
# Trauma Regional Plan

# 2024

Next Review: 2026

# Trauma Regional Plan

## Introduction

Texas Trauma Service Area F (TSA-F) serves eight counties spanning 5,500 square miles and an approximate population of 300.000. NETRAC members include 6 acute care facilities and 6 ground and air medical EMS services. The regional trauma plan should be reviewed routinely in the Acute Care/Trauma Committee with suggestions and review from the General Assembly. Final approval of changes and revisions are made by the NETRAC General Assembly.

## Objective

The NETRAC Trauma Plan is to provide a systemic plan with a comprehensive continuum of care through triage, treatment, and transport for all victims of traumatic injuries. Develop and implement injury prevention and education to decrease overall mortality of the citizens of TSA-F. It is crucial that each involved entity be accountable for participation requirements within NETRAC rules and guidelines to remain in compliance with standards set forth by The Department of State Health Services. Only with collaboration of each participant can an effective and efficient plan function.

## Medical Oversight

An essential component of system networking is the presence of strong medical direction (off-line/indirect/prospective/retrospective) and available medical control (on-line/direct/immediate) for pre-hospital EMS service throughout an entire regional trauma system. Texas TSA-F is both rural and urban. Each EMS system and Hospital has their own Medical Directors who are experienced in emergency medical systems and trauma care in both the pre-hospital and acute care setting. Triage, patient delivery decisions, treatments, and transfer protocols should be integrated within the system. Field triage is according to the American College of Surgeons' system. Pre-hospital protocols for all levels of EMS personnel are presently in place and revised routinely.

## System Access

BASIC 9-1-1 is a regional system providing dedicated trunk lines which allow direct routing of emergency calls. Routing is based on the telephone exchange area, not municipal boundaries. Automatic Number Identification (ANI) is not provided with BASIC 9-1-1.There are no basic 9-

1-1 systems within the NETRAC 9-1-1 Emergency Communication System Plan. All systems are enhanced 9-1-1 with different levels of service

## Enhanced 9-1-1

Enhanced 9-1-1 is a system which automatically routes emergency calls to a pre-selected answering point based on geographical location from which the call originated.
In TSA-F, the primary emergency communication systems for public access is Enhanced 9-1-1,The emergency communication systems were implemented providing citizen's access to emergency communications to municipalities and counties(incorporated and unincorporated areas) in the TSA-F.

## Communications Network

The Ark-Tex Council of Governments administers the 9-1-1 Emergency Communications Systems. The communications system includes the following counties:

| | |
|---|---|
| Bowie | Fannin (not part of TSA-F) |
| Cass | Lamar |
| Morris | Delta |
| Titus | Hopkins |
| Red River | Miller (not part of TSA-F) |
| Franklin | |

The contingency plan for the 9-1-1 system includes redundancy of all communications links, with alternate routing capabilities for either system overflow, or evacuation of any of the communications centers. Each center is equipped with an emergency backup power source, and ring down circuits, connecting each 9-1-1 answering point. Connectivity is available through the cellular network, as well as radio communications.

## Communications

In TSA-F, Life Net EMS, and Hopkins County EMS maintain individual emergency medical dispatch systems location in each EMS administrative offices and dispatch for their respective agencies. The City of Paris dispatches EMS calls in Lamar County. Christus EMS dispatches calls in Morris County and parts of Cass County. Life Net EMS dispatches EMS calls in Bowie, Red River, Titus and parts of Cass counties. All dispatch personnel are currently trained in pre-arrival instructions according to their agency policy.
There are high frequency and ultra-high frequency radio capabilities throughout TSA-F region. Within the UHF radio band, ten paired sets of frequencies which are reserved for EMS communication have been assigned. Aeromedical communication capabilities are also available. All landing zone communications and assigned to the teams Fire 23 interoperable frequency.

## Pre- hospital Triage Criteria

Major trauma patients are either categorized as “Critical” or “Urgent” on the Triage Decision Scheme and it includes recommendations for transfer based on the type of facility which provides initial care.

Trauma centers are identified by the type of resources provided by institution. Triage and transport protocols are based on the resources these hospitals provide. Patients who sustain major injuries may require care at a Level 1 or Level II trauma center. They may be able to receive initial stabilization at a Level III or Level IV trauma center if the injury occurs in a rural area of the service area. Their clinical needs may include access rapid transport to Level I or Level II facility.

The trauma service area has six ground EMS services and three air medical services providing emergency care and transports to trauma centers. Appendix A shows the staffing and service level of each of these agencies.

Texas Department of State Health Services is the regulatory agency for the emergency vehicles, equipment, and personnel.

The trauma services area utilizes Enhanced 9-1-1 capabilities for accessing the EMS system. Emergency vehicles are dispatched based on the proximity to the injured patient(s). Air medical transport via helicopter or fixed wing is available throughout the region.

Ground ambulances follow treatment and transportation guidelines defined by their local medical director, which conform to the RAC protocol guidelines. Air Medical Transport treatment and transportation protocols are available through the respective services. All protocols are based on nationally recognized standards. These standards may include Pre-hospital Trauma Life Support (PHTLS), Pediatric Advanced Life Support (PALS), Advanced Cardiac Life Support (ACLS), Trauma Nursing Core Course (TNCC) and Advance Trauma Life Support (ATLS).

Current licensed acute care facilities in the service area are listed in Appendix A. Pre-hospital protocols are reviewed on an annual basis for revisions and refinement. Protocol update classes provide pre-hospital care personnel with information about changes in patient care recommendations.

Trauma facilities are notified using the triage decision scheme of patents via radio, cell phone, or telephone from ambulances and aeromedical transportation. The nationally designated radio frequencies are utilized for the transmission of patient information to the hospital (including expected time of arrival at the Emergency Department).

Time and distance are extremely important variables to consider when triaging injured patients to local hospitals or trauma centers. Patients who meet the following guidelines and are within twenty (20) minutes transport time to a trauma center should be strongly considered for transport directly to that center in the rural environment. An injured patient may be at a substantial distance from a trauma center and as such injured patients should ideally be treated initially at the nearest available hospital facility. Patients with major severe injuries should then be secondarily triaged to more distant trauma centers should local resources prove inadequate for continued care.

The below criteria are suggestive operating guidelines. The time frame set is a collective guideline set by TSA-F members. Agencies should go by their established protocols set by their medical director.

## Referral to Trauma Center

### Initial Procedures

Upon encountering any injured patient, pre-hospital personnel must make a rapid assessment of the patient pausing as necessary to treat life threatening situations.

This assessment includes:

1. Vital signs and breath sounds
2. Glascow Coma Scale Score/ Revised Trauma Score.
3. A thorough secondary survey as the situation permits

### Trauma Center Referral

Any patient presenting with one or more of the following physiological signs or anatomical injuries in a traumatic setting are considered trauma center candidates:

1. Systolic blood pressure less than 90 with clinical evidence of impending shock
2. Respiratory rate less than 10 or greater than 29, with evidence of trauma
3. Penetrating injury to chest, abdomen, head, neck or groin
4. Flail Chest

NOTE: Patients in cardiac arrest secondary to hypovolemia due to blunt trauma are not trauma center candidates due to uniformly poor outcome regardless of treatment.
All patients meeting the above criteria are to be directly triaged from the scene to the nearest tertiary care center or regional resource trauma center (if transport time is less than 20 minutes).
This assessment/regional referral is to be made by the EMT/Paramedic (if transport exceeds 20 minutes, call the closest hospital for consultation and advice).
The EMT/Paramedic should employ the treatment regimen as outlined in the Pre-hospital trauma protocol while enroute to the trauma center.

### Potential Trauma Center Referral

Traumatically injured patients not evidencing absolute criteria for trauma center referral may still be candidates if; on the basis of anatomical sites and/or mechanism of injury, the potential exists for the patient to have sustained critical injuries. Considerations include:

1. *Two or more proximal large bone fractures*
2. *Combination with burns greater than ten percent, face, or airway*
3. *Evidence of high impact*
    a. *Falls greater than 10 feet or for pediatric patient falls that are two times the patient's height.*
    b. *Passenger compartment intrusion 18 inches on patient side of car*
    c. *Ejection of patient*
    d. *Rollover*
    e. *Death of same car occupant*

*f. Pedestrian struck at 20 mile per hour or more*
*g. EMS judgement*

For patients not meeting trauma center referral criteria or for directed by medical control physician to be transported to the local hospital, the EMT and EMT Paramedic will proceed with BLS and/ or ALS treatment as appropriate and transport to the nearest hospital.
It must be remembered that transportation of trauma patients is a high priority. On the scene treatment should be limited only to those techniques to stabilize life threatening injuries. Once enroute, further splinting, bandaging, and IV therapy should be initiated and/ or continued.

Trauma Helicopter Service

Multiple factors are involved in determining the most expedient method of transportation to the trauma center. In some cases, the most expedient means may be via a helicopter service. The following are guidelines to be utilized in determining ground vs air transportation.
Utilize land transport to nearest regional or regional resource trauma center when:

1. Patient is non-entrapped, or extricated and time from scene to trauma center (by land) is 20 minutes or less.
2. Helicopter is not available to fly

Consider air transport to nearest regional or regional resource trauma center when:

1. Patient is entrapped, helicopter can arrive at scene prior to extrication, and scene-to-trauma center time can be considerably shortened by utilizing helicopter.
2. Patient is non-entrapped or extricated and land transport time to the nearest trauma center is greater than 20 minutes. In case, transport to a rendezvous landing zone should be employed.

Radio/ Communication Failure

When communications cannot be established, or once established are interrupted, the decision to triage potential trauma center candidates to a trauma center must be made by the EMT/Paramedic. The decision of the EMT or paramedic to "by-pass" a local hospital for a trauma center is expected to be made with the patient's best interest in mind and in accordance with the trauma referral criteria.

Description of Triage Decision Scheme

The Trauma Triage Scheme was a collaborative of the American College of Surgeons And American College of Emergency Physicians guidelines.
The Triage Decision Scheme was a collaborative effort of the Bypass/ Diversion Committee. This scheme was to serve as a model for TSA-F to incorporate hospital from Levels I to IV. The Triage Decision Scheme is an algorithm approach to differentiating patient categories as well as a mechanism for activation of Trauma Team Alerts in Facilities.

Patient Categories- The Triage Decision Scheme defines patient categories as critical and urgent.

Critical patients meet criteria for instability of hemodynamic and neurologic functions, as well as specific anatomical injury patterns that place them at a high suspicion for significant risk

Urgent categorized patients are those that are evaluated for evidence of mechanism of injury, high-energy impact, and age, or disease specific history.

## Inter-Hospital Transfers

All inter-hospital transfers must comply with current Federal and State regulations, with appropriate transfer memoranda and patient data accompanying the patient.

Inpatient to inpatient transfers are accomplished directly from transferring attending to receiving attending physician, and from transferring hospital administration to receiving hospital administration.

Trauma patients requiring specialized treatment or specialized care are identified via the Triage Decision Scheme and transfer to an appropriate facility is based on this criteria.

Written transfer agreements are available to the major tertiary care facilities within the region. These agreements may be broad in nature or specific, i.e., burn or pediatric.

## System Quality Management Program

### Mission Statement

To get the "right patient" to the "right place" in the "right time"
Trauma Service Area F is dedicated to the provision of quality healthcare for the community and the surrounding region. It provides accessible, comprehensive, high quality healthcare to all disaster, trauma, and acute patients regardless of age, race, sex, nationality, ability to pay, diagnosis or prognosis, to assure that all patients receive the optimal level of care.

The purpose of continuous quality management is to provide ongoing quality assessment and improvement activities designed to objectively and systematically monitor and evaluate the quality of patient care through system analysis, to identify and pursue opportunities to improve patient care, and sustain improvement over time and ultimately to improve survival and reduce morbidity from injury.
By participating in the TSA-F RAC, all member organizations embrace the guiding principles for Trauma System QI outlined by the Texas Department State Health Services.

### Goals/Objectives

The Trauma Service Area F quality management plan is designed to achieve the following goals:

1. To facilitate continuous quality improvement in patient care and services provided, by establishing mechanisms to identify opportunities to improve. This can be achieved by evaluation of clinical processes which may affect patient outcomes and clinical aspects of care or services which are key function activities.
2. To pursue opportunities for improving patient care by evaluating systems and addressing educational issues. Actions will be taken to rectify identified issues.
3. To centralize the flow of information through the organized committee structure, to prevent duplication of effort and to facilitate early awareness of opportunities for improvement.
4. To achieve a 5% decrease in trauma morbidity/mortality within TSA-F over the next five years.

5. To identify and recommend corrective action for components of the trauma system which will significantly decrease delays in meeting our mission of getting patients to tertiary care within the "golden hour" for optimum outcomes.
6. Develop a data base through continuous quality improvement activities that will allow identification of trends and/or significant events
7. To assist in developing guidelines and standards of care in TSA-F through identification of educational needs via system continuous quality improvement activities.

Functional Authority:
The final authority and ultimate responsibility for a flexible, comprehensive and integrated quality management plan shall rest with the Northeast Texas Regional Advisory Council.

Program Evaluation
The effectiveness of the program to meet the above goals is monitored through an ongoing performance improvement process. This process is monitored using audit filters based on the standards of the American College of Surgeons-Committee on Trauma. Each participating facility should submit/report data to the RAC and should be reviewed within the Acute Care/Trauma Committee (see appendix C). If opportunities for process improvement are identified, the data should be shared with the appropriate committee with the shared responsibility to institute a plan for improvement. All improvement plans and status reports should be shared and approved by the General Assembly.
Similarly, injury prevention and control is a critical area where NETRAC can have a major impact on lessening the injury and morbidity in our region. As performance improvement areas becomes better defined, more specific injury control indicators can be developed to better serve the NETRAC community.

Confidentiality
All documents generated concerning quality management activities within the region shall be confidential and used only in the exercise of designated functions of the Quality Management Plan.

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

## Education/Prevention Plan

The trauma education/prevention committee has identified three major areas of focus:

1. Education of Pre-hospital personnel.
2. Education of hospital-based personnel.
3. Education of the public, particularly in the area of injury prevention.

Continuing Education:
A NETRAC Training calendar should be published on an as needed basis. The calendar should be expanded to incorporate information about hospital based training education,

training/education available through all schools and departments at local community colleges, and relevant training/education available through other Regional organizations.

## Trauma Prevention & Education

Goal
Activities which increase public understanding of the trauma care system and which encourage the prevention and reduction of injuries through education of the public and through legislation will be identified and supported, collaboratively with TSA F, other Trauma Service Areas and the Texas Department States Health Services..

## Facility Diversion Policy

Goal
To establish a recommended NETREC wide policy for facility diversion. Aside from the RAC approved diversion policy each hospital is responsible to develop a diversion policy/procedure.

Policy
Diversion of ambulance traffic will occur only by prearrangement. In order to implement the diversion period, as well as to extend the period, the facility must have a person in authority (house supervisor, administrative representative, or emergency physician) contact the appropriate communications communication system (9-1-1 communications center, lead facility, etc.) identify him/herself, and request this stand-down status.
In the event that multiple facilities request simultaneous diversion status, then ambulances would rotate delivery of patients among the other facilities until those facilities are off diversion status. EMS personnel will be notified of facility status via the communications centers. Facilities can request to be taken off diversion status in the same manner as the request is made to be placed on diversion.

Recommended Guidelines for Diversion Protocol
Under the present system each facility will designate a person (ED Physician, Administrative representative, etc.) to be responsible for decisions regarding diversion.

1. Each facility will develop a procedure for their facility to be put on diversion status.
2. Reason for facilities to be on diversion status:
    a. Trauma Surgeon is not available
    b. Internal disaster
    c. Specialty Surgeon (Neuro, Ortho) is not available
    d. Or Specialty equipment (CT scanner, MRI) is not available
3. Each facility must have records showing why they were put on diversion.
4. Each facility must have policies and procedures for plans to open up critical care beds.
5. Each facility must have a Mass Casualty protocol and know how to access other resources within TSA-F region.
6. Level 2, 3 and 4 facilities must notify all EMS communication centers within their service area whenever a facility goes on or off diversion.

## Air Ambulance Usage Policy

Goal

To establish the guideline for access to and dispatch of helicopter emergency care services to achieve, effective, efficient, and coordinated responses to emergencies involving major trauma victims.

Helicopter capabilities

Must be equipped to meet all the standards of an Advanced Life Support Unit (without using ground unit's equipment). Flight crew must have at least two allied medical personnel capable of providing Advance Life Support in Texas (not including ground personnel).

Policy

Helicopter services may be utilized for the care and transport of major trauma victims according to the Texas Trauma Service-F Guidelines, under the following circumstances:

1. Scenes involving major trauma victims where treatment or transport will be delayed and this delay may impact outcome.
2. When helicopter services can respond and deliver the major trauma victims to a trauma center more rapidly than land transportation, i.e., ground transportation time is greater than 25 minutes. In prolonged extrication, call medical control as per trauma protocol.
3. Scenes inaccessible by ground routes.

Dispatch

All dispatch and coordination of helicopter services shall be accomplished through the responding helicopter communication system.

Helicopter Stand-By

Helicopter services may be placed on the stand-by mode by police, fire, and EMS personnel. The stand-by mechanism is a means of alerting the helicopter personnel of a possible call and assist in shortening the response time by allowing the pilot to locate the accident and coordinates from appropriate maps.

Dispatch procedure

EMS personnel on scene may request helicopter services for dispatch.

1. Contact responding unit dispatch center and request a helicopter dispatch.
2. Advise the dispatch of the following information:
    a. City (if not already given)
    b. Accident location (if not already given)
    c. Nearest landing site (if not already given)
    d. Requesting units name and unit number (if not given)
    e. Nature of the incident (if not already given)
    f. Frequency to communicate (if not already given)
    g. Unit name and number that will set up landing site (if not already given)
    h. Number of patients (if not already given)
    i. Patient approximate weight (if available)
3. Vital signs (only if available)
4. Level of consciousness (only if available)
5. Specific injuries (only if available)

6. If patients are trapped

Safety Rules

All personnel working with or around helicopter service will adhere to the following safety rules:

1. NEVER approach the helicopter until signaled to do so by the flight crew.
2. Always approach the helicopter from the front.
3. NO ONE is permitted near the tail rotor of the helicopter at any time.
4. No smoking or running and avoid placing loose objects around the helicopter.
5. Do not assist the flight crew in opening or closing the helicopter doors.
6. The flight crew will assist, the loading and unloading of patient and equipment.
7. Crowds must be kept back 150 feet from the helicopter at all times.

Landing Zone

A minimum area of 100 x 100 feet, a red light or marker at each corner, clear of wires, trees, brush, bush, large rocks, emergency vehicles, signs, and loose objects is required.
The pilot will, at all times, be the final authority on determining the appropriateness of the landing site and all matters concerning the aircraft and safety of the aircraft.

## Regional Facility Triage Criteria Policy

Purpose

The purposes of the Regional Facility Triage Criteria scheme are:

1. To categorize patients for determination for facility transport and/or transfer
2. To specify facility action plans for transfer of patients
3. To include pediatric and burn criteria for patient transport and/ or transfer

Policy

Trauma patients should be placed into one of the following categories by the attending physician based upon the severity of their injuries. Inter-Hospital transfer should then be initiated as appropriate according to the Regional Trauma System's Facility Triage Decision Scheme.

Category I patients (Critical)

Central Nervous System:

- Neurological injuries producing prolonged loss of consciousness, posturing, paralysis, or lateralizing sign
- Spinal injuries with or without neurological deficit
- Deterioration of the neurological status as indicated by Glascow Coma Scale of < 10.
- Open, penetrating, or depressed skull fracture
- CSF leak
- Deterioration of GCS of 2 or more points

Chest

- Major chest wall injury
- Suspected great vessel or cardiac injuries
- Patients who may require protracted mechanical ventilation
- Respiratory distress with a rate > 35 or < 10
- Penetrating thoracic wound

Pelvis
- Pelvic ring disruption with shock requiring more than five units transfusion-evidence of continued hemorrhage
- Compound/open pelvic injury or pelvic visceral injury
- Blunt abdominal trauma with hypotension or penetrating abdominal wound

Multiple System Injury
- Severe injury to two or more body regions

Specialized problems
- Second or third degree burns greater than 10% of body surface are or involving airway
- Barotrauma
- Uncontrolled hemorrhage
- Severe maxillofacial or neck injuries
- Revised Trauma Score of 11 or less
- Open fractures
- Second/ third trimester of pregnancy
- Age < 6 with suspected major injuries

Secondary deterioration
- Patients requiring mechanical ventilation
- Sepsis
- Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal, or coagulation)
- Osteomyelitis

<u>Category II Patients (Urgent)</u>
Patients who are hemodynamically and physiologically stable whose injuries may include:

Central Nervous System
- Transient loss of consciousness

Chest
- Injuries not producing respiratory distress
- Rib fractures without flail segments

Abdomen
- Blunt trauma not producing hypotension

Specialized Problems
- Closed fractures
- Soft tissue injuries with controlled hemorrhage
- Second/third trimester of pregnancy

<u>Category III Patients (Urgent)</u>
Patients who are continually stable but whose injuries may include:
- Closed fracture without neurological deficit
- Normotensive and / or hemodynamically stable
- Soft tissue injuries of moderate degree

See appendix B for transport algorithm

**Appendix A:**

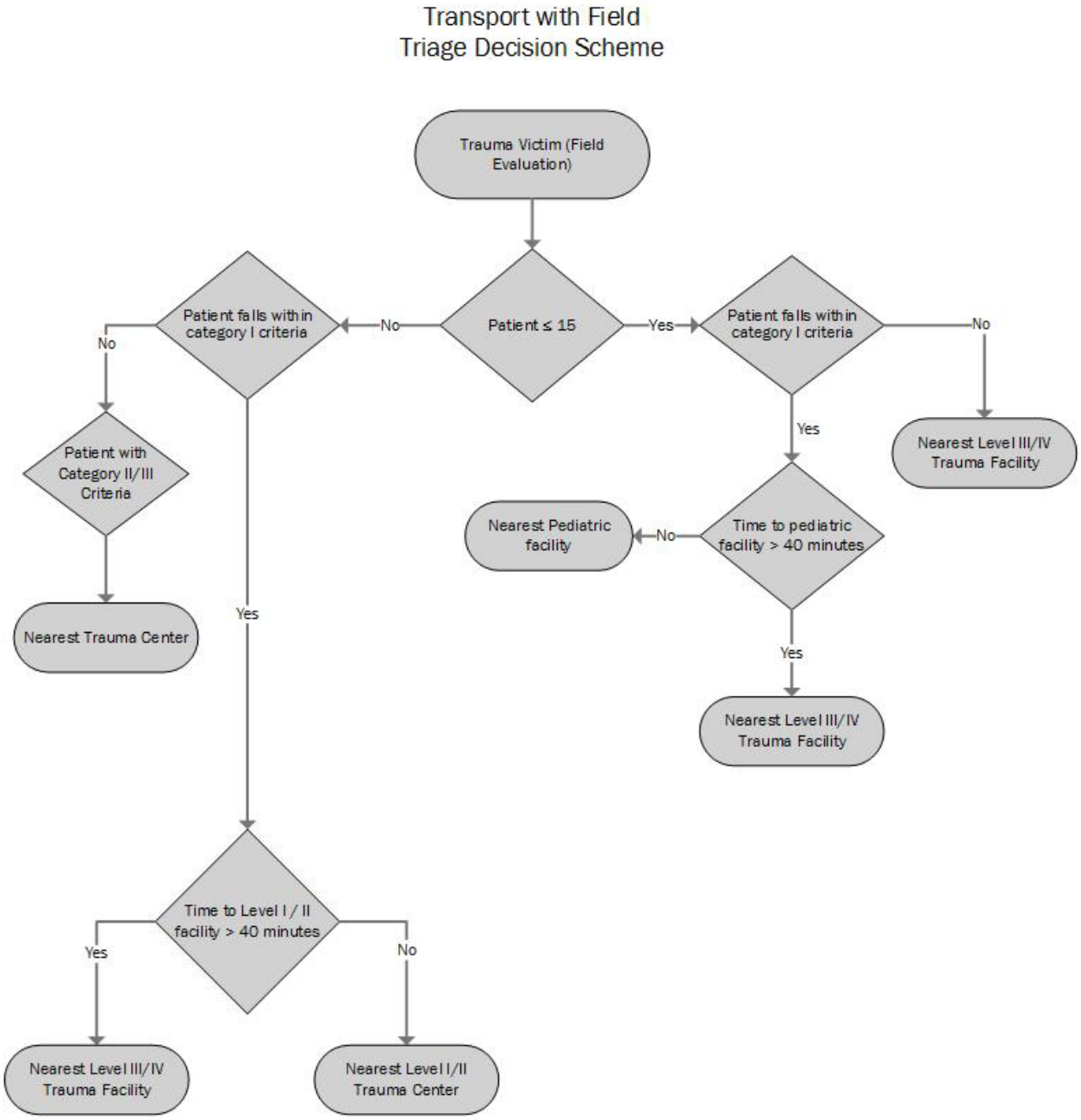
EMS Services

| Agency | Service | County |
|---|---|---|
| Titus EMS<br>2001 N. Jefferson<br>Mt. Pleasant, TX 75455 | Ground | Titus |
| LifeNet EMS LLC<br>6225 St. Michael Drive<br>Texarkana, TX 75503 | Ground | Bowie<br>Cass<br>Red River |
| LifeNet EMS LLC<br>6225 St. Michael Drive<br>Texarkana, TX 75503 | Air | Bowie<br>Cass<br>Red River |
| Hopkins County EMS<br>116 Airport Road<br>Sulphur Springs, TX 75482 | Ground | Hopkins<br>Delta<br>Franklin |
| City of Paris EMS<br>1444 N Main<br>Paris, TX 75460 | Ground | Lamar |
| Atlanta Fire/EMS Department<br>606 S Louise<br>Atlanta, TX 75551 | Ground | Cass |
| CHRISTUS Flight for Life<br>2201 S. Mobberly Ave<br>Longview, Tx 75602 | Air | All Counties |
| Air Evac 139<br>675 Deshong Drive<br>Paris, TX 75460 | Air | Lamar |

Acute Care Facilities

| Facility | Trauma Designation Level |
|---|---|
| Titus Regional Medical Center<br>2001 N. Jefferson<br>Mt Pleasant, TX 75455 | IV |
| Christus Mother Frances- Sulphur Springs<br>115 Airport Road<br>Sulphur Springs, TX 75482 | IV |
| Christus St. Michael Health System<br>2600 St Michael Dr.<br>Texarkana, TX 75503 | III |
| Christus St Michael Hospital-Atlanta<br>1007 S. William St.<br>Atlanta, TX 75551 | IV |
| Paris Regional Health<br>865 Deshong Drive<br>Paris, TX 75460 | III |
| Wadley Regional Medical Center<br>1000 Pine<br>Texarkana, TX 75501 | III |

**Appendix B:**




Appendix B

**Appendix C:**

Performance Improvement data schedule

| Annual Schedule | | |
|---|---|---|
| Quarter | Data Months Included | Submission Due Date |
| 1 | Jan-Feb-Mar | May 15 |
| 2 | Apr-May-Jun | Aug 15 |
| 3 | Jul-Aug-Sep | Nov 15 |
| 4 | Oct-Nov-Dec | Feb 15 |

List of data elements for tracking and PI

| |
|---|
| Total number of patients entered into the registry |
| Total number of ADULT patients that died? (include ED, DOA, and admissions) |
| Total number of PEDI patients that died? (include ED, DOA, and admissions) |
| Total number of patients transferred into your facility |
| Total number of those transferred in that were discharged from the ED |
| Total patients transferred out of TSA-F |
| Number of adult transfers out of TSA-F |
| Number of pediatric transfers out of TSA-F |
| For Adult ONLY transfers out: Number of patients with ED LOS > 2 hours |
| For Adult ONLY transfers out: Number of patients with ED LOS > 4 hours |
| For Adult ONLY transfers out: Number of patients with ISS >= 16 |
| For Adult ONLY transfers out: Average ED LOS time (in minutes) |
| For Pediatric ONLY transfers out: Number with ED LOS > 2 hours |
| For Pediatric ONLY transfers out: Number of ED LOS > 4 hours |
| For Pediatric ONLY transfers out: Number of patients with ISS >= 16 |
| For Pediatric ONLY transfers out: Average ED LOS time (in minutes) |
| For all transfers: Number transported via ground |
| For all transfers: Number transported via air |
| For all transfers: Number of cases with transport time (EMS called to EMS arrival) of 61-119 min. |
| For all transfers: Number of cases with transport time (EMS called to EMS arrival) of 120 minutes or more |
| For all transfers: Number of cases with acceptance concerns (acceptance > 60 minutes, or repeat calls to the receiving facility) |
| Give a brief description of the acceptance concern |