



**Texas Organization of
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July 7, 2006

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

Dear Mr. Janda:

Strong participation among rural hospitals has helped Texas to develop a true statewide trauma care system. Even more facilities have been designated since the passage of HB 3588. The Texas Organization of Rural & Community Hospitals wants to share some concerns that our members have voiced over proposed changes to the rules governing trauma designated hospitals in the rural parts of the state. TORCH's comments have to do with two rule changes that affect level III and IV facilities primarily. While the rules that relate to larger facilities are also important, none of our hospitals provide the level of care that meets level I or II criteria.

First, the increased number of hours or percentage of time dedicated to a "trauma nurse coordinator" is too high for most level III and IV hospitals (25 TAC § 157.25(x)(A)(3)(c) and (25 TAC § 157.25(y)(A)(2)(c)). For most facilities, the cost-benefit of being trauma-level designated is not substantial enough to warrant an increase in the amount of staff time being proposed in the rule. Staff shortages, especially among nurses, could be considered moderate to severe in most rural areas and full time registrars for higher volume facilities could also be burdensome. In short, we would advise that hospitals be given the flexibility to use whatever amount of staff time is necessary to maintain their trauma designation.

Second, the new requirement for full-time orthopedic coverage for level III facilities (25 TAC § 157.25(x)(B)(1)(b)) is a difficult condition for rural hospitals to meet. While full-time orthopedic coverage is certainly desirable for a level III facility, in rural areas this simply may not be possible due to the limited number of available surgeons. Therefore, our advice would again be to make full-time coverage optional, but not essential for level III facilities. In the absence of orthopedic coverage, transfer agreements and protocols are already in place to ensure patients

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receive the appropriate level of care. The same comments would apply to any rules regarding a full-time neurosurgeon.

Finally, there is an issue with the use of the RAC's alternative dispute resolution (ADR) process for any unresolved issues between a hospital and medical air transport providers regarding the use of the hospital's helipad (25 TAC § 157.125(r)(4)(D)). This provision should state that the ADR process is non-binding, since the helipad is the private property of the hospital. Ultimately, a hospital should have a right to control what takes place on their own property.

It is clear that much time, effort and expertise has gone into this rulemaking process and we feel that these few changes would resolve the majority of concerns being expressed by trauma designated facilities that are located in rural areas. We appreciate the opportunity to deliver these comments.

Sincerely,



David Pearson

Vice President, Advocacy/Communications