

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Trauma Center or Facility Designation

Type of Rule: Legislative Interpretive Procedural

Agency Department of Health Address 1800 Washington Street, East
Charleston, WV 25305

1. Effect of Proposed Rule	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
Estimated Total Cost	\$	\$	\$ 0	\$ 0	\$ 0
Personal Services					
Current Expense					
Repairs and Alterations					
Equipment					
Other					

2. Explanation of above estimates.

No increase in expenditure of state funds is anticipated.

3. Objectives of these rules:

The proposed amendments incorporate new criteria adopted for the designation of trauma centers or facilities in the national system published by the American College of Surgeons.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

NONE

B. Economic Impact on Political Subdivisions; Specific Industries;
Specific groups of citizens.

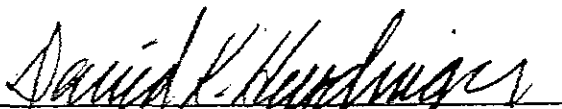
NONE

C. Economic Impact on Citizens/Public at Large.

NONE

Date June 17, 1987

Signature of Agency Head or Authorized Representative



David K. Heydinger, M.D., Director
Department of Health

DATE: November 18, 1987

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: Health Department

FILED

NOV 19 10 19 1987

LEGISLATIVE RULE TITLE: Trauma Center or Facility Designation

1. Authorizing statute(s) citation _____
Chapter 16, Article 1, Section 7(4)

2. a. Date filed in State Register with Notice of Hearing:
July 24, 1987

b. What other notice, including advertising, did you give of the hearing?

Notices were sent to all hospitals, county health departments and concerned professional associations.

c. Date of hearing (s): August 28, 1987

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached No comments received

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

November 18, 1987

f. Name and phone number of agency person to contact for additional information:

Kay Howard, Director, Regulatory Development, 348-3223.

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

NA

b. Date of hearing: - NA

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

NA

d. Attach findings and determinations and reasons:

Attached NA

WEST VIRGINIA BOARD OF HEALTH

RULE ABSTRACT

Rule Title: Trauma Center or Facility Designation

CSR Title & Series: 64 CSR 27 Type: Legislative

Objective/Purpose: The revisions are for the purpose of incorporating changes in the national system published by American College of Surgeons.

For further information contact: Kay Howard, Director,
Regulatory Development Section, Telephone 348-3223 or Fred M.
Cooley, M.D., Director, Emergency Medical Services, Telephone
348-3956, Health Department, 1800 Washington Street, East,
Charleston, WV 25305.

WEST VIRGINIA BOARD OF HEALTH
MAY 13 1964
REGULATORY DEVELOPMENT SECTION

FILED
NOV 18 PM 1:20
CLERK OF COURTS

[PROPOSED]

TITLE 64

WEST VIRGINIA LEGISLATIVE RULES
DEPARTMENT OF HEALTH

Trauma Center or Facility Designation

Series 27

198__

For Filing with Legislative
Rule-Making Review Committee

WEST VIRGINIA LEGISLATIVE RULES
DEPARTMENT OF HEALTH

Trauma Center or Facility Designation

64 CSR 27

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[PROPOSED]
TITLE 64
WEST VIRGINIA LEGISLATIVE RULES
DEPARTMENT OF HEALTH
Series 27

FM 77
1987 NOV 18 PM 1:20

Title: Trauma Center or Facility Designation

General

1.1. Scope - This legislative rule establishes the standards, criteria and methods of designating various health care facilities in the State of West Virginia as meeting specific levels of care capability as trauma centers or facilities in order to identify those facilities best equipped and staffed to care for the critically injured patient.

1.2. Authority - This rule is issued by the director of health under the authority of Chapter 16, Article 17, Section 7 (4) and is related to Chapter 16, Article 4C, Section 1 et seq. of the West Virginia Code.

1.3. Filing Date -

1.4. Effective Date -

Section 2. Supersession and Repeal of Former Rules - This rule supersedes and repeals Trauma Center or Facility Designation, West Virginia Department of Health Legislative Rules, 64 CSR 27, Series-27, 1984 1986. and the emergency rule Trauma Center or Facility Designation, West Virginia Board of Health Emergency Rules, Chapter 16-17-Series-XXVII, 1984, amended.

Section 3. Application and Enforcement

3.1. Application - This rule shall apply to all health care institutions, facilities, hospitals, clinics, corporations, partnerships and governmental agencies engaged in the provision of care to critically injured patients in the state.

3.2. Enforcement - The enforcement of this rule is vested with the director of the West Virginia department of health or his lawful designee.

Section 4. Definitions

4.1. Level II - This means a health care facility which meets most but not all of the standards, criteria, resources and capabilities of trauma care as listed herein (Advanced).

4.2. American College of Surgeons Guidelines - A listing of hospital resources necessary for optimal care of the injured patient as published by the American College of Surgeons in 1983 1986 in the Bulletin of the American College of Surgeons.

4.3. Regional Emergency Medical Services Agency - One of several multi-county operational agencies established by the office of emergency medical services for the purpose of age

coordinating the development, implementation and planning for emergency medical services within the regional area. Each region is staffed by area program personnel who function under a board of directors appointed by the several emergency medical services regions served.

4.4. Basic - This means a health care facility which meets the minimum standards, criteria, resources and capabilities of trauma care as listed herein.

4.5. Board - Means the West Virginia board of health.

4.6. Level I - This means a health care facility which meets all of the standards, criteria, resources and capabilities of trauma care as listed herein (Comprehensive).

4.7. Critical Care Committee - A committee established at the regional and state emergency medical service agency level, composed of specialty physicians representing the eight critical patient care areas of trauma, cardiac, high risk infant, poisoning, drug and alcohol detoxification, behavioral, spinal and burn for the purpose of advising the respective agency on medical care principles and activities, including categorization of health care facilities.

4.8. Dedesignation - This means the withdrawal of a previous designation level by the West Virginia department of health when it is determined by review and audit of an institution that such institution no longer meets the standards, criteria, resource availability or commitment for trauma care.

4.9. Designation - This means an official notification from the West Virginia department of health to a particular health care facility indicating the level of trauma care capability determined by the site visit process.

4.10. Level III - This means a health care facility that meets some of the standards, criteria, resources and capabilities of trauma care as listed herein, but does not have the specialty care capabilities to manage the more severely injured patient throughout the course of hospitalization (Intermediate).

4.11. Levels of Care Capability - This refers to the resources, staffing, equipment and commitment that a particular health care facility evidences in the trauma care area. The terms comprehensive, advanced, intermediate and basic are used to identify the various levels.

4.12. Office of Emergency Medical Services - An official division of the West Virginia department of health.

4.13. Proposal - A document submitted by a health care facility which indicates the existing resources, care capability, commitments and cooperative assurances of that institution in regards to trauma care. Normally, the proposal process will be used when two or more institutions located in the same community

or general area are competing for designation at a particular level.

4.14. West Virginia Categorization Committee - A committee appointed by the director of the department of health to periodically review and recommend changes in the West Virginia State Emergency Facility Categorization Plan. The committee shall be composed of three (3) representatives each of the West Virginia State Medical Association, the West Virginia State Hospital Association, the West Virginia regional or area Emergency Medical Service agencies, regional Emergency Medical Service Medical Directors, two (2) each from the West Virginia Chapter of the American College of Emergency Physicians, the West Virginia Nurses Association, the West Virginia Emergency Nurses Association, one (1) from the West Virginia Society of Osteopathic Medicine and three (3) representatives from the public at large. The director of health may name additional representatives to the committee at his discretion.

Section 5. Site Visit - No health care facility center, unit or hospital shall be designated in accordance with the following process without a site visit being performed by individuals authorized to perform such site visit by the West Virginia department of health.

Section 6. General Criteria for Determining Trauma Care Capability

6.1. Basic - A facility which is capable of caring for a minimally injured patient and is able through its medical staff to stabilize patients with more severe injuries prior to transfer to a facility with higher care capability.

6.2. Level III - (Intermediate) An institution with approximately 100 one hundred to 250 two hundred fifty beds which has a clear commitment to excellence of trauma care. Transfer protocols in selected specialty areas are required.

6.3. Level II - (Advanced) An institution with approximately 200 two hundred to 500 five hundred beds which treats a large volume of seriously approximately three hundred fifty to six hundred urgent or severely injured patients per year.

6.4. Level I - (Comprehensive trauma facility) A hospital operating in a metropolitan area and experiencing approximately six hundred to one thousand (1,000) admissions per year of seriously injured patients, or the treatment of approximately fifty urgent and severely injured patients per year for each surgeon taking trauma call.

Section 7. Specific Standards and Criteria for Designation of Health Care Facilities as Trauma Centers.

7.1. Basic Level Facility (No National Level Designated)

7.1.1. Care Capability

A. The hospital and its medical and nursing staffs are capable of treating and stabilizing patients with:

1. Closed fractures
2. Soft tissue injuries with stabilized bleeding
3. Multiple rib fractures without flail chest
4. Blunt abdominal trauma not producing hypotension

B. Required resources and equipment:

1. X-Ray facilities with adequate interpretation and laboratory facilities, both available 24 twenty four hours a day
2. Regularly available physicians capable of caring for the patient injuries described in A. above
3. Experienced nurses available to care for and evaluate such patients
4. Available stored blood
5. Cut-down trays
6. Surgical supplies for hemostasis and wound repair
7. Splints and slings
8. Oxygen supplies
9. Nasogastric tube sets
10. Suction equipment
11. Parenteral fluids and infusion equipment including dextran or similar product and blood administration sets
12. Standard emergency drugs
13. Stretchers capable of Trendelenberg position
14. Electrocardioscope-graph-defibrillator equipment

7.2. Level III Trauma Center (Intermediate)

7.2.1. Care Capability - The hospital and its medical, nursing and administrative staffs are capable of treating and stabilizing patients with most types of traumatic injuries. Available resources include all those listed under "Basic Level Facility," plus the following:

A. Hospital organization:

1. Departments/divisions/services or sections which are staffed by qualified physicians:

a. Required:

(1) General surgery

(2) Trauma service

b. Recommended/Desired:

(1) Trauma-service

2. Surgical specialties availability. On-call and promptly available from inside or outside the hospital. (May be fulfilled by residents capable of assessing emergency situations in their respective specialties and of providing any immediately indicated treatment. When residents are used to fulfill availability requirements, staff specialists are to be on-call and promptly available for consultation.)

a. Required:

(1) General surgery specialists

b. Recommended/Desired:

(1) Ophthalmic surgery specialists

(2) Orthopedic surgery specialists

(3) Otorhinolaryngologic surgery specialists

(4) Plastic and maxillofacial surgery specialists

(5) Thoracic surgery specialists

(6) Urologic surgery specialists

(7) Neurological surgery specialists

3. Non-surgical specialties availability: (May be fulfilled by residents as before specified).

a. Required:

(1) Emergency medicine

(2) Anesthesia department (May be physician-directed program staffed by nurse anesthetists.)

(3) Internal medicine

(4) Pathology

~~(5)-Pediatrics~~

~~(6)-Radiology~~

b. Recommended/Desired:

(1) Cardiology

(2) Hematology

(3) Nephrology

(4) Pediatrics

(5) Radiology

B. Special facilities, resources and capabilities

1. Emergency department:

a. Personnel: (Required)

(1) Designated medical director

(2) Physician(s) with special competence in the care of the critically injured patient who are on duty in the emergency department 24 twenty four hours a day

(3) Registered nurses, licensed practical nurses and nurses' aides in adequate numbers

b. Equipment for resuscitation and to provide life support for the critically or seriously injured patient shall include, but not be limited to the following: (Required)

(1) Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, sources of oxygen and mechanical ventilator

(2) Suction devices

(3) Electrocardiograph-scope-defibrillator

(4) Apparatus to establish monitor central venous pressure monitoring

(5) All standard intravenous fluids and administration devices, including intravenous

catheters

- (6) Sterile surgical sets for procedures standard for emergency departments, such as thoracotomy, cut-down trays, etc.
 - (7) Gastric lavage equipment
 - (8) Drugs and supplies necessary for emergency care
 - (9) Two-way radio linked with vehicles of emergency transport system and with essential on-call physicians in-hospital
 - (10) X-ray capability, 24 twenty four hour coverage by technicians
 - (11) MAST garment (Medical Anti-shock Trousers)
 - (12) Skeletal tongs
2. Intensive care unit for trauma patients (May be separate specialty units.):
- a. Required:
 - (1) Designated medical director
 - (2) Physician on duty or immediately available from inside the hospital
 - (3) Nurse-patient ratio at a minimum of 1:2 on each shift
 - (4) Immediate access to clinical laboratory services
 - (5) Equipment required:
 - (a) Airway control and ventilation devices
 - (b) Oxygen source with concentration controls
 - (c) Cardiac emergency cart
 - (d) Temporary transvenous pacemaker
 - (e) Electrocardiograph-scope-defibrillator
 - (f) Mechanical ventilator-respirator
 - (g) Pulmonary function measuring device
 - (h) Temperature control devices (patient)

- (i) Pressure distribution equipment
- (j) Drugs, intravenous fluids and supplies
- (k) Patient weighing devices

b. Recommended/Desired:

- (1) Physician on duty or immediately available from inside the hospital
- +1+ (2) Cardiac output monitoring devices
- +2+ (3) Electronic pressure monitoring devices
- +3+ Patient-weighing-devices
- (4) Intracranial pressure monitoring devices

3. Postanesthetic recovery room (a surgical intensive care unit is acceptable):

a. Required:

- (1) Registered nurses and other essential personnel available 24 twenty-four hours a day
- +2+ A-physician-(usually-an-anesthesiologist) providing-supervision-in-hospital-24-hours-a day
- +3+ (2) Appropriate monitoring and resuscitation equipment

4. Radiological-special-capabilities:

a. Recommended/Desired:

- +1+ Angiography-of-all-types

5- 4. Hemodialysis:

a. Recommended/Desired:

- (1) Acute hemodialysis capability or transfer agreements in place

+2 5. Organized Burn Care

+3 a. Essential - Required

- +1 (1) Physician-directed burn center staffed by nursing personnel trained in burn care and

equipped properly for care of the extensively burned patient, or

14 (2) Transfer agreement with nearby burn center or hospital with a burn unit.

6. Acute Spinal Cord/Head Injury Management Capability

15 a. Essential - Required

17 (1) In circumstances where a designated spinal cord injury rehabilitation center exists in the region, early transfer should be considered; transfer agreements should be in effect.

18 (2) In circumstances where a head injury center exists in the region, transfer should be considered in selected patients; transfer agreements should be in effect.

7. Radiological Special Capabilities

19 a. Recommended/Desired

20 (1) Angiography of all types

21 8. Rehabilitation Medicine

22 a. Essential

23 (1) Physician-directed rehabilitation service staffed by nursing personnel trained in rehabilitation care and equipped properly for care of the critically ill patient, or

24 (2) Transfer agreement when medically feasible to a nearby rehabilitation service.

C. Operating suite special requirements, equipment and instrumentation:

1. Required:

- a. Thermal control equipment for patients and blood supplies
- b. X-ray capability
- c. Endoscopes, all varieties
- d. Monitoring equipment

2. Recommended/Desired:

- a. Operating room adequately staffed and immediately available 24 twenty-four hours a day
- b. Craniotome
- D. Clinical laboratory services - required 24 twenty-four hours a day
 - 1. Standard analysis of blood, urine
 - 2. Blood typing and cross-matching
 - 3. Coagulation studies capability
 - 4. Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities
 - 5. Blood gases and pH determinations
 - ~~6. Serum and urine osmolality determinations~~
 - ~~7. 6. Microbiology~~
 - ~~8. Drug and alcohol screening (Desired/Recommended)~~
Recommended/Desired
 - 1. Serum and urine osmolality determinations
 - 2. Drug and alcohol screening
- E. Programs for quality assurance - required
 - ~~1. Medical care evaluation, including:~~
 - 1. Organized quality assurance program
 - a. ~~2.~~ Special audits for trauma deaths
 - b. ~~3.~~ Trauma morbidity and mortality reviews
 - c. ~~4.~~ Medical nursing audits, utilization review and tissue review
 - d. ~~5.~~ Medical records Trauma registry review
 - ~~6. Review of pre-hospital and regional systems of trauma care (desired)~~
- F. ~~2.~~ Public education program (recommended /desired)
 - a. Program(s) to cover injury prevention in the home, in industry, on the highway and on athletic fields. To include

programs of standard first aid, problems confronting the public, medical profession and hospitals regarding optimal care for the injured patient.

G. Trauma Research Program (desired)

H. Training Program (desired)

1. Formal programs in continuing education provided by hospital for:

- a. Staff physicians
- b. Nurses
- c. Allied health personnel
- d. Community physicians

7.3. Level II Trauma Center (Advanced)

7.3.1. Care Capability - The hospital and its medical, nursing and administrative staffs are capable of treating and stabilizing patients with all but the most serious or complicated traumatic injuries. Resources include all of those required elements of basic and intermediate trauma facilities, plus the following:

A. Hospital organization:

1. Departments/divisions/services or sections which are staffed by qualified physicians:

a. Required:

- (1) Neurologic surgery
- (2) Orthopedic surgery
- (3) Trauma Service

b. Recommended/Desired:

- (1) Cardiothoracic surgery
- (2) Obstetrics-gynecologic surgery
- (3) Ophthalmic surgery
- (4) Oral surgery (dental)
- (5) Otorhinolaryngologic surgery
- (6) Pediatric surgery

(7) Plastic and maxillofacial surgery

(8) Urologic surgery

2. Surgical specialties availability: (Requirement may be fulfilled by residents capable of assessing emergency situations in their respective fields and of providing any immediately indicated treatment. When residents are used to fulfill availability requirements, staff specialists are to be on-call and promptly available for consultation.)

a. Required:

(1) General surgery - in-hospital 24 twenty-four hours a day: (May be fulfilled when local conditions insure that the physician will be in the emergency department at the time of the patient's arrival.)

(2) Neurologic surgery - An attending neurosurgeon must be promptly available and dedicated to that hospital's trauma service. The in-house requirement may be fulfilled by an in-house neurosurgeon or surgeon (or physician in Level II facilities) who has special competence, as judged by the chief of neurosurgery, in the care of patients with neural trauma, and who is capable of initiating measures directed toward stabilizing the patient and initiating diagnostic procedures.

+2+ (3) On-call and promptly available from inside or outside the hospital:

(a) Ophthalmic surgery

(b) Orthopedic surgery

(c) Otorhinolaryngologic surgery

(d) Plastic and maxillofacial surgery

(e) Thoracic surgery

(f) Urologic surgery

+g+ Neurologic-surgery

b. Recommended/Desired:

(1) On-call and promptly available from inside or outside the hospital:

- (a) Cardiac surgery
- (b) Microsurgical capabilities
- (c) Gynecologic surgery
- (d) Pediatric surgery
- (e) Hand surgery
- (f) Oral surgery (dental)

3. Non-surgical specialties availability: (May be fulfilled by residents as specified previously.)

a. Required:

(1) In hospital twenty-four hours a day:

- +1+ (a) Emergency medicine
- +2+ (b) Anesthesiology (may be physician directed program staffed by nurse anesthetist).

+3+ (2) On-call and promptly available from inside or outside the hospital:

- (a) Cardiology
- (b) Hematology
- (c) Nephrology
- (d) Pathology
- (e) Pediatrics
- (f) Radiology

b. Recommended/Desired

(1) On-call and promptly available from inside or outside the hospital:

- (a) Gastroenterology
- (b) Infectious disease
- +e+ Pulmonary-disease
- +d+ (c) Psychiatry
- +e+ (d) Chest medicine

B. Special facilities, resources and capabilities:

1. Emergency department: As before under Level III

2. Intensive care unit(s):

a. Required:

(1) Physician on duty in ICU twenty-four hours a day or immediately from in-hospital

~~(2)~~ (2) Cardiac output monitoring device

~~(3)~~ (3) Electronic pressure monitoring device

~~(4)~~ (4) Patient weighing devices

~~(5)~~ (5) Intracranial pressure monitoring devices

3. Postanesthetic recovery room: As before under level III.

4. Hemodialysis capability: Recommended/Desired

5. Radiological special capabilities:

a. Required:

(1) Angiography capability

(2) In-hospital computerized tomography (or equivalent), with technicians

b. Recommended/Desired:

(1) Sonography

(2) Nuclear scanning

~~(3) In-hospital-computerized-tomography-(or equivalent)-with-technicians.~~

6. Rehabilitation Medicine: Recommended/Desired
(Essential-Required)

C. Operating suite special requirements, equipment and instrumentation:

1. Required:

a. Operating room adequately staffed and immediately available 24 twenty-four hours a day

b. Craniotome

2. Recommended/Desired:

- a. Cardiopulmonary bypass pump-oxygenator capability
- b. Operating microscope
- D. Clinical laboratory services: As before under Level III
 - 1. Required:
 - a. Drug and alcohol screening
- E. Programs-~~for~~ Quality assurance: Same as Level III
 - 1. Medical-care-evaluation Trauma conference, multidisciplinary, required
 - a. ~~Required.~~
 - b. Recommended/Desired
- (1) F. Public education programs to cover injury prevention in the home, in industry, on the highway and on athletic fields. To include programs of standard first aid, problems confronting the public, medical profession and hospitals regarding optimal care for the injured patient.
 - (2) Trauma-conference, -multidisciplinary
 - b. Recommended/Desired
- (2) G. Outreach program with telephone and on-site consultations with physicians of the community and outlying areas
- F. H. Training program: Required
 - 1. Formal program in continuing education provided by the hospital for:
 - a. Staff physicians
 - b. Nurses
 - c. Allied health personnel
 - d. Community physicians

I. Trauma Research Program (desired)

7.4. Level I Trauma Center (Comprehensive)

7.4.1. Care Capability - The hospital and its medical, nursing and administrative staffs are capable of treating and stabilizing patients with all types of trauma within the existing state of the art technology and knowledge. The facility or center operates as a dedicated trauma service with all of the resources and capabilities afforded to the other national Level I (Comprehensive) trauma centers across the nation.

The resources available to the comprehensive trauma facility include all of those previously listed as required for "Basic," "Intermediate" and "Advanced" trauma facilities, plus the following:

- A. Hospital organization:
 - 1. Required departments/divisions/services or sections which are staffed by qualified physicians:
 - a- ~~Trauma-service~~
 - b- a. Cardiothoracic surgery service
 - c- b. Ophthalmic surgery service
 - d- c. Otorhinolaryngologic surgery service
 - e- d. Pediatric surgery service
 - f- e. Plastic and maxillofacial surgery service
 - g- f. Urologic surgery service
 - 2- ~~Surgical-specialties-availability:--(In-hospital 24--hours-a-day-or-resident-coverage-as-before)~~
 - a- ~~General-surgery-specialists~~
 - b- ~~Neurologic-surgery-specialists:--(This requirement-may-be-fulfilled-by-in-hospital neurosurgeons-or-an-in-hospital-surgeon-with special-competence-in-the-care-of-patients-with nervous-systems-trauma, as-judged-by-the-chief-of the-neurosurgical-service, and-who-is-capable-of initiating-measures-directed-toward-stabilizing the-patient-and-initiating-neurologic-diagnostic procedures.--An-attending-neurosurgeon-must-be promptly-available-and-dedicated-to-that hospital's-trauma-service.)~~
 - 3- 2. Surgical specialties availability: (On-call and promptly available from inside or outside the hospital)
 - a. Required:
 - (1) Cardiac surgery specialist
 - (2) Microsurgery capabilities
 - (3) Gynecologic surgery specialist
 - (4) Pediatric surgery specialist

(5) Hand surgery specialist

(6) Oral surgery (dental) specialist

4- 3. Non-surgical specialities availability: (Resident services as previously indicated for Levels II and III)

a. Required:

(1) Anesthesiology

(2) (1) Gastroenterology

(3) (2) Infectious disease

(4) (3) Nephrology

(5) (4) ~~Pulmonary disease~~ Chest medicine

(6) (5) Psychiatry

(7) Emergency-medicine

b. Recommended/Desired:

(1) Neuroradiology

B. Special facilities; resources and capabilities:

1. Emergency department - As before for Level II

2. Intensive care unit(s): As before for Level II

a. Required:

(1) ~~Physician-on-duty-in-intensive-care-unit-24 hours-a-day-or-immediately-available-from-in hospital~~

(2) ~~Intracranial-pressure-monitoring-devices~~

3. Postanesthetic recovery room: (Surgical intensive care unit is acceptable) - As before for Level II

4. Hemodialysis capability required

5. Radiological special capabilities:

a. Required:

(1) Sonography

(2) Nuclear scanning

(3) Computerized tomography or equivalent 24-

twenty-four hours a day availability.

6. Rehabilitation medicine - Required
- C. Operating suite special requirements, equipment and instrumentation:
 1. Cardiopulmonary bypass pump-oxygenator-or-transfer agreement-to-appropriate-facility--Required capability
 2. Operating microscope - Required
- D. Clinical laboratory services: As before for Level II
- E. Programs for quality assurance - Required:
 1. Trauma-conference, multidisciplinary Review of pre-hospital and regional systems of trauma care
- 2-F. Outreach program with telephone and on-site consultation with physicians of the community and outlying areas - Required
 3. The-qualifications-of-trauma-care-personnel-are specified-in-writing-by-the-applicable-department
- F-G. Trauma research program: Required
 1. A defined and documented program for the study of the various aspects of trauma treatment, diagnosis, management and patient response must be provided.

Section 8. Notification and Site Visit Process

8.1. The designation of health care facilities providing emergency or critical trauma care services to patients in this state shall be accomplished in a manner consistent with mutual cooperation of the facility to be evaluated and the agency performing or causing to be performed the site visit intended to obtain the necessary facts and information to facilitate such designation.

8.2. The evaluation process shall only address the resources, equipment, care capability and commitment for trauma care on the part of the institution and its medical, nursing and administrative staffs, as recommended by the West Virginia Categorization Committee and published by the West Virginia department of health office of emergency medical services.

8.3. Notification of Intention to Perform a Site Visit - The regional emergency medical services agency through its board of directors shall notify in writing each health care institution within the emergency medical services regional borders that a site visit by qualified physicians and others is to be accomplished upon acceptance in writing of such site visit by the health care facility, institution, clinic, center, unit or

hospital.

8.4. The site visit team as selected by the regional emergency medical services board of directors and approved by the West Virginia department of health shall include specialists in the care of traumatized patients and if necessary, other medical specialists, as well as others appointed by the board of directors to assist in the site visit process.

8.5. Each facility to be visited shall be provided a copy of this rule as well as a copy of the evaluation form or forms to be used by the site visit team, such copies to be provided free of charge by the regional emergency medical services agency involved.

8.6. The hospital and its medical staff shall appoint appropriate individuals to accompany the site visit team and provide access to the various clinical and administrative areas of the hospital during the site visit.

8.7. Patient confidentiality will be maintained throughout the process and names or other patient identifying information shall not be published or recorded in any form by the site visit team. Review of patient records by physician members of the team shall be permitted even though the physicians may not be members of the hospital medical staff. The hospital may require that one of their medical staff or medical records personnel accompany the site visit team physician or physicians during review of patient records.

8.8. The site visit team leader, previously appointed by the regional emergency medical services board of directors, shall review the results of the survey prior to departing the hospital or facility in order to give the hospital administrator and the medical staff representative a preliminary judgment as to the level of trauma care determined. Such verbal reports shall not be interpreted as final, but shall be used to allow the hospital and its medical staff the opportunity of preparing a response upon official notification and to allow the re-evaluation of specific areas by the site visit team leader or his representative(s) if significant changes are made prior to submission of the results of the site visit to the regional emergency medical services board of directors.

8.9. The regional emergency medical services board of directors may delegate to its critical care committee and the regional emergency medical services medical director the authority to carry out the entire site visit process, but the ultimate responsibility for the actions of the critical care committee and emergency medical services medical director remains with the regional emergency medical services board of directors.

8.10. The regional emergency medical services board of directors or its designee shall prepare a report indicating the findings of the site visit team and recommend to the West Virginia department of health office of emergency medical

services the levels of trauma care capability for each health care facility, institution, clinic, center, unit or hospital so evaluated. A copy of the final recommendations related to each facility shall be sent to each facility individually with no reference to the findings on other facilities included in such report. The report to the state office of emergency medical services shall be prepared in matrix form showing the name of each facility in the left hand column and the level of care capability in rows across the top of the page. In addition, the report to the state office shall contain the names of the individuals participating in the site visits and any other pertinent comments related to the acceptance of the verbal report by the hospital administrative or medical personnel.

8.11. Upon receipt of the recommendations from the regional emergency medical services board of directors, the state office of emergency medical services shall prepare a letter of provisional designation to each facility. Such designation shall be limited to trauma care capability and shall not be interpreted as implying total facility care capability or expertise in other areas of health care.

Section 9. Designation Process

9.1. The West Virginia department of health shall have the power to designate health care facilities in the state which meet or exceed the standards and criteria listed herein as "Basic," "Intermediate," "Advanced" or "Comprehensive" trauma facilities, units or centers. Such designation will be provided in writing by the director of the department of health upon determination that the appropriate standards and criteria have been met or exceeded by a health care facility.

9.2. The initial review of a particular health care facility will be accomplished by regional emergency medical service agencies utilizing the standards and criteria listed in this rule and performed in accordance with the mechanisms outlined in Sections 5 and 6 of these this rules.

9.3. Upon review and recommendation of the board of directors of the regional emergency medical services agency, or their designated body, the proposed level of designation will be submitted to the West Virginia department of health, office of emergency medical services for review and action.

9.4. The director of the West Virginia department of health shall issue a provisional designation to the health care facility upon determination that the information submitted by the regional emergency medical services agency is in order and reflects compliance with this rule.

9.5. Upon granting the provisional designation, the director or his designee may enlist the assistance of outside reviewers to perform a site visit at the health care facility in order to confirm the original findings. If outside reviewers are not utilized, the director or his designee will perform such site visits accompanied by specialists and others recruited from West

Virginia licensed physicians practicing critical care medicine in the specialty or subspecialty related to trauma care.

9.6. Upon verification that the health care facility has met the appropriate criteria and standards, an official letter of designation will be forwarded to the hospital administrator by the director of the West Virginia department of health.

9.7. Should the regional emergency medical service agency refuse or be unable to provide the initial evaluation through their own resources or from outside consultants, the director shall arrange for such initial appraisal of the institution or institutions in question.

9.8. In areas of the state where the most likely institution for trauma care refuses to allow site visits by the regional emergency medical services agency or the designees of the West Virginia department of health, and, where no other appropriate institution is located within a reasonable distance, the director of the West Virginia department of health or his designee may enter such facility in order to accumulate the necessary information to evaluate the institution's trauma care capability, but no official designation will be made. The level of trauma care capability may be provided to the public and emergency ambulance squads in order to facilitate proper transportation to the most appropriate facility for the care of a particular type of injury.

9.9. No institution, health care facility, unit, center or hospital shall hold itself out to be a trauma center, unit or facility until such time as a designation level is assigned by the director of the West Virginia department of health. Any public advertisement or claim of such trauma care capability on the part of a health care facility prior to receiving the appropriate designation may result in civil proceedings against such institution.

9.10. Any institution, health care facility, unit, center or hospital having received a designation as a trauma center, unit or facility from the West Virginia department of health shall be exempted from the antitrust laws of this state pertaining to antitrust actions brought as a result of such designation by an individual, individuals, corporation, partnership, other health care institution, or governmental agency.

Section 10. Review or Audit of Designated Facilities

10.1. The director of the West Virginia department of health or his designee shall have the power to periodically review or cause to be reviewed the trauma care capability of a previously designated health care facility. Such review or audit may include a site visit or visits to the institution in order to verify that the original standards and criteria are still in place. Such audit or review may be performed at the discretion of the director of the West Virginia department of health, but in

no case more frequently than annually and with the time and date of such site visit being mutually agreed upon by the official spokesperson of the institution and the director of health.

10.2. The director may authorize qualified individuals outside state government to perform such site visits.

10.3. Should such site visit audit result in a report indicating less than acceptable levels of care capability as indicated by the standards and criteria listed herein, the institution may be dedesignated at a lower level until such time as required to meet the standards and criteria of the previous designation level.

10.4. A health care facility receiving notification from the department of health of its intention to lower the designation level shall be given the opportunity to respond in writing within ten working days upon receipt of such notification of dedesignation. Such response shall contain the reasons for recommending that no change in designation be made. The director of the department of health may revoke the notice of dedesignation based upon factual information provided by the facility that substantially alters the results of the site visit.

Section 11. Combined Hospital Designation of Trauma Centers

11.1. General - Due to limitations in particular areas of trauma care in basically similar hospitals located in a community, there is a need to recognize the combined capabilities of these hospitals in the designation process.

11.2. Requirements - Two or more hospitals within a particular community which share a common physician attending staff and which would be eligible for a certain designation if the resources of each of the hospitals were to be combined in a trauma care plan, may be individually designated at the combined level. In order to qualify for a combined trauma center designation the following requirements must be met.

11.2.1. A current (annual) written plan of trauma patient care must be available and endorsed by each hospital.

11.2.2. Specific care capabilities for all major injury types must be addressed and the plan must indicate the resources available for treatment of these major injuries, including personnel, equipment and facilities.

11.2.3. Specific triage protocols (based upon types of injury) must be provided in writing and endorsed by each participating hospital. The medical command center must accept these protocols and follow the triage patterns in directing patient flow.

11.2.4. The participating hospitals must address each of the standards for designation and must as a combined effort, meet the standards upon which designation is based. All facilities

may then be designated at that particular level although separately none of the facilities would be capable of meeting all of the standards for such level of care.

11.3. Minimum Care Capabilities - Each facility participating in a combined designation process must meet certain minimum standards in order to be eligible for such combined designation.

11.3.1. Each facility participating in a combined designation process must be capable of meeting all of the required/essential standards of a Level III (Intermediate) trauma center.

11.3.2. Each facility must meet the following Level II standards individually in order to qualify for combined designation as Level II:

- A. All of the standards listed under "Hospital organization" as listed under Section 7.3.1., A., of these this rules and regulations.
- B. All standards listed under "Special facilities/resources/capabilities" as listed under Section 7.3.1, B., of these this rules and regulations.
- C. All standards listed under "Operating suite special requirements" as listed under Section 7.3.1.,C., of these this rules. and regulations.

11.4. Combined Designation as Level I (Comprehensive) Trauma Center - Each facility must meet as a minimum all of the minimum care capabilities as listed under Section 11.3. above, and in addition, must individually meet the following standards:

11.4.1. All standards under "Special facilities/resources/capabilities," Section 7.4.1.,B.

11.4.2. All standards under "Program for quality assurance," Section 7.4.1., B.

11.5. Shared Resources - Other than those requirements listed above under 11.4. and 11.5., all other human resources, specialists, equipment or facilities may be located in one or the other hospital.

11.6. Restrictions - If only a single hospital within a community meets all of the standards of a Level II or above trauma center, then only that hospital may be the designated trauma center for that community or area. All other hospitals approaching Level II, but not meeting all of the standards as required herein for Level II designation shall not be eligible for combined designation as Level II trauma centers.

Section 12. Proposal Method and Review Process

12.1. In those cases where it is impractical or when one or more qualified hospitals in a community insists upon designation of the trauma center through the proposal process rather than the method of combined or single designation as previously described, each hospital will be given the opportunity to present a written proposal stating the qualifications of that hospital that would indicate the resources, personnel, equipment and facilities necessary for designation at a particular level. Standard forms for this purpose will be supplied by the West Virginia department of health upon request. Upon receipt of the completed forms from all participating hospitals, the emergency medical services regional board of directors will submit the entire group of proposals to the West Virginia department of health, office of emergency medical services for review and processing.

12.2. Submission of Proposals - Each hospital participating in the proposal process within an emergency medical services region will submit the completed forms to the regional emergency medical services board of directors for review as to completeness and proper preparation. The regional emergency medical services board will make no judgements or decisions regarding the individual proposals, but will provide appropriate written comments as to the compatibility of the proposals with the regional trauma care strategy. Upon receipt and review of a proposal that is found to be incorrectly prepared or is incomplete, the regional emergency medical services board shall return such proposal to the respective hospital for corrections.

12.3. The director of the West Virginia department of health, or his designee, will appoint a site visit team composed of physicians and others familiar with trauma center designation principles to visit each facility submitting a proposal within a West Virginia emergency medical service region in order to ascertain the validity of the individual proposals and make recommendations regarding the findings of the site visit to the director of health.

12.4. Upon receipt of the site visit reports, the proposal and findings of the site visit team will be evaluated by the director or his designee and outside consultants if necessary, in order to determine which facility, if any, will be designated as the trauma center.

12.5. Written confirmation of the receipt of all materials submitted will be sent to each hospital participating in the proposal process.

12.6. Upon review of the submitted proposals, the director may elect to follow any of the following actions:

12.6.1. Selection of one facility to be designated as the trauma center.

12.6.2. Submit materials or portions of the proposal back to a hospital to obtain additional information or to properly

complete the proposal.

12.6.3. Arrange for an additional site visit at one or more hospitals to verify previous findings or to evaluate additional resources.

12.6.4. Make a determination that none of the proposals meet the requirements for any level of designation.

12.6.5. Recommend that two or more facilities request combined designation.

Section 13. Appeal Mechanism

13.1. Upon receipt of official designation action, a health care facility may appeal the designation through the following mechanism:

13.1.1. The facility may request a re-evaluation of any specific areas by the original site visit team. Should this review remain unchanged and the hospital continue to disagree with any part of the site visit team's findings, the hospital may request review and recommendations by the state critical care committee.

13.1.2. A request for re-evaluation may be made at any time within thirty (30) working days of receipt of the notice of provisional designation from the director by any participating hospital. Requests may be made for re-evaluation at any future time that the hospital administration feels that the level of care has been changed due to improvements, additions or deletions from conditions or resources existing at the time of the original or subsequent site visits.

13.1.3. Requests for re-evaluation must include the specific area or areas of concern on the part of the facility and must include those facts or factors which would significantly affect the level of care previously designated.

13.1.4. A request to the state categorization committee for review of a site visit evaluation which has been acted upon by the regional and state critical care committees will be acted upon by the West Virginia categorization committee within three (3) months of such request on the part of a hospital. This action constitutes the programmatic appeals mechanism and will only be utilized when an agreement cannot be reached between the hospital and the critical care committees.

13.1.5. The West Virginia categorization committee may follow one of several alternatives in reaching a decision:

13.1.5.1. Appointment of a special site visit team, approved by the director, to review the original report and perform an additional evaluation of specific areas of concern and report the findings to the state categorization committee for action.

13.1.5.2. Refer the request to the original critical care committee for review and re-evaluation with specific recommendations as to the action to be taken.

13.1.5.3. Alter the level of care capability previously reported based upon results of the site visit, additional information received from the hospital and make appropriate recommendations to the department of health regarding designation level.

13.1.5.4. Reaffirm the re-evaluation recommended designation level as made by the critical care committees.

13.1.5.5. Regardless of the alternative method chosen by the state categorization committee, the hospital will be informed by letter from the chairperson of the committee as to the action taken and/or final decision.

Section 14. Administrative Due Process - Those persons adversely effected by the enforcement of this rule desiring a contested case hearing to determine any rights, duties, interests or privileges shall do so in a manner prescribed in Rules of Procedure for Contested Case Hearings and Declaratory Rulings, West Virginia Department of Health Procedural Rules, Series-17, 1983 64 CSR 1. The aforementioned procedural rules are incorporated by reference.

Section 15. Severability - If any provisions of this rule or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or the application of this rule which can be given effect without the invalid provisions or application, and to this end the provisions of this rule are declared to be severable.

KEN HECHLER
Secretary of State

MARY P. RATLIFF
Deputy Secretary of State

BARBARA STARCHER
Deputy Secretary of State

RICHARD S. STEPHENSON
Deputy Secretary of State

Telephone: (304) 345-4000
Corporations: 342-8000



STATE OF WEST VIRGINIA
SECRETARY OF STATE

Charleston 25305

WILLIAM H. HARRINGTON
Chief of Staff

RICH O. HARTMAN
Director, Administrative Law

DONALD R. WILKES
Director, Corporations

VIRGINIA SKEEN
Special Assistant

(Plus all the volunteer
help we can get)

RECEIVED

JUN - 9 1988

REGULATORY DEVELOPMENT
SECTION

TO: Kay Howard - Hqs/Hq
FROM: RICH O. HARTMAN, DIR. ADMIN. LAW DIV.
DATE: June 8, 1988

THE ATTACHED RULE(S) RECENTLY FILED BY YOUR AGENCY HAVE BEEN ENTERED INTO THE COMPUTER. PLEASE REVIEW AND PROOF AND RETURN WITH ANY CORRECTIONS. IF THERE ARE NO CORRECTIONS PLEASE SIGN THIS MEMO AND RETURN TO THIS OFFICE. YOU WILL BE SENT A FINAL VERSION OF YOUR RULE(S) FOR YOUR RECORDS.

PLEASE RETURN EITHER THE CORRECTED RULE OR THIS FORM WITHIN TEN (10) WORKING DAYS OF THE DATE YOU RECEIVED THIS REQUEST. CALL IF YOU HAVE ANY QUESTIONS.

Series 27

THE ATTACHED RULE(S) HAVE BEEN REVIEWED AND ARE CORRECT.

SIGNED: _____

TITLE OF PERSON SIGNING: _____

DATE: _____

THE ATTACHED RULE(S) HAVE BEEN REVIEWED AND NEEDS CORRECTED. THESE CORRECTIONS HAVE BEEN MARKED. *Corrected page only.*

SIGNED: Kay Howard

TITLE OF PERSON SIGNING: Director, Regulatory Development

DATE: June 24, 1988

Proposed Rules
Public Comments Received
Discussion and Response

FILED
NOV 16 11:20

Title: Trauma Center or Facility Designation, West Virginia
Department of Health Legislative Rules, 64 CSR 27.

A public hearing regarding this rule was held on August 24, 1987, and was attended by B. M. Atkinson, M.D., Diane Rogers and George Rider of St. Joseph's Hospital; Eileen Alexander, R.N., WVU Hospital; Alice Vautier and Karen Daniels, Cabell-Huntington Hospital; Paul M. James, Jr., M.D., and Betty Sargus, Ohio Valley Medical Center; and Judith Keagy, CAMC. Comments were received by mail from James W. Kessel, M.D., CAMC; Bruce Carter, President, United Hospital Center; S. G. Nazzaro, Administrator, Wheeling Hospital; and Paul M. James, Jr., M.D., Ohio Valley Medical Center.

- (1) Comment (Mr. Carter, United Hospital Center): United Hospital Center wishes the record to reflect its strong support for the proposed legislative rules related to Trauma Center or Facility Designation.
- (2) Comment (Mr. Nazzaro, Wheeling Hospital): Section 6.3. I do not feel a Level II should be required to do a specific number of cases. In West Virginia, a facility may meet all requirements but still not do the number proposed because of the limited numbers available. I would instead suggest we concentrate on making designation dependent on the successful outcome of cases treated rather than the number of cases treated.

Response: The number of cases is not a standard - it is a recommended case load. The recommended numbers of cases for each trauma surgeon in a Level I or a Level II center is 50 per year.

Proposed: No change.

- (3) Comment (Mr. Nazzaro, Wheeling Hospital): Section 7.3.1. A.2a(2). It is not realistic to require an in-house neurosurgeon given the limited number available in West Virginia. Neurosurgery requirements should be fulfilled when local conditions insure a neurosurgeon will always be promptly available.

Response: An in-hospital neurosurgeon is not required. A physician designated by the chief of neurosurgery meets the requirements as stated in the regulations.

Proposed: No change.

- (4) Comment (Dr. Kessel, CAMC): Section 7.3.1.A.3a(1)(b) - I wish to have clarification of the requirement for 24-hour in-house anesthesiologist for Level II designation. It was my understanding that in-house CRNA with prompt availability of the anesthesiologist was satisfactory. I also was under the impression that the same requirement for a Level I designation was satisfactory. The current WV Level I program satisfies the MD part of the requirement, I suspect, by use of resident physicians who, by definition, are not fully trained or qualified. I fail to see very much distinction between the care capability of a hospital starting a case with an experienced CRNA vs. a PGY 1 MD. In either case the prompt availability of a fully trained anesthesiologist is assured.

Response: This provision was inadvertently omitted from this section. Language should be added.

Proposed: (b) Anesthesiology (may be physician directed program staffed by nurse anesthetist).

- (5) Comment (Dr. Atkinson, St. Joseph's Hospital and Mr. Nazzaro, Wheeling Hospital): Section 7.3.1.B.2a(1) - Commentors questioned the requirement that a physician be on duty in ICU 24 hours a day or immediately available from in-hospital. They felt that promptly available from in or outside the hospital is more reasonable.

Response: This national standard is important and should not be relaxed.

Proposed: No change.

- (6) Comment (Mr. Nazzaro, Wheeling Hospital): Section 7.3.1.B.5a(2). The requirement for in-house computerized tomography should be either recommended or promptly available on call. In-house, 24-hour capability should not be required.

Response: This national standard is important and should not be relaxed.

Proposed: No change.

- (7) Comment (Mr. Nazzaro, Wheeling Hospital): Section 7.3.1.B.6. Rehabilitation medicine should be desired but not required. Another alternative, if rehabilitation medicine is not available, would be to require a transfer agreement with another facility having this capability.

Response: Transfer agreements are acceptable.

Proposed: No change.

- (8) Comment (Ms. Alexander, WVU Hospital): In general, we support the language of the proposed rule. However, we would suggest additional clarification in Section 8.4. It is our view that the site visit team composition is not clearly enough defined as to the number, qualifications and mix of health care professionals to be included. Lack of a clear definition of the site team membership could potentially raise legal questions on the fairness and consistency of the review process.

Comment (Dr. James, Ohio Valley Medical Center): It worries me that in-state physicians not entirely up-to-date in the trauma field might be the persons doing the inspection and quality assurances.

Response: The Department has entered into an agreement with the West Virginia College of Surgeons, Committee on Trauma to perform site visits. In addition, Doctor Walt Moran has been asked to participate in all site visits of Level I and Level II facilities. Funding for out-of-state teams is not available.

Proposed: No change.

- (8) Comment (Mr. Nazzaro, Wheeling Hospital): Under the fiscal note for the proposed rules, no economic impact on the public or state government is noted. Hospitals cannot implement the increased requirements without significant cost increases which must be passed on to the public and government. There will be definite cost increases to provide 24-hour, in-house physicians and CT technicians, plus provide rehabilitation services.

Response: There is no requirement for a hospital to request designation or for the State to designate a hospital if the facility does not have the resources available to meet the requirements.

Proposed: No change.

Comments Received By Mail
Regarding Proposed
Amendments to Trauma Center
or Facility Designation

James. W. Kessel, M.D.
CAMC

Bruce Carter, President
United Hospital Center

S. G. Nazzaro, Administrator
Wheeling Hospital

Paul M. James, Jr., M.D.
Ohio Valley Medical Center

PUBLIC HEARING

Plasma Center on Facility Designation
August 24, 1987 - 1:00 PM.

NAME ADDRESS GROUP REPRESENTED DO YOU WISH TO COMMENT (YES/NO)

Carl M. Atkinson, M.D. Parkersburg WV St. Joseph's Hospital Y

Elean Alexander Cow ~~township~~ Morgantown WV West Virg University Hosp Y

Franci Rogers Parkersburg WV St. Joseph's Hospital Y (Question)

George Rader Parkersburg, WV St. Joseph's Hospital N

Alice Pantee Huntington WV Cabell Huntington Hospital N

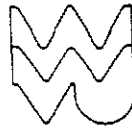
Karen Daniels Huntington WV Cabell Huntington Hospital N

Becky Sargood Wheeling, WV OVMC No

Paul M. ^(over 92) Wheeling, WV OVMC Y

Paul M. ^(over 92) Wheeling, WV OVMC Y

Dr. Paul Dooling Dearborn, MI Dearborn, MI



West Virginia University Hospitals, Inc.

Office of the President

WEST VIRGINIA UNIVERSITY HOSPITALS, INC.

Comments On

Proposed Rules for Trauma Center or Facility Designation

West Virginia University Hospitals, Inc., is pleased to have the opportunity to comment on the Department of Health's proposed legislative rules on Trauma Center or Facility Designation.

In general, we support the language of the proposed rule. However, we would suggest additional clarification in Section 8.4. It is our view that the site visit team composition is not clearly enough defined as to the number, qualifications and mix of health care professionals to be included. Lack of a clear definition of the site team membership could potentially raise legal questions on the fairness and consistency of the review process.

We appreciate the opportunity to provide this brief comment.



CHARLESTON AREA MEDICAL CENTER

1210 Elmwood Avenue • P. O. Box 1547
Charleston, West Virginia 25326

August 19, 1987

Department of Health
Regulatory Development Section
P & G Building, Room 7
2019 Washington Street, E.
Charleston, WV 25305

RULE TITLE: Trauma Center or Facility Designation
CSR TITLE & SERIES: 64 CSR 27 TYPE: Legislative

Public Hearing - Written - August 24, 1987

Dear Sirs:

I wish to have clarification of the requirement for 24-hour in-house Anesthesiologist for Level II designation. It was my understanding that in-house CRNA with prompt availability of the anesthesiologist was satisfactory.

I also was under the impression that the same requirement for a Level I designation was satisfactory. The current W.V. Level I programs satisfies the MD part of the requirement, I suspect, by use of Resident Physicians whom by definition are not fully trained or qualified. I fail to see very much distinction between the care capability of a hospital starting a case with an experienced CRNA vs. a PGY 1 MD. In either case the prompt availability of a fully trained anesthesiologist is assured.

Thank you very much for your time and attention.

Sincerely,

James W. Kessel, M.D.
Director, Trauma Services

JWK/da

cc: Phillip H. Goodwin
Executive Vice President

Judith C. Keagy
Associate Administrator

CENTRAL DIVISION • MEMORIAL DIVISION

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AUG 21 1987

REGULATORY DEVELOPMENT
SECTION



TRAUMA SERVICE

RECEIVED

AUG 19 1987

REGULATORY DEVELOPMENT
SECTION

Paul M. James, Jr., M.D., FACS
Director
304-234-8852
304-234-0123

August 14, 1987

Ms. Kay Howard
Director of Regulatory Development Section
Department of Health
1800 Washington Street East
Charleston, WV 25305

Dear Ms. Howard:

I would like to submit the following questions for the public hearing on August 24, 1987, regarding Trauma Center or facility designation. What will the means of invoking penalties or putting a stop to self designation as many hospitals have done? Will the new rules make us competitive with the Trauma Centers in the surrounding states? Allegheny General's Level I is quite close to us as is Ohio State University's Level I Trauma Center. Are there going to be in-state or out-state trauma surgeons and teams picked to do this? Who will do the picking and what credentials will be used to establish their neutrality and expertise? In my survey of the state as a member of the American Association for the Surgery of Trauma, which at present I am the only member of this national Trauma organization in the state, it worries me that in-state physicians not entirely up-to-date in the Trauma field might be the persons doing the inspections and the quality assurance. I would wonder if out-of-state evaluators would be planned as was the Pennsylvania experience. Finally, is there a possibility of forming a private, nonprofit corporation to manage designation as was done in Pennsylvania and develop a Trauma System as well as a group of Trauma Centers across the state?

Thank you for receiving these questions, I hope you will have some interesting answers for us at the meeting.

Sincerely,

Paul M. James Jr., M.D.
Director of Trauma
Ohio Valley Medical Center
Clinical Professor
West Virginia University

PMJ:las

Ohio Valley Medical Center, Inc.

2000 Eoff Street Wheeling, West Virginia 26003



United Hospital Center
Clarksburg, West Virginia

August 18, 1987

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AUG 25 1987

REGULATORY DEVELOPMENT
SECTION

David K. Heydinger, M. D.
Director, Department of Health
Regulatory Development Section
P & G Building, Room 7
2019 Washington Street, E.
Charleston, WV 25305

RE: Proposed Rules for Trauma Center or Facility
Designation

Dear Doctor Heydinger:

United Hospital Center wishes the record to reflect its strong support for the proposed legislative rules related to Trauma Center or Facility Designation (CH. 16, Art. 1, Sec. 7(4), Series 27), a hearing for which is scheduled on Monday, August 24, 1987.

Thank you for the opportunity to respond to these proposed changes.

Sincerely,

Bruce C. Carter
President

BCC: jm

WHEELING HOSPITAL

August 21, 1987

RECEIVED

AUG 25 1987

REGULATORY DEVELOPMENT
SECTION

Department of Health
Regulatory Development Section
P & G Building, Room 7
2019 Washington Street, East
Charleston, West Virginia 25305

Gentlemen:

I am writing to comment on the proposed rule changes for Trauma Center of Facility Designation.

Although I realize the proposed changes are consistent with recommendations of the American College of Surgeons, I have serious reservations as to if they truly serve the interests of our citizen. Our regulations already allow designation of a basic-level facility for which no national level designation exists because of the particular needs in our State. I believe some of the changes proposed should not be adopted as they too do not meet our State needs.

In particular, I would suggest the following changes not be made:

1. Section 6.3

I do not feel a Level II should be required to do a specific number of cases. In West Virginia, a facility may meet all requirements but still not do the number proposed because of the limited numbers available. I would instead suggest we concentrate on making designation dependent on the successful outcome of cases treated rather than the number of cases treated.

2. Section 7.3.1, A2a(2)

It is not realistic to require an in-house neurosurgeon given the limited number available in West Virginia. Neurosurgery requirements should be fulfilled when local conditions insure a neurosurgeon will always be promptly available.

3. Section 7.3.1, B2a(1)

It is not realistic to require a physician in ICU 24 hours a day or immediately available from in hospital. Again, promptly available if needed from in or outside the hospital is more reasonable.

4. Section 7.3.1, B5a(2)

The requirement for in-house computerized tomography should be either recommended or promptly available on call. In-house, 24-hour capability should not be required.

5. Section 7.3.1, B6

Rehabilitation medicine should be desired but not required. Another alternative, if rehabilitation medicine is not available, would be to require a transfer agreement with another facility having this capability.

Under the fiscal note for the proposed rules, no economic impact on the public or state government is noted. Hospitals cannot implement the increased requirements without significant cost increases which must be passed on to the public and government. There will be definite cost increases to provide 24-hour, in-house physicians and CT technicians, plus provide rehabilitation services.

To date, only West Virginia University Hospital has been designated as a Level I or II Center, yet we are already upgrading the regulations. I would strongly suggest we do not amend the rules at this time until more facilities are designated and the true economic impact of the proposed changes can be determined.

Sincerely,



S. G. Nazzaro
Administrator / C.E.O.

SGN/pb

c: David Heydinger, M.D.
Gil Delaura