I. Key Issues Previously Discussed; Language Presented by DSHS in 6/3/06 Draft Hospital Licensing Rules

Note: The term "current rule" refers to the adopted hospital licensing rules.

§133.2. Definitions.

- Pg. 2 – (6) – The definition of "available" would be changed from "on the premises and sufficiently free of other duties to enable the individual to respond rapidly to an emergency situation" to "on the premises and able to rapidly perform hands-on care in an emergency situation." A word search for "available" should be done to see if conflict arises in the rules due to the requirement that a person must be on the premises and be able to rapidly perform hands-on care.

DEPARTMENT RESPONSE: Search completed. "When referring to on-site personnel" added.

- Pg. 5 – (26) – The definition of "medical staff" would add the phrase "and other practitioners" in line two. The definition in the Health and Safety Code, § 241.003(8), includes physicians and podiatrists and does not include "and other practitioners." The inclusion of this phrase exceeds the department's statutory authority. THA recommends that the phrase "and other practitioners" be deleted.

DEPARTMENT RESPONSE: Agree. Phrase deleted.

- Pg. 6 – (31) – Since definition (30 – Outpatient) was revised, then "outpatient services" definition needs to be revised to allow observation not to exceed total of 48 hours.

DEPARTMENT RESPONSE: Agree. Definition revised.

- Pg. 9 – (48) - Centers for Disease Control should be replaced with Centers for Disease Control and Prevention. The term should be similarly updated wherever it appears in the rules.

DEPARTMENT RESPONSE: Agree. Corrected.

§133.21. General

Pg. 10 – (c)(4)(C)(iv) – Since TUV will be another accrediting body approved by CMS on June 27, 2006, revise subsection to read: …accredited by a CMS-approved organization.

§133.22. Application and Issuance of Initial License.

Pg. 14 – (b)(1)(D) – Since TUV will be another accrediting body approved by CMS by late 2006, revise subsection to read: …accredited by a CMS-approved organization. **THIS IS §133.23(b)(1)(D).**

§133.23. Application and Issuance of Renewal License.

Pg. 15 – same changes as above in §133.22. **THIS IS §133.23((b)(1)(D).**

DEPARTMENT RESPONSE: Agree. Changes made.

§133.25. Time Periods for Processing and Issuing Hospital Licenses

Pg. 18 – Why has "(e) Contested Case Hearings" been deleted?

DEPARTMENT RESPONSE: *Contested case hearing section was deleted in 133.25(e) because 25 TAC section 1.34 no longer exists, 133.25 was improperly placed in the license application and renewal section, and Notice and Hearings are dealt with in 133.121(7-11) and H&SC 241.053-060.*

§133.41. Hospital Functions and Services. *(Note: the reference to "133.47" at the top of pages 18 to 100 probably is a typo. Instead, it probably should read "133.41")*

DEPARTMENT RESPONSE: Headers, a very time-consuming project, will be corrected when the draft proposed rules are completed.

Anesthesia services
THA recommends that the entire subsection (a) be revised to read as follows:

(a) Anesthesia services. If the hospital furnishes anesthesia services, these services shall be provided in a well-organized manner under the direction of a qualified physician. The hospital is responsible for and shall document all anesthesia services administered in the hospital.
(1) Organization and staffing. The organization of anesthesia services shall be appropriate to the scope of the services offered. Only qualified personnel who have been credentialed by the facility to provide anesthesia services shall administer anesthesia. Any delegation of an anesthesia service shall be documented and include the training, experience, and qualifications of the person who provide the service.
(2) Delivery of services. Anesthesia services shall be consistent with needs and resources. Policies on anesthesia procedures shall include the delineation of pre-anesthesia and post-anesthesia responsibilities. The policies shall ensure that the following are provided for each patient.
(A) A pre-anesthesia evaluation by an individual qualified to administer anesthesia under paragraph (1) of this subsection shall be performed within 48 hours prior to surgery.
(B) An intraoperative anesthesia record shall be provided. The record shall include any complications or problems occurring during the anesthesia including time, description of symptoms, review of affected systems, and treatments rendered. The record shall correlate with the controlled substance administration record.
(C) A post-anesthesia follow-up report shall be written by the person administering the anesthesia before transferring the patient from the recovery room and shall include evaluation for recovery from anesthesia, level of activity, respiration, blood pressure, level of consciousness, and patient color.
(i) With respect to inpatients, a post-anesthesia evaluation for proper anesthesia recovery shall be performed after transfer from recovery and within 48 hours after surgery by the person administering the anesthesia, registered nurse (RN), or physician in accordance with policies and procedures approved by the medical staff and using criteria written in the medical staff bylaws for post-operative monitoring of anesthesia.
(ii) With respect to outpatients, immediately prior to discharge, a post-anesthesia evaluation for proper anesthesia recovery shall be performed by the person administering the anesthesia, RN, or physician in accordance with policies and procedures approved by the medical staff and using criteria written in the medical staff bylaws for post-operative monitoring of anesthesia.

DEPARTMENT RESPONSE: Agree. Revision made.

Emergency services

- Pg. 33 – (e) – The draft rule would require all licensed hospital locations to have an emergency suite that complies with the requirements for emergency suites under §133.163(f). Sec. 133.163 relates to spatial requirements for new construction. In effect, the draft language on pg. 33 would create several new structural and physical-plant requirements for many emergency suites in existing hospitals – without any phase-in. For example, the configuration for multiple-bed emergency treatment rooms under current rules is "80 square feet clear floor area per patient cubicle with a minimum dimension of eight feet exclusive of fixed and movable cabinets and shelves." *See* current rule § 133.163(f)(1)(B)(v)(II). In contrast, the configuration for multiple-bed emergency treatment rooms in all hospitals under the draft rules would require: four-foot clearance between bed and wall; six-foot clearance between bed sides; seven-ten feet minimum distance at the foot of the bed; and four feet of passage space. *See* draft rule §133.163(f)(1)(A)(i)(II). In addition, the draft rules would set forth entirely new requirements for all hospital emergency treatment rooms regarding locked storage space, alcoves, and patient toilet rooms. *See* draft rule §133.163(f)(1)(A)(i)(V)-(VII). Because of the resources and time needed to comply with this new requirement, THA recommends that the following sentence be added immediately after the first sentence of §133.41(e) on pg. 33:
  <u>The emergency suite requirements of § 133.163(f) shall become effective 12 months following the effective date of these rules.</u>

DEPARTMENT RESPONSE: Gerard Van De Werken will respond to this. Added §133.161(a)(1)(A) to §133.41(e). Deleted §133.161(a)(1)(D).

- Pg. 33 – (e)(1) – At its meeting with DSHS staff in April, THA recommended that language be added to the hospital licensing rules addressing the need to increase emergency care participation by hospitals. THA recommends the following new provision be added to §133.41(e)(1) (relating to the organization of hospital emergency services):

  (E)(i) Except as provided by subclause (ii), all general hospitals shall maintain a certain number of beds in their emergency treatment room for emergency care. The following requirements shall apply:

  (I) the number of such beds shall, at a minimum, be equal to 5 percent of the hospital's number of inpatient hospital beds (based on design bed capacity);

  (II) the number of such beds shall be based on community needs and hospital diversion; and

  (III) each general hospital included under the hospital license, including a hospital licensed as a multiple-location hospital, must meet the emergency bed requirements.

  (ii) The provisions of subclause (i) do not apply to a comprehensive medical rehabilitation hospital or to a pediatric and adolescent hospital that generally provides care that is not administered for or in expectation of compensation.

DEPARTMENT RESPONSE: The department is requesting THA to conduct a survey of all licensed hospitals to determine the fiscal impact of the new provision, so this can be discussed prior to adding the new provision to the rules. Department will conduct the survey. Rule added.
07/21/06: Rule deleted.

- Pg. 33 – (e)(1)(C) and (D) – THA recommends changing "emergency service or department" in (C) and "emergency room" in (D) to "suite".

DEPARTMENT RESPONSE: Agree. Changes made.

Infection control

- Pg. 39 – (g)(1)(A and (B) – A word search should be done to replace the words "nosocomial infections" with "health care associated infections" as stated in (r)(1)(B) Quality Assessment and Performance Improvement on page 60.

DEPARTMENT RESPONSE: Agree. Changes made.

Medical record services

- Pg. 43 - (j)(7) – would require all verbal orders to be dated, timed, and authenticated within 48 hours. There is no similar requirement in the CoPs or JCAHO. THA recommends changing (j)(7) to read as follows:

  All verbal orders must be dated, timed, and authenticated promptly as specified by hospital policy.

DEPARTMENT RESPONSE: Agree. Change made.

Nursing services

- Pg. 51 – (o)(2)(H)(ii) – After the nurse staffing rules were adopted in 2002, the hospital licensing director, the Texas Nurses Association and THA agreed that this section should be revised by deleting the requirement that the representative from infection control, quality assurance or risk management be a registered nurse. It is quite possible that the person employed in these jobs, especially in smaller hospitals, is not an RN. THA recommends that (o)(2)(H)(ii) be deleted.

DEPARTMENT RESPONSE: Agree. RN changed to representative.

- Pg. 54 – (o)(3)(B)(ii) – would require all telephone or verbal orders for drugs and biologicals to be authenticated within 48 hours. There is no similar requirement in the CoPs or JCAHO. THA recommends that the phrase "authenticated within 48 hours" in (o)(3)(B)(ii) be changed to read as follows: "authenticated promptly as specified by hospital policy".

DEPARTMENT RESPONSE: Agree. Change made.

- Pg. 57 – (o)(7)(B)(vii) – In negotiations on the underlying legislation last session, THA and representatives from nursing and long-term care facilities intended Health & Safety Code § 256.002(b)(7) to require the annual report be

submitted to the *hospital's* governing body or the *nursing facility's* quality assurance committee. Therefore, "or the quality assurance committee" should be deleted.

DEPARTMENT RESPONSE: Agree. Phrase deleted.

§ 133.44. Hospital Patient Transfer Policy.

- Pgs. 91-92 – (c)(4)(A)(ii), (c)(4)(B)(i), and (c)(4)(B)(ii) – These expand the categories of persons who can assess and report to a physician regarding the condition of a patient who arrives at the hospital, and sign the transfer order. Current rule requires an RN to assess and report patient's condition, and sign transfer order. **THA supports the department's proposal to add "physician assistant or other qualified medical personnel".**

- Pg. 93 – (c)(6)(C) – This would require hospitals' transfer policies to provide that transfers be undertaken only for medical reasons. THA had recommended that the current rule providing for exceptions for transfers based in contract or those based on certain statutory requirements be retained and read as follows: Except as is specifically provided in subsections (b)(8) and (9) of this section, the hospital's policy shall provide …. The 6/3/06 draft does not contain these exceptions. THA continues to recommend that they be retained.

DEPARTMENT RESPONSE: Agree. Phrase added.

- Pg. 95 – (c)(10) – The laundry list of items to be included in the memorandum of transfer fails to include an item in the current rules: the time and date the transferring physician secured a receiving physician. This should be put back in due to reinsertion of "transferring physician" in subsections (c)(6)(D) and (D)(i).

DEPARTMENT RESPONSE: Agree. Phrase added.

§ 133.81 Waivers.

Pg. 112 – (b)(2) –Since TUV will be another accrediting body approved by CMS in late 2006, consider revising subsection to read: …accredited by a CMS-approved organization.

DEPARTMENT RESPONSE: Agree. Change made.

EXCEPTIONS FOR PEDIATRIC AND ADOLESCENT HOSPITALS AND FOR COMPREHENSIVE MEDICAL REHABILITATION HOSPITALS

THA and DSHS previously agreed to acknowledge exceptions from certain requirements relating to emergency services for pediatric and adolescent hospitals and for comprehensive medical rehabilitation hospitals. THA provided language at a meeting with DSHS on April 18, 2006, and DSHS agreed to the changes. This language has not been included in the latest rules draft. THA continues to make the following recommendations:

- Pg. 33 – § 133.41(e)(2)(B), (C) – Because of the mission and resources of certain kinds of general hospitals, THA believes that they should be exempted from these personnel requirements. THA recommends the following language be added to the draft rule:

  (B) <u>Except for comprehensive medical rehabilitation hospitals and pediatric and adolescent hospitals that generally provide care that is not administered for or in expectation of compensation:</u>

  <u>(i)</u> There shall be on duty and available at all times at least one person qualified as determined by the medical staff to initiate appropriate lifesaving measures.

  <u>(ii)</u> In general hospitals where the emergency treatment area is not contiguous with other areas of the hospital that maintain 24 hour staffing by qualified staff (including but not limited to separation by one or more floors in multiple occupancy buildings), qualified personnel must be physically present in the emergency treatment area at all times.

  (C) <u>Except for comprehensive medical rehabilitation hospitals and pediatric and adolescent hospitals that generally provide care that is not administered for or in expectation of compensation, (t)</u>[T]he hospital shall provide that one or more physicians shall be available at all times for emergencies<u>, as follows:</u>

  (i) General hospitals located in counties with a population of 100,000 or more shall have a physician qualified to provide emergency medical care on duty in the emergency treatment area at all times.

(ii) Special hospitals and general hospitals located in counties with a population of less than 100,000 shall have a physician on call and able to respond in person, or by radio or telephone within 30 minutes.

- Pg. 179 - §133.163 – Spatial Requirements for New Construction – under subsection (f) relating to emergency suite, make the following change regarding additional requirements for a general hospital:
  (1)(A)(ii) Additional requirements for a general hospital. Except for a comprehensive medical rehabilitation hospital or a pediatric and adolescent hospital that generally provides care that is not administered for or in expectation of compensation, [A] a general hospital shall also meet the following requirements.

DEPARTMENT RESPONSE: Agree. Phrase added.

II. NEW Key Issues in NEW DSHS Language in 6/3/06 Draft Hospital Licensing Rules

§133.21. General.

- Pg. 9 – (c)(3) – Deletes the three current-rule provisions which require separate licenses for multiple hospitals in one building (*See* current rule sec.133.21(c)(3)(A)-(C): separate license; no dual licensure for any part of the building; compliance with multiple-occupancy rules). Should they be reinstated?

DEPARTMENT RESPONSE: Error corrected.

§133.41. Hospital Functions and Services. *(Note: the reference to "133.47" at the top of pages 18 to 100 probably is a typo. Instead, it probably should read "133.41")*

DEPARTMENT RESPONSE: Headers, a very time-consuming project, will be corrected when the draft proposed rules are completed.

Infection control

- Pg. 39 – (g) - Replace "nosocomial infections" in (1)(A) and (B) with "hospital –acquired infections."

DEPARTMENT RESPONSE: Agree. Change made.

Renal dialysis services

- Pgs. 62-77 – (t) – This is an entirely new set of requirements for renal dialysis services. Covers equipment; water treatment, dialysate concentrates and reuse; and prevention requirements relating to vaccinations, screening, and isolation procedures. THA is still reviewing it.

DEPARTMENT RESPONSE: Reuse has been deleted.

Surgical services

- Pg. 82 – (w)(1)(C) –This changes current rule permitting a qualified RN to perform circulating duties in the O.R., to a requirement that a qualified RN perform circulating duties in the O.R. Changes the current rule requiring that a qualified RN supervise LVNs and surgical technologists performing circulatory duties, to a requirement of direct supervision by a qualified RN circulator. Health & Safety Code §241.0262 was a highly negotiated law and the rules should not expand the language cited in the statute. Therefore, the phrase "who is immediately available to respond to emergencies" should be deleted.

DEPARTMENT RESPONSE: Agree. Phrase deleted.

§ 133.45. Miscellaneous Policies and Protocols.

- Pg. 97 – (c)(2) – Adds a new requirement to the disaster preparedness subsection that hospitals report bed availability updates through the EMSystem. Proprietary systems come and go, depending on technology and funding. In addition, some localities may be able to comply using some other system. For these reasons, THA recommends that reference in the rules to a proprietary system be deleted. Instead, the rules should speak to expected outcomes and need not speak to a proprietary system. THA recommends that the language in (c)(2) be replaced with the following language:

Hospitals must:
(A) cooperate with local emergency management systems. This includes participating in city, county and regional planning efforts;
(B) maintain current contact information for local emergency management offices;
(C) cooperate in patient evacuation planning;
(D) participate in state approved systems that collect information about hospital bed availability during declared disasters; and
(E) provide information to the state approved patient tracking system during declared disasters.

DEPARTMENT RESPONSE: Kathy Perkins is revising these rules.

§ 133.101. Inspection and Investigation Procedures.

- Pg. 113 – (a)(2) – The timeframe in the rules is no longer appropriate due to the new Joint Commission unannounced survey process. The JCAHO unannounced cycle is 18-39 months. TUV will conduct annual visits so this would not apply to them. THA recommends changing the language to read as follows:
  (a)(2) The department may conduct an inspection of a hospital exempt from an annual licensing inspection under paragraph (l) of this subsection before issuing a renewal license to the hospital if the certification or accreditation body has not conducted an on-site inspection of the hospital in the preceding three years and the department determines that an inspection of the hospital by the certification or accreditation body is not scheduled within [60] 90 days.

DEPARTMENT RESPONSE: Agree. Change made.

- Pg. 114 – (d) – Clarifies that the department's authority to access and copy any hospital records necessary to verify compliance does not extend to a hospital's root cause analyses or action plans. **THA supports this clarification.**

§ 133.121. Enforcement Action.

As a general matter, THA is concerned about the prescriptive nature and expansion in scope of the draft rules relating to enforcement. While THA acknowledges the department's stated desire to bring the enforcement provisions of the hospital licensing rules more in line with other health programs' enforcement rules, this language was not discussed in previous meetings regarding the hospital licensing rules revision process during the past 18 months. THA is still reviewing this section. THA recommends that that DSHS staff and THA staff schedule a separate meeting in the near future to discuss the draft revisions to the enforcement rules.

DEPARTMENT RESPONSE: Marc Allen Connelly is revising these rules.

133.162. New Construction Requirements.

Pg. 148 – (d)(4(A)(i)(VIII) – The last sentence prohibits bottled water from being stored for emergency use. In disasters and other emergencies, the hospital might not have access to water transport systems. Furthermore, hospitals can set up a "first in/first out" system of bottled-water usage during nonemergency periods to ensure that their bottled water supply stays fresh. **THA thus recommends that the sentence "Bottled water stored for emergency use to meet this requirement is not acceptable" be retained.**

Alternative Accreditation

TUV is scheduled to be approved as a national accreditation organization in late 2006. THA recommends language changes to accommodate alternative accreditation, such as "accredited by a CMS-approved organization," in the following places:

- § 133.21 (c)(4)(C)(iv) – page 10
- § 133.23 (b)(1)(D) – page 14
- § 133.81(b)(2) – page 112
- § 133.101 (a)(1)(B) – page 113
- § 133.168 (b) – page 311

DEPARTMENT RESPONSE: Agree. Change made.

Quality Assurance

The term "quality assurance" appears throughout the draft rules. There is no requirement in the rules for a hospital quality assurance committee; however, there are a number of instances where the rules mandate reporting of something to the hospital quality assurance committee. THA recommends that the references in the following places should be to the quality assessment and performance improvement (QAPI) program - with the exception of renal dialysis water testing. There are several instances where "quality assurance" is used, including the following:

- § 133.41 (d)(2)(D)(i) - page 30
- § 133.41~~(f)~~(g)(2)(A) – page 40
- § 133.41 (o)(3)(C) – page 54
- § 133.41 (q)(5)(F) – page 60

DEPARTMENT RESPONSE: Agree. Quality assurance changed to quality assessment and performance improvement including §133.41(o)(2)(H)(ii).

- § 133.41 (t)(2)(B)(xix)(III) – page 69 – water testing for renal dialysis - it is inappropriate to refer to quality assurance committee. THA questions the role of the quality assessment and performance improvement program (or a quality assurance committee) in retesting renal dialysis machines and water treatment systems.

DEPARTMENT RESPONSE: Agree. Deleted or the quality assurance committee.

- § 133.41 (t)(2)(C)(i) – page 71

DEPARTMENT RESPONSE: Agree. Deleted and quality assurance.

- § 133.41 (t)(2)(C)(xi)(V)(-b-) page 73 – water testing for renal dialysis – it is inappropriate to refer to a quality assurance committee. THA questions the role of the quality assessment and performance improvement program (or a quality assurance committee) in retesting renal dialysis machines and water treatment systems.

DEPARTMENT RESPONSE: Agree. Changed facility quality assurance committee to medical director.

THA's Comments Regarding the Draft All-Hazard Disaster Preparedness Rules – New § 133.45(c) (Kathy Perkins' 6/7/06 draft)

THA general comment: Requiring hospitals to do something that is dependent upon city/county emergency management who have no corresponding statutory or regulatory responsibility to reciprocate is not practical or enforceable. The following are preliminary recommendations. THA is still reviewing this section. THA recommends that that DSHS staff and THA staff schedule a separate meeting in the near future to discuss the draft rules regarding all-hazard disaster preparedness.

<u>Line 14, (c)(2).</u> This proposal is premature. It appears to be based upon provisions of the Governor's evacuation plan. There is no basis in law that requires community disaster managers "sign-off" on hospital plans. Suggest this section be reworded to require hospitals <u>send</u> their plans to city and county disaster management offices.
<u>Line 30, (c)(3)(c).</u> The intent is excellent, but again there is no way to enforce this since there are no comparable rules that apply to cities and cuties. Suggest you try to meet the intent of this section by requiring that hospital plans contain the names and contact numbers of city and county emergency management officers.
<u>Line 38, (c)(3)(e).</u> Notifying the department violates NIMS/ ICS standards. If the rules are used in emergencies the information should flow up the chain of command. Even if adopted the rule is too vague. The rule needs to answer "who, what, where, when."
<u>Line 38, (c)(3)(f).</u> A cell phone meets this requirement. DSHS has not established communication standards that make this requirement meaningful. Suggest DSHS use HRSA fund to put in place a meaningful communication system. Suggest standardized satellite based system with voice and text capacity.
<u>Line 57, (c)(3)(i).</u> More coordination needs to be completed before rules of this detail can be proposed. Suggest as an alternative that hospitals report bed availability to local EOC or if local EOC does not collect this information directly to THA/DSHS using these categories:

1. Available Beds
    - Med surgery
    - ICU
        i. Pedi
            1. airborne isolation/negative pressure/hepa filtration
        ii. Adult
            1. airborne isolation/negative pressure/hepa filtration
    - Pedi med surgery
    - Burn
    - Psychiatric

Line 72, (c) (3)(j)(10)(A). Delete requirement. The proposed rules suggest that DSHS plans to relax the requirement that a bed be licensed. Hospitals can not be required to increase staffed bed capacity in a disaster. Some hospitals could increase bed capacity if the new beds did not need to be licensed. Staffing for these beds probably would come from outside the disaster area.

Line 88, (c)(3)(j)(1)(F). Hospitals should not be viewed as shelters. Provision for sheltering employee families for the duration of a response is overly broad. DSHS could suggest that hospitals could maintain necessary staffing by providing shelter to the family members of staff who are needed to maintain hospital operations in a disaster. Note: There is a legal issue that DSHS needs to explore. If a hospital is in a mandatory evacuation county, but the hospital remains open at the request of county officials, can hospitals require that their employees report to work? If so, then the rules should clarify that hospitals can require certain employees to work at the hospital during the disaster.

Line 90, (c)(3)(j)(1)(G). This regulation is too vague and needs to be deleted or clarified. Many counties don't have mental health professionals. In evacuation situations mental health professionals may have evacuated. Perhaps if we knew the intent of the rule the language would be easier to develop. The biggest mental health problem in disaster is brought on by exhaustion. Addressing the mental health situation in this situation probably means letting people get sleep when they are needed to keep the hospital open.

Line 95, (c)(3)(j)(2)(A). Suggest deleting ",levels and phases of implementation, and routes and exits." The phrase is vague and the reference to routes and exits is unnecessary.

When to activate is a major public policy question, and is confused by various "trigger points" that state and federal agencies are trying to enforce.

Line 101, (c)(3)(j)(2)(C). Some hospitals will not be able to comply with the requirement to execute written commitments from receiving hospitals. The inability of state and federal governments to identify financial responsibility makes this requirement unenforceable. Operationally, these agreements are also suspect. Circumstance often makes agreements unenforceable. For example, you cannot know in advance which facilities will be open or have limited capacity.

Line 107,(c)(3)(j)(2)(D). The section is awkward and needs editing. The last phrase is unclear (", and communication will be maintained for staff and outside resources".).

Line 113, (c)(3)(j)(2)(E). The meaning if this requirement is not clear. Obviously, all hospitals cannot be prepared for all levels of clinical complexity.

Line 115, (c)(3)(j)(20)(F). Since there are inadequate evacuation assets, if an ironclad commitment is required, you may find that agreements cannot be executed. Suggest DSHS, local EOCs and hospitals discuss how the intent of this suggestion can be met. It is possible that large hospital systems might get iron clad commitments for evacuation resources that DSHS might want in other places. Be careful what you ask for.

Line 121, (c)(3)(j)(2)(G). Rules should discuss how patient destination will be determined when within control of the hospital. Sometimes destination is beyond hospital control as when evacuation assets are commandeered or when federal assets are used to evacuate patients. Events also control evacuation plans. Hospitals should be asked to develop a number of contingencies - not a rigid plan that can be made obsolete by events.

Line 126, (c)(3)(j)(2)(H). In most cases it is beyond the control of a hospital to define the process that will be used to track a patient at the destination and the plan for return. This section must be changed or deleted. The role of the local emergency authority cannot be regulated in this rule making. The bulleted items need community agreement. Suggest you convene a discussion group for the purpose of developing this section or delete the section until more research can be completed.

Line 142, (c)(3)(j)(2)(J). It is not clear what the intent of this section is.

DEPARTMENT RESPONSE: Kathy Perkins is revising these rules.