

T E X ★ S Hospitals

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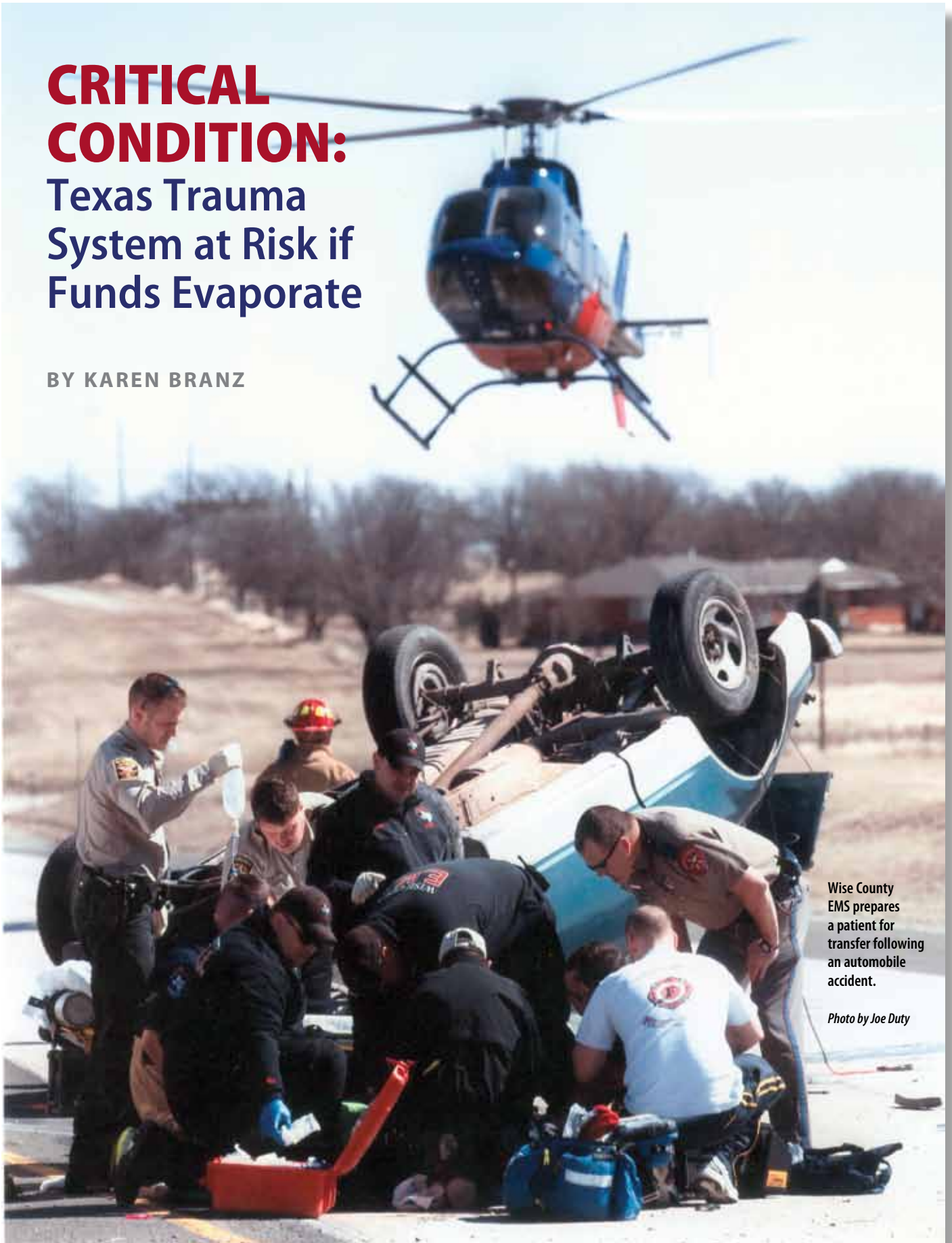
state of Emergency



**Adequate Funding Needed to Maintain
Texas Trauma System**

CRITICAL CONDITION: Texas Trauma System at Risk if Funds Evaporate

BY KAREN BRANZ



Wise County EMS prepares a patient for transfer following an automobile accident.

Photo by Joe Duty

When disaster strikes, every second is critical. But what happens when the needed emergency resources aren't available? Houston hospitals found out in September 2008, when Hurricane Ike flooded The University of Texas Medical Branch at Galveston. Because UTMB's Level I trauma center was shut down, patients were sent to the two Level I trauma centers in the Houston area.

"The pressure on Houston hospitals was tremendous," said Jim Parisi, chief operating officer at Memorial Hermann Katy Hospital. "It had a ripple effect across the region."

The pressure didn't end after Hurricane Ike subsided. UTMB remained closed for almost a year, meaning lower-level trauma centers that normally would send patients there after stabilizing them had to send them to Houston instead.

"There were logistical issues. We have the one helipad for trauma patients to fly in. Ambulances had to travel further and therefore were unavailable for longer periods of time," Parisi said. "There are a lot of downstream ramifications when a trauma center is taken out of the mix."

Trauma centers stand ready 24/7 to respond to much more than natural disasters. In fact, the most common causes of traumatic injuries are car accidents, falls, self-inflicted injuries/attempted suicides and unintentional poisonings. In 2003, the Texas Legislature created the Driver Responsibility Program to provide a stable source of funds to maintain the trauma system. The program assesses fines and surcharges for drivers cited repeatedly for certain types of violations. Despite funding from this program, hospitals reported another increase in uncompensated trauma care for 2009. When funds are tight, many hospitals can't afford to make the investments needed for trauma center designation. Those that already have made that investment may not be able to keep their designation. That is a scenario Parisi would rather not imagine.

"It's important to continue to find ways to fund trauma. If the funding goes away, we would see a lot of hospitals making hard decisions about whether to stay in or drop out," he said. "We have been working collaboratively as a state for many years to improve the overall care of our patients through the system. We've seen what happens when one Level I trauma center shuts down: patient care suffers. I'd hate for that to happen on a broader scale."

The Creation of the Current Trauma System

Geography and lack of funding were the dominant factors in the design of the Texas trauma care system. In 1989, the Texas Hospital Association and its members worked to pass a bill that mandated the development of a statewide system of care for critical injury victims, including the designation of trauma centers and development of a trauma registry to monitor implementation of the system. An advisory body, the Trauma Technical Advisory Council, also was established to provide technical and clinical advice to the department. No state funds were appropriated for this project at the time.

Kathy Perkins, assistant commissioner of regulatory services at the Texas Department of State Health Services, was hired as a trauma system specialist about six months after the bill passed. Perkins quickly realized that, in a state the size of Texas, trauma care could not be managed from a central location.

Perkins, TTAC members and health care professional volunteers designed a system of 22 trauma service areas led by a regional advisory council and anchored by at least a Level III trauma center. Many of the RACs are anchored by Level I or II trauma centers, such as the ones in Austin, Dallas, El Paso, Houston, Lubbock and San Antonio. Each RAC is responsible for planning and coordinating trauma care and emergency preparedness in its area. It's a hub-and-spoke system, with the highest level of trauma care at the hub and first responders (fire and EMS) and stabilization facilities (Level IV trauma centers) on the spokes.

Persuading the small hospitals to make the investment in equipment and staff training to become a Level IV trauma center wasn't easy. A major incentive was the state's policy decision in 1993 that hospitals eligible for Medicaid disproportionate share hospital funds must achieve designation to maintain that eligibility. This helped spur all DSH hospitals in the state to work quickly to get their designation.

Finding Funding

As the trauma system grew, the need for adequate funding grew as well. THA worked tirelessly to get the first 911 trauma funds and championed Rep. Dianne Delisi's creation of the Driver Responsibility Program. Under this program, driving under the influence, driving without a valid license, failure to carry insurance and violations that result from reckless behavior are supposed to result in large yearly surcharges. A portion of the funds derived goes toward reimbursing hospitals for the unpaid trauma care they provide.

When the program was established in 2003, the impact on the trauma system was immediate. Because establishing a trauma center is an expensive undertaking, the new funding from the Driver Responsibility Program attracted many hospitals. Of the 254 existing designated facilities, 66 joined since 2003 – a 35 percent increase.

The program collects only a fraction of the fines imposed, however. In April, an article in *The Dallas Morning News* reported that more than 60 percent of the fines go unpaid. Additionally, not all money collected goes to the trauma system. The Driver Responsibility Program collects \$125 million a year on average. By the end of fiscal year 2011, it will have a balance of \$360 million. For the 2010-11 biennium, the Texas Legislature appropriated \$75 million from the Driver Responsibility Program to the trauma system.

Because of the bill's impact on low-income Texans, several groups are pushing for repeal of the program. During the last legislative session, Sen. Eliot Shapleigh (D-El Paso) sponsored a bill to repeal the program. THA successfully stopped the bill and secured an amendment to another bill that exempts violators whose income is less than 125 percent of the federal poverty level. That bill becomes effective in 2011.

"The premise and policy behind the Driver Responsibility Program are sound. People who commit traffic offenses like driving under the influence and repeated speeding are more likely to cause accidents and harm themselves or others and send them to an emergency room," said Denise Rose, J.D., senior director of advocacy and public policy at THA. "This money is critical to preserve statewide access to trauma care and to ensure that Texans can get life-saving care quickly when they need it."

A Community Issue

Jorie Klein, RN, director of trauma and disaster services at Parkland Health & Hospital System in Dallas, notes that maintaining a trauma program can be costly. The Driver Responsibility Program does not cover all the costs – but it helps.

“Parkland had \$61 million in uncompensated care last year. We won’t receive all that money, but we may receive \$6-7 million, which will cover staff and outreach activities. That funding is critical,” she said.

Klein points out that hospitals must meet stringent criteria to become a designated trauma facility. Not only must they meet the required standards of care, but they also must engage the community in understanding how to prevent trauma. Additionally, they are evaluated every three years by a third-party reviewer. If funding is cut, hospitals may consider cutting, modifying or downsizing their trauma centers, which will affect the care patients receive.

“The citizens of Texas will be affected the most,” Klein said. “Whether we’re talking about an infant in a car crash or a 65-year-old who falls off a ladder, these are the people who will suffer.”

Lower Levels in Trouble

Tina Leech, director of trauma services at University Medical Center of El Paso, says her biggest concern about the trauma system in her area is the stability of the Level IV centers. In much of West Texas, a critically injured patient could be 150 to 200 miles from the nearest tertiary care hospital. The only thing standing between those patients and death are the first responders (often volunteer fire and EMS personnel) and a small rural hospital that has made the investment to become a Level IV trauma center.

“A Level I Trauma Center doesn’t stand alone. We rely on Level III and Level IV centers to help with identification of patients, stabilization and arranging transport to the appropriate trauma center. Twenty-five percent of trauma deaths each year could have been prevented if appropriate acute care had been available,” Leech said. “If I have a patient 200 miles away, how do they get here, and what happens while they are being transported? Helicopters can’t always fly because of the weather. We need Level IIIs and Level IVs to help us pick up and stabilize patients so they can be transported safely.”

Without adequate funding, these lower-level centers may lack more than the proper equipment – they may lack the necessary personnel. At Llano Memorial Healthcare System, a Level IV trauma center, seniors who fall and break a bone are a common sight in the ER. The patients aren’t there long. Despite full facilities for orthopedic surgery and a nursing staff trained to handle orthopedic care, those patients must be sent on to a tertiary care facility. The issue is a lack of funds to pay an orthopedic surgeon to take call at the hospital.

THA advocacy staff, including Matt Wall, J.D., second from right, and Sharon Johnson, far right, recently met with trauma team members Oliver Geslani, RN, Tracy Buck, RN, Courtney Cardenas, RN, and Peter Garcia, RN, at Parkland Health & Hospital System in Dallas to get an in-depth look at a Level I trauma center to better understand everything it does and is required to do to maintain that Level I status.

“Many of these patients are frail and elderly. Instead of getting care near their home, they are sent an hour or more away to get care in San Antonio, Austin or Temple. And they often have equally frail spouses or other relatives who must then drive into the city to see their loved one,” said Randall Grimshaw, M.D., medical director for trauma at Llano Memorial.



At Llano Memorial Healthcare System, trauma team members Julie Ferguson, RN, left; Kathy Moon, RN; and Randall Grimshaw, M.D., often see patients who have fallen.

While the Level I and II centers in urban areas will feel the budget crunch if funds dry up, they are unlikely to close their doors, said Leech. But for Level IIIs and IVs, budget cuts may be their death blow.

“I’m concerned that with the state budget in crisis, the Level IIIs and IVs aren’t going to develop, or the ones we have won’t be able to sustain their operations and will close their doors. That shuts down our system. That’s the thing that scares us,” she said.

In May, the American College of Surgeons conducted a survey of the Texas trauma care system. The Legislature originally asked for an evaluation to determine if the state needs more Level I and Level II trauma centers, but TDSHS staff decided that it was a good opportunity to do a thorough survey of the entire system. Results from the survey are expected at the end of July.

“Appropriation of designated trauma funds continues to be a top priority for THA,” Rose said. “Maintaining a trauma center is a significant and often money-losing endeavor for hospitals, who choose to be in the program because of their mission and for the sake of the communities they serve. THA is committed to working with the Legislature to make the DRP more effective while keeping the program intact.” ★

