House
Legislative
Analysis
Section

House Office Building, 9 South
Lansing, Michigan 48909
Phone: 517/373-6466

TRAUMA CARE COMMISSION

House Bill 4596 as enrolled
Public Act 440 of 2000
Sponsor: Rep. Paul N. DeWeese

House Committee: Health Policy
Senate Committee: Health Policy

Third Analysis (12-19-00)

THE APPARENT PROBLEM:

Trauma injuries, which include internal injuries to organs, head and spinal cord injuries, and other serious injuries, can result in death, loss of a limb, or permanent disability if a person does not receive appropriate care within one hour. Trauma injuries most often occur in falls, traffic accidents, and violent assaults such as beatings, shootings, and stabbings, but also result from accidents in the home and workplace. An injury is categorized as a trauma injury if the person has sustained multiple injuries that will lead to death or disability, such as brain damage or loss of a limb, if appropriate medical care is not provided within the first hour of the accident. According to information supplied by the Michigan Trauma Coalition, this type of injury accounts for approximately five to 10 percent of the injuries seen in hospital emergency rooms, but ranks nationally as one of the top three causes of premature death for all ages and is the number one killer of children and young adults in Michigan. In 1990, there were 5,400 injury deaths and over 167,000 trauma injuries statewide.

Besides causing significant human suffering, trauma injuries result in staggering financial costs to society. Escalating medical costs and rehabilitation services are part of the financial impact of trauma injuries, but lost wages and productivity have even a greater impact on society: an average of over $760,000 per fatal injury, of which roughly 90 percent is lost productivity. In Michigan, traumatic injuries are estimated to result in costs of $2.2 billion a year. Yet, a 1996 Michigan Preventable Mortality Study found that up to 18 percent of traumatic injury fatalities were preventable. Death and disability are reduced when injuries are properly assessed and the patient is transported to the "right" hospital to treat his or her injuries. One national study reported that if injured persons were transported to the facilities and medical personnel that they needed within the hour, or golden hour as it is called, after the injury occurred, the mortality and morbidity rate could be decreased by up to 30 percent.

Advocates of a statewide trauma system maintain that a coordinated communication system, accurate identification of the level of care a patient needed, the provision of rapid transport to an appropriate facility, and the availability of integrated support and rehabilitative services designed to return the patient to a productive life would greatly benefit citizens of the state. Indeed, the Michigan Trauma Coalition and the Michigan Department of Public Health, now the Department of Community Health, concluded in a "1994 Vision 2000 Statement" that a Michigan trauma system "could reduce trauma mortality by an estimated 1,350 lives, and could prevent another 15,000 in permanent or long-term disability" for patients with trauma injuries. Yet, Michigan remains one of only seven or eight states that does not have a system in place to coordinate the delivery of trauma services. Since the majority of states already have such a system in place, there are data to support the benefit of coordinated statewide trauma systems. For instance, the state of Oregon recently found that its statewide trauma system has reduced preventable trauma deaths to less than three percent, down from over 25 percent in the early 1980s. In Canada, a recent study found that regionalization of trauma care in the province of Quebec resulted in decreased prehospital time (time from the accident to hospital arrival), decreased preadmission time, and decreased mortality (from 52 percent before regionalization to 18 percent in the third phase of the regionalization). In light of the possible benefits to state citizens, legislation has been introduced to create a commission to study the current status of trauma care delivery in the state and to make recommendations regarding the operational and administrative structure of a statewide trauma care delivery system.

THE CONTENT OF THE BILL:

The bill would amend the Public Health Code to establish the Statewide Trauma Care Commission in the Department of Consumer and Industry Services (DCIS). The commission's duties would include the assessment of trauma care in the state, obtaining information on trauma care systems in other states, gathering public opinion regarding the status of trauma care in Michigan, and filing a report on its findings. The provision would be repealed on July 1, 2004.

Members of the commission, and the position of chairperson, would be appointed by the governor no later than July 1, 2001, and would serve two-year terms. At least three of the 17 seats on the commission would have to be filled by residents of rural counties, one of whom would represent a rural county in the Upper Peninsula. (A "rural county" is defined in the code as a county located outside of a metropolitan area.) Membership would have to include at least eight health professionals with expertise in trauma and emergency services (one of whom would be a registered professional nurse with training in emergency and trauma services), two representatives of hospitals, two representatives of health care purchasers or payers (e.g., insurers, self-insured employers, or Taft-Hartley health and welfare funds), two health care services consumers, one representative from ambulance service providers, one representative from the Department of Community Health, and the chair of the Emergency Medical Services Coordinating Committee. Within 30 days of the seats being filled, the chairperson would have to convene the first meeting of the commission.

The bill would require the commission to hold public hearings throughout the state, including at least one in each of the state's eight health planning areas. By July 1, 2002, the commission would have to file a report with the governor, director of DCIS, and the Emergency Medical Services Coordinating Committee. The report would have to contain recommendations on the following:

• Statewide trauma care delivery and the operational and administrative structure of that delivery.

• Fiscally responsible model policies for a statewide system that includes appropriate classification of trauma care facilities and services, coordinated communication between first responders and trauma care providers, and rapid transport to an appropriate trauma care facility. The costs, benefits, and impacts on public and private third party payers of the recommendations would also have to be evaluated.

• The unique needs and constraints of rural areas.

• The unique needs and constraints of communities located adjacent to the state border with other states (Wisconsin, Indiana, and Ohio). Specific recommendations would have to be made on how to get emergency medical services to such communities quickly, and also on criteria to determine whether a response would be appropriate from Michigan emergency services personnel or from personnel from the bordering state.

The report would be available to the public at no charge. All meetings of the commission would be subject to the Open Meetings Act (MCL 15.261 to 15.275), and writings prepared, owned, used, retained by, or in the possession of the committee would be subject to the Freedom of Information Act (MCL 15.231 to 15.246). The legislature would establish per diem compensation for commission members, and the department would have to provide office space and administrative support, which would include, but not be limited to, clerical and professional staff.

MCL 333.20917

BACKGROUND INFORMATION:

The Michigan Trauma Coalition is a voluntary, non-profit organization that has provided leadership in the planning, organizing, and testing of trauma systems at both the state and regional levels since 1991. During this eight-year period, the coalition has worked with the state Division of Emergency Medical Services to, among many things, identify and organize stakeholders of trauma care and identify sources of funding; research and discuss other states' delivery of trauma care; develop consensus regarding the basic elements of a state coordinated trauma system; secure agreement by stakeholders on key guidelines, criteria, protocols, and definitions of a state trauma system; develop a "Vision 2000" statement that summarized recommendations; fund the establishment of four regional trauma networks throughout the state to test the implementation and operation of draft state trauma system guidelines, criteria, and protocols; compile data regarding the incidence of trauma in Michigan; conduct a Rural Preventable Mortality Study; develop a coordinated statewide injury prevention program; and

advocate, with public and private organizations, the introduction of trauma system legislation.

FISCAL IMPLICATIONS:

The House Fiscal Agency reports that the per diem, office space, and administrative support provisions would increase state costs by roughly $150,000 per year according to information supplied by the Department of Consumer and Industry Services. (12-19-00)

ARGUMENTS:

For:

The bill would create a commission to study and make recommendations regarding the structure and administration of a statewide trauma delivery system. The commission would be required to submit a final report to the legislature and to the state Emergency Medical Services Coordinating Committee, as well as to the governor and director of the Department of Consumer and Industry Services, at which time the commission would be dissolved. The bill's provisions would be repealed on July 1, 2004.

The commission would collect data and make recommendations about a trauma system, such as proposing which tasks would be the responsibility of the state or a state trauma advisory committee, the establishment of regional trauma systems, verification of trauma resources and the designation of trauma facilities, integration of the trauma and Emergency Medical Services system, and funding issues. In addition, the commission would study the unique needs of communities that border other states. Since the majority of states already have statewide trauma service systems, there are successful state plans that can be reviewed and adapted to fit the needs of Michigan residents. Also, much work has already been done by the Michigan Trauma Coalition, a voluntary non-profit organization that has provided leadership in the planning, organizing, and testing of trauma systems at the state and regional levels since 1991.

Research on the national and state level has shown that development of a trauma system is likely to greatly reduce the deaths and seriousness of trauma injuries. Though trauma injuries are a small part of the overall number of injuries sustained across the state each year, the high rates of death and severe disability, such as brain damage and paralysis, result in a tremendous cost to society, both in actual medical and rehabilitative costs and in lost productivity. Indeed, though trauma injuries occur only five to 10 percent of the time, they are the number one cause of death for children and young adults in the state. In addition, many of the injuries can be prevented in the first place through the use of safety equipment such as helmets for cyclists and seatbelts for motorists, and deaths and injuries can be mitigated through prompt and appropriate medical care. The bill is necessary to further prevention policies and the provision of appropriate medical care to those who sustain trauma injuries.

For:

The commission that the bill would establish is a necessary first step in studying the current status of the delivery of trauma services in Michigan. Currently, trauma centers in Michigan are found primarily in urban areas. A trauma center differs somewhat from an emergency room in a hospital in that a trauma center must meet stringent criteria set by the American College of Surgeons, and must be able to handle certain injuries on a 24-hour basis. Many believe that creation of a statewide trauma system could better utilize existing emergency services in the state to ensure that patients received the needed care regardless of where in the state the injuries occurred. For example, a person sustaining a head injury in one area of the state may be transported to a hospital that did not do neurosurgery, even though the patient may need the expertise of a neurosurgeon. The patient would eventually be transported to a hospital that did have a neurosurgeon on staff, but the critical hour to begin appropriate treatment would have passed. In testimony before the House committee, a trauma center nurse reported treating a patient who arrived seven hours after his accident because he had previously been sent to two other hospitals before being transported to the trauma center.

It is precisely issues such as these that make it all the more important to coordinate trauma resources statewide. Where in some areas of the state a person may be transported to a hospital based on the injuries sustained, in other areas a patient is transported to the nearest emergency room. Some areas have an abundance of ambulance services offering a high level of care, where some rural areas may have few ambulances or have ambulances that primarily offer only basic first aid. Rural areas in particular may have unique needs in being prepared to treat trauma injuries, as some counties may not currently have a trauma center. Though an injured person can be transported to a trauma center, doing so may tie up one of the few ambulances available in the area for several hours. Through better planning and coordination of existing emergency services resources, appropriate and timely

medical care can be rendered to individuals who have sustained trauma injuries regardless of the geographic area in which the accident occurred.

Against:

Because the primary task of the commission is to study the state's need for a statewide trauma coordination system and to make recommendations to develop an adequate system, it is imperative that the majority of positions on the commission be filled by people with an expertise in trauma and emergency services. The version reported by the House Health Policy Committee would have done just that. However, subsequent amendments would add a member from the ambulance service providers and from the Department of Community Health. Though certainly a part of the team providing care to a trauma victim, paramedics and emergency medical technicians are restricted in the level of care that they are legally allowed to provide and so generally do not provide the same level of care that trauma centers do. Input by members of ambulance service providers is definitely valuable, but by increasing the commission to 17 members to include a representative from the ambulance service providers, trauma experts no longer have the majority of seats on the commission. If the bill were to be amended further to add representatives from other sectors of the medical community, the ability of the trauma experts to develop an effective strategy for the coordination of trauma services could be eroded still more. It is vital that those with extensive training and knowledge in the area of traumatic injuries have the greater voice in shaping this important service to the citizens of the state.

Analyst: S. Stutzky

#This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.