

**SAN ANTONIO BRAC 2005
GROWTH MANAGEMENT PLAN**

TASK 6a REPORT

**REDISTRIBUTION OF HEALTHCARE
AS A RESULT OF THE
WILFORD HALL MEDICAL CENTER (WHMC)
REALIGNMENT**

PREPARED FOR
CITY OF SAN ANTONIO
OFFICE OF MILITARY AFFAIRS

BY
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Acronyms and Glossary of Terms

59th Medical Wing – Wilford Hall Medical Center
AHA – American Hospital Association
Air Life – San Antonio regional air ambulance service
AMR – The regional ambulance system
BAMC – Brooke Army Medical Center
BRAC – Base Realignment and Closure
Catchment area – A defined geographical area from which a hospital's patients are drawn
Code 3 – An Emergency Medical Services trauma severity code. Most severely injured
CPTF – Contingency Planning Task Force
DoD – The United States Department of Defense
Design beds – The number of beds a hospital was designed to accommodate
Staffed beds – The number of beds for which the facility has nurses and support staff
EMS – Emergency Medical Services
ER – Emergency Room
FEDS-HEAL – Federal Strategic Alliance
GIS map – Geographic Information System map
GMP – Growth Management Plan
GSAHC – Greater San Antonio Hospital Council
GWOT – Global War on Terror
ICU – Intensive Care Unit
JTTR – Joint Theater Trauma Registry
JTTS – Joint Theater Trauma System
Level I Trauma Center – Highest level trauma care capability. In-house specialty care
Level II Trauma Center – Same as Level 1 except there is no research capability
Level III Trauma Center – Comprehensive care where specialists are available within 30 min.
Level IV Trauma Center – Basic trauma stabilization and transport
MHS – Military Health System
MTF – Military Treatment Facility. A medical facility (hospital, clinic, etc.) owned and operated by the uniformed services—usually located on or near a military base.
MTTF – Military Transformation Task Force
MEDCOM – Medical Communications clearinghouse for patient transfers
MFP – Master Facility Plan
MRR – Medical Readiness Review
OM&MFR – Operational Medicine and Medical Force Readiness
OR – Operating room
PDHA – Post Deployment Health Assessment
PDHRA – Post Deployment Health Re-Assessment
SAIO – San Antonio Integration Office
SAMBIO – San Antonio Medical BRAC Integration Office
SAMMC – San Antonio Military Medical Center
SAMMC- N – San Antonio Military Medical Center North – formerly Brooke Army Medical Center SAMMC-S – San Antonio Military Medical Center South, formerly Wilford Hall Medical Center
STRAC – Southwest Texas Regional Advisory Council
TBI – Traumatic Brain Injury
TRICARE – The health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses.
(See Appendix A for a definition of Alternative TRICARE Programs)
UHS – University Health System, including University Hospital at the South Texas Medical Center
WHMC – Wilford Hall Medical Center, SAMMC South
WT – Warrior in Transition (Returning from deployment)

SAN ANTONIO BRAC 2005 GROWTH MANAGEMENT PLAN

REDISTRIBUTION OF HEALTH CARE AS A RESULT OF REALIGNMENT OF WILFORD HALL MEDICAL CENTER TASK 6A REPORT

INTRODUCTION

The Growth Management planning process includes eight mandatory tasks, shown in the figure at the right. This report responds to Task 6a. It builds on the planning document "Conceptual Plan for Adjusting to Change in Military Medicine in San Antonio" dated May 13, 2005, and generated by the City of San Antonio through an advance planning effort funded by the Office of Economic Assistance within the Department of Defense. In addition, the study has involved coordination with Fort Sam Houston and

Wilford Hall Medical Center. The City works in cooperation with a Military Transformation Task Force that includes Bexar County and the Greater San Antonio Chamber of Commerce. The task force has seven standing committees that correspond to assigned tasks outlined above. All work on this task has been accomplished in coordination with the Military Transformation Task Force – Health Care Services Delivery and Medical Partnership Committee, which includes military representatives.

In accordance with 2005 BRAC recommendations the city's two big military medical platforms, Brooke Army Medical Center (BAMC) at Fort Sam Houston and portions of the 59th Medical Wing's Wilford Hall Medical Center (WHMC) at Lackland Air Force Base are to be consolidated at Fort Sam Houston, to become the jointly staffed 425-bed San Antonio Regional Medical Center North (SAMMC-N). Trauma care at Wilford Hall will be closed. Wilford Hall will become a world-class outpatient and ambulatory surgery center which will be designated as San Antonio Military Medical Center South (SAMMC-S).

The San Antonio Military Medical Center (SAMMC), which includes SAMMC-N and SAMMC-S, will provide the full spectrum of medical care and support five separate Centers of Excellence, including the Cardio-Vascular Center, the Battlefield Health & Trauma Center, the Eye Center; the Maternal Child Care Center and the Amputee Center. (Source: San Antonio Integration Office {SAIO} briefing on Medical Integration).

- Task 1: BRAC Community and Economic Impacts Analysis
- Task 2: San Antonio Military Medical Center Public Transportation
- Task 3: Fort Sam Houston Off-Post and On-Post Transportation Infrastructure
- Task 4: Fort Sam Houston Commercial Revitalization and Reuse of Army Surplus Property
- Task 5: Fort Sam Houston Sustainable Neighborhood Revitalization and Redevelopment Planning
- Task 6a: Redistribution of Health Care as a Result of Realignment of Wilford Hall Medical Center (WHMC)
- Task 6b Military Clinical Training
- Task 7: Regional Coordination and Communications
- Task 8: Integrate Work Accomplished for Tasks 1- 7 into a Growth Management Plan

FINDINGS AND CONCLUSIONS

This task has addressed possible implications of BRAC decisions on civilian hospitals. Specific questions that the plan was to address include:

1. Possible displacement of patient load from military to civilian hospitals
2. Possible implications of realignment of Level 1 Trauma and in-patient care

The GMP also addresses certain civilian health care needs seemingly related to BRAC.

In summary, the findings in each of the foregoing study areas are:

1. The military hospitals are handling an ever growing caseload. However, there is still a small movement of patient load from military health care providers to civilian health care providers. That movement has nothing to do with BRAC. It stems, instead, from a variety of factors, principally a priority need for military hospitals to treat casualties. A secondary factor is the continued gradual increase in the general military health care beneficiary population. These and other factors are leading to a minor displacement of care to the civilian system. The civilian system is adding capacity, and can easily handle this small incremental case load.
2. Overall impacts of BRAC on medicine in San Antonio will be small, and to the extent that there are such impacts, they are expected to increase capability.
3. BRAC will have no significant impact on trauma care relationships in the City. The military fully expects to continue the cooperative relationship which exists, and BRAC improvements are expected to more than off-set a slight increase in travel distance for the small number of Level 1 trauma cases that arise in the vicinity of Wilford Hall and are currently seen there.
4. A general review of health care needs was clearly beyond the scope of the GMP, however some needs were or are apparent, and those are reported here.
 - a. The primary civilian health care question the GMP addressed was the need for the expansion of University Hospital. There was a clear need at the start of the study period. While there were many causes, this need had nothing to do with BRAC. The principal concern, in terms of inclusion as an area of inquiry for the GMP, was an extremely heavy case load, which could have meant that the University Hospital would have had difficulty handling even small BRAC-related impacts. During the course of the study, the University Hospital System has announced a major expansion program. This expansion program is expected to fully address concerns that prompted inclusion of such tasking in the GMP study (For details, See: <http://www.universityhealthsystem.com/master-facility-plan/default.shtml>).
 - b. There is an expressed need for more ambulances to respond to the ever-increasing number of emergency calls. Staging of such ambulances could reduce the response time for patients from the vicinity of WHMC who might have been taken there prior to closure of their Level One Trauma Center.

The overall study conclusion is that closure of the WHMC ER will have no significant long-term impact on patient care on the southwest side of the metropolitan area.

- This is a small number, and the need arises principally from population growth and traffic growth in the expanding metropolitan area.
- c. There is a similar need for expansion of Air Life Services.

POPULATION GROWTH

Consideration of the impacts of BRAC is complicated by the rapidly changing San Antonio landscape. Population growth in the Greater San Antonio area is impressive.

The greater San Antonio area is now one of the fastest growing cities in the nation. Bexar County is growing at a rate of more than 2% per year. In addition, the five most populated adjoining counties continue to grow even faster. The population needing health care and contributing to the trauma load is expected to exceed two million people by 2011. This is the equivalent of adding another city the size of Amarillo or Lubbock to the current workload. (Source: U. S. Census Bureau).

HEALTHCARE REDISTRIBUTION

At the beginning of the study, some concerns were expressed that BRAC changes might displace care into the civilian health care system. As the study has progressed, these concerns have been put to rest. The principal conclusion of the study is that some displacement of care into the civilian system has occurred, but the causes are not related to BRAC. Primary factors are growth in the population of persons eligible for care and growth in the war related "Warriors in Transition" (WT)

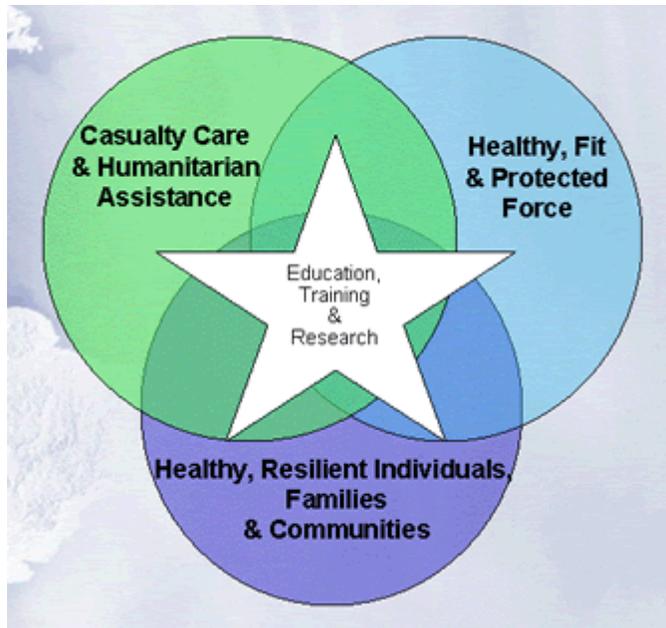
who have priority for care within the military system. However, at present over 90% of the care for the military beneficiary population is provided in military treatment facilities and less than 10% is provided by the civilian TRICARE Provider, Humana Military. BRAC related changes in military healthcare will benefit both the military and the cooperative military-civilian relationships that exist within the San Antonio health care system. As such BRAC changes occur, deliberative documentation of the Medical Joint Cross Services Working Group states that change will not result in a reduction in overall clinical productivity or capability. A modest reduction in personnel has been planned as "BRAC savings" but this will be off-set by facility enhancements and productivity increases.

To understand the findings and conclusions of the report, it is necessary to consider the system for providing military health care. America's Military Health System (MHS) is a unique partnership of medical educators, medical researchers, and healthcare providers and their support personnel worldwide. MHS delivers world-class healthcare to service members, retirees, and their families while maintaining capability to respond with comprehensive medical capability to military operations; natural disasters and

There is every intention and every expectation that SAMMC will continue to provide the current level of care for the military beneficiary population in San Antonio.

By 2011, growth will have the impact of adding another city the size of Amarillo or Lubbock to San Antonio.

humanitarian crises around the globe. The MHS is also a source of innovative education, medical training, research, technology and policy. Two operational components of the MHS System include: (1) Operational Medicine and Medical Force Readiness (OM&MFR); and, (2) TRICARE.



OM&MFR maintains and projects the continuum of healthcare resources required to provide for the health of the force. The OM&MFR capability areas are:

- Medical Force Readiness Programs
 - Medical Readiness Review (MRR)
 - Medical Logistics
 - Theater Trauma Management
 - Joint Theater Trauma System (JTTS)
 - Joint Theater Trauma Registry (JTTR)
 - Enroute Care Policies and Programs
 - Blast Injury Management
 - Traumatic Brain Injury (TBI) Management
 - Forward Resuscitative Care
 - Theater Medical Records
 - Deployment Health Follow-up
 - Post Deployment Health Assessment (PDHA)
 - Post Deployment Health Re-Assessment (PDHRA)
 - Combat Operational Stress
 - Rehabilitative Care
 - Federal Strategic Alliance (FEDS-HEAL)
- (Source: <http://fhp.osd.mil>)

TRICARE is the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses worldwide. As a major component of the Military Health System, TRICARE brings together the health care resources of the uniformed services and supplements them with networks of civilian health care professionals, institutions, pharmacies and suppliers to provide access to high-quality health care services while maintaining the capability to support military operations. TRICARE offers several health plan options to meet the needs of the beneficiary population. (Source: <http://www.tricare.mil>)

<p>Eligible Beneficiaries Approximately 9.2 million</p> <p>Military Facilities Worldwide 63 military hospitals 413 medical clinics 413 dental clinics</p>

<p>San Antonio Eligible Beneficiaries Approximately 214 thousand</p> <p>San Antonio Military Facilities 2 military hospitals 3 medical clinics</p>
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Wilford Hall and Brooke Army Medical Center are flagship facilities in Air Force and Army medicine. Thus, the hospitals play a major role in Operational Medicine, providing care for the Military Force and serving as both teaching and research hospitals. They also serve as major resource centers for provision of care under TRICARE. The BRAC change will consolidate certain functions of these two hospitals, as shown in Appendix A. However, compared to the existing hospitals, capacity to provide both OM&MFR and TRICARE services in the joint system will be maintained and service delivery will be enhanced. Three other factors, all of which must be considered in an analysis of impacts, have occurred simultaneously: (1) There has been a continual increase in efficiency and productivity; (2) There has been deployment of personnel to support the war effort; and, (3) There has been an increased need to provide care for the Warriors in Transition. The net effect has been a modest transition of patient load to the private sector care providers, with the expectation that most will go to hospitals which are part of the TRICARE support system.

Thus, with regard to the BRAC related displacement of persons to private sector, the study conclusions are:

1. No additional displacement is anticipated;
2. Displacement occurring as a result of other factors is small in comparison to growth in the TRICARE population; and
3. The TRICARE System includes provision to accommodate small shifts in patient care.

Information that supports such conclusions follows.

Almost all of the patients of the two military hospitals are within the TRICARE population which includes active duty, active duty Family Members, retirees and their Family Members. In 2004, just prior to the 2005 BRAC announcements, the total admissions at BAMC were 15,858 and clinic visits were 645,003. By the end of 2007 that number had increased to 18,174 admissions and 791,582 clinic visits. Increases were in all categories except for Retired/Retired Family members older than sixty five. These numbers fell from 5085/126,440 to 4755/120,087. The change in provision of care to this demographic group is due to the effect of the Global War on Terror (GWOT) and the priority given to Warriors in Transit (WT) at Military Treatment Facilities.

Total admissions at WHMC fell between 2004 and 2007, while clinic visits increased. In 2004 admissions were 17,457 and clinic visits were 683,014. In 2007 the patient admissions had fallen to 15,614 while clinic visits had risen to 734,846. The decrease in inpatient care is explained by deployment of WHMC personnel, especially the critical care professionals, to staff Theatre Hospitals in Balad, Iraq and Bagram, Afghanistan.

Clinic visits for the combined facilities rose from 1,328,017 to 1,526,428. This increase was across all categories except for active duty dependents and those retired over age 65. These two categories fell from 253,321 to 119,415. The decrease in such care was due, again, to priority given to care for the WT. This Medicare eligible population was referred to civilian facilities accepting TRICARE for Life.

By the time BRAC has been fully implemented, demand for care will have increased in most categories. The incoming BRAC population and other movements into the San Antonio area are predicted to increase the patient population by about 18,000. BRAC

movements are not expected to have an influence on the over-age 65 population. The over-age 65 population is predicted to slowly grow in concert with general growth and aging of the population. The military health care system will have the capacity to care for the active duty, active duty Family Members, retiree, and retiree Family Member populations, with care for the over-age-65 population expected to remain at current levels. Should demand in that category increase, care can easily be accomplished in civilian TRICARE support facilities.

At the time of BRAC 2005, the total number of TRICARE eligible beneficiaries in the San Antonio area was reported to be over 210,000. The data on TRICARE eligible personnel since the 2005 BRAC announcement varies with the source, probably as the result of the geographic area being surveyed by that source. Based on the numbers from the SAMBIO and the Fort Sam Houston BRAC Transformation Office, the estimate is that the number of TRICARE eligible

persons will increase from about 214,000 in 2005 to over 230,000 by 2012. Of the known 214,000 TRI-CARE eligible beneficiaries in the area in 2005, records show that 144,056 were enrolled to one of the Military Treatment Facilities, 9,291 were enrolled to a network provider, and the remainder was in TRICARE Standard. These various categories of care are described in Appendix A. At the present time (three years post BRAC) the number enrolled to the Military Treatment Facilities is now 149,056 (TRICARE office data).

	Total Eligible	Military Treatment Facility	Network Provider	TRICARE Standard or Extra
2005	214,000	114,056	9,219	90,725
2008		149,056		
2012	230,000			

Data Source: TRICARE (Date: October 2008)

Demand for care at both WHMC and BAMC has been significantly increased and influenced by ongoing hostilities. Not only have the warriors in transition (WT) returning from the theatre demanded complex immediate medical care, they have also required ongoing and sometimes intensive care for physical and mental disabilities. In addition to fulfilling the mission of providing care to the WT, the staffs of both WHMC and BAMC have deployed extensively to support the hospitals in Iraq and Afghanistan. The impact has been significant in critical care; the staff that provides supports intensive care units and the Operating Rooms. Also directly affected have been specialties with only a few providers. Loss of any of these few providers creates vacancies which are difficult to fill. While deployments are of limited duration, one specialist often rotates out as another returns, creating an ongoing specialty shortage.

The military health care system will have the capacity to care for the active duty, active duty dependent, retiree, and retiree dependent populations.

Where possible, both WHMC and BAMC have hired contract health care providers to fill in for deployed personnel.

As mentioned, despite numerous deployments over the past few years total healthcare delivery at military hospitals has actually increased. Concurrently, there has been an increase in the number of war-related disabilities and rehabilitation patients who require continued care.

Despite numerous deployments over the past few years overall productivity at military hospitals has actually increased.

In addition to SAMMC, military health care facilities include the clinic at Randolph Air Force Base, a new Air Force/Veterans Administration military health care clinic on the north side of town and a new facility at Camp Bullis. These clinics provide primary care and some specialty services. Two of these clinics are expected to function at the same level of care post-BRAC, while the Camp Bullis clinic will increase in size, allowing an increased primary care enrollment of approximately 7,000 military beneficiaries.

At the time of BRAC 2005, while Wilford Hall Medical Center and BAMC were seeing over 1.5 million outpatients per year, the clinics at Brooks and Randolph AFB saw an additional 20,575 outpatients per year. At the present time, despite reduced resources from deployments, the combined outpatient visits and admissions of these facilities for 2007 were 1,547,003 outpatients and 33,788 admissions. (SAMBIO Figures)

As mentioned above, the number of retirees and their dependents receiving care in the civilian sector is gradually increasing, as is the number of patients who are over age 65. The reasons for increases in the care provided in the civilian sector are care of the returning wounded WT and the continued gradual increase in the general beneficiary population. The overflow, reflecting an increase in demand within the non-military system will occur throughout the geographical areas in which retired and active duty military live. This will be predominantly inside Loop 1604 and shift further north as future retirees move toward those areas. Anticipation of this demographic shift has resulted in the recent increase in medical facilities by several major civilian hospital systems and the VA hospital system with its new Polytrauma Hospital and the Camp Bullis clinic.

Based on the current plans for SAMMC North and projected staffing of that facility, closure of WHMC to inpatient care will have little or no effect on civilian hospitals. All plans project a shift in workload between military facilities but no requirement for civilian hospitals to assume any additional workload other than that which may come from new TRICARE eligible (usually over 65 TRICARE-for Life) patients who have voluntarily elected to seek care in the civilian sector. Projected civilian population growth on the north and west sides is substantial and will be largely accommodated by the four or five new hospitals and free standing clinics that are opening in these areas.

The military expects that BRAC changes will actually improve the availability of care in the region

Appendix A includes a map with the location of hospitals in the San Antonio metropolitan area, showing the population within the census districts around each hospital.

TRAUMA

INTRODUCTION

Trauma is any wound; blunt, such as produced by a fall or physical impact from a vehicular accident, or penetrating as by a bullet or knife wound. Trauma patients usually require specialized care, including surgery and often blood transfusions. It is important for patients to receive care within the “golden hour” or the first sixty minutes following the trauma. This “golden hour” concept recognizes that many deaths, which could be prevented by timely care, occur a relatively short time after injury. (Source: http://en.wikipedia.org/wiki/Physical_trauma). There are currently three Level I trauma centers in San Antonio. These are University Hospital, Wilford Hall Medical Center or WHMC, and Brooke Army Medical Center or BAMC. Level I centers are those best able to treat the most serious traumatic injuries.

BRAC involves relocation of WHMC trauma capability into a new San Antonio Military Medical Center at Fort Sam Houston, built around the existing Brooke Army Medical Center. Thus, after BRAC, the three Level I trauma centers will have been reduced to two. At the outset of the study there were two potential concerns about such a change. One of these was that the availability of trauma care provided by the military might be diminished. This concern has been put to rest. The level of support is expected to be maintained. A second potential concern was that there might be a negative impact, due to the longer transit time to a more remote hospital, on seriously injured patients whose injuries occurred in the area immediately around WHMC. This concern has also been put to rest.

Important factors to consider in analyzing the relationship of BRAC to trauma are: (1) The proximity of trauma patients to emergency medicine services; (2) The relationship of San Antonio trauma facilities within the Region; (3) The system for characterizing the severity of trauma and determining which hospitals are equipped to receive patients with increasingly serious trauma; and (4) The relationships between Military and Civilian Trauma Facilities.

Additional considerations include: (1) The actual number of patients with extremely serious trauma injury that arise within the area near WHMC is very small; (2) There are now plans to increase the number of ambulances and to position them so that service is maintained in the sector; and (3) Improvements in the landing configuration at SAMMC will reduce times for air-ambulance transport, more than off-setting any small increase in air-flight time for helicopter transported patients. These factors together, mitigate or entirely off-set the potential increase in travel time that might have otherwise been experienced by a post BRAC Level I trauma patient whose injury occurred in proximity to WHMC. However, the planning team recommends that the planned additions and improvements to the surface and air emergency transport systems should be supported.

THE RELATIONSHIP OF TRAUMA TO EMERGENCY MEDICINE

The emergency response system is depicted conceptually in the diagram at the right. As the bottom of the diagram indicates, there are different levels of care that are related to the seriousness of the patient's trauma. A definition of the four levels is provided in the Trauma and Hospitals Section which follows.

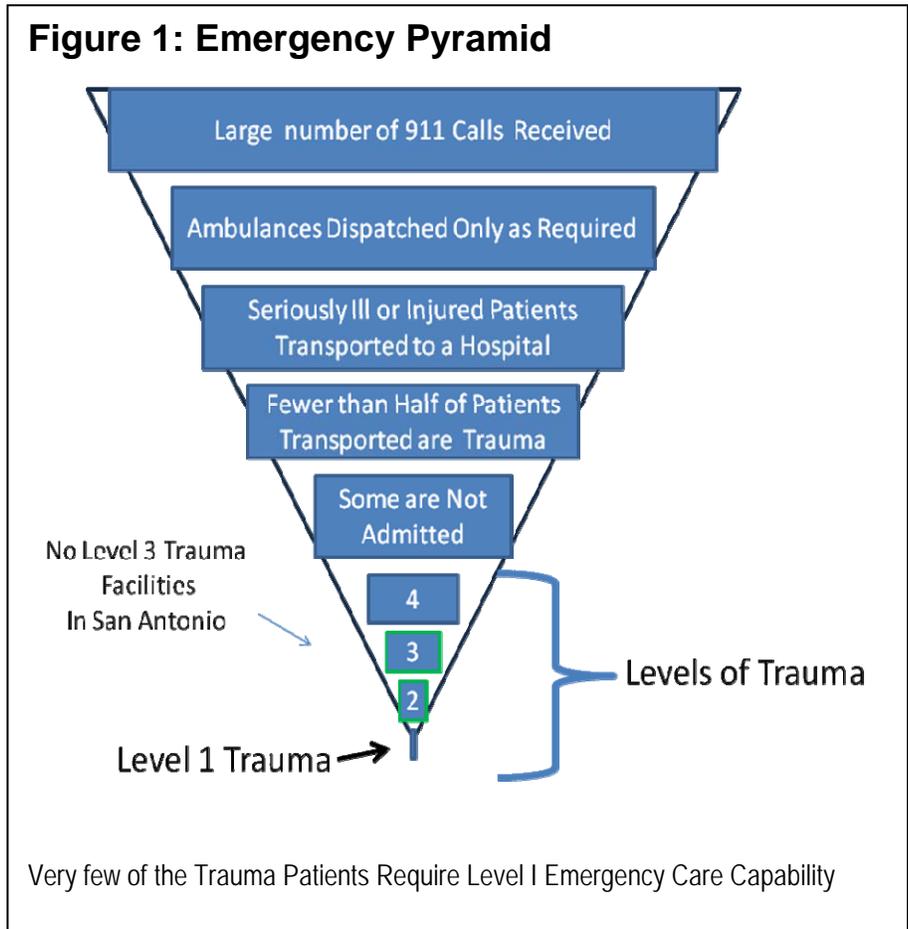
When a call comes in, an ambulance may be dispatched and there are guidelines which help to determine where the patient will be taken. Many complex circumstances explain decreases as one moves down the pyramid depicted in the figure. A complete review of the reasons for the decrease is not possible within the limitations of this report. Rather, the goal is to illustrate the fact that very few of the initial calls, hospital transports,

or hospital admissions require admission to a Level 1 trauma center that can handle the most serious trauma cases. As the figure depicts:

1. Some calls do not result in an ambulance dispatch
2. Ambulances may not be necessary to transport patients to the hospital
3. Many patients who arrive at a hospital are not admitted because evaluation of their status reveals that their condition is not that serious
4. Most patients who are admitted are not trauma patients. They often have medical conditions such as seizure, stroke, or heart attack
5. Of the trauma patients arriving at the hospital most do not require the extensive capabilities of a Level 1 facility capable of treating the most seriously injured.

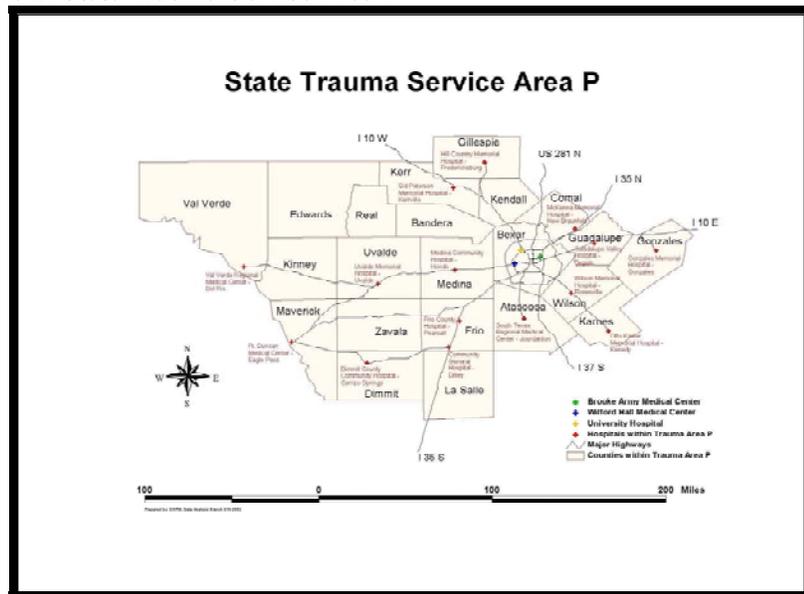
SAN ANTONIO AS A TRAUMA CARE CENTER FOR THE REGION

The State of Texas has organized a trauma care system which places San Antonio at the heart of a 28 county region known as "State Trauma Service Area P". This region is shown in Figure 2, along with a listing of the 28 counties that are included in the region. A larger version of the figure is contained in the Appendix.



University Hospital is the lead Level I Trauma Center for this South Texas area as depicted in the figure on this page. Through a cooperative agreement between the three San Antonio hospitals, Wilford Hall will provide up to 25% of the region’s trauma care, while BAMC will provide up to an additional 25%. The result of this arrangement is that seriously injured trauma patients requiring Level I care receive such care in one of the three Level I trauma care facilities in San Antonio if their injury has occurred anywhere in the State Trauma Service Area.

Figure 2: State Trauma Service Area P



Atascosa	Dimmit	Guadalupe	La Salle	Val Verde
Bandera	Edwards	Jackson	Lavaca	Victoria
Bexar	Frio	Karnes	Maverick	Wilson
Calhoun	Gillespie	Kendall	Medina	Zavala
Comal	Goliad	Kerr	Real	
De Witt	Gonzales	Kinney	Uvalde	

Southwest Texas Regional Advisory Council (STRAC) has been established to facilitate the development, implementation, and operation of a comprehensive trauma care system for Texas Trauma Service Area P.

TRAUMA AND HOSPITALS

Hospitals are characterized according to the level of care they are able to provide to trauma patients. Hospital care capability is verified by the Committee on Trauma of the American College of Surgeons. There are four separate categories of verification (Level I, II, III, and IV), each with specific criteria that must be met by a facility seeking that level of certification. A list of the hospitals in the Service Area, showing the location and the level of care they can provide, is contained in the Appendix.

A Level I Trauma Center is a comprehensive regional resource, central to the trauma system and capable of providing total care for every aspect of injury – from prevention through rehabilitation. Key elements of a Level I Trauma Center include 24-hour in-house coverage by general surgeons, and prompt availability of care in specialties such as orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology, internal

medicine and critical care. Other capabilities include cardiac, hand, pediatric, microvascular surgery and hemodialysis. The Level I Trauma Center provides leadership in prevention, public education and continuing education of the trauma team members. The Level I Trauma Center is committed to continued improvement through a comprehensive quality assessment program and an organized research effort to help direct new innovations in trauma care. Most large cities are lucky to have one Level 1 trauma center. San Antonio currently has three.

A Level II Trauma Center is able to initiate definitive care for all injured patients. Key elements of a Level II Trauma Center include 24-hour immediate coverage by general surgeons, as well as coverage by the specialties of orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology and critical care. Tertiary care needs such as cardiac surgery, hemodialysis and microvascular surgery may be referred to a Level I Trauma Center. There are no such centers in Area P.

A Level III Trauma Center has demonstrated an ability to provide prompt assessment, resuscitation, stabilization of injured patients and emergency operations. Key elements of a Level III Trauma Center include 24-hour immediate coverage by emergency medicine physicians and the prompt availability of general surgeons and anesthesiologists. The Level III program is dedicated to continued improvement in trauma care through a comprehensive quality assessment program. **The Level III Trauma Center has developed transfer agreements for patients requiring more comprehensive care at a Level I or Level II Trauma Center. Two of San Antonio's larger hospitals are Level III. Most are Level IV.**

A Level IV Trauma Center has demonstrated an ability to provide advanced trauma life support (ATLS) prior to transfer of patients to a higher level trauma center. Key elements of a Level IV Trauma Center include basic emergency department facilities to implement ATLS protocols and 24-hour laboratory coverage. **Transfer to higher level trauma centers follows the guidelines outlined in formal transfer agreements.** (Source: <http://www.barnesjewish.org/groups/default.asp?NavID=1090>). From the foregoing, it is clear that all patients requiring level I care are currently transferred to one of the three cooperating San Antonio level I facilities for care.

MILITARY/CIVILIAN TRAUMA CARE RELATIONSHIPS

The City of San Antonio is unique. Even very large Metropolitan Areas have one, or at most two Level I trauma facilities, while San Antonio presently has three. With BRAC changes, the number will be reduced to two as trauma care at the two military facilities is consolidated at SAMMC – North. Level I Facilities are normally associated with teaching and research. Indeed, in addition to being large hospitals, all three of the Level 1 Facilities in San Antonio are also teaching and research centers. There is cooperation among the three facilities in many areas. One aspect of that cooperation is the agreement, previously noted, under which each of the two military facilities will provide up to 25% of the trauma care in the region. Such an agreement benefits the military by ensuring the availability of cases for training of military surgeons, a key mission of each military facility. Such an agreement benefits the Community by providing excellent care for individuals who would not otherwise be candidates for admission to the Military Medical System. While the

military facilities each accept 25% of the trauma transports only 11% to 13% of these are actually level I trauma patients. The military fully expects to continue the cooperative relationship which exists, and SAMMC-N is programmed to continue providing up to 50% of the City's trauma care. The existing trauma care relationship between Department of Defense and the San Antonio medical community is expected to be maintained. Because of changes in the helicopter receiving facilities it is anticipated that SAMMC will be able to provide enhanced support for level I trauma care, as outlined in the sections which follow.

ANALYSIS OF BRAC IMPACTS

University Hospital's Level I trauma center currently sees close to 9,000 trauma patients per year (78% of the annual total). Around 4,500 of these arrive by way of surface and air emergency medical services ambulances. The remaining trauma patients are brought in by private auto. WHMC and BAMC currently each receive around 1,300 trauma patients per year, or about 11% of the annual total each.

When completed, the SAMMC-N Emergency Medical Service will be expanded, more operating rooms will be added, and there will be 52 new Intensive Care Unit (ICU) beds and over 100 ward beds. The expansion will provide enough capacity to absorb the inpatient medical mission currently provided at WHMC.

GROWTH IN SERVICE NEEDS

With the rapid growth in the SA metropolitan area and expansion of the highway system and increase in commercial vehicle traffic, there is a need for continued growth of this area's Emergency Medicine and Trauma care capability. One index of such a growing need is the number of calls for ambulance service. Based on reported San Antonio Emergency Medical Service data, the total number of calls for service to area hospitals is increasing by approximately 5,000 per year. That number has increased 16% from 108,203 in 2004 to 125,420 in 2007. The city's population during the same time period has increased by only 6%. When projected to 2012 the calls for service could reach 160,000 per year. These numbers are exclusive of: (1) Ambulance service calls covering the rural counties; (2) Small city independent EMS services like Alamo Heights; and (3) Patients transported by helicopter on AirLife. Projected growth could increase as a result of significant projected growth on the west and north sides of town and the increased traffic load on an evolving freeway system. Using the 2007 data just cited only about 57,000 of the calls for service resulted in a patient transport and only about 6,000 of those were admitted to the hospital. Further, many of these are not trauma patients.

The three flagship Baptist, Methodist, and Santa Rosa Hospitals see over 36% of the EMS transported patients. The remaining patients are distributed among other area hospitals. It is significant that new hospital construction is following the population growth with several new hospitals already under construction. Some of these are planning to develop Level III trauma capability. In addition, over ten privately owned Urgent Care and Minor Emergency Clinics have been opened all around the San Antonio area. These have become popular and will relieve some of the stress on hospital emergency rooms.

The study conclusions are that relocation of Trauma care from Wilford Hall is not expected to have an impact on such care either in San Antonio or in State Trauma Service Area P. Medical facilities proximate to WHMC have the capability to care for less severely injured ambulance patients, including most medical and surgical emergencies. The newer hospitals will establish enhanced trauma care on the west and south side of town.

TRAVEL TIME

Another concern about closure of in-patient and trauma care at Wilford Hall involved whether the additional travel time in getting to another location would put trauma patients at significant risk. At the present time transportation from WHMC to BAMC via Hwy 90 and I-35 is approximately 28 minutes. Transportation times by automobile from WHMC to UHS are about 20 minutes and somewhat shorter by ambulance. As noted previously, an acuity analysis of the large population of trauma patients has shown that there is only a very small percentage for whom a surface travel time of less than 15 minutes would make a significant difference in their survival. Since most of the very critically injured patients are transported by air, and the travel times are comparable to each of the facilities, very few of these patients would be impacted at all.

Conclusions of the GMP Study are:

1. With closure of the WHMC inpatient services some transportation times will increase and some will decrease depending on the site of the trauma pickup
2. New civilian hospitals are opening in the region, so transportation will be reduced for a significant number of patients. An example is the movement of SE Baptist hospital from Southcross Boulevard to Brooks City Base which is closer to a more likely site of serious accidents along Interstate 37 and Loop 410.
3. Current transportation times from most outlying areas to WHMC, UHS, and BAMC via Air Life helicopter are roughly comparable. The only significant variable is the individual facilities' reception and turnaround capability. The new helipad proposed for SAMMC-N should cut travel time for patients going there. Air Life recognizes its need to expand its transportation capability, but that requirement is based on the population and traffic increases, not on BRAC related change at WHMC
4. A report from the SAMMC Task Force of STRAC (which includes the chief of EMS, San Antonio) proposed 4 new ambulance units that would be stationed in existing southwest side fire stations near WHMC. This would decrease the initial response time for patients in the WHMC catchment area. With shortened initial response time, the total time from dispatch to arrival at SAMMC-N or UHS could be maintained or reduced.
5. If the WHMC Emergency Services were closed prior to the opening of services at new hospitals on the southwest side, transportation times for the moderately injured from sites in the vicinity of WHMC could increase somewhat. However, most of the

Four new ambulances could be stationed at fire stations near WHMC to decrease response time – in order to offset the loss of WHMC as a potential destination for trauma patients

moderate-injury patients now treated at WHMC are not injured near WHMC, and for such cases transportation time to an appropriate facility could actually decrease.

In 2007 STRAC formed the SAMMC Task Force composed of trauma surgeons, trauma center representatives and EMS personnel to discuss methods of making the transportation more efficient and reduce transport times. Traffic monitoring and routing of EMS vehicles by way of real-time directions emerged as the best possible solution for decreasing transport times. Such a system should be funded and implemented. A patient severity system has also been suggested and may well be under further development. A current need for additional ambulance and helicopter capability in the Hwy 90/ Loop 410 area has already been emphasized and this need will be further accentuated with population growth and any decrease in trauma capability.

The conclusions are that the planned improvements for both surface and air emergency transport will mitigate or off-set the travel times to alternate care facilities. This will be true for the very small numbers of critically injured persons who are injured in the vicinity of WHMC, and who might have been taken there had the level I care facility remained at that location. The community needs to support the recommended improvements to these emergency transportation systems.

UNIVERSITY HOSPITAL EXPANSION

As noted earlier, the primary civilian health care question the GMP addressed was the need for expansion of University Hospital. There was a clear need prior to the start of the study period. While there were many causes, this need had nothing to do with BRAC. The principal concern, in terms of inclusion as an area of inquiry for the GMP, was the heavy case load, which could have meant that the University Hospital would have had difficulty handling even small BRAC related impacts. During the course of the study, the University Hospital System has announced its major expansion program. This expansion program is expected to fully address concerns that prompted inclusion of such tasking in the GMP study.

The University of Texas (UT) Health Science Center at San Antonio is a nationally recognized academic medical center. Facilities include University Hospital, the primary teaching hospital for the UT Health Science Center. Currently operating 400 beds, University Health System is the public hospital district for Bexar County, Texas. Six community clinics provide outpatient primary and specialty care. University Health System is a joint owner of San Antonio Air Life, one of the nation's most recognized emergency air medical transport services and the hospital is a sponsor of the Center for Health Care Services.

University Hospital is also the primary level 1 trauma center for the 28 counties comprising State Trauma Area P. It currently handles about 9,000 of a total of some 11,600 annual level I trauma cases, with about 1,300 each going to the two military hospitals.

The University Hospital System (UHS) includes the University Hospital at the South Texas Medical Center and a University Health Center Downtown campus with three connected buildings as well as a number of ancillary buildings. The Medical Center Hospital, with 500

beds, was designed to see some 30,000 patients per year. Currently it is operating with only 400 beds and seeing more than twice that number of patients, or some 70,000 patients per year. The UHS emergency room (ER) is frequently closed to minor trauma because of the lack of ICU beds and an overload of walk-in patients that use the emergency room for their primary care. University Hospital's current trauma bed capacity is barely capable of meeting today's San Antonio's trauma needs. Patients often have to be kept in the emergency area for extended periods of time waiting for the availability of an acute care bed.

To address these needs, University Hospital has developed a ten year Master Facility Plan (MFP) and is in the process of hiring a program manager to oversee the implementation of that plan. The plan can be found at: <http://www.universityhealthsystem.com/master-facility-plan/docs/Vol-2-UHCD-Doc.pdf>. The release describing the plan included the following:

In an effort to "right size" University Hospital and provide the appropriate mix of diagnostic and treatment services at the hospital, as well as at its large downtown clinic, the University Health Center - Downtown, the University Health System Board of Managers is considering options to construct a Trauma Tower at University Hospital and a new Urgent Care building downtown.

Needed because of growth, Board members have already identified Phase I priorities for both campuses. The four urgent projects for University Hospital include:

1. Emergency Center expansion
2. Additional inpatient rooms & replacement of many existing adult rooms in the oldest part of the hospital, which opened in 1968
3. Appropriately sizing diagnostic and treatment areas
4. Constructing more parking for patients and staff

Priorities for the University Health Center - Downtown (formerly the Robert B. Green Hospital, constructed in 1915) include expanding:

5. Acute and crisis care services
6. Diagnostic imaging
7. Pharmacy services
8. Parking

The total project costs estimates for Phase I priorities under consideration for both campuses are in the range of \$650 to \$700 million. The major components and cost estimates (in millions \$) include:

9. New Trauma Tower with Expanded Emergency Center & Surgical Capacity	\$519
10. University Health Center Downtown	\$ 80
11. Central Utility Plant for University Hospital	\$ 54
12. New Parking Garage at University Hospital	\$ 42

Total project costs could be less, depending on the outcomes of a series of management initiatives, which include working with The UT Health Science Center at San Antonio to construct a parking garage on a section of its property adjacent to University Hospital and explorations by University Health System and CPS Energy on the feasibility of constructing a state-of-the-art Cogeneration energy plant. Cogeneration harnesses steam and heat, which would otherwise be discarded as waste, and redirects it to create energy for heating and cooling.

University Health System currently has about \$100 million available in cash reserves to fund portions of this project, and is working with financial advisors to develop a combination of financial options.

Phase I includes replacing 283 beds in the 1968 tower and adding 140-210 beds in the new Trauma Tower. "There is no doubt we need to address the community's needs, particularly in the areas of emergency services and trauma care," said Chair of the board's Planning and Operations Committee - Ira Smith, "as the hospital is currently experiencing severe overcrowding and lengthy emergency room wait times."

While the preliminary schedule indicates that the new hospital building will not be completed until the first quarter of 2012, it is intended that during the Project Implementation Planning, the Project Manager will help UHS analyze alternatives that would deliver the project sooner. If funded in a proposed November 2008 bond package the new facility could be ready for occupancy by mid 2012. The web page further indicates that construction management fees and other factors could push the total estimated cost to the range of \$900 million. (<http://www.city-data.com/forum/san-antonio/372584-proposed-university-hospital-expansion-rendering-2.html>).

Conclusions of the report are that issues with care are related to growth rather than BRAC. Expansion of University Hospital addresses those concerns. The community should strongly support the University Hospital expansion program.

CONTINGENCY PLANS

The GMP was to address Contingency Plans. In 2003 STRAC formed a contingency task force in response to medical deployments in wartime. The task force expanded on a system that had been established in 1994 by the Greater San Antonio Hospital Council (GSAHC). They also adopted Guidelines that address: (1) Patient distribution systems; (2) Transportation and other approaches to improve the management of mobilization and escalating trauma scenarios. These STRAC documents are consistent with the recommendations of a 1995 Trauma Task Force, and are based on STRAC's extensive data base. The conclusion of the GMP is that a plan exists, and it reflects the input and ideas from medical professionals engaged in providing services such as those which would need to respond in the event of an emergency.

SAN ANTONIO BRAC 2005 GROWTH MANAGEMENT PLAN

REDISTRIBUTION OF HEALTH CARE AS A RESULT OF REALIGNMENT OF WILFORD HALL MEDICAL CENTER

TASK 6A

Appendix A

Supporting Information

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San Antonio Military Medical Center (SAMMC)

SAMMC NORTH

Inpatient beds
 Pediatric Oncology
 Pediatric Subspecialty
 Gastro/Endo
 Hematology/Oncology
 Chemotherapy
 Infectious Disease
 Nephrology
 Neurology
 Rheumatology
 Pulmonary
 Respiratory Therapy
 Emergency/Trauma
 Cardiac Rehabilitation
 Cardiac Catheterization/Angiography
 General/Plastic Surgery
 Neurosurgery
 Physical Therapy
 Occupational Therapy
 Mental Health
 Invitro Fertilization
 Nuclear Medicine
 Radiation Oncology
 Pharmacy
 Pre-Admissions
 Surgery
 Central Sterile
 Anesthesia

SAMMC

Primary Care
 Pediatrics
 Internal Medicine
 Cardiovascular/Vascular
 Cardiology
 Oral & Maxillofacial
 Urology/Systoscopy
 Otolaryngology
 Ophthalmology/Optomety
 Orthopedics/Cast/Physical Medicine
 Physical Therapy
 Occupational Therapy
 Women's Health Clinic
 Mental Health
 General Radiology/RF/US
 Computed Tomography
 MRI
 Mammography
 Pharmacy
 Laboratory

SAMMC SOUTH

Sleep Study
 COPD Rehabilitation
 Allergy
 Dermatology
 Endocrinology
 Pain Clinic
 Podiatry
 Orthotics
 Chiropractic
 Lasik/Refractive Surgery
 Audiology
 Speech Therapy

TRICARE PROGRAM DEFINITIONS

Source: <http://www.humana-military.com/south/bene/tricare-plans.asp>

TRICARE – Is the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses.

TRICARE Prime – Covers patients under age 65 enrolled in managed care PPO network is a managed care option offering the most affordable and comprehensive coverage. TRICARE Prime is available in areas near military treatment facilities and where Humana Military has established TRICARE Prime networks.

TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members provide active duty service members and their eligible family members with a TRICARE Prime-like option while they are assigned to remote duty stations in the United States.

TRICARE Standard is a fee-for-service option. Persons electing TRICARE Standard, have more choice in providers as they can seek care from any TRICARE-authorized provider, but they have higher out-of-pocket costs.

TRICARE Plus – patients over 65 enrolled in managed care PPO network

TRICARE For Life is TRICARE's Medicare-wraparound coverage available to all Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A and B. While Medicare is the primary insurance, TRICARE acts as a secondary payer minimizing the insured's out-of-pocket expenses. TRICARE benefits include covering Medicare's coinsurance and deductible.

TRICARE Reserve Select is a premium-based health plan that qualified National Guard and Reserve members may purchase. TRS offers coverage similar to TRICARE Standard and Extra. It is available worldwide to most Selected Reserve members (and families) when not on active duty orders or covered under the Transitional Assistance Management Program. National Guard and Reserve members may qualify to purchase TRS coverage if they are: (1) A member of the Selected Reserve of the Ready Reserve; and (2) Not eligible for enrolment in the Federal Employee Health Benefits program or any other non-premium-based TRICARE health coverage. Qualified members may purchase Member-Only or Member-and-Family coverage.

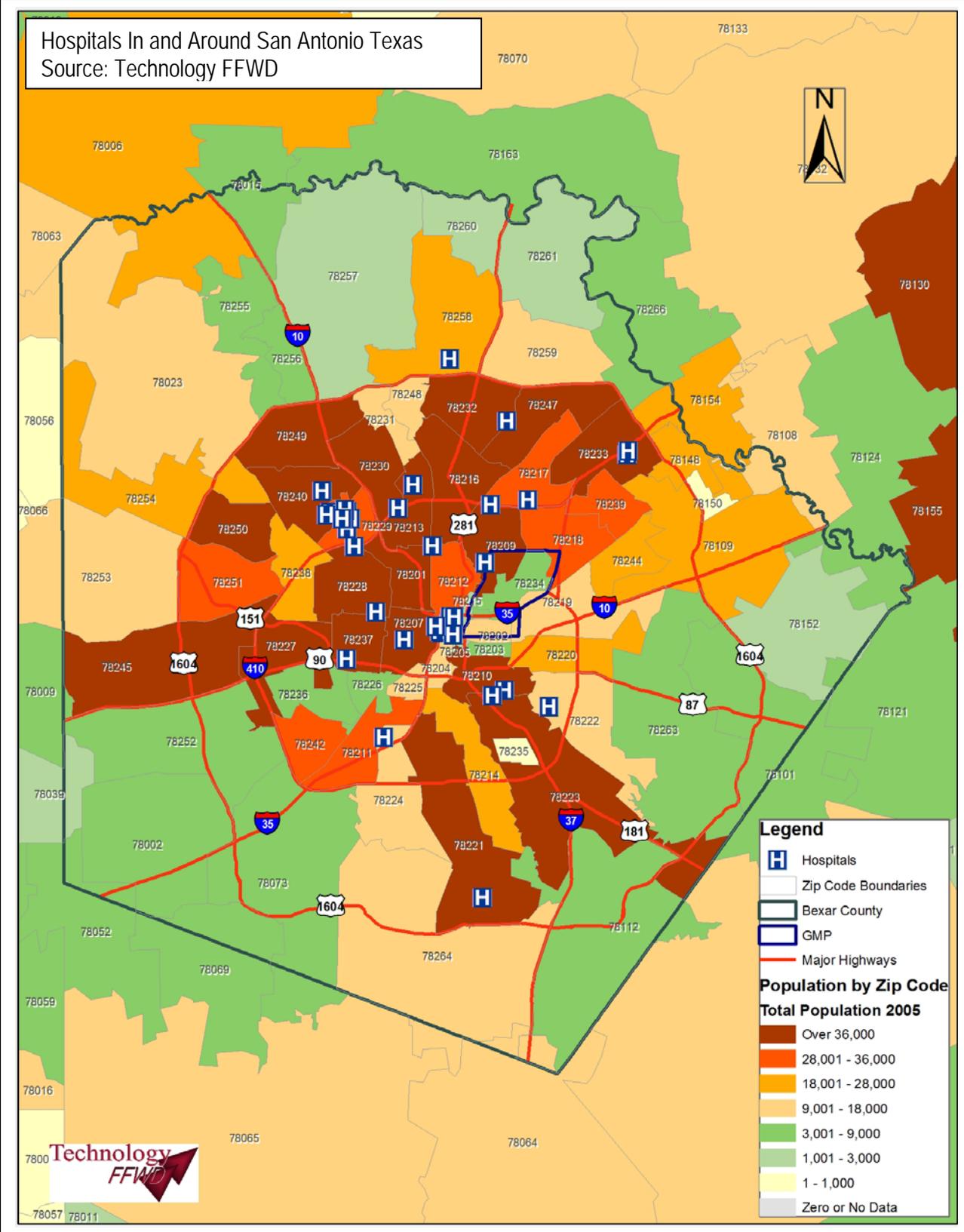
**American Hospital Association (AHA)
2007 Hospital Guide Data for Hospitals in the San Antonio Area**

Note: Staffed beds and patients admitted are as reported by individual hospitals.

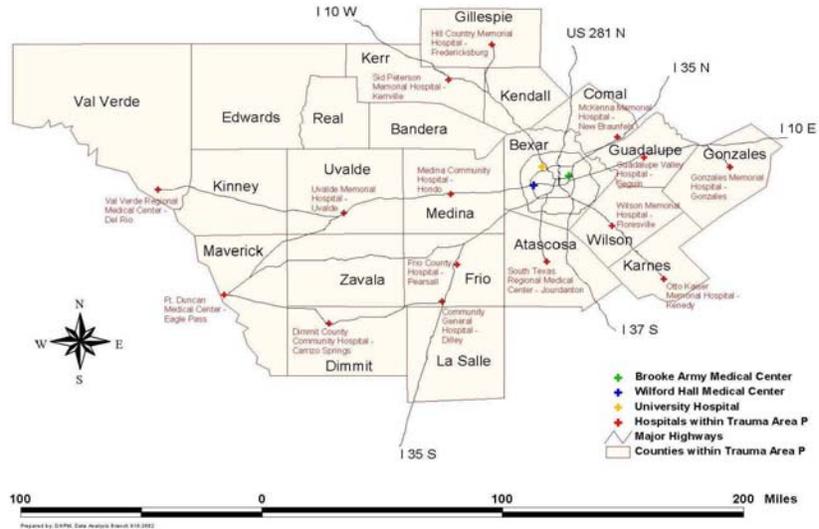
Name	Beds	Staffed beds	Admissions
WHMC	288	284	15,596
BAMC	450	226	10,137
University Hospital	604	369	22,000
Audie Murphy VA		332	4,812
(Includes Kerrville)	154	20	-----
SW Texas Methodist Hospital	845	-----	64,756
Methodist Children's	150	150	-----
Methodist Specialty and Transplant	379	-----	-----
Metropolitan Methodist	279	244	-----
NE Methodist	149	149	-----
Texsan Heart Hospital	45	-----	3,178
Baptist Medical Center	612	400	17,955
NE Baptist	291	222	12,500
SE Baptist	175	146	7,016
St. Luke's Baptist	326	244	11,842
N. Central Baptist (Stone Oak)	126	126	9,382
Christus Santa Rosa Hosp	388	388	17,500
Christus Santa Rosa Medical Center	178	165	-----
Christus Santa Rosa Children's	196	196	5,800
Nix Medical Center (Blackstone)	294	181	7,800
SW General (IASIS)	291	212	9,102
Compass Hosp	35	35	377
Health S. RIOSA	108	96	1,630
Warm Springs	65	64	1,109
Kindred Hospital (old Vancor)	59	-----	632
LifeCare Hospital	34	-----	380
Mission Vista		34	-----
685			
SA State Hosp (psych)	285	-----	3,121
Westover Hills(Christus)	120	-----	-----
Stone Oak (Methodist)	350	132	-----
Boerne Methodist Emergency			-----
McKenna	132	132	1,069
Floresville	44	-----	1,069
Guadalupe Valley Seguin	117	-----	5,155
Hondo	25	-----	803
Kerrville	145	109	5,500
Gonzales	35	-----	1,352
Jourdanton	39	-----	3,162

A map showing the location of hospitals as well as the population in the census area tracts around the hospitals is provided on the next page

Hospitals In and Around San Antonio Texas
 Source: Technology FFWD



State Trauma Service Area P



28 Counties in Area P

28 Counties in Area P

Atascosa	Karnes
Bandera	Kendall
Bexar	Kerr
Calhoun	Kinney
Comal	La Salle
De Witt	Lavaca
Dimmit	Maverick
Edwards	Medina
Frio	Real
Gillespie	Uvalde
Goliad	Val Verde
Gonzales	Victoria
Guadalupe	Wilson
Jackson	Zavala

EMERGENCY TRANSPORTS TO AREA HOSPITALS IN 2007

HOSPITAL	SA EMS
TRAUMA CENTERS	
BAMC	1,344 (2.56%)
WHMC	1,348 (2.57%)
UHS	<u>3,931 (7.49%)</u>
TOTAL	6,623 (11.95%)
BAPTIST SYSTEM	
DTB	6,972 (13.29%)
NEB	4,852 (9.25%)
SEB	3,672 (7.0%)
NCB	2,945 (5.61%)
SLB	2,259 (4.3%)
NCBCh	<u>417 (0.79%)</u>
TOTAL	21,117 (38.09%)
METHODIST SYSTEM	
ST METH	6,459 (12.31%)
MET	4,040 (7.7%)
MST	1,246 (2.37%)
NEM	1,210 (2.31%)
METH C	<u>1,073 (2.04%)</u>
TOTAL	14,028 (25.30%)
CHRISTUS	
SRA	5,803 (11.06%)
SRNW	1,834 (3.49%)
SRCh	<u>1,886 (3.59%)</u>
TOTAL	9,523 (17.18%)
OTHERS	
NIX	373 (0.71%)
SWG	2,962 (5.64%)
TXSAN	339 (0.65%)
VAH	<u>473 (0.90%)</u>
TOTAL	5,5438 (7.90%)

NOTES:

1. Data for Air Life, AMR, Independent and on request. Will probably add some 5000 or more to the total
2. Civilian systems see about 88% of transports. Trauma centers 12%
3. Trauma centers. Higher acuity. Mostly admitted
4. Civilian systems lower acuity - lower admission percentage
5. WHMC more penetrating trauma
6. UHS & BAMC more blunt trauma
7. Newer hospitals will pick up more future load
8. WHMC trauma will be assimilated
9. Data reported does not discriminate between trauma and medical emergencies

STRAC Hospitals by Tier

Rev. 06/24/06

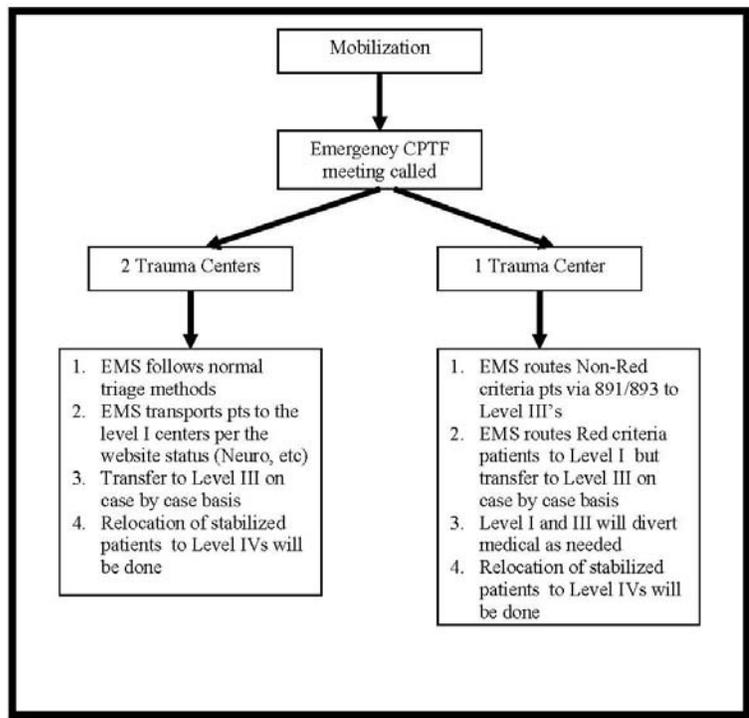
Hospital	Urban or Rural	NDMS	Trauma Level	Tier	Gen/Spec	DSHS License	ER?
Baptist Medical Center	Urban	Yes	4	1	General	Acute	Yes
Brooke Army Medical Center	Urban		1	1	General	n/a	Yes
Christus Santa Rosa Children's Hospital	Urban	Yes	ND	2	General	Acute	Yes
Christus Santa Rosa City Centre	Urban	Yes	3	1	General	Acute	Yes
Christus Santa Rosa Medical Center	Urban	Yes	4	2	General	Acute	Yes
Community General Hospital	Rural		4	3	General	Acute	Yes
Connally Memorial Medical Center	Rural	Yes	4	3	General	Acute	Yes
Dimmit County Memorial Hospital	Rural		4	3	General	Acute	Yes
Frio Regional Hospital	Rural		4	3	General	Acute	Yes
Ft. Duncan Medical Center	Rural		4	3	General	Acute	Yes
Gonzales Healthcare System	Rural		4	3	General	Acute	Yes
Guadalupe Regional Medical Center	Rural	Yes	4	3	General	Acute	Yes
Hill Country Memorial Hospital	Rural		ND	3	General	Acute	Yes
Kerrville VA Medical Center	Rural		ND	3	General	n/a	No
McKenna Memorial Hospital	Rural	Yes	ND	3	General	Acute	Yes
Medina Community Hospital	Rural		4	3	General	Acute	Yes
Methodist Ambulatory Surgery Center	Urban		ND	2	General	Acute	No
Methodist Children's Hospital	Urban	Yes	ND	2	General	Acute	Yes
Methodist Hospital	Urban	Yes	3	1	General	Acute	Yes
Methodist Specialty and Transplant Hospital	Urban	Yes	4	2	General	Acute	Yes
Metropolitan Methodist Hospital	Urban	Yes	4	2	General	Acute	Yes
Nix Health Care System	Urban	Yes	ND	2	General	Acute	Yes
North Central Baptist Hospital	Urban	Yes	4	2	General	Acute	Yes
Northeast Baptist Hospital	Urban	Yes	4	2	General	Acute	Yes
Northeast Methodist Hospital	Urban	Yes	4	2	General	Acute	Yes
Otto Kaiser Memorial Hospital	Rural		ND	3	General	Acute	Yes
Sid Peterson Memorial Hospital	Rural		ND	3	General	Acute	Yes
South Texas Regional Medical Center	Rural		4	3	General	Acute	Yes
South Texas Veterans Health Care Center	Urban		ND	2	General	n/a	Yes
Southeast Baptist Hospital	Urban		4	2	General	Acute	Yes
Southwest General Hospital	Urban	Yes	4	2	General	Acute	Yes
Spine Hospital of South Texas	Urban	Yes	ND	3	General	Acute	No
St. Luke's Baptist Hospital	Urban	Yes	4	2	General	Acute	Yes
Texas Center for Infectious Diseases	Urban	Yes	ND	3	General	Acute	No
TexSAN Heart Hospital	Urban		ND	2	General	Acute	Yes
University Hospital	Urban	Yes	1	1	General	Acute	Yes
Uvalde Memorial Hospital	Rural		4	3	General	Acute	Yes
Val Verde Regional Medical Center	Rural		4	3	General	Acute	Yes
Wilford Hall Medical Center	Urban		1	1	General	n/a	Yes

STRAC Hospitals by Tier
(continued)

Specialty Hospitals							
The Compass Hospital of San Antonio	Urban		ND	3	Spec	Acute	No
Healthsouth RIOSA	Urban	Yes	ND	3	Spec	Acute	No
Innova Hospital San Antonio	Urban		ND	3	Spec	Acute	No
Kerrville State Hospital	Rural		4	3	Spec	Psychiatric	No
Kindred Hospital	Urban	Yes	ND	2	Spec	Acute	No
La Hacienda Treatment Center	Rural		ND	3	Spec	Acute	No
Laurel Ridge Treatment Center	Urban		ND	3	Spec	Psychiatric	No
LifeCare Hospitals of San Antonio (MSTH)	Urban		ND	3	Spec	Acute	No
Mission Vista Behavioral Health Center	Urban		ND	3	Spec	Psychiatric	No
Promise Specialty Hospital (SW General)	Urban		ND	3	Spec	Acute	No
San Antonio State Hospital	Urban	Yes	ND	3	Spec	Psychiatric	No
San Antonio Warm Springs Rehab Hospital	Urban		ND	3	Spec	Acute	No
Select Specialty Hospital of San Antonio (BMC)	Urban		ND	3	Spec	Acute	No
Southwest Mental Health Center	Urban		ND	3	Spec	Psychiatric	No
Texas Specialty Hospital at San Antonio	Urban		ND	3	Spec	Acute	No
Totals							35
General							
Specialty							
NDMS							
Tier 1				6			
Tier 2				16			
Tier 3				32			
Trauma Level I			3				
Trauma Level III			2				
Trauma Level IV			22				
Not Designated - General			13				
Not Designated - Specialty			14				
Urban Facility - All	36						
Rural Facility - All	18						
Urban - General							
Urban - Without ER							
Rural - General							
Rural - Without ER							
*not licensed as a separate facility							



**Trauma Service Area-P (San Antonio and South Texas)
Contingency Planning Task Force (CPTF) for Military
Mobilization
Final – January 21, 2003**





CPTF Operational Guidelines

Mobilization is defined as military medical facilities suffering detriment due to activation for war or other national security issues.

1. The STRAC Executive Committee will declare a "Trauma State of Emergency" and reserves the right to refuse outside of TSA-P transfers. The Public Health Authorities (SAMHD and TDH), Mayor and County Judge will be notified in this declaration.
2. Level I and Level III Trauma Centers may need to implement medical divert, including exclusion from Diversion Override.
3. Code 3 Plus patient triage procedures will not change.
4. The Level III's agree to accept (within capability/capacity) transfers from the Level I's on a case by case basis.
5. Level III's agree that, depending on the flow chart, patients not meeting 1 or more red/ 2 or more blue criteria may be routed directly to Level III centers.
6. MEDCOM requests will continue to be sent to the Level I Trauma Centers, but the patient may be then routed to the Level III centers, at the Level I Trauma Medical Director's discretion, based on Red/Blue criteria.
7. The CPTF agrees that maintaining the Level I trauma center's availability and accessibility is a priority and the Level I trauma medical directors will exclusively handle the transfers to the Level IIIs.
8. STRAC will notify and coordinate with contiguous RACs and also all STRAC agencies/facilities of the Trauma State of Emergency Declaration.
9. Level IV facilities throughout the region agree to accept patients for repatriation on a case by case basis.

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