HELP TEXT FOR LEVEL IV TRAUMA APPLICATION:

General information:

The application was placed on line with only the fill-in portions available for modification. To change from one form field (_____) to another, use the "tab" key on your keyboard, or click on each area. "Check boxes" (☐) can be changed by clicking on them so they are X'ed out (☒). Type as much text as you like in the form field area; however, **the length of visible text that will print out is limited to the size of the box around the text, or the end of that line.** This was done purposely to avoid changing the layout and format of the document. **If you can't see it, it won't print**.

Timely and Sufficient Application:

Excerpts from Trauma Facility Designation Rule 157.125

*(d) For a facility seeking **INITIAL designation**, a timely and sufficient application shall include:*

(1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office;
(2) full payment of the designation fee enclosed with the submitted "Complete Application" form;
(3) any subsequent documents submitted by the date requested by the office;
(4) a trauma designation survey completed within one year of the date of the receipt of the application by the office; and
(5) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office.

(e) If a hospital seeking initial designation fails to meet the requirements in subsection (d)(1) - (5) of this section, the application shall be denied.

*(f) For a facility seeking **RE-DESIGNATION**, a timely and sufficient application shall include:*

(1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office one year or greater from the designation expiration date;
(2) full payment of the designation fee enclosed with the submitted "Complete Application" form;
(3) any subsequent documents submitted by the date requested by the office; and
(4) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office no less than 60 days prior to the designation expiration date.

(g) If a healthcare facility seeking re-designation fails to meet the requirements outlined in subsection (f)(1) - (4) of this section, the original designation will expire on its expiration date.

Frequently Asked Application Questions:

(1) Question: Many parts of the application ask for additional narratives, policies, forms, etc. How do I organize the application so the Texas Department of State Health Services (DSHS) knows which question I'm answering?

(1) Answer: Organize the application in a way that all attachments (narratives, policies, etc.) are easily referenced. Place the entire application questionnaire at the front of the packet and then behind that section, sequentially insert the attachments. Reference each question in the application to the corresponding attachment number.

Example:

Describe your hospital..... See Attachment 1
Attach RAC letter..... See Attachment 2
Medical Staff Resolution..... See Attachment 3

(2) Question: Should I bind all three copies of the application?

(2) Answer: If you bind your application, only bind the two copies. The original should be paper clipped or rubber banded, without any tabs or dividers. The original application goes into your permanent file at DSHS.

(3) Question: Whom do I call for information or guidance while completing the application?

(3) Answer For *Technical* Difficulties call Terri Vernon 512/834-6700 ext. 2375.

For content or clarification of questions please call or email us at:

Lisa Fallon – 512/834-6700 ext. 2457
lisa.fallon@dshs.state.tx.us

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Application Submission Instructions: (for initial and re-designation)

1. Fill out the "*Complete Application for Level IV Designation*." Answer all questions completely and enclose attachments as necessary. If a question does not apply to your facility, answer with "n/a" (*not applicable*).

2. Complete the "*Criteria Checklist for Level IV Trauma Facility Designation*" utilizing the columns labeled "Hospital". This document can be downloaded at:
   www.dshs.state.tx.us/emstraumasystems/formsresources.shtm#trauma
   or a copy can be requested from the OEMS/TS Program at (512) 834-6700 ext. 2375 or by email: terri.vernon@dshs.state.tx.us

3. Submit the following documents:

   - three (3) copies of the "*Complete Application for Level IV Designation*
   - three (3) copies of the completed "*Checklist for Level IV Trauma Facility Designation*".
   - the application fee* *($10.00 per licensed bed, $500.00 minimum/$1,000 maximum).*
   - a letter from the Regional Advisory Council (RAC) with which the facility is affiliated confirming facility participation in RAC activities.

4. Submit the required documents by US Mail to:

   Texas Department of State Health Services
   Cash receipts branch, MC 2003
   Office of EMS/Trauma Systems Coordination
   P.O. Box 149347
   Austin, Texas 78714-9347

5. For further information relating to the designation process following submission of the application, refer to the "*Process for Basic (Level IV) Trauma Facility Designation Application*" document at the following OEMS/TS web address:

   www.dshs.state.tx.us/emstraumasystems/formsresources.shtm#trauma

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Office of EMS/Trauma Systems Coordination
P. O. Box 149347
Austin, TX 78714
(512) 834-6700

Basic (Level IV) Trauma Facility Designation Application

Date: _____
Hospital Name: _____
Mailing Address: _____
City, State, Zip: _____
County: _____ Trauma Service Area (TSA):---Choose---

☐ **Initial Designation** ☐ **Re-Designation** **Expiration Date:**_____

Contact Person: _____
Title/position: _____
Phone Number(s): (___) - or (___) -
Fax Number(s): (___) - or (___) -
Email Address: _____

Number of licensed beds (*based on most recent licensing survey*):_____

DSHS License Number:_____

Amount enclosed: $_____ Make check payable to: "*Texas Department of State Health Services*"

(Fee for Level IV: $10.00 per licensed bed – minimum fee $500 / maximum fee $1,000)

Signature *(of CEO or authorized person)*: _____ Date:_____

(Typed name of CEO or authorized person)

Title: _____
Phone:(___) -

COMPLETE ALL SECTIONS.
IF A QUESTION DOES NOT APPLY TO YOUR FACILITY, MARK "N/A".

General Information

In narrative format, describe your hospital, including tax status, governance and affiliations. Define your hospital's role in the community, including regional trauma system development and implementation. Include applicable organizational charts.

Attach a letter of participation from your Regional Advisory Council (RAC).
(As evidence of your participation in RAC activities)

Is there a resolution supporting the trauma center signed by the hospital's governing body and dated within the past three years?
☐ Yes - enclose copy with application
☐ No

Is there a resolution supporting the trauma center signed by the hospital's medical staff and dated within the past three years?
☐ Yes - enclose copy with application
☐ No

Is there specific budgetary support for the trauma service? ☐ Yes ☐ No

If "Yes" specify	

Describe the commitment of your administration to trauma care, in detail.

Attach additional sheets if necessary

Pre-Hospital System

Who has authority over EMS in your system *(city, county, other)*?	-- choose --

Describe the EMS governing body, including medical leadership.

Attach additional sheets if necessary

What type of public access to EMS is used in your community? (*check all that apply*)
☐ 911 ☐ Enhanced 911 ☐ Other (*define*): ____

How are EMS personnel dispatched to the scene of an injury? (*check all that apply*)
☐ EMS Center or 911 Center ☐ Fire Department ☐ Law Enforcement Agency
☐ Other *(define)*:____

Identify the initial responders to injury scenes in your catchment's area (*check all that apply*):

Agency	Basic Level	Advanced Level
EMS	☐	☐
Fire	☐	☐
First Responder	☐	☐
Police	☐	☐
Other (*specify*)	☐	☐

Define the "Air Medical" support services available in your area.

Attach additional sheets if necessary

Does your hospital have a designated heli-pad? ☐ Yes ☐ No
If "No", describe location, access and protocols for air transport.

Does your hospital serve as a base station for EMS operations and provide online medical control?
☐ Yes ☐ No

Detail your hospital's participation in pre-hospital training and pre-hospital performance improvement.

Describe your hospital's participation in regional disaster planning. *(DO NOT send your hospital disaster plan)*

Attach additional sheets if necessary

Trauma Program

Complete Table A

Physician Director:

Enclose a narrative job description and curriculum vitae for your Trauma Medical Director.

Describe the trauma service including how the Trauma Medical Director oversees all aspects of the multi-disciplinary care, from the time of injury through discharge and involvement in the trauma performance improvement process.

Attach a separate sheet if necessary

Trauma Coordinator:
Enclose a narrative job description and curriculum vitae for your Trauma Coordinator.

Is Trauma Coordinator a full-time position? ☐Yes ☐No
If "No", list the percentage of time spent performing trauma coordinator duties and describe other duties of this position.

-- choose -- %	

Enclose your trauma program's organizational chart.

Describe the administrative reporting structure for the Trauma Coordinator.

Attach addtional sheets if necessary

Trauma Response:
Enclose copies of the following policies/protocols:

- Trauma Team Activation Policy
- Roles and Responsibilities of the Trauma Team
- Trauma Resuscitation Protocol (*not ACLS resuscitation*)
- Trauma Triage Transfer & Admission Criteria Policy
- Trauma Standards of Care Manual
  (*for the manual, **send only a copy of the "table of contents"** – DO NOT send a copy of your entire manual*)

Trauma Service Statistical Data:

Reporting year: _____to_____
(*For reporting year, choose the most recent year with complete data, i.e. 4/07 to 4/08)*

Total number of ED visits for reporting year, including DOA and DIE: _____

Total number of trauma-related ED visits: _____

Disposition from ED:

Disposition	
ED to OR	0
ED to ICU	0
ED to Floor	0
Deaths	0
Total	0

Trauma Transfers:

Number of Critical Trauma Transfers	**Air**	**Ground**	**Total**
In (*from hospitals*)	0	0	0
Out	0	0	0

Do you have written agreements for transfer of trauma patients out of your facility for acute injury management? (*Have agreements available on-site for examination.*) ☐ Yes ☐ No

Do you have Transfer Protocols? (*Have protocols available on-site for examination.*) ☐Yes ☐No

List receiving hospitals, their level of trauma designation and distance from your facility.

Hospital	Trauma Designation	Distance (*in miles*)
	-- choose --	
	-- choose --	
	-- choose --	
	-- choose --	
	-- choose --	

Trauma Bypass/Divert:

Enclose a copy of your diversion policy.

Who has the authority to issue/cancel a diversion?_____

Has your facility gone on trauma bypass/divert during the previous year? ☐Yes ☐ No
If "Yes", complete **Table H** - "Trauma Bypass/Divert Occurrences" *(located at end of the application).*

Hospital Facilities

Emergency Department:

List the Emergency Department nursing personnel who care for trauma patients by completing **Table B** (*located at end of this document*). Include all requested information and submit with application.

List the Emergency Department physicians who care for trauma patients by completing **Table C** *(located at end of this document*). Include all requested information and submit with application.

Describe below your ED nursing staffing pattern. (*Explain how you ensure an adequate nurse to patient ratio.)*

Nursing staff certifications:

Total number of staff	-- choose --	Explain here
Percent with TNCC	-- choose -- %	
Percent with PALS	-- choose --%	
Percent with ENPC	-- choose --%	
Percent with ACLS	-- choose --%	
Percent with CEN	-- choose -- %	

Enclose a copy of your current ED trauma flow sheet.

Describe how pre-hospital personnel communicate with your Emergency Department.	
Attach additional sheets if necessary	
What is the average lead time from EMS communication with the ED to their arrival?	
By ground?	
By air?	

Radiology / Ultrasound:

Do you have resuscitation and monitoring equipment available in the radiology suite?
☐ Yes ☐ No

Who accompanies and monitors the trauma patient to the radiology suite? _____

Is there a 24-hour CT technician available in-hospital?
☐ Yes ☐ No
If "No", is there a performance improvement program which reviews timeliness of CT response?
☐ Yes ☐ No

Who interprets the radiographs after hours? ____

Is teleradiography available to augment the initial interpretations by a non-radiologist?
☐ Yes ☐ No

What is available at your facility?
CT ☐
MRI ☐
Radiology ☐

Surgical Capabilities:

Complete Tables D, E, F & G

Does your facility have full-time* general surgery capabilities in place? ☐ Yes ☐ No

Does your facility have full-time* orthopaedic surgery capabilities in place? ☐ Yes ☐ No

Does your facility have full-time* anesthesia capabilities in place? ☐ Yes ☐ No

Does your facility have full-time* neurosurgery capabilities in place? ☐ Yes ☐ No

**** In general, physician service capability must be in place 24/7. In determining whether capability is present, DSHS may use the concept of substantial compliance, which is defined as having capability at least 90% of the time (i.e. 27 out of 30 days in a month).***

Under what circumstances do you take **trauma** patients to the operating room?

Attach additional sheets if necessary

Clinical Laboratory:

Describe your source of blood products and include the number of units of O negative your facility has on hand and how long the units are maintained.	
Amt of O Neg:	Briefly describe your source

Is there a massive transfusion protocol to facilitate blood component therapy? ☐ Yes ☐ No
(Have protocol available on-site for examination.)

Do you have uncross-matched blood immediately available? ☐ Yes ☐ No

If "Yes", define mechanism.

What is the average turn around time, in minutes, for an emergency?

Type specific blood _____ minutes

Full crossed-matched blood _____ minutes

Does your facility have:

Micro-sampling capabilities for children	☐Yes ☐No
Blood Gas	☐Yes ☐No
Drug/Alcohol Screening	☐Yes ☐No
Trauma panel	☐Yes ☐No
H&H	☐Yes ☐No
Is there 24-hour staffing?	☐Yes ☐No

Standards of Care:

Burn Patients

Enclose a copy of your Burn Resuscitation protocol.

With which facilities do you have transfer agreements? _____

Total number of burn patients transferred for acute care during the last reporting year: _____

Total number of burn patients admitted to your facility during the last reporting year:_____

Spinal Cord Injuries

Enclose a copy of your Spinal Cord Injury protocol,

With which facilities do you have transfer agreements with? _____

Total number of spinal cord injuries treated at your facility during the last reporting year: _____

Total number of patients with acute spinal cord injury transferred during the last reporting year:_____

Pediatric Trauma

Enclose a copy of your Pediatric Trauma Resuscitation protocol.

With which facilities do you have transfer agreements with? _____

Trauma Performance Improvement (PI) Program

Do not send any performance improvement minutes or patient specific information! These should be available on-site at the time of your survey.

Enclose a narrative description of your Trauma PI program. Include the following:

- how issues are identified and tracked
- personnel responsible for supervision of both system and peer review issues
- list all members of any trauma committees
- provide the frequency of the trauma committee meetings
- describe the Physician Director's involvement and oversight of the PI program

Enclose blank copies of all PI forms used to track "loop closure". Include your audit filters and all referral forms. *(Have PI reports available on-site for examination.)*

Describe any changes or improvements made as a result of your trauma PI process *(i.e. new policies, improved documentation, peer review, lengths of stay, etc.)*
Attach additional sheets if necessary

Morbidity & Mortality Review: *(for reporting year)*

Total number of deaths categorized as preventable: _____
Total number of deaths categorized as non-preventable: _____
Total number of deaths categorized as possibly preventable: _____

Trauma Registry:

	Months	Years
Total number of months/years of complete trauma registry data?		

When did you last upload to the State EMS/Trauma Registry? _____
What registry program does your facility use? _____
Who abstracts data from the charts for entry into the registry? _____
What trauma registry training is available for this position? _____

Describe the inclusion criteria for patient entry into the trauma registry.
Attach additional sheets if necessary

Educational Activities / Outreach Programs

Describe trauma education programs provided for your physicians, nurses, staff and pre-hospital personnel.
Attach additional sheets if needed

Describe the TRAUMA orientation process and skills evaluation for nurses in the emergency department.
Attach additional sheets if needed

Is there hospital funding for physician, nursing or EMS trauma education? ☐ Yes ☐ No
If "yes", describe.

Attach additional sheets if needed

Describe your injury prevention/public trauma education programs, including Regional Advisory Council (RAC) involvement AND how the effectiveness of these programs is evaluated.
Attach additional sheets if needed

Signature (*Trauma Coordinator*)

Signature (*Physician Director*)

Date

Date

APPLICATION ATTACHMENT CHECKLIST

General Information

- ☐ Designation Application Fee
- ☐ Hospital Narrative
- ☐ Organizational Chart – Hospital Administration
- ☐ RAC Letter of Participation
- ☐ Hospital's Governing Body Resolution
- ☐ Medical Staff Resolution

Trauma Program

- ☐ Table A – Trauma Program
- ☐ Job Description: Trauma Physician Director (*include description of authority*)
- ☐ CV: Trauma Physician Director
- ☐ Job Description: Trauma Coordinator
- ☐ CV: Trauma Coordinator
- ☐ Organizational Chart: Trauma Program
- ☐ Trauma Team Activation Policy
- ☐ Roles and Responsibilities of the Trauma Team
- ☐ Trauma Resuscitation Protocol
- ☐ Trauma Triage Transfer & Admission Criteria Policy
- ☐ "Table of contents" copy from Trauma Manual
- ☐ Diversion Policy
- ☐ Table H – Trauma Bypass/Divert Occurrences

Hospital Facilities

- ☐ Table B – Education of Nursing Personnel
- ☐ Table C – Education of Emergency Department (ED) Medical Personnel
- ☐ Trauma Flow Sheet (ED)
- ☐ Table D – General Surgeons
- ☐ Table E – Orthopaedic Surgeons
- ☐ Table F – Anesthesiology
- ☐ Table G – Neurosurgeons
- ☐ Burn Resuscitation Protocol
- ☐ Spinal Cord Injury Protocol
- ☐ Pediatric Trauma Resuscitation Protocol

Performance Improvement

- ☐ Narrative - Trauma PI Program
- ☐ Trauma PI Forms (*audit, "loop closure" tracking*)

Essential Criteria Checklist

- ☐ Check list completed by facility

TABLE A
Trauma Program

1. Physician Director, Emergency Department – ENCLOSE Curriculum Vitae

   Name:_____

   Board Certification: _____

   ATLS Course completion date:_____

   ACLS Course completion date: _____

   Pediatric course completion date: _____

   Number of trauma CME hours in last 12 months:_____

2. Trauma Nurse Coordinator - ENCLOSE Curriculum Vitae

   Name: _____ Degree:_____

   ACLS Course completion date: _____

   Pediatric course completion date: _____

   TNCC Course completion date: _____

   Other specialty certification(s): _____

   Number of trauma CE hours in last 12 months: _____

Table B

EDUCATION/CERTIFICATION OF NURSING PERSONNEL

Complete the chart; include only nursing personnel who cover the Emergency Department.

NAME	LICENSURE (RN/LVN)		COURSE COMPLETION DATES				NUMBER OF *TRAUMA* CE HOURS IN LAST 12 MONTHS
	RN	LVN	ACLS	PALS/ENPC	TNCC/ATCN	OTHER	
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	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
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	☐	☐					
	☐	☐					

Table C

EDUCATION/CERTIFICATION OF MEDICAL PERSONNEL

Complete the chart; include only physicians and physician assistants who cover the Emergency Department.

Name	Residency		Board Certified		ATLS		Number of trauma CME hours in last 3 years-hours	Frequency of shifts/call per month	
	Where	When Completed	Type (abbr.)	Year	Check if Instructor	Expiration (mm/yy)		**Freq**	**# calls**
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☐ **N/A**

Table D

GENERAL SURGEONS

List all general surgeons currently taking call

Name	Residency		Board Certified		ATLS		Trauma CME Hours (3yr total)	Frequency of call per month	Trauma patients admitted per year	Trauma patients admitted per year (ISS >9)	Operative cases per year
	Where	Year	Type (abbr.)	Year	Instructor?	Exp Date (mm/yy)					
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☐ **N/A**

Budget/Fund: ZZ100-160 356002

Table E

ORTHOPAEDIC SURGEONS

List all orthopaedic surgeons taking call

Name	**Residency**		**Board Certified**		**ATLS**		**Trauma CME Hours** (3yr total)	**Frequency of call per month**
	Where	Year	Type (abbr.)	Year	Instructor?	Exp. Date?		
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☐ **N/A**

Table F

ANESTHESIOLOGY

List all anesthesiologists taking call

Name	Residency		Board Certified		ATLS		Trauma CME Hours (3yr total)	Frequency of call per month
	Where	Year	Type (abbr.)	Year	Instructor ?	Exp. Date?		
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☐ **N/A**

Table G

NEUROSURGEONS

List all neurosurgeons taking call

Name	Residency		Board Certified		ATLS		Trauma CME Hours (3yr total)	Frequency of call per month
	Where	Year	Type (abbr.)	Year	Instructor ?	Exp. Date?		
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TABLE H

TRAUMA BYPASS/DIVERT OCCURRENCES

Date of Occurrence	Time on Bypass	Time Off Bypass	Reason for Bypass

Total number of occurrences of bypass during reporting period? _____ # of occurrences

Total number of hours on diversion during reporting period? _____# of hours