Regional Perinatal Care System Plan

Endorsed by SETRAC Board of Directors
Date:

Approved by SETRAC Stakeholders
Date: 6/5/2024

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SETRAC serves the counties of Austin, Colorado, Fort Bend, Harris, Matagorda, Montgomery, Walker, Waller, and Wharton.

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INTRODUCTION

This plan is intended as a guide to decision-making in the care of perinatal patients and does not determine a legal standard of care. The Regional Perinatal System Plan is not intended to be understood or interpreted as medical advice. This plan does not supersede physician or healthcare provider judgement.

MISSION

The SETRAC Perinatal Committee's mission is to enhance the quality of care and improve outcomes for pregnant and postpartum women and newborns throughout Perinatal Care Region Q (PCR-Q) by reducing perinatal related morbidity and mortality.

ORGANIZATION

The SETRAC Perinatal Committee provides infrastructure and leadership to the nine-county region delineated as Perinatal Care Region Q (PCR-Q). Through this plan the perinatal committee will endeavor to set perinatal regional standards. The committee will focus on education, prevention, prehospital management, hospital care, and long-term outcomes for perinatal patients through informed decision making from stakeholder data analysis. The Perinatal Care Regional System Plan is a guideline developed in accordance with generally accepted perinatal guidelines in line with Texas DSHS levels of neonatal and maternal care rules.

REGIONAL DEMOGRAPHICS

Perinatal Care Region Q (PCR-Q) is a geographical designation that includes the nine south east Texas urban and rural counties: Austin, Colorado, Fort Bend, Harris, Matagorda, Montgomery, Walker, Waller, and Wharton counties. Each PCR region in the states falls under the coordination and authority of a Regional Advisory Council (RAC) as designated by the Texas Department of State Health Services. PCR-Q is composed of a total land mass of 8,896 square miles, and a population that exceeds 6.2 million.

Currently, SETRAC is served by four Level IV Advanced Intensive Care Neonatal Facilities, seventeen Level III Intensive Care Neonatal Facilities, thirteen Level II Special Care Nursery Neonatal Facilities, and four Level I Well Nursery Neonatal Facilities. The PCR-Q area has 181 ground and air EMS services and 45 first responder organizations.

PERINATAL SYSTEM OF CARE GOALS

The SETRAC Perinatal Committee will encourage regional participation from health care facilities, EMS, and professional organizations involved in perinatal health care to provide high quality perinatal care. Regional care should be patient- focused, comply with state and national guidelines, and seek to provide the most appropriate level of care. SETRAC Perinatal Committee shall develop a regional system of perinatal care plan that:

- Promotes collaboration among EMS providers, hospitals, and members of the SETRAC Committees.
- Develops perinatal system standards that addresses perinatal care, outcomes, and process improvement.
- Promotes perinatal care at hospitals most capable of delivering appropriate care.
- Provides guidance for appropriate and timely inter-hospital transfers.
- Promotes education to improve frontline provider competency in care of the perinatal patient.
- Identifies patterns of care that do not consistently comply with the Regional Perinatal Care System Plan.
- Provides representative to participate in RHPC disaster preparedness planning and drills for the perinatal patient.

PERINATAL FACILITY CAPABILITIES/EXTERNAL CREDENTIALING

- To ensure that there is understanding throughout the region with regards to facility capabilities for the care of the maternal and neonatal patient, information is available for patient destination decision making via EMResource.
- EMResource is the official means of notification of these capabilities and their availability. To remain listed in EMResource as a maternal or neonatal facility, the facility must remain in good standing through the participation requirements listed below.
- As required by DSHS, perinatal facilities within the PCR-Q region have an obligation to maintain SETRAC membership in good standing as well as meet active participation requirements of SETRAC. SETRAC participation requirements include, but are not limited to:
    - Payment of SETRAC dues as an accredited center.
    - Participation in SETRAC—6 meetings annually with at least 3 being perinatal committee or subcommittee meetings.
    - Submission of accurate and complete perinatal data to SETRAC on a quarterly basis.
    - Compliance with all rules established by the SETRAC Board and the Perinatal Committee (with approval by the SETRAC Board.)
- The SETRAC Perinatal Committee will support member hospitals in seeking Texas DSHS levels of maternal and neonatal designation. The SETRAC Perinatal Committee will utilize the Texas Department of State Health Services (DSHS) recognized designation process for maternal and neonatal levels of care. The SETRAC Perinatal Committee will strive to support standardized interpretation of the Texas Administrative Code maternal and neonatal designation rules and provide feedback to DSHS to improve the designation process. SETRAC Perinatal Committee will promote the use of a standard data set for perinatal outcomes to analyze disparities and improve the process of care for the patients we serve.

NOTE: Any facility that does not meet participation requirements of the above-mentioned committees and misses two fiscal quarters of data submission will be deemed “Not participating with SETRAC” and arrangements will need to be made on an individual basis between the facility and SETRAC in relation to any discrepancies.

SYSTEM ACCESS

Goal: Persons in the region will have access to emergency perinatal care. In portions of this region, First Responder Organizations (FRO) may provide initial treatment pending EMS arrival.

All counties in PCR-Q coordinate emergency systems through the 911 service. In the event of telephone or network communication system outage, EMS agencies have access to two-way radios to communicate with dispatch and hospitals. CMOC coordinates response teams for disaster and regional surge responses through applications such as EMResource and WebEOC.

COMMUNICATIONS

The communication system is an essential part of a regional plan for the care of maternal and neonatal patients. Communication between hospitals, EMS providers, and medical control units utilizes methods such as electronic platforms, cell phones, landline phones, and dedicated radio frequencies. Hospitals communicate information regarding hospital and department saturation status, bed availability count, and clinical service line availability through EMResource. SETRAC encourages the use of redundant methods of communication in the event of a primary communications failure. SETRAC supports WebEOC utilization during surge or disaster events and beginning July 1, 2024, recognizes Pulsara for patient tracking across the region.

MEDICAL DIRECTION/OVERSIGHT

- Each EMS agency Medical Director is responsible for developing local protocols and for monitoring and improving their agencies performance.
- Local guidelines should be generally compatible with regional prehospital guidelines but may be modified at the discretion of the agency Medical Director.
- The SETRAC Perinatal Committee should work with the Medical Director and EMS Committees to complete a periodic review and update of prehospital guidelines.

PRE-HOSPITAL TRIAGE CRITERIA

Survival of the maternal and neonatal patient requires rapid recognition, management, and transport to the closest appropriate facility. EMS agencies should follow their protocols on determining the closest appropriate facility utilizing EMResource as a source for facility capability and capacity.

FACILITY SATURATION/BYPASS

Goal: SETRAC Maternal and Neonatal facilities will communicate “facility saturation” (formerly known as “facility diversion”) status promptly and clearly to regional EMS and other facilities through EMResource to assure that maternal and neonatal patients are transported to the nearest appropriate facility.

Facility Saturation is used by Perinatal System entities to assure maternal and neonatal patients will be transported to the nearest appropriate facility when the facility cannot at that time accept a patient for safe and appropriate patient care. All facilities and pre-hospital providers should use the EMResource to notify EMS partners of saturation status. Each facility will report accurate information to EMResource at minimum every 24 hours and ensure correct contact information quarterly. EMResource is the primary communication source in PCR-Q for hospitals to communicate any facility issues that may be relevant to EMS patient destination decisions. EMS services are expected to continuously monitor EMResource for current system information. EMS agencies should use EMResource to help inform patient destination decisions.

FACILITY TRIAGE CRITERIA

GOAL: To promote the use of national, evidence-based guidelines for the triage of Maternal and Neonatal patients

Each perinatal facility defines its internal facility triage criteria. There is not currently a regional standard for internal facility triage criteria. Triage criteria should be standardized and based on research and best practices from ACOG and AAP.

INTER-HOSPITAL TRANSFERS

Patients will be interfacility triaged to the appropriate maternal and/ or neonatal facility with appropriate capabilities. The ability of perinatal facilities to monitor and communicate their resource capabilities is through EMResource. Individual facilities are responsible for determining if a patient exceeds the facility's capability or available resources per federal EMTALA requirements.

Indications for Patient Transfer

Maternal and neonatal patients should be transferred to a higher level of care when the medical needs of the patient outweigh the resources and/or capability at the initial treating facility. Decisions about the most appropriate facility for transport should meet EMTALA standards and align with maternal and neonatal levels of care designation.

Time to Transfer

Expeditious transfer to care at the closest, most appropriate designated facility with definitive care capabilities is a primary goal in perinatal patient care. Compliance with EMTALA and Texas transfer laws should be adhered to when transferring maternal or neonatal patients. Primary stabilization of the perinatal patient should avoid any non-essential testing or procedure that would delay transfer. Inter-facility transfers should predominantly occur within PCR-Q outside of disaster events, resource issues, or patient/family preference.

Method of Transfer

Specialty care transport teams should be utilized to provide the appropriate level of care during transport if available. The sending physician must determine the appropriate mode of transport as well as the resources needed during transport.

Back Transfers

Returning patients to their home community promotes a system of support for families. If a patient has stabilized and no longer requires the level of care provided by the receiving facility, efforts should be made to return the patient to the nearest appropriate facility in the patient's home community. This also maintains the availability of beds at higher level facilities for patients with complex care needs. The determination of appropriateness for back transfer should be a collaboration between the sending and receiving Physicians.

MATERNAL LEVEL OF CARE

Texas Administrative Code (TAC) Rule §133.203 definitions of maternal levels of care are:

Level I Basic Care:

- Provide care for pregnant and postpartum patients who are generally healthy and do not have medical, surgical, or obstetrical conditions that present a significant risk of maternal morbidity or mortality; and
- Have skilled personnel with documented training, competencies, and annual continuing education specific for the patient population served.

Level II Specialty Care:

- Provide care for pregnant and postpartum patients with medical, surgical, or obstetrical conditions that present a low to moderate risk of maternal morbidity and mortality; and
- have skilled personnel with documented training, competencies, and annual continuing education specific for the patient population served.

Level III Subspecialty Care:

- Provide care for pregnant and postpartum patients with low-risk conditions to significant complex medical, surgical, or obstetrical conditions that present a high risk of maternal morbidity and mortality;
- Ensure access to consultation to a full range of medical and maternal subspecialists and surgical specialists, and behavioral health specialists;
- Ensure capability to perform major surgery on-site;

- Have physicians with critical care training available at all times to actively collaborate with Maternal Fetal Medicine physicians or Obstetrics and Gynecology physicians with obstetrics training and privileges in maternal care;
- Have skilled personnel with documented training, competencies, and annual continuing education, specific for the population served;
- Facilitate transports;
- Provide outreach education related to trends identified through the QAPI Plan, specific requests, and system needs to lower-level designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.
- Level III maternal designated facilities that serve as referral centers for placenta accreta spectrum disorder must fulfill all the Level IV requirements for a Placenta Accreta Spectrum Disorder Team defined in §133.209 of this title (relating to Maternal Designation Level IV).

Level IV Comprehensive Care:

- Provide comprehensive care for pregnant and postpartum patients with low-risk conditions to the most complex medical, surgical or obstetrical conditions and their fetuses, that present a high risk of maternal morbidity or mortality;
- Ensure access to on-site consultation to a comprehensive range of medical and maternal subspecialists, surgical specialists, and behavioral health specialists;
- Ensure capability to perform major surgery on-site;
- Have physicians with critical care training available at all times to actively collaborate with Maternal Fetal Medicine physicians or Obstetrics and Gynecology physicians with obstetrics training, experience and privileges in maternal care;
- Have a maternal fetal medicine critical care team with expertise and privileges to manage or co-manage highly complex, critically ill or unstable maternal patients;
- Have a placenta accreta spectrum disorder multidisciplinary care team with expertise to complete risk factor screening, evaluation, diagnosis, consultation, and management of patients with anticipated or unanticipated placenta accreta spectrum disorder, including postpartum care;
- Have skilled personnel with documented training, competencies, and annual continuing education, specific for the patient population served;
- Facilitate transports; and

- Provide outreach education related to trends identified through the QAPI Plan, specific requests, and system needs to lower-level designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

References:

TAC Rule 133.203 General Requirements

TAC Rule 133.208 Maternal Designation Level III

NEONATAL LEVEL OF CARE

Texas Administrative Code (TAC) Rule §133.183 General Requirements defines neonatal levels of care as:

Level I Well Care:

- Provide care for mothers and their infants of generally more than or equal to 35 weeks gestational age who have routine, transient perinatal problems;
- Have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served; and
- Provide the same level of care that the neonate would receive at a higher-level designated neonatal facility and complete an in-depth critical review and assessment of the care provided to these infants through the neonatal QAPI Plan and process if an infant less than 35 weeks gestational age is retained.

Level II Special Care:

- Provide care for mothers and their infants of generally more than or equal to 32 weeks gestation and birth weight more than or equal to 1500 grams who have physiologic immaturity or problems that are expected to resolve rapidly and are not anticipated to require subspecialty services on an urgent basis;
- Provide care, either by including assisted endotracheal ventilation for less than 24 hours or nasal continuous positive airway pressure (NCPAP) until the infant's condition improves, or arrange for appropriate transfer to a higher-level designation facility; and
- Have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served.

Level III Neonatal Intensive Care Unit:

- Provide care for mothers and comprehensive care for their infants of all gestational ages with mild to critical illnesses or requiring sustained life support;
- Ensure access to consultation of a full range of pediatric medical subspecialists and pediatric surgical specialists, and the capability to perform major pediatric surgery on-site or at another appropriate neonatal designated facility;
- Have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served;
- Facilitate neonatal transports; and

Provide outreach education related to trends identified through the neonatal QAPI plan, specific requests, and system needs to lower-level neonatal designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

Level IV Advanced Neonatal Intensive Care Unit:

- Provide care for mothers and comprehensive care for their infants of all gestational ages with the most complex and critical medical and surgical conditions or requiring sustained life support;
- Ensure access to a comprehensive range of pediatric medical subspecialists and pediatric surgical subspecialists available to arrive on-site, in person for consultation and care, and the capability to perform major pediatric surgery, including the surgical repair of complex conditions on-site;
- Have skilled medical staff and personnel with documented training, competencies, and annual continuing education specific for the patient population served;
- Facilitate neonatal transports; and
- Provide outreach education related to trends identified through the neonatal QAPI Plan, specific requests, and system needs to lower-level neonatal designated facilities, and as appropriate and applicable, to non-designated facilities, birthing centers, independent midwife practices, and prehospital providers.

References:

TAC 133.183 General Requirements

SYSTEM QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

GOAL: To promote participation in SETRAC's data collection registry for regional performance improvement.

SETRAC has established regional data filters which indicate process and outcome performance of the PCR-Q/TSA-Q area system of care. The QI Program purpose is for ongoing evaluation and quality improvement of the Emergency Healthcare System. The Medical Director(s) for the Perinatal Committee will facilitate case reviews based on criteria and processes established in the SETRAC QI Plan.

SETRAC System Performance Improvement (SPI) processes are responsible for oversight of regional performance improvement activities. Any stakeholder may notify the perinatal chair or medical director of a perinatal case or system issue that has been reported and needs review. Any stakeholder may also submit requests online via the SETRAC QI page for case review.

Case Review may be requested for any of the following reasons:

- Provide advisory information to the EMS agencies and hospital systems related to issues and policies that could alter regional guidelines.
- Monitor processes and outcomes of patient care related to current regional guidelines.
- Presenting opportunities for analysis of data and information of scientific value for studies and strategic planning of the emergency healthcare system.
- Provide educational forums for improved patient care.
- Periodic mortality and morbidity case reviews.
- Other cases may also be reviewed that are regarded as having exceptional educational or scientific benefit.

All requests for case review should be submitted in writing and will be presented to the Medical Director Committee for consideration.

Data Collection (Neonatal and Maternal data analysis)

Member hospitals are required by SETRAC requirements of participation to submit data to support Neonatal and Maternal SMART Goals which are essential elements of the PI/QI objectives of the of Perinatal Committee.

Perinatal System Performance Improvement

The Maternal and Neonatal Quality Improvement subcommittees have been established by the Perinatal Committee to assist with evaluating regional data for disparities, improvement project needs, identifying data needs, providing education, and sharing best practices. These subcommittees collaborate with the Maternal and Neonatal Morbidity and Mortality workgroups to define committee goals and performance indicators for the region.

Morbidity/Mortality Reduction & Outreach Education

The purpose of the Perinatal Committee is to strive in efforts to reduce morbidity and mortality in the maternal and neonatal population. Data collection on perinatal morbidities and mortality factors are tracked and shared with committee members to develop quality improvement projects. Intervention programs implement smart goals to track program success and development needs.
Outreach education is a task of the Perinatal Committee as well as each individual hospital within the regional advisory council.

DISASTER PREPAREDNESS & RESPONSE

The Perinatal Disaster preparedness and response activities will comply with the SETRAC regional disaster preparedness plans. The perinatal committee of SETRAC will appoint one or more member(s) to participate in the SETRAC Regional Healthcare Preparedness Coalition (RHPC), providing guidance on the unique needs of the perinatal patient with the goal of moving patients out of disaster affected facilities into capable facilities when possible.
Disaster preparedness and response activities among the emergency healthcare system in PCR-Q are conducted at the regional level through the Regional Healthcare Preparedness Coalition (RHPC).

The RHPC has been developed and funded as part of the federal Hospital Preparedness Program (HPP). The TSA-Q RHPC is divided into five corridors and is composed of partner organizations: hospitals, EMS, City, county, public health, and emergency management. RHPC works together to organize emergency preparedness and healthcare delivery response.

The disaster affected facility may ask for provider and nursing support from other member facilities, regional, state, and federal resources if available. Should a facility be unable to coordinate the movement of patients within their organization and obtain needed resources on their own, they can contact the SETRAC on-call officer at 281-822-4444 or the Catastrophic Medical Operations Center (CMOC). CMOC can be activated 24/7 by calling the Harris County Office of Homeland Security at 713-426-9508 and requesting "activation of the CMOC." CMOC must be activated by an authorized governmental entity and will coordinate with the local office of emergency management to ensure proper activation levels and support.

Disaster Preparedness Activities

EMResource is utilized to maintain current information from each perinatal facility such as contact information, bed status, and facility and service line status. A representative from each perinatal facility will report accurate information to EMResource at minimum every 24 hours and ensure correct contact information quarterly. Frequency of reporting may increase during a disaster event. Perinatal facility leaders should work with their facility emergency management staff for EMResource and WebEOC training. A perinatal leader should participate in their facility emergency management planning committee. The perinatal committee representative(s) will participate in disaster drills held by the SETRAC Regional Healthcare Preparedness Coalition (RHPC) and report findings/recommendations to the Perinatal Committee.

Disaster Response Activities

Perinatal committee leaders should participate in conference calls when a disaster occurs that will involve perinatal patients. The perinatal committee members support the regional healthcare surge plan set forth by SETRAC and RHPC.

Recovery activities

Perinatal facilities in the PCR-Q will promote continuity of care for perinatal patients transferred during a disaster that includes follow up care, return transfers, and reunification of families.

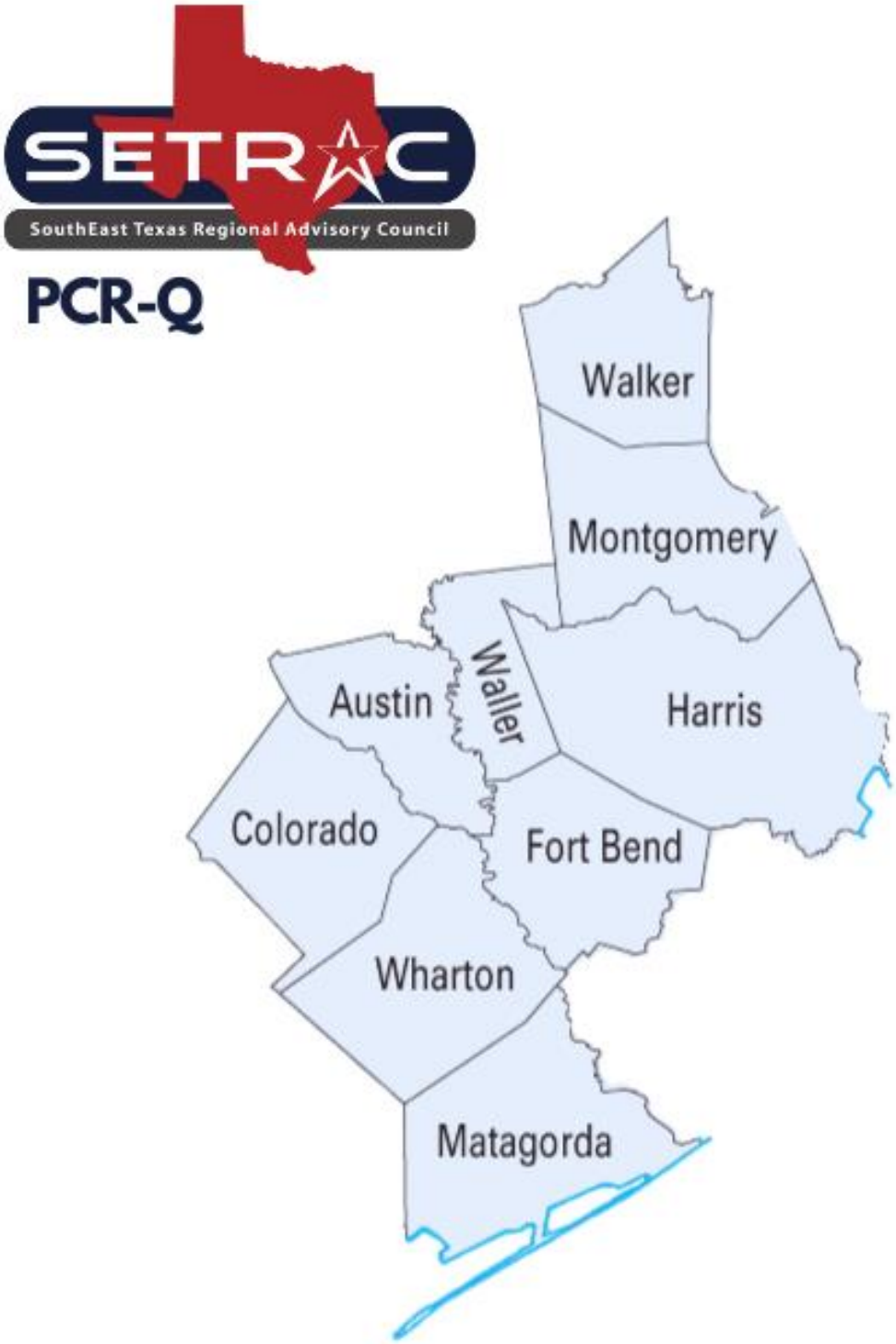
RESEARCH

SETRAC participates in system research as the need arises. Requests for participation in research should be approved by SETRAC. The Board of Directors is responsible for governance and release of the data for all research purposes. Abstracts and poster presentations to be disseminated outside of the SETRAC committees will require submitter to follow the SETRAC approval process.

Annex A: Demographics & Organizations

Appendix A-1	Map of Region
Appendix A-2	List of Hospitals
Appendix A-3	List of EMS, Air Medical & FRO Agencies

Appendix A-1: Map of the Region



Appendix A-2: List of Perinatal Designated Hospitals

Facility	Maternal Designation	Neonatal Designation
CHI Baylor St. Luke's Medical Center	*Non-Designated*	*Non-Designated*
CHI St. Luke's Health - Patients Medical Center	*Non-Designated*	*Non-Designated*
CHI St. Luke's Health - Sugar Land Hospital	Specialty Care (Level II)	Special Care (Level II)
CHI St. Luke's Health - The Vintage Hospital	*Non-Designated*	*Non-Designated*
CHI St. Luke's Health - The Woodlands Hospital	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
Columbus Community Hospital	Specialty Care (Level II)	Well Care (Level I)
El Campo Memorial Hospital	*Non-Designated*	*Non-Designated*
Harris Health System- Ben Taub Hospital	Comprehensive Care (Level IV)	Neonatal Intensive Care (Level III)
Harris Health System- Lyndon B. Johnson Hospital	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
HCA Houston Healthcare Clear Lake	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
HCA Houston Healthcare Conroe	Specialty Care (Level II)	Special Care (Level II)
HCA Houston Healthcare Kingwood	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
HCA Houston Healthcare Medical Center	*Non-Designated*	*Non-Designated*
HCA Houston Healthcare North Cypress	*Non-Designated*	*Non-Designated*
HCA Houston Healthcare Northwest	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
HCA Houston Healthcare Southeast	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
HCA Houston Healthcare Tomball	Specialty Care (Level II)	Special Care (Level II)
HCA Houston Healthcare West	Specialty Care (Level II)	Special Care (Level II)
HCA Woman's Hospital of Texas	Comprehensive Care (Level IV)	Advanced Neonatal Intensive Care (Level IV)
Houston Methodist Baytown Hospital	Specialty Care (Level II)	Special Care (Level II)
Houston Methodist Clear Lake Hospital	Specialty Care (Level II)	Special Care (Level II)
Houston Methodist Hospital	Subspecialty Care (Level III)	Special Care (Level II)
Houston Methodist Sugar Land Hospital	Specialty Care (Level II)	Neonatal Intensive Care (Level III)
Houston Methodist The Woodlands Hospital	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
Houston Methodist West Hospital	Specialty Care (Level II)	Neonatal Intensive Care (Level III)

Facility	Maternal Designation	Neonatal Designation
Houston Methodist Willowbrook Hospital	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
Huntsville Memorial Hospital	Basic Care (Level I)	Well Care (Level I)
Matagorda Regional Medical Center	Basic Care (Level I)	Well Care (Level I)
Memorial Hermann - Texas Medical Center	Comprehensive Care (Level IV)	Advanced Neonatal Intensive Care (Level IV)
Memorial Hermann Cypress Hospital	Specialty Care (Level II)	Special Care (Level II)
Memorial Hermann Greater Heights Hospital	Specialty Care (Level II)	Special Care (Level II)
Memorial Hermann Katy Hospital	Specialty Care (Level II)	Neonatal Intensive Care (Level III)
Memorial Hermann Memorial City Medical Center	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
Memorial Hermann Northeast Hospital	Specialty Care (Level II)	Special Care (Level II)
Memorial Hermann Southeast Hospital	Specialty Care (Level II)	Special Care (Level II)
Memorial Hermann Southwest Hospital	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
Memorial Hermann Sugar Land Hospital	Specialty Care (Level II)	Special Care (Level II)
Memorial Hermann The Woodlands Hospital	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
Michael E. DeBakey VA Medical Center	*Non-Designated*	*Non-Designated*
Midcoast Medical Center -Bellville	*Non-Designated*	*Non-Designated*
OakBend Medical Center	Specialty Care (Level II)	Special Care (Level II)
OakBend Medical Center - Williams Way	Specialty Care (Level II)	Special Care (Level II)
Rice Medical Center	*Non-Designated*	*Non-Designated*
St. Joseph Medical Center	Subspecialty Care (Level III)	Neonatal Intensive Care (Level III)
Texas Children's Hospital	Comprehensive Care (Level IV)	Advanced Neonatal Intensive Care (Level IV)
Texas Children's Hospital - The Woodlands	*Non-Designated*	Neonatal Intensive Care (Level III)
Texas Children's Hospital - West Campus	*Non-Designated*	*Non-Designated*
United Memorial Medical Center	*Non-Designated*	*Non-Designated*
UTMB Clear Lake Campus	Specialty Care (Level II)	Special Care (Level II)

Appendix A-3: EMS, Air Medical, & FRO

RAC Q EMS, AIR MEDICAL, & FRO	RAC Q EMS, AIR MEDICAL, & FRO
A BELIEVERS EMS LLC	CITY OF LA PORTE FIRE DEPARTMENT
ABERDEEN AMBULANCE EMS	CITY OF NASSAU BAY EMS
ABOVE AVERAGE EMS LLC	CITY OF SEABROOK
ACUTE CARE EMS INC	CITY OF SOUTH HOUSTON EMS DEPARTMENT
ADAMS EMS	CITY OF WEBSTER FIRE DEPARTMENT
ADJUVANT AMBULANCE TRANSPORT	CITY OF WHARTON EMS
ADVANCE EMS AMBULANCE SERVICE LTD	CLEVELAND EMS DBA DFWEMS; TEXOMA EMS; ECTOR-MIDLAND COUNTY EMS
AERO EMS INC	COLASSAL EMS LLC
AFFIRMATIVE EMS	COLORADO COUNTY EMS
AIR AMBULANCE 1	COMMUNITY VFD
ALDINE FIRE RESCUE	COMPASSIONATE EMS LLC
ALERT MEDICAL RESPONSE	CONCORD EMS INC
AM / PM EMS INC	CONOCOPHILLIPS COMPANY
AMBU-CARE TRANS	CORRECTIONAL MANAGED CARE
AMERICAN ADVANCED CARE	COUNTY EMS
AMERICAN CARE EMS, INC	CRABBS PRAIRIE VOLUNTEER FIRE DEPARTMENT
AMERICAN MEDICAL RESPONSE DBA AMR DBA P&S AMBULANCE	CY-FAIR FIRE DEPARTMENT
AMGREF EMS INC	CYPRESS CREEK FIRE DEPARTMENT
APEX AMBULANCE SERVICES	D & L EMS
ATASCOCITA FIRE DEPARTMENT	DALIA AMBULANCE SERVICE
ATLANTIS EMS	DAYSTAR EMS INC
ATWELL EMS, INC	DEER PARK VOLUNTEER FIRE DEPARTMENT
AUSTIN COUNTY EMERGENCY MEDICAL SERVICES	DIGNITY BEST EMS INC
AVANTE AMBULANCE INC	DODGE VOLUNTEER FIRE DEPARTMENT INC
BAYOU CITY EMS	DYNAMO EMS INC
BAYTOWN FIRE DEPARTMENT	EAST BERNARD EMERGENCY MEDICAL SERVICE INC
BEASLEY COMMUNTY VOLUNTEER FIRE DEPT	EVENT EMS
BEST CARE AIR & GROUND AMBULANCE SERVICE	EXECUTIVE EMERGENCY MEDICAL SERVICES LLC
CARE EMS INC	FAIRCHILD VOLUNTEER FIRE DEPARTMENT INC
CAT SPRING VOLUNTEER FIRE DEPARTMENT	FIRST CHOICE AMBULANCE SERVICE INC
CHAMPIONS ESD	FIRST MED CARE EMS
CHANNELVIEW FIRE DEPARTMENT	FIRST MEDICAL RESPOND
CHILDREN'S AMBULANCE SERVICE	FIRST MEDICAL RESPONSE, KIDDIEMED EMS
CITY AMBULANCE SERVICE, FIRST MEDICAL RESPONSE, CYPRESS CREEK EMS	FOREST BEND VFD
CITY OF BELLAIRE FIRE DEPT	FORT BEND COUNTY EMS
CITY OF EL CAMPO	FORT BEND COUNTY ESD #8
CITY OF LA PORTE EMS	FULSHEAR SIMONTON FIRE DEPARTMENT
	GALENA PARK FIRE DEPARTMENT

RAC Q EMS, AIR MEDICAL, & FRO	RAC Q EMS, AIR MEDICAL, & FRO
GARWOOD VOLUNTEER FIRE DEPT	LIFERITE EMS
GREATER CARE EMS LLC	LIFESTAR EMS
HARRIS COUNTY EMERGENCY CORPS	LITTLE YORK VOLUNTEER FIRE DEPARTMENT
HARRIS COUNTY EMERGENCY SERVICE DISTRICT #17	LONE STAR EMS INC
HARRIS COUNTY EMERGENCY SERVICES DISTRICT NO. 5	LONGHORN AMBULANCE SERVICES
HARRIS COUNTY ESD 10 DBA	LYNBROOK EMS
HARRIS COUNTY ESD 11 MOBILE HEALTHCARE	MAGNOLIA EMS
HARRIS COUNTY ESD 12 FIRE DEPARTMENT	MEDIC TRANSIT EMS INC
HARRIS HEALTH SYSTEM EMS	MEDIX EMS
HATZALAH OF HOUSTON	MEDXPRESS EMS
HCESD 48 FIRE DEPARTMENT	MEGA CARE EMS
HCESD5	MEMORIAL HERMANN HOSP LIFE FLIGHT, MEMORIAL HERMANN LIFE FLIGHT
HEALTH QUEST EMS LLC	METRO EMS
HEALTHSOURCE MEDICAL RESPONSE LLC	MISSOURI CITY FIRE & RESCUE SERVICES
HEALTHSTAR EMS	MISSOURI HEALTH SERVICES INC
HHT GROUP INC DBA	MOBILE EMS PLLC
HIDALGO COUNTY EMS/SOUTH TEXAS AIRMED/CAMERON COUNTY EMS	MONTGOMERY COUNTY FIRST RESPONSE
HIGHLANDS VOLUNTEER FIRE DEPARTMENT	MONTGOMERY COUNTY HOSPITAL DISTRICT EMS
HOLINESS & BROTHERS EMS	NASSAU BAY VOLUNTEER FIRE DEPARTMENT
HOLISTIC CARE EMS LLC	NATIONAL CARE EMS
HOUSTON FIRE DEPARTMENT	NEEDVILLE FIRE DEPARTMENT
HOUSTON LIVESTOCK SHOW & RODEO SAFETY COMMITTEE	NEW QUEST EMS INC
HOUSTON MEDICAL RESPONSE	NEW STAR EMS
HOUSTON METHODIST HOSPITAL	NEW WAVERLY VFD
HUFFMAN VOLUNTEER FIRE DEPARTMENT INC	NOA EMEGENCY MEDICAL SERVICE
HUMBLE FD EMS	NORTH CHANNEL EMERGENCY MEDICAL SERVICES
HUNTSVILLE FIRE DEPARTMENT	NORTH CHANNEL EMS
I D F EMS INC	NORTH CYPRESS EMS
INSTACARE EMS	NORTHEAST FORT BEND COUNTY VOLUNTEER FIRE DEPT
INSTAMED EMS	NORTHWEST COMMUNITY HEALTH
INTEGRITY ALLIANCE PARTNERS LLC	NORTHWEST VOLUNTEER FIRE DEPARTMENT
JACINTO CITY FIRE DEPARTMENT	NURSE MANAGEMENT EMS
JERSEY VILLAGE FIRE DEPARTMENT	ORION EMS LLC
JEWEL AMBULANCE SERVICE INC	PATRIOT EMS
KANGAROO CREW	PEDIATRIC TRANSPORT EMS LLC
KATY FIRE DEPARTMENT	PHI AIR MEDICAL
KLEIN VFD	PLATINUM STAR EMS LLC
LIFE LINE EMS LLC	PLEAK FD
LIFE MED CARE INC	PONDEROSA VOLUNTEER FIRE DEPARTMENT INC
LIFECARE EMS	PORT OF HOUSTON FIRE DEPARTMENT

RAC Q EMS, AIR MEDICAL, & FRO
PRECISE CARE EMS
PRECISE EMS; TEXAS MEDICAL RESPONSE
PREFERRED MEDICAL TRANSPORT
PREMIER CARE EMS LLC
PREMIUM CARE EMS LLC
PRIME AMBULANCE SERVICE INC
PRIORITY AMBULANCE TRANSFER LLC
PROCARE EMS LLC
PROGRESSIVE AMBULANCE SERVICE LLC
PULSE EMS
QUICK RESPONSE EMS
RAPID MEDICAL TRANSPORTATION CORPORATION
RELIEF AMBULANCE SERVICES
REPUBLIC EMS LTD
RESCUE EMS
RICE UNIVERSITY EMS
RICHMOND FIRE DEPARTMENT
RIGHT CHOICE EMS
RIVERSIDE VOLUNTEER FIRE DEPT
ROBINHOOD EMS INC
ROSEHILL FIRE DEPARTMENT
ROSENBERG FIRE DEPARTMENT
SEABROOK VOLUNTEER FIRE DEPARTMENT
SEALY FIRE DEPARTMENT
SHELDON COMMUNITY VOLUNTEER FIRE & RESCUE INC
SIGNA EMS INC
SKYLINE EMS
SOCIETY TEAM EMS
SOLID ROCK EMS
SOUTH LAKE HOUSTON EMS
SOUTHEAST VOLUNTEER FIRE DEPARTMENT
SPARTANS EMS LLC
SPECIALTY MEDICAL TRANSPORT INC.
SPRING FIRE DEPARTMENT
ST ANDREW'S EMS
ST CHRISTINAS EMS
ST JOSEPHS AMBULANCE SERVICE INC
ST STEPHEN EMS
STAFFORD FIRE DEPARTMENT
STANDARD EMS INC
SUGAR LAND EMS

RAC Q EMS, AIR MEDICAL, & FRO
SUGAR LAND FIRE-EMS, SUGAR LAND FIRE DEPARTMENT
SUPPORT SYSTEMS EMS INC
SWEENY COMMUNITY HOSPITAL
SYNERGY AMBULANCE SERVICE
TENDER CARE AMBULANCE
TEXANS AMBULANCE
TEXAS CRITICAL CARE
THOMAS LAKE ROAD VFD INC
THREE STAR EMS INC
TOMBALL FIRE DEPARTMENT
TRANSPARENT CARE EMS LLC
TRANS-STAR MEDICAL TRANSPORT INC
TRULIFE AMBULANCE TRANSFER INC
UAC EMS
UNICARE EMS LLC
UNIFIRST EMS INC
UNITED AMBULANCE
VELOCITY HEALTHCARE SERVICES LLC
VENTURA EMS
VILLAGE FIRE DEPARTMENT
WALKER COUNTY EMS
WALLER COUNTY EMS
WALLER-HARRIS COUNTY EMERGENCY SERVICES DISTRICT 200
WEST UNIVERSITY PLACE FD
WESTLAKE VOLUNTEER FIRE DEPARTMENT INC
WILLOWBROOK EMS
WILLOWFORK FIRE DEPT
WINDSOR EMS INC
WOODLANDS FIRE DEPARTMENT
ZAP EMERGENCY MEDICAL SERVICES

Annex B Governance

Appendix B-1 Perinatal Committee Charter
Appendix B-2 Perinatal Committee Structure

Appendix B-1: Perinatal Committee Charter

Southeast Texas Regional Advisory Council
Perinatal Committee Charter

The Southeast Texas Regional Advisory Council's (SETRAC) Board of Directors recognizes the Perinatal Committee for the geographic area encompassing TSA-Q/ PCR-Q and as a Standing Committee to the SETRAC Board, with the authority, responsibilities and specific duties as described in this Charter.

DEFINITION
For the purposes of this instrument, *Charter* shall be defined as: "A written instrument given as evidence of agreement."

COMPOSITION

The Perinatal Committee is open to all healthcare, emergency medical services providers, public health professionals, jurisdictional entities, business, and volunteer organizations within the pre-designated region. The Perinatal Committee will establish a leadership structure which shall consist of select members of the perinatal region as set forth in the SETRAC bylaws to include:

PERINATAL COMMITTEE

- 2 Healthcare Representatives from each Maternal and/or NICU designated hospital in the SETRAC region (1 Physician, 1 Nurse) appointed by the CEO or CNO of the facility.
- 2 EMS representatives from each county
- 1 Chair
- 2 Medical Directors (1- Neonatal, 1- Maternal)
- 2 Vice Chairs

Voting: All appointed representatives by entity CEO/ CNO
Non-Voting: Invited guests

PURPOSE AND SCOPE

The purpose and scope of the Perinatal Committee is to facilitate the belief that each patient in the region should have the best possible maternal and neonatal medical care.

RESPONSIBILITIES

1. Coordinate with local, regional, and state officials/jurisdictions in perinatal program development and education efforts for the healthcare community.
2. Identify and determine gaps in clinical outcomes, resources, education, or training and develop actionable plans to support educational and process refinement.
3. Facilitate integration with local, regional, and state perinatal partners.
4. Assist in development and execution of education based on identified needs/issues, formulate corrective action plans, and perform follow-up measures to ensure best practices have been instituted.
5. Disseminate education and perinatal initiatives.
6. Provide guidance and recommendations to the Board on planning initiatives, program development and grant expenditures.
7. Identify regional data-based initiatives to improve maternal and neonatal morbidity and mortality.

SUBCOMMITTEES/WORKGROUPS

The perinatal committee may establish subcommittees and workgroups as part of the committee structure designated to accomplish these responsibilities.

Standing perinatal subcommittees include:

a) Maternal Subcommittee - The purpose of this subcommittee is to analyze quality data related to maternal care and implement education and projects to improve the care of this population throughout the region.
b) Neonatal Subcommittee – The purpose of this subcommittee is to analyze quality data related to perinatal care and implement education and projects to improve the care of this population throughout the region.
c) Neonatal & Maternal Program Managers Subcommittee – this subcommittee is comprised of Neonatal and Maternal Program Managers across the region and SETRAC clinical staff. The purpose is to identify training gaps and develop and offer educational opportunities to enhance neonatal and maternal program development at member institutions.

Current workgroups are subject to change based on the needs of the committee:

a) Infant Mortality & Morbidity Workgroup – The purpose of this workgroup is to analyze data on factors contributing to infant mortality and morbidity. Through this data, the workgroup will create education and projects to help reduce infant mortality and morbidity.
b) Maternal Mortality & Morbidity Workgroup – The purpose of this workgroup is to analyze data on factors contributing to maternal mortality and morbidity. Through this data, the workgroup will create education and projects to help reduce maternal mortality and morbidity.
c) Antibiotic Timeliness Project Group - The purpose of this workgroup is to improve antibiotic timeliness through a collaborative effort throughout the region.
d) Perinatal Planning Project Group – The purpose of this workgroup is to develop and implement projects aimed at improving the care of the perinatal population throughout the region.
e) Breastmilk at Discharge Project Group – The purpose of this workgroup is to improve the support of breastmilk through a collaborative effort throughout the region.

REPORTING STRUCTURE

The perinatal committee leaders will report to the perinatal Chair, who in turn reports to the SETRAC Board of Directors. Reports are provided periodically, but on at least an annual basis.

CHAIR

The Chair and Co-Chairs will be elected by and from the perinatal committee. The Chair must be affiliated with a designated healthcare organization. The Co-Chair will assume the position of Chair in the absence of the Chair.

TERM

Terms of chairs, co-chairs, and Medical Directors are designated through SETRAC bylaws.

ROLE OF PERINATAL COMMITTEE CHAIR

The Chair of the perinatal committee is responsible for the following:

- Working with the SETRAC Clinical Leadership on setting the agenda and ensuring that agenda items are addressed.
- Facilitating achievement of committee priorities.
- Communicating the activities of the perinatal committee to the SETRAC Board of Directors and following up on issues identified.
- Identifying planning gaps within the purview of the perinatal committee and addressing those issues in an appropriate manner.

- Referring planning gaps or concerns outside the purview of the perinatal committee to the appropriate committees/departments
- Facilitating regional database development and data collection to include requirements of the RAC rules and RAC assessment.

PARTICIPATION REQUIREMENTS

The following are the requirements of participation:

- Membership dues
- Six (6) meeting credits annually with at least three (3) credits earned in perinatal committee, subcommittee, and/or workgroup meetings.
- The three (3) other credits can be earned by attending any SETRAC Board meeting, or any other SETRAC standing committee meeting in person or virtually.
- Submit completed and accurate perinatal data to SETRAC (last fiscal year + current).

ATTENDANCE

Members of the perinatal committee are expected to attend and actively participate in all meetings. If an appointed member is unable to attend and will send an alternate delegate, this should be communicated to the SETRAC clinical leadership in advance.

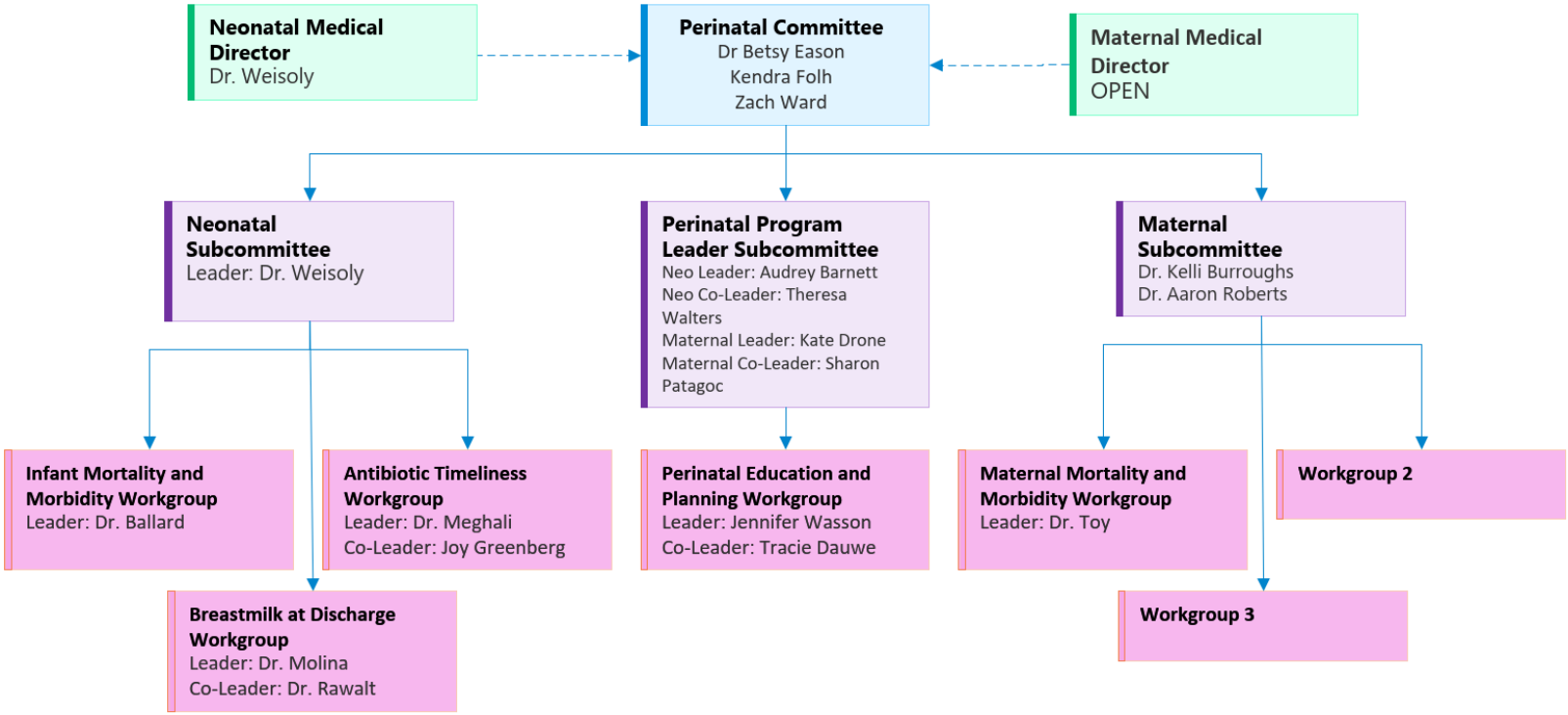
The Chair and Co-Chair are expected to attend and actively participate in all meetings and must be present (in-person) for 50% of all Perinatal Committee meetings. Failure to meet these criteria will result in removal as Chair/Co-Chair and will initiate an election process to replace the vacant position(s). Committee leaders must remain in good standing with attendance and data submission requirements.

COMPLIANCE

- No member or leader of committees, subcommittees or workgroup may speak on behalf of SETRAC, provide interviews, or publish related work within these committees without express permission from SETRAC leadership.
- All data requests require completion of data usage form and should adhere to the usage requirements within.
- Any revision of the SETRAC bylaws that conflict with any item in this charter will supersede as the rules by which the committee is governed.

Appendix B-2: Perinatal Committee Structure

SETRAC Perinatal Committee Structure 2024



Perinatal Committee

Purpose: The purpose of the Southeast Texas Regional Advisory Perinatal Committee is to improve the quality of healthcare and access to care for pregnant women and newborns in the regions, and be leaders for such processes for the state of Texas.