Virginia Department of Health
Office of Emergency Medical Services

Trauma Fund Report on:

Use of Funds in
Improving Virginia's Trauma System, and

Review of Feasible Long Term Financing
Mechanisms and Potential
Funding Sources for Virginia's Trauma Centers

Pursuant to Items 286-D and 297 of 2006 Appropriation Act

December 18, 2007

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Executive Summary: In Virginia, 13 hospitals voluntarily undergo trauma center designation and commit to provide a higher level of care necessary to the seriously injured. Despite the value trauma centers provide to the community, trauma centers face a variety of challenges that have led to a loss of trauma center designation or downgrades in coverage across the nation as well as in Virginia. These challenges are deterring additional hospitals from seeking trauma center designation.

Trauma Fund Summary: In the 2004 General Assembly Session House Bill (HB) 1143 amended the *Code of Virginia* by adding section 18.2-270.01 which established the Trauma Center Fund for the Commonwealth of Virginia. This was the first step in addressing the challenges faced by Virginia's trauma centers.

This bill required that persons convicted of criminal violations pursuant to §§ 18.2-36.1, 18.2-51.4, 18.2-266 or 46.2-341.24 (DUI), and who had also been previously convicted of one or more of these violations, pay a fine of $50 into the Trauma Center Fund.

House Bill 2664, passed during the 2005 Legislative Session, required that before granting or restoring a license or registration to any person whose driver's license or other privilege to drive motor vehicles or privilege to register a motor vehicle has been revoked or suspended, the Commissioner of the Department of Motor Vehicles must collect from that person a fee of $40 in addition to all other fees provided for in this section. The additional $40 fee must be paid into the Trauma Center Fund.

The 2006 Appropriations Act had allocated $1,884,877 (General Fund) per year in FY07 and FY08 for the Trauma Center Fund. However, these funds were eliminated as a consequence of the budget reduction plan due to the FY08 budget shortfall. The 2006 Appropriations act also included language regarding how the new dollars were to be used and reported. The language on how trauma funds are to be used and reported is still being followed despite with the existing funding sources despite the removal of this revenue stream.

The 2006 Appropriations Act, Item 286D requires the Virginia Department of Health, in consultation with the State Emergency Medical Services Advisory Board's Trauma System Oversight and Management Committee, to (i) review the criteria used to distribute funding to the trauma centers, (ii) make refinements as necessary to encourage existing trauma centers to upgrade their trauma designation, and (iii) assess whether this additional general fund support can be used as matching funds to maximize federal Medicaid revenues. The Department shall report on the use of these funds in improving Virginia's trauma system to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by December 1 of each year.

Additionally, Item 297 requires that the Commissioner of Health review current funding provided to trauma centers to offset uncompensated care losses, report on feasible long-term financing mechanisms, and examine and identify potential funding sources on the federal, state and local level that may be available to Virginia's trauma centers to support the system's capacity to provide quality trauma services to Virginia citizens. As sources are identified, the Commissioner shall work with any federal and state agencies and the Trauma System Oversight and Management Committee to assist in securing additional funding for the trauma system.

CHAPTER 999

An Act to amend the Code of Virginia by adding a section numbered 18.2-270.01, relating to DUI offenders; payment to Trauma Center Fund.

[H 1143]

Approved April 21, 2004

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 18.2-270.01 as follows:

§ 18.2-270.01. Multiple offenders; payment to Trauma Center Fund.

A. The court shall order any person convicted of a violation of §§ 18.2-36.1, 18.2-51.4, 18.2-266, 18.2-266.1 or § 46.2-341.24 who has been convicted previously of one or more violations of any of those sections or any ordinance, any law of another state, or any law of the United States substantially similar to the provisions of those sections within 10 years of the date of the current offense to pay $50 to the Trauma Center Fund for the purpose of defraying the costs of providing emergency medical care to victims of automobile accidents attributable to alcohol or drug use.

B. There is hereby established in the state treasury a special non-reverting fund to be known as the Trauma Center Fund. The Fund shall consist of any moneys paid into it by virtue of operation of subsection A hereof and any moneys appropriated thereto by the General Assembly and designated for the Fund. Any moneys deposited to or remaining in the Fund during or at the end of each fiscal year or biennium, including interest thereon, shall not revert to the general fund but shall remain in the Fund and be available for allocation in ensuing fiscal years. The Department of Health shall award and administer grants from the Trauma Center Fund to appropriate trauma centers based on the cost to provide emergency medical care to victims of automobile accidents. The Department of Health shall develop, on or before October 1, 2004, written criteria for the awarding of such grants that shall be evaluated and, if necessary, revised on an annual basis.

VIRGINIA ACTS OF ASSEMBLY -- CHAPTER

An Act to amend and reenact § 46.2-411 of the Code of Virginia, relating to fees for reinstatement of suspended or revoked license or other privilege to operate or register a motor vehicle.

[H 2664]
Approved

Be it enacted by the General Assembly of Virginia:

1. That § 46.2-411 of the Code of Virginia is amended and reenacted as follows:

§ 46.2-411. Reinstatement of suspended or revoked license or other privilege to operate or register a motor vehicle; proof of financial responsibility; reinstatement fee.

A. The Commissioner may refuse, after a hearing if demanded, to issue to any person whose license has been suspended or revoked any new or renewal license, or to register any motor vehicle in the name of the person, whenever he deems or in case of a hearing finds it necessary for the safety of the public on the highways in the Commonwealth.

B. Before granting or restoring a license or registration to any person whose driver's license or other privilege to drive motor vehicles or privilege to register a motor vehicle has been revoked or suspended pursuant to §§ 46.2-389, 46.2-391, 46.2-391.1, or § 46.2-417, the Commissioner shall require proof of financial responsibility in the future as provided in Article 15 (§ 46.2-435 et seq.) of this chapter, but no person shall be licensed who may not be licensed under the provisions of §§ 46.2-389 through 46.2-431.

C. Whenever the driver's license or registration cards, license plates and decals, or other privilege to drive or to register motor vehicles of any resident or nonresident person is suspended or revoked by the Commissioner or by a district court or circuit court pursuant to the provisions of Title 18.2 or this title, or any valid local ordinance, the order of suspension or revocation shall remain in effect and the driver's license, registration cards, license plates and decals, or other privilege to drive or register motor vehicles shall not be reinstated and no new driver's license, registration cards, license plates and decals, or other privilege to drive or register motor vehicles shall be issued or granted unless such person, in addition to complying with all other provisions of law, pays to the Commissioner a reinstatement fee of $30. The reinstatement fee shall be increased by $30 whenever such suspension or revocation results from conviction of involuntary manslaughter in violation of § 18.2-36.1; conviction of maiming resulting from driving while intoxicated in violation of § 18.2-51.4; conviction of driving while

intoxicated in violation of § 18.2-266 or § 46.2-341.24; conviction of driving after illegally consuming alcohol in violation of § 18.2-266.1 or failure to comply with court imposed conditions pursuant to subsection D of § 18.2-271.1; unreasonable refusal to submit to drug or alcohol testing in violation of § 18.2-268.2; conviction of driving while a license, permit or privilege to drive was suspended or revoked in violation of § 46.2-301 or § 46.2-341.21; disqualification pursuant to § 46.2-341.20; violation of driver's license probation pursuant to § 46.2-499; failure to attend a driver improvement clinic pursuant to § 46.2-503 or habitual offender interventions pursuant to former § 46.2-351.1; conviction of eluding police in violation of § 46.2-817; conviction of hit and run in violation of § 46.2-894; conviction of reckless driving in violation of Article 7 (§ 46.2-852 et seq.) of Chapter 8 of Title 46.2 or a conviction, finding or adjudication under any similar local ordinance, federal law or law of any other state. Five dollars of the additional amount shall be retained by the Department as provided in this section and $25 dollars shall be transferred to the Commonwealth Neurotrauma Initiative Trust Fund established pursuant to Chapter 3.1 (§ 51.5-12.1 et seq.) of Title 51.5. When three years have elapsed from the termination date of the order of suspension or revocation and the person has complied with all other provisions of law, the Commissioner may relieve him of paying the reinstatement fee.

D. No reinstatement fee shall be required when the suspension or revocation of license results from the person's suffering from mental or physical infirmities or disabilities from natural causes not related to the use of self-administered intoxicants or drugs. No reinstatement fee shall be collected from any person whose license is suspended by a court of competent jurisdiction for any reason, other than a cause for mandatory suspension as provided in this title, provided the court ordering the suspension is not required by § 46.2-398 to forward the license to the Department during the suspended period.

E. Except as otherwise provided in this section and § 18.2-271.1, reinstatement fees collected under the provisions of this section shall be paid by the Commissioner into the state treasury and shall be set aside as a special fund to be used to meet the expenses of the Department.

F. Before granting or restoring a license or registration to any person whose driver's license or other privilege to drive motor vehicles or privilege to register a motor vehicle has been revoked or suspended, the Commissioner shall collect from such person, in addition to all other fees provided for in this section, an additional fee of $40. The Commissioner shall pay all fees collected pursuant to this subsection into the Trauma Center Fund, created pursuant to § 18.2-270.01, for the purpose of defraying the costs of providing emergency medical care to victims of automobile accidents attributable to alcohol or drug use.

2006 Appropriations Act
(Trauma System Funding)

Department of Heath (601)
Item 286
D. Out of this appropriation, $1,884,877 the first year and $1,884,877 the second year from the general fund shall be provided to the Virginia Trauma Fund to recognize uncompensated care losses, including readiness costs and clinical services, incurred by providing care to uninsured patients by Virginia hospitals with trauma centers. The Virginia Department of Health, in consultation with the Trauma System Oversight and Management Committee, shall (i) review the criteria used to distribute funding to the trauma centers, (ii) make refinements as necessary to encourage existing trauma centers to upgrade their trauma designation, and (iii) assess whether this additional general fund support can be used as matching funds to maximize federal Medicaid revenues. The Department shall report on the use of these funds in improving Virginia's trauma system to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees by December 1 of each year.

Item 297
The Commissioner of Health shall review current funding provided to trauma centers to offset uncompensated care losses, report on feasible long-term financing mechanisms, and examine and identify potential funding sources on the federal, state and local level that may be available to Virginia's trauma centers to support the system's capacity to provide quality trauma services to Virginia citizens. As sources are identified, the Commissioner shall work with any federal and state agencies and the Trauma System Oversight and Management Committee to assist in securing additional funding for the trauma system.

Overview of the Virginia Trauma System: Under the *Code of Virginia* **§** 32.1-111.3, The Office of Emergency Medical Services (OEMS), acting on behalf of the Virginia Department of Health (VDH), has been charged with the responsibility of establishing and maintaining a process for designation of appropriate hospitals as trauma centers.

The Virginia Trauma System is an inclusive system and currently 14 of the state’s 94 hospitals are designated as trauma centers; five are designated as Level I (highest level), three as Level II, and six as Level III. The Virginia Trauma System is intended to provide quality trauma care to the citizens of Virginia by assessing the system’s needs and improving the system to accommodate changing state demographics and changes in the delivery of trauma care. Establishing a comprehensive statewide trauma system, incorporating healthcare facilities, transportation, human resources, communications, and other components as integral parts of a unified system, will serve to improve the delivery of trauma care and thereby decrease morbidity, hospitalization, disability, and mortality.

Traumatic injury is the leading cause of death in the U.S. from the age of one to forty-four. A fatal injury occurs every five minutes and a disabling injury every 1.6 seconds in the U.S. For every fatal injury there are an additional 10 people hospitalized and another 178 treated and released from the hospital. Injury accounts for a $225 billion loss annually and for more years of productive life being lost than cardiac, cancer, and stroke combined. It is for this reason that trauma injuries should be recognized as an important public health issue. Furthermore, trauma center designation to be considered as important as the other public safety and welfare services provided by the government.

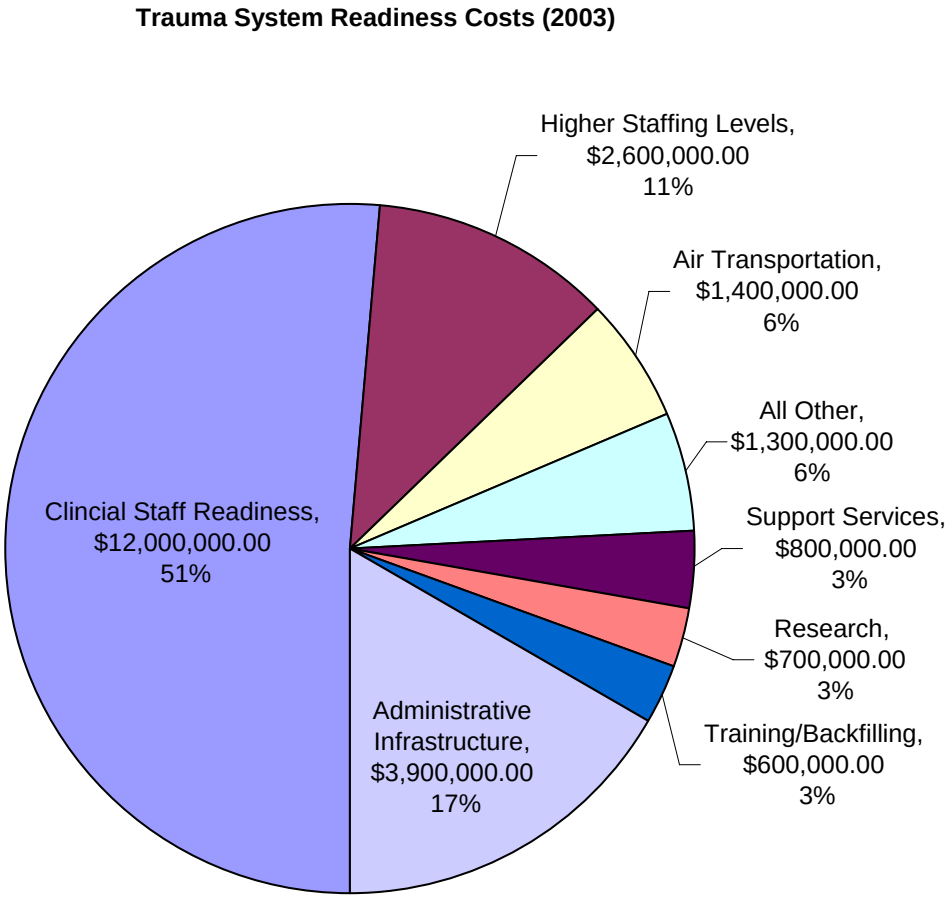
The goals stated in § 32.1-111.3 can be achieved by reducing the time period during which acutely injured patients are identified and assisted in reaching definitive high quality trauma care. A coordinated effort between ground and air prehospital resources, as well as hospitals, whether trauma designated or not, can lead to getting the right patient to the right hospital, in the shortest amount of time possible, while maximizing resources.

Virginia's trauma system would benefit from recognition of the burden that trauma care places on the EMS and hospital systems in the Commonwealth. The costs of planning for and preparing to respond to the countless challenges facing these systems are immeasurable.

Current Trauma System Funding: Trauma System readiness costs are not accounted for by public or private payers. Payment from these sources is based on the actual clinical care that was provided. The specialized training, extra staffing, surgical specialties that must be immediately available, and extra infrastructure required by trauma center designation must be absorbed by the facility and are usually either cross-subsidized by other initiatives or else abandoned.

Figure 1 shows the system-wide $23,000,000 cost of readiness for one year:

Figure 1



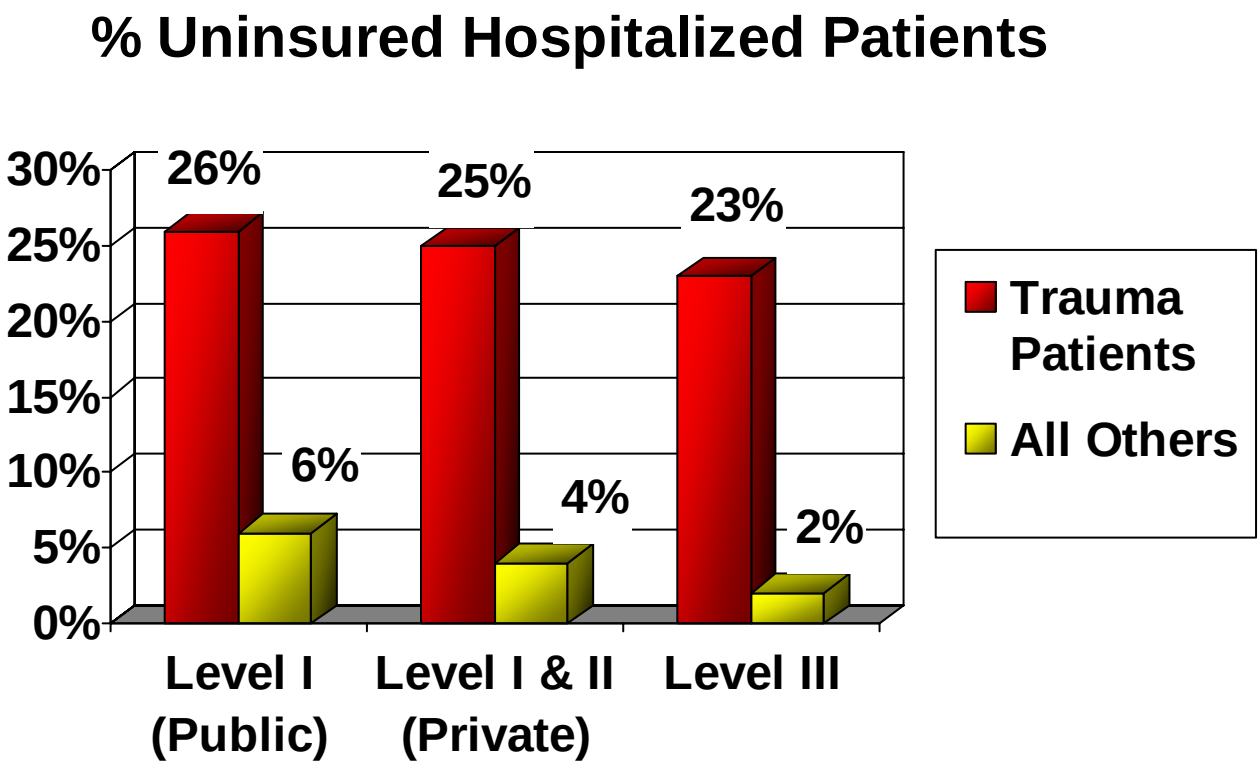
Source: *2004 JLARC report on The Use and Financing of Virginia Trauma Centers.*

To ensure that Virginia maintains a quality trauma system, support must be given to those areas that are required for being designated as a trauma center. With the exception of the Trauma Center Fund, no state or federal program exists to offset readiness costs associated with being a hospital that has trauma center designation. Medicare and Medicaid reimbursement rates could potentially be adjusted to account for the higher cost of providing trauma care.

In addition to advocating for increased reimbursement rates, trauma system stakeholders may seek federal matching funds for part or all of the trauma fund monies distributed. However, success in achieving increased Medicare and Medicaid reimbursement rates and also receiving some level of matching funds would only partially solve the problem of uncompensated clinical care.

Trauma patients are disproportionately uninsured. Figure 2 shows the percentage of uninsured trauma patients, during 2003, compared to other hospital patients. The information comes from the 2004 JLARC study, "The Use and Financing of Virginia Trauma Centers".

Figure 2



Currently three programs are in place to offset the amount of uncompensated care provided by hospitals. These programs are not specific to trauma. The programs are the Disproportionate Share Hospital (DSH) program, the State and Local Hospitalization (SLH) program and the Indigent Health Care Trust Fund program.

Medicaid and Medicare make lump-sum payments to eligible hospitals that treat uninsured indigent patients. Medicaid funds the largest portion of Disproportionate Share Hospital (DSH) payments, and Medicare has a similar but much smaller program. DSH payments compensate hospitals for the cost of caring for the indigent from whom, usually, no payment is received. The size of DSH payments is determined by the proportion of services provided to Medicaid patients.

When indigent patients qualify for the program, hospitals may also receive funding through the SLH program. SLH is a venture between the state and local governments that provides health care coverage to indigent patients who are not eligible for Medicaid.

Finally, hospitals that provide charity care in excess of the median level of charity care costs (calculated across all hospitals in the State) receive a lump-sum payment through the Indigent Health Care Trust Fund to partially cover the cost of providing this care. Hospitals that provide charity care below the median must contribute to the fund. The amount of funds available under the program is capped, and typically falls short of fully funding the amount of indigent care hospitals provide every year.

Despite these funds, trauma centers still fall short of recouping their losses due to un-reimbursed trauma care. This is especially true for the private not-for-profit and proprietary hospitals. Public hospitals such as UVA, MCV/VCU, and Eastern Virginia Medical School are typically reimbursed at a higher rate by these funds. They are also reimbursed by Medicare and Medicaid at a higher rate.

The Virginia Department of Health, Office of Emergency Medical Services (OEMS) administers the Trauma Center Fund and has developed a methodology for disbursing monies from the fund. The OEMS has encouraged stakeholder participation in the development of a disbursement policy for the Trauma Center Fund by establishing the Trauma Fund Panel (Panel), a subcommittee of the State EMS Advisory Board's, Trauma System Oversight and Management Committee. The Panel assists the Office of EMS in annually reviewing the disbursement methodology and revising it as needed.

HB 1443 of 2004 stated that the Trauma Fund would be used for the purpose of defraying the costs of providing emergency medical care to victims of automobile accidents attributable to alcohol or drug use. Although it is obvious within the trauma system that these victims cause a financial burden to trauma centers, data to identify these victims are lacking.

However, the 2006 Appropriations Act, contained language that more clearly identifies how trauma centers are to use the monies from the Trauma Center Fund. The new language adds reporting requirements for the trauma centers and the Office of EMS, and directs the VDH to explore other sources of federal, state, and local funding.

The percentages assigned to each trauma center, for use in distributing the FY07 trauma funds was reached by consensus agreement, by the Trauma Fund Panel. The panel felt that this policy met the spirit of the *Code* language that established the Trauma Center Fund, and equitably distributed the dollars to assist Virginia's designated trauma centers.

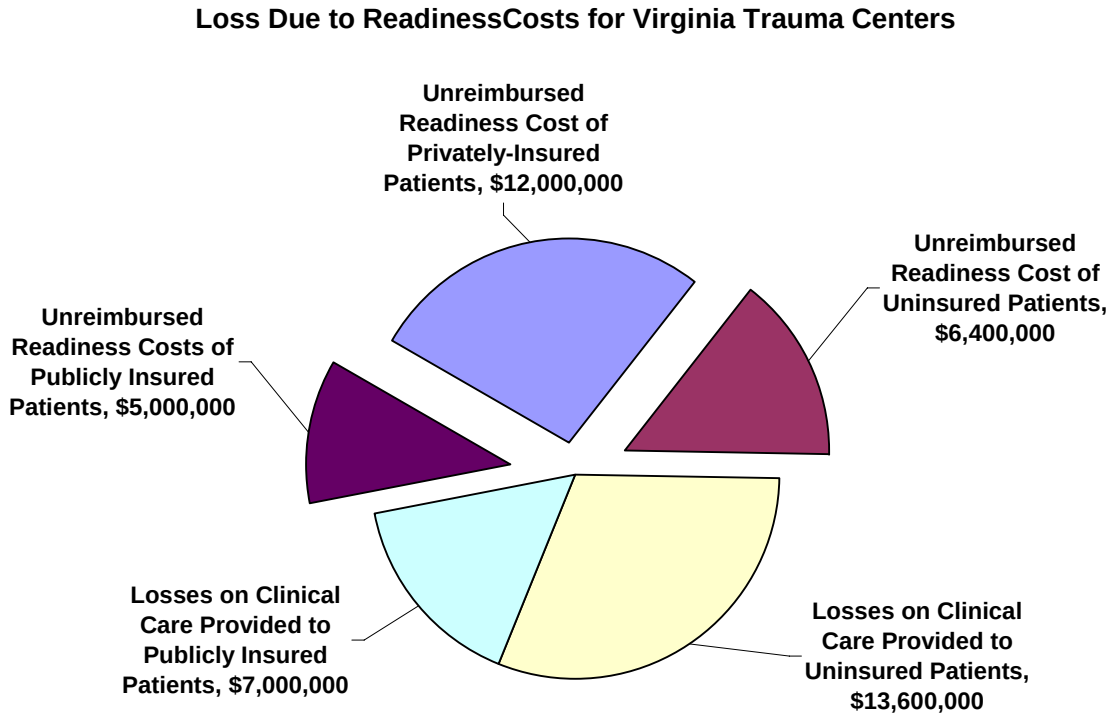
The Use of Newly Appropriated Funds in Improving Virginia's Trauma System: Beginning with the August 2006 version (a mid-year revision developed in response to the receipt of new general funds) of the Trauma Fund Disbursement Policy, it has become necessary to provide direction on the usage of trauma funds by recipients. The 2006 Appropriations Act includes language that is designed to ensure that these funds are used to improve Virginia's trauma system.

The Trauma Fund directs funds to be used for defraying the costs of providing emergency medical care to victims of automobile accidents attributable to alcohol or drug use and to recognize uncompensated care losses. Appendix A demonstrates how the Office of Emergency Medical Services accomplishes this criterion.

The 2006 Appropriations Act describes uncompensated care losses as including readiness costs and clinical services incurred by providing care to uninsured trauma patients. The level of readiness required of a trauma designated hospital is unparalleled by other disciplines. Figure 3 shows that $23,400,000 of the $44,000,000 lost in 2003 by Virginia trauma centers was directly attributable to the cost of readiness.

Hospitals designated as trauma centers incur readiness costs because they must be ready to treat trauma patients 24 hours a day, have a host of specialists available to care for patients in any condition, employ a larger clinical staff than other hospitals, and maintain an administrative infrastructure designed to ensure that the highest level of care is consistently provided.

Figure 3



Source: *2004 JLARC report on The Use and Financing of Virginia Trauma Centers.*

The cost of readiness is not included in the reimbursement rates provided by health insurers. This disconnect occurs because insurers reimburse health care providers for treating patients rather than for being ready to treat them. In addition, many insurers set rates based on the expected cost of treating a patient in an average hospital rather than on the actual cost of the resources deployed to treat the patient. Finally, the costs of readiness for a given trauma center designation level does not vary substantially based on the volume of trauma patients, at least in the short term.

The initial payments made by the Trauma Fund were issued during the last week of December, 2005. These were followed by regular quarterly payments beginning in January, 2006. Table 1 illustrates the percentage of funding each Designated Trauma Center has been receiving, from all sources, and the amount of each distribution for the reporting period included in this document.

Table 1

Trauma Center & Level	Percent Distribution FY07	Percent Distribution FY08	1st Qtr. FY07	2nd Qtr. FY07	3rd Qtr. FY07	Total Reported Disbursement
I						
Roanoke Memorial Hospital	14.16%	7.21%	$318,972.02	$332,126.52	$405,133.92	$1,368,683.89
Inova Fairfax Hospital	26.98%	23.54%	$607,758.83	$632,822.98	$771,928.89	$2,012,510.70
Norfolk General Hospital	14.84%	11.83%	$334,289.88	$348,076.10	$424,589.50	$1,106,955.48
UVA Health System	13.23%	12.99%	$298,022.59	$310,313.12	$378,525.55	$986,861.26
VCU Health Systems	17.38%	29.11%	$391,506.62	$407,652.46	$497,261.83	$1,296,420.91
II						
Lynchburg General Hospital	1.12%	2.81%	$25,229.43	$26,269.89	$32,044.49	$83,543.81
Riverside Regional Medical Ctr.	1.39%	3.45%	$31,311.52	$32,602.81	$39,769.50	$103,683.83
Winchester Medical Ctr.	2.67%	4.19%	$60,145.15	$62,625.55	$76,391.78	$199,162.47
III						
New River Valley Medical Ctr.	0.25%	0.22%	$5,631.57	$5,863.82	$7,152.79	$18,648.18
CJW Medical Ctr.	1.81%	0.24%	$40,772.55	$42,454.03	$51,786.19	$135,012.77
Montgomery Regional Hospital	0.65%	0.17%	$14,642.08	$15,245.92	$18,597.25	$48,485.25
Southside Regional Medical Ctr.	0.64%	0.39%	$14,416.81	$15,011.37	$18,311.14	$47,739.32
Virginia Beach Gen'l Hospital	4.88%	3.84%	$109,928.21	$114,461.68	$139,622.42	$364,012.31
					Total 3 Qtrs. FY07	$7,771,720.18

Source: Virginia Department of Health, Office of Emergency Medical Services

The percentage of funding that each trauma center receives from the Trauma Center Fund will be recalculated annually, each July, using current Virginia Statewide Trauma Registry (VSTR) data.

Use of the funds has varied by trauma center. Examples of how the funds have been used include providing support for training programs, physician on-call pay, and increased staffing. The most recent revisions of the Trauma Fund Disbursement Policy provide guidance on how the funds are to be used, as well as associated reporting requirements. Beginning in September of 2007, recipients of trauma center funding will begin to provide an annual report outlining how funds have been used to improve trauma care.

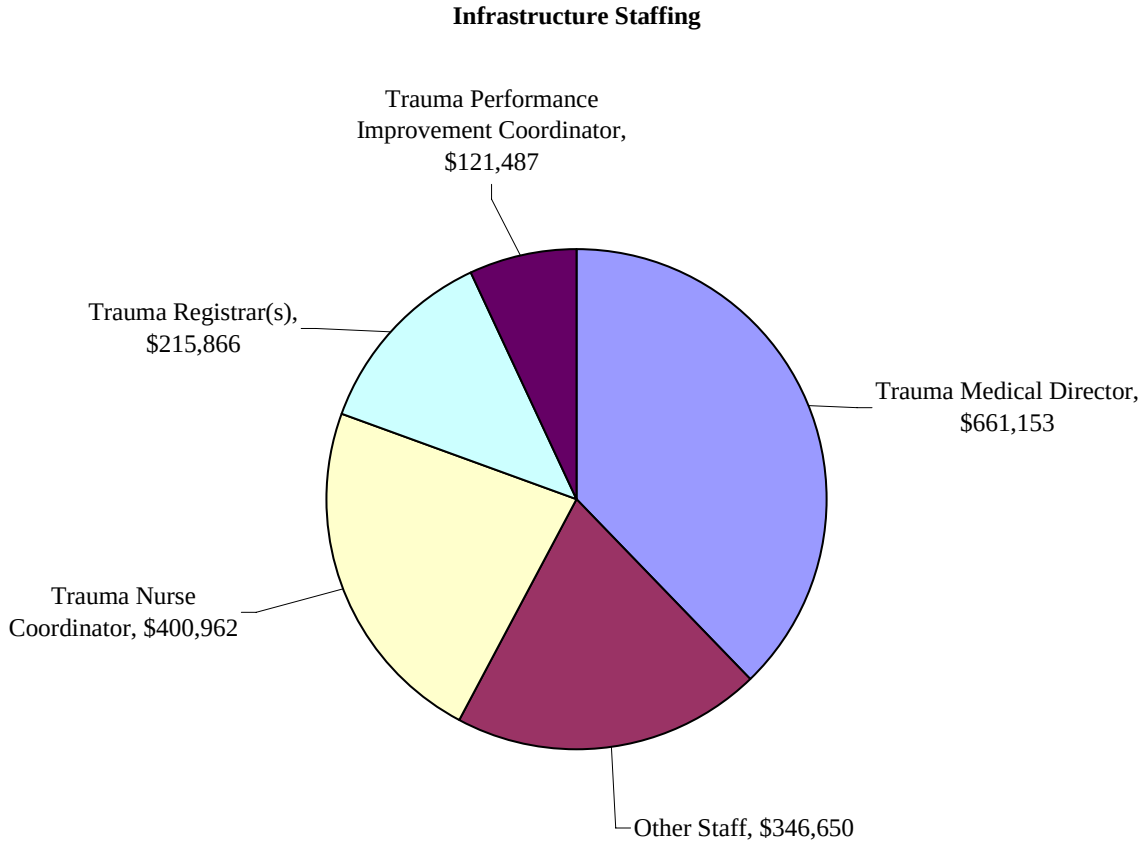
Eligible recipients of the Trauma Fund must use the funds they receive for specific areas.

- Support administrative infrastructure dedicated to the trauma program as required for designation, including, but not limited to (figure 4):
    - Trauma Medical Director,
    - Trauma Nurse Coordinator,
    - Trauma Registrar(s),
    - Trauma Performance Improvement Coordinator,
    - Other administrative staff to support program.
- Support higher staffing levels that will assure quality trauma care day or night to include (figure 5):
    - Trauma Surgeons,
    - Other physician specialties,
    - Mid level/physician extenders,
    - Increased nursing staff to meet required nurse patient ratios,
    - Ancillary support staff needed to meet state designation criteria.
- Support extensive trauma-related staff training either by hosting or funding staff for any of the following:
    - Continuing medical education for all levels of clinicians,
    - Trauma-related certification classes, i.e. Advanced Trauma Life Support, Trauma Nurse Core Curriculum, Advanced Trauma Care for Nurses, Course for Advanced Trauma Nursing,
    - Trauma-related classes or conferences,
    - Training equipment, aids, materials and supplies,
    - Backfilling for staff attending trauma educational events.
- Support a trauma specific comprehensive performance improvement program by funding any of the following:
    - The purchase or maintenance of a trauma registry software that is capable of also submitting data to the Virginia Statewide Trauma Registry,
    - Information Technology support for trauma registry software to assure its use on a day to day basis and to provide support for exporting data to state and national databanks,
    - Support of multidisciplinary performance improvement committees,
    - Offsetting the cost of preparing and undergoing state trauma verification.
- Support for injury prevention/community outreach to include any of the following:
    - Trauma center and system awareness,
    - Community/Public education program(s) related to injury prevention (staffing, supplies marketing, travel supplies etc.).

- Support for outreach program(s) such as:
  - Educating staff at non designated hospitals on trauma care and trauma triage,
  - Providing performance improvement related feedback to non designated hospitals and their staff,
  - Educating prehospital providers on trauma care and trauma triage,
  - Providing performance improvement related feedback to prehospital providers/agencies.
- Support for trauma related research that will be shared with and support the Virginia Trauma System.

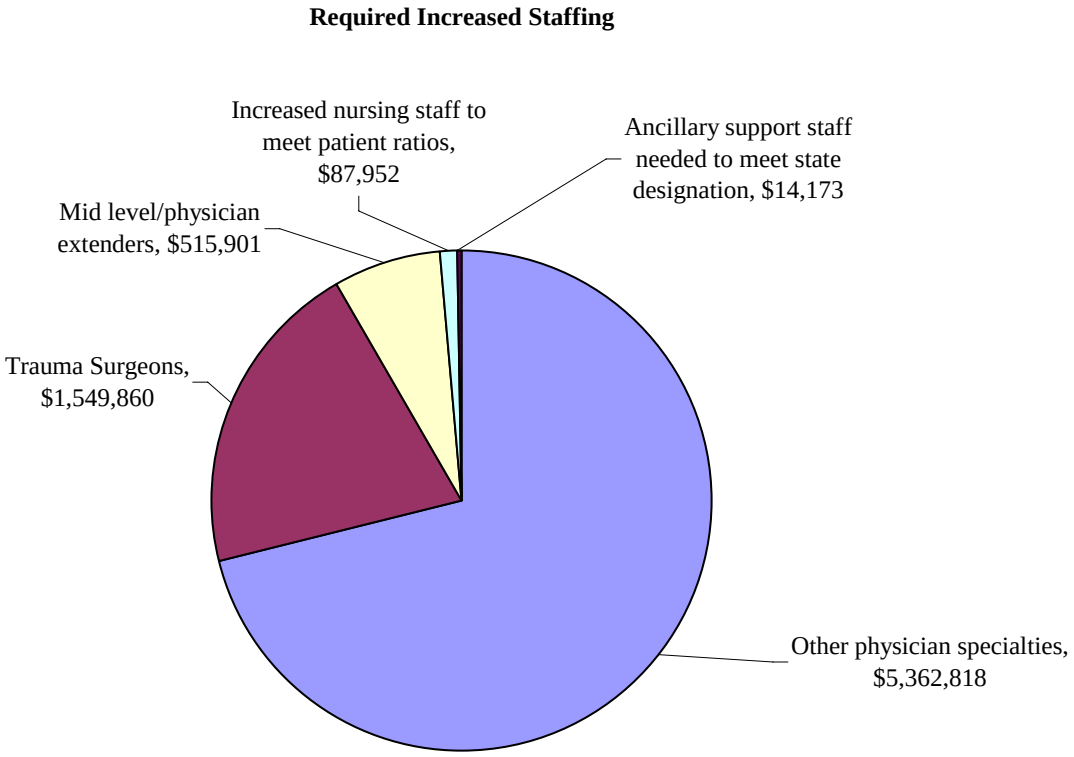
Directing the funds to be used in this manner supports the funds being used to enhance and maintain a viable trauma system.

Figure 4



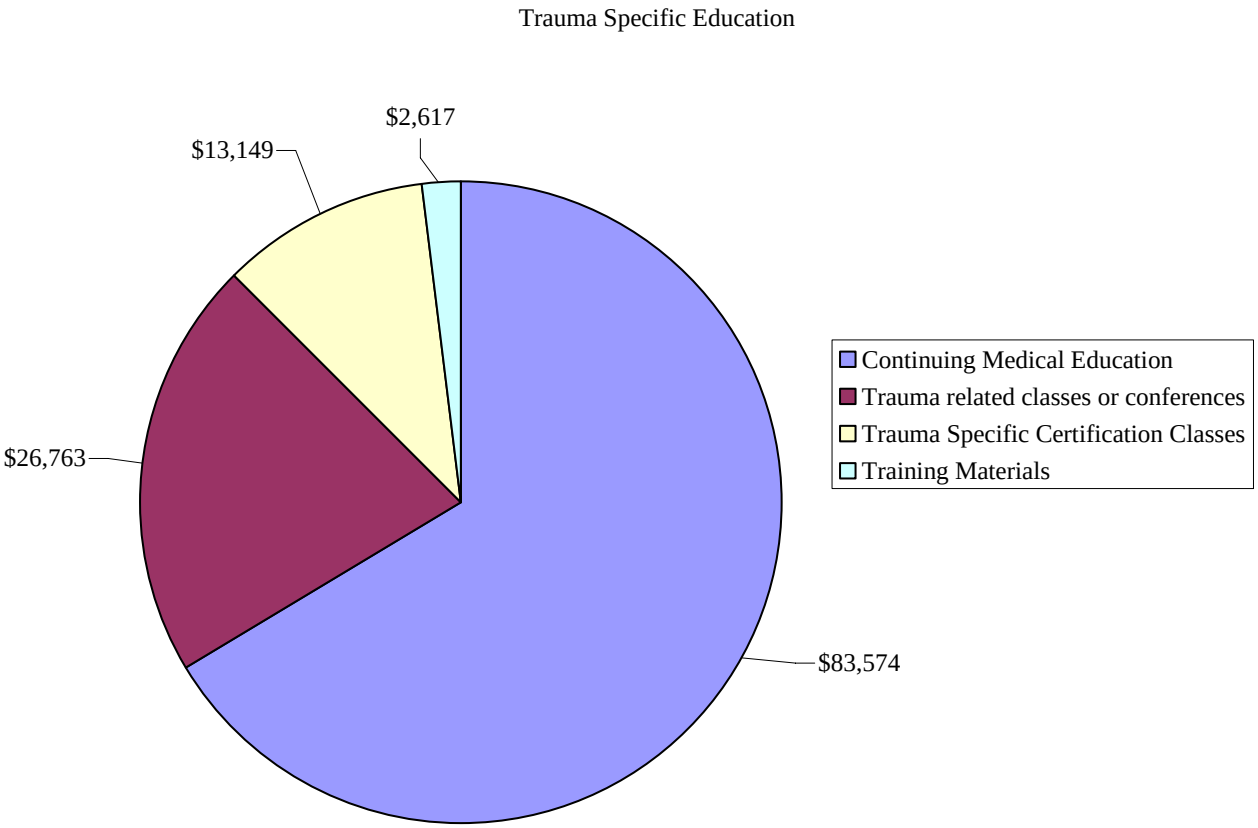
Virginia trauma center designation requires hospitals to maintain a surgical medical director, trauma nurse coordinator, and a trauma registrar. Trauma criteria also require strict performance improvement programs. These programs require additional infrastructure support.

Figure 5



In addition to the staffing required establishing the infrastructure required to maintain a trauma program, an adequate number of trauma surgeons, surgical specialty physicians, nursing staff, and ancillary support are required. For example, a Level I trauma center must have 12 physician surgical specialties, 11 physician medical specialties, and increased nursing staff available day or night for the severely injured patient. The national trend by specialty physicians is to require significant compensation for being “on-call” for trauma patients.

Figure 6



Trauma center physicians, physician extenders, and nursing staff are required to maintain a higher level of trauma specific continuing medical education (CME) than that of their counterparts in community hospitals. In addition to the normal costs associated with providing medical continuing education, trauma centers, must maintain staffing levels within the various sections of the hospital that provide care to trauma patients. Maintaining adequate staffing levels add significant additional cost when providing trauma specific education as backfilling, many times at a higher rate of pay is required.

Figure 7

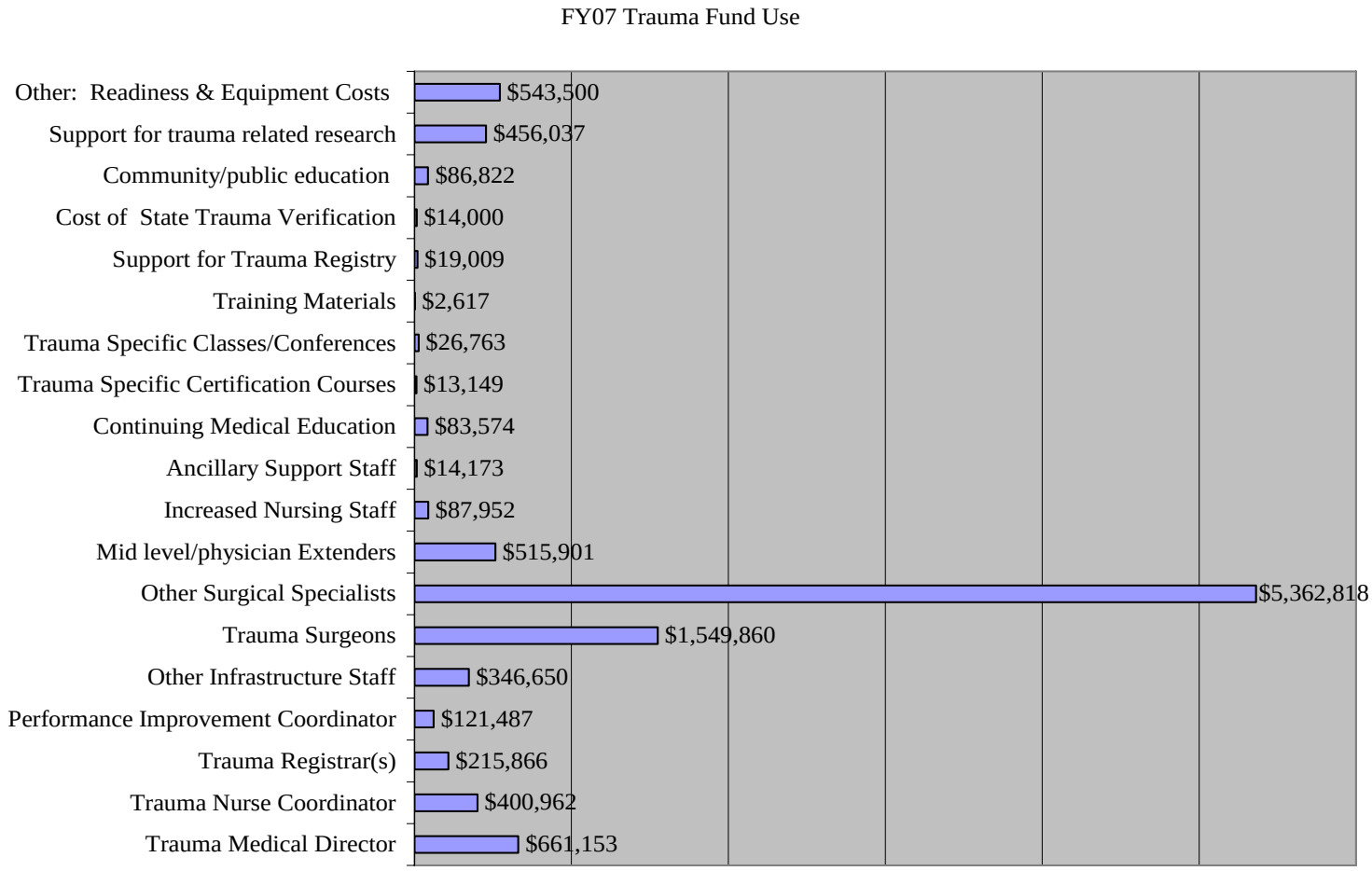


Figure 7 shows how the trauma centers report using trauma center funds from first, second and third quarters of FY07. Fourth quarter spending will be included in next year's report.

Review Feasible Long Term Financing Mechanisms, Examine, and Identify Potential Funding Sources for Virginia's Trauma Centers: Currently the only long term financing dedicated to Virginia's Trauma System is the Trauma Center Fund. Table 2 illustrates the projected trauma funds that will be available for FY08.

Table 2

Anticipated Funding	
From DUI Source	$20,000 to $30,000
From License Reinstatement	$8,000,000

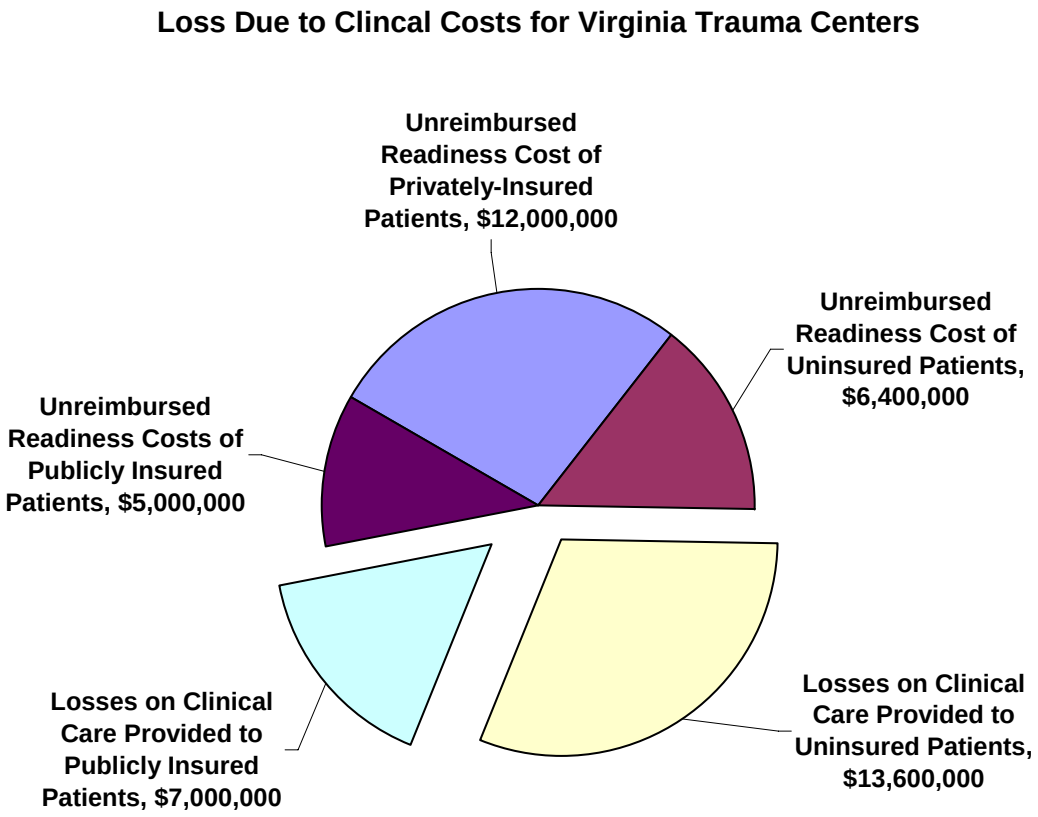
*The above are merely estimates, income from these items above will vary from year to year.

Other long term financing may be achievable by increasing reimbursement rates for trauma patients through Medicare and Medicaid. Figure 4 shows the amount of losses through un-reimbursed or under-reimbursed clinical care.

The Virginia General Assembly can support the trauma system by restoring general funds, at either the previous level of $1.8 million dollars per year or at an increased level, directed to the Trauma Center Fund. As stated in the 2004 JLARC report, trauma centers face significant financial challenges. General fund appropriations could help to ensure this critical public safety service is maintained until reimbursement rates can be addressed to offset the un-reimbursed cost of readiness.

Trauma system stakeholders will seek avenues to advocate the concept of higher reimbursement rates for patients deemed as “trauma patients.” High incremental costs are associated with caring for trauma patients due to the multiple resources required being available day and night, specialized training, and support of a dedicated infrastructure.

Figure 8



Source: *2004 JLARC report on The Use and Financing of Virginia Trauma Centers.*

By making Medicaid reimbursement rates more comparable to the actual cost of providing trauma care, along with the corresponding federal matching payment, it is hoped that private carriers will follow suit. With state, federal, and private carriers reimbursing at higher rates, trauma programs will not be dependent on their institution funding the trauma service using cross subsidization from profitable service lines.

Additional support could be provided by the Virginia Congressional Delegation to help federal policy makers understand that trauma is a public health issue. A first step by the federal government could be to restore the Health Resources Services Administration's (HRSA) Trauma/EMS Program, which was eliminated during federal fiscal year 2006.

The HRSA Trauma/EMS Program provided funding to states through grants that provided support for developing a state trauma system. HRSA's Trauma/EMS Program was also supporting states to understand traumatic injury as a public health issue. Without this federal program, state systems will remain fragmented.

On a national level, the federal government could assist state trauma systems by increasing the reimbursement rates of federal programs, such as Medicare. Initiatives to create alternative funding streams directed at supporting trauma system development could also be beneficial, i.e. grants, or tax relief programs.

Virginia could consider a funding stream similar to those used in other states. Washington and Mississippi collect $5 for every moving violation. States such as Texas, Illinois, California, Florida and North Carolina either have or are proposing fines for first offenders of driving under the influence of intoxicating substances (DUI). Some states are using tobacco settlement funds for trauma, while others imposes taxes or fees for ammunition, gaming, or motor vehicle registration.

The state of Florida, on October 1, 2005, began imposing a $500 penalty to drivers involved in motor vehicle crashes when they cause others to be injured. If the driver is required to appear before the court after committing this type of infraction, they can be fined up to $1,000. Additionally, if a driver causes a death during a motor vehicle accident they are fined $1,000

State agencies alike, must support efforts to work collaboratively to support the Virginia Trauma System by assisting with assessing and justifying the need for increased re-imbursement rates.

Virginia's designated trauma centers should also play a role in their financial stability. Trauma centers that do not already charge a "trauma alert activation" fee should consider this funding source. Hospitals with trauma designation are also encouraged to renegotiate reimbursement rate contracts with private carriers.

Appendix A

Grant Disbursement Policy:

- Trauma Fund Panel
- Timeline
- Eligibility to receive funding
- Use of funds

Purpose: To provide financial support to trauma centers to defray uncompensated care costs associated with the high level of readiness that is required for trauma designation and maintaining the availability of specialty clinical services needed to provide emergency medical care to victims of severe injury, otherwise known as trauma, 24 hours per day, 7 days per week, 365(6) days per year.

Trauma Fund Panel: A sub committee, to be called the Trauma Fund Panel, shall be appointed each year by the Trauma System Oversight and Management Committee (TSO&MC) Chairperson at its March meeting. The panel will consist of 6 members: the TSO&MC Chair or his/her designee, the State Medical Director, the Office of EMS Trauma/Critical Care Coordinator, one representative of a level I trauma center, one representative of a level II trauma center, and one representative of a level III trauma center.

The Trauma Fund Panel shall:

- Review annually and update, as needed, the disbursement policy of the Trauma Fund
- Use the disbursement policy to provide the Office of EMS Fiscal Division with a percentage of funds to be used for the State's next fiscal year
- Present changes in the Trauma Fund Grant Criteria to the Trauma System Oversight and Management Committee at its June Meeting.

Timeline:

- At the March meeting of the Trauma System Oversight and Management Committee, the Chair will form the year's Trauma Fund Panel.

- The Committee may choose not to convene the trauma fund panel for the upcoming year if, after reviewing the document, the OEMS and the Chair recommend either that the document does not require revision or the revisions that are required are not significant enough to warrant panel meetings.

- Between the months of March and May, the Trauma Fund Panel will meet to evaluate and revise as needed the disbursement policy and the percentage of funds each designated trauma center will receive from the Trauma Fund Grant

- Changes that have been made to the Trauma Fund Grant Criteria by the Trauma Fund Panel will be presented at the June Trauma System Oversight and Management Committee Meeting on an informational basis, to make potential recipients aware of any significant changes.

- At the beginning of the State Fiscal Year in July the Trauma Fund Panel will inform the Office of EMS' Fiscal Division of the percentage of funding each center will receive. This information will be placed into the Lotus notes program that distributes the funds electronically.

- Before each September meeting, OEMS will forward a report to the Chair of the TSO&MC that outlines how the Trauma Center Fund distributed dollars for the past fiscal year to each designated trauma center.

- As directed by the Trauma Fund Panel at its October meeting, the Office of EMS' Fiscal Division will make electronic disbursements on a quarterly basis to the recipients being funded.

Quarter	When Disbursed
July – September	October
October – December	January
January – March	April
April - June	July

Eligibility: To be eligible to receive funding through The Commonwealth of Virginia Trauma Center Fund, a hospital must be a Virginia designated trauma center (Level I, II, or III), located within the Commonwealth of Virginia, designated by the Virginia Department of Health, and be in good standing.

For the purpose of the Trauma Fund, designated trauma centers considered not in good standing include any center that has been identified during any phase of the verification process as having a critical deficiency or deficiencies. This verification process includes the application process, onsite review, or receiving the site review team's final report that cites a specific critical deficiency or deficiencies.

Once the Office of EMS identifies a center as not in good standing, payments from the Trauma Center Fund shall be held in escrow until such time that the critical deficiency has been corrected or a suitable corrective action plan has been accepted. If a modified site review is required as part of the action plan, funds will be held until a successful modified site visit has occurred.

Each eligible trauma center must notify the Office of EMS' Fiscal Division of its method to receive funds electronically. The eligible center must be compliant with reporting to the data source (i.e. Trauma Registry) being used by OEMS and the Trauma Fund Panel to establish the percentage of the trauma fund that will go to each facility. Each recipient of Trauma Center Fund monies shall be required to submit an annual report as prescribed by the Office of EMS. Failure to comply with these provisions will result in forfeiting these funds until compliance has been achieved.

If it becomes known that a center(s) is not using the funds in accordance with the "*Virginia Office of Emergency Medical Services Trauma Fund Grant Information and Disbursement Policy*" the OEMS must respond to such an event. The OEMS staff will attempt to resolve the matter in the following manner:

- Communicate in writing to the facility's trauma program representative and hospital administrative representative and attempt to clarify and resolve the issue(s).
- Notify the Chair of the TSO&MC of the issue(s) at hand to determine if the matter should come before the Committee for recommended action.
- Report the issue(s) via the VDH chain of command to Virginia's Office of the Attorney General for appropriate resolution.

Use of Funds:

Beginning with the August 2006 version of the Trauma Fund Disbursement Policy, it has become necessary to provide direction on the usage of trauma funds by its recipients. HB 5002 includes language that is designed to ensure that these funds are used to improve Virginia's Trauma System.

The Trauma Fund, being comprised of several pieces of legislation, directs funds to be used *for the purpose of defraying the costs of providing emergency medical care to victims of automobile accidents attributable to alcohol or drug use* and to recognize uncompensated care losses.

HB5002 describes uncompensated care losses as including readiness costs and clinical services incurred by providing care to uninsured trauma patients. The level of readiness required of a trauma designated hospital is unparalleled by other disciplines.

- Readiness costs that support the trauma systems will vary from institution to institution and may include any of the following:
  - Support an administrative infrastructure dedicated to the trauma program as required for designation to include, but not be limited to:
    - Trauma Medical Director,
    - Trauma Nurse Coordinator,
    - Trauma Registrar(s),
    - Trauma Performance Improvement Coordinator,
    - Other administrative staff to support program.
  - Support higher staffing levels that will assure quality trauma care day or night to include:
    - Trauma Surgeons,
    - Other physician specialties,
    - Mid level/physician extenders,
    - Increased nursing staff to meet required nurse patient ratios,
    - Ancillary support staff needed to meet state designation criteria.
  - Support extensive trauma related training to staff either by hosting or funding staff to attend any of the following:
    - Continuing medical education (CME) for all level of clinicians,
    - Trauma related certification classes, i.e. ATLS, TNCC, ATCN, CATN,
    - Trauma related classes or conferences,
    - Obtain training equipment, aids, materials and supplies,
    - Backfilling for staff attending trauma educational events.
  - Support a trauma specific comprehensive performance improvement program by funding any of the following:

        - The purchase or maintenance of a trauma registry software that is capable of also submitting data to the Virginia Statewide Trauma Registry,
        - Information Technology support for trauma registry software to assure its use on a day to day basis and to provide support exporting data to state and national databanks,
        - Support multidisciplinary performance improvement committees,
        - Offset the cost of preparing and undergoing state trauma verification.
    - Support for Injury prevention/community outreach to include any of the following:
        - Trauma center and system awareness,
        - Community/Public education program(s) related to injury prevention (staffing, supplies marketing, travel supplies etc.),
    - Support for outreach program(s) such as:
        - Educating staff at non designated hospitals on trauma care and trauma triage
        - A program to provide performance improvement related feedback to non designated hospitals and their staff,
        - Educating Prehospital providers on trauma care and trauma triage,
        - A program to provide performance improvement related feedback to Prehospital providers/agencies.
    - Support for trauma related research
        - Provide support for trauma related research that will be shared with and support the Virginia Trauma System.