Trauma System Plan

Prereview Questionnaire

1. Describe the process for the development or revision of the trauma system plan.

a. Include the role of advisory and stakeholder groups in the process.

The Texas Trauma System Plan is not a separate document; it is inherent in the enabling and subsequent statutes, regulations, and other related documents including a Texas Trauma System overview, external assessments and reassessments, an EMS State Plan and a Strategic Plan for Texas EMS/Trauma System are included as attachments: see attachment (1.0) *Texas Trauma System;* attachment (1.1) *NHTSA Technical Assistance Team Recommendations and Status of Recommendations*; attachment (1.2) *EMS State Plan 1992-1996 & Status of Objectives, August, 2001*; attachment (1.3) *Emergency and Trauma Care in Texas-Policy Brief*; attachment (1.4) *Emergency and Trauma Care in Texas-Primer*; attachment (1.5) A *Strategic Plan for the Texas EMS/Trauma System, December, 2002*; attachment (1.6) *Appendix G-Emergency and Trauma Care in Texas: Assessment, Challenges, and Options, October, 2005.*

The strategic plan, attachment (1.5), mentioned above, developed in December, 2002, was the result of work of GETAC, GETAC Committees, task forces and stakeholder groups from around the state. The timing of their comprehensive assessment of emergency health care needs was partially in response to the dramatic events of September 11 and the significant changes in demands on Emergency Medical Services and Trauma Systems throughout the state. A concerted effort was made to solicit maximum participation and explore every possible issue identified in order to develop a strong consensus for the plan.

As stated above, the state trauma system plan, as such, is defined by statute, rules and related documents (see Section 2: Statutory Authority and Administrative Rules) and by contracts administered through the Office of EMS/TS Coordination and the DSHS Client Services Contracting Unit (CSCU). The state trauma system is a network of the 22 different Trauma Systems, one for each RAC in the state, as defined in each RAC's trauma system plan. As examples, see attachment (1.7) *Trauma System Plan for Texas "J" RAC (frontier)*; attachment (1.8) *Trauma System Plan for Piney Woods RAC G (rural)*, attachment (1.9) *Trauma System Plan of Southwest Texas RAC P (mixed)*; attachment (1.10) *Trauma System Plan for North Central Texas RAC E (urban)*; attachment (1.11) *Trauma System Plan for Far West Texas & Southern New Mexico RAC I (multi-state)* . A hardcopy manual will be provided on-site and will include every TSA-RAC Trauma System Plan for review.

2. Is there ongoing assessment of trauma resources and asset allocation with the system?

Yes; ongoing assessment of trauma resources and asset allocation within the system is accomplished by each RAC as an annual report requirement by contract and rule. Annual needs assessments drive decision making as required by rule. Please see Texas Administrative Code, TITLE 25, RULE §157.123, the attached graphic included in the rule(2.0) *Figure: 25 TAC §157.123(c), commonly referred to as the "Essential Criteria"*. The annual report includes the most recent years' revisions to bylaws and regional trauma system plan. See attachment: (2.1) *Annual Report Format.* Each RAC is also required by contract to make quarterly financial reports. See attachments, (2.2), (2.2) *Contract,* and attachment (2.3) *Annual Report Format.* Programmatic monitoring is conducted by the OEMS/TS first, by RAC self-assessment, then by OEMS/TS desk review or site visit, and evaluation reports. See attachments: (2.4) *Desktop Review Tool*, attachment (2.5) *Required Modification Letter Blank*, and attachment (2.6) *Compliance Letter.* Fiscal monitoring is routinely performed on-site by the Fiscal Monitoring Branch, Contract Oversight and Support Section of DSHS.

3. Describe the process used to determine trauma system standards and trauma system policies.

The process used in Texas to determine trauma system standards and trauma system policies is by statutory authority and administrative rule and has been described in detail in a previous section by that name. Stakeholders have state input into revisions of rule and through their advisory roles by participation in their own regional RAC, the Governor's EMS/Trauma Advisory Council (GETAC), the Texas EMS Trauma & Acute Care Foundation (TETAF), and other stakeholder organizations.

a. How are they reviewed and evaluated?

From the state perspective, trauma system standards and trauma system policies are reviewed and revised on a schedule described in a previous section titled: *"Statutory Authority and Administrative Rules"*. DSHS contracts with RACs and EMS entities are administered for the most part through the DSHS Client Services Contracting Unit (CSCU). Once the contract is finalized, with input from the Office of EMS/Trauma Systems Coordination, and signed by the contractor, monitoring of contract standards and policies authorized by statue and rule is accomplished in several different ways. See attachment (3a.0) *Contracts* and attachment, (3a.1)) *Annual Report Format.* Programmatic monitoring is conducted by the OEMS/TS first, by RAC self-assessment, then by OEMS/TS desk review or site visit, and evaluation reports. See attachments: (3.a.2) *Desktop Review Tool*, attachment (3a.3) *Required Modification Letter Blank*, and attachment (3a.4) *Compliance Letter.*

b. What standards and policies exist for special populations, including rural and frontier regions?

Each RAC addresses special populations, identified through their needs assessment and on-going system quality improvement, in their trauma system plan. In addition, there are provisions in the statute that address rural areas. See below:

81st Legislature, General Appropriation Act, Rider 24 -- Trauma Formula Distribution. It is the intent of the Legislature that the Department of State Health Services allocate monies from the emergency medical services and trauma care system fund in accordance with all applicable laws including Health and Safety Code, §773.122(c) and §780.004(d). It is further the intent of the Legislature that the Department of State Health Services weight the statutory criteria in such fashion that, in so far as possible, 40 percent of the funds are allocated to urban counties and 60 percent of the funds are allocated to rural and frontier counties.

Health and Safety Code, Chapter 773. Emergency Medical Services, contains the following in regard to rural standards and policies for rural populations:

Sec. 773.0045. TEMPORARY EXEMPTIONS FOR EMERGENCY MEDICAL SERVICES PERSONNEL PRACTICING IN RURAL AREA.

(a) In this section, "rural area" means:
  (1) a county with a population of 50,000 or less; or
  (2) a relatively large, isolated, and sparsely populated area in a county with a population of more than 50,000.

(b) The department on a case-by-case basis may temporarily exempt emergency medical services personnel who primarily practice in a rural area from a requirement imposed either by Section 773.050 or 773.055 or by a rule adopted by the department under Section 773.050 or 773.055 if specific circumstances that affect the rural area served by the emergency medical services personnel justify the exemption. The department may temporarily exempt the emergency medical services personnel from a requirement imposed:
  (1) by a department rule adopted under Section 773.050 or 773.055 only if the department finds that, under the circumstances, imposing the requirement would not be in the best interests of the people in the rural area who are served by the emergency medical services personnel; and
  (2) by Section 773.050 or 773.055 only if the department finds that, under the circumstances, there is a substantial risk that imposing the requirement will detrimentally affect the health or safety of one or more persons in the affected rural area or hinder the ability of emergency medical services personnel who practice in the area to alleviate a threat to the health or safety of one or more persons in the area.

(c) The exemption must be in writing, include the findings required by Subsection (b), and expire at a stated time. The written findings must be accompanied by a concise and explicit statement that specifically describes the circumstances that support the finding.

(d) In granting the exemption, the department in writing must require the affected emergency medical services personnel or the appropriate emergency medical

services provider to adopt a written plan under which the applicable requirement will be met as soon as possible.

(e) A temporary exemption under this section may allow emergency medical services personnel who are applicants for certification at a higher level of training to temporarily practice at the higher level.

Added by Acts 2003, 78th Leg., ch. 848, Sec. 1, eff. June 20, 2003.

Sec. 773.012. ADVISORY COUNCIL.

(a) The governor shall appoint an advisory council to advise the board regarding matters related to the responsibilities of the board, commissioner, and department under this chapter. In making appointments to the advisory council, the governor shall ensure that approximately one-half of the members of the advisory council are residents of rural areas of the state.

(10) a representative of hospitals, who is affiliated with a hospital that is a designated trauma facility in a rural community, appointed from a list of names recommended by a statewide association of hospitals;

Sec. 773.025. ACCESSIBILITY OF TRAINING.

(b) A delivery area plan must include provisions for encouraging emergency medical services training so as to reduce the cost of training to emergency medical services providers and to make training more accessible to low population or remote areas.

(c) A governmental entity that sponsors or wishes to sponsor an emergency medical services provider may request the bureau to provide emergency medical services training for emergency care attendants at times and places that are convenient for the provider's personnel, if the training is not available locally.

(d) A governmental entity or nongovernmental organization that sponsors or wishes to sponsor an emergency medical services provider or first responder organization in a rural or underserved area may request the bureau to provide or facilitate the provision of initial training for emergency care attendants*, if the training is not available locally. The bureau shall ensure that the training is provided. The bureau shall provide the training without charge, or contract with qualified instructors to provide the training without charge, to students who agree to perform emergency care attendant services for at least one year with the local emergency medical services provider or first responder organization. The training must be provided at times and places that are convenient to the students. The bureau shall require that at least three students are scheduled to take any class offered under this subsection.

* **81st Legislature, General Appropriation Act, Rider 49 -- Emergency Care Attendant (ECA) Training.** Out of funds appropriated above, the Department of State Health Services (DSHS) shall allocate $50,000 in fiscal year 2010 and $50,000 in fiscal year 2011 for the purpose of providing training grants to local Emergency

Medical Services (EMS) instructors to conduct Emergency Care Attendant courses in or near communities lacking local training resources. DSHS shall contract with certified EMS instructors to conduct the 40-hour Emergency Care Attendant courses.

Sec. 773.114. SYSTEM REQUIREMENTS.

(a) Each emergency medical services and trauma care system must have:
  (1) local or regional medical control for all field care and transportation, consistent with geographic and current communications capability;
  (2) triage, transport, and transfer protocols; and
  (3) one or more hospitals categorized according to trauma care capabilities using standards adopted by board rule.

(b) This subchapter does not prohibit a health care facility from providing services that it is authorized to provide under a license issued to the facility by the department.

Added by Acts 1991, 72nd Leg., ch. 14, Sec. 267, eff. Sept. 1, 1991.
Redesignated from Health & Safety Code Sec. 773.084 by Acts 1991, 72nd Leg., ch. 605, Sec. 9, eff. Sept. 1, 1991.

No specific references were found for frontier standards and policies.

c. How are specialized needs addressed, including burns, spinal cord injury, traumatic brain injury, and reimplantation?

Specialized needs are addressed through the trauma system designation process, see attachment (3c.0) *Texas Administrative Code §157.125.Requirements for Trauma Facility Designation.*

RACs also develop and approve medical guidelines for treatment on-scene and transportation of specialized needs patients. See attachment (3c.1) *Brazos Valley Regional Advisory Council, TSA N, Regional System Plan, 2008-2009, pages 46-61* and see attachment (3c.2) *Central Texas RAC.TSA L. Emergency Healthcare System Plan.2009, pages 58-63.* Both the regions referred to by these attachments are considered rural regions.