



EMS/Trauma Systems Section Designation Virtual Survey Guidelines

Goal: Establish a standardized process for virtual facility site surveys for the EMS/Trauma Systems Section.

Key Points: The survey organization's survey team's purpose is to validate through the medical record reviews, documents, and survey activities that the facility has met the required criteria for the requested designation for the past 12 months or timeframe defined in the application process or pre-review questionnaire (PRQ).

The survey organization's team documents findings to justify the decision of "criteria met" or "criteria not met" in the medical record reviews and survey summary report, providing reference back to the specific documents.

The Department of State Health Services (DSHS) EMS/Trauma Systems Section receives the final survey report and defines the designation recommendation for the Commissioner of Health. The designation recommendation is based on the detailed review of the survey summary report and requested clarification information from the facility. It is important to note that only the Commissioner of Health can designate a facility.

Survey Organization Guidelines:

1. The virtual survey process can be utilized for initial designation surveys or surveys for facilities increasing their level of designation, however on-site surveys are strongly recommended for these types of surveys.
2. Virtual surveys can be utilized for re-designation surveys. It is recommended that virtual surveys be utilized every other survey cycle, and when major changes have occurred in the facility between the survey cycle.

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3. Approved survey organizations will schedule site surveys with the facilities and notify DSHS of the scheduled survey and survey team members.
4. The organization must ensure scheduled surveyors meet the minimum requirements and do not have a conflict of interest with the facility or have served as a previous surveyor (last survey or consultation review).
5. The survey organization should follow the DSHS recommended agenda for the specific survey.
6. The survey organization is responsible to ensure all Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines are followed.
7. Survey process must be conducted simultaneously by the survey team with capabilities for communication between the lead reviewer, review team, and key facility leaders.
8. Survey organizations must provide an opportunity for DSHS EMS/Trauma Systems staff to monitor and participate in the entire survey process.
9. Survey process must provide opportunity to review and validate the information in facility's completed application or PRQ.
10. Survey process must provide opportunity for each surveyor to review and document findings of 10 medical records to include records that were preselected by the survey organization. The surveyor shall review:
 - the actual medical record to identify if care is consistent with the national standards of care and the facility's written standards of care, evidence-based practice, guidelines, policies, and procedures;
 - the facility's written standards of care, evidence-based practice, guidelines, policies, and procedures;
 - the Emergency Medical Services (EMS) patient care record;
 - registry profile as applicable;
 - specific performance improvement or quality assurance (QAPI) findings identified by the facility, to include the facility's documented level of harm, levels of review, corrective action plans

- through to event resolution to include the operations committee and peer review committee minutes as appropriate, and;
 - associated education and credentialing documentation.
11. The medical records reviewed must reflect the appropriate patient categories for the type and level of designation the facility is seeking, the medical record admission dates should be within 6 months of the survey date and cannot be greater than 12 months prior to the survey; most recent admissions are recommended.
12. Surveyor record summaries must reflect the following:
- type of record being reviewed;
 - specific surveyor;
 - severity index and when appropriate the injury severity score (ISS)
 - standard of care provided to include any variations in the standard of care;
 - timeliness and coordination of care to include procedures, diagnostics, and consultant follow-through and if any variations or delays occurred;
 - performance improvement (QAPI) issues identified by the facility to include the level of harm, level of review, committee activity, and event resolution;
 - performance improvement (QAPI) issues not identified by the facility to include the level of harm;
 - appropriate level of medical director and program level involvement in the case review and performance improvement activities;
 - morbidity and mortality outcomes, and;
 - document any opportunities found during the medical record review.
13. Minutes and follow-up for cases referred to the program's operations committee and peer review committee must be available for surveyor's review.
14. Survey team members must have processes to visually review the performance improvement plan and the minutes for the program's performance improvement operations committee and peer review committees.

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15. Survey team must have access to related benchmark reports, all actions taken after the facility's review of the benchmark report, and follow-up outcomes.
16. Survey team must have the ability to review applicable registry guidelines, inclusion criteria, and submission validation documentation for the past survey gap years.
17. Survey team must have access to review all program-related documentation including:
 - The specific performance improvement (QAPI) plan;
 - The standards of care, guidelines, protocols, policies, and procedures;
 - All stakeholder discipline education and certifications; to include but not limited to nursing, respiratory therapist, pharmacy, radiology, social services, rehabilitation consultants, and medical staff/consultants specifically related to the type of designation;
 - Provider credentialing criteria and process (including the APPs assigned to the program) specifically related to the type of designation;
 - The diversion plan;
 - The EMS integration and communication activities;
 - Admission and transfer criteria;
 - Outreach education;
 - Prevention/injury prevention programs specifically related to the requested designation;
 - The disaster plan and integration of the specific service in planning, preparedness, response, and after-action reviews, and;
 - The regional advisory council (RAC)/perinatal care region (PCR) participation documents and reports.
18. Survey team must have measures to conduct specific interviews with program liaisons, consultants, staff nurses, and stakeholders to clarify issues and validate information provided in the application (questionnaire).
19. The survey team must have processes to review the disaster response plan, any drill or event after-action reports with outcomes, and capabilities specific to the type of designation.

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20. The survey team must have processes for a virtual tour of the facility to review the physical plant and key areas, with the goal of following the movement of the patient and necessary equipment.
21. The surveyors must have process for a private session discussion with only the site surveyors and DSHS staff.
22. The surveyors must have processes to conduct an exit summary to clarify issues and define the facility's potential deficiencies to the key stakeholders.
23. The survey team must have the final complete survey report, in a single collated document, forwarded and received at the facility within thirty days of the survey.
24. Survey organizations are expected to have a performance improvement process to review their survey processes and documents for completeness, accuracy, and timeliness.
25. Survey organizations and surveyors will delete and destroy all files and documents related to the site survey ninety days following the survey date.
26. DSHS will process all survey reports through the DSHS site survey performance improvement process to ensure quality patient care and standard performance across Texas.

Facility Guidelines

1. Facility must have approval for the virtual survey by the Chief Executive Officer, Chief Nursing Officer, Chief Medical Officer, Risk Manager, Privacy Officer, and Chief Information Technology (IT) Officer.
2. The medical director and the program manager must be present during the survey process and serve as the lead for the facility.
3. Facility must have an IT individual available to assist with any technical issues during the survey process.

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4. Facility must forward to the surveying organization a de-identified Excel list of records selected for the survey that include the correct categories of patients and the patient's date of admission, chief diagnosis, severity index or injury severity score, diagnostic procedures, operative procedures, list of consulting services, ICU length of stay, hospital length of stay, list of complications, and outcome, with the admission date not to exceed greater than 6 months from the survey date. (The only exceptions are deaths which should be included from 12 months prior to the survey date to the survey date.)
5. Survey organization will return the selected medical records for review within 10 days of receiving the list and the facility must provide access to these medical records electronically to include all pertinent documents related to the case review. (Note: Best practice is to develop a secured electronic copy of the medical record and all associated documents to include related standards of care, procedures/protocols/guidelines, performance improvement related documents (QAPI) and credentialing/education documents for each medical record to be reviewed into a file to send to the reviewers at least 48 hours prior to the site survey.)
6. The facility must provide access to (electronic or paper) copies of the documented on-call schedules requested, standards of care, evidence-based practice guidelines, protocols, procedures, and policies specific to the survey, all related research produced by the program, and peer review publications produced by the program a minimum of 10 days prior to the survey.
7. The facility must provide a copy of their performance improvement (QAPI) plan a minimum of 10 days prior to the survey.
8. The facility must assign a navigator to each surveyor to coordinate the review of the medical record and all associated documents related to the medical record review such as performance improvement (QAPI) to include the event identified, processes through the levels of review, actions plans to event resolution with minutes from the case discussion in operations or peer review, education or credentials of individuals involved, EMS record, and documents of follow-up or pertinent to the case.

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9. Facility must provide measures for the survey team to meet with DSHS staff alone to discuss events and findings periodically.
10. Facility must provide options for the surveyors to interview key individuals during the survey process. (Note: This may be a formal scheduled interview, or the interview may be requested during a medical record review to clarify issues.)
11. Facility must provide a virtual tour of the areas requested.
12. Facility must provide measures to provide an opening conference to review the survey agenda, and an exit conference to review findings of the survey.
13. Facility is responsible for reviewing the site survey summary report and validating any questions with the survey organization within 60 days of receiving the survey summary report.
14. The facility is responsible for forwarding the site survey summary report to DSHS within the timeframe defined in the specific designation rules.
15. Facilities are responsible for including this external review in the written performance improvement (QAPI) plan and marking all documents as "confidential" to ensure disclosure is protected.

Recommended Site Survey Agenda

1. The lead surveyor and the facility medical director and/or program manager will define the survey agenda and distribute to those who need to know a minimum of 60 days prior to the review to ensure schedules align.
2. The lead surveyor has the authority to alter or change the agenda based on issues identified at any time.
3. Recommended agenda includes the following:

First day of the Survey

- 0800 - 0845 Survey Introductory Conference that includes all key individuals

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- 0900 – 1145 – Medical Record Review
- 1145 – 1215 – Lunch
- 1215 – 1230 – Briefing with Surveyors, DSHS, the Program Medical Director and Program Manager to define needs (Closed Meeting)
- 1235 – 1530 – Medical Record Review
- 1540 – 1600 – Survey Team Debrief (Closed Meeting)
- 1610 – 1650 – Performance Improvement (QAPI) Review
- 1650 – 1715 - Key Interview with Liaisons
- 1720 – 1745 - Briefing with Survey Team and Medical Director, Program Manager, and facility key leaders
- 1745 – 1800 – Survey Team Wrap-up (Closed Meeting)

Second Day of the Survey

- 0800 – 0830 - Survey Briefing with Facility Key Leaders to discuss the previous day's findings
- 0830 – 0930 – Virtual Tour as Defined by Lead Surveyor
- 0945 – 1145 – Interviews with Key Leaders as defined by the lead reviewer and previous day's findings
- 1145 – 1215 – Lunch
- 1225 – 1300 – Surveyor Team Debrief (Closed Meeting)
- 1310 – 1400 – Consultant Interviews
- 1415 – 1500 – Specialty Service Reviews
- 1510 – 1530 – Credentialing / Education Review / Research / Publications
- 1540 – 1600 – Prevention / Outreach
- 1605 – 1640 – Surveyor Team Debrief (Closed Meeting)
- 1645 – 1710 – Surveyor Team Meeting with Program Key Leaders
- 1715 – 1745 – Survey Exit Summary with Facility Leaders and Stakeholders. The exit will include:
 - Review of the key points of the survey process
 - Define the potential criteria deficiencies identified and provide examples when appropriate (criteria deficiencies are directly linked to required criteria for designation).
 - Review recommendations to address the deficiencies (recommendations should be specifically linked to a potential criteria deficiency).
 - Review the opportunities to improve patient care identified during the survey process (opportunities may or may not be linked to a potential deficiency).

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Individuals with questions, needing clarification, or needing additional information should contact the DSHS EMS/Trauma Section leadership team.