

Definitive Care Facilities Prereview Questionnaire

I. Describe the extent to which all acute care facilities participate in the trauma system.

Acute care facilities participate in the trauma system in varying degrees. Participation by facilities with their regional RAC is purely voluntary and is not required by hospital licensing rule. Facilities who participate with their RAC participate at a higher level, because they are involved in decisions regarding protocol development and trauma system planning. Facilities intending to pursue designation must submit a letter of participation from their RAC with their application: see attachment (1.0) *Complete Application for Level IV Designation*. Even non-designated facilities can participate and vote on protocols and system planning. Facilities not participating in their RAC would not be involved in those decisions. Non-designated facilities generally receive patients whose injuries are determined to be minor by the first responder/EMS providers, but may play an integral role in rural and frontier areas.

a. Describe the availability and roles of specialty centers within the system (pediatric, burn, TBI, SCI).

Each facility has by statute, addressed their own capabilities and those of receiving facilities through hospital policies that result in medically appropriate transfers from physician and from hospital to hospital: See below: Health and Safety Code, Chapter 241. Hospital, Section 241.027 Patient Transfers, and Section 241.028 Transfer Agreements.

Sec. 241.027. PATIENT TRANSFERS. (a) The board shall adopt rules to govern the transfer of patients between hospitals that do not have a transfer agreement and governing services not included in transfer agreements.

(b) The rules must provide that patient transfers between hospitals be accomplished through hospital policies that result in medically appropriate transfers from physician to physician and from hospital to hospital by providing:

(1) for notification to the receiving hospital before the patient is transferred and confirmation by the receiving hospital that the patient meets the receiving hospital's admissions criteria relating to appropriate bed, physician, and other services necessary to treat the patient;

(2) for the use of medically appropriate life support measures that a reasonable and prudent physician exercising ordinary care in the same or a similar locality would use to stabilize the patient before the transfer and to sustain the patient during the transfer;

(3) for the provision of appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care in the same or a similar locality would use for the transfer;

(4) for the transfer of all necessary records for continuing the care for the patient; and

(5) that the transfer of a patient not be predicated on arbitrary, capricious, or unreasonable discrimination because of race, religion, national origin, age, sex, physical condition, or economic status.

(c) The rules must require that if a patient at a hospital has an emergency medical condition which has not been stabilized, the hospital may not transfer the patient unless:

(1) the patient or a legally responsible person acting on the patient's behalf, after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility;

(2) a licensed physician has signed a certification, which includes a summary of the risks and benefits, that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient and, in the case of labor, to the unborn child from effecting the transfer; or

(3) if a licensed physician is not physically present in the emergency department at the time a patient is transferred, a qualified medical person has signed a certification described in Subdivision (2) after a licensed physician, in consultation with the person, has made the determination described in such clause and subsequently countersigns the certificate.

(d) The rules also shall provide that a public hospital or hospital district shall accept the transfer of its eligible residents if the public hospital or hospital district has appropriate facilities, services, and staff available for providing care to the patient.

(e) The rules must require that a hospital take all reasonable steps to secure the informed refusal of a patient or of a person acting on the patient's behalf to a transfer or to related examination and treatment.

(f) The rules must recognize any contractual, statutory, or regulatory obligations that may exist between a patient and a designated or mandated provider as those obligations apply to the transfer of emergency or nonemergency patients.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 83, eff. Sept. 1, 1991; Acts 1993, 73rd Leg., ch. 584, Sec. 5, eff. Sept. 1, 1993.

Sec. 241.028. TRANSFER AGREEMENTS. (a) If hospitals execute a transfer agreement that is consistent with the requirements of this section, all patient transfers between the hospitals are governed by the agreement.

(b) The hospitals shall submit the agreement to the department for review for compliance with the requirements of this section. The department shall complete the review of the agreement within 30 days after the date the agreement is submitted by the hospitals.

(c) At a minimum, a transfer agreement must provide that:

(1) transfers be accomplished in a medically appropriate manner and comply with Sections 241.027(b)(2) through (5) and Section 241.027(c);

(2) the transfer or receipt of patients in need of emergency care not be based on the individual's inability to pay for the services rendered by the transferring or receiving hospital;

(3) multiple transfer agreements be entered into by a hospital based on the type or level of medical services available at other hospitals;

(4) the hospitals recognize the right of an individual to request transfer to the care of a physician and hospital of the individual's choice;

(5) the hospitals recognize and comply with the requirements of Chapter 61 (Indigent Health Care and Treatment Act) relating to the transfer of patients to mandated providers; and

(6) consideration be given to availability of appropriate facilities, services, and staff for providing care to the patient.

(d) If a hospital transfers a patient in violation of Subsection (c)(1), (2), (4), (5), or (6), relating to required provisions for a transfer agreement, the violation is a violation of this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 84, eff. Sept. 1, 1991; Acts 1993, 73rd Leg., ch. 584, Sec. 6, eff. Sept. 1, 1993.

Each RAC has identified specialty centers, within their own TSA or another TSA in the state. Specialty centers play an important role in the continuum of care. Depending on the specialty of the center, regional transport guidelines describe where a patient needing a specialty center should be taken directly to or transferred from an acute care facility to the specialty center. Reports from the Texas Trauma Registry of mean transport time and destination can be compared between Trauma Service Areas and are available by request. This is an excellent resource for RAC Executives and EMS Medical Directors to evaluate their regional protocols in standing PI committees.

2. Describe the roles of the non-designated acute care facilities in the trauma system.

Non-designated acute care facilities would typically receive only patients with minor injuries, unless to stabilize the patient before transfer and to sustain the patient during transfer to the most appropriate facility.

a. Address their representation on the regional trauma committee.

Participation by a non-designated facility with their RAC is purely voluntary and is not required by hospital licensing rule. Those non-designated facilities who choose to participate with their regional RAC help develop transport protocols, the region's trauma system plan, and define the role of the non-designated trauma facility. CEOs of non-designated facilities that do not currently participate with their regional RAC, are usually approached by the Executive Committee of the regional RAC and encouraged to consider how participation would benefit their facility and what impact pursuing designation might make for their facility and for the RAC. This approach is RAC-driven and not required by rule except that: Texas Administrative Code §157.123(b)(A) All health care entities who care for trauma patients should be offered membership on the RAC, and that (i) be operated in a manner that maximizes inclusion of their constituents . . .

b. Do they submit registry and/or financial data?

Not as a trauma system requirement, though they are required by hospital licensing to have a PI process in place. DSHS Registry rules require that non-designated acute care facilities submit registry/financial data. See link below for: Texas Administrative Code, Title 25, Chapter 103, Rule 103.4 Who Shall Report and List of Reportable Injuries and Events; Rule 103.7 Reporting Requirements for Hospitals, Rule 103.8 Reporting Requirements for Acute or Post-Acute Rehabilitation Facilities. Although required by rule, their compliance is minimal and to date there is no enforcement. Of the 381 undesignated hospitals in 2010, only 57, or 15%, were reporting registry data in 2007. Refer to links below for information.

- **Chapter 103 of the Texas Administrative Code**

Highlights include:

- 103.4 Who shall report and List of Reportable Injuries.
- 103.7 Reporting requirements for hospitals. All hospitals must submit data to the EMS/Trauma Registry.

c. What is their degree of engagement in the system-wide performance improvement process?

Not known.

3. Describe the process for verification and designation. Briefly outline the extent of authority granted to the lead agency to receive applications and to verify, designate, and de-designate regional trauma centers.

Designation/Re-designation at the state level requires facilities comply with Texas Administrative Code §157.125. See attachment (3.0) *Requirements for Trauma Facility Designation*. The designation process consists of three phases. First the facility submits an application the OEMS/TS. The office reviews the survey report and makes recommendations to the commissioner whether or not to designate the facility and at what level(s). The final phase ends with the commissioner's review and ends with a final decision.

For verification, Level I and II facilities and all free-standing children's facilities request a survey through the ACS trauma verification program. Level III and Level IV facilities can request through ACS or be surveyed through a contractor (TETAF) approved by the department.

The survey team composition is:

(1) Level I or Level II facilities shall be surveyed by a team that is multi-disciplinary and includes at a minimum: 2 general surgeons, an emergency physician, and a trauma nurse all active in the management of trauma patients.

(2) Free-standing children's facilities of all levels shall be surveyed by a team consistent with current ACS policy and includes at a minimum: a pediatric surgeon; a general surgeon; a pediatric emergency physician; and a pediatric trauma nurse coordinator or a trauma nurse coordinator with pediatric experience.

(3) Level III facilities shall be surveyed by a team that is multi-disciplinary and includes at a minimum: a trauma surgeon and a trauma nurse (ACS or department-credentialed), both active in the management of trauma patients.

(4) Level IV facilities shall be surveyed by a department-credentialed representative, registered nurse or licensed physician. A second surveyor may be requested by the facility or by the department. Please see §157.125 for credentialing requirements.

If a facility wishes to apply for a lower level of trauma designation, it may do so at any time. If the facility chooses to relinquish its trauma designation it shall provide at least 30 days notice to the OEMS/TS, it's RAC and other affected RACs; and the healthcare facilities to which it customarily transfers-out trauma patients or from which it customarily receives trauma transfer-in, of the change(s).

4. Describe your standards for trauma center verification (including pediatric standards) and the extent to which they are aligned with national standards.

Level I and Level II trauma centers must meet ACS standards and survey for state designation. See attachment (3.0) *Requirements for Trauma Facility Designation*. The attached graphics to the rule (x)(1)(2) and (y)(1)(2) describe Level III and IV standards. ACS criteria, as well as those of other states, were taken into account in the development of these standards.

Each Level III trauma facility has age-specific policies/processes that demonstrate knowledge of the special resources potentially needed in injured patients of all ages, and is cognizant of the pediatric capabilities of the hospitals to which it customarily transfers so that it can determine the most appropriate facility. A Level III trauma facility shall present its own pediatric capabilities to the RAC so that both EMS providers and other hospitals can determine the most appropriate facility to transport or transfer critically injured pediatric patients.

Level IV trauma facilities have age-specific policies/processes that demonstrate knowledge of the special resources potentially needed by injured patients of all ages, and is cognizant of the pediatric capabilities of the hospital to which it customarily transfers so that it can determine the most appropriate facility.

a. Describe any waivers or program flexibility granted for centers not meeting verification requirements.

Texas Administrative Code Rule §157.125(w) states: The office may grant an exception to this section if it finds that compliance with this section would not be in the best interests of the persons served in the affected local system. See:

- Policy and Procedure: Request for Temporary Exception to The Joint Commission Survey within One Year Requirement
- Policy and Procedure: Facility with Conditional Certification as Primary Stroke Center and De-Certification with The Joint Commission

b. Describe the process and frequency of use of dedesignation of trauma centers.

See Texas Administrative Code 157.128, Denial, Suspension, and Revocation of Trauma Facility Designation

5. Outline how the geographic distribution and number of designated acute care facilities is aligned with patient care needs.

There are currently 249 designated trauma facilities in the state of Texas.

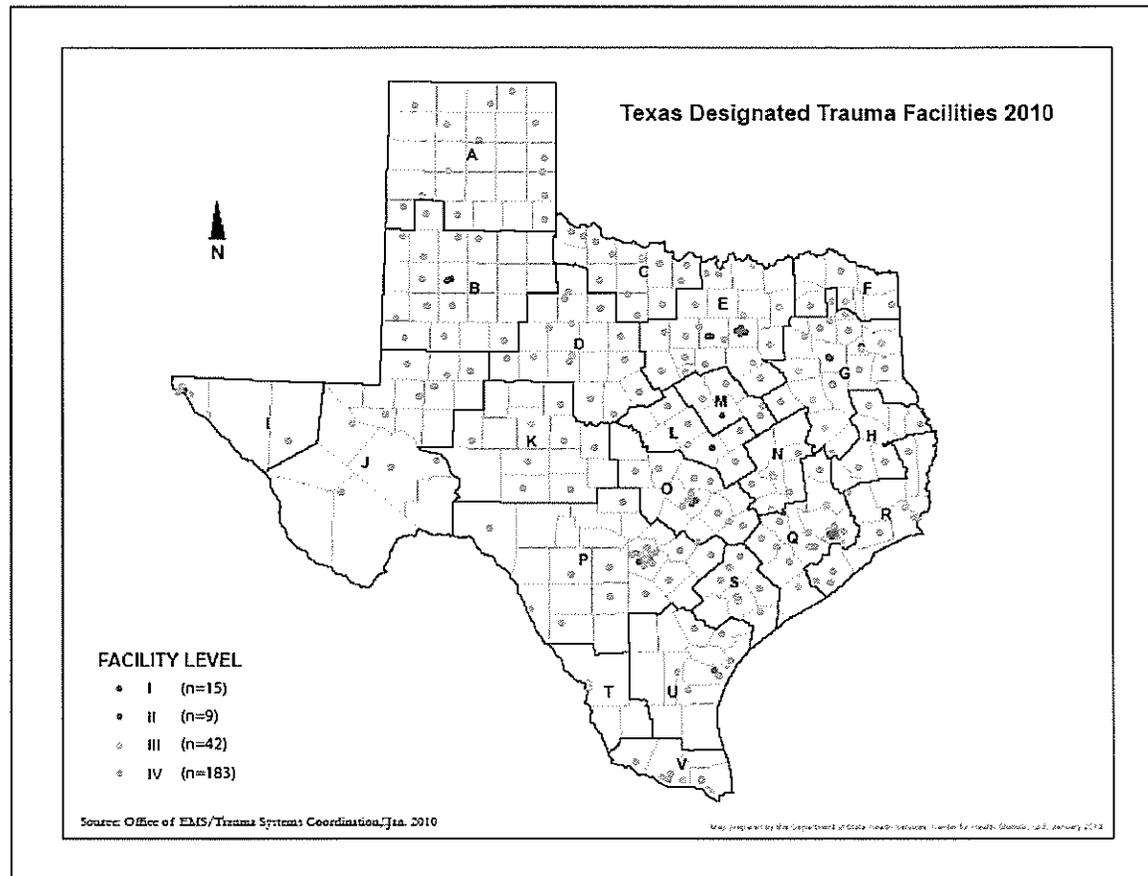
Level I Comprehensive Trauma Facilities: 15 facilities are currently designated.

Level II Major Trauma Facilities: 9 facilities are currently designated.

Level III Advanced Basic Trauma Facilities: 42 facilities are currently designated.

Level IV Basic Trauma Facilities: 183 facilities are currently designated.

See the most current map (2010) for designation by level in Texas on the next page.



a. Describe the process by which additional trauma centers are brought into the systems.

Facilities submit an application per the Texas Administrative Code Rule §157.125. When facilities are identified as being eligible for disproportionate share funds they are very likely to begin participation per the “Trauma Designation Yearly Stair-Step Requirements for Dispro Eligible Facilities.”

Another way additional trauma centers are brought into the system is with the incentive of uncompensated trauma care funding. Texas Health and Safety Code §780.004 directs DSHS to use 96% of funds in the DTF/EMS Account (3588 monies) to fund a portion of uncompensated trauma care provided at hospitals designated as state trauma facilities or a hospital meeting “in active pursuits” requirements.

Additionally, Texas Health and Safety Code §773.122 directs DSHS to use at least 27% of funds from the *Emergency Medical Services and Trauma Care System Account* (911 Monies) and *Emergency Medical Services, Trauma Facilities, & Trauma Care System Fund* (1131 Monies) to fund a portion of uncompensated care provided at hospitals designated as state trauma facilities.

b. Describe the system response to the voluntary withdrawal of designation by acute care facilities.

Each Trauma Service Area would be affected differently. While it might appear to be a disadvantage for any level of designated facility to relinquish designation, lower level and non-designated facilities play a very important role in the rural and frontier areas.

c. Describe the mechanism for tracking and monitoring patient volume and flow between centers and how this influences the overall configuration of designated facilities.

By rule TAC 25 §157.123(b)(2)(iii), in each RAC trauma system plan, (iii) the following components have been addressed: (I) injury prevention; (II) access to the system; (III) communications; (IV) medical oversight; (V) pre-hospital triage criteria; (VI) diversion policies; (VII) bypass protocols; (VIII) regional medical control; (IX) regional trauma treatment guidelines. Please see attachment (5.0) *NCTTRAC RAC E Trauma System Plan, 2010*, sections XV. Definitive Care Facilities, XVI. System Coordination and Patient Flow, XVIII Disaster Preparedness, for an example of how tracking and monitoring patient volume and flow between centers works on a regional level. Also, see attachment (5.1) *SETTRAC_MH Diversion* as an example of a real-time RAC response to a hurricane disaster.

In Texas, all hospitals and trauma systems have access to and can utilize internet-based communication tools like EMSsystems and WebEOC. EMSsystems provides the capability to monitor hospital status, ER status, bed availability, blood supplies, levels, available ventilators, available ambulances, and provide event notifications, etc. EMSsystems also provides data on End Stage Renal Disease (ESRD) facility status. EMSsystems and WebEOC have been integrated so that HA vBED reporting data in EMSsystems can be flowed into WebEOC when requested by the state. This capability provides available hospital beds by trauma Service Area. The RAC of each region report available beds and post this board as requested during a response.

6. Describe your system for assessing the adequacy of the workforce resources available with participating centers.

Except as required by designation rule or facility licensing, we do not assess the adequacy of the workforce resources available with participating centers. Assessment of the adequacy of the workforce resources is determined by the facility.

7. Describe the educational standards and credentialing for emergency physicians and nursing staff, general surgeons, specialty surgeons, and critical care nurses caring for trauma patients in designated facilities.

These standards are described in the Texas Administrative Code §157.125.(x)(y); Trauma Facility Criteria.

a. What regional educational multidisciplinary conferences are provided to care providers? Who is responsible for organizing these events?

These standard are described in the Texas Administrative Code§157.125(x)(y) Trauma Facility Criteria. The regional RACs are required in Texas Administrative Code §157.123(c)(II)(E) Essential Criteria to provide education and training to meet the needs identified in the annual needs and/or in performance improvement activities. See attachment (7a.0) *RAC Trauma Symposium*. TETAF also coordinates educational opportunities. See attachment (7a.1) *Texas EMS and Acute Care Foundation*. Also see attachment (7a.2) *TETAF Injury Prevention Symposium (TIPS)*. The DSHS OEMS/TS organizes and annual EMS Conference is one of the largest in the nation, by attendee number and vendor participation. See attachment (7a.3) *2009 Texas EMS Conference*.

Documentation Required

Before the site visit:

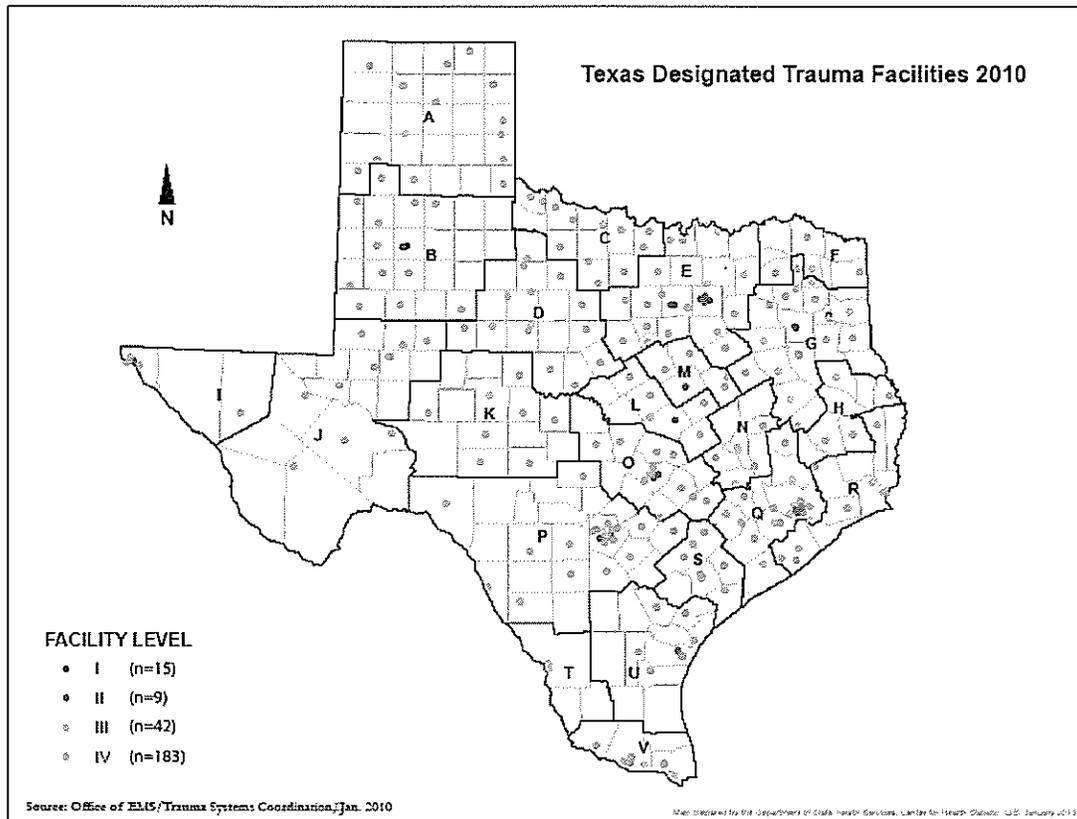
- ✓ Copy of the document outlining the process for designation, redesignation, and dedesignation (if necessary) of the trauma centers

Texas Administrative Code 157.125, Requirements for Trauma Facility Designation

Texas Administrative Code 157.128, Denial, Suspension, and Revocation of Trauma Facility Designation

- ✓ Copy of the standards (if other than ACS) used for trauma center verification- Answered above: TAC §157.125 and all attached graphics of the rule.

- ✓ A list of acute care facilities with the following data for each:
 - Level of designation/verification: List of Facilities by Designation Level
 - A geographic map showing the location, catchment areas, and designation for all acute care facilities



- Patient volume (total and with Injury Severity Score (ISS) > 15, if available)
 - Emergency department (ED) visits
 - Admissions
- A list of trauma facilities with their level of designation and trauma patient volume (total and with ISS > 15)

On-site:

- ✓ Copy of the sample contract or memorandum of understanding between the lead agency and a trauma system if such exists. See attachments OSV.0 *Designation Letter*, OSV.1 *Designation Certificate*, and OSV.3 *Contracts*.
- ✓ Flyer for the most recent multidisciplinary educational trauma conference. See the attached files: OSV.4 *Austin Trauma & Critical Care Conference*; OSV.5 *Annual EMS Conference Brochure, 2009*; OSV.6 *CTRAC March 3, 2010 Trauma Conference*

Brochure; OSV.7 RAC F-G-H Web EOC-Final Brochure; OSV.8 TETAF Injury Prevention Symposium. OSV.8 Harris County Trauma Brochure