



TEXAS HOSPITAL ASSOCIATION

July 10, 2006

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OFFICE OF EMS/TS

Stephen C. Janda, Director
Office of EMS/Trauma Systems Coordination
Department of State Health Services
1100 West 49th Street
Austin, Texas 78756

Re: Trauma Designation Standards Rules and Level III and Level IV Criteria, 31 Tex. Reg. 4690-4696, 4742-4765 (2006) (prop. to be codified at 25 TEX. ADMIN. CODE §157.25 and §157.28) (Dep't of State Health Serv.)

Dear Mr. Janda:

On behalf of the Texas Hospital Association, we would like to provide the following comments related to the proposed Trauma Designation Standards Rules and to the proposed Level III and Level IV Facility Criteria. THA supports the development of the Texas Trauma System and appreciates the opportunity to have been included as a stakeholder in the over two-year process related to drafting revisions to the designation rules and Level III and Level IV criteria. However, following discussion by the Association's Policy Committee on Trauma and Emergency Services, where 90 percent of the committee members represent designated trauma facilities, several issues have been identified that require further revisions. Comments related to suggested revisions are categorized by issue and recommendation.

Fiscal Note

The Preamble states that there will be no fiscal implications to state and local governments unless "a local government operates a healthcare facility *and voluntarily chooses to seek trauma designation.*" (Emphasis added.) THA believes this statement may be misleading; a local government operating a healthcare facility must seek trauma designation to qualify for receipt of DSH funds.

Also, the Preamble states that once the rules are adopted, "local governments that currently operate or seek Level III trauma designation *may* incur costs to maintain 24/7

often uncompensated care. In addition, many rural Level III trauma designated facilities will lack the necessary resources to fund the relocation and on-call contracts of orthopedic surgeons.

Therefore, THA recommends that the Preamble be revised to address these two statements.

Alternative Dispute Resolution Process relating to Air Medical Access Changes

Proposed Sections 157.125(s)(4)(C)-(D) require that conflicts relating to helipad air medical access changes be negotiated between the designated trauma facility and the EMS provider and that any unresolved issues be handled utilizing the alternative dispute resolution process of the RAC in which the helipad is located. Texas hospitals will work with air medical providers to resolve concerns and possible conflicts as required by proposed subsection (C). Proposed Section 157.125(s)(4)(D) should be deleted; it is unreasonable to force hospitals to adhere to an ADR decision issued by the RAC when the property in question, the helipad, is the private property of the hospital.

In the alternative, proposed subsection (D) should be clarified to read that the ADR process and decision of the RAC is non-binding. The helipad is the private property of the hospital and must be under the control of the facility.

Therefore, THA recommends that proposed Section 157.125(s)(4)(D) be deleted or, in the alternative, clarified to read as follows: (D) Any unresolved issue ... and the ADR decision of the RAC shall be non-binding on the facility.

Orthopedic Surgeon Requirement – Level III Trauma Facility Criteria

Proposed Section 157.125(x)(B)(1)(b) requires that all Level III designated trauma facilities, not just “lead” Level III facilities, provide and maintain 24/7 orthopedic surgeon coverage. The criterion states that “the orthopedic surgeon providing trauma coverage shall be promptly available (physically present) at the major or severe trauma patient’s bedside within 30 minutes of request by the attending trauma surgeon or emergency physician from inside or outside hospital.” While orthopedic surgeon coverage is certainly desirable in an advanced, “lead” Level III trauma facility, such coverage for many Level III facilities, especially rural facilities, will be unobtainable. As noted above, THA believes that there is a shortage of orthopedic surgeons available to relocate to the more than 20 smaller, rural communities with Level III trauma designated facilities. Also, many rural Level III trauma designated facilities will lack the necessary resources to fund the relocation and on-call contracts of orthopedic surgeons.

Therefore, THA recommends that proposed Section 157.125(x)(B)(1)(b) be revised to mandate that the orthopedic surgeon requirement remain as an essential requirement for “lead” Level III facilities and a desirable requirement for other Level III facilities.

Neurosurgeon Requirement – Level III Trauma Facility Criteria

Proposed Section 157.125(x)(B)(1)(c) requires neurosurgery coverage when a Level III facility has “either full-time, routine or limited neurosurgical coverage.” Neurosurgery

coverage is certainly desirable in a Level III trauma facility. However, the requirement that this criterion become “essential” when only routine or limited neurosurgical coverage exists will be unobtainable for most Level III facilities. With the current shortage of neurosurgeons, the requirement to have a neurosurgeon “bedside within 30 minutes of an emergency request” when a facility only has routine or limited coverage simply is not possible.

Therefore, THA recommends that proposed Section 157.125(x)(B)(1)(c) be revised to read: Neurosurgery coverage is desired in a Level III, but these criteria are “essential” when a Level III has full-time neurosurgical coverage.

Trauma Nurse Coordinator/Trauma Program Manager Requirement – Level IV Trauma Facility Criteria

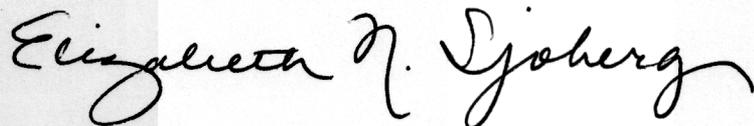
Proposed Section 157.125(y)(A)(2)(c) requires that “trauma programs should have a minimum of 0.8 FTE dedicated to the trauma nurse coordinator/trauma program manager position” (TNC/TPM). THA agrees that this position is imperative for the success of the trauma program. However, the proposed TNC/TPM staffing ratio for the smaller, rural or remotely-located Level IV trauma facilities is overly burdensome. With Texas in the throes of a severe nursing shortage, nurses in some Level IV facilities are required to “wear many hats” – and they wear them safely. To mandate that TNC/TPM in all Level IV facilities dedicate 32 hours a week to trauma activities may result in non-productive use of time. This especially would be true for the very small facilities, such as the Critical Access Hospitals.

Since there is vast difference in Level IV facilities relating to size, location and number of trauma visits per month, the criterion for the amount of time dedicated to the TNC/TPM position should be revised to allow for variance in rural and urban Level IV facilities. Instead of mandating a specific ratio for rural facilities, the amount of time required for the TNC/TPM position could be determined utilizing many of the factors listed in the Nurse Staffing Rules of the Texas Hospital Licensing Rules, adopted in 2002. (See 25 TEXAS ADMINISTRATIVE CODE §133.41(o)(2)(F)) These factors include patient characteristics for whom care is being provided, including number of admissions, discharges and transfers; intensity of patient care being provided; scope of services provided; context within which care is provided, including architecture and geography of the environment, and the availability of technology; and the staff characteristics, including staff consistency and tenure, preparation and experience, and the number and competencies of clinical and non-clinical support staff.

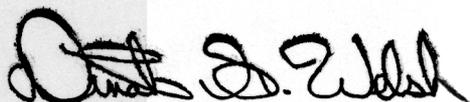
Therefore, THA recommends that proposed Section 157.125(y)(A)(2)(c) be revised to provide an alternative to the mandated 0.8 FTE dedicated to the position of TNC/TPM for the smaller, rural or remotely-located Level IV trauma facilities. In determining such alternative, THA recommends consideration of factors listed in the Nurse Staffing Rules of the Texas Hospital Licensing Rules.

On behalf of the Texas Hospital Association, we appreciate the opportunity to provide these comments. If THA can be of further assistance, please contact Elizabeth Sjoberg at 512/465-1539.

Respectfully submitted,



Elizabeth N. Sjoberg, RN, J.D.
Associate General Counsel



Dinah S. Welsh
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