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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE STANDARDS & REGULATORY REFORM
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 895

RELATING TO: Pediatric Trauma Centers

SPONSOR(S): Representative Dawson-White

STATUTE(S) AFFECTED: Sections 395.402 and 395.4025, F.S.

COMPANION BILL(S): SB 872 (I)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE STANDARDS & REGULATORY REFORM
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

The bill makes several changes in the manner in which trauma centers are regulated. It establishes a minimum service capability threshold of 150 cases as the number of pediatric trauma patients a pediatric trauma referral center is capable of treating, as has been done previously for adult trauma patients. The number will serve as a gross planning guideline for determining need within established trauma service areas.

Local or regional trauma agencies are included in the initial phases of the selection process, as well as giving the trauma agencies authority to provide input in the trauma center application review process. The bill requires the Department of Health (department) to give consideration to input received from the trauma agency on the merits of the trauma center application. Language is added regarding a process for renewal of trauma center verification.

The bill requires the department to convene a task force on pediatric trauma. The task force will assist the department in developing a planning document for pediatric trauma services.

The department indicates that the bill has no fiscal impact on state or local government, or the private sector.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Injury is the most common cause of death and disability for the pediatric population. Pediatric trauma centers are institutions which commit the resources, equipment, and personnel to immediate availability for care of children with severe poly-system injury. These centers also maintain an active and effective public education program and serve as the coordinating body for a regional emergency medical services system.

Pediatric trauma is defined as emergency care provided to children age 14 and under, although patients through age 16 are routinely tended to. trauma is the most common killer of children over one year of age. Each year, injuries kill over 20,000 children ages 19 and younger. At least 30,000 more children in this age group are left permanently disabled as a result of brain injury. Estimate indicate that children account for about 30 million of the total U.S. emergency department visits annually--approximately one-third of a reported total of 92 million in 1990.

Pediatric trauma injuries consist of, among others, car wrecks, gun shot wounds, falls from ladders or other high places, and car versus pedestrian and car versus car injuries.

In Florida, trauma services are provided through a system involving the coordinated efforts of the Department of Health (department), local or regional trauma agencies, and state-approved trauma centers.

The department is responsible for developing a state trauma system plan, approving local or regional system plans of the local or regional trauma agencies and approving trauma centers through a state selection process. The process for selecting a state-approved trauma center includes: hospital submission of a letter of intent, preliminary review of the hospital application by the department, selection as a “provisional” state-approved trauma center, in-depth evaluation of trauma patient outcomes for each provisional state-approved center by out-of-state experts, and final approval as a state-approved trauma center. Currently, there are 17 state-approved trauma centers operating in 10 out of 19 possible trauma service areas.

Local and regional trauma agencies are also an integral part of the trauma service system. These agencies are responsible for local trauma services administration, including planning, implementing, and evaluating the trauma service system. Trauma agencies also review the need for additional state-approved trauma centers. As part of their application to the department, hospitals are required to submit written confirmation by the local or regional trauma agency that the verification of the hospital as a state-approved trauma center is consistent with the plan of the local or regional agency. The law does not require the department to consider the trauma agency’s input on the merits of the hospital’s application. The law also does not specify a process for renewing a trauma center verification once a hospital obtains state-approval and maintains compliance with the trauma center standards.

Currently, there are three types of state-approved trauma centers. A level I trauma center is a hospital which meets trauma center and pediatric trauma referral center verification standards as established by rule of the department. The center must also have formal trauma research and education programs, serve as a resource facility to

Level II trauma centers, pediatric trauma referral centers and community hospitals, and ensure an organized system of trauma care. A Level II trauma center is a hospital which meets trauma center verification standards as established by rule of the department, serves as a resource facility to community hospitals, and ensures an organized system of trauma care. A pediatric trauma referral center is a hospital which meets pediatric trauma referral center standards as established by rule of the department.

Current law requires the department to review the trauma service areas prior to the next 7-year verification cycle for developing a system of state-sponsored trauma centers. The law does not speak specifically to pediatric trauma referral centers in this review process.

B. EFFECT OF PROPOSED CHANGES:

The bill establishes a certain a certain level of service capability for pediatric trauma referral centers by prescribing the number and types of patients to be treated at these centers. It establishes 150 cases as a planning guideline, and that an applicant pediatric trauma referral center or verified center is capable of treating 150 pediatric patients annually.

Redundancies are eliminated which require an applicant hospital to obtain verification twice from a local or regional trauma agency, as far as the fact that their intent to become a trauma center is consistent with the local or regional trauma system plan. The authority for trauma agencies to participate in the trauma center application review process should result in a more comprehensive review of the merits of a hospital's application to become a trauma center. Language providing a renewal process for operating trauma centers eliminates the requirement for each facility complete and submit a new application at the end of their 7-year verification.

An operating trauma center is required to submit its renewal 90 days prior to expiration, which will eliminate the opportunity for another facility within the same trauma service area the ability to compete for an allocated position if all positions are filled.

The grandfather clauses which exempt entities from the applicability of certain letters of intent and local plan consistency requirements are modified.

The department is required to convene a task force, including members from Children's Medical Services, representatives from the Agency for Health Care Administration, representatives of health care facilities, emergency medical services providers, and health care practitioners. The department is to draft and submit a planning document for pediatric trauma care and submit it to the chairs of the health care and appropriations committees of each house by December 1, 1998.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

   a. Does the bill create, increase or reduce, either directly or indirectly:

      (1) any authority to make rules or adjudicate disputes?

      No.

      (2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

      No.

      (3) any entitlement to a government service or benefit?

      No.

   b. If an agency or program is eliminated or reduced:

      (1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

      N/A

      (2) what is the cost of such responsibility at the new level/agency?

      N/A

      (3) how is the new agency accountable to the people governed?

      N/A

2. Lower Taxes:

   a. Does the bill increase anyone's taxes?

   No.

   b. Does the bill require or authorize an increase in any fees?

   No.

c. Does the bill reduce total taxes, both rates and revenues?

The bill provides for a credit against the assessment (tax) which will reduce the overall tax collected by the state for deposit into the Public Medical Assistance Trust Fund (PMATF).

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

N/A

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

No.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

No.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 395.402(1) and (2), F.S., and renumbers s. 395.402(3), F.S., to s. 395.402(4), F.S., and adds a new s. 395.402(3), F.S., relating to trauma service agencies and number and location of trauma centers. This section adds a minimum anticipated service capability caseload of 150 pediatric patients with an injury severity score of 9 or greater for each pediatric trauma referral center. Currently, Level I and

Level II trauma centers and center applicants should each be capable of annually treating a minimum of 1,000 and 500 patients, respectively, with an injury severity score of 9 or greater.

This section also clarifies that for the purpose of meeting the new requirement, patients treated at pediatric trauma referral centers must be pediatric trauma patients and must be considered separate and apart from adult patients treated at a Level I or Level II trauma center.

Section 2. Amends s. 395.4025(1), (2), (4), and (6), 1996 Supplement, relating to selection of state-approved trauma centers. This section makes changes to existing law.

First, subsection (1) is amended to allow the local or regional trauma system plans to supersede the guidelines and procedures outlined in the plans and report are in conflict. Currently, the department is required to use the 1990 report except when the report is in conflict with the provision of s. 395.4025, F.S.

Second, paragraph (b) of subsection (2) is amended to clarify that letters of intent to become a state-approved trauma center be filed with both the department and the local or regional trauma agency. Currently, in order to be considered by the department, a hospital that operates within the geographic area of a local or regional trauma agency must certify that its intent to operate as a state-approved trauma center is consistent with the trauma service plan of the local or regional trauma agency. This paragraph is also amended to clarify that the grandfather or exclusionary clause to this requirement applies only to those centers which were centers on January 1, 1992 and have continuously operated since that date.

Third, paragraph (b) of subsection (2(is amended to specifically require the department to instruct applicants on the procedures necessary for obtaining the written confirmation from the local or regional agencies as required by this section.

Fourth, paragraph (c) establishes certain procedures regarding obtaining input from the local or regional trauma agencies. Specifically, a hospital must obtain written communication from an agency as to whether the operation of a new state-approved trauma center is consistent with the local or regional agency plan. The procedures also include time frames for action by the applicant and the agencies. Moreover, the department must deny any application which does not include the required written communications from the agencies.

New language is created to modify the grandfather or exclusionary clause. As previously indicated, applicants for a state-approved trauma center must submit written confirmation by the local or regional trauma agency that the verification of the hospital as a state-approved trauma center is consistent with the plan. Currently, this does not apply to any hospital that was not a provisional or verified trauma center on January 1, 1992.

Language has been added to restrict the department from granting an extension of time for a hospital to meet the requirement of submitting written confirmation by the local or regional trauma agency that the verification of the hospital as a state-approved trauma center is consistent with the plan of the local or regional trauma agency, if such agency exists.

Section 3. Provides language requiring the Department of Health to convene a task force on pediatric trauma, with members to be appointed by the department. Membership is to include representatives of health care facilities, emergency medical services providers, and health care practitioners (all having expertise in pediatric trauma care), representatives from the Department of Health Office of Children's Medical Services, from the Agency for Health Care Administration with special expertise in health planning, hospital regulation, and children's health care. The department is required to draft a planning document for pediatric trauma care and submit it to the chairs of the health care and appropriations committees of each house by December 1, 1998.

Section 4. Provides an effective date of upon becoming law.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

None.

2. Direct Private Sector Benefits:

Minimum caseloads for treating pediatric patients are intended to improve quality of care. To the extend that these thresholds are reached, greater efficiency and cost effectiveness should accrue.

3. Effects on Competition, Private Enterprise and Employment Markets:

Not Determined.

D. FISCAL COMMENTS:

The Department of Health indicates that they will have to bear the costs of participation on the task force on pediatric trauma and production of the required planning document. They also indicate that private sector participants on the task force will have to bear their own costs, which are indeterminate.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE STANDARDS & REGULATORY REFORM:

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