TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services
A Program of the Texas EMS Trauma & Acute Care Foundation

3400 Enfield Road
Austin, TX 78703
512-524-2892
www.tetaf.org
www.texasperinatalservices.org

September 23, 2022

Jorie Klein, RN, BSN
EMS/Trauma Systems Director
Texas Department of State Health Services
1100 West 49th Street
Austin, TX 78756-3199

Dear Ms. Klein:

Texas EMS, Trauma & Acute Care Foundation (TETAF) appreciates the opportunity to comment on Chapter 157, Subchapter A. The additional language and clarification throughout the rules will further improve trauma patient care in Texas and further evolve the Texas Trauma System.

We commend the Texas Department of State Health Services (DSHS) for the clarification of the use of telemedicine when managing a trauma patient. The requirements are better defined in this document, include the state of Texas credentialing, and will lead to an improved utilization of this resource.

A much-needed revision was accomplished with the additional language limiting trauma medical directors and trauma program managers to oversight of trauma programs on one campus only including the requirement to practice within the hospital where the program is being managed. The complexity of the trauma program, including oversight of care, education, injury prevention and quality assurance demands on-site leadership to ensure optimal patient care is provided. This change will be beneficial to all trauma patients in Texas.

We appreciate the expanded definitions of terms and words. These clarifications will better define the expectations for hospitals and will prove very useful in the on-site reviews of programs.

Some opportunities have been identified of which we would appreciate your consideration.

§157.2. Definitions.
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(10) Advanced Level III trauma facility
"...submits data to the State Trauma Registry, the National Trauma Data Bank (NTDB), and the Trauma Quality Improvement Program (TQIP); and has appropriate services for dealing with stressful events for the emergency/trauma care providers."

The requirement for Advanced Level III trauma facilities to submit data to the NTDB and to the TQIP is an additional, annual expense for the hospitals to the American College of Surgeons (ACS); requires additional trauma registrar work hours dedicated to this essential requirement and will result in a higher cost to the hospital to maintain the registry for their hospital. While the ACS will benefit from the fees and the use of the data, the Level III's are not reviewed by the ACS and already submit data to the state registry. Submitting Level III data to the ACS database would be a luxury the hospitals would bear a significant financial burden.

Within this rule there are additional quality requirements, a tighter time frame for quality reviews and the initiation of the trauma registry within 24 hours that add to the financial burden through dedicated staff hours. Combined, the increase of data submission to the state and to ACS would be a significant financial strain on hospitals. Through this new rule, the state will be receiving this data. The state should be able to submit the data to the ACS on behalf of Level IIIs in Texas and not require the Level IIIs to submit data to the NTDB and TQIP, reducing the hospital financial burden, or the state should negotiate with the ACS a lower annual cost for hospitals not verified through the ACS.

(166) Verification--Process used by the ACS to review a facility seeking trauma verification to validate that the defined standards are met with documented compliance for successful trauma center verification. **If a Level I or Level II facility is not verified by the ACS, the department will not designate the facility.**

Currently, ACS is the only approved surveying organization for Level I and Level II facilities. The statement limits additional opportunity as need may arise for other organizations to verify Level I and/or Level II hospitals in Texas. TETAF recommends the last sentence be eliminated. At one time, only Joint Commission was certified in Texas. Today, we have at least three certification organizations. The application process to verify in Texas should ensure appropriate reviews.

157.123 Regional Advisory Councils
(B) a completed regional self-assessment within the first year of the RAC's contract with the department and a current trauma and emergency health care system plan during the second year of this departmental contract with documented evidence the performance criteria are met, as outlined in Texas Health and Safety

Self-assessments have been in place for many years. A site survey by a qualified, outside survey organization or the state would provide a non-biased review of the RAC's performance, identify opportunities for improvement and lend further credibility to the RAC system.

157.125 Trauma Facility Designation
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(2) Each hospital must demonstrate the capability to stabilize and transfer or treat an acute trauma patient, have written trauma standards of care, and a written trauma performance improvement and patient safety plan.

Written trauma standards of care should be hospital specific, based on hospital resources and the hospital's scope of practice. TETAF recommends further definition here or in the survey guidelines, as commercial products will not meet this requirement.

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(E) trauma standards of care based on evidence-based practice;

Written trauma standards of care should be hospital specific, based on hospital resources and the hospital's scope of practice. TETAF recommends further definition here or in the survey guidelines, as commercial products will not meet this requirement.

Page 35/64. Regarding the TMD.

(E) demonstrate effective administrative skills and oversight of the trauma performance and patient safety plan and associated processes, secondary level of performance reviews, trauma operations committee, trauma multidisciplinary peer review committee, and communication and collaboration with defined trauma liaisons for emergency medicine, orthopedics, neurosurgery, critical care, radiology, anesthesia, rehabilitation, and other surgical and medical specialists;

Recommend specifically stating chair or co-chair of the trauma operations committee as stated on 36/65 (D) to ensure authority and continuity across the continuum of care and to avoid physicians not actively involved in trauma patient care chairing this critical committee.

Page 43/64. Regarding the composition of the survey teams.

(4) Level III facilities that admit 200 or fewer patients that meet trauma activation criteria and NTDB criteria must be surveyed by a multidisciplinary team to include one trauma or general surgeon with trauma expertise, one emergency medicine physician, and a TPM, all currently participating in the management or oversight of trauma patients at a facility designated at the same or higher level.

The addition of the third surveyor will result in additional financial burden for the hospital in a hospital with a limited number of comprehensive patients for review. If a Level III transfers surgical patients, consider eliminating the trauma surgeon or the emergency medicine physician as the bulk of trauma patient care occurs under the direction of the emergency physician if patients are routinely transferred for surgical intervention.

(7) Level IV facilities that do not admit patients who meet trauma activation criteria to the operating suite or intensive care unit must be surveyed by an emergency medicine physician or trauma or general surgeon with trauma expertise, and a TPM,

Level IV facilities who routinely transfer less than 200 patients a year should not have to bear the financial burden of a second surveyor.

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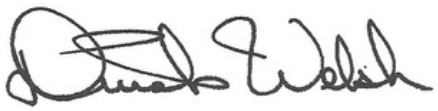
(1) All members of the survey team for Level III or IV, except department staff, cannot be from the same TSA or a contiguous TSA of the facility's location.

TETAF strongly supports filters to reduce and eliminate conflicts of interest for surveyors and hospitals surveyed, however, inserting the additional "contiguous" Trauma Service Area (TSA) verbiage in the surveyor eligibility rule language will decrease the eligibility of Texas surveyor clinical expertise from high-level, receiving trauma centers in Texas, along with the knowledge of Texas' systems of care. Additionally, the subsequent loss of the coaching and educational impact of these health care providers while on-site, who are intimately involved in Texas health care systems, will result in a loss of opportunity to improve patient outcomes and increase the cost of surveying hospitals in a financially stressed hospital environment. National surveying organizations that have increased access to out-of-state surveyors while already utilizing non-Texas surveyors, do not have knowledge of the Texas systems of care and will not be affected by this rule.

The additional financial burden these rules are adding to the program management resources required for Level III and Level IV trauma centers are not supported with additional funding. In the SDA trauma add on, the Level I and Level II hospitals receive significantly higher reimbursements for the trauma add on than IIIs and IVs. Please consider reviewing the percentages of the SDA trauma add-on for Level IIIs and Level IVs.

One final comment. Multiple times throughout this document, we note the utilization of the American College of Surgeons (ACS) as a surveying body with only the addition of "a department approved survey organization." Texas EMS, Trauma & Acute Care Foundation (TETAF) has been surveying in Texas for over 14 years and surveys more than 80% of trauma hospitals every three-year cycle. With respect for TETAF's contribution to the Texas Trauma System, we respectfully request that TETAF be included in the survey organizations approved just as has been done with ACS along with "a department approved survey organization."

Regards,



Dinah Welsh
President/CEO
TETAF/Texas Perinatal Services