Texas Hospital Association

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PUBLIC COMMENT LETTER

DSHS EMA/Trauma Systems Section
4601 W. Guadalupe St.
P.O. Box 13247
Austin, Texas 78711-3247
Via electronic submission to: DSHS.EMS-TRAUMA@dshs.texas.gov

Re: Proposed Rules, concerning Trauma Designation; Project No. 21R151

Dear Sir or Madam:

On behalf of our more than 460 member hospitals, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to comment on the proposed rule amending Title 25 Texas Administrative Code Chapter 157, setting forth the trauma designation requirements for Texas hospitals. THA hopes these comments help improve the rule as it applies across Texas and minimizes operational impacts of the Texas hospitals making every effort to comply.

THA commends the department's vision toward improving the state trauma system. However, adopting some of these changes would require hospitals to expend significant costs to comply. In some instances facilities, especially Level IV and rural facilities, may choose not to or be unable to re-designate, which could strain the state's entire trauma network. Neighboring trauma centers may not be able to accommodate the increased capacity and Texans would have to travel further from their homes and communities for care. The rule preamble states that the 108 rural trauma designated facilities may incur additional costs to comply with the proposed Level IV trauma designation requirements, and our rural membership confirms this is the case. THA reminds the department that achieving and maintaining trauma designation is already expensive and resource-intensive for hospitals.

In order to work towards improving the trauma system while maintaining access to care for Texans, THA recommends focusing on incorporating the rule changes that align with ACS guidelines and holding off on more ambitious requirements or stair step the changes and ease the transition. The department could also consider increasing the time that facilities have to comply with the new requirements for trauma designation. A longer on-ramp would allow facilities to seek additional funds, clarification, and/or staffing as needed.

The comments shared below are not exhaustively reflective of all feedback received from the THA membership but highlight those most reiterated.

1. The rule refers to the "EMS wristband tracking number," a concept we understand is to be implemented over time to allow tracking of a patient though a unique identifier throughout the entire healthcare continuum. The concern amongst hospitals is the need to integrate this new identifier into the patient's medical record in a manner that accomplishes this purpose. This may include exporting this unique identifier into a statewide registry, for example. Several Texas hospitals engaged third-party solutions for similar unique identifier programs within their systems. If the State of Texas is proposing to create a new program for these purposes, a more feasible alternative may be for the State to engage and utilize a program already in use within Texas hospitals.

2. The requirement for facilities, through the Trauma Medical Director (TMD) and Trauma Program Manager (TPM), to participate in in their local Regional Advisory Council may have disparate effect across the state. The meetings amongst the RAC's are not uniform in timing and content, meaning hospitals operating in multiple RACs must abide by different schedules and requirements. For example, one RAC may meet once per quarter and via a call-in option, while other RACs require in-person attendance. Promoting uniformity amongst the RACs would be helpful, especially with an option for physicians to attend meetings virtually. Also, including flexibility for the TMD and TPM to coordinate participation between them or enlist a liaison to assist in the participation would help with capacity issues.

3. There are many references to defining rural tied to population level. THA recommends making the references consistent and tying it to a definition source that is continually updated with the census.

4. Sec. 157(j)(22) lists the qualifications and responsibilities of Trauma Medical Director (TMD). Many Level IVs have an emergency medicine physician as a TMD. It also maybe extremely difficult and cost prohibitive for smaller and/or rural facilities to attract a surgeon in general, much less to serve as a TMD. We recommend keeping the option of having an emergency medicine physician as a TMD. We also recommend aligning required responsibilities with the ACS guidelines and not surpassing them at this time.

5. Sec. 157.125(b)(1) requires a designation application to include an annual summary of the trauma performance improvement and patient safety (PIPS) plan. Similarly, Sections 157.125(g)(1)(F), (g)(2)(F), (g)(3)(F),(g)(4)(F), & (j)(32) require all facility levels to submit an annual performance improvement summary report. THA suggests removing this requirement as this is currently not an ACS standard and designation information is currently delayed. Alternatively, THA recommends providing a simple, efficient summary template that facilities can use to reduce any confusion on the requirement.

6. Sec. 157.125(h) sets out requirements which are not currently an ACS Level IV standard and may result in hardships for Level IV facilities that may not need Level III resources to successfully function or treat patients accordingly. Many Level IV trauma centers utilize

Emergency Medicine Physicians as Trauma Medical Director and thus may not be able to meet the ICU standard for surgical co-director. THA appreciates the increased ISS threshold; however, suggests removing this altogether. If not removed, THA suggests re-wording it to meet the Level III ACS verification standards for the laboratory, blood bank, operating room, and rehabilitation with a requirement for an ICU liaison.

7. Sec. 157.125(j)(10)(D) will require additional guidance regarding the requirement to utilize funds to improve the trauma program and care provided. There are numerous options for a hospital to meet this requirement, with diverging opinions at the state and federal levels. If this requirement will result in a significant change for current hospital processes, that and any specific expectations should be clearly identified. THA also recommends focusing on only requiring processes to monitor and track the items listed in (A)-(D) of Sec. 157.125(j)(10) and removing the list of personnel that must establish such processes. This provides facilities more flexibility to utilize existing bodies and processes as many have a financial or reimbursement team charged with these tasks.

8. Sec. 157.125 (j)(19) states a trauma registered nurse is a participating member of the nurse staffing committee. THA recommends providing clarification on how the State defines "trauma registered nurse".

9. Sec. 157.125(j)(35) The draft rule would have resulted in a significant financial impact on trauma centers across Texas. THA appreciates the change to align with the current ACS accepted standard of a 0.5 FTE for every 200-300 register entries. However, ongoing staffing issues across hospitals do not allow for universal and full-time compliance with the other sections of 157.125(j)(35).

10. Texas hospitals request clarification on whether the individual required by Sec. 157.125(j)(38) may be shared amongst individual facilities. The proposed requirement is beyond current standards and the ability to share this requirement amongst facilities could reduce any resulting financial hardship.

11. Sec. 157.2 (124) should account for virtual survey options.

12. Sec. 157.125(d)(3)(C) requires further clarification; the rules seem to allow for different designation levels and hospitals will want to avoid confusion with this requirement.

13. Sec. 157.125(j)(40)(C) requires additional clarification on whether this includes inter-facility transfers or just scene arrivals.

14. Sec. 157.125(j)(40)(D) requires clarification as to why a 30-day timeframe for feedback when there are 60 days to complete abstraction in the registry. THA recommends changing to 60 days from discharge to align with abstraction deadline.

15. Sec. 157.125(q) requires additional members for the survey teams that review facilities applying for designation and/or re-designation. Adding more roles in a verification team will add more cost to the facility and may not be feasible if the additional staff is not available due to workforce constraints. THA recommends keeping the survey team composition requirements as stated in the current rule.

THA hopes these comments will help improve the rule, provide the best opportunity for hospitals to comply, and minimize the opportunity for noncompliance.

THA sincerely thanks you for the opportunity to comment and participate in this process, and for your time and attention to this matter. We look forward to working with you, and please feel free to contact me at (512) 465-1027 / clopez@tha.org or Erika Ramirez at (512) 635-5344 / eramirez@tha.org with any questions, comments, or if there is anything else THA can assist with.

Respectfully Submitted,

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Texas Hospital Association