DHSR received 2/11/21

Hello, I am Scott Wilson, Regional Trauma Coordinator for Metrolina Trauma Advisory Committee, one of the eight Trauma Regional Advisory Committees (RACs) in North Carolina and a key stakeholder in the Trauma System. I am also making these comments with the support of Gail Shue, RAC Coordinator for the Triad RAC. After reviewing the proposed rule changes for EMS and Trauma Systems (10A NCAC 13P .0904, .0905, and .1101), having discussions with the other RAC Coordinators across the state, giving opportunities for comment to members of our RACs consisting of EMS agencies and Trauma Centers, hearing the statements of the North Carolina Committee on Trauma, Trauma Program Managers Subcommittee, and the RAC Subcommittee from the State Trauma Advisory Committee (STAC), in addition to commentary from the general public, it is our belief that proposed changes in their current format will negatively impact the care of trauma patients in North Carolina by altering the trauma landscape and jeopardizing safeguards that help maintain the highest level of patient care.

In the proposed changes to .0904 B.3, removal of the 1,200-patient volume prerequisite for a Trauma Center to change their status to Level II may benefit that hospital, but it ultimately takes away from the patient. Level I and II Trauma Centers should clinically offer the same trauma care to patients. They should also be held to the same standards when judging whether they are eligible to upgrade their status. Two reasons for this change that were listed in the DHHS Fiscal Note were alignment with the American College of Surgeons (ACS) Orange Book, which is actually about to change, and to assist military hospitals in their efforts to increase the level of care provided. While I generally support aligning trauma standards to the College, which some may say is considered a higher standard, by removing the volume requirement, we are actually lowering the standard of care for our patients and we should make sure the data supports the need. As for the rationale of assisting military hospitals in their process, this impacts all seventeen Trauma Centers and if the true reason for the change, would benefit only the two military Trauma Centers in North Carolina. Additionally, the way the military medical system is designed, this change would not benefit the citizens of North Carolina as they are not able to seek care on a military base. If for some highly unlikely case that they did receive initial care at these two Trauma Centers, they would then be transferred to a civilian hospital after initial stabilization.

As part of this same section (B.3), an important portion is completely removed. This being that "the criteria…shall be met without compromising the quality of care or cost effectiveness of any

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other Trauma Center in…their catchment area." The addition of a Trauma Center with no qualifying standards or a proven need will inevitably impact other Trauma Centers. It has been estimated that additional Trauma Centers would impact existing Centers by decreasing their volume by up to 40%. If anything, this section should be strengthened through adding the requirement for a needs assessment (regional or statewide), not weakened by this removal.

In Rule .0904 C, D, and E, data submission requirements to the state, RAC, and County Commissioners are removed. We use this data to analyze, trend, and identify opportunities for improvement. Without making this information available, we limit our ability to improve the care given to our patients. A decision to literally change the trauma landscape should be data driven with evidence to show that the need is truly there. Why would we not want the opportunity for outside organizations to have information and the opportunity to review changes to the care provided to their community and in this case, by those Commissioners who were elected by their citizens to represent them in decisions such as this and the RACs that serve as quality control. The same argument goes against the proposed removal of Section F which would not notify either the hospital's RAC or their County Commissioners of a Trauma Center application moving forward in the process. Hospitals are mandated by these same rules to work with the RACs. Why would we not notify them? Over the past few years, there has been an effort in the trauma community to strengthen the RACs and their ability to deliver one of their main tenants, which is quality and performance improvement of their Trauma System. These changes do the opposite.

In Section J of .0904, the requirement for a site visit within 6 months after review and approval of the initial application is removed. By removing this timeframe, the process could be dragged on indefinitely and allows for additional preparation time for a site visit. A hard stop deadline should remain in place but with exemptions on an as needed basis. Additionally, this rule directly conflicts with Rule .0905 which governs renewal of Trauma Center status and states a defined timeframe for a site visit. A Trauma Center should be ready for their site visit the moment they submit their paperwork.

As mentioned, Rule .0905 deals with renewal of Trauma Center status and I share the same concerns in this section with the lack of notification of local government representatives in section C.3. This decreases the oversight and opportunity for input from those who are impacted the most by any changes- the community these hospitals serve.

Changes to Rule .0904 and .0905 are not unwarranted. In fact, the state would likely benefit from additional full-service Trauma Centers. However, the changes should be based on evidence and actual need, not convenience. If anything, these proposals suggest the need to reevaluate the trauma system through a full-scale review. Watering down the requirements does a disservice to our system and most importantly, the patient.

Rule .1101, section C removes OEMS from the reporting of RAC alliances. Why? This method works and no problems with this reporting system have been reported. OEMS is an integral part of the trauma network and should remain as currently designated. Section D reverses the process by requiring the RAC Coordinators to reach out to each EMS Agency and Hospital in their region to confirm their RAC affiliation. However, in the same rule it also asks those same agencies and hospitals to do the reverse and report to the state if they intend to change RACs. This is conflicting and adds confusion to the process, especially when the requirement to provide written notification to the state is also proposed for removal. Additionally, this allows for the difficult situation where one RAC could potentially encroach on another by recruiting hospitals and EMS systems. Keeping OEMS as the primary contact makes the most sense.

Thank you for your time and consideration. As RAC coordinators, we cannot support the proposed rule changes. If anything, these proposed changes, their inconsistencies and at times, contradictions, suggest that we need to strengthen existing rules, not weaken them as proposed. We should ensure that if we are referencing such things as the ACS Orange Book to govern the individual Trauma Center, that we also look at the impact on the system by also using all available texts such as Regional Trauma Systems: Optimal Elements, Integration, and Assessment Systems Consultation Guide, which is used by the College to guide both Trauma Centers AND Trauma Systems. Before any changes are made or proposed, we should assess the status of our Trauma System both on the local or regional level as well as statewide to ensure that we all deliver the best care possible to those who are impacted the greatest, our patients.

Sincerely,

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