

2026

EMERGENCY HEALTHCARE SYSTEM PLAN



CENTEX
Regional Advisory Council

INTRODUCTION

The Central Texas Trauma Regional Advisory Council (CENTEX RAC) was incorporated in March 1993. Initial funding was provided by contract from the Texas Department of Health, which became Texas Department of State Health Services in 2005. CENTEX RAC is one of 22 Regional Advisory Councils (RACs) established across the State of Texas to coordinate and oversee emergency healthcare systems within designated Trauma Service Areas (TSAs). CENTEX RAC serves the six-county region, which includes Bell, Coryell, Hamilton, Lampasas, Milam, & Mills counties.

The CENTEX RAC Membership Committees, Workgroups, and Taskforces serve as the driving force behind the development, coordination, and continuous improvement of our regional emergency healthcare system. Through collaborative leadership across cardiac, trauma, stroke, perinatal, emergency department, EMS, preparedness, and performance improvement initiatives, these groups ensure system oversight, facility designation support, data review, training advancement, and coordinated disaster response.

SERVICE AREA/FACILITIES

The CENTEX RAC service area comprises five rural counties (Coryell, Hamilton, Lampasas, Milam, and Mills) and one suburban county (Bell). This geographical boundary is utilized for Trauma Service Area (TSA) L as well as Perinatal Care Region (PCR) L. Interstate 35, a major traffic corridor through Bell County, sees frequent multi-vehicular crashes. Other travel occurs mainly on state highways, farm to market roads, and county roads.

Bell County (population 399,578) is the only urban county in the Region and covers 1053.83 square miles in Central Texas. Bell County's median income is \$66,051 and 16.4% of the population does not have health insurance (Census Bureau, 1).

Bell County Healthcare Facilities:

BSW – Temple, in Temple, is a 634-bed acute care facility with surgical capability. BSW - Temple is the Region's Lead Trauma Facility as the only Level I Trauma Center between the DFW Area and Austin. The facility has also received Joint Commission certification as a Comprehensive Stroke Center and a Primary Chest Pain Center with PCI Capability. BSW - Temple is also the Lead Perinatal Facility with the only Level IV Maternal designation.

- McLane Children's Medical Center BSW, in Temple, is a 112-bed acute care facility with surgical capability. McLane Children's is the only Pediatric hospital between the DFW Area and Austin. McLane Children's is the Region's Lead Pediatric Level II Trauma Facility. While BSW – Temple physically houses the Level IV NICU, it is part of McLane Children's with pediatric and neonatal transport ambulance and helicopter.
- Carl R Darnall Army Medical Center (CRDAMC), at Ft. Hood, is a 151-bed acute care facility with surgical capability. CRDAMC is a designated Level III Trauma Center in addition there is a designated Level II NICU.

- Advent Health Central Texas (AHCT), a 269-bed hospital, is an acute care facility located in Killeen. AHCT is a designated Level IV Trauma Center and accredited as a Primary Chest Pain Center with PCI capability. AHCT is accredited as a Primary Stroke Center. The facility is also designated as a Level II maternal/nursery facility. AHCT also has a behavioral health emergency department. On the same property, Advent Health Behavioral Health Center is a 60-bed facility specializing in mental health with acute care capabilities.
- Seton Medical Center Harker Heights is a 63-bed acute care hospital in Harker Heights with surgical capabilities. Seton is a designated Level IV Trauma Center. Seton Medical Center Harker Heights is Joint Commission Accredited, an Accredited Chest Pain Center, and Advanced Primary Stroke Center.
- BSW – Continuing Care Hospital (CCH) is a 48-bed facility located in Temple. CCH provides Long-Term Acute and Skilled Nursing care.
- Temple Rehabilitation Hospital is a 36-bed facility located in Temple.
- ClearSky Rehab Hospital of Harker Heights
- Select Physical Therapy (Temple)- Outpatient
- Select Physical Therapy (Killeen)- Outpatient
- Baylor Scott & White Institute for Rehabilitation (Temple)- Inpatient
- Cedar Crest Behavioral Health- Inpatient
- Canyon Creek Behavioral Health- Inpatient

Bell County EMS Providers (Appendix VII):

- AMR
- Allegiance Mobile Health
- Acadian EMS
- Harker Heights Fire Department
- Killeen Fire Department
- City Ambulance
- Superior Mobile Health
- Multiple First Responder Organizations (FROs)

Coryell County (population 86,370) encompasses 1052.25 square miles. Coryell County's median income is \$68,904 annually and 14.7% of the population does not have health insurance (Census Bureau, 2). **Coryell Health System** is centrally located in Gatesville. Coryell Health is a 25-bed critical access hospital with surgical capabilities and a designated Level IV Trauma facility. Coryell Health has skilled nursing and rehabilitation services. There are (3) ground ambulances that are owned and operated by Coryell Health System. Coryell County has multiple FROs that provide pre-hospital care. **Copperas Cove Fire Department** runs (3) ground ambulances operated by Copperas Cove Fire Department and owned by the City of Copperas Cove.

Hamilton County located in the northwestern portion of the region, (population 8,644) and encompasses 835.92 square miles. Hamilton County's median income is \$55,339 and 22.3% of the population does not have health insurance (Census Bureau, 3). Hamilton General Hospital is in the center of the county in the City of Hamilton. **Hamilton General Hospital** is a 25-bed critical access hospital with surgical capability and is a designated Level IV Trauma facility. There are (2) ground ambulances, owned and operated by the Hamilton Health System as well as FROs that provide prehospital care in Hamilton County.

Lampasas County Located in the western portion of the region, (population 23,539) encompasses 712.53 square miles. Lampasas County's median income is \$76,919 and 17.5% of the population does not have health insurance (Census Bureau, 4). Advent Health Rollins Brook, a 25-bed critical access hospital in Lampasas. Advent Health Rollins Brook has surgical capabilities and is designated as a Level IV Trauma Center. There are (3) ground ambulances owned and operated by the Hamilton Health System as well as FROs that provide prehospital care in Lampasas County.

Milam County Located in the eastern-most portion of the region, (population 26,159) includes 1016.36 square miles of primarily farm and ranch land. Milam County's median income is \$59,076 and 19.3% of the population does not have health insurance. Milam County does not have a hospital (Census Bureau, 5). Healthcare is provided by local clinics and the (5) EMS ground ambulances provided by Allegiance Mobile Health as well as FROs that provide prehospital care in Milam County.

Mills County Located in the western-most portion of the Region, (population 4,563) includes 749.23 square miles of primarily farm and ranch land. Mills County's median income is \$64,494 and 21.6% of the population does not have health insurance. Mills County has 6.0 individuals per square mile just short of the Frontier County designation but for RAC purposes it is considered as frontier (Census Bureau, 6). Mills County does not have a hospital. Healthcare is provided by local clinics and the (1) EMS ground provider, owned and operated by the Hamilton Health System, and FROs that provide prehospital care in Mills County.

REGIONAL PLAN

This plan has been developed in accordance with generally accepted emergency healthcare standards for sustainment of a comprehensive Emergency Healthcare System Plan. This plan does not establish a legal standard of care but rather is intended as an aid to decision-making in general time-sensitive patient care scenarios. It is not intended to supersede the physician's prerogative to order treatment.

Due to the rural areas in this Region, the CENTEX RAC promotes and supports First Responder Organizations (FRO) and Volunteer Fire Departments (VFD) in order to help ensure expedited prehospital emergency care for our residents and those traveling in our Region.

CENTEX Regional Advisory Council

Mission Statement

Enhancing Emergency Healthcare: We support member organizations in delivering the highest level of emergency healthcare to reduce morbidity and mortality and improve patient outcomes.

Promoting Cooperation: We encourage collaborative activities among member organizations and provide a platform to resolve conflicts related to patient care.

Community Education: We facilitate educational programs for the public to raise awareness about an inclusive trauma system, with a strong emphasis on prevention.

Vision

To be a model leader in Texas for meeting the needs of the entire emergency healthcare system. To provide coordination of acute medical services in mass casualty and disaster settings.

BOARD OF DIRECTORS

<u>Position</u>	<u>Name</u>	<u>Entity</u>
Chair	Elizabeth Hicks	Hicks Signs
Vice Chair	Angie Gentry	Baylor Scott & White – Temple
Secretary	Angela Newton	Hamilton Hospital
Treasurer	Chancy Lay	Coryell Health
Immediate Past Chair	Angie Gentry	Baylor Scott & White – Temple
Cardiac	James Lampley	AdventHealth Central Texas
EMS Operations	Chyanne Brake	Hamilton EMS
Healthcare Coalition (HCC-L)	Lacey Sanders	Temple Rehab Hospital
Medical Advisory Committee	Dr. Michelle Strong	BSW - Temple
Stroke	Penelope McCabe	BSW – Temple
Trauma	Dylan Newsom	PHI Air Medical
Perinatal	Apiffany Spears	Advent Central Texas
Emergency Department	Chivon Brown	Seton Medical Center Harker Heights

Military Facility	Dr. Cord Cunningham	Carl R Darnall Army Medical Center
Lead Pediatric Facility	Sarah Wheat	McLane Children's Medical Center - BSW
Rural Area At-large	Daniel Lay	Coryell Health EMS
Physician At-large	Dr. Grace Ng	BSW – Temple
Community At-large	Jesse Hennage	CTCOG

COMMITTEES & WORKGROUPS

Active engagement and meaningful participation from members are essential to maintaining a high-functioning, responsive, and forward-moving regional system. The effectiveness of CENTEX RAC depends on the commitment, expertise, and collaboration of its members to advance patient care, strengthen partnerships, and support best practices across the continuum of care.

EMS PROVIDERS

See Appendix VII For Complete List.

FIRST RESPONDER ORGANIZATIONS

See Appendix VII For Complete List.

AIR MEDICAL PROVIDERS

See Appendix VII For Complete List.

FIXED WING PROVIDERS

See **Appendix VII For Complete List.**

FACILITY CAPABILITIES

Use matrix to determine closest appropriate facility. See Chart in **Appendix VII** Chart

FACILITY CONTACTS

See **Appendix VII For Complete List.**

FREESTANDING EMERGENCY DEPARTMENTS

See **Appendix VII For Complete List.**

REGION 7 PUBLIC HEALTH ORGANIZATIONS AND COVERAGE

See **Appendix VII For Complete List.**

SYSTEM ACCESS

GOAL

Individuals in the CENTEX RAC area have rapid access to request emergency care and that Emergency Medical Services (EMS) are promptly available to deliver high-quality care and transport. In some areas, First Responder Organizations (FRO) may provide initial treatment until EMS arrival.

COMMUNICATIONS

DESCRIPTION

All 911 systems within CENTEX RAC are Enhanced 911 centers, providing Automatic Number Identification (ANI) and Automatic Location Identification (ALI) to improve call routing and response. Calls are routed by geographic location, not municipal boundaries, with Selective Routing (SR) and Alternate Routing ensuring continuity of service if lines are busy or Public Safety

Answering Point (PSAP) closes. Service levels vary, but all systems in the region support enhanced routing to the appropriate answering point.

GOAL

CENTEX RAC strives to ensure communication capability between EMS providers, medical control, receiving facilities, and other First Responders. Rapid dispatch and notification of the need for emergency care at any location within CENTEX RAC Region must be available to all individuals in the Region. Each agency is responsible for monitoring their own response time(s) using established guidelines for their geographical area.

OBJECTIVE

Support CTCOG in developing interagency communications protocols that follow the Texas Statewide Interoperability Channel Plan whenever possible.

DISCUSSION

The CENTEX RAC uses many communication systems. During a disaster, it's critical that all agencies can communicate seamlessly and that personnel are fully familiar with their available communication tools. Regular communication methods may become overloaded or fail in emergencies. Using multiple systems helps maintain communication between EMS, police, fire, hospitals, and other agencies, but all personnel must be trained and proficient in using these systems under worse-case conditions.

Emergency dispatches in the six CENTEX RAC counties are handled by sheriff's offices, local police, or county 911 services. All 911 PSAPs use Director IP radio systems (or equivalents), which operate on agency-assigned frequencies as well as VHF and 800 MHz interoperability channels. These systems can also cross-link radios, allowing users on different frequencies to communicate with each other.

Prehospital Providers:

EMS agencies in CENTEX RAC use various frequencies and devices, typically VHF and 800 MHz, though hospitals may use additional methods. CENTEX RAC aims to streamline communications to meet each agency's needs in the simplest, most effective way.

Hospitals:

All CENTEX RAC hospitals can communicate with EMS using VHF, UHF, 800 MHz, cellular, or standard phones. Each facility has also been provided with a HAM radio.

Interoperability:

CENTEX RAC actively participates in regional interoperability planning through CTCOG, maintaining Level 4 interoperability and supporting efforts to reach and sustain Level 6.

Interagency Air Medical Operations:

To ensure safety during air medical operations, ground units must have reliable communication with responding helicopters. Air medical crews should be able to tune to various departmental frequencies, but agencies should

primarily use **VMED28, Copperas Cove Helicopter, or Bell County** talk-groups. Backup channels include **VFIRE21** and **Bell County VFD main**. When multiple helicopters respond to the same incident, the incident commander must notify dispatch of each aircraft's ETA and the frequency to use. If air-to-air communication is needed, crews should use **123.025 MHz**

Interagency Operations:

When multiple agencies respond to the same emergency, they should communicate on priority channels designated by the Texas Statewide Interoperability Channel Plan under the direction of the incident commander.

800 MHz users in Copperas Cove and Bell County should use the Mutual Aid channels set by the Bell County Communications Center. If VHF and 800 MHz users need to work together, the incident commander may establish radio patches as needed.

Radio Site on Wheels (SOW):

Bell County EMA has a SOW that is deployable upon request. For deployment, contact **Bell County Comm Center or Bob Reinhard at 254-933-5587 (ofc) or 254-394-9345 (cell)**.

PREHOSPITAL MEDICAL OVERSIGHT

PURPOSE

Each EMS Agency within the CENTEX Region has a EMS Medical Director that dictates scope of practice, Protocols and treatment procedures independently.

PERFORMANCE IMPROVEMENT

GOAL

To establish a method for monitoring and evaluating system performance over time and assess the efficacy of the regional emergency healthcare system.

OBJECTIVES

1. To provide a multidisciplinary forum for emergency care providers to evaluate emergency healthcare patient outcomes from a system perspective and to assure the optimal delivery of emergency care.
2. To facilitate the sharing of information, knowledge, and scientific data.
3. To provide a process for medical oversight of regional emergency healthcare.

PROCEDURE

The following standing committees are responsible for identifying a minimum of 2 PI Indicators annually and submitting them to the PI Committee for review and approval.

- EMSOC, Trauma, Stroke, Cardiac, Perinatal, Pre-Hospital Whole Blood (PHWB) and other clinical committees as established by the CENTEX RAC BOD.

- Standing committees will submit relevant data to the PI committee for review quarterly.
- Upon completion of the review, opportunities for improvement are referred to by the PI Committee to the MAC quarterly.
- MAC attendees will review referred opportunities for improvement to make determinations and recommend further actions if applicable.
 - MAC expectations: Refer to “Medical Advisory Committee (MAC) Case Review” Policy.
 - MAC stakeholders should be prepared to provide a short description and answer questions on these cases.
- Committee progress and outcome reports will be communicated quarterly in a standard format.
- Statement of Confidentiality - All data will be presented in a HIPAA compliant, de-identified in the spirit of improving emergency healthcare quality.

OUTREACH AND PUBLIC AWARENESS

Outreach and Public Awareness:

CENTEX RAC provides timely information, expertise, and public safety leadership for emergency healthcare in the six-county region. Outreach helps improve outcomes through public awareness, information sharing, and access to care. Activities include social media, prevention education, and signs & symptoms awareness.

Outreach focus areas vary by location, season, issue prevalence, and types of deaths reviewed. Each January, CENTEX RAC publishes a Prevention Calendar highlighting main focus areas, which is shared with members and on the RAC website. Social media campaigns are aligned with these focus areas.

AIR MEDICAL ACTIVATION

To minimize delays, provide the highest level of care, and improve outcomes by reducing morbidity and mortality. Helicopter activation/scene response should be considered when it could reduce transportation time and or definitive care for critical patients. Early activation should be utilized when feasible.

ACTIVATION CONSIDERATIONS:

- Once a helicopter has been activated to a scene, the decision to cancel the air response should be made by the transporting EMS provider
- Milam and Bell Counties both have “Auto-Launch” criteria for an algorithm utilized by the communication center for early activation of certain “Trauma” related calls.
- Ground EMS providers should not remain on scene awaiting arrival of air medical if an appropriate Trauma, Cardiac, or Stroke facility is nearby and the patient can be transported faster by ground.

- Other factors to consider: Location of Incident, Number of Patients, Age of patients, Weight of Patients, Response time of air medical.
- Patients should be taken to the closest appropriate facility based on the provider on scene and air crews' decision.

Pre-Hospital Whole Blood

GOAL

To improve survival and outcomes for patients experiencing severe hemorrhage by providing early transfusion of whole blood in the pre-hospital setting, ensuring rapid restoration of oxygen-carrying capacity and clotting factors before arrival at definitive care.

Refer to Appendix IV for a list of regional PHWB Providers and partners and Documents.

Cardiac System

STEMI

The classification of STEMI patients is based on a standard definition of the “STEMI patient” which is applied in a consistent manner in both the pre-hospital and facility settings. Within the CENTEX region, a STEMI is identified in any patient who shows symptoms consistent with an acute myocardial infarction accompanied by new ST-segment elevation of **1 mm or greater in at least two contiguous leads** on the 12-lead ECG.

PREHOSPITAL STEMI MANAGEMENT

GOAL

Patients will be rapidly and accurately assessed and based on identification of their actual or suspected onset of symptoms, will be transported to the nearest appropriate facility. Our regional goal is 90 minutes from first medical contact to device at a PCI facility.

See Appendix I for facility capabilities

Perinatal System

GOAL

To ensure the health and well-being of mothers and babies during the **perinatal period**, which spans from pregnancy through childbirth and the first weeks after birth.

FACILITY DIVERSION

GOAL

Regional transport practices ensure that patients who meet the criteria for activation of the Perinatal System are transported to the nearest appropriate designated maternal and/or neonatal facility—rather than merely the closest facility—when medically safe to do so.

Considerations

The following list of conditions should be reviewed when evaluating the need for activation of the Perinatal System. It is understood that every situation is unique, and the judgment of the provider remains essential in determining the most appropriate course of action.

Obstetrical Conditions and Complications

- Premature rupture of membranes (≥23 weeks with viable fetus)
- Preterm labor (≥23 weeks with viable fetus)
- Preeclampsia, or other hypertensive complications
- Multiple gestation
- Second or third trimester vaginal bleeding (≥23 weeks with viable fetus)
- Placenta Accreta Spectrum Disorder

Medical Complications

- Serious infection
- Cardiovascular disease including poorly controlled chronic hypertension
- Poorly controlled diabetes mellitus
- Endocrine disorder including hyperthyroidism
- Renal disease with deteriorating function or increasing hypertension
- Drug overdose or addiction
- Acute and chronic liver disease
- Cancer in pregnancy
- Neurologic disorder (cerebral aneurysm, encephalitis, history of cranial hemorrhage, etc)
- Collagen vascular disease
- Maternal pulmonary disease

- Coagulopathy
- Maternal pulmonary disease complicated by pulmonary insufficiency

Surgical Complications

- Trauma requiring intensive care or requiring a procedure that may result in preterm labor
- Acute abdominal emergency

Fetal Conditions

- Need for antenatal fetal evaluation when there is question about fetal condition or well being
- Intrauterine growth restriction, severe with oligohydramnios

Neonatal Conditions

- A. Preterm infant less than 32-34 weeks or less than 1500-1800 grams
- B. Persistent respiratory distress
- C. Respiratory failure from any cause
- D. Suspected sepsis, meningitis, or other serious neonatal infections
- E. Hypoglycemia
- F. Seizures
- G. Hypoxemia with evidence of encephalopathy or other organ involvement
- H. Drug withdrawal

TRANSPORT AND NON-MATERNAL RESOURCES

See Appendix II

Stroke System

HOSPITAL STROKE DESIGNATIONS

LEVEL OF DESIGNATION DEFINITIONS

Comprehensive Stroke Centers (Level I):

Thrombectomy Capable (Level II):

Primary Stroke Centers (Level III):

Support Stroke Centers (Level IV):

Non-designated Stroke Acute Care Facilities that utilize thrombolytics:

See **Appendix IV** for list of Stroke Facilities in CENTEX Region.

PREHOSPITAL CARE

GOAL

Suspected stroke patients will be rapidly and accurately assessed and based on identification of their actual or suspected onset of symptoms, will be transported to the nearest appropriate facility.

SYSTEM TRIAGE

- Suspected stroke patients (positive prehospital screening, such as FAST, CPHSS) with a negative LVO screening and a last known well of 4 hours or less should be taken to the closest IV Thrombolytic facility.
- Suspected stroke patients (positive prehospital screening, such as FAST, CPHSS) with a positive LVO screening (such as VAN, RACE) and a last known well of 4 hours or less should be taken to the closest Comprehensive Stroke Center - unless such transport would delay hospital arrival to a IV Thrombolytic capable facility by more than 30 minutes.
- Suspected stroke patients outside the thrombolytic window of 4 hours since last known well, or those with a clear thrombolytic contraindication confirmed by online medical control who have a POSITIVE LVO screen should be taken to the closest Comprehensive Stroke Center.
- Suspected stroke patients with a last known well of greater than 4 hours who are negative on LVO screen or all suspected strokes greater than 24 hours may be taken to the closest most appropriate acute care facility.
- Prehospital providers should consider using aeromedical transport if doing so will significantly shorten transport time and improve time to intervention.
- Prehospital personnel should communicate any stroke scales done and the outcome when calling report on the suspected stroke patient.

FACILITY TRIAGE CONSIDERATIONS

GOAL

The goal of establishing and implementing facility triage criteria in CENTEX Region, is to standardize the definitions and classifications of stroke patients, which may allow for uniform patient reporting and assist with inter-facility transfer decisions for all facilities in the Region.

DISCUSSION

- In the CENTEX Region, all acute care facilities are equipped to administer IV thrombolytics to eligible stroke patients.

- If a stroke patient is LVO positive and within a 24-hour window since last known well, they should be immediately given thrombolysis if indicated and transferred to the closest Comprehensive Stroke Center.
- If a stroke patient presents at a Primary Stroke Center or a IV Thrombolytic capable acute care facility with a last known well of less than 4.5 hours and negative LVO screening, then IV Thrombolytic should be started as appropriate. The patient should be transferred out within 90 minutes.
- If a stroke patient presents at an acute care facility with a last known well of 4.5 to 24 hours and a negative LVO screening, the patient should be transferred to a Primary or Comprehensive Stroke Center.
- If a stroke patient presents at an acute care facility with a last known well greater than 24 hours, the stroke patient may stay if the facility is able to provide appropriate rehabilitation.

Trauma System

PREHOSPITAL TRIAGE GUIDELINES

GOAL

Patients will be identified, rapidly and accurately assessed, and based on identification of their actual or potential for serious injury, will be transported to the nearest appropriate CENTEX RAC trauma facility.

OBJECTIVES

In order to ensure the prompt availability of medical resources needed for optimal patient care, each patient will be assessed for the presence of abnormal vital signs, obvious anatomic injury, mechanism of injury, and concurrent disease/predisposing factors.

DEFINITION

Trauma Patient—the patient is a victim of an external cause of injury that results in major or minor tissue damage or destruction caused by intentional or unintentional exposure to thermal, mechanical, electrical, or chemical energy, or by asphyxia, submersion, or hypothermia.

SYSTEM TRIAGE

Unless immediate stabilization (ABC's, cardiac arrest, etc.) is required, patients in CENTEX RAC with the following injuries, with significant mechanism of injury, should be taken directly to the closest Level 1 / Level II Trauma Facility if ground transport time is ≤ 30 minutes. Also refer to the CENTEX RAC Prehospital Trauma Triage Criteria Algorithm for additional high- risk considerations for transporting the patient directly to Scott & White Medical Center – Temple or Baylor Scott & White McLane Children's Medical Center:

Refer to graphic in **Appendix V**.

AIR MEDICAL ACTIVATION

GUIDELINES FOR AIR ACTIVATION FOR TRAUMA PATIENTS

Refer to Infographic in **Appendix V**

FACILITY DIVERSION

GOAL

CENTEX RAC facilities should communicate “facility diversion” status promptly and clearly to regional EMS and trauma facilities through EMResource® to ensure that trauma patients are transported to the nearest appropriate alternate trauma system hospital.

ACKNOWLEDGEMENTS

CENTEX RAC facilities, both designated and undesignated, should request diversion activation only when the resources or capabilities of that facility have been exhausted to the point that further EMS traffic would jeopardize the care and treatment of patients at that facility as well as any subsequent patient transported to that facility by EMS. It is recognized in advance that no diversion strategy can guarantee total compliance with these guidelines and it is likely that EMS will deliver patients to hospitals that have requested diversion activation. It is further understood that a request for diversion activation is honored as a courtesy by EMS. Patient's informed wishes should be honored. Each facility is responsible for defining facility-specific policies and procedures for implementation of these guidelines.

DEFINITIONS

1. **Transfer:** Movement of a patient from one hospital to another based upon the patient's need (inter-hospital transport) or request.
2. **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.
3. **Diversion:** Intentional movement of a patient from the scene to an alternate hospital capable of providing appropriate care at the request of the diverting hospital due to lack of available resources or capability.
4. **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.

AUTHORIZATION FOR DIVERSION STATUS IMPLEMENTATION AND DEACTIVATION:

Hospital administrator or designee

Communication of diversion status:

- A hospital should communicate “facility diversion” status promptly and clearly too regional EMS and trauma facilities through EMResource®.

TIME PERIOD FOR DIVERSION STATUS:

- Diversion status is determined by each individual facility and is updated on EMResource® based on resolution of situation.
- In the event the hospital diversion status goes beyond 24 hours, the RAC will verify the need for continued diversion.

AUTHORIZATION FOR OVER-RIDE OF DIVERSION STATUS:

- EMS may over-ride a diversion status after consideration of the following:
 - The patient's clinical presentation
 - Distance and estimated time to an alternate appropriate facility
 - Inclement weather conditions
 - Resource availability and capability of the transporting prehospital provider
 - An Informed Patient Preference

FACILITY BYPASS

GOAL

Patients who have been assessed and determined to be medically unstable, unconscious, or at high risk of multiple and/or severe injuries will be safely and rapidly transported to the nearest appropriate Level I or Level II trauma center. All other trauma patients will be safely and rapidly transported to the nearest appropriate trauma facility or nearest appropriate acute care facility within TSA L.

DECISION CRITERIA

Regional transport protocols ensure that patients who meet the triage criteria for activation of the CENTEX RAC Regional Emergency Healthcare System Plan will be transported directly to the nearest appropriate trauma facility rather than to the nearest hospital except under the following circumstances:

1. If unable to establish and/or maintain an adequate airway, or in the case of traumatic cardiac arrest, the patient should be taken to the nearest acute care facility for stabilization.
2. A Level III or Level IV trauma facility may be appropriate if the expected scene to Level I Trauma Center transport time is excessive (> 30 minutes) and there is a qualified physician available at the facility's Emergency Department capable of delivering stabilizing care.
3. Medical Control may wish to order bypass in any of the above situations as appropriate, such as when a facility is unable to meet hospital resource criteria or when there are patients in need of specialty care (burns).
4. If expected ground transport time to the nearest appropriate Trauma Center is excessive (> 30 minutes) or if a lengthy extrication time (> 20 minutes) is expected, medical control or the EMS crew on scene should consider activating air transportation resources.

Note: Should there be any question regarding whether to bypass a facility, on-line medical control should be consulted for the final decision from the receiving facility.

FACILITY TRIAGE CRITERIA

GOAL

The goal of establishing and implementing facility triage criteria in CENTEX RAC is to ensure that all regional hospitals use standard definitions to classify trauma patients in order to ensure uniform patient reporting and facilitate inter-hospital transfer decisions.

DISCUSSION

1. The Trauma Patient - The definition of the trauma patient in CENTEX RAC is derived from the American College of Trauma Surgeon's definition of trauma. In CENTEX RAC, the trauma patient is defined as one who is a victim of an external cause of injury that results in major or minor tissue damage or destruction caused by intentional or unintentional exposure to thermal, mechanical, electrical, or chemical energy, or by asphyxia, drowning, or hypothermia.
2. Facility Triage Criteria - Trauma patients are assessed in the pre-hospital setting and transferred to the closest appropriate trauma facility in accordance with the CENTEX RAC Pre-hospital Trauma Triage Criteria. Upon admission to the hospital emergency department, trauma patients receive initial treatment and re-assessment of their condition. The severity of injury of the trauma patient in the initial treating emergency department determines the optimal level of trauma care needed. Inter-hospital transfer is initiated as appropriate according to CENTEX RAC facility triage decision criteria.

TRAUMA FACILITY TRIAGE CRITERIA

Trauma patients meeting the criteria in **Appendix V** should be considered high-risk and transfer to closest appropriate Level I or Level II Trauma Center should be initiated. Also refer to the CENTEX RAC Facility Trauma Triage Criteria Algorithm for additional high-risk considerations for initiating early transfer:

REGIONAL TRANSFER GUIDELINE

GOAL

The goal for establishing and implementing inter-hospital transfer criteria in CENTEX RAC is to ensure that those Trauma, Stroke, Maternal or STEMI patients requiring additional or specialized care and treatment beyond a facility's capability are identified and transferred to an appropriate facility as soon as possible.

DISCUSSION

The level of care and resources required for specialty care patients is determined by the transferring facility and specialty care (Trauma, Maternal, Pediatric, Burn, PCI and Stroke) center in collaboration.

SEEKING SPECIALTY DESIGNATION

PROCESS

When a facility in the CENTEX RAC Region decides to proceed with initial specialty designation or upgrade of current specialty designation, the facility shall formally notify the RAC of its plans to seek stroke designation and at what level. The facility must submit a letter of attestation **Appendix VI** signed by CENTEX RAC to the accrediting body.

Non-Accidental Trauma

CHILD ABUSE RECOGNITION, EVALUATION, MANAGEMENT, & TRANSFER GUIDELINES

Refer to the ACS TRAUMA QUALITY PROGRAMS BEST PRACTICES GUIDELINES FOR TRAUMA CENTER RECOGNITION OF Child Abuse, Elder Abuse, and Intimate Partner Violence.

chrome-

extension://efaidnbmnnnibpcajpcgiclfendmkaj/https://www.facs.org/media/o0wdimys/abuse_guidelines.pdf

and Infographic in **Appendix V**

All facilities within the CENTEX RAC Region have a child abuse screening tool built into their electronic medical records systems. However, EMS providers in the Region do not have a specific protocol for suspected child abuse outside of their legal requirements to report.

Emergency Response Employee (ERE) Regional Exposure Plan

CENTEX RAC Facility and Agency partner follow the Federal requirements for healthcare exposure plans mandated and enforced by the **Occupational Safety and Health Administration (OSHA)** under its [Bloodborne Pathogens \(BBP\) Standard \(29 CFR 1910.1030\)](#). This standard requires any employer with workers exposed to blood or other potentially infectious materials (OPIM) to create a written **Exposure Control Plan and Policies (ECP)**.

Multi-Patient Event Response

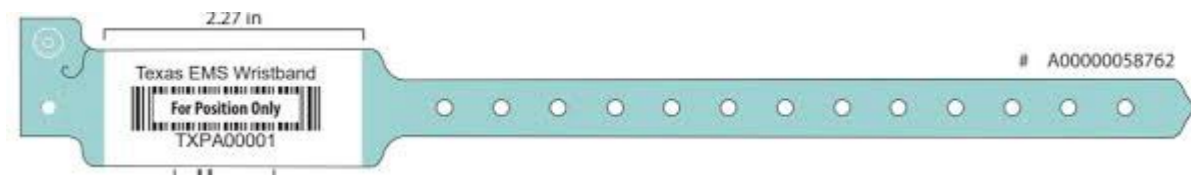
GOAL

Patients will be identified, rapidly and accurately assessed, and based on identification of their actual or suspected onset of symptoms, will be transported to the nearest appropriate Heart of Texas facility.

TEXAS EMS WRISTBAND

GOAL

To link pre-hospital and hospital records across disparate electronic medical record systems throughout the continuum of care, and to track patients during mass casualty incidents, evacuations, and disasters. Wristbands will be appropriately distributed to DSHS-licensed EMS agencies, First Responder Organizations and hospitals to facilitate EMS transport, inter-facility transfers, and/or other CENTEX RAC approved situations or events in which wristbands may be needed or required.



MCI-Wristband



EMRESOURCE®

PURPOSE

To provide a method of tracking available resources within the region. This supports the best possible emergency care for the sick and injured within the CENTEX RAC region.
t acceptance status.

STATUS UPDATE RECOMMENDATIONS

- 1) All listed facilities are asked to update EMResource® at least once every **24 hours**

- 2) Prehospital entities are asked to update EMResource® at least **once per week**, preferably on Mondays.
- 3) In the event of a disaster or mass casualty event within the region, more frequent updates may be requested.

PULSARA

PURPOSE

To streamline healthcare communication for time-sensitive emergencies and large-scale incidents by connecting entire care teams (EMS, hospitals, specialists) to a single mobile and desktop platform.

Use of Pulsara is expected and serves as the regional standard for communication. All patients transported to a acute care facility within our region are expected to be entered and monitored through the platform to promote seamless coordination and optimal patient outcomes.



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CENTEX RAC 2026 EHSP
EMERGENCY HEALTHCARE SYSTEM PLAN
APPENDIX I



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Appendix I: Percutaneous Coronary Intervention (PCI) Facilities

This appendix identifies PCI-capable facilities for cardiac interventional services.

A. Central Texas PCI Facilities (TSA L)

Baylor Scott & White Medical Center – Temple

AdventHealth Central Texas

Seton Medical Center – Harker Heights

B. PCI Centers Located Outside TSA L

TSA M

Ascension Providence

Baylor Scott & White – Hillcrest

TSA O

Baylor Scott & White Medical Center – Round Rock

Baylor Scott & White – Lakeway

Cedar Park Regional Medical Center

Central Texas Medical Center

Dell Seton Medical Center at The University of Texas

Heart Hospital of Austin

Seton Medical Center – Williamson

Seton Medical Center – Austin

Seton Medical Center – Hays

St. David's Medical Center

St. David's North Austin Medical Center

St. David's Round Rock Medical Center

St. David's South Austin Medical Center

Westlake Medical Center



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CENTEX RAC 2026 EHSP
EMERGENCY HEALTHCARE SYSTEM PLAN
APPENDIX II



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Appendix II: Local and Regional Neonatal and Maternal Designated Hospitals

A. Maternal Facilities

Carl R. Darnall Army Medical Center

Designation: Level II

Phone: 254-553-8686

AdventHealth Central Texas

Designation: Level II

Baylor Scott & White Medical Center – Temple

Designation: Level IV

Phone: 254-724-2111

B. Neonatal Facilities

Carl R. Darnall Army Medical Center

Designation: Level II

Phone: 254-553-8686

McLane Children’s Medical Center

Designation: Level IV

Phone: 254-935-KIDS

AdventHealth Central Texas

Designation: Level II

Baylor Scott & White Medical Center – College Station

Designation: Level III

Baylor Scott & White Medical Center – Hillcrest

Designation: Level III



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Neonatal Resuscitation Checklist

Birth	• Early Team activation • Early Tertiary facility consult and doctor to doctor communication • Early decision on Maternal, NICU/PICU Transport activation
Warm	• Umbilical cord clamp • Preheated warmer • Warm towels or blankets • Temperature sensor and sensor cover for prolonged resuscitation • Hat • Plastic bag or plastic wrap (<32 weeks' gestation) • Thermal Mattress (<32 weeks' gestation)
Clear airway	• Bulb syringe • 10F or 12F suction catheter attached to wall suction, set at 80 to 100 mm Hg • Meconium aspirator
Auscultate	• Stethoscope
Oxygenate	• Equipment to give free-flow oxygen • Pulse oximeter with sensor and cover • Target oxygen saturation table
Intubate	• Laryngoscope with size-0 and size-1 straight blades (size 00, optional) • Stylet (optional) • Endotracheal tubes (sizes 2.5, 3.0, 3.5) • Carbon dioxide (CO₂) detector • Measuring tape and/or endotracheal tube insertion depth table • Waterproof tape or tube-securing device • Scissors • Laryngeal mask (size 1) and 5-mL syringe
Medicate	Access to • 1:10,000 (0.1 mg/mL) epinephrine • Normal saline • Supplies for placing emergency umbilical venous catheter and administering medications • Electronic cardiac (ECG) monitor leads and ECG monitor



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Apgar Score	Assess Apgar score at 1 and 5 minutes	Heart rate	• 100+ bpm 2 • <100 bpm 1 • No pulse 0
	Score 2, 1, or 0 for each category	Breathing	• Regular 2 • Irregular 1 • No breathing 0
	Add the scores for all 5 categories	Muscle tone	• Active movement 2 • Moderate movement 1 • Limp 0
	Apgar scores of 7 to 10 are normal Scores below 7 are abnormal	Skin color	• Pink 2 • Blue hands/feet 1 • Blue entirely 0
	The test may need to be repeated with a score of less than 7.	Response to stimulus	• Crying 2 • Whimpering 1 • Silent 0

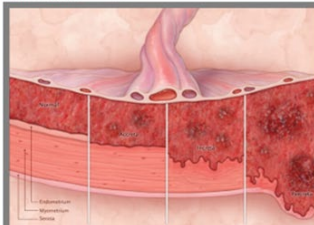
Placenta Accreta Spectrum Disorder (PASD)

What does this mean for you?

Morbidity and mortality can occur because of severe and sometimes life-threatening hemorrhage. Postoperative patients are at risk for ongoing abdominopelvic bleeding. Due to these risks:

- ☒ Anticipate the admission of a patient with this diagnosis postoperatively
- ☒ Prepare for hemodynamic monitoring
- ☒ Prepare for administration of blood/blood products and/or activation of MTP (consider use of a rapid transfuser)

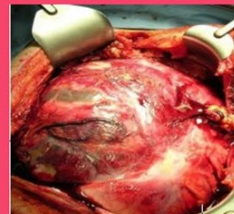
Alison G. Cahill, Richard Ragni, R. Phillips Morris, Robert M. Silver, Joseph R. Wax, Placenta Accreta Spectrum, American Journal of Obstetrics and Gynecology, Volume 210, Issue 6, 2018, Pages S0-S16, S104-S105, S119, <https://doi.org/10.1016/j.ajog.2018.08.042>



Placenta accreta spectrum disorder (PASD), formerly known as morbidly adherent placenta, refers to the growth of the placenta into the myometrium (accreta), through the myometrium (incretas), or into surrounding tissues/organs (percreta). Patients with PASD have an 80-90% chance of massive hemorrhage, with 1 in 3 patients requiring transfer to ICU postoperatively. The most generally accepted approach to treatment for this condition is a hysterectomy with the placenta left in situ after delivery of the fetus.

Placenta accreta spectrum, Obstetric Care Consensus No. 7, American College of Obstetrics and Gynecologists, Obstet Gynecol 2018; 132:e255-75

PASD is a growing problem in obstetrics resulting in increased maternal and neonatal morbidity and mortality. Maternal morbidity and mortality is secondary to postpartum hemorrhage. The average blood loss for PASD patients is 3-5 liters. There is a ten fold increase of incidence of PASD.



- If a patient has a known diagnosis and is unstable for transfer prior to delivery, a multidisciplinary consult will be completed if time allows.
- If a patient is undiagnosed until the time of delivery, if possible, stabilize and transfer to the PASD center.
- Known diagnoses may have an orange band (below) and all should be transferred to a PASD center for management and delivery.



PASD Bracelets



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C. Non-Maternal Facilities Recommended Supplies and Equipment

Supplies

- ▶ IV start supplies
- ▶ Angiocaths
- ▶ IV tubing
- ▶ IV extension set
- ▶ Blood product transfusion tubing
- ▶ Blood warmer tubing
- ▶ Urinary catheter kit with urometer
- ▶ Flashlight
- ▶ Lubricating jelly
- ▶ Assorted sizes sterile gloves
- ▶ Lab tubes: CBC, coagulation studies, etc.
- ▶ Venipuncture supplies
- ▶ Pressure infuser bags
- ▶ Chux-Pad
- ▶ Peri-pads
- ▶ Vaginal packing (consider arm banding to indicate packing used)
- ▶ Hemorrhage balloon and supplies
- ▶ Skin marker
- ▶ Syringes
- ▶ Needles
- ▶ Tegaderm
- ▶ 2x2 gauze
- ▶ Adhesive bandages
- ▶ Alcohol swabs
- ▶ Paper tape
- ▶ Cloth tape
- ▶ Manual BP cuff
- ▶ Stethoscope
- ▶ Povidone iodine



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- ▶ Personal Protection Equipment (PPE)
- ▶ Operating room towels
- ▶ Sterile speculum
- ▶ Diagrams depicting various procedures (e.g., B-Lynch, uterine artery ligation, balloon placement)
- ▶ IV fluids for administration and hemorrhage balloons as your institution permits

Instruments

- ▶ Set of vaginal retractors (long right angle); long weighted speculum
- ▶ Sponge forceps (minimum: 2)
- ▶ Sutures (for cervical laceration repair and B-Lynch)
- ▶ Banjo curettes, several sizes
- ▶ Long needle holder
- ▶ Uterine forceps

Rapid Access Medications

- ▶ Oxytocin (Pitocin)
- ▶ Methylergonovine (Methergine)
- ▶ Carboprost (Hemabate)
- ▶ Tranexamic Acid (TXA)
- ▶ Misoprostol (Cytotec)

Vaginal Birth

- ▶ Vaginal retractors
- ▶ Long weighted speculum
- ▶ Long instruments (needle holder, scissors, Kelly clamps, sponge forceps)
- ▶ Intrauterine balloon
- ▶ Banjo curette
- ▶ Bright task light
- ▶ Procedural instructions (balloon)

Cesarean/Laparotomy

- ▶ Hysterectomy tray



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- ▶ #1 chromic or plain catgut suture & reloadable straight needle for B-Lynch sutures
- ▶ Intrauterine balloon
- ▶ Procedural instructions (balloon, B-Lynch, arterial ligations)

Rapid Access Medications

- ▶ Oxytocin (Pitocin)
- ▶ Carboprost (Hemabate)
- ▶ Misoprostol (Cytotec)
- ▶ Methylergonovine (Methergine)

Sources:

California Maternal Quality Care Collaborative's OB Hemorrhage Toolkit V3.0 - Appendix E:
Checklist: Carts, Kits and Trays

California Maternal Quality Care Collaborative's OB Hemorrhage Toolkit V3.0 - Appendix E: Checklist:
Carts, Kits and Trays

American College of Obstetricians and Gynecologists District II's
Safe Motherhood Initiative **Example Obstetric Hemorrhage Recommended Instruments
Checklist**



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EMERGENCY HEALTHCARE SYSTEM PLAN
APPENDIX III



Appendix III: Stroke Designated Facilities – TSA L

Comprehensive Stroke Centers (Level I)

- Baylor Scott & White Medical Center – Temple

Thrombectomy-Capable Stroke Centers (Level II)

There are no facilities currently designated as Thrombectomy-Capable Stroke Centers in TSA L.

Primary Stroke Centers (Level III)

- AdventHealth Central Texas
- Seton Medical Center – Harker Heights

Support Stroke Centers (Level IV)

There are no facilities currently designated as Support Stroke Centers in TSA L.

Non-Designated Stroke Acute Care Facilities Utilizing Thrombolytics

- AdventHealth Rollins Brook-Lampasas

Carl R. Darnall Army Medical Center (CRDAMC)

Central Texas Veterans Healthcare System – Temple

Coryell Health System

Hamilton General Hospital

McLane Childrens Medical Center - Baylor Scott & White



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CENTEX RAC 2026 EHSP
EMERGENCY HEALTHCARE SYSTEM PLAN
APPENDIX IV



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Appendix IV: Stroke Designated Facilities – TSA L

Stroke Facility Designation Definitions

Level	Name	Key Capabilities	EMS Routing Guidance
Level I	Comprehensive Stroke Center (CSC)	Neurosurgery & neurointervention 24/7; Advanced imaging; Stroke unit + Neuro-ICU; IV thrombolytics, endovascular therapy (mechanical thrombectomy), aneurysm & carotid treatment	Severe/complex stroke (ie: suspected LVO) or neurosurgical need
Level II (*Currently no Level II facilities in TSA L)	Advanced / Thrombectomy-Capable	IV thrombolytics; Endovascular therapy (mechanical thrombectomy); Stroke unit + Neuro-ICU	Suspected LVO
Level III	Primary Stroke Center (PSC)	24/7 CT/CTA; Stroke unit beds; IV thrombolytics + medical mgmt	Standard ischemic stroke, no LVO suspected
Level IV	Acute Stroke Ready Hospital (ASRH)	24/7 CT; IV thrombolytics, tele-neuro; No stroke unit or neurosurgery	Closest facility for rapid thrombolytics, no LVO suspected



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Comprehensive Stroke Centers (Level I)

- Baylor Scott & White Medical Center – Temple

Thrombectomy-Capable Stroke Centers (Level II)

There are no facilities currently designated as Thrombectomy-Capable Stroke Centers in TSA L.

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Non-Designated Stroke Acute Care Facilities Utilizing Thrombolytics

AdventHealth Rollins Brook

Carl R. Darnall Army Medical Center (CRDAMC)

Central Texas Veterans Healthcare System – Temple

Coryell Health System

Hamilton General Hospital

McLane Childrens Medical Center - Baylor Scott & White



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EMERGENCY HEALTHCARE SYSTEM PLAN
APPENDIX V



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Appendix V: CENTEX RAC Prehospital Trauma Triage Criteria Algorithm

The following criteria identify additional high-risk considerations for transporting trauma patients directly to Baylor Scott & White Medical Center – Temple or Baylor Scott & White McLane Children’s Medical Center.

National Guideline for the Field Triage of Injured Patients

RED CRITERIA

High Risk for Serious Injury

Injury Patterns	Mental Status & Vital Signs
- Penetrating injuries to head, neck, torso, and proximal extremities - Skull deformity, suspected skull fracture - Suspected spinal injury with new motor or sensory loss - Chest wall instability, deformity, or suspected flail chest - Suspected pelvic fracture - Suspected fracture of two or more proximal long bones - Crushed, degloved, mangled, or pulseless extremity - Amputation proximal to wrist or ankle - Active bleeding requiring a tourniquet or wound packing with continuous pressure	All Patients - Unable to follow commands (motor GCS < 6) - RR < 10 or > 29 breaths/min - Respiratory distress or need for respiratory support - Room-air pulse oximetry < 90% Age 0–9 years - SBP < 70mm Hg + (2 x age years) Age 10–64 years - SBP < 90 mmHg or - HR > SBP Age ≥ 65 years - SBP < 110 mmHg or - HR > SBP

Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

YELLOW CRITERIA

Moderate Risk for Serious Injury

Mechanism of Injury	EMS Judgment
- High-Risk Auto Crash - Partial or complete ejection - Significant intrusion (including roof) >12 inches occupant site OR >18 inches any site OR - Need for extrication for entrapped patient - Death in passenger compartment - Child (Age 0–9) unrestrained or in unsecured child safety seat - Vehicle telemetry data consistent with severe injury - Rider separated from transport vehicle with significant impact (eg, motorcycle, ATV, horse, etc.) - Pedestrian/bicycle rider thrown, run over, or with significant impact - Fall from height > 10 feet (all ages)	Consider risk factors, including: - Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact - Anticoagulant use - Suspicion of child abuse - Special, high-resource healthcare needs - Pregnancy > 20 weeks - Burns in conjunction with trauma - Children should be triaged preferentially to pediatric capable centers If concerned, take to a trauma center

Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)



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D. Air Medical Activation Guidelines for Trauma Patients

RED CRITERIA – HIGH RISK FOR SERIOUS INJURY

Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

INJURY PATTERNS

- Penetrating injuries to head, neck, torso and proximal extremities
- Skull deformity, suspected skull fracture
- Suspected spinal injury with new motor or sensory loss
- Chest wall instability, deformity or suspected flail chest
- Suspected pelvic fracture
- Suspected fracture of two or more proximal long bones
- Crushed, degloved, mangled or pulseless extremity
- Amputation proximal to wrist or ankle
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

MENTAL STATUS & VITAL SIGNS

ALL PATIENTS

- Unable to follow commands (motor GCS<6)
- RR <10 or >29 breaths/min
- Respiratory distress or need for respiratory support
- Room-air pulse oximetry <90%

AGE 0–9 YEARS

- SBP <70mm Hg + (2X age in years)

AGE 10–64 YEARS

- SBP <90 mmHg or
- HR > SBP

AGE ≥ 65 YEARS

- SBP <110 mmHg or
- HR > SBP

- Major Burns > 20 % or burns to the Airway, hands, feet or genitalia- To Burn Center

CENTEX RAC Hospital Trauma Transfer Triage Criteria Algorithm

This appendix outlines prehospital trauma triage criteria, air medical activation guidelines, and early transfer indicators for adult and pediatric trauma patients within the CENTEX RAC region.

A. Additional High-Risk Transport Considerations

B. Pediatric Unstable Vital Signs

C. Mechanism of Injury Criteria

D. Air Medical Activation Guidelines

E. Trauma Patients Requiring Early Transfer to Level I or Level II Trauma Centers

Trauma patients meeting the criteria below should be considered high-risk. Early transfer to the closest appropriate Level I or Level II Trauma Center should be initiated. Refer to the CENTEX RAC Facility Trauma Triage Criteria Algorithm for additional guidance.



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Adult Patient Criteria

Penetrating injuries to head, neck, and torso
Respiratory compromise, obstruction, and/or intubation
Glasgow Coma Scale (GCS) ≤ 13
Traumatic paralysis (excluding numbness or tingling)
Amputation proximal to the wrist or ankle
Two or more proximal long bone fractures (femur, humerus)
Pelvic fractures
Burns $\geq 20\%$ TBSA or $\geq 10\%$ if under 6 years old – transport to burn center if possible
Unstable Vital Signs – Any ONE of the following:
 Systolic blood pressure < 90 mmHg (< 100 mmHg if > 60 years old)
 Respiratory rate < 10 or > 29 with distress
 Oxygen saturation $< 90\%$

Pediatric Patient Criteria

Penetrating injuries to head, neck, and torso
Respiratory compromise, obstruction, and/or intubation
Glasgow Coma Scale (GCS) ≤ 13
Traumatic paralysis (excluding numbness or tingling)
Amputation proximal to the wrist or ankle
Two or more proximal long bone fractures (femur, humerus)
Pelvic fractures
Burns $\geq 20\%$ TBSA or $\geq 10\%$ if under 6 years old – transport to burn center if possible
Pediatric Unstable Vital Signs – Any ONE of the following:
 Blood pressure not appropriate for age ($70 + 2 \times \text{age}$)
 Neonate: systolic BP < 60 mmHg
 Infant (< 2 years): systolic BP < 65 mmHg
 Child (2–5 years): systolic BP < 70 mmHg
 Child (6–14 years): systolic BP < 80 mmHg
 Respiratory rate < 10 or > 60
 Tachycardia for age with signs of poor perfusion
 Pediatric Trauma Score > 9

High-Energy Mechanisms of Injury

Ejection from vehicle, ATV, large animal, motorcycle, or bicycle
Significant fall: ≥ 2 times patient height or > 10 feet if ≤ 6 years old
Auto–pedestrian impact
Significant assault

Burns

Dell-Seton Hospital (Level I Trauma) – TSA O, Austin
Parkland Health & Hospital System (Level I Trauma/Burn) – TSA E, Dallas
Methodist Dallas Medical Center (>18 yp) – TSA E, Dallas



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Medical City Plano (Level I Trauma/Burns) – TSA E, Plano

University Medical Center (Level I Trauma/Burns) – TSA P, San Antonio

University Medical Center (Level I Burns) – TSA B, Lubbock

Major vs Severe (DSHS Health & Safety Code, Rule 157.2)

Major is defined as an ISS score of 9-14

Severe is defined as an ISS score of ≥ 15

E. PreHospital Whole Blood

Participating Agencies

<u>Facility</u>	<u>Address</u>
Baylor Scott & White Medical Center – Temple ED Director: Angie Gentry TMD: Dr. Michelle Strong TPM: Karis Emert TPD: Tracy Pouncy-Cotner QA: Jonathon Fuchs BBQA: Lori Powe	2401 S. 31 st MS-11-A306 Temple 76503 254-724-8202
Killeen Fire/EMS Deputy Chief: James Schambers QA: Mark DiGiacomo MD: Dr. Chris Colvin	201 N. 28 th Killeen 76541
Coryell Health EMS Chief: Daniel Lay QA: Melea Butler MD: Dr. Jeff Bates	222 Memorial Dr Gatesville, TX 76528
Allegiance Mobile Health Regional Supervisor: Tracie Schuh QA: Adam Baer MD: Dr. Bryan Everett	3201 S Austin Ave #335, Georgetown, TX 78626



Clinical Best Practice Recommendations: Prehospital Blood Product Transfusion in

EMS Systems

PURPOSE

This Best Practice Recommendations provides essential instructions for prehospital blood product transfusion in civilian emergency medical service (EMS) systems. This Best Practice supports early resuscitation with blood products for patients experiencing hemorrhagic shock, regardless of etiology, with the objective of reducing mortality and improving clinical outcomes. Implementation of a prehospital blood transfusion program requires careful planning, appropriate training, quality control measures, adherence to regulations, close physician medical oversight, and coordination with regional blood suppliers and receiving facilities. This document is a Best Practice Statement by the CENTEX RAC PHWB Task Force and is in no way a Protocol, Guideline or Structure intended to supersede Medical Director Oversight and authorization to practice.

INTRODUCTION

Early administration of blood products to patients experiencing hemorrhagic shock, irrespective of etiology, has been demonstrated to improve survival. Research indicates that patients who receive blood products within the initial minutes after injury or onset of hemorrhagic shock exhibit significantly decreased mortality compared with those who receive delayed transfusion. Prehospital transfusion programs are, by their nature, resuscitation programs intended for patients with clear evidence of hemorrhagic shock.

The body of evidence surrounding prehospital transfusion continues to evolve. When creating this CPG, the recent literature was reviewed, including, but not limited to, the 2025 Prehospital Trauma Compendium: Transfusion of Blood Products in Trauma—A Position Statement and Resource Document of the National Association of Emergency Medical Services Physicians (NAEMSP) by Brown et al. This CPG represents the current position of the prehospital blood transfusion coalition and is meant to complement existing recommendations, while building on established principles. It is based on current evidence and best practices and is expected to evolve as the body of evidence expands. These guidelines serve to reaffirm the importance of robust clinical planning and implementation while addressing evolving needs in prehospital transfusion programs. As such, this CPG represents a living document intended to outline the indications, procedures, equipment, and monitoring required to safely administer blood products in the prehospital setting.



Effective team communication and coordination constitute the cornerstone of successful resuscitation from hemorrhagic shock. Team members are often tasked with multiple urgent interventions occurring in parallel; therefore, effective communication is essential to ensure positive patient outcomes and to prevent adverse effects. Structured handoffs between prehospital clinicians and hospital resuscitation teams are essential to ensure that relevant information is conveyed without delaying critical interventions. EMS systems seeking to implement prehospital blood transfusion are encouraged to implement standardized team communication and structured handoff procedures to enhance patient care continuity from the prehospital environment to definitive care.

These guidelines should be implemented in concert with local medical oversight and are not intended to supersede local protocols or medical direction. Successful prehospital blood programs must be thoughtfully planned, incorporate multiple safeguards, ensure adequate training and credentialing processes, and involve responsible stewardship of blood resources. Implementation requires clear indications for transfusion, both clinical and programmatic accountability, and appropriate documentation procedures.

Prehospital Principles of Resuscitation and Transfusion

(APPENDIX A&B are Regional Practice Recommendations)

1. 1. Rapid recognition of life-threatening hemorrhagic shock:
 - Clinical assessment remains the cornerstone for recognition, including physiological parameters such as vital signs, shock index, end-tidal carbon dioxide (ETCO₂), and others.
 - Consider point-of-care testing devices if available, such as lactate measurement.
2. 2. Hemorrhage control with appropriate adjuncts:
 - Pressure dressings and wound packing (preferably with hemostatic products) for severe wounds.
 - Tourniquets for significant extremity hemorrhage.
 - Pelvic binders for suspected pelvic fractures.
 - Wound packing or junctional tourniquets for junctional hemorrhage.
3. 3. Vascular access must be promptly obtained:
 - Intravenous access (18 g or greater) is preferred.



- If intravenous access cannot be rapidly established, obtain intraosseous access.
 - Humeral intraosseous access is preferred over tibial access due to significantly higher flow rates.
4. 4. Hemostatic resuscitation:
- WB when available.
 - Low-titer O WB.
 - Plasma.
 - Packed RBCs.
 - Aim for balanced 1:1 ratio of plasma to RBCs when possible.
5. 5. Minimize crystalloid use:
- Limit crystalloid resuscitation to less than 500 mL.
 - Excessive crystalloid worsens coagulopathy and contributes to hemodilution.
6. 6. Prevent hypothermia:
- Use appropriate warming devices for blood products.
 - Maintain patient temperature with passive warming measures.
 - Consider active warming devices when available.
7. 7. Tranexamic Acid (TXA) administration:
- **For patients who will receive blood and are within 3 hours of injury.**
 - **Adult dose options:**
 - 2 g intravenous/intraosseous once.
 - 1 g intravenous/intraosseous over 10 min, followed by 1 g over 8 hours.
 -
 - **Pediatric dose:**
 - 15 mg/kg (maximum 1 gram) intravenous over 10 min.
8. 8. Calcium replacement:



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- Consider calcium intravenous after 2 units of blood products have been administered and after other hemostatic interventions are completed.
- Calcium Gluconate 3 g (less caustic to tissue).
- Calcium chloride 1 g.
- Monitor for signs of hypercalcemia.
- Pediatric dose:
 - 60 mg/kg calcium gluconate. or
 - 20 mg/kg calcium chloride.
- Flush the line with a minimum of 10 mL of saline.
- Monitor closely for signs of intravenous/intraosseous infiltration/extravasation.

Criteria for Transfusion

Clinical indications

Suspected hemorrhagic shock from trauma or medical cause

Adults

- ▶ Systolic blood pressure (SBP) less than 90 mm Hg (or less than 100 mm Hg in patients 65 years and older), or weak or absent radial pulse, and
- ▶ Heart rate (HR) greater than or equal to 100 bpm unresponsive to initial interventions, or
- ▶ Shock Index (HR/SBP) greater than 1.0.

Pediatrics

- ▶ SBP less than 70+ (age in years $\times$ 2).
- ▶ HR:
 - ▶ 1 year: greater than 190.
 - ▶ 2–10 years: greater than 140.

AND (for all patients)

One or more of the following physiological criteria indicative of hypoperfusion



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- ▶ Altered mental status (not believed to be due to intoxication or head injury).
- ▶ Pale, cool, clammy skin; pale mucosa.
- ▶ Delayed capillary refill (>2 s).
- ▶ Tachypnea.
- ▶ $\text{ETCO}_2 < 25$ mm Hg.

Exclusions from Transfusion

- ▶ Conscious patients, with decision-making capacity, should be evaluated for refusal of blood transfusion, whether for religious, cultural, social, or personal reasons.
- ▶ Unconscious or incapacitated patients should be briefly assessed for the presence of medical alert identifiers, power of attorney wallet cards, or other obvious documents indicating patient objection to receiving blood products.
- ▶ This good-faith effort shall not delay transfusion more than 1 min and should ideally occur in approximately 30 s.

Examples of Patient Presentations Consistent with Suspected Hemorrhagic Shock Necessitating Prehospital Blood Transfusion

Trauma patients with uncontrolled hemorrhage

- ▶ Any proximal amputation above knee/elbow or amputations requiring a tourniquet.
- ▶ Penetrating trauma to neck/chest/abdomen/pelvis with signs of shock.
- ▶ Evidence of significant blood loss (>500 mL estimated).
- ▶ Unstable pelvic fracture with hemodynamic instability.

Medical patients with significant hemorrhage

- ▶ Gastrointestinal bleeding.
- ▶ Ruptured ectopic pregnancy.
- ▶ Peripartum hemorrhage.
- ▶ Ruptured aortic (thoracic or abdominal) aneurysm.
- ▶ Ruptured arteriovenous (AV) fistulas/grafts.
- ▶ Postsurgical complications.
- ▶ Epistaxis.
- ▶ Post-tonsillectomy bleeding.



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- ▶ Other causes of significant blood loss.

Prehospital Blood Transfusion Guidelines

Special Populations

Patients with known bleeding disorders who are in hemorrhagic shock

- ▶ Resuscitation priority should be given to the administration of blood products first, followed by appropriate treatment for the specific bleeding disorder.

Pregnant patients

- ▶ Consider early blood administration for suspected obstetric or postpartum hemorrhage with signs of hemorrhagic shock.
- ▶ Place in left-lateral recumbent position (left side down).
- ▶ When O-positive blood is administered to females of childbearing potential, ensure that it is communicated to the receiving attending physician that Rhesus Factor positive (Rh+) blood was transfused.

Special considerations

- ▶ If O-positive blood is administered to Rh-negative females of childbearing potential, inform receiving facility for potential post discharge consultation with hospital transfusion services and maternal-fetal medicine.
- ▶ Additional information and resources can be found at <https://allohopefoundation.org>.
- ▶ There is no role for the administration of RhoGAM in the acute resuscitation of hemorrhagic shock.

Equipment Requirements

1. FDA-approved blood storage container/cooler validated for prehospital use.
2. Temperature monitoring devices with local alarms, as well as remote tracking and audit capabilities consistent with established requirements.
3. Blood administration sets with 170–260 μ m filter.
4. Blood warming devices.
5. Rapid infusion devices.
6. Large-bore intravenous/intraosseous access equipment.
7. Vital signs monitoring equipment.



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Procedure

Preparation and storage

1. Maintain blood products in approved storage containers between 1°C and 6°C or as outlined in the agency Blood Services Agreement.
2. Monitor and document temperature continuously.
3. Inspect blood products for:
 - Expiration date.
 - Integrity of the bag.
 - Evidence of hemolysis, clotting, or contamination.
 - Temperature indicator compliance.

Adult dosing guidance

- ▶ Initial dose: One unit of any blood product.
- ▶ Reassess vital signs and clinical response every 3 min and after each unit.
- ▶ Administer additional units as indicated.
- ▶ Target SBP 90–100 mm Hg for hemorrhagic shock from trauma or obstetric/medical conditions.
- ▶ Target higher SBP (>110 mm Hg) for patients with traumatic brain injury (TBI) or

suspected neurological injury.

Pediatric dosing guidance

- ▶ Initial dose:
 - <35 kg: 10 mL/kg of unit of any blood product.
 - >35 kg: One unit of any blood product.
- ▶ Reassess vital signs and clinical response after each unit.
- ▶ Additional units based on clinical response and transport time.
- ▶ Target age-appropriate SBP for hemorrhagic shock from trauma or obstetric/medical conditions.
- ▶ Target higher SBP (>110 mm Hg) for patients with TBI or suspected neurological injury.



Transfusion Process

1. Obtain preferably two points of intravenous/intraosseous access (18 gauge or larger preferred).
2. Quickly assess for any indicators that the patient would not want to receive blood products.
3. Verify and document blood product identification:
 - Product type
 - Unit/donor number
 - Expiration date
 - Blood type
 - Temperature indicator status (if present)
4. Connect administration set with appropriate filter to blood product.
5. Prime straight-type blood tubing with blood (no saline).
6. Prime Y-type blood tubing with saline.
7. Connect to warming device and/or rapid infusion device.
8. Connect the blood tubing directly to the intravenous/intraosseous hub.
9. Infuse over 3–5 min as clinically indicated.
10. Monitor vital signs every 5 min during transfusion:
 - BP
 - HR
 - Respiratory rate
 - Oxygen saturation
 - ETCO₂
 - Temperature when possible



Prehospital Blood Transfusion Guidelines: Transfusion Reactions, Documentation, and Quality Control

Transfusion Reactions:

Signs and Symptoms Hypotension or hypertension. Flushed face, urticaria, or rash.

Wheezing or respiratory distress. Fever or chills.

Flank pain.

Chest pain or back pain. Nausea/vomiting.

Management

Stop transfusion immediately.

Maintain intravenous access to keep the line open. Administer oxygen as needed.

For anaphylaxis:

- Epinephrine 0.3–0.5 mg of 1:1000 intramuscular.
- Diphenhydramine 25–50 mg intravenous/intraosseous/intramuscular.
- Consider methylprednisolone 125 mg or dexamethasone 4-8g intravenous for severe reactions.

Notify receiving facility of suspected transfusion reaction. Transport all blood product bags/documentation to hospital.

Documentation Requirements

Blood products are documented as a medication. Every transfusion should have two procedures listed:

- Route (intravenous/intraosseous).
- Transfusion of blood products. Blood product information:
 - Type of blood product.
 - Unit/donor number.
 - Expiration date.
 - Time of removal from storage.
- Temperature status during storage and transport. Transfusion details:
 - Time transfusion started and completed.



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Regional Advisory Council

- Total volume transfused.
- Route of administration.
- Post-transfusion physician authorization statement with signature. Patient assessment:
- Verification of consent (verbal or implied).
- Vital signs pretransfusion, during (every 3 min), and post-transfusion.
- Clinical presentation and indication for transfusion.
- Patient response to transfusion. Additional interventions:
- Hemorrhage control.
- Calcium administration.
- TXA administration.
- Other medications or interventions. Adverse events:
- Description of any reaction.
- Interventions performed.
- Patient response.

Handoff information:

- Notification to receiving facility.
- Blood product bag(s) with segments attached.
- Transfusion-related paperwork.
- Disposition of unused blood products.

Quality Control Measures

Storage and transport:

- Continuous temperature monitoring with documentation.
- Regular inspection of storage containers.
- Proper handling procedures. Equipment maintenance:



- Regular checks of administration equipment.
- Calibration of warming devices, if needed. Personnel:
- Initial and ongoing training.
- Skills verification for all providers.
- Competency-based assessment annually. Program management:
- Case review of all prehospital transfusions (consider as sentinel event).
- Tracking of clinical outcomes.
- Regular reporting to medical director.
- Blood product utilization analysis.

Training Requirements and Program Implementation Considerations

Training Requirements

Initial training:

- Pathophysiology of hemorrhagic shock.
- Blood product overview and indications.
- Recognition of hemorrhagic shock.
- Transfusion procedures and equipment.
- Recognition and management of transfusion reactions.
- Storage and transport requirements.
- Documentation requirements.
- Practical skills demonstration.
- Processes for non-conformance, recall, quarantine, and discard of blood products. Continuing education:
- Annual refresher training.
- Annual skills verification and simulation.
- Case reviews and lessons learned.



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- Updates to protocols or equipment. Competency validation:
- Written examination.
- Practical skills assessment.
- Simulation scenarios.
- Clinical oversight during initial cases.

Program Implementation Considerations

Training and education:

- Initial didactic training.
- Hands-on skills practice and sign-off.
- Simulation and case-based training.
- Ongoing demonstration of procedural competency and skills currency. Medical oversight:
- Transfusion Administration Service Medical Director shall have authority and responsibility for all medical and technical policies, processes, and procedures that relate to the care and safety of the transfusion recipient.
- Regular protocol review and updates.
- Credentialing of all personnel who are authorized to administer prehospital blood.
- 100% total quality review on every prehospital transfusion case.
- Reports, reviews, audits, and follow-up of transfusion-related reactions, including Food and Drug Administration Fatality Reporting events.

Blood product management:

- Coordination with blood suppliers.
- Storage and transport requirements.
- Rotation protocols to minimize wastage.
- Documentation requirements.
- Return policies for unused products. Hospital coordination:
- Communication protocols with receiving facilities including the hospital blood bank.



CENTEX Regional Advisory Council

- Handoff procedures for transfused patients.
- Handoff procedures for blood products.
- Tracking of patient outcomes. Infrastructure requirements:
- Proper storage facilities.
- Temperature monitoring systems.
- Administration equipment. Community engagement:
- Outreach to local EMS agencies regarding operational questions, the handling of mutual aid requests, and deployment strategies.
- Public messaging and communication with general and healthcare community members including resources and frequently asked questions.
- Support from policy-makers to help facilitate program implementation. Administrative considerations:
- Costs and billing procedures.
- Legal and regulatory compliance.
- Document control, reviewed minimum of every 2 years.
- Data collection for quality improvement.
- Outcomes reporting, registry participation. Legal and regulatory compliance.:
- Document control reviewed minimum of every 2 years.
- Data collection for quality improvement.
- Outcomes reporting, registry participation.



CENTEX

Regional Advisory Council

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Appendix C



CENTEXRAC REGIONAL WHOLE BLOOD* PROGRAM MEMORANDUM OF UNDERSTANDING

**Whole Blood refers to Low Titer O-Positive Whole Blood*

PURPOSE

The purpose of this Memorandum of Understanding (MOU) is to establish a framework for collaboration among program stakeholders in the development, operation, and sustainment of the Regional Whole Blood Program. This agreement defines the roles, responsibilities, and expectations of each participating organization to ensure the appropriate collection, distribution, and utilization of Low Titer O+ Whole Blood in compliance with regulatory guidelines. While not legally binding, this MOU serves to guide cooperative efforts enhancing patient care outcomes across the region.

BACKGROUND

The CENTEXRAC Whole Blood Program is established as a multi-disciplinary, multi-institutional initiative involving regional helicopter and ground EMS agencies, regional trauma center, Baylor Scott and White Temple, Blood Center, and CENTEXRAC. It was created by likeminded professionals dedicated to developing a program that ensures appropriate, timely, and early resuscitation using Low Titer O+ Whole Blood in pre-hospital and rural hospital settings. The program's objectives include managing the regional supply of donors to meet demand without excess waste, maintaining strict compliance with regulatory guidelines, and sustaining an evidence-based system of care to optimize patient outcomes.

DEFINITIONS

Circular of information for the Use of Human Blood and Blood Components: In accordance with FDA requirements under 21 CFR 606.122, this circular must be available for review by transfusion Services, prescribing physicians, and staff anywhere blood is issued or transfused. <https://www.aabb.org/news-resources/resources/circular-of-information>

Rotation site: EMS agency or hospital with return privileges to Baylor Scott and White Temple, Blood Center (ensuring the LTOWB is rotated through to a higher usage rotational center).

Rotation center: Medical Facility receiving LTOWB already cycled through the prehospital or rural hospital setting. This process is intended to be free of bias, agnostic to any entity and in the best interest of those involved.

Transfusion Administration Service (TAS): A service provider responsible for receiving and transmitting orders of blood for transfusion, transporting blood to the transfusion site, performing the transfusion, monitoring the patient during transfusion, reporting outcomes, and ensuring the traceability of the unit is maintained.

Transfusion Site: The patient care area where a transfusion is performed.

ROLES AND RESPONSIBILITIES

All Participating Agencies and Facilities Agree to the Following:

1. Program Resources & Training
 - Program updates and training information are available through CENTEXRAC.
2. Regional Process Improvement
 - This is a regional process improvement program. All data and shared information will be used solely to enhance the delivery of care in the Central Texas region.
3. Governance and Participation
 - The CENTEXRAC Regional Whole Blood Task Force will serve as the guiding body for the regional Low Titer O+ Whole Blood (LTOWB) program.
 - Membership includes all EMS agencies (air and ground), healthcare facilities (or systems), and organizations contributing to the supply, administration, accounting, and patient care aspects of LTOWB.
 - The committee meets monthly, and each member agency/organization is required to attend at least nine (9) meetings annually. All agencies will be given attendance credit for cancelled meetings. Compliance will be evaluated annually in accordance with the CENTEXRAC Fiscal Year, Sep-Aug.
 - Key program execution and operational decisions will be made by consensus among all participating members.
 - Any agencies not meeting a program requirement, to include Committee Meeting attendance, the CENTEXRAC WB Program Manager will schedule a meeting to discuss a 6-month performance improvement plan. If no improvements are made a re-evaluation of deficiencies will be conducted and dismissal from Regional Whole Blood Program may be recommended. Dismissal recommendations will be referred to and decided by the WB Task Force Chair, CENTEXRAC Executive Director, and the CENTEXRAC WB Program Manager. dismissal from the program will be for 12 months and consideration for re-entry into the program will require a performance improvement process verification.
4. Clinical and Administrative Support

- Baylor Scott and White Blood Center will provide administrative training on ordering, managing, and storing LTOWB at participating sites.
- Each agency and facility will designate a primary point of contact to address concerns

and actively participate in discussions and decision-making.

5. Blood Supply Standardization

- To maintain regional consistency, Baylor Scott and White Temple, Blood Center will serve as the single supplier of rotational LTOWB.

6. Performance Improvement and Data Sharing

- Agencies and facilities will provide clinical and administrative performance improvement

data as requested by CENTEXRAC.

7. Documentation Requirements

- Prehospital LTOWB transfusions must be documented using the CENTEXRAC Regional

Prehospital Blood Product Transfusion Record (Appendix B).

- This record is not a replacement for an agency's electronic patient care record (EPCR) but serves as a real-time communication tool between EMS providers, receiving emergency departments, and hospital blood banks/transfusion services.
- Hospital blood banks/transfusion services must receive immediate notification when

untyped and uncross-matched blood has been administered.

- The Transfusion Administration Service (TAS) shall be responsible for recording the final disposition of blood or blood components, ensuring proper tracking and compliance with AABB standards.

PROCEDURES

A. Receiving Blood

1. Agencies and facilities will follow CENTEXRAC and Baylor Scott and White Temple, Blood Center

policies and procedures for blood product ordering and delivery.

2. Blood and blood components shall be inspected each time they are received to verify the following:

- The unit has remained in a validated transport container or storage device within the specified period.
- The unit appearance meets visual inspection criteria.
- The unit has an attached label or tag indicating the donation identification number, and compatibility testing has not been performed.

3. Receipt of a unit of blood shall be annotated using the CENTEXRAC Whole Blood app (BloodCOMM Premium). Agency representative will log into the app, select “Initial Receipt” and scan all appropriate bar codes assigning the unit to their agency.

B. Storing and Transporting Blood

1. Temperature Monitoring & Recording

- Low Titer O+ Whole Blood will be stored in an approved program cooler between the temperatures of 1-6°C. The blood supplier, Baylor Scott and White Temple, Blood Center acceptance criteria regarding product suitability for return to available inventory for re-issue is based on the visual temperature indicator (Safe-T-Vue 10). A white indicator means the blood has been kept below 10°C for the duration of issuance. If the indicator turns red, the blood temperature reached or exceeded 10°C. (Appendix A)
- In those instances where the cooler temperature has deviated from the 1-6°C range, corrective action and blood temperature verification using an infrared thermometer must be performed.
- The TAS shall ensure all containers are validated for the handling, storage, and transport

of blood and blood components.

- Blood containment temperatures shall be continuously monitored in accordance with

procedures established by the program administrators and the Whole Blood Task Force.

- Temperature recordings must be documented at least every four (4) hours.
- If a temperature deviation occurs rendering the product unusable (any color change), it must be reported immediately to agency leadership, Baylor Scott and White Blood Center, and CENTEXRAC WB Program Manager.

2. An inventory check, utilizing the CENTEXRAC Whole Blood app will be conducted daily. During the handling of the unit for scanning in the app, the unit should be inspected for any clots, bag leaks, frothing, or any other suspicious defects.

C. Equipment

1. General Equipment Use

- All equipment used in the handling, storage, transport, and administration of blood shall be operated in strict accordance with the manufacturer’s written instructions and shall be limited to devices explicitly specified on the approved products list referenced in Appendix X “Approved Products List”.
- Blood and blood components shall be transfused through a sterile, pyrogen-free transfusion set that has a filter designed to retain particles potentially harmful to the recipient.
- Except for 0.9% sodium chloride, drugs or medications shall not be added to blood or blood components unless: they have been approved for the use by the FDA or component Authority or there is documentation available to show that the addition is safe and does not adversely affect the blood or blood component.

2. Coolers

- Storage and transport devices must be designed to maintain proper temperatures.
- Blood and blood components shall remain within the acceptable temperature range during storage and transport.
- Calibration will be performed by the manufacturer as required by our Blood Center partner to ensure continued compliance with FDA regulations.

3. Warming Devices

- Warming devices shall be equipped with a temperature-sensing device and a warning system to detect malfunctions and prevent hemolysis or other damage to blood components.

D. Administration

1. Verification Prior to Administration

- Immediately before transfusion, the following information shall be verified:
 - The intended unit for transfusion meets TAS protocol and has not expired.
 - Unit ABO group.
 - Unit appearance meets visual inspection criteria.
 - The unit has remained in compliance with temperature requirements during

Storage/Transport.

2. The patient shall be monitored for potential transfusion-related adverse events by the TAS until the time of transfer of care.

3. Documentation & Compliance

- All EMS agencies will use the CENTEXRAC Whole Blood form to notify the receiving hospital and/or other prehospital care providers of the patient's transfusion status, the unique patient identifier, and any transfusion-related adverse reactions through the continuum of care.
- The statement on the CENTEXRAC Whole Blood form indicating that the "clinical situation was sufficiently urgent to require emergency release of un-crossmatched blood before completion of compatibility testing" shall be signed, either physically, or electronically, by the ordering physician. This signature can occur before or after the release/transfusion of the blood.
- The CENTEXRAC Whole Blood Application ("Whole Blood App") shall be utilized for inventory management, and transfusion documentation.

E. Reporting and Process Improvement

1. All organizations shall capture, assess, investigate, and monitor failures to meet specified requirements both local and programmatic, and any adverse events or non-compliance issues related to blood administration.

2. All organizations shall collect data, perform analysis, and follow up on issues requiring corrective/preventive action, including near-miss events.
3. The TAS shall have a process for providing relevant unit and/or patient information as requested when notified by the blood collection facility and/or transfusion service.
4. The TAS shall have a process for the monitoring of blood utilization and wastage.
5. CENTEXRAC will maintain program records using data from prehospital providers, Baylor Scott

and White Blood Center, and receiving facilities.

6. If a fatality is suspected or confirmed to have occurred as a result of a transfusion, this is to be considered a Sentinel Event and shall notify organizational leaders and CENTEXRAC Whole Blood Program Manager immediately. The Program Manager will notify Baylor Scott and White Blood Center, CENTEXRAC Leaders, and any appropriate stakeholder to initiate investigation and FDA notification if required.

TERM

This MOU is a living document and will be evaluated every 2 years. The signatories are attesting to the commitment of their organization to follow and enforce the practices, roles, and responsibilities for their organizations as delineated in this MOU.

*This memorandum of understanding is in effect on the date on which it is signed and remains in effect until written notification is received revoking the Memorandum of Understanding with the CENTEXRAC. All parties reserve the right to terminate this MOU at any time, with or without cause. Thirty (30) day written notification is required for termination of the MOU.

ORGANIZATION: .

(Indicate Hospital or Agency Name here)

PRIMARY POC:

(This is a role, not a person. Example ED shift supervisor)

PRIMARY POC CONTACT INFORMATION (EMAIL/PHONE):

(Business URL only, NO gmail/yahoo, etc., personal accounts)

POC FOR PROVIDING FEEDBACK (OUTCOMES DATA FOR TRAUMA AND MEDICAL):

(This is a role, not a person. Example ED shift supervisor)

POC FOR PROVIDING FEEDBACK CONTACT INFORMATION (EMAIL/PHONE):

(Business URL only, NO gmail/yahoo, etc., personal accounts)



Pre-Hospital Whole Blood Transfusion: Maternal Best Practice Recommendations

Purpose: To provide guidance on the use of Low Titer Group O Whole Blood in the resuscitation of reproductive-aged female trauma patients, including pregnant patients, prior to admission to a treating facility.

Definitions and Abbreviations:

- Reproductive age female: 0-50 years
- Low Titer O Whole Blood: LTO+WB
- Rhesus Factor: Rh
- Rh immunoglobulin: RhIG

Practice Guideline:

- For reproductive-aged females with clinical parameters indicative of hemorrhage shock from trauma or medical causes (e.g., ruptured ectopic pregnancy, pregnancy-related hemorrhage) who are unresponsive to initial resuscitative measures, administration of LTOWB prior to hospital arrival is recommended.
- Use of LTOWB is recommended for use in reproductive-aged females regardless of pregnancy status as the benefit of maternal life-saving measures outweighs theoretical risks to the pregnancy or future childbearing.

Special Considerations:

- Pregnant individuals should maintain the same guidelines for initial evaluation and management as they would for a nonpregnant patient.
- In a pregnant patient beyond 20 weeks gestation (fundus at level of umbilicus), ensure displacement of uterus by placing maternal patient in left-lateral recumbent position.
- Use of LTOWB may result in Rh mismatch where an Rh negative reproductive-aged female receives LTOWB.
- Consultation of a Women's Health Provider is required for pregnant individuals who have an Rh mismatch later identified following resuscitation from trauma.
- All Rh-negative women should be counselled about risks to their pregnancies and followed by Women's Health Providers in cases of Rh alloimmunization.



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Documentation requirements:

- When administering LTOWB to reproductive-aged females, teams are required to communicate this to receiving facility.
- When Rh mismatch of Rh negative reproductive-aged female is identified, a notification of Transfusion Medicine Specialist/Pathologist or Women's Health Provider is required. Follow-up antibody testing at 4-14 weeks is required. Additional management strategies that may be considered are provided in Best Practices.

Best Practices for Reproductive-Aged Females:

1. Example letter for reproductive-aged female patient following Rh mismatch during trauma resuscitation:

[Date]

[Patient Name] [Patient Address]

Subject: Important Information Regarding Rh-Positive Blood Transfusion and Pregnancy Dear [Patient Name],

This letter is to provide you with important information regarding your recent trauma and the Rh-positive blood transfusion you received. In order to treat your life-threatening hemorrhage as quickly as possible, you received whole blood during your medical care. This means that we gave you a blood type that is safe for all patients because we could not safely wait to determine your blood type or could not safely wait for blood that matched your type.

Your blood type was ultimately determined to be Rh-negative [insert exact blood type here], while the blood you received was Rh-positive. Understanding this difference is crucial, especially if you plan to become pregnant in the future.

When a Rh-negative woman is exposed to Rh-positive blood, such as during a transfusion or delivery of a child, she can develop antibodies against the Rh-positive blood. If she later becomes pregnant and the fetus is Rh-positive, these antibodies can cross the placenta and harm the developing fetus. This condition, called erythroblastosis fetalis, can lead to serious health problems for the baby.

The first step to understand your risk is to check an antibody screen at least 4-14 weeks after the transfusion you received in the hospital. If this test is abnormal you will be referred to the Maternal Fetal Medicine clinic for counseling to understand your risks in future pregnancies.

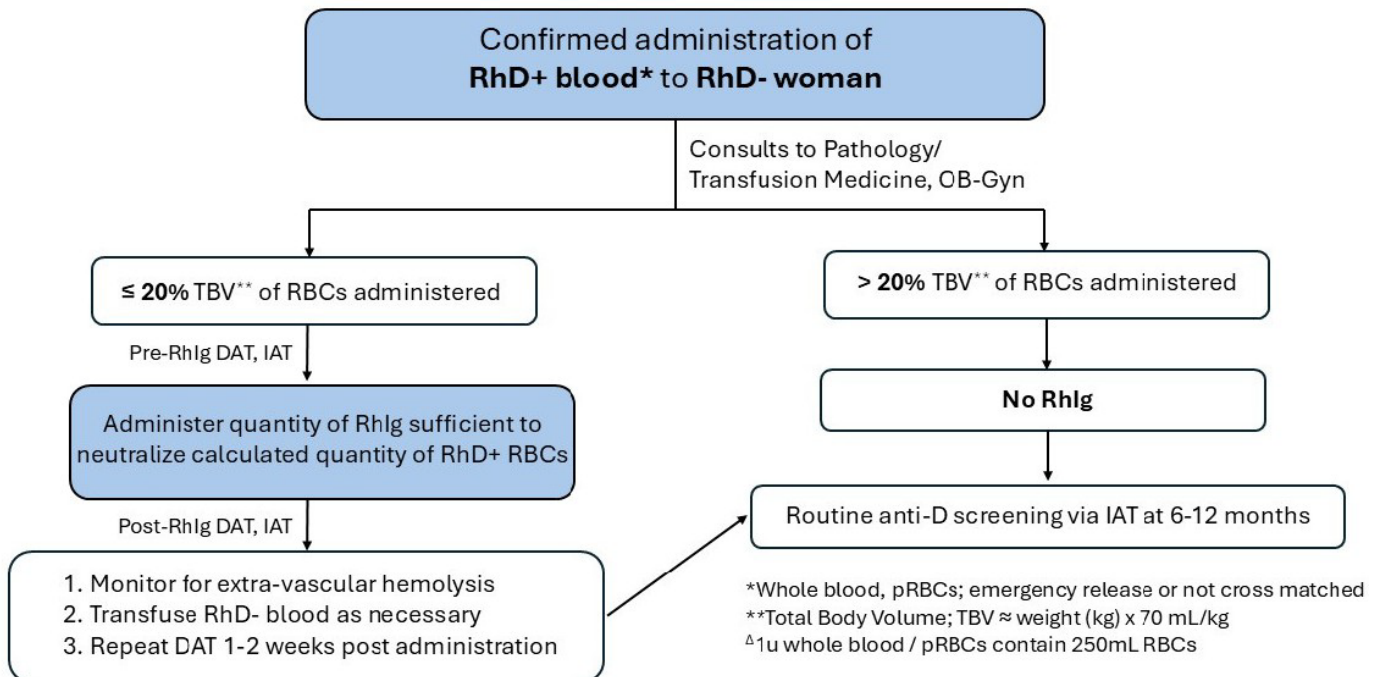
Important Steps to Take: Complete antibody testing at least 4-14 weeks after exposure, either at [treating facility] or with your usual health care provider



CENTEX

Regional Advisory Council

2. Example treatment algorithm for Rh mismatch in reproductive-aged female for use of RhIG. Specific treatment recommendations can be found in references.



Note: some organizations may use differing threshold of total blood volume transfused in Rh mismatch, including observation only.



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F. Non-Traumatic Injuries

Pre-Hospital Recognition of

CHILD MALTREATMENT

in the Central Texas RAC Region.

Document *all*
history and
injuries
thoroughly.

Consider transporting to
McLane Children's or
another pediatric trauma
center.

CPS referral if any indicators
below are identified.
Communicate with receiving
facility staff.

Consider child and
provider safety
during assessment
and treatment.

CDC definition of child abuse and neglect: any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential harm, or threat of harm to a



Development Milestones

2 months – improving head control.
4 months – starting to roll.
6 months – sitting with(out) help
9 months – crawling, standing
12 months and beyond – Walking, running, & climbing

History Red Flags:

- Changing/inconsistent story
- Injury mechanism inconsistent with the developmental age of the child
- Caregiver appears under the influence of ETOH or drugs or appears to be incapable of adequately caring for the child
- No history of injury/unwitnessed in younger child

Physical Exam & Evaluation Red Flags:

- Submersion or Suspected Asphyxiation event
- Untreated obvious fracture(s)
- Extensive or patterned bruising
- Any burn on a child < 3 years old
- Unexplained burns to a child < 3 years old
- Child present or injuries sustained during family violence
- Any other reason or suspicion for maltreatment



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Recognizing

CHILD MALTREATMENT

in the Central Texas Region



CDC definition of child abuse and neglect: any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child

Development
Milestones

2 months – improving head control

4 months – starting to roll

6 months – sitting with[out] help

9 months – crawling, standing

12 months and beyond –
walking, running, climbing



Red Flags History

- No history of injury
- Changing/inconsistent history
- Unwitnessed injury
- Delay in seeking care
- Age of injury not consistent with history provided
- Injury mechanism inconsistent with the developmental age of the child
- Caregiver appears intoxicated or under the influence of drugs/ ETOH or positive screen for drugs at the time the child was injured



Red Flags Physical Exam & Eval

- Unexplained death < 18 years of age
- Unexplained injury to a child of any age
- Fatal or near fatal submersion or asphyxiation event
- Fracture with an inconsistent mechanism
- Fracture in a non-ambulatory infant
- Any bruising in a non-mobile infant or child that is patterned, extensive, or located on the ears, neck, or torso
- Frenulum tear in a non-ambulatory child
- Any burn in a child ≤ 3 years of age or unexplained burn at any age
- Unexplained skull fracture or intracranial injury
- Traumatic retinal hemorrhages
- STD in a pre-pubertal child
- Unexplained solid organ or internal injury
- Child ≤ 12 years of age with a positive drug/ETOH screen
- Multiple injuries at different stages of healing
- Metaphyseal fractures (corner)
- Rib or sternal fractures
- Scapular, spinous process, or vertebral body fractures
- Multiple fractures or undiagnosed healing fractures
- Intracranial hemorrhages in a young child
- Injury that occurred during an incident of family violence
- Concern for medical child abuse or caregiver fabricated illness

Thoroughly document
all history
and
injuries!



Consult **social work** & consider transfer to BSW
McLane Children's Medical Center for further evaluation including skeletal survey and lab work

CPS referral
if indicated
(inform the parents)



Be direct & objective with family; **focus on the child's safety**



Ask for assistance if needed and **report child abuse: 1-800-252-5400**



Infographic by Betsy Habert, MD



~Other resources: www.txabusehotline.org and the Child Protector App~
For questions & transfers, please call McLane Children's admissions at 254-935-KIDS (5437).



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EMERGENCY HEALTHCARE SYSTEM PLAN
APPENDIX VI



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Appendix VI: Letter of attestation



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2180 Main Street, Suite H-5 • Belton, Texas 76513 (254) 500-4611

January 12, 2026

Jennifer McAdams, DNP, RNC-OB, C-EFM
Maternal Program Manager
Labor & Delivery
254-724-9602
Baylor Scott & White Health - Temple
Jennifer.McAdams@BSWHHealth.org

Dear Ms. McAdams,

Per your request, I am writing to confirm the active participation of Baylor Scott & White Medical Center – Temple with the CENTEX Regional Advisory Council (RAC) – TSA L. As a dedicated member, Baylor Scott & White Medical Center – Temple has consistently demonstrated its commitment to advancing the regional Perinatal and Maternal care system by engaging in collaborative efforts focused on Perinatal and Maternal patient planning and system development within the region.

Baylor Scott & White Medical Center – Temple has taken a proactive role in attending the necessary meetings, contributing to the ongoing discussions, and ensuring their involvement. These efforts are essential to ensuring the continual enhancement of Perinatal and Maternal care protocols, improving patient outcomes, and fostering a network of excellence across the region.

Should you require any additional information or have further questions, please do not hesitate to reach out. We look forward to continuing our partnership and advancing our collective goals for Stroke care in the region.

Respectfully,

Tracy Arther
Executive Director
CENTEX RAC

Participating Counties: Bell, Coryell, Hamilton, Lampasas, Milam, and Mills



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Multi-Patient Event Response Triage Priorities:

Red Category – First Priority, most urgent

Airway and breathing difficulties
Uncontrolled or suspected severe bleeding
Shock
Open chest or abdominal wounds
Severe head injuries

Yellow Category – Second Priority, Urgent

Burns
Major or multiple fractures
Back injuries with or without spinal damages

Green Category – Third Priority, Non-urgent

Transportation and treatment are required for minor injuries (but not necessarily by EMS personnel), minor fractures, or other injuries of a minor nature.

Black Category – Impending death or deceased, Non-urgent



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Pulsara



RAC Mass Casualty Patient Tracking & Follow-up

Facility	Patient First Name	Patient Last Name	Sex	DOB	Mode of Arrival	Triage Level (on scene)	Triage Level (at facility)	dx	status of patient	Discharged	admitted to floor
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Directions: Each facility reports the list of patients and the status. The RAC will obtain follow up daily until patient is discharged or expires. The RAC will share patient information as provided by regional, state, and/or federal processes, protocols, and procedures.



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*Report can be downloaded from Pulsara in place of this document.



CENTEX RAC 2026 EHSP

Emergency Healthcare System Plan

Appendix VII

Appendix VII: Pre-Hospital and FRO Providers



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<u>County</u>	<u>EMS Provider</u>	<u>Contact</u>	<u>Level</u>	<u>RAC Member</u>
Bell	Belton EMS (AMR) MD: Dr. Margaret McGraw	505 N. 3 rd Temple 76501	BLS w/MICU	Yes
	Harker Heights Fire/EMS MD: Dr. Zachary Brady	401 Indian Trail Harker Heights 76548	MICU	Yes
	Baylor Scott & White EMS MD: Dr. Margaret McGraw	2401 S. 31 st Temple 76503	BLS w/ MICU	Yes
	Temple EMS (AMR) MD: Dr. Margaret McGraw	505 N. 3 rd Temple 76501	BLS w/ MICU	Yes
	Killeen Fire/EMS MD: Dr. Chris Colvin	201 N. 28 th Killeen 76541	MICU	Yes
	Ft. Hood EMS MD: Dr. Cord Cunningham	36065 Santa Fe Avenue Ft Hood 76544	BLS w / MICU	Yes
	Acadian Ambulance MD: Dr. Emily Kidd	4100 Ed Bluestein Blvd #100 Austin 78721	BLS w/ MICU	Yes
	Allegiance Mobile Health MD: Dr. Bryan Everitt	3201 S Austin Ave #335, Georgetown, TX 78626	BLS w/ MICU	Yes
	City Ambulance MD: Dr. Niam Rosines	7111 Five Forks Dr, Spring TX, 77379	BLS w/MICU	Yes
	Superior Healthcare EMS MD: Dr. Rachel Littlefield	4655 Walzem Rd, San Antonio, TX 78218.	BLS w/MICU	No
Coryell	Coryell Health EMS MD: Dr. Jeff Bates	1507 W. Main Gatesville 76528	BLS w/ MICU	Yes
	Copperas Cove Fire/EMS MD: Dr. Zachary Brady	415 S. Main St Copperas Cove 76522	BLS w/ MICU	Yes
Hamilton	Hamilton EMS MD: Dr. Tim Rudolph	400 N. Brown Hamilton 76531	BLS w/ MICU	Yes
Lampasas	Hamilton EMS MD: Dr. Tim Rudolph	400 N. Brown Hamilton 76531	BLS w/ MICU	Yes
Milam	Allegiance Mobile Health MD: Dr. Bryan Everitt	3201 S Austin Ave #335, Georgetown, TX 78626	BLS w/ MICU	Yes
Mills	Hamilton EMS MD: Dr. Tim Rudolph	400 N. Brown Hamilton 76531	BLS w/ MICU	Yes



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AirLift 1	Waco	7909 Karl May Drive, Waco, TX 76705 Base Phone: 254-727-0747 MD: Dr. Rama Heyratifar Assoc MD: Dr. Taylor Ratcliff	844-424-7543		
PHI Air Medical Med 15	Temple	7720 Airport Rd. Temple, TX 76508 MD: Dr. Jay Kovar	877-435-9744		
Air Evac LifeTeam AEL66	Killeen	1210 Bell Tower Dr. Killeen, TX 76540 Base Phone: 254-628-1275 MD: Dr. Darioush Kavospour	877-633-3544		
Apollo Med Flight	Amarillo	5601 I-40 Suite 300, Amarillo, TX 79106	866-443-5566		
CareFlite	Hill/Burnet Counties	CareFlite 6 Whitney (Hill County) 4517 FM 933 Whitney, TX 76692 CareFlite 7 Burnet (Burnet County) 2002 S. Water St. Burnet, TX 78611	1-800-442-6260		
CSI Aviation	Killeen	6006 Reese Creek Rd, Killeen, TX 76549	833-435-9274		
County	First Responder Organization		Address	Phone	RAC Member
	Bartlett VFD MD: Dr. Taylor Ratcliff		PO Drawer H Bartlett, TX 76511	254-527-3219	no
	Central Bell County Fire/Rescue MD: Dr. Taylor Ratcliff		3000 FM 1670 Belton, TX 76513	254-466-3211	no
	Fort Hood Fire Department MD: Cord Cunningham		Bldg. 23025 Fort Hood, TX 76544	254-553-0640	no



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Bell	Holland VFD MD: Dr. Taylor Ratcliff	PO Box 326 Holland 76534	254-857-2365	no
	Little River Academy VFD MD: Dr. Taylor Ratcliff	PO Box 351 Little River 76554	254-982-4251	no
	Moffat VFD MD: Dr. Taylor Ratcliff	5660 Lakeair Blvd Temple 76502	254-986-8388	no
	Morgan's Point First Responders MD: Dr. Taylor Ratcliff	8 Morgan's Point Blvd Belton 76513	254-780-2022	yes
	Nolanville VFD MD: Dr. Taylor Ratcliff	84 N Main St, Nolanville, TX 76559	254-698-6335	no
	Rogers VFD MD: Dr. Margaret McGraw	PO Box 309 Rogers 76569	817-642-3312	no
	Salado VFD MD: Dr. Margaret McGraw	PO Box 503 Salado 76571	254-947-8961	yes
	Southwest Bell County VFD MD: Dr. Chris Colvin	PO Box 10792 Killeen 76547	254-526-4500	no
	Sparta VFD MD: Dr. Taylor Ratcliff	7041 Sparta Rd Belton 76513	254-721-6085	no
	Temple Fire and Rescue MD: Dr. Margaret McGraw	210 N. 3 rd Temple 76501	254-298-5682	no
	Troy VFD MD: Dr. Taylor Ratcliff	PO Box 1 Troy 76579	254-938-2188	no
	Gatesville VFD MD: Dr. Jeff Bates	109 S 23rd St, Gatesville, TX 76528	254-865-6416	no
	Turnersville VFD MD: Dr. Jeff Bates	8200 Farm to Market Rd 182, Gatesville, TX	254-494-1111	no
	Levita VFD MD: Dr. Jeff Bates	4310 Co Rd 107, Gatesville, TX 76528	254-553-0640	yes



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Coryell	Oglesby VFD MD: Dr. Jeff Bates	500 S. Columbia Ave Oglesby, TX 76561	815-883-3151	no
	Flat VFD MD: Dr. Jeff Bates	130 E FM 931 Gatesville, 76528	254-421-1075	no
	Jonesboro VFD MD: Dr. Jeff Bates	105 c.r. 193 Jonesboro, 76538	254-499-0081	no
Lampasas	Lampasas VFD MD: Dr. Timothy Rudolph	1107 East 4th St Lampasas, 76550	737-299-1231	yes
	Lampasas City FD MD: Dr. Timothy Rudolph	1107 E. 4th Street Lampasas, 76550	512-556-3446	yes



Appendix VI: Facility Capabilities

	Advent Health Central Texas	Advent Health Rollins Brook	Baylor Scott & White - Temple	Carl R Darnall Army Medical Center (CRDAMC)	Coryell Health System	Hamilton General Hospital	McLane Childrens	Seton Medical Center Harker Heights
Trauma Designation	IV	IV	I	III	IV	IV	II	IV
CT Capability	Yes (2)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Weight limit	450&650	650	550	450	550	350	450	450
MRI Capability	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Weight limit	550	No	550	450	550	450	500	450
Operating Rooms	8	2	Yes	8	4	1	5	5
Hyperbaric Chamber(s)	Yes (5)	Yes (1)	No	No	Yes (1)	No	No	Yes (2)
Anti-venom	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Stroke Designation	Primary	ND	CSC	ND	ND	ND	ND	Primary
Cardiac Accreditation	PCI	ND	PCI	ND	ND	ND	ND	PCI
Nursery Designation	II	ND	IV	III	ND	ND	IV	II
Maternal Designation	II	ND	IV	ND	ND	ND	IV	ND
Licensed Beds	230	25	634	157	25	25	112	63
Critical Access Recognized		YES			YES	YES		



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Appendix VII: Facility Point of Contacts

<u>Facility</u>	<u>Address</u>
Baylor Scott & White Medical Center – Temple ED Director: Angie Gentry TMD: Dr. Michelle Strong TPM: Dawn McKeown SMD: Dr. Lauren Fornier SPM: Penelope McCabe CMD: Dr. Jay Widmer CPM: Jennifer Allard MMD: Dr. Jessica Ehrig MPM: Jennifer McAdams	2401 S. 31 st MS-11-A306 Temple 76503 254-724-8202
McLane Children's Medical Center - BSW TMD: Dr. Hayden Stagg TPM: Sarah Wheat NMD: Dr. Vinayak Govande NPM: Michelle Hempel	1901 SW HK Dodgen Loop MS- CH-1205 Temple 76502 254-771-8600
Carl R Darnall Army Medical Center TMD: Dr. Joseph Ganshert TPM: Megan Garcia	36065 Santa Fe Avenue Ft Hood 76544 254-553-3979
AdventHealth Central Texas TMD: Dr. Christopher Colvin TPM: Shea Turner SMD: Dr. Christopher Long SPM: Enid Cook CMD: Dr. Jonathan Mock CPM: James Lampley MMD: Dr. April Schiemenz MPM: Nicole Allsopp NMD: Dr. Greg Miller NPM: Nicole Allsopp	2201 S. Clear Creek Rd Killeen 76549 254-526-7523



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Seton Medical Center Harker Heights TMD: Dr. Aaron Russell TPM: Mary Murrey SMD: Dr. Kelly Casey SPM: Stacy Sepeda CMD: Dr. Randy McCollough CPM: Michael Moore/Garrett Andrade	850 W. Central Texas Exp. Harker Heights 76548 254-690-0900
Cedar Crest Hospital (currently not a member of the RAC)	3500 S IH-35 Belton 76513 254-939-2100
Olin E. Teague Veteran's Medical Center, Central Texas Veteran's Health Care System (currently not a member of the RAC)	1901 Veterans Memorial Dr Temple 76504 254-778-4811
Advent Health Behavioral Health POC: Brandy Groves	2201 S Clear Creek Rd Killeen 76549 254-628-1000
BSW - Continuing Care Hospital Director: Lea Ann Duwe Manager: Amy Gallozzi	546 N Kegley Rd Temple 76502 254-215-0900
Coryell Health System TMD: Dr. Carl Kornman TPM: Chancy Lay	1507 W. Main St Gatesville 76528 254-248-6300
Hamilton General Hospital TMD: Dr. Tim Rudolph TPM: Becky Thompson	400 N. Brown St Hamilton 76531 254-386-1600
Advent Health Rollins Brook TMD: Dr. Seth Parkey TPM: Tara Davis	608 N. Key Ave Lampasas 76550 512-564-3200
ClearSky Rehab (currently not a member of the RAC)	
Select Medical Rehab (currently not a member of the RAC)	
Canyon Creek Behavioral (currently not a member of the RAC)	
Temple Rehab Lacey Sanders	23621 SE H K Dodgen Temple, TX 76502 (254) 410-0555



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<u>Facility</u>	<u>Address</u>
Premier ER Plus – Temple RAC POC: Melodie Willoughby Medical Director: Dr. Josh Strommen	7010 W Adams Avenue Temple, TX 76502 254-228-1200
Express ER (currently not a member of the RAC) RAC POC: Medical Director:	1551 W Central Avenue Temple, TX 76504 254-282-0516
Express ER (currently not a member of the RAC) RAC POC: Medical Director:	980 Knight's Way building 1 ste 100, Harker Heights, TX 76548
Signature Care Emergency Center Killeen RAC POC: Lauren Weaver Medical Director: Dr. Michael Hasegawa	800 W Central Texas Expressway Killeen, TX 76548 254-220-4117

Appendix VII: Public Health Point of Contacts

<u>Location</u>	<u>Address</u>
Public Health Region 7 Headquarters <i>The Public Health Region 7 Headquarters office in Temple is temporarily closed due to storm damages. For public health services, please contact our 24/7 number at (254) 778-6744.</i>	PO Box 129 Temple, TX 76503 254-778-6744
Travis Austin Public Health	7201 Levander Loop Austin, Texas 78702 512-972-5000
Travis Travis County Health & Human Services	100 N Interstate 35 Frontage Rd. #2000, Austin, Texas 78701 512-854-4100
Bell Bell County Public Health District	309 N. 2nd Street Killeen, TX 76541 254-532-9800



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Brazos Brazos County Health District	201 North Texas Avenue Bryan, Texas 77803 979-361-4440
Hays Hays County Health Department	401-A Broadway San Marcos, Texas 78666 512-393-5520
Milam Milam County Health Department	209 South Houston Street Cameron, Texas 76520 254-697-7039
McLennan Waco-McLennan County Public Health District	225 West Waco Drive Waco, Texas 76707 254-750-5450
Williamson Williamson County and Cities Public Health District	355 Texas Avenue Round Rock, Texas 78664 512-943-3600
Bell County EMC Bob Reinhardt Rebecca Eaton	708 W. Avenue O Belton, Texas 76513 254-933-5518
Coryell County EMC Judge Roger Miller	800 E Main St Gatesville, TX 76528 254 -865-5911 ext. 323
Hamilton County EMC Lacy Alexander	102 N Rice Street Hamilton, TX 76531 512-525-1375
Lampasas County EMC Angela Rainwater	407 S. Pecan St., Suite 103 Lampasas, TX. 76550 512-734-1824
Mills County EMC David Shaw	2111 Priddy Rd Goldthwaite, TX 76844 512-589-2351
Milam County EMC Kenzie Oliver	102 S Fannin Ave Cameron, TX 76520 254-697-7060
Temple EMC Jennifer Henager	210 N. 3rd Street Temple, TX 76501 254-298-5682
Killeen EMC Sara Williams	9200 Trimmier Road Killeen, TX 76542 254-501-7706
Harker Heights EMC Paul Sims	401 Indian Trail Harker Heights, TX 76542 254-699-2688



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*Waco-McLennan County Public
Health District*

*Williamson County & Cities Health
District*

Austin Public Health

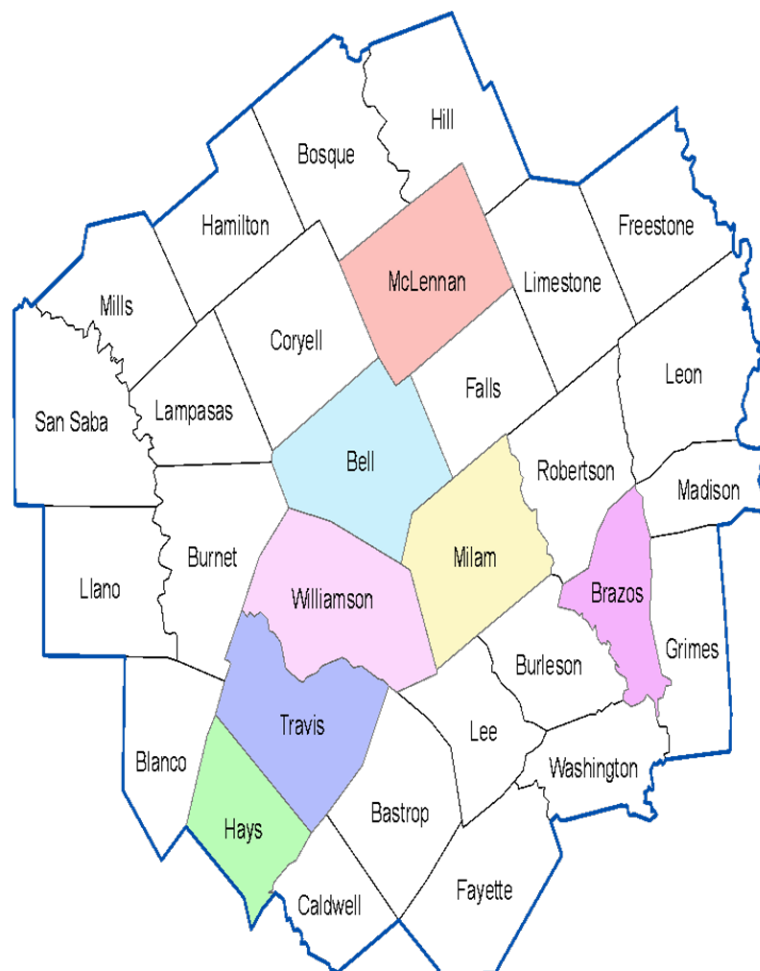
DSHS, Health Service Region 7

Bell County Public Health District

Brazos County Public Health District

*Hays County Local Health
Department*

*Milam County Public Health
Department*





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CENTEX RAC 2026 EHSP
EMERGENCY HEALTHCARE SYSTEM PLAN
APPENDIX VIII



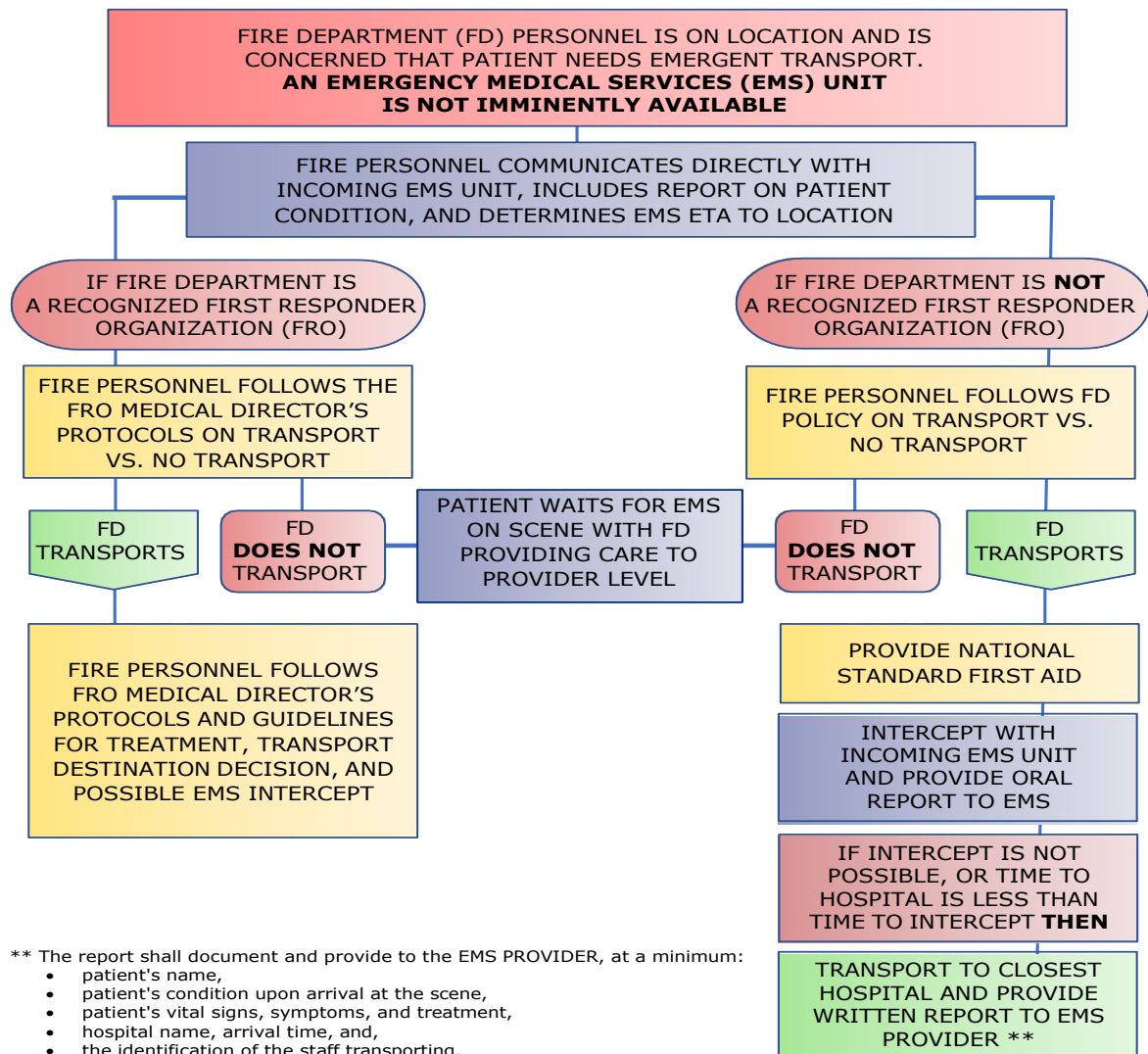
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Appendix VIII: HB 624 FD Transport When EMS Delayed

House Bill 624

Recommendation for fire departments transporting when EMS is delayed





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Appendix VIII: EMS Time Out (MIST)

The EMS Time Out mirrors other types of health care time outs, such as medication administration cross checks and pre-operative right site, right patient and right procedure confirmations. The 40 second report best occurs on the EMS stretcher prior to patient movement to the ED stretcher.

EMS TIME OUT REPORT

M	Mechanism or Medical Complaint	Name, Age, Gender Mechanisms: Speed, Mass, Height, Restraints, Number and Type of Collisions, Helmet Use and Damage, Weapon Type Medical: Onset, Duration, History, Allergies
I	Injuries or Illness Identified	Time of Injury or onset of illness List injuries Head to Toe Pain, Deformity, Injury Patterns STEMI - 12 lead / Stroke - LAPPS and LAMS / Sepsis - temp
S	Signs and Symptoms	Symptoms and Vitals Initial, Current, Lowest Confirmed BP HR, BP, SPO2, RR, ETCO2, BG GCS: Eyes _____ Verbal _____ Motor _____ Vital signs: first set and significant changes, including glucose
T	Treatments	Tubes, Lines (Location and Size), Fluids Medications and Response, Dressings, Splints Defibrillation / Pacing



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CENTEX RAC 2026 EHSP
EMERGENCY HEALTHCARE SYSTEM PLAN
APPENDIX X



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Appendix X: Definitions and Acronyms

Definitions

Emergency Healthcare System Plan (EHSP): Regional emergency system plan.

Regional Advisory Council (RAC): Coordinating body for trauma and EMS services.

Trauma Service Area (TSA): State-designated emergency healthcare region.

Acronyms

PCI – Percutaneous Coronary Intervention

EMS – Emergency Medical Services

DSHS – Texas Department of State Health Services

RAC – Regional Advisory Council

EHSP – Emergency Healthcare System Plan

TMD – Trauma Medical Director

TPD – Trauma Program Director

TPM – Trauma Program Manager

CNO – Chief Nursing Officer

CMO – Chief Medical Officer

MD – Medical Director

SMD – Stroke Medical Director

SPM – Stroke Program Manager

PHWB – Prehospital Whole Blood

Source List:

1. US Census Bureau (2023, July 1). QuickFacts Bell County, Texas. Retrieved April 17, 2025, from <https://www.census.gov/quickfacts/fact/table/bellcountytexas/PST045223>
2. US Census Bureau (2023, July 1). *Quick Facts Coryell County*. Retrieved April 17, 2025, from <https://www.census.gov/quickfacts/fact/table/coryellcountytexas/PST045224>
3. US Census Bureau (2023, July 1). *Quick Facts*. Retrieved April 17, 2025, from <https://www.census.gov/quickfacts/fact/table/hamiltoncountytexas/PST045224>
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11. AAFP (2025, January 1). Advanced Life Support in Obstetrics (ALSO) Program. Retrieved April 28, 2025, from <https://www.aafp.org/cme/programs/also.html>
12. AHA (2025, January 1). Neonatal Resuscitation Study Guide. National CPR Association. Retrieved April 28, 2025, from <https://www.nationaleprassociation.com/neonatal-resuscitation-study-guide/>