NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

Regional Trauma System Plan

Endorsed by NCTTRAC Board of Directors
Date: August 8, 2023

Approved by NCTTRAC General Membership
Date: October 10, 2023

Supersedes Regional Trauma System Plan
Date: August 9, 2022

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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, Rokwall, Somervell, Tarrant, and Wise counties.

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

Signature on File

Secretary

Date

RECORD OF CHANGES

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

The plan will undergo updates and revisions:

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

The Regional Trauma 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)
Cover	5/11/2023	1. Change dates of approval	Corrine Cooper
Table of Contents	8/2/2023	2. Remove Appendix C-2	Corrine Cooper
Section 2	5/11/2023	3. Updated Regional demographics with current 2020 census statistics	Corrine Cooper
Section 6.2	8/2/2023	4. Remove reference to WebEOC	Corrine Cooper
Section 7.2	8/2/2023	5. Remove reference to WebEOC	Corrine Cooper
Section 12.2	8/2/2023	6. Remove reference to WebEOC	Corrine Cooper

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

Table of Contents

1. SCOPE

1.1 The Trauma System Plan for Trauma Service Area (TSA) – E was developed to meet the requirements within Texas Administrative Code (TAC) § 157.123 and related Department of State Health Services (DSHS) documents forming the Regional Advisory Council (RAC) and Regional Trauma System Essential Criteria RAC Implementation Guidelines. These Guidelines define the regional emergency medical services trauma system plan, the purpose of which is to "facilitate trauma and emergency healthcare system networking within a TSA."

1.2 This plan, updated annually and approved by NCTTRAC membership, is a resource for providers of trauma care across the spectrum, from first responder organizations to rehabilitation facilities. It identifies strategies to focus diverse resources in a collective way to reduce morbidity and mortality due to trauma, and includes additional key components such as injury prevention, public and professional education, system performance improvement, and disaster preparedness.

1.3 The Regional Trauma System Plan is a Guideline and has been developed in accordance with generally accepted trauma guidelines. (https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/) In addition, the State of Texas DSHS levels of trauma care documents and rules will inform this guideline.(https://dshs.texas.gov/emstraumasystems/etrauma.shtm) 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 trauma patients. The Regional Trauma System Plan is not intended to supersede the physician's or caregiver's judgement.

2. REGIONAL DEMOGRAPHICS

2.1 Trauma Service Area E (TSA-E), known as the North Central Texas Trauma Regional Advisory Council (NCTTRAC), incorporates nineteen north central Texas rural, suburban, and urban counties: Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise counties. See *Annex A Appendix A-1* for map of region. Recent population estimates indicate that 8.4 million people reside within the 15,574.71 square miles of TSA-E, representing over 28% of the entire population of the State of Texas.

2.2 The business community includes an international airport, a multiservice regional airport, multiple small airports, a military base, a nuclear power plant, and several regional entertainment venues. Entertainment venues include an NFL stadium, an NBA/NHL arena, an MLB stadium, a multipurpose stadium, a NASCAR circuit speedway, several large-scale amusement parks, and many large convention centers that play host to cultural, business, and political events. The region has large college system campuses, multiple community colleges, and medical school campuses. TSA-E is home to an automobile assembly plant and many other national and international business headquarters. These factors must be taken into account when planning an integrated trauma system.

2.3 Dallas Fort Worth International Airport is the 3rd busiest airport in the world by aircraft movements and 2nd busiest airport in the world by passenger traffic (2021 statistics). Naval Air Station Joint Reserve Base Fort Worth (NAS JRB), also known as Carswell Field, is a military airfield located within TSA-E with 9,600 active duty, Reserve, Air National Guard, and civilian employees working at the base. The Comanche Peak Nuclear Power Plant is a two-unit nuclear-fueled power generating facility located in Somervell County.

2.4 Numerous entertainment venues are available to the residents and visitors within TSA-E including Six Flags Over Texas, the Texas State Fair at Fair Park, MayFest in Fort Worth,

and many concert settings and sports arenas. In particular, the American Airlines Center in Dallas is a venue for hockey, basketball, and arena football games as well as concerts and various other events. Globe Life Field in Arlington is home to the Texas Rangers and is located within walking distance from Six Flags and AT&T Stadium in the heart of Arlington and TSA-E. Texas Motor Speedway hosts several NASCAR series, seating over 138,000 spectators in southwestern Denton County.

2.5 As of the date of approval for this document NCTTRAC is served by the following:
- 2.5.1 Seven Level I adult trauma centers and one Level I pediatric trauma center.
- 2.5.2 Six Level II adult trauma centers and one Level II pediatric trauma center.
- 2.5.3 Eighteen Level III adult trauma centers.
- 2.5.4 Nineteen Level IV adult trauma centers and one Level IV pediatric trauma center.
- 2.5.5 Three facilities "in active pursuit" of trauma designation.
- 2.5.6 Numerous acute care hospitals. See list of all hospitals within the region in *Annex A Appendix A-2*.
- 2.5.7 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*.
- 2.5.8 For a current and complete list of all trauma designated facilities, please refer to the Texas Department of State Health Services website.

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. A list of all 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 and Finance 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. Committees may establish a "core group" by SOP to ensure balanced and appropriate participation in committee activities. NCTTRAC standing committees are open to any individual who wants to attend, with the exception of the System Performance Improvement Committee 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 trauma system planning are sent electronically to NCTTRAC membership to allow participation from interested members and to include a broad range such as physicians, nurses, EMS prehospital providers, and staff. Members have the option to attend meetings either virtually via teleconference or in person at the NCTTRAC offices.

5.2 Announcements are made at the Board of Directors meetings for maximum visibility of members to participate. To provide evidence and track actual participation in trauma

system planning, rosters are kept at NCTTRAC offices. Trauma designated facilities are required to meet minimum participation guidelines per the NCTTRAC Membership and Participation SOP.

6. SYSTEM ACCESS

6.1 All counties in the State of Texas have access to the EMS System utilizing 911 service. Additionally, all Trauma Service Area (TSA) E counties received recent and robust updates including technology for cellular location. In the event 911 is out of service, anyone needing 911 should contact their local city's non-emergency line for EMS, Fire, or Police. These numbers can generally be found on the municipality's website.

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 systems are 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 TSA-E resource and crisis applications such as EMResource and. These responses include Emergency Medical Task Force (EMTF)- 2 composed of Ambulance Strike Teams (AST) and task forces with Ambulance Strike Team Leaders (ASTL), AMBUSes, Mobile Medical Units (MMU), RN Strike Teams and Medical-Incident Support Team (M-IST) personnel, which are also coordinated with DSHS and other EMTFs around the state. NCTTRAC is the lead agency for EMTF-2, which covers not only TSA-E but also TSA-C (Abilene) and TSA-D (Wichita Falls).

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 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. 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 two Mobile Emergency Response Communications (MERC) trailers that can be deployed to provide temporary communications capabilities. 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 that 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.

8. MEDICAL OVERSIGHT

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

8.2 NCTTRAC has an established Medical Directors Committee, which meets quarterly to provide guidance in the development and review of hospital and pre-hospital assessment tools, regional system plans, and triage and transport guidelines. The committee is comprised of the elected committee medical directors of the following committees: Air Medical, Cardiac, Emergency Department Operations, Emergency Medical Services, Pediatric, Perinatal, Regional Emergency Preparedness (Disaster), Stroke, and Trauma. Each Medical Director is responsible for participating with and providing medical oversight for their service line committee, as well as collaborating with other RAC committees and Medical Directors.

9. PRE-HOSPITAL TRIAGE CRITERIA

9.1 The survival of the trauma patient is dependent upon rapid recognition/management of life-threatening injuries and rapid transport to an appropriate facility. The NCTTRAC Trauma 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 most recent national Trauma Center Field Triage Criteria outlined in the *American College of Surgeons, Resources for Optimal Care of the Injured Patient* [1], and the Centers for Disease Control (CDC). The Trauma Triage and Transport Guidelines are reviewed annually and revised as necessary by the EMS and Trauma Committees with a final review and recommendation by the Medical Directors Committee and endorsement by the Board of Directors. See in *Annex D Appendix D-1: NCTTRAC Trauma Triage and Transport Guidelines.* Regional air transport resources may be appropriately utilized in order to reduce delays in providing optimal trauma care. Refer to *Aircraft Utilization Guidelines*. These documents are also posted on the NCTTRAC website at www.NCTTRAC.org.

10. DIVERSION POLICIES AND BYPASS PROTOCOLS

10.1 As the result of a cooperative effort between NCTTRAC and the Dallas Fort Worth Hospital Council (DFWHC), there is no longer an official category of "divert" in Trauma Service Area (TSA) E. Facilities may communicate information to EMS that may be relevant in the decision to transport to their destination, such as ED saturation, but may not post a "divert" status or comment within EMResource.

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

decisions. EMResource is used to report on the saturation level of a facility's Emergency Department, the overall status of a facility's Emergency Department, specific clinical service capabilities, facility bed availability, and interfacility transfer availability for MedSurg & ICU patients.

10.3 The *Hospital Intake Status* in EMResource is the official method for hospitals to communicate their ED status to pre-hospital partners.

10.3.1 If a hospital can accept incoming EMS traffic with no restrictions and without extended ambulance patient offload times, they should list their status as **Open.** If a facility's Hospital Intake Status is **Open**, they must update their status at least once every 24 hours.

10.3.2 Hospitals experiencing high levels of patient surge can change their Hospital Intake Status to **Advisory – ED Surge**; this notifies EMS agencies to anticipate extended patient off-load times and asks them to consider the hospital's current status when making patient destination decisions. When EMS sees that a potential destination hospital is on **Advisory – ED Surge**, they should consider whether the patient will be better served going to an alternate facility when deciding where to take the patient.

10.3.3 Hospitals unable to accept certain types of patients due to a clinical service closure can change their Hospital Intake Status to Advisory – Capability and list the types of patients they are unable to accept in the comments. When EMS sees that a potential destination hospital is on **Advisory – Capability**, they should reroute patients of the types listed in the comments to a facility that has the capability to treat that patient. Hospitals can pre-select if they are unable to accept Trauma, Stroke, or STEMI patients, and may utilize an "Other" category for all other patient types.

10.3.4 Hospitals experiencing an internal or external environmental disaster that prevents them from safely accepting any new patients can set their Hospital Intake Status to **Closed**. This should only be used when there is an external hazard at the facility that presents a danger to the patient (i.e. fire, flooding, active shooter); hospitals cannot go on **Closed** due to extreme patient surge or hospital staffing shortages.

10.4 In addition to Hospital Intake Status, NCTTRAC has integrated the use of National Emergency Department Over Crowding Score (NEDOCS) within EMResource for hospitals to help determine emergency department saturation and reporting. Hospitals with emergency departments are required to update their NEDOCS once every 6 hours; if they do not, the system marks their NEDOCS as "Overdue". EMS providers are required to monitor the NEDOCS of facilities in their service area. This can be accomplished by either actively monitoring EMResource on the website or mobile application or by receiving notifications when the NEDOCS goes above a certain threshold. A high NEDOCS is generally associated with longer patient offload times for EMS.

10.5 Trauma Centers can note specific trauma-related service capabilities, such as Hand, Replant, Burn etc., using the appropriate EMResource status types. A full list of Trauma-related status fields can be found in EMResource under the view titled "TSA-E: Trauma".

10.6 All hospitals and EMS providers have the ability to create event notifications in EMResource. These events are used to inform the emergency healthcare partners in TSA-E about any incidents or occurrences that might affect the overall emergency healthcare system in TSA-E. 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.

10.7 Proper posting on EMResource is considered the official and standard mechanism for notification in TSA-E. All EMS services are expected to monitor EMResource at all times for current system information. An EMS 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.

10.8 A full listing of EMResource status types, policies, and procedures in TSA-E can be found in *Annex E: TSA-E 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 TSA-E.

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

12. FACILITY TRIAGE CRITERIA

12.1 Patients will be triaged to the appropriate trauma facility, following the NCTTRAC Trauma Triage and Transport guidelines, with injured patients being transported to centers with appropriate capabilities. Each regional trauma center defines its own internal facility triage criteria. There is currently not a regional standard for internal facility triage criteria. Some centers have a single level trauma activation while others have multi-tiered and/or specialty population specific criteria.

12.2 The ability of trauma facilities to monitor their resource capabilities is through NCTTRAC's web-based resource and crisis applications, such as EMResource. Individual trauma centers are responsible for determining if a patient exceeds the center's available resources and maintaining current capabilities, including the availability of call coverage for surgical specialties. Communication of hospital capabilities to pre-hospital and hospital providers is addressed through EMResource.

13. INTER-HOSPITAL TRANSFERS

13.1 Indications for Patient Transfer

13.1.1 Injured 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 NCTTRAC Trauma Transfer Guidelines (See *Annex D Appendix D-2*) identifies injury patterns that would benefit from a higher level of care and thus should be transferred to a Level I or Level II Trauma Center. Injury criteria includes, but is not limited to the following:

13.1.2 Neurosurgical:
- 13.1.2.1 Open skull fractures
- 13.1.2.2 Lateralizing signs
- 13.1.2.3 Spinal Cord injuries

13.1.3 Thoracic:
- 13.1.3.1 Major chest wall injury
- 13.1.3.2 Signs suggesting mediastinal injury
- 13.1.3.3 Continued blood loss from chest injury

13.1.4 Extremity Injuries:
- 13.1.4.1 Fractures with evidence of vascular injury
- 13.1.4.2 Open long bone fractures

13.1.5 Pelvis:
- 13.1.5.1 Unstable ring fracture
- 13.1.5.2 Pelvic injuries with ongoing evidence of blood loss
- 13.1.5.3 Open pelvic injury

13.1.6 Multi-System:
- 13.1.6.1 Multiple long bone fractures
- 13.1.6.2 Burns with other associated injuries
- 13.1.6.3 Injury to two or more body systems

13.1.7 Comorbid Issues:
- 13.1.7.1 Greater than 55 years old
- 13.1.7.2 Less than 5 years old
- 13.1.7.3 Cardiac or respiratory disease
- 13.7.7.4 Pregnancy

13.1.8 Pediatric*:
- 13.1.8.1 Intracranial hemorrhage
- 13.1.8.2 Suspected abuse and neglect
- 13.1.8.3 *Age <15 according to ACS defined criteria

13.2 Time to Transfer

13.2.1 Access to timely trauma care is a system goal in TSA E. The focus should be to reduce time from onset of injury 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:
- 13.2.1.1 Maintenance and protection of airway
- 13.2.1.2 Decompression of tension and simple pneumothorax
- 13.2.1.3 Establishment of redundant large bore IV or IO
- 13.2.1.4 Maintenance of normothermia
- 13.2.1.5 Decompression of stomach if indicated, especially if transported by air

13.2.2 Attempts to stabilize the patient should be continued until the transfer is completed; however, the most severely injured patients may not be completely stabilized prior to transfer. Inability to completely stabilize a patient is not a contraindication of transfer.

13.2.3 Per NCTTRAC Trauma SPI Performance Indicators and DSHS Trauma Facility

Audit Filters:

13.2.3.1 Major or severe trauma patients should be transferred to an appropriate higher level of designated trauma facility within 2 hours of arrival in the ED (single system injuries with ISS less than 10 excluded).

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

13.2.3.3 Inter-facility transfers should not occur more than once per patient. In the event two or more transfers occur before the patient reaches definitive care, a referral shall be made to review by the NCTTRAC SPI Committee.

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

13.2.5 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.

13.2.6 Physician to physician communication is essential between the initial facility and the accepting referral center. Physicians at the comprehensive and major trauma centers should be available for consultation with the sending provider prior to transfer. Early communication with the receiving trauma surgeons can streamline the transfer process and satisfies one of the EMTALA requirements for transfer.

13.3 Transfer Agreements

13.3.1 Trauma centers are required to have a process to expedite the transfer of applicable major and severe trauma patients to a higher level of care to include written guidelines, written transfer agreements, and/or the NCTTRAC Trauma Transfer Guidelines. Level I and II trauma facilities may have written transfer agreements with other Level I and II facilities for specialty populations such as pediatrics, burn, replant, etc.

13.3.2 Coordination of the interfacility transfer is the responsibility of the initial facility. Transfers may be coordinated directly with referring hospitals through transfer centers or directly with accepting providers. Transfer Center phone numbers for Level I and II Trauma centers in TSA-E can be found within the NCTTRAC Trauma Transfer Guidelines (*Annex D Appendix D-2*).

13.3.3 As referenced in the NCTTRAC Triage and Transport Guidelines (*Annex D Appendix D-1*), if a patient and/or family refuses transfer to the accepting referral facility or higher level of care, an emergency physician or trauma surgeon at the referral facility will be notified of the situation. Any refusal shall be documented on the patient record.

13.4 Interfacility Transfer Communication

13.4.1 Hospitals should list their ability to accept interfacility transfers in EMResource using the statuses called *Status: MedSurg* and *Status: ICU*. Hospitals can show that their status to accept MedSurg or ICU level transfers is **Available**, **Available**

w/Restrictions (can only accept certain transfers/case-by-base basis), or **Unavailable** (cannot accept any transfers). Hospitals who list their status as **Available w/Restrictions** or **Unavailable** must update the status every 12 hours.

14. PLAN FOR DESIGNATION OF POTENTIAL TRAUMA FACILITIES

14.1 As required by DSHS, Trauma facilities within the TSA E region have an obligation to maintain NCTTRAC membership in good standing, as well as meet active participation requirements. Facilities seeking In Active Pursuit (IAP) trauma designation status shall notify DSHS, NCTTRAC, and local providers of IAP intent.

14.2 Trauma Facilities that cannot meet an essential criterion must notify the Office of EMS/Trauma Systems, NCTTRAC, all other affected RACs and EMS agencies, and healthcare facilities to which it customarily transfers-out trauma patients or from which it customarily receives trauma transfers-in.

14.3 DSHS defines the critical elements that must be reported to the State as the following:

- 14.3.1 Loss of Trauma Medical Director (all levels)
- 14.3.2 Loss of Trauma Program Manager / Trauma coordinator (all levels)
- 14.3.3 Loss of Neurosurgery Coverage (Level I & II)
- 14.3.4 Loss of Orthopedic Coverage (Level I, II, & III)
- 14.3.5 Loss of general / trauma surgery capabilities (all levels)
- 14.3.6 Loss of Trauma Registry (all levels)
- 14.3.7 Loss of anesthesiology (Level I, II, & III)
- 14.3.8 Loss of ability to provide acute trauma resuscitation and critical care stabilization

14.4 In support of the facility, the NCTTRAC Trauma Committee Systems Performance Improvement (SPI) Subcommittee will help determine appropriate resolution efforts. The facility will notify affected EMS agencies of the limitations of the facility.

15. SYSTEM PERFORMANCE IMPROVEMENT PROGRAM

15.1 The NCTTRAC Trauma System Performance Improvement (SPI) Subcommittee is 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.

15.2 The Trauma SPI Subcommittee will notify the Trauma Committee Chair of any trauma cases or system issues that have been reported and are in need of review. The Trauma SPI focus group, comprised of the Trauma Committee Chair, Chair Elect, Medical Director, and two elected committee members as approved by the committee. The Trauma SPI focus group will review each reported case/issue in a closed session and make recommendations to the Trauma Committee, the Executive Committee, and as appropriate, the Board of Directors for determinations and action plans.

15.3 Data Collection

- 15.3.1 Regional data collected and managed by an outsourced third-party service provider is utilized to support Trauma Committee goals and performance improvement initiatives. Member hospitals with a capable registry are required by the Trauma Committee to submit data through the regional registry to support a comprehensive and useful data set. Resources are made available through

NCTTRAC to facilitate the training of individual members on data submissions. The regional registry utilizes the National Trauma Data Bank (NTDB) inclusion criteria and data set.

15.3.2 Other NCTTRAC committees may request registry data. All data requests should be submitted through the NCTTRAC ticket system available on the website. The Executive Committee will approve/deny all data requests. If approved, the Chair or Chair Elect of the committee requesting the data will be required to share the results with the Board of Directors.

15.4 Trauma System Performance Improvement

15.4.1 The goal of Trauma System Performance Improvement is to reduce injury and death from trauma in TSA-E by identifying educational needs and opportunities for improvement in trauma patient care and system processes.

15.4.2 The Trauma Committee collaborates with the System Performance Improvement (SPI) Committee to define committee goals and trauma performance indicators for the region. The Trauma Committee standards and performance indicators are developed from committee consensus, evidence-based practice guidelines, the *American College of Surgeons Resources for Optimal Care of the Injured Patient*[1], and DSHS Trauma Facility Designation rules/requirements. All designated trauma centers must comply and adhere to the standards of care determined by their verifying and designating agencies.

15.4.3 The Trauma Committee monitors regional trauma performance indicators and goals on a monthly dashboard which shall be presented to the committee and the Board of Directors. The trauma performance indicators and goals are reviewed/revised annually and defined in the Trauma Committee SOP, which is attached to this plan as *Annex B Appendix B-4*.

15.4.4 A Trauma Registry Workgroup has been established by the Trauma Committee to assist with evaluating regional data, identifying data needs, providing education to other registrars, and sharing best practices.

16. REHABILITATION

16.1 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.

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

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

17. INJURY PREVENTION AND PUBLIC EDUCATION

17.1 Unintentional and intentional injuries are a significant public health concern within the State of Texas. Trauma systems must develop prevention strategies that help control injury as part of an integrated, coordinated, and inclusive trauma system.

17.2 Prevention 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 increased use of seatbelts), that have measurable outcomes in a specific timeline. Staffing and community partners are essential for success.

17.3 The NCTTRAC Public Education and Injury Prevention committee serves as a resource to identify prevention programs, events, and other prevention resources available to members and the community in TSA-E. Regional, state, and national data will be utilized to determine current trauma trends and address specific priorities. Workgroups and coalitions may also be developed to focus on specific mechanisms and/or populations for educational opportunities.

18. COALITION AND PARTNERSHIP BUILDING

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

18.2 Currently most initiatives around Injury Prevention are carried out by members of NCTTRAC hospital and prehospital providers. NCTTRAC supports collaborative partnerships with community leaders to assist with injury awareness and prevention activities.

19. DISASTER PREPAREDNESS AND RESPONSE

19.1 Disaster preparedness and response activities among the emergency healthcare system in TSA-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:

19.1.1 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 TSA-E.

19.1.2 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.)

19.1.3 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.

19.2 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*.

19.3 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 TSA-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.

19.4 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.

19.5 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-2*.

20. RESEARCH

20.1 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.

21. REFERENCES

21.1 American College of Surgeons, Committee on Trauma. (2022). Resources for optimal care of the injured patient.

NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

Regional Trauma System Plan

Endorsed by NCTTRAC Board of Directors
Date: ~~July 12, 2022~~TBD

Approved by NCTTRAC General Membership
Date: ~~August 9, 2022~~TBD

Supersedes Regional Trauma System Plan
Date: ~~July,~~July 12, 2022

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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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Admin@NCTTRAC.org

APPROVAL AND IMPLEMENTATION

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

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

_____ _____

Secretary Date

RECORD OF CHANGES

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

The plan will undergo updates and revisions:

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

The Regional Trauma 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)
Cover	~~12/1/2021~~5/11/2023	1. ~~Removed year from title~~Change dates of approval	Corrine Cooper
Table of Contents~~Pg. 6 Section 1.3~~	~~5/19/2022~~8/2/2023	2. ~~Added verbiage regarding guideline development and intention~~Remove Appendix C-2	Corrine Cooper~~Corrine Cooper~~
Section 2~~Pg 6, Section 2.5~~	5/11/2023~~12/1/2021~~	~~3.~~ Updated Regional demographics with current 2020 census statistics~~Updated list of designated trauma facilities.~~ ~~4.~~3. ~~Added hyperlink to refer current list of designated facilities on~~	Corrine Cooper~~Corrine Cooper~~
Section 6.2~~Pg 8, Section 6.1~~	8/2/2023~~5/19/2022~~	~~5.~~4. ~~Updated verbiage regarding 911 power outages~~Remove reference to WebEOC	~~Jim Dickerson~~Corrine Cooper
Section 7.2~~Pg 9, Section 10~~	~~1/17/2022~~8/2/2023	~~6.~~5. ~~Updated Diversion and Bypass Policies to accurately reflect current policies within the region.~~Remove reference to	Corrine Cooper~~Jacob Seil~~
Section 12.2~~Pg 13, Section 13.2.3.1~~	~~12/1/2021~~8/2/2023	~~7.~~6. ~~Updated SPI Indicators to reflect FY22 SOP~~Remove reference to WebEOC	~~Corrine Cooper~~Corrine Cooper
~~Pg. 13, Section 13.4~~	~~1/17/2022~~	~~8.~~7. ~~Interfacility Transfer Communication statuses updated to reflect current definitions within EMResource~~	~~Jacob Seil~~
~~Pg. 14, Section 14.3~~	~~6/6/2022~~	~~9.~~8. ~~Updated essential criteria to reflect DSHS TAC~~	~~Corrine Cooper~~

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 The Trauma System Plan for Trauma Service Area (TSA) – E was developed to meet the requirements within Texas Administrative Code (TAC) § 157.123 and related Department of State Health Services (DSHS) documents forming the Regional Advisory Council (RAC) and Regional Trauma System Essential Criteria RAC Implementation Guidelines. These Guidelines define the regional emergency medical services trauma system plan, the purpose of which is to "facilitate trauma and emergency healthcare system networking within a TSA."

1.2 This plan, updated annually and approved by NCTTRAC membership, is a resource for providers of trauma care across the spectrum, from first responder organizations to rehabilitation facilities. It identifies strategies to focus diverse resources in a collective way to reduce morbidity and mortality due to trauma, and includes additional key components such as injury prevention, public and professional education, system performance improvement, and disaster preparedness.

1.3 The Regional Trauma System Plan is a Guideline and has been developed in accordance with generally accepted trauma guidelines. (https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/) In addition, the State of Texas DSHS levels of trauma care documents and rules will inform this guideline.(https://dshs.texas.gov/emstraumasystems/etrauma.shtm) 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 trauma patients. The Regional Trauma System Plan is not intended to supersede the physician's or caregiver's judgement.

2. REGIONAL DEMOGRAPHICS

2.1 Trauma Service Area E (TSA-E), known as the North Central Texas Trauma Regional Advisory Council (NCTTRAC), incorporates nineteen north central Texas rural, suburban, and urban counties: Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise counties. See *Annex A Appendix A-1* for map of region. Recent population estimates indicate that ~~7.97~~8.4 million people reside within the 15,574.71 square miles of TSA-E, representing over 2~~87~~% of the entire population of the State of Texas.

2.2 The business community includes an international airport, a multiservice regional airport, multiple small airports, a military base, a nuclear power plant, and several regional entertainment venues. Entertainment venues include an NFL stadium, an NBA/NHL arena, an~~an~~ MLB stadium, a multipurpose stadium, a NASCAR circuit speedway, several large-scale amusement parks, and many large convention centers that play host to cultural, business, and political events. The region has large college system campuses, multiple community colleges, and medical school campuses. TSA-E is home to an automobile assembly plant and many other national and international business headquarters. ~~–~~These factors must be taken into account when planning an integrated trauma system.

2.3 Dallas Fort Worth International Airport is the 3rd busiest airport in the world by aircraft movements and 2nd~~10th~~ busiest airport in the world by passenger traffic (2021~~19~~ statistics). Naval Air Station Joint Reserve Base Fort Worth (NAS JRB), also known as Carswell Field, is a military airfield located within TSA-E with 9~~11~~,6~~3~~00 active duty, Reserve, Air National Guard, and civilian employees working at the base. ~~–~~ The Comanche Peak Nuclear Power Plant is a two-unit nuclear-fueled power generating facility located in Somervell County.

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2.4 Numerous entertainment venues are available to the residents and visitors within TSA-E including Six Flags Over Texas, the Texas State Fair at Fair Park, MayFest in Fort Worth,

and many concert settings and sports arenas. In particular, the American Airlines Center in Dallas is a venue for hockey, basketball, and arena football games as well as concerts and various other events. Globe Life Field in Arlington is home to the Texas Rangers and is located within walking distance from Six Flags and AT&T Stadium in the heart of Arlington and TSA-E. Texas Motor Speedway hosts several NASCAR series, seating over 138,000 spectators in southwestern Denton County.

2.5 As of the date of approval for this document NCTTRAC is served by the following:

- 2.5.1 Seven~~ix~~ Level I adult trauma centers and one Level I pediatric trauma center.
- 2.5.2 Six~~Five~~ Level II adult trauma centers and one Level II pediatric trauma center.
- 2.5.3 ~~Seventeen~~ Eighteen Level III adult trauma centers.
- 2.5.4 ~~Nineteen~~ Nineteen Level IV adult trauma centers and one Level IV pediatric trauma center.
- 2.5.5 Three~~Five~~ facilities "in active pursuit" of trauma designation.
- 2.5.6 Numerous acute care hospitals. See list of all hospitals within the region in *Annex A Appendix A-2*.
- 2.5.7 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*.
- 2.5.8 For a current and complete list of all trauma designated facilities, please refer to the Texas Department of State Health Services website.

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. A list of all 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 and Finance 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. Committees may establish a "core group" by SOP to ensure balanced and appropriate participation in committee activities. NCTTRAC standing committees are open to any individual who wants to attend, with the exception of the System Performance Improvement Committee 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 trauma system planning are sent electronically to NCTTRAC membership to allow participation from interested members and to include a broad range such as physicians, nurses, EMS prehospital providers, and staff. Members have the option~~capability~~ to ~~call in through both audio and visual forms of technology~~attend meetings either virtually via teleconference ~~the Zoom platform~~ or in person at the NCTTRAC offices.

5.2 Announcements are made at the Board of Directors meetings for maximum visibility of members to participate. To provide evidence and track actual participation in trauma system planning, rosters are kept at NCTTRAC offices. Trauma designated facilities are required to meet minimum participation guidelines per the NCTTRAC Membership and Participation SOP.

6. SYSTEM ACCESS

6.1 All counties in the State of Texas have access to the EMS System utilizing 911 service. Additionally, all Trauma Service Area (TSA) E counties received recent and robust updates including technology for cellular location. In the event 911 is out of service, anyone needing 911 should contact their local city's non-emergency line for EMS, Fire, or Police. These numbers can generally be found on the municipality's website.

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 systems are 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 TSA-E resource and crisis applications such as EMResource ~~and WebEOC~~. ~~—~~ These responses include Emergency Medical Task Force (EMTF)- 2 composed of Ambulance Strike Teams (AST) and task forces with Ambulance Strike Team Leaders (ASTL), AMBUSes, Mobile Medical Units (MMU), RN Strike Teams and Medical-Incident Support Team (M-IST) personnel, which are also coordinated with DSHS and other EMTFs around the state. NCTTRAC is the lead agency for EMTF-2, which covers not only TSA-E but also TSA-C (Abilene) and TSA-D (Wichita Falls).

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 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.~~ 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 two Mobile Emergency Response Communications (MERC) trailers that can be deployed to provide temporary communications capabilities. 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 that 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.

8. MEDICAL OVERSIGHT

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

8.2 NCTTRAC has an established Medical Directors Committee, which meets quarterly to provide guidance in the development and review of hospital and pre-hospital assessment tools, regional system plans, and triage and transport guidelines. The committee is comprised of the elected committee medical directors of the following committees: Air Medical, Cardiac, Emergency Department Operations, Emergency Medical Services, Pediatric, Perinatal, Regional Emergency Preparedness (Disaster), Stroke, and Trauma. Each Medical Director is responsible for participating with and providing medical oversight for their service line committee, as well as collaborating with other RAC committees and Medical Directors.

9. PRE-HOSPITAL TRIAGE CRITERIA

9.1 The survival of the trauma patient is dependent upon rapid recognition/management of life-threatening injuries and rapid transport to an appropriate facility. The NCTTRAC Trauma 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 most recent national Trauma Center Field Triage Criteria outlined in the *American College of Surgeons, Resources for Optimal Care of the Injured Patient* [1], and the Centers for Disease Control (CDC). The Trauma Triage and Transport Guidelines are reviewed annually and revised as necessary by the EMS and Trauma Committees with a final review and recommendation by the Medical Directors Committee and endorsement by the Board of Directors. See in *Annex D Appendix D-1: NCTTRAC Trauma Triage and Transport Guidelines.* Regional air transport resources may be appropriately utilized in order to reduce delays in providing optimal trauma care. Refer to *Aircraft Utilization Guidelines*. These documents are also posted on the NCTTRAC website at www.NCTTRAC.org.

10. DIVERSION POLICIES AND BYPASS PROTOCOLS

10.1 As the result of a cooperative effort between NCTTRAC and the Dallas Fort Worth Hospital Council (DFWHC), there is no longer an official category of "divert" in Trauma

Service Area (TSA) E. Facilities may communicate information to EMS that may be relevant in the decision to transport to their destination, such as ED saturation, but may not post a "divert" status or comment within EMResource.

10.2 EMResource is the primary tool in TSA-E for hospitals to communicate with EMS providers about any facility issues that may be relevant to EMS patient destination decisions. EMResource is used to report on the saturation level of a facility's Emergency Department, the overall status of a facility's Emergency Department, specific clinical service capabilities, facility bed availability, and interfacility transfer availability for MedSurg & ICU patients.

10.3 The *Hospital Intake Status* in EMResource is the official method for hospitals to communicate their ED status to pre-hospital partners.

10.3.1 If a hospital can accept incoming EMS traffic with no restrictions and without extended ambulance patient offload times, they should list their status as **Open**. If a facility's *Hospital Intake Status* is **Open**, they must update their status at least once every 24 hours.

10.3.2 Hospitals experiencing high levels of patient surge can change their *Hospital Intake Status* to **Advisory – ED Surge**; this notifies EMS agencies to anticipate extended patient off-load times and asks them to consider the hospital's current status when making patient destination decisions. When EMS sees that a potential destination hospital is on **Advisory – ED Surge**, they should consider whether the patient will be better served going to an alternate facility when deciding where to take the patient.

10.3.3 Hospitals unable to accept certain types of patients due to a clinical service closure can change their *Hospital Intake Status* to **Advisory – Capability** and list the types of patients they are unable to accept in the comments. When EMS sees that a potential destination hospital is on Advisory – Capability, they should reroute patients of the types listed in the comments to a facility that has the capability to treat that patient. Hospitals can pre-select if they are unable to accept Trauma, Stroke, or STEMI patients, and may utilize an "Other" category for all other patient types.

10.3.4 Hospitals experiencing an internal or external environmental disaster that prevents them from safely accepting any new patients can set their *Hospital Intake Status* to **Closed**. This should only be used when there is an external hazard at the facility that presents a danger to the patient (i.e. fire, flooding, active shooter); hospitals cannot go on **Closed** due to extreme patient surge or hospital staffing shortages.

10.4 In addition to *Hospital Intake* Status, NCTTRAC has integrated the use of National Emergency Department Over Crowding Score (NEDOCS) within EMResource for hospitals to help determine emergency department saturation and reporting. Hospitals with emergency departments are required to update their NEDOCS once every 6 hours; if they do not, the system marks their NEDOCS as "Overdue". EMS providers are required to monitor the NEDOCS of facilities in their service area. This can be accomplished by either actively monitoring EMResource on the website or mobile application or by receiving notifications when the NEDOCS goes above a certain threshold. A high NEDOCS is generally associated with longer patient offload times for EMS.

10.5 Trauma Centers can note specific trauma-related service capabilities, such as Hand, Replant, Burn etc., using the appropriate EMResource status types. A full list of Trauma-related status fields can be found in EMResource under the view titled "TSA-E: Trauma".

10.6 All hospitals and EMS providers have the ability to create event notifications in EMResource. These events are used to inform the emergency healthcare partners in TSA-E about any incidents or occurrences that might affect the overall emergency

healthcare system in TSA-E. 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.

10.7 Proper posting on EMResource is considered the official and standard mechanism for notification in TSA-E. All EMS services are expected to monitor EMResource at all times for current system information. An EMS 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.

10.8 A full listing of EMResource status types, policies, and procedures in TSA-E can be found in *Annex E: TSA-E 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 TSA-E.

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

12. FACILITY TRIAGE CRITERIA

12.1 Patients will be triaged to the appropriate trauma facility, following the NCTTRAC Trauma Triage and Transport guidelines, with injured patients being transported to centers with appropriate capabilities. Each regional trauma center defines its own internal facility triage criteria. There is currently not a regional standard for internal facility triage criteria. Some centers have a single level trauma activation while others have multi-tiered and/or specialty population specific criteria.

12.2 The ability of trauma facilities to monitor their resource capabilities is through NCTTRAC's web-based resource and crisis applications, such as EMResource ~~and WebEOC~~. Individual trauma centers are responsible for determining if a patient exceeds the center's available resources and maintaining current capabilities, including the availability of call coverage for surgical specialties. Communication of hospital capabilities to pre-hospital and hospital providers is addressed through EMResource.

13. INTER-HOSPITAL TRANSFERS

13.1 Indications for Patient Transfer

13.1.1 Injured 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 NCTTRAC Trauma Transfer Guidelines (See *Annex D Appendix D-2*) identifies injury patterns that would benefit from a higher level of care and thus should be

transferred to a Level I or Level II Trauma Center. Injury criteria includes, but is not limited to the following:

- 13.1.2 Neurosurgical:
  - 13.1.2.1 Open skull fractures
  - 13.1.2.2 Lateralizing signs
  - 13.1.2.3 Spinal Cord injuries
- 13.1.3 Thoracic:
  - 13.1.3.1 Major chest wall injury
  - 13.1.3.2 Signs suggesting mediastinal injury
  - 13.1.3.3 Continued blood loss from chest injury
- 13.1.4 Extremity Injuries:
  - 13.1.4.1 Fractures with evidence of vascular injury
  - 13.1.4.2 Open long bone fractures
- 13.1.5 Pelvis:
  - 13.1.5.1 Unstable ring fracture
  - 13.1.5.2 Pelvic injuries with ongoing evidence of blood loss
  - 13.1.5.3 Open pelvic injury
- 13.1.6 Multi-System:
  - 13.1.6.1 Multiple long bone fractures
  - 13.1.6.2 Burns with other associated injuries
  - 13.1.6.3 Injury to two or more body systems
- 13.1.7 Comorbid Issues:
  - 13.1.7.1 Greater than 55 years old
  - 13.1.7.2 Less than 5 years old
  - 13.1.7.3 Cardiac or respiratory disease
  - 13.7.7.4 Pregnancy
- 13.1.8 Pediatric*:
  - 13.1.8.1 Intracranial hemorrhage
  - 13.1.8.2 Suspected abuse and neglect
  - 13.1.8.3 *Age <15 according to ACS defined criteria

13.2 Time to Transfer

- 13.2.1 Access to timely trauma care is a system goal in TSA E. The focus should be to reduce time from onset of injury 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:
  - 13.2.1.1 Maintenance and protection of airway
  - 13.2.1.2 Decompression of tension and simple pneumothorax
  - 13.2.1.3 Establishment of redundant large bore IV or IO
  - 13.2.1.4 Maintenance of normothermia
  - 13.2.1.5 Decompression of stomach if indicated, especially if transported by air
- 13.2.2 Attempts to stabilize the patient should be continued until the transfer is completed; however, the most severely injured patients may not be completely stabilized prior to transfer. Inability to completely stabilize a patient is not a

contraindication of transfer.

13.2.3 Per NCTTRAC Trauma SPI Performance Indicators and DSHS Trauma Facility Audit Filters:

13.2.3.1 Major or severe trauma patients should be transferred to an appropriate higher level of designated trauma facility within 2 hours of arrival in the ED (single system injuries with ISS less than 10 excluded).

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

13.2.3.3 Inter-facility transfers should not occur more than once per patient. In the event two or more transfers occur before the patient reaches definitive care, a referral shall be made to review by the NCTTRAC SPI Committee.

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

13.2.5 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.

13.2.6 Physician to physician communication is essential between the initial facility and the accepting referral center. Physicians at the comprehensive and major trauma centers should be available for consultation with the sending provider prior to transfer. Early communication with the receiving trauma surgeons can streamline the transfer process and satisfies one of the EMTALA requirements for transfer.

13.3 Transfer Agreements

13.3.1 Trauma centers are required to have a process to expedite the transfer of applicable major and severe trauma patients to a higher level of care to include written guidelines, written transfer agreements, and/or the NCTTRAC Trauma Transfer Guidelines. Level I and II trauma facilities may have written transfer agreements with other Level I and II facilities for specialty populations such as pediatrics, burn, replant, etc.

13.3.2 Coordination of the interfacility transfer is the responsibility of the initial facility. Transfers may be coordinated directly with referring hospitals through transfer centers or directly with accepting providers. Transfer Center phone numbers for Level I and II Trauma centers in TSA-E can be found within the NCTTRAC Trauma Transfer Guidelines (*Annex D Appendix D-2*).

13.3.3 As referenced in the NCTTRAC Triage and Transport Guidelines (*Annex D Appendix D-1*), if a patient and/or family refuses transfer to the accepting referral facility or higher level of care, an emergency physician or trauma surgeon at the referral facility will be notified of the situation. Any refusal shall be documented on the patient record.

13.4 Interfacility Transfer Communication

13.4.1 Hospitals should list their ability to accept interfacility transfers in EMResource

using the statuses called *Status: MedSurg* and *Status: ICU*. Hospitals can show that their status to accept MedSurg or ICU level transfers is **Available**, **Available w/Restrictions** (can only accept certain transfers/case-by-base basis), or **Unavailable** (cannot accept any transfers). Hospitals who list their status as **Available w/Restrictions** or **Unavailable** must update the status every 12 hours.

14. PLAN FOR DESIGNATION OF POTENTIAL TRAUMA FACILITIES

14.1 As required by DSHS, Trauma facilities within the TSA E region have an obligation to maintain NCTTRAC membership in good standing, as well as meet active participation requirements. Facilities seeking In Active Pursuit (IAP) trauma designation status shall notify DSHS, NCTTRAC, and local providers of IAP intent.

14.2 Trauma Facilities that cannot meet an essential criterion must notify the Office of EMS/Trauma Systems, NCTTRAC, all other affected RACs and EMS agencies, and healthcare facilities to which it customarily transfers-out trauma patients or from which it customarily receives trauma transfers-in.

14.3 DSHS defines the critical elements that must be reported to the State as the following:

14.3.1 Loss of Trauma Medical Director (all levels)
14.3.2 Loss of Trauma Program Manager / Trauma coordinator (all levels)
14.3.3 Loss of Neurosurgery Coverage (Level I & II)
14.3.4 Loss of Orthopedic Coverage (Level I, II, & III)
14.3.5 Loss of general / trauma surgery capabilities (all levels)
14.3.6 Loss of Trauma Registry (all levels)
14.3.7 Loss of anesthesiology (Level I, II, & III)
14.3.8 Loss of ability to provide acute trauma resuscitation and critical care stabilization

14.4 In support of the facility, the NCTTRAC Trauma Committee Systems Performance Improvement (SPI) Subcommittee will help determine appropriate resolution efforts. The facility will notify affected EMS agencies of the limitations of the facility.

15. SYSTEM PERFORMANCE IMPROVEMENT PROGRAM

15.1 The NCTTRAC Trauma System Performance Improvement (SPI) Subcommittee is 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.

15.2 The Trauma SPI Subcommittee will notify the Trauma Committee Chair of any trauma cases or system issues that have been reported and are in need of review. The Trauma SPI focus group, comprised of the Trauma Committee Chair, Chair Elect, Medical Director, and two elected committee members as approved by the committee. The Trauma SPI focus group will review each reported case/issue in a closed session and make recommendations to the Trauma Committee, the Executive Committee, and as appropriate, the Board of Directors for determinations and action plans.

15.3 Data Collection

15.3.1 Regional data collected and managed by an outsourced third-party service provider is utilized to support Trauma Committee goals and performance improvement initiatives. Member hospitals with a capable registry are required

by the Trauma Committee to submit data through the regional registry to support a comprehensive and useful data set. Resources are made available through NCTTRAC to facilitate the training of individual members on data submissions. The regional registry utilizes the National Trauma Data Bank (NTDB) inclusion criteria and data set.

15.3.2 Other NCTTRAC committees may request registry data. All data requests should be submitted through the NCTTRAC ticket system available on the website. The Executive Committee will approve/deny all data requests. If approved, the Chair or Chair Elect of the committee requesting the data will be required to share the results with the Board of Directors.

15.4 Trauma System Performance Improvement

15.4.1 The goal of Trauma System Performance Improvement is to reduce injury and death from trauma in TSA-E by identifying educational needs and opportunities for improvement in trauma patient care and system processes.

15.4.2 The Trauma Committee collaborates with the System Performance Improvement (SPI) Committee to define committee goals and trauma performance indicators for the region. The Trauma Committee standards and performance indicators are developed from committee consensus, evidence-based practice guidelines, the *American College of Surgeons Resources for Optimal Care of the Injured Patient*[1], and DSHS Trauma Facility Designation rules/requirements. All designated trauma centers must comply and adhere to the standards of care determined by their verifying and designating agencies.

15.4.3 The Trauma Committee monitors regional trauma performance indicators and goals on a monthly dashboard which shall be presented to the committee and the Board of Directors. The trauma performance indicators and goals are reviewed/revised annually and defined in the Trauma Committee SOP, which is attached to this plan as *Annex B Appendix B-4*.

15.4.4 A Trauma Registry Workgroup has been established by the Trauma Committee to assist with evaluating regional data, identifying data needs, providing education to other registrars, and sharing best practices.

16. REHABILITATION

16.1 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.

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

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

17. INJURY PREVENTION AND PUBLIC EDUCATION

17.1 Unintentional and intentional injuries are a significant public health concern within the State of Texas. Trauma systems must develop prevention strategies that help control injury as part of an integrated, coordinated, and inclusive trauma system.

17.2 Prevention 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 increased use of seatbelts), that have measurable outcomes in a specific timeline. Staffing and community partners are essential for success.

17.3 The NCTTRAC Public Education and Injury Prevention committee serves as a resource to identify prevention programs, events, and other prevention resources available to members and the community in TSA-E. Regional, state, and national data will be utilized to determine current trauma trends and address specific priorities. Workgroups and coalitions may also be developed to focus on specific mechanisms and/or populations for educational opportunities.

18. COALITION AND PARTNERSHIP BUILDING

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

18.2 Currently most initiatives around Injury Prevention are carried out by members of NCTTRAC hospital and prehospital providers. NCTTRAC supports collaborative partnerships with community leaders to assist with injury awareness and prevention activities.

19. DISASTER PREPAREDNESS AND RESPONSE

19.1 Disaster preparedness and response activities among the emergency healthcare system in TSA-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:

19.1.1 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 TSA-E.

19.1.2 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.)

19.1.3 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.

19.2 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*.

19.3 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 TSA-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.

19.4 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.

19.5 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-2*.

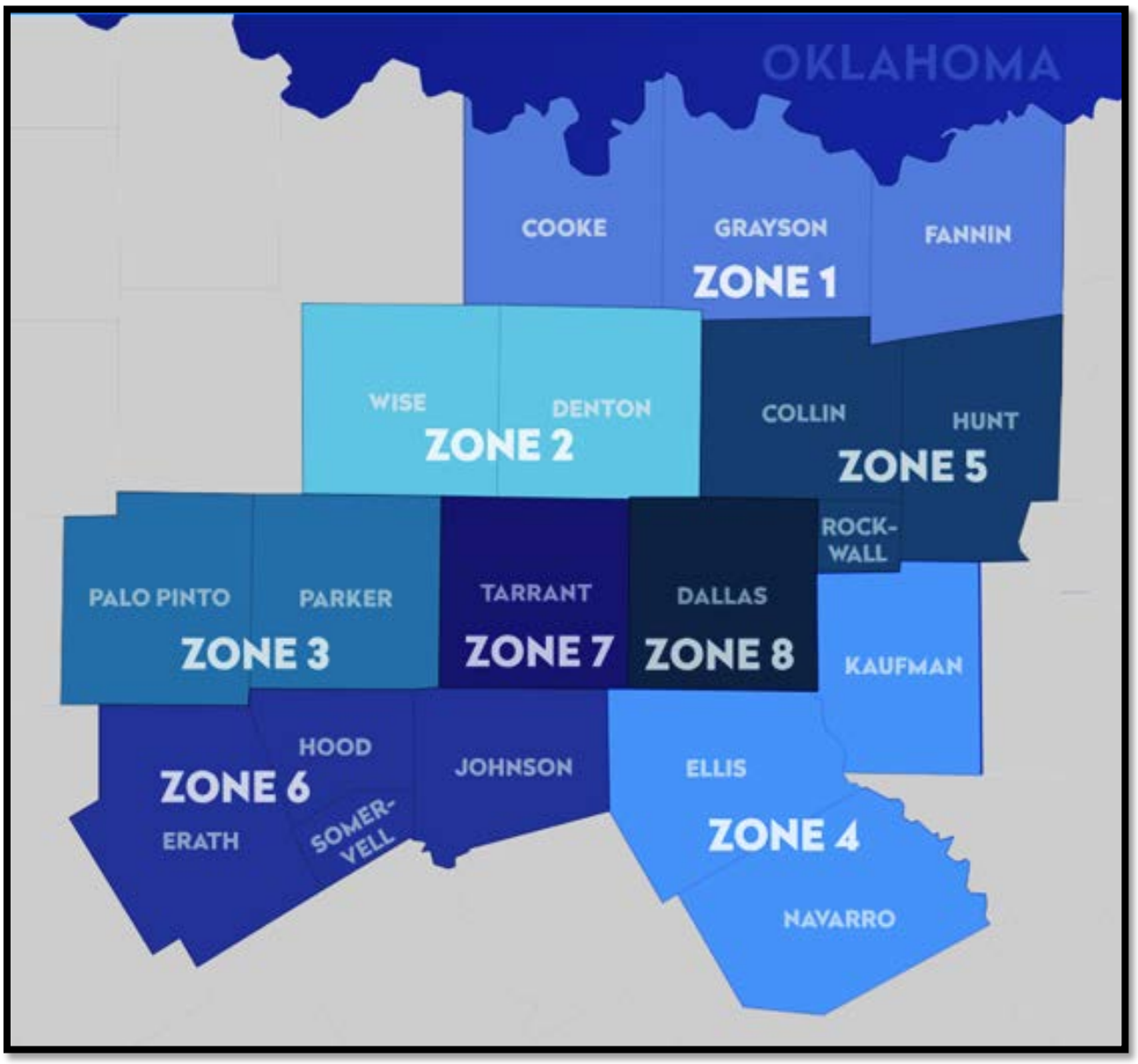
20. RESEARCH

20.1 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.

21. REFERENCES

21.1 American College of Surgeons, Committee on Trauma. (2022). Resources for optimal care of the injured patient.

Annex A
Demographics & Organizations



SOURCE: https://ncttrac.org/zones/
As of 7/21/2023

#	NAME	ADDRESS	CITY	COUNTY	TRAUMA LEVEL	IN PURSUIT
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	
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	TRAUMA LEVEL	IN PURSUIT
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 III	
21	BAYLOR SCOTT & WHITE MEDICAL CENTER - FRISCO	5601 WARREN PARKWAY	FRISCO	COLLIN		
22	BAYLOR SCOTT & WHITE MEDICAL CENTER - GRAPEVINE	1650 WEST COLLEGE STREET	GRAPEVINE	TARRANT	Level II	
23	BAYLOR SCOTT & WHITE MEDICAL CENTER - IRVING	1901 NORTH MACARTHUR BOULEVARD	IRVING	DALLAS		
24	BAYLOR SCOTT & WHITE MEDICAL CENTER - LAKE POINTE	6800 SCENIC DRIVE	ROWLETT	ROCKWALL	Level III	
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	2400 N I-35 E	WAXAHACHIE	ELLIS	Level IV	

#	NAME	ADDRESS	CITY	COUNTY	TRAUMA LEVEL	IN PURSUIT
	CENTER AT WAXAHACHIE					
29	BAYLOR SCOTT & WHITE SURGICAL HOSPITAL AT SHERMAN	3601 N CALAIS STREET	SHERMAN	GRAYSON		
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 I	
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 I	
38	CHILDRENS MEDICAL CENTER PLANO	7601 PRESTON ROAD	PLANO	COLLIN	Level IV	
39	CITY HOSPITAL AT WHITE ROCK	9440 POPPY DRIVE	DALLAS	DALLAS		
40	COOK CHILDRENS MEDICAL CENTER	801 SEVENTH AVENUE	FORT WORTH	TARRANT	Level II	
41	CRESCENT MEDICAL CENTER LANCASTER	2600 WEST PLEASANT RUN ROAD	LANCASTER	DALLAS		
42	DALLAS MEDICAL CENTER	7 MEDICAL PARKWAY	DALLAS	DALLAS	Level IV	
43	DALLAS REGIONAL MEDICAL CENTER	1011 NORTH GALLOWAY AVE	MESQUITE	DALLAS	Level IV	
44	EMINENT MEDICAL CENTER	1351 W PRESIDENT BUSH HWY	RICHARDSON	COLLIN		
45	ENCOMPASS HEALTH REHABILITATION	3200 MATLOCK ROAD	ARLINGTON	TARRANT		

#	NAME	ADDRESS	CITY	COUNTY	TRAUMA LEVEL	IN PURSUIT
	HOSPITAL OF ARLINGTON					
46	ENCOMPASS HEALTH REHABILITATION HOSPITAL OF CITY VIEW	6701 OAKMONT BOULEVARD	FORT WORTH	TARRANT		
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	Level IV	
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 IV	
55	ICARE REHABILITATION HOSPITAL	3100 PETERS COLONY ROAD	FLOWER MOUND	DENTON		
56	JOHN PETER SMITH HOSPITAL	1500 SOUTH MAIN STREET	FORT WORTH	TARRANT	Level I	
57	JPS HEALTH NETWORK - TRINITY SPRINGS NORTH	1000 ST LOUIS AVENUE	FORT WORTH	TARRANT		
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		

#	NAME	ADDRESS	CITY	COUNTY	TRAUMA LEVEL	IN PURSUIT
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		
64	LAKE GRANBURY MEDICAL CENTER	1310 PALUXY ROAD	GRANBURY	HOOD	Level IV with Contingencies	
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 II	
71	MEDICAL CITY DALLAS HOSPITAL	7777 FOREST LANE	DALLAS	DALLAS	Level IV with Contingencies	
72	MEDICAL CITY DENTON	3535 SOUTH I-35 EAST	DENTON	DENTON	Level II	
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		In Pursuit of Level III
75	MEDICAL CITY LAS COLINAS	6800 NORTH MACARTHUR BOULEVARD	IRVING	DALLAS	Level III	
76	MEDICAL CITY LEWISVILLE	500 WEST MAIN STREET	LEWISVILLE	DENTON	Level III	
77	MEDICAL CITY MCKINNEY	4500 MEDICAL CENTER DRIVE	MCKINNEY	COLLIN	Level III	
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	Level III	
80	MEDICAL CITY PLANO	3901 WEST 15TH STREET	PLANO	COLLIN	Level I	

#	NAME	ADDRESS	CITY	COUNTY	TRAUMA LEVEL	IN PURSUIT
81	MEDICAL CITY WEATHERFORD	713 E ANDERSON ST	WEATHERFORD	PARKER	Level IV	
82	MESQUITE REHABILITATION INSTITUTE	1023 NORTH BELT LINE ROAD	MESQUITE	DALLAS		
83	MESQUITE SPECIALTY HOSPITAL	1024 NORTH GALLOWAY AVENUE	MESQUITE	DALLAS		
84	METHODIST DALLAS MEDICAL CENTER	1441 NORTH BECKLEY AVENUE	DALLAS	DALLAS	Level I	
85	METHODIST CHARLTON MEDICAL CENTER	3500 WHEATLAND ROAD	DALLAS	DALLAS	Level III	
86	METHODIST HOSPITAL FOR SURGERY	17101 DALLAS PARKWAY	ADDISON	DALLAS		
87	METHODIST MANSFIELD MEDICAL CENTER	2700 BROAD STREET	MANSFIELD	TARRANT	Level III	
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		In Pursuit of 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	Level IV	
94	NAVARRO REGIONAL HOSPITAL	3201 WEST HIGHWAY 22	CORSICANA	NAVARRO	Level IV	
95	NORTH CENTRAL SURGICAL CENTER LLP	9301 NORTH CENTRAL EXPRESSWAY #100	DALLAS	DALLAS		

#	NAME	ADDRESS	CITY	COUNTY	TRAUMA LEVEL	IN PURSUIT
96	NORTH TEXAS MEDICAL CENTER	1900 HOSPITAL BOULEVARD	GAINESVILLE	COOKE	Level IV	
97	OUR CHILDRENS HOUSE	1340 EMPIRE CENTRAL DRIVE	DALLAS	DALLAS		
98	PALO PINTO GENERAL HOSPITAL	400 SOUTHWEST 25TH AVENUE	MINERAL WELLS	PALO PINTO	Level IV	
99	PAM REHABILITATION HOSPITAL OF ALLEN	1001 RAINTREE CIRCLE	ALLEN	COLLIN		
100	PARKLAND MEMORIAL HOSPITAL	5200 - 5201 HARRY HINES BOULEVARD	DALLAS	DALLAS	Level I	
101	PINE CREEK MEDICAL CENTER	9032 HARRY HINES BOULEVARD	DALLAS	DALLAS		
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	800 WEST RANDOL MILL ROAD	ARLINGTON	TARRANT	Level IV	

#	NAME	ADDRESS	CITY	COUNTY	TRAUMA LEVEL	IN PURSUIT
	MEMORIAL HOSPITAL					
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 IV	
116	TEXAS HEALTH HARRIS METHODIST HOSPITAL AZLE	108 DENVER TRAIL	AZLE	TARRANT	Level IV	
117	TEXAS HEALTH HARRIS METHODIST HOSPITAL CLEBURNE	201 WALLS DRIVE	CLEBURNE	JOHNSON	Level IV	
118	TEXAS HEALTH HARRIS METHODIST HOSPITAL FORT WORTH	1301 PENNSYLVANIA AVENUE	FORT WORTH	TARRANT	Level II	
119	TEXAS HEALTH HARRIS METHODIST HOSPITAL HURST-EULESS-BEDFORD	1600 HOSPITAL PARKWAY	BEDFORD	TARRANT	Level III	
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		In Pursuit of Level III
122	TEXAS HEALTH HARRIS METHODIST HOSPITAL STEPHENVILLE	411 NORTH BELKNAP	STEPHENVILLE	ERATH	Level IV	
123	TEXAS HEALTH HEART & VASCULAR HOSPITAL ARLINGTON	811 WRIGHT STREET	ARLINGTON	TARRANT		
124	TEXAS HEALTH HOSPITAL	1401 E TRINITY MILLS RD	CARROLLTON	DALLAS		

#	NAME	ADDRESS	CITY	COUNTY	TRAUMA LEVEL	IN PURSUIT
125	TEXAS HEALTH HOSPITAL FRISCO	12400 DALLAS PKWY	FRISCO	COLLIN		In Pursuit of Level III
126	TEXAS HEALTH HOSPITAL CLEARFORK	5400 CLEARFORK MAIN ST	FORT WORTH	TARRANT		
127	TEXAS HEALTH HUGULEY HOSPITAL	11801 SOUTH FREEWAY	BURLESON	TARRANT	Level IV	
128	TEXAS HEALTH PRESBYTERIAN HOSPITAL ALLEN	1105 CENTRAL EXPRESSWAY NORTH SUITE 140	ALLEN	COLLIN	Level IV	
129	TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS	8200 WALNUT HILL LANE	DALLAS	DALLAS	Level II	
130	TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON	3000 I-35	DENTON	DENTON		
131	TEXAS HEALTH PRESBYTERIAN HOSPITAL FLOWER MOUND	4400 LONG PRAIRIE ROAD	FLOWER MOUND	DENTON		
132	TEXAS HEALTH PRESBYTERIAN HOSPITAL KAUFMAN	850 ED HALL DRIVE	KAUFMAN	KAUFMAN	Level IV	
133	TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO	6200 WEST PARKER ROAD	PLANO	COLLIN	Level II	
134	TEXAS HEALTH PRESBYTERIAN HOSPITAL ROCKWALL	3150 HORIZON ROAD	ROCKWALL	ROCKWALL		
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	425 ALABAMA AVENUE	FORT WORTH	TARRANT		

#	NAME	ADDRESS	CITY	COUNTY	TRAUMA LEVEL	IN PURSUIT
	HOSPITAL OF FORT WORTH					
139	TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN	2222 WELBORN STREET	DALLAS	DALLAS		
140	TEXOMA MEDICAL CENTER	5016 SOUTH US HIGHWAY 75	DENISON	GRAYSON	Level III	
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	Level IV	
144	UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS	6201 HARRY HINES BLVD	DALLAS	DALLAS		In Pursuit of Level IV
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		
150	WILSON N JONES REGIONAL MEDICAL CENTER	500 NORTH HIGHLAND AVENUE	SHERMAN	GRAYSON	Level III	
151	WISE HEALTH SURGICAL HOSPITAL	3200 NORTH TARRANT PARKWAY	FORT WORTH	TARRANT		
152	WISE HEALTH SYSTEM	609 MEDICAL CENTER DRIVE	DECATUR	WISE	Level IV	
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
Amy Atnip	Chair	Medical City Plano
William Bonny	Chair Elect	Prosper Fire Department
Nakia Rapier	Secretary	Baylor University Medical Center
Rachal Bracker	Interim Treasurer	Texas Health Harris Methodist Fort Worth
Ricky Reeves	Finance Chair	Texas EMS Granbury

NAME	OFFICE / COMMITTEE	MEMBER ORGANIZATION
Jeff Donson	Air Medical Chair	CareFlite Air
Jason Piecek	Air Medical Chair Elect	PHI Air Medical
Karen Yates	Cardiac Chair	Methodist Mansfield Medical Center
Casey Rauschuber	Cardiac Chair Elect	Wise Health System
Donald Tucker	ED OPS Chair	Medical City Alliance
Jessica Lucio	ED OPS Chair Elect	Texas Health Hospital Mansfield
Kevin Sandifer	EMS Chair	Midlothian Fire Department
Matthew Baker	EMS Chair Elect	Cedar Hill Fire Department
Ricky Reeves	Finance Chair	Texas EMS Granbury
Kenneth Simpson	Finance Chair Elect	Medstar Mobile Healthcare
John Phillips	Hospital Executive - East	Methodist Dallas Medical Center
Corey Wilson	Hospital Executive - West	Texas Health Harris Methodist Fort Worth
Dr. Justin Northeim	EMS Medical Directors Chair	Grapevine Fire Department
Vacant	EMS Medical Directors Chair Elect	
KaLinda Evans	Pediatric Chair	Cook Children's Medical Center
Colyn Turnbow	Pediatric Chair Elect	Baylor Scott & White All Saints Medical Center - Fort Worth
Dr. David Nelson	Perinatal Chair	Parkland Health & Hospital System
Vacant	Perinatal Chair Elect	
Stephan Epley	REPC Chair	Texas Health Harris Methodist Fort Worth
Brian Lugo	REPC Chair Elect	Baylor University Medical Center
Dr. Robin Novakovic	Stroke Chair	UT Southwestern Medical School
Dr. Rachel Aubert	Stroke Chair Elect	UT Southwestern Clements Hospital
Danielle Sherar	Trauma Chair	JPS Health Network
Phillip Angelo	Trauma Chair Elect	Baylor Scott & White Medical Center - Grapevine

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

NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

BYLAWS

Endorsed by the NCTTRAC Board of Directors
September 12, 2023

Approved by the NCTTRAC General Membership
Pending

Supersedes Bylaws approved
June 13, 2023

ANNOTATED INDEX

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 (TS–) - 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 & 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 corporate entities 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 & Guest Speaker 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 & 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 General Membership Meeting at the end of each odd fiscal 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 & 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 and/or Leads of all ad-hoc or Committee, 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 shall serve as one of the two NCTTRAC Representative positions to the TETAF General Assembly.

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

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

5.3.1.8 The Chair, as an officer of the Board, participates in the hiring, termination, disciplinary actions, and/or performance evaluations 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 shall serve as one of the two NCTTRAC Representative positions to the TETAF General Assembly.

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

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

5.4.1.7 The Chair Elect, as an officer of the Board, participates in the hiring, termination, disciplinary actions, and/or performance evaluations of the Executive Director.

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

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

5.5.1.3 The Secretary shall be responsible for determining a quorum at each Board and General Membership Meeting.

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

5.5.1.5 The Secretary provides oversight and certification, as appropriate, for all voting actions at each Board and General Membership Meeting.

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

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

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

5.5.1.9 The Secretary, as an officer of the Board, participates in the hiring, termination, disciplinary actions, and/or performance evaluations 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 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 an officer of the Board, participates in the hiring, termination, disciplinary actions, and/or performance evaluations 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 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

6.2 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/appointment by their respective committee/organization 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 Boar€(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, Chair Elect, or other Board Officers/Directors recognize their responsibility to attend 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 EMS 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 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/appointment by their respective committee/organization 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 associated obligations.

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 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, Director, and Committee Chair Elect shall read and attest to the Conflict of Interest and Code of Ethics SOPs 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 & Elections SOP.

7.4.2 The Officers and Directors shall participate in accordance with the Membership & 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 at least 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 act.

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 reporting on quorum and 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 Attendance rosters will be maintained on a rolling two-year or individual fiscal year basis as appropriate to Officers/Directors terms of office.

7.8.2 Officers and Directors attending virtually are encouraged to utilize video capabilities where available to facilitate meaningful discussion and participation in NCTTRAC meetings and events.

7.8.3 Excused absence requests should be conveyed to NCTTRAC Administration for review by the Executive Committee prior to the missed meeting.

7.8.4 If an Officer or Director is absent for two consecutive regular Board Meetings, or failing to attend at least 50% of the meetings in person, without accepted excuse, the Officer or Director will be notified in writing of the applicable concerns.

7.8.4.1 If, after being notified, the Officer or Director misses the next regular Board Meeting, NCTTRAC Administration will bring the situation to the Executive Committee's attention for discussion and resolution.

7.9 Committee Chairs Elect Attendance

7.9.1 Committee Chairs Elect are highly encouraged but not required to attend Board Meetings.

7.9.2 A Chair Elect attending in-person would not count in place of Director attendance.

7.10 The Chair has the authority to call or postpone ad-hoc, special, and closed Board Meetings in accordance with the Closing a Meeting SOP. If 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 8.2.3 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 & 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 (15) days nor more than sixty days (60) 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. If 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 are limited to the: Air Medical Committee, Cardiac Committee, Emergency Department Operations Committee, Emergency Medical Services Committee, Finance Committee, EMS Medical Director Committee, Pediatric Committee, Perinatal Committee, Regional Emergency Preparedness Committee, Stroke Committee, and Trauma Committee. Subcommittees to 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. Standing Committees and Subcommittees may be comprised of RAC Member and Non-Member organizations with voting rights as identified in approved Standing Committee SOPs. In addition, non-member agencies or organizations representing key partners in Trauma Service Area–E (TSA-E) are also encouraged to participate regardless of voting status.

9.1.1 Standing Committee/Subcommittee Meetings, apart from closed sessions as defined in the Closing a Meeting 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 committee 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 9.1.4.1 and approved by a simple majority vote of the Board in accordance with the Voting & 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 & Elections SOP.

9.1.9 Call for removal of or complaint against any Chair or Chair Elect 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.

9.2 Purpose and responsibilities of Standing Committees/Subcommittees:

9.2.1 Air Medical Committee

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

9.2.1.2 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:

9.2.1.2.1 Professional Development

9.2.1.2.2 Injury / Illness Prevention and Public Education

9.2.1.2.3 System Performance Improvement

9.2.1.2.4 Data Initiatives

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

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

9.2.2 Cardiac Committee

9.2.2.1 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.

9.2.2.2 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:

9.2.2.2.1 Professional Development

9.2.2.2.2 Injury / Illness Prevention and Public Education

9.2.2.2.3 System Performance Improvement

9.2.2.2.4 Data Initiatives

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

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

9.2.3 Emergency Department Operations Committee

9.2.3.1 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.

9.2.3.2 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:

9.2.3.2.1 Professional Development

9.2.3.2.2 Injury / Illness Prevention and Public Education

9.2.3.2.3 System Performance Improvement

9.2.3.2.4 Data Initiatives

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

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

9.2.4 Emergency Medical Services (EMS) Committee

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

9.2.4.2 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:

9.2.4.2.1 Professional Development

9.2.4.2.2 Injury / Illness Prevention and Public Education

9.2.4.2.3 System Performance Improvement

9.2.4.2.4 Data Initiatives

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

9.2.4.4 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.

9.2.5 Finance Committee

9.2.5.1 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.

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

9.2.6 EMS Medical Director Committee

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

9.2.6.2 The committee will be comprised of EMS physicians providing medical direction and oversight to prehospital providers within TSA-E:

9.2.6.3 Provide guidance in the development and review of prehospital assessment tools, regional plans and treatment guidelines, and Committee SOP based on evidence, quality, and safety.

9.2.6.4 Provide interface with other RAC committees, professional associations appropriate to the provision, direction, and oversight of prehospital emergency medical services, and the Governor's EMS and Trauma Advisory Council (GETAC).

9.2.7 Pediatric Committee

9.2.7.1 Responsible for promoting pediatric expertise through advocacy and education.

9.2.7.2 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:

9.2.7.2.1 Professional Development

9.2.7.2.2 Injury / Illness Prevention and Public Education

9.2.7.2.3 System Performance Improvement

9.2.7.2.4 Data Initiatives

9.2.7.3 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.

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

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

9.2.8 Perinatal Committee

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

9.2.8.2 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:

9.2.8.2.1 Professional Development

9.2.8.2.2 Injury / Illness Prevention and Public Education

9.2.8.2.3 System Performance Improvement

9.2.8.2.4 Data Initiatives

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

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

9.2.9 Regional Emergency Preparedness Committee (REPC)

9.2.9.1 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.

9.2.9.1.1 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.

9.2.9.2 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.

9.2.9.3 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:

9.2.9.3.1 Professional Development

9.2.9.3.2 Injury / Illness Prevention and Public Education

9.2.9.3.3 System Performance Improvement

9.2.9.3.4 Data Initiatives

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

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

9.2.10 Stroke Committee

9.2.10.1 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.

9.2.10.2 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:

9.2.10.2.1 Professional Development

9.2.10.2.2 Injury / Illness Prevention and Public Education

9.2.10.2.3 System Performance Improvement

9.2.10.2.4 Data Initiatives

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

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

9.2.11 Trauma Committee

9.2.11.1 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.

9.2.11.2 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:

9.2.11.2.1 Professional Development

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

9.2.11.2.3 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.

9.2.11.2.4 Data Initiatives

9.2.11.3 Provide guidance in the development and review of

hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the Committee SOP

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

9.3 Purpose and Responsibilities of the Zones

9.3.1 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. The Zone Representatives for each of the eight (8) geographic zones represent grassroots discussion of issues affecting the trauma and emergency healthcare systems in that area. Responsibilities include but are not limited to:

9.3.1.1 Improve communication efforts between Zone participants, Zone Representatives, NCTTRAC Committees, and staff.

9.3.1.2 Provide Systems Performance Improvement (SPI) and related NCTTRAC Committee feedback as necessary for regional needs, interests, and issues.

9.3.2 The current Zones are:

9.3.2.1 Zone 1 – Cooke, Grayson, and Fannin counties

9.3.2.2 Zone 2 – Denton and Wise counties

9.3.2.3 Zone 3 – Palo Pinto and Parker counties

9.3.2.4 Zone 4 – Ellis, Kaufman, and Navarro counties

9.3.2.5 Zone 5 – Collin, Hunt, and Rockwall counties

9.3.2.6 Zone 6 – Erath, Hood, Johnson, and Somervell counties

9.3.2.7 Zone 7 – Tarrant County

9.3.2.8 Zone 8 – Dallas County

9.3.3 Participant Criteria

9.3.3.1 The Zone participants may be representatives from hospitals, pre-hospital agencies, public health, emergency management, and other key partnering agencies within the geographic boundaries of the Zone. Zone meeting voting authority is afforded to the Zone participants.

9.3.4 Zone Representative

9.3.4.1 Each Zone Representative is chosen by vote of the present and eligible voting participants of the Zone.

9.3.4.2 Nominations for each Zone Representative shall come from the Zone participants.

9.3.4.3 The Zone Representative of each of the eight (8) Zones serve as the principal liaison among Zones, Committees, and staff with responsibilities that include, but are not limited, to:

9.3.4.3.1 Host local meetings to provide a place to allow local hospital and prehospital agencies / organizations to meet and discuss local issues.

9.3.4.3.2 Facilitate and lead their respective Zone meetings.

9.3.4.3.3 Scheduling of local meetings.

9.3.4.3.4 Provide NCTTRAC staff with meeting dates, times, and locations for posting on the NCTTRAC website calendar.

9.3.4.3.5 Provide NCTTRAC Staff with any materials desired to be posted on their respective Zone webpage on the NCTTRAC website.

9.3.4.3.6 Coordinate with NCTTRAC staff on the desire or need to provide a virtual meeting platform.

9.3.4.3.7 Present grassroots issues such as system performance improvement concerns to the appropriate NCTTRAC Service Line Committee for discussion and action as needed.

9.3.4.4 If the Zone Representative is unable to fulfill their term, there shall be an election at the next Zone meeting to replace them.

9.3.4.5 All zone meetings will be held as open meetings and are open to any individual who wants to attend the meeting.

9.3.4.6 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.

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 in accordance with the Financial Policies and Procedures Manual.

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 – An Officer/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 an Officer/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 Officer/Director to NCTTRAC or that involves intentional misconduct or a knowing violation of the law.

10.9.3 A transaction from which an Officer/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 an Officer/Director is expressly provided for by statute.

10.10 Annual Audit – The NCTTRAC Finance Committee shall ensure that an annual audit of NCTTRAC financial records be performed every year by a qualified agency or individual within four months of the end of the fiscal year. The NCTTRAC Finance Committee is responsible for providing full audit findings to the Board of Directors annually.

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 Membership & Participation 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 Representative of a Member Organization in Good Standing can be represented by proxy.

14.1.1 Such proxy shall be originated and/or signed by the Member Organization's documented Primary Voting Representative and filed with NCTTRAC at least 24 hours prior to the vote as outlined in the Voting & 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 Member Organization's Primary Voting Representative assigning proxy.

14.1.3 No individual shall hold more than one proxy at a time, unless granted between Member Organizations 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.

14.3 Committees that include appointees from peer groups (i.e., Hospital systems, County Fire Chiefs Associations, etc.) may only accept proxies originated and/or signed by appointing authorities identified in the respective Committee's SOP.

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 NCTTRAC property.

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 and the Financial Policies and Procedures Manual.

16.5 NCTTRAC Officers, Directors, and Committee Chairs Elect shall sign a Code of Ethics acknowledgement and a Conflict of Interest statement annually and update as needed.

16.5.1 Individuals are required to disclose any conflict of interest to the Executive Committee of the Board at the time that the conflict is identified as outlined in the Conflict of Interest SOP.

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 5th of October 2023.

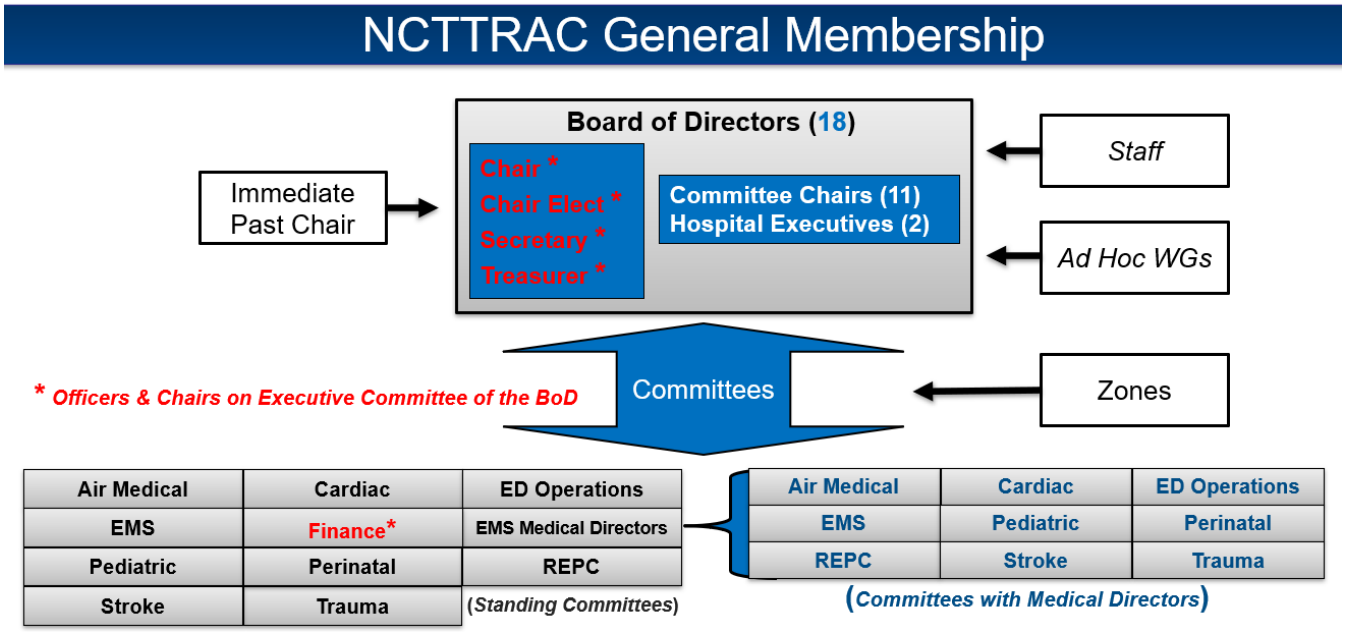
In Witness Whereof, I have signed this certification on this the 5th day of October 2023.

Original Signed by

_____
Nakia Rapier, Secretary

Attachment 1
Governance & Organization Chart

Governance Structure



1. Executive Summary of Committee Responsibilities

1.1. The Trauma Committee is responsible for the oversight of the trauma system in Trauma Service Area (TSA) - E, including the Regional Trauma System Plan. This Plan includes strategies to focus diverse resources in a collective strategy to reduce morbidity and mortality due to trauma. The committee will provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans, treatment guidelines, and the committee SOP. Additionally, the committee will interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).
1.2. Establish standards and procedures for the Trauma Committee.
1.3. Create broad stakeholder representation while working to provide an opportunity to share resources leading to the development, operation, and evaluation of trauma education and advocacy within the 19 counties served.
1.4. Provide guidance in the development of pre-hospital assessment tools and treatment guidelines related to trauma care to the EMS and Air Medical Committees.
1.5. Organize, support, and/or coordinate health care evidenced-based education identified through the NCTTRAC needs assessments.
1.6. Provide oversight to the Trauma Committee Workgroups and Subcommittees.
1.7. Serve as a source to identify trauma expert resources available in TSA-E to members and community partners.

2. Subcommittees and Work Groups

2.1. Subcommittees must be approved in conjunction with a change to the NCTTRAC Bylaws. Work Groups may be established at the discretion of the Chair of the Board of Directors and will operate in due consideration of NCTTRAC's Bylaws and this SOP. Current subcommittees and workgroups include:
- 2.1.1. Public Education/ Injury Prevention Subcommittee
  - 2.1.1.1. Responsible for promoting injury prevention and public awareness through advocacy and education.
- 2.1.2. SPI Subcommittee
  - 2.1.2.1. Responsible for oversight of trauma performance improvement activities of NCTTRAC.
  - 2.1.2.2. Assist committee with evaluating regional data, identifying data needs and/or requirements.
  - 2.1.2.3. Review, evaluate, and recommend to the Trauma Committee referrals and tools.
    - 2.1.2.3.1. SPI Referrals.
    - 2.1.2.3.2. Designation Review Tool
- 2.1.3. Trauma Registry Work Group
  - 2.1.3.1. Assist committee with evaluating regional data, identifying data needs and/or requirements.
  - 2.1.3.2. Share education and information related to National Trauma Data Standard (NTDS), state registry, and Trauma Quality Improvement Program (TQIP).
  - 2.1.3.3. Share registry best practices
- 2.1.4. Regional Prehospital Transfusion Workgroup

2.1.4.1. Identify and research the community and agency need for a Regional Prehospital Transfusion Program
2.1.4.2. Develop framework for the prehospital transfusion program
2.1.4.3. Review data collected for system performance improvement efforts
2.1.4.4. Review and approve agency participation applications

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 Trauma 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.
3.1.4. The Chair may only vote in the event of a tie; however, the Chair's organization may assign an appropriately documented voting delegate to fill their committee core group position during the Chair's term.
3.1.5. In the event the Chair is unable to fulfill the term, the Chair Elect shall ascend to Chair in accordance with the NCTTRAC Bylaws
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 Trauma 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 Trauma Committee annually or when the incumbent has vacated this position.
3.2.5. In the event the Chair is unable to fulfill the term, the Chair Elect shall ascend to Chair in accordance with the NCTTRAC Bylaws.

4. Committee Medical Director

4.1. The Trauma Committee will establish a Co-Medical Director position, who meets the same criteria below, to assist as desired.
4.2. The elected Trauma Committee Medical Director is responsible for

4.2.1. Participating directly with their service line committee
4.2.2. Attend at minimum 50% of committee meetings
4.2.3. Establishing and maintaining a standing coordination method with their service line peers
4.2.4. 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.

4.3. The Trauma Committee Medical Director provides current physician insight and involvement in support of the Trauma committee and its responsibilities, including:
4.3.1. 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.
4.3.2. Active partnership in the coordination and support of the following service line committee products (see appendix A for the Coordination Flow Chart):
4.3.2.1. Service Line Regional Plans
4.3.2.2. Guidelines
4.3.2.3. Texas Department of State Health Services (DSHS) Rules Reviews

4.4. The Trauma Committee Medical Director must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.
4.5. The Trauma Committee Medical Director position will be voted on by the Trauma Committee annually, with each Fiscal Year, or if otherwise vacated.
4.6. The Trauma Committee Medical Director should be prepared, with NCTTRAC staff assistance, to facilitate a peer group of trauma medical directors (by email or meeting) in support of Trauma Committee efforts, as appropriate.
4.7. The Trauma Committee Medical Director will be a liaison to the NCTTRAC EMS Medical Directors Committee.
4.8. The Trauma Committee Medical Director may facilitate a trauma medical directors meeting as a focus group of the Trauma Committee.

5. Committee Representation

5.1. In accordance with NCTTRAC Bylaws Article IX, there is a voting core group identified within the Trauma Committee.
5.2. The Trauma Committee core group shall be comprised of Trauma Program Managers/Coordinators, unless delegated otherwise, from Trauma Designated and In Active Pursuit (IAP) Hospitals that are NCTTRAC member organizations in good standing.

6. Committee Attendance

6.1. While attendance is highly encouraged in support of meaningful participation, there are no specific attendance requirements at committee level.
6.2. Virtual attendees are highly encouraged to utilize video capabilities where available to facilitate meaningful discussion and participation in NCTTRAC meetings and events.

7. Committee Active Participation

7.1. In addition to attendance Trauma Committee identifies the following to be creditable for active participation at the committee level:
  7.1.1. Attend at minimum 50% of Trauma Committee meetings, preferably in person
  7.1.2. Meet Texas DSHS Data submission requirements, as applicable
  7.1.3. For members with a capable registry, evidence of data submission to NCTTRAC's outsourced data reporting service on a quarterly basis

8. Quorum & Voting

8.1. A quorum is a simple majority (50% or more) of the documented and eligible Trauma Committee representatives that are physically or virtually present and participating in a meeting.
8.2. The Chair shall manage voting issues in accordance with existing NCTTRAC bylaws and procedures. Appropriately eligible and documented Trauma Committee representatives shall exercise the right to vote on Trauma Committee matters, as necessary. While the Chair will generally facilitate routine activity by consensus, non-routine, or electronic voting activity will normally be facilitated and documented by supporting staff.
8.3. The Trauma Committee Leadership Group (Chair, Chair Elect, and Co-Medical Directors) may convene on an ad hoc basis to represent the committee in matters necessary to maintain contractual compliance, execute deliverables, and/or endorse emergency, off-cycle purchases for regional benefit. Actions taken will be reported at the next scheduled committee meeting.
8.4. Standing Committees/Subcommittees voting may be conducted by the following methods, unless otherwise addressed in the committee/subcommittee SOP:
  8.4.1. In person or virtually during the meeting.
  8.4.2. Electronically (e.g., email, fax, website) for unscheduled votes between meetings.
  8.4.3. Votes may be cast by proxy in accordance with NCTTRAC Bylaws Article XIV.
  8.4.4. The outcome of each action item will be recorded in the meeting minutes or notes.
8.5. As an alternative to a consensus vote at a Trauma Committee Meeting, electronic votes may be employed. A record of responses and results must be maintained in the Meeting Notes or Minutes.
  8.5.1. Electronic Votes may be called via:
    8.5.1.1. Polls
    8.5.1.2. Surveys
    8.5.1.3. Ballots
    8.5.1.4. Other technologies

9. Committee Liaisons

9.1. Governor's EMS and Trauma Advisory Council (GETAC) Trauma Committee
9.2. Texas Trauma Coordinators Forum (TTCF)
9.3. Dallas Fort Worth Hospital Council Foundation
9.4. Texas EMS Trauma & Acute Care Foundation (TETAF)

10. Standing Committee Obligations

10.1. Annual Review of the Trauma Committee SOP
10.2. Annual Review of Regional Trauma System Plan & Guidelines (listed)
  10.2.1. Trauma Triage and Transport Guideline
  10.2.2. Trauma Transfer Guideline
10.3. DSHS "Essential Criteria", Rules and/or contractual deliverables, as applicable
10.4. GETAC Strategic Plan objectives and strategies, as applicable
10.5. Annual Review of Program Guidance and Regional Initiatives (STB, Falls, Etc.)

11. Projected Committee Goals, Objectives, Strategies, Projects

11.1. Annual Committee Goals
  11.1.1. Traumatically injured patients requiring transfer will be transferred within 2 hours of arrival to emergency department (single system injuries with ISS less than 10 excluded) Goal: 75% by end of NCTTRAC FY24
  11.1.2. Designated and in active pursuit (IAP) Trauma centers with a capable trauma registry will submit data to NCTTRAC's outsourced data reporting service. Goal: 80% by end of NCTTRAC FY24
  11.1.3. Implement a minimum of five regional prehospital transfusion provider sites as funding allows.
  11.1.4. Establish a reportable prehospital transfusion data set.
  11.1.5. Achieve Texas EMS Wristband Compliance of 70% or greater for all EMS transports/transfers in TSA-E
11.2. NCTTRAC's "Accountability Scorecard" spreadsheet will be used to document commitments and progress with associated efforts.

12. System Performance Improvement (SPI)

12.1. The Trauma Committee will support the SPI Subcommittee responsibilities by establishing a standing meeting agenda item and corresponding accountability.
12.2. At minimum, the Committee will review, evaluate, and report trauma facility 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. At minimum, the SPI Subcommittee will review, evaluate, and report SPI indicators and referred events as afforded by the Texas Statute and Rule.
12.4. Prior to submitting an SPI event, the referring/requesting agency is expected to first contact the involved agencies/facilities in an attempt to satisfactorily resolve the issue or concern. Only after appropriate attempts have been made to satisfactorily resolve an SPI event should the referring/requesting agency formally submit an SPI event notification/request via the NCTTRAC secured ticket system.
12.5. Closed SPI Subcommittee meetings will support detailed reviews of Performance Improvement (PI) Indicators and referred PI events as afforded by Texas Statute and Rule.
  12.5.1. Representation:

12.5.1.1. Trauma Committee Chair
12.5.1.2. Trauma Committee Chair Elect
12.5.1.3. Trauma Committee Medical Director
12.5.1.4. Two (2) elected Trauma Committee representatives (As needed)

12.5.2. Closed SPI Subcommittee meeting participants will sign a confidentiality statement prior to the start of a closed meeting.

12.5.3. Meeting notes, attendance rosters, and supporting documents of Closed SPI subcommittee meetings must be provided to NCTTRAC staff within 48 hours following each meeting to be secured as a confidential record of committee activities.

12.6. SPI Products
- 12.6.1. Trauma SPI Indicators
- 12.6.2. Trauma SPI Referral Form
- 12.6.3. Trauma Designation Letter of Support Review Forms

12.7. SPI Indicators
- 12.7.1. Hospitals will meet and maintain the appropriate trauma facility designation at all times. NCTTRAC will be immediately notified if designation is lost or in jeopardy.
- 12.7.2. Hospitals will communicate their open/closed/advisory status through EMResource.
- 12.7.3. Hospitals with a capable registry will submit data to NCTTRAC's outsourced data reporting service.
- 12.7.4. Trauma patients will only be transferred one time to the appropriate higher level of designated facility. Receiving facility shall inform the SPI Subcommittee of a double transfer.
- 12.7.5. All trauma patient transfers will be managed within Trauma Service Area-E as the capacity of the tertiary care facilities allow and the patient's condition dictates. All patient transfers outside RAC-E shall be presented to the SPI Subcommittee.
- 12.7.6. Trauma patients will be transferred within two hours of arrival (single system injuries with ISS less than ten excluded) to their emergency department.

13. Injury Prevention / Public Education

13.1. The Trauma Committee will support the Trauma Injury Prevention and Public Education subcommittee responsibilities by establishing a standing meeting agenda item and corresponding accountability (e.g., appoint individual facilitator, workgroup, or subcommittee).

13.2. Focus on injury prevention and education of the public health needs within TSA - E.

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 prevention efforts within TSA - E.

13.4. Base decisions on current Trauma 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 prevention programs.

13.6. Recommend/support prevention priorities for TSA-E according to the injury geographic location, cost, and outcome.
13.7. Serve as a resource to identify prevention programs, events, and other prevention resources available in TSA-E to members and community members.
13.8. Establish Ad Hoc Task Forces, as necessary, to address specific issues.
13.9. Review the Public Education and Injury Prevention Resource Document on a bi-annual basis.

14. Professional Development

14.1. The Trauma Committee will support Trauma 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 Trauma Committee will:
14.2.1. Participate in the development of the Annual NCTTRAC Needs Assessment.
14.2.2. Sponsor educational events based on needs assessment results and potential committee request.

15. Unobligated Budget Requests

15.1. Recommendations from the Trauma 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 TSA-E.

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. *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 – Capability" status should be updated every 4 hours; a "Closed" status or an "Advisory – ED Surge" status should be updated every 2 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 state and federal hospital bed reporting requirements. These numbers should be updated at least once every 24 hours – since March of 2020, there have been federal and state requirements for hospitals to update this information 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.

Annex D

Trauma Triage Transport & Transfer Guidelines

Trauma Triage & Transport Guidelines

I. Introduction

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

1.2 These guidelines do not establish a legal standard of care, but rather are intended as an aid to decision-making in the care of trauma patients are not intended to supersede the physician's or caregiver's judgement.

II. Overview

A. For the trauma patient, as for other critically ill patients, assessment is the foundation on which all management and transportation decisions are based.

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

C. The first step in trauma assessment is the **Scene Assessment**/Scene Size-Up. As you approach the scene, assure safety for yourself and the patient while taking BSI precautions. Rapidly identify the number/type of patients and request additional resources as appropriate.
   1. Additional resources (e.g. Air Medical evacuation, special rescue, additional ambulances, police, hazmat) should be notified based off of dispatch information; and requested to proceed with arrival/landing on scene during scene assessment/scene size-up.
   2. Recognition of multi-patient incidents and mass-casualty incidents is critical. In these incidents, priority shifts from focusing all resources on the most injured patient to providing the greatest good to the greatest number of patients.

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

E. The **Primary Assessment** begins with a simultaneous, or *global*, overview of the status of the patient's respiratory, circulatory, and neurological systems to identify obvious, significant problems with oxygenation, circulation, hemorrhage, or gross deformities; followed by a rapid focused assessment of Airway, Breathing/Ventilation, Circulation/Bleeding, Disability, and Expose/Environment.
   1. Make immediate interventions to correct life-threats in the order assessed. Progress from BLS (least invasive) to ALS (most invasive), utilizing the most appropriate intervention warranted in a given situation.
   2. **Assess the Patient's Mental Status:** If unresponsive, check for a pulse. If no pulse, initiate CPR per local protocol.

3. **Airway:** While simultaneously applying C-spine precautions (if able), the provider should establish/ensure a patent airway by opening (e.g., jaw-thrust), clearing (e.g., suction), assessing, and intervening with appropriate device.
4. **Breathing:** Ensure adequate oxygenation and ventilation of the lungs utilizing appropriate oxygen-delivery devices. If abnormal ventilation is present, expose the chest and visually assess for trauma while assessing breath sounds. If an open pneumothorax is present, cover with an occlusive dressing. If a tension pneumothorax is suspected, rapidly decompress the affected side.
5. **Circulation:** Control massive hemorrhage utilizing appropriate hemorrhage control devices. Observe the color, temperature, and moisture of the skin while rapidly assessing for the presence/location/quality of pulses (e.g., carotid, femoral, and radial) to estimate Blood Pressure and/or perfusion. IV access and fluid administration are secondary to initiation of Rapid Transport.
6. **Disability:** Rapidly assess Level of Consciousness, pupils, and motor/sensory responses. If Central Nervous System injury suspected, utilize appropriate devices to restrict spinal motion. Observe for increased ICP and signs/symptoms of impending brain-stem herniation (e.g., unequal pupils, bradycardia, hypertension, irregular respirations).
7. **Expose/Environment:** Rapidly extricate/remove patients from dangerous environments (e.g., fire, snow, pool, etc.). Remove patients clothing in order to fully assess for injury. After assessing, cover patient to maintain normothermia.

F. The **Secondary Assessment** begins after the recognition/management of life-threatening injuries found in the Primary Assessment, and after a transport decision has been made. The objective of the Secondary Assessment is to identify injuries not initially found.
   1. Reassess/Confirm Airway, Breathing, and Circulation. Make appropriate interventions as necessary.
   2. Obtain full, detailed vital signs utilizing available equipment.
   3. Obtain vascular access and administer appropriate fluid boluses to restore/maintain a radial pulse and/or SBP > 90 mmHg. Do not over-resuscitate trauma patients. Do not attempt to restore baseline vital signs.
   4. Perform a detailed head-to-toe physical examination.
   5. Immobilize/Splint suspected fractures and dress secondary wounds. Reassess circulation, motor and sensory after intervention.
   6. Obtain SAMPLE history if able.

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

III. Transport Algorithm

See Attachment D-1-A: Adult Trauma Triage & Transport Algorithm and Attachment D-1-B: Pediatric Trauma Triage & Transport

IV. Special Considerations

A. **Air Medical Evacuation:** When requesting air medical assets, confirm the aircraft's Estimated Time of Arrival (ETA) to the scene, in addition to the aircraft's Total Time for transport (start-up, take-off, move to scene, land, load patient, take-off, move to hospital,

land).

1. If the aircraft's ETA is greater than the time it would take to transport by ground to the closest appropriate facility, initiate ground transport and direct the aircraft to change heading to the respective facility.
2. If the aircraft's Total Time is greater than the time it would take to transport by ground to a Level 1 or Level 2 Trauma Center, initiate ground transport.
3. Air medical assets may be utilized to deliver higher echelons of care and/or specialty services when indicated (e.g., need for advanced airway management, surgical amputation teams, delivery of blood products).

B. **Burns:** Life threatening traumatic injuries should be identified and treated prior to burns. The following patients generally require treatment at a verified Burn Center per the American College of Surgeons and the American Burn Association. In addition, treatment of these conditions at other facilities often results in transfer to a Burn Center and an overall delay in care.

1. >10% TBSA Partial-thickness burns
2. Full-thickness burns
3. Electrical burns including lightning injuries
4. Chemical burns
5. Inhalation injury
6. Burns to the face, hands, feet, genitalia, and/or major joints

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

1. Pulseless and apneic in addition to signs incompatible with life (e.g., decapitation, dependent lividity, rigor mortis, and decomposition).
2. No pupillary reflexes, no spontaneous movement, and no organized cardiac rhythm on the ECG greater than 40 complexes per minute.

D. **Geriatrics:** Traumatic injury in the geriatric population is increasing in prevalence and is associated with higher morbidity and mortality rates compared with younger patients. The risk of injury/death starts to increase after age 55 years. Elderly patients can experience significant injury in spite of relatively trivial mechanism. Because of altered baseline vital signs due to changes associated with aging, preexisting disease (e.g., hypertension), or medications (e.g., beta-blockers), the physiologic response to injury might differ from that seen in younger patients. Alterations in mentation may be attributed to dementia or delirium, potentially leading to late recognition of shock or traumatic brain injury. These factors increase the risk for under-triage by both EMS and ED personnel.

E. **Pregnancy:** Trauma has become the leading cause of maternal death in the U.S.; therefore, the main principle guiding therapy must be aimed towards aggressive resuscitation of the mother.

1. Any pregnant woman who has reached 20 weeks gestation or more (palpable uterus at/above umbilicus), who has been involved in any trauma, especially a motor vehicular crash, regardless of the absence of any perceived contractions or pain, should be evaluated at the nearest trauma center that has OB capabilities.
2. Increased plasma volume may delay hypotension.
3. Pelvic fractures have increased risk for fetal demise.
4. Carbon monoxide exposure in a pregnant female should be considered a mandatory transport.

5. Stretching of the peritoneum during the third trimester of pregnancy blunts the normal perception of pain. Therefore, relying on complaints of abdominal pain in the pregnant woman to alert the care provider to possible injury is unreliable.
6. Treatment Recommendations:
   a. Perform Doppler fetal heart rates (FHR) – normal 110-160; every 5 min FHR checks for 30 seconds (if capable).
   b. Padded stretcher
   c. Displace the gravid uterus (lateral tilt)
   d. Normal Saline or Lactated Ringers preferred (500-1000 ml bolus) – refer to local protocol
   e. Oxygen – keep SpO2 > 95%
   f. Consider tocolytics (medical director protocol)

F. **Pediatrics:** Pediatric is defined by the American College of Surgeons and recognized by GETAC, and NCTTRAC as < 15 years of age. Pediatric patients should be triaged preferentially to a Pediatric Trauma Center.
1. If the term "lethargic" is used by the caregiver, the term needs to be described.
2. When evaluating a patient that has experienced a possible life-threatening event and the parents/guardians refuse medical treatment or transport, contact medical control.

G. **Special Needs Population:**
1. Have legal guardians or caregivers pre-notify EMS of the presence of a special needs patient in the area.
2. Inform legal guardians or caregivers to notify EMS of specific special needs and request the information be added to EMS call text records.
3. Be prepared and equipped for patient latex allergies.
4. General recommendations:
   a. Treat ABCs first (like any other patient)
   b. Ask for help from caregivers (they know the patient best)
      i. Assume ill or injured if affect or level of consciousness changes
      ii. Copy, scan, or take picture of the ready sheet from the caregiver
      iii. Inquire about additional supplies and bring with the patient
      iv. Look for USB bracelet with patient information
   c. If the emergency is secondary to the patient's equipment – USE YOURS
   d. Communicate with the patient based upon her/his developmental age, but do not underestimate their ability to communicate based on physical limitations.
   e. Clear, calm, SLOW, and helpful communication with the patient and caregivers is key to easing the patient's stress.
   f. Do not rush, if possible
   g. Never underestimate the strength of some of the special needs patients
   h. Stay at arm's length away from the agitated patient
   i. Only use restraints as a last resort
   j. Some patients respond to items that provide tactile feedback
5. Transport recommendations:
   a. A slow, careful transfer with two or more people may be required
   b. Position of comfort
   c. Do not attempt to straighten contractures as this may result in a fracture
   d. Transport family member or caregiver with you if possible; if not possible consider a comfort item (e.g., blanket, toy).
   e. Transport to the patient's medical "home" hospital if possible

H. **Bariatric:** Patient habitus does NOT change trauma field triage criteria
1. Agencies need to develop bariatric patient management guidelines
2. Mutual aid inter-agency agreements

3. Equipment:
   a. Wider stretcher, higher related construction for load handling
   b. More robust ambulance construction
   c. Ramp equipment or hoist to load patient into vehicle
   d. Air mattress for lateral transfers
   e. Diagnostic equipment to proper fit these patients

I. **Transfer of Patient Care Info:** The regional standard for Patient Care Report (PCR/ePCR) handoff communication is as follows:
   1. The receiving facility should be notified of patient and patient status prior to EMS arrival.
   2. At the time of transfer of patient care, at a minimum, verbal communication will occur, and a paper short-list and/or electronic draft-report will be delivered.
   3. A final written or electronic full care report will be available within one business day.
   4. *This regional standard expounds upon the minimum requirements set-forth in TDSHS EMS Rule §157.11(m).*

Unstable Airway?

YES → Transport to the closest appropriate Trauma Center or Hospital Emergency Department.

NO

Measure Vital signs and level of consciousness

- Glasgow Coma Scale (GCS) ≤13
- Systolic Blood Pressure (mmHg) <90 mmHg (<110 for ≥ 65 years old)
- Respiratory Rate <10 or >29 or need for ventilator support

YES → Transport preferentially to the highest level of care within the local Trauma System via ground or air.

NO

Assess Anatomy of Injury

- Penetrating injuries to head, neck, torso
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long-bone fractures (humerus/femur)
- Crushed, de-gloved, mangled, and/or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fracture(s)
- Open or depressed skull fracture
- Paralysis

YES → Transport preferentially to the highest level of care within the local Trauma System via ground or air.

NO

Assess mechanism of injury and evidence of high-energy impact

- Falls ≥ 20ft
- High-risk auto crash evidenced by:
  - Intrusion, including roof: > 12 inches occupant site
    > 18 inches any site
  - Ejection from automobile (partial or complete)
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with high risk of injury
  - Extrication ≥ 20 minutes
- Auto vs. Pedestrian/Bicyclist > 20 mph impact and/or thrown/run over
- Motorcycle crash > 20 mph
- Burns > 10% TBSA
  - Without other trauma mechanism: triage to burn facility
  - With trauma mechanism: triage to trauma center

YES → Transport to closest appropriate trauma center

NO

Assess special patient or system considerations

- Geriatric patients (> 65 years of age)
  - May require higher-level triage and/or care
  - Low impact mechanisms (e.g. ground level falls) may result in severe injury
- Anticoagulants (DOACs) and bleeding disorders
  - Patients with head injury are at high risk for rapid deterioration
- ESRD/Dialysis patients
- Pregnancy > 20 weeks
- EMS provider judgment

YES → Transport to closest appropriate trauma center

NO

Transport per local protocol

- **Trauma centers are designated Level I-IV.**
- **A Level I center has the greatest amount of resources and personnel for care of the injured patient and provides regional leadership in education, research, and prevention programs.**
- **A Level II facility offers similar resources to a Level I facility, possibly differing only in continuous availability of certain subspecialties or sufficient prevention, education, and research activities. Level II facilities are not required to be resident or fellow education centers.**
- **A Level III center is capable of assessment, resuscitation, and emergency surgery, with severely injured patients being transferred to a Level I or II facility.**
- **A Level IV trauma center is capable of providing 24-hour physician coverage, resuscitation, and stabilization to injured patients before transfer to a facility that provides a higher level of trauma care**

Centers for Disease Control and Prevention. (n.d.). *Guidelines for field triage of injured patients: Recommendations of the national expert panel on Field Triage, 2011*. Centers for Disease Control and Prevention. Retrieved June 8, 2022, from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6101a1.htm

Unstable Airway or Traumatic Arrest

YES → Transport to the closest appropriate Trauma Center or Hospital Emergency Department.

NO

Measure vital signs and levels of consciousness

Age	SBP (mmHg)	*RR
< 1 y	< 70	< 20 or > 45
1-10 y	< 70 + 2x age	< 10 or > 29
> 10 y	< 90	< 10 or > 29

- Glasgow Coma Scale (GCS): ≤ 13
- *Respiratory compromise, obstruction, or intubation
- Blood Products to maintain vital signs

YES → Transport via ground or air preferentially to the highest level of Pediatric Trauma Center within the local Trauma System.

NO

Assess Anatomy of Injury

- GSW to head, neck, torso and/or extremities proximal to elbow and/or knee
- Burns > 10% TBSA and/or inhalation injury
  - Without other trauma mechanism: triage to burn facility
  - With trauma mechanism: triage to trauma center
- Amputation proximal to wrist or ankle
- Paralysis or suspected spinal fracture with neurological deficits
- Two or more long-bone fractures
- Open skull fracture
- Unstable pelvis
- Tender and/or distended abdomen

YES

NO

- Isolated closed head injury with loss of consciousness or altered mental status, currently A & O x 3
- Single long bone fractures
- Dislocations without neurovascular deficits
- Maxillofacial
  - Lacerations
  - Isolated open fractures
  - Orbit trauma/avulsed teeth

YES → Transport via ground or air preferentially to a Pediatric Trauma Center

NO

Assess mechanism of injury and evidence of high-energy impact

- Falls ≥ 10ft or 2-3 times the height of the patient
- High-risk auto crash evidenced by:
  - Intrusion, including roof: > 12 inches occupant site
    > 18 inches any site
  - Ejection from automobile (partial or complete)
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with high risk of injury
  - Extrication ≥ 20 minutes
- Auto vs. Pedestrian/Bicyclist > 20 mph impact and/or thrown/run over
- Motorcycle crash > 20 mph
- Isolated head injury with loss of consciousness or altered mental status
- Suspected Non-accidental trauma
- Burns >10% TBSA and/or inhalation injury
  - Without other trauma mechanism: triage to burn facility
  - With trauma mechanism: triage to trauma center

YES

NO

Transport per local protocol

- **Trauma centers are designated Level I-IV.**
- **A Level I center has the greatest amount of resources and personnel for care of the injured patient and provides regional leadership in education, research, and prevention programs.**
- **A Level II facility offers similar resources to a Level I facility, possibly differing only in continuous availability of certain subspecialties or sufficient prevention, education, and research activities. Level II facilities are not required to be resident or fellow education centers.**
- **A Level III center is capable of assessment, resuscitation, and emergency surgery, with severely injured patients being transferred to a Level I or II facility.**
- **A Level IV trauma center is capable of providing 24-hour physician coverage, resuscitation, and stabilization to injured patients before transfer to a facility that provides a higher level of trauma care**

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For Trauma Transfers Only

*****TRAUMA TRANSFER GUIDELINE*****

As stated in the Trauma Service Area – E Regional Trauma System Plan, this poster should serve as a template for your facility to utilize in the decision-making process regarding what injury patterns seen in trauma patients benefit from a higher level of care and hence an appropriate transfer.

SUGGESTED CRITERIA FOR CONDITIONS OF TRANSFER INCLUDE BUT ARE NOT LIMITED TO

Neurosurgical:
- Open skull fractures
- Lateralizing signs
- Spinal Cord injuries

Thoracic:
- Major chest wall injury
- Signs suggesting mediastinal injury
- Continued blood loss from chest injury

Multi-System:
- Multiple long bone fractures
- Burns with other associated injuries
- Injury to two or more body systems

Extremity Injuries:
- Fractures with evidence of vascular injury
- Open long bone fractures

Pelvis:
- Unstable pelvic ring fracture
- Pelvic injuries with ongoing evidence of blood loss
- Open pelvic injury

Comorbid Issues:
- >55 years old
- Cardiac or respiratory disease
- Pregnancy
- Blood thinners except aspirin

Pediatric:
Age < 15 according to ACS defined criteria
- Intracranial hemorrhage
- Suspected abuse or neglect

Reference ACEP

SUGGESTED PROCESS FOR TRANSFER

1) **If you already have transfer agreements with a trauma center, contact them directly per your protocol.**

2) **If you have a victim of trauma that exceeds your capabilities for care (see above criteria) and you have no transfer agreements with a specific trauma center, or they cannot accept your patient, call the transfer center phone number (listed below) associated with the most appropriate destination hospital.**

Baylor Scott & White ……..…….. 214.820.6444
Baylor University Medical Center (L1)
Baylor Scott & White Medical Center - Grapevine (L2)
Baylor Scott & White Medical Center – McKinney (L2)
Children's Medical Center Dallas (Pediatric, L1) ……..…. 888.730.3627
Cook Children's Medical Center (Pediatric, L2) ……..…….. 682.885.3901
John Peter Smith Hospital (L1) …….. 817.702.8417
Medical City (HCA) …….. 877.422.9337
Medical City Plano (L1)
Medical City Arlington (L2)
Medical City Denton (L2)
Medical City McKinney (L2)
Methodist Dallas Medical Center (L1) ……..…….. 214.947.4325
Parkland Hospital (L1) …… 214.590.6690
Texas Health …….. 888.730.3627
Texas Health Harris Methodist Hospital Fort Worth (L1)
Texas Health Presbyterian Hospital Dallas (L1)
Texas Health Presbyterian Hospital Plano (L2)

3) **EMResource, a web-based (www.NCTTRAC.org) regional medical capabilities application, is available to assist you in determining current capabilities at hospitals near you. Please contact NCTTRAC staff at (817) 608-0390 or NCTTRAC_EMCC@ncttrac.org for assistance with access credentials if needed.**

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 - Capability" status should be updated every 4 hours; a "Closed" status or "Advisory – ED Surge" 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 state and federal hospital bed reporting requirements. These numbers should be updated at least once every 24 hours – since March of 2020, there have been federal and state requirements for hospitals to update this information 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. DSHS may require certain data elements to be added to EMResource and/or they may set reporting requirements based on federal or state guidance; in such cases, NCTTRAC will work to identify common data elements to reduce redundant reporting requirements whenever possible.

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 – Capability”, and every 2 hours if the status is “Closed” or “Advisory – ED Surge”.

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 theirBed 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 – ED Surge	Service Line Statuses marked “Unavailable”	Psych ED Holds	All Bed Availability Categories	
	Service Line Statuses marked “Unavailable”			

4. EMResource Organization & Views

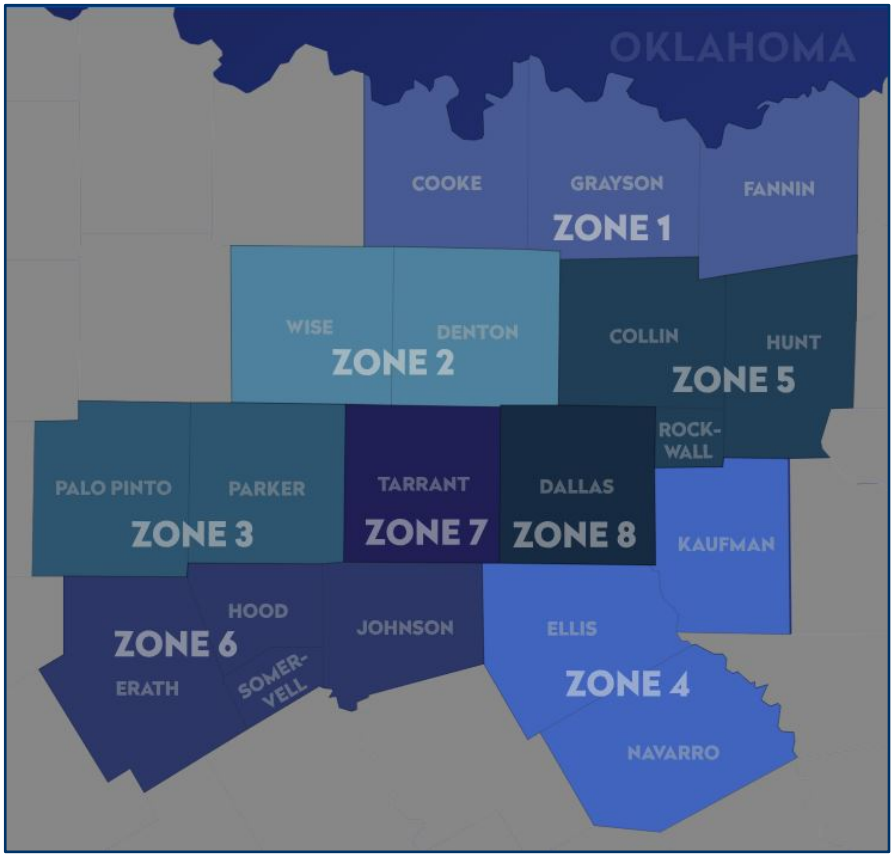
4.1 General Organization

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:

- Hospital Intake Status
- NEDOCS
- Psych ED Holds
- Phone: Transfer Line

- DSHS Trauma Designation
- DSHS Stroke Designation
- Status: MedSurg
- Status: ICU
- 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 TSA-E: Deployable Assets View

4.5.1 The TSA-E: Deployable 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 COVID-19 Hospital Data Reporting Fields/Statuses

5.1.1.1 Since March of 2020, the state and federal governments have imposed a wide variety of COVID-19 reporting requirements on hospitals. In Texas, hospitals report data to meet these requirements in EMResource. To find the most current version of the required COVID-19 Hospital Data Reporting fields, please visit the COVID-19 page on the NCTTRAC website.

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", at least once every 4 hours if the status is "Advisory – Capability", and at least once every 2 hours if the status is "Advisory – ED Surge" 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 about a clinical service closure so that EMS can make an informed decision regarding patient destinations. Hospitals may still receive EMS patients in order to provide immediate stabilization.. Reason for the Advisory and an ETA to normal operations is mandatory for the comments section. NEDOCS should be updated at the same time. This status option must be updated at least once every 4 hours. Hospitals must select one or more of the following status reasons: "Trauma", "Stroke", "STEMI", or "Other – see comments". Other examples for when this status is appropriate include (but are not limited to) the following: lack of CT due to a tube failure, Trauma surgeon unavailable, no, OR available for emergent cases, Cath lab unavailable.

5.1.1.2.3 Advisory – ED Surge: Hospital is advising EMS about extended off-load times due to current census and throughput status of the EDso 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 capacity. Hospitals may still receive EMS patients. This status option must be updated at least once every 2 hours. Comments are mandatory and NEDOCS should be updated at the same time. Examples for when this status is appropriate include (but are not limited to) the following: the ED has a NEDOCS in a Severe or Disaster status for a prolonged period of time, the ED is holding multiple inpatients requiring monitoring and average EMS offload times are greater than 20 minutes, a large influx of patients in a short amount of time has drastically increased EMS offload times.

5.1.1.2.4 Closed: The ED is experiencing an internal disaster or facility emergency that is preventing them from safely receiving patients. 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. Examples for when this status is appropriate include (but are not limited to) the following: fire, flooding, power outage, water shortage, structural damage, internal disaster, external disaster.

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 Available Staffed Bed Categories

5.1.12.1 Available Staffed bed categories indicate the current number of available beds of a particular type with the staffing, supplies, and equipment necessary to take care of a patient. In other words, "This is the number of this type of patient that my facility can currently accept."

5.1.12.3

5.1.12.3.1 Available Staffed ED Beds – Number of staffed available beds in the Emergency Department. Do not include occupied beds.

5.1.12.3.2 Available Staffed Med/Surge – Number of staffed available adult MedSurg beds capable of treating adult patients who do not require intensive care. Do not include occupied beds.

5.1.12.3.3 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.

5.1.12.3.4 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.

5.1.12.3.5 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. This count excludes NICU, newborn nursery beds, and outpatient surgery beds.–

5.1.12.3.6 Available Staffed Pediatric ICU (PICU) – 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. This count excludes NICU, newborn nursery beds, and outpatient surgery beds. Note: all pediatric ICU beds should be considered regardless of the unit on which the bed is housed. This includes ICU beds located in non-ICU locations, such as mixed acuity units.

5.1.12.3.7 Available Staffed NICU Beds – The number of telemetry-capable Neonatal ICU beds with the staffing, supplies, and equipment currently available to treat ill or premature newborn infants. Should not include beds that are currently occupied.

5.1.12.3.8 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.

5.1.12.3.9 Available Staffed Psychiatric Beds – Number of staffed available beds on a psychiatric unit. Do not include occupied beds.

5.1.12.3.10 Available Staffed Neg Pressure Isolation – Number of staffed available beds that can provide respiratory isolation through negative pressure airflow. Do not include these beds in other bed availability categories. Do not include occupied beds.

5.1.12.3.11 Available Staffed Outpatient Beds – Number of staffed available outpatient beds. Do not include occupied beds.

5.1.12.3.12 Available Staffed Observation Beds – Number of staffed available observation beds. Do not include occupied beds.

5.1.12.3.13 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.

5.1.12.3.14

5.1.12.3.15

5.1.12.3.16

5.1.12.3.17
5.1.12.3.18
5.1.12.3.19

5.1.12.5 MCI Patient Surge Capacities
- 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.
- 5.1.12.5.5 MCI Black - The facility's capacity for additional deceased victims.

5.1.12.6 Ventilator/BiPAP Availability
- 5.1.12.6.1 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.
- 5.1.12.6.2 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.
- 5.1.12.6.3

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 Describes a hospital's ability to accept interfacility transfers requiring ICU-level care. Should be updated once per day if the status is "Available" and once every 12 hours if the status is "Unavailable" or "Available w/Restrictions".
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 can currently accept interfacility transfers of patients requiring ICU-level care.
5.1.30.2.2 Available w/Restrictions: This facility can currently accept interfacility transfers of patients requiring ICU-level care, but with restrictions (i.e. can't accept COVID-positive patients, can only accept Trauma, Stroke, and STEMI patients, etc). List the

restrictions in the comments; comments are mandatory. Must be updated once every 12 hours.

5.1.30.2.2 Unavailable: The facility is temporarily unable to accept any interfacility transfers of patients requiring ICU-level care regardless of patient type. List the reason in the comments; comments are mandatory. This status option must be updated at least once every 12 hours.

5.1.30.2.3 Not Provided: This facility does not have the capability to treat ICU-level patients.

5.1.31 Status: MedSurg

5.1.31.1 Describes a hospital's ability to accept interfacility transfers requiring MedSurg-level care. Should be updated once per day if the status is "Available" and once every 12 hours if the status is "Unavailable" or "Available w/Restrictions".

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 accept interfacility transfers of patients requiring MedSurg-level care.

5.1.31.2.2 Available w/Restrictions: This facility can currently accept interfacility transfers of patients requiring MedSurg-level care, but with restrictions (i.e. can't accept COVID-positive patients, can only accept Trauma, Stroke, and STEMI patients, etc). List the restrictions in the comments; comments are mandatory. Must be updated once every 12 hours.

5.1.31.2.2 Unavailable: This facility is temporarily unable to accept any interfacility transfers of patients requiring MedSurg-level care regardless of patient type. List the reason in the comments; comments are mandatory. This status option must be updated at least once every 12 hours.

5.1.31.2.3 Not Provided: This facility does not have the capability to treat MedSurg-level patients.

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

I. Background

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.

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 guidance and motive to reduce trauma incidents and improve outcomes.

II. Purpose

The purpose of this document is to:

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

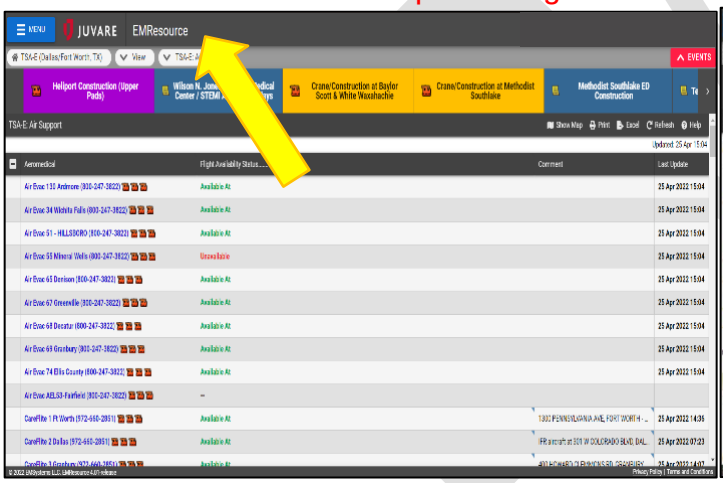
III. Desired Outcomes

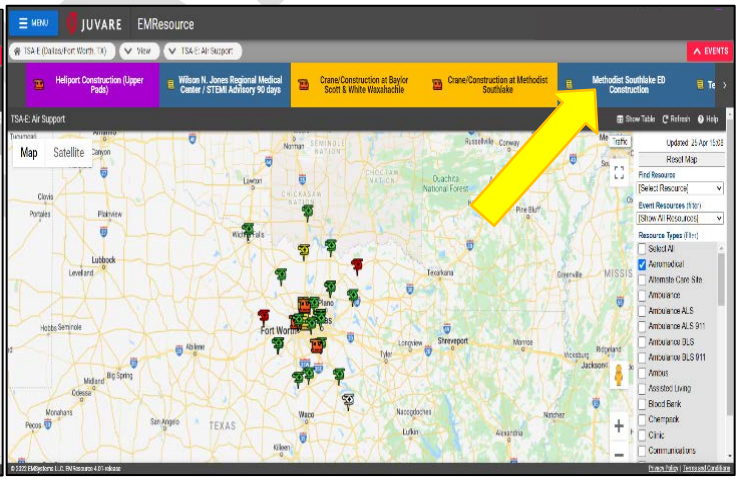
The desired outcome is to request the closest appropriate aircraft and integrate air medical providers into the NCTTRAC System Performance Improvement (SPI) process. The goal of the NCTTRAC SPI process is to reduce morbidity and mortality in TSA-E by identifying educational needs and opportunities for improvement in patient care and system processes while preserving and promoting the interworking relationships and collaboration among emergency healthcare providers. For this reason, the NCTTRAC SPI process should only be engaged after collegial attempts have been made to resolve patient care issues or concerns by and between the respective emergency healthcare providers.

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

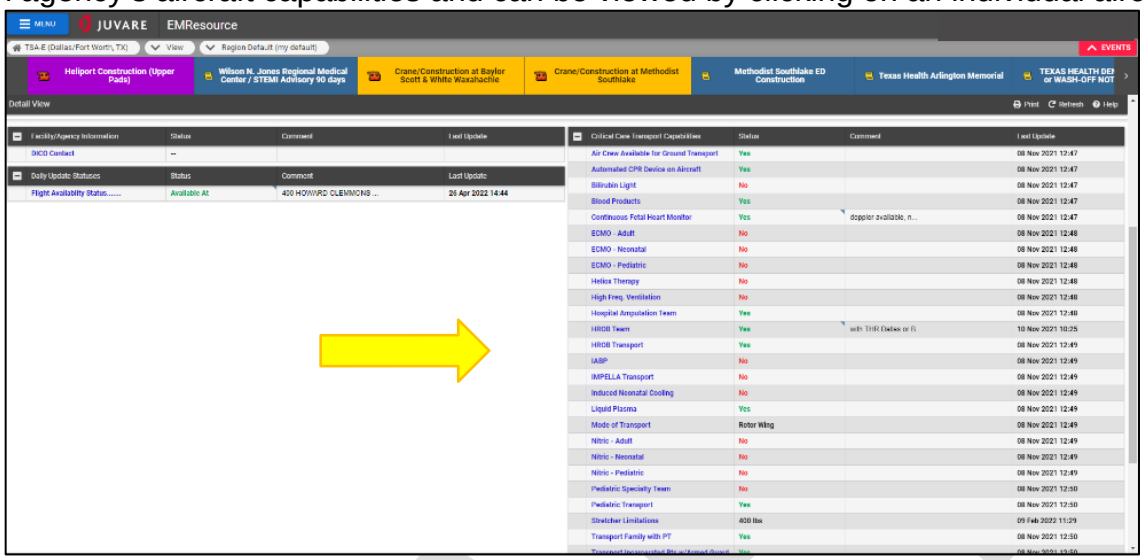
IV. Process to Locate, Request, Communicate, and Improve Air Medical Services

A. 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.
B. Obtain a facility or personal login by creating a support ticket with NCTTRAC
   1. Visit our website at http://ncttrac.org/
   2. Click on the SUPPORT icon , upper right corner
   3. Click on the TICKETS icon
   4. Click on 'Start Ticket'
   5. In the DEPARTMENT drop down box, choose "Crisis Applications – New Account Request TSA-E/DFW Region"
   6. Click Submit
C. Once Log In is attained, go to https://emresource.emsystem.com/login.htm
D. 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).
E. 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.
F. 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 patient flight





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.
The Critical Care Transport (CCT) Capability Matrix within EMResource shares information about each agency's aircraft capabilities and can be viewed by clicking on an individual aircraft.



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

G. **Air Medical Indicators** to be referred to the Air Medical SPI Focus Group **if not met**:
1. Air Medical Services will provide a **launch location of the aircraft responding**
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.
3. **ETE** (flight time only) will not exceed **5 minutes past time given**
4. **ETA** (clock time arrival given to include lift time) will not exceed **5 minutes past time given** (ETA is preferred over ETE by the GETAC Air Medical and Specialty Care Transport Committee)
5. Air Medical Services **scene times should not exceed 20 minutes** (does not include specialty teams)
6. Air Medical Services **inter-facility transfer times should not exceed 40 minutes** (does not include specialty teams)
7. Airway modality of choice successful on first attempt
8. Blood Glucose check for AMS should be reported using GAMUT data and definitions
9. Provide air medical transport response for inter-facility patients within 30 minutes from the time of the request

H. If a performance **indicator falls outside** of the above parameters and remains unresolved despite appropriate attempts among the involved providers, the event **may be referred to the NCTTRAC Air Medical SPI function group** for review and action.

I. The process for reporting a concern or submitting a referral to the Air Medical SPI function group is detailed below:
   1. Go to https://www.ncttrac.org/
   2. On the bottom right select Create A Helpdesk Ticket
   3. Start a Ticket
   4. Choose “Member – SPI Referral Form Request”
   5. Then fill in the necessary fields. Be as specific as possible to allow for a sufficient review.

Annex G
Disaster Preparedness & Response

Healthcare Coalition - E

Preparedness Strategy

NCTTRAC
600 Six Flags Dr. Suite 160
Arlington TX, 76011
May 2023

RECORD OF REVIEW

TSA-E Healthcare Coalition 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	2/2/2021	NCTTRAC Staff
Approved by the NCTTRAC Board of Directors	2/9/2021	NCTTRAC Staff
NCTTRAC Staff Review	3/28/2023	NCTTRAC Staff
Approved By REPC	Pending 6/6/2023	NCTTRAC Staff
Approved by the NCTTRAC Board of Directors	Pending 6/13/2023	NCTTRAC Staff

RECORD OF CHANGES

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

- Location within document (i.e., article, section)
- 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

Healthcare Coalition Preparedness Strategy

Article/Section	Change Number	Date of Change	Summary of Changes	Change Made by (Print Name)
All	1	1/19/2021	General Review & Touch-Ups	LaShanda Hernandez
All	2	12/03/2021	General Review and revisions to the following pages: G-1-19: Top Ten Hazard Vulnerability Analysis Regional Results; revised and included the 2021 hazards G-1-8 – G-1-10: Updated Activities and Responsibilities Matrix G-1-8 G-1-21: A: Appendix E: G-1-22: Update link	Stephanie McKinnis
All	3	01/18/2022	Changed font based on the NCTTRAC Style Branding Book guidance.	Stephanie McKinnis
All	4	04/12/2022	Cover Page: removed TSA-E G-1-9: Updated the HCC-E Structure G-1-17: Revised 2017 HPP Statement of Work and updated link for LMS. G-1-14: E Healthcare Coalition Objectives -Updated Short Term and Long-Term Healthcare Coalition objectives.	Stephanie McKinnis
All	5	04/19/2022	G-1-15 Updated Appendix B: HCC Partner List with the current HPP Contacts 2022 G-1-18 Updated Appendix F: TSA-E Training and Exercise Program	Stephanie McKinnis

Article/Section	Change Number	Date of Change	Summary of Changes	Change Made by (Print Name)
All	6	5/20/2022	Article V, Section B: Removed Gap Analysis and Responsibilities Matrix to be placed within the IPP.	Jeremy Brettschneider
All	7	5/22/2022	Appendix I: Inserted IPP link to	Jeremy Brettschneider
All	8	5/23/2022	References II: Updated References Links	Jeremy Brettschneider
All	9	3/6/2023	Updated HCC Partners List and Links	Jessica Dupree
G-1-34	10	3/7/2023	Updated link for 2022 HVA Report	Stephanie McKinnis

RECORD OF DISTRIBUTION

TSA-E Healthcare Coalition 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
HCC	Via NCTTRAC Website	6/20/2021
REPC	Via Email Addresses on File	6/20/2021
Board of Directors	Via Email Addresses on File	6/20/22

TABLE OF CONTENTS

II. References

Federal

- Office of the Administration for Strategic 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 (March 2020)
- 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,2021-2025
- 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 (2022)
- HCC-E Infectious Disease Response Annex
- 2022- 2023 HPP YR 21 HPP Scope of Work (SOW)

III. Introduction

A. Purpose

The Healthcare Coalition Healthcare Coalition-E (HCC-E) Preparedness Strategy is intended to provide a guide for current and future HCC-E preparedness activities. The document sets out the processes by which the HCC-E 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-E partnership 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 HCC-E Preparedness Strategy covers HCC preparedness activities for the Hospital Preparedness Program (HPP) 7-year block running from July 1, 2017, through June 30, 2024. The most recent revisions reflect planned activities from July 1, 2022 through June 30, 2024. This document applies to the Healthcare Coalition in TSA-E, which covers a 19-county area in North Central Texas. Specific geographical boundaries are identified further in the document. In addition to HCC-E partnership, 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 Council of Governments. This document does not supersede existing plans for individual agencies, facilities, and jurisdictions.

The HCC-E engages in activities across a continuum of preparedness and response efforts 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 HCC-E Preparedness Strategy will be reviewed and updated annually. All revisions and review activities will be noted in the Record of Changes section of 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 HCC-E for review and comments.
4. NCTTRAC staff reviews the Revised Preparedness Strategy Draft and HCC partner comments. NCTTRAC staff recommends approval to REPC and the Disaster Clinical Advisory Group (DCAG).

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. Healthcare Coalition Overview

A. Role of the Healthcare Coalition

The Healthcare Coalition HCC-E works with all partner 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 Healthcare Coalition planning can be achieved in TSA-E.
- Identify and assess regional needs 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.

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

- **Foundation for Health Care and Medical Readiness** – The HCC-E 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 HCC-E 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 HCC-E 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 HCC-E 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 HCC-E, in collaboration with DSHS Public Health Region 2/3,

coordinates information and available resources for its partners 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 Healthcare 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.

A regional medical response that is timely, well-coordinated, and regularly exercised can mitigate damages and save lives. The response goal of the HCC-E is to promote resiliency and ensure adequate surge capacity and capability across the HCC during a mass casualty or disaster situation. Effective response and recovery require a coordinated effort among public and private entities. Hospitals and healthcare facilities are critical during an emergency and therefore must be active participants in emergency preparedness efforts by partnering with EMS agencies, emergency management, public health, and other entities that are active in an emergency response. The HCC-E 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. Figure 1 shows the basic structure of the HCC-E.

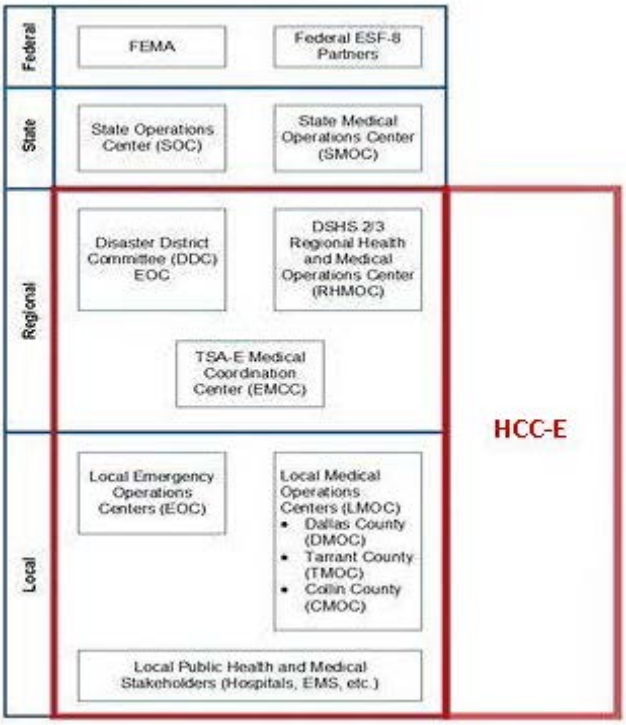


Figure 1: HCC-E Structure

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 partner organizations are often represented in HCC-E meetings and activities to ensure consistency between LMOC efforts and HCC efforts. Specific information concerning the coordination between LMOCs and other HCC partner organizations during an emergency response will be found in HCC-E. The HCC-E recognizes the need for a more intentional coordination effort between LMOCs and the HCC-E.

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 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 HCC-E Regional Response Strategy.

The HCC-E 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:

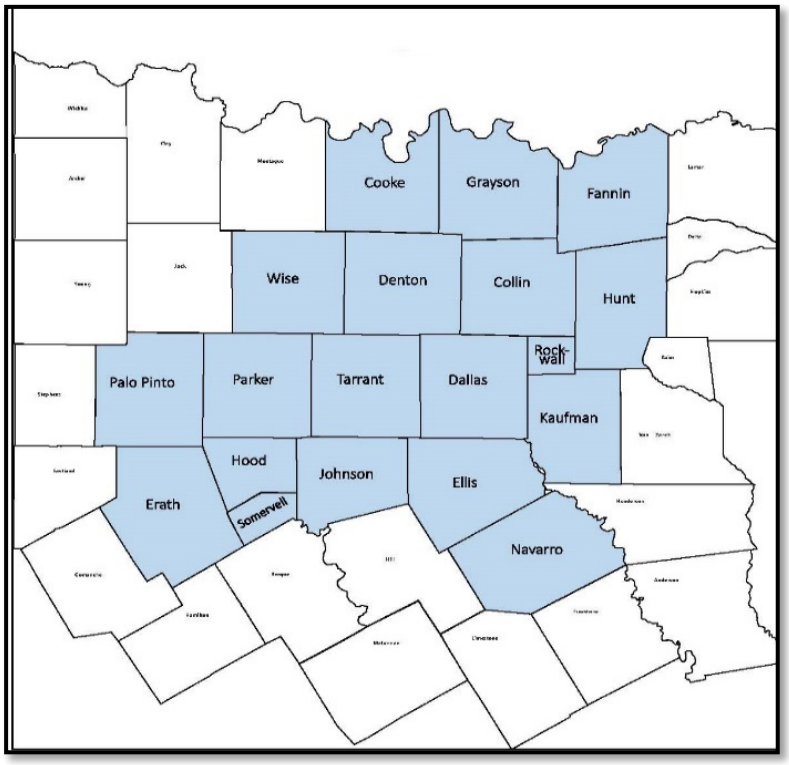
1. DSHS Public Health Region 2/3, serving Ellis, Hood, Hunt, Johnson, Kaufman, Parker, Rockwall, Somervell, and Wise counties
2. Collin County Health Care Services;
3. Dallas County Health and Human Services;
4. Denton County Health Department;
5. Grayson County Health Department;
6. Tarrant County Public 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 HCC-E 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. Healthcare Coalition Boundaries

The geographic boundaries of HCC-E align congruently with Trauma Service Area-E (TSA-E). TSA-E is the geographic area, whereas HCC-E consists of the organizations that make up coalition, including EMS, Hospitals, Public Health, and Emergency Management. Healthcare Coalition The following counties are included in TSA-E:

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



The HCC-E Healthcare 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 HCC-E coordinates with adjacent Healthcare Coalitions in TSA-C and TSA-D regarding Emergency Medical Task Force (EMTF) activities.

C. Healthcare Coalition Partners

Partnership in the Healthcare Coalition is 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), HPP Letter of Agreement Amendment, 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 Asset Transfer, Assignment And Assumption Agreement with NCTTRAC
- Completed other criteria as established and approved by REPC

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

- Acute Care Hospitals
- Emergency Medical Services (EMS)
- Emergency Management Organizations (EM)
- Public Health Agencies
- Medical Societies
- Behavioral Health Services and Organizations
- Dialysis centers and regional Centers for Medicare and Medicaid Services (CMS)-funded end-stage renal disease (ESRD) network
- Home Health Agencies
- VA Medical System
- Jurisdictional Partners (cities, counties, and tribes)
- Local chapters of health care professional organizations
- Schools and Universities (academic medical centers)
- Skilled Nursing, Nursing, and Long-term Care Facilities
- Other Types

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

D. Organizational Structure/Governance

The HCC-E Healthcare 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 Voting Representatives. 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 Co-Medical Directors
- Immediate Past REPC Chair
- Subcommittee Chairs and Chairs Elect

The REPC Voting Representatives serve as the governing body for the HCC-E and comprises representatives from hospitals, EMS, public health, emergency management, and other key partnering agencies. The REPC Voting Representatives hold voting authority within REPC (except were noted in the REPC SOP). Specific REPC Voting Representatives can be found in Appendix C. REPC forms temporary task force, specifically to handle individual projects which work to provide recommendations to the REPC Voting Representatives and the HCC-E at large. Healthcare Coalition

NCTTRAC staff serves as administrative support for HCC-E 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 Partner Organizations

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

HCC partner organizations identify the internal roles of their executive leadership on an individual basis. Generally, partner 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 partner organizations prior to execution. This process generally includes partner organization discussion with their leadership, regional surveys, and ad hoc meetings dedicated to partner organizational leadership.

E. Healthcare Coalition Objectives

The following list contains the HCC-E 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)

- Approve and oversee subcommittee goals throughout the program year.
- Review and approve HCC Project Proposals throughout the program year.
- Establish Ad Hoc Task Forces, as necessary, to address specific projects.
- Complete activities outlined in Appendix I: Healthcare Coalition-E Integrated Preparedness Plan (IPP)

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 Medical Response Strategy Annually
- Develop and approve an , Burn, Chemical, Infectious Disease, Pediatric, and Radiation Surge Annex to the HCC-E Medical Response Strategy prior to June 30, 2024.
- Develop an HCC-E Continuity of Operations Plan (COOP) in BP4 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 HCC-E has a number of operational objectives. These objectives 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 Healthcare Coalition

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

HCC-E activities are funded primarily through the Hospital Preparedness Program, while individual partner organizations are funded through a variety of revenue sources. The HCC-E 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-E recognizes that the development of additional revenue streams beyond the HPP will enhance stability and sustainment of HCC-E preparedness activities.

The HCC-E shares information regarding best practices and lessons learned in a variety of ways. REPC has a standing agenda item offering HCC-E partners the opportunity to share lessons learned and best practices with the rest of the HCC-E; 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 HCC-E is engaging with specific partners and stakeholders within the HCC-E partnership. 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 partner organizations in the overall governance of the HCC is noted in part D, subsection 1, “Role of Leadership within Partner 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 partner organizations in REPC and its associated subcommittees. REPC also has designated Co-Medical Directors 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. This collective group is know as the REPC Disaster Clinical Advisory Group (DCAG). Per ASPR the role of the Clinical Advisory Group is to:

- 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.
- Review and provide input on coalition plans, exercises, and educational activities to assure clinical accuracy and relevance.
- 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 mass casualty event.

Individual HCC partner 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-E partner organizations engage community leaders on an individual level. The HCC-E 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-E activity in the NCTTRAC Annual Report.

IV. Engagement of Partners and Stakeholders: Special Populations

The HCC-E includes partner organizations that represent special populations. Each partner organization can inform HCC-E 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. HCC-E can address intentional engagement of special populations through representation on the REPC Voting Representatives. To further partner engagement the HCC-E has established a Long-Term Care Task Force (LTC) to address vulnerabilities within long-term care facilities located in TSA-E.

HCC-E is also provided with the HHS emPOWER Emergency Planning De-identified Datasets semiannually. The de-identified (HIPAA masked) dataset includes at-risk Medicare beneficiaries from the Medicare Fee-For-Service (FFS/Parts A& B) and Medicare Advantage (CMS' HMO plans/Part C) Programs that rely upon the electricity-dependent durable medical equipment (DME) and cardiac implantable devices and healthcare services that include ESRD (dialysis), oxygen tank services, and home health visits. This information is provided to to enhance situational awareness of and support emergency planning for and public health response activities for at-risk individuals that rely upon select electricity-dependent durable medical equipment (DME), facility-based dialysis and oxygen tank services prior to, during, or after an emergency or disaster. The DME that are included are: ventilators, oxygen concentrators, IV infusion pumps, suction pumps, at-home dialysis, electric wheelchairs, and electric beds.

G. Compliance Requirements and Legal Authorities

The HCC-E Healthcare 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 HCC-E are listed in the 2020 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 HCC-E 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 partner organizations developing internal Emergency Preparedness programs and plans. The HCC-E strives to address gaps identified in the individual plans of HCC partner organizations. HCC partner 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 HCC-E 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 partner 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 LMS link.

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 to maintain their status as an HPP sub-recipient. The LoA also lays out the responsibilities of NCTTRAC in regard 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 1 Mobile Emergency Response Communications (MERC) trailers, 4 AMBUSes, 3 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 partner 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 partner organization could provide during an EMTF response.

The HCC-E understands the process and information required to request necessary waivers and suspension of regulations. Specifically, the HCC-E 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 HCC-E has adopted the North Texas Mass Critical Care Guidelines developed by the North Texas Mass Critical Care Task Force (NTMCCTF). The NTMCCTF was a regional collaboration of physicians, hospitals, ethicists, clergy, legal professionals, public health experts, elected leaders, and others who gathered to create clinical guidelines for use by physicians, hospitals, first responders, and other healthcare professionals during an overwhelming disaster. Crisis standards of care documentation for adults and pediatrics (including clinical treatment guidelines) can be found in the HCC-E Regional Medical Response Strategy in Annex A, North Texas Mass Critical Care Guidelines and the TSA-E Regional Trauma System Plan.

V. Healthcare Coalition Risk Summary and Gap Analysis

A. Regional Hazard Vulnerability Analysis -November 2022

The Regional Hazard Vulnerability Assessment (HVA) Report is a product of the HCC-E Healthcare Coalition including The North Central Trauma Regional Advisory Council, HCC – E hospital and prehospital partners. The Regional HVA is drawn from information reported by HCC partner 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 HCC-E. The Regional HVA is then used to guide HCC preparedness activities. The Regional HVA is updated annually.

Top Ten Hazard Vulnerability Analysis Regional Results – November 2022
1) **Tornado**
2) **Severe Weather**
3) **Winter Weather/Freeze Event**
4) **Pandemic**
5) **IT System Outage**
6) **Active Shooter**
7) **Epidemic**
8) **Power Outage**
9) **Temperature Extremes/Heat Extremes**
10) **Infectious Disease Outbreak**

VI. Healthcare 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
   - Regional event notification
   - Information gathering and sharing
   - Bed availability reporting
   - Crisis applications/communications support
   - Regional medical resource coordination
   - Patient tracking administration support
   - Patient destination decision support
   - HCC liaison support to the DDCs and local EOCs
   - EMTF mobilization/activation coordination
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 Healthcare 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

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

B. Preparedness Activity Tracking

Preparedness activity tracking will be accomplished in two ways. HCC-E preparedness activities will be tracked on a strategic level and reported to DSHS using the Coalition Assessment Tool (CAT). HCC-E preparedness activities will be tracked internally using the Activities and Responsibilities Matrix found in the Integrated Preparedness Plan (IPP). 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	Administration for Strategic Preparedness and Response
AST	Ambulance Strike Teams
CAT	Coalition Assessment Tool
CLO	County Liaison Officers
CMS	Centers for Medicare & Medicaid Services
COG	Council of Governments
CST	Coalition Surge Test
DBH	Disaster Behavioral Health
DCAG	Disaster Clinical Advisory Group
DDC	Disaster District Chair/Committee/Coordinator
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
EOC	Emergency Operations Center
ESF-8	Emergency Support Function-8
HCC	Healthcare Coalition
HCO	Health Care Organization
HVA	Hazard Vulnerability Analysis
ICU	Intensive Care Unit
IDRU	Infectious Disease Response Unit
IPP	Integrated Preparedness Plan
LMHA	Local Mental Health Authority
LMOC	Local Medical Operation Center
LTC	Long Term Care
MHMR	My Health My Resources
MICU	Mobile Intensive Care Unit
M-IST	Medical Incident Support Teams
MMU	Mobile Medical Unit
MRSE	Medical Response Surge Exercise
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
SALT	Sort, Assess, Life-saving Interventions, Treatment / Transport
SMHA	State Mental Health Authority
SOC	State Operations Center
SOG	Standard Operating Guideline
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: 2022-2023 HCC-E Partner List

Organization Name	Partner Type	Participation Type
ACADIAN AMBULANCE SERVICE INC	EMS	EMTF
ADDISON FIRE DEPARTMENT	EMS	EMTF
CAREFLITE-GROUND	EMS	EMTF
CHILDRENS MEDICAL CENTER TRANSPORT	EMS	EMTF
CITY OF CELINA FIRE DEPARTMENT	EMS	EMTF
CITY OF GRAND PRAIRIE DBA GRAND PRAIRIE FIRE	EMS	EMTF
CITY OF LUCAS FIRE~RESCUE	EMS	EMTF
CITY OF SACHSE FIRE DEPARTMENT	EMS	EMTF
CITY OF WYLIE FIRE RESCUE	EMS	EMTF
COPPELL FIRE DEPARTMENT	EMS	EMTF
DUNCANVILLE FIRE DEPARTMENT	EMS	EMTF
FARMERS BRANCH FIRE DEPARTMENT	EMS	EMTF
FLOWER MOUND FIRE DEPARTMENT	EMS	EMTF
FRISCO FIRE DEPARTMENT	EMS	EMTF
GARLAND FIRE DEPARTMENT	EMS	EMTF
IRVING FIRE DEPARTMENT	EMS	EMTF
KRUM FIRE DEPARTMENT	EMS	EMTF
LIFECARE EMS - PARKER COUNTY HOSPITAL DISTRICT	EMS	HPP / EMTF
MIDLOTHIAN FIRE DEPARTMENT	EMS	EMTF
RICHARDSON FIRE DEPARTMENT	EMS	EMTF
ROWLETT FIRE DEPARTMENT	EMS	EMTF
WISE COUNTY EMS	EMS	EMTF
ADVANCED DALLAS HOSPITAL	Hospital	HPP
AIR EVAC EMS INC	EMS	EMTF
AMERICAN MEDICAL RESPONSE AMBULANCE INC DBA ARLINGTON EMS	EMS	Partner
AMERICAN MEDICAL RESPONSE AMBULANCE SERVICE INC - DALLAS	EMS	EMTF
AREA METROPOLITAN AMBULANCE AUTHORITY	EMS	EMTF
ARGYLE VOLUNTEER FIRE DISTRICT	EMS	EMTF
AZLE FIRE DEPARTMENT	EMS	Partner
BAYLOR SCOTT & WHITE ALL SAINTS MEDICAL CENTER - FORT WORTH	Hospital	HPP
BAYLOR SCOTT & WHITE EMERGENCY HOSPITAL AUBREY	FSED	Partner
BAYLOR SCOTT & WHITE HEART AND VASCULAR HOSPITAL - DALLAS	Hospital	HPP
BAYLOR SCOTT & WHITE INSTITUTE FOR REHABILITATION - FORT WORTH	Hospital	HPP

Organization Name	Partner Type	Participation Type
BAYLOR SCOTT & WHITE INSTITUTE FOR REHABILITATION - FRISCO	Hospital	HPP
BAYLOR SCOTT & WHITE INSTITUTE FOR REHABILITATION-DALLAS	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - CENTENNIAL	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - FRISCO	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - GRAPEVINE	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - IRVING	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - LAKE POINTE	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - MCKINNEY	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - PLANO	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - SUNNYVALE	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - TROPHY CLUB	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER - UPTOWN	Hospital	HPP
BAYLOR SCOTT & WHITE MEDICAL CENTER AT WAXAHACHIE	Hospital	HPP
BAYLOR SCOTT & WHITE SURGICAL HOSPITAL - FORT WORTH	Hospital	HPP
BAYLOR SCOTT & WHITE SURGICAL HOSPITAL - LAS COLINAS	Hospital	HPP
BAYLOR SCOTT & WHITE THE HEART HOSPITAL - DENTON	Hospital	HPP
BAYLOR SCOTT & WHITE THE HEART HOSPITAL - MCKINNEY	Hospital	Partner
BAYLOR SCOTT & WHITE THE HEART HOSPITAL - PLANO	Hospital	HPP
BAYLOR SURGICARE FRISCO	Hospital	Partner
BAYLOR UNIVERSITY MEDICAL CENTER	Hospital	HPP
BEACON EMERGENCY SERVICES TEAM, P.A.	Other	EMTF
BEDFORD FIRE DEPARTMENT	EMS	Partner
BIOTEL	Other	Partner
BURLESON FIRE DEPARTMENT	EMS	HPP
CANNEFAX CONSULTING	Other	EMTF
CAREFLITE-AIR	EMS	Partner
CARROLLTON FIRE DEPARTMENT	EMS	EMTF
CARROLLTON REGIONAL MEDICAL CENTER	Hospital	HPP
CHILDRENS MEDICAL CENTER OF DALLAS	Hospital	HPP
CHILDRENS MEDICAL CENTER PLANO	Hospital	HPP
CITIZENS EMS	EMS	EMTF
CITY OF ARLINGTON	Other	Partner
CITY OF CEDAR HILL	EMS	EMTF

Organization Name	Partner Type	Participation Type
City of Denison	Other	Partner
CITY OF DENTON	EMS	Partner
CITY OF DUBLIN	EMS	EMTF
CITY OF EULESS FIRE DEPARTMENT	EMS	EMTF
CITY OF FORT WORTH	EMS	EMTF
City of Fort Worth OEM	OEM	Partner
CITY OF GRAND PRAIRIE OFFICE OF EMERGENCY MANAGEMENT	OEM	Partner
CITY OF GRAPEVINE FIRE DEPARTMENT	EMS	EMTF
CITY OF HURST FIRE DEPARTMENT	EMS	EMTF
CITY OF LANCASTER	EMS	EMTF
CITY OF LEWISVILLE FIRE DEPARTMENT / OEM	EMS	EMTF
CITY OF MANSFIELD FIRE DEPARTMENT	EMS	EMTF
CITY OF MIDLOTHIAN	Other	Partner
COLLEYVILLE FIRE DEPARTMENT	EMS	Partner
COLLIN COUNTY PUBLIC HEALTH	Public Health	Partner
COOK CHILDRENS MEDICAL CENTER	Hospital	HPP
COOK CHILDRENS MEDICAL CENTER - EMS	EMS	EMTF
COOK CHILDREN'S MEDICAL CENTER PROSPER	Hospital	HPP
COOKE COUNTY EMS	EMS	EMTF
CORSAIR CONSULTING	Other	EMTF
CRESCENT MEDICAL CENTER LANCASTER	Hospital	HPP
DALE AVIATION INC DBA MEDICAL AIR RESCUE COMPANY	EMS	EMTF
DALLAS BEHAVIORAL HEALTHCARE HOSPITAL LLC	Hospital	HPP
DALLAS COUNTY HHS	Public Health	Partner
DALLAS FIRE RESCUE	EMS	Partner
DALLAS MEDICAL CENTER	Hospital	HPP
DALLAS REGIONAL MEDICAL CENTER	Hospital	HPP
DENTON COUNTY PUBLIC HEALTH	Public Health	Partner
DENTON FIRE DEPARTMENT	EMS	EMTF
DESOTO FIRE RESCUE	EMS	EMTF
DFW AIRPORT DPS	EMS	Partner
DSHS 2-3	Public Health	Partner
EDGECLIFF VILLAGE FIRE DEPARTMENT	EMS	Partner
ELLIS COUNTY OEM	OEM	Partner
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF ARLINGTON	Hospital	HPP
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF CITYVIEW	Hospital	HPP

Organization Name	Partner Type	Participation Type
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF DALLAS	Hospital	HPP
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF PLANO	Hospital	HPP
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF PROSPER	Hospital	HPP
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF RICHARDSON	Hospital	HPP
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF THE MID-CITIES	Hospital	HPP
ENHABIT HOSPICE	LTC	Partner
ENNIS REGIONAL MEDICAL CENTER	Hospital	HPP
ENVISION	Other	Partner
ERATH COUNTY EMERGENCY MEDICAL SERVICES	EMS	EMTF
EULESS PD	Public Safety	HPP
GIATROS HOLDINGS, LLC	Other	EMTF
GLEN OAKS HOSPITAL	Hospital	HPP
GLEN ROSE MEDICAL CENTER	Hospital	HPP
GRAYSON COUNTY OEM	OEM	Partner
GRAYSON COUNTY PUBLIC HEALTH DEPARTMENT	EMS	Partner
HEALTH TRANSPORT INC	EMS	EMTF
HEART OF TEXAS EMS	EMS	EMTF
HELPING RESTORE ABILITY	Other	Partner
HICKORY TRAIL HOSPITAL	Hospital	HPP
HIGHLAND VILLAGE FIRE DEPARTMENT	EMS	EMTF
HUNT COUNTY EMS	EMS	Partner
HUNT REGIONAL MEDICAL CENTER GREENVILLE	Hospital	HPP
JOHN PETER SMITH HOSPITAL	Hospital	HPP
JOHNSON COUNTY OEM	OEM	Partner
KELLER FIRE RESCUE	EMS	Partner
KINDRED HOSPITAL DALLAS CENTRAL	Hospital	HPP
KINDRED HOSPITAL-TARRANT COUNTY (ARLINGTON)	Hospital	HPP
KINDRED HOSPITAL-TARRANT COUNTY (FORT WORTH OAKMONT)	Hospital	HPP
LAKE GRANBURY MEDICAL CENTER	Hospital	HPP
LEGENT HOSPITAL FOR SPECIAL SURGERY	Hospital	Partner
LIFECARE HOSPITALS OF FT WORTH	Hospital	HPP
LIFECARE HOSPITALS OF NORTH TEXAS - DALLAS	Hospital	HPP
LIFECARE HOSPITALS OF PLANO	Hospital	HPP
MCKINNEY FIRE DEPARTMENT	EMS	EMTF

Organization Name	Partner Type	Participation Type
MEDICAL CITY ALLIANCE	Hospital	HPP
MEDICAL CITY ARLINGTON	Hospital	HPP
MEDICAL CITY DALLAS - Children's HOSPITAL	Hospital	Partner
MEDICAL CITY DALLAS HOSPITAL	Hospital	HPP
MEDICAL CITY DENTON	Hospital	HPP
MEDICAL CITY FORT WORTH	Hospital	HPP
MEDICAL CITY FRISCO A MEDICAL CENTER OF PLANO FACILITY	Hospital	HPP
MEDICAL CITY GREEN OAKS HOSPITAL	Hospital	HPP
MEDICAL CITY HEART & SPINE HOSPITALS	Hospital	Partner
MEDICAL CITY LAS COLINAS	Hospital	HPP
MEDICAL CITY LEWISVILLE	Hospital	HPP
MEDICAL CITY MCKINNEY	Hospital	HPP
MEDICAL CITY NORTH HILLS	Hospital	HPP
MEDICAL CITY PLANO	Hospital	HPP
MEDICAL CITY WEATHERFORD	Hospital	HPP
MEDSTAR	EMS	Partner
MESQUITE REHABILITATION INSTITUTE	Hospital	HPP
MESQUITE SPECIALTY HOSPITAL	Hospital	HPP
METHODIST CHARLTON MEDICAL CENTER	Hospital	HPP
METHODIST DALLAS MEDICAL CENTER	Hospital	HPP
METHODIST HOSPITAL FOR SURGERY	Hospital	Partner
METHODIST MANSFIELD MEDICAL CENTER	Hospital	HPP
METHODIST MCKINNEY HOSPITAL LLC	Hospital	HPP
METHODIST MIDLOTHIAN MEDICAL CENTER	Hospital	HPP
METHODIST REHABILITATION HOSPITAL	Hospital	Partner
METHODIST RICHARDSON MEDICAL CENTER	Hospital	HPP
METHODIST RICHARDSON MEDICAL CENTER CAMPUS FOR CONTINUING CARE	Hospital	Partner
METHODIST SOUTHLAKE HOSPITAL	Hospital	HPP
MHMR - TARRANT COUNTY	Other	Partner
MINERAL WELLS FIRE EMS	EMS	EMTF
MUENSTER MEMORIAL HOSPITAL	Hospital	Partner
NAVARRO REGIONAL HOSPITAL	Hospital	HPP
NORTH CENTRAL SURGICAL CENTER LLP	Hospital	HPP
NORTH CENTRAL TEXAS COUNCIL OF GOVERNMENTS	Other	Partner
NORTH RICHLAND HILLS FIRE DEPARTMENT	EMS	EMTF
NORTH TEXAS MEDICAL CENTER	Hospital	HPP
NORTH TEXAS MEDICAL CENTER COMPLETE CARE	Other	Partner

Organization Name	Partner Type	Participation Type
PALO PINTO GENERAL HOSPITAL	Hospital	HPP
PANTEGO FIRE DEPARTMENT	EMS	Partner
PARKER COUNTY EMERGENCY SERVICES - OEM	OEM	HPP
PARKER COUNTY ESD 1	EMS	HPP
PARKER COUNTY ESD 6	EMS	HPP
PARKLAND MEMORIAL HOSPITAL	Hospital	HPP
PECAN PLANTATION VFD & EMS INC	EMS	Partner
PLANO FIRE RESCUE	EMS	EMTF
POSSUM KINGDOM LAKE VOL FIRE AND AMB SERVICE	EMS	EMTF
POSSUM KINGDOM WESTLAKE VOL EMS	EMS	EMTF
POTTSBORO FIRE DEPARTMENT	EMS	EMTF
PROSPER FIRE DEPARTMENT	EMS	EMTF
QUESTCARE DFW EM	Other	EMTF
REBA MCENTIRE CENTER FOR REHABILITATION	Hospital	HPP
RED OAK HEALTH AND REHABILITATION	Hospital	Partner
RENDON FIRE DEPARTMENT	EMS	Partner
RICHLAND HILLS FIRE RESCUE	EMS	Partner
ROANOKE FIRE DEPARTMENT	EMS	EMTF
SACRED CROSS EMS INC	EMS	EMTF
SELECT REHABILITATION HOSPITAL OF DENTON	Hospital	HPP
SHERMAN FIRE DEPT	EMS	EMTF
SOMERVELL COUNTY	EMS	EMTF
STEPHENVILLE FIRE DEPT	EMS	EMTF
STONEGATE SENIOR LIVING - LEWISVILLE	Other	Partner
SUNNYVALE FIRE RESCUE DEPARTMENT	EMS	Partner
Surepoint Arlington	Stand Alone ED	HPP
Surepoint Azle	Stand Alone ED	HPP
Surepoint Denton	Stand Alone ED	HPP
Surepoint Fort Worth North	Stand Alone ED	HPP
Surepoint Grand Prairie	Stand Alone ED	HPP
Surepoint Gus Thomasson	Stand Alone ED	HPP
Surepoint Pantego	Stand Alone ED	HPP
Surepoint Rowlett	Stand Alone ED	HPP

Organization Name	Partner Type	Participation Type
Surepoint Samuell Farm	Stand Alone ED	HPP
Surepoint Stephenville	Stand Alone ED	HPP
Surepoint Weatherford	Stand Alone ED	HPP
TARRANT COUNTY MEDICAL EXAMINERS DISTRICT	Other	Partner
TARRANT COUNTY OEM	OEM	Partner
TARRANT COUNTY PUBLIC HEALTH	Public Health	Partner
TDEM DDC 4A - HURST	OEM	Partner
TERRELL STATE HOSPITAL	Hospital	HPP
TEXAS HEALTH - COOPERATE OFFICE	Other	Partner
TEXAS HEALTH ARLINGTON MEMORIAL HOSPITAL	Hospital	HPP
TEXAS HEALTH CENTER FOR DIAGNOSTICS & SURGERY PLANO	Hospital	HPP
TEXAS HEALTH HARRIS METHODIST HOSPITAL ALLIANCE	Hospital	HPP
TEXAS HEALTH HARRIS METHODIST HOSPITAL AZLE	Hospital	HPP
TEXAS HEALTH HARRIS METHODIST HOSPITAL CLEBURNE	Hospital	HPP
TEXAS HEALTH HARRIS METHODIST HOSPITAL FORT WORTH	Hospital	HPP
TEXAS HEALTH HARRIS METHODIST HOSPITAL HURST-EULESS-BEDFORD	Hospital	HPP
TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHLAKE	Hospital	HPP
TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHWEST FORT WORTH	Hospital	HPP
TEXAS HEALTH HARRIS METHODIST HOSPITAL STEPHENVILLE	Hospital	HPP
TEXAS HEALTH HEART & VASCULAR HOSPITAL ARLINGTON	Hospital	HPP
TEXAS HEALTH HOSPITAL BURLESON	Hospital	Partner
TEXAS HEALTH HOSPITAL CLEARFORK	Hospital	Partner
TEXAS HEALTH HOSPITAL FRISCO	Hospital	HPP
TEXAS HEALTH HOSPITAL MANSFIELD	Hospital	Partner
TEXAS HEALTH HOSPITAL ROCKWALL	Hospital	HPP
TEXAS HEALTH HUGULEY HOSPITAL	Hospital	HPP
TEXAS HEALTH PRESBYTERIAN HOSPITAL ALLEN	Hospital	HPP
TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS	Hospital	HPP
TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON	Hospital	HPP
TEXAS HEALTH PRESBYTERIAN HOSPITAL FLOWER MOUND	Hospital	HPP
TEXAS HEALTH PRESBYTERIAN HOSPITAL KAUFMAN	Hospital	HPP
TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO	Hospital	HPP

Organization Name	Partner Type	Participation Type
TEXAS HEALTH RESOURCESE WILLOW PARK	Hospital	Partner
TEXAS HEALTH SEAY BEHAVIORAL HEALTH HOSPITAL PLANO	Hospital	HPP
TEXAS HEALTH SPECIALTY HOSPITAL FORT WORTH	Hospital	HPP
TEXAS HEALTH SPRINGWOOD BEHAVIORAL HEALTH HOSPITAL	Hospital	HPP
TEXAS INSTITUTE FOR SURGERY AT TEXAS HEALTH PRESBYTERIAN DALLAS	Hospital	Partner
TEXAS REHABILITATION HOSPITAL OF ARLINGTON	Hospital	Partner
TEXAS REHABILITATION HOSPITAL OF FORT WORTH	Hospital	HPP
TEXAS REHABILITATION HOSPITAL OF KELLER	Hospital	Partner
TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN - DALLAS	Hospital	HPP
TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN - FRISCO	Hospital	Partner
TEXOMA MEDICAL CENTER	Hospital	HPP
THE BELLS-SAVOY COMMUNITY EMERGENCY SERVICE INC DBA TEXAS VITAL CARE EMS	EMS	EMTF
TMC BEHAVIORAL HEALTH CENTER	Hospital	HPP
TMC BONHAM HOSPITAL	Hospital	HPP
TOWN OF LITTLE ELM FIRE DEPARTMENT	EMS	EMTF
TRANS-STAR AMBULANCE	EMS	EMTF
TRINITY REGIONAL HOSPITAL SACHSE	Hospital	Partner
USMD HOSPITAL AT ARLINGTON	Hospital	HPP
USMD HOSPITAL AT FORT WORTH	Hospital	Partner
UTSW WILLIAM P CLEMENTS HOSPITAL	Hospital	HPP
VAN ALSTYNE FIRE/RESCUE	EMS	EMTF
VARMC BONHAM	Hospital	Partner
VARMC DALLAS	Hospital	Partner
VERNON FIRE DEPARTMENT	EMS	EMTF
VIBRA SPECIALTY HOSPITAL	Hospital	HPP
WHITE ROCK MEDICAL CENTER	Hospital	HPP
WILSON N JONES REGIONAL MEDICAL CENTER	Hospital	HPP
WISE HEALTH SURGICAL HOSPITAL	Hospital	Partner
WISE HEALTH SYSTEM-DECATUR	Hospital	HPP

Appendix C: REPC Standard Operating Procedures

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

SOP 2022-2023 Regional Emergency Preparedness Committee

Appendix D: Hospital Preparedness Program Agreements

The most current Hospital Preparedness Program (HPP) Letters of Agreement (LOA) can be found at the following links:

Public Agency HPP YR 16-20 LOA
Private Agency HPP YR 16-20 LOA
HPP Letter of Agreement Amendment
HPP Memorandum of Sharing

Appendix E: HCC-E Hazard Vulnerability Assessment Report

The most current HCC-E Hazard Vulnerability Assessment Report may be found at the following link:

NCTTRAC HCC-E 2022 Hazard Vulnerability Analysis Report

The most current HCC-E Hazard Vulnerability Assessment Report Dashboard may be found at the following link:

NCTTRAC HCC-E Hazard Vulnerability Report Dashboard

Appendix F: HCC-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 hospitals, EMS, public health, emergency management, and long-term care facilities into discussion-based and operations-based exercises. Exercises are based on regional and state hazard vulnerability assessments as well as contractual requirements under the Hospital Preparedness Program (HPP) which funds HCC-E activity.

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 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) HCC-E Integrated Preparedness Plan (IPP) contains preparedness activities including training and exercises necessary to strengthen the core capabilities that are essential to preventing, protecting against, mitigating the effects of, responding to, and recovering from regional threats and hazards.

HCC- E hosts the annual Integrated Preparedness Plan Workshop (IPPW) formally known as the Training and Exercise Planning Workshop (TEPW) to revise the multi-year schedule of preparedness activities. The workshop 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 Appendix I: Healthcare Coalition-E Integrated Preparedness Plan (IPP), which provides a yearly guide to projected training opportunities and a five-year plan for exercises in the region.

Both the HCC-E Gap Analysis and Activities and Responsibilities Matrix may be found in Appendix I: Healthcare Coalition-E Integrated Preparedness Plan (IPP).

Appendix G: Bed Availability Tracking

A general concept of bed availability is referenced in the HCC-E Medical Response Plan. Bed availability is reported by hospitals in EMResource at a frequency determined by current events: during "normal" non-response times, hospitals are encouraged to update their bed availability daily. 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.

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. This is most recently outlined in the NCTTRAC Self Standing Care Centers CONOPS.
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.

Appendix I: Healthcare Coalition-E Integrated Preparedness Plan

The purpose of the North Central Texas Trauma Regional Advisory Council's (NCTTRAC) Healthcare Coalition E (HCC-E) Integrated Preparedness Plan (IPP) – formerly known as the Multiyear Training and Exercise Plan (MYTEP) - is to document the process necessary to strengthen the core capabilities that are deemed essential in preventing, protecting against, mitigating the effects of, responding to, and recovering from regional threats and hazards. The IPP 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 Trauma Service Area - E (TSA-E).

Healthcare Coalition (HCC) E Regional Medical Response Strategy

NCTTRAC
600 Six Flags Dr. Suite 160
Arlington TX, 76011
April 3, 2023

RECORD OF REVIEW

Review Actions	Date	Review Body
Initial Draft, consolidation of related publications	01/07/2019	Regional Partners & NCTTRAC EMCC Staff
Review by the HCC Planning Subcommittee	12/04/2018	NCTTRAC Staff
Approved by REPC	06/11/2019	NCTTRAC Staff
NCTTRAC Staff Review and Recommendations for changes and updates	03/03/2022 03/07/2022 03/22/2022	NCTTRAC Staff
EHS Committees	06/01/2022 – 06/07/2022	
REPC Approval	06/06/2022	
Board of Directors Approval	6/14/2022	
NCTTRAC Staff Review and Recommendations for changes and updates	3/28/23	NCTTRAC Staff
EHS Committees		
REPC Approval		
Board of Directors Approval		

RECORD OF CHANGES NOTICE

The North Central Texas Trauma Regional Advisory Council ensures that necessary changes and revisions to the HCC-E Regional Medical Response Strategy 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 HCC-E Medical Response Strategy revised copies will be dated and marked to show where changes have been made.

The Record of Changes table may be found on the following pages.

RECORD OF CHANGES

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

- Location within document (i.e., article, section)
- 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	Change Number	Date of Change	Summary of Change	Change Made by
Whole Document	1	02/03/2022	Updated language and updated STATS throughout whole document	J. Brettschneider
I, C, 1	2	02/10/2022	Updated TSA map and HVA	J. Brettschneider
I, C, 1c	3	02/16/2022	Updated trauma facilities	J. Brettschneider
II, B	4	02/28/2022	Updated member roles and responsibilities	J. Brettschneider
Unapplicable	5	03/08/2022	Deleted approval and implementation page / Deleted EMCC activation organization / Deleted EMCC Floor Plan	J. Brettschneider
IV, H	6	03/15/2022	Added transfer centers and transfer phone number table	J. Brettschneider
IV, F	7	03/20/2022	Revised and updated communications and information section	J. Brettschneider
III, A/B/C	8	03/28/2022	Updated TX EMTF section	J. Brettschneider
V, A/B/C	9	04/01/2022	Revised and updated regional mass causality incident section	J. Brettschneider
IV, F	10	04/01/2022	Added family reunification and patient tracking section	J. Brettschneider
VII, A	11	04/04/2022	Updated appendices	J. Brettschneider
VIII	12	04/06/2022	Updated and reformatted Annexes	J. Brettschneider
Whole Document	13	02/02/2023	Updated WebEOC changes and updated STATS throughout whole document	M. Murray
IV, D/E/F	14	03/03/2023	Revised and updated Incident Response Section	M. Murray, D. Shadd
Whole Document	15	03/28/2023	Updated language throughout entire document	NCTTRAC Staff
VII/VIII	16	04/01/2023	Updated Contact information and Links	R. Pignatelli
V, C, 3	17	04/14/2023	Updated the Regional MCI Recommendations	M. Murray

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TABLE OF CONTENTS

I. Introduction

A. Purpose

1. The purpose of the Health Care Coalition-E (HCC-E) Regional Medical Response Strategy is to provide an overview of medical response coordination efforts to natural and manmade events that threaten the emergency healthcare system within HCC-E. This strategy describes the HCC-E's support of strategic planning, information sharing, and resource management efforts during large-scale emergency medical response.

B. Scope

1. The HCC-E Regional Medical Response Strategy covers regional medical response coordination efforts to large-scale emergency events affecting the HCC-E. While this strategy lays out activities and efforts that are common to most emergency incidents, not all incidents are the same, and the elements of this strategy that are executed will vary based on the hazard and scope of any individual incident. This strategy only covers the response for the HCC-E; there may be other agencies within the coalition that may also have a response strategy. Similarly, each resource (i.e., EMS agencies, FROs, and Public Health, Emergency Management) may have their own protocols in place. *Please note, these plans do not supersede jurisdictional or agency plans.*
2. The statutory authority of HCC-E is limited to the items defined in the following agreements:
   a. Hospital Preparedness Program (HPP) Public/Private Letter of Agreement (LoA) and amendment
   b. Healthcare Coalition Memorandum of Sharing (MoS)
   c. TX Emergency Medical Task Force (EMTF) Memorandum of Agreement (MoA)
   d. NCTTRAC Asset Transfer, Assignment, and Assumption Agreement
   e. Resource-Specific Memorandums of Agreement (MoA)

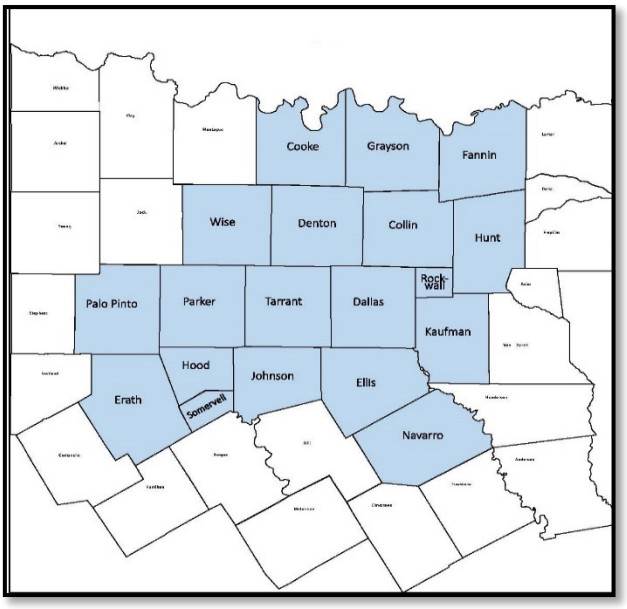
   Please note, these agreements do not supersede jurisdictional or agency plans nor existing mutual aid agreements and compacts.
3. This strategy was developed with the input of and includes (but is not limited to) the following HCC-E partners and components:
   a. Regional Emergency Preparedness Committee (REPC)
   b. Trauma Service Area - E Medical Coordination Center (EMCC)
   c. Emergency Medical Task Force 2 (EMTF-2) Subcommittee
   d. Participant Hospitals & Hospital Systems
   e. Participant EMS Agencies
   f. Participant Public Health Agencies
   g. Participant Jurisdictional Emergency Managers
   h. Other Provider Types impacted by CMS Emergency Preparedness Rule

C. Situation & Assumptions

1. Situation
   a. The geographic boundaries of HCC-E align congruently with Trauma Service Area-E (TSA-E). TSA-E is the geographic area, whereas HCC-E consists of the organizations that make up the coalition. A regional map, list of counties, and a summarized regional Hazard Vulnerability Assessment (HVA) are in the figures below. The DFW Metro-Area is the pulse of the 19-county region with its four most populous counties, Dallas, Tarrant, Collin, and Denton being central within the region and adjacent to one another. The population of these four counties make up 84% of the total estimated population of 7.7M within TSA-E per census.gov.

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

County Map of TSA-E



Top Ten Hazard Vulnerability Assessment - 2022
1) Tornado
2) Severe Weather
3) Winter Weather/Freeze Event
4) Pandemic
5) IT System Outage
6) Active Shooter
7) Epidemic
8) Power Outage
9) Temperature Extremes/Heat Extremes
10) Infectious Disease Outbreak

The HVA Dashboard may be found at: https://ncttrac.org/programs/healthcare-coalition-hpp/tsa-e/training-exercise/

b. TSA-E contains the following DSHS Trauma-Designated facilities as of April 3, 2023. Individual facilities can be found in the TSA-E Regional Trauma System Plan or on the DSHS website at https://dshs.texas.gov/emstraumasystems/etrahosp.shtm

8 – Level I Comprehensive Trauma Facilities
7 – Level II Major Trauma Facilities
17 – Level III Advanced Trauma Facilities
21 – Level IV Basic Trauma Facilities

c. TSA-E is generally considered to be medically resource rich with regards to capacity and capabilities. The following are the number of some resources within TSA-E as of January 5, 2023:

154 General Hospitals
136 Special Care Facilities
113 EMS Agencies

141 First Responder Organizations (FRO)
942 Long Term Care Facilities
18 Psychiatric Hospitals

2. Assumptions
   a. The potential for substantial loss of life is significant during Mass Casualty Incidents (MCI) and patient survival is dependent on the availability and rapid deployment of critical resources.
   b. As established in Texas Disaster Medical System (TDMS), the Department of State Health Services (DSHS) Public Health Region (PHR) 2/3 is the Emergency Support Function-(8) (ESF-8) Lead Agency in TSA-E.
   c. The TSA-E Medical Coordination Center (EMCC) provides support for health and medical care delivery by hospitals and Emergency Medical Services (EMS) agencies. The EMCC is staffed and operated by NCTTRAC with potential support from local medical incident support team members (MIST).
   d. Local jurisdictions should exhaust available resources, including local mutual aid resources, before requesting additional assistance from NCTTRAC.
   e. Emergency Medical Task Force-2 (EMTF-2) may activate in support of a regional disaster. The EMTF-2 Coordination Center is housed in and supported by the EMCC.
   f. EMTF-2 will coordinate with the TX EMTF State Coordination Office (SCO) routinely and in disaster response.
   g. During mass casualty incidents, regionally supported Crisis Standards of Care, or deviation from conventional standards of care and triage may be implemented to provide the highest level of medical care capable of being delivered under disaster conditions. The HCC-E Crisis Standards of Care may be found in Annex A and Annex B, *North Texas Mass Critical Care Guidelines Document* for Adults and Pediatrics. It is important to note that the responsibilities for implementing the crisis standard of care, lies solely with the organization.
   h. Primary medical treatment facilities may be damaged or inoperable after an incident occurs.
   i. The establishment of alternate care sites may be necessary to supplement local healthcare systems. However, barring major infrastructure damage, it is generally preferred to increase surge capacity at existing healthcare facilities as opposed to building temporary care facilities in austere conditions.
   j. Deploying agencies are responsible for responder safety and health during all phases of emergency response.
   k. Hospitals and EMS agencies will coordinate with their local county Emergency Management Office routinely and in a disaster response.

D. Administrative Coordination

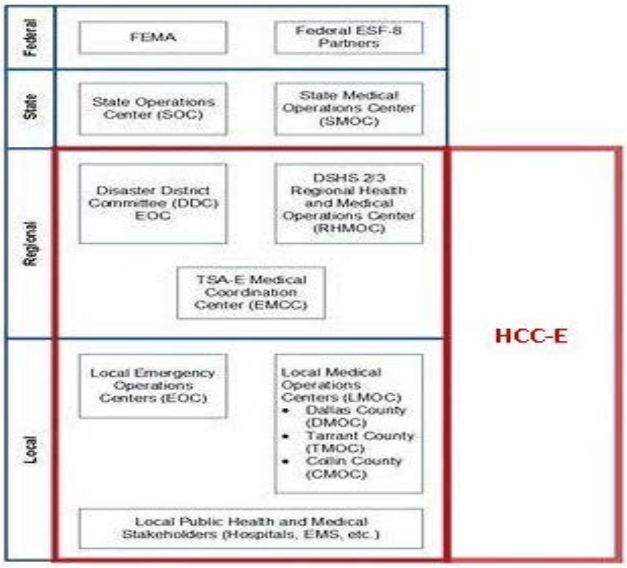
1. The HCC-E Regional Medical Response Strategy will be reviewed and updated annually. All revisions and review activities will be noted in the Record of Changes in the front of the document. General review procedures involve the following:
   a. NCTTRAC staff annually reviews Response Strategy to ensure consistency with other regional plans.
   b. NCTTRAC staff annually reviews recent exercise and real-world incidents and incorporates identified areas of improvement into the Response Strategy.
   c. Revised Response Strategy Draft is distributed to HCC members for review and comments.
   d. REPC votes to recommend approval of revised Response Strategy.
   e. Disaster Clinical Advisory Group votes to recommend approval of revised Response Strategy.
   f. NCTTRAC Board of Directors votes to endorse the Revised Response Strategy.
   g. Revised Response Strategy is voted for approval by NCTTRAC General Membership as part of the TSA-E Regional Trauma System Plan.

h. Revised Response Strategy is submitted into the Administration for Strategic Preparedness and Response (ASPR) Coalition Assessment Tool (CAT)

II. Role of the Coalition

A. Summary

1. A regional medical response that is timely, well-coordinated, and regularly exercised can mitigate damages and save lives. The response goal of the HCC-E is to promote resiliency and ensure adequate surge capacity and capability across the HCC during a mass casualty or disaster situation. Effective response and recovery require a coordinated effort among public and private entities. Hospitals and healthcare facilities are critical during an emergency and therefore must be active participants in emergency preparedness efforts by partnering with EMS agencies, emergency management, public health, and other entities that are active in an emergency response. The HCC-E 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. Figure 1 shows the basic structure of the HCC-E Health Care Coalition.



B. Member Roles and Responsibilities

1. Generally, the emergency response roles of the HCC-E and its composite partner organizations follow the following structure:
   a. Individual EMS agencies respond to emergency scenes, provide pre-hospital triage and treatment, and transport patients to appropriate healthcare facilities. Immediate response activities are coordinated and overseen by the local incident command structure.
   b. Healthcare facilities provide in-depth medical care to patients who arrive at their location (whether via EMS transport, inter-facility patient transfers, or patient self-presentation).
   c. In TSA-E, some counties maintain County Medical Operations Centers (MOCs). The exact roles and responsibilities of a County MOC will vary between counties, but generally County MOCs provide medical operations support and coordination within their designated county. County MOCs often serves as the medical liaison between county emergency management and individual healthcare facilities or EMS agencies.
   d. The TSA-E Medical Coordination Center (EMCC) serves as the regional response support arm of the HCC-E. The EMCC does not direct the response activities of individual HCC partner organizations, but rather it provides coordination and support for those response activities to ensure that overall regional medical needs are being met. While EMCC activities may vary based on the hazard and scope of the incident, generally the EMCC will notify the HCC-E of emergency incidents, gather, and share essential elements of information across the HCC, coordinate EMTF-2 response activation activities, provide medical resource support for regional medical operations, and help coordinate large-scale patient movement.

e. County Public Health Agencies serve as the ESF-8 Lead Agency for their counties and provide public health surveillance and response to their jurisdictions.
f. DSHS PHR 2/3 operates the Regional Health and Medical Operations Center (RHMOC) and serves as the ESF-8 lead agency within their jurisdiction. The RHMOC supports and coordinates regional public health related activities whereas the EMCC supports and coordinates regional medical care related activities.
g. Local emergency management organizations coordinate overall emergency response activities within their jurisdiction. The Texas Division of Emergency Management (TDEM) will activate local Disaster District Committees (DDC) which support and coordinate regional emergency management related activities.

A detailed breakdown of HCC-E partner organizations and their roles, responsibilities, and resources can be found below.

HCC Partner Types	Roles & Responsibilities	Resources
TSA-E Medical Coordination Center (EMCC)	• Sharing information between HCC members and with other jurisdictional partners • Maintaining situational awareness • Sharing and coordinating resources • Coordinating patient movement and evacuation • Assisting with coordination of mass shelter operations • 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	• Blue-Med Medical Tent • Radiation Detection Portal • Drive Thru Screening Tent • Flexmort System • Mass Fatality Trailer • Shelter Support • The Mintie Environmental Containment Unit • Medical Operations Coordination Kits • Plum Case Enterprise • RadEye B20 Radiation Survey Meters
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 and care • Wildland fire medical support	• AMBUS • Ambulance Staging Management Team (ASM) • Ambulance Strike Team (AST) • Mobile Medical Unit (MMU) • VIPER Trailer • ASM Trailer • Infectious Disease Response Unit and PPE • MIST • Registered Nurse Strike Team (RNST) • Tactical Medic Support Unit • Texas Mass Fatality Operations Response Team (TMORT)

HCC Partner Types	Roles & Responsibilities	Resources
		• Wildland Fire Medical Support Unit
EMS	• Provide emergency medical care and transportation • Triage & tag patient with unique identifier • Activate mutual aid plans or procedures • Notify the EMCC about emergent disasters, including MCIs • Establish an Ambulance Staging Area • Request additional EMS resources	• Advanced Life Support (ALS) • Basic Life Support (BLS) • Mobile Intensive Care Unit (MICU) • Special services (USAR, Trench Rescue, Swift Water, etc.)
Hospitals	• Provide quality patient care to the sick and injured. • 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 Hospitals • Specialty Care Hospitals • Burn Centers • Pediatric Hospitals • General Acute Hospitals
Hospital System Transfer Centers	• Participates in HCC-E patient coordination and patient transfer calls during mass patient movement (e.g., Evacuations, hurricanes, internal disasters) • Day to day operations still applicable	• Baylor Scott and White Health System • Medical City Health System • Methodist Health System • Texas Health Resources System • Children's Health System • Cook Children's Healthcare System
Emergency Management	• Disaster Surveys • Incident Related Situational Awareness • Disaster Summary Outlines • Assist local healthcare providers with resource requests through the STAR process	• City/ County Emergency Managers • City Emergency Operation Centers (EOC) • County EOCs
DSHS PHR 2/3 Regional Health and Medical Operations Center (RHMOC)	• Medical material management and distribution • Public Health surveillance and epidemiological investigation • Coordination of regional infectious disease testing • Provide Public Health liaison to regional DDC	• Regional Health Medical Operations Center (RHMOC) • Epidemiologist • Strategic National Stockpile (SNS) • Clinical Field Offices

HCC Partner Types	Roles & Responsibilities	Resources
	• Coordinate Public Health education and communication efforts • Provide Public Health services to non-public health counties	
Local Public Health Departments	• Public Health Surveillance • Public Health Education • Strategic National Stockpile coordination • Points of Dispensing coordination • Fatality Management • Vector Control • Environmental Inspections	• Epidemiologists • SNS • Shelter Operations Team • Health Department EOC/MOC • Medical Reserve Corp
Texas District Disaster Committee/ Chair (DDC)	• Assist local officials in carrying out emergency planning, training, and exercises, and developing emergency teams and facilities • Coordinate resources of state agencies, as requested by local jurisdictions. • Collect information for situation reports to state operations center. • Receives and processes STAR request • Identify urgent needs, advise local officials regarding state assistance, • Coordinate deployment of state emergency resources to assist local emergency responders.	• State Resources
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

C. ESF-8 Lead Agency Integration – Department of State Health Services

1. As the ESF-8 Lead Agency, The Texas Department of State Health Services (DSHS), Public Health Region 2/3 (PHR 2/3) provides essential emergency public health response information during urgent and emergency situations, such as a natural, manmade, or technological disaster. PHR 2/3 Staff will activate, establish, and staff the Regional Health Medical Operations Center (RHMOC) as a single point of contact for directing regional information to local and statewide public health stakeholders.
2. The basic organizational structure of the PHR 2/3 RHMOC consists of the Command Staff, Operations Section, Logistics Section, Planning Section, and Finance Section. Within each of these sections, subunits are created based on the complexity of the incident, functions needed, and tasks assigned to each unit.

3. DSHS and NCTTRAC will mutually support mass casualty events and disasters, including the mutual provision of ESF-8 liaisons to local Emergency Operations Centers (EOCs) and Disaster District Committees (DDCs). Generally, the RHMOC supports and coordinates regional public health activities whereas the EMCC supports and coordinates regional medical activities. At the DDC level, RHMOC liaisons and EMCC liaisons are generally stationed next to one another to ensure that all ESF-8 response support efforts are well-coordinated. The RHMOC and the EMCC communicate during emergency incidents via point-to-point contact (such as by cell phone, email, or radio).
4. The DSHS Public Health Region (PHR) 2/3 Community Preparedness section is an established notification group in the EMCC Mass Notification System and are notified as HCC-E activity levels change in response to emergencies within the region.

D. TSA-E Medical Coordination Center (EMCC)

1. While individual HCC partner organizations are responsible for clinical healthcare delivery and other immediate medical response operations, the EMCC serves as the regional medical response support and coordination arm of the HCC-E. As the HPP Contractor, NCTTRAC staffs and operates the EMCC. The objective of the EMCC is to support medical services delivery by hospitals and EMS agencies during emergencies.
2. The EMCC may support response to local, regional, state, and federal emergencies. Response activities will be scaled as appropriate for the given event and may range from desk support during working hours to 24/7 activation of the EMCC and the provision of liaison officers to work with various regional and state response agencies. Primary functions of the EMCC include:
   a. Regional event notification
   b. Information gathering and sharing
   c. Bed availability reporting
   d. Crisis applications/communications support
   e. Regional medical resource coordination
   f. Patient tracking administration support
   g. Patient destination decision support
   h. HCC liaison support to the DDCs and local EOCs
   i. EMTF mobilization/activation coordination
3. The EMTF-2 Coordination Center is a component of the NCTTRAC EMCC. The EMTF-2 Coordination Center is activated upon publication of State Mission Assignment (SMA) and/or as an emergency incident escalates and such activity is warranted.
4. The NCTTRAC EMCC works in conjunction with and in support of individual HCC partner organizations and other regional response organizations. The NCTTRAC Executive Director serves as the EMCC Executive Director and maintains final authority for all EMCC actions.
5. Specific details relating to EMCC position structure and internal operations can be found in Annex B, *Trauma Service Area E Medical Coordination Center Standard Operating Guidelines.*

III. Emergency Medical Task Force-2

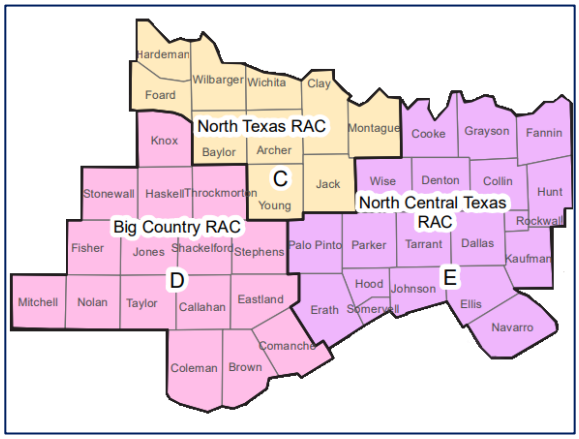
A. Overview

1. The goal of the Texas EMTF program is to provide a well-coordinated response, offering rapid professional medical assistance to emergency operation systems during large-scale incidents. Eight Emergency Medical Task Forces can be rostered across Texas.
2. TX EMTF is a regional and statewide medical response capability. NCTTRAC serves as the lead agency for administration of the EMTF-2 Program for North Central Texas (TSA-E – DFW), North Texas (TSA-C – Wichita Falls), and West Central Texas (TSA-D – Abilene). TX EMTF elements

will stand ready to provide medical surge support throughout the State of Texas, and regionally as requested for mutual aid. Designated EMTF-2, the regional task force can provide the following:

a. Ambulance Strike Team *(Team of paramedics to provide emergency medical services during a disaster).*
b. Medical Incident Support Teams (Provides *ESF-8 integrated subject matter expertise to EOCs).*
c. RN Strike Team *(Team of Registered Nurses to augment Emergency Department capabilities during a disaster).*
d. AMBUS *(Treatment and transport capability for 20+ patients during a disaster).*
e. Ambulance Staging Management Team *(Team dedicated to set up and operate a regional ambulance staging area).*
f. Mobile Medical Unit *(Temporary care facility during a disaster with 16 – 32 beds. Consists of tentage, equipment, and staffing).*
g. Infectious Disease Response Unit *(Dedicated transport services and hospital care capability for suspected and confirmed High-Consequence Infectious Disease patients).*
h. Wildland Fire Medical Support Teams *(Teams embedded within wildland firefighting units to provide immediate medical care).*
i. Air Medical Strike Team *(Air medical transport & evacuation services during a large-scale disaster).*
j. Tactical Medic Support Unit *(Support for Large-Scale/Complex Coordinated Terror Incidents).*
k. Texas Mass Fatality Operations Response Team *(Operational assistance to medicolegal authorities with site operations, morgue operations, Victim Identification Center, and Victim Information Center operations following a mass-fatality incident).*

3. Asset deployment time may be anywhere between 20 minutes to 2 hours, depending on asset(s) needed and the situation. When called upon by the State, teams and assets will deploy with costs reimbursed by the State. When called upon locally or regionally, costs must be reimbursed by the receiving jurisdiction, or be absorbed by the providing agency. More information on EMTF-2 processes and procedures can be found in Annex B, *Trauma Service Area E Medical Coordination Center Standard Operating Guidelines.*



B. Mission

1. Emergency Medical Task Force 2 (EMTF-2) is designed to respond to disasters or events to provide care and/or transportation. EMTF-2 resources may be requested by contacting NCTTRAC or local Disaster District Chair (DDC).

2. The mission of EMTF-2 is to augment and support the needs of an impacted community with temporary healthcare infrastructure configured to meet incident needs.
3. EMTF-2 will ensure that member agencies and deployment personnel are adequately prepared to perform at their highest level under the dynamic and often adverse circumstances faced in disaster medical operations. To facilitate this readiness, EMTF-2 will utilize the EMTF Coordinator to ensure that the highest level of preparedness by sending members to local, regional, and State trainings and exercise. EMTF-2/NCTTRAC annually hosts a MIST refresher, and a MMU and Advanced Logistics Warehouse Day. EMTF-2 also hosts a monthly meeting for team members and agencies to receive information and updates about the program.

C. Rosters & Notification

1. Notification – In the event of a notification of deployment the Texas Emergency Medical Task Force State Coordinating Office (TX-EMTF-SCO) will notify the EMTF-2 Coordination Center. The EMTF-2 Coordinator will then send a message via the Everbridge Notification System, polling for specific assets and their availability. EMTF-2 has developed a system of maintaining a pre-screened roster of persons and or assets who have signed Memorandum of Agreement's (MOA) with The Texas Emergency Medical Task Force.
2. Rostering – The EMTF-2 Coordinator will compile a "Roster" of agencies and their available assets based on their responses to the Everbridge. Everbridge is the software used for quick communication among EMTF-2 member agencies. Leadership from each agency will communicate to the coordinator the appropriate individuals from their agency they want notified; by type of deployment. When an Everbridge is sent out, partners will be notified by cell number, email, or office number. The notifications last 2-hours and will stop once the individual acknowledges it. The Everbridge will have specific information starting with the type of readiness level (Awareness, Standby, Activation) and the relevant support information like what personnel and assets are being requested, for how long, and when to muster. The coordinator will compile all of the information, make calls to confirm submission and build out the relevant team. Once completed, the EMTF-2 Coordinator will enter the information into appropriate boards on the TXEMTF WebEOC server. Rostering in TXEMTF WebEOC is the primary method of communicating team availability and roster details from the region to the SCO and SMOC.
3. Activation – The SCO will notify the EMTF-2 Coordinator that the rostered assets have been activated once a State Mission Assignment (SMA) has been granted. The EMTF-2 Coordinator will then notify the rostered assets and have them muster at the NCTTRAC Warehouse. While enroute to the muster point, the EMTF-2 Coordinator will activate tracking devices, enter members into GroupMe, Stage Gear, and assign personnel in WebEOC. Upon completion of pre-deployment tasks, the EMTF-2 Coordinator will ensure all members have been briefed on deployment expectations, safety requirements, issued radios, tracking gear, and other deployable equipment. In coordination with the TX-EMTF SCO, all units will be tracked throughout the entire deployment.
4. Demobilization – The TX-EMTF SCO will notify the EMTF-2 Coordination Center its plans to DEMOB from a deployment. The EMTF-2 Coordinator will work with the deployed members to have them muster at the NCTTRAC warehouse upon departure from area of deployment. Upon arrival to NCTTRAC warehouse the EMTF-2 Coordinator will collect any gear that accompanied the deployed members. The EMTF-2 coordinator and member will continue to track demobilization statuses via GroupMe. Once members clear Parent Organization, the will continue to be tracked until the member makes it back to their home of residence. Once all activated resources have reported being demobilized complete, then EMTF-2 Coordinator will report to the TX EMTF SCO the region is demobilization complete.
5. Reconstitution – After the deployment is complete, the EMTF-2 Coordinator along with the NCTTRAC Preparedness and Response personnel will thoroughly inspect all gear and note any

damage or issues. Function checks, and gear cleaning will occur with any broken or non-functional equipment being reported to the NCTTRAC Response leadership and immediately taken out of service. The reconstitution process of equipment and communication assets are a major priority in the time following an activation; proper reconstitution is critical to maintaining proper standards for readiness.

IV. Incident Response: General Concept of Operations

A. Incident Planning

1. Immediate emergency response goals and objectives are determined by the Incident Command Structure established by the authority having jurisdiction. Similarly, individual HCC partner organizations are responsible for internal strategic planning and goal setting. If the incident affects the HCC Coalition, leadership will meet virtually to help drive the specific strategic planning and goals.
2. The HCC-E supports regional medical strategic planning efforts through multi-agency coordination. This is usually accomplished through a combination of virtual coordination (via crisis applications and point-to-point communications) and physical coordination in the form of liaison support from HCC partner organizations to the EMCC and from the EMCC to local EOCs.
3. The EMCC will engage in virtual multi-agency coordination during every operating period. This ensures that important information is being gathered and shared across all levels of the emergency healthcare response and that regional ESF-8 response plans, strategies, and objectives are effective and well-informed. Virtual multi-agency coordination activities include:
   a. Information Sharing as described in the “Communications and Information Sharing” section of this document.
   b. Point-to-point communication with relevant affected entities, including (but not limited to) the following:
      i. HCC partner organizations (hospitals, EMS agencies, etc.) in the affected area.
      ii. County MOCs
      iii. County Public Health Agencies
      iv. County EOCs
      v. DSHS PHR 2/3 RHMOC
      vi. DDC 4A (Garland)
      vii. DDC 4B (Fort Worth/Hurst)
      viii. DDC 22 (Sherman)
      ix. EMTF State Coordination Office (SCO)
      x. DSHS State Medical Operations Center (SMOC)
4. The EMCC will provide or arrange HCC liaison support to local EOCs, DDCs, or the RHMOC as needed. EMCC liaisons may be a combination of NCTTRAC staff and/or EMTF-2 Medical Incident Support Team (MIST) members. While ideally the EMCC would provide a liaison to all affected EOCs, personnel resources to fill liaison roles can be scarce. EMCC liaison preference will be given to regional EOCs (such as the DDC or RHMOC) first, county MOCs and EOCs (such as the Dallas Medical Operations Center or the Tarrant County Emergency Operations Center) second, and city EOCs (such as the City of Denton Emergency Operations Center) third.
   a. To request an EMCC liaison, partner organizations should call the 24/7 Duty Phone at (817) 607-7020. A formal request via a State of Texas Assistance Request (STAR) may be required.
   b. The EMCC Liaison will serve as a subject matter expert on supporting pre-hospital and hospital emergency medical operations in TSA-E to ensure that regional response strategies, plans, and objectives are consistent with the needs of the HCC-E and its composite partner organizations. Additionally, the EMCC Liaison will help transfer information from the EMCC to the DDC or local EOC and vice versa, including medical resource requests.

5. The EMCC may request liaison support from HCC partner organizations to balance EMCC staffing with appropriate subject matter expertise. Representatives from EMS, Public Health, Hospital Systems, and jurisdictional Emergency Management may be requested to augment and inform emergency medical support operations during an EMCC activation. These representatives may be physically located in the EMCC or provide representation virtually.

B. EMCC Emergency

1. The EMCC is located at 600 Six Flags Drive Suite 150, Arlington, TX 76011. The EMCC has a radio room with multiple redundant communications systems built-in, a large open space with adjustable table and computer/phone setups, bathrooms, and a shower.
2. The NCTTRAC Warehouse is located at 4408 Barnett Boulevard, Arlington, TX 76017. The NCTTRAC Warehouse functions as a mobilization, demobilization, and reconstitution site for EMTF personnel and HPP medical supplies and equipment. It is also built out with communications and information system redundancy to ensure that it can serve as a secondary EMCC operational site.
3. While the EMCC maintains the physical space at the 600 Six Flags Drive address, most EMCC work can be done virtually using email, video conferencing, crisis applications, and point-to-point communications (such as cell phones or business phones). Physical EMCC activation versus virtual EMCC activation will be determined based on the details of the incident at hand.
4. Other relevant emergency facilities for the HCC-E include (but are not limited to):
   a. Healthcare System Emergency Operations Centers
   b. City Emergency Operations Centers
   c. County Medical Operations Centers
   d. County Emergency Operations Centers
   e. Regional Health and Medical Operations Center (RHMOC)
   f. DDC Emergency Operations Centers
   g. Public Safety Dispatch Centers
   h. Hospitals and Health Care Facilities

C. Readiness Levels

1. Many emergencies follow some recognizable build-up period during which actions can be taken to achieve a gradually increasing state of readiness. The EMCC uses a four-tier system. Readiness Levels will be determined by the NCTTRAC Executive Director or as directed under contract with DSHS State Medical Operations Center (SMOC). General actions to be taken at each readiness level are outlined below; specific functions during emergency situations will be directed by the NCTTRAC Executive Director.
2. The following Readiness Levels will be used as a means of recognizing increases in EMCC support posture:
   a. Normal – Normal refers to situations that are routine in nature and do not cause an interruption in daily operations for NCTTRAC Staff or HCC partner organizations. Limited assistance may be requested from jurisdictions or partners pursuant to established inter-local agreements, mutual aid agreements, or standard operating procedures.
   b. Elevated – Elevated refers to a situation that presents a greater potential threat than “Normal Conditions” but pose no immediate threat to life and/or property. General readiness actions may include increased situation-monitoring, a review of plans and resource status, determining staff availability, and placing personnel on-call for potential emergency operations. Advisory notifications may be published for general situational awareness.
   c. Partial Activation – Partial Activation refers to a situation with a significant potential and probability of causing loss of life and/or destruction of property. Declaration of a Partial Activation will normally require some degree of warning to the public. General readiness

actions may include continuous situation monitoring, identifying worst-case decision points, increasing preparedness of personnel and equipment, developing/providing the public with information designed to improve emergency health care delivery, preparing for evacuation and shelter operations, and identifying available medical resources including equipment, supplies, and personnel. Other actions may include establishing contact with public health and emergency management partners.

d. Full Activation – Full Activation refers to situations in which hazardous conditions are imminent. This condition denotes a greater sense of danger and urgency than is associated with a "Partial Activation" event. During a Full Activation, the EMCC is staffed for 24/7 operations. General readiness actions may include continuous situation monitoring, implementing active resource and information systems support, putting hospitals, EMS, and emergency management professionals on alert, and preparing for the deployment of medical services assets (including EMTF-2). A State Mission Assignment (SMA) will generally accompany a Full Activation and the time-period will generally exceed 12 hours.

D. Incident Recognition

1. Generally, individual HCC partner organizations will be the first to learn about emergent incidents. Upon recognition of an emergent incident that will affect the HCC-E, individual HCC partner organizations should notify the EMCC by calling the 24/7 Duty Phone. The 24/7 Duty Phone can be reached using the following numbers:
   a. 24/7 Duty Phone Primary Number: 817-607-7020
   b. 24/7 Duty Phone Secondary Number: 682-225-3559
2. The EMCC actively monitors real-world events which have the potential to impact the healthcare system in TSA-E. Severe weather incidents are often precipitated by some forewarning by the National Weather Service (NWS) in the form of an email NWS Weather Alert. The EMCC will forward significant NWS Weather Alerts to the HCC at-large using email distribution lists and EMResource event notifications. Similarly, planned community events with the potential to turn into a Mass Casualty Incident (MCI) may result in the EMCC notifying the HCC at-large and initiating a bed availability report in EMResource.
3. Information received by the EMCC regarding an incident will be vetted and shared along appropriate distribution lines on EMResource, email, and/or Everbridge.

E. Activation

1. The general process for a partner organization to request an EMCC activation is listed below:
   a. Affected HCC partners should notify the EMCC using the 24/7 Duty Phone as emergency situations begin to develop. The EMCC 24/7 emergency duty phone may be reached at (817) 607-7020.
   b. Initial activation requests may be made verbally to start regional support processes – these include (but are not limited to) region-wide alerting and issuing regional bed availability reports.
   c. All formal activation requests must be provided in writing within the first 24 hours following the initial request and should originate from the leadership of the requesting organization.
   d. For non-state activations of the EMCC, a general message such as an ICS-213RR may be used. If email submission of the 213RR is not available, a fax copy of the 213RR may be sent to (817) 608-0399. External partners should establish telephone contact with the EMCC to ensure reception of the request. For state activations of the EMCC, the preferred method is the State of Texas Assistance Request (STAR) in WebEOC. Telephone contact to the EMCC 24/7 Duty Phone at (817) 607-7020 to ensure delivery is recommended.
   e. If a 213RR is not available in electronic or hard copy form, written activation requests may be provided in any written narrative format. Follow local jurisdiction processes.

f. All EMCC activation requests should be concurrently provided to supporting jurisdictional partners. NCTTRAC will provide partners a copy of any activation request when it appears that jurisdictional emergency management partners have not been included in the request distribution.

2. The EMCC is activated in one of three ways:
   a. At the direction of the NCTTRAC Executive Director, his/her designee, or available senior staff member.
   b. At the direction of the DSHS SMOC (via a State Mission Assignment)
   c. At the request of HCC partner organizations and other regional partners. The authority to approve EMCC activation requests rests with the NCTTRAC Executive Director. Partner organizations that can request EMCC activation include, but are not limited to, the following:
      i. Regional hospitals, EMS agencies, and EMS Medical Directors
      ii. DDC 4A (Fort Worth/Hurst), DDC 4B (Garland), DDC 22 (Sherman), DDC 7 (Abilene), or DDC 3 (Wichita Falls)
      iii. DSHS PHR 2/3 (RHMOC)
      iv. City and county governments within TSA-E
3. Individual HCC partner organizations may activate their own command centers, emergency operations centers, or emergency operations plans independently of EMCC activations. Individual HCC partner organizations (including County MOCs) maintain activation criteria and protocols that are specific to their organization, jurisdiction, or county, and EMCC activation criteria, methods, and protocols do not supersede those individual procedures.
4. Initial EMCC activation actions can be found in Appendix C, *EMCC Activation Activities.*

F. Notifications

1. Mass notifications to HCC-E partner organizations occur primarily in EMResource using the "Events" feature. All EMResource users can create events in EMResource, but the EMCC is the primary creator of event notifications. When an emergent incident (such as an active shooter) occurs, HCC partner organizations should create an event notification in EMResource. If they are unable to do so, they should contact the 24/7 EMCC Duty Phone and staff will create the event notification instead. Urgent EMResource event notifications will also be distributed via email using NCTTRAC distribution lists to ensure that all relevant partners are notified.
2. The EMCC also receives EMResource notifications when certain statuses change – for example, when a hospital updates their status to "Closed" in EMResource, the EMCC is notified via email and text message. This notification can then be passed on to other relevant HCC partner organizations. HCC partner organizations also may set up status change notifications in EMResource. Deployable assets (such as AMBUSs, MERC Trailers, or Mass Fatality Trailers) changing their deployment status in EMResource also triggers email and text notifications to EMCC staff. This information can then be passed on to HCC partner organizations as needed.

G. Communications and Information Sharing

1. Information sharing and communication both within HCC-E and from the HCC to external partners occurs on a day-to-day basis during normal operations. The methods used to share information and communication amongst the HCC on a day-to-day basis form the foundation for information sharing and communication methods during response operations. Point-to-point communication during response operations should take place using the same primary methods as during normal operations, but information sharing will expand significantly. The following sections describe the platforms and methods used for communication and information sharing within the HCC to external partners during response operations, alerting and notification procedures, situational awareness, Essential Elements of Information (EEIs) sharing and redundant communications protocols should

primary communications systems become inoperable. More details on communication and information sharing in the HCC-E can be found in Annex C, *HCC-E Communications, and Information Sharing Concept of Operations* at the end of this document.

2. The primary point-to-point communications methods for HCC-E include email, cell phones, business phones, fax lines, and public safety radio systems. The primary information sharing platform for HCC-E is EMResource. All the aforementioned systems are used for communication and information sharing on a day-to-day basis in TSA-E and will continue to be used for those purposes during a regional emergency incident.
3. The secondary point-to-point communications methods for HCC-E include Public Safety Radio Systems, the D/FW Wide Radio System, the D/FW CONNCT Radio Overlay, Amateur Radio, Satellite Phones, and MSAT units. While some HCC partner organizations use public safety radio systems as a means of point-to-point communication during normal operations, they also play a significant role during emergency response operations as the primary means of interoperable communication between emergency response organizations. Each individual HCC partner organization maintains some combination of primary and secondary communications and information sharing methods. Secondary communications and information sharing methods will be employed as needed during an emergency response scenario.
4. EMTF-2 notifications and alerts are initiated using the Everbridge Notification System. This includes putting EMTF personnel on standby and rostering EMTF response components. The EMTF-2 Coordinator is responsible for issuing EMTF Everbridge alerts and analyzing their responses.
5. The Essential Elements of Information (EEIs) to be shared among HCC-E will vary depending on the type of hazard or scope of the emergency scenario (for example, the post-Hurricane Harvey IV fluid shortage saw the daily reporting of available IV fluids in EMResource). Generally, all EEIs that can be provided as status updates (hospital ED status, bed availability numbers, etc.) are shared through EMResource. Custom EEIs can be built on-the-fly in EMResource to allow for unanticipated EEI reporting. EEIs that are common to most or all incidents are listed below:
   a. Hospital ED Status (EMResource; updated daily)
   b. Hospital NEDOCS (EMResource; updated every six hours)
   c. Hospital Transfer Line Contact (EMResource; updated as needed)
   d. Hospital Staffed Bed Availability (EMResource; updated daily)
   e. Hospital MCI Patient Capacity (EMResource; updated daily)
   f. Hospital Interfacility Transfer Availability (EMResource; updated daily)
   g. Air Medical Unit Availability (EMResource; updated daily)
   h. Deployable Asset Deployment Status (EMResource; updated as needed)
   i. HCC Partner Organizations Response Actions Taken (email; updated upon request)
   j. MCI Patient Tracking Information (Pulsara)
6. Certain emergency/disaster scenarios might impact the functionality of primary communications methods. For example, a tornado might damage critical communications infrastructure rendering business and cell phones inoperable, or a cyber security threat might make email communication impossible. In scenarios where primary communications methods go down, individual HCC partner organizations should begin activating their own redundant communications plans and equipment to maintain communication channels with other individual HCC partner organizations. The NCTTRAC EMCC will begin reaching out to HCC partner organizations in the affected area using all secondary communications methods available. For example, in the event of a cell and landline phone outage, the NCTTRAC EMCC will use a satellite phone to call HCC member organizations with satellite phones, will use the D/FW Wide and D/FW Connect regional radio systems to contact HCC partner organizations who have access to those systems, and will use amateur radio to contact all other HCC partner organizations. Individual HCC partner organizations are expected to manage the operation and staffing of secondary communications systems for their organization.

H. Pre-Hospital Patient Transportation

1. Patient Destination Decisions
   a. To assist EMS with patient destination decision-making, EMCC staff will issue MCI patient surge capacity request to Hospitals via EMResource.
   b. Patient destinations for EMS transports are ultimately set by the on-scene command structure. The on-scene command structure can access EMResource to view MCI bed availability at local hospitals to make effective patient destination decisions. If the on-scene command structure is unable to access EMResource, they can call the EMCC using the 24/7 Duty Phone at (817) 607-7020. The EMCC will then relay bed availability information to the on-scene command structure as needed.
   c. Recent national MCIs have revealed that most MCI patients arrive at healthcare facilities using non-conventional methods of transport (self-transport, civilian vehicles, law enforcement, etc.) For this reason, hospitals cannot assume that they will only receive the number of patients they report to EMS that they can take; similarly, non-Trauma designated facilities should still expect to receive self-presenting Trauma patients who simply aim for the nearest hospital. HCC-E recommends that all hospitals create internal surge plans for up to 20 percent of their number of licensed beds.

2. Patient Transportation
   a. Responsibility for transporting patients from the scene to area hospitals ultimately lies with the on scene command structure. NCTTRAC will support patient transportation operations through coordination of local mutual aid mass casualty agreements and/or by rostering EMTF assets as needed. To ensure timeliness, the NCTTRAC Duty Phone (817-607-7020) can be called 24/7 for immediate support. Potential EMTF assets to assist with patient transportation include Ambulance Strike Teams (AST) and Ambulance Buses (AMBUS). AST and AMBUS requests should follow the identified resource request process using a STAR.
   b. Upon identification of the patient reception center, NCTTRAC will coordinate with the appropriate decision-makers in charge of patient transport to ensure that everyone is following the same patient distribution plan. Starting July 1, 2023, HCC-E will be moving to the Pulsara Platform for all patient tracking needs. The MCI Joint Task Force will also have a second round of meetings to discuss patient destination across the region. When we update the MCI Framework with these steps, we will also strengthen this section.

I. Inter-Facility Patient Transfer Coordination

1. Inter-Facility Patient Transfer Coordination during a disaster utilizes many of the same processes and resources that are utilized in day-to-day patient transfer activities. In some emergency or disaster scenarios (including some hospital evacuations), hospitals may be able to coordinate interfacility patient transfers using their normal methods. The TSA-E Medical Coordination Center will only assist a hospital with identifying transfer destinations if the evacuating hospital is unable to identify destinations using their normal methods and requests an EMCC activation.
2. In TSA-E there are 6 healthcare system patient transfer centers. Transfer centers are at centralized locations managing all components of a patient transfer into a hospital system. This includes the process of identifying an accepting physician and coordinating the workflow required to place a patient in the most appropriate patient care unit. Hospitals that do not fall underneath a system transfer center each maintain their own transfer request line to receive incoming transfer requests. This may be the House Supervisor or it may be a dedicated Bed Management/Access center. Below are the 6 healthcare system patient transfer centers in TSA-E and their contact information.

Transfer Centers	Transfer Phone Number
Baylor Scott and White Health System	(214) 820-6444
Medical City Health System	(877) 422-9337
Methodist Health System	(214) 947-4325
Texas Health Resources System	(888) 782-8233
Children's Health System	(888) 730-3627
Cook Children's Medical Center	(682) 885-3901

3. During a Regional or State mass patient movement event (such as a hospital evacuation) in which the EMCC has been activated to help coordinate interfacility patient transfers, NCTTRAC will notify the Virtual Patient Transfer Coordination Cell (VPTCC) to begin forming a patient distribution plan. The VPTCC consists of representatives from all 6 of the system patient transfer centers plus representatives from Parkland Memorial Hospital and John Peter Smith (JPS). The VPTCC will be notified via an Everbridge notification that prompts representatives from each VPTCC organization to get on a Zoom call 30-60 minutes after receiving the notification. Note that in the event that a hospital evacuation contains specialty patients (such as NICU patients or burn patients), the EMCC will ensure that subject matter experts related to the specialty group are represented in the VPTCC to provide input on the best destination for each patient.
4. On the coordination call with the VPTCC, NCTTRAC will use Pulsara to present the VPTCC with a manifest of patients who need to be placed. Representatives from each VPTCC organization will inform the VPTCC of which patients their organizations can accept. The EMCC will update patient destination information directly in Pulsara.
5. NCTTRAC staff do not make patient destination decisions; it is up to the VPTCC organizations to claim which patients they can accept, and the EMCC will relay that information back to the evacuating hospital (if they are not on the VPTCC call). Ultimate decision-making authority for patient destinations rests with the evacuating facility.
6. Detailed information regarding mass patient movement into TSA-E can be found in Annex B, Trauma Service Area E Medical Coordination Center Standard Operating Guidelines.

J. Patient Tracking
   1. Mass Patient Tracking
      a. Beginning July 1, 2023, the EMCC will transition all dedicated monitoring and Patient Tracking activities to the Pulsara Platform. All partners who previously had a NCTTRAC WebEOC account to communicate via the Patient Tracking Toolkit will need to sign-up for Pulsar before June 30, 2023. Pulsara allows EMS, hospitals, and jurisdictional partners to communicate seamlessly during large-scale or mass casualty incidents. As we build out Pulsara for patient tracking and family reunification efforts, we will update this section.
      b. *Texas ETN* – the Texas Emergency Tracking Network board is a state system for tracking general population evacuees from the Texas coast throughout the state. While hospitals in TSA-E are not primary users of this system, they may be asked to use ETN to track any evacuees who are transferred from a regional shelter to the hospital and back. The NCTTRAC EMCC will post instructions for using ETN to both the TSA-E Medical Events board and to EMResource.

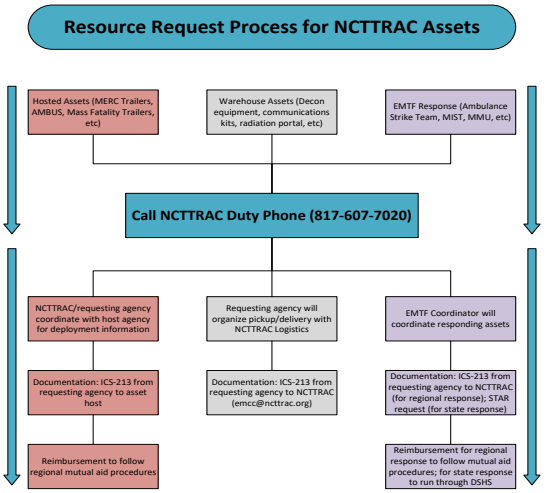
   2. Family Reunification
      a. NCTTRAC will communicate with county public health departments and the Department of State Health Services (DSHS) Region 2/3 to coordinate the standing up of a regional Family Reunification Center (FRC) or Family Assistance Center (FAC). The responsibility of standing up a FAC/FRC is the responsibility of the jurisdiction having authority over the incident. This Family Reunification Center will take phone calls from family members looking for patients who

have been moved into our region. NCTTRAC will not staff or operate the Family Reunification Center but will provide support via crisis applications and other methods as requested.

b. The HCC-E supports the reunification of MCI patients with their families by coordinating with EMS agencies and hospitals to ensure they are entering all patients into Pulsara. This creates a regional database for hospitals and family assistance centers to locate patients reported missing by their families and begin the reunification process.
c. Generally, hospitals continue to follow the same family reunification procedures that they follow for non-MCI unidentified patients. Large-scale regional incidents may see the establishment of jurisdiction-sponsored Family Assistance Centers (FACs) to assist in that endeavor. These jurisdictions sponsored FACs provide a single point of contact for persons missing family members involved in the MCI to file missing persons reports and receive news about victims of the MCI. DSHS PHR 2/3 may support jurisdiction sponsored FACs by establishing a missing persons hotline at their phone bank to field calls from individuals reporting a missing person involved with the MCI.

K. Medical Resource Management

1. Individual HCC partner organizations manage internal resources according to internal plans and procedures. Medical resource management in the immediate response is directed by the Incident Command Structure of the jurisdiction having authority. The HCC-E coordinates the sourcing and delivery of medical response resources at the regional level.
2. HCC partners organizations that receive supplies and equipment purchased with HPP funds are required to sign a Healthcare Coalition Memorandum of Sharing (MoS), NCTTRAC Property Transfer Agreement, or a resource-specific Memorandum of Agreement (MoA). The MoS, MoA, and NCTTRAC Property Transfer Agreement each outline how all HPP-purchased and tracked supplies and equipment can be shared from one HCC partner organization to another based on need. The Healthcare Coalition MoS can be found in Appendix D, *Healthcare Coalition Memorandum of Sharing.*
3. The NCTTRAC Warehouse maintains several medical assets that can assist with large-scale medical response and medical sheltering operations. The EMCC is poised to provide these assets to regional medical response and sheltering partners upon request. Organizations should attempt to fill resource needs through existing mutual aid contracts and through their city/county government prior to requesting resources or assets from NCTTRAC. A summary list of the deployable assets hosted in the NCTTRAC Warehouse can be found in Appendix E, *NCTTRAC Regional Assets List*
4. HCC partner organizations and external partners can request regional assets by contacting the EMCC using the 24/7 Duty Phone at (817) 607-7020. Submission of an official ICS-213RR will be required prior to the transfer of assets. During large-scale emergency events, the WebEOC STAR process may replace the ICS-213RR. All receiving agencies will be required to sign a NCTTRAC Transfer Agreement (Appendix F, *NCTTRAC Transfer Agreement*) upon receipt of requested assets. Figure 6 diagrams the resource request process for NCTTRAC assets.



5. All non-disposable items are required to be returned to NCTTRAC upon completion of their use. The requesting agency should contact the 24/7 Duty Phone at (817) 607-7020 when finished using the items to coordinate the return of the items to the NCTTRAC Warehouse. NCTTRAC Logistics will either receive the items at the NCTTRAC Warehouse or pick up the items from their temporary location. For disposable items, NCTTRAC Logistics will provide the requesting agency with guidance regarding proper disposition paperwork.
6. When deploying resource caches, manufacturer's guidance pursuant to operation and storage may not be available in a disaster response. Certain durable medical equipment and cache crates should be returned to NCTTRAC. Non-durable equipment, medical devices, and drugs should be charged as a disaster response loss/cost. NCTTRAC Logistics will provide guidance to receiving organizations regarding reconstitution and/or disposition of deployed resource caches. If items that require climate control are returned with appropriate records proving sustainment of climate controls, then these items may be returned to the cache during the post-disaster reconstitution phase of operations. If no records validate adherence to manufacturer's guidance during transportation, storage, or operational periods, then returned items shall be quarantined, appropriately disposed of, and charged as a disaster response cost.
7. In addition to supporting regional medical response operations, the NCTTRAC Warehouse holds supplies that can be used to support medical operations in local or regional general population shelters. While not intended to be all that is required to support a medical clinic, Table 2 (shown below) identifies medical support supplies held in the NCTTRAC Warehouse that may support medical operations in a general population shelter.
   - Gloves, Nitrile, S-XL
   - Beds, Bariatric
   - Wheelchairs
   - Temp Beds
   - N95 Masks
   - Gowns Patient
   - Crutches
   - Face Shields
8. Mass fatality incidents require specialized resource support. A summary of HCC-E resource support of mass fatality operations follows.
   a. Any fatalities associated with mass casualties or large-scale patient movements will be handled through standard procedures between hospitals and county medical examiners offices. The EMCC will support these efforts in any way possible, including giving county medical examiners offices access to Pulsara to assist with next of kin notification.

b. NCTTRAC has purchased deployable refrigerated Mass Fatality Trailers (MFT), each with a holding capacity of 20 decedents. There are currently four MFTs in TSA-E with the following agencies: Ferris FD, Burleson FD, Grayson County EMC, and the NCTTRAC Warehouse. For a full list of MFTs, please consult the Regional Assets List. Partner agencies can request the temporary use of an MFT by calling the 24/7 Duty Phone at (817) 607-7020 or contacting the host agency directly.
c. In addition to Mass Fatality Trailers, NCTTRAC owns mass fatality management equipment and supplies such as a BioSeal Mass Fatality Response System, FlexMorts, and multiple cases of post-mortem bags. To request the use of NCTTRAC's mass fatality management equipment, partner agencies should follow the resource request process identified above.

L. North Texas Mass Critical Care Guidelines

1. The HCC-E has adopted the North Texas Mass Critical Care Guidelines developed by the North Texas Mass Critical Care Task Force (NTMCCTF). The NTMCCTF was a regional collaboration of physicians, hospitals, ethicists, clergy, legal professionals, public health experts, elected leaders, and others who gathered to create clinical guidelines for use by physicians, hospitals, first responders, and other healthcare professionals during an overwhelming disaster. Crisis standards of care documentation for adults and pediatrics (including clinical treatment guidelines) can be found in Annex A, *North Texas Mass Critical Care Guidelines*.
2. Individual HCC partner organizations involved in the direct delivery of emergency healthcare services maintain individual emergency operations plans and surge plans that include guidelines intended to prevent the need to implement crisis standards of care for their organization. These guidelines typically cover procedures for conserving critical supplies, substituting available resources, and other methods of adapting clinical practices to ensure that emergency healthcare delivery can continue unimpeded. Additionally, NCTTRAC hosts a cache of durable medical equipment that can be deployed in an emergency scenario to supplement the existing clinical capabilities of a healthcare provider organization. A full listing of the durable medical equipment available can be found in Appendix E, *NCTTRAC Regional Assets List.*

M. Continuity of Operations

1. Individual HCC partner organizations are expected to develop, exercise, and execute individual Business Continuity/Continuity of Operations plans to minimize the impact of a disaster on their ability to provide emergency healthcare services.
2. As the HPP Contractor, NCTTRAC has developed a Continuity of Operations plan that is designed to establish policy and guidance to ensure the execution of mission essential functions and to direct the relocation of personnel and resources to an alternate facility capable of supporting operations. This plan outlines procedures for alerting, notifying, activating, and deploying employees; identify mission essential functions; establish an alternate facility; and roster personnel with authority and knowledge of functions. It also identifies essential personnel, essential functions, organizational order of succession, alternate facilities, and communication and information technology (IT) systems to be used during an interruption of normal operating procedures. The HPP Grantee Continuity of Operations Plan can be found in Annex D, *HPP Grantee Continuity of Operations Plan*.
3. Holistic continuity of operations for the emergency healthcare system in TSA-E are addressed through a combination of individual HCC partner organizations business continuity actions and NCTTRAC continuity of operations actions.

N. Demobilization

1. Demobilization Orders: Full activations are generally accompanied by a mobilization/demobilization order from the DSHS SMOC. This date may be extended or shortened to align with response activities. This order will include the duration of the activation and the estimated financial liability associated with the activation. A notification of the demobilization of the EMCC will be issued to the HCC at-large via email distribution lists.
2. Partial Activations: For incidents that do not reach full activation and in the absence of a DSHS SMA the EMCC Director will scale down support activities with briefings to staff and notifications to the HCC at-large. The EMCC will make direct contact with affected entities to ensure that support is no longer needed prior to reducing activation levels.
3. Archives: The EMCC Staff will archive all mobilization/demobilization orders, activity records, transfer forms, SITREPS etc. associated with an incident for future reference and for development of after-action reviews.
4. Reconstitution & Reimbursement: NCTTRAC Logistics will make every reasonable effort to reestablish a pre-incident level of supplies/equipment. The funding for replacement of supplies/equipment may be requested in a reimbursement packet from NCTTRAC Finance to DSHS Finance. Reimbursement may also flow through jurisdictional or other governmental reimbursement procedures. If no reimbursement opportunities exist, a funding proposal may be moved to REPC for consideration in the Asset Review Process.
5. After Action Review: As the ESF-8 lead agent, DSHS PHR 2/3 is responsible for the development of a region-wide ESF-8 Public Health and Medical After-Action Report. NCTTRAC will coordinate with and support DSHS PHR 2/3 throughout this effort. A series of gatherings may be planned to obtain input from stakeholders. Additionally, EMCC Staff will design a broad survey to capture sustainment and improvement elements with respect to the HCC response. The information gathered in this survey will provide essential content for a draft after action report. A formal AAR, with improvement plan, will be developed by NCTTRAC Staff, shared among the HCC, and submitted to DSHS HEPRS. HCC Members are encouraged to participate in regional after actions that are multi-discipline and collaborative which allow for integration of medical support activities among all responding entities.

O. Recovery

1. It is mutually beneficial for governmental bodies and healthcare facilities, partners, and coalitions to work together in an organized fashion to expedite recovery efforts after a disaster. Depending on the size and scope of a particular disaster, specific regulatory agencies (local, state, and/or federal) may require specific inspections and approval before allowing occupancy of an affected facility or approval to provide clinical services.
2. Following an evacuation of a healthcare facility or several facilities following a significant regional disaster, the affected hospitals and healthcare facilities will work closely with the authority having jurisdiction and the EMCC to conduct an organized and efficient recovery. For utilizing common language and communicating needs and activities throughout the recovery process, HCC-E will follow a three-phased approach:
   a. Phase 1 – Damage Assessment
   b. Phase 2 – Restoration
   c. Phase 3 – Medically Operational
3. It is important to understand that different hospitals and healthcare facilities may be conducting operations within different phases at the same time. Likewise, specific geographical areas may be operating under different phases based upon damage, accessibility, and security considerations. The identification of phases is at the discretion of the healthcare facility leadership for individual

hospitals and healthcare facilities and by the authority having jurisdiction as it pertains to a geographical cordon or secured area.

a. Damage Assessment Phase - This phase initiates when emergency response operations are complete, and personnel can begin to make damage assessments. The EMCC will begin to survey regional hospitals and healthcare facilities via EMResource, and/or electronic survey delivered through email. The goal of this phase is for hospitals and healthcare facilities to conduct an in-depth assessment of damage and other impacts of the disaster on their facility. The EMCC will also be gathering pertinent information regarding jurisdictional damages or outages that could potentially impact the healthcare system. This information will be summarized and shared with regional HCC-E Stakeholders, other regional MOCs, and the DSHS SMOC as necessary and warranted to begin the restoration phase.
b. Restoration Phase - The restoration phase includes the repair and restoration of services to the affected area or facility, including power, water, sewer, and logistical needs required to make the facility function. The EMCC will actively monitor facilities that are in the restoration phase and will support efforts to reestablish critical services. The provision of certain resources may be available through the EMCC. These resources include electrical power generators, emergency PPE, and emergency durable medical equipment. Additionally, the EMCC may be able to support the identification and logistical coordination of certain services such as waste disposal, medical oxygen, and critical communications. The goal of this phase is to complete repairs to render the facility functional and allow the hospital to provide services to the community. This phase is completed as services are restored and healthcare facilities become capable of caring for patients. The EMCC will share healthcare facility statuses with EMS and other stakeholders so that patients are directed to the proper care facility. This information will also be shared on EMResource.
c. Medically Operational - This phase describes partial or complete capability to provide patient care within a hospital or healthcare facility. This phase is initiated when the hospital or healthcare facility completes the restoration phase of recovery for the entire facility or a portion of the facility that provides critical services to the community. The goal of this phase of recovery is for the hospital or healthcare facility to return to normal operations or at least provide critical access services such as emergency services. This phase is complete when the hospital becomes fully operational and can provide patient care at the same level as prior to the disaster.

V. Regional Mass Casualty Incident

A. Overview

1. A mass casualty incident (MCI) is generally defined as any emergent incident that generates patients in numbers great enough to overwhelm the local emergency healthcare response capabilities. Each jurisdiction and HCC partner organization will have different thresholds for what constitutes an MCI; the current Regional MCI Framework collaborative project between NCTTRAC, the North Central Texas Council of Governments (NCTCOG), and DSHS PHR 2/3 seeks to standardize regional MCI thresholds to ensure that all regional partners share common language when describing and responding to emergency incidents. This section provides an overview of the HCC-E response to an MCI that affects multiple HCC partner organizations.
2. NCTTRAC partnered with NCTCOG and DSHS PHR 2/3 to develop a Regional Mass Casualty Incident Framework. The Regional MCI Framework will inform HCC-E's response to a mass casualty incident in future iterations of the HCC-E Regional Medical Response Strategy and may be found within this document at *References, Regional and Local, F* or within the NCTTRAC website.

B. Scope

1. Individual HCC partner organizations are responsible for developing and maintaining individual MCI response plans, and this plan does not override or supplant those efforts. Direct healthcare delivery and patient treatment remain the responsibility of individual healthcare providers and on-scene response coordination remains the responsibility of the Incident Command System activated by the jurisdiction having authority. This section describes the general concept of operations for a regional HCC response to a mass casualty incident.

C. Concept of Operations

1. HCC Notification of MCI
   a. Generally, local 911 Public Safety Answering Point (PSAP) is the first entity to be notified of a mass casualty incident. Local 911/PSAP then notifies local emergency responders, who then notify city/county emergency management or public health organizations. It is critical that hospitals be notified of an MCI as soon as possible to allow for the early execution of patient surge plans geared towards enhancing a facility's ability to receive an influx of patients; however, recent national MCIs have shown that often hospitals are first notified by incoming patients themselves. To address this gap, the Healthcare Coalition has recommended the use of Pulsara. Pulsara allows EMS and hospitals to communicate within minutes. Once added to an incident, viewing patients, and updating their information (demographics, vitals, missing vs united) can easily be accomplished in Pulsara. Efforts are being made to encourage local 911/PSAPs to notify the EMCC 24/7 Duty Phone of emergency MCIs.
   b. HCC-E notification is currently accomplished through the EMResource event notification template "Mass Casualty Incident," which sends emergency email and text notifications to HCC-E partner organizations containing details about the MCI and instructing hospital users to begin updating the MCI bed availability categories for their facility. The EMResource event notification can be created and distributed by local EMS or by a hospital who begins receiving MCI-related patients. If an EMS agency or hospital is notified about a Mass Casualty Incident and has not seen an EMResource event notification go out, they should create the notification themselves provided that occupying the resources necessary to do so does not affect their ability to provide patient care.
   c. Once an MCI is discovered, local EMS agencies and receiving hospitals should notify the EMCC using the 24/7 Duty Phone at (817) 607-7020 or adding the NCTTRAC EMCC to an incident in Pulsara. The EMCC will then create the EMResource event notification (if it has not yet been created) and send emails through existing distribution lists to notify the HCC-E at large about the MCI.
2. HCC-E Common Operating Picture
   a. To ensure that all HCC-E partner organizations are operating with up-to-date information regarding the incident and its associated hazards, the HCC-E uses EMResource and email distribution lists to share information and develop a common operating picture.
   b. Individual HCC partner organizations update specific statuses in EMResource to inform the HCC about the situation at a particular facility or organization (for example, "Hospital Command Center Status").
   c. In addition to the initial event notifications sent to the HCC at-large, the EMCC will continue to distribute critical information using EMResource event notifications and email distribution lists throughout the course of the incident.
3. HCC-E On-Scene Response Support
   a. **Triage**
      HCC-E has recommended that responding agencies use SALT/START/JUMP-START for triage in TSA-E. The initial responding ambulance crew will be responsible for the initial scene size-

up, activating the MCI Plan, and contacting the Incident Commander on scene. Incident Command will be established and conducted in accordance to ICS Procedures.

i. Establish a Medical Branch structure to meet the needs of the incident
ii. Objective of the Medical Branch is to provide rapid Triage, Treatment and Transport
iii. Rapidly evaluate the scene
iv. Working with the Incident Commander, develop a management strategy.
v. Request necessary resources to manage the incident
vi. Assign responsibility and delegate authority to subordinates to accomplish incident needs and objectives by use of Sections, Branches, Groups and/or Units according to the National Incident Management System.
vii. Constantly review and evaluate the effectiveness at the incident site and revise as needed
viii. Phase down the incident and demobilize as appropriate

b. **Scene Size-Up (**A scene size-up will consist of the following:)
   i. Safety assessment for any threats and/or hazards
   ii. Type and/or cause of the incident
   iii. Approximate number of patients involved
   iv. Triage categories if known
   v. Declare and MCI to activate the plan
   vi. Establish Incident Command & request additional resources
   vii. Identify and control staging, ingress

c. **Initial on scene resources will promptly begin triage**
   1. Establish and identify a Triage Area at or near the entrance of the Ambulance Exchange Point (AEP)
   2. A Texas wristband, which has a colored triage tag attached (Green, Yellow, Red, Grey, and Black) will be placed on the victims.
   3. The Triage Group is responsible for initiating a Casualty Collection Point (CCP) if the incident warrants it.
   4. If a CCP is established, the Triage Group will be responsible for selecting the order of patients to be moved into formal treatment areas.

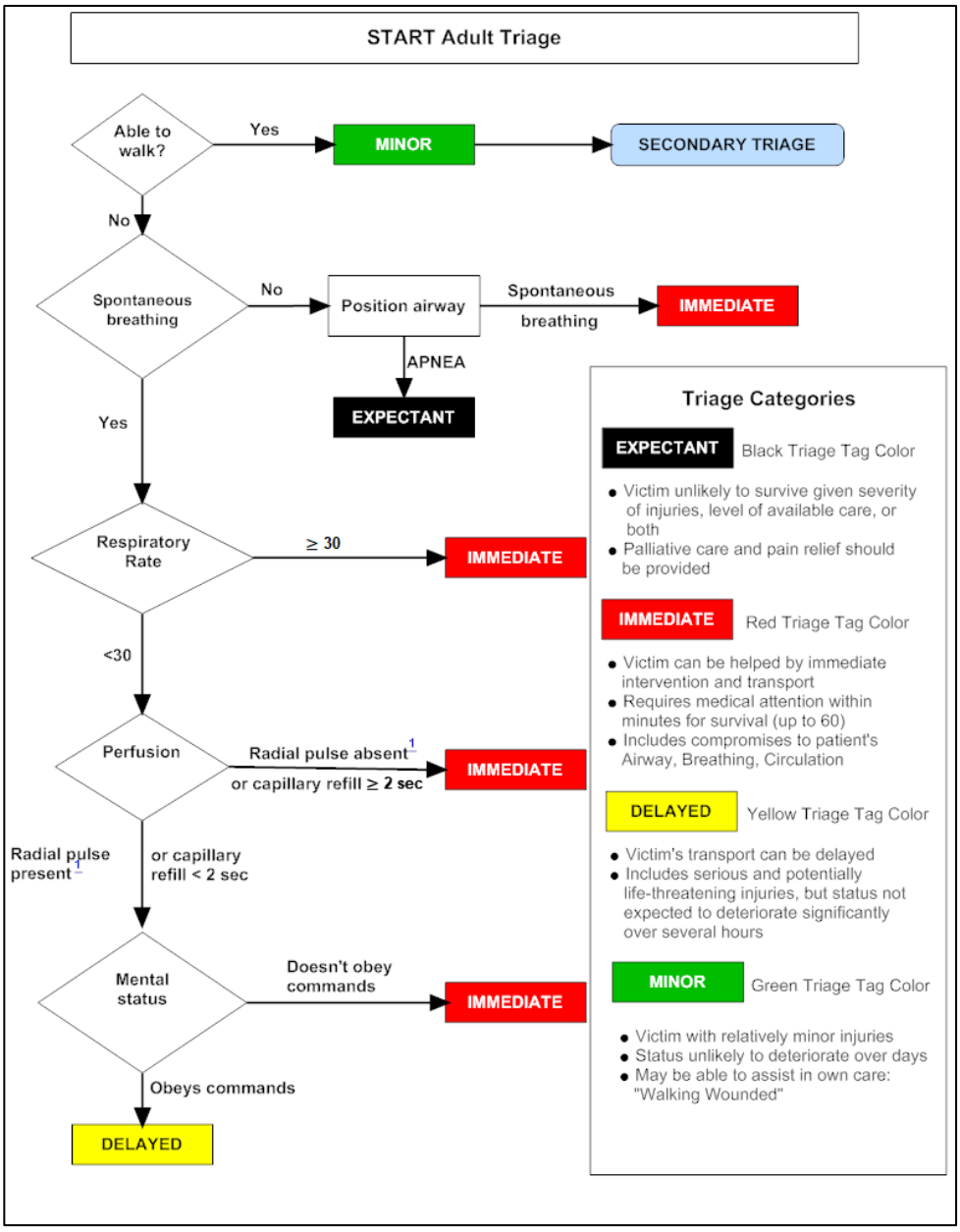
d. **START Triage**

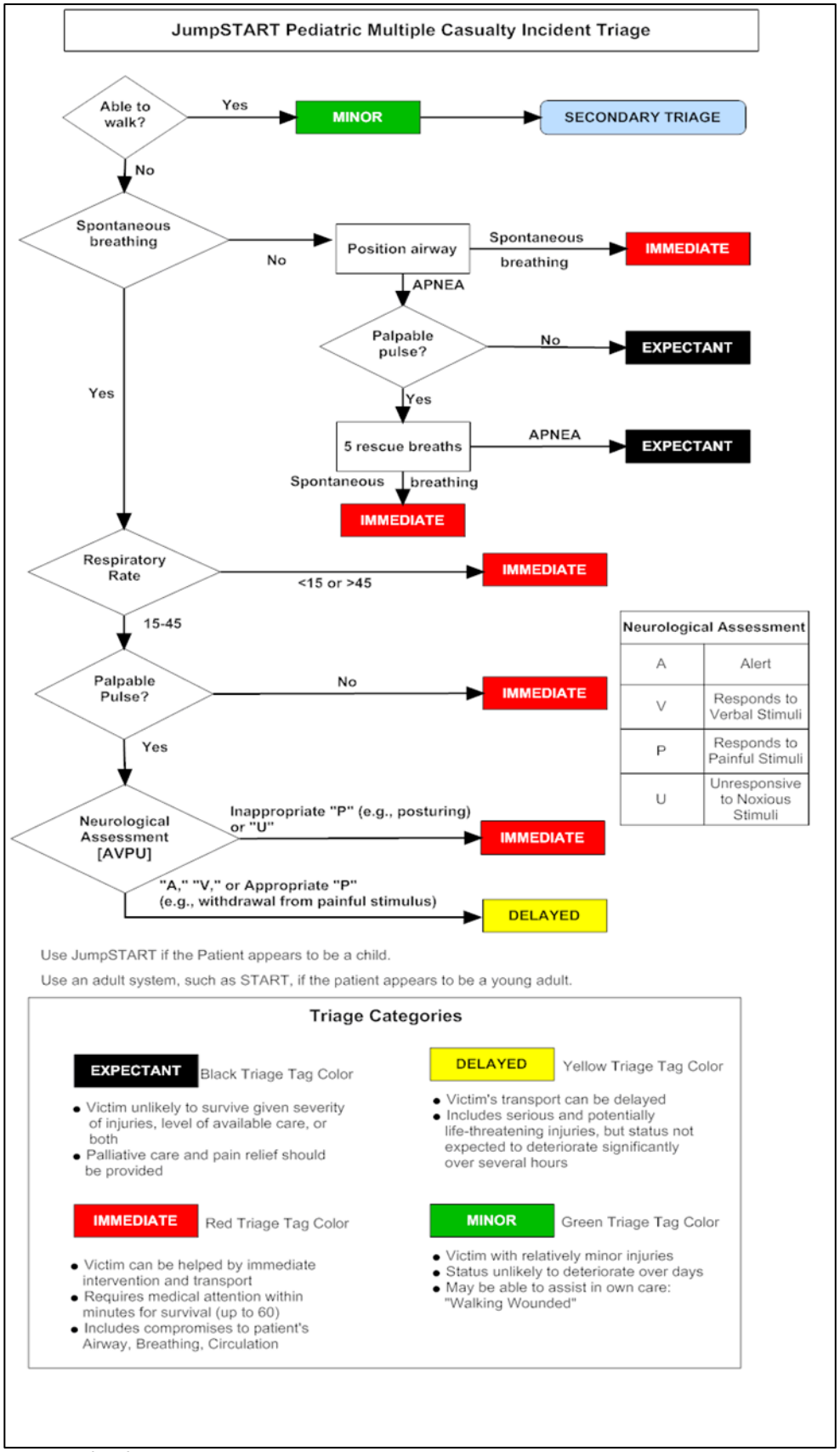
The Simple Triage And Rapid Treatment (START) system was developed to allow first responders to triage multiple victims in 30 seconds or less, based on three primary observations: Respiration, Perfusion, and Mental Status (RPM). JumpSTART was designed specifically for triaging children in disaster settings. Though JumpSTART was developed for use in children from infancy to age 8, where age is not immediately obvious, it is used in any patient who appears to be a child (patients who appear to be young adults are triaged using START).

1. Only two interventions are allowed during triage:
   ii. Opening the airway (two times) to verify respirations.
   iii. Controlling life-threatening hemorrhaging.
2. Triage color coding to patient priorities of treatment and/or transportation as follows:
   i. BLACK (DECEASED): Do not remove bodies from the scene until authorized by proper officials. DO NOT START CPR until all patients have been tagged and the necessary resources are available.
   ii. RED (IMMEDIATE): Patients requiring immediate treatment and transport.
   iii. YELLOW (DELAYED): Patients whose transport can be delayed up to one hour.

iv. GREEN (MINOR): Walking wounded whose injuries do not require ambulance transportation.

3. The triage process will begin with a patient assessment and should be limited to 30 seconds per patient.




JumpSTART Pediatric Multiple Casualty Incident Triage
Able to walk?
Yes
MINOR
SECONDARY TRIAGE
No
Spontaneous breathing
No
Position airway
Spontaneous breathing
IMMEDIATE
APNEA
Palpable pulse?
No
EXPECTANT
Yes
Yes
5 rescue breaths
APNEA
EXPECTANT
Spontaneous breathing
IMMEDIATE
Respiratory Rate
<15 or >45
IMMEDIATE
15-45
Palpable Pulse?
No
IMMEDIATE
Yes
Neurological Assessment [AVPU]
Inappropriate "P" (e.g., posturing) or "U"
IMMEDIATE
"A," "V," or Appropriate "P" (e.g., withdrawal from painful stimulus)
DELAYED
Neurological Assessment
A Alert
V Responds to Verbal Stimuli
P Responds to Painful Stimuli
U Unresponsive to Noxious Stimuli
Use JumpSTART if the Patient appears to be a child.
Use an adult system, such as START, if the patient appears to be a young adult.
Triage Categories
EXPECTANT Black Triage Tag Color
• Victim unlikely to survive given severity of injuries, level of available care, or both
• Palliative care and pain relief should be provided
DELAYED Yellow Triage Tag Color
• Victim's transport can be delayed
• Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours
IMMEDIATE Red Triage Tag Color
• Victim can be helped by immediate intervention and transport
• Requires medical attention within minutes for survival (up to 60)
• Includes compromises to patient's Airway, Breathing, Circulation
MINOR Green Triage Tag Color
• Victim with relatively minor injuries
• Status unlikely to deteriorate over days
• May be able to assist in own care: "Walking Wounded"

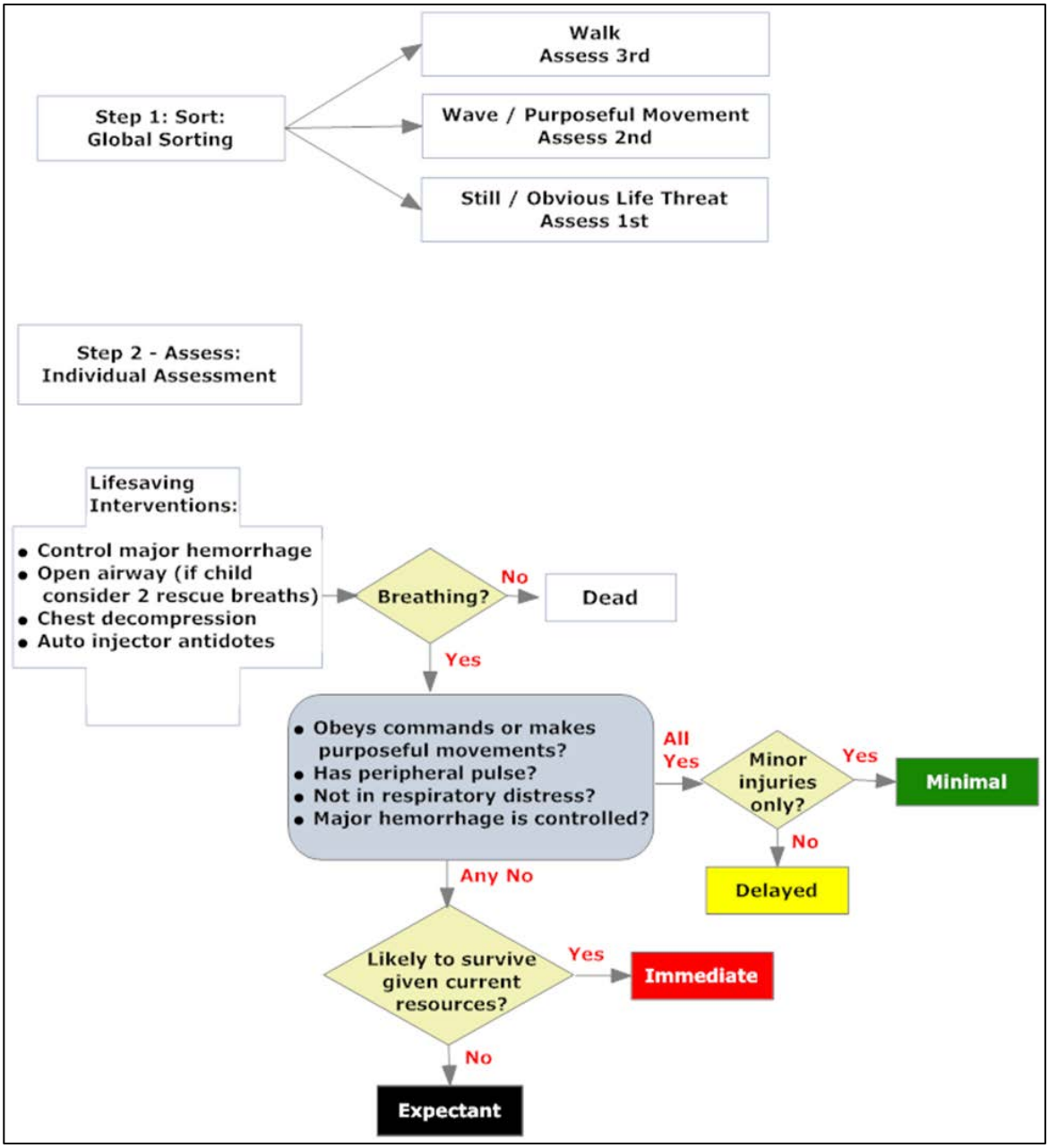
e. **SALT Triage**

SALT Triage is the product of a CDC Sponsored working group. SALT (Sort-Assess-Lifesaving Interventions-Treatment and/or Transport) was developed as a national all-hazards mass casualty initial triage standard for all patients (eg, adults, children, special populations). The big difference between START and SALT triage is that SALT includes a grey or "expectant" category for patients who are still clinically alive but have obvious, massive injuries or other conditions that will almost certainly be fatal. The Expectant category is intended to keep those patients from being triaged Red or Immediate and using resources that could be better assigned to patients with a better chance of living.

1. Sort patients
    a. Move "Walking wounded" from the scene to a designated area
2. Assess remaining patients
    b. Perform the following lifesaving interventions:
        i. Control major hemorrhage
        ii. Open airway
            1. If child, consider 2 rescue breaths
        iii. Chest decompression
    c. Auto-injector antidotes
3. Triage color coding to patient priorities of treatment and/or transportation as follows:

    I. BLACK (DECEASED): Do not remove bodies from the scene until authorized by proper officials. DO NOT START CPR until all patients have been tagged and the necessary resources are available.
    II. GRAY (EXPECTED): Patient is expected to die. DO NOT START CPR until all patients have been tagged and the necessary resources are available.
    III. RED (IMMEDIATE): Patients requiring immediate treatment and transport.
    IV. YELLOW (DELAYED): Patients whose transport can be delayed up to one hour.
    V. GREEN (MINOR): Walking wounded whose injuries do not require ambulance transportation

SALT Triage Algorithm



f. HCC-E also recommended the use of the EMS Triage wristband during an MCI. This wristband has been designed with the triage categories included. Responders can simply rip off and discard the triage categories that they do not need, leaving the remaining color as the triage category of the patient. This wristband is designed to stay on the patient throughout their entire healthcare experience. For patient's that did not arrive at the hospital by EMS, once identified that they were apart of the MCI, should receive an EMS Triage wristband, so that they too can

be tracked as apart of the incident.

EMS Responsibility

- EMS is responsible for placing a wristband on every patient transported to a hospital-based emergency department.
- EMS should also manually enter or scan the wristband's unique identifier into a pre-identified NEMSIS compliant, query-able field within the electronic patient care report (ePCR).

Hospital Responsibility

- Leave the wristband on the patient until discharged home – do not cut or remove
- Manually enter or scan the wristband's unique identifier into a pre-identified query-able field within the electronic medical record (EMR)
- If the wristband is inadvertently removed:
    1. Place a new wristband on the patient
    2. Cover or cross out the new barcode and identification number
    3. Write the previous identification number on the new wristband with a permanent marker

g. Pulsara was also recommended by the HCC-E as a tool that allows for quick patient entry. Pulsara is a day-to-day patient-focused communication tool that links EMS and hospitals on a single "channel" for each patient. Users can control how small or wide an incident can be viewed. Users can also control who has access to their incident by adding only relevant partners to the incident channel. Once an incident is started, partners added to the channel can create new patients to the channel by adding minimal information (sex, triage category) or very detailed information by scanning the Texas EMS wristband or an individual's driver's license.

h. HCC-E supports on-scene response support primarily through the coordination of EMTF assets and teams. A detailed description of EMTF-2 assets, teams, and how to request them can be found in Section VI, *Emergency Medical Task Force-2*.

4. HCC-E Hospital Response Support

a. As patients generated by a mass casualty incident are transported (by EMS and by non-EMS means) to local hospitals, those hospitals are likely to face resource shortages due to the rapid patient surge. To help support affected hospitals, the EMCC will reach out to hospitals closest to the scene of the mass casualty incident via cell phone and business phone when possible and via public safety radio or amateur radio if cell and business phone services fail. The EMCC will confirm that the hospital is executing internal surge protocols and gather a list of needs for each affected facility.

b. At the request of an affected facility, the EMCC will help coordinate deployable EMTF assets including Ambulance Strike Teams (ASTs), AMBUSes, Registered Nurse Strike Teams (RNSTs), and a Mobile Medical Unit (MMU). These assets can help hospitals offload patients to unaffected medical facilities or increase surge capacity to alleviate the resource strain on the affected hospital.

VI. References

A. Federal

1. Office of the Assistant Secretary for Preparedness and Response, 2017-2022 Health Care Preparedness and Response Capabilities
2. 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)
3. Robert T. Stafford Disaster Relief & Emergency Assistance Act, 42 U.S.C. 5121
4. Emergency Planning and Community Right-to-Know Act, 42 USC Chapter 116
5. Emergency Management and Assistance, 44 CFR
6. National Incident Management System
7. National Response Framework
8. National Strategy for Homeland Security, October 2007

B. State

1. Government Code, Chapter 418 (Emergency Management)
2. Government Code, Chapter 421 (Homeland Security)
3. Government Code, Chapter 433 (State of Emergency)
4. Government Code, Chapter 791 (Inter-local Cooperation Contracts)
5. State of Texas Emergency Management Plan Annex H: Public Health and Medical (August 2015)
6. Texas Administrative Code, Title 25, Part 1, Chapter 133, Subchapter C, Rule 133.45 (Hospital Disaster Preparedness Requirements)
7. Health & Safety Code, Chapter 778 (Emergency Management Assistance Compact)
8. Executive Order of the Governor Relating to Emergency Management and Homeland Security
9. Executive Order of the Governor Relating to the National Incident Management System
10. Administrative Code, Title 37, Part 1, Chapter 7 (Division of Emergency Management)
11. The Texas Homeland Security Strategic Plan,2021-2025
12. The State of Texas Disaster Medical System Overview
13. DSHS: Disaster and Recovery - State Medical Operation Center (SMOC)

C. Regional and Local

1. NCTTRAC Regional Trauma System Plan (2022)
2. TSA-E Health Care Coalition Regional Preparedness Strategy, December 2018
3. Health Service Region 2/3 Regional Health Medical Operation Center Procedural Guide, Version 1.0, February 2017
4. TSA-E Regional Health Care Preparedness Coalition, TSA-E Regional High Consequence Infectious Disease (HCID) Concept of Operations (CONOPS)
5. NCTTRAC 2022-2023 HPP Scope of Work (SOW)
6. NCTTRAC Mass Casualty Incident Framework

VII. Appendices

Appendix A: HCC Member Contact Information

State and Regional Partners		
Agency	**Phone Number**	**Email**
TX DPS SOC	512-424-2208	SOC2@dps.texas.gov
DSHS SMOC	512-563-4455/4638	DSHSIncidentCMD@txhhs.onmicrosoft.com
TDEM CIS	512-424-2208	Support@dps.texas.gov
HSR Region 2/3	817-264-4616	HSR23.RHMOC@dshs.texas.gov
TDEM Region 1	817-212-7013	Kevin.Starbuck@tdem.texas.gov
DC 4A	940-452-7757	Brian.Brumfield@tdem.texas.gov
DC 4B	214-629-4271	Sarah.Haak@tdem.texas.gov
DC 22	903-328-7504	Brian.Brockett@tdem.texas.gov
Bio Tel	214-590-8848	Luann.mckee@phhs.org
EPAB	817-995-1027	DHowerton@medstar911.org
THR Duty Phone	844-320-3075	N/A
HCC-C	640-257-8092	scomer@ncttrac.org
HCC-D	325-762-6405	tharbuck@ncttrac.org

Healthcare Facilities			
Facility Name	**ED / Facility Phone Number**	**Patient Transfer Phone Number**	**Point of Contact / EM Coordinator**
Baylor Heart And Vascular Center	214-820-0600	817-433-9600	Nancy Vish 214-820-3688 nvish@uspi.com
Baylor Institute for Rehabilitation - Dallas	214-820-9537	214-820-9300	Josh Waits 214-820-8909 jwaits@bir-rehab.com
Baylor Institute for Rehabilitation - Fort Worth	817-433-9994	817-433-9600	Josh Wait 817-820-9617 jwaits@bswrehab.com
Baylor Institute for Rehabilitation - Frisco	467-888-5100	214-820-9300	Lindsay Concannon 214-820-8900 lconcannon@bir-rehab.com
Baylor Medical Center at Trophy Club	817-837-4630	214-820-6444	Elizabeth Madigan 518-956-2267 emadigan@uspi.com
Baylor Medical Center at Uptown	214-443-3000	214-443-3000	Gregory Young 214-927-6160 gyoungs@uspi.com

Healthcare Facilities			
Facility Name	**ED / Facility Phone Number**	**Patient Transfer Phone Number**	**Point of Contact / EM Coordinator**
Baylor Scott & White All Saints Medical Center – Fort Worth	817-922-7070	214-820-6444	Colyn Turnbow 817-922-2878 colyn.turnbow@bswhealth.org
Baylor Scott & White Medical Center – Centennial	580-235-1095	214-820-6444	Leslie Wieebe Leslie.Wiebe@BSWHealth.org 469-764-8170
Baylor Scott & White Medical Center – Frisco	214-407-5326	972-369-2947	Frank Geasland 214-407-5000/5080/5439 fgeasland@bmcf.com
Baylor Scott & White Medical Center – Grapevine	817-388-3900	214-820-6444 817-233-1511	RJ Johnson 817-424-4819 RJ.Johnson@bswhealth.org
Baylor Scott & White Medical Center – Irving	972-990-8110	214-820-6444	Lawrence Scarbrough 972-990-8444 lawrence.scarbrough@bswhealth.org
Baylor Scott & White Medical Center – Lake Pointe	972-520-8111	214-820-6444	Cory Sockwell 972-520-8198 cory.sockwell@bswhealth.org
Baylor Scott & White Medical Center – Plano	469-814-2500	469-820-6444	Casey Cox 469-814-2527 casey.cox@bswhealth.org
Baylor Scott & White Medical Center – Sunnyvale	972-892-3970	214-820-6444	Lakisha Taylor 972-892-3970 kistaylor@uspi.com
Baylor Scott & White Medical Center - Waxahachie	469-843-5070	214-820-6444	John Odip 469-843-5048 jodip@baylorhealth.edu
Baylor Surgical Hospital at Fort Worth	682-703-5632	682-703-5641	Stephanie Clements 682-703-5600
Baylor Surgical Hospital at Las Colinas	972-868-4111	972-868-4000	David Unell 972-868-4004 dunell@uspi.com
Baylor University Medical Center	214-820-2505	214-820-6444	Meghan Illiiee 214-820-7727 milliee@bhcs.com
Children's Medical Center of Dallas	214-456-3888	888-730-3627	Dana Derossett 214-231-0818 Dana.Derossett@childrens.com
Children's Medical Center Plano	469-303-4925	888-303-3627	Dana Derossett 214-213-0818 Dana.Derossett@childrens.com

Healthcare Facilities			
Facility Name	**ED / Facility Phone Number**	**Patient Transfer Phone Number**	**Point of Contact / EM Coordinator**
City Hospital of White Rock	214-324-6111	214-324-6789	Jenny Humpal 214-324-6117 jenny.humpal@whiterockmedicalcenter.com
Cook Children's Medical Center	682-885-4093	682-885-3901	Melinda Weaver 682-885-3958 melinda.weaver@cookchildrens.org
Crescent Medical Center Lancaster	469-297-5477	214-757-6524	Brennan Bryant 469-297-5417 brennanbryant@cmclancaster.com
Dallas Behavioral Healthcare Hospital LLC	972-982-0897	972-897-3738	Mike Harrington 972-238-4637 mike.harrington@dallasbehavioral.com
Dallas Medical Center	214-766-9451	214-320-1693	Will Blackmon 214-810-5091 wblackmon@primehealthcare.com
Dallas Regional Medical Center	214-320-7190	214-320-7190	Lisa Fox 521-635-3637 lfox1@primehealthcare.com
Glen Rose Medical Center	254-897-1423	254-897-1423	Joe Sillivent 817822-8842 jsillivent@grmf.org
Hunt Regional Medical Center Greenville	903 408-1412	903-408-1650	Bret Freeman 903-408-1260 bfreeman@huntregional.org
John Peter Smith Hospital	817-702-7829	817-702-8417	Aaron Freedman 817-702-7986 afreedki@jpshealth.org
Lake Granbury Medical Center	817-579-2380	817-219-1373	Kenneth Rogers 817-578-6704 kenneth_rogers@chs.net
Medical City Arlington	682-509-6888	877-422-9337	Josh Taff 682-509-4968 josh.taff@hcahealthcare.com
Medical City Fort Worth	817-347-5830 817-347-4250	877-422-9337	Jacob Jonson 817-874-9982 jacob.johnson@medicalcityhealth.com
Medical City Green Oaks Hospital	972-770-0830	972-324-3700	Alexis Johnson 972-438-2346 alexis.johnson@medicalcityhealth.com

Healthcare Facilities			
Facility Name	**ED / Facility Phone Number**	**Patient Transfer Phone Number**	**Point of Contact / EM Coordinator**
Medical City Las Colinas	972-969-2000	877-422-9337	Steven Palmer 817-821-0377 steven.palmer@medicalcityhealth.com
Medical City Lewisville	469-370-2011	877-422-9337	Nathan Fowlkes 469-370-2872 nathan.fowlkes@medicalcityhealth.com
Medical City Alliance	817-639-1001	877-422-9337	Jason Quick 817-239-8218 Jason.Quick@medicalcityhealth.com
Medical City Dallas	972-566-3302	877-422-9337	Craig Brein 972-566-6032 Craig.Brein@MedicalCityHealth.com
Medical City Denton	940-384-3501	877-422-9337	David Bridges 940-384-3488 David.Bridges@MedicalCityHealth.com
Medical City McKinney	972-540-4700	877-422-9337	Cassidi Roberts 972-540-4812 Cassidi.roberts@medicalcityhealth.com
Medical City North Hills	817-255-1801	877-422-9337	Jacob White 817-255-1875 jacob.white@medicalcityhealth.com
Medical City Plano	972-519-1505	877-422-9337	Gary Clouse 469-318-0667 gary.clouse@medicalcityhealth.com
Methodist Charlton Medical Center	214-947-0999	214-947-0985	Jimmy White 214-947-6600 JimmyWhite@mhd.com
Methodist Dallas Medical Center	214-947-8100	214-947-4325	Erin Farrell 214-933-8157 erinfarrell@mhd.com
Methodist Mansfield Medical Center	682-242-7182	214-947-2233	Karen Yates 682-622-7182/7199 karenyates@mhd.com
Methodist Richardson Medical Center	469-201-8000	469-204-0725	Karyn Harris 469-204-8005 KarynHarris@mhd.com
Muenster Memorial Hospital	940-759-6147	940-759-6147	Kerri Synder 940-759-6162

Healthcare Facilities			
Facility Name	**ED / Facility Phone Number**	**Patient Transfer Phone Number**	**Point of Contact / EM Coordinator**
			ksnyder@trhta.net
Navarro Regional Hospital	903-875-8451	903-229-0783	Kristy Hopper 903-654-6820 Kristy.Hopper@navarrohospital.com
North Central Surgical Center LLP	214-930-7539	214-265-2810	Taylor Callis 214-365-8176 tcallis@uspi.com
North Texas Medical Center	940-612-8160	940-612-8400	Carrie Zbierski 940-736-9727 carrie.zbierski@ntmconline.net
Palo Pinto General Hospital	940-325-7891	940-328-6391	Steven Thompson 940-328-6516 sthompson@ppgh.com
Parkland Memorial Hospital	214-590-8000	214-590-6690	Kaitlyn Cross 214-590-6690 kaitlyn.cross@phhs.org
Texas Health Arlington Memorial Hospital	817-960-6205	972-955-5404	Jesse Collin 817-960-6583 jessecolin@texashealth.org
Texas Health Harris Methodist Hospital Alliance	682-212-2300	888-782-8233	Michael Barkman 682-212-2051 MichaelBarkman@texashealth.org
Texas Health Harris Methodist Hospital Azle	817-444-8667	888-782-8233	Robert Potter 817-444-8763/8667 robertpotter@texashealth.org
Texas Health Harris Methodist Hospital Cleburne	817-556-5548	888-782-8233	Catherine Gonzales 817-556-5464 catherinegonzales@texashealth.org
Texas Health Harris Methodist Hospital Fort Worth	817-250-3333	888-782-8233	Elaine Nelson 817-250-3382 elainenelson@texashealth.org
Texas Health Harris Methodist Hospital Hurst-Euless-Bedford	817-848-4611	888-782-8233	Thomas Cassidy 817-848-4358 thomascassidy@texashealth.org
Texas Health Harris Methodist Hospital Southlake	817-488-8777	888-782-8233	Dinah Cannefax 817-748-8700 214-908-9253 dinahcannefax@me.com
Texas Health Harris Methodist Hospital Southwest Fort Worth	682-760-2834	682-236-5800 888-782-8233	Clint Sanders 817-433-6570 clintsanders@texashealth.org

Healthcare Facilities			
Facility Name	**ED / Facility Phone Number**	**Patient Transfer Phone Number**	**Point of Contact / EM Coordinator**
Texas Health Harris Methodist Hospital Stephenville	254-965-1217	888-782-8233 682-236-5800	James Robardey 254-965-8777 817-528-7630 jamesrobardey@texashealth.org
Texas Health Huguley Hospital	817-551-2729	888-782-8233	Barbara Jarmon 817-551-2466 Barbara.Jarmon@adventhealth.com
Texas Health Presbyterian Hospital Allen	972 747-6110	888-782-8233	James Brown 972 747-6100 jamesbrown2@texashealth.org
Texas Health Presbyterian Hospital Dallas	214-345-7885	888-782-8233	Doug Willis 214-345-8480 DougWillis@texashealth.org
Texas Health Presbyterian Hospital Denton	940-898-7059	888-782-8233	Stephanie Adams 940-898-7061 stephanieadams2@texashealth.org
Texas Health Presbyterian Hospital Flower Mound	469-322-7100	888-782-8233	Amanda Fox 469-322-7112 Amanda.fox@phfmtexas.com
Texas Health Presbyterian Hospital Kaufman	972-932-5531	888-782-8233	Toya White 972-932-7370 toyawhite@texashealth.org
Texas Health Presbyterian Hospital Plano	972-981-8003	888-982-8233	Stephan Nepley 972-981-3156 stephanepley@texashealth.org
Texas Health Presbyterian Hospital Rockwall	469 698-1013	888-782-8233 682-236-5800	Karen Casey 469 698-1723 214-392-0722 karen.casey@phrtexas.com
Texas Health Seay Behavioral Health Hospital	972-981-8303	214-552-2899	Debra Iverson 817-848-4611 debraiverson@texashealth.org
Texas Health Specialty Hospital Fort Worth	817-250-5531	682-236-5800	Leanne Meason 817-250-4521 leamason@texashealth.org
Texas Health Springwood Hospital	817-848-4611	817-848-4358	Thomas Cassidy 817-848-4358 thomascassidy@texashealth.org
Texas Scottish Rite Hospital for Children	214-559-5000	214-559-5155	Kyle Cavin 214-559-8373 kyle.cavin@tsrh.org

Healthcare Facilities			
Facility Name	**ED / Facility Phone Number**	**Patient Transfer Phone Number**	**Point of Contact / EM Coordinator**
Texoma Behavioral Health Center	903-819-7555	903-416-3025	Donna Glenn 903-819-7555 dglenn@thcs.org
Texoma Medical Center	903-640-7334	903-640-7351	Amy Norwood 903-249-2496 Amy.Norwood@thcs.org
Texoma Medical Center Bonham Hospital	903-583-8585	903-640-7351	John Bird 903-416-4113 John.bird@thcs.org
The Heart Hospital Baylor Denton	214-460-9500	214-820-6444	J D Barbee 469-814-4238 jdbarbee@northtexashospital.com
USMD Hospital at Arlington	817-472-3805	817-472-2780	Ronnie Ursin 817-223-1579 ronnie.ursin@usmdhospital.com
UTSW William P Clements Hospital	214-633-4494	972-382-3800	BJ White 817-463-3767 bj.white@utsouthwestern.edu
Veterans Affairs Hospital- Dallas	214-742-8387	972-238-0900	817-698-3745
Weatherford Regional Medical Center	817-609-3082	817-338-3800	Rany Vaughn 817-238-4672 rany_vaughn@chs.net
Wilson N Jones Regional Medical Center	903-870-4122	903-870-4485	Amy Coffman 903-870-4534 acoffman@wnj.org
Wise Regional Health System	214-633-0100	877-645-0911	214-698-4526 emergencymanagement@wisehealthsystem.com

EMS and Fire Agencies				
Agency	**Dispatch Number**	**Point of Contact**	**Phone Number**	**Agency Email**
Acadian Ambulance	214-585-6347	Billy Skiles	337-521-3662	billy.skiles@acadian.com
Addison Fire Department	469-289-3270	CJ Alexander	972-450-7203	calexander@addisontx.gov
AMR Dallas	469-816-5803	Marjorie Muccie	214-414-1240	marjorie.muccie@amr.net
AMR Arlington	817-861-5555	Mark Kessler	817-861-5555	Mark.kessler@gmr.net
Argyle Fire Department	940-600-2249	Cameron Miller	972-341-2394	cmiller@argylefire.com
Azle Fire Department	817-232-9800	Thomas Scott	817-444-7093	tscott@cityofazle.org
Bedford Fire Department	817-952-2127	Mark Williams	817-952-2503	mark.williams@bedfordtx.gov

EMS and Fire Agencies				
Agency	**Dispatch Number**	**Point of Contact**	**Phone Number**	**Agency Email**
Benbrook Fire Department	817-249-1610	Jackie Hartman	817-249-6082	jhartman@benbrook-tx.gov
CareFlite	972-660-2851	James Wagner	817-933-4677	jwagner@careflite.org
Carrolton Fire Department	214-243-0327	Steven Heath	792-466-3393/4739	ricky.vaughan@cityofcarrollton.com
Cedar Hill Fire Department	469-628-1786	Mike Harrison	214-906-1929 972-291-5100 Ext 2333	mike.harrison@cedarhilltx.com
Celina Fire Department	972-742-9451	Eric Everson	972-382-9858	eeverson@celina-tx.gov
Children's Medical Center Transport	903-724-8049	Jeff Seale	903-724-8049	jeffrey.seale@childrens.com
City of Grand Prairie	214-533-6975	Robert Fite	972-237-8301	rifte@gptx.org
City of Lancaster	972-743-7343	Stephen Smith	804-462-5404	msmith@lancova.com
City of Roanoke	817-822-8991	Shaun Eager	817-491-2301	seager@roanoketexas.com
City of Van Alstyne	903-267-1232	Robert Dockery	903-482-6666	rdockery@cityofvanalstyne.us
Cleburne Fire Department	817-645-0964	Scott Lail	817-556-8821	scott.lail@cleburne.net
Colleyville Fire Department	817-743-4523	Mark Cantrell	817-503-1400	mcantrell@colleyville.com
Cook Children's Medical Center Transport	214-218-3274	Deborah Boudraux	682-885-3901	deborah.boudraux@cookchildrens.org
Cooke County EMS	940-206-0924	Kevin Grant	940-668-5560	Kevin.grant@co.cooke.tx.us
Coppell Fire Department	469-289-3270	Tim Russell	972-304-3512	trussell@coppelltx.gov
Crowley Fire Department	817-297-1638	Larry Swartz	817-297-2276	lswartz@ci.crowley.tx.us
Dallas Fire Department	214-670-5466	Bobby Ross	214-670-4609	bobby.ross@dallascityhall.com
Denton Fire Department	940-349-7920	Kenneth Hedges	940-349-8841	kenneth.hedges@cityofdenton.com
Desoto Fire Rescue	972-989-1328	Brian Whitacre	972-230-9682	bsouthard@desototexas.gov
DFW Airport DPS	972-979-3496	Jeff Benezue	972-574-8670	jbenezue@dfwairport.com
Duncanville Fire Department	972-780-4920	Mike Ryan	972-707-3828	mryan@ci.duncanville.tx.us
Erath County EMS	936-577-2827	Wesley Green	817-279-3172	EMSDirector@co.erath.tx.us
Euless Fire Department	817-832-9540	Wes Rhodes	817-685-1600	cbennett@eulesstx.gov
Everman Fire Department	972-780-4920	Randy Sanders	817-293-2923	s00@evermantx.net
Farmers Branch Fire Department	972-919-2640	Gabriel Vargas	972-919-2640	gabriel.vargas@farmersbranchtx.gov
Fisher County Hosp District	325-669-0015	Harold Fillingim	972-237-4627	hfillingim@sbcglobal.net
Flower Mound Fire Department	972-874-6270	Strider Floyd	972-874-6203	strider.floyd@flower-mound.com
Fort Worth Fire Department	817-392-3000	Rudy Jackson	817-923-3890	Rudy.Jackson@fortworthtexas.gov
Frisco Fire Department	972-523-4560	Jake Owen	972-292-6314	jowen@friscofire.com

EMS and Fire Agencies				
Agency	**Dispatch Number**	**Point of Contact**	**Phone Number**	**Agency Email**
Garland Fire Department	972-485-4874	Glenn Johnson	972-781-1111 214-287-4777	gjohnson@garlandtx.gov
Glenn Heights Fire Department	972-223-2478	Keith Moore	972-223-1690	keith.moore@glennheightstx.gov
Graham Young County	940-550-5638	Kevin Hudson	817-238-4723	khudson@grahamrmc.com
Granbury/Hood County EMS	817-579-3307	Ricky Reeves	817-279-1408	rreeves@mytexasems.org
Grand Prairie Fire Department	972-237-8700	Sheri Adams	972-237-8208	sadams@gptx.org
Grapevine Fire Department	817-564-3443	Jamey Shipler	817-410-4400	jshipler@grapevinetexas.gov
Highland Village Fire Department	972-317-0890	John Glover	972-317-0890	jglover@highlandvillage.org
Hurst Fire Department	817-781-7688	David Palla	817-788-7246	dpalla@hursttx.gov
Hutchins Fire Department	972-225-2225	Matthew Lehmann	972-225-3522	mlehmann@cityofhutchins.org
Irving Fire Department	972-721-2514	Steven Deutsch	972-721-4653	sdeutsch@cityofirving.org
Keller Fire Department	817-743-4400	Shane Gainer	817-743-4428	sgainer@cityofkeller.com
Kennedale Fire Department	817-985-2150	Ryan Florence	817-478-5322	rflorence@cityofkennedale.com
Keene Fire Department	817-556-2474	Matt Gillin	817-566-2474	mgillin@keenebroadband.com
Krum Fire Department	940-349-1600	Corey Gregory	940-482-6257	cgregory@krumfire.com
Lancaster Fire Department	972-218-2600	Laura Hillary	972-218-2604	Lhillary@lancaster-tx.com
Lewisville Fire Department	972-219-3640	Michael Spinuzzi	972-219-7082	mspinuzzi@cityoflewisville.com
Life Care EMS	817-599-1197	Paul Smith	817-599-1197	paul.smith@pchdtx.org
Little Elm Fire Department	214-975-0420	Todd Jamieson	214-975-0429	tjamison@littleelm.org
Lucas Fire Department	972-422-8171	Aaron Alderdice	972-727-1242	aalderdice@lucastexas.us
Mansfield Fire Department	817-473-0211	Kevin Sandifer	817-804-5772	kevin.sandifer@mansfield-tx.gov
McKinney Fire Department	903-258-4651	Russell Griffin	972-547-2869	rgriffin@mckinneytexas.org
Medical Air Rescue Company	817-657-6050	Michael Nelson	817-682-4000	mnelson@medicalairrescue.com
MedStar Mobile Healthcare	817-927-9620	Christopher Cunningham	817-632-0529	Ccunninghman@medstar911.org
Mesquite Fire Department	972-216-6312	Justin James	972-216-6312	Jjames@mesquitefire.org
Midlothian Fire Department	972-775-3333	Kevin Cunningham	972-7775-7664	kevin.cunningham@midlothian.tx.us
Mineral Wells Fire Rescue	817-946-4355	Ryan Dunn	940-328-7330	rdunn@mineralwellstx.gov
Mitchell County EMS	325-242-2529	Jason Stark	325-284-2369	jstark@mitchellcountyhospital.com
North Richland Hills Fire Department	817-281-1000	Chris Jungst	817-427-6977	cjungst@nrhfd.com

EMS and Fire Agencies				
Agency	**Dispatch Number**	**Point of Contact**	**Phone Number**	**Agency Email**
Pecan Plantation EMS	817-579-3307	Sandra Winfield	817-573-1643	sandrawin@charter.net
Plano Fire Department	972-207-2085	James Reyes	972-841-7945	jaimer@plano.gov
Prosper Fire Department	972-347-3010	Scott Dilliberto	972-347-2424	scott.diliberto@prosperfire.com
Richardson Fire Department	214-215-7010	Curtis Poovey	972-744-5700	Curtis.Poovey@cor.gov
Richland Hills Fire Department	817-616-3750	Russell Shelley	817-616-3755	rshelley@richlandhills.com
Roanoke Fire Department	871-491-8101	Kevin McCally	817-491-2301	kmccally@roanoketexas.com
Rowlett Fire Rescue	469-853-2715	Chris Brown	972-412-6231	cbrown@rowletttx.gov
Sachse Fire Rescue	214-876-8709	Robert Knappage	972-495-0975	rknappage@cityofsachse.com
Sacred Cross	940-566-1188	Sarah Clasby	940-556-5588	sclasby@sacredcrossems.net
Sherman Fire Department	903-209-8141	Christopher Riso	903-892-7273	chriso@ci.sherman.tx.us
South Taylor EMS	325-674-1300	David Allman	325-500-4950	david.allman@southtaylorems.org
Stephenville Fire Department	254-918-1210	Jimmy Chew	254-918-1243	jchew@stephenvilletx.gov
Stonewall County Ambulance Service	432-209-1943	Jaffin Durham	325-676-6676	jaffin.durham@stonewallhospital.org
Sweetwater Fire Department	806-217-1306	William Schafer	817-328-3773	willschafer15@gmail.com
The Colony Fire Department	972-625-1887	Jason Bonds	972-624-2320	jbonds@thecolonytx.gov
Town of Addison Fire Department	972-979-5342	Michael Thomson	817-372-4622	mthomson@addisontx.gov
Trans Star Ambulance	940-636-8556	Ryan Matthews	972-238-4746	ryan.matthews@transstar.net
University Park Fire Department	214-978-5370	Scott Green	214-987-5388	sgreen@uptexas.org
Watauga Fire Department	817-514-5897	Randy Barkley	817-514-5791	rbarkley@wataugatx.org
Wise County EMS	940-627-5971	Randall Preuninger	940-627-4204	rpreuninger@ems.co.wise.tx.us
Wilmer Fire Department	972-441-6373	Mark Hamilton	972-977-7599	Mhamilton@wilmertx.gov
Wylie Fire Rescue	972-442-8171	Brandon Blythe	972-429-8110	brandon.blythe@wylietexas.gov

Appendix B: EMCC Activation Activities

EMCC Activation: The First Five Minutes

1. Upon the decision to activate the EMCC the following should be done:
    a. All staff meets in the EMCC and assures the safety of their affected family members.
    b. EMCC Director:
        1) Gain access to crisis applications, prepare Sit-rep notes for in-brief, and prepare activation notification (EMResource, Radio Frequencies, etc.)
        2) Prepare safety brief for staff
        3) Conduct staff muster and accountability
    c. EMTF Coordinator:
        1) Gain access to crisis applications and update EMTF asset status
        2) Have current EMTF contact list
    d. Planning:
        1) Gain access to crisis applications
        2) Prepare to draft IAP
    e. Operations:
        1) Set up the EMCC with Section placement and supplies
        2) Assist with activation notification preparation
        3) Gain access to crisis applications
    f. Logistics:
        1) Review sustainability policies / procedures
        2) Bring current hard copies of inventory, MOU's, and vendor agreements to EMCC
    g. Administration / Finance:
        1) Set up station to begin receiving all calls
        2) Print off and bring current EPC Contact List
        3) Get phone extension map and prefill ICS 214 Activity Log to make copies
        4) Pass around sign in sheet, phone extension map, and ICS 214 Activities Logs to all present
    h. Information Technologies:
        1) At EMCC Director command, roll over Duty Phone (x7020) to Administration
        2) Set up phones, computers, security levels, and crisis applications
        3) Set up all TV's, VTN, and Smart Boards
        4) Troubleshoot any issues from staff
        5) Create any visitor access badges as necessary

EMCC Activation Checklist

1. **Immediate Actions (First 4 Hours)**
    a. Staff Coordination
        1) HPP Director contacted
        2) Staff Conference Call activated as needed (817-607-7080)
        3) NCTTRAC EMCC GroupMe utilized as needed
        4) For after-hours notifications: make decision to return to EMCC or work virtually
    b. Appropriate Outside Organization Coordination
        1) Contact the relevant partner organizations from the following groups: DSHS; Disaster District Coordinator (DDC); State Coordinating Officer (SCO); Jurisdictional Emergency Management (City/County); Hospitals; EMS/FD; County Public Health
    c. Request Previous EAPs for Situational Awareness
    d. Begin ICS-214 (Activity Log)
    e. Develop Briefing for Staff and Potential Partners
    f. Alert Notifications via Everbridge or EMResource

g. Issue a Bed Report in EMResource (if necessary)

2. **Continued Actions (Next 8 Hours)**
   a. EMTF Notifications (as Needed)
   b. Logistics Continued Coordination (as Needed)
   c. Expense Report Tracking
   d. Continued Coordination with Outside Partners
   e. Media Reports/Update Situational Awareness
   f. Update Briefing on Status and Needs
   g. Continued Bed Reporting in EMResource (as Needed)
   h. Force Protection Measures for Staff Considerations
      1) Extended Operations?
      2) Food/Drinks
      3) Bathroom
      4) Shift work schedule
   i. Communications Plan/Implementation
   j. Applicable Incident Contact Sheet Created/Distributed

3. **Continued Actions (Next 24 Hours)**
   a. Continued Coordination with Outside Partners
   b. Updated Situational Awareness
   c. Media Updates
   d. Staff Update Briefing
   e. Determination of Work Schedule
   f. Update on Deployed Resources/SitRep
   g. Update on any Additional Needs Requests or Unmet Current Needs
   h. Assess Deployed Units Sustainability
      1) Food/Water
      2) Hygiene
      3) Sleeping Area
      4) Supplies
      5) Number of Personnel
   i. Consideration of Resource Rest/Replacement

For incidents lasting longer than 24 hours, continue with Items 2 and 3.

Appendix C: ICS-213RR

RESOURCE REQUEST MESSAGE (ICS 213 RR)

2. Date/Time	3. Resource Request Number:

4. Order (Use additional forms when requesting different resource sources of s						
Qty.	Kind	Type	Detailed Item Description: (Vital characteristics, brand, sp experience, size, etc.)	Arrival Date and Time		Cost
				Requested	Estimated	

5. Requested Delivery/Reporting Location:		
6. Suitable Substitutes and/or Suggested Sources:		
7. Requested by Name/Position:	8. Priority: □ Urgent □ Routine □ Lo	9. Section Chief Approval:
10. Logistics Order Number:		11. Supplier Phone/Fax/Email:
12. Name of Supplier/POC:		
13. Notes:		
14. Approval Signature of Auth Logistics Rep:		15. Date/Time:
16. Order placed by (check box): □ SPUL □ PROC		
17. Reply/Comments from Finance:		
18. Finance Section Signature:		19. Date/Time:

VIII. ANNEXES

*Due to the sensitive nature of these documents, you must be logged into ncttrac.org to access these in a view only capacity

Annex A: North Texas Mass Critical Care Guidelines: Adult

Annex B: North Texas Mass Critical Care Guidelines: Pediatric

Annex C: TSA-E Medical Coordination Center Standard Operating Guidelines

Annex D: HCC-E Communications & Information Sharing Concept of Operations

Annex E: Healthcare Coalition Memorandum of Sharing

Annex F: NCTTRAC Regional Assets List

Annex G: NCTTRAC Property Transfer Agreement

Annex H: HCC-E Infectious Disease Response Annex

Annex I: HPP Grantee Continuity of Operations Plan

Annex J: The State of Texas Disaster Medical System Overview

Annex K: North Central Texas Mass Casualty Incident Framework

Annex L: HCC-E Pediatric and Perinatal Surge Annex

Annex M: HCC-E Regional Burn Surge Annex

Annex N: HCC-E Regional Radiation Surge Annex

NCTTRAC
NORTH CENTRAL TEXAS TRAUMA REGIONAL ADVISORY COUNCIL

Coordination Flowchart

Plan/Program/Guideline Currently in Place?

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

Yes

Documentation Review of:

NCTTRAC Regional Trauma System Plan

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

Trauma Committee Review Date: 06/01/2023
Comments: Reviewed and approved
NCTTRAC Staff Initials CC Chair Sign Off: Danielle Sherrar Date: 06/01/2023

Committee Coordination

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

Air Medical Committee Review Date: 08/01/2023
Comments: Reviewed and approved
NCTTRAC Staff Initials CC Chair Sign Off: Jeff Donson Date: 08/01/2023

ED Ops Committee Review Date: 08/01/2023
Comments: Reviewed and approved
NCTTRAC Staff Initials CC Chair Sign Off: Donald Tucker Date: 08/01/2023

EMS Committee Review Date: 08/01/2023
Comments: Reviewed and approved
NCTTRAC Staff Initials CC Chair Sign Off: Kevin Sandifer Date: 08/01/2023

Pediatric Committee Review Date: 08/01/2023
Comments: Reviewed and approved
NCTTRAC Staff Initials CC Chair Sign Off: Kalinda Evans Date: 08/01/2023

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: CC - 5/10/2022

Medical Directors Committee

Medical Directors Committee Review Date: 08/01/2023
Comments: Electronic Vote
NCTTRAC Staff Initials CC Chair Sign Off: Dr. Justin Northeim Date: 08/01/2023

Legal Counsel Review (PRN)

Signature _____
Date: _____

Finance Committee Review (PRN)

Signature _____
Date: _____

Final NCTTRAC Staff Review

NCTTRAC Staff Review Date: 08/02/2023
Comments: Reviewed
Staff Initials JD Date: 08/02/2023

NCTTRAC Administration Review Date: 07/31/2023
Comments: Reviewed,reformatted
Staff Initials SB Date: 07/31/2023

NCTTRAC Executive Review Date: 08/01/2023
Comments: Recommend Approval
Staff Initials HJA Date: 08/01/2023

Board of Directors Endorsement/Approval

NCTTRAC Administration submit to Board of Directors Date: 08/01/2023
NCTTRAC Board of Directors Approval Date: 08/08/2023

General Membership approval (PRN)
Date: _____

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

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

For further Committee review continue on next page

Committees Continued

Perinatal Committee Review Date: 08/01/2023
Comments: Reviewed and approved
NCTTRAC Staff Initials CC Chair Sign Off: Dr. David Nelson Date: 08/01/2023

REPC Committee Review Date: 08/01/2023
Comments: Reviewed and approved
NCTTRAC Staff Initials CC Chair Sign Off: Stephan Epley Date: 08/01/2023

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

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