Regional Advisory Councils – DRAFT (version 7.0 –Feb 9, 2016)

SUGGESTED TIMELINE:

Immediately: Some of the Maternity (OB) and Neonatal leaders of the region should make contact with Trauma RAC their region to plan next steps for forming a **Perinatal** Regional Advisory Council

- Notify all hospitals in region that provide OB or Neonatal care of need to "actively participate" in Perinatal RAC as a requirement of designation
- Look for best structure for the Perinatal Regional Advisory Council within the Trauma RAC system (may be a Workgroup or Committee)
- Schedule a meeting (aim for May/June 2016) for all hospitals in region to agree on a structure for Perinatal Regional Advisory Council

At May/June Meeting, need to select a leadership team, approve governing principles, set up meeting structure (need to coordinate with Trauma RAC Leadership). This should be a preliminary structure with intent of a more permanent structure within 2-3 years.

Recommendations for Defining Active Participation: Designation requires every hospital to show "active participation" in region. This should be a relatively "low bar" for the first 2 years during transition. For example, each facility appointing one Neonatal and one Maternity representative, perhaps send basic information via email/online (# deliveries, # beds).

I. **Definitions**

a. **Maternal**- dealing with mother, pregnancy
b. **Neonatal**- dealing with newborn especially the first month of life
c. **Perinatal**- dealing with both pregnancy, postpartum, and neonatal (includes both maternal and neonatal)
d. **Perinatal Regional Advisory Council**- stipulated by HB15 but not specified regarding its exact structure. Dept of State Health Services has further defined that these Perinatal Regional Advisory Councils should reside within the Trauma Regional Advisory Council system, and may take the form of a workgroup, committee, or other structure.

II. **Background**

House Bill 15 (83R) calls for the state of Texas to be divided into neonatal and maternity regions, and to facilitate transfer agreements through regional coordination. To best understand the community needs in the different regions and encourage collaboration and coordination, Perinatal Regional Advisory Councils are to be developed. The purpose of these Perinatal Regional Advisory Councils is to improve the care of the patients in the region; these councils should not have authority to influence specific hospital payments, dictate transfers, or affect specific hospital designation. Participation from the hospitals in the region is vital for proper coordination, yet requirements for participation that are excessive would be unreasonable and onerous. These guidelines are written

to give some examples for overall structure for each region, encourage the avoidance of undesirable practices (such as one hospital taking unfair advantage over another hospital), and provide sufficient leeway to allow each region to construct its own **Perinatal** Regional Advisory Council to best serve its region's hospitals, practitioners, and patients. Each facility needs to have neonatal designation by Sept 1, 2018 to receive Medicaid payments for newborn care; each facility needs to have maternity designation by Sept 1, 2020 to receive Medicaid payment for obstetrical care by Sept 1, 2020. A requirement of designation is "active participation" in the Perinatal Regional Advisory Council, which has subsequently been defined as the 22 Trauma Regions.

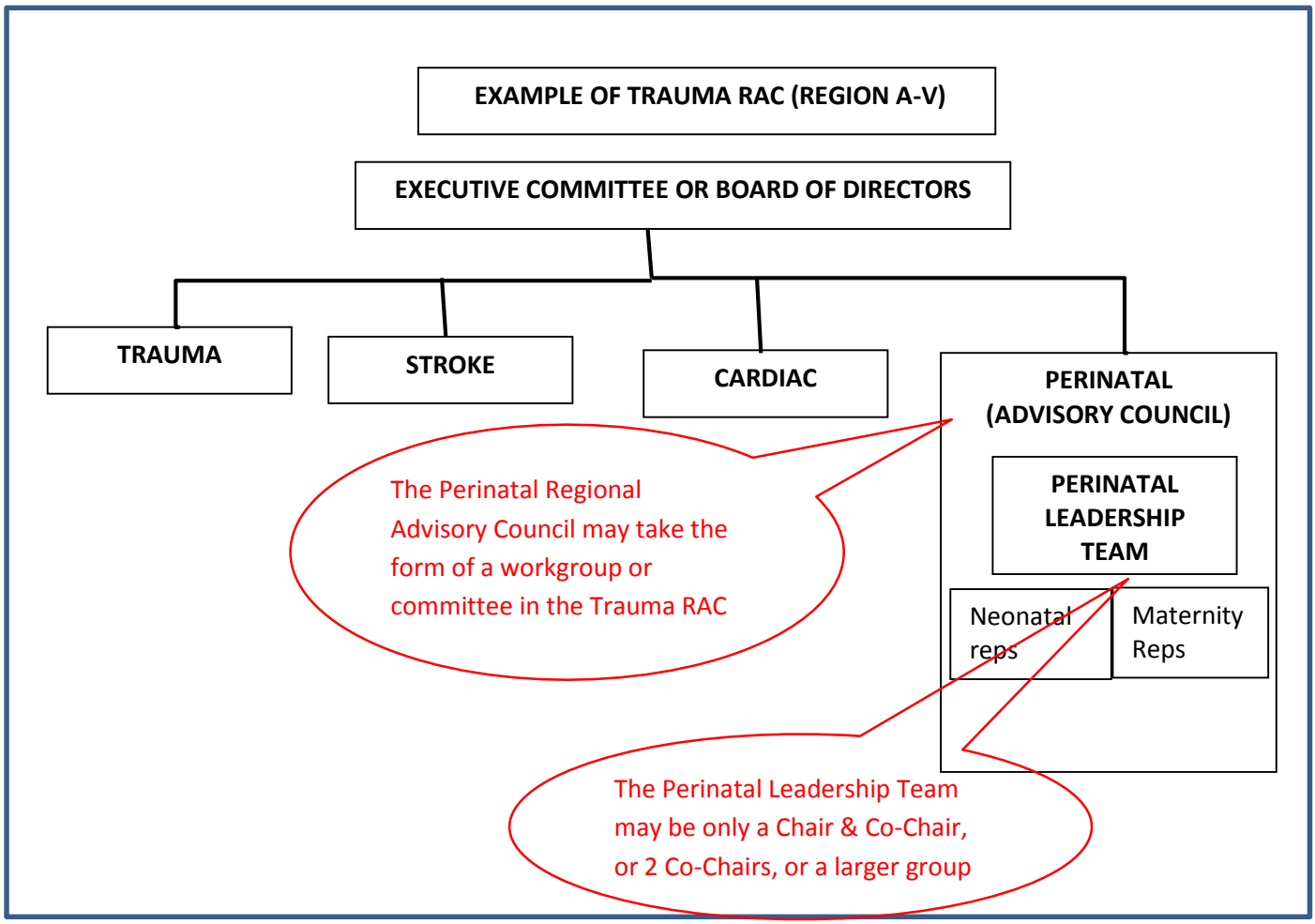
III. The state of Texas will be divided into regions based on the 22 Trauma Regions, and each of the Perinatal Regional Advisory Councils will be under the Trauma RAC system, and may be in the form of a workgroup or committee (likely analogous to stroke or cardiac). **Because each of the Trauma RACs is unique and independent, the exact working structure may differ from region to region. There is the option of Perinatal Regional Advisory Councils being composed of two or more regions for logistical reasons.**

IV. PURPOSE, MISSION, AND SCOPE

a. Each region of the state will have a Perinatal Regional Advisory Council, which needs to fit within the context and rules of the Trauma RAC (work group vs committee etc)
b. **Example of Purpose Statement:** "The Purpose of the Perinatal Regional Advisory Council is to improve the quality of healthcare and access to care for pregnant women and newborns in the region."
c. **Example of Execution:** The Means by which the Perinatal Regional Advisory Councils will reach their goals will be by collaboration of the healthcare providers and healthcare facilities in the region, and partnering with other community entities, and working within the current Trauma RAC framework. By improved education, communication, collaboration, quality improvement, and resource coordination, the patients in the region will be served.
d. **Example of Mission Statement** for each Perinatal Regional Advisory Council: "Each patient in the region should have the best possible neonatal and maternity medical care"
e. The Perinatal Regional Advisory Councils will **not** have any oversight over referral or transfer of patients, payments or denial of services, or specific patient complaints
f. **Dealing with Data:** The Perinatal Regional Advisory Councils will deal with outcome or other data in aggregate form such as per region or per county, and not via specific hospital. The data is derived from hospital data that is collated and de-identified, but must be confidential and protected. The Perinatal Regional Advisory Councils will not be authorized to investigate specific hospitals or healthcare providers, will not have input into a specific hospital's application for designation, and are not the proper venue for specific patient or hospital complaints, or peer review matters.

V. SOME EXAMPLES OF COMPOSITION

a. The Perinatal Regional Advisory Council for each region should be composed of both neonatal and maternity representatives.
b. Each hospital in a particular region should appoint two (2) representatives to the Perinatal Regional Advisory Council. Please recall that **there will be separate designations for neonatal and maternal level of care regardless if they are in the same facility or not.**
    i. Since most hospitals provide both obstetrical and newborn care, they should appoint one neonatal representative and one maternity representative, one of whom must be a clinical practitioner. Alternates with suitable credentials may be named.
    ii. Each licensed hospital per location is **separately designated** and should have unique representatives. For example a hospital system cannot have one individual representing multiple hospitals. Likewise, one individual cannot represent multiple independent hospitals.
    iii. Less commonly, a hospital that provides only newborn care (children's hospitals) will appoint two neonatal representatives, one of whom will be a clinical practitioner. Alternates with suitable credentials may be named.



APPENDIX A – SAMPLE MEETING STRUCTURE

I. MEETING REQUIREMENTS
   a. The meeting requirements should be consistent with the region's current practice.
   b. Each region's Perinatal Advisory Council should aim to meet several times a year (such as four times a year, once a quarter).
   c. Ideally, at least one meeting each calendar year should be designated as the Annual Meeting and with face-to-face in which business and voting is conducted. The other meetings may be by telephonic or videoconferencing if desired. Distance or logistics of the region may allow for flexibility.
   d. **NOTE**: At the time of application for designation, each hospital MUST DEMONSTRATE ACTIVE INVOLVEMENT IN ITS PERINATAL RAC. Thus, a Perinatal RAC must be formed, and define active involvement and document whether a hospital has met this definition. During the initial transition, the Perinatal RAC may elect to be more lenient in its definition of "active participation" and then more formalized in 2 years, example by 2018.
   e. Written minutes should be kept of each Perinatal Advisory Council meeting. All minutes must be made submitted in a timely manner as per the Trauma Regional Advisory Council procedure.

II. FACILITY ATTENDANCE REQUIREMENTS
   a. Each hospital that receives state neonatal and/or maternity designation must actively participate in their region's Perinatal Regional Advisory Council meetings (which is required in HB15)
   b. Active Participation by a facility in the Perinatal Regional Advisory Council should be defined as fulfilling requirements as set up by the region. It would be ideal to discuss with the current Trauma RAC leadership for consistency. (Example of one option):
      i. the facility's two representatives or designees each individually attending a minimum of 50% of Perinatal Regional Advisory Council meetings each calendar year, and
      ii. at least one representative attending the Annual face-to-face meeting.
   c. If either representative fails to attend at least 50% of meetings in any calendar year, that facility will be noncompliant with the attendance requirement and be in jeopardy of losing designation status.
   d. Examples
      i. Hospital XYZ appoints representatives A and B to the Regional Advisory Council.
         1. Representative A attends Spring, Summer meetings, but misses Fall and Winter meetings.
         2. Representative B attends the Summer and Winter (Annual) meeting. The face-to-face Annual Meeting is in the Winter.
         3. Hospital XYZ is in compliance with the attendance requirement because Representative A and attended 50% of meetings, and Representative B has

attended 50% of meetings, and at least one (Representative B) attended the face-to-face meeting.

ii. Hospital ABC appoints representatives D and E to the Regional Advisory Council.
    1. Both of the representatives attend the Spring and Summer meetings, but no others.
    2. The Winter meeting is the Annual Face-to-face meeting (neither rep attended)
    3. The facility is noncompliant with the attendance requirement and faces possible loss of designation status.

iii. Hospital DEF appoints representatives Y and Z to the Regional Advisory Council.
    1. Representative Y attends each of the 3 quarterly meetings, and designee R attends the Winter face-to-face meeting.
    2. Representative Z attends the Winter face-to-face meeting and no other meeting and did not arrange for an alternate to attend.
    3. Hospital DEF is noncompliant with attendance since Representative Z did not attend at least 50%.

III. ORGANIZATION OF PERINATAL REGIONAL ADVISORY COUNCIL

a. **FEB-MAR 2016:** A group of perinatal leaders in EACH region should organize as an ad hoc committee for the purpose of disseminating information, and coordinating a first meeting, and contacting the Trauma RAC leadership for guidance and coordination. This initial leadership group may consist of Perinatal Advisory Council members or other interested parties, and **should not** be viewed as self-appointed Perinatal RAC leadership.

b. At its first meeting, the **Perinatal** Regional Advisory Council members should appoint a Leadership Team, in consultation with the Trauma RAC leadership. Options include a Chair, Vice Chair, and Secretary, or a Leadership "Group" (ie, Committee) composed of an equal number of neonatal and maternity representatives, in general numbering approximately 10-14 members, and in consultation with the Trauma RAC leadership.
    i. The process of nomination to the Leadership Team should be an open process with adequate notice, and selection of the Leadership Team should be based on an individual's qualifications as well as representative area (ie, rural area, level II facility). Any single hospital system should in general be limited to 2 nominees per region.
    ii. Because of the large geographic or population size of the region, the Perinatal Regional Advisory Council committee may choose to subdivide the region into 2 or 3 smaller subregions for more convenient communication or collaboration. Subregions may also choose to meet, but those meetings are not applicable to the Meetings Attendance Requirement (IV-c, and V).

c. LEADERSHIP TEAM
   i. Composition: The composition of the Leadership Team should be diverse.
      1. Care should be taken to ensure that the leadership team is geographically diverse, represent different hospitals or hospital systems, smaller as well as larger hospitals, and community hospitals as well as academic centers.
      2. Care should be taken to ensure that the Leadership team have an approximately equal number of maternity and neonatal representatives
      3. The Leadership team should have a mixture of expertise and experience including physicians, nurses, and hospital administrators

   ii. CHAIRS
      1. Each Leadership team should choose its two Co-Chairs or Chair and Vice Chair, one representing neonatal care, and one representing maternity care; they should not be from the same institution, physician group, or hospital system
      2. A member of the state Perinatal Advisory Council who practices in the region may be asked by the Leadership team to serve ex officio on the Board, but should not be a chairperson

   iii. DUTIES- the Leadership team has responsibility to oversee the Perinatal Regional Advisory Council (which may be a workgroup or committee under the Trauma RAC system), schedule meetings, set the agenda, provide organization to the Advisory Council, keep accurate attendance to meetings, ensure minutes of all meetings are kept and distributed, promote an orderly transition of officers, and ensure fair representation from the various facilities and geographic areas of the state
   iv. JURISDUCTION OF PERINATAL LEADERSHIP TEAM-
      1. The leadership team should not be viewed as “the rule making entity” for the region, but be the vehicle to allow broad input and discussion, and represent the needs of the region, and the voices and concern of the region’s healthcare providers and facilities.
      2. Leadership should avoid actions that are self-promoting or give unfair advantage to one’s own institution, and should avoid issues represents a clear conflict of interest.
   v. ATTENDANCE RECORDS – Because of the strict requirement for attendance, the Leadership team should ensure that each facility have access to their representatives’ attendance with percent attendance for the calendar year.
   vi. The Perinatal Regional Advisory Council Chair or designee, in consultation with the Trauma RAC leadership, should formally notify any facility that have one or more representative failing to meet the attendance requirement, and the Department of State Health Services should also be promptly notified.
   vii. The Chair will serve also as a liaison to the Trauma RAC Leadership.

viii. SOME EXAMPLES OF TERMS (These are only suggestions)- Leadership team members should have terms of no more than 3 years, and preferably rotate off after their term.
    1. Consecutive terms may be discouraged; however, non-consecutive terms of service may be allowed.
    2. STAGGERED TERMS-
        a. Because the first Perinatal Leadership team has all of its members starting simultaneously and would turn over in its entirety when the terms are completed, the Perinatal Regional Advisory Council may choose to designate up to half of the first Leadership team members to one extra year of service (maximum 4 years for total term) to allow for overlap in Leadership team.
        b. However, for each circumstance after the first Leadership team terms, each Leadership member's term is limited to a maximum of 3 years.

d. RULES AND ADOPTION OF RULES-
    i. Each Perinatal Regional Advisory Council should determine its rules and overall structure with consultation with its region's Trauma RAC leadership. The perinatal RAC may choose to empower its Leadership team to draft proposed rules, but the entire Perinatal RAC should vote (example, with at least 2/3 approving any rules or changes to rules). Other examples:
        1. Rules relevant to the Leadership team's internal operating procedures should be developed and approved by the leadership team by at least 2/3 majority.
        2. Rules that may affect matters outside the simple operating of the Leadership team should be taken to the entire **Perinatal** Regional Advisory Council for vote.
            a. Substantial decisions such as proposed changes to RULES or proposed region quality project must have at least 2/3 approval of the Leadership team to then present to the entire Regional Advisory Council.
                i. Exceptions include urgent issues or unanticipated circumstances that require timely intervention. In these cases, the Perinatl Leadership team may approve a change in the rule by 2/3 approval of the Perinatal Leadership Team in consultation with the Trauma RAC Leadership, but send the specific rule change to the full Perinatal Regional Advisory Council with the rationale.
            b. Less substantial decisions such as approval of minutes may be determined by a simple majority.

e. Written Report- Each Perinatal Regional Advisory Council should submit a written report once a year (Due Nov 1) to the state Perinatal Advisory Council, HHSC, and the state DSHS with the following:

i. Summary of the meetings for the year, key discussions and resolutions, and notable events
ii. Quality Improvement Project(s)
    1. Describe the outcome of any region Quality Improvement projects from the past year including successes, lessons learned, challenges, and next steps. As much as possible, quantitative and meaningful data should be used in the report.
    2. Describe at least one quality improvement project for the region the upcoming year. The quality improvement project should be patient and community centered. Ideally, the project should use aggregate data for the region identifying a significant quality of care concern, and a proposed plan to address the issue.
iii. Listing of any educational programs that were developed for the region including location, attendance, impact, and their rationale
iv. Best practices identified in facilities or practices in the region, including the background, facility or community, patients served, implementation, and effects.
v. Address the region's outcomes that fall below national or state average (aggregate data), or other issues assigned by the DSHS, HHSC, or the State Perinatal Advisory Council; this should include explanations for the possible reason(s) for the suboptimal outcomes, and proposed strategies to improve outcomes.
vi. Other Comments or Recommendations

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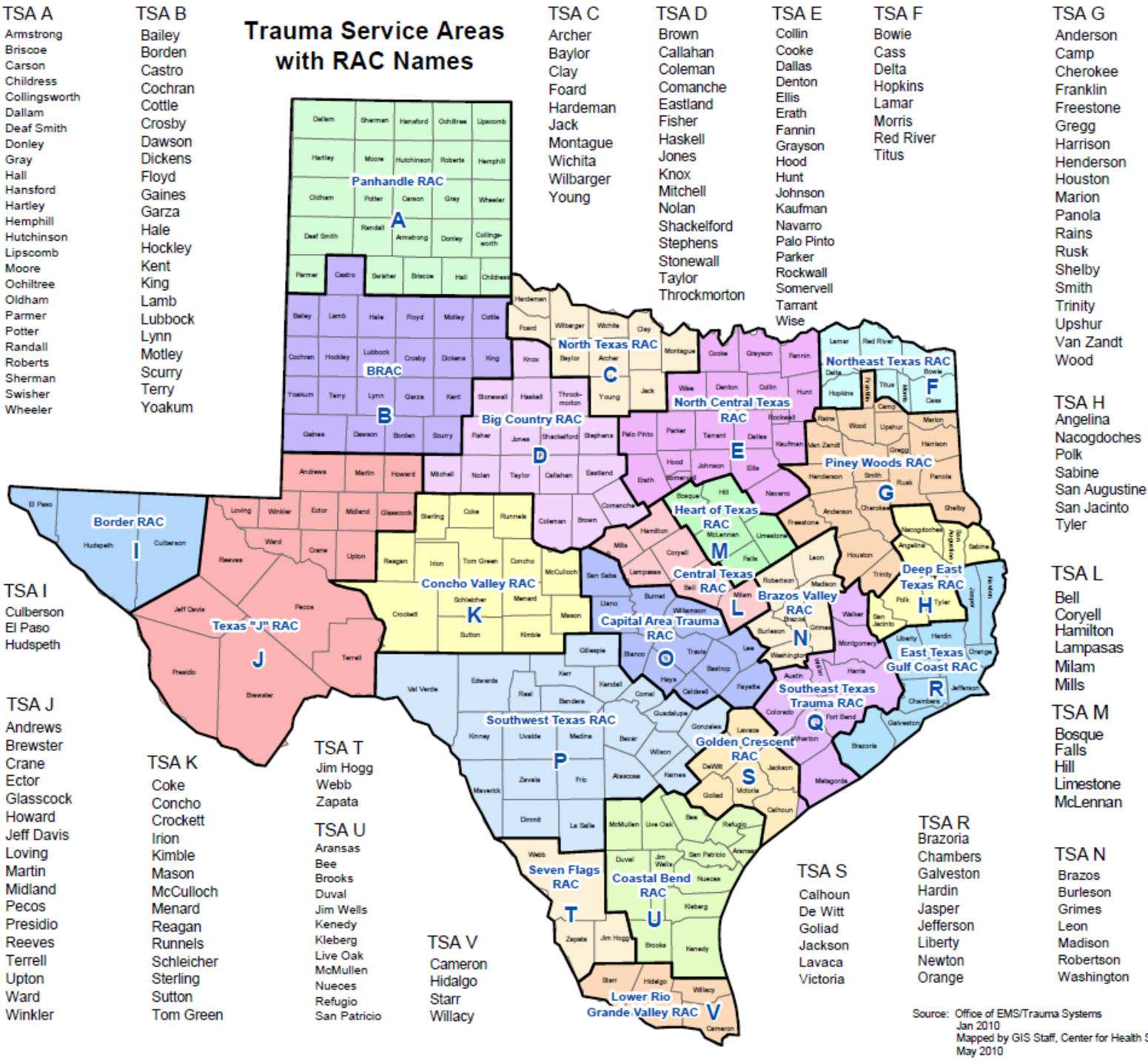
APPENDIX C: MAP OF REGIONS



TSA A
Armstrong
Briscoe
Carson
Childress
Collingsworth
Dallam
Deaf Smith
Donley
Gray
Hall
Hansford
Hartley
Hemphill
Hutchinson
Lipscomb
Moore
Ochiltree
Oldham
Parmer
Potter
Randall
Roberts
Sherman
Swisher
Wheeler

TSA B
Bailey
Borden
Castro
Cochran
Cottle
Crosby
Dawson
Dickens
Floyd
Gaines
Garza
Hale
Hockley
Kent
King
Lamb
Lubbock
Lynn
Motley
Scurry
Terry
Yoakum

TSA C
Archer
Baylor
Clay
Foard
Hardeman
Jack
Montague
Wichita
Wilbarger
Young

TSA D
Brown
Callahan
Coleman
Comanche
Eastland
Fisher
Haskell
Jones
Knox
Mitchell
Nolan
Shackelford
Stephens
Stonewall
Taylor
Throckmorton

TSA E
Collin
Cooke
Dallas
Denton
Ellis
Erath
Fannin
Grayson
Hood
Hunt
Johnson
Kaufman
Navarro
Palo Pinto
Parker
Rockwall
Somervell
Tarrant
Wise

TSA F
Bowie
Cass
Delta
Hopkins
Lamar
Morris
Red River
Titus

TSA G
Anderson
Camp
Cherokee
Franklin
Freestone
Gregg
Harrison
Henderson
Houston
Marion
Panola
Rains
Rusk
Shelby
Smith
Trinity
Upshur
Van Zandt
Wood

TSA H
Angelina
Nacogdoches
Polk
Sabine
San Augustine
San Jacinto
Tyler

TSA I
Culberson
El Paso
Hudspeth

TSA J
Andrews
Brewster
Crane
Ector
Glasscock
Howard
Jeff Davis
Loving
Martin
Midland
Pecos
Presidio
Reeves
Terrell
Upton
Ward
Winkler

TSA K
Coke
Concho
Crockett
Irion
Kimble
Mason
McCulloch
Menard
Reagan
Runnels
Schleicher
Sterling
Sutton
Tom Green

TSA T
Jim Hogg
Webb
Zapata

TSA U
Aransas
Bee
Brooks
Duval
Jim Wells
Kenedy
Kleberg
Live Oak
McMullen
Nueces
Refugio
San Patricio

TSA V
Cameron
Hidalgo
Starr
Willacy

TSA L
Bell
Coryell
Hamilton
Lampasas
Milam
Mills

TSA M
Bosque
Falls
Hill
Limestone
McLennan

TSA R
Brazoria
Chambers
Galveston
Hardin
Jasper
Jefferson
Liberty
Newton
Orange

TSA S
Calhoun
De Witt
Goliad
Jackson
Lavaca
Victoria

TSA N
Brazos
Burleson
Grimes
Leon
Madison
Robertson
Washington

Source: Office of EMS/Trauma Systems
Jan 2010
Mapped by GIS Staff, Center for Health Statistics
May 2010