REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Virginia's Trauma Care System and Access to Health Care in the Commonwealth and Its Relationship to Present Developments in the Health Care Industry and Medical Technology

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Interim Report of the Joint Subcommittee Studying Virginia's Trauma Care System and Access to Health Care in the Commonwealth and its Relationship to Present Developments in the Health Care Industry and Medical Technology

To

The Governor and the General Assembly
of Virginia
Richmond, Virginia
January, 1987

To: Honorable Gerald Baliles, Governor of Virginia,
and
The General Assembly of Virginia

I. ORIGIN OF THE STUDY

During the 1986 Regular Session of the General Assembly, two resolutions were introduced calling for studies of various aspects of the health care system. House Joint Resolution No. 65, as introduced, requested a study of access to health care and its relationships to present developments in the health care industry and medical technology. House Joint Resolution No. 97 requested a study of Virginia's trauma care system. House Joint Resolution No. 65 became the vehicle for the consolidation of these two issues into a two-year study.

At the first meeting of the Joint Subcommittee appointed pursuant to HJR 65, Delegates J. Samuel Glasscock and Bernard S. Cohen explained the reasons for the introduction of the original resolutions. Conveying the observations of legislators, Delegate Glasscock pointed out that, although there have been a number of legislative studies related to access to care, none of these studies have been comprehensive in scope or addressed the relationships between access to health care and innovations in medical technology and the substantial changes taking place in the industry as well as the reimbursement systems. Delegate Cohen stated that HJR 97 had been initiated because of his concern about some seriously injured individuals who had not received the critical care which is so important during the first hour following the injury.

House Joint Resolution 65, as approved, established a seven-member committee consisting of three members of the House Committee on Health, Welfare and Institutions and one member of the House Committee on Appropriations and two members of the Senate Committee on Education and Health and one member of the Senate Committee on Finance.

The Joint Subcommittee was charged with studying (i) the needs of Virginia's trauma care system, including, but not limited to, the collection of data on trauma, appropriate triage of patients, evaluation and research on trauma, and the economic impact of trauma; and (ii) access to health care in the Commonwealth and its relationship to present developments in the health care industry and medical technology.

II. BACKGROUND OF THE STUDY

A. Trauma: A Twentieth Century Epidemic

The term "disease" is defined as "any deviation from or interruption of the normal structure or function of any body part, organ, or system that is manifested by a characteristic set of symptoms and signs and whose etiology, pathology, and prognosis may be known or unknown." (Dorland's Pocket Medical Dictionary, Philadelphia, W.B. Saunders Co., 23rd Edition, 1982.)

Trauma is defined as "an injury (as a wound) to living tissue caused by an extrinsic agent." (Webster's New Collegiate Dictionary, Springfield, Massachusetts, G. & C. Merriam Co., 1979.) Although trauma has, undoubtedly, always been a major cause of human death and illness, it was not until the twentieth century and the advent of modern medicine that trauma was categorized as a "disease." The reasons for this change in academic attitudes are related to the remarkable advances in the accuracy of medical diagnosis of and efficacious treatment for conventional diseases as well as the development of effective technological and surgical methods for handling physical injuries. Although medical science has virtually eliminated such diseases as whooping cough, small pox and polio, and antibiotics have decreased the incidence of morbidity and mortality from infection in the United States, the severity and incidence of trauma appear to have increased as the population has grown and the use of high speed vehicular travel has become ubiquitous.

According to the Bureau of Health Statistics in the Virginia Department of Health, 2,185 residents of Virginia died from accidental causes in 1984 and 2,176 residents of Virginia died from accidental causes in 1985. Motor vehicle accidents were responsible for 1,009 of these deaths in 1984 and 999 of these deaths in 1985. Homicides accounted for 461 deaths in Virginia in 1984 and 427 deaths in Virginia in 1985. Suicides accounted for 710 deaths in 1984 and 751 deaths in 1985 Virginia.

Experts differ in their estimates of the number of people who die from trauma in the United States, with the figures ranging from more than 140,000 per year to approximately 165,000 per year. Even if these figures are in reality much smaller, there is no question about the impact of trauma in terms of human suffering, economic loss and social distress. The extent of the problem is clear from the fact that physical trauma is the major cause of death of individuals from age 1 to age 44 in the nation and in Virginia.

In recent years, Virginia has made substantial strides in confronting the problem of trauma. Since 1968, the Board of Health has been vested with the authority to set standards for and to license ambulance services and to certify "emergency medical care attendants" (See House Bill No. 163, Chapter 430, Acts of Assembly, 1968). The legislation which provided this authority also established an "Advisory Committee on Emergency Services." Although the name and membership of this body have changed over the years, it still exists and performs an increasingly important role in the evolution of Virginia's emergency medical services system (See §32-310.2, 1968, c. 430; 1974, c. 446; §32.1-310.2:1, 1978, c. 517; §32.1-114, 1979, c. 711; 1984, c. 778; 1985, c. 448).

In 1974, the General Assembly approved Senate Bill 467, thereby authorizing the Board of Health to develop "a comprehensive, coordinated, emergency medical care system in the Commonwealth." The regional emergency medical services councils and the Virginia Rescue Squads Assistance Act were statutorially created in 1978 (See Chapter 517, Acts of Assembly, 1978). In 1981, the need for developing a statewide air medical evacuation system was recognized and statutorily mandated in Virginia law (see §32.1-112, Chapter 170, Acts of Assembly, 1981).

In 1983, a major step in state financing of the emergency medical services system was initiated through the passage of Senate Bill No. 10, the so-called "One for Life" bill. This bill added $1 to the motor vehicle registration fee, which is dedicated to financing emergency medical and rescue services. The development of a source of state funding for the emergency medical services system in Virginia was particularly fortuitous at this time in view of the major reductions in federal funding which took place in 1981, as a result of the consolidation of the EMS Systems Act funding into the Preventive Health and Health Services block grant.

Because of the requirements of the federal categorical programs prior to 1981, the EMS systems in many states were regionally controlled and there were few states in which statewide standards were implemented. Many states are only beginning to synthesize statewide EMS systems and to develop state standards for the training of personnel and delivery of the services. Statewide standards for training and services were required by Virginia law from 1968 and a statewide system was mandated in 1974. Therefore, Virginia has an eighteen-year history of aggressive state leadership in the development of an EMS system. As can be deduced from the remarkable history of legislative events in this Commonwealth, the evolution of emergency medical services in Virginia has been richly enhanced through the leadership provided by the Department of Health, particularly that of the current director of the Division of Emergency Medical Services.

Although tremendous advances have been made in Virginia's emergency medical services system, this evolution has not been without controversy. Virginia still has, as do many other states, primarily volunteer emergency medical services personnel. The commitment and devotion of these volunteers cannot be exaggerated. Most of the rescue squad volunteers work hard at full-time jobs and then spend countless hours working as emergency medical services personnel, frequently under very stressful conditions. However, remaining current in the healing arts is difficult for professionals, much less for laymen. As medical technology has advanced, the Board of Health and the Division of Emergency Medical Services have revised the regulations for the certification of emergency medical services personnel. Any other action would have been unconscionable, when human life and well-being are at stake.

In some localities, notably rural areas, increasingly stringent certification requirements have been resisted. Local officials and rescue squad volunteers have sometimes objected to the training standards for certification. In 1979, a provision authorizing the Commissioner of Health to grant variances and the Board of Health to grant waivers from the EMS regulations was enacted (see §32.1-154). The applications for

variances and waivers have not been numerous and it appears that, although obtaining additional hours of training may work a hardship on some volunteers, the need for continuing education and state-of-the-art skills is understood by most citizens. The training programs for the volunteer and paid EMS personnel have been continually improved in Virginia, as has the technology in the prehospital treatment of patients. Currently, the Department of Health is investigating the use of alternative methods for training, such as interactive television and computers. The controversy surrounding high standards for certification may disappear with time as volunteer personnel become more knowledgeable, and more convenient systems for providing training are developed.

In addition to these improvements, the Division of Emergency Services within the Department of Health is addressing such issues as improving response times, triage, treatment of multiple injury patients and the different needs of various trauma patients, such as infants, small children, and pregnant women.

Further, the goal of providing a statewide air medevac plan is being realized. Five air evacuation systems are in place in Virginia. The one area with a critical need for an air evacuation system is the southwest since there is no helicopter medevac service west of Roanoke. For much of 1986, the Department was in the process of negotiation for an air evacuation service for the southwestern part of the State. In October, 1986, the Governor announced that these negotiations had been completed and that the State Police will implement air evacuation services for this area by January 1987.

Although there is a generally good communication system between prehospital personnel and hospital personnel, there are gaps in some areas of Virginia because the 911 system has not been implemented statewide.

Presently, there are two 911 systems available- the basic 911 system and the enhanced 911 system. Both systems provide easy access to public safety agencies. In the basic 911 system, each call is directed to a central location, known as a public safety answering point, at which a trained dispatcher routes it to the appropriate response agency, i.e., police, fire or emergency medical services. In addition to these features, the basic 911 system includes free dialing from pay phones, call holding to allow tracing, ring back, forced disconnect, and identification of on-hook or off-hook status of the caller's phone and may include call transfer and conference call capabilities. One problem which has been identified in the basic 911 system is that a basic 911 system in one jurisdiction may receive calls from an adjacent jurisdiction because the boundaries of the telephone service areas and political jurisdictions do not correspond.

The enhanced 911 system, which is the most effective system for expediting rapid dispatch, provides the dispatcher with the address of the caller and prevents the call from being disconnected precipitously. In addition, the enhanced 911 system includes automatic selective routing to the public safety answering point based in the location of the caller. These features enable the dispatcher to control crank calls more effectively and to direct an appropriate response even if the caller is unable to provide clear or accurate information.

Although the 911 systems are effective methods of providing easy access and speedy response, the installation and operation of these systems, particularly the enhanced 911, are expensive. There are ninety-five counties in Virginia. At this time eighteen counties have implemented the basic 911 system and five counties have implemented the enhanced 911 system. One of the counties which has implemented the basic 911 system does not, at present, have county-wide coverage. One county has begun preliminary studies for installation of a 911 system. Twelve counties, several of which have already implemented the basic 911 system, have plans to install the enhanced 911 system and fourteen counties are in the process of installing the enhanced 911 system. Ten counties are studying the feasibility of installing a 911 system and one county may study the feasibility in the future, but this study is not predicted to take place before the 1990's.

Thirteen cities have implemented the basic 911 system and five cities have installed the enhanced 911 system. Nine cities have plans to install the enhanced 911 system and fourteen cities are in the process of installing the enhanced 911 system. Three cities are studying the feasibility of installing a 911 system. One city is collaborating with the county in preliminary studies.

In at least one county in Virginia, the governing body has decided to discontinue the operation of the basic 911 system because of the burden of the costs. A specific barrier to implementation of the basic 911 system in Virginia is that §58.1-3813 of the Code of Virginia allows localities to impose a special tax on consumers for implementation of the enhanced 911. No such tax is authorized for the implementation of the basic 911. At this time, localities are struggling to compensate for withdrawn federal funding and may not have the funds available to deliver even the most basic services. Further, jurisdictions imposing the enhanced 911 tax must reduce the tax after the initial capital, installation and maintenance costs of the system are satisfied to "the level necessary to offset recruiting maintenance costs only."

One of the primary problems facing the emergency medical services system in Virginia is developing a consistent, effective system for triage. Triage, in the context of emergency medical services, means a system for the classification of trauma victims to determine the appropriate treatment facility. The question which is posed is: Given the injuries of the patient, to which facility should he be transported? Experts identify the first hour following the injury as the critical time for administration of definitive care for multiple trauma victims. Dr. R. Adams Cowley, Director of the Maryland Institute for Emergency Medical Services Systems, calls these crucial minutes for appropriate treatment, the "golden hour." For each hour lost in obtaining effective care, the mortality rate among multiple trauma victims is said to double and the level of disability may be much greater than it would be with speedy, appropriate treatment.

The Department of Health, using criteria established by the Committee on Trauma of the American College of Surgeons, is in the process of designating trauma centers according to their staffing, equipment and capabilities. Level I trauma centers have the capabilities for handling the most seriously injured victims. There are currently five Level I trauma centers in Virginia: the Medical College of Virginia, the University of Virginia Medical Center, Fairfax Hospital,

Roanoke Memorial Hospital and Norfolk General Hospital. Level II trauma centers provide intermediate care which is appropriate for most injured victims under most circumstances, and Level III trauma centers care for the less severely injured victims. Although it may appear that the care provided by the Level II and Level III trauma centers is within the scope of most hospitals, it must be understood that all designated trauma centers are required to guarantee twenty-four-hour availability of certain critical services such as immediate surgical intervention, X-ray, laboratory analyses, and blood supply. Most small community hospitals cannot afford the personnel, equipment and commitment that are required to obtain such a designation. Indeed, in this time of changing patterns in the health care industry, it would be economically counter-productive for community hospitals to attempt to deliver the sophisticated care provided by the designated trauma centers.

The implementation of the prospective payment system based on diagnosis related groups by Medicare as well as cost containment controls implemented by the Virginia Medicaid program and health insurers have created disincentives for hospitals to become trauma centers, because the reimbursements for patient care are frequently inadequate to compensate the hospitals for the increased costs incurred for the high technology treatment of multiple trauma victims. Multiple trauma victims require complicated, diverse treatments for injuries to multiple organ systems which were not accommodated in the development of the DRG system. The reason for the insufficiency of the reimbursement for trauma patients under the Medicare prospective payment system is that the reimbursement is on the basis of one DRG, and multiple trauma victims who have injuries to many organ systems do not fit within the organ-based diagnosis related groups.

The problem facing the EMS system in Virginia at this time is how to assure that multiple trauma patients are transported to the most appropriate treatment facility within the shortest possible time. Although the designation of trauma centers has provided a limited resolution to these problems, the lack of statewide data makes it impossible to perform a system-wide evaluation or to design an effective quality assurance program. At this time, the Department is developing a plan for establishing a comprehensive patient care information system and a statewide trauma registry in order to collect and evaluate the information which is critical to the future of the EMS system in Virginia.

B. Access to Care: An Ethical and Economic Dilemma

In the late 1960's, the health care industry in the United States began to experience a spurt of growth which is perhaps unequaled by any other industry. The reasons for this growth were many, but the primary catalysts for the increase in the number of facilities and individual providers were the cost-based reimbursement systems, particularly Medicare and Medicaid. Cost-based reimbursement meant that providers were reimbursed according to what was spent. In other words, no fixed fees were established for specific services and all costs identifiable as related to patient care were factored into the reimbursements. Medicare and Medicaid reimbursement as well as private health insurance reimbursement were historically based on "reasonable costs." However, no definition of "reasonable costs" existed and it quickly became apparent that "reasonable" in the perspective of the complicated health care industry and "reasonable" in terms of finite national and state resources were very different concepts.

From 1966 until the late 1970's, the growth of third party reimbursement systems - Medicare, Medicaid, Blue Cross/Blue Shield and commercial health insurance - was phenomenal. The majority of the population of this country was covered by some kind of third party provider and very few were paying for health care out of their own pockets. Health insurance plans became comprehensive, because of consumer demand and state-mandated coverage of various services. The cost of health insurance grew by leaps and bounds as the cost of health care services increased in most cases to match the maximum allowable reimbursements.

Access to health care came to be viewed as a "right" which included access to all of the latest technology. The reimbursement systems reinforced this philosophy by separating the consumer from an understanding of the actual costs of the care received and by rewarding the health care industry for overutilization of services. National inflation was enhanced in the health care industry by ever-advancing technology and ever-increasing personnel, building and equipment costs. New facilities sprang up without planning for the needs of local or regional communities (an issue commonly referred to as "redundant capitalization"). It seemed that regardless of the location, a new health care facility filled its beds. For most Americans, this heralded a new level of expectancy in the quality and quantity of health care.

For the first time in this country's history, institutional health care was a profitable undertaking. It was in this period that the corporate, investor-owned chains of hospitals and nursing homes began to develop. The majority of health care institutions had been nonprofit corporations prior to Medicare and Medicaid. The for-profit chains are still growing and some experts estimate that they will capture 20% of the market in the 1980's.

In March, 1983, the federal government passed amendments to the Social Security Act relating to Medicare reimbursements, which have been viewed by all constituencies of the health care industry as revolutionary. Medicare costs were becoming overwhelming and a drastic step was taken by the Congress to contain them. The federal amendments established a prospective reimbursement system for hospitals based on "diagnosis related groups" or DRG's. Rates were established for each of 471 DRG's. DRG's might be defined as "best estimates." They are computations of the average cost of treatment for specific illnesses.

Because each DRG has an established "length of stay" and hospitals are reimbursed the same amount for the patient's services based on the patient's DRG regardless of the days in the hospital (with certain exceptions called Outliers), this system provides an incentive for hospitals to contain costs and an incentive to discharge the patient as soon as possible. The advent of the Medicare prospective payment system has initiated much cost containment activity among other third party payors and hospitals, thereby creating strong competitive forces in the health care industry which have initiated the development of new systems of care, such as immediate care centers, and innovative combinations of alternative delivery systems. Many issues related to access to health care are being raised as a result of the implementation of the DRG's, changes in state Medicaid programs and health insurance plans, inflation, changing economic conditions, the use of experimental or costly technology, and fluctuating patterns of unemployment.

The health care industry is going through a metamorphosis and no one is certain what the emerging entity will be like. Hospital admissions have begun to change pattern and some hospitals are beginning to suffer budget problems, especially in inner cities and rural areas. Many hospitals are adjusting to this system by diversifying (buying homes for adults, nursing homes, health spas, etc.) and by offering services such as home health services, mental health services, extensive outpatient services, particularly surgery, and even health maintenance organizations. Some hospitals appear to be specializing in those patients who require only the most profitable services. Hospitals including mental health facilities are engaging in aggressive advertising campaigns for patients. Private hospitals appear to be "dumping" very sick Medicare, Medicaid and indigent patients on public institutions, particularly the state medical schools. (See Section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272 for antidumping provision concerning emergency care and women in labor.)

Quality of care may be affected because of the initiatives to contain costs and maximize profits. For example, the incentive created by the DRG system to discharge patients as soon as possible means that more families are facing the difficult task of providing care to an individual for which they are not trained, such as suctioning of ventilator-dependent patients. Older people who may be ill or overburdened themselves are being placed in the unavoidable position of providing care which requires patience and endurance to sick or disabled elderly spouses or parents.

Nursing home admissions are being profoundly impacted by the changes in the hospital industry as well as the revisions to the reimbursement systems. Nursing home administrators say they are receiving sicker patients from hospitals. The practice of selective admissions policies appears to be widespread in some areas, e.g., accepting private pay patients more quickly and more often than Medicaid patients. Because there is no differential payment for heavy-care patients, nursing homes prefer to admit the more profitable light-care patients. The local government-owned nursing homes allege that they are receiving the heavy care patients that private nursing homes do not want. Often individuals cannot be placed in their home communities and the stress of nursing home placement is compounded by loss of contact with family members and friends.

It is unquestionably true that medical technology advances more quickly than the social and legal systems can respond. Therefore, the grimness of the long term care picture is worsened by the growing number of technology-dependent individuals and increasing populations of infants, children and young adults who are in need of long term care. These individuals do not fit into any neat categories and their needs, which include education, medical and vocational rehabilitation services, are much more diverse than those of the elderly.

Former Vice-President Walter Mondale has been quoted as saying that "A public commitment of $1 billion could buy enough kidney dialysis centers to serve 25,000 persons in the next decade - or it could provide ambulatory care of a general nature for 1.2 million poor people." In other words, the question is: Are investments of enormous sums of money

and resources for the (sometimes marginal) benefit of a few justified when these funds could be used to provide primary care which would improve the health and lives of thousands or millions?

The present ethical and economic dilemmas facing policy-makers in regard to access to health care are so complex and profound that even after very careful study only limited solutions may be discernible. Any analysis of the many issues related to access to health care must address the fact that national and state resources are finite and there are no magic answers to the complex problems related to access to health care.

III. SCOPE OF THE 1986 STUDY

During the 1986 Regular Session, several other studies related to access to health care were requested. The Bureau of Insurance was directed to conduct a study to identify the number of uninsured and underinsured in Virginia through language in the appropriations act (H.B. 30). Also, a Governor's Task Force on Indigent Care was established pursuant to SJR 32. The Department of Medical Assistance Services was delegated the responsibility for staffing this task force. The Department will be utilizing the data produced by the Bureau of Insurance in its study, which is predicted to be a multiyear project requiring substantial field work. Although this Subcommittee will need to evaluate issues other than those related to insurance coverage and indigent care, the work of these two studies will be essential to the evaluation of access to care. Therefore, in order to accomplish as much as possible during the first year of its study, the Joint Subcommittee decided to concentrate its 1986 activities on trauma care and the emergency medical services system.

IV. WORK OF THE JOINT SUBCOMMITTEE

The first meeting of the Joint Subcommittee was held on June 23, 1986. At this time, substantial background information was presented and the schedule for the 1986 study was established. In August, 1986, the Joint Subcommittee toured the Norfolk area EMS system and heard presentations from many individuals working at different levels of the emergency medical services system. During this meeting, several members of the Committee engaged in a round table discussion with people from the Norfolk area EMS system, Northampton-Accomack area EMS system and Franklin area EMS system.

In September, the Committee also received presentations from individuals working in EMS systems in different demographic areas of Virginia. In addition, they considered an analysis of the problems discussed at the previous meetings and examined the progress of the Bureau of Insurance in its study to identify uninsured and underinsured individuals and the Department of Medical Assistance Services in staffing the Governor's Task Force on Indigent Care. In October, a work session was held to discuss various approaches to the issues which had been brought to the Subcommittee's attention. The decisions made during the October meeting incorporated the findings and recommendations of this report.

V. FINDINGS AND RECOMMENDATIONS OF THE JOINT SUBCOMMITTEE

A. Deficiencies in the EMS communications system

Although the Joint Subcommittee believes that the EMS communications system is in general adequate in Virginia, the gaps in this system caused by the lack of statewide implementation of a 911 system are a matter of concern. In at least one instance recently, a locality waited until tragedy struck and two children lost their lives before purchasing the 911 system. The volunteer nature of much of the Commonwealth's EMS system personnel exacerbates the possible effects of inadequate communications, particularly in rural areas. In rural areas, it is frequently difficult to reach emergency personnel on weekends and holidays. Often, the sheriff's office substitutes as the dispatcher during these times and the individuals answering the calls may not be experienced in emergency medical services.

The Joint Subcommittee examined the elements of the basic 911 and enhanced 911 systems and believes the installation of the enhanced 911 system is the best approach. The Committee understands that the costs of installing and maintaining the enhanced 911 system have been estimated to be much greater than those of the basic 911 system. In addition, the Subcommittee is aware of other difficulties with the implementation of the enhanced 911 system in rural areas. Because the enhanced 911 system requires addresses to be in the form of street names and numbers, many rural areas in Virginia which still use rural box route addresses would have to revise their addressing system. Such a revision is time consuming and tedious to effect. However, Virginia's demography is changing and it is no longer true that everyone knows everyone else in rural areas. In many rural localities, locating the site of an emergency can be a serious problem and revision of the addressing systems would be helpful to the law enforcement, fire, and postal systems as well as the emergency medical services system.

The Joint Subcommittee is convinced that the features of the enhanced 911 system provide benefits that will save lives and minimize injuries which are not available in the basic 911 system. As has already been discussed in this report, §58.1-3813 authorizes localities to levy a telephone tax to fund the implementation costs and some of the maintenance cost of the enhanced 911 system. The Joint Subcommittee believes that many localities will be able to afford the implementation of this system if they take advantage of this funding mechanism. Although mandating the implementation of enhanced 911 by a date certain was seriously considered, the Joint Subcommittee did not believe that such a mandate is appropriate at this time because of lack of accurate data on the costs and implementation difficulties. It is the hope of the Joint Subcommittee that statewide implementation of the enhanced 911 system will occur as part of the natural evolution of the Commonwealth's local jurisdictions. However, in the opinion of the Joint Subcommittee, as experience with the enhanced system increases in Virginia and viable cost-benefit data becomes available, the need for mandating the installation of the enhanced 911 system should be reevaluated by the General Assembly. Therefore, at this time, the Joint Subcommittee recommends:

1. That all localities evaluate the benefits of implementation of an enhanced 911 system vis-a-vis the difficulties in installing and costs of such a system and implement the enhanced 911 system as soon as practicable.

B. Rapid transport of patients to the most appropriate facility

The problem of how to assure that patients are transported to the most appropriate hospital in the least amount of time is among the most important problems facing the EMS system in Virginia in the opinion of the Joint Subcommittee. The Joint Subcommittee became aware of the difficulties related to community status, currency of training, professional competency and even the reimbursement systems which affect transportation of patients to the most appropriate facility. This is a many faceted problem related to such factors as preserving the "Golden Hour" through effective triage and prehospital care, the need to evaluate the trauma classification criteria for effectiveness, identification of the factors preventing the transfer of patients to the most appropriate facility, the need to assure that expensive medevac systems are only used when appropriate, the need to improve standards of care and the need to vest responsibility for improper retention or improper transfer of patients.

The Joint Subcommittee understands that one of the basic concepts behind triage and quality control is the collection and analysis of accurate, complete data. Therefore, the Committee believes that statewide data is essential in order to identify and remediate problems in the delivery of effective care in the emergency medical services system. At this time, the Department of Health is developing a comprehensive patient data collection system and a statewide trauma registry. Although there is general statutory support for these activities, there is no specific statutory authorization. For these reasons, the Joint Subcommittee recommends:

2. That a comprehensive EMS patient care data collection and evaluation system and a statewide trauma registry be established in law and the designation of trauma centers and specialty care centers be provided statutory basis.

C. Inadequacies in the reimbursement systems

The issues concerned with rapid transport of patients to the most appropriate facility are also interwoven with the adequacy of the reimbursement systems. As already discussed in this report, the Medicare prospective payment system reimburses hospitals for the treatment of multiple trauma victims on the basis of one injury. Reimbursement on the basis of one injury for multiple trauma victims by Medicare results in the patient incurring large bills because the Medicare payment is insufficient to cover the costs of the sophisticated treatment.

The Health Care Finance Administration has also proposed a reduction in reimbursement for ambulance services provided to Medicare patients. This reduction, at a time when the costs of the services are increasing, the hospital reimbursement for the multiple trauma victim is woefully inadequate and the epidemic proportions of trauma are being recognized, would substantially affect the development of the private, commercial agencies that are crucial to supplement the volunteer

personnel that form the backbone of the EMS system in Virginia. Some hospitals may become reluctant to continue their trauma center status or to increase emergency services because a heavy load of trauma patients will not be profitable.

In addition to the reimbursement, there are other provisions of federal law which have potential for impact of these issues. For example, the Consolidated Omnibus Reconciliation Act of 1985, P.L.99-272, includes a provision requiring hospitals as a condition of the Medicare provider agreement to provide either medical examination and treatment to stabilize an emergency medical condition or woman in active labor or to transfer the individual to another medical facility. This requirement applies to all patients coming to the emergency department of the hospital certified for Medicare reimbursement and not just to Medicare patients. At this time, the effects of this new antidumping provision are not known. Although the Joint Subcommittee agrees with the concept in the federal legislation which is intended to prevent hospitals from refusing treatment to injured patients and women in labor, the Subcommittee is concerned that hospitals may reduce emergency room services or simply develop policies of transferring such patients as soon as they are medically stable to public institutions. Virginia has already experienced difficulties in this area and the wording of the antidumping provision does not appear to be structured to prevent this practice.

The Virginia Medicaid program is focused, as are all Medicaid programs, on providing the best possible care to greatest number of individuals. For this reason, a limitation on hospital stay has been in effect for years. In Virginia, Medicaid pays for twenty-one days of hospital care per admission for individuals over the age of twenty-one. In the case of individuals under the age of twenty-one, Medicaid reimburses in excess of twenty-one days for medically necessary stays. In the case of the multiple trauma victim, twenty-one days is most often an inadequate time to stabilize the patient. When the hospital must treat an individual over twenty-one on an inpatient basis for longer than twenty-one days, Medicaid does not reimburse for the care. This means that hospitals may incur large amounts of uncompensated care for the multiple trauma victim who is a Medicaid recipient. However, the Joint Subcommittee is pleased to note that the Virginia Medicaid program has expanded its coverage of rehabilitation.

Although the federal waivers have allowed the Medicaid program to implement flexible programs such as personal care services for those who are eligible for nursing home placement in order to reduce institutionalization, there is no mechanism in the federal law for providing expanded coverage to multiple trauma victims. Services for multiple trauma victims have not been a priority in the Virginia Medicaid program, primarily because there is little, if any, flexibility allowed by the federal law.

It appears to the Joint Subcommittee that federal authorities do not have an understanding of the extent or severity of trauma as a disease. This lack of sensitivity was demonstrated graphically by the recommendation to reduce the Medicare reimbursement for ambulance services. At the state level, there is a sense of frustration because of the federal perceptions of emergency medical services as solely a state

concern rather than a national crisis. The Joint Subcommittee believes that federal authorities need to evaluate the options for multiple trauma victims with a view towards providing flexibility to state programs. For these reasons, the Joint Subcommittee recommends:

3. That the emergency medical services personnel in Virginia aggressively pursue solutions to these problems in Congress; and

4. That Congress study the impact that lack of flexibility in federal programs and federal law has on state emergency medical services systems; and

5. That the Department of Medical Assistance Services examine its policies vis-a-vis trauma patients to determine if any revisions to the State Plan for Medical Assistance Services can be made to assist the multiple trauma victim.

D. Unmet training and equipment needs

In many areas of the state, volunteer personnel assume the responsible for providing emergency medical services. In others, the volunteer personnel have been supplemented with paid personnel. There is no doubt that some volunteer personnel have experienced feelings of isolation from the paid personnel and that incidences of conflict have occurred between the volunteer and paid personnel in some parts of the state. The reasons for these feelings and conflicts are diverse; however, they appear to be created primarily by the resentment felt among the volunteers when paid agencies are initiated. Some volunteers may feel that the public and local government officials are ungrateful for the long hours and hard work they have contributed without pay to the system and may feel that instituting paid personnel implies that they have not done a good job.

The Joint Subcommittee believes that all of the knowledgeable citizens of Virginia are aware that the volunteer emergency medical services personnel have done a superb job and that the gratitude of public officials and citizens is great and should be expressed. The need to supplement the volunteer personnel with paid personnel appears to be a simple matter of more demand for services than can be physically met through the use of volunteer personnel, all of whom have other major responsibilities such as jobs and families.

In addition, it is sometimes difficult for volunteer personnel to remain current in their skills, whereas paid personnel may not have a choice since remaining state-of-the-art might be part of their job responsibilities. It has been suggested that in those areas with paid personnel, the response times are shorter. Certainly, shorter response times by paid personnel would be logical because the paid agencies are staffed twenty-four hours a day. However, it should be clearly understood that many volunteer agencies are also staffed twenty-four hours a day and that many of the volunteer personnel are highly skilled and dedicated. As medical technology advances in the treatment of trauma and the requirements for certification of emergency medical services personnel increase it will become more difficult for laymen to obtain the training necessary to render these services. At this time, instructors are already scarce in some areas of the state. Further, it has already become difficult for many volunteer personnel to attend the traditional training programs in a classroom setting for the required hours.

The training needs are significant, however, and ways to provide this training must be found. At this time, there is a need to provide more emphasis on the treatment of multiple trauma patients in the training of prehospital personnel. It appears that an emphasis on triage is needed and that training must be instituted to assure that multiple trauma patients are stabilized effectively and transported to the nearest, most appropriate facility. In this regard, benefits might be gained from an examination of the use of the medevac system, particularly in relationship to those who may order this service, under what circumstances this service may be ordered and any gaps that may exist after the implementation of the helicopter service in the Southwest Virginia. Further, not only must effective training be provided to the emergency medical services personnel, but dispatchers, who play a critical role in effective delivery of emergency services, must also be trained.

Among physicians, there are also training problems, in the opinion of the Joint Subcommittee. It has been alleged that not all physicians are trained to diagnose multiple trauma victims accurately and that even so fundamental a condition as a ruptured spleen may go unnoticed. Emergency medicine has only recently been recognized as a medical specialty; therefore, there are not enough physicians available with this specialty to staff every emergency room in the Commonwealth. In those hospitals which contract for emergency room services, the doctors may not have the same sense of commitment and dedication to service in an emergency room as those physicians trained and hired as emergency room physicians.

In the final analysis, the Joint Subcommittee believes that the standards of care for all emergency medical personnel - physicians, hospital and prehospital - should be examined and may need revision.

Some testimony before the Joint Subcommittee indicated a need to establish duty of care standards for physicians and facilities to assure that patients are not retained in facilities lacking the capabilities to handle their injuries and to require the transport of multiple trauma patients to the most appropriate facility. Because of the lack of data and the difficulties in developing legislation on standards of care, the Joint Subcommittee did not reach a consensus on this matter. However, the Committee wishes to emphasize strongly its belief that the implementation of the trauma registry will provide viable data which will reveal problem areas and that the medical community should act immediately to establish protocols to remedy any problems if it wishes to avoid legislative action.

The Joint Subcommittee is keenly aware that all emergency medical personnel, whether paid or volunteer, are subject to intense stress from their contact with tragic and gory circumstances. This stress should be ameliorated through the use of debriefing teams or other counseling designed to provide critical incidents stress relief.

The Rescue Squads Assistance Fund and the one-for-life program appear to be providing sufficient funds for equipment needs at this time. However, there are indications that additional funds may be necessary in the future for staffing as well as equipment if Virginia is to have a comprehensive program. The Joint Subcommittee feels that the

benefits of providing for a statewide, comprehensive program capable of resolving unknown future system needs will be great in terms of human lives and property.

The Joint Subcommittee wishes to request that local governments provide basic services within the limits of their resources and to encourage local officials to be sensitive to the needs of the emergency medical services system and to supplement the volunteer personnel, if necessary.

In order to facilitate remediation of its findings related to training, the Joint Subcommittee recommends:

6. That the Department of Health develop alternative training methods utilizing communications technology such as interactive television, teleconferencing, and computer instruction and that units on critical incidents stress relief be included in such training where appropriate; and

7. That the Department of Health utilize the data from the trauma registry and the patient data collection system to identify gaps in training and deficiencies in medical standards of care and to remedy these problems where possible.

E. Public education on trauma prevention

Many experts testified before the Joint Subcommittee to the effect that the public needs to realize the extent of trauma as a disease and to become informed on trauma prevention. All such experts mentioned the involvement of substance abuse, particularly alcohol, in motor vehicle accidents and other traumas and recommended restraining methods of modifying public behavior such as drunk driving laws and mandatory safety belt legislation. Several experts stated that alcohol and drugs are, in their opinions, involved in a much higher percentage of motor vehicle accidents than the national figures would indicate. A number of these individuals spoke of the use of weapons as causes of trauma and emphasized the need to caution the public about the use of guns and knives.

The Joint Subcommittee was particularly impressed by the testimony on the effectiveness of the use of safety belts. During the course of this study, the Joint Subcommittee has come to understand the profound impact of trauma as a disease. The experience gained by the Subcommittee in reviewing the emergency medical services system in Virginia has convinced the members that requiring the use of safety belts in automobiles would substantially reduce the number of deaths and the extent of serious injuries in automobile accidents. Therefore, the Joint Subcommittee strongly supports the approval of a mandatory safety belt law by the General Assembly of Virginia.

In order to facilitate public education on trauma prevention, the Joint Subcommittee recommends:

8. That the Department of Health intensify its attention to trauma as a disease and prevention of trauma in its health education programs with particular focus on encouraging the use of safety belts in automobiles and avoiding drinking and driving and on exercising caution in the storage and use of fire arms and other weapons.

VI. CONCLUSION

The Joint Subcommittee has made a number of recommendations and findings in this report which are intended to encourage or stimulate various activities. Although the members understand that recommendations of this kind do not carry any mandate, they believe that such recommendations are taken seriously by the agencies or other entities to whom they are directed. It is the hope of the Joint Subcommittee that no other actions will be required to initiate these recommendations. However, since this is a two-year study, the Joint Subcommittee intends to monitor the development of activities related to these recommendations in the coming year as its study of access to care and its relationship to the reimbursement systems and medical technology progresses.

The Joint Subcommittee wishes to express its thanks to the many individuals who assisted with this study, particularly Ms. Susan McHenry and Ms. Mary Camp of the Department of Health.

Respectfully submitted,

J. Samuel Glasscock, Chairman
William E. Fears, Vice-Chairman
Daniel W. Bird, Jr.
Bernard S. Cohen
Jean W. Cunningham
George J. Heilig, Jr.
Edward M. Holland

A P P E N D I C E S

APPENDIX A - ENABLING RESOLUTION

GENERAL ASSEMBLY OF VIRGINIA -- 1986 SESSION

HOUSE JOINT RESOLUTION NO. 65

Establishing a joint subcommittee to study Virginia's trauma care system and access to health care in the Commonwealth and its relationship to present developments in the health care industry and medical technology.

Agreed to by the House of Delegates, March 4, 1986
Agreed to by the Senate, February 28, 1986

WHEREAS, traumatic injuries are the leading cause of death for persons under forty-four and the third leading cause of death overall; and

WHEREAS, each year, one person in three suffers a nonfatal injury requiring medical treatment and, nationwide, more than 80,000 people suffer permanently disabling injuries of the brain or spinal cord; and

WHEREAS, the National Research Council reports that injuries constitute one of our most expensive health problems, costing $75 to $100 billion a year, directly and indirectly; and

WHEREAS, cases have been reported of trauma patients being retained inappropriately in community hospitals where facilities and personnel were not available to provide the necessary level of care, though recent data indicates that the time between a severe injury and definitive treatment in a trauma center is the critical determinant in survivability and degree of disability; and

WHEREAS, although the Emergency Medical Services Program in Virginia has designated trauma centers, promoted and coordinated air medical evacuation resources, improved training programs for emergency medical personnel and hospital personnel, and initiated the development of a statewide Trauma Registry, there are currently no assurances that the critically injured are arriving at appropriate medical facilities within the critical time period; and

WHEREAS, medical expertise and technology have provided society with such miracles as organ transplants and lithotripsy, which is the nonsurgical removal of kidney stones, and this same expertise has saved the lives of thousands of trauma and disease victims; and

WHEREAS, there are growing numbers of chronically ill individuals who are expecting the Commonwealth to respond to their needs, the expense of highly technical medical procedures and the scarcity of costly equipment rendering it impossible for many citizens to avail themselves of its benefits; and

WHEREAS, federal and state governmental efforts to contain the escalating costs of health care have affected access to health care and revolutionized the health care industry; and

WHEREAS, although issues related to the cost of indigent health care and access to long-term care continue to be of great concern to policy-makers, there has been no address of the many difficult ethical and policy issues related to access to health care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the House Committees on Health, Welfare and Institutions, on Corporations, Insurance and Banking and on Appropriations and the Senate Committees on Education and Health and on Finance are requested to establish a joint subcommittee to study (i) the needs of Virginia's trauma care system, including, but not limited to, the collection of data on trauma, appropriate triage of patients, evaluation and research on trauma, and the economic impact of trauma; and (ii)access to health care in the Commonwealth and its relationship to present developments in the health care industry and medical technology. The joint subcommittee is requested to consider the issues of quality care rationing of health care, preventive health care services for the indigent, setting limitations on the access to experimental medical procedures and ethical issues raised by modern medical technology relative to the responsibility of the medical profession and society's obligation to protect the health and safety of its members.

The joint subcommittee shall be composed of seven members as follows: two members of the House Committee on Health, Welfare and Institutions, one member of the House Committee on Corporations, Insurance and Banking, and one member of the House Committee on Appropriations to be appointed by the Speaker, and two members of the Senate Committee on Education and Health and one member of the Senate Committee on Finance to be appointed by the Senate Committee on Privileges and Elections.

The joint subcommittee shall complete its work prior to November 15, 1987.

The direct and indirect costs of this study are estimated to be $33,965.

1987 SESSION

HOUSE JOINT RESOLUTION NO. 332

Offered January 27, 1987

Requesting local governments to implement the enhanced 911 system as soon as feasible.

Patrons—Cohen, Glasscock, Heilig, Crouch and Agee

Referred to the Committee on Corporations, Insurance and Banking

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WHEREAS, although there is a generally good communication system between prehospital and hospital emergency medical services personnel in Virginia, there are gaps in this system because 911 has not been implemented statewide; and

WHEREAS, presently there are two 911 systems available - the basic 911 system and the enhanced 911 system; and

WHEREAS, both systems provide easy access to public safety agencies through directing calls to a central location at which trained dispatchers route such calls to appropriate response agencies; and

WHEREAS, one problem which has been identified in the basic 911 system is that a basic 911 system in one jurisdiction may receive calls from an adjacent jurisdiction because the boundaries of the telephone service areas and political jurisdictions do not correspond; and

WHEREAS, the enhanced 911 system, which is the most effective system for expediting rapid dispatch, has many benefits such as providing the dispatcher with the address of the caller and preventing the call from being disconnected precipitously; and

WHEREAS, enhanced 911 systems require the addresses in the jurisdiction to be listed according to street numbers and names; and

WHEREAS, many rural jurisdictions in Virginia still use rural box numbers for addresses, often rendering it difficult for emergency services personnel to identify the location of the caller; and

WHEREAS, out of the ninety-five counties in Virginia, only eighteen have implemented the basic 911 system and five have implemented the enhanced 911 system; and

WHEREAS, the Joint Subcommittee Studying Trauma and Access to Care has become convinced that the implementation of a statewide 911 system, particularly the enhanced 911 system, is a crucial element in the evolution of a quality emergency medical services system; and

WHEREAS, the Joint Subcommittee realizes that such systems, especially the enhanced 911 systems, are expensive and that many local governments must budget their resources carefully in order to provide essential services; and

WHEREAS, tragedies have occurred in this Commonwealth because the emergency personnel could not identify the location of the callers; and

WHEREAS, the Joint Subcommittee feels strongly that any such future tragedies must be averted; and

WHEREAS, many local officials may not be aware that § 58.1-3813 of the Code of Virginia allows localities to impose a special tax on consumers for implementation of an enhanced 911 system; and

WHEREAS, in the opinion of the Joint Subcommittee, the benefits, in terms of saving lives and property, of implementing the 911 systems can be profound; and

WHEREAS, the Joint Subcommittee believes that the 911 systems will be implemented statewide on a voluntary basis and that mandating such systems should only be considered if local governments do not take the initiative to improve their emergency communications through implementation of 911; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That local governments are hereby requested to implement the enhanced 911 system as soon as feasible. In this regard, local governments are requested to (i) ascertain the benefits of revising their addressing system if they are still using rural box route numbers, (ii) assess the available

1 resources for implementation of 911, (iii) conduct a cost/benefit analysis of having a 911
2 system, and (iv) examine the feasibility of utilizing the tax authorized by § 58.1-3813 to
3 implement the enhanced 911 system; and, be it
4 RESOLVED FURTHER, That, in any case in which a local government concludes that
5 implementation of the enhanced 911 is impossible, such local government is requested to
6 study the feasiblity of implementing the basic 911 system; and, be it
7 RESOLVED FINALLY, That although the Joint Subcommittee is reluctant to recommend
8 mandating implementation of 911 through law, the members feel strongly that if voluntary
9 implementation and the financial incentive of § 58.1-3813 do not stimulate the establishment
10 of 911 systems, then the General Assembly should consider other methods of ensuring that
11 all citizens of the Commonwealth have this important service available.
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Official Use By Clerks

Agreed to By The House of Delegates		Agreed to By The Senate	
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Date: ____________________ Date: ____________________

Clerk of the House of Delegates — Clerk of the Senate

HOUSE JOINT RESOLUTION NO. 331

Offered January 27, 1987

Requesting the Department of Medical Assistance Services to evaluate Title XIX of the Social Security Act and the Virginia State Plan for Medical Assistance Services with respect to care for multiple trauma victims.

Patrons--Cohen, Glasscock and Heilig

Referred to the Committee on Health, Welfare and Institutions

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WHEREAS, Medicaid is a program intended to provide the broadest range of services to the greatest number of those in need within limited resources; and

WHEREAS, the Virginia Medicaid program is considered to be a model of efficient and effective planning for medical assistance services by many experts in this country; and

WHEREAS, the Department of Medical Assistance Services has demonstrated its willingness to initiate innovative programs for the delivery of services to Medicaid recipients through the implementation of the personal care services program and its application for federal waivers; and

WHEREAS, the needs of multiple trauma victims are profound and include high technology treatment in an acute care setting as well as rehabilitation; and

WHEREAS, Virginia Medicaid pays for twenty-one days of acute care per admission for individuals over the age of twenty-one; and

WHEREAS, this limitation is a prudent method of allocating scarce resources; however, multiple trauma patients frequently require more than twenty-one days of hospital care; and

WHEREAS, multiple trauma patients do not fall within any of the discrete groups traditionally served by Medicaid because they are individuals of every age, and each individual's needs are different according to the nature and extent of their injuries; and

WHEREAS, the Joint Subcommittee studying trauma has come to believe that the impact of trauma as a disease is not well understood by many federal and state officials; and

WHEREAS, trauma is a modern day epidemic to which every citizen is potentially susceptible; and

WHEREAS, although the federal law does not appear to provide any measure of flexibility for state Medicaid programs in relation to covered services for multiple trauma patients, it is possible that some options have been overlooked which may not be costly or far reaching; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services is hereby requested to evaluate Title XIX of the Social Security Act as amended and the Virginia State Plan for Medical Assistance Services with respect to care for multiple trauma victims. In evaluating these provisions, the Department is further requested to ascertain whether there are any services or reimbursements which could be revised to provide more adequate services to multiple trauma patients.

1 **HOUSE JOINT RESOLUTION NO. 337**
2 Offered January 27, 1987
3 *Memorializing Congress to evaluate the provisions of Title XVIII, known as Medicare, and*
4 *Title XIX, known as Medicaid, of the Social Security Act as these laws relate to care*
5 *for multiple trauma victims.*
6 ———
7 Patrons–Cohen, Glasscock and Heilig
8 ———
9 Referred to the Committee on Health, Welfare and Institutions
10 ———
11 WHEREAS, trauma is the leading cause of death for individuals from age 1 to age 44
12 in the nation and in Virginia; and
13 WHEREAS, as the result of injuries received from accidents or other traumas,
14 thousands of people in the United States are killed or disabled every year; and
15 WHEREAS, frequently, multiple trauma victims become incapable of leading normal
16 lives and other family members must assume the burden of their support; and
17 WHEREAS, emergency medical technology is an evolving specialty with the goal of
18 developing procedures to minimize the effects of severe trauma; and
19 WHEREAS, the Medicare prospective payment system which was implemented in
20 October, 1983, is based on diagnosis-related groups; and
21 WHEREAS, reimbursement under the DRG system is provided for only one DRG with
22 payment keyed to medical procedures and treatments for conditions involving one organ;
23 and
24 WHEREAS, multiple trauma victims require sophisticated, high technology care for
25 injuries to various organs which cannot be adequately reimbursed under a system restricted
26 to payment based on a single procedure; and
27 WHEREAS, although the federal Medicaid provisions authorize state Medicaid programs
28 to implement optional coverage for certain classes of individuals, such as personal care
29 services for the aged and disabled and model waivers for technology-dependent patients,
30 there is no flexibility provided for the care of multiple trauma patients; and
31 WHEREAS, many experts in emergency medical services are greatly frustrated by
32 federal insensitivity to the needs of multiple trauma victims; now, therefore, be it
33 RESOLVED by the House of Delegates, the Senate concurring, That the General
34 Assembly of Virginia, by this resolution, memorializes the Congress of the United States to
35 evaluate the provisions of Title XVIII, known as Medicare, and Title XIX, known as
36 Medicaid, of the Social Security Act as these laws relate to care for multiple trauma
37 victims; and, be it
38 RESOLVED FURTHER, That the Clerk of the House of Delegates transmit copies of
39 this resolution to the members of the Virginia delegation to the Congress, to the Speaker of
40 the United States House of Representatives and the President of the United States Senate
41 in order that they may be apprised of the sense of the General Assembly.
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Official Use By Clerks

Agreed to By The House of Delegates		**Agreed to By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
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Clerk of the House of Delegates Clerk of the Senate

1987 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 480

An Act to amend and reenact §§ 32.1-112 through 32.1-114 and §§ 32.1-148, 32.1-149 and 32.1-153 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 4 of Title 32.1 an article numbered 3.1, consisting of sections numbered 32.1-116.1 and 32.1-116.2, relating to the statewide emergency medical care system and an emergency medical services patient care information system.

[H 1633]

Approved MAR 26 1987

Be it enacted by the General Assembly of Virginia:
1. That §§ 32.1-112 through 32.1-114 and §§ 32.1-148, 32.1-149 and 32.1-153 are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 4 of Title 32.1 an article numbered 3.1, consisting of sections numbered 32.1-116.1 and 32.1-116.2, as follows:

§ 32.1-112. Statewide emergency medical care system.–A. The Board *of Health* shall have the authority and responsibility to develop a comprehensive, coördinated, emergency medical care system in the Commonwealth and to prepare a Statewide Emergency Medical Services Plan, which shall incorporate , but not be limited to , the plans prepared by the regional emergency medical services councils. The Board shall review such plan ~~annually~~ *triennially* and make such revisions as may be necessary ~~or desirable~~ . The objectives of such plan *and the system* shall include, but not be limited to, the following:

1. To establish a comprehensive statewide emergency medical care system which will incorporate facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability and mortality;

2. To reduce the time period between the identification of an acutely ill or injured patient and the definitive treatment and to increase the accessibility of high quality emergency medical services to all citizens of Virginia;

3. To promote continuing improvement in system components including ground, water and air transportation, communications, hospital emergency departments and other emergency medical care facilities, consumer health information and education, and health manpower and manpower training;

4. To improve the quality of emergency medical care delivered on site, in transit, in hospital emergency departments and within the hospital environment;

5. To work with medical societies, hospitals, and other public and private agencies to develop approaches whereby the many persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be served more appropriately and economically;

6. To conduct, promote and encourage programs of education and training designed to upgrade the knowledge and skills of health manpower involved in emergency medical services;

7. To provide review and consultation for agencies and organizations that wish to make application to governmental or other sources for grants or other funding to support emergency medical services programs; ~~and~~

8. To establish a statewide air medical evacuation system which shall be developed by the Department of Health in coordination with the Department of State Police and other appropriate state agencies ~~.~~ *;*

9. To establish and maintain a process for designation of appropriate hospitals as trauma centers and specialty care centers based on an applicable national evaluation system; and

10. To establish a comprehensive emergency medical services patient care data collection and evaluation system pursuant to Article 3.1 of this chapter.

B. ~~No voluntary emergency medical service organization shall be required to participate in the comprehensive, statewide emergency medical care planning system provided for in this article.~~

C. Whenever any state-owned aircraft, vehicle, or other form of conveyance is utilized under the provisions of this section, an appropriate charge not to exceed the actual costs of operation may be charged by the agency having administrative control of such aircraft, vehicle or other form of conveyance.

§ 32.1-113. Regional emergency medical services councils.–A. The Board shall designate

regional emergency medical services ~~units~~ *councils* which shall be ~~existing boards,~~ ~~mmissions, agencies or nonprofit organizations~~ authorized to receive and disburse public ds. Each ~~unit~~ *council* shall ~~function under the policy direction of a regional emergency~~ ~~dical services council and shall~~ be charged with the development and implementation of an efficient and effective regional emergency medical services delivery system.

B. Each regional emergency medical services council shall include, if available, representatives of each participating local government, fire protection agencies, law-enforcement agencies, emergency medical service agencies, hospitals, licensed practicing physicians, emergency care nurses, mental health professionals, emergency medical technicians and other appropriate allied health professionals.

C. Each regional emergency medical services council shall adopt and ~~thereafter~~ revise as necessary ~~and desirable~~ a regional emergency medical services plan in cooperation with ~~its unit and~~ the Board ~~and shall review all applications for federal and state funds by its respective regional emergency medical services unit before such applications are submitted~~ .

D. ~~Each regional emergency medical services unit shall submit to the State Emergency Medical Services Advisory Board all applications for federal and state funds.~~

§ 32.1-114. State Emergency Medical Services Advisory Board.–A. ~~The State Emergency Medical Services Advisory Council is continued and shall hereafter be known as the State Emergency Medical Services Advisory Board.~~ The *State* Emergency Medical Services Advisory Board shall be composed of not more than thirty-seven members. The membership of the Advisory Board shall include representatives from the following groups who shall be appointed by the Governor: Virginia Municipal League, Virginia Association of Counties, Medical Society of Virginia, Old Dominion Medical Society, American College of Emergency Physicians, American College of Surgeons, Neuro-Psychiatric Society of Virginia, Virginia Nurses' Association, Virginia Pharmaceutical Association, Emergency ~~Department~~ Nurses Association, Virginia affiliate of the American Heart Association, University of Virginia Medical School, Virginia Commonwealth University-Medical College of Virginia, Eastern Virginia Medical School, Virginia Hospital Association, American Red Cross, Virginia Association of Volunteer Rescue Squads, Inc., Virginia State Fireman's Association, nmercial emergency medical services, governmental emergency medical services, The sociated Public Safety Communications Officers, State Department of Emergency Services, Department of Motor Vehicles, the Virginia Statewide Health Coordinating Council, three consumers and each regional emergency medical services council. Appointments may be made from lists of nominees submitted by such organizations and groups, where applicable. Each regional emergency medical services advisory council shall submit three nominations, at least one of which shall be a representative of providers of prehospital care.

B. Of the members first appointed to the Emergency Medical Services Advisory Board, ten members shall be appointed for a term of one year and the remaining members for a term of two years. Thereafter, appointments shall be made for terms of two years or the unexpired portions thereof in a manner to preserve insofar as possible the representation of the specified groups. No member may serve more than three successive terms. The chairman shall be elected from the membership of the Emergency Medical Services Advisory Board for a term of one year and shall be eligible for reelection. The Advisory Board shall meet at least four times annually at the call of the chairman or the Commissioner.

C. The Emergency Medical Services Advisory Board shall:

1. Advise the State of Board of Health in the administration of this article and Article 5 (§ 32.1-148 et seq.) of Chapter 5 of this title; *and*

2. Review and make recommendations on the Statewide Emergency Medical Services Plan and any revisions thereto ~~;~~ ~~and~~ .

3. ~~Review and comment on all applications for federal and state funds made by regional emergency medical services units.~~

Article 3.1.

Emergency Medical Services Patient Care Information System.

§ 32.1-116.1.–Prehospital patient care reporting procedure; trauma registry; confidentiality.–A. In order to collect data on the incidence, severity and cause of trauma, egrate the information available from other state agencies on trauma and improve the ivery of prehospital and hospital emergency medical services, there is hereby established e Emergency Medical Services Patient Care Information System. The Emergency Medical Services Patient Care Information System shall include the prehospital patient care reporting procedure and the trauma registry.

All licensed emergency medical services agencies shall participate in the prehospital

patient care reporting procedure by making available to the Commissioner or his designees the minimum data set on forms prescribed by the Board or locally developed forms which contain equivalent information. The minimum data set shall include, but not be limited type of medical emergency or nature of the call, the response time, the treatm provided and other items as prescribed by the Board.

The Commissioner may delegate the responsibility for collection of this data to the Regional Emergency Medical Services Councils, Department of Health personnel or individuals under contract to the Department. The Advisory Board shall assist in the design, implementation, subsequent revisions and analyses of the data of the prehospital patient care reporting procedures.

B. All licensed hospitals which render emergency medical services shall participate in the trauma registry by making available to the Commissioner or his designees abstracts of the records of all patients admitted to the institutions' trauma and general surgery services with a diagnosis related to trauma. The abstracts shall be submitted on forms provided by the Department and shall include the minimum data set prescribed by the Board.

The Commissioner shall seek the advice and assistance of the Advisory Board and the Committee on Trauma of the Virginia Chapter of the American College of Surgeons in the design, implementation, subsequent revisions and analyses of the trauma registry.

§ 32.1-116.2. Confidential nature of information supplied; publication; liability protections.—A. The Commissioner and all other persons to whom data is submitted shall keep patient information confidential. Mechanisms for protecting patient data shall be developed and continually evaluated to ascertain their effectiveness. No publication of information, research or medical data shall be made which identifies the patients by names or addresses. However, the Commissioner or his designees may utilize institutional data in order to improve the quality of and appropriate access to emergency medical services.

B. No individual, licensed emergency medical services agency, hospital, Regional Emergency Medical Services Council or organization advising the Commissioner shall be liable for any civil damages resulting from any act or omission performed as required by this article unless such act or omission was the result of gross negligence or will misconduct.

§ 32.1-148. Definitions.—As used in this article:

" Advisory Board" means the State Emergency Medical Services Advisory Board.

~~1.~~ "Agency" means any person engaged in the business, service or regular activity, whether or not for profit, of transporting persons who are sick, injured, wounded or otherwise incapacitated or helpless or of rendering immediate medical care to such persons.

"Emergency medical services personnel" means persons responsible for the direct provision of emergency medical services in a given medical emergency including any or all persons who could be described as an attendant, attendant-in-charge, or operator.

~~2.~~ "Emergency medical service vehicle" means any privately or publicly owned vehicle, vessel or aircraft that is specially designed, constructed, or modified and equipped and is intended to be used for and is maintained or operated to provide immediate medical care to or to transport persons who are sick, injured, wounded or otherwise incapacitated or helpless.

§ 32.1-149. Exemptions from operation of article.—The following are exempted from the provisions of this article:

1. Emergency medical service ~~vehicles~~ *agencies* based outside this Commonwealth, except that any such ~~vehicle~~ *agency* receiving a person who is sick, injured, wounded, incapacitated or helpless within this Commonwealth for transportation to a location within this Commonwealth shall comply with the provisions of this article;

2. Emergency medical service ~~vehicles owned and~~ *agencies* operated by the United States government.

§ 32.1-153. Certification of emergency medical services personnel.—A. The Board shall prescribe by regulation the qualifications required for certification of emergency medical care attendants.

B. Each person desiring certification as ~~an~~ emergency medical ~~care attendant~~ *servic personnel* shall apply to the Commissioner upon a form prescribed by the Board. Up receipt of such application the Commissioner shall cause the applicant to be examined a if the Commissioner determines that the applicant meets the requirements of such regulations, the Commissioner shall issue a certificate to the applicant. An emergency medical ~~care attendant~~ *services personnel* certificate so issued shall be valid for a period

~~not to exceed two years and~~ *prescribed by the Board. The certificates* may be renewed after successful reexamination of the holder. Any certificate so issued may be suspended at any time ~~it is determined~~ that *the Commissioner determines that* the holder no longer meets the qualifications prescribed for such ~~attendants~~ *emergency medical services personnel* .

C. The Commissioner may issue a temporary certificate with or without examination when the Commissioner finds that such will be in the public interest. A temporary certificate shall be valid for a period not exceeding ninety days.

President of the Senate

Speaker of the House of Delegates

Approved:

Governor