COASTAL BEND

REGIONAL ADVISORY COUNCIL

REGIONAL TRAUMA and EMERGENCY HEALTHCARE SYSTEM PLAN

Approved by CBRAC board of directors and General Membership ***Date: 5/28/25***

2024 – 2029

Coastal Bend Regional Advisory Council

DECEMBER 2024 FISCAL YEAR 2025

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CBRAC | REGIONAL TRAUMA and EMERGENCY HEALTHCARE SYSTEM PLAN

This document summarizes the Regional Trauma and Emergency Healthcare System Plan for the area of responsibility of CBRAC.

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.

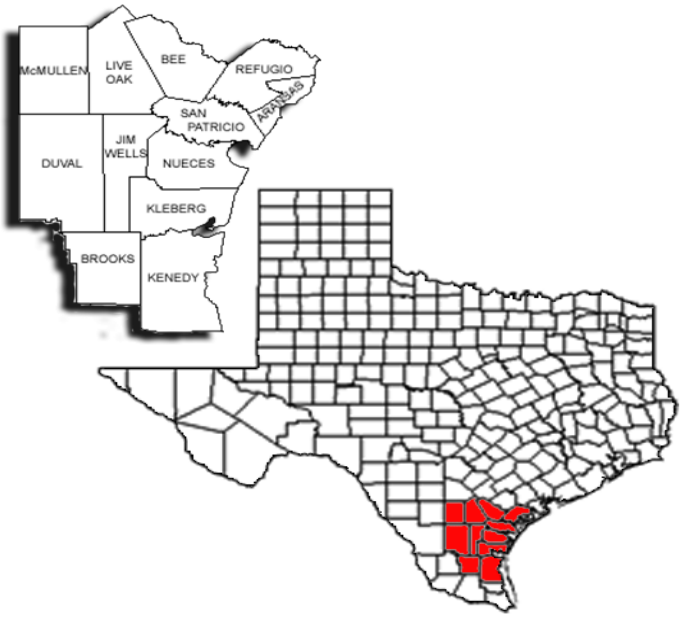
DEFINITION OF REGIONAL ADIVISORY COUNCIL

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 derived from the authority of the Texas Department of State Health Services which was instructed by the 1989 Omnibus Rural Health Care Rescue Act.

TSA-U is defined as the Trauma Service Area so designated by DSHS.

CBRAC is a 501(C3) non-profit, tax-exempt organization, which is led by a Board of Directors and in accordance with CBRAC bylaws and Standard Operations Procedure.



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.

OUR PURPOSE

The purpose of the organization shall be to facilitate a coordinated and comprehensive regional trauma, disaster and emergency health care system.

REVISIONS AND MODIFICATIONS

Each section of this plan will be reviewed annually by appropriate committees. Ultimate approval of revisions and updates will reside with the CBRAC board of directors.

Regional Agency List

Hospital

AGENCY	ADDRESS	TELEPHONE
CCMC Bay Area	7101 S Padre Island Dr, CC, TX 78412	(361)761-1000
CHRISTUS Spohn Shoreline	600 Elizabeth St, CC, TX 78404	(361)881-3000
Driscoll Children's Hospital	3533 S Alameda St, CC, TX 78411	(361)694-5000
CCMC- Doctors Regional	3315 S Alameda St CC, TX 78411	(361)761-1000
CHRISTUS Spohn South	5950 Saratoga Blvd, CC, TX 78414	(361)985-5000
Refugio Memorial	107 Swift St, Refugio, TX 78377	(361)526-2321
CHRISTUS Spohn Alice	2500 E Main St, Alice, TX 78332	(361)661-8000
CHRISTUS Spohn Beeville	1500 E. Houston St. Beeville, TX 78102	(361)354-2000
CHRISTUS Spohn Kleberg	1311 E General Cavazos Blvd, Kingsville, TX 78363	(361)595-1661
CCMC 24/7 Northwest	13725 Northwest Blvd, CC, TX 78410	(361)761-1000
CCMC 24/7 Rockport	400 Enterprise Blvd, Rockport, TX 78382	(361)727-8200
CCMC 24/7 Portland	1702 US-181 N Suite A-11, Portland, TX 78374	(361)761-2273

Emergency Medical Services

AGENCY	ADDRESS	TELEPHONE
Allegiance Mobile Health	500 N. Shoreline Blvd. Suite 906 CCTX, 78401	855-935-2424
Beeville Angel Care Ambulance Service	1105 W. Corpus Christi St. Beeville, TX 78104	361-358-6472
City Ambulance Service	1705 Grandstand, San Antonio, TX 78238	888-227-8527 Dispatch 210-625-4100 Office
City of Port Aransas EMS	705 West Avenue A, Port Aransas, TX 78373	361-749-4405
City of San Diego EMS	100 S. Doctor E E Dunlap Hwy, San Diego, TX 78384	361-279-3321
Corpus Christi Fire Dept.	2406 Leopard St. Ste. 200, CCTX 78408	361-826-3941

DCH Critical Care Transport Team	3533 Alameda St. CCTX 78411	361-694-5000
Duval ESD #1 Freer VFD/EMS	1106 S. Norton Street, Freer, TX 78357	361-394-6553
Freedom Ambulance	104 S. Jefferson St. Beeville, TX 78102	361-358-4808
Homestead Ambulance	926 S. Hwy 281, Falfurrias, TX 78355	956-227-4555
Kingsville Fire Dept.	119 N. 10th Street, Kingsville, TX 78363	361-592-6445
Medi-Van EMS	5222 Bell Street, CCTX 78417	361-851-0355
NCESD District #1 – Annaville FD	5241 County Road 73, Robstown, TX 78380	361-241-1372
NCESD District #2 – Flour Bluff	337 Yorktown, CCTX 78418	361-937-2645
NCESD District #4 – Bluntzer	5781 FM 666, Robstown, TX 78380	361-387-4066
Refugio County EMS	107 Swift St. Refugio, TX 78377	361-526-1696 Dispatch 361-526-2321 x137 Office
Republic EMS, Ltd.	33300 Egypt Lane Ste. D300, Magnolia, TX 77354	281-996-9700 Dispatch 281-857-6457 Office
Sensible Care EMS LLC	15346 Cartagena Ct, CCTX 78418	361-442-2362
Tac- MED	5315 Everhart Rd. #8, CCTX 78411	361-882-4290
Tri-County EMS	2565 1st St., Ingleside, TX 78362	361-776-0025
Victory EMS	208 N. TX Blvd., Benavidez, TX 78341	361-256-4000

Long Term Care Facilities/ Nursing Facilities

PAM Long-Term Acute Care North	600 Elizabeth CC. TX 78404	(361)881-3223
PAM Rehab Bayfront	345 S. Water Street CC, TX 78401	(361)500-0600
Corpus Christi Rehab Hospital	5727 Esplanada Drive CC, TX 78414	(361)906-3706

Dialysis Centers

DaVita Riverside Renal Center	3710 FM 1889, Robstown, TX 78380	833-413-0309
DaVita Morgan Avenue Dialysis	2222 Morgan Ave # 104, CCTX 78405	833-413-0353
Fresenius Kidney Care - Robstown	902 Lincoln Ave., Robstown, TX 78380	361-767-0408
U. S. Renal Care Beeville Dialysis	100 W. Huntington St., Beeville, TX 78102	361-358-8200
Fresenius Kidney Care Falfurrias	720 N. Saint Mary's St., Falfurrias, TX 78355	361-325-3528
Fresenius Kidney Care Saratoga	6017 Parkway Dr. CCTX 78414	361-986-1567
Fresenius Kidney Care Rockport	1102 FM 3036, Rockport, TX 78382	361-790-5675
DaVita Greenwood Holly Renal Center	1533 Holly Rd., CCTX 78417	833-413-1842

Behavioral Health Facilities

CCMC HCA Bayview Behavioral Health	600 Wooldridge CC, TX 78414	(361)986-9444
Oceans Behavioral Health	600 Elizabeth, Bldg. B 5 East	(361)371-8933

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/committees 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.

CBRAC TSA-U provides education and resources for Injury Prevention including but not limited to:

Stop The Bleed

Fall Prevention

Child Passenger Safety Technician

Bicycle Safety

Distracted/Impaired Driving Education- Shattered Dreams

Safe Sleep

Fire/Water Safety

Hot Car Injuries Prevention

EDUCATION AND CLINICAL EXCELLENCE INITIATIVES

The Coastal Bend Regional Advisory Council is committed to advancing healthcare education and patient outcomes through structured training and case review initiatives.

- Quarterly Outcomes Presentations, conducted by CBRAC, provide continuing education (CE) credits to healthcare professionals across the region. These clinician-led case reviews encompass a broad spectrum of specialties, including trauma, obstetrics, stroke, and other critical care areas, fostering continuous learning and system-wide improvements in patient care.

These initiatives ensure that both community members and healthcare professionals are prepared to respond effectively to medical emergencies, enhancing regional healthcare resilience.

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 Level IV to Level II Trauma Centers.

Nueces County is the most urban of the counties within TSA-U. A tiered patient delivery system based upon acuity is geared toward transfer of the patients from the scene to the most appropriate level of care within an appropriate time frame. This goal is accomplished through the application of well-established off-line medical control protocols and utilization of on-line medical control when patient circumstances are contrary to these protocols.

Off-line medical control means medical supervision provided through the EMS system medical director or who is responsible for the day-to-day medical care provided by EMS personnel. This includes EMS personnel education, protocol development, quality management, peer review activities, and EMS administrative responsibilities related to assurance of quality medical care.

On-line medical control, also known as direct medical control, refers to consultation between EMS providers and a physician, typically by radio or telephone, to guide care for an individual patient or EMS incident.

- For continuity of care purposes, EMS providers should contact the ED they are transporting the patient to for pre-hospital care guidance.
- For pronouncement of death, EMS providers should contact CHRISTUS Spohn Shoreline.
- In the event of an MCI, the EMS incident commander or designee will contact hospitals to determine capability/capacity and will assign patient destinations.

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 that 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 CBRAC, 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 at hospitals that have reached unsafe levels. It is 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.

PATIENT TRANSFER & COORDINATION PLAN

Facility-to-Facility Transfers/ Out of Region Transfers:
Patient transfers between healthcare facilities, including but not limited to, post-acute hospitals and rehabilitation centers, are managed internally through each facility's transfer center.

Disaster Response & Regional Coordination:
In the event of a disaster or large-scale emergency, the Coastal Bend Regional Healthcare Operations Center (RHMOC) will be activated to assist with patient coordination and movement. This includes managing evacuations and addressing extenuating circumstances that impact patient transfers.

This structured approach ensures patient safety, resource optimization, and continuity of care across all levels of medical needs.

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 for improvement.
- To create a structure which will provide coordination, integration, and accountability of quality management activities commensurate with established standards.
- **THIS PROCESS IS NOT A 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 located on the website.
- Issues of concern that are being 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 be responsible for data collection
- What specific data needs to be collected
- The frequency at which data will be collected
- The method for collecting data
- Identified sources for data collections

Data Evaluation:

The PI Committee will analyze the data to identify potential areas for improvement. When such areas are identified, the root causes will be determined, and recommendations will be made to address them. The evaluation of key functions will include the analysis of trends and patterns in the collected data.

When an opportunity for improvement is identified, corrective actions will be focused on addressing the root cause with the ultimate goal of enhancing the quality of service. These actions may include education, system analysis, or other committee recommendations. Statistical analysis will be used to assess whether the actions taken have been successful in improving care or services.

Additionally, once issues have been identified and corrective actions implemented, a loop closure document will be created. This loop closure document will be provided upon request to monitor the subject for the next six months, ensuring ongoing oversight and evaluation of progress.

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 upon request.

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.

How to Submit a PI Request Form:

Go to cbrac.org, use the dropdown under committees to view the Systems Performance Improvement page and the form is located at the bottom of the page

DESIGNATED FACILITIES

AGENCY	TRAUMA LEVEL	STROKE LEVEL	MATERNAL LEVEL	NEONATAL LEVEL	License Bed No.
CCMC- Bay Area	II	Primary	IV	III	152
CHRISTUS Spohn Shoreline	II	Comprehensive	NONE	NONE	787
Driscoll Children's	III	Diagnosis Only	NONE	IV	243
CCMC- Doctors Regional	IV	Primary	NONE	NONE	250
CHRISTUS Spohn South	IV	Primary	IV	III (Driscoll NCC)	172
Refugio Memorial	IV	TPA Capable	NONE	NONE	20
CHRISTUS Spohn Alice	IV	Acute Stroke Ready	I	I	135
CHRISTUS Spohn Beeville	IV	Acute Stroke Ready	I	I	69
CHRISTUS Spohn Kleberg	IV	Acute Stroke Ready	I	I	96
CCMC – 24/7 Northwest	IV	Acute Stroke Ready	NONE	NONE	89

Trauma Level Designations are 1 to 4, highest to lowest.

Maternal and Neonatal Designations are 4 to 1, highest to lowest.

Stroke Level Designations are 1 to 4, highest to lowest.

NON-DESIGNATED

Agency	License Bed No.
CHRISTUS Spohn Surgical Hospital	33
CCMC 24/7 Rockport	12
CCMC 24/7 Portland	6
Post Acute Medical North	24
Post Acute Medical Rehab Hospital	19
Corpus Christi Rehab Hospital	35
Oceans Behavioral Hospital	42
CCMC HCA Bayview Behavioral Hospital	68

Non-designated healthcare facilities play a vital role in the resilience and effectiveness of our regional healthcare system. To enhance collaboration and preparedness, these facilities are encouraged to actively participate in committees that align with their specialties and capabilities.

As integral members of the Coastal Bend Healthcare Preparedness Coalition, non-designated facilities contribute valuable expertise and resources, ensuring a comprehensive, coordinated response to all-hazard events. Their involvement strengthens regional emergency planning, facilitates resource sharing, and enhances overall healthcare delivery during critical situations.

EMS Agencies

***= 911 providers**

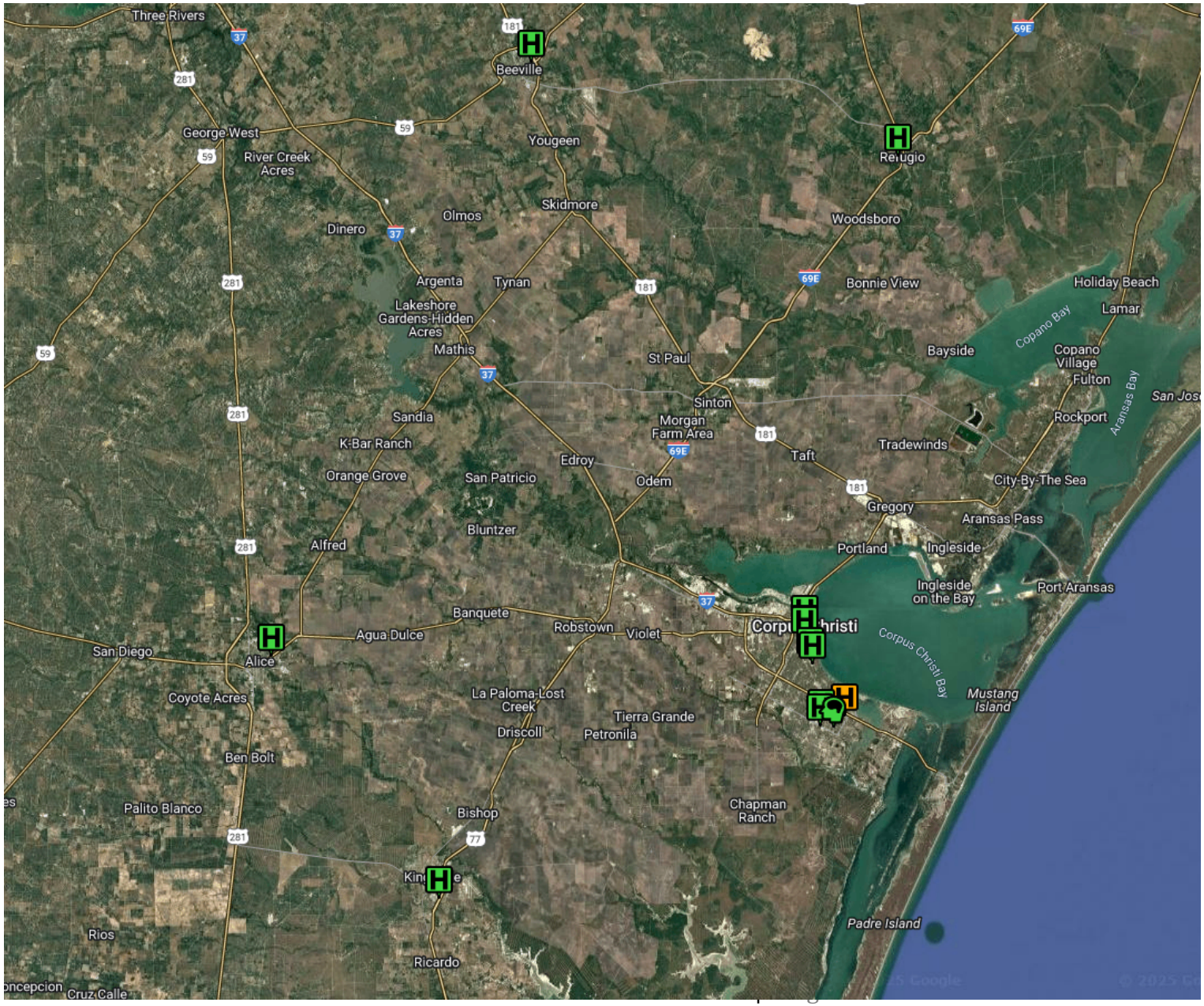
Agency	Licensed Ambulances	BLS	BLS ALS	BLS MICU	MICU Ground	ALS	Specialty
Advance EMS LTD	7		4	3			
Allegiance Mobile Health *	47	9		4	28		
Beeville Angel Care Ambulance Service *	4			5			
City Ambulance Service	5			10			
City of Port Aransas EMS *	3			3			

City of San Diego EMS *	2			2			
Corpus Christi Fire Dept. *	16			15			1
DCH Critical Care Transport Team	6	1		1			7
Duval ESD #1 Freer VFD/EMS *	2	2					
Freedom Ambulance	2	2		1			
Homestead Ambulance		7		2			
Kingsville Fire Dept.*	3			3			
Medi-Van EMS	3	2	1				
NCESD District #1 – Annaville FD *	3			3			
NCESD District #2 – Flour Bluff *	1			1			
NCESD District #4 – Bluntzer *	2			2			
Refugio County EMS*	3				3		
Republic EMS , Ltd.	2	1					
Sensible Care EMS LLC	3			3			
Tac- MED	6	3		2			
Tri-County EMS *	3				3		
Victory EMS	2		2				

Air-Medical

Driscoll Children's Hospital	2- FW AIR MICU
HALO – Flight Inc *	5- RW AIR MICU

Regional Hospital Map



CBRAC Hospital Selection Guide

HOSPITAL SELECTION GUIDE

	TRAUMA LEVEL	CARDIAC ALERT 24/7 CATH LAB	POST ROSC HYPOTHERMIA	ANTI VENOM	STROKE ALERT	LABOR & DELIVERY AVAILABILITY	MATERNAL FACILITY LEVELS	NEONATAL FACILITY LEVELS	CO POISONING	CT LIMITATIONS LBS. / CENTIMETERS	MRI LBS. / CENTIMETERS
CCMC- Bay Area	L 2	YES	YES	YES	PRIMARY L3	YES 24/7	L 4	L 3	NONE	650/70, 450/70	500/60
Spohn Shoreline	L 2	YES	YES	YES	COMPREHENSIVE L1	(ON CALL)	NONE	NONE	NONE	660/78	550/70
Driscoll Children's Hospital (DCH)	L 3	YES	YES	YES	DIAGNOSIS ONLY	NO	NONE	L 4	NONE	694/78	650/70
CCMC- Doctors Regional	L 4	YES	YES	YES	PRIMARY L3	NO	NONE	NONE	NONE	650/72, 500/80	300/60
Spohn South	L 4	NO	YES	YES	PRIMARY L3	YES 24/7	L 4	L 3	NONE	650/76	500/60
Refugio Memorial	L 4	NO	NO	YES	TPA CAPABLE	NO	NONE	NONE	NONE	650/70	350/50
Spohn Alice	L 4	NO	NO	YES	ACUTE STROKE READY L4	(ON CALL)	L 1	L 1	NONE	500/70	350/60
Spohn Beeville	L 4	NO	NO	YES	ACUTE STROKE READY L4	(ON-CALL)	L 1	L 1	NONE	500/70	500/72
Spohn Kleberg	L 4	NO	NO	YES	ACUTE STROKE READY L4	(ON-CALL)	L 1	L 1	NONE	500/70	550/68
CCMC- 24/7 Northwest	L4	NO	YES	YES	ACUTE STROKE READY L4	NO	NONE	NONE	NONE	450/70	NONE
CCMC- 24/7 Rockport	None	NO	YES	YES	TPA CAPABLE	NO	NONE	NONE	NONE	450/70	NONE
CCMC- 24/7 Portland	None	NO	YES	YES	TPA CAPABLE	NO	NONE	NONE	NONE	450/70	NONE

PEDIATRIC

SERVICE NOT AVAILBLE

SEXUAL ASSAULT- SANE EXAMS

<18 : Transport to Driscoll Children's Hospital

Ages 18-21: Assess medical needs; transport to CCMC Doctors Regional if **mental health needs, intoxicated,incarcerated, or adult trauma services are required**. Driscoll can conduct SANE exam up to age 21 if no additional adult specialty care is needed.

Ages 21 and older: Transport to CCMC Doctors Regional

Trauma Level Designations are 1 to 4, highest to lowest.
Maternal and Neonatal Level Designations are 4 to 1, highest to lowest.
Stroke Level Designations are 1 to 4, highest to lowest.
OB ON CALL= A physician has 30 minutes to respond to a case.

Emergency Room Numbers for EMS		
FACILITY	PHONE	FAX
Spohn Shoreline ER	361-881-3119	361-902-6194
Spohn South ER	361-985-5811	361-985-5645
Spohn Alice ER	361-661-8018	361-661-8062
Spohn Beeville ER	361-354-2845	361-354-2879
Spohn Kleberg ER	361-595-0858	361-595-9898
CCMC Bay Area ED	361-761-3637	361-761-3528
CCMC Doctors Regional ED	361-761-1467	361-761-3528
CCMC Portland ED	361-761-5436	361-761-1551
CCMC Northwest ED	361-767-4565	361-761-5402
CCMC Rockport ED	361-727-8200	361-767-4314
Refugio Memorial Hospital	361-526-2321	361-486-7215
Driscoll Childrens Hospital	361-694-5100	361-694-4074

Pulsara Resources
www.pulsara.com /texas-resources

If suspected Pediatric Stroke under the age of 18 transfer to DCH. If drive is >30 min consider Air Transport to closest appropriate facility.

cbrac.org

To download and better view this form is located on the cbrac.org website under Pre-Hospital.

TRAUMA

MISSION AND PURPOSE:

The Coastal Bend Regional Advisory Council 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 Coastal Bend Regional Advisory Council TSA-U will utilize the state trauma registry database and other state and national databases to catalog and identify trauma trends in the region in order to implement strategies to reduce these trends.

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 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 exceeds 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.

CBRAC Regional EMS Time Out Report

Regional EMS Time Out Report

M	Age/Sex, **Mechanism** or **Medical** Complaint	Age, Sex (include patient's name for handover), Mechanism of Injury or Medical Complaint/History
I	**Injuries** or **Inspections**	Time of Injury, list injuries head to toe; or Inspections (time of onset, brief medical exam/findings)
S	Vital **Signs**	Vital signs: first set and significant changes; include glucose.
T	**Treatment**	Treatment

Give EMS 30 seconds, we'll tell you everything you need to know!

- ☐ Receiving Nurse will call "EMS Time Out" when EMS arrives with patient.
- ☐ Trauma Alert, Heart Alert, & Stroke Alert Patients will remain on the stretcher during report ('Non-Alert')
  Patients may be moved to the gurney if the nurse is not present to receive report).
- ☐ EMS has **30 seconds** to provide report.
- ☐ Nurse will document report on Regional EMS Time Out Report form.
- ☐ Patient will be moved to the gurney.
- ☐ Nurse provides registration sticker to EMS.
- ☐ Patient Transfer of Care (TOC) completed.

To download and better view this form is located on the cbrac.org website under Pre-Hospital.

Fillable CBRAC Regional EMS Time Out Report

ePCR Run Number:_____
Agency:_____
Medic #:_____

Form to be filled out by Receiving ER Nurse
Date:_____Time:_____
Receiving ER Nurse:_____

PLACE HOSPITAL STICKER HERE
(Highlight Visit Number)

Regional EMS Time Out Report

☐ Heart Alert ☐ Stroke Alert ☐ Trauma Alert Time ER notified by EMS of Alert:_____

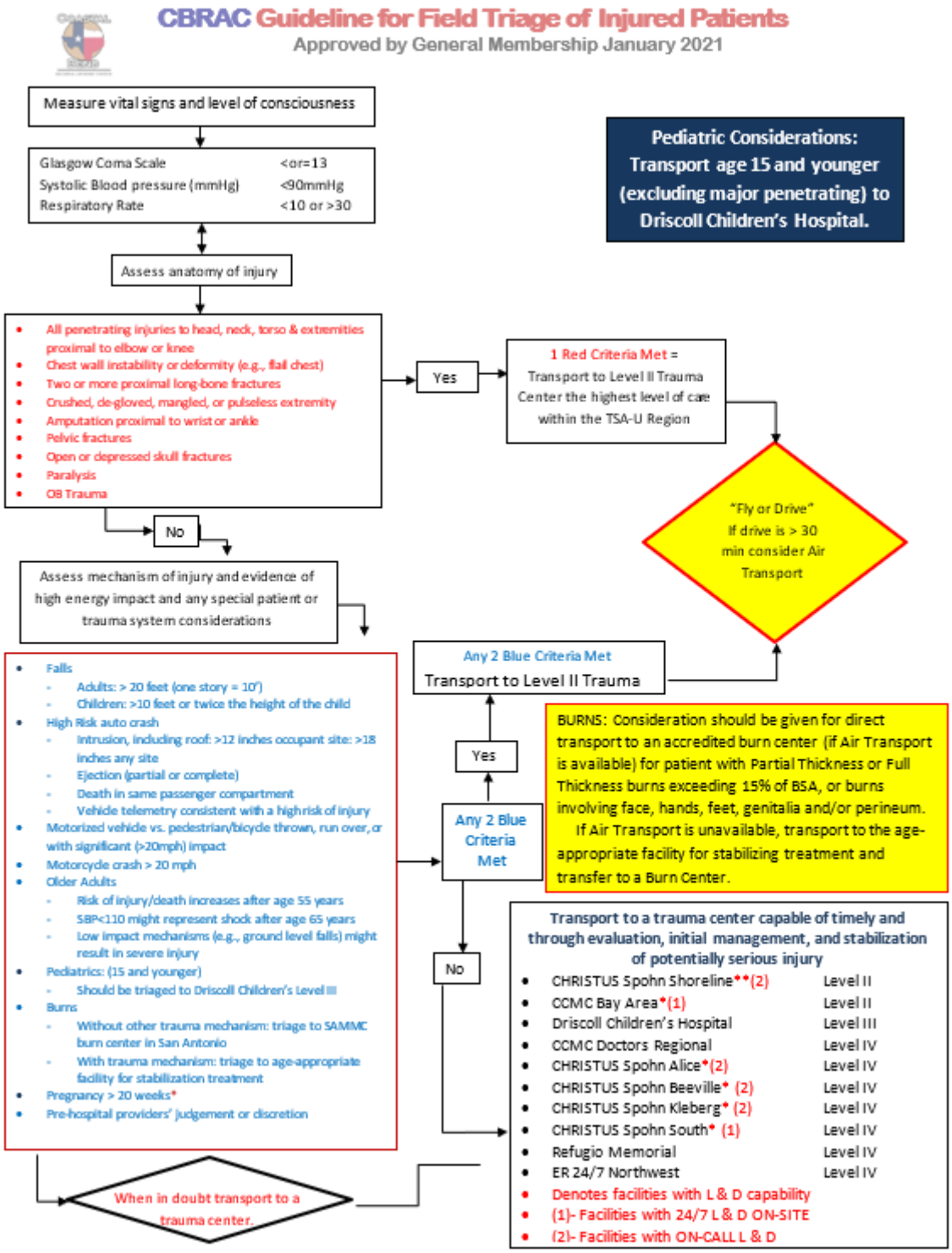
M	Age/Sex, **Mechanism** of Injury; or **Medical** Complaint/History	
I	**Injuries** (time of injury, list head to toe); **Inspections** (time of onset, brief medical exam/ findings)	
S	Vital **Signs** (first set & significant changes)	1) Time: _____am/pm; B/P: _____ / _____ HR: _____ RR: _____ SPO2: _____% etCO2: _____% GCS: _____ 2) Time: _____am/pm; B/P: _____ / _____ HR: _____ RR: _____ SPO2: _____% etCO2: _____% GCS: _____ Glucose _____
T	**Treatment** and **Transfer of Care Signature**	

Disclaimer: *This is a preliminary hand off report as verbalized by EMS for documentation by the ER Nurse receiving the report at the time of patient hand off. All portions need not be completed. This document serves as the interim EMS Medical Record until arrival of the required completed Electronic Patient Care Record (EPCR).*

To obtain the latest version, visit: http://strac.org/index.php/home/docman-files or search: ER Handoff v8_20160803

To download and better view this form is located on the cbrac.org website under Pre-Hospital.

CBRAC Field Triage Guide



To download and better view the CBRAC Field Triage Guidelines visit Cbrac.org under the Trauma Systems committee page.

PERINATAL

MISSION AND PURPOSE:

The CBRAC Perinatal Care Region Committee is committed to enhancing patient outcomes and elevating care standards for pregnant and postpartum patients and their babies. We engage CBRAC members, regional acute hospital systems, physicians, and frontline EMS providers to achieve our goals utilizing evidence-based practices, community collaboration, comprehensive education, and diligent data monitoring. Our overarching mission is to improve perinatal healthcare, striving to advance healthcare quality, equity, and safety for all mothers and babies.

NEONATAL AND SPECIAL MATERNAL CONSIDERATIONS

POSTPARTUM IDENTIFICATION- WRISTBAND INITIATIVE

The implementation of the *I Gave Birth* postpartum wristband serves as a visible identifier for individuals who have recently delivered. All designated maternal facilities in the region utilize wristbands that include their facility and unit-specific telephone numbers and distribute them to patients upon discharge. This supports rapid recognition of postpartum status by both pre-hospital providers and emergency department personnel, while also enabling direct communication with the discharging facility when needed. By enhancing situational awareness and communication from the field through emergency department arrival, this initiative reduces delays in recognition, diagnosis, and treatment that may contribute to increased maternal mortality and morbidity during the postpartum period and strengthens coordination across Trauma Service Area-U.

PLACENTA ACCRETA SPECTRUM DISORDER-

Placenta accreta spectrum disorder (PASD), also called abnormally invasive placenta (AIP), describes a clinical situation where the placenta does not detach spontaneously after delivery and cannot be forcibly removed without causing massive and potentially life-threatening bleeding. (1)

Transport Pre-Hospital Considerations:

Regional Identification Initiative:

TEAL Placenta Accreta Wristband- Identifies patients with suspected or diagnosed Placenta Accreta. Provides facility numbers for delivering hospital for EMS providers.

Communication and Coordination:

- Contact the receiving hospital immediately to alert them of known placenta accreta spectrum disorder (PASD) patient.
    - Search for presence of turquoise wristband that will indicate treating
- facility information.
- Utilize Pulsara for accurate tracking of known placenta accreta cases: Ensure that the hospital receives appropriate notification for specialty team to be alerted in real time about the patient's condition, enabling them to prepare the necessary resources and staff. Pulsara's platform facilitates precise communication between pre-hospital teams and the receiving facility, including direct notification to the OB specialty team, ensuring timely, coordinated care for both mother and baby.

Transport Considerations:

- Transport to a designated Level IV maternal center.
- Consider the need for a dedicated transport team with advanced life support capabilities.
- Ensure adequate blood products are readily available during transport (when available, whole blood).

Facility Considerations:

- The facility shall have a written hospital preparedness and management **policy** for patients with placenta accreta spectrum disorder (PASD) who are undiagnosed until delivery, including educating hospital and medical staff involved in the treatment and management of PASD about risk factors, diagnosis, and management.
- **Regional Physician Collaboration:** There must be a robust regional collaboration between healthcare providers to ensure that known placenta accreta patients can be shared across institutions. This allows for the seamless transfer of care and avoids delays in treatment, ensuring timely intervention and minimizing risks associated with PASD.
- Placenta accreta spectrum disorders, including team education, risk factor assessment, screening, evaluation, diagnosis, referral, treatment, and multidisciplinary management of both anticipatedand/or unanticipated PASD cases.
- Have a placenta accreta spectrum disorder care team with the expertise and privileges to screen, diagnose, consult, and manage patients with suspected or unanticipated PASD.

Placenta Accreta Spectrum Disorder Team

The facility shall have a Placenta Accreta Spectrum Disorder (PASD) Team whose members have expertise to assume responsibility for the diagnosis and management of pregnant or postpartum patients with suspected or unanticipated PASD, including the following elements: (A) The multidisciplinary team must be comprised of:

- A primary response team consisting of a minimum of these components: an anesthesiologist with training and/or experience in obstetric anesthesia, obstetrician/gynecologist or maternal-fetal medicine physician, surgeon or surgeons with expertise in pelvic, urologic, and gastroenterological surgery, a neonatologist, and experienced nursing and operating room personnel; and
- A secondary response team consisting of a minimum of these components: a radiologist with critical interventional radiology skills and blood bank/transfusion

medicine service specialist.
(B) All team members must have full hospital privileges; and:

- A representative of each component of the primary response team must be available at all times for on-site consultation and management, and to arrive at the patient bedside within 30 minutes of an urgent request in attending to a patient with PASD;
- A representative of each component of the secondary response team must be available at all times for on-site consultation and management, and be able to arrive at the patient's bedside for an urgent request to attend to a patient with PASD within a time frame commensurate to the clinical situation and consistent with current standards.

(C) The team shall participate in regular and ongoing staff and team-based education and training to care for patients with PASD; and
(D) A board-certified MFM physician or an obstetrician/gynecologist with expertise in the diagnosis and management of PASD to lead the team; and.
(E) Participates in regular, ongoing outreach and education on PASD to other maternal facilities not specializing in PASD, inclusive of QAPI.
(F) A documented on-call schedule of team members will be readily available to the facility and maternal staff on the labor and delivery unit and operating rooms.

Placenta Accreta Spectrum Disorder (PASD) Training Goals and Ongoing Initiatives:

1. **Quality Performance Improvement (QPI):** Implement ongoing QPI initiatives focused on optimizing clinical outcomes for PASD cases, ensuring timely identification, and enhancing care protocols.
2. **Quarterly Case Reviews:** Conduct comprehensive quarterly case reviews, analyzing both successful and challenging PASD cases across the region. These reviews will provide valuable insights to refine practices, identify areas for improvement, and share best practices.
3. **Quarterly Drills and Simulation Training:** Facilitate quarterly simulation drills with EMS teams and hospitals within the region, focusing on PASD-specific scenarios. Utilizing the CBRAC OB mannequin, these drills will improve hands-on response, communication, and coordination during real-life PASD events.

By consistently reviewing and enhancing these initiatives, we will strengthen our system's readiness, ensuring better outcomes for patients with PASD.

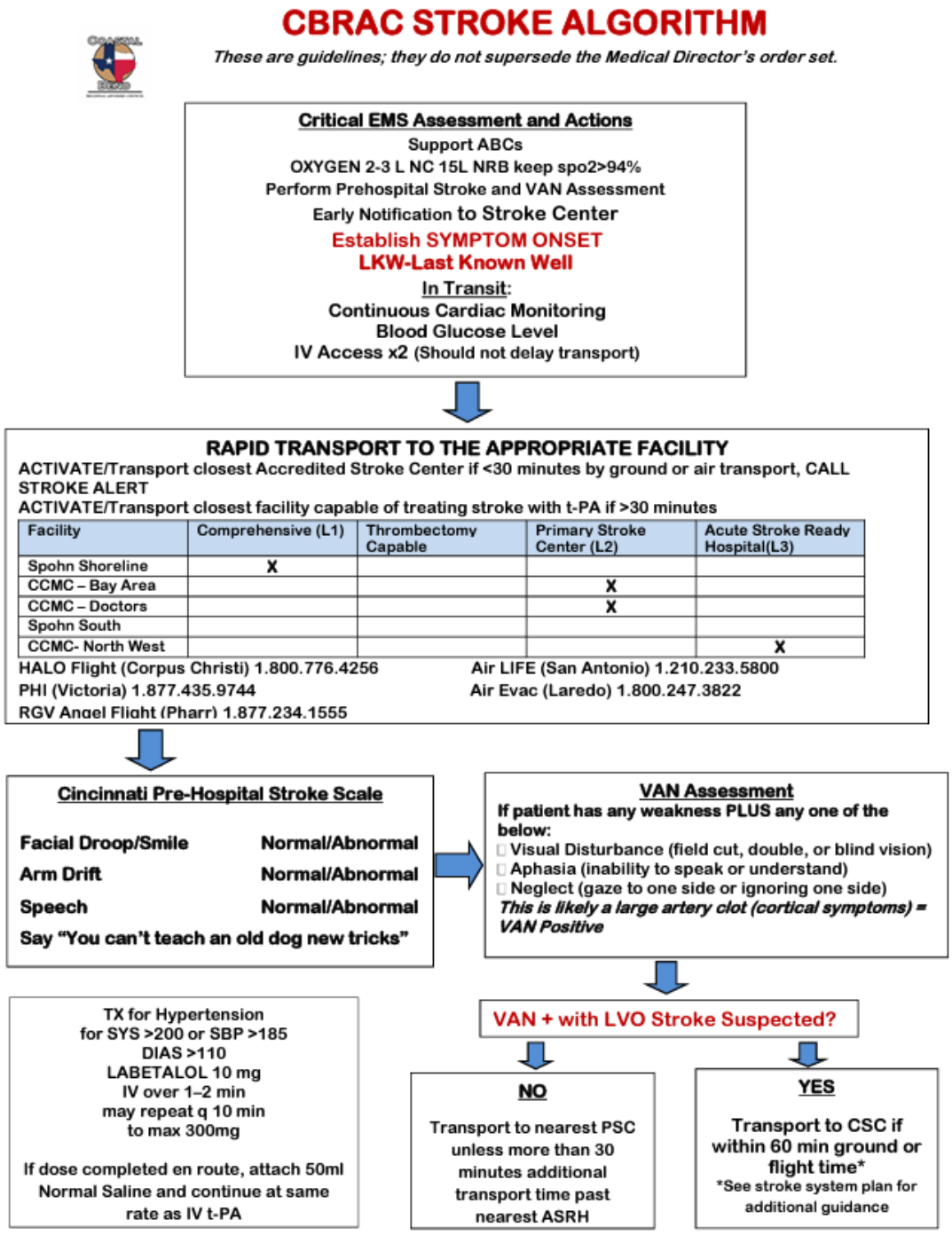
STROKE

MISSION AND PURPOSE:

The CBRAC Acute Care Committee is devoted to developing and enhancing protocols for patients suffering from Stroke/STEMI or other acute disease processes by following evidence-based practices, community education, and tracking relevant data. This is accomplished by a collective effort between CBRAC members, regional Acute Hospital Systems, and our front- line EMS providers. We hope to ultimately improve outcomes in the communities we serve.

SEE FOLLOWING STROKE ALGORITHMS

STROKE ALGORITHM



To download and better view the CBRAC Stroke documents visit Cbrac.org under the Stroke Systems committee page.

BYPASS PROTOCOL FOR THE SUSPECTED STROKE PATIENT

Coastal Bend Regional Advisory Council
Trauma Service Area - U

STROKE SYSTEM PLAN

Reviewed/Revised/Approved: June 2024

BYPASS PROTOCOL FOR THE SUSPECTED STROKE PATIENT

GOAL: Rapidly identify and assess; using a pre-hospital stroke scale, and transport patients suspected of an acute stroke to the nearest stroke accredited hospital in an expeditious manner.

Decision Criteria: This bypass protocol is intended to ensure that patients with signs and symptoms of acute stroke be transported to an **accredited stroke center**. *Exceptions to the bypass protocol requiring the patient to be transported to the NEAREST facility are:* Inability to establish and/or maintain an airway or in the event of a cardiac arrest.

- Rural:
  - LVO Suspected: Is Comprehensive (CSC/L1) within 60 minutes max transport time?
    - YES - Transport to Comprehensive Stroke Center (CSC/L1)
    - NO - Transport to nearest Stroke Center
    - If no stroke centers available within 60 minutes consider air medical transport per regional point of entry plan
- Urban:
  - LVO Suspected: Is Comprehensive (CSC/L1) within 30 min max transport time?
    - YES – Transport to Comprehensive Stroke Center (CSC/L1)
    - NO – Transport to nearest stroke center
- Suburban:
  - LVO Suspected: is Comprehensive (CSC/L1) within 45 minutes max transport time?
    - YES – Is Comprehensive Stroke Center (CSC/L1) within 45 minutes max transport time?
      - YES – Transport to Comprehensive Stroke Center (CSC/L1)
      - NO – Transport to nearest stroke center

To download and better view this form is located on the cbrac.org website under Stroke.

Patient Criteria for Activation of Bypass Protocol for the Confirmed Witnessed Acute Stroke Patient:
The activation of the Bypass Protocol for the symptomatic acute stroke patient should be initiated upon the recognition of confirmed witnessed changes in patient condition as to **"Last Known Well"** in less than 24 hours.
If "Last Known Well" temporarily unknown due to patient's inability to talk or the lack of a witness, activate a stroke alert via Pulsara

Air Ambulance/Hand-Off:
Hand off of the acute stroke patient to advanced life support, mobile intensive care unit or air transport will be initiated in the following circumstances:

- Basic life support unit is first responder only and unable to leave service area
- If air transport/pick-up total time is less than ground transport time.

Notes:

- If there should be any questions regarding activation of treatment protocol, the receiving facility should be contacted regarding a decision for treatment.
- The receiving facility should be notified at the earliest possible time via Pulsara by EMS to provide the facility with the ability to activate a stroke alert.
- Patient's rights, choices and best interest will be respected in the determination of hospital destination.

Recommended Pre-hospital Stroke Assessment Scale:

Cincinnati Prehospital Stroke Scale (CPSS)

Facial Droop (have patient smile)
Normal: Both sides of the face move equally
Abnormal: One side of face does not move as well

Arm Drift (have patient hold arms out for 10 seconds)
Normal: Both arms move equally or not at all
Abnormal: One arm drifts compared to the other, or does not move at all

Speech (have patient speak a simple sentence)
Normal: Patient uses correct words with no slurring
Abnormal: Slurred or inappropriate words, or mute

VAN Assessment Tool

If patient has **any weakness PLUS** any one of the below:

- Visual Disturbance (field cut, double, or blind vision)
- Aphasia (inability to speak or understand)
- Neglect (gaze to one side or ignoring one side)

To download and better view this form is located on the cbrac.org website under Stroke.

This is likely an LVO (large vessel occlusion) = VAN Positive

Thrombolytic (IV-tPA/TNK) Screening Exclusion Criteria in the Field:

- Clearly defined onset of stroke symptoms 4.5 hours or greater or patient awakens with stroke symptoms
- History of intracranial hemorrhage, neoplasm, arteriovenous malformation, or aneurysm
- Recent (within 3 months) intracranial or intraspinal surgery or serious head trauma
- Active internal bleeding

(*If all exclusion criteria "NO" the patient is a potential candidate for IV-tPA*)

EMS Treatment Guidelines:

Refer to CBRAC Stroke Algorithm

Hospital Treatment Guidelines for the Stroke Alert Patient:

- Door to Triage by Doctor – 10 minutes
- Door to CT Scan – 20 minutes
- Door to CT Read/Lab Results – 45 minutes
- **Door to Thrombolytic – 30 minutes**
- **Door to Puncture for LVO –**
  - **90 minutes from field**
  - **60 minutes for facility transfer patients**

EMS Post-IV Alteplase (t-PA)/Tenecteplase (TNK) Transfer Protocol:

All post t-PA/TNK patients should be sent by Critical Care Transport (MICU)

- Document vital signs prior to transport and verify that SBP <180, DBP <105. *If BP above limits, sending hospital should stabilize prior to transport*
- Obtain contact method for family or caregiver (preferably cell phone) to allow contact during transport or upon patient arrival
- **Obtain and record Vital Signs and Neurological checks (CPSS) every 15 minutes via CBRAC EMS Inter-facility Transfer Thrombolytics Protocol form**
  - Notify the receiving facility for any worsening changes in neuro checks or vital signs
- Perform and record baseline GCS
- Continuous cardiac monitoring
- **Strict NPO – this includes all *PO* medications**

To download and better view this form is located on the cbrac.org website under Stroke.

- Verify total dose and time of IV t-PA/TNK bolus
- If IV Alteplase (t-PA) dose administration will continue en route:

  -Verify estimated time of completion.
  -Verify with the sending hospital that the excess t-PA has been withdrawn and discarded (for example, if the total dose of t-PA to be given is 70mg, then verify the remaining 30cc has been wasted since a 100mg bottle of t-PA contains 100cc of fluid)
- If Alteplase (t-PA) dose completed en route, attach 50 ml Normal Saline and continue at the same rate of the Alteplase (t-PA) drip
- If SBP >180 or DBP >105, and if antihypertensive medication started at sending facility, then adjust as follows:
  - If Labetalol IV drip started at the sending hospital, increase by 2mg/min every 10 minutes (to a maximum of 5mg/min) until SBP <180 and DBP <105; If SBP <150 or DBP <80 or HR <60, turn off drip and call receiving hospital for furtherinstructions.
  - If Nicardipine IV drip was started at the sending hospital, may increase dose by 2.5mg/hr every 5 minutes. To a maximum of 15mg/hr until SBP <180 and DBP <105; IfSBP <150 or DBP <80 or HR <60, turn off drip and call receiving hospital for further instructions.
- For any acute worsening of neurologic condition, if patient develops severe headache, acute hypertension or vomiting (suggestive of intracerebral hemorrhage), profuse bleeding not controlled bypressure, OR angioedema:
  - Discontinue t-PA infusion (if still being administered)
  - Call receiving facility for further instructions including decision to adjust blood pressure medication and/or divert to nearest hospital.
  - Continue to monitor vitals and neuro checks every 15 mins.

Reference:

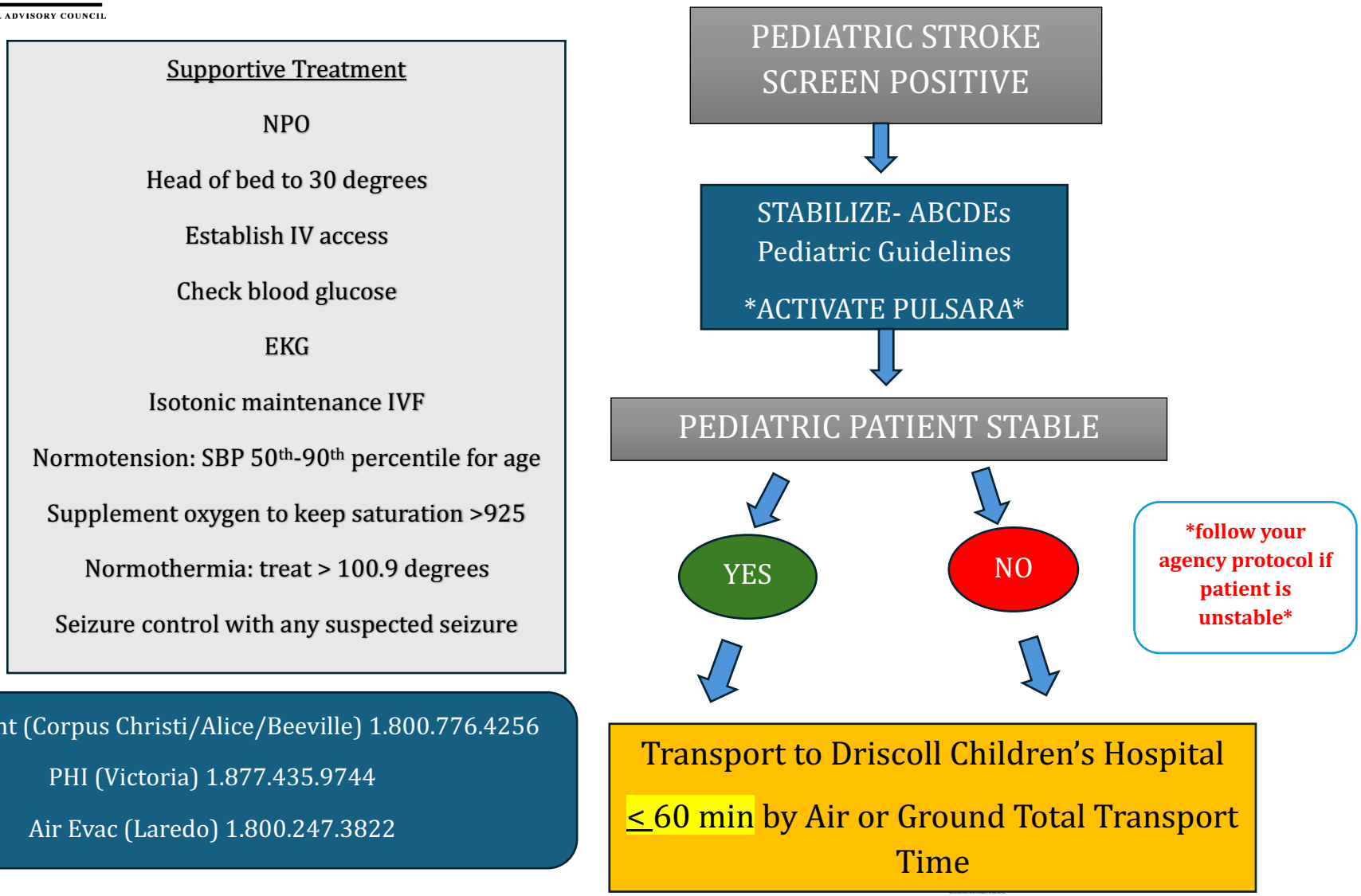
Jauch, E. C., Schwamm, L. H., Panagos, P. D., Barbazzeni, J., Dickson, R., Dunne, R., . . . Yallapragada, A. (2021). Recommendations for regional stroke destination plans in rural, suburban, and urban communities from the Prehospital Stroke System of Care Consensus Conference: A Consensus Statement from the American Academy of Neurology, American Heart Association/American Stroke Association, American Society of Neuroradiology, National Association of EMS Physicians, National Association of State EMS officials, Society of Neurointerventional Surgery, and society of vascular and Interventional Neurology: Endorsed by the Neurocritical Care Society.Stroke,52(5).doi: 10.1161/strokeaha.120.033228

To download and better view this form is located on the cbrac.org website under Stroke.

CBRAC EMS Pediatric Acute Stroke Protocol Recommendations

<18 years of age

These are guidelines; they do not supersede the Medical Director's order set.



To download and better view this form is located on the cbrac.org under Stroke.

CBRAC Pediatric Acute Stroke Protocol Recommendations for Non-Appropriate Facilities <18 years of age

These are guidelines; they do not supersede the Medical Director's order set.

Supportive Treatment

NPO

Head of bed to 30 degrees

Establish IV access

Check blood glucose

EKG

Isotonic maintenance IVF

Normotension: SBP 50th-90th percentile for age

Supplement oxygen to keep saturation >92%

Normothermia: treat > 100.9 degrees

Seizure control with any suspected seizure

Signs & Symptoms can include-Sudden onset of:

New severe headache (no known cause) New focal seizures

Multiple or prolonged seizures, status epilepticus

New focal weakness or sensory loss

New impairment in speech or language

New sudden visual loss or double vision

↓

Determine child's last known well time

Perform Neuro Assessment for suspicion

Of Ischemic or Hemorrhagic Stroke

↓

ED MD

Initiate rapid transport by contacting Driscoll access center with Neurology dept consultation. This will help minimize delays and reduce the overall transfer time, ensuring timely and effective care.

→

Driscoll Access Center

(361) 694-5133

*Non-Appropriate Facilities for **Pedi Stroke Patients**: FSEDs, CCMC ERs, CS ERs*

2025 CBRAC Thrombolytic Monitoring Form

Coastal Bend Regional Advisory Council Trauma Service Area - U

EMS-INTER-FACILTY TRANSFER THROMBOLYTICS PROTOCOL:
Stroke Patient/Cardiac Patient: During or after Tenecteplase (TNKase)

ALS Transport Required

Patient Sticker	TNK Start Time:	TNK Amt Given (MG):
	Other Medications given:	
Document Vital Signs and Neurological Exam every 15 min	Last BP prior to transfer:	Last NIHSS prior to Transfer: / Last blood glucose:

Date:	15 min	15 min	15 min	15 min	15 min	15 min	15 min	15 min
Time								
Facial Droop	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Right Arm Drift	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Left Arm Drift	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Right Leg Drift	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Left Leg Drift	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Glasgow Coma Scale								
Eye Opening								
Verbal Response								
Motor Response								
GCS Score								
Vital Signs: Goal SBP<180mmHg & DBP <105 mmHg								
Blood Pressure								
Heart rate								
Respirations								
Pulse Oximetry								
EMS Initials								

Calculating Glasgow Coma Scale						Monitoring
Eye Opening		Verbal Response		Motor Response		
Spontaneous To Speech Only with Noxious stimuli No eye opening	4 3 2 1	Oriented Disoriented/confused Inappropriate speech Incomprehensible sounds No verbal response	5 4 3 2 1	Obeys commands Localizes Withdraws Flexor posturing Extensor posturing No motor	6 5 4 3 2 1	- Goal to keep SBP< 180 mmHg & DBP <105mmHg - Continuous cardiac monitoring - Continuous pulse oximetry monitoring - Strict NPO (including medication and ice chips)

Monitor for angioedema and/or decline in neurologic status - First: call receiving facility
Contact receiving facility with cardiac/blood pressure issues or acute worsening conditions or decline in neurological status. Tell the operator you need the ED physician

Sending facility must be able to maintain systolic blood pressure below 180 mmHg and diastolic blood pressure below 105 mmHg prior to transport.

Transferring Facility:	
Receiving Facility:	
Family/Caregiver Emergency Contact #:	
Patient Last Known Well (date/time):	

1

EMS Initials/Signature: _____ Date/Time: _____

RN Initials/Signature: _____ Date/Time: _____

CBRAC Stroke and Cardiac Systems Committees v3 July 2025

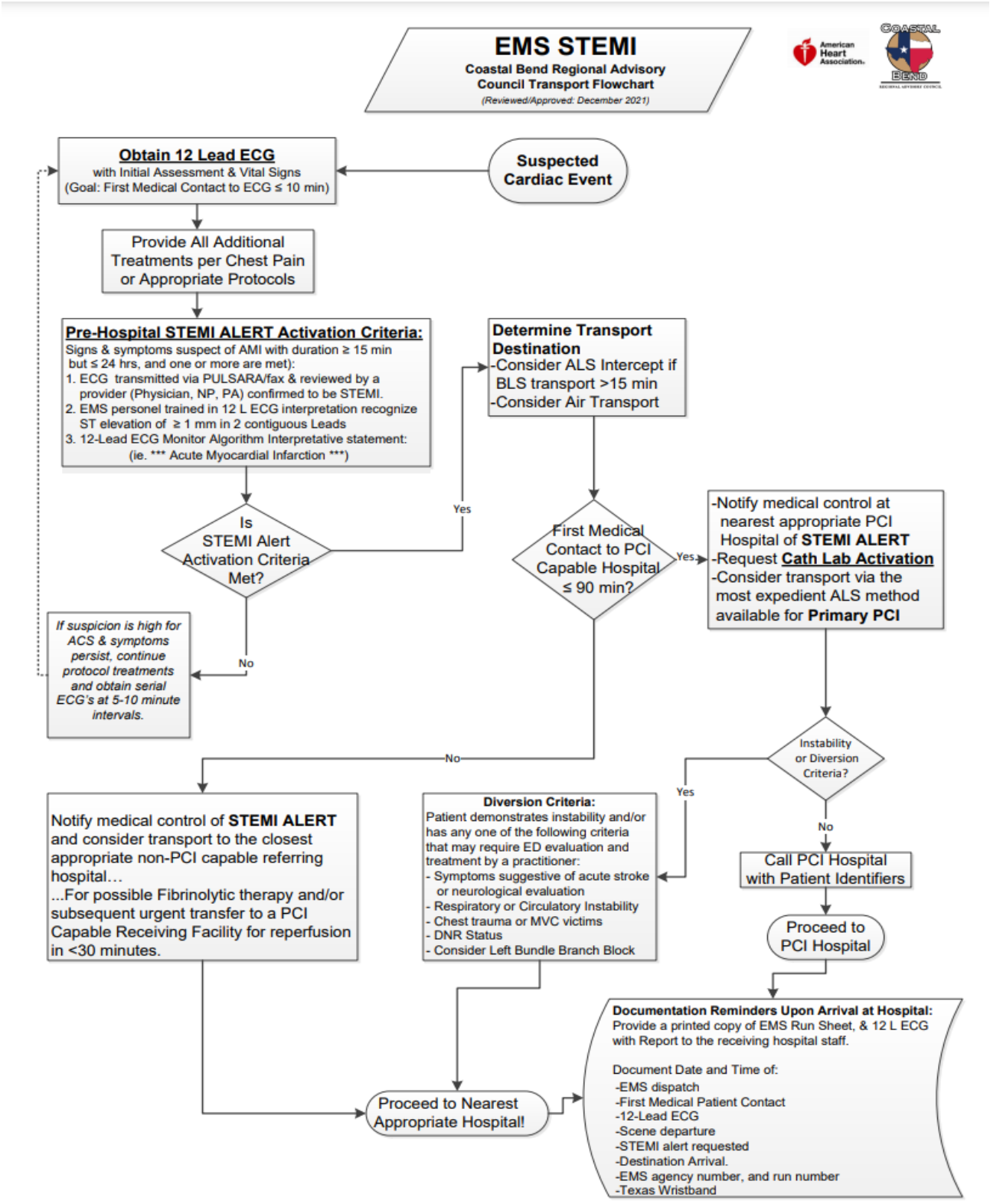
To download and better view this form is located on the cbrac.org website under Stroke.

CARDIAC

MISSION AND PURPOSE:

The CBRAC Acute Care Committee is devoted to developing and enhancing protocols for patients suffering from Stroke/STEMI or other acute disease processes by following evidence-based practices, community education, and tracking relevant data. This is accomplished by a collective effort between CBRAC members, regional Acute Hospital Systems, and our front-line EMS providers. We hope to ultimately improve outcomes in the communities we serve.

EMS STEMI TRANSFER FLOWCHART



To download and better view this form is located on the cbrac.org website under Cardiac Systems.

Coastal Bend Regional Advisory Council Trauma Service Area - U

STEMI SYSTEM PLAN

Revised/ Reviewed/ Approved- December 2021

BYPASS PROTOCOL FOR THE STEMI PATIENT

GOAL: To improve patient outcomes and decrease the morbidity/mortality of cardiac relatedemergencies by adherence to evidence based & best practices: pre-hospital recognition, codeSTEMI activation, rapid transport, treatment initiation and delivery to definitive care.

DECISION CRITERIA

TRANSPORT TO THE CLOSEST HOSPITAL FOR STABILIZATION when:

- CPR Is In Progress.
- Unable To Secure An Airway.
- The Patient's Condition Is Rapidly Deteriorating & Help **Is Not** en Route.
- EMS Personnel/Provider Are Unable To Provide ACLS Care.
- Leaving The Service Area Would Leave The Community Without An Ambulance.

TRANSPORT TO CLOSEST *IV FIBRINOLYTIC THERAPY CAPABLE FACILITY* when there is a *suspected* > 90.

MINUTE DELAY FROM FMC TO PRIMARY PCI TO ACHIEVE MECHANICAL REPERFUSION.

---In the absence of contraindications and when PCI is not available, fibrinolytic therapy is reasonable for patients withSTEMI if there is clinical and/or ECG evidence of ongoing ischemia within 12 to 24

hours of symptom onset and a large area of myocardium at risk or hemodynamic instability.

Absolute Exclusion Criteria for Fibrinolytic Therapy:

- Previous history of IntraCranial Hemorrhage
- Known structural cerebral vascular lesion (e.g., arteriovenous malformation)
- History of ischemic stroke within 3 months
- EXCEPT acute ischemic stroke within 4.5 h
- Head trauma or brain surgery within 6 months
- Known malignant intracranial neoplasm (primary or metastatic)
- Suspected aortic dissection
- Active bleeding or bleeding diathesis (excluding menses)
- Significant closed-head or facial trauma within 3 months
- Intracranial or intraspinal surgery within 2 months
- Severe uncontrolled hypertension (unresponsive to emergency therapy)
- For streptokinase, prior treatment within the previous 6 months

TRANSPORT TO *PCI ACCREDITED OR CHEST PAIN ACCREDITED HOSPITAL* when there is a *suspected* <90

MINUTE DELAY FROM FMC to PRIMARY PCI to ACHIEVE MECHANICAL PERFUSION and:

- Chest pain or squeezing, fullness, and/or discomfort in the center or left side of the chest that lasts for morethan a few minutes or that goes away and comes back. Feeling weak, light-headed, or faint. You may also break out into a cold sweat. Pain or discomfort in the jaw, neck, back, one or both arms or shoulders. Shortness of breath.
- ST elevation at the J point in at least 2 contiguous leads of 2 mm (0.2 mV) in men or 1.5 mm (0.15 mV) in women in leads V2–V3 and/or of 1 mm (0.1 mV) in other contiguous chest leads or the limb leads (7). The majority of patients will evolve ECG evidence of Q-wave infarction. New or presumably new LBBB has beenconsidered a STEMI equivalent.
- EMS transport directly to a PCI-capable hospital for primary PCI is the recommended triage strategy forpatients with STEMI, with an ideal FMC-to-device time system goal of 90 minutes or less*
- Immediate transfer to a PCI-capable hospital for primary PCI is the recommended triage strategy for patients with STEMI who initially arrive at or are transported to a non–PCI-capable hospital, with an FMC-to-device time system goal of 120 minutes or less*
- In the absence of contraindications, fibrinolytic therapy should be administered to patients with STEMI at non–PCI-capable hospitals when the anticipated FMC-to-device time at a PCIcapable hospital exceeds 120 minutesbecause of unavoidable delays.
- When fibrinolytic therapy is indicated or chosen as the primary reperfusion strategy, it should be administeredwithin 30 minutes of hospital arrival*
- See attached algorithm- (PG.46)

Pediatric Committee

MISSION AND PURPOSE:

The CBRAC Pediatric Committee is committed to advancing high-quality, coordinated, and equitable emergency care for pediatric patients across the Coastal Bend. Through collaboration, education, and data-driven quality improvement, the committee works to ensure that children receive timely, age-appropriate, and evidence-based care throughout the continuum of emergency and trauma services.

MULTI-DISCIPLINARY MEDICAL DIRECTOR'S COMMITTEE

MISSION AND PURPOSE:

The Medical Director Committee was established to foster collaboration among healthcare leaders, provide ongoing education, review and analyze relevant data, and identify and address gaps in patient care within our region. The committee aims to enhance the quality and effectiveness of healthcare delivery through strategic discussions and evidence-based decision-making.

PROFESSIONAL EDUCATION

MISSION AND PURPOSE:

The mission of the Coastal Bend Regional Advisory Council (CBRAC) Education Committee is to promote excellence in prehospital and hospital-based education through regional collaboration, standardized training, and professional development. We are dedicated to improving patient outcomes by supporting EMS and healthcare educators, advancing evidence-based practices, and fostering a culture of continuous learning across the Coastal Bend region.

SPECIAL POPULATIONS

MISSION AND PURPOSE:

Considerations for special populations are fully integrated across all CBRAC committees to ensure that every service line incorporates equitable access, safety, and compassionate support for vulnerable and underserved individuals. Through inclusive planning, targeted education, and strong collaborative partnerships, all committees share responsibility for ensuring special populations are considered and protected in every aspect of regional emergency preparedness and response.

Resources:

As we continue to identify gaps and underserved special populations within our region, we encourage the use of 2-1-1 Texas, a trusted resource for locating local services and support. Their online directory includes information on healthcare, housing, mental health, elderly assistance, transportation, food access, and more.

Visit www.211texas.org or dial 2-1-1 to search by zip code or service category.

The regional 2-1-1 representative is an active member of both our CBRAC General Membership and Special Populations Committee and also plays a key role in the Coastal Bend Emergency Managers group, helping ensure coordination across health, human services, and emergency management sectors.

EMERGENCY DEPARTMENT OPERATIONS

MISSION AND PURPOSE:

The CBRAC Regional Emergency Department Operations (ED Ops) committee is charged with overseeing all aspects of the clinical and operational issues that impact Emergency Departments in Trauma Service Area – U (TSA-U). This includes, but is not limited to ED Diversion, EMS Interaction, sharing of best practices, state and regional initiatives, and identification of issues that have impact to the emergency patient. The committee works collaboratively with the trauma, cardiac, stroke, and emergency preparedness (CBHPC) committees to ensure continuity of care for those time-dependent pathologies. The group is multi-disciplinary multi-organizational and will utilize collaboration and consensus as the model for decision-making.

PRE- HOSPITAL

MISSION AND PURPOSE:

The Pre-Hospital Committee is dedicated to enhancing the delivery of emergency medical services across our coastal communities. We strive to enhance patient care through effective collaboration, education, and innovation, ensuring that everyone receives timely and compassionate pre-hospital care. Together, we aim to enhance patient outcomes and foster a culture of preparedness and response throughout the Coastal Bend region.

Affidavit Acknowledging Utilization of the Coastal Bend Regional Advisory Council, Trauma Service Area U Regional Protocols Regarding Patient Destination and Transport

To be eligible for funding from the EMS/Trauma Care System Account, an EMS provider must, as specified in EMS rule §157.130 (d)(2)(B) and §157.131 (d)(2)(B), "demonstrate utilization of the Regional Advisory Council (RAC) regional protocols regarding patient destination and transport in all TSA's (Trauma Service Areas) in which they operate".

Coastal Bend Regional Advisory Council
Trauma Service Area – U, Inc.

STANDARD OPERATING PROCEDURE

SOP Title: CBRAC Medical Treatment and Transport Guidelines
SOP Number:
SOP effective Date: November 15, 2023
SOP Reviewed/Revised:

Transport of a Sick or Injured Patient to a Health Care Facility in a Vehicle Other Than an EMSVehicle

INTRODUCTION

Trauma Service Area Regional Advisory Councils (TSA/RACs) must have medical treatment and transport guidelines for the transportation of a sick or injured patient to a health care facility in a vehicle other than an Emergency Medical Services vehicle by January 1, 2024[1,2]. In response, a collaborative effort of the Texas Chapter of the National Association of EMS Physicians (TX NAEMSP), and, the Pediatric Committee, Injury Prevention and Public Education Committee, EMS Committee, and EMS Medical Directors Committee of the Governor's EMS Trauma Advisory Council (GETAC) drafted guidelines that RAC's may utilize as their own.

These treatment and transport guidelines were developed in accordance with language outlined in House Bill 624 (HB624), 88th Legislative Session, effective as Section 773.0043, Health and Safety Code[1,2], as well as any national published standards (internet and print) by recognized national or federal organizations. The Following transfer guidelines are meant to beinclusive of pediatric and adult patients.

These guidelines are not part of the Texas Administrative Code and are merely a guide that RAC's may adopt in order to fulfill requirements of Section 773.0043, Health and Safety Code. This workgroup recognizes the varying resources of different RAC's and that approaches that work for one RAC may not be suitable for others. As such, it is understood and expected that some RAC's will develop their own guidelines. The decision to use these, or any guidelines in any particular situation always depends on the independent medical judgement of the medicalprovider and his/her medical director's guidance and medical protocols.[3]

Users should consult with their departmental council and/or other appropriate resources to assure compliance with any state or local requirements as well as determining the applicabilityto their equipment and individual circumstances. These guidelines in and of themselves do notconstitute a standard subject to enforcement. [3]

PURPOSE

The purpose of Section 773.0043, Health and Safety Code is to allow firefighters to transport sick or injured patients to the hospital during emergencies in which an ambulance is unable to transport the patient in a timely manner. Firefighters may use their fire apparatus, rescue vehicles, command and support units, privately owned vehicles, and any other vehicles operated by fire department members to transport injured patients when as ambulance isunable to do so. [1,2]

Per Section 773.0043, Health and Safety Code, firefighter means an individual who is defined asfire protection personnel under Section 419.021, Government Code: or an individual who is a volunteer fire fighter certified by the Texas Commission on Fire Protection or the State Firefighters' and Fire Marshals' Association of Texas.[1,2]

Section 773.0043, Health and Safety Code allows that firefighters may transport a sick or injuredpatient to a health care facility in a vehicle other than an emergency medical services vehicle, provided that the appropriate medical service provider (1) is notified of the patient's clinical condition and, (2) is unable to provide emergency medical services immediately at the patient'slocation; and if the medical treatment and transport operating guidelines for the patient's apparent clinical condition authorize transport of the patient in a vehicle other that an emergency medical services vehicle.[1,2]

OPERATING GUIDELINES

As fire apparatus are not designed for patient transport, the best option for any patient, regardless of age, is in a vehicle designed for patient transport, as well as continuing assessmentand care during transport. Transportation of a patient is a vehicle that is not designed or equipped for patient transport is a high-risk option and should only be considered, if ever, for patients with immediate life threats. Fire departments first responders should continue on- scene treatment, on-going assessment, request status updates through dispatch, and keep the patient, family, and bystanders up to date on the ambulance's arrival time.[4,5]

TRANSPORT DECISION CONSIDERATIONS

1. Each Fire Department should work with its transport EMS agency to determine if and when patients may be transported by a firefighter in specific situations. This should takeinto consideration regional practice, geography, healthcare system capabilities, and the patient's presentation.
2. Each fire department and EMS agency shall pre-determine how the EMS agency will benotified of the patient's clinical condition and what time period is considered "imminently": in consultation with EMS Provider.
3. A firefighter operating in a department with a physician medical director shall follow their medial director's protocols concerning transport of patients in a non-EMS vehicle. [6,7,8]

4. A firefighter operating in a department that does not have a physician medical director who,in a specific circumstance in which EMS agency is not able to imminently provide service, feels that the patient in front of them would benefit from immediate transport in a non- EMS vehicle, shall contact the responding EMS agency and notify them of the patient
   condition and that they are transporting on their own in a non-EMS vehicle. That fire department should have written guidelines (made in consideration of the medical treatment and transport operating guidelines developed by their trauma service area regional advisory council) which describe the circumstances in which non-EMS transport isauthorized.
5. Each fire department that develops this guidance shall provide a copy of it to their local EMS agency.
6. It is understood that the local EMS system, EMS medical director, and first responder organization (FRO) with medical direction, and FRO medical directors, do not have the legalauthority or responsibility to provide medical treatment guideline or medical direction for firefighters or departments/agencies for whom they do not provide medical direction and are not responsible for any medical treatment or transport provided by these firefighters.[6,7,8]

TRANSPORT OPERATIONAL CONSIDERATIONS

1. **When possible, the responding EMS agency (including air medical providers) should intercept the patient being transported by the fire service vehicle to render appropriate medical care and safe transport of the patient to the hospital.**
2. Recommended vehicles used for transportation other than an EMS vehicle (ambulance):
    a. Hybrid pumper transport units that combine Type 1 pumper unit with an EMS ambulance type compartment.
    b. Command and support units.
    c. Fire apparatus, e.g., pumper units, ladder trucks, heavy rescue trucks.
3. Except for cases of major catastrophe, the transport vehicle should be an enclosed environment vehicle.[9] Refrain from transporting a patient in an open cab fire apparatus,pickup truck bed, fire apparatus hose bed, or back step fire apparatus.
4. Fire department personnel shall follow all applicable state and local laws governing vehicles other than EMS vehicles.
5. Fire departments shall follow all vehicle operating safety guidelines as outlined in national standard guidelines, e. g., Texas Transportation Code Section 547.702, NationalFire Protection Agency (NFPA) 1500, International Association of Fire Chief's (IAFC) Policies and Procedures for Emergency Vehicle Safety, and the United States Fire Administration (USFA) and International Association of Fire Fighters (IAFF) emergency vehicle safety program.[10,11,12]
6. When possible, an attendant should be present with the patient during transport. If anyof the firefighters on scene have EMS or other medical licensure or certification, the individual with the highest level of licensure or certification should accompany the patient during transport. At minimum, the firefighter transporting the patient needs to be CPR certified and it must include First Aid Training.
7. When possible, and if it will not compromise patient well-being, adult patients shall beseated in approved riding positions with seatbelts or safety restraints fastened at all times when the vehicle is in motion.
8. When possible, and if it will not compromise patient well-being, pediatric patients (≤15y/o for the purpose of this guideline) shall be transported in appropriately sized child restraint system(s) and /or appropriately sized car safety seat following national standard guidelines, e.g., National Association of State EMS Officials (NASEMSO), National Highway Traffic Safety Administration (NHTSA), and the American Academy ofPediatrics (AAP).
9. When possible, and if it will not compromise patient well-being, pediatric patients should not be transported unrestrained on the lap of a provider or parent or held in thearms of a provider or parent.
10. When possible, and if it will not compromise patient well-being, the driver shall not begin to move the vehicle until all passengers are seated and properly secured. All patients shall remain seated and secured as long as the vehicle is in motion. Seatbeltsshall not be loosened or released while enroute.
11. Transport of patients by non-FRO should be transported to the closest hospital.
12. Non-FRO departments need to have guidelines from their EMS transporting agency to follow when they must transport a patient in a non-EMS vehicle. These guidelines, at minimum, should include: how to contact the EMS Provider, what information must be given to the EMS Provider,

specification on “a reasonable amount of time”, and thenon-FRO must fill out a form provided by the EMS Provider that must be signed by thereceiving facility to be turned into the EMS Provider.

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Coastal Bend Regional Advisory Council

Trauma Service Area - U

Pre-Hospital Regional Sepsis Alert Criteria

Reviewed/Revised/Approved: January 2026

SEPSIS ALERT CRITERIA - CBRAC

Ages 15 and Greater

These are regional guidelines and do not supersede a Medical Director's Order set.

Determine a Suspected or Confirmed Infection

AND

At Least TWO of the Following

- **Altered Mentation (Confused, Agitated, A Change from Baseline)**
- **Respiratory Rate greater than 20 breaths per minute**
- **Heart rate >90 bpm at rest**
- **An SBP < 90 mm Hg or a MAP < 65 mm Hg**
- **Temperature <96.8 or >100.9**
    - **Exception:** Pregnant patients ≥ 20 weeks gestation or within 3 days postpartum, the fever threshold is > 100.4 °F
- **End Tidal CO2 of < 30 mmHg**

SEPSIS ALERT MANAGEMENT

EMT Level

1. **Scene Time:** Minimize to < 10 minutes
2. **Notification:** Notify receiving facility and activate PULSARA Sepsis Alert as soon as practical once criteria are met.
3. **Oxygen:** Administer via the least invasive method necessary to maintain $SpO_2 \geq 94\%$

Paramedic Level

4. **Notification:** Declare "**Sepsis Alert**" via PULSARA and transport to the closest appropriate facility as soon as practical. Consider air transport depending on location and per protocol.

5. **Fluid Resuscitation:**
   - Preferred Fluid: Lactated Ringer's (LR)

   Alternate: Normal Saline (NS) if LR unavailable
   - Obtain IV access
   - Consider early IO placement (humeral head preferred)
   - Administer an initial 500 mL Crystalloid Bolus rapidly
   - Subsequent Boluses: Administer 250 mL at a time, reassessing after each bolus for improvement or signs of fluid overload
   - Maximum total: Up to 2000 mL may be administered without Medical Control contact
   - Document and verbally report start time of fluids and total amount given en route.

6. **Antibiotic Administration (If Authorized by Agency Protocol):**
   - Rocephin (Ceftriaxone) 2 grams IVP/IO, administered slowly over several minutes
   - *Confirm no known allergy to cephalosporins or penicillins before administration
   - Use clinical judgment: Consider that the illness may be viral in nature; antibiotics may not be appropriate for every patient.
     - Evaluate history, presentation, and likelihood of bacterial infection before administration.
   - Document time and route of administration and notify the receiving facility verbally upon arrival.
7. **Vasopressors (if unresponsive to fluids):**

Preferred Pressor:

   - Norepinephrine: Start at 4 mcg/min IV, titrate to maintain

   SBP ≥ 100 mmHg or MAP ≥ 65 mmHg
   - Consult Medical Control as needed
   - If Norepinephrine is not available, follow your company guidelines.

CBRAC DATA GOVERNANCE GUIDELINES

MISSION AND PURPOSE:

The purpose of these Data Governance Guidelines is to establish a framework for managing, protecting, and utilizing data within CBRAC. These guidelines ensure data integrity, security, and compliance, aligning with organizational goals and regulatory requirements.

SCOPE:

These guidelines apply to:

- All data collected, stored, processed, and disseminated by CBRAC related to RAC programs.
- All CBRAC technological systems, applications, and databases related to RAC programs.
- All employees, contractors, and member organizations who handle or access organizational data.
- The information noted above is also governed by the CBRAC information systems policy

Business Overview:

Business Objectives

Our primary objectives are to:

- Decrease morbidity/mortality resulting from injury or illness.
- Inform data-driven decisions that support the advancement of healthcare outcomes.
- Conduct performance improvement for service lines which include, but are not limited to cardiac, maternal, neonatal, pediatric, stroke, trauma, and mental health.

Roles and Responsibilities:

CBRAC Responsibilities:

- Comply with data governance guidelines, BAA's, and Data Usage Agreements, as applicable
- Ensure the accuracy and appropriate use of data
- Follow organizational policies

Processes and Procedures:

Data Security Management Process:

- CBRAC will conduct risk assessments, manage access controls, and monitor data security.

Procedures:

- Security Incident Response: Maintain and execute a plan for responding to security incidents. CBRAC IT to inform Business Associate in a timely manner. Business Associate to inform Covered Entities.
- Security Training: CBRAC IT to provide ongoing training on data security best practices.
- Access Controls: CBRAC IT enforces role-based access controls to restrict data access to authorized personnel only.
- Encryption: CBRAC IT to use end-to-encryption technologies to secure data both at rest and in transit.
- Incident Response: CBRAC IT to maintain a plan for responding to data security incidents; CBRAC to follow policies.

Data Application Security Overview Process:

Technology environment is virtual cloud-based service called Tresorit.

Access Controls:

- Role-based using individual unique credentials and iterative tiered permission levels. All access is tracked via access logs.

Platform Security and HIPAA Compliance – Tresorit:

CBRAC has a signed HIPAA Business Associate Agreement (BAA) with Tresorit to support secure management of protected health information (PHI). Tresorit is a zero-knowledge, end-to-end encrypted cloud platform designed to meet stringent data protection requirements. All files are encrypted client-side before they leave the device, ensuring that only authorized users can access the data. Tresorit's infrastructure includes secure key management, granular access controls, and compliance with relevant standards such as HIPAA, GDPR, and ISO/IEC 27001. This partnership reinforces our commitment to maintaining the confidentiality, integrity, and availability of sensitive health information.

Data Privacy Management

Procedures:

- Consent Management: Implement and manage consent processes
- Data Anonymization: Use anonymization techniques where applicable
- Privacy Training: Offer training on data privacy laws and practices

Compliance

Guideline Compliance Requirements:

- Adherence to these guidelines is mandatory for all employees, contractors, and member organizations.

Ensuring Compliance:

- Member Organizations: Non-compliance will be reported to the Executive Director and Board of Directors pursuant to CBRAC Bylaws Section 3 A:6.

Violations and Penalties Reporting Violations:

- Suspected violations should be reported.

Investigation:

- Detailed investigations will be conducted on all reported and potential compliance violations.

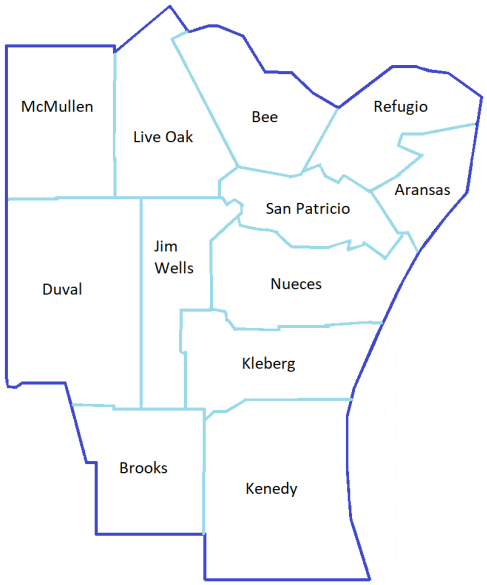
Continuous Improvement

- Performance Reviews: Annual review of the effectiveness of data governance initiatives

Contact Information If you have any questions or concerns, please email ithelpdesk@cbrac.org

DISASTER PREPAREDNESS

COASTAL BEND REGIONAL HEALTHCARE PREPAREDNESS COALITION



The CBHPC is committed to protecting the well-being of the local community as well as its property and facilities. To help ensure that we as a region are as prepared as we can be to protect this region in the event of a serious threat, hazard, or emergency situation, the CBHPC and the CBRAC have developed the All-Hazards Emergency Response Plan with the purpose of providing direction and guidance to the CBHPC and supporting agencies.

MISSION:

The CBHPC, a network of Aransas, Bee, Brooks, Duval, Kenedy, Kleberg, Live Oak, Jim Wells, McMullen, Nueces, Refugio, and San Patricio counties with endeavors to develop and promote the emergency and disaster preparedness, mitigation, response, and recovery capabilities of local healthcare entities.

DRIVEN BY:

- Strengthening community medical resiliency, surge capacity and capabilities
- Building relationships and partnerships
- Developing emergency preparedness, mitigation, response, and recovery capability guidelines
- Facilitating communication, information, and resource sharing
- Maximizing utilization of existing resources
- Coordinating training, drills, and exercises

SCOPE:

The goal of this plan is to be a guide by an emergency response framework and management structure with a concept of operations that will allow the CBHPC a process which enables the coordination of activities during emergency situations and/or disasters – that cause severe illness, injury and/or fatalities – between hospitals, other healthcare facilities, public health, and social services, Regional Health and Medical Operations Center (RHMOC), Department of State Health and Human Services (DSHS), Disaster District Committee 20 (DDC 20), Emergency Medical Services – Prehospital Care, neighboring healthcare regions, and state agents to deliver emergency care, inpatient services and social health and welfare services.

To request a copy of the CBHPC All Hazards Response Plan
Please contact Scott Marsh – HCC-U Program Director scott.marsh@cbrac.org

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