beds.

Overflow and Surge Beds	Additional staffed beds that can be utilized if necessary within the walls of the hospital. Could also be called Available Staffed Surge Beds Located in Inpatient and/or Overflow Areas. Do not double-count beds; if you reported an overflow or surge bed in another available bed field, do not report it here.
Census: Adult Hospital Beds	Total number of staffed inpatient adult beds that are occupied.
Census: Adult ICU Beds	Total number of staffed adult ICU beds that are occupied.
Census: Pediatrics	Total number of staffed inpatient pediatric beds that are occupied.
Census: PICU	Total number of staffed PICU beds that are occupied.
Available Adult Vents	Total number of adult ventilators available, to include adult ventilators that are capable of ventilating a pediatric patient. Any device used to support, assist or control respiration through the application of positive pressure to the airway when delivered via an artificial airway.
Ventilators in Use - Adult	Total number of adult ventilators in use, to include adult ventilators that are capable of ventilating a pediatric patient.
Available Pedi Vents	Total number of pediatric specific ventilators available, not to include pediatric ventilators that can also be used as adult ventilators. Any device used to support, assist, or control respiration through the application of positive pressure to the airway when delivered via an artificial airway.
Ventilators in Use - Pediatrics	Total number of pediatric specific ventilators in use, not to include pediatric ventilators that can also be used as adult ventilators
BiPAPs Available - Adult	The number of adult bi-level positive airway pressure (BiPAP or BPAP) machines with the staffing, supplies, and equipment currently available to treat adult patients. Typically used for treatment of sleep apnea and may be used to support patients with respiratory insufficiency provided appropriate monitoring (as available) and patient condition. Do not include BiPAP machines currently in use.
BiPAPs in Use - Adult	The total number of adult bi-level positive airway pressure (BiPAP or BPAP) machines in use.
BiPAPs Available - Peds	The number of pediatric bi-level positive airway pressure (BiPAP or BPAP) machines with the staffing, supplies, and equipment currently available to treat pediatric (<= 17) patients. Do not include BiPAP machines currently in use.
BiPAPs in Use - Pediatric	The total number of pediatric bi-level positive airway pressure (BiPAP or BPAP) machines in use.
Current Anesthesia Machines Available	Anesthesia machines available (can also be reported as Available Staffed Operating Rooms).
Current Anesthesia Machine in Use	Total number of anesthesia machines w/ventilators in use by patients, including suspected and lab confirmed COVID-19 patients admitted to general, isolation or ICU beds.
Vents: Transport Available	Number of portable or transport ventilators that are currently available. Do not double count ventilators that were reported in other ventilator availability fields.
Vents: Transport in Use	Number of portable or transport ventilators that are currently in use. Do not double count ventilators that were reported in other ventilator availability fields.

Appendix H: Hospital Planning Guidance

Texas Administrative Code Title 25, Part 1, Chapter 133, Subchapter C, Rule 133.45 and the CMS Emergency Preparedness Rule both require hospitals to develop all-hazards response plans. Hospitals participating in the Texas DSHS Hospital Preparedness Program are likewise required to develop all-hazards response plans and protocols that include elements identified in the 2017-2022 Health Care

Preparedness and Response Capabilities, Capability 2, Objective 1, Activity 1. While each document has different specific requirements and should be referenced in the creation and revision of hospital emergency plans, a few common elements are listed below.

1. **Hospital evacuation**, including horizontal and vertical evacuation, evacuation within the immediate hospital area, and remote evacuation. Evacuation plans should consider communications, medical records, mobile assets, patient tracking, repatriation, staffing, supplies, pharmaceuticals, and transportation requirements.
2. **Mass fatality management** in which deceased human remains exceed the hospital's storage capacity and where normal mortuary support may not be functioning.
3. **Hospital sheltering–in–place**, for situations in which it may be safer and more medically responsible to remain within the hospital versus evacuating.
4. **Pandemic influenza response** addressing alternate care sites, triage of the ill, science-based triggers for action, personal protective equipment, just-in-time training of staff, education of the workforce, education of the ill and caregivers, and equipment and supplies.
5. **Alternate care sites**. Plans for alternate care sites during pandemic situations should include site locations, bed reporting, staff management, staff and patient support services, transportation, security, communications, level of care provided and types of patients that can be taken care of, and plans for supply and resupply of the alternate care site.
6. **Personal Protective Equipment (PPE) and Decontamination** planning for the purchase, sustainment, training, use, and rotation of PPE and decontamination equipment. PPE and decontamination plans should be implemented in a way that meets Occupational Safety and Health Administration (OSHA) guidelines required under 29 Code of Federal Regulations §1910.132, and OSHA Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents.
7. **Pharmaceutical cache planning**, including considerations for accessing caches, the provision of prophylactic medications and vaccines to hospital personnel and their families, and the stockpiling, rotation, and funding of the cache.
8. **Patient tracking and bed reporting** plans reflecting hospital staff utilization of EMResource and the WebEOC NCTTRAC Regional Patient Tracking Toolkit (or its future equivalent).
9. **Business Continuity** plans reflecting health care agency continuity of operations plans and needs.
10. **Utility Management** plan describes how the organization will manage risks associated with its utility systems i.e. electrical power, HVA systems, gas systems, etc.

North Central Texas Trauma Regional Advisory Council

Trauma Service Area – E
Health Care Coalition

Pediatric and Perinatal Surge Annex

NCTTRAC
600 Six Flags Dr. Suite 160
Arlington TX, 76011
June 2020

RECORD OF REVIEW AND CHANGES

NCTTRAC TSA-E Health Care Coalition Pediatric and Perinatal Surge Annex

Change #	Date	Entered By
Initial Draft	June 30, 2020	NCTTRAC Staff

SUMMARY OF CHANGE

NCTTRAC TSA-E Health Care Coalition Pediatric and Perinatal Surge Annex

This publication, dated 6/30/20 –

Initial publication

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Approval & Implementation

The NCTTRAC TSA-E Health Care Coalition Pediatric and Perinatal Surge Annex will follow the approval & implementation process set forth in the TSA-E Regional Medical Response Strategy Section E. Administrative Coordination, Section E.1.a-h.

Contents

1. INTRODUCTION

1.1 Purpose

The purpose of the Pediatric and Perinatal Surge Annex is to inform the TSA-E Regional Medical Response Strategy by incorporating a practical annex for healthcare delivery to the pediatric and perinatal segment of the patient population during disasters. This annex is intended to guide regional coordination between local medical services, provide information on the care of children, support patient destination decisions and movements, assist with system decompression, and identify resources and subject matter expertise during major medical surge events.

1.2 Scope

An all Health Care Coalition (HCC) response to a pediatric medical surge incident is the orientation of this annex, including hospitals, EMS, Public Health and Emergency Management. This annex is intended to support local responses, policies, and does not supersede or replace existing plans or mutual aid agreements.

Pediatric hospitals facilities are natural centers of gravity in disasters involving children[1]. It is the desire of the HCC that pediatric hospital facilities act as points of coordination during such an event particularly in situations in which the normal pediatric care capacity has been exhausted. A corresponding theme of this annex is ensuring an adequate level of pediatric medical surge capacity and capability among short term acute care facilities and EMS agencies within TSA-E.

1.3 Situation and Methodology

According to US Census Bureau[2] estimates there are approximately 2.1 million children living within the boundaries of TSA-E. The region is supported by six children's hospitals with approximate licensed bed capacity of 1,146 beds. Of these facilities, one is an American College of Surgeons (ACS) verified Level I Pediatric Trauma Facility, two are ACS verified Level II Pediatric Trauma Facilities and one is an orthopedic children's facility.

- Children's Health Plano
- Children's Health Dallas
- Cook Childrens Medical Center
- Medical City Childrens Hospital
- Our Childrens House – Children's Health
- Scottish Rite for Children

Pediatric surge is unique due to the specialized equipment and resources needed: pediatric experts, mechanical and alternative modes of ventilation, medication and pediatric beds[3]. This plan was developed with the support of several Subject Matter Experts in the field of pediatric medicine representing each of the childrens facilities in TSA-E. The Joint Pediatric Surge Task Force was created by members from

[1] Disaster Preparedness Advisory Council, Committee on Pediatric Emergency Medicine. (2015). Ensuring the health of children in disasters. *Pediatrics, 136*(5), 1407-1417. DOI: 101.1542/peds.2015-3112
[2] US Census Bureau. (2019). American Housing Survey (AHS). AHS 2017 Public Use File. https://www.census.gov/programs-surveys/ahs/data.html
[3] Chung, Sarita., Foltin, George., & Schonfeld, David, J. (2019). American Academy of Pediatrics, Pediatric Disaster Preparedness and Response Topical Collection, Itasca, IL; American Academy of Pediatrics.

four standing NCTTRAC Committees. The Regional Emergency Preparedness Committee (REPC), the Pediatric Committee, the Perinatal Committee and the EMS Committee each delegated representatives to shape the planning concepts described herein.

In order to create a mechanism for pediatric medical surge the group met over a period of time from September 2019 to February 2020. The joint task force convened four times to introduce the topic, develop a coordinating body, and identify key resources and concepts. The Joint Pediatric Surge Task Force recommended the establishment of a Pediatric Patient Coordination Module (PPCM) comprised of impacted facilities, pediatric and perinatal subject matter experts, the TSA-E Medical Coordination Center and other coordination entities as a situation dictates (e.g. adjacent HCC, TX Emergency Medical Task Force, DSHS and/or Texas Division of Emergency Management). This group is activated, utilizing the NCTTRAC Notifications System, at the onset of, or in preparation to, a regional incident that has the potential to create a disruption on the emergency healthcare system and primarily involves pediatric, neonatal, or obstetric patients. The PPCM will support a pediatric surge response from a regional perspective, monitor regional bed capacities, identify gaps in local responses and attempt to direct regional/state support to the most critical needs.

A non-exclusive list of partners that comprise the PPCM are outlined in the acknowledgements above. The group also determined that maintaining the ability to add just in time coordination with responding agencies and/or departments will be critical to the effectiveness of the coordinating body.

The TSA-E Medical Coordination Center surveyed 120 HCC hospital facilities utilizing an assessment modeled from the National Pediatric Readiness Project[4]. The assessment generally describes key elements for pediatric care readiness intended for non-pediatric facilities with a fully supported emergency department. 43 respondent results are summarized in the appendices. The results describe a relatively strong level of pediatric readiness across the region. However, there were a couple of noteworthy observations. Nearly 70% of respondents answered no to the questions regarding physician/nurse coordinators assigned the role of overseeing various administrative aspects of pediatric emergency care. Additionally, 56% of facilities answered no to having a written elements of hospital disaster plans that address issues specific to the care of children and no written guideline for the transfer of children with social and mental health issues to an appropriate facility.

According to Texas EMSC State Partnership Program Manager, Fatma Diouf, MPH the TSA-E region leads the state with the number of engaged emergency department and EMS agencies in the EMSC program. Within the region, 26 EMS agencies have Pediatric Emergency Care Coordinators (PECC) and at emergency departments there are 27 Physician PECC and 37 Nurse PECC.

1.4 Planning Assumptions

- Each hospital in TSA-E with a fully supported emergency department is capable of providing initial triage and resuscitation for pediatric patients.
- Each ACS verified pediatric trauma center maintain a facility surge plan which is fully leveraged prior to the activation of this Pediatric Surge Annex[5].

[4] US Health and Human Services. (2017). Pediatric readiness assessment. National EMS for Children Data Analysis Resource Center. Health Resources and Services Administration. https://www.pedsready.org/

- Planning and medical operations support will be coordinated with other response plans as most disasters are broader than a single pediatric segment of the patient population.
- The TSA-E Medical Coordination Center will follow standard practices regarding medical operations support specifically with the use of EMResource, WebEOC and Everbridge for notifications, hospital surveillance, information sharing, situational awareness and patient tracking.
- Regional coordination during a pediatric or perinatal medical surge event should be conducted with the activation of the Pediatric Patient Coordination Module (PPCM).
- Determination of whether a child meets pediatric age should follow organizational definitions, assessment of physical maturity and anatomical characteristics[5].
- In disaster situations transportation determinations may vary from typical scenarios, however, when possible and time allows antenatal transfers are preferable to neonatal transfers[6].

2. CONCEPT OF OPERATIONS

2.1 Indication and Activation

Children facilities and NICU designated facilities will likely activate their internal hospital command centers and/or emergency operations plans upon the realization of an incident. At the point the incident expands beyond local capacity the EMCC will begin to conduct assessment activities to determine medical operations and coordination support needs and the proper level of EMCC activation.

The general process for a partner organization to request an EMCC activation and Initial EMCC activation actions can be referenced in the EMCC Standard Operating Guidelines and the TSA-E Regional Medical Response Strategy

2.2 Notifications

The TSA-E Medical Coordination Center will notify regional healthcare and EMS partners of a pediatric medical surge event utilizing the EMResource application. Notification for the activation of the PPCM (comprised of the individuals in the acknowledgements), to the Clinical Advisory Group (CAG) and the Emergency Medical Task Force (EMTF) will be conducted in the Everbridge application. The notification for the activation of the PPCM will contain summary information regarding the incident and provide a bridge to a coordination call. The notification to the CAG will provide situational awareness information and provide a bridge to the conference call for CAG support. The initial notification to EMTF will provide summary details and assess response availability.

2.3 Roles and Responsibilities

The table describes Health Care Coalition Partner roles and responsibilities during a pediatric and perinatal medical surge event. The table below does not intend to describe every facet of each

[5] Remick, Katherine., Gausche-Hill, Marianne., Joseph, Madeline, M., Brown, Kathleen., Snow, Sally., & Wright, Joseph. (2018). Pediatric readiness in the emergency department. American College of Emergency Physicians. *Annals of Emergency Medicine, 72*(6), 122-136. DOI:10.1016/j.annemergmed.2018.08.431

[6] Committee on Obstetric Practice. (2016). Hospital-based triage of obstetric patients. The American College of Obstetricians and Gynecologists. Retrieved from https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co667.pdf?dmc=1&ts=20191230T1959123625

partner type but to provide a general overview of particular considerations for strategic planners and response coordinators.

HCC Partner Types	Roles & Responsibilities	Resources
TSA-E Medical Coordination Center (EMCC)	• Activate the PPCM • Sharing information between HCC members and with other jurisdictional partners • Maintaining situational awareness • Coordinate with the Clinical Advisory Group • Sharing and coordinating resources • Assisting with coordination of patient movement and evacuation through activation of Virtual Patient Transfer Network • Assisting with coordination for alternate care sites • Tracking patients and supporting family reunification • Coordinating assistance centers and call centers • Coordinating psychological care services • Providing HCC liaison support to emergency operations centers • Coordinating EMTF Activation activities	• Medical Caches • Emergency Diagnostic Equipment & DME • Medical Devices • Emergency electrical power generation • PPE • Radiological detection equipment • Communication equipment • Triage Tags • ESF-8 LNO
Pediatric Patient Coordination Module	• Convene (virtually) upon notice from the EMCC of a pediatric medical surge event • Coordinate with the EMCC • Liaise on current status of medical surge capacity and medical surge capability at children's facilities in TSA-E • Provide general hospitals an indication of the capacity needs based on the size of the event • Coordinate with EMS on transportation considerations, including specialized pediatric or perinatal transportation teams • Assess the needs for special resources • Assess surge strategies being employed at local facilities	• Everbridge Notification System • WebEOC Information Board • GoTo Webinar/ZOOM for virtual communication • Read access to facility bed management systems

[7] NCTTRAC. (2020). COVID-19 Self-Standing Care Center CONOPS. Regional Emergency Preparedness Committee.

[8] Texas Health and Human Services. (2020). State of Texas Strategy for Medical Surge Implementation Process (Draft). Department of State Health Services.

Regional Emergency Preparedness Committee Disaster Clinical Advisory Group	• Provide clinical leadership to the coalition and serve as a liaison between the coalition and medical directors/medical leadership at health care facilities, supporting entities (e.g. blood banks), and EMS agencies. • Act as an advocate and resource for other clinical staff to encourage their involvement and participation in coalition activities. • Assure that subject matter experts are available, and a process exists to meet the needs during a specialty surge or mass casualty/mass trauma event	• Physicians, advanced practice providers, or registered nurses who are clinically active and, • Knowledgeable of medical surge issues, chemical, biological, radiological, nuclear, and explosives (CBRNE), trauma, burn, and pediatric emergency response principles.
Public Health	• Public Health recommendations • Community Resilience • Medical Countermeasures • Biosurveillance	• PHEP Funding • Regional Medical Director • Laboratory Response Network
Local Government & Emergency Management	• Incident Management Teams • Emergency Operations Center • Resource Requests via STAR • Inter-agency Coordination	• Law Enforcement • Texas Government Code Chapter 418 • Mobile EOC
Hospitals	• Healthcare • Respond to Immediate Bed Availability Request • Update EMResource; NEDOCS and ED Status • Establish Hospital Command Center • Respond to informational surveys (Critical Infrastructure Survey, Supply Shortages Survey, etc.) • Participate in Patient Tracking efforts • Provide healthcare system LNO to EMCC	• Trauma designated facilities • Specialty care facilities • Burn Centers • Pediatric Hospitals • Electronic Health Record System • Pharmacy, Laboratory, Imaging
HCC Partner Types	• Roles & Responsibilities	• Resources
EMS	• Provide emergency medical care and transportation • Triage & tag patient with unique identifier • Activate mutual aid plans or procedures • Coordinate with EMCC on incident details, scene size-up • Establish an Ambulance Staging Area • Request additional EMS resources	• MICU • AMBUS • Special services (USAR, Trench Rescue, Swift Water, etc.)

[7] NCTTRAC. (2020). COVID-19 Self-Standing Care Center CONOPS. Regional Emergency Preparedness Committee.

[8] Texas Health and Human Services. (2020). State of Texas Strategy for Medical Surge Implementation Process (Draft). Department of State Health Services.

Emergency Medical Task Force-2	• Coordinated regional medical response • Emergency medical care • Emergency medical transportation • Provision of an Alternate Care Site • Augmentation of medical personnel • HCID medical transportation	• Ambulance Strike Team • Mobile Medical Unit • Medical supply cache • Medical Incident Support Team • Task Force Leaders • IDRU PPE
Local EMS Medical Control Centers	• Communication between EMS and Hospitals • Situational awareness for their EMS agencies • Coordination with mass patient movement	• 24/7 Operations • Medical direction • Established communication channels with EMS and Hospitals

2.4 Logistics

2.4.1 Space

In terms of support to hospitals during a pediatric medical surge activities the HCC has two previously published texts that can be referenced in addition to the specialized considerations for a surge of pediatric and neonatal patients described in this annex. The NCTTRAC COVID-19 Self-Standing Care Center CONOPS[7] and the State of Texas Strategy for Medical Surge Implementation Process[8] were both developed in the onset of the COVID-19 Pandemic. The state plan describes 5 levels of medical surge:

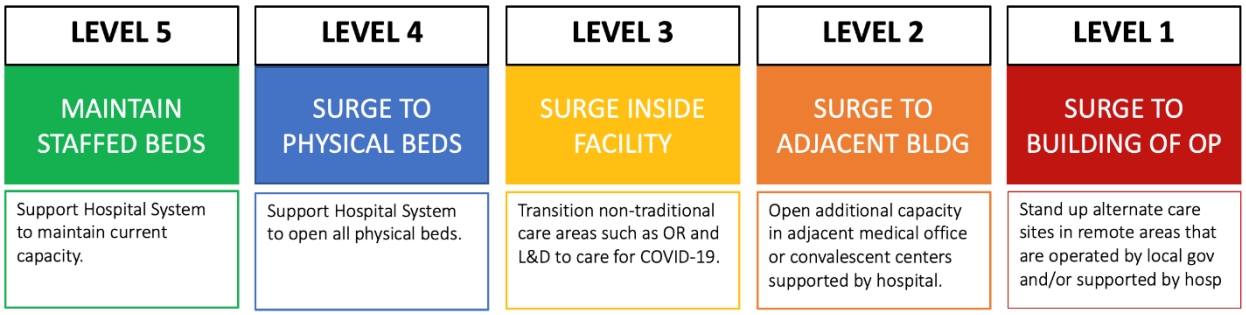


Figure 1: Surge Levels in DSHS State Medical Surge Strategy

The NCTTRAC COVID-19 Self-Standing Care Center CONOPS was written in the context of a health emergency that overwhelms local healthcare systems and the role of alternate care sites. The concepts outlined within the document describe the regional roles and responsibilities for agencies by function (hospital, EMS, PH, etc.), it outlines potential state agency actions and has a list of potential alternate care sites.

Individual hospital and local EMS agencies each have strategies to increase capacity for providing care. The role of the PPCM is to understand the effectiveness of these strategies and potentially direct regional or state support to a realized need among health care coalition partners. The HCC can collect and analysis hospital capacities based on self-reported information in EMResource. This information provides indications on the current status of hospitals. The PPCM, being comprised of representatives from the pediatric and perinatal community, will have a natural sense into the capacities of pediatric facilities and alternatively be able to provide guidance to general

[7] NCTTRAC. (2020). COVID-19 Self-Standing Care Center CONOPS. Regional Emergency Preparedness Committee.

[8] Texas Health and Human Services. (2020). State of Texas Strategy for Medical Surge Implementation Process (Draft). Department of State Health Services.

short-term acute care facilities for creating physical space with pediatric considerations. The Centers for Medicare and Medicaid Services (CMS) have produced a fact sheet that describes CMS Programs & Payment for Care in Hospital Alternate Care Sites (ACS).

2.4.2 Staff

A pediatric medical surge event will require agencies to fully engage available staff in order to increase and maintain expanded workforce and staffing levels[9]. Regulatory considerations should be taken into consideration when implementing surge staffing strategies, including but not limited to state licensure, liability insurance and CMS 1135 waivers. Some potential staff augmentation strategies include:

- Cross training for clinical staff
- Contracting from clinical staffing agencies
- Emergency Medical Task Force / State Support
- Use of non-conventional staff or expanded scope of practice (i.e. student nurses, medical student, military licensed staff)
- Use of non-conventional staff for non-clinical roles (i.e. volunteers)

2.4.3 Supplies

Ensuring that adequate levels of supplies and equipment are maintained for healthcare providers is critical[10]. The NCTTRAC warehouse maintains certain amounts of supplies and equipment that may be requested for support to an event. Realizing potential short supply and scarce equipment was a primary consideration for the joint pediatric task force. The TSA-E Pediatric Readiness Assessment Questions 41-43 (full summary can be found in the appendices) indicated that generally hospitals may need to increase their supply of certain pediatric supplies, particularly airway, breathing and circulation supplies. In the event that a facility or the emergency healthcare system at-large begins to realize a shortage of critical supplies the HCC has the ability to make resource purchases or requests to the state to meet any unexpected demand in supplies.

2.5 Operations Support – Medical Care

2.5.1 Triage

Initial triage will be conducted under the medical direction of the responding entity. Responding agencies will follow internal agency protocols and based on the type of surge event may utilized the Simple Triage and Rapid Treatment (START) triage method, especially for a mass casualty/mass trauma event. Medical directors and providers may determine that more deliberate and appropriate triage protocol should be employed for an infectious disease or biohazard situation. EMS agencies should communicate with the receiving hospital(s) as early as possible when transporting to the nearest appropriate facility. If activated, the PPCM may be able to coordinate with EMS to support destination decisions in a deliberate effort to avoid overloading any one emergency department.

[9] Remick, Katherine., Gausche-Hill, Marianne., Joseph, Madeline, M., Brown, Kathleen., Snow, Sally., & Wright, Joseph. (2018). Pediatric readiness in the emergency department. American College of Emergency Physicians. *Annals of Emergency Medicine, 72*(6), 122-136. DOI:10.1016/j.annemergmed.2018.08.431

10 Bohn, D., Kanter, R., Burns, J., Bargield, W., & Kissoon, N. (2011). Supplies and equipment for pediatric emergency mass critical care. *Pediatric Critical Care Medicine, 12*(60), 120-S127.

Hospital triage should be conducted in accordance with facility protocols and rapidly assess each pediatric patient based on actual or suspected onset of symptoms or mechanism of injury. Each receiving facility should ensure prompt availability of medical resources for optimal patient care. The patient should be treated appropriately or transferred to the nearest acute care facility for appropriate intervention.

2.5.2 Treatment

Standard treatment protocols under agencies medical directors should be followed at all times. In the appendices there are a two documents that may be utilized as guidelines regarding treatment and transfers; the NCTTRAC Pediatric Algorithm (see section 3.3) for Field Triage & Transportation developed by NCTTRAC EMS & Pediatric Committee and the *Consideration for Pediatric Consultation & Transfer*[11] developed by GETAC Pediatric Committee. In conjunction with agency protocols these document may provide decision support for proper destining of pediatric and neonatal patients. As of the publish date of the annex, the TSA-E Medical Coordination Center is engaged in a development and implementation project designed to create a virtual transfer network across the region. Leveraging the software application Xferall the EMCC intends to connect pediatric facility access centers, healthcare system transfer centers and sending facilities to promote efficiency and proper destinations for patients. The system includes a tracking mechanism for understanding patient movements, filters for appropriate medical criteria and an interface to transportation which can supplement existing transfer contracts and provide additional support should any single hospital system require support above the capacity of their transfer center.

2.6 Transportation

During a pediatric medical surge event transportation resources will be critical to effective scene clearance or facility decompression operations. Routine inter-facility transfer patterns may become disrupted during a pediatric medical surge incident. Health care facilities that typically transfer their acutely ill/injured pediatric patients or children with special health care needs to pediatric tertiary care centers/specialty care centers may need to care for these patients for longer periods of time until they are able to transfer these patients to a higher level of care. The pediatric task force recommendation is to, if feasible, utilize pediatric EMS resources as a primary means of transportation. Children's Health, Cook Children's and Medical City Dallas – Children's each have dedicated pediatric transportation units, which can support the event initially while a coordinated EMS response is established based on complexity and impact of a certain event. Request for Pediatric transportation units from outside the region prior to Regional EMS coordination will be accomplished through the TSA-E Medical Coordination Center in alignment with EMTF-2 operational plans and partners. There are currently 80 EMS agencies in the EMTF-2 program that can support in a regional assistance capacity during the first operational period (12 hour) of an incident. Beyond regional coordination a request will be made to the TX EMTF State Coordination Office for additional EMS transportation units.

As of the date of this publication, the EMCC is developing an EMS transfer surge support model utilizing the AMR/GMR software application OLOS. An agreement for participation is in legal review and at least 8 regional EMS transfer providers are involved in this unified effort. The system

[11] Governor's EMS and Trauma Advisory Council. (2019). Texas consideration for pediatric consultation and transfer guideline. GETAC Pediatric Subcommittee. https://www.dshs.state.tx.us/emstraumasystems/pediatricscommittee.shtm

will allow for virtual and centralized dispatch of EMS units with filtering and specialized preferences based on patient conditions and destination determinations.

2.7 Tracking & Reunification

During a disaster displaced and unaccompanied children are at increased risk of maltreatment, neglect and exploitation. Therefore, medical providers, the EMCC, public health, local jurisdictions and volunteer organizations should be vigilant in supported patient tracking and family reunification. The standard system for patient tracking in TSA-E is the NCTTRAC WebEOC Patient Tracking Toolkit Board.

EMS agencies and hospitals within TSA-E have been issued customized pediatric START triage tags. These tags include a unique identifier that is utilized to anchor the patient tracking process. At the onset on a pediatric medical surge event, the EMCC will create a WebEOC event, EMS and Hospitals will input the unique identifier for pediatric patients into the patient tracking toolkit. This process can be completed in at various times of patient custody, the sooner a patient is assigned a unique identifier the early that patient can be loaded into the tracking database. Recognizing the field environment of EMS many planners in TSA-E have promoted the initiation of the patient tracking process at the facility level. Hospitals tend to have more resources and an infrastructure that can better support the initial patient tracking demands. Hospitals utilize patient access teams to tag and input patient information into the patient tracking database. Due to the increased potential for secondary or tertiary transfers of pediatric/neonatal patients, initiation of the tracking process should be completed at the first destination facility. If unaccompanied children find their way to fire departments or hospitals regardless of needs for care they should be banded in an attempt to support accountability for a very vulnerable segment of the population.

In TSA-E, Dallas County PH has lead a unifying effort on family reunification. In addition, the Red Cross can provide volunteer support to administer the patient tracking and family reunification process. There are a number of different positions established in the NCTTRAC Patient Tracking Toolkit that can be assigned to individuals just in time and a number are extant and currently assigned to full time staff at the Red Cross. Hospitals in TSA-E continue to work closely with jurisdictional emergency manage to establish physical Family Assistance Centers. It is imperative that children are properly identified, mistaken identity can lead to delay in reunification, failure to identify proper medical care needs or release of child to a non-custodial parent. Protective services may need to be coordinated with along with law enforcement to search for legal custodians. Additional staffing needs may include security, social work, chaplaincy and/or additional information management support.

2.8 Deactivation and Recovery

Deactivation will follow standard processes as described in the TSA-E Regional Medical Response Strategy. In short, if applicable, the EMCC will demobilize at the request of the DSHS SMOC through a demobilization order. If an activation order was not received the EMCC will coordinate with the participation agencies, especially those agencies supporting in the PPCM. To effectively determine the appropriate time to begin recovery operations. The EMCC will utilize appropriate distribution lists to reach the HCC at-large and will deliberately archive information related to the event.

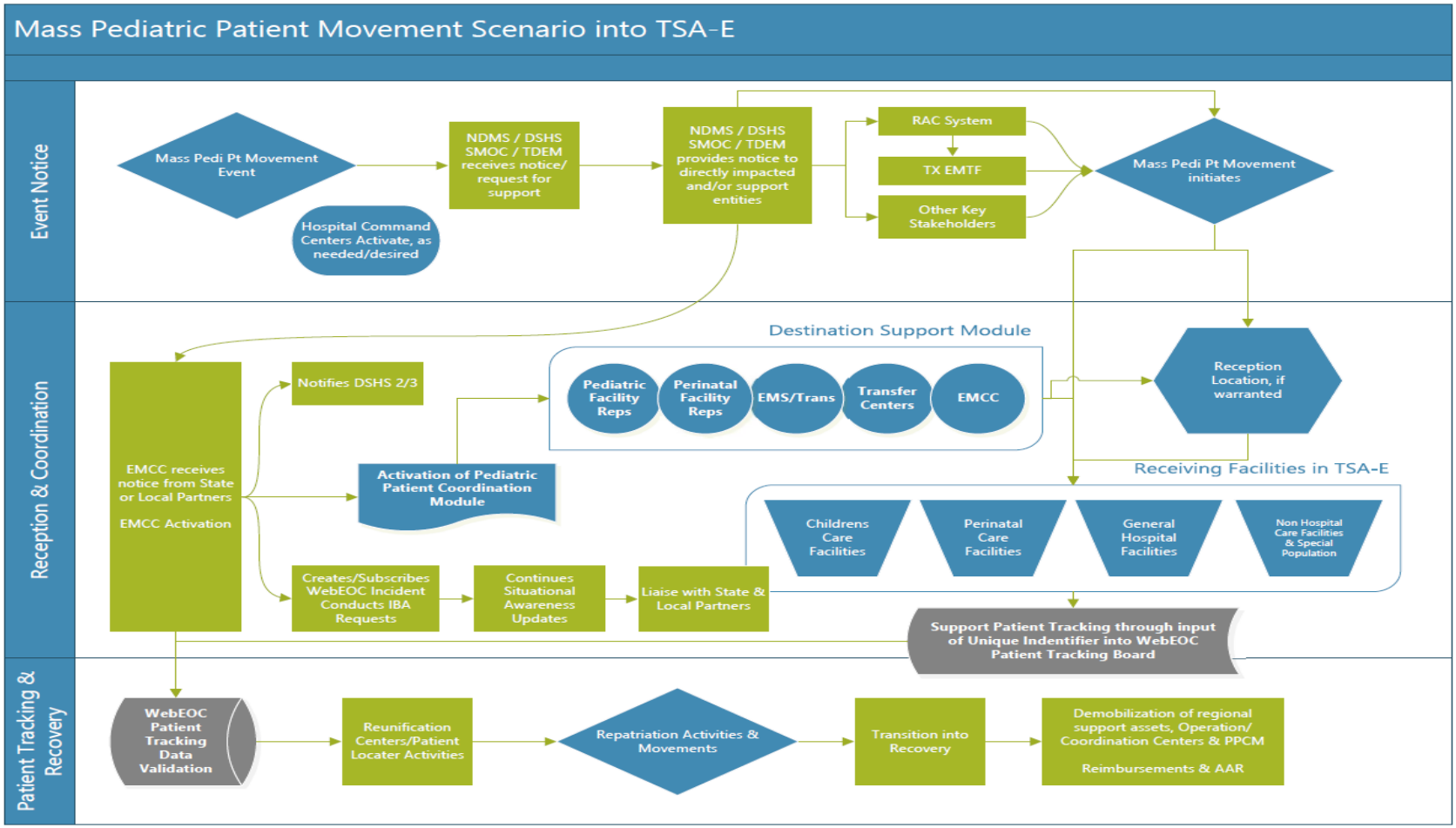
Recovery processes will also follow those outlined in the TSA-E Regional Medical Response Strategy. This activity is typically described in 3 phases, the Damage Assessment Phase, Restoration Phase and Medically Operational Phase. Events involving children may slow the recovery process as legal considerations and determinations may be unique given the population.

3. APPENDICES

3.1 Patient Movement Diagrams

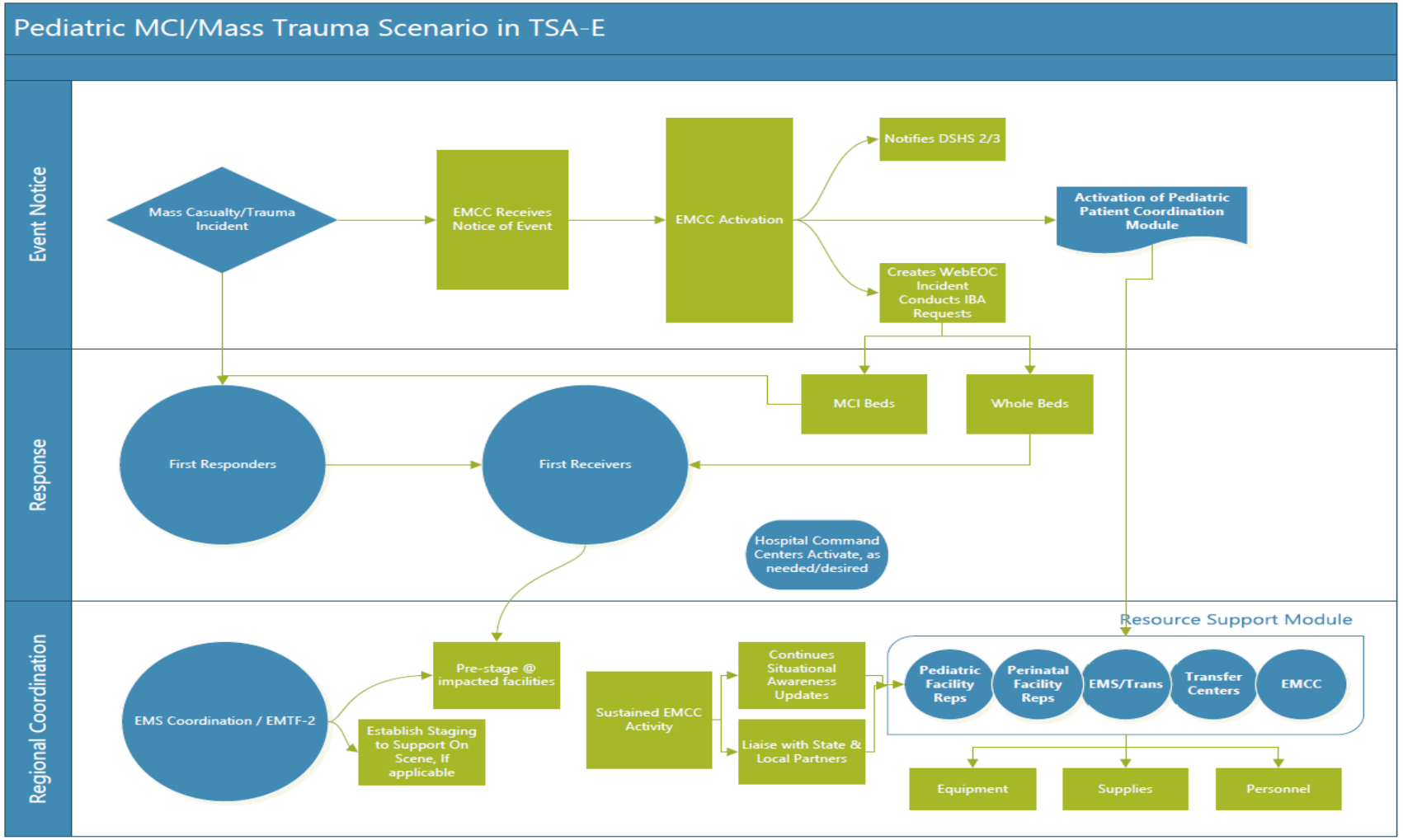
3.1.1 Mass Pediatric Patient Movement

The diagram below represents the inter-agency coordination of a Mass Pediatric Patient Movement Event. Possible scenarios may include NDMS movements, coastal evacuation of a children's facility, regional evacuation of a children's facility, etc.



3.1.2 Pediatric MCI/Mass Trauma Scenario

The diagram below represents the inter-agency coordination of a Pediatric MCI or Mass Trauma Incident. Possible scenarios may include school shooting, school bus accident, gas explosion at a school, etc.



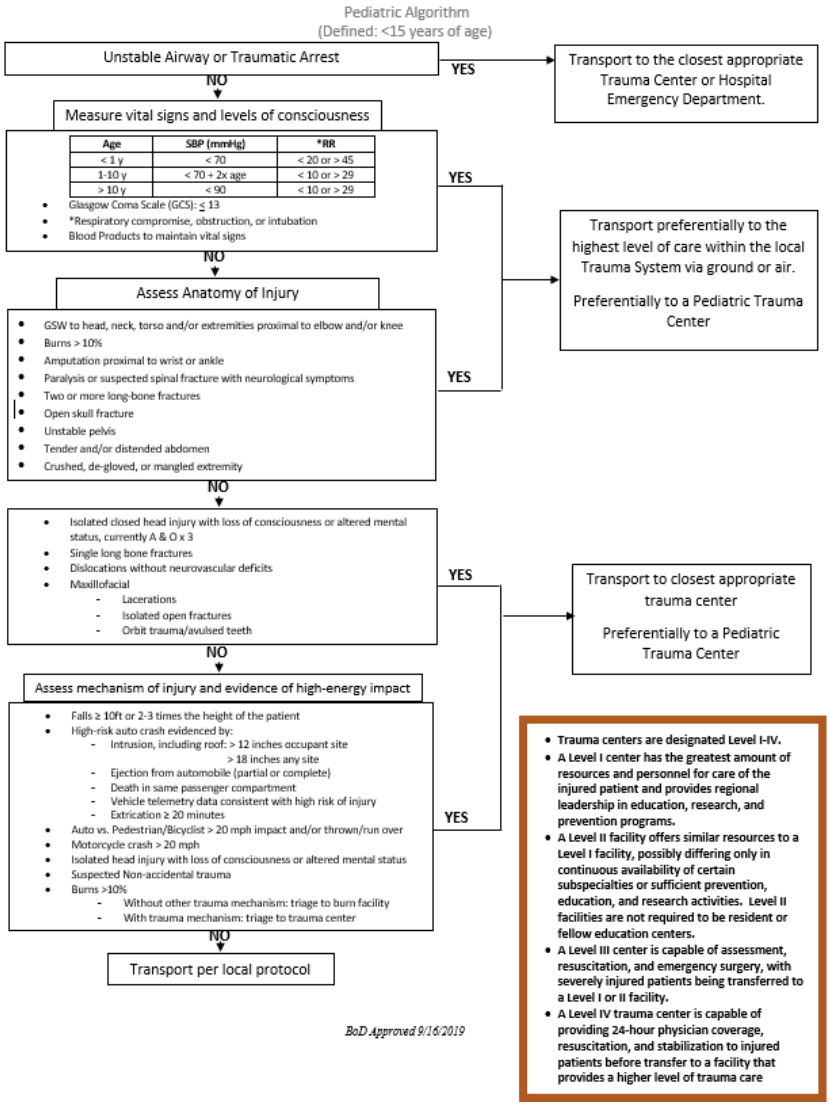
3.2 TSA-E Pediatric Readiness Assessment

The TSA-E Pediatric Readiness Assessment was published to the health care coalition on November 26, 2019 and remained open for participation until January 21, 2020. 43 respondent hospitals participated and an aggregated summary of those results are embedded below.

TSA-E Pediatric Readiness Assessme

3.3 NCTTRAC Pediatric Algorithm for Field Triage & Transport

The following pediatric algorithm was designed by the NCTTRAC EMS Committee as a field triage and destination support tool for EMS providers in TSA-E. This document may be used as a baseline reference during a pediatric medical surge incident.



[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

3.4 Consideration for Pediatric Consultation and Transfer

The following document was developed by the pediatric subcommittee of the Governor's EMS and Trauma Advisory Council (GETAC) in Texas. The applicability with this plan is to provide a baseline reference for pediatric inter-facility transfers that may be utilized during a pediatric medical surge incident.

Consideration for Pediatric Consultation and Transfer

Drafted by a work team of the Governor's EMS and Trauma Advisory Council Pediatric Subcommittee

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[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Consideration for Pediatric Consultation and Transfer

Introduction

Hospitals that are designated trauma centers must have transfer guidelines in place as part of the designation process. In response to the many requests for a template or guideline, the Pediatric Subcommittee of the Governor's EMS and Trauma Advisory Council drafted a compilation of guidelines that hospitals may utilize as their own transfer guidelines.

The transfer guidelines were developed in accordance with published standards (internet and print) across the nation at other trauma centers, a publication from the AAP (American Academy of Pediatrics) as well as published NHTSA (National Highway and Transportation Safety Administration) standards in regards to mode of transport. The transfer guidelines are meant to be inclusive of pediatric critical illness as well as pediatric trauma.

The following guidelines are not part of the Texas Department of State Health Services Safety and Administrative Code and are merely a template that facilities may adopt in order to fulfill requirements for trauma designation or simply to facilitate development of appropriate pediatric inter-facility transfer guidelines.

The Department of Health does not mandate Texas State designated trauma centers or non-trauma center hospitals to use these guidelines, but offers them to assist trauma centers and non-trauma centers in the development of their own guidelines. The Department recognizes the varying resources of different centers and that approaches that work for one hospital may not be suitable for others. The decision to use these guidelines in any particular situation always depends on the independent medical judgment of the medical provider.

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Consideration for Pediatric Consultation and Transfer
Trauma and Critical Illness

The transfer of pediatric patients with traumatic injuries as well as non-traumatic illness is addressed in the following document. The State of Texas has adopted four levels of trauma care in order to enhance the care of injured patients across the State. The acutely injured child who does not require critical care management can be cared for in a level 3 or level 4 Trauma Center. It is only the critically injured child and/or a child whose level of care needs exceed the local area capability that should be transferred to the most appropriate designated trauma facility with pediatric capabilities. It is accepted that some level 3 trauma patients may be admitted to an ICU for close observation; but if the patient begins to require ICU management, the patient should be transferred to the most appropriate designated trauma center with pediatric capabilities to care for a critically injured child. When a pediatric trauma center is not available, its role should be carried out by an adult trauma center that fulfills the requirement for provision of optimal trauma care to children.[1]

In addition, pediatric patients with a non-traumatic illness can also be cared for in regional facilities. However, patients should be transferred to a higher level of care when their medical and/or nursing care exceeds what is available in their community.

Because the state of Texas is such a vast geographically challenging state and Trauma Services Areas are well defined with existing referral patterns, it is not the intent of this guideline to change those already established relationships. However, it is intended to encourage hospitals to align themselves with a facility that has the capacity to manage pediatric critical care and pediatric trauma. It is not intended to mandate transfer outside a region but to heighten the awareness of the need for Pediatric Critical Care and Trauma Services.

The following contains guidelines of when to transfer the critically injured and/or ill pediatric patient. The guidelines serve as a resource for hospitals in the State of Texas. The Texas Governor's EMS and Trauma Advisory Council recognizes a pediatric patient as one aged 14 years and under. It is noted that many pediatric patients in their early teens may be the size of a small adult which may prompt physicians and surgeons to keep them in their local facility. Much Caution is advised with this practice, as these patients still have emotional and physical needs akin to all children such as child life services as well as nurses and ancillary staff, trained to care for the pediatric patient.

[1] Resources for Optimal Care of the Injured Patient: 2014, American College of Surgeons Committee on Trauma., Chapter 10 page 66.

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Consideration for Pediatric Trauma Transfer

Physiologic Criteria:

1. Depressed or deteriorating neurologic status (GCS ≤14) with focus on changes in the motor function
2. Respiratory distress or failure
3. Children requiring endotracheal intubation and/or ventilatory support
4. Shock, uncompensated or compensated
5. Injuries requiring any blood transfusion
6. Children requiring any one of the following:
    a. Invasive monitoring (arterial and/or central venous pressure)
    b. Intracranial pressure monitoring
    c. Vasoactive medications

Anatomic Criteria:

1. Fractures and deep penetrating wounds to an extremity complicated by neurovascular or compartment injury
2. Fracture of two or more major long bones (such as femur, humerus)
3. Fracture of the axial skeleton
4. Spinal cord or column injuries
5. Traumatic amputation of an extremity with potential for replantation
6. Head injury when accompanied by any of the following:
    a. Cerebrospinal fluid leaks
    b. Open head injuries (excluding simple scalp injuries)
    c. Depressed skull fractures
    d. Sustained decreased level of consciousness (GCS ≤14)
    e. Intracranial hemorrhage
7. Significant penetrating wounds to the head, neck, thorax, abdomen or pelvis including the groin
8. Pelvic fracture
9. Significant blunt injury to the chest, abdomen or neck (e.g. hanging or clothesline MOI's)

Other Criteria:

1. Suspicion for Child Maltreatment as evidenced by:
    a. injuries sustained with no reported explanation
    b. Injuries sustained that do not match the developmental capability of the patient
    c. History of apparent life threatening event
    d. Upper extremity fractures in a non-ambulatory child

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Pediatric patient with burn injuries should be transferred to a Burn Center per the following burn criteria:

American Burn Association Transfer Criteria:

A burn center may treat adults, children, or both. Burn injuries that should be referred to a burn center include the following:

1. Partial-thickness burns of greater than 10 percent of the total body surface area.
2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
3. Third-degree burns in any age group.
4. Electrical burns, including lightning injury.
5. Chemical burns.
6. Inhalation injury.
7. Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
8. Burns and concomitant trauma (such as fractures) when the burn injury poses the greatest risk of morbidity or mortality. If the trauma poses the greater immediate risk, the patient's condition may be stabilized initially in a trauma center before transfer to a burn center.
9. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
10. Burn injury in patients who will require special social, emotional, or rehabilitative intervention.

Burns in children

Children with burns should be transferred to a burn center verified to treat children. In the absence of a regional pediatric burn center, an adult burn center may serve as a second option for the management of pediatric burns.

Other criteria for transfer:

1. Children requiring pediatric intensive care other than for close observation
2. Any child who may benefit from consultation with, or transfer to, a Pediatric Trauma Center or a Pediatric Intensive Care Unit.
3. Children with injuries suspicious of child maltreatment e.g. inflicted burn injury

Reference: *Resources for the Optimal Care of the Injured Patient: 2014*

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Consideration for Pediatric Non-Trauma Transfer

Physiologic Criteria

1. Depressed or deteriorating neurologic status (GCS≤14).
2. Severe respiratory distress and/or respiratory failure
3. Children requiring endotracheal intubation and/or ventilatory support.
4. Serious cardiac rhythm disturbances,
5. Status post cardiopulmonary arrest.
6. Heart failure.
7. Shock responding inadequately to fluid resuscitation.
8. Children requiring any one of the following

    a. Arterial pressure monitoring.
    b. Central venous pressure or pulmonary artery monitoring.
    c. Intracranial pressure monitoring.
    d. Vasoactive medications.
    e. Treatment for severe hypothermia or hyperthermia
    f. Treatment for hepatic failure.
    g. Treatment for renal failure, acute or chronic requiring immediate dialysis.

Other Criteria

1. Near drowning with any history of loss of consciousness, unstable vital signs or respiratory problems.
2. Status epilepticus.
3. Potentially dangerous envenomation. Use of a snakebite protocol is encouraged
4. Potentially life threatening ingestion of, or exposure to, a toxic substance.
5. Severe electrolyte imbalances.
6. Severe metabolic disturbances.
7. Severe dehydration.
8. Potentially life-threatening infections, including sepsis.
9. Children requiring intensive care other than for close observation.
10. Any child who may benefit from consultation with, or transfer to, a Pediatric Intensive Care Unit
11. Suspicion for child maltreatment. e.g. found "down" for no apparent reason
12. Any condition that exceeds the capability of the facility

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Consideration for Interfacility Transport:

Transport Team and Method of Transport

Decision: The decision to transfer a patient is based on the previously listed anatomic and/or physiologic criteria in which the care of the patient is above and beyond the capability of the referring institution. Referring institutions need to have established policies and procedures in regards to the process of initiating the transfer (i.e. who talks to whom), gathering the required paperwork, as well as the process of informing the family and giving them maps to the receiving institution. The list of hospitals at the end of this document indicates the phone number(s) suggested by the referring institution to contact them for pediatric transfers.

Method: The method of interfacility transport is dependent on many variables. The state of Texas holds many geographic as well as weather challenges which will influence the referring provider's decision on moving a patient from one facility to the next. Transport by private vehicle is not encouraged with **critically** sick and/or injured children. Two areas to address in this determination of transport team as well as method of transport are patient related factors and general transport issues. Special consideration should be made for international transports. Intercept transports should be avoided.

Definition: For the purposes of this document, a pediatric transport team is considered a specialty care transport team. The Texas Administrative Code Title 25, Part I, Chapter 157 Subchapter B, Rule 157.11 defines a Specialty Care Transport as follows:

> Specialty Care Transports. A Specialty Care Transport is defined as the interfacility transfer by a department licensed EMS provider of a critically ill or injured patient requiring specialized interventions, monitoring and/or staffing. To qualify to function as a Specialty Care Transport the following minimum criteria shall be met:
>
> (1) Qualifying Interventions:
>
> (A) patients with one or more of the following IV infusions: vasopressors; vasoactive compounds; antiarrhythmics; fibrinolytics; tocolytics; blood or blood products and/or any other parenteral pharmaceutical unique to the patient's special health care needs; and
>
> (B) one or more of the following special monitors or procedures. mechanical ventilation; multiple monitors, cardiac balloon pump; external cardiac support (ventricular assist devices, etc.); any other specialized device, vehicle or procedure unique to the patient's health care needs.
>
> (2) Equipment. All specialized equipment and supplies appropriate to the required interventions shall be available at the time of the transport.
>
> (3) Minimum Required Staffing. One currently certified EMT-Basic and one currently certified or licensed paramedic with the additional training as defined in paragraph (4) of this subsection; or, a currently certified EMT-Basic and a currently certified or licensed paramedic accompanied by at least one of the following: a Registered Nurse with special knowledge of the patient's care needs; a certified Respiratory Therapist; a licensed physician; or, any licensed health care professional designated by the transferring physician.
>
> (4) Additional Required Training for Certified/Licensed Paramedics: Evidence of successful completion of post-paramedic training and appropriate periodic skills verification in management

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

of patients on ventilators, 12 lead EKG and/or other critical care monitoring devices, drug infusion pumps, and cardiac and/or other critical care medications, or any other specialized procedures or devices determined at the discretion of the provider's medical director.

If available, a specialty transport team should be used to transport critically ill or injured children.

Equipment: Choosing the type of transport team (i.e. ALS, MICU, and/or specialty team) can be challenging given our state's rural nature as well as geographic obstacles. The following gives a synopsis of what type of patient can/should be transferred according to their level of care. At all times, the referring institution should be knowledgeable about the transport mode's pediatric capabilities, especially in regards to pediatric equipment on-board. If they do not have a specific item on-board (example: pediatric nebulizer) then the referring institution must ensure the patient leaves their facility with the needed piece of equipment.

Communication:
1. Both the referral (sending) and receiving (accepting) institution should have policies regarding hospital-to-hospital communication in regards to:
- Work-up required or not required prior to transport (i.e. CT scan),
- Helping the referral institution determine mode/method of transport (i.e. air vs ground) and
- Patient stabilization requirements for transport.
- Communication back to the receiving institution in regards to:
  - Patient arrival at the receiving institution with updated patient health status
  - Overall patient outcome
  - The ability to discuss any patient care specifics enabling both facilities to optimize patient care for future transfers.

Back-transfer:

The referring institution needs to be prepared for those patients requiring long-term or chronic care post injury/illness. Back-transfer is encouraged if the referring institution has the capability to care for the pediatric patient in the inpatient setting.

The method of transport:

The method of transport is dependent on the variables listed below. Air transport, either by fixed wing (airplane) or rotary wing (helicopter) is typically utilized when speed is critical, long distances are involved, and/or a specialty team is required and available for patient care. However, there are circumstances where taking an ALS unit out of a community, for example, renders the community without an advanced life support unit for a prolonged period of time. Therefore, in this situation, use of air medical transport may be required so as not to endanger the rest of the community.

The following guidelines will help the provider to determine which type of transport method to utilize when transferring a critically ill or injured child. This can also be divided into categories when assessing the method of transfer (ground vs air) as well as crew composition. (Per NHTSA April 2006 guidelines)

1. The availability of critical care and/or specialty care transport teams within a reasonable proximity.
2. The modes of transportation and/or transport personnel available as options in the particular geographic area.
3. Specific circumstances associated with the particular transport situation (e.g. inclement weather, major media event, etc.)

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

4. Anticipated response time of the most appropriate team and/or personnel.
5. Established state, local, and individual transfer service standards and/or requirements.
6. Combined level of expertise and specific duties/responsibilities of the individual transporting team members.
7. Degree of supervision required by and available to the transporting team members.
8. Complexity of the patient's condition.
9. Anticipated degree of progression of the patient's illness/injury prior to and during transport.
10. Technology and/or special equipment to be used during transport.
11. Scope-of-practice of the various team members

Transport Team Configuration: Patient factors

The referring facility needs to determine the risk for deterioration of the pediatric patient in order to determine the crew composition and ultimately, the method of transport. According to the National Highway Traffic Safety Administration (NHTSA) guidelines from April 2006, the following categories for risk are utilized. The desired team configuration is based on the NHTSA guidelines and adapted for pediatrics:

Stable with no risk for deterioration

Basic Life Support:

Oxygen, monitoring of vital signs, saline lock at the discretion of medical control

Stable with low/medium risk of deterioration

Advanced Life Support or MICU as defined by Texas Health and Safety Code rule 157.11 with consideration for use of Pediatric Transport Team based on the patient's underlying medical condition and reason for transfer:

Running IV, some IV medications including pain medications, pulse oximetry, increased need for assessment and interpretation skills, 3-lead EKG monitoring, basic cardiac medications, e.g., heparin or nitroglycerine

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Stable with high risk of deterioration or Unstable

Use of Pediatric Transport Team highly encouraged when available in the following patient situations:

- advanced airway management required; secured airways, intubated, on ventilator
- multiple vasoactive medication drips,
- condition has been initially stabilized, but has likelihood of deterioration, based on assessment or knowledge of provider regarding specific illness/injury,
- cannot be stabilized at the transferring facility,
- condition deteriorating or likely to deteriorate, such as patients who require invasive monitoring, balloon pump,
- post-resuscitation, or who have sustained multiple trauma.

Strong consideration for air medical transport or critical care ground transport is recommended when pediatric transport team is unavailable

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

TSA-E Childrens Hospitals

Medical City Children's Hospital

Address: 7777 Forest Ln, Dallas, TX 75230

Hours:

Open 24 hours

Phone: (972) 566-7000

Number of beds: 876

Children's Health Dallas

Address: 1935 Medical District Dr, Dallas, TX 75235

Hours: Open 24 hours

Emergency room: Open 24 hours ·

Phone: (214) 456-7000

Number of beds: 496

Children's Health Plano

7601 Preston Rd, Plano, TX 75024

Hours: Open 24 hours

Emergency room: Open 24 hours

Number of beds: 72

Phone: (469) 303-7000

Cooks Children's Medical Center

Address: 801 7th Ave, Fort Worth, TX 76104

Hours: Open 24 hours

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Emergency room: Open 24 hours

Phone: (682) 885-4000

Number of beds: 430

Our Childrens House - Children's Health

Address: 1340 Empire Central, Dallas, TX 75247

Open 24 hours

Phone: (214) 867-6700

Scottish Rite for Children

Address: 2222 Welborn St, Dallas, TX 75219

Open · Closes 4:30PM

Phone: (214) 559-5000

Trauma Facilities

Level I (Comprehensive) Trauma Facilities

Children's Medical Center of Dallas
Dallas, 75235 (TSA-E)
Expires 2/1/2023

Level II (Major) Trauma Facilities

Cook Children's Medical Center
Ft. Worth, 76104 (TSA-E)
Expires 8/1/2022

Level III Advanced Trauma Facilities

Children's Medical Center Plano
Plano, 75024 (TSA-E)

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Please note the following amended updates on the above guideline:

Cook Children's Northeast Hospital has closed

*Children's Medical Center Dallas
1935 Medical District Dr.
Dallas, TX 75235
TSA-E
*****Children's Medical Center Dallas is an American College of Surgeons verified Level I Pediatric Trauma Center

3.5 Neonatal Designated Facilities in TSA-E[12]

Level IV: (Advanced Intensive Care Unit) Neonatal Facilities
Level III: (Intensive Care Unit) Neonatal Facilities
Level II: (Special Care Nursery) Neonatal Facilities
Level I: (Well Nursery) Neonatal Facilities

Facility	Health System	Designation Level	Children's Facility	Zone
Baylor Scott & White All Saints Medical Center - Fort Worth	Baylor Scott & White	III	No	7
Baylor Scott & White Medical Center - Centennial	Baylor Scott & White	II	No	5
Baylor Scott & White Medical Center - Frisco	Baylor Scott & White	II	No	5
Baylor Scott & White Medical Center - Grapevine	Baylor Scott & White	III	No	7
Baylor Scott & White Medical Center - Irving	Baylor Scott & White	II	No	8
Baylor Scott & White Medical Center - Lake Pointe	Baylor Scott & White	II	No	5
Baylor Scott & White Medical Center - McKinney	Baylor Scott & White	III	No	5
Baylor Scott & White Medical Center - Waxahachie	Baylor Scott & White	I	No	4
Facility	Health System	Designation Level	Children's Facility	Zone
Baylor University Medical Center	Baylor Scott & White	III	No	8
Children's ~~Medical Center Dallas~~		IV	Yes	8
City Hospital at White Rock		II	No	8
Cook Children's Medical center		IV	Yes	7

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Dallas Regional Medical Center		I	No	8
Hunt Regional Medical Center Greenville		III	No	5
John Peter Smith Hospital		III	No	7
Lake Granbury Medical Center		I	No	6
Medical Center of Alliance		III	No	7
Medical City Arlington	HCA	III	No	7
Medical City Dallas Hospital	HCA	IV	Yes	8
Medical City Frisco	HCA	I	No	5
Medical City Las Colinas	HCA	II	No	8
Medical Center of Lewisville	HCA	III	No	2
Medical City McKinney	HCA	II	No	5
Medical City Plano	HCA	III	No	5
Medical City Weatherford	HCA	I	No	3
Methodist Charlton Medical Center	Methodist	II	No	8
Methodist Dallas Medical Center	Methodist	III	No	8
Methodist Mansfield Medical Center	Methodist	II	No	7
Methodist Richardson Medical Center	Methodist	III	No	8
Navarro Regional Hospital		I	No	4
North Texas Medical Center		I	No	2
Palo Pinto General Hospital		I	No	3
Parkland Health & Hospital Systems		III	No	8
Texas Health Arlington Memorial Hospital	THR	III	No	7
Texas Health Harris Methodist Hospital Alliance	THR	II	No	7
Texas Health Harris Methodist Hospital Cleburne	THR	I	No	6
Texas Health Harris Methodist Hospital Fort Worth	THR	III	No	7
Texas Health Harris Methodist Hospital Hurst-Euless-Bedford (HEB)	THR	II	No	7
Texas Health Harris Methodist Hospital Southwest Fort Worth	THR	II	No	7
Texas Health Harris Methodist Hospital Stephenville	THR	I	No	6
Facility	Health System	Designation Level	Children's Facility	Zone
Texas Health Huguley Hospital	THR	II	No	7
Texas Health Presbyterian Hospital Allen	THR	II	No	5

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

Texas Health Presbyterian Hospital Dallas	THR	III	No	8
Texas Health Presbyterian Hospital Denton	THR	II	No	2
Texas Health Presbyterian Hospital Flower Mound	THR	II	No	2
Texas Health Presbyterian Hospital Plano	THR	IV	No	5
Texas Health Presbyterian Hospital Rockwall	THR	I	No	5
Texoma Medical Center		II	No	1
University of Texas Southwestern Medical Center (University Hospital)		III	No	8
Wilson N Jones Regional Medical Center		I	No	1
Wise Regional Health System		II	No	2

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

4. ADDITIONAL RESOURCES/REFERENCES

4.1 Training

*On June 4-5, 2020 NCTTRAC will host the Pediatric Disaster Response and Emergency Preparedness Course (MGT-439). The topics for this course include:

- Introduction to Pediatric Response
- Emergency Management Considerations
- Implications for Planning and Response
- Functional Access Needs Considerations
- Mass Sheltering
- Pediatric Triage and Allocation of Scare Resources
- Pediatric Reunification Considerations
- Pediatric Decontamination Considerations

This course will be offered to all members of the Pediatric Patient Coordination Module with priority due to their role and development of this annex. The culminate period of the course will include a table top exercise to evaluate and access the relevance of this annex.

* Postponed due to COVID-19 Response and Medical Operations Support Activity.

4.2 Exercises

On November 15, 2019 the North Central Texas Health Care Coalition conducted an All Health Care Response to Pediatric Surge Tabletop Exercise. The scenario was a mass trauma incident during a school field trip creating pediatric medical surge across the region. The scenario was designed to stress the regional healthcare system and require interagency coordination. HPP Capability 1: Foundations for Health Care and Medical Readiness, HPP Capability 2: Health Care and Medical Response Coordination and HPP Capability 4: Medical Surge were tested and evaluated. The objectives of the exercise were:

- Measure HCC response capabilities, capacities, and resources in the event of a pediatric surge in the region.
- Measure disaster response interface between EMS and hospitals in the region.
- Stress pediatric systems in place to identify shortfalls and make adjustments to preparedness and disaster plans

The exercise was conducted with participation from 46 personnel representing of 20 hospitals and three hospital systems, including three children hospitals. Participation also included 3 EMS agencies, 3 County Public Health Departments, the Department of State Health Services and 3 non-hospital providers.

Strengths from the exercise included:

- Relationships developed between hospitals and respective EMS agencies over years of working together.
- Agencies were prepared for scenario by studying protocols and procedures relevant to exercise.

- Open communication and understanding of regional alignment based on area of incident and nearest capable receiving hospitals for pediatric patient surge.
- Leadership from pediatric hospitals being present during exercise, able to identify common areas of need for pediatric patients.
- Cooperative effort from parties involved to understand importance of routing pediatric patients to proper destinations for treatment.

Areas for Improvement from the exercise included:

- Increased proficiency from the region in Crisis Applications (EM Resource/Web EOC) emergency response interfaces.
- Education on regional resources that are available to support a pediatric surge event.
- While IBA details basic capacity, a coordination group with understanding of regional facility capabilities to support destination decisions.

Feedback forms were utilized to survey the relevance of the exercise for participants. 48 responses are summarized in the graph below. In general the exercise provided an opportunity for HCC partners to learn more about regional capabilities and coordination within a pediatric medical surge incident. It also provided a forum for regional partners to understand the interdependency of the regional emergency medical healthcare system. The feedback summary below represents an overwhelmingly positive experience for Health Care Coalition Partners.

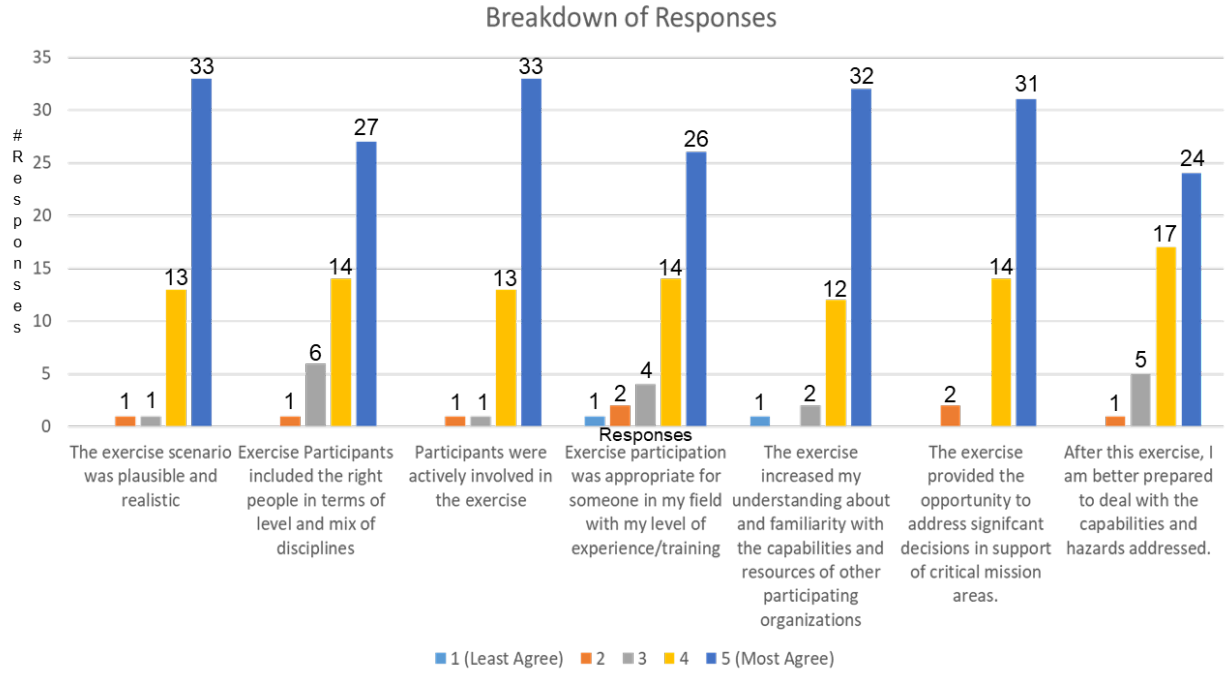

Figure 2: Feedback Summary for All Healthcare Response to Pediatric Surge TTX

4.3 Legal Authorities

The Texas Administrative Code compiles all state agency rules in Texas. Applicable Codes are listed below. This list is not intended to be a comprehensive and sole source of legal authorities for pediatric medical surge.

Title 25 Health Services
- Part 1 Department of State Health Services
  - Chapter 2 Emergency Preparedness
  - Chapter 13 Health Planning and Resource Development
  - Chapter 37 Maternal and Infant Health Services
  - Chapter 38 Children with Special Health Care Needs Services Program
  - Chapter 39 Primary Health Care Services Program
  - Chapter 85 Health Authorities
  - Chapter 133 Hospital Licensing
  - Chapter 137 Birthing Centers
  - Chapter 157 Emergency Medical Care
  - Chapter 448 Standard of Care
- Part 6 Statewide Health Coordinating Council
  - Chapter 571 Health Planning and Resource Development

Title 26 Health and Human Services
- Part 1 Health and Human Services Commission
  - Chapter 550 Licensing Standards for Prescribed Pediatric Extended Care Centers

4.4 References

[1] Disaster Preparedness Advisory Council, Committee on Pediatric Emergency Medicine. (2015). Ensuring the health of children in disasters. Pediatrics, 136(5), 1407-1417. DOI: 101.1542/peds.2015-3112

[2] US Census Bureau. (2019). American Housing Survey (AHS). AHS 2017 Public Use File. https://www.census.gov/programs-surveys/ahs/data.html

[3] Chung, Sarita., Foltin, George., & Schonfeld, David, J. (2019). American Academy of Pediatrics, Pediatric Disaster Preparedness and Response Topical Collection, Itasca, IL; American Academy of Pediatrics.

[4] US Health and Human Services. (2017). Pediatric readiness assessment. National EMS for Children Data Analysis Resource Center. Health Resources and Services Administration. https://www.pedsready.org/

[5] Remick, Katherine., Gausche-Hill, Marianne., Joseph, Madeline, M., Brown, Kathleen., Snow, Sally., & Wright, Joseph. (2018). Pediatric readiness in the emergency department. American College of Emergency Physicians. *Annals of Emergency Medicine, 72*(6), 122-136. DOI:10.1016/j.annemergmed.2018.08.431

[6] Committee on Obstetric Practice. (2016). Hospital-based triage of obstetric patients. The American College of Obstetricians and Gynecologists. Retrieved from https://www.acog.org/-

/media/Committee-Opinions/Committee-on-Obstetric-Practice/co667.pdf?dmc=1&ts=20191230T1959123625

[7] NCTTRAC. (2020). COVID-19 Self-Standing Care Center CONOPS. Regional Emergency Preparedness Committee.

[8] Texas Health and Human Services. (2020). State of Texas Strategy for Medical Surge Implementation Process (Draft). Department of State Health Services.

[9] Remick, Katherine., Gausche-Hill, Marianne., Joseph, Madeline, M., Brown, Kathleen., Snow, Sally., & Wright, Joseph. (2018). Pediatric readiness in the emergency department. American College of Emergency Physicians. *Annals of Emergency Medicine, 72*(6), 122-136. DOI:10.1016/j.annemergmed.2018.08.431

[10] Bohn, D., Kanter, R., Burns, J., Bargield, W., & Kissoon, N. (2011). Supplies and equipment for pediatric emergency mass critical care. *Pediatric Critical Care Medicine, 12*(60), 120-S127.

[11] Governor's EMS and Trauma Advisory Council. (2019). Texas consideration for pediatric consultation and transfer guideline. GETAC Pediatric Subcommittee. https://www.dshs.state.tx.us/emstraumasystems/pediatricscommittee.shtm

[12] Texas Department of State Health Services. (2019). Neonatal system development. Texas neonatal facilities. https://www.dshs.texas.gov/emstraumasystems/neonatalfacilities.aspx

[INSERT HOSPITAL LOGO]

Perinatal Disaster Checklist

Date: _____ Time of Disaster initiation: _____

Perinatal Disaster Coordinator: _____ Phone: _____

Designated Neonatal Leader: _____ Phone: _____

Designated OB Leader: _____ Phone: _____

Downtime process initiated: ☐ Census Lists Printed: ☐ Oxygen shut off: ☐
(if EMR unavailable)

Location of staging transfer area: _____ Main Phone: _____

Location of L&D patients who will not be transferred: _____

Provider Leads *(with contact numbers)*
OB: _____
Anesthesia: _____
Newborn: _____

Staging Area Responsible Leader: _____

RAC Communication Contact: _____

Document on Census list:

- Patients that are too unstable to transfer
- Confirmation of patient ID band
- Where each patient was transferred to and family contact
- If infant is born, confirmation that Dyad is together and bands checked
- NICU patients—Identification and parent notification of location
- MOT completions

Individual Patient needs:

- Nurses to prepare medications/nutrition for their individual patients.
- Nurses to assure written hand off report is with each patient
- Nurses to contact OB/Anesthesia/Newborn leader provider for orders (i.e. shutting off epidurals, Pitocin, etc)

NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

20221 Perinatal Care Regional System Plan

Endorsed by NCTTRAC Board of Directors
Date: Pending~~March 9, 2021~~
Approved by NCTTRAC General Membership
Date: ~~April 13, 2021~~Pending
Supersedes Perinatal Care Regional System Plan Date: April 13, 2021

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:

Perinatal 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.

Signature on File

_____ _____

Secretary Date

RECORD OF CHANGES

The North Central Texas Trauma Regional Advisory Council ensures that necessary changes and revisions to the Perinatal Care Regional 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 Perinatal Care Regional 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	7/7/21	Changed dates to reflect FY22 approval	Corrine Cooper
Pg 13, XII	7/8/2021	Changed to transported to transferred and added interfacility regarding interfacility triage criteria	Corrine Cooper

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

North Central Texas Trauma Regional Advisory Council (NCTTRAC)

2021 PERINATAL CARE REGIONAL SYSTEM PLAN

Table of Contents

Introduction

I. *Scope*

Mission
To improve outcomes for pregnant and postpartum women and newborns throughout Perinatal Care Region E (PCR-E), as supported by the NCTTRAC Perinatal Committee.

Vision

The NCTTRAC Perinatal Care Regional System Plan (PCRSP) shall involve all PCR-E perinatal stakeholders. It shall utilize data-driven evidence-based practices to improve the triple aim of perinatal care. Improvement in pregnancy, newborn and postpartum population health shall be our priority. In addition, we will strive to make perinatal care more cost effective and improve the perinatal health care experience.

The PCRSP builds on Texas' existing state-wide legislative mandate for perinatal hospital levels of designation and works with the Regional Advisory Council (RAC) Perinatal Care Regional Alliance (RAC-PCR Alliance) and Texas Collaborative for Healthy Mothers and Babies (TCHMB) to realize statewide coordination in the improvement of perinatal care for all Texans.

Organization

The NCTTRAC Perinatal Committee provides infrastructure and leadership to the nineteen-county region known as Perinatal Care Region E (PCR-E). NCTTRAC standing committees and member organizations (hospitals, first responder organizations, emergency medical services (EMS) providers, air medical providers, emergency management and public health) work collaboratively to ensure that quality care is provided to perinatal patients by pre-hospital and hospital professionals. The primary goal of the RPSP is to provide a detailed plan to reduce perinatal related morbidity and mortality via specific actions set forth by the PCR-E perinatal committee. Through this plan the perinatal committee will strive to establish uniform perinatal system standards. The organization will focus on education, prevention, prehospital management, hospital care, and long-term outcomes for perinatal patients. One of our highest organizational goals is to have patient outcome specific data inform process improvement work for all PCR-E member hospitals.

The Perinatal Care Regional Plan is a Guideline
The RPSP has been developed in accordance with generally accepted perinatal guidelines. (https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.)
In addition, the State of Texas DSHS levels of neonatal and maternal care documents and rules will inform this guideline.
(https://dshs.texas.gov/emstraumasystems/neonatal.aspx#Designation)

This plan does not establish a legal standard of care, but rather it is intended as an aid to decision-making in the care of perinatal patients. The Regional Perinatal System Plan is not intended to supersede the physician's or care giver's judgement.

Perinatal Care Regional System Plan (PCRSP) Goals

The purpose of the RPSP Committee shall be to facilitate the collaboration and advancement of a regional system of perinatal care that is based on accepted standards of care. The NCTTRAC Perinatal Committee will solicit participation from health care facilities, organizations, entities and professional societies involved in perinatal health care. The NCTTRAC Perinatal Committee will encourage regional participation in providing and outlining high quality perinatal care that is patient-focused, complies with state and national guidelines and seeks to provide perinatal patients with the most appropriate level of care. NCTTRAC Perinatal Committee shall develop a plan for a regional system of perinatal care that:

- Promotes collaboration and commitment among EMS providers, hospitals, and members of the NCTTRAC Committees
- Develops uniform perinatal system standards that addresses patients' needs, outcomes and opportunities for improvement
- Promotes delivery of at-risk neonates at hospitals most capable of delivering appropriate care (not solely based on level of designation)
- Promotes care of the pregnant and postpartum women at hospitals most capable of delivering appropriate care (not solely based on level of state designation)
- Promotes appropriate and timely structure for inter-hospital transfers. These structures will establish continuity and uniformity of care among the providers of perinatal care (strive to have a goal of 85% of very low birth weight (VLBW) infants being delivered at hospital most appropriate to deliver care).
- Promotes educational opportunities to improve frontline provider's competencies and skill
- Provides a review mechanism for discussing patterns of care that do not consistently comply with the RPSP goals
- Provide a written report (annually) to the Texas Perinatal Advisory Council (PAC) on PCR-E stakeholder concerns (potentially through the RAC-PCR Alliance) regarding the neonatal and maternal levels of designation process.
- Promote disaster preparedness planning and drills for unique aspects of the perinatal patient.

This plan, updated annually and approved by NCTTRAC membership, shall serve as resource guidance for providers of perinatal care across the Region.

II. *Regional Demographics*

Perinatal Care Region E (PCR-E), supported by the North Central Texas Trauma Regional Advisory Council (NCTTRAC), incorporates nineteen north central Texas non-metropolitan and metropolitan counties: Cooke, Fannin, Grayson, Wise, Denton, Palo Pinto, Parker, Ellis, Kaufman, Navarro, Collin, Hunt, Rockwall, Erath, Hood, Johnson, Somervell, Tarrant and Dallas counties. See Annex A, Appendix A-1 for map of region. Recent population estimates

indicate that 7.97 million people reside within the 15,574.71 square miles of TSA-E, representing over 27% of the entire population of the State of Texas.

Currently, NCTTRAC is served by four Level IV Advanced Intensive Care Neonatal Facilities, eighteen Level III Intensive Care Neonatal Facilities, eighteen Level II Special Care Nursery Neonatal Facilities, and twelve Level I Well Nursery Neonatal Facilities (for a total of 52). See list of all hospitals within the region in Annex A, Appendix A-2. There are also approximately 130 ground and air EMS services and over 140 first responder organizations. See list of all EMS/FRO and Air Medical Providers for the region in Annex A, Appendix A-3.

- https://dshs.texas.gov/emstraumasystems/neonatal.aspx
- https://dshs.texas.gov/emstraumasystems/maternal.aspx

III. *List of RAC Officers*

A list of RAC officers, including members of the Board of Directors and the Executive Committee of the Board of Directors are available in Annex B, Appendix B-1. The Executive Committee of the Board of Directors consists of the Board Chair, Chair Elect, Secretary, Treasurer, Finance Committee Chair, and Medical Directors Committee Chair.

IV. *Standing Committees*

Committee leadership consists of a Committee Chair, Chair Elect, and Medical Director. These positions are elected for one year terms; they are chosen by vote of the present and eligible voting members of the committee and ratified by a simple majority vote of the Board of Directors. The Chair Elect automatically ascends to the Chair position at the end of the current Chair's term. NCTTRAC standing committees are open to any individual who wants to attend, with the exception of the System Performance Improvement Subcommittee closed sessions.

A list of standing committees, with the chairperson for each, are available in Annex B, Appendix B-2. The list of standing committees, as well as committee's purpose, Chair terms, job descriptions, and voting participation are defined in the NCTTRAC bylaws. A copy of the bylaws is attached to this plan as Annex B, Appendix B-3.

V. *Evidence of System Participation*

Announcements for perinatal care region meetings and planning opportunities are sent electronically to NCTTRAC membership to allow participation from interested members and to include a broad range of participants such as physicians, nurses, EMS providers, and staff. Members have the capability to attend meetings through both audio and visual forms of technology.

Additionally, announcements are made at Committee and Board of Directors meetings for maximum visibility of members to participate. To provide evidence and track actual

participation in perinatal care region planning, rosters are kept at NCTTRAC offices. Perinatal designated facilities are required to meet minimum participation guidelines per the NCTTRAC Membership and Participation SOP, as well as those requirements specifically identified in the NCTTRAC Perinatal Committee SOP.

Plan Components

VI. *System Access*

All counties in the State of Texas have access to the EMS System utilizing 911 service. Additionally, all PCR-E counties received recent and robust updates including technology for cellular location. 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, Appendix C-1.

The 911 capabilities for all EMS providers allow for efficient dispatch of response teams/agencies to the scene. If the telephone or network communication system is down, EMS facilities and key agencies have access to two-way radios to communicate with dispatch, hospitals, and the NCTTRAC Emergency Medical Coordination Center (EMCC).

The EMCC helps coordinate response teams for disaster and regional surge responses through PCR-E resource and crisis applications such as **EMResource** and **WebEOC**.

VII. *Communication*

Communication between hospitals, EMS providers, and medical control entities takes place using a variety of methods. Hospitals communicate information regarding Emergency Department saturation, Emergency Department Advisory status, bed availability numbers, and clinical service line availability by updating dedicated status types in EMResource (see the section on *Diversion Policies and Bypass Protocol*). Direct communication between EMS providers, hospitals, and medical control entities generally occurs using a combination of cell phones, landline phones, and dedicated radio frequencies. Hospitals, EMS providers, and medical control entities work together to determine the best method of communication for their specific circumstances. For example, in some areas the most effective means of communication is for EMS providers to call the hospital's Emergency Department business line phone using cell phones held by individual paramedics, whereas other areas are better served by the hospital ED using a public safety radio with a dedicated channel for EMS communications.

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 facility of incoming maternal/neonatal patient transports.

NCTTRAC supports the implementation of redundant communication systems to ensure that hospitals, EMS providers, and medical control entities can still communicate with one another in the event of a primary communications method failure. In addition to administering the regional EMResource system, NCTTRAC hosts a WebEOC server with information sharing boards and patient tracking boards dedicated to EMS provider and hospital use. See Annex C, Appendix C-3. Using Hospital Preparedness Program (HPP) funding, NCTTRAC purchased amateur radios and VHF, UHF, and 700/800 public safety radios that can be given to hospitals and EMS providers as a means of redundant communication. NCTTRAC also purchased 2 Mobile Emergency Response Communications (MERC) trailers that can be deployed to provide temporary communications capabilities. These trailers are currently hosted by Parker County Hospital District/Lifecare EMS and Medical City North Texas. Additionally, NCTTRAC maintains multiple communications equipment caches that can be deployed in the event of a major communications failure.

Communications between multiple agencies responding to the same scene is generally dictated by the Incident Commander. Most neighboring jurisdictions share common radio frequencies or talk-groups that allow for interoperable radio communications – the exact frequencies or radio systems vary based on the jurisdiction having authority. In addition to jurisdiction-specific interoperable systems, it is recommended that EMS providers ensure their responding units are equipped with radios that have been programmed with the Texas Statewide Interoperability Channels identified in the Texas Statewide Interoperability Channel Plan.

The communication system is an integral part of a regional plan for the care of maternal and neonatal 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.

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 100% participation from all EMS agencies within the nineteen counties that comprise PCR-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 performance improvement (SPI) procedures.

VIII. *Medical Oversight*

The development of a regional system for perinatal care requires the active participation of qualified physician providers with expertise and competence in the treatment of perinatal patients.

NCTTRAC has an established Medical Directors Committee. This committee meets quarterly to provide guidance in the development and review of hospital and pre- hospital 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.

IX. *Pre-hospital Triage Criteria*

The survival of the maternal/neonatal patient is dependent upon rapid recognition/management of life-threatening injuries and rapid transport to an appropriate facility. The NCTTRAC maternal/neonatal Triage and Transport Guidelines were developed to assist emergency care providers at the scene, in conjunction with standard medical operational procedures and on-line medical control, to evaluate the level of care required by the injured or ill person and to determine the patient's initial transport destination. These guidelines align with the EMTALA Criteria found in the Guidelines for Perinatal Care, 8th ED, AAP Committee on Fetus and Newborn and ACOG Committee on Obstetric Practice a collaboration between The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The Maternal/Neonatal Triage and Transport Guidelines will be reviewed annually and revised as necessary by the EMS and Perinatal Committees with a final review and recommendation by the Medical Directors Committee and endorsement by the Board of Directors. See Annex D: *NCTTRAC Perinatal Triage and Transport Guidelines*. Regional air transport resources may be appropriately utilized in order to reduce delays in providing optimal maternal/neonatal care. Refer to Annex F: *Aircraft Utilization and Sytems Performance Review*. These documents are also posted on the NCTTRAC website at www.NCTTRAC.org.

X. *Diversion Policies and Bypass Protocols*

EMResource is utilized to maintain up to date information from each perinatal facility including but not limited to contact information, bed status, and open/closed status. A representative from each perinatal facility will report accurate information to EMResource at minimum every 24 hours and ensure correct contact information quarterly.

EMResource is the primary tool in PCR-E for hospitals to communicate with EMS providers

about any facility issues that may be relevant to EMS patient destination decisions.

All hospitals and EMS providers can create event notifications in EMResource. These events are used to inform the emergency healthcare partners in PCR-E about any incidents or occurrences that might affect the overall emergency healthcare system in PCR-E. For example, hospitals can create event notifications to alert EMS providers about construction that affects EMS traffic, or an EMS provider can create an event notification that alerts hospitals to an emergent mass casualty incident.

Proper posting on EMResource is considered the official and standard mechanism for notification in PCR-E. All EMS services are expected to monitor EMResource at all times for current system information. An EMS agency may call a receiving hospital for information on the status of facilities in their area if they do not have access. 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.

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

XI. *Regional Medical Control*

Regional Medical Control is defined as a centralized location for receiving on-line and off-line medical orders and for regional development of treatment protocols. As defined, there is no regional medical control in PCR-E.

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. PCR-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 PCR-E assumes the responsibility for maternal/neonatal oversight as well as specific performance improvement to investigate patient outcomes for his or her EMS personnel.

XII. *Inter-Facility Transfers*

Inter-Facility Triage Criteria

Patients will be interfacility triaged to the appropriate perinatal/neonatal facility, following the Perinatal Transport guidelines, with perinatal patients and/or their neonates being ~~trans~~transferred~~ported~~ to centers with appropriate capabilities. Each perinatal/neonatal care facility defines its internal facility triage criteria. There is not currently a regional standard for internal facility triage criteria

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The ability of perinatal/neonatal facilities to monitor their resource capabilities is through

NCTTRAC's web-based resource and crisis applications such as EMResource and WebEOC. See Annex C, Appendix C-2. Individual facilities are responsible for determining if a patient exceeds the facility's available resources and maintaining current capabilities. Communication of hospital capabilities to pre-hospital and hospital providers is addressed through EMResource.

Indications for Patient Transfer

Perinatal and neonatal patients should be transferred to a higher level of care when the medical needs of the patient outweigh the resources at the initial treating facility. The goal of patient transfer within PCR-E is to move patients to the nearest facility that is most capable of meeting the patient's medical needs. Decisions about the most appropriate facility for transport should be informed by and align with the rules set forth by the Texas State legislature regarding maternal and neonatal levels of care designation. These rules establish the criteria that delineates the minimum service and resource requirements for each level of designation. Specific definitions of each maternal and neonatal designation level may be found on the Texas Department of State Health Services EMS &Trauma Systems website (https://dshs.texas.gov/emstraumasystems/default.shtm). Examples of patients that may be appropriate for each level include, but are not limited to the following:

Maternal

Level 1 Maternal:
- Uncomplicated term twin gestation
- Trial of labor after cesarean delivery (TOLAC)
- Uncomplicated cesarean delivery
- Preeclampsia at term

Level 2 Maternal: Any patient appropriate for level 1 care, plus higher-risk conditions such as:
- Severe preeclampsia
- Placenta previa with no prior uterine surgery

Level 3 Maternal: Any patient appropriate for level 2 care, plus higher-risk conditions such as:
- Suspected placenta accreta or placenta previa with prior uterine surgery
- Suspected placenta percreta
- Adult respiratory syndrome or any condition requiring ventilator support
- Expectant management of early severe preeclampsia at less than 34 weeks of gestation

Level 4 Maternal: Any patient appropriate for level 3 care, plus higher-risk conditions such as:
- Severe maternal cardiac conditions
- Severe pulmonary hypertension or liver failure

- Pregnant women requiring neurosurgery or cardiac surgery
- Pregnant women in unstable condition and in need of an organ transplant

Neonatal

Level 1 Neonatal: Well infants at low risk
- Physiologically stable infants at 35 – 37 weeks gestation
- Can stabilize infants less than 35 weeks or those who are ill until they can be transferred to a higher level of care

Level 2 Neonatal: Any patient appropriate for level 1 care, plus higher-risk conditions such as:
- Moderately ill infants who are born at ≥32 weeks gestation or who weigh ≥1500g at birth with problems that are expected to resolve rapidly and who are not anticipated to need subspecialty-level services on an urgent basis.

Level 3 Neonatal: Any patient appropriate for level 2 care, plus higher-risk conditions such as:
- Infants born at <32 weeks gestation
- Infants weighing less than 1500 g at birth
- Infants with medical or surgical conditions, regardless of gestational age

Level 4 Neonatal: Any patient appropriate for level 3 care, plus higher-risk conditions such as:
- Infants with complex and critical conditions requiring availability of pediatric medical and surgical specialty consultants continuously available 24 hours a day.
- Infants requiring care for complex congenital cardiac malformations that require cardiopulmonary bypass, with or without ECMO

Time to Transfer

Access to timely and appropriate perinatal and neonatal care is a system goal in PCR-E. The focus should be to reduce time from onset of complication to definitive care. Facilities should provide initial stabilization and timely transport to the closest, most appropriate designated facility with definitive care capabilities. The time required to make the decision to transfer accounts for the greatest transfer delay. It is critical to make the decision to transfer early. Non-essential diagnostic testing and procedures will delay transfer and should be avoided.

Attention should be directed at life-saving stabilization. Examples of stabilization that should be undertaken prior to transport include:

- Maintenance and protection of airway
- Establishment of IV access
- Initiating treatment for severe maternal hypertension
- Maintenance of normothermia

- Delivery of fetus(es) if delivery is immediately imminent or emergently required

Attempts to stabilize the patient should be continued until the transfer is completed; however, the most critically ill patients may not be completely stabilized prior to transfer. Inability to completely stabilize a patient is not a contraindication of transfer. If stabilization is not possible, the referring facility shall obtain written informed consent from the patient or her/his surrogate and/or written certification from the physician that the expected medical benefits of transfer outweigh the risk.

Inter-facility transfers should primarily occur within PCR-E however there may be occasions in which patients are transferred outside of PCR-E due to availability of resources or patient/family preference.

Transferring facilities shall make efforts to send medical records and radiographic studies obtained during initial management to the accepting referral center.
Copies of studies may be sent in hard copy or electronically through web-based programs. Exhaustive scanning frequently must be repeated at the receiving facility, often because of the quality of images, failure to transfer the images to the receiving facility, or inability to read the disc transported with the patient. This results in further delays in definitive care and avoidable exposure of the patient to ionizing radiation, and thus should also be avoided.

Physician to physician communication is essential between the initial facility and the accepting referral center. Physicians at accepting referral center should be available for consultation with the sending provider prior to transfer. Early communication with the receiving perinatal and/or neonatal provider can streamline the transfer process and satisfies one of the EMTALA requirements for transfer.

Method of Transfer

The sending physician maintains responsibility for determining the appropriate mode of transport as well as the transport team utilized. When possible and as available, perinatal/neonatal specialty care transport teams should be utilized to provide the appropriate level of care during transport.

Back Transfers/Home Transfers

In the event that a patient has stabilized and no longer requires the level of care and particular expertise provided by the receiving facility, efforts should be made to return the patient to the facility of origin, or the nearest facility to the patient's home community that is capable of providing the medical services needed to appropriately meet the patient's medical needs. This allows patients to be nearer to their homes and local communities in support of family-centered care models, which includes proximal access to ongoing discharge education for specialty care needs. This also promotes the availability of beds at higher level facilities for patients with more critical needs. The determination of appropriateness for back transfer should be made by the patient's physician at the higher-level facility in collaboration with the physician who will be involved in the care of the patient in the lower level facility/facility of origin.

XIII. *Plan for Designation of Potential Perinatal Facilities*

The NCTTRAC Perinatal Committee will support member hospitals in seeking Texas DSHS levels of maternal and neonatal designation. The NCTTRAC Perinatal Committee will utilize the Texas Department of State Health Services (DSHS) recognized designation process for maternal and neonatal levels of care. As outlined in Texas Administrative code for requirements of maternal and neonatal levels of care (TAC, Title 25, Chapter 133, Subchapter K and J respectively) the NCTTRAC Perinatal Committee will strive to support uniform interpretation of these rules and help provide feedback to DSHS to improve the designation process. Whenever possible NCTTRAC Perinatal Committee will promote the use of a uniform data set for perinatal outcomes to improve the process of care for the patients we serve.

As required by DSHS, Perinatal facilities within the PCR-E region have an obligation to maintain NCTTRAC membership in good standing as well as meet active participation requirements.

XIV. *System Performance Improvement Program*

NCTTRAC System Performance Improvement (SPI) processes are responsible for shared oversight of trauma and emergency healthcare system performance improvement activities. SPI processes are divided among nine (9) service line committees: Air Medical, Cardiac, Emergency Department Operations, Emergency Medical Services, Pediatric, Perinatal, Regional Emergency Preparedness, Stroke, and Trauma.

Generally, PCR members or staff will notify the Perinatal Committee Chair of any perinatal cases or system issues that have been reported and are in need of review. The Perinatal SPI focus group, comprised of the Perinatal Committee Chair, Chair Elect, Medical Director, and two elected committee members as approved by the committee, will review each reported case/issue in a closed session and make recommendations to the full Perinatal Committee and the Executive Committee for determinations and action plans.

Data Collection (Neonatal and Maternal data analysis)

Regional data will be collected and utilized to support Perinatal Committee goals and PI initiatives. Member hospitals are required by the Perinatal Committee to submit data for all Neonatal/Maternal SMART Goals which are deemed part of the PI/QI goals of the of Perinatal Committee.

Perinatal System Performance Improvement

The goal of Perinatal System Performance Improvement is to deepen and accelerate improvement efforts for maternal and infant health outcomes.

The **mission** of the Perinatal Quality and Performance Improvement focus group is to support

the development and to enhance the quality of care for the NCTTRAC regional stakeholders. Ultimately, the focus group is responsible for making measurable improvements in maternal and infant health outcomes.

The Perinatal Quality and Performance Improvement focus group collaborates with the Perinatal System Performance Improvement (SPI) focus group to define committee goals and Neonatal/Maternal performance indicators for the region. The Perinatal Quality and Performance Improvement standards and performance indicators are developed from committee consensus, evidence-based practice guidelines, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists and DSHS Maternal and Neonatal Facility Designation rules/requirements. All neonatal / maternal designated centers must comply and adhere to the standards of care determined by their verifying and designating agencies.

The Perinatal Quality and Performance Improvement focus group monitors regional neonatal / maternal performance indicators and goals on a monthly dashboard which shall be presented to the committee and the Board of Directors. The Neonatal/Maternal performance indicators and goals are reviewed/revised annually and defined in Appendix B-4: *Perinatal Committee SOP*

A Perinatal Committee Quality and Performance Improvement focus group has been established by the Perinatal Committee to assist with evaluating regional data, identifying data needs, providing education, and sharing best practices.

XV. *Rehabilitation*

Rehabilitation is the process of helping a patient adapt to a disease or disability by teaching them to focus on their existing abilities. Within a rehabilitation center, physical therapy, occupational therapy, and speech therapy can be implemented in a combined effort to increase a person's ability to function optimally within the limitations placed upon them by disease or disability.

To uphold the continuum of care from illness to health and offer a high-level of service, rehabilitation is a critical service offered within PCR-E through hospital- based programs and private organizations. A list of rehabilitation resources for the region are available in Annex A Appendix A-4.

Transfer protocols for rehabilitation facilities are determined by individual facilities.

XVI. *Morbidity/Mortality Reduction and Outreach Education (DSHS: Prevention and outreach)*

Maternal and neonatal morbidity and mortality are higher than average in the state of Texas and in many situations, avoidable. Activities focused to reduce morbidity and mortality associated with pregnancy, birth, post-partum recovery and infant care in the newborn period

are integrated into the Perinatal Committee activities. Data collection on these morbidities and mortality reasons are tracked and shared with committee members in order to develop quality improvement projects.

Prevention and Awareness strategies are based on epidemiologic data that is collected through available local, regional, state and national patient data systems. Collaboration with community coalitions and partners, policy makers, and other vested stakeholders defines the interventions targeting specific populations. Intervention programs seek to create a measurable reduction of injury and increase prevention strategies (such as safe sleep initiatives, or newborn admission temperatures as examples), that have measurable outcomes in a specific timeline. Staffing and community partners are essential for success.

Outreach education is a task the Perinatal Committee as well as each individual hospital within the regional advisory council. Individual hospitals provide targeted education to other like or lower levels of maternal and neonatal designation. The Perinatal committee supports all facilities by conducting regular needs assessments and providing financial support as available and assistance in securing the requested education.

XVII. *Coalition and Partnership Building (DSHS: Identification of health care system coalition and community partners for the purpose of system integration and improvement.)*

NCTTRAC supports collaborative partnerships with community leaders to focus on bringing in business partners and community leaders to assist with injury awareness and prevention activities.

Coalition and Partnership building is a continuous process of cultivating and maintaining relationships with stakeholders within the NCTTRAC perinatal care region. Collaboration on system development with community partnerships are key. Constituents include health care professionals, prehospital providers, insurers, payers, data experts, consumers, advocates, policy makers, perinatal center administrators, and media representatives. Coalition priorities are perinatal system development, regional system guidelines, financing initiatives and disaster preparedness, system integration, and promoting collaboration rather than competition between perinatal centers and prehospital providers. It is desired that every member of NCTTRAC participate in at least one activity or one committee.

XVIII. *Disaster Preparedness and Response (DSHS: Disaster preparedness)*

The Perinatal Disaster preparedness and response activities will comply with the PCR-E disaster preparedness plans. The perinatal committee of PCR-E will appoint members to participate in the NCTTRAC Regional Emergency Preparedness Committee (REPC).

The goal of perinatal disaster response is to move patients out of disaster affected facilities into capable facilities if possible. If this is not possible, the disaster affected facility may ask for provider and nursing support from other member facilities or from available regional, state, and

federal resources. If a facility is unable to coordinate the movement of patients and identification/requesting of resources on their own, they can contact the PCR-E Medical Coordination Center (EMCC) for assistance. The EMCC has a 24/7 Duty Phone at 817-607-7020, or can be contacted via routine email at nctrac_emcc@ncttrac.org.

Disaster preparedness and response activities among the emergency healthcare system in PCR-E are conducted at the regional level through the Health Care Coalition (HCC). The HCC has been developed and funded as part of the federal Hospital Preparedness Program (HPP). The TSA-E HCC is composed of partner organizations from 4 core groups: hospitals, EMS, public health, and emergency management. These 4 groups work together as the HCC to promote emergency preparedness and healthcare delivery response. The HCC's purpose is to:

- Lead collaborative regional planning, formulate strategies, and make recommendations to the NCTTRAC Board of Directors to ensure that the best possible approaches to regional HCC planning can be achieved in PCR-E.

- Identify and assess regional needs in order to develop possible options for strengthening the overall resiliency of regional response capabilities based upon federal and state guidance and best practices (these include the Hospital Preparedness Program, Centers for Medicare and Medicaid Services, Federal Emergency Management Agency, etc.)

- Serve to identify the regional priorities set forth by current federal and state guidelines by utilizing input from Subject Matter Experts to set strategic planning goals and initiatives.

The TSA-E HCC conducts disaster preparedness activities in accordance with the *Trauma Service Area-E Health Care Coalition Regional Preparedness Strategy,* which can be found in Annex G Appendix G-1.

Coordinated medical responses that are timely and exercised routinely can mitigate damages and save lives. The response goal of the HCC is to promote resiliency and adequate surge capacity and capability across PCR-E during a mass casualty or disaster situation. Effective response and recovery requires a coordinated effort among public and private entities. Hospitals and healthcare facilities are encouraged to be active participants in emergency preparedness efforts, including partnering with EMS, emergency management, public health, and other entities.

The TSA-E HCC regional response structure promotes jurisdictional cooperation and coordination, but recognizes the autonomy, operational authority, and unique characteristics of each jurisdiction at the facility, local, regional, and state levels. The TSA-E HCC conducts disaster response activities in accordance with the *Trauma Service Area-E Health Care Coalition Regional Medical Response Strategy*, which can be found in Annex G Appendix G-1.

Disaster Preparedness Activities

EMResource is utilized to maintain up to date information from each perinatal facility including

but not limited to contact information, bed status, and open/closed status. A representative from each perinatal facility will report accurate information to EMResource at minimum every 24 hours and ensure correct contact information quarterly. Frequency of reporting may increase during a disaster event.

Perinatal facility leaders work with their facility emergency management staff to learn usage of **WebEOC** for disaster patient tracking. A perinatal leader should participate in their facility emergency management planning committee.

The perinatal committee will review EMResource reports monthly to ensure compliance. Compliance rates will be reported during monthly perinatal committee meetings.

The perinatal committee will participate in the annual Coalition Surge Test (or other mass patient movement-related exercises) held by the TSA-E Healthcare Coalition and the Regional Emergency Preparedness Committee (REPC). Perinatal Committee participants will then report findings/recommendations to the Perinatal Committee.

A one-page check list is available for all perinatal facilities to utilize in disaster preparation and response situations. Facilities are encouraged to utilize the checklist during drills as well. See Annex G Appendix G-2 for checklist.

Disaster Response Activities

Perinatal committee members participate in any RAC/local/state/national conference calls when a disaster occurs that will involve perinatal patients as available. The *Pediatric and Perinatal Surge Annex* is part of the *Trauma Service Area E Healthcare Coalition Regional Medical Response Strategy*, see Annex G Appendix G-3. This document describes the activities of a Pediatric/Perinatal Patient Coordination Module to guide the placement of pediatric and perinatal patients in a mass patient movement scenario. It also describes available assets, guidance, and other resources available to hospitals to respond to a Pediatric/Perinatal surge event.

The perinatal committee members support the regional plan set forth by the NCTTRAC.

Recovery activities

Perinatal facilities will make efforts to assure continuity of care for all transferred patients including follow up care, return transfers, and reunification of families.

XIX. *Research*

NCTTRAC participates in system research on an ad hoc basis. The Board of Directors is responsible for governance and release of the data for all research purposes.

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 Perinatal System Plan

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

Perinatal Committee Review Date: 07/07/2021
Comments: Reviewed and approved
NCTTRAC Staff Initials CC Chair Sign Off: Pam Gessling 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 approval - administrative update only - GM vote not needed
Staff Initials HJA Date: _____

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: 08/11/2021

Publish and Post on website
Date: 08/11/2021

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 CC Chair Sign Off: Lance Lynch Date: 07/19/2021

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

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

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