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Ohio General Assembly
House of Representatives
Representative Cheryl L. Grossman

TO: Chair Anne Gonzales

Cc: Members of the House Health and Aging Committee

FROM: State Representative Cheryl L. Grossman

DATE: May 3, 2016

RE: Summary of changes and Funding proposals to Sub. HB 261, Trauma Bill

This memo is meant to provide justification for a number of the positive changes outlined in the dash 6 version of Sub. HB 261. Many of these changes are the result of conversations with stakeholders and representatives and represent a true consensus among interested parties.

Admission of patients to level IV trauma centers: This change clarifies that trauma patients will not be admitted or transferred to level IV trauma centers. The American College of Surgeons has only recently defined criteria and begun verifying level IV trauma centers and there are currently no level IV trauma centers in Ohio. Level IV trauma centers will have a different role in the trauma system than other trauma centers; this change allows the state to further define their role in the overall care of trauma patients.

Regional trauma organizations: This provision provides greater clarity to the role of the State Trauma Board in regulating regional trauma organizations, or RTO's. For an RTO to be recognized by the State Trauma Board, the board would need to approve the RTO's fee structure. Hospitals would still have the option to contribute more to an RTO, however this change would ensure that RTO participation is not cost prohibitive. This change also provides more clarity over the role of RTO's in setting regional triage rules. RTO's like the Central Ohio Trauma System (COTS) and the Northern Ohio Trauma System (NOTS) have done excellent work in improving outcomes and lowering mortality rates.

Regional Trauma Organization Participation Requirements: A second RTO-related provision provides greater specificity regarding the relationship between hospitals and RTO's. It is the intent of the State Trauma Board to have trauma centers participate in a regional trauma

organization once that RTO is recognized by the Board. RTO's are formed by trauma centers to set triage guidelines and perform quality improvement activities.

Trauma Regions: This language simply requires the State Trauma Board to establish regions for RTO's to operate within; we want to ensure every county is served by an RTO and has access to quality trauma care. This provision will be especially important for areas that are not currently served by an RTO.

Level III trauma center designation requirements: The role of the State Trauma Board in regulating Level III trauma centers has received a significant amount of attention throughout this process. This language would allow the State Trauma Board to designate a Level III trauma center that fails to obtain ACS verification only for a limited two year period. During that time, the trauma center would need to submit a corrective action plan to the Board and then, at the end of the two year period, reapply for ACS verification. If the hospital failed to obtain verification on the second try, then it could not come back to the Board for a temporary designation. Level III trauma centers perform an important role, especially in rural areas; these facilities sometimes run into staffing challenges that could impact their ACS verification. The goal of this language is to provide these hospitals with a temporary designation so that they may correct any issues while still providing quality trauma care to the regional they serve. The State Trauma Board has discretion regarding the use of this provision.

Grandfathering Provision: This provision ensures that trauma centers already verified by ACS can continue to operate while the State Trauma Board is appointed, staff is hired, and the designation process is fully developed. This will ensure continuity of care while the State Trauma Board is created; hospitals will not be required to seek designation from the board until such time as the board is ready to perform its duties fully.

Provisional designation:

House Bill 261 as introduced removed the current process for provisional designation and instead required the State Trauma Board to create a new process through rule. Provisional designation is granted to hospitals that are seeking verification from the American College of Surgeons. Once verification is granted, provisional status expires and a hospital will be designated by the State Trauma Board. The current process for provisional designation is confusing and cumbersome. This language will ensure that hospitals can continue to apply for provisional status as they establish a new trauma center and that the process for provisional designation will be easy to navigate.

State Trauma Board Appointments: Under prior versions of HB 261, the appointing authority for the State Trauma Board was divided between the Governor, Speaker of the House, and President of the Senate. This is a departure from other regulatory boards, which granted appointing authority to the Governor with the advice and consent of the Senate. In an effort to be consistent with other regulatory boards, HB 261 is being amended to allow the Governor to appoint members of the Board with the advice and consent of the Senate.

Court Costs: This provision creates a funding mechanism for the State Trauma Board by adding a modest assessment on individuals involved in motor vehicle accidents. The schedule for these court costs is as follows: \$10 for a minor accident, \$50 for an accident with an injury, \$100 for an accident with a fatality. In examining crash statistics for Ohio, we estimate that this will generate \$4-\$6 million per fiscal year, which is more than enough to fully fund the State Trauma Board.

Time Critical Diagnosis System of Care: This change encourages the state to pursue comprehensive TCD legislation in the future in lieu of a piecemeal approach. We feel that Ohio's trauma system has developed to the point where HB 261 is a logical next step and that other areas of the TCD system require more discussion among stakeholders. This change ensures we continue to think comprehensively about the establishment of a TCD system that encompasses stroke, STEMI, and trauma in the future.

Time Critical Diagnosis Committee: This provision creates a Time Critical Diagnosis Committee that will meet within 90 days of the first meeting of the State Trauma Board. This committee will be responsible for facilitating a dialogue among stakeholders regarding the establishment of a time critical diagnosis system of care. The committee will develop a comprehensive report within three years of its first meeting and submit that report to the General Assembly.

State Trauma Registry: This language allows the State Trauma Board to share information with other states regarding trauma injuries as well as federal databases such as the American College of Surgeon's trauma data bank. Data sharing between states and nationally already occurs; this simply ensures the Board has statutory authority to continue this practice. Information that would potentially identify a trauma patient or provider is required to be kept confidential. This amendment is largely technical and is meant to ensure that information that would identify a specific trauma patient is kept confidential when shared with other states and/or the National Trauma Data Bank. The 'dash 6' sub-bill allows the State Trauma Board to share information regarding trauma patients and providers so long as the information is kept confidential. This amendment ensures consistency between different sections of the bill and sets the same level of confidentiality and protection for trauma patients and providers.

EMFTS Board membership: This provision modifies a seat on the EMFTS Board currently held by a trauma nurse. Under this language, the seat would be held by an EMT appointed by the Ohio Association of Professional Firefighters. There are continued conversations about EMFTS Board composition, but generally we have no issues with modifying the EMFTS Board to reflect the removal of trauma regulation.

Patient Identifying Information: Similar to language related to the Trauma Registry and the National Trauma Data Bank, this language allows the EMFTS Board to transit information from the EMS Incident Reporting System (EMSIRS) to the National EMS Information System. Information that identifies a specific patient must remain confidential at all times.

EMS Grant Awards: The current EMS Grant program administers grants to EMS and trauma care providers as well as organizations that perform trauma and injury research. There is a six-tier system for awarding grants with the highest priority being given to EMS organizations for training, equipment, and vehicles. At the request of the Ohio Fire Alliance (Ohio Fire Chiefs' Association, Ohio State Firefighters Association, and the Ohio Association of Professional Fire Fighters) we are modifying the prioritization for EMS grants to better reflect the scope of the EMFTS board following the removal of trauma oversight.

Under this amendment, priorities two, three and four will be removed; these priorities provide grants exclusively to trauma providers and trauma-related research. Priority five, which provides grants for research related to emergency medical services, will become the second priority. A new third priority will be added for entities that conduct research related to emergency medical services including trauma. This amendment will ensure that entities currently receiving EMS grants will have the ability to continue to apply while ensuring the EMS grant program better reflects the scope of the EMFTS board's oversight.

We expect the State Trauma Board created under HB 261 to establish a grant program for trauma centers, trauma-related research, and regional trauma organizations. These funds will be more robust than the current EMS grants, and provide for a greater investment in trauma care. It is important that we maximize grant funding for EMS and trauma providers and avoid duplication wherever possible. This change is supporting by the Ohio Chapter of the American College of Surgeons.

Funding:

The latest HB 261 substitute bill included a provision that would assess fees on automobile accidents that would be collected as a 'court cost'. Under this proposal, an individual who was found guilty or pled guilty would pay one of the following based on the circumstances of the accident: \$10 for an accident, \$50 for an accident with an injury, and \$100 for an accident with a fatality. These costs could only be waived if all court costs were waived as a result of a defendant's inability to pay. According to LSC, if we had a 100% collection rate, this would generate just over \$6 million per fiscal year. Even if only two-thirds of individuals paid, that is still \$4 million in revenue, which is well above the needs of the trauma board and LSC's fiscal note estimate. In addition, the Ohio Judicial Conference and other organizations raised some concerns with how this language was written. Under a compromise proposal that is currently being vetted, judges would be given absolute discretion to levy a fee not to exceed \$100 in cases involving an automobile accident. There would be no set fee structure, and this would be treated as a fine, not a court cost.

Finally, the court where the fine is assessed would only be required to remit 50% of funds collected to the state. The other portion of funding would remain with the court to be used at its discretion to offset administrative costs and fund other items. While these changes would affect the overall funding coming to the state, we are confident that it would still generate adequate

funding as identified in LSC's fiscal note. However, if interested parties do not agree on this funding source we are prepared to move forward with other options. A number of states fund their trauma systems through fees on moving/motor vehicle violations or criminal fines. The logic behind this is that users of the trauma system or actions that result in a traumatic injury should be the source of trauma funding. Our proposal is consistent with this approach as it is a fair and responsible way to fund trauma oversight and system development.

Option 1—Modify Current Funding Proposal

- Change structure from a 'court cost' to a fine for an auto accident or collision require only half of moneys collected under this proposal to be transmitted to the treasurer of state
- Adopt recommendations from the Ohio Judicial Conference that would grant a judge the ability to set the fee amount ('not to exceed one-hundred dollars') and to waive all or a portion of this fee if a person is indigent or unable to pay.
- Under this proposal, half of the fines collected would stay with the county and, unless we specify otherwise, treated like any other fine. This would provide the court with funding to cover the administrative cost and would grant judges absolute discretion over when to assess this fine and when to waive it.
- Suggested language for review: *The court in which any person is convicted or pleads guilty to a violation of sections 4511.20 to 4511.34 or 4511.711 to 4511.75 of the Revised Code may impose an additional fine not to exceed one hundred dollars. Half of the revenue generated by fines imposed by each court pursuant to this section shall be transmitted to the treasurer of state for deposit in the general operations fund created under section 3701.83 of the Revised Code for purposes specified in section 3728.30 of the Revised Code. Half of the revenue generated by fines imposed by each court pursuant to this section shall be deposited into a fund or funds specified by the court.*

However, we have also crafted placeholder language as an alternative amendment to HB 261 that would simply state the General Assembly's intent to assess a fee on trauma users and fund the trauma board in either an MBR or next year's operating budget. It is unlikely that another funding source could be identified that would generate revenue at the level indicated in LSC's fiscal note. Therefore we have asked interested parties to revise the potential budget for the state trauma board to reflect this reality.

If fully funded, the trauma board would be able to hire a full staff of 12-14 individuals, including the two positions identified in HB 261 (trauma medical director and trauma board executive director). In addition, the board would have funding to support six medical director and six trauma coordinator positions at regional trauma organizations across the state. Finally, the Trauma Board would have funding to distribute in the form of grants to trauma centers to support staff training, new equipment, and facility upgrades. However if this is too much of a lift then the placeholder language discussed above could be added so that HB 261 can advance and allow

the state to begin assembling the key parts of a trauma system. At a minimum, funding for the two staff positions identified in HB 261 along with 5-6 support staff would be \$750,000. This figure represents the minimum funding needed to staff the board and provide an immediate benefit to the state. As funding increases, the impact of the board will also increase. But even with a modest investment, the state can take a significant step forward in improving outcomes and lower Ohio's mortality rate.

Option 2—Adopt Intent/Placeholder Language in HB 261; Seek Funding in Separate Bill

- Remove all language related to court costs (lines 111-183) and all language related to designation fees on hospitals (lines 1084-1093)
- Add in 'Section 6' at the end of the bill with the following language: *The General Assembly hereby declares that it intends to seek funding pursuant to section 3728.30 of the Revised Code that would levy a fee on users of the trauma system. In developing this funding source, the General Assembly will seek input from trauma experts, other states that fund trauma, and stakeholders. If the board created under section 3728.02 of the Revised Code holds its initial meeting prior to the General Assembly adopting a funding source, then that board may prepare a recommendation for the General Assembly to review.*
- Seek GRF or other funding either in HB 483 (DD MBR) or SB 319 (prescribing MBR); this would largely be start-up funding to get staff hired and cover administrative costs
- Seek permanent funding in FY 18/19 operating budget pursuant to intent language added to HB 261—this would flow to same line item as other funding in MBR (if we are successful)
- The intent language in HB 261 along with the removal of hospitals fees would make it clear that our intent is not to fund this on the backs of trauma centers.