1988

Session Law 88-186

Florida Senate & House of Representatives

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**Other Documentation**

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A bill to be entitled
An act relating to trauma care; amending s.
395.031, F.S.; changing definition of "trauma
center"; specifying standards for evaluating
trauma medical services systems and approving
local and regional plans; requiring
implementation of plans; specifying rules from
which the Department of Health and
Rehabilitative Services may exempt trauma
agencies; providing for the delegation of the
pediatric referral center verification process
to trauma agencies; prohibiting discrimination
by certain hospitals against trauma victims on
specified grounds; providing for written
notices of intent to cease local plan
implementation and local agency operation;
specifying time for applications to renew
verification; amending s. 395.032, F.S.;
specifying where state trauma regions must be
designated and their purpose; removing
duplication provisions relating to trauma
center verification standards, requests,
expiration, and service provision; amending s.
395.035, F.S.; providing trauma registry
proceedings and providing that certain
proceedings, records, and reports are
confidential; amending s. 320.0801, F.S.;
specifying uses of revenues in the Emergency
Medical Services Trust Fund; providing an
effective date.

CODING: Words stricken are deletions; words underlined are additions.
Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.031, Florida Statutes, is amended to read:

395.031 Trauma medical services system plans; verification of trauma centers and pediatric trauma referral centers; procedures; renewal.—

(1) For the purposes of this section, the term:

(a) "Department" means the Department of Health and Rehabilitative Services.

(b) "Local or regional trauma agency" means an agency established and operated by the county, an entity with which the county contracts for the purposes of local trauma medical services administration, or a regional agency created for the administration of trauma medical services by agreement between counties.

(c) "Trauma center" means any hospital that has been determined by the department or by a local or regional trauma agency to be in substantial compliance with trauma center verification standards.

(d) "Pediatric trauma referral center" means a hospital that is determined to be in substantial compliance with pediatric trauma referral center standards as established by rule of the department pursuant to subsection (5).

(e) "Trauma scorecard" means a statewide methodology adopted by the department by rule under which a trauma victim is graded as to the severity of his injuries or illness and which methodology is used as the basis for making destination decisions.

(f) "Trauma victim" means any person who has incurred a single or multisystem life-threatening injury due to blunt
(2)(a) The local or regional trauma agency shall plan, implement, and evaluate a trauma medical services system, in accordance with this section and ss. 395.032, 395.035, and 395.036 this act, which consists of an organized pattern of readiness and response services based on public and private agreements and operational procedures.

(b) The local or regional trauma agency shall develop and submit to the department for review a plan for a local or regional trauma medical services system. The plan must include, at a minimum, the following components:

1. The organizational structure of the trauma system.
2. Prehospital care management guidelines for triage and transportation of trauma cases.
3. Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.
4. The number and type of major trauma cases necessary to assure that trauma centers will provide quality care to trauma cases referred to them.
5. The resources and equipment needed by trauma facilities to treat trauma cases.
6. The availability and qualifications of the health care personnel, including physicians and surgeons, who comprise the trauma teams that treat major trauma cases within a trauma facility.
7. Data collection regarding system operation and patient outcome.
8. Periodic performance evaluation of the trauma system and its components.
9. The utilization of air transport services within the jurisdiction of the local trauma agency.

10. Public information and education about the trauma system.

11. Emergency medical services communication system usage and dispatching.

12. The coordination and integration between the verified trauma care facility and the nonverified health care facilities.

13. Medical control and accountability.

14. Quality control and system evaluation.

(c) The department shall receive plans for the implementation of trauma care systems from local or regional trauma agencies. The department may approve or not approve the local or regional plans based on the conformance of the local or regional plans with this section and ss. 395.032, 395.035, and 395.036 act and the rules adopted by the department pursuant to those sections this act. A local or regional trauma agency shall may implement the local plan developed pursuant to this section act unless the department determines that the plan does not effectively meet the needs of the persons served and is not consistent with applicable rules of the department, or the local or regional trauma agency submits to the department written notice of intent to cease implementation of the local plan.

(d) The department may grant an exception to a portion of the rules adopted pursuant to this section or s. 395.032 act if the local or regional trauma agency proves that, as defined in the rules, compliance with that requirement would not be in the best interest of the persons served within the affected local trauma area.
(e) A local or regional trauma agency may implement a trauma care system only if the system meets the minimum standards set forth in the rules for implementation established by the department and if the plan has been submitted to, and approved by, the department. Before the local or regional trauma agency submits the plan for the trauma care system to the department, the agency shall hold a public hearing and give adequate notice of the public meeting to all hospitals and other interested parties in the area proposed to be included in the system.

(f) 1. At the option of a local or regional trauma agency which is implementing a trauma care system approved by the department, the department may delegate to the local or regional trauma agency the hospital trauma center and pediatric referral center verification process within the geographic boundaries of the local or regional trauma agency. 2. For those local or regional trauma agencies selecting to verify hospital trauma centers and pediatric referral centers, the direct or indirect cost of verification shall be borne by the applicant, based on a fee schedule set up by the local or regional trauma agency; however, a fee may not exceed the reasonable cost of implementation, operation, maintenance, evaluation, and development of the verification process.

(g) Local or regional trauma agencies shall contract only with hospitals with verified trauma centers or those willing to seek verification.

(h) Local or regional trauma agencies providing service for more than one county shall, as part of their formation, establish interlocal agreements between or among the several counties in the regional system.
(1) This section does not restrict the authority of a health care facility to provide service for which it has received a license pursuant to this chapter.

(j) Any hospital which is verified as a trauma center and has a contract with a local or regional trauma agency shall accept all trauma victims that are appropriate for the facility regardless of race, sex, creed, or ability to pay.

(k) It is unlawful for any hospital or other facility to hold itself out as a trauma center unless it has been so verified.

(l) A county, upon the recommendations of the local or regional trauma agency, may adopt ordinances governing the transport of a patient who is receiving care in the field fromprehospital emergency medical personnel, when the patient meets specific criteria for trauma, burn, or pediatric centers adopted by the local or regional trauma agency. These ordinances shall, to the furthest possible extent, ensure that individual patients receive appropriate medical care while protecting the interests of the community at large by making maximum use of available emergency medical care resources.

(m) The local or regional trauma agency shall, consistent with such plan, coordinate and otherwise facilitate arrangements necessary to develop a trauma medical services system.

(n) After the submission of the initial trauma care system plan, a local or regional trauma agency which has implemented a trauma care system shall annually submit to the department an updated plan which identifies the changes, if any, to be made in the trauma care system. A local or regional trauma agency shall submit to the department written notice of its intent to cease operation of the local or

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regional trauma agency within 90 days before the date on which the local or regional trauma agency will cease operation.

(o) This section does not preclude a local or regional trauma agency from adopting trauma care system standards or trauma facilities standards that are more stringent than those adopted by rule of the department.

(3) Any hospital licensed in the state that desires to be verified as a trauma center or as a pediatric trauma referral center must submit to the department, or to the appropriate local or regional trauma agency, a request for verification as such a center. The request shall be reviewed by the department or the local or regional trauma agency to determine whether the hospital is in substantial compliance with the standards specified in subsection (5). Within 30 days after receiving a request from a hospital for verification as a trauma center or pediatric trauma referral center, the department or the local or regional trauma agency shall notify the hospital of any apparent errors or omissions in its application and shall request any additional information necessary to determine the hospital's substantial compliance with this section and department rules. This additional information must be submitted within 60 days after the hospital's receipt of the request for additional information. Upon receipt of the additional information from the hospital, the department or the local or regional trauma agency shall deem the application to be complete. An application must be approved or denied within 90 days after receipt of the original application or receipt of documentation that apparent errors or omissions have been corrected. Upon determining that the hospital is in substantial compliance with the standards, the hospital shall
be verified as a trauma center or pediatric trauma referral
center. If the application is denied by the department, the
hospital shall must be notified of any right to a hearing
pursuant to chapter 120.

(4) A verification, unless sooner suspended or
revoked, automatically expires 2 years from the date of
issuance and is renewable biennially upon application for
renewal, provided the hospital is in substantial compliance
with trauma center or pediatric trauma referral center
verification standards in effect at the time of application.
An application for renewal shall be processed in the same
manner as prescribed for initial applications, except that the
application must be made at least 180 days prior to
expiration of the verification, on a form provided by the
department or the appropriate local or regional trauma agency.

(5) The department shall adopt, by rule, standards for
verification of trauma centers based on national guidelines,
including those established by the American College of
Surgeons, entitled "Hospital and Prehospital Resources for
Optimal Care of the Injured Patient," and published appendices
thereto. Standards specific to pediatric trauma referral
centers shall also be adopted by rule of the department.

Section 2. Section 395.032, Florida Statutes, is
amended to read:

395.032 State regional trauma planning; trauma
regions.--

(1) The department shall may establish trauma regions
for the purpose of providing planning and coordination to
ensure adequate trauma care throughout the state. Local or
regional trauma system agencies may be established without
regard to regional boundaries established by the department.
for the purpose of trauma analysis and planning, in those geographical areas where there are no department-approved local or regional trauma system agencies and plans and where the department determines there is need for organized trauma services for the residents of the geographical area. The department shall base its definition of the regions upon:

(a) Geographical considerations so as to ensure rapid access to trauma care by patients;

(b) Historical patterns of patient referral and transfer in an area;

(c) Inventories of available trauma care resources;

(d) Predicted population growth characteristics;

(e) Transportation capabilities, including ground and air transport;

(f) Medically appropriate ground and air travel times;

and

(g) Other appropriate criteria.

(2) The department shall develop trauma systems plans for the department-defined trauma regions which include at a minimum, the following components:

(a) The organizational structure of the trauma system.

(b) Prehospital care management guidelines for triage and transportation of trauma cases.

(c) Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.

(d) The number and type of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.

(e) The resources and equipment needed by trauma facilities to treat trauma cases.
(f) The availability and qualifications of the health care personnel, including physicians and surgeons, who treat trauma cases within a trauma facility.

(g) Data collection regarding system operation and patient outcome.

(h) Periodic performance evaluation of the trauma system and its components.

(i) The utilization of air transport services within the service region.

(j) Public information and education about the trauma system.

(k) Emergency medical services communication system usage and dispatching.

(l) The coordination and integration between the designated trauma care facility and the nondesignated health care facilities.

(m) Medical control and accountability.

(n) Quality control and system evaluation.

†3†—The-department-shall-adopt, by-rule, standards-for
the-verification-of-trauma-centers-based-on-national
guidelines, including those-established-by-the-American
College-of-Surgeons—entitled—“Hospitals-and-Prehospital
Resources-for-Optimal-Care-of-the-Injured-Patient,”—and
published-appendices-thereeto—The-department-shall-also-adopt
by-rule-standards-specific-to-pediatric-trauma-referral
centers:

†4†—In-those-geographic-areas-where-the-department
determines-the-need-for-trauma-services, any-hospital-that
desires-to-be-verified-as-a-trauma-center-must-submit-to-the
department-a-request-for-verification-as-such-center—The
request-shall-be-reviewed-by-the-department-to-determine

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whether the hospital is in substantial compliance with the standards specified in subsection (3) -- within 30 days after receiving a request from a hospital for verification as a trauma-center, the department shall notify the hospital of any apparent errors or omissions in its application and shall request any additional information necessary to enable the department to determine the hospital's substantial compliance with this section and the rules of the department. This additional information must be submitted to the department within 60 days after receipt of the request from the department. Any application must be approved or denied within 90 days after receipt of the original application or receipt of documentation that apparent errors or omissions have been corrected. Upon determining that the hospital is in substantial compliance with the standards, the department shall verify the hospital as a trauma-center. If the department denies an application, the hospital must be notified of any right to a hearing pursuant to chapter 230 if a hospital does not desire to contest the findings of the department but continues to desire to be verified as a trauma center, the hospital shall be given 90 days in which to come into substantial compliance with the standards specified in subsection (3) -- after verification of compliance with those standards, the department shall verify the hospital as a trauma-center. 

(5) -- A verification, unless sooner suspended or revoked, automatically expires 2 years after the date of issuance and is renewable biennially upon application for renewal and payment of the fee prescribed in the rules of the department if the hospital is in substantial compliance with trauma-center verification standards in effect at the time of

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the-application—An-application-for-renewal-shall-be
processed-in-the-manner-prescribed-for-initial-applications;
except-that-the-application-must-be-made-at-least-120-days
prior-to-expiration-of-the-verification-on-a-form-provided-by
the-department;

(6)—Any-hospital-which-is-verified-as-a-trauma-center
shall-accept-all-trauma-victims-that-are-appropriate-for-the
facility-regardless-of-race,-sex,-creed,-or-ability-to-pay;

(7)—It-is-unlawful-for-any-hospital-or-other-facility
to-hold-itself-out-as-a-trauma-center-unless-it-has-been-so
verified-under-this-section-by-the-department;

Section 3. Section 395.035, Florida Statutes, is
amended to read:

395.035 Review of trauma registry data; proceedings,
records, and reports specified confidential.—Each trauma
center and all hospitals shall furnish their-and-each-hospital's
shall-allow-for-department-review-of-trauma-registry-data-as
prescribed by rule of the department for the purpose of
monitoring patient outcome and ensuring compliance with the
standards of verification. Other-hospitals-may-participate-in
the-registry-at-their-option. Patient care quality assurance
proceedings, records, or reports made pursuant to this section
or s. 119.07(3)(x), s. 395.017(3)(f), s. 395.031, or s.
395.032 act shall be held confidential within the hospital and
the department and shall not be available to the public
pursuant to s. 119.07 or any other law providing access to
public records, or be discoverable or admissible in any civil
or administrative action. A person in attendance at such
proceedings may not be required to testify as to what
transpired at the meeting.

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Section 4. Section 320.0801, Florida Statutes, is amended to read:

320.0801 Additional license tax on certain vehicles.--

In addition to the license taxes specified in s. 320.08, there is hereby levied and imposed an annual license tax of 10 cents for the operation of a motor vehicle, as defined in s. 320.01, and moped, as defined in s. 316.003(77), which tax shall be paid to the department or its agent upon the registration or renewal of registration of the vehicle. Notwithstanding the provisions of s. 320.20, revenues collected from the tax imposed in this section shall be deposited in the Emergency Medical Services Trust Fund created in s. 401.34(4) and used solely for the purpose of carrying out the provisions of ss. 395.031, 395.032, 395.035, and 395.036 and section 11 of chapter 87-399, Laws of Florida this act including the cost of contracting with local or regional trauma agencies.

Section 5. This act shall take effect July 1, 1988, or upon becoming a law, whichever occurs later.

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SENATE SUMMARY

Expands the definition of the term "trauma center" as used in laws regulating trauma medical services to include hospitals determined by a local or regional trauma agency to be in compliance with trauma center verification standards. Specifies standards for evaluating trauma medical services systems and approving local and regional plans. Requires implementation of plans except under specified circumstances. Specifies the rules from which the Department of Health and Rehabilitative Services may exempt trauma agencies. Allows the delegation of the pediatric referral center verification process to trauma agencies. Prohibits discrimination by certain hospitals against trauma victims on specified grounds. Provides that written notice of intent to cease local plan implementation must be given to the department. Changes the time within which applications to renew verification must be submitted. Specifies where state trauma regions must be designated and their purpose. Provides for trauma registry proceedings and for certain proceedings, records, and reports to be confidential. Prescribes the uses for revenues in the Emergency Medical Services Trust Fund.

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A bill to be entitled
An act relating to trauma care; amending s. 395.031, F.S.; changing definition of "trauma center"; specifying standards for evaluating trauma medical services systems and approving local and regional plans; requiring implementation of plans; specifying rules from which the Department of Health and Rehabilitative Services may exempt trauma agencies; providing for the delegation of the pediatric referral center verification process to trauma agencies; prohibiting discrimination by certain hospitals against trauma victims on specified grounds; providing for written notices of intent to cease local plan implementation and local agency operation; specifying time for applications to renew verification; amending s. 395.032, F.S.; specifying where state trauma regions must be designated and their purpose; removing duplication provisions relating to trauma center verification standards, requests, expiration, and service provision; amending s. 395.035, F.S.; prescribing dates by which trauma centers and acute care hospitals must submit registry information; providing trauma registry proceedings and providing that certain proceedings, records, and reports are confidential; amending s. 320.0801, F.S.; specifying uses of revenues in the Emergency Medical Services system.

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Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.031, Florida Statutes, is amended to read:

395.031 Trauma medical services system plans; verification of trauma centers and pediatric trauma referral centers; procedures; renewal.--

(1) For the purposes of this section, the term:

(a) "Department" means the Department of Health and Rehabilitative Services.

(b) "Local or regional trauma agency" means an agency established and operated by the county, an entity with which the county contracts for the purposes of local trauma medical services administration, or a regional agency created for the administration of trauma medical services by agreement between counties.

(c) "Trauma center" means any hospital that has been determined by the department or by a local or regional trauma agency to be in substantial compliance with trauma center verification standards.

(d) "Pediatric trauma referral center" means a hospital that is determined to be in substantial compliance with pediatric trauma referral center standards as established by rule of the department pursuant to subsection (5).

(e) "Trauma scorecard" means a statewide methodology adopted by the department by rule under which a trauma victim is graded as to the severity of his injuries or illness and

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which methodology is used as the basis for making destination decisions.

(f) "Trauma victim" means any person who has incurred a single or multisystem life-threatening injury due to blunt or penetrating means and who requires immediate medical intervention or treatment.

(2)(a) The local or regional trauma agency shall plan, implement, and evaluate a trauma medical services system, in accordance with this section and ss. 395.032, 395.035, and 395.036 this-set, which consists of an organized pattern of readiness and response services based on public and private agreements and operational procedures.

(b) The local or regional trauma agency shall develop and submit to the department for review a plan for a local or regional trauma medical services system. The plan must include, at a minimum, the following components:

1. The organizational structure of the trauma system.
2. Prehospital care management guidelines for triage and transportation of trauma cases.
3. Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.
4. The number and type of major trauma cases necessary to assure that trauma centers will provide quality care to trauma cases referred to them.
5. The resources and equipment needed by trauma facilities to treat trauma cases.
6. The availability and qualifications of the health care personnel, including physicians and surgeons, who comprise the trauma teams that treat major trauma cases within a trauma facility.

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7. Data collection regarding system operation and patient outcome.

8. Periodic performance evaluation of the trauma system and its components.

9. The utilization of air transport services within the jurisdiction of the local trauma agency.

10. Public information and education about the trauma system.

11. Emergency medical services communication system usage and dispatching.

12. The coordination and integration between the verified trauma care facility and the nonverified health care facilities.

13. Medical control and accountability.

14. Quality control and system evaluation.

(c) The department shall receive plans for the implementation of trauma care systems from local or regional trauma agencies. The department may approve or not approve the local or regional plans based on the conformance of the local or regional plans with this section and ss. 395.032, 395.035, and 395.036 act and the rules adopted by the department pursuant to those sections this act. A local or regional trauma agency shall may implement the local plan developed pursuant to this section act unless the department determines that the plan does not effectively meet the needs of the persons served and is not consistent with applicable rules of the department, or the local or regional trauma agency submits to the department written notice of intent to cease implementation of the local plan.

(d) The department may grant an exception to a portion of the rules adopted pursuant to this section or s. 395.032

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300-1849-88
CS for SB 598

set if the local or regional trauma agency proves that, as
defined in the rules, compliance with that requirement would
not be in the best interest of the persons served within the
affected local trauma area.

(e) A local or regional trauma agency may implement a
trauma care system only if the system meets the minimum
standards set forth in the rules for implementation
established by the department and if the plan has been
submitted to, and approved by, the department. Before the
local or regional trauma agency submits the plan for the
trauma care system to the department, the agency shall hold a
public hearing and give adequate notice of the public meeting
to all hospitals and other interested parties in the area
proposed to be included in the system.

(f) At the option of a local or regional trauma
agency which is implementing a trauma care system approved by
the department, the department may delegate to the local or
regional trauma agency the hospital trauma center and
pediatric referral center verification process within the
geographic boundaries of the local or regional trauma agency.

2. For those local or regional trauma agencies
selecting to verify hospital trauma centers and pediatric
referral centers, the direct or indirect cost of verification
shall be borne by the applicant, based on a fee schedule set
up by the local or regional trauma agency; however, a fee may
not exceed the reasonable cost of implementation, operation,
maintenance, evaluation, and development of the verification
process.

(g) Local or regional trauma agencies may enter into
contracts for the purpose of implementing the local plan. If
local or regional agencies contract with hospitals, such

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agencies must contract only with hospitals with verified trauma centers or those willing to seek verification.

(h) Local or regional trauma agencies providing service for more than one county shall, as part of their formation, establish interlocal agreements between or among the several counties in the regional system.

(i) This section does not restrict the authority of a health care facility to provide service for which it has received a license pursuant to this chapter.

(j) Any hospital which is verified as a trauma center and has a contract with a local or regional trauma agency shall accept all trauma victims that are appropriate for the facility regardless of race, sex, creed, or ability to pay.

(k) It is unlawful for any hospital or other facility to hold itself out as a trauma center unless it has been so verified.

(l) A county, upon the recommendations of the local or regional trauma agency, may adopt ordinances governing the transport of a patient who is receiving care in the field from prehospital emergency medical personnel, when the patient meets specific criteria for trauma, burn, or pediatric centers adopted by the local or regional trauma agency. These ordinances shall, to the furthest possible extent, ensure that individual patients receive appropriate medical care while protecting the interests of the community at large by making maximum use of available emergency medical care resources.

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(n) After the submission of the initial trauma care system plan, a local or regional trauma agency which has implemented a trauma care system shall annually submit to the department an updated plan which identifies the changes, if any, to be made in the trauma care system. A local or regional trauma agency shall submit to the department written notice of its intent to cease operation of the local or regional trauma agency within 90 days before the date on which the local or regional trauma agency will cease operation.

(o) This section does not preclude a local or regional trauma agency from adopting trauma care system standards or trauma facilities standards that are more stringent than those adopted by rule of the department.

(3) Any hospital licensed in the state that desires to be verified as a trauma center or as a pediatric trauma referral center must submit to the department, or to the appropriate local or regional trauma agency, a request for verification as such a center. The request shall be reviewed by the department or the local or regional trauma agency to determine whether the hospital is in substantial compliance with the standards specified in subsection (5). Within 30 days after receiving a request from a hospital for verification as a trauma center or pediatric trauma referral center, the department or the local or regional trauma agency shall notify the hospital of any apparent errors or omissions in its application and shall request any additional information necessary to determine the hospital's substantial compliance with this section and department rules. This additional information must be submitted within 60 days after the hospital's receipt of the request for additional information. Upon receipt of the additional information from
the hospital, the department or the local or regional trauma
agency shall deem the application to be complete. An
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(5) The department shall adopt, by rule, standards for
verification of trauma centers based on national guidelines,
including those established by the American College of
Surgeons, entitled "Hospital and Prehospital Resources for
Optimal Care of the Injured Patient," and published appendices
thereto. Standards specific to pediatric trauma referral
centers shall also be adopted by rule of the department.

Section 2. Section 395.032, Florida Statutes, is
amended to read:

CODING: Words struck are deletions; words underlined are additions.
395.032 State regional trauma planning; trauma regions.--

(1) The department shall may establish trauma regions for the purpose of providing planning and coordination to ensure adequate trauma care throughout the state. Local or regional trauma system agencies may be established without regard to regional boundaries established by the department for the purpose of trauma analysis and planning. In those geographical areas where there are no department-approved local-or-regional-trauma-system-agencies-and-plans-and-where the department determines there is need for organized trauma services for the residents of the geographical area. The department shall base its definition of the regions upon

(a) Geographical considerations so as to ensure rapid access to trauma care by patients;

(b) Historical patterns of patient referral and transfer in an area;

(c) Inventories of available trauma care resources;

(d) Predicted population growth characteristics;

(e) Transportation capabilities, including ground and air transport;

(f) Medically appropriate ground and air travel times;

and

(g) Other appropriate criteria.

(2) The department shall develop trauma systems plans for the department-defined trauma regions which include at a minimum, the following components:

(a) The organizational structure of the trauma system.

(b) Prehospital care management guidelines for triage and transportation of trauma cases.

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(c) Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.

(d) The number and type of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.

(e) The resources and equipment needed by trauma facilities to treat trauma cases.

(f) The availability and qualifications of the health care personnel, including physicians and surgeons, who treat trauma cases within a trauma facility.

(g) Data collection regarding system operation and patient outcome.

(h) Periodic performance evaluation of the trauma system and its components.

(i) The utilization of air transport services within the service region.

(j) Public information and education about the trauma system.

(k) Emergency medical services communication system usage and dispatching.

(l) The coordination and integration between the designated trauma care facility and the nondesignated health care facilities.

(m) Medical control and accountability.

(n) Quality control and system evaluation.

The department shall adopt, by rule, standards for the verification of trauma centers based on national guidelines, including those established by the American College of Surgeons and Prehospital Resources for Optimal Care of the Injured Patient.
published appendices thereto: The department shall also adopt
by-rule standards specific to pediatric trauma referral
centers:
(f) In those geographical areas where the department
determines the need for trauma services, any hospital that
desires to be verified as a trauma center must submit to the
department a request for verification as such center: The
request shall be reviewed by the department to determine
whether the hospital is in substantial compliance with the
standards specified in subsection (f) within 30 days after
receiving a request from a hospital for verification as a
trauma center, the department shall notify the hospital of any
apparent errors or omissions in its application and shall
request any additional information necessary to enable the
department to determine the hospital's substantial compliance
with this section and the rules of the department: This
additional information must be submitted to the department
within 60 days after receipt of the request from the
department: Any application must be approved or denied within
90 days after receipt of the original application or receipt
of documentation that apparent errors or omissions have been
corrected: Upon determining that the hospital is in
substantial compliance with the standards, the department
shall verify the hospital as a trauma center: If the
department denies an application, the hospital must be
notified of any right to a hearing pursuant to chapter 120
if a hospital does not desire to contest the findings of the
department but continues to desire to be verified as a trauma
center, the hospital shall be given 90 days in which to come
into substantial compliance with the standards specified in
subsection (f): After verification of compliance with those

CODING: Words stricken are deletions; words underlined are additions.
Section 3. Section 395.035, Florida Statutes, is amended to read:

395.035 Review of trauma registry data; proceedings, records, and reports specified confidential. --

(1) Effective October 1, 1988, each trauma center shall furnish, and all acute care hospitals shall maintain, and allow for department review of, trauma registry data as prescribed by rule of the department for the purpose of monitoring patient outcome and ensuring compliance with the standards of verification. Acute care hospitals having 300 beds or more shall furnish the department trauma registry data effective October 1, 1989. Acute care hospitals having fewer beds shall verify the hospital as a trauma center.

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than 300 beds shall furnish the department trauma registry
data effective October 1, 1990. Notwithstanding this
schedule, any acute care hospital may submit trauma registry
data prior to the dates established in this schedule.

(2) Notwithstanding the provisions of ss. 413.48 and
413.612, each trauma center and acute care hospital shall
submit severe disability and head-injury registry data to the
department as provided by rule in lieu of submitting such
registry information to the Department of Labor and Employment
Security. Each trauma center and acute care hospital shall
continue to provide initial notification of severe
disabilities and head injuries to the Department of Labor and
Employment Security within time frames provided in chapter
413. Such initial notification shall be made in the manner
prescribed by the Department of Labor and Employment Security
for the purpose of providing timely vocational rehabilitation
services to the severely disabled or head-injured person. The
schedule provided in subsection (1) does not apply to the
current requirement for reporting of severe disabilities and
head injuries, but applies only to the requirement for
providing trauma registry information. Other-hospitals-may
participate-in-the-registry-at-their-option-

(3) Patient care quality assurance proceedings,
records, or reports made pursuant to this section or s.
119.07(3)(x), s. 395.017(3)(f), s. 395.031, or s. 395.032 act
shall be held confidential within the hospital and the
department and shall not be available to the public pursuant
to s. 119.07 or any other law providing access to public
records, or be discoverable or admissible in any civil or
administrative action. A person in attendance at such
proceedings may not be required to testify as to what
transpired at the meeting.

Section 4. Section 320.0801, Florida Statutes, is
amended to read:

320.0801 Additional license tax on certain vehicles.--
In addition to the license taxes specified in s. 320.08, there
is hereby levied and imposed an annual license tax of 10 cents
for the operation of a motor vehicle, as defined in s. 320.01,
and moped, as defined in s. 316.003(77), which tax shall be
paid to the department or its agent upon the registration or
renewal of registration of the vehicle. Notwithstanding the
provisions of s. 320.20, revenues collected from the tax
imposed in this section shall be deposited in the Emergency
Medical Services Trust Fund created in s. 401.34(4) and used
solely for the purpose of carrying out the provisions of ss.
395.031, 395.032, 395.035, and 395.036 and section 11 of
chapter 87-399, Laws of Florida this act, including the cost
of contracting with local or regional trauma agencies.

Section 5. This act shall take effect July 1, 1988, or
upon becoming a law, whichever occurs later.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 598

Permits local or regional trauma agencies to enter
contracts for the implementation of trauma system plans.

Requires phase-in reporting of trauma registry data by
all acute care hospitals to the Department of Health and
Rehabilitative Services.

Consolidates reporting requirements of trauma registry
data and reporting of severe disability and head injury
registry data as mandated by sections 413.48 and 413.612,
Florida Statutes.

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A bill to be entitled
An act relating to emergency medical care;
amending s. 320.0801, F.S.; specifying uses of
revenues in the Emergency Medical Services
Trust Fund; amending s. 395.031, F.S.;
redefining trauma center; requiring local or
regional trauma agencies to implement trauma
medical services system plans; specifying
standards for evaluating trauma medical
services systems; providing exemptions; adding
pediatric trauma referral centers to hospitals
which can be verified; specifying contracting
authority of local and regional trauma
agencies; providing for acceptance of trauma
patients; requiring notice when local or
regional trauma agency ceases operation;
requiring the Department of Health and
Rehabilitative Services to notify hospitals of
rights to a hearing; extending the time frame
for renewal applications for verification;
amending s. 395.035, F.S.; requiring certain
hospitals to furnish trauma registry data;
providing a schedule for submission; requiring
submission of data on severe disabilities and
head injuries; providing trauma registry
proceedings; providing that certain
proceedings, records, and reports are
confidential; creating s. 395.0142, F.S.;
establishing access to emergency services and
care; providing legislative intent; providing
definitions; providing for emergency services

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and care; providing for policies and transfer protocols; prohibiting discrimination; providing certain immunity from liability; providing for records of transfers and providing reporting requirements; providing penalties; requiring the Department of Health and Rehabilitative Services to determine the availability of emergency departments of hospitals and requiring the publication of such information; repealing s. 395.0145, F.S., relating to prohibition against requiring advance payment for emergency medical care; repealing s. 395.032(3), (4), (5), (6), and (7), F.S., relating to trauma center verification; deleting duplicative language relating to the department's authority to establish standards and verify trauma centers; deleting duplicative language relating to a hospital's responsibilities if verified as a trauma center; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 320.0801, Florida Statutes, is amended to read:

320.0801 Additional license tax on certain vehicles --
In addition to the license taxes specified in s. 320.08, there is hereby levied and imposed an annual license tax of 10 cents for the operation of a motor vehicle, as defined in s. 320.01, and moped, as defined in s. 316.003(77), which tax shall be paid to the department or its agent upon the registration or

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renewal of registration of the vehicle. Notwithstanding the provisions of s. 320.20, revenues collected from the tax imposed in this section shall be deposited in the Emergency Medical Services Trust Fund created in s. 401.34(4) and used solely for the purpose of carrying out the provisions of ss. 395.031, 395.032, 395.035, and 395.036 and section 11 of chapter 87-399, Laws of Florida this act, including the cost of contracting with local or regional trauma agencies.

Section 2. Section 395.031, Florida Statutes, is amended to read:

395.031 Trauma medical services system plans; verification of trauma centers and pediatric trauma referral centers; procedures; renewal.--

(1) For the purposes of this section, the term:
(a) "Department" means the Department of Health and Rehabilitative Services.
(b) "Local or regional trauma agency" means an agency established and operated by the county, an entity with which the county contracts for the purposes of local trauma medical services administration, or a regional agency created for the administration of trauma medical services by agreement between counties.
(c) "Trauma center" means any hospital that has been determined by the department or by a local or regional trauma agency to be in substantial compliance with trauma center verification standards.
(d) "Pediatric trauma referral center" means a hospital that is determined to be in substantial compliance with pediatric trauma referral center standards as established by rule of the department pursuant to subsection (5).

CODING: Words stricken are deletions; words underlined are additions.
(e) "Trauma scorecard" means a statewide methodology adopted by the department by rule under which a trauma victim is graded as to the severity of his injuries or illness and which methodology is used as the basis for making destination decisions.

(f) "Trauma victim" means any person who has incurred a single or multisystem life-threatening injury due to blunt or penetrating means and who requires immediate medical intervention or treatment.

(2)(a) The local or regional trauma agency shall plan, implement, and evaluate a trauma medical services system, in accordance with this section and ss. 395.032, 395.035, and 395.036, which consists of an organized pattern of readiness and response services based on public and private agreements and operational procedures.

(b) The local or regional trauma agency shall develop and submit to the department for review a plan for a local or regional trauma medical services system. The plan must include, at a minimum, the following components:

1. The organizational structure of the trauma system.

2. Prehospital care management guidelines for triage and transportation of trauma cases.

3. Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.

4. The number and type of major trauma cases necessary to assure that trauma centers will provide quality care to trauma cases referred to them.

5. The resources and equipment needed by trauma facilities to treat trauma cases.
6. The availability and qualifications of the health care personnel, including physicians and surgeons, who comprise the trauma teams that treat major trauma cases within a trauma facility.

7. Data collection regarding system operation and patient outcome.

8. Periodic performance evaluation of the trauma system and its components.

9. The utilization of air transport services within the jurisdiction of the local trauma agency.

10. Public information and education about the trauma system.

11. Emergency medical services communication system usage and dispatching.

12. The coordination and integration between the verified trauma care facility and the nonverified health care facilities.

13. Medical control and accountability.

14. Quality control and system evaluation.

(c) The department shall receive plans for the implementation of trauma care systems from local or regional trauma agencies. The department may approve or not approve the local or regional plans based on the conformance of the local or regional plans with this section and ss. 395.032, 395.035, and 395.036 etc and the rules adopted by the department pursuant thereto to this act. A local or regional trauma agency shall may implement the local plan developed pursuant to this section act unless the department determines that the plan does not effectively meet the needs of the persons served and is not consistent with applicable rules of the department, or unless the local or regional trauma agency

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submits to the department written notice of intent to cease implementation of the local plan.

(d) The department may grant an exception to a portion of the rules adopted pursuant to this section or s. 395.032 if the local or regional trauma agency proves that, as defined in the rules, compliance with that requirement would not be in the best interest of the persons served within the affected local trauma area.

(e) A local or regional trauma agency may implement a trauma care system only if the system meets the minimum standards set forth in the rules for implementation established by the department and if the plan has been submitted to, and approved by, the department. Before the local or regional trauma agency submits the plan for the trauma care system to the department, the agency shall hold a public hearing and give adequate notice of the public meeting to all hospitals and other interested parties in the area proposed to be included in the system.

(f)1. At the option of a local or regional trauma agency which is implementing a trauma care system approved by the department, the department may delegate to the local or regional trauma agency the hospital trauma center and pediatric trauma referral center verification process within the geographic boundaries of the local or regional trauma agency.

2. For those local or regional trauma agencies selecting to verify hospital trauma centers and pediatric trauma referral centers, the direct or indirect cost of verification shall be borne by the applicant, based on a fee schedule set up by the local or regional trauma agency; however, a fee may not exceed the reasonable cost of

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implementation, operation, maintenance, evaluation, and
development of the verification process.

(g) Local or regional trauma agencies may enter into
contracts for the purpose of implementation of the local plan
If local or regional agencies contract with hospitals, such
agencies shall contract only with hospitals with verified
trauma centers or those willing to seek verification.

(h) Local or regional trauma agencies providing
service for more than one county shall, as part of their
formation, establish interlocal agreements between or among
the several counties in the regional system.

(i) This section does not restrict the authority of a
health care facility to provide service for which it has
received a license pursuant to this chapter.

(j) Any hospital which is verified as a trauma center
and has a contract with a local or regional trauma agency
shall accept all trauma victims that are appropriate for the
facility regardless of race, sex, creed, or ability to pay

(k) It is unlawful for any hospital or other facility
to hold itself out as a trauma center unless it has been so
verified.

(l) A county, upon the recommendations of the local or
regional trauma agency, may adopt ordinances governing the
transport of a patient who is receiving care in the field from
prehospital emergency medical personnel, when the patient
meets specific criteria for trauma, burn, or pediatric centers
adopted by the local or regional trauma agency. These
ordinances shall, to the furthest possible extent, ensure that
individual patients receive appropriate medical care while
protecting the interests of the community at large by making
maximum use of available emergency medical care resources.
(m) The local or regional trauma agency shall, consistent with such plan, coordinate and otherwise facilitate arrangements necessary to develop a trauma medical services system.

(n) After the submission of the initial trauma care system plan, a local or regional trauma agency which has implemented a trauma care system shall annually submit to the department an updated plan which identifies the changes, if any, to be made in the trauma care system. A local or regional trauma agency which intends to cease operation shall submit to the department written notice of such intent within 90 days prior to the date on which operation will cease.

(o) This section does not preclude a local or regional trauma agency from adopting trauma care system standards or trauma facilities standards that are more stringent than those adopted by rule of the department.

(3) Any hospital licensed in the state that desires to be verified as a trauma center or as a pediatric trauma referral center must submit to the department, or to the appropriate local or regional trauma agency, a request for verification as such a center. The request shall be reviewed by the department or the local or regional trauma agency to determine whether the hospital is in substantial compliance with the standards specified in subsection (5). Within 30 days after receiving a request from a hospital for verification as a trauma center or pediatric trauma referral center, the department or the local or regional trauma agency shall notify the hospital of any apparent errors or omissions in its application and shall request any additional information necessary to determine the hospital's substantial compliance with this section and department rules. This

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additional information must be submitted within 60 days after the hospital's receipt of the request for additional information. Upon receipt of the additional information from the hospital, the department or the local or regional trauma agency shall deem the application to be complete. An application must be approved or denied within 90 days after receipt of the original application or receipt of documentation that apparent errors or omissions have been corrected. Upon determining that the hospital is in substantial compliance with the standards, the hospital shall be verified as a trauma center or pediatric trauma referral center. If the application is denied by the department, the hospital shall be notified of any right to a hearing pursuant to chapter 120.

(4) A verification, unless sooner suspended or revoked, automatically expires 2 years from the date of issuance and is renewable biennially upon application for renewal, provided the hospital is in substantial compliance with trauma center or pediatric trauma referral center verification standards in effect at the time of application. An application for renewal shall be processed in the same manner as prescribed for initial applications, except that the application must be made at least 180 days prior to expiration of the verification, on a form provided by the department or the appropriate local or regional trauma agency.

(5) The department shall adopt, by rule, standards for verification of trauma centers based on national guidelines, including those established by the American College of Surgeons, entitled "Hospital and Prehospital Resources for Optimal Care of the Injured Patient," and published appendices.

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thereto. Standards specific to pediatric trauma referral centers shall also be adopted by rule of the department.

Section 3. Section 395.035, Florida Statutes, is amended to read:

395.035 Review of trauma registry data; proceedings, records, and reports specified confidential.--

(1) Effective October 1, 1988, each trauma center shall furnish, and all acute care hospitals shall maintain and allow for department review of, trauma registry data as prescribed by rule of the department for the purpose of monitoring patient outcome and ensuring compliance with the standards of verification. Acute care hospitals having 300 beds or more shall furnish the department trauma registry data beginning October 1, 1989. Acute care hospitals having less than 300 beds shall furnish the department trauma registry data beginning October 1, 1990. However, any acute care hospital may submit trauma registry data prior to the dates established in the above schedule.

(2) Notwithstanding the provisions of ss. 413.38 and 413.612, each trauma center and acute care hospital shall submit registry data concerning severe disabilities and head injuries to the department as provided by rule in lieu of submitting such registry information to the Department of Labor and Employment Security. Each trauma center and acute care hospital shall continue to provide initial notification of severe disabilities and head injuries to the Department of Labor and Employment Security within time frames provided in chapter 413. Such initial notification shall be made in the manner prescribed by the Department of Labor and Employment Security for the purpose of providing timely vocational rehabilitation services to the severely disabled or head-

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injured person. The schedule provided in subsection (1) shall not apply to the current requirement for reporting severe disabilities and head injuries, but shall apply only to the requirement for providing trauma registry information. Other hospitals may participate in the registry at their option.

[3] Patient care quality assurance proceedings, records, or reports made pursuant to this section, s. 119.07(3)(x), s. 395.017(3)(f), s. 395.031, or s. 395.032 shall be held confidential within the hospital and the department and shall not be available to the public pursuant to s. 119.07 or any other law providing access to public records, or be discoverable or admissible in any civil or administrative action. A person in attendance at such proceedings may not be required to testify as to what transpired at the meeting.

Section 4. Section 395.0142, Florida Statutes, is created to read:

395.0142 Access to emergency services and care.--

(1) LEGISLATIVE INTENT.--The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the department vigorously enforce the ability of persons to receive emergency services and care and that the department act in a thorough and timely manner against hospitals which deny persons emergency services and care.

(2) DEFINITIONS.--As used in this section:

(a) "Active labor" means a labor at a time at which:

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1. There is inadequate time to effect safe transfer to
another hospital prior to delivery; or
2. A transfer may pose a threat to the health and
safety of the patient or the unborn child.

(b) "Department" means the Department of Health and
Rehabilitative Services.

(c) "Emergency medical condition" means a medical
condition manifesting itself by acute symptoms of sufficient
severity, which may include severe pain, such that the absence
of immediate medical attention could reasonably be expected to
result in any of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

(d) "Emergency services and care" means medical
screening, examination, and evaluation by a physician, or, to
the extent permitted by applicable law, by other appropriate
personnel under the supervision of a physician, to determine
if an emergency medical condition or active labor exists and,
if it does, the care, treatment, or surgery by a physician
necessary to relieve or eliminate the emergency medical
condition, within the service capability of the facility.

(e) "Stabilized" means, with respect to an emergency
medical condition, that no material deterioration of the
condition is likely, within reasonable medical probability, to
result from the transfer of the patient from a hospital.

27 (3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF
FACILITY OR HEALTH CARE PERSONNEL.--

(a) Every hospital which has an emergency department
shall provide emergency services and care for any emergency
medical condition or for active labor when:

CODING: Words stricken are deletions; words underlined are additions.
1. Any person requests emergency services and care on behalf of a person by:

   a. An emergency medical services provider who is rendering care to or transporting the person;

   b. Another hospital, when such hospital is seeking a medically necessary transfer for a patient who has been stabilized, when such transfer meets the requirements of s. 395.0144 and applicable federal law.

2. In no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

   (c) Neither the hospital nor its employees, nor any physician, dentist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, that the person is not in active labor, or that the hospital does not have the appropriate facilities or qualified personnel available to render those services.

   (d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. No hospital to which another hospital is transferring a person in need of emergency...
services and care may require the transferring hospital to
guarantee payment for the person as a condition of receiving
transfer. However, the patient or his or her legally
responsible relative or guardian shall execute an agreement to
pay therefor or otherwise supply insurance or credit
information promptly, after the services and care are
rendered.

e) If a hospital subject to the provisions of this
chapter does not maintain an emergency department, its
employees shall nevertheless exercise reasonable care to
determine whether an emergency medical condition exists and,
in addition to meeting the requirements of s. 395.0143, shall
direct the persons seeking emergency care to a nearby facility
which can render the needed services, and shall assist the
persons seeking emergency care in obtaining the services,
including transportation services, in every way reasonable
under the circumstances.

§ 4. POLICIES AND TRANSFER PROTOCOLS; DISCRIMINATION;
FAILURE TO ADOPT POLICIES AND PROTOCOLS; SUBMISSION FOR
APPROVAL.--

(a) As a condition of licensure, each hospital with an
emergency department shall adopt, in consultation with the
medical staff, policies and transfer protocols consistent with
this section and rules adopted hereunder.

(b) As a condition of licensure, each hospital shall
adopt a policy prohibiting discrimination in the provision of
emergency services and care based on race, ethnicity,
religion, national origin, citizenship, age, sex, preexisting
medical condition, physical or mental handicap, insurance
status, economic status, or ability to pay for medical
services, except to the extent that a circumstance such as

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age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(c) As a condition of licensure, each hospital shall adopt a policy to ensure that sufficient numbers and qualified types of personnel and professional and occupational disciplines are on duty and available at all times to provide emergency services and care.

(d) As a condition of licensure, each hospital shall require that physicians who serve on an "on-call" basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(e) As a condition of licensure, each hospital shall inform each person who arrives at the hospital requesting emergency services and care, or his representative if one is present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care and of the person's ability to receive emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subsection requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied, and notification of the person is not possible because of the

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person's physical or mental condition, and the hospital has made a reasonable effort to locate a representative. Each hospital shall prominently post a sign in its emergency room informing the public of the hospital's obligation to provide emergency services and care. Both the posted sign and written communication concerning any transfer or refusal to provide emergency services and care shall give the address of the department as the government agency to contact in the event the person wishes to complain about the hospital's conduct.

(f) If a hospital does not adopt the policies and protocols required in this subsection, the hospital, in addition to suspension, denial, or revocation of any of its licenses, shall be subject to a fine not to exceed $1,000 each day after expiration of 60 days' written notice from the department that the hospital's policies or protocols required by this section are inadequate, unless the delay is excused by the department upon a showing of good and sufficient cause by the hospital. The notice shall include a detailed statement of the department's reasons for its determination and suggested changes to the hospital's protocols which would be acceptable to the department.

(g) Each hospital's policies and protocols required pursuant to this subsection shall be submitted for approval to the department within 90 days of the department's adoption of rules pursuant to this section.

(5) RECORDS OF TRANSFERS; REPORT OF VIOLATIONS.--

(a) Each hospital shall maintain records of each transfer made or received for a period of 3 years.

(b) Any hospital employee, physician, other licensed emergency room health care personnel, or certified prehospital emergency personnel who knows of an apparent violation of this...
section or the rules adopted hereunder shall report the
apparent violation to the department on a form prescribed by
the department within 1 week following its occurrence.

(c) No hospital, government agency, or person shall
retaliate against, penalize, institute a civil action against,
or recover monetary relief from, or otherwise cause any injury
to, a physician or other personnel for reporting in good faith
an apparent violation of this section or the rules adopted
hereunder to the department, hospital, medical staff, or any
other interested party or government agency.

(d) No hospital, government agency, or person shall
retaliate against, penalize, institute a civil action against,
or recover monetary relief from, or otherwise cause any injury
to, a physician who refused to transfer a patient when the
physician determines, within reasonable medical probability,
that the transfer or delay caused by the transfer will create
a medical hazard to the person.

(6) PENALTIES.--

(a) The department may deny, revoke, or suspend a
license or impose an administrative fine, not to exceed
$10,000 per violation, for the violation of any provision of
this section or rules adopted hereunder.

(b) Any person who suffers personal harm as a result
of a violation of this section or the rules adopted hereunder
may recover, in a civil action against the responsible
administrative or medical personnel, damages, reasonable
attorney's fees, and other appropriate relief.

(c) Any administrative or medical personnel who
knowingly or intentionally violates any provision of this
section is guilty of a misdemeanor of the second degree.

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punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 5. The Department of Health and Rehabilitative Services shall establish and maintain an inventory of hospitals with emergency departments. Included in the inventory shall be a listing of all services by the hospital. The department shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the general public. The department shall report to the Governor, the Speaker of the House of Representatives, and the President of the Senate, by March 1, 1989, the status of the inventory.

Section 6. Section 395.0145, Florida Statutes, and subsections (3), (4), (5), (6), and (7) of section 395.032, Florida Statutes, as created by chapter 87-399, Laws of Florida, are hereby repealed.

Section 7. This act shall take effect October 1, 1988.

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HOUSE SUMMARY

Specifies uses of revenues in the Emergency Medical Services Trust Fund for the trauma medical services system. Amends "trauma center" definition. Requires local or regional trauma agencies to implement trauma medical services system plans. Specifies standards for evaluating trauma medical services systems. Provides exemptions. Provides for verification of pediatric trauma referral centers. Specifies contracting authority of local and regional trauma agencies. Provides for acceptance of trauma patients. Requires notice as to cessation of operation of local or regional trauma agency. Requires Department of Health and Rehabilitative Services to notify hospitals of rights to hearing. Extends time frame for verification renewal applications.

Requires acute care hospitals to furnish trauma registry data pursuant to a specified schedule. Requires submission of data on severe disabilities and head injuries. Provides trauma registry proceedings. Provides for confidentiality of specified proceedings, records, and reports.

Provides conditions under which hospitals with emergency departments are required to provide emergency services and care. Prohibits discrimination in the provision thereof. Protects hospitals and health care personnel from liability for refusal to render emergency services under certain circumstances.

Requires hospitals with emergency departments to adopt, as a condition for licensure, policies and transfer protocols, including policies prohibiting discrimination in the provision of emergency services and care, ensuring the presence of personnel for such services and care, and providing for notification of rights to such services and care and reasons for transfer. Provides a penalty for failure to adopt such policies.

Requires records of transfers. Requires reports to the department by health care personnel of violations of access to emergency services and care provisions, and protects persons who make such reports. Provides penalties for violation of access to emergency services and care provisions, and authorizes civil actions for damages. Requires the department to determine the availability of hospitals with emergency departments, to make such information available to the public, and to report it to the Governor and the Legislature.

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CODING: Words stricken are deletions; words underlined are additions.
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12. Solicit and accept gifts, grants, loans, and other aids from any source or participate in any other way in any government program to carry out the purposes of this section.

13. Require and collect administrative fees and charges in connection with any transaction and impose reasonable penalties, including default, for delinquent payments or for entering into an advance payment contract on a fraudulent basis.

14. Procure insurance against any loss in connection with the property, assets, and activities of the fund or of the board.

15. Impose reasonable time limits on use of the tuition benefits provided by the program. However, any such limitation shall be specified within the advance payment contract.

16. Delineate the terms and conditions under which payments may be withdrawn from the fund and impose reasonable fees and charges for such withdrawal. Such terms and conditions shall be specified within the advance payment contract.

17. Provide for the receipt of contributions in lump sums or installment payments.

18. Establish other policies, procedures, and criteria to implement and administer the provisions of this section.

(d) The board shall administer the fund in a manner that is sufficiently actuarially sound to defray the obligations of the board and to annually evaluate the actuarial soundness of the fund. If the board perceives a need for additional assets in order to preserve actuarial soundness, the board may adjust the terms of subsequent advance payment contracts to ensure such soundness.

(e) The board shall establish a comprehensive investment plan for the purposes of this section. The board may place assets of the fund in savings accounts or use the same to purchase fixed or variable life insurance or annuity contracts, securities, evidence of indebtedness, or other investment products pursuant to the comprehensive investment plan and in such proportions as the board may determine. Such insurance, annuity, savings, or investment products shall be underwritten and offered in compliance with the applicable federal and state laws, regulations, and rules by persons who are duly authorized by applicable federal and state authorities. Within the comprehensive investment plan, the board may authorize investment vehicles, or products incident thereto, as may be available or offered by qualified companies or persons.

(f) The board may delegate responsibility for administration of the comprehensive investment plan required in paragraph (e) to a person or persons determined by the board to be qualified. Such person shall be compensated by the board. Directly or through such person, the board may contract with a private corporation or institution to provide such services as may be a part of the comprehensive investment plan or as may be deemed necessary or proper by the board or such person, including, but not limited to, providing consolidated billing, individual and collective recordkeeping and accountings, and asset purchase, control, and safekeeping.

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(q) The board shall annually prepare or cause to be prepared a report setting forth in appropriate detail an accounting of the fund and a description of the financial condition of the program at the close of each fiscal year. Such report shall be submitted to the President of the Senate, the Speaker of the House of Representatives, and members of the Board of Education on or before November 15 each year. In addition, the board shall make the report available to purchasers of advance payment contracts. The accounts of the fund shall be subject to annual audits by the Auditor General or his designee.

(h) The board shall solicit answers to applicable ruling requests from the Internal Revenue Service regarding the tax status of fees paid pursuant to an advance payment contract to the purchaser of a qualified beneficiary and from the Securities and Exchange Commission regarding the application of federal securities laws to the trust. The board shall make the status of such requests known before entering into an advance payment contract.

(i) The board shall solicit proposals for the marketing of the Florida Prepaid Postsecondary Education Expense Program pursuant to s. 287.057. The entity designated pursuant to this paragraph shall serve as a centralized marketing agent for the program and shall be solely responsible for the marketing of the program. Any materials produced for the purpose of marketing the program shall be submitted to the board for review. No such materials shall be made available to the public before the materials are approved by the board. Any educational institution may distribute marketing materials produced for the program; however, all such materials shall have been approved by the board. Neither the state nor the board shall be liable for misrepresentation of the program by a marketing agent.

Section 18. This section and sections 15, 16, and 17 of this act shall take effect July 1, 1988, or upon becoming a law, whichever occurs later; the remainder of this act shall take effect October 1, 1988.

Approved by the Governor July 1, 1988

Filed in Office Secretary of State July 1, 1988

CHAPTER 88-186

Committee Substitute for Senate Bill No 98

An act relating to trauma care; amending s. 287.057, F.S.; changing definition of "trauma center", specifying standards for evaluating trauma medical services systems and approving local and regional plans, requiring implementation of plans, specifying rules from which the Department of Health and Rehabilitative Services may exempt trauma agencies; providing for the delegation of the pediatric referral center verification process to trauma agencies; prohibiting discrimination by certain hospitals against trauma victims on specified grounds; providing for written notices of intent to cease local plan implementation and local agency operation; specifying time for applications to renew verification.
amending s. 395.032, F.S.; specifying where state trauma regions must be designated and their purpose; removing duplication; provisions relating to trauma center verification standards, requests, expiration, and service provision; amending s. 395.035, F.S.; prescribing dates by which trauma centers and acute care hospitals must submit registry information; providing trauma registry proceedings and providing that certain proceedings, records, and reports are confidential, amending s. 395.0801, F.S.; specifying uses of revenues in the Emergency Medical Services Trust Fund, amending s. 401.245, F.S.; increasing from two years to three years the terms of Office of Emergency Medical Services Advisory Council members; creating s. 395.0142, F.S.; establishing access to emergency services and care; providing legislative intent; providing definitions; providing for emergency services and care; providing certain immunity from liability; providing for records of transfers and providing reporting requirements; providing penalties; requiring the Department of Health and Rehabilitative Services to determine the availability of emergency departments of hospitals and requiring the publication of such information; amending s. 401.265, F.S.; providing that certain instructions given by a medical director are deemed to be emergency medical care; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.031, Florida Statutes, is amended to read:

395.031 Trauma medical services system plans; verification of trauma centers and pediatric trauma referral centers; procedures; renewal.--

(1) For the purposes of this section, the term

(a) "Department" means the Department of Health and Rehabilitative Services.

(b) "Local or regional trauma agency" means an agency established and operated by the county, an entity with which the county contracts for the purposes of local trauma medical services administration, or a regional agency created for the administration of trauma medical services by agreement between counties.

(c) "Trauma center" means any hospital that has been determined by the department or by a local or regional trauma agency to be in substantial compliance with trauma center verification standards.

(d) "Pediatric trauma referral center" means a hospital that is determined to be in substantial compliance with pediatric trauma referral center standards as established by rule of the department pursuant to subsection (5).

(e) "Trauma scorecard" means a statewide methodology adopted by the department by rule under which a trauma victim is graded as to the severity of his injuries or illness and which methodology is used as the basis for making destination decisions.

(f) "Trauma victim" means any person who has incurred a single or multisystem life-threatening injury due to blunt or penetrating means and who requires immediate medical intervention or treatment.

(2)(a) The local or regional trauma agency shall plan, implement, and evaluate a trauma medical services system, in accordance with this section and ss. 395.032, 395.035, and 395.036 that are consistent with public and private agreements and operational procedures.

(b) The local or regional trauma agency shall develop and submit to the department for review a plan for a local or regional trauma medical services system. The plan must include, at a minimum, the following components:

1. The organizational structure of the trauma system.

2. Prehospital care management guidelines for triage and transportation of trauma cases.

3. Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provisions for interfacility transfer.

4. The number and type of major trauma cases necessary to assure that trauma centers will provide quality care to trauma cases referred to them.

5. The resources and equipment needed by trauma facilities to treat trauma cases.

6. The availability and qualifications of the health care personnel, including physicians and surgeons, who comprise the trauma teams that treat major trauma cases within a trauma facility.

7. Data collection regarding system operation and patient outcome.

8. Periodic performance evaluation of the trauma system and its components.

9. The utilization of air transport services within the jurisdiction of the local trauma agency.

10. Public information and education about the trauma system.

11. Emergency medical services communication system usage and dispatching.

12. The coordination and integration between the verified trauma care facility and the nonverified health care facilities.

13. Medical control and accountability.

14. Quality control and system evaluation.

(c) The department shall receive plans for the implementation of trauma care systems from local or regional trauma agencies. The department may approve or not approve the local or regional plans based on the conformance of the local or regional plans with this section and ss. 395.032, 395.035, and 395.036 and the rules.
A local or regional trauma agency shall implement the local plan developed pursuant to this section unless the department determines that the plan does not effectively meet the needs of the persons served and is not consistent with applicable rules of the department, or the local or regional trauma agency submits to the department written notice of intent to cease implementation of the local plan.

The department may grant an exception to a portion of the rules adopted pursuant to this section or s. 395.032 if the local or regional trauma agency proves that, as defined in the rules, compliance with that requirement would not be in the best interest of the persons served within the affected local trauma area.

A local or regional trauma agency may implement a trauma care system only if the system meets the minimum standards set forth in the rules for implementation established by the department and if the plan has been submitted to, and approved by, the department. Before the local or regional trauma agency submits the plan for the trauma care system to the department, the agency shall hold a public hearing and give adequate notice of the public meeting to all hospitals and other interested parties in the area proposed to be included in the system.

At the option of a local or regional trauma agency which is implementing a trauma care system approved by the department, the department may delegate to the local or regional trauma agency the hospital trauma center and pediatric referral center verification process within the geographic boundaries of the local or regional trauma agency.

For those local or regional trauma agencies selecting to verify hospital trauma centers and pediatric referral centers, the direct or indirect cost of verification shall be borne by the applicant, based on a fee schedule set up by the local or regional trauma agency; however, a fee may not exceed the reasonable cost of implementing, operation, maintenance, evaluation, and development of the verification process.

Local or regional trauma agencies may enter into contracts for the purpose of implementing the local plan. If local or regional trauma agencies contract with hospitals, such agencies must contract only with hospitals verified trauma centers or those willing to seek verification.

Local or regional trauma agencies providing service for more than one county shall, as part of their formation, establish interlocal agreements between or among the several counties in the regional system.

This section does not restrict the authority of a health care facility to provide service for which it has received a license pursuant to this chapter.

Any hospital which is verified as a trauma center and has a contract with a local or regional trauma agency shall accept all trauma victims that are appropriate for the facility regardless of race, sex, creed, or ability to pay.
trauma referral center verification standards in effect at the time of application. An application for renewal shall be processed in the same manner as prescribed for initial applications, except that the application must be made at least 180-220 days prior to expiration of the verification, on a form provided by the department or the appropriate local or regional trauma agency.

(5) The department shall adopt, by rule, standards for verification of trauma centers based on national guidelines, including those established by the American College of Surgeons, entitled "Hospital and Prehospital Resources for Optimal Care of the Injured Patient," and published appendices thereto. Standards specific to pediatric trauma referral centers shall also be adopted by rule of the department.

(6) The department may withdraw local or regional agency authority, prescribe corrective actions, or use the administrative remedies as provided in s. 395.018 for the violation of any provision of this section and ss. 395.032, 395.035, and 395.036 or rules adopted thereunder. All amounts collected pursuant to this subsection shall be deposited into the Emergency Medical Services Trust Fund provided in s. 401.34.

Section 2. Section 395.032, Florida Statutes, is amended to read

395.032 State regional trauma planning; trauma regions.--

(1) The department may establish trauma regions in those geographical areas where there are no department approved local or regional trauma system agencies and plans and where the department determines there is need for organized trauma services for the residents of the geographical area. The department shall base its definition of the regions upon:

(a) Geographical considerations so as to ensure rapid access to trauma care by patients;
(b) Historical patterns of patient referral and transfer in an area;
(c) Inventories of available trauma care resources;
(d) Predicted population growth characteristics;
(e) Transportation capabilities, including ground and air transport;
(f) Medically appropriate ground and air travel times; and
(g) Other appropriate criteria.

(2) The department shall develop trauma systems plans for the department-defined trauma regions which include at a minimum, the following components:

(a) The organizational structure of the trauma system.
(b) Prehospital care management guidelines for triage and transportation of trauma cases.
(c) Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.
(d) The number and type of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.
(e) The resources and equipment needed by trauma facilities to treat trauma cases.
(f) The availability and qualifications of the health care personnel, including physicians and surgeons, who treat trauma cases within a trauma facility.
(g) Data collection regarding system operation and patient outcome.
(h) Periodic performance evaluation of the trauma system and its components.

(i) The utilization of air transport services within the service region.
(j) Public information and education about the trauma system.
(k) Emergency medical services communication system usage and dispatching.

(l) The coordination and integration between the designated trauma care facility and the non-designated health care facilities.
(m) Medical control and accountability.

(n) Quality control and system evaluation.
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rehabilitation services to the severely disabled or head-injured. The current requirement for reporting of severe disabilities and head injuries is established in this schedule. Effective October 1, 1990. Notwithstanding this schedule, any acute care hospital or other facility to which patient outcome and ensuring compliance with trauma center verification standards in effect at the time of the application--An application for renewal shall be processed in the manner prescribed for initial applications; except that the application must be made at least 120 days prior to the expiration of the verification; on a form provided by the department.

(6) Any hospital which is verified as a trauma-center shall accept all trauma victims that are appropriate for the facility regardless of race, sex, creed, or ability to pay.

(7) It is unlawful for any hospital or other facility to hold itself out as a trauma-center unless it has been so verified--under this section by the department.

Section 3. Section 395.035, Florida Statutes, is amended to read:

395.035 Review of trauma registry data; proceedings, records, and reports specified confidential.--

(1) Effective October 1, 1988, each trauma center shall furnish, and all acute care hospitals shall maintain, and allow for department review of, trauma registry data as prescribed by rule of the department for the purpose of monitoring patient outcome and ensuring compliance with the standards of verification. Acute care hospitals having 100 beds or more shall furnish the department trauma registry data effective October 1, 1989. Acute care hospitals having fewer than 100 beds shall furnish the department trauma registry data effective October 1, 1990. Notwithstanding this schedule, any acute care hospital may submit trauma registry data prior to the dates established in this schedule.

(2) Notwithstanding the provisions of ss. 413.48 and 413.612, each trauma center and acute care hospital shall submit severe disability and head-injury registry data to the department as provided by rule in lieu of submitting such registry information to the Department of Labor and Employment Security. Each trauma center and acute care hospital shall continue to provide initial notification of severe disabilities and head injuries to the Department of Labor and Employment Security within time frames provided in chapter 413. Such initial notification shall be made in the manner prescribed by the Department of Labor and Employment Security for the purpose of informing the affected person of the nature of the severe disability or head injury.

Section 4. Section 320.0801, Florida Statutes, is amended to read:

320.0801 Additional license tax on certain vehicles.--In addition to the license tax specified in s. 320.08, there is hereby levied and imposed an annual license tax of 10 cents for the operation of a motor vehicle, as defined in s. 320.01, and mapped, as defined in s. 316.003(77), which tax shall be paid to the department or its agent upon the registration or renewal of registration of the vehicle. Notwithstanding the provisions of s. 320.08, revenues collected from the tax imposed in this section shall be deposited in the Emergency Medical Services Trust Fund created in s. 401.14(4) and used solely for the purpose of carrying out the provisions of s. 395.032, 395.033, 395.035, and 395.036 and section 11(1) of chapter 88-186, Laws of Florida this year, including the cost of contracting with local regional-trauma agencies.

Section 5. Subsection (1) of section 401.245, Florida Statutes, is amended to read:

401.245 Emergency Medical Services Advisory Council.--

(1) The provisions of s. 20.194(4)(a), notwithstanding, the secretary of the Department of Health and Rehabilitative Services may appoint an advisory council for the purpose of acting as the advisory board to the emergency medical services program. No more than 15 members may be appointed to this council. Each district of the department shall be represented on the advisory council by July 1, 1981. In addition to the number of members required for terms of 1-year each, thereafter, Members shall be appointed for 3-year, 2-year terms in such a manner that each year the terms of one-third of the members expire. The chairman of the council shall be designated by the secretary and shall serve for a term of 1-year. Vacancies shall be filled for the remainder of unexpired terms in the same manner as the original appointment. Members shall receive no compensation, but may be reimbursed for per diem and travel expenses.

Section 6. Section 395.0142, Florida Statutes, is created to read:

395.0142 Access to emergency services and care.--

(1) LEGISLATIVE INTENT.--The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the department vigorously enforce the ability of persons to receive emergency care.
services and care and that the department act in a thorough and timely manner against hospitals which deny persons emergency services and care.

(2) DEFINITIONS.—As used in this section:

(a) "Active labor" means a labor at a time at which:

1. There is inadequate time to effect safe transfer to another hospital prior to delivery; or

2. A transfer may pose a threat to the health and safety of the patient or the unborn child.

(b) "Department" means the Department of Health and Rehabilitative Services.

(c) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the patient's health.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(d) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(e) "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the patient from a hospital.

(3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(a) Every hospital which has an emergency department shall provide emergency services and care for any emergency medical condition or for active labor when:

1. Any person requests emergency services and care; or

2. Emergency services and care are requested on behalf of a person by:

   a. An emergency medical services provider who is rendering care to or transporting the person; or

   b. Another hospital, when such hospital is seeking a medically necessary transfer for a patient who has been stabilized, when such

(b) In no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(c) Neither the hospital nor its employees, nor any physician, dentist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, that the person is not in active labor, or that the hospital does not have the appropriate facilities or qualified personnel available to render those services.

(d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital to guarantee payment for the person as a condition of receiving transfer. However, the patient or his or her legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly, after the services and care are rendered.

(e) If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and, in addition to meeting the requirements of s. 395.0143, shall direct the persons seeking emergency care to a nearby facility which can render the needed services, and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(4) RECORDS OF TRANSFERS; REPORT OF VIOLATIONS.—

(a) Each hospital shall maintain records of each transfer made or received for a period of 3 years.

(b) Any hospital employee, physician, other licensed emergency room health care personnel, or certified prehospital emergency personnel who knows of an apparent violation of this section or the rules adopted hereunder shall report the apparent violation to the department on a form prescribed by the department within 1 week following its occurrence.

(c) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to, a physician or other personnel for reporting in good faith an apparent violation of this section or the rules adopted hereunder to the department, hospital, medical staff, or any other interested party or government agency.
(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to, a physician who refused to transfer a patient when the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the person.

(5) PENALTIES.--

(a) The department may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $10,000 per violation, for the violation of any provision of this section or rules adopted hereunder.

(b) Any person who suffers personal harm as a result of a violation of this section or the rules adopted hereunder may recover, in a civil action against the responsible administrative or medical personnel, damages, reasonable attorney's fees, and other appropriate relief.

(c) Any administrative or medical personnel who knowingly or intentionally violates any provision of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083, or s. 775.084.

Section 7. The Department of Health and Rehabilitative Services shall establish and maintain an inventory of hospitals with emergency departments. Included in the inventory shall be a listing of all services by the hospital. The department shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the general public. The department shall report to the Governor, the Speaker of the House of Representatives, and the President of the Senate, by March 1, 1989, the status of the inventory.

Section 8. Subsection (3) is added to section 401.265, Florida Statutes, to read:

401.265 Medical directors.--

(3) Any medical director who in good faith gives oral or written instructions to certified emergency medical services personnel for the provision of emergency care shall be deemed to be providing emergency medical care of treatment for the purposes of s. 768.13(2).

Section 9. This act shall take effect October 1, 1988.

Approved by the Governor July 1, 1988.

Filed in Office Secretary of State July 1, 1988.

Be It Enacted by the Legislature of the State of Florida

Section 1. Subsection (1) of section 517.051, Florida Statutes, as amended by section 4 of chapter 87-237, Laws of Florida, and as section 3 of chapter 87-316, Laws of Florida, is amended to read:

517.051 Exempt securities.--The registration provisions of s. 517.07 do not apply to any of the following securities:

(1) A security issued or guaranteed by the United States or any territory or insular possession of the United States, by the District of Columbia, or by any state of the United States or by any political subdivision or agency or other instrumentality thereof; provided that no person shall directly or indirectly offer or sell securities, other than general obligation bonds, under this subsection if the issuer or guarantor is in default or has been in default at any time after December 31, 1975, as to principal or interest:

(a) With respect to an obligation issued by the issuer or successor of the issuer which was guaranteed by the guarantor or successor of the guarantor; or

(b) With respect to an obligation guaranteed by the guarantor or successor of the issuer issued by the issuer or successor of the guarantor if the guarantor is in default or has been in default at any time after December 31, 1975, as to principal or interest:

(a) With respect to an obligation issued by the issuer or successor of the issuer which was guaranteed by the guarantor or successor of the guarantor; or

(b) With respect to an obligation guaranteed by the guarantor or successor of the issuer issued by the issuer or successor of the guarantor if the guarantor is in default or has been in default at any time after December 31, 1975, as to principal or interest:

(a) With respect to an obligation issued by the issuer or successor of the issuer which was guaranteed by the guarantor or successor of the guarantor; or

(b) With respect to an obligation guaranteed by the guarantor or successor of the issuer issued by the issuer or successor of the guarantor if the guarantor is in default or has been in default at any time after December 31, 1975, as to principal or interest:

except by an offering circular or statement containing a full and fair disclosure of said default as prescribed by rule of the department.

Section 2. Subsections (6), (10), and (11) of section 517.12, Florida Statutes, are amended to read:

517.12 Registration of dealers, associated persons, investment advisers, and branch offices.--

(6) A dealer, associated person, investment adviser, or branch office in order to obtain initial registration, must file with the department a written application, in a form which the department may by rule prescribe, verified under oath. Each dealer or investment adviser must also file an irrevocable written consent to service of civil process similar to that provided for in s. 517.101. The application shall contain such information as the department may require concerning such matters as:

(a) The name of the applicant and the address of its principal office and each office in this state.

(b) The applicant's form and place of organization; and, if the applicant is a corporation, a copy of its articles of incorporation and amendments to the articles of incorporation or, if a partnership, a copy of the partnership agreement.

(c) The applicant's proposed method of doing business and financial condition and history, including a certified financial
FLORIDA LEGISLATURE

FINAL
LEGISLATIVE BILL
INFORMATION

1987 Special Sessions B, C, D
1988 Regular Session
1988 Special Sessions E, F

prepared by:

Joint Legislative Management Committee
Legislative Information Division
Capitol Building, Room 826 — 488-4371
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<td>HOUSE Comm. Report: Favorable with 4 amendment(s) by Appropriations, placed on Calendar -HJ 1066, Placed on Special Order Calendar</td>
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<tr>
<td>06/01/88</td>
<td>HOUSE Idem./Senate Bill substituted, Laid on Table under Rule, Idem./Sim./Compare Bill passed, refer to CS/SB 526 (Ch. 58-196) &amp; CS/SB 528 (Ch. 58-204) -HJ 1099</td>
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**H 1611 JOINT RESOLUTION/ENG by Finance & Taxation; Simon and others (Simpler H 388, Compare H 819)**

**Taxation & Budget Reform Commission:** constitutional amendment to transfer authority to review matters re state & local taxation & budgetary processes from Constitution Revision Commission to newly created Taxation & Budget Reform Commission to be established in 1990 & every 10 years thereafter; provides that new commission will issue report & may propose statutory changes to Legislature & submit proposed const changes to voters

**Amendment adopted -HJ 538**

07/01/88 HOUSE Comm. Report: Favorable with 3 amendment(s) by Appropriations, placed on Calendar -SJ 463, Passed as amended; YEAS 29 NAYS 10 —SJ 463

05/03/88 HOUSE Filed

**H 1612 GENERAL BILL by Judiciary; Press; Simon**

**Child Custody & Visitation:** creates Child Custody & Visitation Study Commission & provides for appointment of members, provides duties, responsibilities & staffing of commission, provides for per diem for members, requires report to Legislature & Governor; provides for expiration of commission.

**Effective Date: Upon becoming law.**

05/06/88 HOUSE Filed

06/03/88 HOUSE Introduced, referred to Appropriations -HJ 362

05/13/88 HOUSE Withdrawn from Appropriations -HJ 595, Placed on Calendar

06/01/88 HOUSE Placed on Special Order Calendar -HJ 649, Passed as amended; YEAS 115 NAYS 1 —HJ 1106

06/12/88 HOUSE Second read time; Read third time; Passed; YEAS 114 NAYS 0 —HJ 1105

06/18/88 SENATE In Messages

06/18/88 SENATE Died in Messages

**H 1613 GENERAL BILL by Judiciary; Simon; Dunbar; Diaz-Balart and others**

**Master & Homemakers Assoications:** provides that powers & duties of Fla. Land Sales Commissions & M.M.A. associations; provides for regulation of homeowners associations consisting principally of condo units; provides for incorporation, powers & duties, insurance, official records, financial statements, association meetings, budgets, & fidelity bonding, voluntary bonding arbitration, etc. Amend Ch. 496, Sec. 718 Effective Date 10/01/98.

05/06/88 HOUSE Filed

05/06/88 HOUSE Introduced, referred to Appropriations -HJ 362

05/13/88 HOUSE On Committee agenda—Appropriations, 05/17/88, 3:30 pm, Morris Hall—Not considered

05/24/88 HOUSE Withdrawn from Appropriations -HJ 469; Placed on Calendar

06/07/88 HOUSE Died on Calendar

**H 1614 RESOLUTION by Casas; Souto (Identical S 1394)**

**Coppolela Dr. Villas Castro, commends Dr Coppolela for her outstanding accomplishments in promoting the nation's literary values & culture**

05/03/88 HOUSE Filed

05/06/88 HOUSE Introduced, referred to Appropriations -HJ 362

06/08/88 HOUSE On Committee agenda—Appropriations, 05/17/88, 3:30 pm, Morris Hall—Not considered

06/07/88 HOUSE Died in Committee on Tourism & Cultural Affairs, Iden./Sim./Compare bill passed, refer to SR 1394 (Approved)

**H 1615 GENERAL BILL by Health Care; Press, Abrams (Compare CS/CS/ENG/S 534, CS/ENG/S 559)**

**Trauma Centers & Services:** specifies uses of revenues in Emergency Medical Services Trust Fund; redefines trauma center; requires local or regional trauma agencies to implement trauma medical service system plans, specifies standards for evaluating trauma medical service systems, adds pediatric trauma referral centers to hospitals which can be verified, requires certain hospitals to furnish trauma registry data, etc. Amend 320 5001, Ch. 396. Effective Date: 10/01/98

05/06/88 HOUSE Filed

05/06/88 HOUSE Introduced, referred to Appropriations -HJ 362

05/23/88 HOUSE On Committee agenda—Appropriations, 06/24/88, 5:00 pm, Morris Hall —For ratification of subreferral

05/26/88 HOUSE Placed on Special Order Calendar, Read second time, Amendment adopted -HJ 538

05/31/88 HOUSE Comm. Report: Favorable with 4 amendment(s) by Appropriations, placed on Calendar -HJ 1066, Placed on Special Order Calendar

06/01/88 HOUSE Idem./Senate Bill substituted, Laid on Table under Rule, Idem./Sim./Compare Bill passed, refer to CS/SB 545 (Ch. 58-196) & CS/SB 546 (Ch. 58-204) -HJ 1099
I. SUMMARY:

This committee bill clarifies current law relating to trauma centers and trauma system plans, requires all hospitals to submit trauma registry data and, establishes the responsibilities of providers regarding the provision of hospital emergency services and care.

A. PRESENT SITUATION:

Section 395.031, F.S., establishes procedures for verification of hospital trauma centers by the Department of Health and Rehabilitative Services (DHRHS) or a local or regional trauma agency if delegated to by the department. Any hospital wishing to be verified as a trauma center is required to apply, be reviewed, and meet standards as a trauma center by level of care capability. The law further prohibits any hospital or other facility from holding itself out as a trauma center unless it has made application and been verified as having met certain standards.

The legislation establishing trauma center verification procedures was first enacted in 1982. Its purpose was to develop a network of trauma centers throughout the state so that victims of trauma would receive the best possible medical care, thus reducing the possibility of permanent disability or death. A trauma victim is defined as a person who has incurred a single or multi-system life threatening injury due to blunt or penetrating means.

Chapter 87-399, Laws of Florida, modified Florida's verification system to create a bifurcated trauma planning and verification
system. Local or regional trauma system agencies (single- or multi-county) may be established by a local initiative. These local agencies are responsible for developing and implementing trauma system plans. In addition, DHRS may delegate to the local or regional agencies the trauma center verification process. DHRS must approve all local or regional trauma plans. In those geographic areas of the state without local or regional trauma agencies, DHRS must develop trauma plans and verify hospital trauma centers based on population and geographic factors.

The law also requires each emergency medical services (EMS) provider to transport a trauma victim to the most appropriate trauma center based on a trauma scorecard and transport protocol. It also requires DHRS to establish a trauma registry so that the outcome of trauma treatment can routinely be assessed.

All hospitals are currently required to provide data to the Department of Labor and Employment Security on each severe disability (generally spinal cord injuries), and on each head injury for purposes of providing timely vocational rehabilitative services to the patient. There is no similar requirement that the data be reported to the trauma registry.

As to the actual provision of emergency care, testimony before both the Committee on Health Care and the Subcommittee on Health Regulation indicated that persons throughout the state have been denied emergency services and care by hospitals and physicians. Persons have been diverted from one hospital to another, been refused emergency care by a hospital and have been treated by one hospital but denied care by another hospital when the first hospital sought a medically necessary transfer.

The law regarding patients' access to emergency care is found in Florida and Federal statutes. Although there are several court decisions relating to treatment and transfer of indigent patients, on the specific issue of denial of emergency care the clearest legal direction is found in statutes and administrative rules.

A hospital's duty to treat persons seeking emergency services is found in ss. 395.0143, 395.0144, 395.0145 and 401.45, F.S. Also relevant is 395.005, F.S., relating to the Department of Health and Rehabilitative Services rule-making and enforcement authority over hospitals.

Section 395.0143, F.S., requires all general hospitals and all specialty hospitals with an emergency room to treat any person for any emergency medical condition which will deteriorate from a failure to provide such treatment. A person has recourse for a hospital's refusal to provide emergency treatment only if in fact his or her condition deteriorates as a result of not being treated and reasonable care has not been exercised in the determination of the condition of the patient and the appropriateness of the facility and personnel to render needed treatment. Although the plain language of the statute speaks to a prohibition against denial of
treatment for any emergency medical condition and therefore could apply to a hospital to accept a transfer, the Department of Health and Rehabilitative Services does not interpret this section accordingly.

Section 395.0144, F.S., requires any general (but not specialty) hospital which operates a full-time emergency room to admit any patient, regardless of economic criteria or indigency, upon the determination by a licensed staff physician that the patient should be admitted. If the physician responsible for emergency room service determines that the hospital is unable to render appropriate treatment, the hospital would be required to transfer the patient and all information relative to medical condition and history to an alternate hospital which has the facilities to treat the patient. This transfer could occur only after the physician has determined the patient's condition is stable enough for transfer. This section is silent as to whether the appropriate receiving hospital must agree to the transfer, although subsection (2) states that the first hospital shall "contact an appropriate receiving hospital and notify such hospital that the patient is in transit."

Finally in this series of emergency care sections, 395.0145, F.S., prohibits hospitals with emergency departments from requiring payment prior to rendering emergency medical care to a patient when the patient has shown evidence of adequate health insurance coverage. This section would appear to be superseded by the language in s. 395.0144, F.S., which prohibits refusal to admit based on economic criteria or indigency.

Regarding the rule-making enforcement authority of the Department of Health and Rehabilitative Services, the Department is required by statute to adopt and enforce rules to ensure the compliance by hospitals to these aforementioned sections and to ensure that sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care and safety, s. 395.005(1)(a), F.S.

In addition to Florida law, Federal law requires evaluation and treatment of persons seeking emergency services. In a measure to prevent patient dumping, Section 9121 of the Consolidated Budget Reconciliation Act of 1986 (COBRA) states that patients who have not been stabilized cannot be transferred to another hospital without the receiving hospital agreeing to the transfer.

B. EFFECT OF PROPOSED CHANGES:

The changes provided for in this bill generally correct or clarify the existing "glitches" in the law relating to trauma system plans. In addition, it requires the local or regional trauma agencies to implement the local plan once developed, unless the department determines the plan is not effective or the agency submits to the department written notice of its intent to cease implementation of the local plan.
The bill deletes duplicative language relating to the state's role in establishing trauma regions, and clarifies language allowing trauma agencies to contract with verified trauma centers.

By October 1, 1990, the bill also requires all acute care hospitals, as well as all verified trauma centers, to report trauma data to the trauma registry. In addition, the bill requires the detailed data on spinal cord and head injury patients currently being reported to the Department of Labor and Employment Security to be reported to DHRS to be included in the registry's data bank. Hospitals will still be required to notify the Department of Labor and Employment Security of initial injury in order for the department to provide timely vocational rehabilitative services.

This committee bill also establishes the responsibilities for providers regarding the provision of hospital emergency services and care. The major provisions of this part of the bill include:

1) Providing needed definitions for emergency medical condition and emergency services and care.

2) Specifying the circumstances when emergency care and services must be provided. It prohibits discrimination in the provision of emergency care based on a person's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status or ability to pay for medical services.

3) Strengthening the enforcement provisions of the Department of Health and Rehabilitative Services.

4) Requiring the Department of Health and Rehabilitative Services to establish, maintain and publish an inventory of hospitals with emergency departments.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 395.031, F.S., relating to trauma medical services systems plans and verification of trauma centers and pediatric trauma referral centers. Clarifies in the definition of trauma center that trauma center verification shall be determined by the Department of Health and Rehabilitative Services unless the responsibility is delegated to a local or regional trauma agency. Requires local or regional trauma agencies to implement trauma plans unless the department determines the plan does not meet the needs of the persons served or unless the local or regional agency gives the department written notice of its intent to cease implementation of the plan. Clarifies that verification of pediatric referral centers can also be done by local or regional trauma agencies if delegated to by DHRS. Clarifies language which allows local or regional trauma agencies to enter into contracts for the purpose of implementing the local plan. Deletes language which required only verified trauma centers which have a contract with a local or
regional trauma agency to accept all trauma victims regardless of race, sex, creed or ability to pay, and requires all verified centers to comply regardless of whether or not there is a contract. Requires local or regional trauma agency to submit written notice of its intent, prior to ceasing operation of a local or regional trauma agency. Provides that hospitals which have been denied verification status as a trauma center have the right to a hearing under chapter 120, Florida Statutes. Changes the time for processing application renewals from 120 to 180 days. Gives the Department of Health and Rehabilitative Services regulatory authority over local or regional agencies including the ability to withdraw local or regional agency authority, prescribe corrective actions or use administrative remedies.

Section 2. Repeals subsections (3), (4), (5), (6), and (7) of s. 395.032, F.S. Deletes duplicative language found in s. 395.031, F.S., relating to the department's authority to set standards for verification of trauma centers and verify trauma centers. Deletes duplicative language relating to hospitals renewal process; requirements of hospitals verified as trauma centers to accept all appropriate trauma victims; and non-verified hospitals holding themselves out as trauma centers.

Section 3. Amends s. 395.035, F.S., relating to trauma registry data. Requires all acute care hospitals, not just verified trauma centers, to report trauma data to the department. Provides a phase-in for reporting. Acute care hospitals with 300 beds or more shall furnish data beginning October 1, 1989, and all other acute care hospitals shall report effective October 1, 1990. Requires hospitals to submit severe disability and head injury registry data directly to DHRS in lieu of submitting such registry data to the Department of Labor and Employment Security. Requires that hospitals still provide initial notification of such disabilities to the Department of Labor and Employment Security in order for the department to provide timely vocational rehabilitation services to severely disabled and head injury patients.

Section 4. Amends s. 320.0801, F.S., relating to additional license tax on certain vehicles. Deletes non applicable language relating to revenues collected from the tax to be used to cover the cost of contracting with local or regional trauma agencies. Earlier versions of chapter 87-399, Laws of Florida, included funds for the state to contract with local or regional agencies and is not included in current law.

Section 5. Amends s. 401.245, F.S., relating to Emergency Medical Services Advisory Council. Extends the terms of council members from 2 to 3 years.

Section 6. Access to emergency service and care.

This section creates a new section in the hospital and ambulatory surgical center licensure chapter. The section is composed of five subsections as follows.
Section 395.0142(1), F.S. Legislative intent.

This section creates a legislative finding as to the importance of emergency service and care and recognizes that there have been instances of the denial of such care. It also states the intent of the Legislature for the Department of Health and Rehabilitative Services to enforce the provisions of this law in a vigorous and timely manner.

Section 395.0142(2), F.S. Definitions.

This section provides several needed definitions including "active labor," "emergency medical condition" and "emergency services and care." The first two are essentially the same as the Federal definitions enacted by COBRA. This section also provides a definition for "stabilized" which also is the same as found in federal law.

Section 395.0142(3), F.S. Emergency service; discrimination; liability of health facility or health care personnel.

This section sets forth the requirements for the provision of emergency services and care. It seeks to correct the confusion present in the current law by stating when service and care must be given. It specifies who must provide it and who can request it. Any hospital with an emergency department must provide emergency service and care to anyone requesting it. This request may be by or on behalf of an individual including emergency medical personnel or a hospital which has stabilized the patient and seeks a medically necessary transfer. It also prohibits basing the care on a person's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. It also provides immunity from liability for a hospital or provider when refusal to render emergency care is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or that the hospital does not have the appropriate facilities or qualified staff available. This latter provision tracks current law.

Also, this section prohibits conditioning the rendering of care based on ability to pay and prohibits a hospital from accepting a transfer based on a guarantee of payment by the transferring hospital. But this section does require payment, or providing information regarding payment, promptly after the services are rendered. Finally, this section requires health facilities without an emergency department to assist and direct patients in need of care.

Section 395.0142(4), F.S. Records of transfers; reports of violation; summary to Legislature.

This section imposes on hospitals certain record keeping requirements regarding transfers. It also specifies certain
II. procedures for reporting violations and gives immunity for any reporting made by a physician or hospital personnel in good faith.

Section 395.0142(5), F.S. Penalties.

This section increases the amount the Department of Health and Rehabilitative Services may fine a hospital from $500 to $10,000. This section also specifies that an aggrieved person may recover in a civil action against responsible parties, damages, reasonable attorney fees and other appropriate relief. It also provides a criminal penalty of a second degree misdemeanor for someone who knowingly or intentionally violates any provision of this section.

Section 7. Establishment of emergency departments inventory.

This section requires the Department of Health and Rehabilitative Services to establish and maintain an inventory of hospitals with emergency departments. This inventory shall be used to assist emergency medical service providers and hospitals and physicians in locating appropriate emergency medical care. The section requires this information to be made available to the public and by March 1, 1989, to the Legislature.

Section 8. Amends s. 401.265, F.S., relating to medical directors employed or under contract with a medical services system. Provides that any medical director who in good faith gives oral or written instructions to certified EMS personnel shall be deemed to be providing emergency medical care or treatment under the "Good Samaritan Act."

Section 9. Effective date.

The effective date of this act is October 1, 1988.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

Sections 1-5 of this bill should not have any fiscal consequences.

Sections 6-8 of this bill should have the following fiscal consequences:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

The Office of Licensure and Certification of the Department of Health and Rehabilitative Services currently licenses and regulates hospitals. Part of its current responsibilities include investigating complaints regarding possible violations of state and federal law. Present licensure fees are intended to cover expenses related to licensure. Therefore, enforcement of this proposed committee bill should be covered under existing staffing responsibilities. However, to the extent enforcement of this act, as well as implementation of the emergency department inventory increases departmental workload, an increase in license fees may be necessary.
B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Requiring hospitals not only to treat persons in need of emergency care but also tightening transfer procedures will undoubtedly increase treatment expenses for hospitals. To the extent certain hospitals are now treating a disappropriate number of indigent or high risk patients while other hospitals are not, the requirement of this bill will have a tendency to level partially the playing field.

D. FISCAL COMMENTS:

None.

III. LONG RANGE CONSEQUENCES:

By enhancing the accessibility of patients to emergency care and increasing the quality of such care this committee bill is consistent with the health goals and policies of the State Comprehensive Plan which seek to ensure that necessary health services are available to all Floridians (s. 187.201(6)(a) and (b)2., F.S.).

IV. COMMENTS:

Currently all hospitals, regardless of whether they are verified trauma centers or not, are required to complete an eight page report on any severe disability or head injury to the Department of Labor and Employment Security for the purpose of identifying the need for potential vocational rehabilitative services. DHRS proposes to simplify the reporting requirements of hospitals by designing a one page form which would capture the trauma registry information needed, as well as the disability and head injury data. DHRS would then abstract information it receives from other sources available to it as part of the Emergency Medical Services Program, and provide the Department of Labor and Employment Security with the data it needs to complete its vocational rehabilitative program requirements.

V. BILL HISTORY:

This bill originated in the House Health Care Committee with the trauma center and trauma system plan sections contained in PCB 88-11 and the emergency room care sections contained in PCB 88-12. These bills were combined into HB 1615, which was later substituted for and passed as SB 598. The Senate version of the bill tracked the language contained in the two PCB's.
4/11/88  PCB 88-12 passed out of Regulation Subcommittee

4/18/88  SB 598 passed out of HRS Committee as a Committee Substitute. Contained the sections of PCB 88-11 dealing with the trauma centers and the trauma system plans.

4/19/88  PCB 88-11 passed out of Financing Subcommittee with 3 amendments conforming the bill to version passed by the Senate.

4/21/88  PCB 88-11 passed out of Full Committee with 5 amendments. PCB 88-12 was amended onto the bill at this point.

4/26/88  CS/SB 598 was withdrawn from the Appropriations Committee and placed on Calendar.

5/6/88   PCB 88-11 introduced as HB 1615, and referred to Appropriations Committee.

5/26/88  HB 1615 passed Appropriations Committee with 4 amendments. Placed on Calendar.

5/26/88  SB 598 was withdrawn from Appropriations and placed on the Special Order Calendar. Passed with amendments as a Committee Substitute (37 yeas, 0 nays). Amendments included the emergency room care provisions of PCB 88-12. Placed in House Messages.

6/1/88   CS/CS/SB 598 was substituted for HB 1615, passed the House (109 yeas and 0 nays), and ordered enrolled.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by:
Cathie Herndon and Tom Cooper
Staff Director:
Mike Hansen

FINANCE & TAXATION:
Prepared by:

APPROPRIATIONS:
Prepared by:
Kathleen Ockay
Staff Director:
Dr. James A. Zingale

STANDARD FORM 5/88
A bill to be entitled
An act relating to emergency services and care;
creating s. 395.0142, F.S.; establishing a
right to emergency services and care; providing
legislative intent; providing definitions;
providing for emergency services and care;
providing for transfer for nonmedical reasons;
providing for policies and transfer protocols;
providing for records of transfers and
reporting requirements; providing for
penalties; requiring the Department of Health
and Rehabilitative Services to determine the
availability of emergency departments of
hospitals and requiring the publication of such
information; repealing s. 395.0143, F.S.,
relating to requirements for emergency
treatment; repealing s. 395.014, F.S., relating
to prohibition against requiring advance
payment for emergency medical care; providing
an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.0142, Florida Statutes, is
created to read:

395.0142 Right to emergency service and care.—
(1) LEGISLATIVE INTENT.—The Legislature finds and
declares it to be of vital importance that emergency services
and care be provided by hospitals to every person in need of
such care. The Legislature finds that persons have been
denied emergency services and care by hospitals. It is the

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intent of the Legislature that the department vigorously
enforce the right of persons to the provision of emergency
services and care and to act in a thorough and timely manner
against hospitals which deny persons emergency services and
care.

(2) DEFINITIONS.--As used in this section:
(a) "Active labor" means a labor at a time at which
either of the following would occur:
1. There is inadequate time to effect safe transfer to
another hospital prior to delivery,
2. A transfer may pose a threat to the health and
safety of the patient or the unborn child.
(b) "Department" means the Department of Health and
Rehabilitative Services.
(c) "Emergency medical condition" means a medical
condition manifesting itself by acute symptoms of sufficient
severity (including severe pain) such that the absence of
immediate medical attention could reasonably be expected to
result in any of the following:
1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.
(d) "Emergency services and care" means medical
screening, examination, and evaluation by a physician, or, to
the extent permitted by applicable law, by other appropriate
personnel under the supervision of a physician, to determine
if an emergency medical condition or active labor exists and,
if it does, the care, treatment, and surgery by a physician
necessary to relieve or eliminate the emergency medical
condition, within the capability of the facility.

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(3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF
FACILITY OR HEALTH CARE PERSONNEL.--

(a) Every hospital which has an emergency department
shall provide emergency services and care for any emergency
medical condition or for active labor when:

1. Any person requests the emergency services and
care; or

2. Emergency services and care are requested on behalf
of a person by:

   a. an emergency medical services provider who is
      rendering care to or transporting the person; or

   b. another hospital, when such hospital is seeking a
      medically necessary transfer for a patient who has been
      stabilized, when such transfer meets the requirements of s.
      355.0144, and applicable federal law.

(b) In no event shall the provision of emergency
services and care be based upon, or affected by, the person's
race, ethnicity, religion, national origin, citizenship, age,
sex, preexisting medical condition, physical or mental
handicap, insurance status, economic status, or ability to pay
for medical services, except to the extent that a circumstance
such as age, sex, preexisting medical condition, or physical
or mental handicap is medically significant to the provision
of appropriate medical care to the patient.

(c) Neither the health facility, its employees, nor
any physician, dentist, or podiatrist shall be liable in any
action arising out of a refusal to render emergency services
or care if the refusal is based on the determination,
exercising reasonable care, that the person is not suffering
from an emergency medical condition, or that the health

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facility does not have the appropriate facilities or qualified personnel available to render those services.

(d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. However, the patient or his or her legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services are rendered.

(e) If a health facility subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency care to a nearby facility which can render the needed services, and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(4) TRANSFER FOR NONMEDICAL REASONS; CONDITIONS.--No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless each of the following conditions is met:

(a) The person is examined and evaluated by a physician, including, if necessary, consultation, prior to transfer.

(b) The person has been provided with emergency services and care so that it can be determined, within reasonable medical probability, that the transfer or delay

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caused by the transfer will not create a medical hazard to the person.

(c) A physician at the transferring hospital has notified and has obtained the consent to the transfer by a physician at the receiving hospital and confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel, and equipment necessary to treat the person.

(d) The transferring hospital provides for appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to effect the transfer.

(e) All the person's pertinent medical records and copies of all the appropriate diagnostic test results which are reasonably available are transferred with the person.

(f) The records transferred with the person include a "Transfer Summary" signed by the transferring physician which contains relevant transfer information. The form of the "Transfer Summary" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring doctor or emergency department personnel authorizing the transfer; the time and date the person was first presented at the transferring hospital; the name of the physician at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer; the reason for the transfer; and the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient. Neither the transferring physician nor the transferring hospital shall be required to duplicate, in the

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"Transfer Summary," information contained in medical records transferred with the person.

(g) The transfer conforms with regulations established by the department.

(h) Nothing in this subsection shall apply to a transfer of a patient for medical reasons.

(i) Nothing in this subsection shall prohibit the transfer or discharge of a patient when the patient or the patient's representative requests a transfer or discharge and gives informed consent to the transfer or discharge against medical advice.

(5) POLICIES AND TRANSFER PROTOCOLS; DISCRIMINATION; FAILURE TO ADOPT POLICIES AND PROTOCOLS; SUBMISSION FOR APPROVAL.--

(a) As a condition of licensure, each hospital shall adopt, in consultation with the medical staff, policies and transfer protocols consistent with this section and regulations adopted hereunder.

(b) As a condition of licensure, each hospital shall adopt a policy prohibiting discrimination in the provision of emergency services and care based on race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(c) As a condition of licensure, each hospital shall adopt a policy to ensure that sufficient number and qualified types of personnel and occupational disciplines are on duty.
and available at all times to provide emergency services and care.

(d) As a condition of licensure, each hospital shall require that physicians who serve on an "on-call" basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient. Nothing in this subsection shall be construed as requiring that any physician serve on an "on-call" basis.

(e) As a condition of licensure, all hospitals shall inform all persons presented to an emergency room or their representatives if any are present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care and of the person's right to emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subsection requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied and the hospital has made a reasonable effort to locate a representative, and because of the person's physical or mental condition, notification is not possible. All hospitals shall prominently post a sign in their emergency rooms informing the public of their rights. Both the posted sign and written communication concerning the transfer or refusal to provide

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emergency services and care shall give the address of the department as the government agency to contact in the event the person wishes to complain about the hospital's conduct.

(f) If a hospital does not timely adopt the policies and protocols required in this subsection, the hospital, in addition to denial or revocation of any of its licenses, shall be subject to a fine not to exceed one thousand dollars ($1,000) each day after expiration of 60 days' written notice from the department that the hospital's policies or protocols required by this section are inadequate unless the delay is excused by the department upon a showing of good and sufficient cause by the hospital. The notice shall include a detailed statement of the department's reasons for its determination and suggested changes to the hospital's protocols which would be acceptable to the department.

(g) Each hospital's policies and protocols required in or under this subsection shall be submitted for approval to the department within 90 of the department's adoption of regulations under this section.

(6) RECORDS OF TRANSFERS; REPORTS OF VIOLATIONS SUMMARY TO LEGISLATURE; PROCEEDINGS TO IMPOSE FINE.--

(a) All hospitals shall maintain records of each transfer made or received, including the "Memorandum of Transfer" described in subsection (4)(f) for a period of three years.

(b) All hospitals making or receiving transfers shall file with the department annual reports on forms prescribed by the department which shall describe the aggregate number of transfers made and received according to the person's insurance status and reasons for transfers.

CODING: Words struck are deletions; words underlined are additions.
(c) The receiving hospital, and all physicians, other licensed emergency room health personnel, and certified prehospital emergency personnel at the receiving hospital who know of apparent violations of this section or the regulations adopted hereunder shall, and the corresponding personnel at the transferring hospital and the transferring hospital may, report the apparent violations to the department on a form prescribed by the department within one week following its occurrence. The department shall promptly send a copy of the form to the hospital administrator and appropriate medical staff committee of the transferring hospital and the local emergency medical services agency, unless the department concludes that the complaint does not allege facts requiring further investigation, or is otherwise unmeritorious, or the department concludes, based upon the circumstances of the case, that its investigation of the allegations would be impeded by disclosure of the form. When two or more persons required to report jointly have knowledge of an apparent violation, a single report may be made by a member of the team selected by mutual agreement in accordance with hospital protocols. Any individual, required to report by this section, who disagrees with the proposed joint report has a right and duty to separately report.

(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician or other personnel for reporting in good faith an apparent violation of this section or the regulations adopted hereunder to the department, hospital, medical staff, or any other interested party or government agency.

CODING: Words stricken are deletions; words underlined are additions.
(e) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician who refused to transfer a patient when the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the person.

(f) The department shall on an annual basis publish and provide to the Legislature a statistical summary by county on the extent of economic transfers of emergency patients, the frequency of medically hazardous transfers, the insurance status of the patient populations being transferred and all violations finally determined by the department describing the nature of the violations, hospitals involved, and the action taken by the department in response. These summaries shall not reveal the identity of individual persons transferred.

(7) PENALTIES.--

(a) The department may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $10,000 per violation for the violation of any provision of this section or rules promulgated hereunder.

(b) Any person who suffers personal harm as a result of a violation of this section or the regulations adopted hereunder may recover, in a civil action against the responsible administrative or medical personnel, damages, reasonable attorneys' fees and other appropriate relief.

(c) Any administrative or medical personnel who knowingly or intentionally violates any provision of this section is guilty of a misdemeanor of the second degree.

CODING: Words stricken are deletions; words underlined are additions.
punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 2. The Department of Health and Rehabilitative Services shall establish and maintain an inventory of hospitals with emergency departments. Included in the inventory shall be a determination of the level of care the emergency department is capable of providing. The department shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the general public. The department shall report to the Legislature by March 1, 1989 the status of the inventory.

Section 3. Sections 395.0143 and 395.0145, Florida Statutes, are hereby repealed.

Section 4. This act shall take effect October 1, 1988.

CODING: Words struck are deletions; words underlined are additions.
I. SUMMARY:

This proposed committee bill establishes rights of patients and responsibilities of providers regarding the provision of hospital emergency services and care.

A. PRESENT SITUATION:

Testimony before the Committee on Health Care and the Subcommittee on Health Regulation of the Committee on Health Care indicated that persons throughout the state have been denied emergency services and care by hospitals and physicians. Persons have been diverted from one hospital to another, been refused emergency care by a hospital and have been treated by one hospital but denied care by another hospital when the first hospital sought a medically necessary transfer.

The law regarding patients' access to emergency care is found in Florida and Federal statutes. Although there are several court decisions relating to treatment and transfer of indigent patients, on the specific issue of denial of emergency care the clearest legal direction is found in statutes and administrative rules.

A hospital's duty to treat persons seeking emergency services is found in ss. 395.0143, 395.0144, 395.0145 and 401.45, F.S. Also relevant is 395.005, F.S., relating to the Department of Health and Rehabilitative Services rulemaking and enforcement authority over hospitals.

Section 395.0143, F.S., requires all general hospitals and all specialty hospitals with an emergency room to treat any person for any emergency medical condition which will deteriorate from a failure to provide such treatment. A person has recourse for a hospital's refusal to provide emergency treatment only if in fact his or her condition deteriorates as a result of not being treated and reasonable care has not been exercised in the
determination of the condition of the patient and the appropriateness of the facility and personnel to render needed treatment. Although the plain language of the statute speaks to a prohibition against denial of treatment for any emergency medical condition and therefore could apply to a hospital to accept a transfer, the Department of Health and Rehabilitative Services does not interpret this section accordingly.

Section 395.0144, F.S., requires any general (but not specialty) hospital which operates a full-time emergency room to admit any patient, regardless of economic criteria or indigency, upon the determination by a licensed staff physician that the patient should be admitted. If the physician responsible for emergency room service determines that the hospital is unable to render appropriate treatment, the hospital would be required to transfer the patient and all information relative to medical condition and history to an alternate hospital which has the facilities to treat the patient. This transfer could occur only after the physician has determined the patient's condition is stable enough for transfer. This section is silent as to whether the appropriate receiving hospital must agree to the transfer, although subsection (2) states that the first hospital shall "contact an appropriate receiving hospital and notify such hospital that the patient is in transit."

Finally in this series of emergency care sections, 395.0145, F.S., prohibits hospitals with emergency departments from requiring payment prior to rendering emergency medical care to a patient when the patient has shown evidence of adequate health insurance coverage. This section would appear to be superseded by the language in s. 395.0144, F.S., which prohibits refusal to admit based on economic criteria or indigency.

Regarding the rulemaking enforcement authority of the Department of Health and Rehabilitative Services, the Department is required by statute to adopt and enforce rules to ensure the compliance by hospitals to these aforementioned sections and to ensure that sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care and safety, s. 395.005(1)(a).

In addition to Florida law, Federal law requires evaluation and treatment of persons seeking emergency services. In a measure to prevent patient dumping, Section 9121 of the Consolidated Budget Reconciliation Act of 1986 (COBRA) states that patients who have not been stabilized cannot be transferred to another hospital without the receiving hospital agreeing to the transfer.

B. EFFECT OF PROPOSED CHANGES:

This proposed committee bill establishes rights of patients and responsibilities of providers regarding the provision of hospital emergency services and care. The major provisions of the bill include:
1) Providing needed definitions for emergency medical condition and emergency services and care.

2) Specifying the circumstances when emergency care and services must be provided. It prohibits discrimination in the provision of emergency care based on a person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status or ability to pay for medical services.

3) Establishing procedures for transfer for non-medical reasons.

4) Placing, as a condition of licensure, certain requirements for hospitals regarding policies and transfer protocols including adequate staffing to ensure necessary and adequate patient care.

5) Requiring notification to the public by hospitals as to patient rights and complaint procedures.

6) Strengthening the enforcement provisions of the Department of Health and Rehabilitative Services.

7) Requiring the Department of Health and Rehabilitative Services to establish, maintain and publish an inventory of hospitals with emergency departments.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Right to emergency service and care.

This section creates a new section in the hospital and ambulatory surgical center licensure chapter. The section is composed of seven subsections as follows.

395.0142(1) Legislative intent.

This section creates a legislative finding as to the importance of emergency service and care and recognizes that there have been instances of the denial of such care. It also states the intent of the Legislature for the Department of Health and Rehabilitative Services to enforce the provisions of this law in a vigorous and timely manner.

395.0142(2) Definitions.

This section provides several needed definitions including active labor, emergency medical condition and emergency services and care. The first two are essentially the same as the Federal definitions enacted by COBRA.
395.0142(3) Emergency service; discrimination; liability of health facility or health care personnel.

This section sets forth the requirements for the provision of emergency services and care. It seeks to correct the confusion present in the current law by stating when service and care must be given. It specifies who must provide it and who can request it. Any hospital with an emergency department must provide emergency service and care to anyone requesting it. This request may be by or on behalf of an individual including emergency medical personnel or a hospital which has stabilized the patient and seeks a medically necessary transfer. It also prohibits basing the care on a person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. It also provides immunity from liability for a hospital or provider when refusal to render emergency care is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or that the hospital does not have the appropriate facilities or qualified staff available. This latter provision tracks current law.

Also, this section prohibits conditioning the rendering of care based on ability to pay. But it does require payment, or providing information regarding payment, promptly after the services are rendered. Finally, this section requires health facilities without an emergency department to assist and direct patients in need of care.

395.0142(4) Transfer for non-medical reasons; conditions.

This section places conditions on the transfer for non-medical reasons of persons needing emergency services and care. These conditions include: examination and evaluation by a physician; the absence of a medical hazard caused by the transfer; notification to and consent by the receiving hospital; the use of appropriate transfer equipment and personnel; the transfer of pertinent medical information; and the provision of a transfer summary.

395.0142(5) Policies and transfer protocols.

This section requires hospitals, as a condition of licensure, to adopt several policies and transfer protocols consistent with this proposed committee bill. This section requires hospitals to inform patients of their rights under this section including the posting of certain information regarding complaint procedures.

395.0142(6) Records of transfers; reports of violation; summary to Legislature.

This section imposes on hospitals certain recordkeeping requirements regarding transfers. It also specifies certain procedures for reporting violations and gives immunity for any reporting made by a physician or hospital personnel in good
faith. The section requires the Department of Health and Rehabilitative Services to report to the Legislature certain information regarding transfers.

395.0142(7) Penalties.

This section increases the amount the Department of Health and Rehabilitative Services may fine a hospital from $500 to $10,000. This section also specifies that an aggrieved person may recover in a civil action against responsible parties, damages, reasonable attorney fees and other appropriate relief. It also provides a criminal penalty of a second degree misdemeanor for someone who knowingly or intentionally violates any provision of this section.

Section 2. Establishment of emergency departments inventory.

This section requires the Department of Health and Rehabilitative Services to establish and maintain an inventory of hospitals with emergency departments. This inventory shall be used to assist emergency medical service providers and hospitals and physicians in locating appropriate emergency medical care. The section requires this information to be made available to the public and by March 1, 1989, to the Legislature.

Section 3. Repeal of ss. 395.0143 and 395.0145, F.S.

This section repeals s. 395.0143, F.S., relating to requirements for emergency treatment and s. 395.0145, F.S., relating to the prohibition against requiring advance payment for emergency medical care. Both sections are superseded by this proposed committee bill.

Section 4. Effective date.

The effective date of this act is October 1, 1988.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

The Office of Licensure and Certification of the Department of Health and Rehabilitative Services currently licenses and regulates hospitals. Part of its current responsibilities include investigating complaints regarding possible violations of state and federal law. Present licensure fees are intended to cover expenses related to licensure. Therefore, enforcement of this proposed committee bill should be covered under existing staffing responsibilities. However, to the extent enforcement of this act, as well as implementation of the emergency department inventory increases departmental workload, an increase in license fees may be necessary.
B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Requiring hospitals not only to treat persons in need of emergency care but also tightening transfer procedures will undoubtedly increase treatment expenses for hospitals. To the extent certain hospitals are now treating a disproportionate number of indigent or high risk patients while other hospitals are not, the requirement of this proposed committee bill will have a tendency to level partially the playing field.

D. FISCAL COMMENTS:

None.

III. LONG RANGE CONSEQUENCES:

By enhancing the accessibility of patients to emergency care and increasing the quality of such care this proposed committee bill is consistent with the health goals and policies of the State Comprehensive Plan which seek to ensure that necessary health services are available to all Floridians (s. 187.201(6)(a) and (b)2., F.S.).

IV. COMMENTS:

None.

V. AMENDMENTS:

None.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Tom Cooper

FINANCE & TAXATION:
Prepared by:

APPROPRIATIONS:
Prepared by:

Staff Director: Mike Hansen

Staff Director:

Staff Director:
NOTICE OF COMMITTEE MEETING
House of Representatives

Health Care

Health Regulation

April 5 3:30 P.M.-5:30 P.M. 16 HOB

Consideration of:

TAPE I  SIDE A
PCB HC 88-03--Certificate of Need regulation of cardiac catheterization services FAV. w/1 amend 3-1

PCB HC 88-04--Health maintenance organizations: regulation and guaranty of health care services FAV. w/1 amend 3-0

PCB HC 88-12--Hospital emergency care not considered

TAPE I  SIDE A
HB 0299 by Mackenzie & others--Smoking/Public Places FAV. w/10 amend. 4-0

Received in the Office of the Sergeant at Arms on April 1 1988
at 4:25 (time).

Filed by me with the Sergeant at Arms and the Clerk on April 1 1988
in compliance with Rule 6.

Chairman

File Secretary

Distribution: Sergeant; Clerk (Calendar);
Leg. Info.; others as required by Rule 6.
NOTICE OF COMMITTEE MEETING  
House of Representatives  

Health Care  
Health Regulation  

April 11  1:15 P.M.-3:15 P.M.  317 C  

Consideration of:  
- PCB HC 88-07--Human Immunodeficiency Virus infection and Acquired Immunodeficiency Syndrome  
- PCB HC 88-12--Emergency services and care  
- HB 0498 by Smith & others--Patient Records/Copying Fees  

Bill Bell - Florida Hospital Assn.  
Walt Gatter - Florida Medical Assn.  
Tom Guilday - Florida Assn. of Blood Banks  
Rosemary Gallagher - Florida Catholic Corp.  
Steve Schwartz - Florida School Board Assn.  

Dorothy Rue - Dept. of Education  
Guida Marraccini - Fla. Medical Assn.  
Charlotte Shrenberg - Fla. PTA  
Candice Cannuciin - Self  

Mike. Almgren  
Chairman  

Received in the Office of the Sergeant at Arms on  
April 7  1987  
at 3:10 p.m., (time).  

Sergeant at Arms  

Filed by me with the Sergeant at Arms and the Clerk on  
April 7  1987  
in compliance with Rule 6.  

Committee Secretary  

Distribution: Sergeant; Clerk (Calendar);  
Leg. Info.; others as required by Rule 6.  

H-14(1987)
Bill Action Record

Subcommittee on
Committee on HEALTH CARE, Health Regulation

Meeting Time 1:15 4/11/88
Place 317 C

Date received

Bill No. PCB 12

Date reported

Referred to Subcommittee on

Subcommittee report:
✓ favorable
✓ favorable with ___ amendments
___ unfavorable

Committee Action:
___ Temporarily passed
___ Reconsidered
___ favorable
___ favorable with ___ amendments
___ favorable with committee substitute
___ unfavorable

Other action:

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<th>Final vote on bill</th>
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<td>(Chairman)</td>
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<tr>
<td>Rep. Abrams</td>
<td>✓</td>
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40

TOTALS

Yeas Nays Yeas Nays Yeas Nays Yeas Nays
19 1827
House of Representatives

FULL COMMITTEE BILL ACTION WORKSHEET

Committee on Health Care

Meeting Date: 4/31/88
Bill No. PCB 12

Time: 
Place: 
Date Received: 
Subject: 
Date Reported: 

SUBCOMMITTEE ACTION RECORD:

Subcommittee on: 
Favorable
Favorable with amendments
Favorable with Proposed Substitute
Unfavorable
Temporarily Passed

(Not taken up)

FULL COMMITTEE ACTION:

Favorable
Favorable with ___ Amendments
Favorable with Committee Substitute
Unfavorable
Temporarily Passed
Reconsidered
Referred to Subcommittee

Other Action: 

Final Vote
On Bill

MEMBERS

Yeas  Nays  Yeas  Nays  Yeas  Nays  Yeas  Nays  Yeas  Nays  Yeas  Nays
Rep. Bell  
Rep. Canady  
Rep. Frankel  
Rep. Gordon  
Rep. Grindle  
Rep. Guber  
Rep. Harden  
Rep. Hill  
Rep. C.F. Jones  
Rep. D.L. Jones  
Rep. King  
Rep. Langton  
Rep. Lipman  
Rep. McEwan  
Rep. Peeples  
Rep. Press  
Rep. Thomas  
Rep. Abrams (Chair)  

APPEARANCE RECORD

Name
Representing
Address

H-83(1988)
I. SUMMARY:

A. Present Situation:

The legislation establishing trauma center verification procedures was first enacted in 1982. Its purpose was to develop a network of trauma centers throughout the state so that victims of trauma would receive the best possible medical care, thus reducing the possibility of permanent disability or death. A trauma victim is defined as a person who has incurred a single or multisystem life threatening injury due to blunt or penetrating means.

Florida's current system for establishing a trauma network throughout the state has met with mixed success. In order for a trauma system to be effective, there must be enough trauma centers within a geographic region in order to meet the demand. But, there must not be too many trauma centers because a trauma center must treat a certain volume of patients in order to maintain its proficiency and be cost effective.

To date, Florida's existing system for verification of trauma centers has not proven effective in establishing the appropriate number of trauma centers by geographic region. In some areas of the state, too many trauma centers have been established. In other regions, too few centers have been established. Overall, not enough hospitals have applied for trauma center status to support the cost of administering the program by the Department of Health and Rehabilitative Services (HRS). As a result, HRS has not had the resources to do the compliance monitoring as required by law, and it is not known whether the hospitals which have been verified as trauma centers to date would currently meet standards.

The 1987 Legislature, via chapter 87-399, Laws of Florida, modified Florida's existing verification system to create a bifurcated trauma planning and verification system. Local or regional trauma systems agencies (single- or multi-county) may be established at local initiative via section 395.031, Florida Statutes. These local agencies are responsible for developing and implementing trauma systems and may have HRS delegate to them the trauma center verification process. The Department of HRS must approve all local or regional trauma plans. In those geographic areas of the state without local or regional trauma agencies, section 395.032, Florida Statutes, requires HRS to develop trauma plans and verify hospital trauma centers based on population and geographic factors.

The 1987 legislation, codified as section 395.036, Florida Statutes, requires each emergency medical services (EMS) provider to transport a trauma victim to the appropriate trauma center based on a trauma scorecard and transport protocol. Section 395.035, also modified by chapter 87-399, Laws of Florida, requires HRS to establish a trauma registry so that
the outcome of trauma treatment rendered by trauma centers can be routinely assessed.

Under the provisions of section 413.48, Florida Statutes, and section 413.612, Florida Statutes, public and private health and social agencies and attending physicians are required to submit severe disability and head injury registry data, respectively, to the Division of Vocational Rehabilitation of the Department of Labor and Employment Security. Most of this reporting is done by hospitals.

B. Effect of Proposed Changes:

Committee Substitute for Senate Bill 598 addresses technical problems which have been encountered during the implementation of chapter 87-399, Laws of Florida.

Sectional Analysis

Section 1. Amends s. 395.031, F.S., relating to trauma medical services system plans. Major provisions are as follows:

- Modifies the definition of "trauma center" to reflect the fact that a trauma center verification can be performed by a local or regional trauma agency when such function is delegated to the local or regional agency by HRS.
- Requires a local or regional trauma agency to submit written notice to HRS of its intent to cease implementation of its local plan, and specifies a 90-day notice for submission.
- Delegates to local or regional trauma agencies the verification of pediatric referral centers.
- Permits local or regional trauma agencies to contract for the purpose of implementing trauma system plans.
- Deletes reference to hospital contracts relating to acceptance of trauma victims.

Section 2. Amends s. 395.032, F.S., requiring HRS to establish trauma regions for planning purposes and allows local or regional trauma system agencies to be established without regard to the regional boundaries of these state-established regions. Duplicative provisions relating to minimum local or regional plan specifications are deleted. These specifications appear in s. 395.031, F.S., and need not be repeated.

Section 3. Amends s. 395.035, F.S., relating to trauma registry information. Major provisions are as follows:

- Phasing in the reporting of trauma registry information to HRS by acute care hospitals. Hospitals with 300 beds or more shall furnish this information beginning October 1, 1989. Hospitals with less than 300 beds shall furnish this information beginning October 1, 1990.
- Requires trauma centers and acute care hospitals to include, as part of trauma registry reporting, reports of severe disability and head injury registry data, required by sections 413.48 and 413.612, F.S.

Section 4. Amends s. 320.0801, F.S., removing reference to contracting and making technical changes.

Section 5. Provides an effective date of July 1, 1988, or upon becoming law, whichever occurs later.
II. ECONOMIC IMPACT AND FISCAL NOTE:

A. Public:

To the extent that reporting by all acute care hospitals to the trauma registry will result in additional costs to the hospitals, these costs are likely to be passed on to the consumer.

B. Government:

None.

III. COMMENTS:

None.

IV. AMENDMENTS:

None.
SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

ASSIGN TO

SUBJECT:

BRIEF ANALYST STAFF DIRECTOR REFERENCE ACTION

1. Williams Wilson HRS FAV/CS

2. 

3. 

4. 

BILL NO. AND SPONSOR:

Subject: Trauma Care

CS/SB 598 by Committee on HRS and Senator Myers

I. SUMMARY:

A. Present Situation:

The legislation establishing trauma center verification procedures was first enacted in 1982. Its purpose was to develop a network of trauma centers throughout the state so that victims of trauma would receive the best possible medical care, thus reducing the possibility of permanent disability or death. A trauma victim is defined as a person who has incurred a single or multisystem life threatening injury due to blunt or penetrating means.

Florida's current system for establishing a trauma network throughout the state has met with mixed success. In order for a trauma system to be effective, there must be enough trauma centers within a geographic region in order to meet the demand. But, there must not be too many trauma centers because a trauma center must treat a certain volume of patients in order to maintain its proficiency and be cost effective.

To date, Florida's existing system for verification of trauma centers has not proven effective in establishing the appropriate number of trauma centers by geographic region. In some areas of the state, too many trauma centers have been established. In other regions, too few centers have been established. Overall, not enough hospitals have applied for trauma center status to support the cost of administering the program by the Department of Health and Rehabilitative Services (HRS). As a result, HRS has not had the resources to do the compliance monitoring as required by law, and it is not known whether the hospitals which have been verified as trauma centers to date would currently meet standards.

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   B. Government:
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III. COMMENTS:
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IV. AMENDMENTS:
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To date, Florida's existing system for verification of trauma centers has not proven effective in establishing the appropriate number of trauma centers by geographic region. In some areas of the state, too many trauma centers have been established. In other regions, too few centers have been established. Overall, not enough hospitals have applied for trauma center status to support the cost of administering the program by the Department of Health and Rehabilitative Services (HRS). As a result, HRS has not had the resources to do the compliance monitoring as required by law, and it is not known whether the hospitals which have been verified as trauma centers to date would currently meet standards.

The 1987 Legislature, via chapter 87-399, Laws of Florida, modified Florida's existing verification system to create a bifurcated trauma planning and verification system. Local or regional trauma systems agencies (single- or multi-county) may be established at local initiative via section 395.031, Florida Statutes. These local agencies are responsible for developing and implementing trauma systems and may have HRS delegate to them the trauma center verification process. The Department of HRS must approve all local or regional trauma plans. In those geographic areas of the state without local or regional trauma agencies, section 395.032, Florida Statutes, requires HRS to develop trauma plans and verify hospital trauma centers based on population and geographic factors.

The 1987 legislation, codified as section 395.036, Florida Statutes, requires each emergency medical services (EMS) provider to transport a trauma victim to the appropriate trauma center based on a trauma scorecard and transport protocol. Section 395.035, also modified by chapter 87-399, Laws of Florida, requires HRS to establish a trauma registry so that
the outcome of trauma treatment rendered by trauma centers can be routinely assessed.

B. Effect of Proposed Changes:

Senate Bill 598 addresses technical problems which have been encountered during the implementation of chapter 87-399, Laws of Florida.

Sectional Analysis

Section 1. Amends s. 395.031, F.S., relating to trauma medical services system plans. Major provisions are as follows:

- Modifies the definition of "trauma center" to reflect the fact that a trauma center verification can be performed by a local or regional trauma agency when such function is delegated to the local or regional agency by HRS.
- Requires a local or regional trauma agency to submit written notice to HRS of its intent to cease implementation of its local plan, and specifies a 90-day notice for submission.
- Delegates to local or regional trauma agencies the verification of pediatric referral centers.
- Deletes reference to hospital contracts relating to acceptance of trauma victims.

Section 2. Amends s. 395.032, F.S., requiring HRS to establish trauma regions for planning purposes and allows local or regional trauma system agencies to be established without regard to the regional boundaries of these state-established regions. Duplicative provisions relating to minimum local or regional plan specifications are deleted. These specifications appear in s. 395.031, F.S., and need not be repeated.

Section 3. Amends s. 395.035, F.S., requiring all acute care hospitals to furnish trauma registry information to HRS.

Section 4. Amends s. 320.0801, F.S., removing reference to contracting and making technical changes.

Section 5. Provides an effective date of July 1, 1988, or upon becoming law, whichever occurs later.

II. ECONOMIC IMPACT AND FISCAL NOTE:

A. Public:

To the extent that reporting by all acute care hospitals to the trauma registry will result in additional costs to the hospitals, these costs are likely to be passed on to the consumer.

B. Government:

None.

III. COMMENTS:

None.

IV. AMENDMENTS:

None.
Section 6 Section 395.0142, Florida Statutes, is created to read.

395.0142 Access to emergency services and care.—

(1) LEGISLATIVE INTENT.—The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the department vigorously enforce the ability of persons to receive emergency services and care and that the department act in a thorough and timely manner against hospitals which deny persons emergency services and care.

(2) DEFINITIONS.—As used in this section.

(a) "Active labor" means a labor at a time at which:

1. There is inadequate time to effect safe transfer to another hospital prior to delivery; or
2. A transfer may pose a threat to the health and safety of the patient or the unborn child.

(b) "Department" means the Department of Health and Rehabilitation Services.

(c) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serous dysfunction of any bodily organ or part.

(d) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(e) "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the patient from a hospital.

(3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(a) Every hospital which has an emergency department shall provide emergency services and care for any emergency medical condition or for active labor when:

1. Any person requests emergency services and care; or
2. Emergency services and care are requested on behalf of a person by:

   a. An emergency medical services provider who is rendering care to or transporting the person.
   b. Another hospital, when such hospital is seeking a medically necessary transfer for a patient who has been stabilized, when such transfer meets the requirements of s. 395.0144 and applicable federal law.
   c. No hospital, nor its employees, nor any physician, dentist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the patient is not suffering from an emergency medical condition, that the person is not in active labor, or that the hospital does not have the appropriate facilities or qualified personnel available to render these services.

Amendment 1—On page 5, between lines 29 and 30, insert:

(6) The department may withdraw local or regional agency authority, prescribe corrective actions, or use the administrative remedies as provided in s. 395.018 for the violation of any provision of this section and s. 395.025, s. 395.026, and s. 395.0261 or rules adopted thereunder. All amounts collected pursuant to subsection (2) shall be deposited into the Emergency Medical Services Trust Fund, providing an effective date.

Amendment 2—On page 9, strike all of lines 3-13, and insert:

(1) The department may establish trauma regions in those geographical areas where there are no department approved local or regional trauma system agencies and plans and where the department determines there is need for organized trauma services for the residents of the geographical area. The department shall base its definition of the regions upon:

Amendment 3—On page 14, strike all of lines 19 and 20, and insert:

Section 5 Subsection (1) of section 401.245, Florida Statutes, is amended to read:

401.245 Emergency Medical Services Advisory Council.—

(1) The provisions of s. 20.1914(4)(a)13 notwithstanding, the secretary of the Department of Health and Rehabilitative Services may appoint an advisory council for the purpose of acting as the advisory body to the emergency medical services program. No more than 15 members may be appointed to this council. Each district of the department shall be represented on the advisory council by July 1, 1989. Initially, the secretary shall appoint one-half of the members for terms of 3 years and one-half for terms of 1 year. Members shall be appointed for 3-year terms in such a manner that each year the terms of one-third of the members expire. The chairman of the council shall be designated by the secretary and shall serve for a term of 3 years. Vacancies shall be filled for the remainder of unexpired terms in the same manner as the original appointment. Members shall receive no compensation, but may be reimbursed for per diem and travel expenses.
May 26, 1988
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(d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital to guarantee payment for the person as a condition of receiving transfer. However, the patient or his or her legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly, after the services and care are rendered.

(e) If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and, in addition to meeting the requirements of s. 396.0143, shall direct the persons seeking emergency care to a nearby facility which can render the needed services, and shall assign the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(4) RECORDS OF TRANSFERS; REPORT OF VIOLATIONS.—

(a) Each hospital shall maintain records of each transfer made or received for a period of 3 years.

(b) Any hospital employee, physician, other licensed emergency room health care personnel, or certified prehospital emergency personnel who knows of an apparent violation of this section or the rules adopted hereunder shall report the apparent violation to the department on a form prescribed by the department within 1 week following its occurrence.

(c) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to, a physician or other personnel for reporting in good faith an apparent violation of this section or the rules adopted hereunder to the department, hospital, medical staff, or any other interested party or government agency.

(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to, a physician who refused to transfer a patient when the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the person.

(5) PENALTIES.—

(a) The department may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $10,000 per violation, for the violation of any provision of this section or rules adopted hereunder.

(b) Any person who suffers personal harm as a result of a violation of this section or the rules adopted hereunder may recover, in a civil action against the responsible administrative or medical personnel, damages, reasonable attorney’s fees, and other appropriate relief.

(c) Any administrative or medical personnel who knowingly or intentionally violates any provision of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 7. The Department of Health and Rehabilitative Services shall establish and maintain an inventory of hospitals with emergency departments. Included in the inventory shall be a listing of all services by the hospital. The department shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the general public. The department shall report to the Governor, the Speaker of the House of Representatives, and the President of the Senate, by March 1, 1988, the status of the inventory.

Section 8. Subsection (3) is added to section 401.265, Florida Statutes, to read:

401.265 Medical directors.—

(3) Any medical director who in good faith gives oral or written instructions to certified emergency medical services personnel for the provision of emergency care shall be deemed to be providing emergency medical care or treatment for the purposes of s. 768.13(2).

Section 9. This act shall take effect October 1, 1988.
STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

1. SUMMARY

A. PRESENT SITUATION: Chapter 87-399, Laws of Florida, authorized the establishment of trauma systems within the State of Florida. The bill provided for the establishment of local or regional trauma agencies, provided for the verification of trauma centers, and provided for the establishment of a trauma registry to monitor the operation of the trauma systems and provide for quality assessment of the trauma systems.

B. EFFECT OF PROPOSED CHANGES: The bill addresses technical aspects which have been encountered during the implementation of Chapter 87-399. The definition of "trauma center" has been amended to acknowledge the fact that trauma centers may be verified by certain local or regional trauma agencies. The bill requires local or regional trauma agencies to notify the department if a plan is not to be implemented by an agency which has submitted a plan to the department. The department must also be notified if a local or regional trauma agency plans to cease operation of its trauma system. The bill includes "pediatric referral center" in paragraphs relating to trauma center verification. Certain language referring to contracting is deleted, because provisions requiring the department to contract with local or regional trauma agencies was deleted during the
last minutes of the 1987 Session. Accordingly, the references to "contracting" are unnecessary. The bill amends the time frames for re-verification of trauma centers to coincide with actual time frames required for the re-verification process. Finally, the bill provides that hospitals must participate in the trauma registry.

Substantial language is deleted from section 395.031, Florida Statutes. This deletion eliminates duplicative provisions which are found in section 395.031, Florida Statutes. The deletion of the language is of minimal effect substantively.

2. ECONOMIC IMPACT AND FISCAL NOTE

A. There is no substantial fiscal impact associated with this bill.

B. N/A

3. COMMENTS: N/A

4. DISTRICT CONTACTS: N/A

5. LEGAL REVIEW: N/A

6. AMENDMENTS:

Page 5, lines 25-27 are amended as follows:

(g) Local and regional trauma agencies may enter into contracts for the purpose of implementation of the local plan. If local or regional agencies contract with hospitals, such agencies shall contract only with hospitals with verified trauma centers or those willing to seek verification.
See page 1 of bill analysis for contact information.

Fiscal impact on state agencies/state funds:

A. Non-recurring or First Year Start-Up Effects:

B. Recurring or Annualized Continuation Effects:

C. Long Run Effects Other Than Normal Growth:

D. Appropriations Consequences:

Fiscal impact on local governments as a whole:

A. Non-recurring or First-Year Start-Up Effects:

B. Recurring or Annualized Continuation Effects:

C. Long-Run Effects Other Than Normal Growth:

Direct fiscal impact on private sector:

A. Direct private sector costs:

B. Direct private sector benefits:

C. Effects on competition, private enterprise, and employment markets:

Fiscal comments:
COMMITTEE ON HEALTH CARE

September 15, 1987
8:00-12:00 noon
317 Capitol

AGENDA

I. CS/HB 1384 Indigent Health Care/CON - Oversight of Implementation

Overview/Introduction

Chip Kenyon, Deputy Assistant Secretary for Programs

Redistribution of the Public Medical Assistance Trust Fund

Mary Loepp, Director of Administration, HRS
James Bracher, Executive Director Hospital Cost Containment Board

Primary Care Expansion

Gary Clarke, Deputy Director for Health

Demonstration Project--Child Health Assistance Program

William W. Ausbon, M.D., Children's Medical Services Program Director

SOBRA

On-Site Contracted Medicaid Eligibility Determinations

Donna Geller, Program Administrator, Public Assistance Policy Development and Training

Medicaid Provider Fee Increases

Tom Arnold, Acting Deputy Assistant Secretary for Medicaid
Demonstration Project—Improving Access to Alcohol and Substance Abuse Services

Medically Indigent Demonstration Projects—Primary Care Residency Training

Small Business Health Access Corporation

Amendment of the Certificate of Need Rule and Other Rules

II. CS/HB 1385 HMOs/Quality of Care - Oversight of Implementation

Amy Jones
Assistant Regulation and Health Facilities Director
Department of Health and Rehabilitative Services

Bob Griffin, Deputy Assistant Secretary for Regulation and Health Facilities

III. CS/SB 1098 Trauma Care - Oversight of Implementation

Larry Jordan
Program Administrator
Emergency Medical Services

IV. Emergency Medical Care - Access to Care

Amy Jones
Assistant Regulation and Health Facilities Director
Department of Health and Rehabilitative Services

Richard Thomas, M.D.
Director of Emergency Services
Glades General Hospital

William A. Bell, Sr.
Vice President/General Counsel
Florida Hospital Association

Eileen Weimerskirch, M.D.
Emergency Physician
Florida Medical Association
V. Hospital Cost Containment Board - Overview

James Bracher
Executive Director
Hospital Cost Containment Board
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Emergency Medical Care in Hospitals Tab 4
Hospital Cost Containment Board Tab 5
RICHARD E. THOMAS, M.D.  
Director of Emergency Services  

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A CRISIS IN OUR EMERGENCY MEDICAL CARE DELIVERY SYSTEM

An Emergency room physician's view.
By Richard E. Thomas, M.D., J.D.
Director of Emergency Services
Glades General Hospital

A CRISIS exists in the delivery of emergency medical care in our state.

This crisis exists in two areas:

1) The outmoded system for attempting to transfer a seriously injured or ill patient to a facility better able to care for him.

2) High malpractice insurance premiums are in effect a trade barrier which prevents medical and surgical specialists from practicing their specialties in the state of Florida.

OUTMODED TRANSFER SYSTEM

I will discuss first, the problems which exist today in hospital transfers.

A summary of certain pertinent facts is in order.

1): There is an erroneous belief by many people that a patient entering an emergency room will be automatically and rapidly transferred to the appropriate facility if the first emergency room cannot manage the problem. This is a myth. Transfers can take 12 to 16 hours.

2): Many hospitals are not staffed or equipped to handle certain types of injuries or illnesses, such as those requiring neurosurgeons, neurologists, and orthopedists.

3): Many hospitals frequently refuse to accept transfer of such patients unless there is an accepting physician on their staff willing to take the patient.

4): Such hospitals and their emergency rooms frequently refuse to give out the name of the specialist on call for their facility.
5): Such hospitals frequently refuse transfer of such patients even if there is an accepting physician if there is no guaranteed source of payment.

6): Other hospital emergency rooms refuse to accept transfer of such patients regardless of ability to pay.

7): Most orthopedic and neurosurgeons in the County of West Palm Beach, where I practice, refuse to answer calls placed to them from our emergency room physicians. This is regardless of any source of funding available.

8): The reason such physicians refuse to call back include:

a) They are frequently overworked and cannot handle another emergency.

b) They are frequently sued in cases involving serious injury or illness.

c) They frequently do not get paid even in so-called guaranteed sources of payment cases.

9): Hospitals and emergency room physicians in Palm Beach County, diverting ambulance patients to more appropriate facilities, even if not equipped themselves to handle the emergency, have been advised by the Director of Emergency Services that they will be reported to the HRS/OLC and possibly face loss of licensure and criminal prosecution.

10): There thus seems to be considerable risk of prosecution to a physician if he seeks to avail himself of the protection afforded by Florida Statute 395.0143.

11): Ambulance services frequently refuse to make inter-hospital transfers, even in life threatening situations, without CASH payment up front.

12): The present transfer system, as outlined above, results in inordinate life threatening delays. The so called "golden hour" for saving lives is lost in a quagmire of impediments to rapid transfer.
For all the above reasons it is quite clear that an emergency room physician as well as a hospital are placed in an impossible No Win situation. In summary:

a) The physician cannot refuse to accept the patient without facing a threat to his licensure and the inherent legal expenses and costs.

b) He cannot treat the patient and cannot admit the patient because of the lack of the necessary specialists.

c) He cannot transfer the patient because no physician or hospital will accept the transfer.

The real loser however is the patient. The inevitable result of such an outmoded transfer system is that patients face loss of life or greater disability.

TRADE BARRIER

The second area of Crisis is in high malpractice premiums.

It was mentioned earlier that one of the reasons for physicians refusing to return calls placed by emergency room physicians is that he is frequently overworked and cannot handle another case.

The following facts are self evident:

1) We continue to make the practice of medicine in the State of Florida unattractive to physicians.

2) Many skilled physicians have limited their practice to low risk areas thereby depleting the supply of much needed specialties.

3) Many needed specialists have left Florida to practice elsewhere.

4) Many needed specialists have retired early.

5) Needed specialists are extremely fearful and reluctant to move to our state.

I submit that it is no answer to say that a neurosurgeon earns $300,000 a year and can afford to pay in excess of $150,000 in premiums. Surely he will opt to practice elsewhere.
Likewise, it is no solution to the present malpractice crisis to create a plan that merely reduces the malpractice premiums or just makes them more affordable because we will have done nothing to attract new physicians to our area or to prevent needed physicians from leaving their specialty or even leaving the state. We will have done nothing to remove the trade barrier.

How can we expect a physician just completing his residency to come practice in Florida, there is absolutely no way he can afford the high insurance premiums and in every case he will opt to practice where the premiums are lower and the risk of a malpractice suit is less.

I submit that if we do not overhaul our high risk and high premium situation and do something immediately to remove these trade barriers we will soon be living or should I say dying?) in a state that has no medical or surgical specialists. Stopgap measures will not preserve our future.
SUMMARY

An outmoded patient transfer system results in life threatening delays because valuable time is lost in:

1) Trying to verify insurance or obtain county welfare clearance.

2) Trying to find a referral doctor who will not only return calls placed to him, but who will in fact accept the patient.

3) Trying to find a hospital that will accept the patient.

4) Trying to find an ambulance service to transfer the patient.

5) Not permitting stable patients to by-pass emergency rooms that are not staffed or equipped to handle the particular injury so as to permit the patient to be taken directly to the appropriate hospital.

Such an outmoded system must be replaced by a system that provides that:

1) Patients may be transferred immediately and without delay to an appropriate hospital without advance permission by the receiving hospital or physician and without regard to ability to pay.

2) Ambulance services must be required to transfer such patients without regard to ability to pay.

3) Permitting patients to be transported directly to the appropriate hospital and to bypass those hospitals which cannot render the necessary services.

The State must take immediate steps to make the practice of medicine in this state attractive and competitive with other states.

1) The greatest patient transfer plan in the world will be worthless if there are no physicians to supplement it.

2) We are rapidly forcing our physician resources out of the State of Florida by malpractice insurance premiums and verdicts which amount to a trade barrier.
A tort system which allows a few persons to obtain high verdicts but at the cost of denying emergency medical care to the rest of the public should not be tolerated.

The public as a whole has a right to emergency treatment without regard to cost, just as they are entitled to police and fire protection without regard to cost.
The Spring Term St. Johns County Grand Jury in session August 27th and August 28th, 1987, presents the following report:

We, the Grand Jury, have reviewed three separate incidents which occurred on March 15th, May 6th, and July 12th, 1987, wherein the Medical Staff at the Emergency Room of Flagler Hospital diverted Paramedics of the St. Johns County Rescue Service who had in their care and custody indigent mothers, who were in critical stages of giving birth.

We, the Grand Jury, have determined that the procedures for indigent care patients (especially expectant mothers) and the policies surrounding the administration of the St. Johns County Rescue Service are seriously flawed and must be corrected. Therefore, we make the following findings of fact and recommend the following:

1. Flagler Hospital is the only hospital in St. Johns County which is in the business of delivering babies. It is the only hospital in the County with obstetrics equipment. We, the Grand Jury, would recommend that any expectant mother who is in the critical stages of giving birth be taken by the St. Johns County Rescue Service to Flagler Hospital and not to St. Augustine General Hospital.

2. We, the Grand Jury, believe the facts have demonstrated a pattern that Flagler Hospital's Emergency Room denied access to three (3) pregnant mothers. Flagler Hospital has an Emergency Department policy which has been in effect for three years which states:

"It is the policy of Flagler Hospital to provide emergency treatment for all patients who present themselves at our Emergency Department in an emergency condition, regardless of race, creed or ability to pay."

We, the Grand Jury, believe that the Medical Staff at Flagler Hospital's Emergency Room intentionally circumventing Flagler Hospital's Emergency Department policy by diverting the St. Johns County Rescue Service to other hospitals. This diversion procedure occurred in each of the three instances that we investigated. We find that the actions of the Medical Staff at the
Emergency Room of Flagler Hospital exposed each mother and child to potential personal injury. We further find that though the Medical Staff's actions are not criminal in nature, there is no doubt that their actions of diverting the expectant mother violated Florida Statute 795.0143 regarding the duty to render medical aid. We believe the evidence clearly shows the Emergency Room of Flagler Hospital denied each of the three mothers (and babies) treatment for their particular emergency situations. This diversion exposed them to serious risks by sending the mothers to either St. Augustine General Hospital, or, in one instance, diverting the mother to Jacksonville University Hospital even though at one time the St. Johns County Rescue ambulance was approximately one-quarter mile from Flagler Hospital.

We, the Grand Jury, recommend that if the birth of a child is imminent, whether or not the parents are indigent, the Emergency Room at Flagler Hospital should accept the patient. Further, after a medical examination, if the mother and child can not be safely transported to another hospital, the medical staff at Flagler Hospital should subsequently deliver the baby at Flagler Hospital.

3. We, the Grand Jury, recognize the plight of medical doctors and hospitals regarding Malpractice Insurance and Indigent care. We believe the State Legislature should be concerned with the malpractice issue, but we would request that the St. Johns County Commission establish a committee composed of both medical and lay persons to address the issues of Indigent Care in St. Johns County. We further believe that a Hospital Taxing Authority should be considered in order to assist the St. Johns County Indigent Care Program.

We, the Grand Jury, find that only too often our hospitals and doctors have to undertake emergency medical treatment for indigent patients and are not subsequently paid for their services because of current problems in the indigent care program. These inequities should and must be addressed by our proposed special committee.

4. We, the Grand Jury, during our investigation also learned of the special problems regarding the Emergency Medical Technicians and Paramedics who are employed for the St. Johns County Rescue Service. We believe it is an instance the St. Johns County Rescue Service Personnel performed in professional manner. However, because the Doctors on the Medical Board which oversees St. Johns County Rescue Service and the Doctors who are in charge of the St. Johns County Emergency Rooms at Flagler Hospital and St. Augustine General Hospital are one and the same, and are the Doctors who have total
licensing control and authority over the members of the St. Johns County Rescue Service, there is a conflict of interest. If the Emergency Room physicians desire, they can withdraw their Medical License for use by rescue personnel thereby terminating the employment of that person employed by St. Johns County Rescue. We believe this situation is deplorable and must be corrected at once.

We, the Grand Jury, would recommend to the St. Johns County Commission that the Director of the St. Johns County Health Department be given the authority to supervise and oversee the St. Johns County Rescue Service, and to extend his/her license as required to the appropriate St. Johns County Rescue Service personnel.

Further, we, the Grand Jury, would urge the County Commission not to appoint Doctors to the Medical Board of Rescue who own a partial or total interest in the Emergency Room business that they are conducting at either Flagler or St. Augustine General Hospitals, as it places the Rescue personnel in a conflict situation in caring for a patient vs. caring for their job security if they do not follow the Emergency Room Doctor’s order to divert the patient. We, the Grand Jury, believe this current practice gives a very strong appearance of impropriety.

We, the Grand Jury, respectfully request that the Board of County Commissioners of St. Johns County, Florida, and the Board of Trustees of Flagler Hospital give these matters their immediate attention.

We, the Grand Jury, have agreed to meet again, in approximately thirty (30) days, in order to see that our recommendations regarding these matters have been reviewed and given serious consideration by the Board of County Commissioners and the Board of Trustees of Flagler Hospital, and to review what, if any, progress is being made toward implementing practical solutions.

Respectfully Submitted

S/Mary Capo

ATTEST:

CLFWK
HEALTH CARE COMMITTEE

Subcommittee on Health Regulation

December 9, 1987
1:00 - 3:00 PM
16 House Office Building

AGENDA

DISCUSSION AND TESTIMONY ON EMERGENCY MEDICAL SERVICES:
ACCESS TO CARE

Connie Sheren
Director
Office of Licensure and Certification
Department of Health and Rehabilitative Services

Larry Jordan
Program Administrator
Emergency Medical Services
Department of Health and Rehabilitative Services

Richard Slevinski, M.D.
State Medical Director
Emergency Medical Services
Department of Health and Rehabilitative Services
FEDERAL LAW
purposes of carrying out this subpart and implementing the amendments made by this subpart.

(b) Use of Interim Final Regulations.—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subpart and the amendments made by this subpart.

Subpart B—Miscellaneous Provisions

SEC. 9121. RESPONSIBILITIES OF MEDICARE HOSPITALS IN EMERGENCY CASES.

(a) Requirement of Medicare Hospital Provider Agreements.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

1) by striking out “and” at the end of subparagraph (G),
2) by striking out the period at the end of subparagraph (H) and inserting in lieu thereof “, and”, and
3) by inserting after subparagraph (H) the following new subparagraph:

“(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable.”

(b) Requirements.—Title XVIII of such Act is amended by inserting after section 1866 the following new section:

“EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTIVE LABOR

“SEC. 1867. (a) Medical Screening Requirement.—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

“(b) Necessary Stabilizing Treatment for Emergency Medical Conditions and Active Labor.—

“(1) In General.—If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either—

“(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or
“(B) for transfer of the individual to another medical facility in accordance with subsection (c).

“(2) Refusal to Consent to Treatment.—A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a legally responsible person acting on the individual’s behalf) refuses to consent to the examination or treatment.

Sec. 9121
"(3) Refusal to consent to transfer.—A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the transfer.

"(c) Restricting transfers until patient stabilized.—

"(1) Rule.—If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—

"(A)(i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

"(ii) a physician (within the meaning of section 1861(r)(1)), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

"(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

"(2) Appropriate transfer.—An appropriate transfer to a medical facility is a transfer—

"(A) in which the receiving facility—

"(i) has available space and qualified personnel for the treatment of the patient, and

"(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

"(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

"(C) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

"(D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

"(d) Enforcement.—

"(1) As requirement of Medicare provider agreement.—If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to—

"(A) termination of its provider agreement under this title in accordance with section 1866(b), or

"(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

"(2) Civil monetary penalties.—In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a
requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation. As used in the previous sentence, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

"(A) is employed by, or under contract with, the participating hospital, and

"(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

"(3) CIVIL ENFORCEMENT.—

"(A) PERSONAL HARM.—Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

"(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY.—Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

"(C) LIMITATIONS ON ACTIONS.—No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

"(e) DEFINITIONS.—In this section:

"(1) The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part.

"(2) The term 'active labor' means labor at a time at which—

"(A) delivery is imminent,

"(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

"(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

"(3) The term 'participating hospital' means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

"(4)(A) The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

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"(B) The term 'stabilized' means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

"(5) The term 'transfer' means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

"(f) PREEMPTION.—The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

"(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act.

"(d) REPORT.—The Secretary of Health and Human Services shall, not later than 6 months after the effective date described in subsection (c), report to Congress on the methods to be used for monitoring and enforcing compliance with section 1867 of the Social Security Act.

SEC. 9122. REQUIREMENT FOR MEDICARE HOSPITALS TO PARTICIPATE IN CHAMPUS AND CHAMPVA PROGRAMS.

(a) IN GENERAL.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking out "and" at the end of subparagraph (H),

(2) by striking out the period at the end of subparagraph (I) and inserting in lieu thereof ", and"

and

(3) by inserting after subparagraph (I) the following new subparagraph:

"(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to agreements entered into or renewed on or after the date of the enactment of this Act, but shall apply only to inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

(c) REFERENCE TO STUDY REQUIRED.—For a study of the use by CHAMPUS of the medicare prospective payment system, see section 634 of the Department of Defense Authorization Act, 1985 (Public Law 98-525), the deadline for which is extended under section 2002 of this Act.

(d) REPORT.—The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act as a result of the additional conditions imposed under the amendments made by subsection (a).

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An application for renewal of a license shall be made 90 days prior to expiration of the license, on forms provided by the department.

(d) The department shall, at the request of a licensee, issue a single license to a licensee for facilities located on separate premises. Such a license shall specifically state the facilities, services, and licensed beds available on each separate premise. When a licensee requests a single license, the licensee shall designate which facility or office is responsible for receipt of information, payment of fees, service of process, and all other activities necessary for the department to carry out the provisions of this part.

(e) Intensive residential treatment programs for children and adolescents which have received accreditation from the Joint Commission on Accreditation of Hospitals, and which meet the minimum standards developed by rule of the department for such programs, may be licensed by the department under this part.

(3)(a) Each license shall be valid only for the persons and governmental units to whom it is issued and shall not be subject to sale, assignment, or other transfer, voluntary or involuntary, and a license shall not be valid for any premises other than that for which it was originally issued.

(b) An application for a new license is required when a majority of the ownership or controlling interest of a licensed facility is transferred or assigned and when a lessee agrees to undertake or provide services to the extent that legal liability for operation of the facility rests with the lessee. The application for a new license showing such change shall be made at least 60 days prior to the date of the sale, transfer, assignment, or lease.

(4) The department shall issue a license which specifies the number of hospital beds on the face of the license. The number of beds for the rehabilitation or psychiatric service category for which the department has licensed the facility shall be specified on the face of the hospital license. All beds which are not covered by any specialty-bed-need methodology shall be specified as general beds. A licensed facility shall not continuously operate a number of hospital beds greater than the number indicated by the department on the face of the license.

(5) No specialty hospital shall provide any service or regularly serve any population group beyond those services or groups specified in its license.

(6) Licenses shall be posted in a conspicuous place on the licensed premises.

(7) Whenever the department finds that there has been a substantial failure to comply with the requirements established under this part or in rules promulgated hereunder, the department is authorized to deny, modify, suspend, or revoke:

(a) A license;

(b) That part of a license which is limited to a separate premises, as designated on the license; or

(c) Licensure approval limited to a facility, building, or portion thereof, or a service, within a given premises.

History.--s 395.004 Application for license, disposition of fees; expenses.--

(1) An application for a license or renewal thereof shall be made to the department, upon forms provided by it, and shall contain such information as the department reasonably requires, which may include affirmative evidence of ability to comply with applicable laws and rules.

(2) Each application for a general hospital license, specialty hospital license, or ambulatory surgical center license, or renewal thereof, shall be accompanied by a license fee, in accordance with the following schedule:

(a) The biennial license and license renewal fee required of a facility licensed under this part shall be established by rule at the rate of not less than $9.50 per hospital bed, nor more than $15 per hospital bed, except that the minimum license fee hereunder shall be $475 and the total fees collected from all licensed facilities shall not exceed the cost of properly carrying out the provisions of this part.

(b) Such fees shall be payable to the department and shall be deposited in the Hospitale Licensure Trust Fund for the sole purpose of carrying out the provisions of this part.

History.--s 395.005 Rules and enforcement.--

(1) The department shall adopt, amend, promulgate, and enforce rules to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(a) Sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care and safety;

(b) Infection control, housekeeping, sanitary conditions, emergency management plan, and medical record procedures that will adequately protect patient care and safety are established and implemented;

(c) Construction, maintenance, repair, life safety, and renovation of licensed facilities are governed by the most recently adopted, nationally recognized life-safety code, except as may be specifically modified by rule;

(d) Licensed facilities are established, organized, and operated consistent with established standards and rules; and

(e) Hospital beds conform to minimum space, equipment, and furnishings standards as specified by the department.

(f) All hospitals submit such data as necessary to conduct certificate-of-need reviews required under s 381.494. Such data shall include, but shall not be limited to, patient origin data, hospital utilization data, type of service reporting, and facility staffing data. Data collection and dissemination procedures of the department shall include safeguards to ensure the confidentiality of individual patients. The department shall utilize existing uniform statewide data sources when available and shall minimize reporting costs to hospitals.

(2) Separate standards may be provided for general and specialty hospitals and ambulatory surgical centers.
1395.012 Prohibition of interference with prescription of amygdalin (laetrile).—No hospital or health facility shall interfere with the physician-patient relationship by restricting or forbidding the use of amygdalin (laetrile) when prescribed or administered by a physician licensed under chapter 458 or chapter 459 or a podiatrist licensed under chapter 461 and requested by a patient. Furthermore, no hospital or health facility shall remove the staff privileges of a physician or podiatrist solely because the physician or podiatrist prescribed or administered dimethyl sulfoxide (DMSO) to a patient.

1395.014 Access of chiropractors to diagnostic reports.—Each hospital shall set standards and procedures which provide for reasonable access by licensed chiropractors to the reports of diagnostic x rays and laboratory tests of institutions licensed pursuant to this part, subject to the same standards and procedures as other licensed physicians. However, nothing contained in the provisions of this section shall require a licensed facility to grant staff privileges to a chiropractor.

1395.0143 Emergency treatment; when required.—No general hospital licensed under this part, and no specialty hospital with an emergency room, shall deny any person treatment for any emergency medical condition which will deteriorate from a failure to provide such treatment. A hospital or its employees, or any physician or dentist, responding to an apparent need for emergency treatment pursuant to this section shall not be held liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.

1395.0145 Prohibition against requiring advance payment for emergency medical care under specified circumstances.—Hospitals with emergency departments are prohibited from requiring payment prior to rendering emergency medical care to a patient when that patient has shown evidence of adequate health insurance coverage which is payable to the hospital or which is assigned to the hospital by the policyholder. Nothing in this section shall be so construed as to relieve the patient of any indebtedness incurred as a result of the medical care so rendered.

1395.0147 Infectious diseases; notification.—If, while treating or transporting an ill or injured patient to...
the provisions of this part.

History.—s. 10, ch. 83-196

1401.43 Fraudulently obtaining services from emergency medical services vehicle licensee.—Whoever willfully and with intent to defraud obtains or attempts to obtain services from an emergency medical services vehicle licensee is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, for the first offense, and is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, for the second and subsequent offenses.

History.—s. 23, ch. 73-128; s. 3, ch. 78-168; s. 1, ch. 77-457; s. 2, ch. 81-318; s. 21, ch. 24, 25, ch. 82-402; s. 13, ch. 83-196

Amends effective October 1, 1992, pursuant to a 25, ch. 82-402, and is scheduled for review pursuant to s. 11.61 in advance of that date. Repealed effective October 1, 1992, by s. 13, ch. 83-196, and scheduled for review pursuant to s. 11.61 in advance of that date.

1401.44 Turning in a false alarm.—Whoever summons any emergency medical services vehicle pursuant to this act or reports that such a vehicle is needed when such a vehicle is not needed is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, for the first offense, and is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, for the second and subsequent offenses.

History.—s. 24, ch. 73-128; s. 3, ch. 78-168; s. 1, ch. 77-457; s. 2, ch. 81-318; s. 22, ch. 24, 25, ch. 82-402; s. 13, ch. 83-196

1401.45 Denial of emergency treatment; civil liability.—

(1) No person shall be denied treatment for any emergency medical condition which will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.

(2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment pursuant to this section shall not be held liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.

History.—s. 26, ch. 73-128; s. 3, ch. 78-168; s. 1, chs. 77-457, 77-570; s. 2, ch. 81-318; s. 26, 25, 27, ch. 82-402; s. 13, ch. 83-196

1401.46 Air ambulance service; licensure.—

(1) Every person, firm, corporation, association, or governmental entity owning or acting as an agent for the owner of any business or service which furnishes, operates, conducts, maintains, advertises, engages in, proposes to engage in, or professes to engage in the business or service of transporting by air ambulance persons who may need medical attention during transport shall be licensed as an air ambulance service, before offering such service.

(2) The application for such license shall be submitted to the department on forms provided for this purpose. The application shall provide documentation that the licensee meets the appropriate requirements for an air ambulance service as specified by rule of the department. The fee for such license shall be as prescribed in s. 401.34.

(3) An applicant seeking licensure as an air ambulance service shall:

(a) Submit a completed application to the department on such forms and including such information as specified by rule of the department.

(b) Submit the appropriate fee as provided in s. 401.34.

(c) Specify the location of all required medical equipment and provide documentation that all such equipment is available and in good working order.

(d) Provide documentation that all aircraft and crew members meet applicable Federal Aviation Administration (F.A.A.) regulations.

(e) Provide proof of adequate insurance coverage of not less than $100,000 per person and $300,000 per incident or a greater amount as may be specified by rule of the department for claims arising out of injury or death of persons and damage to property of others resulting from any cause for which the owner of such business or service would be liable. Self-insurance is an acceptable alternative as specified in s. 401.25(2)(e).

(f) Specify if the service uses either fixed-winged or rotary-winged aircraft, or both.

(4)(a) If a service provides interhospital air transport, air transport from hospital to another facility, air transport from hospital to home, or similar air transport, the service must provide evidence that it has employed a medical director to advise the service on the appropriate staffing, equipment, and supplies to be used for the transport of any patient aboard an air ambulance and shall provide information to referring physicians regarding special medical requirements and restrictions when transporting by air ambulance.

(b) If the service uses rotary-winged aircraft in conjunction with a community emergency medical advanced life support or basic life support services first response system, the service is required to meet the provisions of ss. 401.47(2)(f), and is also required to meet separate basic life support and advanced life support requirements unique to air ambulance operations as may be specified in rules of the department. Such service is subject to the provisions of s. 401.25 relating to a certificate of public convenience and necessity; however, a service may operate in any county under the terms of mutual aid agreements.

(5) In order to renew a license for air ambulance service, the applicant shall:

(a) Submit a renewal application to the department not more than 90 days nor less than 60 days before the expiration of the license.

(b) Submit the appropriate renewal fee as provided in s. 401.34.

(c) Provide documentation that current standards for issuance of a license are met.

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and review by such board, and no person who was in attendance at a meeting of such board shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such board or as to any findings, recommendations, evaluations, opinions, or other actions of such board or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such board; nor should any person who testifies before such board or who is a member of such board be prevented from testifying as to matters within his knowledge, but such witness cannot be asked about his testimony before such a board or opinions formed by him as a result of such board hearings.

(10)(a) In the event that the defendant prevails in an action brought by an applicant against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section, the court shall award reasonable attorney’s fees and costs to the defendant.

(b) As a condition of any applicant bringing any action against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section and before any responsive pleading is due, the applicant shall post a bond or other security, as set by the court having jurisdiction of the action, in an amount sufficient to pay the costs and attorney’s fees.

(11) Nothing herein shall be construed by the department as requiring an applicant for a certificate of need to establish proof of discrimination in the granting of or denial of hospital staff membership or professional clinical privileges as a precondition to obtaining such certificate of need under the provisions of s. 381.494(2).

395.0144 Duty of hospitals to admit or transfer persons seeking emergency services.—Effective January 1, 1987, any hospital, as defined in s. 395.002(4), which operates a full-time emergency room service shall, upon determination by a licensed hospital physician that a person seeking emergency services shall be admitted, admit such person and shall not refuse to admit such person on the basis of economic criteria or indigency. If, in the medical judgment of the licensed hospital physician responsible for emergency room services, the hospital is unable to render appropriate treatment, thereby necessitating transfer of the patient, the hospital where the patient has presented himself shall:

(1) Within its capabilities, render such emergency services as the circumstances require, which services shall be provided within the scope of generally accepted practice.

(2) Contact an appropriate receiving hospital and notify such hospital that the patient is in transit.

(3) Arrange suitable transportation for the patient, if necessary.

(4) Send to the receiving hospital any available information on the patient’s history and condition.

However, no such transfer shall be authorized until the physician considers the patient sufficiently stabilized for transport.

395.041 Internal risk management program.—

(1) Every facility licensed under this chapter, chapter 390, or chapter 390 shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;

(b) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including at least annual risk management and risk prevention education and training of all nonphysician personnel;

(c) The analysis of patient grievances which relate to patient care and the quality of medical services, and

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the health care facility to report injuries and adverse incidents to the hospital risk manager.

(2) The risk management program shall be the responsibility of the governing board of the health care facility. As of October 1, 1986, every facility licensed under this chapter shall hire a risk manager, certified under part IX of chapter 626, who shall be responsible for implementation and oversight of such facility’s risk management program as required by this section. Part-time risk managers shall not be responsible for risk management programs in more than four such facilities. Regarding facilities licensed under chapter 389 or chapter 390, such facility shall designate one or more individuals as the “risk manager” for the purpose of this section.

(3) In addition to the programs mandated by this act, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Such additional approaches may include extending risk management programs to health care providers’ offices and the assuming of provider liability by a health care facility for acts or omissions occurring within the facility.

(4) The Department of Health and Rehabilitative Services shall, after consulting with the Department of Insurance, promulgate rules governing the establishment of such internal risk management programs to meet the needs of individual establishments. The Department of Insurance shall assist the Department of Health and Rehabilitative Services in preparing such rules. Each internal risk management program shall include the use of incident reports to be filed with an individual of responsibility who is competent in risk management techniques in the employ of each establishment, such as an insurance coordinator, or who is retained by said establishment as a consultant. Said individual shall have free access to all establishment medical records, and the rules
document the organizational steps it has taken to assure that oversight of the quality of nursing care provided to each patient is accomplished.

(2) Each hospital shall document the relationship of the nursing department to other units of the hospital by an organizational chart, and each nursing department shall have a written organizational plan that delineates lines of authority, accountability and communication. The nursing department shall assure that the following nursing management functions are fulfilled:
   (a) Review and approval of policies and procedures that relate to qualifications and employment of nurses.
   (b) Establishment of standards for nursing care and mechanisms for evaluating such care.
   (c) Implementing approved policies of the nursing department.
   (d) Assuring that a written evaluation is made of the performance of registered nurses and ancillary nursing personnel at the end of any probationary period and at a defined interval thereafter.

(3) Each hospital shall employ a registered nurse on a full time basis who shall have the authority and responsibility for managing nursing services and taking all reasonable steps to assure that a uniformly optimum level of nursing care is provided throughout the hospital.
   (a) The nurse shall be responsible for assuring that a review and evaluation of the quality and appropriateness of nursing care is accomplished. The review and evaluation shall be based on written criteria, shall be performed at least quarterly, and shall examine the provision of nursing care and its effect on patients.
   (b) The nurse shall assure that education and training programs for nursing personnel are available and are designed to augment nurses' knowledge of pertinent new developments in patient care and maintain current competence. Cardiopulmonary resuscitation training shall be conducted as often as necessary, but not less than annually, for appropriate nursing staff members who cannot otherwise document their competence.
   (c) Each hospital shall develop written standards of nursing practice and related policies and procedures to define and describe the scope and conduct of patient care provided by the nursing staff. These policies and procedures shall be reviewed at least annually, revised as necessary, dated to indicate the time of the last review, signed by the responsible reviewing authority, and enforced.
   (d) The nursing process of assessment, planning, intervention and evaluation shall be documented for each hospitalized patient from admission through discharge.
      (a) Each patient's nursing needs shall be assessed by a registered nurse at the time of admission or within the period established by the facility's policy.
      (b) Nursing goals shall be consistent with the therapy prescribed by the responsible medical practitioner.
   (c) Nursing intervention and patient response, and patient status on discharge from the hospital, must be noted on the medical record.
   (d) A sufficient number of qualified registered nurses shall be on duty at all times to give patients the nursing care that requires the judgment and specialized skills of a registered nurse, and shall be sufficient to assure immediate availability of a registered nurse for bedside care of any patient when needed, to assure prompt recognition of an untoward change in a patient's condition, and to facilitate appropriate intervention by nursing, medical or other hospital staff members.

(7) Each Class I and Class II hospital shall have at least one licensed registered nurse on duty at all times on each floor or similarly titled part of the hospital for rendering patient care services.
   (8) Each hospital shall maintain a list of licensed personnel, including private duty and per diem nurses, with each individual's current license number, and documentation of the nurses' hours of employment, and unit of employment within the hospital.

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HOSPITAL LICENSURE


(1) Every hospital shall provide emergency care available 24 hours a day within the hospital to patients admitted to the hospital. At a minimum:
   (a) At least one physician shall be available 30 minutes through a medical staff call roster; initial consultation through two-way voice communication is acceptable for physician presence.
   (b) Specialty consultation shall be available by request of the attending physician or by transfer to a designated hospital where definitive care can be provided.

(2) No Class I hospital, and no Class II or Class III hospital with an emergency room or department, shall deny any person treatment for any emergency medical condition which will not deteriorate from a failure to provide such treatment.

(3) When a patient is transferred from one hospital to another, all pertinent medical information shall accompany the patient being transferred.

(4) Each hospital with an emergency room or department shall maintain a transfer manual, a model of which shall be provided by the department, which shall include:
   (a) Decision protocols for when to transfer a patient;
   (b) A list of receiving hospitals with special care capabilities, including the telephone number of a contact person;
   (c) A list of special instructions for patient transfers and any transfer agreements in effect;
   (d) A list of emergency medical transport services as provided by the department which includes
      1. Appropriate telephone numbers and contact persons;
      2. Critical care capabilities, including neonatal
care; and
3. A state map which clearly depicts all special or critical care facilities, their distances from the hospital, and a depiction of all emergency transport services available to the hospital.
4. A list, by critical care specialty, of all critical care physicians available to the hospital, and their telephone numbers and "on-call" status; and
5. Protocols for receiving a call from a transferring hospital, including:
   1. Requirements for specific information regarding the patient's problem;
   2. List of information needed;
   3. Time of patient arrival;
   4. Specific medical requirements;
   5. A request to transfer the patient's medical record with the patient; and
6. The name of the transporting service.
5. Both transporting and receiving hospitals shall assign a specific person on each shift who shall have responsibility for being knowledgeable of the transfer manual and maintaining it.
6. Each hospital with an emergency room or department shall maintain written policies and procedures specifying the scope and conduct of patient care to be rendered to patients in the emergency department or area. Such policies and procedures must be approved by the organized medical staff, reviewed at least annually, revised as necessary, dated to indicate the time of last review, and enforced. Such policies shall include the following:
   (a) Direction of the emergency department by a designated physician who is a member of the organized medical staff
   (b) A defined method of providing for a physician on call at all times.
   (c) Supervision of the care provided by all nursing service personnel with the emergency department by a designated registered nurse who is qualified by relevant training, experience and current competence in emergency care.
   (d) A written description of the duties and responsibilities of all other health personnel providing care within the emergency care area.
   (e) A planned formal training program, and participation, by all health personnel working in the emergency care area.
   (f) A requirement that a control register adequately identifying all persons seeking emergency care be established, and that a medical record be maintained on every patient seeking emergency care that is incorporated into the patient's permanent medical record and that an ambulance run report as required to be provided in F.A.C. 10D-66.060 be included in the medical record, if the patient was delivered by ambulance.
   (g) A method for assuring that a review of emergency patient care is performed and documented at least monthly, using the medical record and pre-established criteria.
7. Every hospital with an emergency room or department shall maintain a communication system that permits immediate contact with law enforcement agencies, rescue squads, licensed ambulance services, and other emergency services and hospitals within the community, to provide advance information concerning critically ill or injured patients.
8. Every hospital with an emergency room or department shall insure the following:
   (a) That clinical laboratory services with the capability of performing all routine studies and standard analyses of blood, urine, and other body fluids are readily available at all times to the emergency room or department.
   (b) That an adequate supply of blood is available at all times, either in-hospital or from an outside source approved by the organized medical staff, and that blood typing and cross-matching capability and blood storage facilities are readily available to the emergency room or department.
   (c) That diagnostic radiology services are readily available at all times to the emergency room or department to provide routine studies.
   (d) That the following are available for immediate use to the emergency room or department at all times:
      1. Oxygen and means of administration;
      2. Mechanical ventilation assistance equipment, including airways, manual breathing bag, and ventilator;
      3. Cardiac defibrillator with synchronization capability;
      4. Respiratory and cardiac monitoring equipment;
      5. Thoracotomies and closed thoracotomy sets;
      6. Tracheostomy set;
      7. Tourniquets;
      8. Vascular cutdown sets;
      9. Laryngoscopes and endotracheal tubes;
      10. Urinary catheters with closed volume urinary systems;
      11. Pleural and pericardial drainage set;
      12. Minor surgical instruments;
      13. Splinting devices;
      14. Emergency obstetrical pack;
      15. Standard drugs, common poison antidotes, syringes and needles, parenteral fluids and infusion sets, and surgical supplies;
      16. Refrigerated storage for biologics and other supplies requiring refrigeration, within the emergency care area, and
      17. Stable examination tables.
9. Every hospital with an emergency room or department is prohibited from establishing a policy, procedure or practice of requiring payment prior to the rendering of emergency medical care when
   (a) The patient or other responsible individual has shown evidence of adequate health insurance coverage which is payable to the hospital, or
   (b) The patient or other responsible individual has shown evidence of adequate health insurance coverage which is assigned to the hospital by the policyholder or other legally authorized person.
   The requirements for adequate health insurance coverage shall not be interpreted to require verifiable insurance coverage for more than 50

percent of the reasonably anticipated bill.

(10) Failure of a patient to provide prior payment or show evidence of adequate health insurance coverage shall not be cause to deny in any way treatment to a person for any emergency medical condition which will deteriorate from failure to provide such treatment.


10D-28.171 Special Care Units.

(1) Subject to the regulation of Chapter 381.493 et seq., F.S. and Chapter 10D-5, F.A.C., and other requirements of these rules, and 10D-86, F.A.C., hospitals may designate on their license one or more units within the hospital as special care units. When a hospital designates a special care unit on its license, it shall indicate to the Department the space where the special care is provided and the number of hospital beds within that space.

(2) When a hospital elects to designate a special care unit the hospital shall ensure that the unit is a physically and functionally distinct entity within the hospital, has controlled access, and has an effective means of isolation for patients suffering from communicable or infectious disease or acute mental disorder. Special care units shall provide:

(a) Direct or indirect visual observation by unit staff of all patients from one or more vantage points;

(b) A direct intercommunication or alarm system between the nurse’s station and the bedside, and

(c) Beds that are adjustable to positions required by the patient, that are easily movable, and that have a locking or stabilizing mechanism to attain a secure, stationary position. Headboards, when present, shall be removable or adjustable to permit ready access to the patient’s head.

(3) Each special care unit shall be advised by a physician who is a member of the organized medical staff, shall have its relationship to other departments and units of the hospital specified in writing (organizational chart), and shall provide relevant in-service education programs to all staff including, but not limited to, annual education concerning cardiopulmonary resuscitation and safety and infection control requirements.

(4) Written policies and procedures shall be developed concerning the scope and provision of care in each special care unit. Such policies and procedures shall be reviewed at least annually, revised as necessary, dated, and include at least the following:

(a) Specific criteria for the admission and discharge of patients;

(b) A system for informing the responsible physician of changes in the patient’s condition;

(c) Methods for procurement of equipment and drugs at all times;

(d) Specific procedures relating to infection and traffic control;

(e) Specification as to who may perform special procedures, under what circumstances, and under what degree of supervision, and specification as to the use of standing orders;

(f) A protocol for handling of emergency conditions related to the breakdown of essential equipment.

(5) No hospital shall hold itself out as a Trauma Center unless it has been verified by the Department in accordance with the Trauma Center provisions of Section 395.031, F. S., and Chapter 10D-86, F. A. C. Any violation of the Trauma Center provisions shall subject any violator to appropriate remedies provided by Section 395.018, F.S.


10D-28.172 Infection Control.

(1) Each hospital shall establish an infection control program involving members of the organized medical staff, the nursing staff, other professional staff as appropriate, and administration. The program shall provide for establishing a practical system for identifying, reporting, evaluating and maintaining records of infections among patients and personnel, for ongoing review and evaluation of all topical isolation and sanitation techniques employed in the hospital, and development and coordination of training programs in infection control for all hospital personnel.

(2) Each hospital shall have written policies and procedures reflecting the scope of the infection control program outlined in subsection (1). The written policies and procedures shall be reviewed at least annually, dated at the time of each review, revised as necessary, and enforced.

(3) The policies and procedures devised by the infection control program shall be approved by the governing body, and shall contain at least the following:

(a) A requirement that a record of all reported infections be maintained that includes the identification and location of the patient, the date of admission, onset of infection, the type of infection, the cultures taken, the results when known, any antibiotics administered, and the identity of the practitioners responsible for the care of the patient.

(b) A classification system that groups all reported infections into categories.

(c) A requirement that at least a weekly check for outdated sterile items be performed, whether in all nursing units or by central supply.

(d) Specific policies and procedures related to accidental needlesticks.

(e) Specific policies related to the handling and disposal of biological waste.

(f) Specific policies and procedures related to admixture and drug reconstitution, and to the manufacture of intravenous and irrigating fluids.

(g) Specific policies related to protective clothing and drapes, sterilization techniques, routine cleaning techniques, and handling of materials and maintenance of the inanimate environment.
Hospital policy creates concerns, rescue workers say

By Olivia Mayer
Staff writer

ST. AUGUSTINE -- Flagler Hospital's diverting of indigent pregnant women in labor has put not only the women involved in a precarious situation, but St. Johns County Rescue Service personnel also.

Some emergency medical technicians and paramedics have said they have feared for their jobs because at least once they have been ordered to take a patient to another hospital by the emergency room physician who also is the medical director of the rescue service.

A St. Johns County grand jury last week found that Flagler Hospital on three occasions denied indigent pregnant women access to the facility and exposed the expectant mothers and babies to potential injury. Flagler Hospital stopped delivering indigent women's babies in July 1986.

The grand jury also found that a conflict of interest exists because the rescue service medical directors are emergency room physicians.

St. Johns Rescue Service has two medical directors: Dr. Joe Campau, an emergency room physician for St. Augustine General Hospital, and Dr. Michael Maxwell, Campau's counterpart at Flagler Hospital, according to Ray Ashton, director of public safety.

Emergency personnel said on at least one occasion a medical director, working as an emergency room physician, ordered rescue personnel to take a patient to another hospital. The order contradicted rescue policy, which is to take the patient to the nearest appropriate facility.

Some rescue personnel said they feared their licenses would be revoked if they did not follow the emergency room physician's directions.

Last month, Maxwell sent the rescue service a letter saying that he would no longer let some of the rescue personnel operate under his license. Those emergency medical technicians and paramedics have continued to work under Campau's license.

Maxwell could not be reached for comment.

The grand jury in its Aug. 28 presentment recommended that Dr. Wayne O'Connell, administrator of the St. Johns County Health Department, assume the responsibility of medical director.

"I think it has posed a problem in the past, and it can be corrected in the near future," O'Connell said. "The control ought to be out of the hands of those that are directly involved. My intent in participating in this is to get the politics out of it."

O'Connell and Ashton have not yet met to discuss the grand jury's suggestion.
University Hospital delivers babies of North Florida’s indigent women

By Olivia Mayer

ST. AUGUSTINE — St. Johns County indigent pregnant women are not the only women in North Florida who have to go out of their counties to deliver, although they do have to travel the farthest.

Neighboring Clay County’s poor have been delivering at University Hospital in Jacksonville since 1981, Ed Stanse1, Clay County Health Department administrator, said these patients have been going out of county since 1977.

Although Clay County has two hospitals, only Humana in Orange Park has obstetric facilities, and its doctors only take private patients, Humana executive Lee Ledbetter said.

In order for Clay County to have a contract with Humana for indigent deliveries, it would have to pay the physicians an additional fee along with the Medicaid reimbursement, Ledbetter said.

The reason behind the subsidy boils down to additional risk, he said.

“The indigent is a suit-prone group of people,” Ledbetter said. “They [the doctors] would have to have some compensation.”

The risk comes into play with the drop-in patient, the one that shows up at the emergency room in labor without any prenatal care, Ledbetter said.

Right now, Stanse1 said, it is more cost efficient to contract with University Hospital where they give the hospital the standard Medicare reimbursement.

But Stanse1 is looking to the state Legislature for help.

“What we’re hoping is that the Legislature will approve sovereign immunity for physicians providing care to the indigent,” he said. “It is essential if we are going to provide quality care for the bona fide indigent.”

Baker and Nassau counties also have contracts with University Hospital for care for their indigent patients.

But in Baker County, it’s not only the poor mothers who have to venture out of the county to have their babies. The rural county’s only hospital has been out of the baby business altogether for quite some time, said Betty Hardin, Baker County Health Department’s director of nursing.

And Nassau County, with a population of 39,822, has only one obstetrician who has “all he can handle” with private patients, county nursing supervisor Ruth Adams said.

Under Nassau, Baker and Clay counties’ contract with University Hospital, midwives come and visit each county health department at least once a month to provide prenatal care. Then when it comes time to deliver, it is the patient’s responsibility to get to the hospital, Stanse1 said.

After Flagler Hospital stopped delivering indigent patients in July 1986, University Hospital originally signed a 90-day contract to deliver all of St. Johns County’s poor pregnant and then lengthened the agreement by another 90 days.

But in December, University Hospital limited its services to St. Johns County’s high-risk patients only because of crowding.

University delivers about 4,200 babies a year, according to Gary Schoenberg, assistant vice president at the hospital.

“Basically, the kind of volume here dictated whether we felt we could continue delivering all of St. Johns indigent,” Schoenberg said. “We had hoped that they could work out some other arrangements.”

University also provides indigent care for Jacksonville...
Flagler Hospital not criminal in refusing access to indigent

\textit{Grand jury says facility only violated civil statute}

By Olivia Mayer
Staff Writer

ST. AUGUSTINE — A St. Johns County grand jury found yesterday that Flagler Hospital on three occasions denied indigent pregnant mothers access to the facility, but did not find any criminal wrongdoing in the actions.

But the jury, which met for two days, did say in its presentment that by diverting the expectant mothers, the medical staff violated a state civil statute regarding the duty to render medical aid.

The State Attorney’s Office began an investigation earlier this month into possible negligence and wrongdoing by Flagler Hospital — the only hospital in the county with an obstetrical ward — in turning away indigent pregnant women in labor from the emergency room.

Assistant State Attorney Steve Alexander said the investigation was prompted after he read newspaper accounts of at least two indigent pregnant women who were refused treatment at the emergency room.

According to the presentment, the grand jury reviewed three separate incidents that occurred March 15, May 6 and July 12.

Flagler Hospital stopped delivering babies of indigent women in July 1986.

According to the presentment, the grand jury found that members of the medical staff “are intentionally circumventing” the hospital’s emergency room policy, which states that it will “provide emergency treatment for all patients who present themselves” to the emergency room, “regardless of race, creed or ability to pay.”

Last month, 29-year-old Karen Stabler, who was seven months pregnant, went into labor. She was en route to Flagler Hospital via ambulance when the emergency room physician told the rescue personnel she would not accept the patient.

The baby, who weighed less than 4 pounds, was delivered about three miles away in a makeshift birthing room at St. Augustine General Hospital.

The grand jury requested that the St. Johns County Rescue Service take expectant mothers in labor to Flagler Hospital and not St. Augustine General Hospital, and that Flagler Hospital deliver the baby if the mother and child cannot be safely transported to another hospital.

The grand jury also asked that the County Commission establish a committee of medical and lay persons to address the issue of indigent care in the county.

The jury did not request that a civil injunction be filed, but the jury is reconvening in 30 days to review the situation and see if a solution is near.

Alexander said the jury may request additional action.

An investigation by the state’s hospital licensing office earlier this month did not find that Flagler Hospital violated hospital regulation.
AMI hospital bars care of boy without insurance

By Alex Beasley
OF THE SENTINEL STAFF

The parents of a toddler suffering from pneumonia said Wednesday they were turned away from AMI Medical Center Orlando because they did not have health insurance.

The hospital took the action Tuesday even though a staff pediatrician had requested that the boy be admitted. Earlier in the day the hospital had announced it was closing the emergency room to people who cannot pay.

An AMI spokesman confirmed the incident Wednesday but said the doctor did not realize the family had no health insurance when she called to make the admission request.

When the family arrived at AMI they were told they would have to go elsewhere unless they had $1,500 to pay for his care, said his mother, Andrea Chavez.

"I can't believe they did that to us," said Chavez, whose husband, Mike, is an ironworker on the SunBank building. "I told them this was ridiculous, my son needed a doctor."

Chavez and her husband moved to Orlando in April from California because he has family here. He had not worked at the construction site long enough to qualify for health insurance.

On Tuesday, AMI caused a flap among area hospitals and emergency personnel when officials announced they were closing the emergency room to everyone except patients of staff physicians and workers' compensation cases.

AMI said it took the action to cut losses from non-paying patients and to distance itself from its image as a community, indigent-care hospital, formerly known as AMI Brookwood Community Hospital.

Also Wednesday, the office of licensure and certification for the Florida Department of Health and Rehabilitative Services sent an investigator to AMI to determine whether the hospital's new policy is violating the law.

However, the investigator said he did not see anyone turned away during the three hours he was there, said Sam Reysen, assistant area supervisor for the office that covers Central and Southeast Florida.

"It was business as usual. I don't know what's going on over there," Reysen said.

HRS began the investigation after receiving a
From B-1

complaint from Orange County’s Department of Emergency Medical Services that AMI refused to accept two other patients being transported by ambulance.

EMS manager Joan Pyle said she rode with paramedics from 9 p.m. Tuesday to 3:35 a.m. Wednesday to ensure that they were not harassed by the hospital. She also said that until further notice paramedics will not notify the hospital before arrival to make it more difficult for AMI to turn them away.

“We will continue to follow that policy until our paramedics do not feel intimidated,” she said.

In the case of the child, AMI spokeswoman Ellen Mahoney said his life was not endangered by the hospital’s action and added that questions about ability to pay are standard for any hospital.

She said the boy’s case was unfortunate but the hospital was determined to stick with its new policy of turning away non-emergency cases involving indigents. However, she said the boy would have been admitted if the situation had been life-threatening.

Chavez said the doctor, Riazunissa Arifuddin, apologized for the misunderstanding and explained to the boy’s family that the hospital does not take indigent patients. Arifuddin could not be reached for comment.

The boy originally was treated in the emergency room of Humana Lucerne Orlando hospital. Officials there called Arifuddin, who was on call for Lucerne, and asked for her advice.

Arifuddin was on duty at AMI and told the hospital she wanted the boy admitted there. The family then drove to AMI. They eventually took Rickie to Orlando Regional Medical Center, where he was making a steady recovery, said ORMC spokesman Joe Brown.
State clears Flagler Hospital in dispute

By Olivia Mayer
Staff writer

ST AUGUSTINE — An official with the state's hospital licensing office said yesterday an investigation found that Flagler Hospital was not in violation of state law when it turned away an indigent pregnant woman in premature labor last month.

Howard Chastain, program supervisor in Jacksonville for the state Office of Licensure and Certification, said the investigation determined that the hospital's emergency room did not refuse treatment but "properly diverted" the patient.

The office began its investigation of Flagler Hospital after a member of the St. Johns County rescue squad notified the licensing office that the hospital had refused to accept a patient.

At month, Karen Stabler, 29, of St. Augustine Beach went into premature labor and was en route to Flagler Hospital, the only county hospital with an obstetrical ward, when the emergency room physician on duty told the ambulance personnel by radio she would not accept the patient.

The baby, who weighed less than 4 pounds, was delivered about three miles away at St. Augustine General Hospital in a makeshift birthing room after rescue workers borrowed obstetrical equipment from the office of Dr. Anthony Mussalem, a St. Augustine obstetrician.

"We confirmed basically that they did not see the person," Chastain said. "But we didn't see that they had refused treatment. They should have diverted the one they diverted."

According to a transcript made by St. Johns County Rescue, ambulance personnel said the patient had been to Mussalem's once or twice for prenatal care.

Dr. Wilma Martin, the emergency room physician on duty, responded: "If this is Dr. Mussalem's patient, she needs to go to General, that's where he practices. He does not take calls here."

Chastain said an investigator from his office spent two days in St. Augustine talking with personnel from both hospitals, but said Mussalem was not interviewed.

The office looked into two additional cases and found the hospital to be in compliance in those instances also.

"We did not find that they violated hospital regulations in any of the three cases we looked at," Chastain said.

The report has been sent to the Health Care Financing Administration Regional Office in Atlanta, Chastain said.

"We accepted those reasons as being reasonable," Chastain said. "But someone in the federal government may not find it so."

If the Health Care Financing Administration finds Flagler Hospital erred, it could suspend the hospital's Medicare and Medicaid privileges, Chastain said.
Flagler Hospital probed

ER's turning away indigent investigated

By Olivia Mayer

ST AUGUSTINE — The State Attorney's Office is investigating possible negligence and wrongdoing by Flagler Hospital in turning away from the emergency room an indigent pregnant woman in labor.

Assistant State Attorney Steve Al- vander said yesterday the investigation was prompted after he read newspaper accounts of at least two indigent pregnant women who were refused treatment at the emergency room. The most recent of those was last month.

Karen Stabler, 29, of St. Augustine Beach was in premature labor and was being taken by ambulance to Flagler Hospital in St. Augustine, the only county hospital with an obstetrical ward, when the emergency room physician on duty told the ambulance personnel by radio that she would not accept the patient.

The baby was delivered about three miles away at St. Augustine General Hospital in a makeshift birthing room after rescue workers brought obstetrical equipment from Dr. Anthony Mussallem's office. Mussallem, a St. Augustine obstetrician, delivered the 31/2-pound baby who was then transported by helicopter to University Hospital in Jacksonville.

Flagler Hospital stopped delivering babies of indigent women in July 1986.

But Alexander said regardless of Flagler Hospital's policy concerning obstetrics for needy women, the hospital may have violated a Florida law that says emergency rooms must take care of patients.

"We can file a civil injunction if they are violating Florida State Law Chapter 395.013, which says they have a duty to take care and treat persons for emergency medical conditions," Alexander said.

There also is the possibility that criminal charges may be filed, Alexander said.

"The doctor could be punished for culpable negligence," Alexander said.

Culpable negligence simply means that someone who has a legal duty to do something fails to perform that duty, he explained.

Alexander said he is now in the process of subpoenaing taped radio conversations between the rescue squad and the physician on duty.

According to a transcript made by St. Johns County Rescue of the radio conversation between the Flagler doctor, Dr. Wilma Martin, and the rescue team the night of the Stabler incident, the ambulance was diverted before arriving at Flagler.

Flagler Hospital President Jim Con Zumus denied the hospital turned away the patient and said the physician, who was under a great deal of stress, made the decision.

"I certainly don't think she violated any law," Con Zumus said. "And none of them [the patients] were turned away, they were simply diverted. Our operating policy is that we accept all people.

"From what I understand, they were involved in a case where a patient was not ready to deliver a baby, and the doctor made a decision that the patient should be taken to the hospital to deliver the patient."

Alexander said he also plans to subpoena a number of witnesses for his investigation, which he hopes to complete by Sept. 1.

Depending on the findings, Alex- ander said he may turn the case over to the grand jury.

"Right now, I can't tell you that there's going to be any bad things that come out of this investigation. We are in the very preliminary stages," he said.

While Alexander is beginning his investigation, the state's Office of Licensure and Certification is wrapping up its independent investigation into the Stabler incident.

The hospital licensing office began its investigation after being contacted by a member of the rescue squad who expressed concern about the hospital's refusal to accept Ms. Stabler.

Howard Chastain, program supervisor in Jacksonville for the state office, said he expects to have the results within the next few days.

If the investigation finds the hospital erred, it could be decertificated or fined, if the procedures and policies are not remedied, Chastain said.
Staff-short Flagler Hospital unable to deliver babies of poor

By Paul Van Osdol
Staff writer

ST. AUGUSTINE — Yesterday was supposed to be the day Flagler Hospital would resume delivering babies of the pregnant poor, after a one-year suspension because of high malpractice insurance rates and a shortage of local obstetricians.

It did not work out that way.

Indigent pregnant women continued to be steered as far as 62 miles away because of a staff shortage at the hospital, according to St. Johns County Public Health Director Dr. Wayne O'Connell. He said he is not sure when the hospital will have sufficient staff to resume deliveries.

Hospital President James Conzemius could not be reached for comment yesterday.

A year ago, the hospital stopped delivering babies of poor mothers, forcing the women to travel 44 miles to University Hospital in Jacksonville or 62 miles to West Volusia Memorial Hospital in Deland.

Since January, only those with complicated pregnancies have been going to University.

St. Augustine General Hospital, the only other hospital in St. Johns County, does not have an obstetrics ward.

County officials last month reached agreement with Flagler officials to resume delivering poor women. The county agreed to bear the cost after the Legislature boosted Medicare payments as part of an indigent health care package.

However, one of the three St. Augustine-based obstetricians publicly criticized Flagler's birthing facilities this week — a factor that, the doctor said may have led the hospital to delay resuming indigent births.

"Missallem noted that only three obstetrical nurses are working at Flagler — two less than he has at his private office — and the head obstetrical nurse is leaving in a month.

Moreover, the hospital has only one obstetrician to deliver babies from poor pregnant women. A second obstetrician was slated to start working for the county last month, but O'Connell said he probably will not be able to start until next month because of delays with licensing.

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"The lack of a backup obstetrician led to a "potential disaster" earlier this week for one indigent woman, Musallam said.

The unidentified woman entered the Flagler emergency room needing a Caesarean section and, except for Musallam — who does not have obstetrical privileges at Flagler — there were no local obstetricians available.

The hospital called Mussallem and he had the woman transported to his office, where he performed a complicated Caesarean section. The woman's delivery was successful, but Musallam said he does not know what would have happened if he had been out of town.

"I was the only doctor in town that could do a C-section that particular morning," he said. "If you got an emergency situation, you can't spend three hours trying to call people."
Wounded teen dies after doctors refuse treatment

SANFORD — Neurosurgeons at several hospitals refused for five hours to operate on a 17-year-old boy with a gunshot wound to the head and the youth died the following day, the Sanford Herald reported Thursday.

Luray Demair Aikens, 17, was shot by a 17-year-old neighbor, police said.

Aikens was taken to the Central Florida Regional Hospital emergency room, where he waited five hours without being treated. Dr. Noberto Priu, the hospital's only neurosurgeon, was on duty, but said he would not take any trauma cases because of the state's medical malpractice problems.

Priu had requested several weeks earlier that his credentials for treating trauma patients be withdrawn, the Herald said.

"It was too risky," Priu said about the operation, in light of malpractice claims that might be brought against him. He added that if help could not be found, he might have changed his mind. He said he was not called a second time.

Telephone calls were made to several hospitals, including the Florida Hospital-Orlando, the Orlando Regional Medical Center, Shands Hospital in Gainesville and Tampa General Hospital, all of which said they could not accommodate Aikens, said Kay Bartholomew, a spokeswoman for Central Florida Regional.

Aikens was taken by helicopter to Univeristy Hospital in Jacksonville at 3:45 a.m., Aug. 12, where he was treated. He died at 1:30 p.m. that day, the newspaper reported.

"Chances are Aikens would have died anyway, doctors say," the Herald said.

Gary Snell, chief of staff at Central Florida Regional, said that in a memo dated Aug. 12, the same day Aikens died, it was announced that Winter Park neurosurgeons Bill Hoffmeister, Robert Shear and F.D. Kendrick would provide "full neurosurgical services" to patients of doctors practicing at Central Florida Regional.

The 17-year-old who shot Aikens was charged in connection with the killing and is being held at a juvenile detention center. Police called it a revenge killing. Aikens had stabbed the neighbor on July 31, the newspaper reported.
14 doctors reject gunshot victim

Uninsured woman gets help after 13 hours, 20 phone calls

By RENEE GRAHAM

BELLE GLADE — For 13 hours, no one wanted to treat Edwina Haynes.

Doctors and nurses at Glades General Hospital spent Wednesday night and Thursday morning calling hospitals and neurosurgeons from Gainesville to Miami hoping to access the Belle Glade woman with a gunshot wound in her back.

Some said they had no available beds for the woman, who has no insurance. Others, fearing lawsuits, said they just were not interested.

“We called 14 neurosurgeons and six hospitals and some just simply said, ‘I’m not interested in her because I’m not interested in a lawsuit,’” said Dr. Richard Thomas, Glades General’s director of emergency services.

“With the state’s malpractice situation, it was just a matter of time before this happened.”

Glades General Hospital has never had neurosurgeons, Thomas said.

Tampa General Hospital finally agreed to accept Haynes. It was the 20th call Thomas and his staff made between 11 p.m. Wednesday and noon Thursday.

Haynes was flown by Atlantic Ambulance Service to the Gulf Coast hospital, where she was listed in stable condition Thursday.

“We accepted her because it seemed medically necessary,” said Dr. Thomas McKell, Tampa General’s medical director. “It was a medical decision based on an emergency that needed immediate care. I didn’t feel we had a choice.”

Boyfriend suspected

Belle Glade police detective Steve Hinton said Haynes, 25, was shot by her boyfriend, Ricky Patrick, in his Southwest Eighth Street home in Belle Glade.

“What we know is that at some point in time while they were together, she was shot,” Hinton said. “We’re still trying to sort things out to see if it was an accident or a domestic situation.”

Patrick, 29, was arrested and charged with possession of a stolen firearm, Hinton said.

The bullet pierced Haynes’ liver, damaged her spinal cord and spinal column and left her paralyzed below the waist, Thomas said. She was stabilized at Glades General, but once doctors there determined the extent of her injuries, they began their scramble to find a hospital with a neurosurgeon.

“It was just absolute frustration. Some doctors wouldn’t even return our phone calls,” he said. “Fortunately, her injuries weren’t life-threatening. If this had been a case where the patient needed immediate surgery, the patient wouldn’t have made it.”

Glades General staff members telephoned five Palm Beach County neurosurgeons, two in Fort Myers, two in Dade County and one each in Gainesville, Fort Pierce, Orlando, Broward County and Polk County, Thomas said. He refused to provide their names.

Beds unavailable

The hospitals contacted were: Jackson Memorial in Miami, Orlando Regional, Shands in Gainesville, Lee Memorial in Fort Myers, Winter Haven Hospital and Tampa General, he said.

“I believe some of the hospitals didn’t have available beds,” Thomas said. “But a big portion of the doctors were worried about the liability situation.”

In recent months, at least five Palm Beach County neurosurgeons have halted their emergency room duties in protest of Florida’s high malpractice insurance rates.

In June, a Texas woman whose neck was fractured in a Palm Beach County auto accident waited six hours before orthopedic and neurosurgeons could be found to treat her.

Annual malpractice rates for Dade and Broward neurosurgeons average $150,420. Rates for neurosurgeons in all other counties average $102,339. In some other states, doctors pay a fifth as much or less.

In Broward and Dade, indigent patients without insurance generally are treated at public hospitals. Palm Beach County has two public hospitals that accept indigent patients — Glades General and Everglades Memorial in Pahokee — but neither has ever had a neurosurgeon on staff.

Arranged helicopter

Twice during Haynes’ ordeal, Glades doctors and county fire rescue officials tried to arrange helicopter transport for the woman.

A Palm Beach County sheriff’s helicopter was set to take the woman to Jackson Memorial Hospital, but officials at the Miami hospital refused to accept her. District fire chief Terry Croke said.

“We didn’t have any critical beds available,” Jackson Memorial spokesman Joyce Goldberg said.

“We don’t have the malpractice problem here because we’re self-insured.”

After Jackson’s refusal, Lee Memorial Hospital in Fort Myers was contacted. Because the county sheriff’s helicopter’s legal range is 100 miles, Croke called the Pentagon in Washington to arrange for an Air Force helicopter to transport Haynes.

“We don’t have the malpractice problem here because we’re self-insured.”

After Jackson’s refusal, Lee Memorial Hospital in Fort Myers was contacted. Because the county sheriff’s helicopter’s legal range is 100 miles, Croke called the Pentagon in Washington to arrange for an Air Force helicopter to transport Haynes.

“We don’t have the malpractice problem here because we’re self-insured.”

Hospital policy

The refusal was a matter of hospital policy. Lee Memorial spokesman Linda Moorey said.

“We don’t accept uninsured out-of-county patients,” Moorey said. “We restrict our acceptance of uninsured patients to Lee County residents.”

By law, no hospital or physician is obligated to accept every patient. It is time, Thomas said, for that rule to be changed.

“I’m not faulting the doctors because I can see where they’re coming from, but I’d like to see a rule making it mandatory for every hospital or doctor to accept any patient,” he said.

“If a hospital has the facility and the medical specialties necessary, they should, regardless of what, accept any patient.”

Herald staff writer Philip Wunstock contributed to this report.
Dumping ground for ID wrist bands of the 'dumped'... The ID wrist bracelets of 271 patients who had been transferred over a recent four-month period were presented to congressmen by Arthur L. Kellerman, MD, medical director of emergency services at the Regional Medical Center in Memphis, Tenn. Dr. Kellerman estimated that 1,100 such patients were transferred to the center's emergency room in the last year 'for primarily economic reasons.' U.S. Rep. Ted Weiss (right) deplored such practices, saying, 'The medical condition of the patient must be the primary consideration in deciding where treatment should take place.'

Patient 'dumping' problems explored at hearing

"A pregnant woman whose labor pains have begun knows she is about to give birth. She goes to the emergency room of a nearby private hospital. The emergency room intake staff interview her and ask her about her ability to pay and her insurance status.

"She is uninsured, and has no means to pay the hospital for delivering her baby. Preliminary tests that might have shown that her baby is in trouble are not done. The hospital staff refuse to admit her.

"After waiting three hours in the emergency room — in active labor — she prevails upon the hospital staff to send her by ambulance to the nearest public hospital. After she arrives at the public hospital, her baby is born... dead.

"According to the physician in the public hospital, had [the mother] received prompt attention, her baby's life could have been spared."

"It's called 'patient dumping,'" said Rep. Ted Weiss, (D, N.Y.), as he opened the July 22 hearing on the subject with this story, which he said happened recently in California.

"Patient dumping can take many forms," he said, "The most common is for economic reasons. It can be carried out by transferring a patient to another hospital, refusing to treat them, or subjecting them to long delays before the patient finally leaves."

TESTIFYING BEFORE the human resources and intergovernmental relations subcommittee of the House Committee on Government Operations, Rep. "Pete" Stark, said, "In 1985, U.S. hospitals provided $7.4 billion in uncompensated care. Virtually all of that care was given by our public and voluntary not-for-profit hospitals. While public hos-
Continued from page 2

Trials have allowed a few hospital beds, they provide 55% of all charity care."

"Many private hospitals dump patients on public hospitals after conducting a 'wallet bonus' and discovering that they cannot pay for treatment," Weiss said. "The medical condition of the patient must be the primary consideration in deciding where treatment should take place."

There are several federal laws designed to curtail inappropriate patient transfer. The Hill-Burton Act requires hospitals built with Hill-Burton funds to provide emergency care to all who reside within the hospital's service area. The Emergency Medical Treatment and Labor Act mandates that patients have the right to emergency care regardless of insurance status. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is supposed to prevent hospitals from transferring medically unstable patients.

"But because patients do not know of such legislation, or because of political reasons (for example, hospitals that were "dumped upon" may be reluctant to file a claim against the dumping hospital, because it needs its support in a community venture), or because of confusion about some of the laws, large numbers of patients are receiving services only incidentally and are not allowed to call the laws enacted for their protection.

"Most of the witnesses at the July 22 hearing agreed that there should be some mechanism whereby patients were informed of laws enacted to protect them from discriminatory activity, and that some of the language in the laws—"for example, the COBRA provision that一般人 'stabilized' patients to be transferred—should be tightened, to provide for clearer direction and better enforcement in that way, one can avoid the dilemma referred to by Judith G. Waxman of the National Health Law Program: "One person's 'stabilized' is another person's 'dumped.'"

She told the subcommittees that "the only way to make patient dumping stop is to guarantee that hospitals will get reimbursement for every individual who comes to them for their facility as if it were own care," she said. "We need more enforcement of the law to give hospitals more leverage in the court of public opinion, in their own defense, the patients' defense and the hospitals' defense." She added that it was not enough to pass laws that would protect patients but that "we need enforcement to make the laws work, to force the hospital to keep its promises." She also called for better regulations governing the treatment of patients who are transferred to other hospitals.

"We must make sure that patients are treated as they deserve," she said. "We must make sure that hospitals do not profit from the mistakes of others.

"We have all seen the situation where a patient is transferred to another hospital but the transfer is not honored. This can lead to serious problems, including confusion, delays in treatment and even death. We need to make sure that hospitals are held accountable for these actions."

Arnold S. Reisman, M.D., editor of The New England Journal of Medicine, testified that a national tax "will have to replace the charity and cross-subsidization which formerly dealt with the problem of patient dumping, however inadequately." He also said that if a patient is not treated because of lack of insurance, "I'll get sick," he said, "my chances were better of getting a $59 flight to London than of getting to the emergency room.

"One person's "stabilized" is another person's "dumped,"" says Judith G. Waxman of the National Health Law Program.

"The only sure way to end patient dumping is to guarantee that hospitals will get reimbursement for every individual who comes to them for their facility needing care or to provide every American with health care coverage.

The language of the law prohibited him from taking this intermediate step, he said, creating a "circuitous" problem in which patients could be cut off. Both suggestions were approved by the House Ways and Means Committee July 27.

TO DATE, a Medicare termination notice was filed against Brookside Hospital in San Pablo, Calif., March 28 of this year, but it was rescinded April 10 after a subsequent site survey determined that it had corrected its deficiencies. The Inspector General of the Office is reviewing the case to determine whether to impose monetary penalties, said department spokeswoman Judy Stroyny.

A termination notice also was filed against the U. of Chicago Hospitals on July 20 for its participation in patient dumping activities.

Chesley Stroyny, HCFA acting regional administrator in Chicago, said that the situation had corrected its violations and had been notified July 27 that its termination was rescinded. The case also had been referred to Kusserow's office for review.

"We're handcuffed," Kusserow, when chewed out by Subcommittee Chairman Weiss for not punishing more violators, told him he needed changes in the law to give his office more enforcement power.

"WE'RE HANDCUFFED," Kusserow said, and asked Congress to increase the maximum allowable fine his office could impose on offenders to $50,000 from $25,000.

"The government shouldn't spend more money than the [violators] pay in fines," he said.

"Additionally, Kusserow noted that although the Health Care Financing Administration (HCFA) had the power to "terminate" violations from participation in the Medicare program, his office needed the authority to "suspend" them from such participation for a definite period of time.

The government of the Netherlands is tightening its generally lass-lax attitude toward smoking in favor of a new anti-smoking stance, the Associated Press reported.

Month a stiffer warning will begin appearing on tobacco packaging, reading "Smoking damages your health. It can cause lung cancer and heart disease."
The previous warning merely stated "Smoking threatens your health."

The Netherlands government also is preparing legislation to cut smoking in public buildings.

"The Netherlands government has now presented one of the highest smoking rates in Europe. Four million people—38% of the adult population—smoked an average of 21 cigarettes a day last year. That rate is equal to the average percentage of smokers, and it is topped in Western Europe only by Spain, where 41% of adults smoke.

According to the Associated Press, tobacco is very much the social drug of choice among the Dutch. The nation's famed dandy "brown calses" get both their name and their hue from their cigarette smoking patrons, and cigarette smoking is still considered a badge of maturity among Dutch youth.

"While tobacco ads are banned on state-financed Dutch television, movie houses are allowed to run pre-feature tobacco spots that imply a connection between specific brands and romantic and adventurous lifestyles.

"The doctor said the whole family has to watch Dddy's cholesterol. I wonder what channel it's on..."
BILL #: PCB HC 88-11

RELATING TO: trauma systems

SPONSOR(S): Committee on Health Care

EFFECTIVE DATE: July 1, 1988 or upon becoming a law

COMPANION BILL(S): Senate Bill 598

OTHER COMMITTEES OF REFERENCE: (1) ________________________________

(2) ________________________________

I. SUMMARY:

A. PRESENT SITUATION:

Section 395.031, F.S., establishes procedures for verification of hospital trauma centers by the Department of Health and Rehabilitative Services (HRS) or a local or regional trauma agency if delegated to by the department. Any hospital wishing to be verified as a trauma center is required to apply, be reviewed, and meet standards as a trauma center by level of care capability. The law further prohibits any hospital or other facility from holding itself out as a trauma center unless it has made application and been verified as having met certain standards.

The legislation establishing trauma center verification procedures was first enacted in 1982. Its purpose was to develop a network of trauma centers throughout the state so that victims of trauma would receive the best possible medical care, thus reducing the possibility of permanent disability or death. A trauma victim is defined as a person who has incurred a single or multi-system life threatening injury due to blunt or penetrating means.

Chapter 87-399, Laws of Florida, modified Florida's verification system to create a bifurcated trauma planning and verification system. Local or regional trauma systems agencies (single- or multi-county) may be established by a local initiative. These local agencies are responsible for developing and implementing trauma systems. In addition, HRS may delegate to them the trauma center verification process. HRS must approve all local or regional trauma plans. In those geographic areas of the state without local or regional trauma agencies, HRS must develop trauma plans and verify hospital trauma centers based on population and geographic factors.

The law also requires each emergency medical services (EMS) provider to transport a trauma victim to the most appropriate trauma center based on a trauma scorecard and transport protocol. It also requires
HRS to establish a trauma registry so that the outcome of trauma treatment can be routinely assessed.

B. EFFECT OF PROPOSED CHANGES:

The changes provided for in this bill generally correct or clarify the existing "glitches" in the law. In addition, it requires the local or regional trauma agencies (instead of merely giving them an option), to implement the local plan, unless the department determines the plan is not effective or the agency submits to the department written notice of its intent to cease implementation of the local plan.

The bill changes the responsibility of the Department of Health and Rehabilitative Services by requiring it to establish state trauma regions for the purpose of analysis, planning and coordination, regardless of whether a local or regional agency exists in the given area. The local or regional trauma agencies may be established independently, and are not restricted or bound by the geographic boundaries established by the department. The bill deletes duplicative language relating to the state's role in establishing trauma regions, and clarifies language allowing trauma agencies to contract with verified trauma centers.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 320.0801 relating to additional license tax on certain vehicles. Deletes language relating to revenues collected from the tax to be used to cover the cost of contracting with local or regional trauma agencies. Earlier versions of chapter 87-399, Laws of Florida, included funds for the state to contract with local or regional agencies and is no longer applicable under current law.

Section 2. Amends s. 395.031, F.S., relating to trauma medical services systems plans and verification of trauma centers and pediatric trauma referral centers. Clarifies in the definition of trauma center that a trauma center can be determined by the Department of Health and Rehabilitative Services or a local or regional trauma agency. Requires local or regional trauma agencies to implement trauma plans unless the department determines the plan does not meet the needs of the person served or unless the local or regional agency gives the department written notice of its intent to cease implementation of the plan. Inserts "pediatric referral center" in paragraphs in which it had inadvertently been omitted in the original act. Clarifies language which allows local or regional trauma agencies to enter into contracts for the purpose of implementing the local plan. Deletes language which required only verified trauma centers which have a contract with a local or regional trauma agency to accept all trauma victims regardless of race, sex, creed or ability to pay, to require all verified centers to comply regardless of whether or not there is a contract. Requires local or regional trauma agency to submit written notice of its
intent, prior to ceasing operation of a local or regional trauma agency. Provides that hospitals which have been denied verification status as a trauma center have the right to a hearing under chapter 120, Florida Statutes. Changes the time for processing application renewals from 120 to 180 days.

Section 3. Amends s. 395.032, F.S., relating to state regional trauma planning. Requires the department to establish trauma regions for the purpose of providing planning and coordination to ensure adequate trauma care throughout the state. Allows local or regional trauma agencies to be established without regard to regional boundaries established by the department. Deletes duplicative language found in s. 395.031, F.S., relating to the department's authority to set standards for verification of trauma centers and verify trauma centers. Deletes duplicative language relating to hospitals renewal process; requirements of hospitals verified as trauma centers to accept all appropriate trauma victims; and non-verified hospitals holding themselves out as trauma centers.

Section 4. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

This bill should not have any fiscal consequences.

III. LONG RANGE CONSEQUENCES:

To the extent this legislation will improve access to necessary and appropriate emergency health services for Floridians, it is consistent with the state comprehensive plan. Requiring the department to plan for trauma regions on a statewide basis, rather than only for areas without local or regional trauma agencies, should provide a more complete picture of the state's needs. The current law puts the state in the position of having to plan "all around" the local regions. Trauma Centers may play a larger role geographically than the local plan calls for and the bill allows the department to plan on a larger scale and coordinate existing local or regional plans with efforts of the department to establish plans where there is no local or regional trauma agency.

IV. COMMENTS:

None

V. AMENDMENTS:

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Cathie Herndon  Staff Director: Michael P. Hansen

[Signature] [Signature]
The following is a list of major issues for consideration by the Committee on Health Care for the 1988 Session: UPDATED 3/4/88

I. SUBCOMMITTEE ON HEALTH FINANCING

A. Indigent Care:

1. Sunset review of Medically Needy Program. (probably keep but could be eliminated and funds used to fund elderly and disabled to 100% of FP.)

2. Hospital redistribution (develop funding options using up to $70 million from PMATF.)

3. Medicaid physician fee increases (Pursue this issue as a GR funded item, cost = $23 m).

4. Additional primary care funding (yes, another $10 million to cover remaining counties in the state - PMATF funded).

5. Demo projects -- Should funding be continued?

6. Should additional SOBRA Medicaid enhancements be enacted? How about extending LOS beyond 45 days for neonates? (Yes to the 45 day issue, fund from RPICC money. Develop cost options for SOBRA.)

B. Tax Exempt Status for Voluntary Hospitals:

1. Should we pursue this issue legislatively or allow the Department of Revenue to handle it through administrative rule making? (Add to this issue the concept of exempting proprietary hospitals from taxes if they do a specified level of indigent care)

C. Trauma Care:

1. HCCB trauma study.

2. Revisions to last year's bill.

D. HCCB Sunset Review:

1. Develop options for budget review, board membership, and placement in an exec agency.

E. Child Health Care:

1. Are their funds available to pursue this issue again this year?

F. Special Tax District Issue

1. Run in subcommittee first week
II. SUBCOMMITTEE ON HEALTH REGULATION

A. AIDS:
1. Education of health care professionals.
2. Education to other members of the public.
3. Testing, counseling and confidentiality.
5. Treatment and research.
6. Public health and criminal justice measures.
7. Insurance.
8. Run bill in task force and sub first week, go to full second week.

B. Emergency Care by Hospitals:
1. Is existing legislation sufficient to ensure all patients access to emergency care?
2. Is HRS adequately enforcing these laws?
3. How do we ensure adequate transfer facilities are available but avoid dumping?
4. How will the Medical Malpractice bill affect the provision of emergency care services?

C. Cardiac Catheterization:
1. How can we move the cardiac cath bill through the process? Should it be linked to the indigent care bill?
2. Take bill up in sub on 3/9

D. HMOs:
1. HMO Guaranty Fund -- How do we protect Medicare subscribers?
2. Take bill up in sub 3/9

III. SUBCOMMITTEE ON HEALTH PRACTICES

A. Rural Hospital Issue:
1. What can be done to help rural hospitals?
2. Should swing beds be Medicaid funded?

B. Health Manpower:
1. Nursing shortage issues: PCB for HCCB to do a study.
2. Revise bill so that study is done by USF. Notice bill for hearing in sub on first week.
C. Teaching Hospital Study:
   1. What should the state's role be in supporting teaching hospitals?

D. Psychiatric Hospital Services:
   1. Should psych hospitals be eligible to receive Medicaid funding?
   2. Schedule issue for hearing on first week.

E. State Employee Health Insurance Plan
   1. Meet with Carl Ogden to get Department's position.
PCB HC 88-11
TRAUMA SYSTEMS

Clarifies and corrects existing "glitches" in the current law relating to trauma systems.

Clarifies that HRS and, if the department delegates the authority, a local or regional trauma agency can verify a hospital as a trauma center.

Requires local or regional agencies to implement trauma plans unless the local or regional agency gives the department written notice of its intent to cease implementation of the plan.

Clarifies language that requires all verified trauma centers to accept all trauma victims regardless of race, sex, creed or ability to pay.

Requires local or regional trauma agencies to submit written notice of its intent to cease operations of a local or regional trauma agency.

Changes the time for processing application renewals from 120 to 180 days.

Provides that hospitals which have been denied verification status as a trauma center have the right to a hearing under chapter 120, Florida Statutes.
April 11, 1988

A bill to be entitled An act relating to trauma care systems;
amending s. 320.0801, F.S.; specifying uses of revenues in the Emergency Medical Services Trust Fund; amending s. 395.031, F.S.; amending trauma center definition; requiring local or regional trauma agencies to implement trauma plans; specifying standards for evaluating medical services systems; providing exemptions; adding pediatric referral centers to hospitals which can be verified; clarifying language relating to contracting; requiring notice when local or regional trauma agency ceases operation; requiring department to notify hospitals of rights to a hearing; extending the time frame for application renewals; amending s. 395.032, F.S.; requiring the department to establish trauma regions for purposes of planning and coordination; allowing local or regional agencies to be established without regard to boundaries set by department; deleting duplicative language relating to the department's authority to establish standards and verify trauma centers; deleting duplicative language relating to hospital's responsibilities if verified as trauma center; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

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Section 1. Section 320.0801, Florida Statutes, is amended to read:

320.0801 Additional license tax on certain vehicles.-- In addition to the license taxes specified in s. 320.08, there is hereby levied and imposed an annual license tax of 10 cents for the operation of a motor vehicle, as defined in s. 320.01, and moped, as defined in s. 316.003(77), which tax shall be paid to the department or its agent upon the registration or renewal of registration of the vehicle. Notwithstanding the provisions of s. 320.20, revenues collected from the tax imposed in this section shall be deposited in the Emergency Medical Services Trust Fund created in s. 401.34(4) and used solely for the purpose of carrying out the provisions of ss. 395.031, 395.032, 395.035, and 395.036 and section 11 of Chapter 87-399, Laws of Florida this act.--including the cost of contracting with local or regional trauma agencies.

Section 2. Section 395.031, Florida Statutes, is amended to read:

395.031 Trauma medical services system plans; verification of trauma centers and pediatric trauma referral centers; procedures; renewal.-- (1) For the purposes of this section, the term:

(a) "Department" means the Department of Health and Rehabilitative Services.

(b) "Local or regional trauma agency" means an agency established and operated by the county, an entity with which the county contracts for the purposes of local trauma medical services administration, or a regional agency created for the administration of trauma medical services by agreement between counties.

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(c) "Trauma center" means any hospital that has been determined by the department or by a local or regional trauma agency to be in substantial compliance with trauma center verification standards.

(d) "Pediatric trauma referral center" means a hospital that is determined to be in substantial compliance with pediatric trauma referral center standards as established by rule of the department pursuant to subsection (5).

(e) "Trauma scorecard" means a statewide methodology adopted by the department by rule under which a trauma victim is graded as to the severity of his injuries or illness and which methodology is used as the basis for making destination decisions.

(f) "Trauma victim" means any person who has incurred a single or multisystem life-threatening injury due to blunt or penetrating means and who requires immediate medical intervention or treatment.

(2)(a) The local or regional trauma agency shall plan, implement, and evaluate a trauma medical services system, in accordance with this section and ss. 395.032, 395.035 and 395.036, which consists of an organized pattern of readiness and response services based on public and private agreements and operational procedures.

(b) The local or regional trauma agency shall develop and submit to the department for review a plan for a local or regional trauma medical services system. The plan must include, at a minimum, the following components:

1. The organizational structure of the trauma system.
2. Prehospital care management guidelines for triage and transportation of trauma cases.

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3. Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.

4. The number and type of major trauma cases necessary to assure that trauma centers will provide quality care to trauma cases referred to them.

5. The resources and equipment needed by trauma facilities to treat trauma cases.

6. The availability and qualifications of the health care personnel, including physicians and surgeons, who comprise the trauma teams that treat major trauma cases within a trauma facility.

7. Data collection regarding system operation and patient outcome.

8. Periodic performance evaluation of the trauma system and its components.

9. The utilization of air transport services within the jurisdiction of the local trauma agency.

10. Public information and education about the trauma system.

11. Emergency medical services communication system usage and dispatching.

12. The coordination and integration between the verified trauma care facility and the nonverified health care facilities.

13. Medical control and accountability.

14. Quality control and system evaluation.

(c) The department shall receive plans for the implementation of trauma care systems from local or regional trauma agencies. The department may approve or not approve
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the local or regional plans based on the conformance of the
local or regional plans with this section and ss. 395.032,
395.035 and 395.036 act and the rules adopted by the
department pursuant to those sections this act. A local or
regional trauma agency shall may implement the local plan
developed pursuant to this section act unless the department
determines that the plan does not effectively meet the needs
of the persons served and is not consistent with applicable
rules of the department, or the local or regional trauma
agency submits to the department written notice of intent to
cease implementation of the local plan.

(d) The department may grant an exception to a portion
of the rules adopted pursuant to this section or s. 395.032
act if the local or regional trauma agency proves that, as
defined in the rules, compliance with that requirement would
not be in the best interest of the persons served within the
affected local trauma area.

(e) A local or regional trauma agency may implement a
trauma care system only if the system meets the minimum
standards set forth in the rules for implementation
established by the department and if the plan has been
submitted to, and approved by, the department. Before the
local or regional trauma agency submits the plan for the
trauma care system to the department, the agency shall hold a
public hearing and give adequate notice of the public meeting
to all hospitals and other interested parties in the area
proposed to be included in the system.

(f)1. At the option of a local or regional trauma
agency which is implementing a trauma care system approved by
the department, the department may delegate to the local or

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1] regional trauma agency the hospital trauma center and
2] pediatric referral center verification process within the
3] geographic boundaries of the local or regional trauma agency.
4] 2. For those local or regional trauma agencies
5] selecting to verify hospital trauma centers and pediatric
6] referral centers, the direct or indirect cost of verification
7] shall be borne by the applicant, based on a fee schedule set
8] up by the local or regional trauma agency; however, a fee may
9] not exceed the reasonable cost of implementation, operation,
10] maintenance, evaluation, and development of the verification
11] process.
12] (g) Local or regional trauma agencies may enter into
13] contracts for the purpose of implementation of the local plan.
14] If local or regional agencies contract with hospitals, such
15] agencies shall contract only with hospitals with verified
16] trauma centers or those willing to seek verification.
17] (h) Local or regional trauma agencies providing
18] service for more than one county shall, as part of their
19] formation, establish interlocal agreements between or among
20] the several counties in the regional system.
21] (i) This section does not restrict the authority of a
22] health care facility to provide service for which it has
23] received a license pursuant to this chapter.
24] (j) Any hospital which is verified as a trauma center
25] shall accept all trauma victims that are appropriate for the
26] facility regardless of race, sex, creed, or ability to pay.
27] (k) It is unlawful for any hospital or other facility
28] to hold itself out as a trauma center unless it has been so
29] verified.

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(1) A county, upon the recommendations of the local or regional trauma agency, may adopt ordinances governing the transport of a patient who is receiving care in the field from prehospital emergency medical personnel, when the patient meets specific criteria for trauma, burn, or pediatric centers adopted by the local or regional trauma agency. These ordinances shall, to the furthest possible extent, ensure that individual patients receive appropriate medical care while protecting the interests of the community at large by making maximum use of available emergency medical care resources.

(m) The local or regional trauma agency shall, consistent with such plan, coordinate and otherwise facilitate arrangements necessary to develop a trauma medical services system.

(n) After the submission of the initial trauma care system plan, a local or regional trauma agency which has implemented a trauma care system shall annually submit to the department an updated plan which identifies the changes, if any, to be made in the trauma care system. A local or regional trauma agency shall submit to the department written notice of intent to cease operation of the local or regional trauma agency within 90 days of the date on which the local or regional trauma agency will cease operation.

(o) This section does not preclude a local or regional trauma agency from adopting trauma care system standards or trauma facilities standards that are more stringent than those adopted by rule of the department.

(3) Any hospital licensed in the state that desires to be verified as a trauma center or as a pediatric trauma referral center must submit to the department, or to the
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appropriate local or regional trauma agency, a request for verification as such a center. The request shall be reviewed by the department or the local or regional trauma agency to determine whether the hospital is in substantial compliance with the standards specified in subsection (5). Within 30 days after receiving a request from a hospital for verification as a trauma center or pediatric trauma referral center, the department or the local or regional trauma agency shall notify the hospital of any apparent errors or omissions in its application and shall request any additional information necessary to determine the hospital's substantial compliance with this section and department rules. This additional information must be submitted within 60 days after the hospital's receipt of the request for additional information. Upon receipt of the additional information from the hospital, the department or the local or regional trauma agency shall deem the application to be complete. An application must be approved or denied within 90 days after receipt of the original application or receipt of documentation that apparent errors or omissions have been corrected. Upon determining that the hospital is in substantial compliance with the standards, the hospital shall be verified as a trauma center or pediatric trauma referral center. If the application is denied by the department, the hospital shall be notified of any right to a hearing pursuant to chapter 120.

(4) A verification, unless sooner suspended or revoked, automatically expires 2 years from the date of issuance and is renewable biennially upon application for renewal, provided the hospital is in substantial compliance.

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with trauma center or pediatric trauma referral center verification standards in effect at the time of application. An application for renewal shall be processed in the same manner as prescribed for initial applications, except that the application must be made at least 180 days prior to expiration of the verification, on a form provided by the department or the appropriate local or regional trauma agency.

(5) The department shall adopt, by rule, standards for verification of trauma centers based on national guidelines, including those established by the American College of Surgeons, entitled "Hospital and Prehospital Resources for Optimal Care of the Injured Patient," and published appendices thereto. Standards specific to pediatric trauma referral centers shall also be adopted by rule of the department.

Section 3. Section 395.032, Florida Statutes, is amended to read:

395.032 State regional trauma planning; trauma regions.--

(1) The department shall may establish trauma regions for the purpose of providing planning and coordination to ensure adequate trauma care throughout the state. Local or regional trauma system agencies may be established without regard to the regional boundaries established by the department for the purpose of trauma analysis and planning, in those geographical areas where there are no department-approved local or regional trauma system agencies and plans and where the department determines there is need for organized trauma services for the residents of the geographical area. The department shall base its definition of the regions upon:

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(a) Geographical considerations so as to ensure rapid access to trauma care by patients;
(b) Historical patterns of patient referral and transfer in an area;
(c) Inventories of available trauma care resources;
(d) Predicted population growth characteristics;
(e) Transportation capabilities, including ground and air transport;
(f) Medically appropriate ground and air travel times;
and
(g) Other appropriate criteria.

(2) The department shall develop trauma systems plans for the department-defined trauma regions which include at a minimum, the following components:
(a) The organizational structure of the trauma system.
(b) Prehospital care management guidelines for triage and transportation of trauma cases.
(c) Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.
(d) The number and type of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.
(e) The resources and equipment needed by trauma facilities to treat trauma cases.
(f) The availability and qualifications of the health care personnel, including physicians and surgeons, who treat trauma cases within a trauma facility.
(g) Data collection regarding system operation and patient outcome.

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(h) Periodic performance evaluation of the trauma system and its components.

(i) The utilization of air transport services within the service region.

(j) Public information and education about the trauma system.

(k) Emergency medical services communication system usage and dispatching.

(l) The coordination and integration between the designated trauma care facility and the non-designated health care facilities.

(m) Medical control and accountability.

(n) Quality control and system evaluation.

(3) The department shall adopt, by rule, standards for the verification of trauma centers based on national guidelines, including those established by the American College of Surgeons, entitled "Hospitals and Prehospital Resources for Optimal Care of the Injured Patient," and published appendices thereto. The department shall also adopt by rule standards specific to pediatric trauma referral centers.

(4) In those geographical areas where the department determines the need for trauma services, any hospital that desires to be verified as a trauma center must submit to the department a request for verification as such center. The request shall be reviewed by the department to determine whether the hospital is in substantial compliance with the standards specified in subsection (3). Within 30 days after receiving a request from a hospital for verification as a trauma center, the department shall notify the hospital of any

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apparent-errors-or-omissions-in-its-application-and-shall
request-any-additional-information-necessary-to-enable-the
department-to-determine-the-hospital's-substantial-compliance
with-this-section-and-the-rules-of-the-department.—This
additional-information-must-be-submitted-to-the-department
within-60-days-after-receipt-of-the-request-from-the
department.—Any-application-must-be-approved-or-denied-within
90-days-after-receipt-of-the-original-application-or-receipt
of-documentation—that-apparent-errors-or-omissions-have-been
corrected.—Upon-determining-that-the-hospital—is-in
substantial-compliance-with-the-standards—the-department
shall-verify-the-hospital-as-a-trauma-center.;—if-the
department-denies-an-application,—the-hospital-must-be
notified-of-any-right-to-a-hearing-pursuant-to-chapter-128;
if-a-hospital—does—not-desire—to-contest—the-findings-of-the
department—but-continues-to-desire-to-be-verified-as-a-trauma
center,—the-hospital—shall-be-given-90-days-in-which-to-come
into-substantial-compliance-with-the-standards-specified-in
subsection-(3);—After-verification-of-compliance-with-those
standards—the-department—shall-verify-the-hospital—as-a
trauma-center.;

(5)—A-verification,—unless-sooner-suspended-or
revoked,—automatically-expires-two-years-after-the-date-of
issuance—and—is-renewable-biennially-upon-application-for
renewal—and-payment-of-the-fee-prescribed-in-the-rules-of-the
department,—if-the-hospital—is-in-substantial-compliance-with
trauma-center-verification-standards—in-effect-at-the-time-of
the-application.—An-application-for-renewal—shall-be
processed-in-the-manner-prescribed-for-initial-applications;
except-that-the-application-must-be-made-at-least-128-days

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prior-to-expiration-of-the-verification,-on-a-form-provided-by
the-department;

(6)--Any-hospital-which-is-verified-as-a-trauma-center
shall-accept-all-trauma-victims-that-are-appropriate-for-the
facility-regardless-of-race,-sex,-creed,-or-ability-to-pay;

(7)--It-is-unlawful-for-any-hospital-or-other-facility
to-hold-itself-out-as-a-trauma-center-unless-it-has-been-so
verified-under-this-section-by-the-department.

Section 4. This act shall take effect on July 1, 1988,
or upon becoming a law, whichever occurs later.

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A bill to be entitled
An act relating to trauma care systems;
amending s. 320.0801, F.S.; specifying uses of
revenues in the Emergency Medical Services
Trust Fund; amending s. 395.031, F.S.; amending
trauma center definition; requiring local or
regional trauma agencies to implement trauma
plans; specifying standards for evaluating
medical services systems; providing exemptions;
adding pediatric referral centers to hospitals
which can be verified; clarifying language
relating to contracting; requiring notice when
local or regional trauma agency ceases
operation; requiring department to notify
hospitals of rights to a hearing; extending the
time frame for application renewals; amending
s. 395.032, F.S.; requiring the department to
establish trauma regions for purposes of
planning and coordination; allowing local or
regional agencies to be established without
regard to boundaries set by department;
deleting duplicative language relating to the
department's authority to establish standards
and verify trauma centers; deleting duplicative
language relating to hospital's
responsibilities if verified as trauma center
amending s. 395.035, F.S.; requiring certain
hospitals to furnish trauma registry data;
providing a schedule for submission; requiring
submission of data on severe disabilities and

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head injuries; providing trauma registry
proceedings and providing that certain
proceedings, records, and reports are
confidential; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 320.0801, Florida Statutes, is
amended to read:

320.0801 Additional license tax on certain vehicles.--
In addition to the license taxes specified in s. 320.08, there
is hereby levied and imposed an annual license tax of 10 cents
for the operation of a motor vehicle, as defined in s. 320.01,
and moped, as defined in s. 316.003(77), which tax shall be
paid to the department or its agent upon the registration or
renewal of registration of the vehicle. Notwithstanding the
provisions of s. 320.20, revenues collected from the tax
imposed in this section shall be deposited in the Emergency
Medical Services Trust Fund created in s. 401.34(4) and used
solely for the purpose of carrying out the provisions of ss.
395.031, 395.032, 395.035, and 395.036 and section 11 of
Chapter 87-399, Laws of Florida this act; including the cost
cf-contracting-with-local-or-regional-trauma-agencies.

Section 2. Section 395.031, Florida Statutes, is
amended to read:

395.031 Trauma medical services system plans;
verification of trauma centers and pediatric trauma referral
centers; procedures; renewal.--

(1) For the purposes of this section, the term:

CODING: Words struck are deletions; words underlined are additions.
(a) "Department" means the Department of Health and
Rehabilitative Services.

(b) "Local or regional trauma agency" means an agency
established and operated by the county, an entity with which
the county contracts for the purposes of local trauma medical
services administration, or a regional agency created for the
administration of trauma medical services by agreement between
counties.

(c) "Trauma center" means any hospital that has been
determined by the department or by a local or regional trauma
agency to be in substantial compliance with trauma center
verification standards.

(d) "Pediatric trauma referral center" means a
hospital that is determined to be in substantial compliance
with pediatric trauma referral center standards as established
by rule of the department pursuant to subsection (5).

(e) "Trauma scorecard" means a statewide methodology
adopted by the department by rule under which a trauma victim
is graded as to the severity of his injuries or illness and
which methodology is used as the basis for making destination
decisions.

(f) "Trauma victim" means any person who has incurred
a single or multisystem life-threatening injury due to blunt
or penetrating means and who requires immediate medical
intervention or treatment.

(2)(a) The local or regional trauma agency shall plan,
implement, and evaluate a trauma medical services system, in
accordance with this section and ss. 395.032, 395.035 and
395.036 etc., which consists of an organized pattern of
readiness and response services based on public and private agreements and operational procedures.

(b) The local or regional trauma agency shall develop and submit to the department for review a plan for a local or regional trauma medical services system. The plan must include, at a minimum, the following components:

1. The organizational structure of the trauma system.
2. Prehospital care management guidelines for triage and transportation of trauma cases.
3. Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.
4. The number and type of major trauma cases necessary to assure that trauma centers will provide quality care to trauma cases referred to them.
5. The resources and equipment needed by trauma facilities to treat trauma cases.
6. The availability and qualifications of the health care personnel, including physicians and surgeons, who comprise the trauma teams that treat major trauma cases within a trauma facility.
7. Data collection regarding system operation and patient outcome.
8. Periodic performance evaluation of the trauma system and its components.
9. The utilization of air transport services within the jurisdiction of the local trauma agency.
10. Public information and education about the trauma system.

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11. Emergency medical services communication system usage and dispatching.

12. The coordination and integration between the verified trauma care facility and the nonverified health care facilities.

13. Medical control and accountability.

14. Quality control and system evaluation.

(c) The department shall receive plans for the implementation of trauma care systems from local or regional trauma agencies. The department may approve or not approve the local or regional plans based on the conformance of the local or regional plans with this section and ss. 395.032, 395.035 and 395.036 act and the rules adopted by the department pursuant to those sections this act. A local or regional trauma agency shall may implement the local plan developed pursuant to this section act unless the department determines that the plan does not effectively meet the needs of the persons served and is not consistent with applicable rules of the department, or the local or regional trauma agency submits to the department written notice of intent to cease implementation of the local plan.

(d) The department may grant an exception to a portion of the rules adopted pursuant to this section or s. 395.032 act if the local or regional trauma agency proves that, as defined in the rules, compliance with that requirement would not be in the best interest of the persons served within the affected local trauma area.

(e) A local or regional trauma agency may implement a trauma care system only if the system meets the minimum standards set forth in the rules for implementation.

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established by the department and if the plan has been submitted to, and approved by, the department. Before the local or regional trauma agency submits the plan for the trauma care system to the department, the agency shall hold a public hearing and give adequate notice of the public meeting to all hospitals and other interested parties in the area proposed to be included in the system.

(f) At the option of a local or regional trauma agency which is implementing a trauma care system approved by the department, the department may delegate to the local or regional trauma agency the hospital trauma center and pediatric referral center verification process within the geographic boundaries of the local or regional trauma agency.

2. For those local or regional trauma agencies selecting to verify hospital trauma centers and pediatric referral centers, the direct or indirect cost of verification shall be borne by the applicant, based on a fee schedule set up by the local or regional trauma agency; however, a fee may not exceed the reasonable cost of implementation, operation, maintenance, evaluation, and development of the verification process.

(g) Local or regional trauma agencies may enter into contracts for the purpose of implementation of the local plan. If local or regional agencies contract with hospitals, such agencies shall contract only with hospitals with verified trauma centers or those willing to seek verification.

(h) Local or regional trauma agencies providing service for more than one county shall, as part of their formation, establish interlocal agreements between or among the several counties in the regional system.

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(i) This section does not restrict the authority of a health care facility to provide service for which it has received a license pursuant to this chapter.

(j) Any hospital which is verified as a trauma center and has a contract with a local or regional trauma agency shall accept all trauma victims that are appropriate for the facility regardless of race, sex, creed, or ability to pay.

(k) It is unlawful for any hospital or other facility to hold itself out as a trauma center unless it has been so verified.

(l) A county, upon the recommendations of the local or regional trauma agency, may adopt ordinances governing the transport of a patient who is receiving care in the field from prehospital emergency medical personnel, when the patient meets specific criteria for trauma, burn, or pediatric centers adopted by the local or regional trauma agency. These ordinances shall, to the furthest possible extent, ensure that individual patients receive appropriate medical care while protecting the interests of the community at large by making maximum use of available emergency medical care resources.

(m) The local or regional trauma agency shall, consistent with such plan, coordinate and otherwise facilitate arrangements necessary to develop a trauma medical services system.

(n) After the submission of the initial trauma care system plan, a local or regional trauma agency which has implemented a trauma care system shall annually submit to the department an updated plan which identifies the changes, if any, to be made in the trauma care system. A local or regional trauma agency shall submit to the department written

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notice of intent to cease operation of the local or regional trauma agency within 90 days of the date on which the local or regional trauma agency will cease operation.

(o) This section does not preclude a local or regional trauma agency from adopting trauma care system standards or trauma facilities standards that are more stringent than those adopted by rule of the department.

(3) Any hospital licensed in the state that desires to be verified as a trauma center or as a pediatric trauma referral center must submit to the department, or to the appropriate local or regional trauma agency, a request for verification as such a center. The request shall be reviewed by the department or the local or regional trauma agency to determine whether the hospital is in substantial compliance with the standards specified in subsection (5). Within 30 days after receiving a request from a hospital for verification as a trauma center or pediatric trauma referral center, the department or the local or regional trauma agency shall notify the hospital of any apparent errors or omissions in its application and shall request any additional information necessary to determine the hospital's substantial compliance with this section and department rules. This additional information must be submitted within 60 days after the hospital's receipt of the request for additional information. Upon receipt of the additional information from the hospital, the department or the local or regional trauma agency shall deem the application to be complete. An application must be approved or denied within 90 days after receipt of the original application or receipt of documentation that apparent errors or omissions have been corrected.
corrected. Upon determining that the hospital is in substantial compliance with the standards, the hospital shall be verified as a trauma center or pediatric trauma referral center. If the application is denied by the department, the hospital shall must be notified of any right to a hearing pursuant to chapter 120.

(4) A verification, unless sooner suspended or revoked, automatically expires 2 years from the date of issuance and is renewable biennially upon application for renewal, provided the hospital is in substantial compliance with trauma center or pediatric trauma referral center verification standards in effect at the time of application. An application for renewal shall be processed in the same manner as prescribed for initial applications, except that the application must be made at least 180 days prior to expiration of the verification, on a form provided by the department or the appropriate local or regional trauma agency.

(5) The department shall adopt, by rule, standards for verification of trauma centers based on national guidelines, including those established by the American College of Surgeons, entitled "Hospital and Prehospital Resources for Optimal Care of the Injured Patient," and published appendices thereto. Standards specific to pediatric trauma referral centers shall also be adopted by rule of the department.

Section 3. Section 395.032, Florida Statutes, is amended to read:

395.032 State regional trauma planning; trauma regions.--

(1) The department shall may establish trauma regions for the purpose of providing planning and coordination to
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ensure adequate trauma care throughout the state. Local or regional trauma system agencies may be established without regard to the regional boundaries established by the department for the purpose of trauma analysis and planning, in those geographical areas where there are no department-approved local or regional trauma system agencies and plans and where the department determines there is need for organized trauma services for the residents of the geographical area. The department shall base its definition of the regions upon:

(a) Geographical considerations so as to ensure rapid access to trauma care by patients;

(b) Historical patterns of patient referral and transfer in an area;

(c) Inventories of available trauma care resources;

(d) Predicted population growth characteristics;

(e) Transportation capabilities, including ground and air transport;

(f) Medically appropriate ground and air travel times; and

(g) Other appropriate criteria.

(2) The department shall develop trauma systems plans for the department-defined trauma regions which include at a minimum, the following components:

(a) The organizational structure of the trauma system.

(b) Prehospital care management guidelines for triage and transportation of trauma cases.

(c) Flow patterns of trauma cases and transportation system design and resources, including air transportation services, and provision for interfacility transfer.

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(d) The number and type of trauma cases necessary to assure that trauma facilities will provide quality care to trauma cases referred to them.

(e) The resources and equipment needed by trauma facilities to treat trauma cases.

(f) The availability and qualifications of the health care personnel, including physicians and surgeons, who treat trauma cases within a trauma facility.

(g) Data collection regarding system operation and patient outcome.

(h) Periodic performance evaluation of the trauma system and its components.

(i) The utilization of air transport services within the service region.

(j) Public information and education about the trauma system.

(k) Emergency medical services communication system usage and dispatching.

(l) The coordination and integration between the designated trauma care facility and the non-designated health care facilities.

(m) Medical control and accountability.

(n) Quality control and system evaluation.

(C) The department shall adopt, by rule, standards for the verification of trauma centers based on national guidelines, including those established by the American College of Surgeons, entitled "Hospital and Prehospital Resources for Optimal Care of the Injured Patient," and published appendices thereto. The department shall also adopt

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By rule standards specific to pediatric trauma referral centers;

(4) in those geographical areas where the department determines the need for trauma services; any hospital that desires to be verified as a trauma center must submit to the department a request for verification as such center. The request shall be reviewed by the department to determine whether the hospital is in substantial compliance with the standards specified in subsection (3). Within 30 days after receiving a request from a hospital for verification as a trauma center, the department shall notify the hospital of any apparent errors or omissions in its application and shall request any additional information necessary to enable the department to determine the hospital's substantial compliance with this section and the rules of the department. This additional information must be submitted to the department within 60 days after receipt of the request from the department. Any application must be approved or denied within 90 days after receipt of the original application or receipt of documentation that apparent errors or omissions have been corrected. Upon determining that the hospital is in substantial compliance with the standards, the department shall verify the hospital as a trauma center. If the department denies an application, the hospital must be notified of any right to a hearing pursuant to chapter 120. If a hospital does not desire to contest the findings of the department but continues to desire to be verified as a trauma center, the hospital shall be given 90 days in which to come into substantial compliance with the standards specified in subsection (3). After verification of compliance with those

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standards; the department shall verify the hospital as a trauma center;

(5) A verification; unless sooner suspended or revoked; automatically expires 2 years after the date of issuance and is renewable biennially upon application for renewal and payment of the fee prescribed in the rules of the department; if the hospital is in substantial compliance with trauma center verification standards in effect at the time of the application; an application for renewal shall be processed in the manner prescribed for initial applications; except that the application must be made at least 120 days prior to expiration of the verification; on a form provided by the department.

(6) Any hospital which is verified as a trauma center shall accept all trauma victims that are appropriate for the facility regardless of race, sex, creed, or ability to pay.

(7) It is unlawful for any hospital or other facility to hold itself out as a trauma center unless it has been so verified under this section by the department.

Section 4. Section 395.035, Florida Statutes, is amended to read:

395.035 Review of trauma registry data; proceedings, records, and reports specified confidential. --

(1) Effective October 1, 1988, each trauma center shall furnish, and all acute care hospitals shall maintain, and allow for department review of, trauma registry data as prescribed by rule of the department for the purpose of monitoring patient outcome and ensuring compliance with the standards of verification. Acute care hospitals having three hundred beds or more shall furnish the department trauma

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registry data effective October 1, 1989. Acute care hospitals having less than three hundred beds shall furnish the department trauma registry data effective October 1, 1990. Notwithstanding the provisions of the above schedule, any acute care hospital may submit trauma registry data prior to the dates established in the above schedule.

(2) Notwithstanding the provisions of sections 413.38 and 413.612, each trauma center and acute care hospital shall submit severe disability and head injury registry data to the department as provided by rule in lieu of submitting such registry information to the Department of Labor and Employment Security. Each trauma center and acute care hospital shall continue to provide initial notification of severe disabilities and head injuries to the Department of Labor within time frames provided in chapter 413. Such initial notification shall be made in the manner prescribed by the Department of Labor and Employment Security for the purpose of providing timely vocational rehabilitation services to the severely disabled or head injured person. The schedule provided in paragraph (1) shall not apply to the current requirement for reporting of severe disabilities and head injuries, but shall apply only to the requirement for providing trauma registry information. Other hospitals may participate in the registry at their option.

(3) Patient care quality assurance proceedings, records, or reports made pursuant to this section or s. 119.07(3)(x), s. 395.017(3)(f), s. 395.031, or s. 395.032, act shall be held confidential within the hospital and the department and shall not be available to the public pursuant to s. 119.07 or any other law providing access to public

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records, or be discoverable or admissible in any civil or
administrative action. A person in attendance at such
proceedings may not be required to testify as to what
transpired at the meeting.

Section 5. This act shall take effect on October 1,
1988 or, upon becoming a law, whichever occurs
later.
I. SUMMARY:

A. PRESENT SITUATION:

Section 395.031, F.S., establishes procedures for verification of hospital trauma centers by the Department of Health and Rehabilitative Services (HRS) or a local or regional trauma agency if delegated to by the department. Any hospital wishing to be verified as a trauma center is required to apply, be reviewed, and meet standards as a trauma center by level of care capability. The law further prohibits any hospital or other facility from holding itself out as a trauma center unless it has made application and been verified as having met certain standards.

The legislation establishing trauma center verification procedures was first enacted in 1982. Its purpose was to develop a network of trauma centers throughout the state so that victims of trauma would receive the best possible medical care, thus reducing the possibility of permanent disability or death. A trauma victim is defined as a person who has incurred a single or multi-system life threatening injury due to blunt or penetrating means.

Chapter 87-399, Laws of Florida, modified Florida's verification system to create a bifurcated trauma planning and verification system. Local or regional trauma systems agencies (single- or multi-county) may be established by a local initiative. These local agencies are responsible for developing and implementing trauma systems. In addition, HRS may delegate to them the trauma center verification process. HRS must approve all local or regional trauma plans. In those geographic areas of the state without local or regional trauma agencies, HRS must develop trauma plans and verify hospital trauma centers based on population and geographic factors.

The law also requires each emergency medical services (EMS) provider to transport a trauma victim to the most appropriate trauma center based on a trauma scorecard and transport protocol. It also requires
HRS to establish a trauma registry so that the outcome of trauma treatment can be routinely assessed.

All hospitals are currently required to provide data to the Department of Labor and Employment Security on each severe disability (generally spinal cord injuries), and on each head injury for purposes of providing timely vocational rehabilitative services to the patient. There is no similar requirement that the data be reported to the trauma registry.

B. EFFECT OF PROPOSED CHANGES:

The changes provided for in this bill generally correct or clarify the existing "glitches" in the law. In addition, it requires the local or regional trauma agencies (instead of merely giving them an option), to implement the local plan, unless the department determines the plan is not effective or the agency submits to the department written notice of its intent to cease implementation of the local plan.

The bill changes the responsibility of the Department of Health and Rehabilitative Services by requiring it to establish state trauma regions for the purpose of analysis, planning and coordination, regardless of whether a local or regional agency exists in the given area. The local or regional trauma agencies may be established independently, and are not restricted or bound by the geographic boundaries established by the department. The bill deletes duplicative language relating to the state's role in establishing trauma regions, and clarifies language allowing trauma agencies to contract with verified trauma centers.

The bill would also require all acute care hospitals, in addition to all verified trauma centers, to report trauma data to the trauma registry through a phase-in, scheduled to be completed by October 1, 1990. Finally, the bill would require detailed data on spinal cord and head injury patients currently being reported to the Department of Labor and Employment Security to be reported to HRS. Hospitals would still be required to notify the Department of Labor and Employment Security of initial injury in order for the department to provide timely vocational rehabilitative services.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 320.0801 relating to additional license tax on certain vehicles. Deletes language relating to revenues collected from the tax to be used to cover the cost of contracting with local or regional trauma agencies. Earlier versions of chapter 87-399, Laws of Florida, included funds for the state to contract with local or regional agencies and is no longer applicable under current law.

Section 2. Amends s. 395.031, F.S., relating to trauma medical services systems plans and verification of trauma centers and pediatric trauma referral centers. Clarifies in the definition of trauma center that a trauma center can be determined by the Department of Health and Rehabilitative Services or a local or
regional trauma agency. Requires local or regional trauma agencies to implement trauma plans unless the department determines the plan does not meet the needs of the person served or unless the local or regional agency gives the department written notice of its intent to cease implementation of the plan. Inserts "pediatric referral center" in paragraphs in which it had inadvertently been omitted in the original act. Clarifies language which allows local or regional trauma agencies to enter into contracts for the purpose of implementing the local plan. Deletes language which required only verified trauma centers which have a contract with a local or regional trauma agency to accept all trauma victims regardless of race, sex, creed or ability to pay, to require all verified centers to comply regardless of whether or not there is a contract. Requires local or regional trauma agency to submit written notice of its intent, prior to ceasing operation of a local or regional trauma agency. Provides that hospitals which have been denied verification status as a trauma center have the right to a hearing under chapter 120, Florida Statutes. Changes the time for processing application renewals from 120 to 180 days.

Section 3. Amends s. 395.032, F.S., relating to state regional trauma planning. Requires the department to establish trauma regions for the purpose of providing planning and coordination to ensure adequate trauma care throughout the state. Allows local or regional trauma agencies to be established without regard to regional boundaries established by the department. Deletes duplicative language found in s. 395.031, F.S., relating to the department's authority to set standards for verification of trauma centers and verify trauma centers. Deletes duplicative language relating to hospitals renewal process; requirements of hospitals verified as trauma centers to accept all appropriate trauma victims; and non-verified hospitals holding themselves out as trauma centers.

Section 4. Amends s. 395.035, F.S., relating to trauma registry data. Requires all acute care hospitals, not just verified trauma centers, to report trauma data to the department. Provides a phase-in for reporting. Acute care hospitals with 300 beds or more shall furnish data beginning October 1, 1989, and all other acute care hospitals shall report effective October 1, 1990. Requires hospitals to submit severe disability and head injury registry data directly to HRS in lieu of submitting such registry data to the Department of Labor and Employment Security. Requires that hospitals still provide initial notification of such disabilities to the Department of Labor and Employment Security in order for the department to provide timely vocational rehabilitation services to severely disabled and head injury patients.

Section 5. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

This bill should not have any fiscal consequences.
III. **LONG RANGE CONSEQUENCES:**

To the extent this legislation will improve access to necessary and appropriate emergency health services for Floridians, it is consistent with the state comprehensive plan.

IV. **COMMENTS:**

Requiring the department to plan for trauma regions on a statewide basis, rather than only for areas without local or regional trauma agencies, should provide a more complete picture of the state's needs. The current law puts the state in the position of having to plan "all around" the local regions. Trauma Centers may play a larger role geographically than the local plan calls for and the bill allows the department to plan on a larger scale and coordinate existing local or regional plans with efforts of the department to establish plans where there is no local or regional trauma agency.

Currently all hospitals, regardless of whether they are verified trauma centers or not, are required to complete an eight page report on any severe disability or head injury to the Department of Labor and Employment Security for the purpose of identifying the need for potential vocational rehabilitative services. HRS proposes to simplify the reporting requirements of hospitals by designing a one page form which would capture the trauma registry information needed, as well as the disability and head injury data. HRS would then abstract information it receives from other sources available to it as part of the Emergency Medical Services Program, and provide the Department of Labor and Employment Security with the data it needs to complete its vocational rehabilitative program requirements.

V. **AMENDMENTS:**

VI. **SIGNATURES:**

SUBSTANTIVE COMMITTEE:
Prepared by: Cathie Herndon
Staff Director: Michael P. Hansen

FINANCE & TAXATION:
Prepared by: 
Staff Director: 

APPROPRIATIONS:
Prepared by: 
Staff Director:
The Committee on Health Care offered the following amendment:

Amendment

On page 15, line 5, after the period insert:

Section 5. Section 395.0142, Florida Statutes, is created to read:

395.0142 Access to emergency services and care.--

(1) LEGISLATIVE INTENT.--The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the department vigorously enforce the ability of persons to receive emergency services and care and to act in a thorough and timely manner against hospitals which deny persons emergency services and care.

(2) DEFINITIONS.--As used in this section:

(a) "Active labor" means a labor at a time at which:

1. There is inadequate time to effect safe transfer to another hospital prior to delivery; or

2. A transfer may pose a threat to the health and safety of the patient or the unborn child.

(b) "Department" means the Department of Health and Rehabilitative Services.
(c) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

(d) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(e) "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a hospital.

(3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.--

(a) Every hospital which has an emergency department shall provide emergency services and care for any emergency medical condition or for active labor when:

1. Any person requests emergency services and care; or
2. Emergency services and care are requested on behalf of a person by:
   a. An emergency medical services provider who is rendering care to or transporting the person; or

Submit original and five copies
Code: h0011/hc01
Date:
Time:
b. Another hospital, when such hospital is seeking a medically necessary transfer for a patient who has been stabilized, when such transfer meets the requirements of s. 395.0144 and applicable federal law.

(b) In no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(c) Neither the hospital nor its employees, nor any physician, dentist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, is not in active labor or that the hospital does not have the appropriate facilities or qualified personnel available to render those services.

(d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. No hospital as a condition of receiving a transfer of a person in need of emergency services and care may require the transferring hospital to guarantee payment for such person. However, the patient or his or her legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly, after the services are rendered.
(e) If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and in addition to meeting the requirements of s. 395.0143 shall direct the persons seeking emergency care to a nearby facility which can render the needed services, and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(4) POLICIES AND TRANSFER PROTOCOLS; DISCRIMINATION; FAILURE TO ADOPT POLICIES AND PROTOCOLS; SUBMISSION FOR APPROVAL.--

(a) As a condition of licensure, each hospital with an emergency department shall adopt, in consultation with the medical staff, policies and transfer protocols consistent with this section and rules adopted hereunder.

(b) As a condition of licensure, each hospital shall adopt a policy prohibiting discrimination in the provision of emergency services and care based on race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(c) As a condition of licensure, each hospital shall adopt a policy to ensure that sufficient number and qualified types of personnel and professional and occupational
disciplines are on duty and available at all times to provide emergency services and care.

(d) As a condition of licensure, each hospital shall require that physicians who serve on an "on-call" basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(e) As a condition of licensure, all hospitals shall inform all persons who arrive at a hospital requesting emergency services and care, or their representatives if any are present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care and of the person's ability to receive to emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subsection requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied, and notification of the person is not possible because of the person's physical or mental condition, and the hospital has made a reasonable effort to locate a representative. All hospitals shall prominently post a sign in their emergency rooms informing the public of the hospital's obligation to provide emergency services and care. Both the posted sign and written communication concerning any transfer or refusal to

Submit original and five copies
provide emergency services and care shall give the address of
the department as the government agency to contact in the
event the person wishes to complain about the hospital's
conduct.

(f) If a hospital does not adopt the policies and
protocols required in this subsection, the hospital, in
addition to suspension, denial or revocation of any of its
licenses, shall be subject to a fine not to exceed $1,000 each
day after expiration of 60 days' written notice from the
department that the hospital's policies or protocols required
by this section are inadequate, unless the delay is excused by
the department upon a showing of good and sufficient cause by
the hospital. The notice shall include a detailed statement
of the department's reasons for its determination and
suggested changes to the hospital's protocols which would be
acceptable to the department.

(g) Each hospital's policies and protocols required
pursuant to this subsection shall be submitted for approval to
the department within 90 days of the department's adoption of
rules pursuant to this section.

(5) RECORDS OF TRANSFERS; REPORT OF VIOLATIONS;
SUMMARY TO LEGISLATURE; PROCEEDINGS TO IMPOSE FINE.--

(a) All hospitals shall maintain records of each
transfer made or received for a period of 3 years.

(b) Any hospital employee, physician, other licensed
emergency room health care personnel, and certified
prehospital emergency personnel who know of an apparent
violation of this section or the rules adopted hereunder shall
report the apparent violation to the department on a form
prescribed by the department within 1 week following its
occurrence.
(c) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to, a physician or other personnel for reporting in good faith an apparent violation of this section or the rules adopted hereunder to the department, hospital, medical staff, or any other interested party or government agency.

(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to, a physician who refused to transfer a patient when the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the person.

(6) PENALTIES.--

(a) The department may deny, revoke, or suspend a license or impose an administrative fine, not to exceed $10,000 per violation, for the violation of any provision of this section or rules adopted hereunder.

(b) Any person who suffers personal harm as a result of a violation of this section or the rules adopted hereunder may recover, in a civil action against the responsible administrative or medical personnel, damages, reasonable attorneys' fees, and other appropriate relief.

(c) Any administrative or medical personnel who knowingly or intentionally violates any provision of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 6. The Department of Health and Rehabilitative Services shall establish and maintain an inventory of
hospitals with emergency departments. Included in the
inventory shall be a listing of all services by the hospital.
The department shall use the inventory to assist emergency
medical services providers and others in locating appropriate
emergency medical care. The inventory shall also be made
available to the general public. The department shall report
to the Legislature by March 1, 1989, the status of the
inventory.

Section 7. Section 395.0145, Florida Statutes, is
hereby repealed.

Renumber subsequent section
Florida House of Representatives
Jon Mills, Speaker
Committee on Health Care

Mike Abrams
Chairman
Lois Frankel
Vice Chairman

HEALTH CARE COMMITTEE

Full Committee
April 21, 1988
8:00 A.M. - 10:00 A.M.
317 Capitol

Ratification of bills to Subcommittee on Health Practices, Health Financing and Health Regulation

Consideration of:

1. PCB HC 88-08--Affordable Health Care Assurance Act (Indigent Care/HCCB) Discussion Only

2. PCB HC 88-10--State Group Insurance Program not taken up

3. PCB HC 88-01--Maternal and infant health FAV. 14-0

4. PCB HC 88-06--Shortage in the supply of registered nurses FAV. 14-0

5. PCB HC 88-09--Rural hospitals TPD

6. PCB HC 88-11--Trauma systems FAV. 14-0 w/5 amend.

7. PCB HC 88-12--Emergency care not taken up

Michael P. Hansen, Staff Director
18 House Office Building Tallahassee, Florida 32399-1300 (904) 488-7384
8. PCB HC 88-03--Certificate of Need regulation of cardiac catheterization services FAV. 12-2
   TAPE 1 SIDE A

9. HB 299 by Mackenzie & others--Smoking/Public Places FAV. 13/1
   TAPE 1 SIDE A

10. HB 406 by Tobin & others--Life-prolonging FAV. 11/3 AS C/S

11. HB 498 by Smith & others--Patient Records/Copying Fees TP'D

12. PCS/HB 598 by Gonzalez-Quevedo--Long-term Health Care/Master Report FAV. 8/5 AS C/S
    TAPE 1 SIDE B

13. HB 836 by Lawson & others--HMO Bids/DOA Authority Removed FAV 14-C AS C/S
    TAPE 1 SIDE A
Committee on Health Care

Meeting Date: 4/21/88  Time: 3:00  Bill No.: PCB 11
Place: 317C  Date Received

SUBCOMMITTEE ACTION RECORD:
Subcommittee on
---
- Favorable
- Favorable with amendments
- Favorable with Proposed Substitute
- Unfavorable
- Temporarily Passed

FULL COMMITTEE ACTION:
- Favorable
- Favorable with 5 Amendments
- Favorable with Committee Substitute
- Unfavorable
- Temporarily Passed
- Reconsidered
- Referred to Subcommittee
- Other Action:

Final Vote On Bill

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19 1830
Committee on Health Care

Meeting Date: 4/21/88  Place: 317 C

Bill No.  RSB 11  Date Reported:  

SUBCOMMITTEE ACTION RECORD:

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FULL COMMITTEE ACTION:

- Favorable
- Favorable with ___ Amendments
- Favorable with Committee Substitute
- Unfavorable
- Temporarily Passed
- Reconsidered
- Referred to Subcommittee

Other Action:

Final Vote On Bill

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APPEARANCE RECORD

Name: ____________________________
Representing: ______________________
Address: __________________________

H-83(1988)
I. SUMMARY:

This committee bill clarifies current law relating to the establishment of trauma systems plans, requires all hospitals to submit trauma registry data and establishes the responsibilities of providers regarding the provision of hospital emergency services and care.

A. PRESENT SITUATION:

Section 395.031, F.S., establishes procedures for verification of hospital trauma centers by the Department of Health and Rehabilitative Services (HRS) or a local or regional trauma agency if delegated to by the department. Any hospital wishing to be verified as a trauma center is required to apply, be reviewed, and meet standards as a trauma center by level of care capability. The law further prohibits any hospital or other facility from holding itself out as a trauma center unless it has made application and been verified as having met certain standards.

The legislation establishing trauma center verification procedures was first enacted in 1982. Its purpose was to develop a network of trauma centers throughout the state so that victims of trauma would receive the best possible medical care, thus reducing the possibility of permanent disability or death. A trauma victim is defined as a person who has incurred a single or multi-system life threatening injury due to blunt or penetrating means.

Chapter 87-399, Laws of Florida, modified Florida's verification system to create a bifurcated trauma planning and verification system. Local or regional trauma systems agencies (single- or multi-county) may be established by a local initiative. These local agencies are responsible for developing and implementing trauma systems. In addition, HRS may delegate to them the trauma center verification process. HRS must approve all local or
regional trauma plans. In those geographic areas of the state without local or regional trauma agencies, HRS must develop trauma plans and verify hospital trauma centers based on population and geographic factors.

The law also requires each emergency medical services (EMS) provider to transport a trauma victim to the most appropriate trauma center based on a trauma scorecard and transport protocol. It also requires HRS to establish a trauma registry so that the outcome of trauma treatment can be routinely assessed.

All hospitals are currently required to provide data to the Department of Labor and Employment Security on each severe disability (generally spinal cord injuries), and on each head injury for purposes of providing timely vocational rehabilitative services to the patient. There is no similar requirement that the data be reported to the trauma registry.

As to the actual provision of emergency care, testimony before both the Committee on Health Care and the Subcommittee on Health Regulation indicated that persons throughout the state have been denied emergency services and care by hospitals and physicians. Persons have been diverted from one hospital to another, been refused emergency care by a hospital and have been treated by one hospital but denied care by another hospital when the first hospital sought a medically necessary transfer.

The law regarding patients' access to emergency care is found in Florida and Federal statutes. Although there are several court decisions relating to treatment and transfer of indigent patients, on the specific issue of denial of emergency care the clearest legal direction is found in statutes and administrative rules.

A hospital's duty to treat persons seeking emergency services is found in ss. 395.0143, 395.0144, 395.0145 and 401.45, F.S. Also relevant is 395.005, F.S., relating to the Department of Health and Rehabilitative Services rulemaking and enforcement authority over hospitals.

Section 395.0143, F.S., requires all general hospitals and all specialty hospitals with an emergency room to treat any person for any emergency medical condition which will deteriorate from a failure to provide such treatment. A person has recourse for a hospital's refusal to provide emergency treatment only if in fact his or her condition deteriorates as a result of not being treated and reasonable care has not been exercised in the determination of the condition of the patient and the appropriateness of the facility and personnel to render needed treatment. Although the plain language of the statute speaks to a prohibition against denial of treatment for any emergency medical condition and therefore could apply to a hospital to accept a transfer, the Department of Health and Rehabilitative Services does not interpret this section accordingly.
Section 395.0144, F.S., requires any general (but not specialty) hospital which operates a full-time emergency room to admit any patient, regardless of economic criteria or indigency, upon the determination by a licensed staff physician that the patient should be admitted. If the physician responsible for emergency room service determines that the hospital is unable to render appropriate treatment, the hospital would be required to transfer the patient and all information relative to medical condition and history to an alternate hospital which has the facilities to treat the patient. This transfer could occur only after the physician has determined the patient's condition is stable enough for transfer. This section is silent as to whether the appropriate receiving hospital must agree to the transfer, although subsection (2) states that the first hospital shall "contact an appropriate receiving hospital and notify such hospital that the patient is in transit."

Finally in this series of emergency care sections, 395.0145, F.S., prohibits hospitals with emergency departments from requiring payment prior to rendering emergency medical care to a patient when the patient has shown evidence of adequate health insurance coverage. This section would appear to be superseded by the language in s. 395.0144, F.S., which prohibits refusal to admit based on economic criteria or indigency.

Regarding the rulemaking enforcement authority of the Department of Health and Rehabilitative Services, the Department is required by statute to adopt and enforce rules to ensure the compliance by hospitals to these aforementioned sections and to ensure that sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care and safety, s. 395.005(1)(a).

In addition to Florida law, Federal law requires evaluation and treatment of persons seeking emergency services. In a measure to prevent patient dumping, Section 9121 of the Consolidated Budget Reconciliation Act of 1986 (COBRA) states that patients who have not been stabilized cannot be transferred to another hospital without the receiving hospital agreeing to the transfer.

B. EFFECT OF PROPOSED CHANGES:

The changes provided for in this bill generally correct or clarify the existing "glitches" in the law relating to trauma system plans. In addition, it requires the local or regional trauma agencies (instead of merely giving them an option), to implement the local plan, unless the department determines the plan is not effective or the agency submits to the department written notice of its intent to cease implementation of the local plan.

The bill deletes duplicative language relating to the state's role in establishing trauma regions, and clarifies language allowing trauma agencies to contract with verified trauma centers.
The bill would also require all acute care hospitals, as well as all verified trauma centers, to report trauma data to the trauma registry through a phase-in, scheduled to be completed by October 1, 1990. In addition, the bill would require detailed data on spinal cord and head injury patients currently being reported to the Department of Labor and Employment Security to be reported to HRS. Hospitals would still be required to notify the Department of Labor and Employment Security of initial injury in order for the department to provide timely vocational rehabilitative services.

This committee bill also establishes the responsibilities for providers regarding the provision of hospital emergency services and care. The major provisions of this part of the bill include:

1) Providing needed definitions for emergency medical condition and emergency services and care.

2) Specifying the circumstances when emergency care and services must be provided. It prohibits discrimination in the provision of emergency care based on a person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status or ability to pay for medical services.

3) Placing, as a condition of licensure, certain requirements for hospitals regarding policies and transfer protocols including adequate staffing to ensure necessary and adequate patient care.

4) Requiring notification to the public by hospitals as to the obligation by hospitals to provide emergency care and complaint procedures for patients.

5) Strengthening the enforcement provisions of the Department of Health and Rehabilitative Services.

6) Requiring the Department of Health and Rehabilitative Services to establish, maintain and publish an inventory of hospitals with emergency departments.

C. SECTION-BY-SECTION ANALYSIS:

**Section 1.** Amends s. 320.0801 relating to additional license tax on certain vehicles. Deletes language relating to revenues collected from the tax to be used to cover the cost of contracting with local or regional trauma agencies. Earlier versions of chapter 87-399, Laws of Florida, included funds for the state to contract with local or regional agencies and is no longer applicable under current law.

**Section 2.** Amends s. 395.031, F.S., relating to trauma medical services systems plans and verification of trauma centers and pediatric trauma referral centers. Clarifies in the definition of trauma center that a trauma center can be determined by the Department of Health and Rehabilitative Services or a local or
regional trauma agency. Requires local or regional trauma agencies
to implement trauma plans unless the department determines the plan
does not meet the needs of the person served or unless the local or
regional agency gives the department written notice of its intent to
cease implementation of the plan. Inserts "pediatric referral
center" in paragraphs in which it had inadvertently been omitted in
the original act. Clarifies language which allows local or regional
trauma agencies to enter into contracts for the purpose of
implementing the local plan. Deletes language which required only
verified trauma centers which have a contract with a local or
regional trauma agency to accept all trauma victims regardless of
race, sex, creed or ability to pay, to require all verified centers
to comply regardless of whether or not there is a contract. Requires
local or regional trauma agency to submit written notice of its
intent, prior to ceasing operation of a local or regional trauma
agency. Provides that hospitals which have been denied verification
status as a trauma center have the right to a hearing under chapter
120, Florida Statutes. Changes the time for processing application
renewals from 120 to 180 days.

Section 3. Repeals subsections (3), (4), (5), (6), and (7) of
s. 395.032, F.S. Deletes duplicative language found in s. 395.031,
F.S., relating to the department's authority to set standards for
verification of trauma centers and verify trauma centers. Deletes
duplicative language relating to hospitals renewal process;
requirements of hospitals verified as trauma centers to accept all
appropriate trauma victims; and non-verified hospitals holding
themselves out as trauma centers.

Section 4. Amends s. 395.035, F.S., relating to trauma registry
data. Requires all acute care hospitals, not just verified trauma
centers, to report trauma data to the department. Provides a
phase-in for reporting. Acute care hospitals with 300 beds or more
shall furnish data beginning October 1, 1989, and all other acute
care hospitals shall report effective October 1, 1990. Requires
hospitals to submit severe disability and head injury registry data
directly to HRS in lieu of submitting such registry data to the
Department of Labor and Employment Security. Requires that hospitals
still provide initial notification of such disabilities to the
Department of Labor and Employment Security in order for the
department to provide timely vocational rehabilitation services to
severely disabled and head injury patients.

Section 5. Access to emergency service and care.

This section creates a new section in the hospital and ambulatory
surgical center licensure chapter. The section is composed of six
subsections as follows.

395.0142(1) Legislative intent.

This section creates a legislative finding as to the importance of
emergency service and care and recognizes that there have been
instances of the denial of such care. It also states the intent of
the Legislature for the Department of Health and Rehabilitative
Services to enforce the provisions of this law in a vigorous and timely manner.

395.0142(2) Definitions.

This section provides several needed definitions including active labor, emergency medical condition and emergency services and care. The first two are essentially the same as the Federal definitions enacted by COBRA. This section also provides a definition for stabilized which also is the same as found in federal law.

395.0142(3) Emergency service; discrimination; liability of health facility or health care personnel.

This section sets forth the requirements for the provision of emergency services and care. It seeks to correct the confusion present in the current law by stating when service and care must be given. It specifies who must provide it and who can request it. Any hospital with an emergency department must provide emergency service and care to anyone requesting it. This request may be by or on behalf of an individual including emergency medical personnel or a hospital which has stabilized the patient and seeks a medically necessary transfer. It also prohibits basing the care on a person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. It also provides immunity from liability for a hospital or provider when refusal to render emergency care is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or that the hospital does not have the appropriate facilities or qualified staff available. This latter provision tracks current law.

Also, this section prohibits conditioning the rendering of care based on ability to pay. But it does require payment, or providing information regarding payment, promptly after the services are rendered. Finally, this section requires health facilities without an emergency department to assist and direct patients in need of care.

395.0142(4) Policies and transfer protocols.

This section requires hospitals, as a condition of licensure, to adopt several policies and transfer protocols consistent with this proposed committee bill. This section requires hospitals to inform patients of their rights under this section including the posting of certain information regarding complaint procedures.

395.0142(5) Records of transfers; reports of violation; summary to Legislature.

This section imposes on hospitals certain recordkeeping requirements regarding transfers. It also specifies certain procedures for reporting violations and gives immunity for any reporting made by a physician or hospital personnel in good faith.
395.0142(7) Penalties.

This section increases the amount the Department of Health and Rehabilitative Services may fine a hospital from $500 to $10,000. This section also specifies that an aggrieved person may recover in a civil action against responsible parties, damages, reasonable attorney fees and other appropriate relief. It also provides a criminal penalty of a second degree misdemeanor for someone who knowingly or intentionally violates any provision of this section.

Section 6. Establishment of emergency departments inventory.

This section requires the Department of Health and Rehabilitative Services to establish and maintain an inventory of hospitals with emergency departments. This inventory shall be used to assist emergency medical service providers and hospitals and physicians in locating appropriate emergency medical care. The section requires this information to be made available to the public and by March 1, 1989, to the Legislature.

Section 7. Repeal of s. 395.0145, F.S.

This section repeals s. 395.0145, F.S., relating to the prohibition against requiring advance payment for emergency medical care. This section is superseded by this proposed committee bill.

Section 8. Effective date.

The effective date of this act is October 1, 1988.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

Sections 1-4 of this bill should not have any fiscal consequences.

Sections 5-7 of this bill should have the following fiscal consequences:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

The Office of Licensure and Certification of the Department of Health and Rehabilitative Services currently licenses and regulates hospitals. Part of its current responsibilities include investigating complaints regarding possible violations of state and federal law. Present licensure fees are intended to cover expenses related to licensure. Therefore, enforcement of this proposed committee bill should be covered under existing staffing responsibilities. However, to the extent enforcement of this act, as well as implementation of the emergency department inventory increases departmental workload, an increase in license fees may be necessary.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.
C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Requiring hospitals not only to treat persons in need of emergency care but also tightening transfer procedures will undoubtedly increase treatment expenses for hospitals. To the extent certain hospitals are now treating a disproportionate number of indigent or high risk patients while other hospitals are not, the requirement of this bill will have a tendency to level partially the playing field.

D. FISCAL COMMENTS:

None.

III. LONG RANGE CONSEQUENCES:

By enhancing the accessibility of patients to emergency care and increasing the quality of such care this committee bill is consistent with the health goals and policies of the State Comprehensive Plan which seek to ensure that necessary health services are available to all Floridians (s. 187.201(6)(a) and (b)2., F.S.).

IV. COMMENTS:

Currently all hospitals, regardless of whether they are verified trauma centers or not, are required to complete an eight page report on any severe disability or head injury to the Department of Labor and Employment Security for the purpose of identifying the need for potential vocational rehabilitative services. HRS proposes to simplify the reporting requirements of hospitals by designing a one page form which would capture the trauma registry information needed, as well as the disability and head injury data. HRS would then abstract information it receives from other sources available to it as part of the Emergency Medical Services Program, and provide the Department of Labor and Employment Security with the data it needs to complete its vocational rehabilitative program requirements.

V. AMENDMENTS:

None.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Cathie Herndon and Tom Cooper

Staff Director: Michael P. Hansen
The Senate bill incorporates the House language regarding:
1. Formation of state regions
2. HRS authority to regulate trauma centers and local regions
3. Emergency care language as agreed upon by interested parties

The Senate bill adds to the House bill:
1. Expands the terms of EMS advisory council members from two years to three years
2. Clarifies the definition of emergency care given by medical directors to include instructions given by the medical director in emergency situations
SENATE AMENDMENTS

- HRS authority to discipline trauma centers and withdraw authority or impose corrective actions on local agencies (conforms to House)

- Reinstates existing language re. state regions (conforms to House)

- Expands terms of EMS advisory council members from 2 years to 3 years

Incorporates House Emergency Care Language

Clarifies the definition of emergency care given my medical directors to include giving instructions re. emergency care
AS MANY OF YOU KNOW, PERSONS THROUGHOUT THE STATE HAVE BEEN DENIED EMERGENCY SERVICES AND CARE BY HOSPITALS AND PHYSICIANS. TESTIMONY BEFORE THE FULL COMMITTEE AND THE SUBCOMMITTEE ON HEALTH REGULATION INDICATED THAT PERSONS HAVE BEEN DIVERTED FROM ONE HOSPITAL TO ANOTHER, HAVE BEEN REFUSED EMERGENCY CARE BY A HOSPITAL AND HAVE BEEN TREATED BY ONE HOSPITAL BUT DENIED CARE BY ANOTHER HOSPITAL WHEN THE FIRST HOSPITAL SOUGHT A MEDICALLY NECESSARY TRANSFER.

THE THRUST OF THIS BILL IS TO ESTABLISH PROVISIONS GUARANTEING ACCESS TO EMERGENCY SERVICES AND CARE. THE MAJOR PROVISIONS OF THIS BILL:
1) PROVIDE NEEDED DEFINITIONS FOR EMERGENCY MEDICAL CONDITION AND EMERGENCY SERVICES AND CARE.

2) SPECIFY THE CIRCUMSTANCES WHEN EMERGENCY CARE AND SERVICES MUST BE PROVIDED. ANY HOSPITAL WITH AN EMERGENCY DEPARTMENT MUST PROVIDE EMERGENCY SERVICE AND CARE TO ANYONE REQUESTING IT. THIS REQUEST MAY BE BY OR ON BEHALF OF AN INDIVIDUAL INCLUDING EMERGENCY MEDICAL PERSONNEL OR A HOSPITAL WHICH HAS STABILIZED THE PATIENT AND SEEKS A MEDICALLY NECESSARY TRANSFER. IT ALSO PROHIBITS BASING THE CARE ON A PERSON'S RACE, ETHNICITY, RELIGION, NATIONAL ORIGIN, CITIZENSHIP, AGE, SEX, PRE-EXISTING MEDICAL CONDITION, PHYSICAL OR MENTAL HANDICAP, INSURANCE STATUS, ECONOMIC STATUS, OR ABILITY TO PAY FOR MEDICAL SERVICES.

3) STRENGTHENS THE ENFORCEMENT PROVISIONS OF THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES.
4) REQUIRES THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES TO ESTABLISH, MAINTAIN AND PUBLISH AN INVENTORY OF HOSPITALS WITH EMERGENCY DEPARTMENTS.
Amendment No. 1 (committee use only)  

The Committee on Health Care offered the following amendment:

Amendment

On page 13, between lines 9 and 10, insert a new section 4 to read:

Section 4. Section 395.035, Florida Statutes, is amended to read:

395.035 Review of trauma registry data; proceedings, records, and reports specified confidential.--

(1) Effective October 1, 1988, each trauma center shall furnish, and all acute care hospitals shall maintain, and allow for department review of, trauma registry data as prescribed by rule of the department for the purpose of monitoring patient outcome and ensuring compliance with the standards of verification. Acute care hospitals having three hundred beds or more shall furnish the department trauma registry data effective October 1, 1989. Acute care hospitals having less than three hundred beds shall furnish the department trauma registry data effective October 1, 1990.

Notwithstanding the provisions of the above schedule, any acute care hospital may submit trauma registry data prior to the dates established in the above schedule.

(2) Notwithstanding the provisions of sections 413.38 and 413.612, each trauma center and acute care hospital shall submit severe disability and head injury registry data to the
Department as provided by rule in lieu of submitting such registry information to the Department of Labor and Employment Security. Each trauma center and acute care hospital shall continue to provide initial notification of severe disabilities and head injuries to the Department of Labor within time frames provided in chapter 413. Such initial notification shall be made in the manner prescribed by the Department of Labor and Employment Security for the purpose of providing timely vocational rehabilitation services to the severely disabled or head injured person. The schedule provided in paragraph (1) shall not apply to the current requirement for reporting of severe disabilities and head injuries, but shall apply only to the requirement for providing trauma registry information. Other hospitals may participate in the registry at their option.

(3) Patient care quality assurance proceedings, records, or reports made pursuant to this section or s. 119.07(3)(x), s. 395.017(3)(f), s. 395.031, or s. 395.032, shall be held confidential within the hospital and the department and shall not be available to the public pursuant to s. 119.07 or any other law providing access to public records, or be discoverable or admissible in any civil or administrative action. A person in attendance at such proceedings may not be required to testify as to what transpired at the meeting.

Renumber subsequent sections
I. SUMMARY:

This committee bill clarifies current law relating to the establishment of trauma systems plans, requires all hospitals to submit trauma registry data and establishes the responsibilities of providers regarding the provision of hospital emergency services and care.

A. PRESENT SITUATION:

Section 395.031, F.S., establishes procedures for verification of hospital trauma centers by the Department of Health and Rehabilitative Services (HRS) or a local or regional trauma agency if delegated to by the department. Any hospital wishing to be verified as a trauma center is required to apply, be reviewed, and meet standards as a trauma center by level of care capability. The law further prohibits any hospital or other facility from holding itself out as a trauma center unless it has made application and been verified as having met certain standards.

The legislation establishing trauma center verification procedures was first enacted in 1982. Its purpose was to develop a network of trauma centers throughout the state so that victims of trauma would receive the best possible medical care, thus reducing the possibility of permanent disability or death. A trauma victim is defined as a person who has incurred a single or multi-system life threatening injury due to blunt or penetrating means.

Chapter 87-399, Laws of Florida, modified Florida's verification system to create a bifurcated trauma planning and verification system. Local or regional trauma systems agencies (single- or multi-county) may be established by a local initiative. These local agencies are responsible for developing and implementing trauma systems. In addition, HRS may delegate to them the trauma center verification process. HRS must approve all local or
regional trauma plans. In those geographic areas of the state without local or regional trauma agencies, HRS must develop trauma plans and verify hospital trauma centers based on population and geographic factors.

The law also requires each emergency medical services (EMS) provider to transport a trauma victim to the most appropriate trauma center based on a trauma scorecard and transport protocol. It also requires HRS to establish a trauma registry so that the outcome of trauma treatment can be routinely assessed.

All hospitals are currently required to provide data to the Department of Labor and Employment Security on each severe disability (generally spinal cord injuries), and on each head injury for purposes of providing timely vocational rehabilitative services to the patient. There is no similar requirement that the data be reported to the trauma registry.

As to the actual provision of emergency care, testimony before both the Committee on Health Care and the Subcommittee on Health Regulation indicated that persons throughout the state have been denied emergency services and care by hospitals and physicians. Persons have been diverted from one hospital to another, been refused emergency care by a hospital and have been treated by one hospital but denied care by another hospital when the first hospital sought a medically necessary transfer.

The law regarding patients' access to emergency care is found in Florida and Federal statutes. Although there are several court decisions relating to treatment and transfer of indigent patients, on the specific issue of denial of emergency care the clearest legal direction is found in statutes and administrative rules.

A hospital's duty to treat persons seeking emergency services is found in ss. 395.0143, 395.0144, 395.0145 and 401.45, F.S. Also relevant is 395.005, F.S., relating to the Department of Health and Rehabilitative Services rulemaking and enforcement authority over hospitals.

Section 395.0143, F.S., requires all general hospitals and all specialty hospitals with an emergency room to treat any person for any emergency medical condition which will deteriorate from a failure to provide such treatment. A person has recourse for a hospital's refusal to provide emergency treatment only if in fact his or her condition deteriorates as a result of not being treated and reasonable care has not been exercised in the determination of the condition of the patient and the appropriateness of the facility and personnel to render needed treatment. Although the plain language of the statute speaks to a prohibition against denial of treatment for any emergency medical condition and therefore could apply to a hospital to accept a transfer, the Department of Health and Rehabilitative Services does not interpret this section accordingly.
Section 395.0144, F.S., requires any general (but not specialty) hospital which operates a full-time emergency room to admit any patient, regardless of economic criteria or indigency, upon the determination by a licensed staff physician that the patient should be admitted. If the physician responsible for emergency room service determines that the hospital is unable to render appropriate treatment, the hospital would be required to transfer the patient and all information relative to medical condition and history to an alternate hospital which has the facilities to treat the patient. This transfer could occur only after the physician has determined the patient's condition is stable enough for transfer. This section is silent as to whether the appropriate receiving hospital must agree to the transfer, although subsection (2) states that the first hospital shall "contact an appropriate receiving hospital and notify such hospital that the patient is in transit."

Finally in this series of emergency care sections, 395.0145, F.S., prohibits hospitals with emergency departments from requiring payment prior to rendering emergency medical care to a patient when the patient has shown evidence of adequate health insurance coverage. This section would appear to be superseded by the language in s. 395.0144, F.S., which prohibits refusal to admit based on economic criteria or indigency.

Regarding the rulemaking enforcement authority of the Department of Health and Rehabilitative Services, the Department is required by statute to adopt and enforce rules to ensure the compliance by hospitals to these aforementioned sections and to ensure that sufficient numbers and qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care and safety, s. 395.005(1)(a).

In addition to Florida law, Federal law requires evaluation and treatment of persons seeking emergency services. In a measure to prevent patient dumping, Section 9121 of the Consolidated Budget Reconciliation Act of 1986 (COBRA) states that patients who have not been stabilized cannot be transferred to another hospital without the receiving hospital agreeing to the transfer.

B. EFFECT OF PROPOSED CHANGES:

The changes provided for in this bill generally correct or clarify the existing "glitches" in the law relating to trauma system plans. In addition, it requires the local or regional trauma agencies (instead of merely giving them an option), to implement the local plan, unless the department determines the plan is not effective or the agency submits to the department written notice of its intent to cease implementation of the local plan.

The bill deletes duplicative language relating to the state's role in establishing trauma regions, and clarifies language allowing trauma agencies to contract with verified trauma centers.
The bill would also require all acute care hospitals, as well as all verified trauma centers, to report trauma data to the trauma registry through a phase-in, scheduled to be completed by October 1, 1990. In addition, the bill would require detailed data on spinal cord and head injury patients currently being reported to the Department of Labor and Employment Security to be reported to HRS. Hospitals would still be required to notify the Department of Labor and Employment Security of initial injury in order for the department to provide timely vocational rehabilitative services.

This committee bill also establishes the responsibilities for providers regarding the provision of hospital emergency services and care. The major provisions of this part of the bill include:

1) Providing needed definitions for emergency medical condition and emergency services and care.

2) Specifying the circumstances when emergency care and services must be provided. It prohibits discrimination in the provision of emergency care based on a person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status or ability to pay for medical services.

3) Placing, as a condition of licensure, certain requirements for hospitals regarding policies and transfer protocols including adequate staffing to ensure necessary and adequate patient care.

4) Requiring notification to the public by hospitals as to the obligation by hospitals to provide emergency care and complaint procedures for patients.

5) Strengthening the enforcement provisions of the Department of Health and Rehabilitative Services.

6) Requiring the Department of Health and Rehabilitative Services to establish, maintain and publish an inventory of hospitals with emergency departments.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 320.0801 relating to additional license tax on certain vehicles. Deletes language relating to revenues collected from the tax to be used to cover the cost of contracting with local or regional trauma agencies. Earlier versions of chapter 87-399, Laws of Florida, included funds for the state to contract with local or regional agencies and is no longer applicable under current law.

Section 2. Amends s. 395.031, F.S., relating to trauma medical services systems plans and verification of trauma centers and pediatric trauma referral centers. Clarifies in the definition of trauma center that a trauma center can be determined by the Department of Health and Rehabilitative Services or a local or
regional trauma agency. Requires local or regional trauma agencies to implement trauma plans unless the department determines the plan does not meet the needs of the person served or unless the local or regional agency gives the department written notice of its intent to cease implementation of the plan. Inserts "pediatric referral center" in paragraphs in which it had inadvertently been omitted in the original act. Clarifies language which allows local or regional trauma agencies to enter into contracts for the purpose of implementing the local plan. Deletes language which required only verified trauma centers which have a contract with a local or regional trauma agency to accept all trauma victims regardless of race, sex, creed or ability to pay, to require all verified centers to comply regardless of whether or not there is a contract. Requires local or regional trauma agency to submit written notice of its intent, prior to ceasing operation of a local or regional trauma agency. Provides that hospitals which have been denied verification status as a trauma center have the right to a hearing under chapter 120, Florida Statutes. Changes the time for processing application renewals from 120 to 180 days.

Section 3. Repeals subsections (3), (4), (5), (6), and (7) of s. 395.032, F.S. Deletes duplicative language found in s. 395.031, F.S., relating to the department's authority to set standards for verification of trauma centers and verify trauma centers. Deletes duplicative language relating to hospitals renewal process; requirements of hospitals verified as trauma centers to accept all appropriate trauma victims; and non-verified hospitals holding themselves out as trauma centers.

Section 4. Amends s. 395.035, F.S., relating to trauma registry data. Requires all acute care hospitals, not just verified trauma centers, to report trauma data to the department. Provides a phase-in for reporting. Acute care hospitals with 300 beds or more shall furnish data beginning October 1, 1989, and all other acute care hospitals shall report effective October 1, 1990. Requires hospitals to submit severe disability and head injury registry data directly to HRS in lieu of submitting such registry data to the Department of Labor and Employment Security. Requires that hospitals still provide initial notification of such disabilities to the Department of Labor and Employment Security in order for the department to provide timely vocational rehabilitation services to severely disabled and head injury patients.

Section 5. Access to emergency service and care.

This section creates a new section in the hospital and ambulatory surgical center licensure chapter. The section is composed of six subsections as follows.

395.0142(1) Legislative intent.

This section creates a legislative finding as to the importance of emergency service and care and recognizes that there have been instances of the denial of such care. It also states the intent of the Legislature for the Department of Health and Rehabilitative
Services to enforce the provisions of this law in a vigorous and timely manner.

395.0142(2) Definitions.

This section provides several needed definitions including active labor, emergency medical condition and emergency services and care. The first two are essentially the same as the Federal definitions enacted by COBRA. This section also provides a definition for stabilized which also is the same as found in federal law.

395.0142(3) Emergency service; discrimination; liability of health facility or health care personnel.

This section sets forth the requirements for the provision of emergency services and care. It seeks to correct the confusion present in the current law by stating when service and care must be given. It specifies who must provide it and who can request it. Any hospital with an emergency department must provide emergency service and care to anyone requesting it. This request may be by or on behalf of an individual including emergency medical personnel or a hospital which has stabilized the patient and seeks a medically necessary transfer. It also prohibits basing the care on a person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. It also provides immunity from liability for a hospital or provider when refusal to render emergency care is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or that the hospital does not have the appropriate facilities or qualified staff available. This latter provision tracks current law.

Also, this section prohibits conditioning the rendering of care based on ability to pay. But it does require payment, or providing information regarding payment, promptly after the services are rendered. Finally, this section requires health facilities without an emergency department to assist and direct patients in need of care.

395.0142(4) Policies and transfer protocols.

This section requires hospitals, as a condition of licensure, to adopt several policies and transfer protocols consistent with this proposed committee bill. This section requires hospitals to inform patients of their rights under this section including the posting of certain information regarding complaint procedures.

395.0142(5) Records of transfers; reports of violation; summary to Legislature.

This section imposes on hospitals certain recordkeeping requirements regarding transfers. It also specifies certain procedures for reporting violations and gives immunity for any reporting made by a physician or hospital personnel in good faith.
395.0142(7). Penalties.

This section increases the amount the Department of Health and Rehabilitative Services may fine a hospital from $500 to $10,000. This section also specifies that an aggrieved person may recover in a civil action against responsible parties, damages, reasonable attorney fees and other appropriate relief. It also provides a criminal penalty of a second degree misdemeanor for someone who knowingly or intentionally violates any provision of this section.

Section 6. Establishment of emergency departments inventory.

This section requires the Department of Health and Rehabilitative Services to establish and maintain an inventory of hospitals with emergency departments. This inventory shall be used to assist emergency medical service providers and hospitals and physicians in locating appropriate emergency medical care. The section requires this information to be made available to the public and by March 1, 1989, to the Legislature.

Section 7. Repeal of s. 395.0145, F.S.

This section repeals s. 395.0145, F.S., relating to the prohibition against requiring advance payment for emergency medical care. This section is superseded by this proposed committee bill.

Section 8. Effective date.

The effective date of this act is October 1, 1988.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

Sections 1-4 of this bill should not have any fiscal consequences.

Sections 5-7 of this bill should have the following fiscal consequences:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

The Office of Licensure and Certification of the Department of Health and Rehabilitative Services currently licenses and regulates hospitals. Part of its current responsibilities include investigating complaints regarding possible violations of state and federal law. Present licensure fees are intended to cover expenses related to licensure. Therefore, enforcement of this proposed committee bill should be covered under existing staffing responsibilities. However, to the extent enforcement of this act, as well as implementation of the emergency department inventory increases departmental workload, an increase in license fees may be necessary.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

None.
C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Requiring hospitals not only to treat persons in need of emergency care but also tightening transfer procedures will undoubtedly increase treatment expenses for hospitals. To the extent certain hospitals are now treating a disappropriate number of indigent or high risk patients while other hospitals are not, the requirement of this bill will have a tendency to level partially the playing field.

D. FISCAL COMMENTS:

None.

III. LONG RANGE CONSEQUENCES:

By enhancing the accessibility of patients to emergency care and increasing the quality of such care this committee bill is consistent with the health goals and policies of the State Comprehensive Plan which seek to ensure that necessary health services are available to all Floridians (s. 187.201(6)(a) and (b)2., F.S.).

IV. COMMENTS:

Currently all hospitals, regardless of whether they are verified trauma centers or not, are required to complete an eight page report on any severe disability or head injury to the Department of Labor and Employment Security for the purpose of identifying the need for potential vocational rehabilitative services. HRS proposes to simplify the reporting requirements of hospitals by designing a one page form which would capture the trauma registry information needed, as well as the disability and head injury data. HRS would then abstract information it receives from other sources available to it as part of the Emergency Medical Services Program, and provide the Department of Labor and Employment Security with the data it needs to complete its vocational rehabilitative program requirements.

V. AMENDMENTS:

None.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Cathie Herndon and Tom Cooper

Staff Director: Michael P. Hansen
Clarifies and corrects existing "glitches" in the current law relating to trauma systems.

Clarifies that HRS and, if the department delegates the authority, a local or regional trauma agency can verify a hospital as a trauma center.

Requires local or regional agencies to implement trauma plans rather than making it an option, unless the the local or regional agency gives the department written notice of its intent to cease implementation of the plan.

Clarifies language that requires all verified trauma centers to accept all trauma victims regardless of race, sex, creed or ability to pay.

Requires local or regional trauma agencies to submit written notice of its intent to cease operations of a local or regional trauma agency.

Changes the time for processing application renewals from 120 to 180 days.

Provides that hospitals which have been denied verification status as a trauma center have the right to a hearing under chapter 119, Florida Statutes.

Requires the department to establish trauma regions for the purpose of providing planning and coordination, but allows local or regional trauma system agencies to be established without regard to the regional boundaries established by the department.

Requires all acute care hospitals, in addition to the verified trauma centers, to provide trauma data to the trauma registry to be phased-in by October 1, 1988.