Legislative Analysis

Mitchell Bean, Director
Phone: (517) 373-8080
http://www.house.mi.gov/hfa

STATEWIDE TRAUMA CARE SYSTEM

House Bill 6102 as enrolled
Public Act 582 of 2004

House Bill 6103 as enrolled
Public Act 581 of 2004

House Bill 6104 as enrolled
Public Act 580 of 2004
Sponsor: Rep. Gary Newell
House Committee: Health Policy
Senate Committee: Health Policy

First Analysis (1-4-05)

BRIEF SUMMARY: Together, the bills would amend the Public Health Code to require the development of a statewide trauma care system, define "statewide trauma care system," and create a statewide trauma care advisory subcommittee.

FISCAL IMPACT: The implementation and operation of a Statewide Trauma Care System, in consultation with a Statewide Trauma Care Advisory Subcommittee, will result in an indeterminate amount of increased costs for the Department of Community Health (DCH). Upon implementation of the statewide trauma care system, the DCH is required to review and identify potential funding mechanisms and sources for the system.

THE APPARENT PROBLEM:

On average, about 5,000 Michiganians die each year from injuries and poisonings. Of these injuries, about five to ten percent represent injuries caused by trauma (e.g., car accidents, falls, drowning, gunshots, fires and burns, stabbings, or physical assaults). Trauma injuries can encompass a broad range of severity and account for five to ten percent of the injuries seen in hospital emergency rooms. Nationally, trauma injury is one of the top three causes of premature death for all ages, and is the number one killer of children and young adults in the state. The financial toll on the state is considerable - the annual medical cost of injuries in the state in 1997-1998 totaled almost $3.6 billion; when work loss and quality of life costs were added in, the figure rose to $54.9 billion. (Information from the Michigan Statewide Trauma Care Commission Report to the Legislature, Nov. 2002.)

It is known that appropriate treatment and stabilization within the first hour of a traumatic injury, known as the "golden hour", can significantly increase a patient's chance of survival and decrease the potential for long-term disability. Therefore, lives could be saved and economic costs associated with loss of productivity could be reduced if the needs of trauma victims were quickly evaluated and each patient sent to the hospital

equipped to provide the medical care needed. In Michigan, however, the now-defunct Statewide Trauma Care Commission identified numerous flaws in the state's delivery of medical care services to trauma victims including long transport times between accident sites and appropriate medical care facilities (all of the state's 14 accredited trauma centers are located in the Southeast portion of the state and none exist north of Flint); the transporting of patients to hospitals that are not equipped to treat their injuries; overcrowded emergency rooms resulting in patients being diverted to other facilities, thus increasing the likelihood that appropriate care would not be delivered within the "golden hour"; a lack of "formal destination protocols" dictating where seriously injured patients were to be transported; and a dire shortage of trained trauma workers. (For more information, see the Background Information section of this analysis.)

Almost all other states address similar problems with a statewide trauma care system. A trauma care system develops and coordinates the delivery of trauma care services within a state's borders. Michigan remains one of only a handful of states that does not currently have a statewide trauma care system. Through the efforts over the past few years of the Michigan Statewide Trauma Commission, the Michigan Trauma Coalition, state agencies, and those involved in the delivery of emergency medical services, the state is now poised to develop and implement a statewide trauma care system. However, legislation is needed to grant authority to do so.

In light of the growing body of research supporting the benefits of statewide trauma care systems, legislation has been offered to address the issues identified by the former Michigan Trauma Commission and the recommendations of the Michigan Trauma Coalition.

THE CONTENT OF THE BILLS:

House Bill 6102 would amend Part 209 of the code entitled “Emergency Medical Service” (MCL 333.20910). Within one year after the Statewide Trauma Care Advisory Subcommittee is established (under provisions of House Bill 6104), the Department of Community Health, in consultation with the subcommittee, would have to develop, implement, and promulgate rules for the implementation and operation of a Statewide Trauma Care System within the Emergency Medical Services System consistent with the "Michigan Trauma Systems Plan" prepared by the Michigan Trauma Coalition, dated November 2003. The implementation and operation of the trauma care system would be subject to approval by the Emergency Medical Service Coordination Committee and the Statewide Trauma Care Advisory Subcommittee. The new rules could not require a hospital to be designated as providing a certain level of trauma care. In addition, the department would have to review and identify potential funding mechanisms and sources for the Statewide Trauma Care System.

House Bill 6103 would amend the code (MCL 333.20908) to define the term “statewide trauma care system” as a comprehensive and integrated arrangement of the emergency services personnel, facilities, equipment, services, communications, medical control

authorities, and organizations necessary to provide trauma care to all patients within a particular geographic region.

House Bill 6104 would add a new section to the code (MCL 333.20917a) to create the Statewide Trauma Care Advisory Subcommittee under the emergency medical services coordination committee. The subcommittee would advise and assist the Department of Community Health on matters concerning the development, implementation, and promulgation of rules for the implementation and continuing operation of a statewide trauma care system.

Ten members would serve three-year terms on the subcommittee and would have to be appointed within 90 days after the bill's effective date; composition of the subcommittee is specified in the bill but would include trauma surgeons, a trauma nurse coordinator, a trauma registrar, an emergency physician, administrative hospital representatives, a life support agency manager, and medical control authority directors. Subcommittee meetings would be subject to the Open Meetings Act.

Before recommendations regarding potential funding mechanisms and sources for the Statewide Trauma Care System could be submitted to the DCH for consideration, the recommendations would first have to receive unanimous support in a vote by all members of the Statewide Trauma Care Advisory Subcommittee

The bills were tie-barred to each other, meaning that none of the bills could take effect unless all were enacted.

BACKGROUND INFORMATION:

Public Act 440 of 2000 (enrolled House Bill 4596 of the 1999-2000 legislative session) established the Michigan Statewide Trauma Care Commission within the Department of Consumer and Industry Services. (DCIS has been renamed the Department of Labor and Economic Growth and, under a 2003 executive order, the Department of Community Health now has oversight of health-related agencies, including the Emergency Medical Services Coordination Committee.) Public Act 440 contained a sunset provision that repealed the act earlier in 2004.

The commission's duties included 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 in November 2002. The executive summary of the report identified many shortcomings in the delivery of trauma care services in the state that included a lack of a comprehensive statewide system to address the delivery of trauma care; delays in treatment due to inclement weather conditions and geographic restrictions (too far between accident sites and appropriate health facilities); patients with trauma injuries being taken to facilities that were not equipped to treat such serious injuries; lack of continuing education and training opportunities for doctors, nurses, and emergency medical services personnel; lack of a statewide system to collect pre-hospital and hospital data needed to evaluate the delivery

of trauma care as well as identify opportunities for improvement; the absence of formal destination protocols that resulted in trauma patients being transferred to hospitals unable to meet those patients' needs, and lack of effective coordination among medical control authorities. In particular, it was observed that there was no legislative authority to design a trauma care system.

In 2003, the Michigan Department of Consumer and Industry Services, Emergency Medical Services received a federal grant with the primary goal of developing a statewide trauma plan. The department contracted with the Michigan Trauma Coalition to convene a Trauma Care Planning Committee and to develop an implementation plan for the establishment of a statewide trauma system. The Michigan Trauma Coalition prepared a document entitled "Michigan Trauma Systems Plan" that was published in November 2003. The plan included 18 recommendations to enable the state to "ensure optimal care of injured patients through the development of a cost-effective and coordinated statewide trauma system."

FISCAL INFORMATION:

The implementation and operation of a Statewide Trauma Care System, in consultation with a Statewide Trauma Care Advisory Subcommittee, will result in an indeterminate amount of increased costs for the Department of Community Health (DCH). Upon implementation of the statewide trauma care system, the DCH is required to review and identify potential funding mechanisms and sources for the system.

Reports from the Michigan Statewide Trauma Care Commission in November of 2002 and Michigan Trauma Coalition, Inc. in November of 2003 indicate that funding will be needed in the following areas: to assist emergency medical services and medical contract authorities with the implementation and maintenance of statewide trauma care system (development of destination protocols, establishment of interfacility transfer agreements, statewide data system to measure effectiveness of trauma care, and regionalization of trauma networks); to assist in communications between hospitals and prehospital elements of a statewide trauma care system; to assist in the classification and designation of hospitals' trauma care capabilities; and to assist in the training and education of health care and emergency medical services in the provision of trauma care services. Additional staff (5.0 full-time equated positions and 2.0 part-time equated positions) will also be required for DCH to support the administration of a Statewide Trauma Care System.

Public Act 349 of 2004 (DCH appropriations act for FY 2004-05) includes $940,600 and 5.0 FTE positions for the Emergency Medical Services (EMS) Program State Staff line item and $1,046,200 for the Emergency Medical Services (EMS) Grants and Services line item. Funding for the first line item supports the EMS Section which is responsible for the licensure of approximately 750 medical first responder and life support agencies and 1,600 life support vehicles. The EMS Section also approves 65 local medical control authorities' pre-hospital care policies, procedures, and protocols prior to implementation. The second line item finances contracts administered by the EMS Section that provide for

continuing education, agency and vehicle inspections, and administration of licensure examinations.

ARGUMENTS:

For:

Research has shown that providing appropriate medical care services to trauma victims within the first hour after the accident significantly increases survival rates and decreases the severity of disabling injuries. This benefits society as a whole by decreasing overall medical costs, reducing the need for state assistance (e.g., Medicaid), and reducing the impact of lost wages and productivity on the state's economy. Currently, Michigan is one of the few states without a statewide trauma care system to coordinate the delivery of emergency services and medical care to such seriously injured persons. The result is that some die unnecessarily while others suffer from long-term disabilities that may have been prevented had appropriate care been received in a timely manner.

Anecdotes abound within Michigan medical communities of accident victims being shuffled from one hospital to another in an attempt to find a facility equipped to deal with the victim's injuries (sometimes for several hours), of patients facing long delays in receiving treatment because an accident happened far from an available ambulance or far from a trauma center, of inclement weather in certain portions of the state (e.g., regions with heavy snowfalls or lake-effect snowfalls) delaying transport times, etc. No one knows for sure how many victims died who could have survived, or how many debilitating injuries could have been lessened, if medical needs had been quickly assessed and the injured party taken immediately to the facility best equipped to treat the injuries, because no such data collection and evaluation system exists. It is difficult to improve a situation when no one knows exactly what the situation is.

The bill package would address this problem by first giving statutory authority to the Department of Community Health and the Statewide Trauma Care Advisory Subcommittee (which would be established by the legislation) to implement and operate a statewide trauma care system within the Emergency Medical Services System. In doing so, the trauma care system would have to incorporate the recommendations outlined in the "Michigan Trauma Systems Plan" prepared by the Michigan Trauma Coalition dated November 2003.

The plan is based an "inclusive" approach, meaning that it encompasses all phases of a trauma victim's care from pre-hospital (emergency services at the scene and during transport), through acute care (hospital), and rehabilitation (nursing home, rehabilitation centers, outpatient care, physical therapy, etc.) It recommends the establishment of data collection systems for an accurate picture of the delivery of emergency services in the state, the establishment of regional trauma networks, implementation of tiered triage protocols, designation of trauma facilities, verification of the trauma care resources of all hospitals in the state, inclusion of trauma injury prevention planning, and the assessment of the training and education needs of trauma care personnel.

It will take time and identification of stable funding sources to develop, implement, and maintain a trauma care system, but the benefits to state residents and visitors will more than make up for the effort and expense of doing so.

Legislative Analyst: Susan Stutzky
Fiscal Analyst: Margaret Alston