



Coastal Bend Regional Advisory Council Trauma Service Area - U

Regional Trauma System Plan

Reviewed/Revised/Approved: April 2023

The Organization is a recognized Regional Advisory Council (RAC) for the area described by The Texas Department of State Health Services (DSHS) as TSA-U (defined below) and organized under the Texas Trauma Rules. All other definitions are in accordance with those set forth by DSHS Rules 157.2.

A RAC is a formal organization originally chartered by DSHS to develop and implement a regional emergency medical services/trauma system plan and to oversee trauma system networking, contracts, and to perform other management services, including, but not limited to, emergency preparedness or other services. The RAC has the authority to expand its purpose for other regional healthcare system coordination.

TSA-U is defined as the Trauma Service Area so designated by DSHS. Currently TSA-U includes the Texas counties of:

Aransas, Bee, Brooks, Duval, Kenedy, Kleberg, Live Oak, Jim Wells, McMullen, Nueces, Refugio, San Patricio.

MISSION:

TO REDUCE DEATH/DISABILITY RELATED TO TRAUMA, DISASTER AND ACUTE ILLNESS, THROUGH IMPLEMENTATION OF APPROPRIATE EDUCATION AND A WELL-PLANNED, COORDINATED DISASTER AND EMERGENCY RESPONSE SYSTEM.

INJURY PREVENTION AND PUBLIC AWARENESS

The Coastal Bend Regional Advisory Council (CBRAC) Trauma Service Area (TSA) U promotes the reduction of the incidence, severity, and cost of intentional and/or unintentional injuries through the implementation of effective prevention strategies, to include education, improved technology, and public policy.

In efforts to promote the reduction of the incidence, severity, and cost of intentional and/or unintentional injuries, the CBRAC TSA-U will utilize local, state, and other national trauma registry databases to catalog and identify trauma trends in the region in order to implement strategies to reduce these trends.

The CBRAC TSA-U Injury Prevention Committee will identify effective access mechanisms with entities that can assist our organization in implementing programs and distributing materials to the public. The CBRAC TSA-U will participate in Injury Prevention activities within the community and develop programs that will educate the public and promote injury prevention within our communities. The CBRAC TSA-U will monitor legislative issues regarding public injury prevention and support or oppose those that fit within our strategic plan.

ACCESS TO THE SYSTEM

Basic 9-1-1 is a regional system providing dedicated trunk lines, which allow direct routing of emergency calls. Routing is based on the telephone exchange area, not municipal boundaries. In TSA-U, all systems are enhanced 9-1-1, which provides for Automatic Number Identification (ANI) and Automatic Location Identification (ALI).

Enhanced 9-1-1 is a system, which automatically routes emergency calls to pre-selected answering points based upon the geographical location from which the call originated. A 9-1-1 system operates by a caller dialing the digits 9-1-1, and then the call is routed to the local telephone company central office. The ANI is attached to the voice and sent to the Public Safety answering point. With the ALI, the call is sent to the central office and the 9-1-1 computer database assigns an address to the phone number, then routes the call to the designated Public Safety Answering Point (PSAP).

In TSA-U, the primary emergency communication systems for public access are Enhanced 9-1-1. The emergency communication systems were implemented providing citizens to emergency communications to municipalities and counties (incorporated and unincorporated) in the TSA-U. In circumstances when all incoming 9-1-1 lines are busy, or the central system is down for a period, the calls are automatically routed to a designated alternate location. In TSA-U, all pay phones offer free 9-1-1 access as well as operator assistance. Phone lines in residences and businesses alike that are not connected have 9-1-1 access. Mobile phone customers also have no charge 9-1-1 access. For the public that is hearing impaired, the Telecommunications Device for the Deaf (TDD) system is linked to 9-1-1, and TDD pay phones offer free access.

COMMUNICATIONS

The current trauma communication network within TSA-U consists of traditional phones, wireless phones, VHF, and 800 MHz radio systems. Due to technical and geographic limitations, the only region-wide communication networks are traditional wire and wireless phones.

EMS Communication Systems in TSA-U currently do not utilize exclusively medical personnel for dispatch. Many systems have calls routed through various other agencies, such as the fire department, sheriff's office, or local hospitals. Emergency Medical Dispatcher (EMD) certified dispatchers are the exception rather than the rule. The CBRAC partners with the Local Emergency Planning Committee (LEPC) to encourage and support the development of EMS certified dispatchers in all Public Service Answering Points (PSAPs) within the region.

The communication network in TSA-U providing for ambulance to ambulance, ambulance to dispatch, ambulance to hospital, ground to air, and hospital to hospital communications consist of several radio frequencies, including, but not limited to VHF high band frequencies, 800 MHz trucking systems and the use of telephones both land-based and cellular. By using these multiple systems, communications with public and private EMS agencies, police, fire, and hospitals are maintained.

Each agency and their vehicles also maintain a listing of their mutual aid responders for ready reference, although written mutual aid agreements are not formally obtained by all the EMS Systems.

MEDICAL OVERSIGHT/REGIONAL MEDICAL CONTROL

TSA-U encompasses both rural and urban areas. Hospitals in the area have capabilities ranging from non-designated to Level II Trauma Centers.

A Level II Lead Trauma Center is in Corpus Christi, Nueces County. Nueces County is the most urban of the counties within TSA-U. A tiered patient delivery system based upon severity of injury is geared toward transfer of the trauma patient from the scene to the most appropriate level of care within an appropriate time frame. This goal is accomplished through application of well-established off-line medical control protocols and utilization of on-line medical control when patient circumstances are contrary to these protocols. Proper communication of facility diversion is also essential to prevent harmful delays in the delivery of patient care. A list of TSA-U medical directors for the EMS Agencies is available upon request.

There are five helicopter rescue systems that may serve patients within the region. These are HALO-Flight in Corpus Christi, Alice, and Beeville, AirLife in San Antonio, PHI in Victoria, AEL in Laredo and Air Lift Texas in Weslaco. HALO-Flight is the only air medical system physically located within the CBRAC region. HALO-Flight has two available helicopters in the rural communities, being 15 to 25 minutes from Corpus Christi proper. In the event of a mass casualty incident, a third local helicopter may be activated, dependent upon staffing and spare helicopter availabilities. The Coast Guard may also be utilized in mass casualty situations, and in times of inclement weather, when the patient's needs do not exceed a BLS level of care need. Note: Coast Guard helicopters are staffed with one EMT-Basic level medical crew member.

Scene to Level I or Level II trauma center by ground time may exceed 70 minutes in some areas of TSA-U and air transport times may be as long as 30 minutes from some areas.

Medical oversight of RAC and trauma related services have been established by involving the physician community into the RAC process. Each EMS agency has its own EMS Medical Director. RAC protocols affecting the medical care of patients are required to be approved annually by the members at the General Membership of the RAC, including physician members. Also, each EMS Medical Director is required to acknowledge the use of various RAC protocols annually.

Regional Medical Control takes two forms, offline and online medical control. Online medical control is offered as needed to all prehospital services in the region from a standard medical radio/radio-phone communications system based at CHRISTUS Spohn Hospital Corpus Christi Shoreline and overseen by Emergency Department (ED) physicians at that facility. The medical directors of the individual services requiring medical direction provide Offline Medical Control. This medical direction includes the provision of standing orders and protocols for patient care and transportation. Offline direction also includes quality assurance practices including run reviews, comparisons of actions to orders, and other methods of control as specified by individual service directors.

AIR MEDICAL PROVIDER (AMP) ACTIVATION GUIDELINES

The Air Medical Provider (AMP) activation guidelines are intended to provide a framework for each RAC to develop a standardized method for ground emergency medical service providers to request a scene response by an AMP, to reduce delays in providing optimal care for severely ill or injured patients, and to decrease mortality and morbidity. AMP resources should be utilized in accordance with the regional trauma plan.

Guidelines for Activation & Selection of AMP: The EMS provider should comply with RAC-approved triage criteria to activate AMP transport.

Factors that should be considered are:

- Location of incident
- Number of patients
- Age of patients
- Response time of AMP(s)
- Severity/MOI (refer to the CBRAC Guidelines for Field Triage of Injured Patients)
- The total AMP response time (response time + scene time + transport time) will result in delivery of the patient(s) to the most appropriate facility faster than transport by ground ambulance.

Any available AMP(s) that best meets the needs of the patient may be utilized.

Other considerations: Patients meeting criteria for AMP dispatch should be transported to the nearest appropriate facility.

AMP Selection Considerations: The following parameters may be considered in the development of RAC AMP activation criteria when more than one AMP provides service in the TSA:

- The AMP should meet the minimum RAC participation standards in the RAC in their primary service area.
- The AMP should participate as requested in RAC performance improvement (PI) activities
- The AMP utilized for patient treatment, and transport should be the AMP that best meets the patient's care and transport needs, including:
 - Performance criteria (dispatch + response time + scene time + transport time) clinical capabilities
 - Operational interface and safety: AMP should always demonstrate safe operations. Safe operations standards include safety standards such as those endorsed by the Federal Aviation Administration, the National Association of EMS Pilots, National Association of Air Medical Services, and the Committee on Accreditation of Air Medical Transportation Services.
 - Clinical and operational PI practices.

MULTI-PATIENT VEHICLE (AMBUS) ACTIVATION GUIDELINES

The Multi-Patient Vehicle (AMBUS) activation guidelines are intended to provide a framework for emergency medical service providers to request a scene response by an AMBUS, to reduce system impact of MCI events, provide transport and care for large numbers of non-critical patients, and distribute patients to appropriate hospitals in a manner than minimizes impact to emergency departments. AMBUS resources should be utilized in accordance with the regional trauma plan.

Guidelines for Activation & Selection of AMBUS: The EMS provider should comply with RAC-approved triage criteria to activate AMP transport.

Factors that should be considered are:

- Location of incident
- Number of patients

- Age of patients
- Response time of AMBUS(s)
- Severity/MOI (refer to the CBRAC Guidelines for Field Triage of Injured Patients)
- The total AMBUS response time (response time + scene time + transport time) will result in delivery of the patient(s) to the most appropriate facilities to minimize impact to ground ambulance services.

Any available AMBUS(s) that best meets the needs of the patient may be utilized.

Other considerations: AMBUS(s) are intended for transport of multiple non-critical patients. Critical patients, or those that may become critical, should be transported by ground ambulance or AMP.

To request an AMBUS, contact Metro-Com at 361-886-2600.

FACILITY DIVERSION GUIDELINES

PURPOSE:

To define uniform system guidelines for a hospital requesting re-direct EMS traffic to an alternate hospital.

DEFINITIONS:

Open: Should be the default status and return to this status from others should be done as quickly as patient care allows.

High Volume: Should be used as an indication to EMS the Emergency Department is busy and wait times will be longer than normal.

Transfer: Movement of a patient from one hospital to another based upon the patient's need (inter-hospital transport).

Bypass: Intentional movement of a patient from the scene to the most appropriate hospital, not necessarily the nearest hospital, based upon the patient's medical need.

Diversion: Intentional movement of a patient from the scene to an alternate hospital capable of providing appropriate care at the request of the primary hospital experiencing unsafe delays due to limitations in resources or in the case of internal disaster. (Such as loss of water, heating/cooling, active shooter, etc.)

Appropriate Facility: A hospital, not necessarily the nearest hospital, with the resources and capability to care for a patient based upon the patient's medical needs.

Regional EMS System: Will include any EMS Provider licensed within the CBRAC on TSA-U.

ACKNOWLEDGMENTS:

When a facility is on diversion, EMS will try to reroute patients as appropriate. It is recognized in advance that there is no guarantee that total compliance with these guidelines will be possible, and it is likely that patients will continue to arrive to hospitals that have reached unsafe levels. It is further understood that honoring such a request from a hospital is a courtesy by the regional EMS system. Patient's informed wishes will be honored.

Authorization for diversion status will be made by a hospital administrator or designee.

Each facility is responsible for defining facility-specific policies and procedures for implementation of these guidelines.

COMMUNICATION OF DIVERSION STATUS:

- TSA-U utilizes EMResource to provide regional EMS and hospitals with status levels.
- A hospital will post the status change on the EMResource status board.
- A hospital will not be considered on divert until EMResource is updated.
- A hospital must notify the appropriate EMS primary point of contact per facility specific protocol.

AUTHORIZATION FOR OVER-RIDE OF DIVERSION STATUS:

EMS may over-ride diversion status after consideration of the following:

- The patient’s clinical presentation, with consideration to the regional Trauma Bypass Protocol.
- Distance and estimated time to an appropriate alternate facility.
- Inclement weather conditions.
- Resource availability and capability of the transporting pre-hospital provider.
- An informed patient preference.

PROTOCOL FOR EMERGENCY DEPARTMENT “Round Robin” ROTATION OF PATIENTS WHILE ON DIVERT:

When any two of the following City of Corpus Christi hospitals are on divert:

- CHRISTUS Spohn Hospital Corpus Christi-Shoreline
- CHRISTUS Spohn Hospital Corpus Christi-South
- Corpus Christi Medical Center-Doctors Regional
- Corpus Christi Medical Center-Bay Area
- Corpus Christi Medical Center – ER 24/7 Northwest
- Driscoll Children’s Hospital

Round Robin – Initiation of rotation of ED will begin and will be coordinated by CHRISTUS Spohn Hospital Corpus Christi-Shoreline.

Patients transported to a specific ED due to preference or presence of traumatic injury will be called into the ED at CHRISTUS Spohn Corpus Christi- Shoreline so that these patients can be included in the rotation.

Location of the call will be considered when routing the Regional EMS System to their destination.

After receiving hospital assignment, a Pulsara report will be sent to the receiving hospital by EMS.

BYPASS PROTOCOL FOR THE MAJOR (Priority 1) TRAUMA VICTIM

Goal: Major trauma patients who are medically unstable, unconscious and/or at high risk of multiple and/or severe injuries will be quickly identified and transported to the appropriate trauma facility.

Decision Criteria: This bypass protocol is intended to ensure that major trauma patients who meet triage criteria will be transported directly to the appropriate trauma facility rather than to the nearest hospital EXCEPT under the following circumstances:

- If unable to establish and/or maintain an airway, or in the event of traumatic cardiac arrest, the patient will be transported to the nearest acute care facility.
- If transport time to the indicated trauma facility exceeds 60 minutes and EMS is unable to arrange air transportation or hand-off of the patient to an EMS service with Advanced Life Support (ALS) capabilities, the patient will be transported to the nearest facility.
- Rural EMS systems with Advanced Life Support (ALS) capabilities and the concurrence of their medical director may bypass local facilities if that facility lacks the resources to address the trauma patient's specialty need.

Criteria for Trauma Facility Destination: The Criteria listed below are guidelines for EMS services in Trauma Service Area-U.

Nearest Hospital / Handoff: The major trauma patient will be transported to the most appropriate Emergency Department under the following conditions:

- If unable to establish and/or maintain an adequate airway
- If the patient is in traumatic cardiac arrest
- If the expected transport time to the appropriate trauma facility exceeds 60 minutes and EMS is unable to arrange air transportation or hand-off the patient to an EMS service with Advanced Life Support (ALS) capabilities.

Patient Criteria for Activation of Regional Trauma System Plan: The Regional Trauma System Plan and Bypass Protocol will be initiated for all trauma patients who are hemodynamically unstable, unconscious and/or at risk of multiple and/or severe injury as indicated by the following (age appropriate where applicable):

SEE CBRAC GUIDELINES FOR FIELD TRIAGE OF INJURED PATIENTS

Patient Criteria for Consideration of Bypass Protocol: These criteria should cause a high index of suspicion that the patient may have sustained a severe injury. Consultation with medical control is recommended to assist in the decision as to whether or not to activate the Regional Trauma System Plan for these patients.

SEE CBRAC GUIDELINES FOR FIELD TRIAGE OF INJURED PATIENTS

Considerations

- Prehospital personnel's judgment of injury severity.
- Under age 5 or over age 55.

- Hostile environment (extremes of heat or cold).
- Cardiac or respiratory disease.
- Insulin-dependent diabetes mellitus, cirrhosis, morbid obesity, bleeding disorders, anticoagulants.
- Immunosuppressed patients
- Second or third trimester of pregnancy

Injuries Requiring Specialized Medical Care:

Pediatric: Driscoll Children’s Hospital will accept all trauma patients aged 15 and younger unless the following criteria are present:

- Penetrating injury to the head, neck, torso, and/or extremities proximal to the knee and elbow
- All pregnant trauma patients

Burns: Consideration should be given for direct transport to an accredited burn center (if Air Transport is available) for patients with Partial Thickness burns exceeding 15% body surface area (BSA), Full Thickness Burns exceeding 10% body surface area (BSA), or burns involving face, hands, feet, genitalia, and/or perineum. If Air Transport is unavailable, transport to age-appropriate facility.

Air Ambulance / Hand-off: If the expected ground transport time to the appropriate trauma facility exceeds 30 minutes, or if extrication time is exceeding 20 minutes; air ambulance transport should be considered.

Hand-off of the trauma patient to an advanced life support (ALS) or mobile intensive care unit (MICU) will be initiated in the following circumstances:

- Unable to arrange air ambulance transfer.
- EMS provider is first responder and unable to leave service area.

Contact Medical Control for questions regarding Trauma System Plan activation. Patient’s rights, choices and best interests will be respected in the determination of hospital destination.

Trauma activation will be based on field triage report from EMS and the activation criteria. Patients brought in by private vehicle will be triaged by facility per activation criteria.

SEE CBRAC GUIDELINES FOR FIELD TRIAGE OF INJURED PATIENTS

Trauma Transfers: All requests for transfer of trauma patients will be initiated either through a transfer center or directly to the ED physician on duty according to the facility’s protocol.

The sending and receiving physicians will discuss the patient’s needs. The receiving trauma center will make efforts to accept the patient based on capability and capacity.

DESIGNATION OF TRAUMA FACILITIES

The CBRAC supports and encourages all hospitals within TSA-U to participate in the trauma system and to seek the appropriate level of designation. There are ten designated trauma facilities within the service area.

Level II

- CHRISTUS Spohn Hospital Corpus Christi-Shoreline
- Corpus Christi Medical Center-Bay Area

Level III - Pediatrics

- Driscoll Children's Hospital

Level IV

- Corpus Christi Medical Center-Doctors Regional
- CHRISTUS Spohn Hospital-Alice
- CHRISTUS Spohn Hospital-Beeville
- CHRISTUS Spohn Hospital-Kleberg
- CHRISTUS Spohn Hospital Corpus Christi-South
- Refugio Memorial Hospital
- Corpus Christi Medical Center - ER 24/7 Northwest

CBRAC supports designation for TSA-U hospitals. CBRAC provides a letter of support for hospitals that meet the participation requirements.

PERFORMANCE IMPROVEMENT (PI) PLAN

Mission Statement: TSA-U is dedicated to the provision of quality healthcare. It provides accessible, comprehensive, quality healthcare to all trauma patients regardless of age, race, religion, sex, nationality, or ability to pay.

The purpose of a PI plan is to provide assessment and improvement activities designed to monitor and evaluate the quality of patient care through system analysis, to identify and pursue opportunities to improve patient care and to sustain improvement over time.

Goals/Objectives: The TSA-U PI plan is designed to achieve the following goals:

- To facilitate improvement in patient care and services provided by establishing mechanisms to identify opportunities to improve.
- To provide a framework for a planned, systematic approach for monitoring and evaluating the quality, appropriateness, and effectiveness of trauma patient services provided within the region.
- To pursue opportunities for improving patient care by evaluating systems and addressing educational issues.
- To centralize the flow of information through the committee structure to prevent duplication of effort and to facilitate early awareness of problems or opportunities of improvement.
- To create a structure which will provide for coordination, integration, and accountability of quality management activities commensurate with established standards.
- THIS PROCESS IS NOT SUBJECT TO DISCOVERY PURSUANT TO TEXAS REVISED CIVIL STATUTES ART.4495b. NO PI DOCUMENTS WILL BE REMOVED FROM THE MEETING ROOM.

PI Committee Description (from the existing bylaws)

- The PI Committee may conduct both open and closed meetings.
- Anyone identifying an issue should use the CBRAC referral form.
- Issues of concern that are brought to the committee for discussion and recommendation will be discussed in closed meetings.
- The chair of the committee will appoint additional members as needed based on the issue with the approval of the Board of Directors
- Decisions will be made by consensus of the working group.

Functional Authority: The final authority and ultimate responsibility for a flexible and integrated PI plan shall rest with the CBRAC.

Organization and Collection of Data: Data shall be collected and organized for review under the direction of the PI Chair. CBRAC members will participate in the PI committee by supplying data as requested.

Consideration for collection will be given to:

- Who will collect data
- What data is to be collected
- Frequency of data collection
- How data should be collected
- Sources for data collection

Data Evaluation: The PI Committee will analyze the data and determine if there are areas where improvement can be identified. When identified, causes will be established, and recommendations made to achieve improvement. The evaluation of key functions includes analyses of trends and patterns in data collected.

When evaluation identifies an opportunity for improvement, actions shall be directed toward the root cause with the overall goal of improving the quality of service. This may be through education, system analysis, or other committee recommendations.

Statistical analysis will be utilized to determine whether actions taken have been successful in improving care or services.

The PI Committee will communicate the results of monitoring and evaluation to the members of the CBRAC. The results of these activities will be available for review by the Texas Department of State Health Services.

Confidentiality: All documents generated concerning the PI plan within the region shall be confidential and used only in the exercise of designated functions of the PI plan.

Conflict of Interest: No practitioner or other individual involved in PI shall be required to review any case in which they are professionally involved but shall be given the opportunity to participate in the review.

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HOSPITAL SELECTION GUIDE

- a) Field paramedics and dispatch shall NOT divert patients from an appropriately selected hospital without the approval of Medical Control; patients with an altered level of consciousness should not be taken to a hospital with a non-functioning CT scanner.
- b) Major and Severe Adult patients are transported to the most appropriate Emergency Department. Pediatric Trauma patients (15 years and Younger) should be taken to Driscoll Children's Hospital unless penetrating trauma to head, neck, chest, or abdomen. Penetrating trauma to these areas should be transported to the nearest Level 2 Trauma Hospital. Transport is done as rapidly and safely as possible. Air medical transport should be considered when appropriate.
- c) Sexual assault patients 18 years or older (non-Trauma) shall be transported to Corpus Christi Medical Center – Doctors Regional; patients not yet 18 years of age shall be transported to Driscoll Children's Hospital.
- d) Cardiac Alert: Percutaneous Coronary Intervention (PCI) certified facility.
- e) Stroke Alert: Comprehensive – Comprehensive Stroke Center certified facility; Primary – Primary Stroke Center certified facility; or Tissue Plasminogen activator (tPA) Capable Only.
- f) For suspected carbon monoxide (CO) poisoning, Full = multi-patient chamber with CO testing available, Partial = CO testing capabilities but does not have multi-patient chamber, none = does not have EMERGENT CO testing capabilities.
- g) For other categories of care use the grid on following page:

	Trauma level	Cardiac Alert 24/7 CATH Lab	Post ROSC Hypothermia	Anti-Venom	Stroke Alert	Obstetrics on-site	Maternal Facilities Level	Neonatal Facilities Level	CO Poisoning	CT Limitations lbs./centimeters
CCMC -Bay Area	II	YES	YES	YES	Level II PRIMARY	YES	IV	III	NONE	650/70 450/70
Spohn Shoreline	II	YES	YES	YES	Level I Comprehensive	NO (ON CALL)	None	None	NONE	660/78
Driscoll Children's Hospital	III	NO	YES	YES	DIAGNOSIS ONLY	NO	None	IV	NONE	694/78
CCMC – Doctor Regional	IV	YES	YES	YES	Level II PRIMARY	NO	None	None	NONE	650/72 500/80
Spohn South	IV	NO	NO	YES	Level II PRIMARY	YES	IV	III	NONE	650/76
CCMC – 24/7 Northwest	IV	NO	YES	YES	Level IV Acute Stroke Ready	NO	None	None	NONE	450/70
Refugio Memorial	IV	NO	NO	YES	tPA Capable	NO	None	None	NONE	650/70
Spohn Alice	IV	NO	NO	YES	Acute Stroke Ready	YES	I	I	NONE	500/70
Spohn Beeville	IV	NO	NO	YES	Acute Stroke Ready	YES	I	I	NONE	500/70
Spohn Kleberg	IV	NO	NO	YES	Acute Stroke Ready	YES	I	I	NONE	500/70
CCMC – 24/7 Rockport	None	NO	YES	YES	tPA Capable	NO	None	None	NONE	450/70
CCMC – 24/7 Portland	None	NO	YES	YES	tPA Capable	NO	None	None	NONE	450/70

Trauma Level Designations are I to IV, highest to lowest.

Maternal and Neonatal Level Designations are IV to I, highest to lowest.

Stroke Level Designations are I to IV, highest to lowest.

TSA-U EMS PROVIDERS

Advance EMS LTD
Allegiance Mobile Health
Beeville Angel Care Ambulance Service
City Ambulance Service
City of Mathis EMS
City of Port Aransas EMS
City of San Diego EMS
Corpus Christi Fire Dept.
DCH Critical Care Transport Team
Duval ESD # 1 - Freer VFD/EMS
Freedom Ambulance
HALO-Flight Inc.
Homestead Ambulance
Kingsville Fire Dept.
McMullen County EMS
Medi-Van EMS
NCESD District # 1 - Annaville FD
NCESD District # 2 - Flour Bluff
NCESD District # 4 - Bluntzer
Refugio County EMS
Republic EMS, Ltd.
Sensible Care EMS LLC
TAC-Med
Tri-County EMS
Victory EMS
Willacy County EMS

