LEGISLATIVE BUDGET BOARD

Texas Trauma System Funding

Presentation to the House Appropriations & House Public Health Committees

PRESENTED BY MIKE DIEHL

LEGISLATIVE BUDGET BOARD STAFF

JULY 2016

Overview

House Appropriations Committee Interim Charge 11 & Public Health Committee Interim Charge 5:

Study the trauma system in the State of Texas, including financing, service delivery, planning, and coordination among Emergency Medical Services providers, Trauma Services Area Regional Advisory Councils, The Emergency Medical Task Force, and hospitals. Determine strengths and weaknesses including challenges for rural areas of the state. Make recommendations to reduce any duplicated services, improve the coordination of services, and advance the delivery of trauma services in Texas.

Content:

- Trauma appropriations out of certain General Revenue Dedicated Accounts for the 2016-17 biennium:
  - Account No. 5111 – Designated Trauma Facility and Emergency Medical Services
  - Account No. 5137 – Regional Trauma
  - Account No. 5007 – Commission on State Emergency Communications
  - Account No. 5046 – Permanent Fund for Emergency Medical Services and Trauma Care
  - Account No. 5108 – Emergency Medical Services, Trauma Facilities and Trauma Care Systems
- Actions of the Eighty-fourth Legislature, 2015

Designated Trauma Facility & EMS Account No. 5111

- Designated Trauma Facility and EMS (Account No. 5111) is a GR-Dedicated account established by Health and Safety Code, Chapter 780, to receive revenues as follows:
  - 33 percent of court fines from persons convicted of traffic related offenses (Transportation Code §542.4031);
  - 49.5 percent of Driver Responsibility Program surcharges (Health and Safety Code §780.002); and
  - 50 percent of civil/administrative penalties & late payment penalties from violation under a photographic traffic signal enforcement programs (Transportation Code §542.406 and §707.007).
- Provides funding for designated trauma facilities, county and regional EMS, and trauma-care systems.
- Provisions relating to the account were amended in the Eighty-second Legislature, First Called Session, 2011 to authorize DSHS to transfer funds to the HHSC to maximize the receipt of federal funds that HHSC receives under Medicaid.
- The 2016-17 General Appropriations Act appropriates $348.4 million for the biennium in the following amounts: $330.9 million at the Department of State Health Services (DSHS) for uncompensated trauma care and $17.3 million at the Higher Education Coordinating Board (THECB) for graduate medical education and nursing education programs.
- House Bill 7, Eighty-fourth Legislature, 2015, abolished Regional Trauma Account No. 5137 and transferred the fund balance ($97.4 million) and revenues to Account No. 5111.

Appropriations from Designated Trauma Facility and EMS Account No. 5111

DSHS was appropriated $330.0 million from Account No. 5111 in the 2016-17 biennium, including:

- $182.2 million in funding for uncompensated trauma care provided by designated trauma facilities and those actively pursuing trauma designations, including:
  - $153.0 million for transfer to HHSC for Medicaid trauma add-on payments
    - Includes an additional $64.5 million appropriated by Special Provision 32, Contingency for House Bill 7 and Use of Trauma Fund Receipts
  - $29.1 million to hold harmless funds for hospitals that serve trauma patients but do not qualify for the Medicaid trauma add-on, as well as:
    - 2 percent distributed to EMS providers
    - 1 percent distributed to Regional Advisory Councils (RACs)
    - 1 percent for administration
- $20.0 million for transfer to HHSC for rural hospital add-on payments per Special Provision 58, Payments to Rural Hospital Providers
- $128.7 million for transfer to HHSC for safety-net hospital add-on payments per Special Provision 59, Contingency for HB 7 and Safety-Net Hospitals.

Account No. 5111 Funding at DSHS

DSHS Trauma Fund Appropriations and Transfers in the 2016-17 General Appropriations Act

	2016-17 Biennium	Transfers to HHSC	Balance at DSHS
Funding for uncompensated trauma care	$115,016,333	$(88,533,180)	$26,416,333
Special Provision 32, Contingency for HB 7 and Use of Trauma Fund Receipts	$67,152,938	$(64,466,820)	$2,686,118
Subtotal	***$182,169,271***	***$(153,000,000)***	***$29,102,451***
Special Provision 58, Payments to Rural Hospital Providers	$20,000,000	$(20,000,000)	—
Special Provision 59, Contingency for HB 7 and Safety-Net Hospitals	$128,693,999	$(128,693,999)	—
Total	**$330,863,270**	**$(301,693,999)**	**$29,102,451**

Source: Legislative Budget Board

Account No. 5111 Revenue & Appropriations

Fiscal Year	Beginning Fund Balance	Estimated Revenue (CRE)	Transfer of GR-D 5137 Fund Balance (HB 7)	Expended/ Appropriated[1]	Actual Revenue Collected
2013	$371,554,005	$114,487,000	—	$197,372,339	$99,850,226
2014	$382,364,707	$95,653,000	—	$219,754,708	$102,760,521
2015	$125,843,601	$95,653,000	—	$199,761,625	$104,171,585
2016	$31,356,314	$117,959,000	$97,392,511	$174,071,636	tbd
2017	$72,636,189[2]	$117,959,000	—	$174,071,634	tbd

Note: Pursuant to Special Provisions relation to all Health and Human Services Agencies Sec. 32(d), if revenue is not collected in the amount appropriated, the appropriation of GRD 5111 funding to Strategy B.1.3, EMS & Trauma Care Systems at DSHS is reduced.

Source: Comptroller of Public Accounts, Cash Reports and Certification Revenue Estimates. Legislative Budget Board, General Appropriations Act.

[1] Amounts shown for fiscal years 2013-2015 are expended. Amount shown for fiscal years 2016 and 2017 are appropriated. Includes appropriations to the Department of State Health Services and the Higher Education coordinating board.

[2] Estimated based on FY 2016 estimated revenue and appropriations.

Other Trauma Funds

Account No. 5007 – Commission on State Emergency Communications

- Citation: Health and Safety Code § 771.072(f), § 771.077
- Funding: 911 equalization surcharges from long-distance intrastate service.
- Primary use: Funding for 911 emergency communications systems and poison control centers. Appropriations to DSHS are to fund county and regional EMS and trauma care systems.

Account No. 5046 – Permanent Fund for Emergency Medical Services and Trauma Care

- Citation: Government Code § 403.106
- Funding: Available earnings of funds transferred to the account at the direction of the Legislature from the tobacco settlement funds, as well as gifts and grants.
- Primary Use: SB 1, Eighty-second Legislature, First Called Session, 2011 expanded the allowable uses of the fund to include debt service related to general obligation bonds for the Cancer Prevention and Research Institute of Texas (CPRIT) from both the corpus and available earnings of the account. Amounts appropriated to DSHS fund administrative costs and provide grants to the Regional Advisory Councils and are made from the available earnings of the account.

Account No. 5108 – EMS, Trauma Facilities, Trauma Care Systems

- Citation: Health and Safety Code § 773.006
- Funding: Receives $100 court cost placed on alcohol-related convictions.
- Primary Use: Fund county and regional EMS, designated trauma facilities, and trauma care systems.

Other Trauma Funds – Revenue and Appropriations

Account	FY 2016-17 Estimated Revenues	DSHS Appropriations	Other Appropriations	Total Appropriations
Account No. 5007 - Commission on State Emergency Communications	$39,700,000[1]	$3,644,345	$32,175,306	$35,819,651
Account No. 5046 - Permanent Fund for EMS and Trauma Care	$45,554,000[2]	$4,774,868	$47,334,941[3]	$52,109,809
Account No. 5108 - EMS, Trauma Facilities, Trauma Care Systems	$8,000,000[2]	$4,765,395	—	$4,765,395

[1] Comptroller of Public Accounts, Certified Revenue Estimate 2016-17
[2] Comptroller of Public Accounts, Biennial Revenue Estimate 2016-17
[3] Other Appropriations from Account No. 5046 include funds for the payment of principle and interest on bonds issued on behalf of CPRIT

Conclusion

- DSHS is the primary agency receiving appropriations for EMS/Trauma
- The majority of trauma funding comes from four trauma-related GR-Dedicated accounts
- Trauma Facility and EMS Account No. 5111 is the largest source of funding for trauma related appropriations. $153.0 million is transferred from DSHS to HHSC for trauma add-on payments
- Regional Trauma Account No. 5137 was abolished during the 84th legislative session and the fund balance and revenues were transferred to Trauma Facility and EMS Account No. 5111
- To continue funding EMS and Trauma at current levels, it is expected that another revenue source would need to be identified or established in the Eighty-fifth Legislature due to depletion of fund balances in key trauma accounts

Contact the LBB

Legislative Budget Board
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Texas Trauma System:
Presentation to the House Appropriations Committee
Article II

Kathy Perkins, R.N.

Assistant Commissioner for Regulatory Services

Department of State Health Services

July 13, 2016

Need for a Trauma System: Injuries in Texas

- 2014 Data from Centers for Disease Control and Prevention (CDC)
  - 40 daily deaths from injury, 27 of which are from unintentional injury
  - 14,652 injury-related deaths each year
  - The leading cause of death for 5 – 34 year old Texans is motor vehicle crash

- 2013 Data from Texas EMS/Trauma Registry
  - Top two injuries causes were:
    - Falls
    - Motor Vehicle/Traffic
  - For every Texan who dies from trauma, at least six were seriously injured
  - 128,929 trauma hospitalizations

The History of the Trauma System in Texas

- Prior to 1989, Texas had no trauma system.
  - No coordination of state resources existed to ensure effective care for the injured.
  - At that time, approximately 1,000 EMS providers and 300 hospitals existed in Texas.

- The Legislature passed House Bill 18, the Omnibus Rural Health Care Rescue Act, in 1989.
  - The goal of this legislation was for emergency health care resources to be available to every person who is critically injured.
  - The key was building a system from the state's wide-ranging and unorganized resources.
  - Initial implementation was challenged by a lack of funding.

The History of the Trauma System in Texas (cont.)

- The original act required DSHS to:
  - Designate trauma facilities,
  - Develop and implement a statewide emergency medical services (EMS) and trauma care system, and
  - Develop a statewide trauma data registry to monitor the system and provide statewide cost and epidemiological statistics.

- Today, the trauma system in Texas includes:
  - 22 Trauma Service Areas governed by Regional Advisory Councils (RACS)
  - 282 designated trauma hospitals
  - 133 designated stroke hospitals
  - 63,395 EMS personnel and 793 EMS providers
  - 4,700 EMS vehicles

Trauma System Partners and Roles

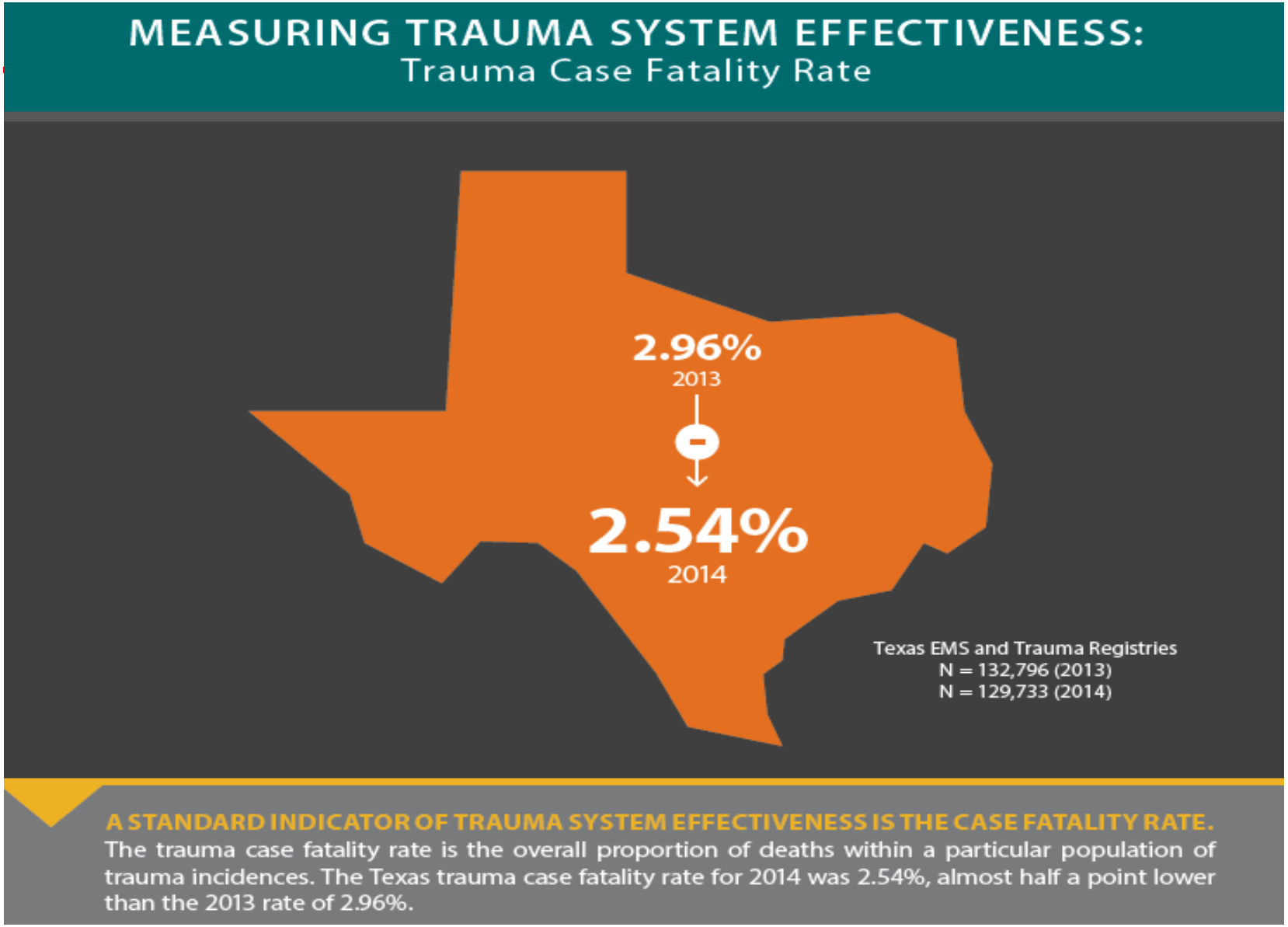
Upon **911** activation, **EMS response** is initiated and the injured patient is transported to a trauma facility or acute care center. Patient data is submitted to the **Texas & EMS Trauma Registries** at the DSHS. These data can be used to guide quality and performance improvement processes.

DSHS EMS Compliance ensures national standards for EMS service quality are met. The **DSHS Trauma Designation Program** ensures injured patients receive definitive levels of care at the appropriate trauma facility.

Regional Advisory Council (RACs) activities affect virtually every aspect of the trauma system. RACs are responsible for emergency healthcare system planning, including EMS transport protocol development, trauma diversion plans, regional performance improvement, disaster preparedness, and public education and outreach regarding injury prevention and incident recognition.

The Governor's EMS and Trauma Advisory Council (GETAC) advises the DSHS on trauma and EMS system development and serves to monitor the effectiveness of the Texas Trauma System.

Effectiveness of the Texas Trauma System



Importance of Trauma System Partnerships

- System partnerships ensure critically injured or ill persons get to the right place, in the right amount of time in order to receive optimal care.

- This partnership includes representatives from:
  - EMS
  - Cardiac, Stroke, and Trauma care entities
  - RACs
  - Texas EMS, Trauma, and Acute Care Foundation (TETAF)
  - Additional statewide organizations
  - Department of Public Safety (DPS)
  - Emergency Medical Task Forces (EMTFs)
  - Disaster Districts

- *If any of the components of the system are ineffective, the system as a whole is less effective and as a result the patient care may not be optimal.*

Regional Approach To Trauma

Texas is divided into 22 trauma service areas (TSAs)

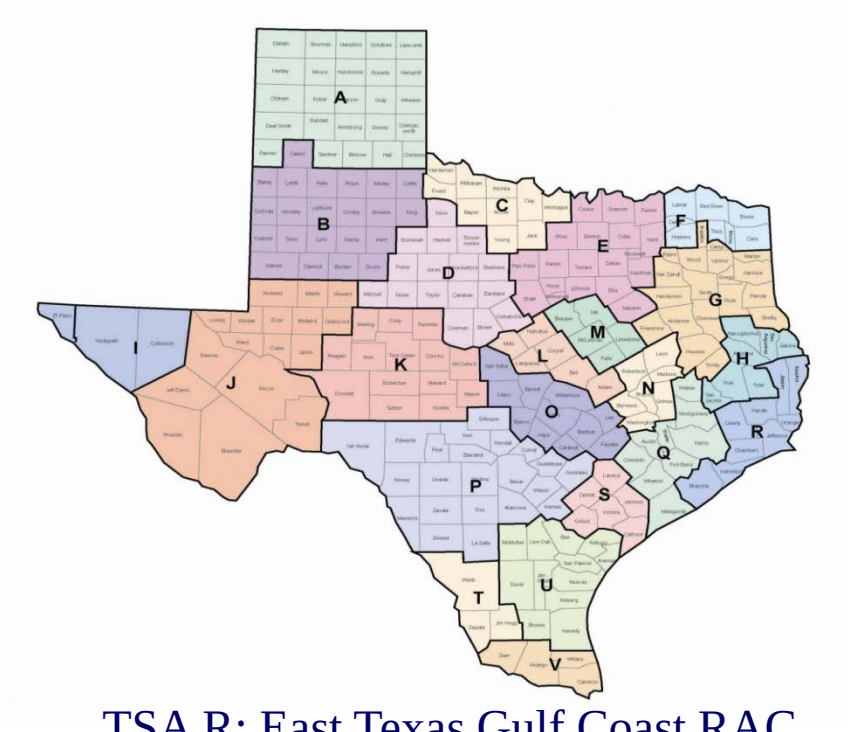
- Geographical trauma regions
- Established around existing patient referral patterns
- Each has a RAC

RACs vary in size, resources, and capacity

- Composition includes health organizations, providers, and interested stakeholders
- Varying staffing levels
- Difference in resources
- Urban versus rural

Texas Trauma Service Areas and Regional Advisory Councils

TSA A: Panhandle RAC
TSA B: TSA-B RAC
TSA C: North Texas RAC
TSA D: Big Country RAC
TSA E: North Central Texas RAC
TSA F: Northeast Texas RAC
TSA G: Piney Woods RAC
TSA H: Deep East Texas RAC
TSA I: Border RAC
TSA J: Texas "J" RAC
TSA K: Concho Valley RAC
TSA L: Central Texas RAC
TSA M: Heart of Texas RAC
TSA N: Brazos Valley RAC
TSA O: Capital Area Trauma RAC
TSA P: Southwest Texas RAC
TSA Q: Southeast Texas RAC



TSA R: East Texas Gulf Coast RAC
TSA S: Golden Crescent RAC
TSA T: Seven Flags RAC
TSA U: Coastal Bend RAC
TSA V: Lower Rio Grande Valley RAC

RAC Responsibilities

- Create and maintain trauma and stroke system plans
  - Tailored to regional resources and needs
  - Arrangement of available resources (EMS providers, hospitals)
  - Coordination of effective delivery of emergency health care service
  - Goal is to minimize the time from onset of injury or illness to appropriate definitive quality care
- Facilitate participation by EMS and designated facilities
  - There is at least one level III (basic) designated trauma facility in each RAC
  - RAC participation is required for designated facilities and EMS entities receiving DSHS funding
- Maintain all hazards emergency preparedness and response
  - Emergency Medical Task Forces (EMTFs) within RACs handle disaster preparedness coordination
  - Plans and equipment
  - Training and exercises
  - Partners in response

State Designations for Health Care Facilities

- Texas has two types of designations for health care facilities
  - Four levels of trauma designation, with level I being the most comprehensive
  - Three levels of stroke designation

- Two new designation types
  - Perinatal levels of care, HB 15 (83R); Texas Health and Safety Code (HSC), Chapter 241, Subchapter H
    - Requires a level of care designation for neonatal and maternal services to be eligible to receive reimbursement through the Medicaid program for those services
    - Neonatal Designation provisions of §133.181 adopted as of June 9, 2016; Maternal Designation rules to be adopted by March 1, 2018.
  - Centers of Excellence for fetal diagnosis and therapy, House Bill 2131 (84R); Texas Health and Safety Code (HSC), Chapter 32, Subchapter D
    - Designate one or more health care entities or programs in Texas, including institutions of higher education as defined by Section 61.003, Education Code.
    - Perinatal Advisory Council to make recommendations for designation rules to DSHS.

Levels of Trauma Designation

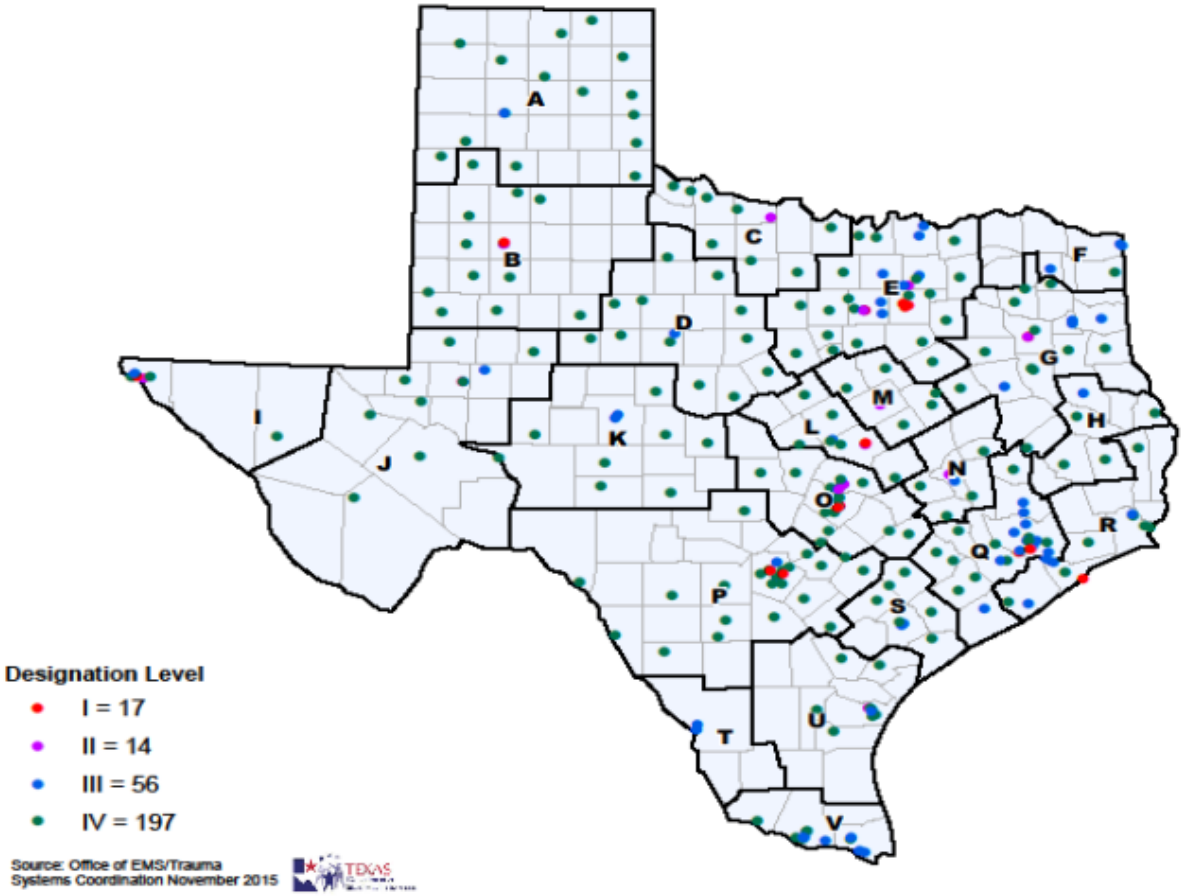
- **Level I** trauma centers provide multidisciplinary treatment and specialized resources for trauma patients and require trauma research, a surgical residency program and an annual volume of 600 major trauma patients per year.

- **Level II** trauma centers provide similar experienced medical services and resources but do not require the research and residency components. Volume requirements are 350 major trauma patients per year.

- **Level III** trauma centers are smaller community hospitals that have services to care for patients with moderate injuries and the ability to stabilize the severe trauma patient in preparation for transport to a higher level designated facility. Level III trauma centers do not require neurosurgical resources.

- **Level IV** trauma centers are able to provide initial care and stabilization of traumatic injury while arranging for transfer to a higher level designated facility.

Designated Trauma Facilities: 2015



Emergency Medical Services (EMS)

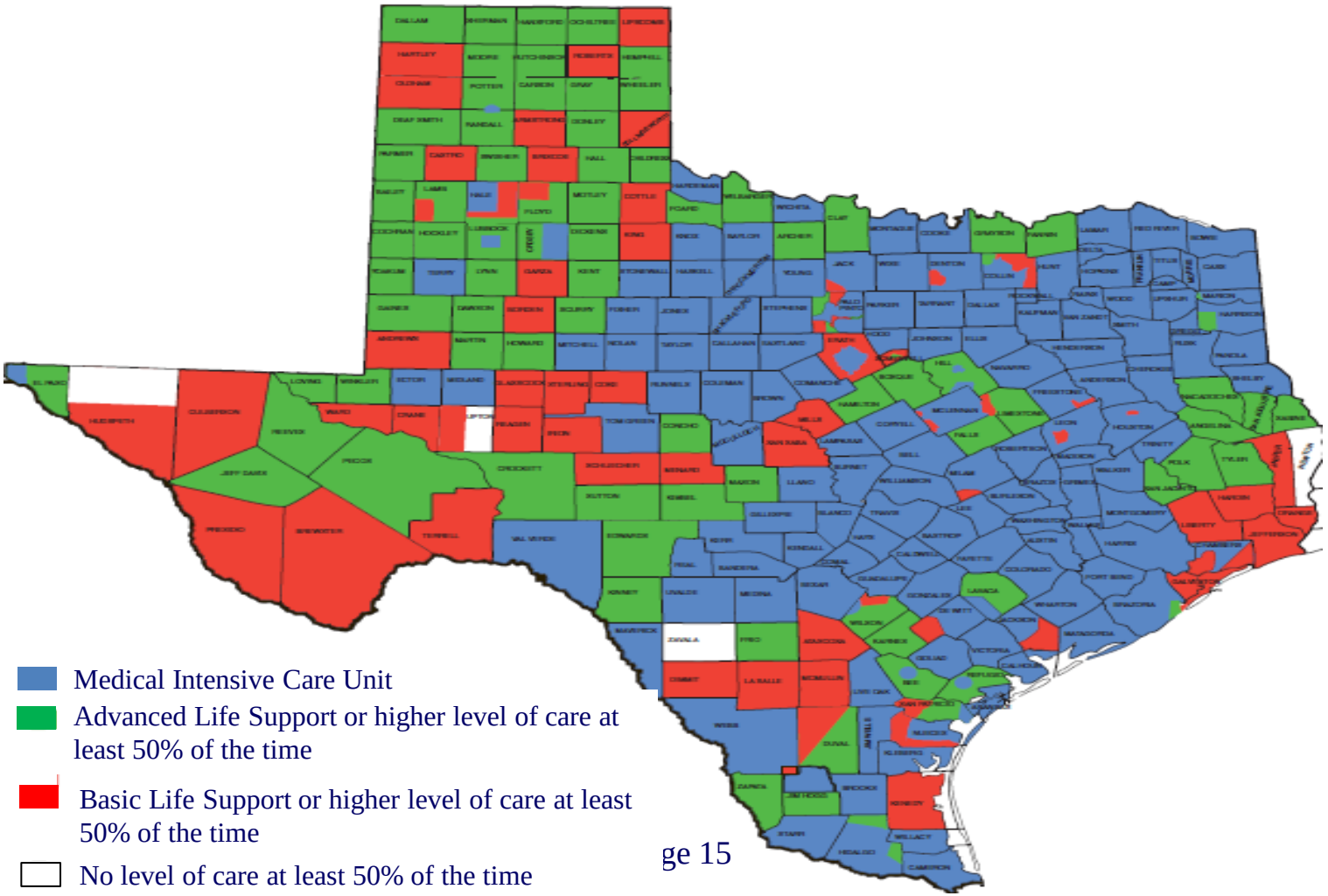
- EMS Providers in 2016
  - Total Number of Providers
    - EMS Agencies: 791
    - First Responder Organizations: 572
  - Ambulances: 4,427

- 63,395 EMS Personnel in 2015
  - 50,889 in 2005
  - 46,500 in 1994

EMS Dispatch Estimation: 2015

- 4,000,000 annual dispatches
- 7.6 dispatches every minute of the day

EMS Coverage in Texas



- Medical Intensive Care Unit
- Advanced Life Support or higher level of care at least 50% of the time
- Basic Life Support or higher level of care at least 50% of the time
- No level of care at least 50% of the time

Trauma System Funding

- Funding Streams
  - Driver's Responsibility Program (DRP) surcharges
  - $10 from the $30 state traffic fine
  - $100 DUI/DWI conviction surcharge
  - 911 Equalization Surcharge Funds
  - EMS and Trauma Care Tobacco Endowment
  - Photographic Traffic Signal Enforcement System (Red Light Cameras)
- Funding Uses
  - Hospital Allocation ($44M to HHSC for Standard Dollar Amount Trauma add on)
  - Extraordinary Emergency Funding
  - EMS Allocation
  - Regional Advisory Councils Allocation
  - DSHS Administrative Costs
  - Trauma Education partnership with Texas Higher Education Coordinating Board

Budget Issue: Uncompensated Trauma Care Reimbursement

- Between 2004 and 2015, hospitals applied for $7.9 billion in DSHS trauma reimbursement to cover their uncompensated trauma care costs
  - Total reimbursement during this time was $765 million

- House Bill 3588 (78R)
  - Created the Driver's Responsibility Program (Fund 5111)
  - Allowed partial reimbursement for Uncompensated Trauma Care to trauma facilities and hospitals in active pursuit of designation

- GR Accounts 5007 and 5108
  - Use at least 27 percent of the appropriated money to fund a portion of the uncompensated trauma care to designated trauma facilities
  - Also use any unexpended portions of the EMS and Trauma Service Area allocations

- DSHS reviews the data submitted for accuracy and reliability
  - May request additional data

- DSHS applies cost-to-charge ratios to all claims.

Budget Issue: Standard Dollar Amount Trauma Add On

- Senate Bill 7 (82(1))
  - Allowed "Trauma add-on" payments to facilities that qualify for Standard Dollar Amount (SDA) payments from the Health and Human Services Commission (HHSC)
- DSHS transfers funds to HHSC each fiscal year
  - Used to maximize federal funding under Medicaid
- HHSC distributes trauma add-on payments through the SDA payment process
  - Applies to Medicaid patients only
  - Not limited to only trauma patients
  - Trauma facilities are held harmless

Budget Issues: Actions by the 84th Legislature

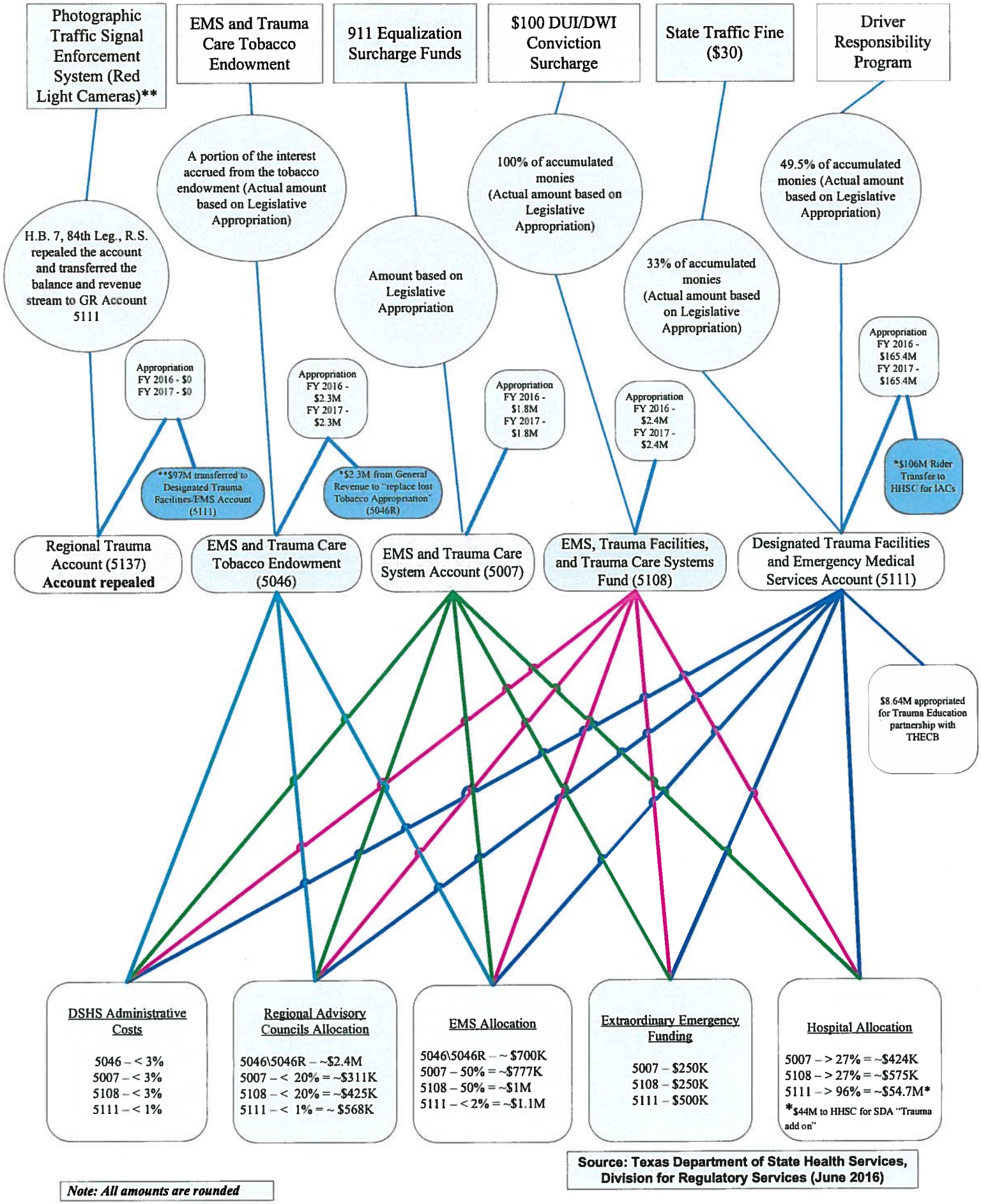
- House Bill 7 (84R)
  - Reduction to certain DRP fines, which may impact future appropriations to DSHS
  - Repeal of General Revenue-Dedicated Regional Trauma Account 5137

- HB 1, Special Provisions 32, 58, and 69
  - Requires DSHS to transfer monies to HHSC for three purposes: trauma add-on, a new rural hospitals add-on, and safety net hospitals.

Challenges to the Trauma System

- Size and Population of Texas
  - One of the largest and most diverse populations in the country
  - Limited number of emergency healthcare providers serving communities
  - Declining access to health care in rural/frontier areas
  - Aging population
- Organizational Issues
  - RACs are challenged to keep up with the demands of the healthcare system and preparedness activities
  - Aging workforce
  - Maintenance of current education and healthcare skills for workforce

DSHS TEXAS EMS/TRAUMA SYSTEMS FUNDING STREAMS



Source: Texas Department of State Health Services, Division for Regulatory Services (June 2016)

Note: All amounts are rounded

Testimony to Special Subcommittee of the Appropriations & Public Health Committees of the Texas House of Representative

By Kenneth L. Mattox, MD, FACS

Distinguished Service Professor

Baylor College of Medicine

Chief of Staff/Chief of Surgery

Ben Taub General Hospital

Chair RAC Q

(SETRAC)

Houston, Texas

Date: July 13, 2016

State Representatives Myra Crownover, Four Price, and other members of this study group:

For every nation of the world, the leading cause of premature years of life lost (Expected number of projected years of life to live X number of persons dying of a cause of death) is INJURY (**TRAUMA**)!!

Trauma SYSTEMS with the graduated levels of Trauma CENTERS and the supporting integrated services of EMS, Rehabilitation, and quality/value quality review SAVES LIVES. This standardized concept was developed through many organizations and agencies, particularly the American College of Surgeons (and its Committee on Trauma) in the 1970-1990 time frames, and continues today.

In Texas, especially due to its shear size, regional operations required more regionally based and knowledgeable personnel than the Department of State Health Services had available. A new concept emerged from one of the finest Texas healthcare pioneers, Kathy Perkins. Kathy created the concept of "Regional Advisory Councils (or RACS)" as a quasi-governmental structure for all 22 Trauma Service Areas in Texas to address EMS, Trauma Center, hospital participation, regional government participation, and quality loop closure. Each RAC developed local bylaws, meeting schedules, and ways to open a meager bank account.

Basically, the RACS brought regional Emergency Medical Services, hospitals, physicians, and emergency product lines together to develop communications, respect, standardization, and quality. **PROFESSIONALS TALKED TO EACH OTHER. It took several years, but at RAC meetings, competitors actually began to identify opportunities to improve care in the region, solutions were implemented and they are now led and sustained by that same group!**

Trauma hospitals became designated in order to differentiate based on capabilities. Trauma centers, particularly level 1 and 2, require the 24 hour availability of specialists, emergency,

operative and critical care venues, cardiac & neurosurgery product lines, and supporting equipment. Such value service for a population are not inexpensive and have become an EXPECTATION BY SOCIETY.

Especially for Level I Trauma Centers there is the extra responsibility **for EDUCATION, RESEARCH, and OUTREACH programs.** As an example, more than 75% of the medical/surgical professionals (>200 disciplines), have received all or a major part of their education at regional trauma centers, like Ben Taub General Hospital. A HUGLY EFFECTIVE SOCIETAL RESOURCE, significantly undervalued for its total service to our communities – SUCH A BARGIN !

The next paragraph is OPTIONAL, if Kathy Perkins has already entered this information into the record

To aid in the creation and financing of the trauma "system" (a system formed through the integration of hospitals and EMS agencies and RACs), state wide innovative funding assistance was developed via both "educational and trauma bills". Examples included the "red light camera fund" and other bills in the "driver's responsibility program" and through dedicated monies generated by "the Tobacco fund". Often, such valuable resources were only partially spent on their intended distributions and today they are no longer a dependable resource. Simultaneously, the value of RACs and the role of RACs continues to grow.

I applaud Speaker Strauss and the members of the legislature in this room for encouraging this important study. The notion of losing historical funding for hospitals and RACs and EMS agencies is a very scary situation. I can guarantee you that if someone in your circle of friends and family have not already needed the emergency services we are talking about this morning, SOMEONE YOU CARE ABOUT IS DUE.

Because of the tremendous efficiency and high value made possible by our integrated trauma system, it became LOGICAL to piggyback other emergency and critical societal medical functions on top of the trauma systems and to build upon the remarkable work of RACs.

RACs are now recognized for bringing together the finest medical minds within their region to collaborate and take steps to save lives when emergencies happen. Today, our trauma system embraces our entire emergency healthcare system. It has evolved from the wisdom of

legislators, DSHS leaders, RAC leaders, and community leaders over two decades. It has happened wisely… and purposefully… to cover most life threatening emergencies.

You may ask, what is different as a result of the work initiated by Ms. Perkins over two decades ago? The answer is that we no longer operate in silos, we operate as a system, - a COLLABORATIVE INTEGRATED NETWORK - and best practices are followed to address topics like:

- **Traumatic injuries due to falls, accidents, or acts of violence** - are now expertly and quickly stabilized in the field by a new class of first responders commonly known to us as "paramedics", pain is addressed, and solid actions are taken to minimize blood loss.

- **Strokes are wisely diagnosed in the field using protocols -** and patients are now transported to specially designated hospitals where, for instance, a clot busting drug is administered to return blood flow to the brain.

- **Heart attacks and life threatening arrhythmias** - are now diagnosed in the field, and results electronically received by hospital teams waiting the patients arrival. When indicated, heart catheters are inserted within 90 minutes or less from the time a patient arrives.

- **Unconsciousness patients** - are now quickly assessed by "paramedics" using protocols and rapid treatment begins in the field as the patient is transported to an appropriate hospital.

- **Pediatric emergencies from trauma, drownings, and even abuse** - are now treated at facilities capable of meeting those needs, and public education programs are numerous.

- **Disaster preparedness and medical responses** due natural disasters, mass casualty incidents, or terrorism is robust and supplemented by RACs forming Emergency Medical Task Forces to help meet needs statewide when resources are depleted.

- **Burns** are now treated by hospitals especially prepared and recognized for their expertise in burn care.

- **Sexual Assault victims** receive meaningful care more swiftly and providers continue to unite to expand services.

- **Comprehensive trauma plans** are maintained by each RAC to address nearly all needs, including options to transport patients from frontier areas for higher levels of care.

Published scientific papers on such linkages have reported some of the best regional results in the world among several of the Texas RACS.

I am optimistic that from your study, bills will emerge to assure that stable funding is identified AND that those funds are fully and swiftly sent to support our hospitals, our RACs, and our EMS agencies. Such funding would aid in the continuance of the essential functions of RACS and the essential components of our trauma and emergency healthcare system.

"THROUGH MY INVOLVEMENT WITH EMERGENCY & CRITICAL CARE TRAUMA, CARDIAC, STROKE, AND DISASTER PROVIDERS ACROSS ALL FIFTY STATES, AND TALKS I GIVE AROUND THE WORLD, I AM CERTAIN THAT THE RETURN ON YOUR INVESTMENT THROUGH THE POWER OF THE RACS (LITERATALLY THE GLUE THAT HOLDS THE REGIONAL SERVICES TOGETHER), MAKES OTHER STATES AND COUNTRIES LOOK AT TEXAS WITH ENVY."

God forbid such an occurrence, but should your constituents, your family or friends or YOU need the tremendously exemplary urgent services of our Texas Trauma and Emergency Healthcare System, we are there to serve you with grace, skill, and compassion. We want to be there for you.

In the words of the JACKSON 5: "Just call my name, I'll be there"

What issues can I help to discuss?

Texas Emergency Medical Task Force Testimony to The Appropriation Subcommittee on Article II & House Committee on Public Health July 13, 2016

Study the trauma system in the State of Texas including financing, service delivery, planning, and coordination between Emergency Medical Services providers, Trauma Services Area Regional Advisory Councils, The Emergency Medical Task Force, and hospitals. Determine strengths and weaknesses including challenges for rural areas of the state. Make recommendations to reduce any duplicated services, improve the coordination of services, and advance the delivery of trauma services in Texas.

Presented by: Eric Epley | Executive Director, Southwest Texas Regional Advisory Council

Thank you for the opportunity to testify in front of the joint committee. My name is Eric Epley. I currently serve as the Executive Director for the Southwest Texas Regional Advisory Council. I have been involved in Emergency Medical Services and Disaster Response since 1985, working as a Ground EMS Provider, Flight Paramedic and in my current role as an administrator in system development and improvement. Additionally, I serve as the Chair of the Governor's EMS and Trauma Advisory Council's Disaster Sub-Committee, the Department of State Health Services Preparedness Coordinating Council, the Texas Division of Emergency Management's First Responder Advisory Council and the Texas Emergency Management Advisory Council.

I am here today representing the Texas Emergency Medical Task Force (EMTF) as a member of the Executive Governance Committee and the Chief Executive Officer of the Regional Advisory Council responsible for coordination of the program on behalf of the Department of State Health Services. The Southwest Texas Regional Advisory Council has been intimately involved in the development and implementation of the Texas EMTF, along with many other RACs, physicians, emergency nurses and paramedics from across this great state.

I am testifying today on the portion of this Interim Charge related to the Emergency Medical Task Force Program. We appreciate the committees taking up this charge and would like to take this opportunity to provide information to the committees about the unique nature of our state's disaster response system, as it pertains to EMS and healthcare. We hope to provide information about preparedness and response activities that are going on in your communities, leveraging the resources that are providing critical EMS and healthcare services everyday, and show how the

EMTF program has allowed the State of Texas to rapidly employ those highly skilled resources in time of disaster.

A Brief History of the EMTF Program

The Texas EMTF Program was developed by the Regional Advisory Councils (RACs) and many of their stakeholders across the State following the Hurricane Season of 2008, which included responses to Dolly, Eduard, Gustav and Ike. The group saw a need to provide a more agile and flexible framework for activating ambulances and healthcare personnel to respond on behalf of the State to large scale disasters. At the time, the task fell to the Department of State Health Services, who during disaster, are the lead agency for Health and Medical activities and have a myriad of responsibilities. DSHS wisely chose to leverage the experience and knowledge in acute healthcare delivery through the RACS, since RACs work directly with EMS and hospitals every day in trauma, cardiac and stroke system development. The group insisted that a regionally-based system that is coordinated through a single entity at the State level would be best suited to engage the stakeholders and partners within their region that could provide these critical resources, while at the same time functioning cohesively within a larger state system when activated by DSHS.

It is important to recognize that the State of Texas owns few, if any, ambulance resources, nor does it operate hospitals or healthcare systems of the size and capability to provide the personnel and resources needed to respond to disaster. For this reason, the State relies on local jurisdictions to participate with local EMS units and other equipment in a larger state response. Likewise, when temporary medical facilities are required to augment hospital capability within an affected area, the State requires the assistance of hospitals and healthcare systems to provide the needed care. The Emergency Medical Task Force was developed to meet these needs through pre-designated response processes and comprehensive agreements with EMS Providers and Healthcare Systems within each of the eight EMTF regions (See Exhibit A). The EMTF capability was cultivated within the Regional Advisory Councils for the obvious reason that these entities already had the appropriate partners around the table for regional trauma system development and preparedness efforts, as well as high-level buy-in from executive leadership within local government and healthcare systems.

The EMTF Program was modeled after the successful processes honed by Texas Task Force-1, our state's Urban Search and Rescue and Swift Water response capability. TxTF-1was developed in the late 90's by gathering local responders from Fire/EMS departments and coordinating them in a single team. The TxTF-1 has been utilized time and again for statewide and national significant incidents. The TX EMTF Program focuses on inclusion of highly skilled providers that are doing the job everyday in the 911 ambulances and hospital emergency departments across the State. The program parallels the Federal DMAT System, or Disaster Medical Assistance Teams, except that it takes that capability a step further; placing preparedness and response capabilities within each EMTF region means that resources and trained personnel can respond faster to regional events, as well as statewide significant events faster and begin managing a situation before resources can arrive from elsewhere across the state or the nation. Additionally, the EMTF Program includes Pre-Hospital/EMS resources which are typically segregated in a separate contract within the Federal Emergency Management Agency.

The EMTF Program brings all of these capabilities for Pre-Hospital and Emergency Medical response under one program, and provides an easy interface for DSHS to rapidly deploy medical resources at the request of affected jurisdictions and elected officials during a disaster.

The Emergency Medical Task Force has been traditionally comprised of four components: ambulance strike teams, ambulance buses, mobile medical units and registered nurse strike teams.

The Ambulance Strike Team is comprised of five ambulances, with a Strike Team Leader in a separate vehicle with common communications and follows the National Incident Management System guidelines set by the Federal Emergency Management Agency (FEMA). Within each of the eight EMTF regions, the Regional EMTF Coordinators work closely with their EMS Partners to maintain agreements and regularly exercise the capability to mobilize five ambulance strike teams (25 ambulances) for a total of 200 or more statewide, available for both regional and statewide response. This component is by far our most active within the program. Ambulance Strike Teams have been mobilized several times in the past year, for flooding, severe storms, tornado response and shelter support.

The Ambulance Bus component was born out of a need to move larger numbers of patients over long distances. In contrast to Hurricane evacuations along the east coast of the United States with larger population centers, Texas offers the unique challenge of significant distance from one urban center to another, especially in the Lower Rio Grande Valley and Coastal Bend. Lengthy round trips for ambulances and other transportation platforms limit the number of trips that any one resource can make in a 24-hour period. The Ambulance Bus was designed to fill this gap, with a capability to move 20 patients at a time, and operate with different crews allowing for 24-hour utilization. The 13 Ambulance Buses currently in service in Texas were built using an identical specification developed by the EMTF Program after exhaustive research and consensus amongst the EMTF regions and partners that would be operating them, as well as hospitals that would be receiving the patients.

The Mobile Medical Unit (MMU) component consists of a 32 bed transportable emergency room designed to be agile and rapidly deployable. The MMU utilizes board-certified emergency room physicians, practicing emergency room nurses and skilled ancillary and support personnel to provide Emergency Department capability in austere environments or to augment local staff in the case of an event that exceeds the capacity of organic medical infrastructure. The component comes complete with personnel, equipment, inflatable shelters, pharmacy supplies and medical materiel required to care for critical patients and minor emergencies anywhere in Texas within hours. This capability is present in all eight regions within the EMTF Program, meaning that the Statewide EMTF Program can bring 256 beds to bear for a large scale disaster and assist with critical access to healthcare in an impacted jurisdiction following a disaster.

The Registered Nurse Strike Team was specifically designed to augment hospital staffing in the event of a mass casualty incident. Recent events, such as the Boston Marathon Bombing, the San Bernardino Shooting and the Orlando Night Club Attack, have reminded us, our healthcare systems will be intimately involved in any terrorist or mass casualty event. These localized incidents can exceed the capability of a hospital, healthcare system or regional healthcare

delivery system to care for the multitude of critical casualties. The RN Strike Team allows the EMTF Program to mobilize qualified and practicing nurses in crucial specialties, such as Emergency Nursing, Operating Room, Critical Care/ICU, Burn or Pediatrics, to be activated to augment and support hospitals in the affected jurisdiction. Because these nurses mainly come from Large Urban Medical Facilities, they require little to no orientation or supervision. Unlike their colleagues in the Mobile Medical Unit, these nurses are practicing in the hospital setting with intact infrastructure, but providing the health systems with access to skilled providers during a crisis.

The Emergency Medical Task Force Program also provides subject matter experts to assist local jurisdictions, as well as State Disaster District Committee Chairs with medical expertise and support during activations, whether EMTF resources are deployed to an area or not. These Medical Incident Support Teams, or M-IST, provide a critical link between the jurisdiction, its emergency management infrastructure and medical resources deployed to that area. Additionally, the M-IST teams have been provided extensive training in state and federal response capability and coordination, allowing them to provide expert guidance regarding other state and federal medical resources that can be requested to augment a response. The M-IST teams are comprised of executive and senior operational leaders within hospital systems and EMS agencies. They are trained to support and assist EMS directors and hospital supervisors within an affected community, providing a critical communication link to the jurisdiction, as well as providing "ground truth" by putting eyes on a situation and relaying real time information, when requested. And because these personnel are comprised of hospital and EMS leaders, they easily assimilate information and jargon because they are immersed in similar situations in their daily work.

Key Successes for the Emergency Medical Task Force

The Emergency Medical Task Force Program has seen broad acceptance across Texas, to include not only State Agency Partners and Stakeholders, but a large number of municipal and private EMS providers, Emergency Physicians Groups, Hospitals and Healthcare Systems, as evidenced by over 300 signed Memorandums of Agreement with participating partner agencies. Beyond that simple figure, however is the overwhelming success the Program has experienced with building infrastructure within the EMTF regions and across the State. The EMTF Program developed an ***Ambulance Staging Managers Course*** that provided detailed training to EMS supervisors in the organization and logistical support necessary to operate a staging area for Ambulances, Ambulance Buses and other transportation platforms during a disaster. More importantly, the course defined the process to task assign and track these critical resources as they conducted the business of evacuation, operational support, continuity of government and other vital functions required of EMS units in a disaster response. This course and the associated materials developed during the process has been recognized at the federal level and is being considered for inclusion in the FEMA Resource Typing document.

Similarly, the Executive Governance Committee of the Emergency Medical Task Force, which includes leadership from the Regional Advisory Councils, the Department of State Health Services and key partners developed the ***Medical Incident Support Team Course***, a two day interactive educational experience that provides in-depth training to executive and senior level

administrators at EMS agencies and Healthcare Facilities with the knowledge to support government, hospitals and local EMS agencies with critical tasks required during a disaster, such as evacuation, sheltering, incident management, critical information systems and collaboration with search and rescue. This course includes presentations from senior leaders from local, regional, state and federal agencies responsible for each element of disaster response. The program has been developed closely with the Department of State Health Services and the Texas Division of Emergency Management to ensure good communication and coordinated response between all disciplines and interoperability within the overall incident management structure.

Most profoundly important to the program is the success of EMTF responses since the inception of the program in early 2009. The Emergency Medical Task Force Program has responded to many significant incidents across Texas, most notably Hurricane Alex in 2011, the Bastrop Wildfires in 2011, the West Fertilizer Plant Explosion in 2013, Memorial Day Floods of 2015, several tornadoes in North Texas in late 2015 and flooding events in 2016.

A key to the success of the EMTF Program is a comprehensive After Action Review of each response to allow the program to celebrate successes within the program, along with our partners who provided resources to the response. It is also vitally important to examine opportunities for improvement, both internal to the program and relating to relationships with other agencies and partners in the response. The Texas EMTF Program participates in all State-level After Action Reviews, in conjunction with DSHS and TDEM. In addition, the regional nature of the EMTF Program allows Regional EMTF Coordinators to participate in review of the overall response alongside the affected jurisdiction. Because of the integration of the EMTF Program in the regional mutual aid process in each region of the State, the program is uniquely positioned to interact with the local jurisdictions we serve.

Next Steps for the Emergency Medical Task Force

The EMTF Program has seen explosive growth and great success in its first seven years. The Program is well known at high levels within the US Health & Human Services Department, as well as the Federal Emergency Management Agency. It serves as a model to the nation for organizing and coordinating local and regional resources for a state response. The key to the success of this system is the close relationship and critical agreements with local EMS providers, hospitals and healthcare systems. These agreements and relationships have set the stage for the future growth of the program. The EMTF Memorandum of Agreement can be seen as a “road”, built to move ambulances, ambulance buses and MMU resources toward a problem. It is important to realize that many other critical needs exist that can also benefit from the “road” that the program has constructed.

The Texas EMTF Program, through the State Coordinating Office, has developed a system to manage the activation and utilization of air medical resources during disaster operations. Working closely with air medical providers throughout the State, and utilizing the EMTF Memorandum of Agreement, the Texas EMTF State Coordinating Office has medically equipped aircraft, crews and personnel ready to assist with deployment and operational management of these critical resources for transporting patients by helicopter and fixed wing aircraft during disaster.

Within the last 12-18 months, the Emergency Medical Task Force Program has been tapped to provide preparedness and response capability for the transportation and care of patients with High Consequence Infectious Disease (HCID), such as Ebola. Utilizing funds allocated by the 84th Legislature, the Department of State Health Services has tasked the EMTF Program with the development of the Infectious Disease Response Unit, or IDRU, that can not only provide a comprehensive solution for safe movement of HCID patients, but assist hospitals and healthcare systems with specially trained clinical staff to augment and support providers that are currently caring for these complex patients. In addition, the IDRU houses and maintains caches of personal protective equipment intended to augment healthcare facilities following a request for State assistance for the care and transportation of these patients.

A similar effort is being undertaken for management of mass fatality incidents with the inclusion of the Texas Mass-Fatality Operations Response Team, or TMORT, in close coordination with the Texas Funeral Directors Association and several larger urban Medical Examiners Offices and Institutes for Forensic Science. This and other capabilities are being included in the EMTF Program primarily because of its ability to activate local and regional resources through the EMTF Memorandum of Agreement … the "road" that has been built over the last seven years.

Challenges for the Emergency Medical Task Force

The Emergency Medical Task Force has recognized some significant, yet unique challenges during the first seven years of its existence which are due in part to the Regional Advisory Council's unique niche as a 501c3 corporation with basis in Texas Statute (Omnibus Rural Healthcare Rescue Act of 1989). The primary concerns revolve around formal recognition of the Emergency Medical Task Force Program and funding concerns.

Issues pertaining to formal recognition focus on resolution of logistical issues, such as vehicle registration. The role of the Regional Advisory Councils within the Emergency Medical Task Force place several RACs in a unique position, requiring them to purchase, register and maintain response-ready vehicles and equipment. Because of the primarily administrative legacy of Regional Advisory Councils, many EMTF regions are struggling to maintain equipment in a mission ready status. We hope that some simple amendments to legislation and rules pertaining to RACs and Disaster response vehicles will help to clarify these issues, and allow the Emergency Medical Task Force to function more effectively, provide more efficient response and be good stewards of funds dedicated to this purpose. The TX EMTF State Coordinating Office and Executive Coordinating Committee for EMTF is eager to assist in any way possible.

The most significant challenge faced by the Emergency Medical Task Force is funding. Currently, the program is funded with CDC's Federal Hospital Preparedness Program (HPP) dollars that are distributed through a sub-award from the Department of State Health Services. The HPP funding has plummeted in recent years, with 20-30% cuts each year for the last several years. Recognizing the importance of the Emergency Medical Task Force Program for the State, and its relevance to many of the preparedness goals of the state and federal Hospital Preparedness Program, the Regional Advisory Councils have historically carved EMTF funds off the top of the statewide HPP funding, prior to distribution to the HPP contractors for hospital

preparedness activities. With the downward trend in federal funding for preparedness, these funds have become insufficient for care and maintenance of the equipment, as well as training and exercise of the EMTF components. Furthermore, no funds have been allocated to address the need to replace equipment as it reaches end of life, such as shelters, trailers, vehicles and ambulance buses.

Infusions of funding have become available following large scale national disasters and incidents, such as Ebola, H1N1 Swine Flu and other events. However, this funding is episodic and is typically targeted toward specific capability, not toward the overall mission-ready capability of the Emergency Medical Task Force. In order to maintain reliable, response-ready capability within each EMTF region, and across the State, the Program requires dependable funding to allow for budgeting of vehicle and equipment purchase, training and exercise for responders and replacement of consumable supplies and equipment that has reached end of life, or is otherwise considered obsolete.

The Emergency Medical Task Force requires $9M biennially to completely fund preparedness and response activities in each of the eight EMTF regions and statewide. This figure includes an allocation for the regional EMTF Coordination Centers, as well as the State Coordinating Office. Funding would include training and exercise for each of the components of the overall EMTF Program, and provide for appropriate staff to ensure the readiness of this critical resource. Replacement funding for vehicles, trailers and ambulance buses would be also be accomplished using these funds, providing resources not only for State activation, but for local and regional response for mass casualty events anywhere in the State. This funding can be accomplished by any combination of grant funding, exceptional item funding, or general revenue allocation, however in the presence of dwindling federal grant dollars, permanent and reliable funding is an absolute necessity.

The Emergency Medical Task Force, as a whole, is a state level program that has far-reaching benefits at the regional and local level, improving preparedness and response capability across the State. Ensuring continuation of the EMTF Program through permanent funding would demonstrate support for the inevitable medical needs of the citizens of Texas affected by disaster, and in doing so support the local and regional agencies that provide that care when the State calls. Significant gaps in EMTF Funding, utilizing the current under-funded and episodic funding model which relies on waning federal funds at the detriment of hospital preparedness activities where the money was originally intended puts Texans at risk, especially the vulnerable populations that rely on Emergency Medical Assistance from the State during times of disaster.

Thank you for allowing me the opportunity to discuss the Emergency Medical Task Force Program with you here today. I genuinely appreciate all of the support that members have provided in the past, the interest many of you have shown in our program over the last year, and your continued support for this critical program that supports the medical needs of Texans during disaster. I am honored to represent the EMTF agencies in your communities who work tirelessly to care for your constituents during a disaster. I speak for myself and the entire EMTF Program when I say I look forward to working alongside the 85th Legislature to ensure Texans are more prepared and ready to respond to disasters anywhere in our Great State.

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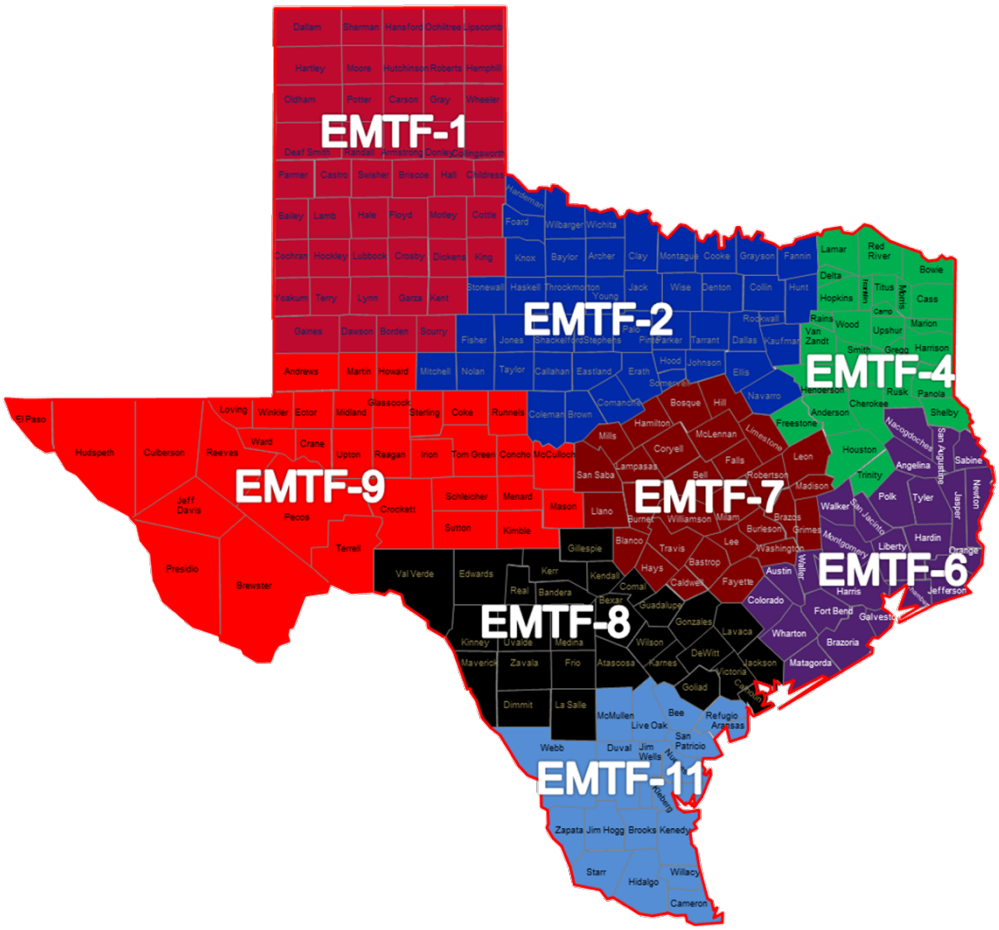
Exhibit A

Texas Emergency Medical Task Force
Regional Map



In order to minimize confusion and maximize synergy with public health partners, the EMTF Regional Map follow the boundaries of the Texas Department of State Health Services Regions.

Texas EMS Alliance Testimony
Appropriation Subcommittee on Article II &
House Committee on Public Health
July 13, 2016

Study the trauma system in the State of Texas including financing, service delivery, planning, and coordination between Emergency Medical Services providers, Trauma Services Area Regional Advisory Councils, The Emergency Medical Task Force, and hospitals. Determine strengths and weaknesses including challenges for rural areas of the state. Make recommendations to reduce any duplicated services, improve the coordination of services, and advance the delivery of trauma services in Texas.

Presented by: Dudley Wait | President, Texas EMS Alliance

Thank you for the opportunity to testify in front of these two committees. My name is Dudley Wait. I am a paramedic and have served in a variety of roles in all types of EMS agencies across my thirty-year career. I currently serve as an Executive Director for the City of Schertz and am responsible for all of public safety including fire, police, and EMS. Additionally, I currently serve as the Chair of the Governor's EMS and Trauma Advisory Council's EMS Subcommittee. I am also the Treasurer for the Southwest Texas Regional Advisory Council for Trauma (known as STRAC), and serve as their Pre-Hospital Committee Chair.

I am here today representing the Texas Emergency Medical Services Alliance (TEMSA) as the President of the Board of Directors. At the end of the 2013 Texas Legislature, several EMS leaders came together to create a collaborative public policy voice for agencies that have demonstrated their commitment to serving our communities across this great state. TEMSA membership accounts for almost 10-percent of all licensed EMS agencies providing 9-1-1 and inter-facility services to both urban and rural areas across Texas. Additionally, our membership represents all of the EMS models that will be discussed later.

I am testifying today on the portion of this Interim Charge related to EMS providers. We appreciate the committees taking up this charge, and would like to take this opportunity to provide information about the unique nature of our state's EMS delivery system. We want to offer some potential public policy solutions for the 85th Texas Legislature for

your consideration to ensure that Texans continue to have access to outstanding ambulance services.

The Cost of Readiness:
Unique Financial Challenges that Texas EMS Agencies Face

EMS agencies either are, or should be, a vital part of every Texas community. Unfortunately, many of our Texas communities are struggling to keep their local EMS service funded. Every citizen of Texas expects to be able to pick up the phone, dial 9-1-1, and receive high quality emergency medical treatment. However, there is currently no revenue source for EMS that provides compensation for providing that "state of readiness."

EMS is a unique segment of the state's healthcare system. EMS is typically utilized as the first entry into the healthcare system. From a clinical standpoint, an EMS agency is the only type of healthcare provider that is licensed to respond to the location of a patient suffering from an acute onset of illness or traumatic injury, provide patients with initial care on scene, and offer timely access to specialized segments of the healthcare system, such as a trauma hospital or stroke center. From a financial standpoint, the hundreds of EMS providers in our state utilize over a dozen different financial models to help ensure that they can hopefully be ready to meet their community's needs.

It is a common misconception that ambulance transportation is a free and essential public service whose cost is completely covered by local taxes like those of police and fire departments. Tax funds do not cover the full cost of providing EMS services to a community. As a result, it is up to the EMS agency to cover the shortfall through billing the users of the system, or even going to greater lengths when patient billing does not provide enough revenue. This sometimes results in EMS agencies turning to fundraisers such as barbecue dinners and pancake breakfasts to keep the lights on and the trucks running.

Additionally, the financial model for ambulance reimbursement is a flawed fee-for-service model. An ambulance provider is only reimbursed by insurance, Medicaid, or Medicare if they transport a patient to a **hospital**. This has resulted in a pre-hospital system where we utilize the most expensive mode of transportation (an ambulance) to take patients to the most expensive place to receive healthcare (a hospital emergency department). In our current environment of increasing value, improving the patient experience, and decreasing costs, this model has become antiquated and is potentially fatal for ambulance organizations across the state.

Some examples of how this flawed model results in excessive costs include:

a. Patients being transported who could be appropriately treated by paramedics at the scene and released to follow up with their primary care physicians. An example is a known diabetic patient whose blood sugar is too low, which

often results in a transport to the hospital where the patient is quickly evaluated and released.

b. Patients who could appropriately be cared for by their physician or at a minor emergency clinic for injuries and conditions such as a simple arm fracture, an episode of gout, or the flu. Instead, these patients are transported to an emergency department where an x-ray is taken or labs are run, and then the patient is released to follow up with an orthopedist or personal physician in their office.

In a better designed reimbursement system, ambulance providers could become an active partner in patient destination and treatment management, instead of just taking everyone to the hospital, even when that is not in the patient or the healthcare system's best interest. I will highlight some new models that address these issues later in the written testimony.

In regards to current reimbursement, Texas EMS agencies typically rely on four different revenue sources to cover operation costs, and they include:

Billing the Patient:

When transported to a hospital, the EMS agency bills the patient for the service. However, since the cost of readiness often far outweighs the revenue generated by billing, such revenue is rarely enough to cover the entire EMS agency's operations. This funding model attempts to put more of the cost of providing EMS on the actual users, instead of all taxpayers in the community.

However, billing the patient is also problematic due to the often low rates paid by both commercial and government (Medicare and Medicaid) health insurance plans. Numerous studies show that Medicare reimburses ambulance providers *substantially less than the cost of providing services*. Texas Medicaid rates *are even lower at approximately 30-percent of the prevailing Medicare rate.*

Meanwhile, commercial health insurance payments are highly variable, both in payment rates and in processing time. Frustrating to both patients and ambulance providers, some commercial health insurance plans make a very small payment, which leaves the remainder of the bill for the patient to be responsible for out of pocket. Often commercial health insurance plans attribute this to the 9-1-1 ambulance provider not being an in-network provider, yet several insurance providers have no in-network ambulance providers anywhere across the state. Furthermore, in an emergency situation, the patient does not have the opportunity to "choose" an in-network provider.

Local Tax Funds:

If billing the patient does not meet the total cost of providing the service, EMS agencies often must rely on local taxpayer dollars, if available, to cover its shortfall. The use of

these tax funds is a local decision, which creates a wide variability in their availability across the State.

In addition, EMS agencies are expected to be ready at all times and respond to every emergency, even if a patient is not transported to a hospital. The "cost of readiness" expense is the largest cost to an EMS agency and includes having staff on duty, vehicles stocked and ready, and other operational factors such as dispatch functions and administrative logistics. These expenses are not billable unless the patient is transported.

Federal and State Grants:

The state and federal government funding of EMS operations is extremely limited. In Texas, the Dedicated Tobacco Fund, which has almost been exhausted due to a change in law during the 2011 special session on education, provided monies for EMS agencies through Local Project Grants, which allow for the purchase of capital assets and life-saving equipment such as AEDs, cardiac monitors, ambulances, stretchers, and enhanced clinical training for EMS personnel.

In addition to the dwindling tobacco dollars, we have limited funding from the Driver Responsibility Program, which offers EMS agencies that participate with their RACs to capitalize on this program. While the funds are small, they are critical to EMS agencies all over Texas in their struggle to survive.

Unfortunately, Federal grant funds for EMS are extremely rare.

Community Fundraisers:

Many EMS agencies in our rural communities are forced to rely on creative fundraising events to help provide revenue for the EMS service. It is not uncommon to hear of Spaghetti dinners, Pancake breakfasts, or even raffle drawings to help cover costs. Occasionally, a community will have a local philanthropic trust or organization that may contribute to the EMS service. Although these funds may be small, scores of EMS services rely on this as well as countless hours from volunteer personnel to continue doing business.

Each EMS Agency Is Different

Fewer than 800 entities are licensed by the Texas Department of State Health Services to provide EMS service to Texas communities. However, each EMS provider may have a specialized skill-set specific to their community or mission:

A. Agencies may specialize in responding to 9-1-1 calls by responding to a patient's acute onset of symptoms and transporting them to an appropriate hospital.

B. Agencies may specialize in continuing care in which an ambulance transfers a patient from a lower level of care to a more specialized setting. An example may

be an ambulance transferring a patient from a rural hospital to a more specialized urban facility. Some of these agencies may also be the 9-1-1 provider or serve as a back-up to the community's primary 9-1-1 EMS provider.

C. Agencies may provide critical care transfers from a hospital to a specialized hospital. These agencies require a higher level of training and equipment to provide continuity of care for patients in critical conditions who already have received intensive care and must have that care continued during transport.

D. Agencies also often have specialized roles such as: Special Rescue Teams, Tactical Medicine Teams, or Event Medicine teams that provide medical services at large scale events or sport venues.

E. Many agencies in Texas provide all of these services, and more.

Texas is such a large and diverse state that each community utilizes a different model for delivering 9-1-1 services to its citizens.

The following is a look at the different EMS models utilized by Texas communities.

A. The Fire Department Model. Some communities have its EMS operations as a part of the community's fire department. The cities of San Antonio, Dallas, Houston, Lewisville, and Flower Mound are examples.

B. The Government Owned and Operated EMS model (3rd Service). Some EMS entities within communities operate as an independent agency within the local government (City, County, Emergency Services District, Hospital District, etc.) and are separate from the fire department. This is called a 3rd Service EMS agency in which the city has three services: a police department, a fire department, and a separate EMS department. Austin/Travis County EMS and the City of Schertz EMS are examples.

C. Contracted EMS. Some cities or counties may contractually outsource the 9-1-1 ambulance function to a private EMS company. Bastrop County and Bexar County contract with Acadian Ambulance and the city of Tyler contracts with East Texas Medical Center EMS to provide their ambulance services.

D. Chartered or Private EMS agency. Other counties or cities may collaborate with an EMS agency, which is a non-profit (often originally formed as a volunteer organization), to provide EMS services to fulfill the community's needs. Harris County Emergency Corps, which was founded in 1927 and served as Texas' first EMS agency, provides EMS 9-1-1 service in north Houston for over 400,000 people. Angleton Area Medical Corps in Brazoria County is another example.

E. **Hospital-based EMS.** In some communities the EMS service is an extension of the local hospital. Coryell Memorial Healthcare System in Gatesville, Texas is an example of this type of system.

F. **A Multitude of other models.** Across Texas, communities provide EMS in different models as diverse and different as Texas is itself. The adage "If you have seen one EMS system, you have seen one EMS system" is very true in Texas.

Clinical Advances in EMS

Recent advances in the fields of trauma, septic shock, heart attack and stroke care have resulted in countless saved lives. EMS serves as the front line health care provider for both these and many other life-threatening conditions. The ability of EMS professionals to provide initial care and assessment during initial contact and to provide continuity of care during transport to a hospital gives the patient the best chance for a favorable outcome.

When symptoms of a heart attack begin to present, cardiologists recommend that a patient call 9-1-1 instead of driving themselves to a hospital. EMS professionals have the ability to begin treatment immediately in the field, which reduces the potential irreversible damage to the patient's heart muscle. EMS professionals can assess the patient's vital signs and cardio electrical activity and trigger the cardiac catheterization lab at the hospital. Research finds that patients who have access to an angioplasty within 90 minutes of first medical contact typically have the best outcomes. Without the early assessment, treatment, and activation by EMS, reaching this 90-minute window is often impossible.

While EMS clinical capabilities are evolving and saving patient lives, the EMS payment system has remained stagnant for decades. With limited exceptions, EMS agencies are only paid if the ambulance ultimately transports a patient to a hospital emergency department.

This creates a system wherein it is in the best interest of the EMS service to transport a patient to the most expensive care source – an overcrowded hospital emergency department – to be seen by a physician who does not know the patient and may not have access to the patient's records. A recent article in the Journal of the American Medical Association stated that although EMS represents less than 1-percent of healthcare expenditures, they drive 23-percent of healthcare expenditures. EMS should be empowered to pursue finding alternative medical options that are ultimately in the patient's and the healthcare system's best interests, without hampering the agency's ability to collect revenue. This issue is being recognized at the Federal level as well. The National Academies released a June 2016 report that recommended, among other things, the modification of the Centers for Medicare and Medicaid Services (CMS) ambulance fee schedule to recognize the new capabilities of EMS agencies.

Ironically, EMS providers' advances in clinical care may hurt their reimbursement in some situations. With better training, paramedics are able to treat more patients at the scene, which results in no hospital transport. While the overall health system saves money due to the lack of a hospital visit, EMS providers ultimately lose money because they are only paid when they transport to the ER.

EMS agencies face a variety of costs associated with responding to 9-1-1 calls including a state of readiness which involves unit availability, personnel, fuel, ambulance maintenance, insurance, and a multitude of other factors. This readiness cost, as well as the costs of supplies and time used to treat patients, is not reimbursed when a patient waives hospital transport.

To help improve patient outcomes, improve the patient's care experience, and reduce healthcare expenditures, the Legislature should work with healthcare stakeholders to allow the testing of innovative economic models for EMS, moving away from the misaligned incentive of using the most expensive transportation mode, (an ambulance) to take the patient to the most expensive treatment destination (an emergency department).

These new models could include payment for the response to the scene versus the actual transport, in the form of capitated payments or payment for delivery models that prevent an ambulance response, such as 9-1-1 nurse triage programs, and community paramedicine. While these models still do not pay for the cost of readiness, they do provide revenue streams outside of transport, which will further incentivize EMS agencies to do what is best for the patient, even if that is not to transport them at all.

Some healthcare stakeholders, such as commercial health insurance plans, are recognizing the value of EMS agencies' non-emergency services and incorporating these into new health care delivery models. The programs, which consist of EMS agencies joining with community healthcare partners to improve outcomes and reduce costs, are often referred to as community paramedicine programs. Texas is home to some of the most innovative models.

MedStar Mobile Healthcare is the ambulance service provider for Fort Worth and 14 other Tarrant County cities. As the EMS provider for more than 938,000 people in the greater Fort Worth area, MedStar sees the value of the 9-1-1 system for medical and trauma conditions that, for the patient's benefit, could best be addressed by a response other than an ambulance trip to an emergency department. In July 2009, MedStar implemented the Mobile Integrated Healthcare (MIH) program that identified high system users and developed individual care plans for each of those patients. Through the MIH program, MedStar is exploring a number of novel approaches to healthcare including providing surgical preparation coordination, directing patients to primary care rather than to the emergency care system, medication reconciliation, and a number of other programs. MedStar is considered one of the national leaders in the area of MIH and community paramedicine.

Higher Education related to EMS

In 2013, The Department of State Health Services began following the national recommendations requiring accreditation for all paramedic education programs. This process has elevated the educational requirements for paramedics so that they are equal to, and sometimes greater than, that of registered nurses. However, it did have the unintended consequence of limiting the number of available paramedic programs, especially in the rural areas of Texas. Exhibit A, at the end of this testimony shows the number of Paramedic training programs in Texas in March, 2011. Exhibit B shows the number of Paramedic programs that exist today in 2016. These exhibits clearly show a 20-percent decrease in the availability of Paramedic training programs across the state with many of the decreases in the more rural and frontier locations. A number of non-college based educational entities and some community colleges elected to end their Paramedic programs in 2013 as they did not have the personnel or funding to go through the accreditation process, or they did not see the program as being break-even or profitable. As you will hear later, this is resulting in a larger shortage of paramedics in the underserved rural and frontier areas of Texas.

Currently there are only a few national undergraduate degree paramedic programs, which tend to focus almost exclusively on management, not on clinical care. There currently are a very limited number of options for paramedics to take their paramedic education and experience and move further into the healthcare system. The 84th Texas Legislature's action that allowed paramedics to work under the supervision of a physician in hospital emergency departments was an important step to offer another career path for Paramedics.

Workforce Challenges

The number of quality EMS professionals is a challenge throughout Texas. This is especially true in the rural areas of the state. The Panhandle RAC recently performed a study that showed alarming demographics regarding the increasing age and decreasing number of paramedics in that region. I think you will find the information about the demographics in our rural regions presented by the second panel of speakers to be quite informative.

In addition, EMS agencies across the state are constantly challenged to compete for healthcare recruits that may also be considering other allied healthcare professions with similar lengths of education requirements, but result in higher wages such as nursing, radiology, and phlebotomy. The current 2-year education requirement to become a paramedic also forces EMS agencies to compete with industries that may require a shorter education process and provides a higher income such as jobs in information technology and other traditional trades. In addition, in the rural and frontier areas of Texas where volunteers are relied upon to staff ambulances every day, the increased requirements of paramedic education make it extremely difficult for someone to invest two years of time just to *volunteer* to help their local communities.

Besides relatively low wages and current education requirements, we believe that other major challenges we face in recruiting more students into EMS is the currently limited number and types of career paths in EMS, as well as the perception that EMS is only a transport provider, rather than a bona fide part of the healthcare system. These are issues that we continue to work on as an industry in order to provide more opportunities to our workforce.

Finally, EMS is losing highly experienced and qualified paramedics due to the effects of high levels of stress and a lack of recognition of Post Traumatic Stress Disorder (PTSD). EMS leaders who are struggling to pay the cost of readiness, recruit, train staff, and maintain daily operations often miss the signs and symptoms of PTSD. Unfortunately, when it is recognized, the EMS agency likely has no means to assist their staff other than to encourage them to utilize their healthcare benefits to seek help. As a result, across our state and nation, we are seeing increased levels of EMS employee suicide attempts, suicides, and substance abuse issues. EMS agencies need to be provided with resources available across the state to help combat this slow debilitating illness.

Issues Specific to Rural EMS Agencies

Rural EMS agencies throughout the state face some of the most difficult challenges related to funding, workforce, education, and providing response to vast areas of Texas. Often rural EMS agencies cover hundreds of square miles of response areas, with limited staff who are overworked and underpaid (or not paid). Patients often have to be transported over a hundred miles to be treated appropriately, leaving the community with less (and sometimes no) EMS coverage for hours while the transporting unit is on the road, in addition to the lengthy times that volunteers are away from their paid jobs and families.

Rural communities often face the challenges of recruiting staff to live and respond in their community, as well as finding the means to educate those that wish to become paramedics. Many rural EMS agencies rely heavily on volunteer on-call responses to provide EMS care, which, when compounded with the limited educational availability, often leads to a small number of staff that are responsible for providing care constantly to the community. Some of these volunteers spend days or even weeks at a time "on call" because there is simply no one else available to respond.

Key EMS Issues in the 85th Texas Legislature

Over two dozen issues had a direct impact on our state's EMS agencies in the 84th Texas Legislature, and we expect a similar level of EMS-related bills in the upcoming session. We realize that revenue will be extremely limited in the 85th Texas Legislature, therefore, we are focusing on several priorities that will enhance the operations of Texas' 9-1-1 providers and not result in large expenditures from the state.

Ambulance Fuel Tax Relief for 9-1-1 Services

The 84th Texas Legislature took an important step in the right direction to provide financial relief to EMS agencies through an effort that provides fuel tax relief for non-profit EMS agencies. (HB 2731 was amended to HB 479, which was signed into law.) The Legislative Budget Board estimated that it will only result in a loss of approximately $92,000 to the state's Available School Fund in 2016.

We encourage the 85th Texas Legislature to consider expanding the motor fuel tax relief to *all* agencies that provide 9-1-1 services. HB 3468 was an example of model legislation in the 84th Legislature. Had it passed, HB 3468 would only have resulted in a loss of $501,000 to the general revenue in 2016.

Saving the Tobacco Fund and Other Emergency Healthcare Funds

As others will testify today, the Tobacco Fund has been depleted and will no longer be able to provide the grants or pass through dollars to EMS agencies. The Texas EMS Alliance is asking the 85th Texas Legislature to ensure that the funding for EMS Local Project Grants are at least maintained at their current level of $1.3M annually and that a plan be developed to expand this grant program in excess of $5M annually. This could be done by utilizing other grant funds across related state agencies, or by allocating an additional $5M of the dedicated EMS licensing and certification fees to DSHS with the sole purpose of expanding the Local Project Grant program.

The Alliance is also asking that the 85th Texas Legislature provide appropriate funding for all twenty-two Regional Advisory Councils (RACs). The bulk of RAC funding was previously allocated through the interest from the dedicated Tobacco Fund. This minimal funding has not changed significantly since the fund was established in the late 1990s, but the requirements of the RACs have increased dramatically. With the demise of the dedicated Tobacco Fund, RAC funding is in danger of disappearing completely.

The RACs are critical to the success of the emergency healthcare system. With all the difficulty in managing the day to day operations of an EMS agency, imagine each of the almost 800 EMS agencies having to coordinate with over 300 hospitals in managing destinations and treatment protocols for trauma, cardiac, stroke, and other acute care patients. The RACs are the lone entities that bring all players in the emergency healthcare system to the table for regional planning, destination management, process improvement, and injury prevention. The overall success of a statewide EMS system is incumbent upon the success of the RAC system.

Draw Down Additional Medicaid Dollars at No Additional Cost to Texas

Over the last several years, Texas has implemented a cost reimbursement program for governmental ambulance providers. This program allows municipal and county ambulance providers to receive additional dollars for transporting Medicaid and uninsured patients. Unfortunately, this option is not available to non-governmental ambulance providers that are providing 9-1-1 services across Texas. We recommend that the 85th Legislature follow the lead of other types of healthcare providers in the state and draw down additional federal dollars at no cost to the state by maximizing the Medicaid

match. It is possible to identify local expenditures that could qualify for a federal match through an intergovernmental transfer (IGT). The Texas EMS Alliance desires to partner with the Legislature to develop a low impact, high result plan that would allow all providers of ambulance service to receive additional cost reimbursement for Medicaid and uninsured patients.

Protecting the Ability of an EMS Agency to Bill a Patient

While we recognize that these committees do not have jurisdiction over commercial insurance issues, we do believe that is important to educate the entire Legislature about the need to protect the ability of EMS agencies to bill a patient for out-of-network services. As mentioned earlier, local taxpayer funds and bills sent to patients provide the greatest source of revenue to cover an EMS agency's operations. If the Legislature eliminates the ability of EMS agencies to balance bill a patient for out-of-network services, local communities will be forced to raise taxes in order to cover the EMS operations.

As we, as an industry, continue to work with commercial health plans to ensure network adequacy of EMS providers and improve healthcare plan coverage of EMS, we are mindful that any costs not covered by the health plans must be covered by the people who use the EMS service, or the taxpayers. Ultimately, the local governmental bodies would prefer to see the cost be placed with the actual users, instead funded through tax subsidies. The ability to balance bill is key to preserving this model. It is also important to note, that unlike virtually any other healthcare provider, EMS must have authorization from a local governmental agency in order to operate in that jurisdiction. Thus, each local government has authority over the EMS agency, and often specifically regulates the billing practices of that agency.

Assisting and Protecting the EMS Workforce

The war on terrorism has brought a greater awareness to the forefront, of the dangerous and debilitating effects of Post-Traumatic Stress Disorder (or PTSD), suffered by our war fighters. This has evolved into a greater awareness of these same effects on the EMS workforce, as well as other First Responders. Besides workforce shortages and challenges mentioned previously, the damaging effects of cumulative stress created by responding shift after shift to scenes of senseless violence and carnage from traumatic accidents, or untimely deaths, has a profound effect on the EMS workforce. In times past, I would have told you that after 30 years of EMS I had no long-term effects from all the years of responding to people on their worst day; but after seeing a presentation on PTSD by Brian Eastridge, MD from University Hospital, that he bravely presented after six deployments oversees with the U.S. Army, it became painfully obvious how PTSD had actually changed me.

Discussing this with other EMS leaders, it has become obvious that we need to be proactive regarding our personnel and this issue. The signs of PTSD are alarming as you look across our workforce. Increased suicides and suicide attempts, increases in medication diversions and substance abuse, and the "results" in personal lives of doing the job that we all thought were normal (divorce, relationship difficulties, illness, etc.),

demonstrate that we need to start taking steps to educate, protect, and treat our current workforce to help them recognize and avoid the destructive behaviors that are a part of PTSD.

We believe Texas should take the lead on this issue and establish the Texas EMS Personnel Resiliency Center. This "Center" would begin by developing an EMS Peer Assistance Program to take immediate steps to curb substance abuse and drug diversions in our ranks across the state. In addition, the Center would provide resources and scientific based resiliency program templates for EMS agencies to adopt across the State to support our efforts on combating this devastating condition.

Conclusion

The Texas EMS Alliance is grateful to the committees for the opportunity to testify in regards to this interim charge and share our insight on the EMS industry. We are honored to represent the EMS communities in Texas and we thank you for your consideration and support. We look forward to working alongside the Legislature in the upcoming session to continue to strengthen EMS care for the citizens of Texas.

Witness Contact Information

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City of Schertz
1400 Schertz Parkway
Schertz, TX 78154
210-619-1025 (O)
210-488-4243 (C)

EXHIBIT A

Texas Paramedic Programs – March 2011

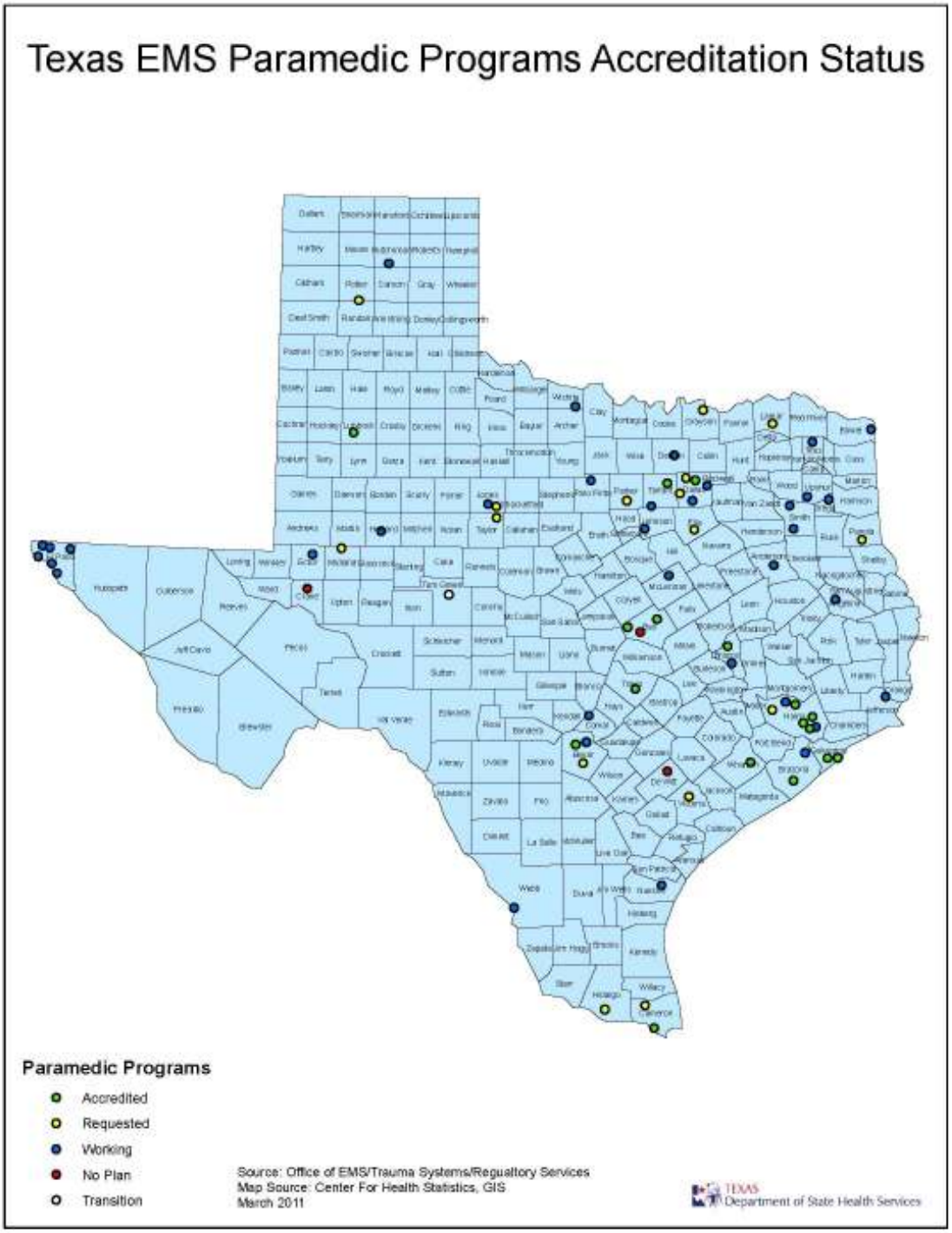
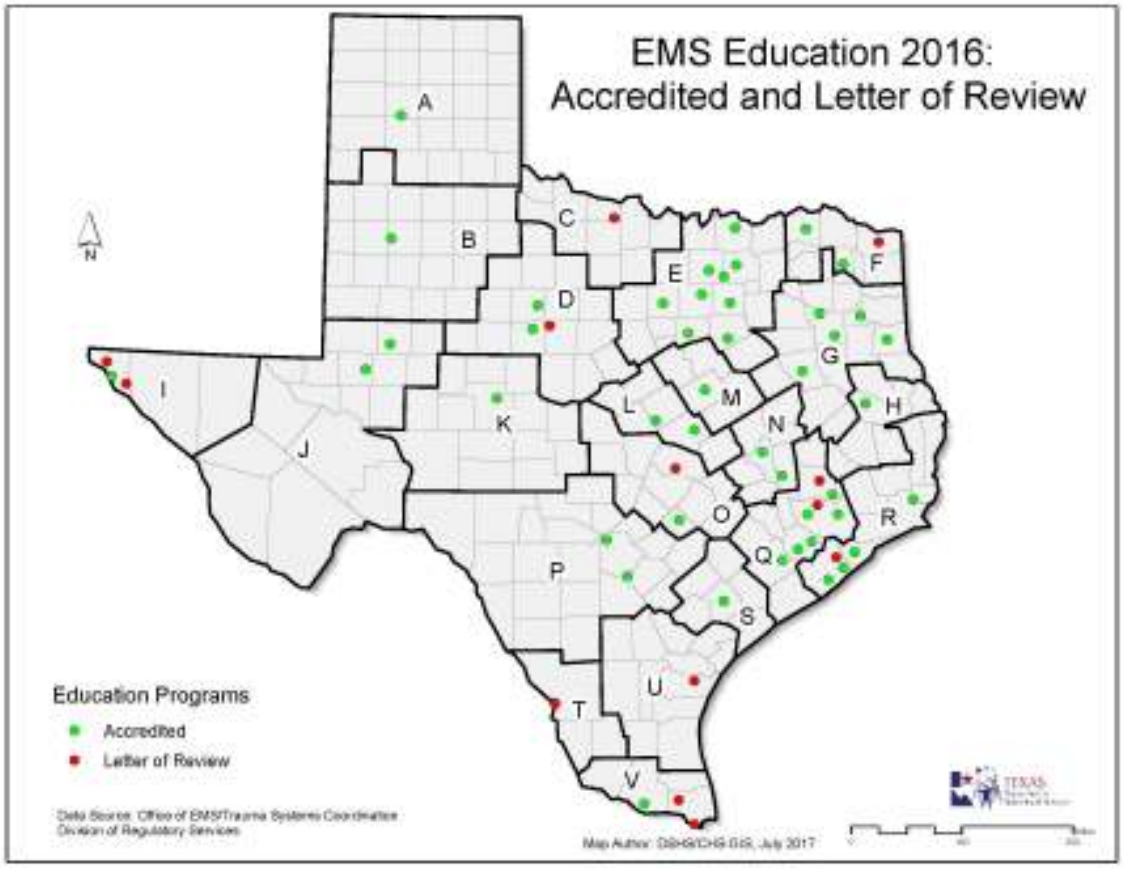


EXHIBIT B

Texas Paramedic Programs – June 2016



Testimony before the Joint Hearing of the House Appropriations Committee Subcommittee on Article II and House Public Health Committee

Presented by
Justin Boyd, Chair-Elect, Panhandle Regional Advisory Council, Trauma Service Area A
And Member, City of Spearman dba H&S EMS

Wednesday, July 13, 2016

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Good morning. My name is Justin Boyd, and I am testifying on behalf of Panhandle RAC A and the Texas EMS, Trauma & Acute Care Foundation.

I live in the frontier community of Spearman, and I have held every position from volunteer to EMS director. I began as a volunteer emergency medical technician and over time, became a paramedic with some financial incentives to volunteer. Then in 2006, I became an EMS director. I got involved with the Panhandle Trauma Regional Advisory Council A in 2007, and will become chair of the RAC for the second time in January. After becoming involved regionally, I got involved at the state level and am a member of the EMS Subcommittee of the Governor's EMS and Trauma Advisory Council. I understand the urban problems of transporting patients, but for those in rural, frontier areas of the state, it's a totally different challenge.

Panhandle RAC A serves 26 counties located in the north-most part of the state. This area has 16 acute care facilities, with two in Amarillo. The average distance to transport a patient from one of the 14 hospitals to Amarillo, which has one Level 3 Trauma Center and our RAC's highest level of care, is 82 miles, with the longest being 117 miles. The average distance to Lubbock, which has a Level 1 Trauma Center to serve the most critical patients, is 177 miles and the longest transport distance from a Panhandle hospital is 241 miles.

In rural and frontier areas we have to cover a large geographical area. My hometown of Spearman is 100 miles from Amarillo, and the closest Level 1 or 2 Trauma Center is 200 plus miles away. Lubbock, which has a Level 1 Trauma Center, is 220 miles from Spearman, and it is 240 miles to Oklahoma City which has one Level 1 and Level 2 trauma center each, and 260 miles to Wichita, Kansas, which has two Level 1 trauma centers.

My town is fortunate to have a hospital, and Hansford County Hospital is a designated Level 4 trauma center. Due to a lack of available volunteers to staff the ambulances, in 2005, the hospital began experiencing problems with transferring patients to the appropriate level of care. Upon becoming EMS director, I created a team approach using trained staff from other towns within 45 minutes of Spearman to take transfers. Critical patients continued to be transported by air ambulance, but non-critical patients that could wait went by ground ambulance. This approach has worked well, and 100 percent of ER patients are transported to a higher level of care if their condition requires it. But even this team approach faces challenges with having trained people available to make patient transport.

In 2010-11, Panhandle RAC A had 50 ground ambulance providers – today we have 43. EMS providers in my RAC are dwindling for several reasons.

1. The volume of ambulance runs does not produce enough revenue to cover costs, and in fact, many rural EMS agencies lose money. The Spearman EMS makes about 300 runs per year and loses about $200,000 annually which the city finances through other services.
2. It's difficult to attract and retain EMS personnel. Frank Phillips Community College in Borger previously offered EMS education, and I taught classes in Spearman. In 2013 when the requirements for EMS changed to require educational programs to be accredited, Frank Phillips discontinued the EMS program due to low volume and the costs associated with becoming and maintaining accreditation. Now, the only accredited educational program is in Amarillo, 100 miles away. From 2008 to 2013, our RAC had an average of 15 to 20 people per year take the test to become a paramedic. After the

educational accreditation requirement was instituted, Amarillo produced only nine paramedics in 2014. That is not even one new graduate per county in the Panhandle RAC.

3. It is difficult to get someone to commute 200 miles several days a week to become a paramedic when the starting salary is only $36,000 per year. Ground ambulance salaries are low, compared with police and fire regionally and other similarly trained health care personnel. Starting salary for a fireman in Amarillo is $44,000 a year and $41,000 for a policeman.
4. It is hard to increase pay when you are losing money due to decreasing reimbursements and a flawed reimbursement methodology that only pays us to transport patients to a hospital. Sometimes, the patient can be treated at the scene, and in other situations, the patient refuses transfer. With the growth of free-standing ERs, patient transport may be made to a non-hospital ER, but there is no EMS reimbursement because those facilities are not hospitals. Urban cities have large volumes of patients so more revenue is generated. More than 67 percent of ambulance providers in the Texas Panhandle make 400 or fewer runs per year. Ground ambulance reimbursement is a combination of medical care and mileage, so short distances within a community produce minimal reimbursement and rural communities lack the volume to make this model work. The long-distance transports help us remain viable, but still fail to generate the revenue needed to just break even.
5. Panhandle RAC A has a shortage of EMS personnel, and the average age across all EMS certification levels is 40. In two counties, the average age is 49 and 51, respectively. The average age of licensed paramedics in Panhandle RAC A is 42. We are not attracting young people into this field.
6. In 2014, 36 rural EMS providers were granted a variance from the state requirement that an ambulance be staffed by two certified EMS personnel. The need to allow an ambulance to respond with only one certified EMS individual is a result of personnel shortages in rural communities. This is a tremendous problem and results in very difficult decisions being made, such as having a law enforcement officer drive the ambulance to the hospital while the EMT or paramedic cares for the patient.
7. Increased funding for ground ambulance providers is needed, especially in rural and frontier areas where volume is low. EMS is about the only part of the medical field where mode of transportation of the patient is one of the criteria in reimbursement. Medicare reimburses $997 for a ground ambulance. Reimbursement for an air ambulance that goes the same 100 miles reimbursement is drastically different – almost eight times the ground amount. Care is the same, although the fixed costs of the air ambulance are much greater.
8. In 2006, Panhandle RAC A had one helicopter and two airplanes. Today, there are two helicopters and five airplanes, and this growth is occurring all over the state. We've seen an increase in air providers because they can succeed financially. Having air ambulance service is an absolute necessity, and is totally appropriate for severely injured or ill patients. However, when the patient can go by ground ambulance and is flown because there is no staff to make the ground transport, there is a problem that results in higher costs to the health care system. One criterion for an air transport to be reimbursed is that a ground ambulance is not available.
9. Air medical is regulated as part of the airline industry, which was de-regulated in 1978. As a result, Texas cannot regulate any aspect of their business except for the patient care they provide. Many times, the air evacuation is necessary and appropriate. However, ground ambulance services need adequate funding so that patients who could be

transported safely and efficiently by ground are not transferred by air because of the unavailability of an ambulance. A patient should not be flown into a facility and discharged the same day.

If the City of Spearman were to increase its tax rate by one cent, only about $9,000 to $10,000 additional ad valorem tax would be generated. The City collects about $500,000 in ad valorem taxes annually. Spearman's EMS budget is $425,000 annually. Fire, police and EMS cost more than taxes produce, and these services are subsidized by other city services such as utilities. This scenario is repeated in most communities across the Panhandle.

In looking at EMS issues, I urge you to consider the differences between rural, frontier communities and urban areas, and look for ways to help us survive in rural areas. Large urban providers are able to provide education and training and have a more diverse workforce. In Panhandle RAC A, we lack adequate resources, and volunteers are declining since it is difficult to get certified as a paramedic and calls take at least six hours to take a patient to Amarillo. Our RAC needs more people with the education and training to work as EMS providers.

We also need a stable financial base so that ground ambulances can continue to provide their appropriate role in the trauma and emergency health care system. I urge the state to work with rural, frontier communities to incentivize other models of delivering services that over time could become self-sustaining.

Thank you.

Panhandle Regional Advisory Council (RAC)
TSA-A

Total Number of Acute Care Hospitals:	16
Total Number of Ground EMS Providers 09/2013:	49
Total Number of Ground EMS Providers 06/2016:	43
Total Number of Ground EMS Providers with zero (0) Paramedics on Roster:	8
Total Number of Ground EMS Providers with 1-3 Paramedics listed on Roster:	10
Current Number of Ground EMS Providers with Paramedic Staff Shortage:	90% +
Highest Trauma Designated Hospital In Area:	Level 3
Average Inter-facility Ground Distance to Level 3:	82 Miles
Longest Inter-facility Ground Distance to Level 3:	117 Miles
Ave. Inter-facility Ground Distance to Closest Level 1 in TX:	177 Miles
Longest Inter-facility Ground Distance to Level 1 in TX:	241 Miles
Number of Newly Licensed/Certified Paramedics graduating from 1 Accredited EMS Program within our RAC 2014:	9
Number of Newly Licensed/Certified Paramedics graduating from 1 Accredited EMS Program within our RAC 2013:	16
Number of Newly Licensed/Certified Paramedics graduating from 3 Education Programs within our RAC 2012:	21
Number of Newly Licensed/Certified Paramedics graduating from 3 Education Programs within our RAC 2011:	21
Number of Accredited EMS Programs in our RAC:	1

John Henderson
Childress Regional Medical Center, CEO
Joint Committee Hearing between the House Appropriations Article II Subcommittee &
House Public Health
Testimony on Behalf of the Texas Hospital Association
July 13, 2016

Interim Charge – Study the trauma system…including financing, service delivery, planning, and coordination among Emergency Medical Services providers, Trauma Service Area Regional advisory Councils, the Emergency Medical Task Force and hospitals. Determine strengths and weaknesses including challenges for rural areas of the state. Make recommendations to reduce any duplicated services, improve the coordination of services and advance the delivery of trauma services in Texas.

Chairman Price, Chair Crownover and committee members, my name is John Henderson, I am CEO of Childress Regional Medical Center located in Childress, Texas. I also get to serve as the president of the Board of Trustees of the Texas Hospital Association this year. I appreciate the opportunity to speak with you today in support of the Texas trauma system on behalf of my hospital and THA's more than 500 hospital members.

Childress Regional has the distinct honor of serving as a Level IV trauma center not only for the city of Childress but for the entire county of Childress. There are no other designated trauma facilities in the county (or bordering counties). The nearest trauma hospital to us is in Lubbock or Abilene, both more than 150 miles away. Only in Texas could you put "nearest" and "150 miles" together in a sentence.

Our designation as a Level IV facility means we treat trauma patients, provide resuscitation, stabilization and assessment of injury victims.. When more intensive care and treatment are required, we arrange for appropriate transfer to a higher-level designated trauma facility. We also provide ongoing educational opportunities in trauma related topics for health care professionals and the public. In order to maintain this Level IV status, we undergo an intense review every three years by the Texas Department of State Health Services to ensure we are providing the services required by state law and the trauma designation rules – and we went through a trauma survey last fall. The reviewers found no deficiencies and made no recommendations for improvement. As a matter of fact, their only request was for us to consider being a reference site - hosting other rural trauma hospital teams.

As a Level IV facility, we are required to meet numerous workforce and equipment requirements. Some of these requirements are:

- Having access to a physician with special competence in the care of critically injured patients who is on-call and available within 30 minutes of request;
- A variety of equipment and supplies, such as mechanical ventilator, two-way communication with all pre-hospital emergency medical services vehicles, stabilization devices, sterile surgical sets and defibrillator; and
- 24-hour lab services

Childress Regional also operates the county's only emergency medical services. Without Childress Regional, the county's residents would have no access to EMTs or paramedics. EMS is an essential part of the trauma system. They deliver life-prolonging pre-hospital care at the trauma scene.

Texas is a big state. Traumatic injuries - motor vehicle crashes, falls, assaults, firearm injuries – don't just occur in our urban areas. The Texas trauma care system is designed to ensure that someone in a very rural area of Texas has the same chance of survival that someone living in one of our big cities would expect.

It's also important to remember that any one of us could be a rural trauma patient, even if we call Austin, Dallas, Houston or another big city our home. Childress attracts visitors from all over the state who come for hunting, outdoor sports, hiking, camping and other recreational activities. Three major highways also meet in the center of Childress. One of these – HWY 287 – sees 20,000 vehicles a day. According to the Texas Department of Transportation, there were 50 motor vehicle crashes in Childress County in 2015. Childress Regional's EMS responded to all of those and that my hospital was the first point of care for the injured.

Building and sustaining this state-of-the-art trauma care system carries a cost, only some of which is paid for by third parties, such as health insurers. Dedicated trauma funding makes it possible for us to meet the resource requirements I described earlier in terms of staff and equipment. Without this funding, we absolutely would not be able to maintain our trauma designation.

On top of the cost to create and maintain a designated trauma facility, there are significant unreimbursed trauma care costs. Annually, Texas hospitals sustain more than $300 million in unreimbursed trauma care. Trauma doesn't discriminate. The uninsured have car accidents and experience injuries and assaults just as those with health insurance do. And Texas hospitals deliver care to all regardless of ability to pay. Payments from several state funding sources

offset SOME of these unreimbursed costs, but even after payments, the cost to Texas hospitals is more than $250 million. At Childress, our unreimbursed trauma care costs last year exceeded $100,000.

The challenges to building and sustaining an effective trauma care system are primarily financial, but the impact is very personal. The trauma system in Texas works. The mortality rate for Texas patients is 2.79 percent, a full percentage point lower than the national average. In that statistic are real people with real families.

I'd like to share with you a couple of stories of patients we have cared for. The first is about Mike. A couple of months ago, Mike was helping a friend build a new deer stand at his ranch about 25 miles outside of Childress. Mike fell off a ladder and sustained a severe leg injury. By the time he got to our emergency department, he had lost blood and was in a great deal of pain. Our team stabilized him and prepared him for transport to UMC Lubbock, which is a Level I trauma facility that would do the necessary surgery. Had our facility not been staffed and equipped to respond, Mike's treatment and recovery undoubtedly would have been much more difficult. Mike wrote a letter to the local newspaper thanking staff of Childress Regional and local emergency services personnel for everything that was done for him. In his words, "the trauma surgeons at Lubbock UMC told me they couldn't remember ever having received a transferred trauma case where the fracture had been as perfectly prepared for transport and for subsequent surgery. They said that will be a very big factor in the overall success of my surgery and recovery…I am on my way to recovery. I know that is due in a big way to the emergency public safety and emergency medical personnel in Childress….I want to remind the citizens of Childress how fortunate they are to have you all."

Another story involves a teenager from Mansfield who was accidentally shot in the face by his brother. Childress Regional was his first point of care, and his care team has shared with me that if he had to go first to Amarillo or Lubbock, he most likely would not have survived his injury. He was quite close to death when he got to our emergency room. We successfully stabilized him and transferred him to a Level I facility where he started his long road to recovery that included extensive time in Dallas for reconstructive surgery and rehab.

One last story. A couple of years ago, a bus of young basketball players from a high school in Paducah slid off the road during an ice storm. One girl died at the scene, and eight others were brought to our emergency room with severe injuries. Again, if Childress Regional hadn't been close by, these young lives would possibly have been lost.

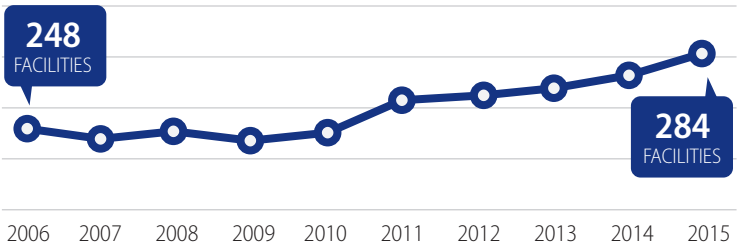
Hopefully that gives you a picture of the type of lifesaving care that a Level IV trauma facility provides and the vital need for a wide network of trauma care services. I appreciate the opportunity to testify today and look forward to working with the committee on this issue.

In a trauma, every second counts.

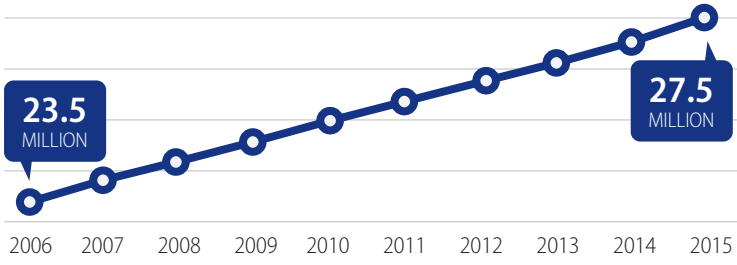
6.9 million (25%) Texans live in a county not accessible* to a Level I trauma hospital.

Texas is one of the fastest growing states in the nation. The number of designated trauma facilities, however, is not keeping pace with population growth.

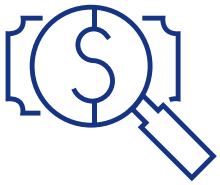
Total Trauma Centers in Texas



Texas Population Growth



Injuries are the **leading cause of death** for Texans ages 1 to 44, with motor vehicle crashes being the leading cause.

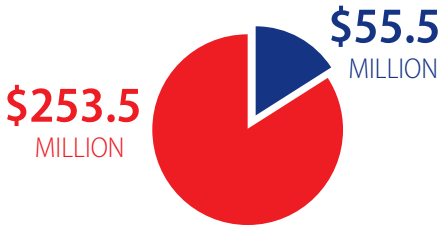


Total uncompensated trauma care costs at Texas trauma hospitals: **$309 million** a year

Payments totaling **$54.5 million** from the Designated Trauma Facilities and Emergency Medical Services Account (5111) (Fines from the Driver Responsibility Program and the $30 state traffic fine fund this account)

Payments totaling **$575,000** from the EMS, Trauma Facilities and Trauma Care Systems Fund (5108) (The $100 DUI/DWI conviction surcharge funds this account)

Payments totaling **$424,000** from the EMS and Trauma Care System Account (5007) (The 911 equalization surcharge funds this account)



Leaves $253.5 million in uncompensated trauma care costs for Texas hospitals

TEXAS HOSPITAL ASSOCIATION

Texas Hospital Association 1108 Lavaca, Suite 700, Austin, TX, 78701-2180 | **www.tha.org**

Contact: Carrie Kroll, ckroll@tha.org

*Accessible is defined as living in a county with a Level I trauma hospital or in a county that is contiguous to one with a Level I trauma hospital.

(TESTIMONY OF MIKE EASLEY – JOINT HEARING OF THE HOUSE PUBLIC HEALTH COMMITTEE AND THE APPROPRIATIONS SUBCOMMITTEE, ARTICLE II – July 13, 2016)

Good morning. My name is Mike Easley. I am the Vice President for Hospital Operations of Preferred Management Corp. We are an Oklahoma-based, for-profit company that specializes in leasing and managing small rural hospitals that have historically struggled financially. We currently lease and operate Texas critical access hospitals located in Van Horn, Eldorado, Coleman, Junction, Hemphill, Wellington, Friona and Muleshoe.

We believe small rural hospitals, like these we operate, are critical not only to their communities but to the state and the nation. Because we are a very mobile society, anyone of us can end up in the emergency room of any hospital, urban or rural, unexpectedly.

I would like to focus this morning on one hospital in particular because it is a prime example of the continuing need for a safety net of trauma care across Texas. Culberson Hospital in Van Horn, Texas is a 14-bed hospital that was built by the residents of Culberson County. We leased the hospital and assumed responsibility for operations in 2004. With 65 employees, we are the second largest employer in Culberson County, second only to the school district.

We are the only hospital on a 210 miles stretch of interstate highway from Pecos to El Paso. Thousands of cars drive through Culberson County every day. However, the hospital has been challenged for years due to its geographically remote location, very low volume of patients and difficulty recruiting and retaining healthcare providers. The county is home to less than 2,300 people spread over 3,800 square miles. Some days we have no patients in the hospital but we must remain fully staffed and prepared for any emergency. If the hospital closed, not only would local residents find themselves hours away from care but also a long stretch on one of the busiest highways in the country would be unprotected without trauma care.

We recently worked with the Texas Organization of Rural & Community Hospitals and analyzed records from one year of emergency room visits at the hospital in Van Horn. This was very revealing as to who uses our emergency room and where they live. You have a copy of a map in your workbook that shows the findings from our study. As you can see, just over 50% of the ER patients were from Van Horn or the immediate area. But, 1/3 were from other parts of Texas – all over Texas; and 13% were from outside Texas and all across the country – from Maine to Washington state – and even Alaska.

This hospital has a long history of saving the lives of people that probably would have died if not for its presence because of the long distance to the nearest next hospital. In 1949, famed golfer Ben Hogan was critically injured in a car accident near Van Horn. Hogan was initially treated at the clinic in Van Horn - which was the precursor to the current hospital and the only medical facility in the county. He was x-rayed and stabilized before a transfer to El Paso for a 60 day hospital stay followed by months of rehab. Many credit the Van Horn medical facility with saving Ben Hogan's life.

We think this is an example of why we need a network of trauma care facilities across the state of Texas with reasonable distances between hospitals. We also operate the Culberson County EMS that is critical to the region. It is commonly accepted that your chances of survival are greatly improved if you receive initial care less than an hour after severe trauma occurs. Given this response time, on a lonely Texas highway you need to be within 30 miles of a trauma center. We believe it is good public policy for the State of Texas to create and maintain an environment that supports hospitals and emergency medical services like the ones in Van Horn.

The hospital in Van Horn struggles financially and faces ongoing challenges recruiting physicians and other health care providers. The hospital receives local tax support as a hospital district. Because property taxes in Texas are based on property values, this ranching and agricultural county has very low property valuations, so that the local tax revenue is low. The community and hospital have certainly done their part.

- In June 2003, the hospital district board pursued and received designation by Medicare as a critical access hospital and a rural health clinic. This provides enhanced reimbursement for Medicare patients to help offset the low patient volume.

- In June 2004 the hospital was within days of closing. In order to avert a tragedy, the hospital district raised the tax rate to 75 cents, the highest allowed by the Texas constitution, to subsidize operations and keep the hospital open. There was no taxpayer call for a roll back.

- In November 2009, the voters of Culberson County passed a $7.5 million bond Issue to fund a 14,500 square foot hospital addition that opened in the summer of 2010. This addition replaced all the in-patient rooms and built a new state-of-the-art emergency department. In order to service this debt, the hospital district had to maintain a property tax of 60 cents – the highest of any hospital district in the state that year and yet the voters overwhelming approved the bond issue by a margin of four to one.

Our hospital is entitled to the higher Rural Hospital Medicaid Reimbursement. However, our volume is low because, even though approximately 30% of our population receives Medicaid benefits, our population is small. As a result, we realize very little in higher payments from Medicaid through this initiative.

In closing, here are the areas where we think the State can assist small, frontier rural hospitals such as Van Horn to assure the safety net for trauma care continues.

1) There should be enhanced financial incentives for physicians to go to frontier counties. The current Texas Physician Education Loan Repayment Program administered by the Texas Higher Education Coordinating Board and partially funded by a tax on smokeless tobacco repays physicians up to $140,000 over four years for medical school debt. Most physicians have a lot more debt than this. Additionally, frontier areas are in competition with more populated, yet medically underserved areas. There are medically underserved

areas of Dallas, Houston, and San Antonio where you can practice and receive the same funds. We believe there should be an enhanced payment if you move to a frontier area by adding a bonus to the loan amount.

2) Texas needs to continue the trauma program with enhanced funding for rural hospitals. We understand the Legislature may have a growing interest in abolishing the current Driver Responsibility Program. If so, the trauma funds from this program that hospitals currently receive must be replaced. Also, payments to rural hospitals from the trauma fund should be increased. Most rural hospitals currently receive the minimum amount of $28,000 a year. That helps but doesn't accomplish much.

3) Telemedicine should be allowed to offset some of the physician requirements in the current Trauma Rules. As a Level IV Trauma Center, we must have a physician on call at all times and that physician must be able to be present in the ER within 30 minutes. That is daunting when you only have one physician who must also cover the hospital and clinic. Even with the use of contract fill-in physicians, there can be times where this is very difficult and cost prohibitive. This year, Culberson Hospital is on track to spend approximately $300,000 for fill-in physicians to staff our emergency room to meet the requirements of Level IV Trauma designation. If our single physician, who is 65 years old, needs more time off or gets sick this expense will increase.

   Because in some cases it is impossible to recruit or retain physicians, we would like to be able to staff the emergency room with qualified physician extenders who are supported by physicians through telemedicine. We support high standards and agree that the face-to-face encounter with a physician is preferable. But, if the alternative to face-to-face is no care at all, then we believe telemedicine can play a role. Or, as a last resort, if we simply drop out of the Trauma System this requirement will go away.

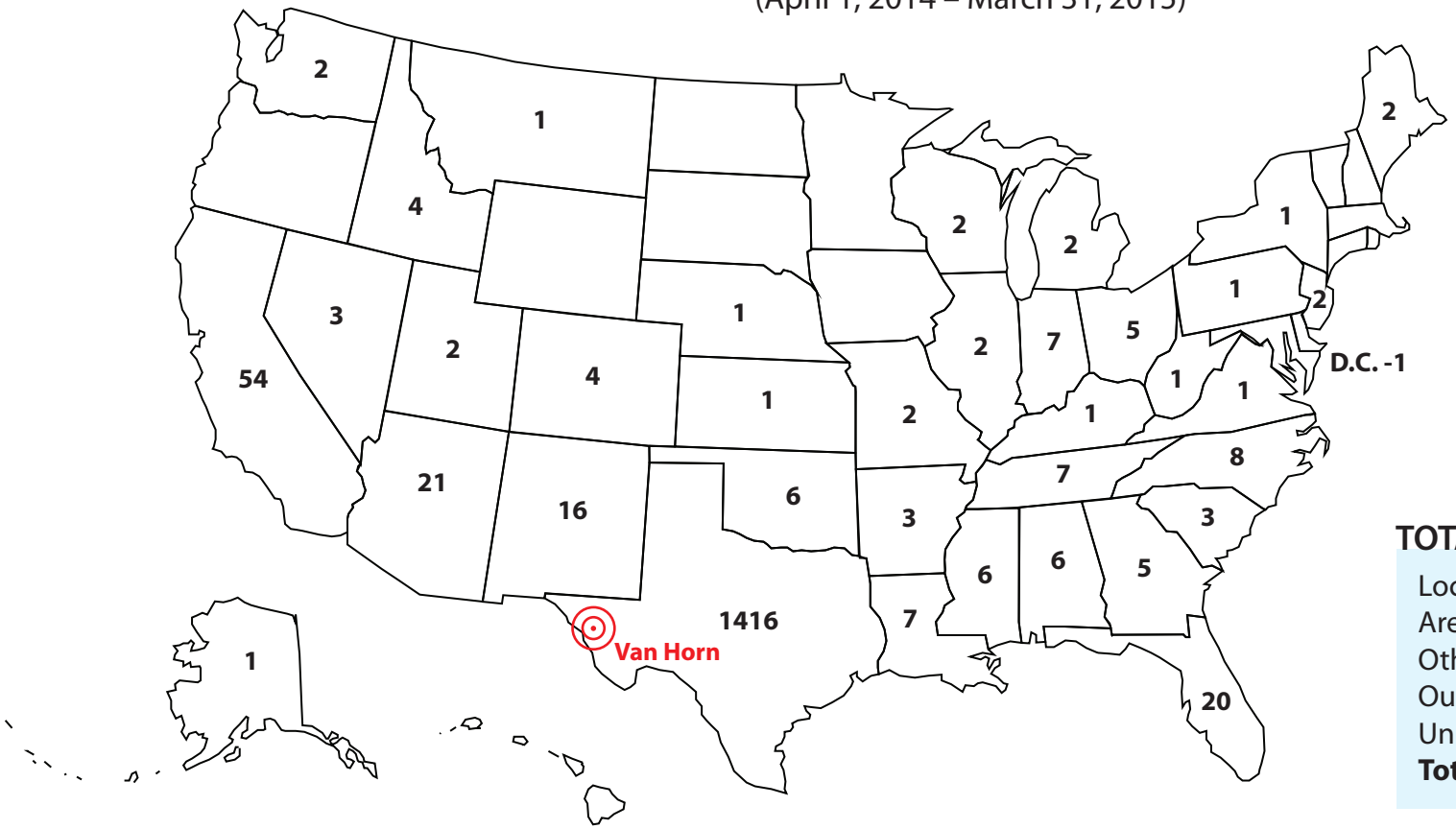
4) Texas needs to strongly assert the continued need for uncompensated care funding associated with renewal of the 1115 waiver. Culberson County in 2015, under the 1115 Waiver, received $738,000 to help cover the cost of uncompensated care. All hospitals continue to struggle with uncompensated care and we think this funding must continue as part of the waiver. I raise this issue because we continually hear that CMS desires to eliminate many, if not all, of the uncompensated care dollars from the 1115 waiver. Texas must fight hard to keep those dollars for all hospitals.

Thanks for your time and I will try to answer any questions that you might have.

ANYONE IN AMERICA CAN END UP BEING A PATIENT IN A TEXAS RURAL HOSPITAL

Hometown or State of Emergency Room Patients at Culberson Hospital in Van Horn, Texas

(April 1, 2014 – March 31, 2015)



TOTAL PATIENTS

Local Admissions	829
Area Admissions	36
Other Texas Admissions	551
Out Of State	211
Unknown	40
Total Admissions	**1667**

TEXAS PATIENTS

Abilene – 1
Alpine – 5
Amarillo – 1
Andrews – 2
Anthony – 1
Arlington – 4
Austin – 6
Barstow – 1
Beeville – 2
Big Spring – 2
Bowie – 1
Buchanan Dam – 1
Burleson – 1
Canutillo – 1
Christoval – 1
Cleveland – 4
Clint – 1
College Station – 1
Copperas Cove – 2
Corpus Christi – 1
Dallas – 2
Dell City – 1
Denton – 2
Denver City – 1
El Paso – 58
Fabens – 3
Fort Hancock – 3
Fort Stockton – 8
Fort Worth – 3
Granbury – 1
Grand Prairie – 3
Gruver – 1
Haltom City – 1
Harlingen – 1
Houston – 7
Joshua – 1
Katy – 1
Keller – 2
Kermit – 2
Lake Dallas – 1
Laredo – 4
Lavon – 1
League City – 1
Levelland – 1
Liberty Hill – 1
Livingston – 1
Lufkin – 1
Magnolia – 1
Marfa – 7
Marshall – 1
Melissa – 1
Mentone – 1
Merkel – 1
Midland – 3
Nemo – 1
New Braunfels – 1
Odessa – 23
Pecos – 3
Pflugerville – 1
Pharr – 1
Plano – 1
Port Arthur – 5
Presidio – 4
Red Oak – 1
Salt Flat – 5
San Antonio – 8
San Benito – 1
San Elizario – 2
San Juan – 1
San Marcos – 1
Sanderson – 1
Seguin – 1
Seminole – 3
Sierra Blanca – 324
Spring – 1
Spring Branch – 2
Stanton – 3
Stephenville – 1
Sunset – 1
Sweetwater – 1
Terlingua – 1
Tornillo – 3
Tyler – 1
Uvalde – 4
Valentine – 13
Van Horn – 829
Victoria – 1
Waxahachie – 1
TEXAS PATIENTS TOTAL – 1416

Created by Texas Organization of Rural & Community Hospitals (TORCH) with the assistance of Preferred Management Corporation, operator of Culberson Hospital – March 2016