IMPROVING TRAUMA SYSTEMS AND EMERGENCY CARE ACT

SEPTEMBER 28, 2022.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. Pallone, from the Committee on Energy and Commerce, submitted the following

REPORT

[To accompany H.R. 8163]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 8163) to amend the Public Health Service Act with respect to trauma care, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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The amendment is as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.
This Act may be cited as the “Improving Trauma Systems and Emergency Care Act”.

29–006
SEC. 2. TRAUMA CARE REAUTHORIZATION.

(a) IN GENERAL.—Section 1201 of the Public Health Service Act (42 U.S.C. 300d) is amended—

(1) in subsection (a)—

(A) in paragraph (3)—

(i) by inserting “analyze,” after “compile,”; and

(ii) by inserting “and medically underserved areas” before the semicolon;

(B) in paragraph (4), by adding “and” after the semicolon;

(C) by striking paragraph (5); and

(D) by redesignating paragraph (6) as paragraph (5);

(2) by redesignating subsection (b) as subsection (c); and

(3) by inserting after subsection (a) the following:

“(b) TRAUMA CARE READINESS AND COORDINATION.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall support the efforts of States and consortia of States to coordinate and improve emergency medical services and trauma care during a public health emergency declared by the Secretary pursuant to section 319 or a major disaster or emergency declared by the President under section 401 or 501, respectively, of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Such support may include—

“(1) developing, issuing, and updating guidance, as appropriate, to support the coordinated medical triage and evacuation to appropriate medical institutions based on patient medical need, taking into account regionalized systems of care;

“(2) disseminating, as appropriate, information on evidence-based or evidence-informed trauma care practices, taking into consideration emergency medical services and trauma care systems, including such practices identified through activities conducted under subsection (a) and which may include the identification and dissemination of performance metrics, as applicable and appropriate; and

“(3) other activities, as appropriate, to optimize a coordinated and flexible approach to the emergency response and medical surge capacity of hospitals, other health care facilities, critical care, and emergency medical systems.”

(b) GRANTS TO IMPROVE TRAUMA CARE IN RURAL AREAS.—Section 1202 of the Public Health Service Act (42 U.S.C. 300d–3) is amended—

(1) by amending the section heading to read as follows: “GRANTS TO IMPROVE TRAUMA CARE IN RURAL AREAS”;

(2) by amending subsections (a) and (b) to read as follows:

“(a) IN GENERAL.—The Secretary shall award grants to eligible entities for the purpose of carrying out research and demonstration projects to support the improvement of emergency medical services and trauma care in rural areas through the development of innovative uses of technology, training and education, transportation of seriously injured patients for the purposes of receiving such emergency medical services, access to prehospital care, evaluation of protocols for the purposes of improvement of outcomes and dissemination of any related best practices, activities to facilitate clinical research, as applicable and appropriate, and increasing communication and coordination with applicable State or Tribal trauma systems.

“(b) ELIGIBLE ENTITIES—

“(1) IN GENERAL.—To be eligible to receive a grant under this section, an entity shall be a public or private entity that provides trauma care in a rural area.

“(2) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to eligible entities that will provide services under the grant in any rural area identified by a State under section 1214(d)(1),”;

and

(3) by adding at the end the following:

“(d) REPORTS.—An entity that receives a grant under this section shall submit to the Secretary such reports as the Secretary may require to inform administration of the program under this section.”

(c) PILOT GRANTS FOR TRAUMA CENTERS.—Section 1204 of the Public Health Service Act (42 U.S.C. 300d–6) is amended—

(1) by amending the section heading to read as follows: “PILOT GRANTS FOR TRAUMA CENTERS”;

(2) in subsection (a)—

(A) by striking “not fewer than 4” and inserting “10”;

(B) by striking “that design, implement, and evaluate” and inserting “to design, implement, and evaluate new or existing”;

(C) by striking “emergency care” and inserting “emergency medical”; and

(D) by inserting “, and improve access to trauma care within such systems” before the period;
(3) in subsection (b)(1), by striking subparagraphs (A) and (B) and inserting the following:
"(A) a State or consortia of States;
(B) an Indian Tribe or Tribal organization (as defined in section 4 of the Indian Self-Determination and Education Assistance Act);
(C) a consortium of level I, II, or III trauma centers designated by applicable State or local agencies within an applicable State or region, and, as applicable, other emergency services providers; or
(D) a consortium or partnership of nonprofit Indian Health Service, Indian Tribal, and urban Indian trauma centers;"

(4) in subsection (c)—
(A) in the matter preceding paragraph (1)—
(i) by striking “that proposes a pilot project”; and
(ii) by striking “an emergency medical and trauma system that—” and inserting “a new or existing emergency medical and trauma system. Such eligible entity shall use amounts awarded under this subsection to carry out 2 or more of the following activities;”;
(B) in paragraph (1)—
(i) by striking “coordinates” and inserting “Strengthening coordination and communication”; and
(ii) by striking “an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;” and inserting “approaches to improve situational awareness and emergency medical and trauma system access.”;
(C) in paragraph (2)—
(i) by striking “includes” and inserting “Providing”;
(ii) by inserting “support patient movement to” after “region to”; and
(iii) by striking the semicolon and inserting a period;
(D) in paragraph (3)—
(i) by striking “allows for” and inserting “Improving”; and
(ii) by striking “;” and “and” and inserting a period;
(E) in paragraph (4), by striking “includes a consistent” and inserting “Supporting a consistent”;
(F) by adding at the end the following:
“(5) Establishing, implementing, and disseminating, or utilizing existing, as applicable, evidence-based or evidence-informed practices across facilities within such emergency medical and trauma system to improve health outcomes, including such practices related to management of injuries, and the ability of such facilities to surge.
“(6) Conducting activities to facilitate clinical research, as applicable and appropriate.”;

(5) in subsection (d)(2)—
(A) in the matter preceding clause (i), by striking “the proposed” and inserting “the applicable emergency medical and trauma system”;
(B) by redesigning subparagraph (B) as subparagraph (C); and
(C) by inserting after subparagraph (A) the following:
“(B) for eligible entities described in subparagraph (C) or (D) of subsection (b)(1), a description of, and evidence of, coordination with the applicable State Office of Emergency Medical Services (or equivalent State Office) or applicable such office for a Tribe or Tribal organization; and”;

(6) in subsection (f), by striking “population in a medically underserved area” and inserting “medically underserved population”;

(7) in subsection (g)—
(A) in the matter preceding paragraph (1), by striking “described in”;
(B) in paragraph (2), by striking “the system characteristics that contribute to” and inserting “opportunities for improvement, including recommendations for how to improve”;
(C) by striking paragraph (4);
(D) by redesigning paragraphs (5) and (6) as paragraphs (4) and (5), respectively;
(E) in paragraph (4), as so redesignated, by striking “;” and inserting a semicolon;
(F) in paragraph (5), as so redesignated, by striking the period and inserting “;” and
I. PURPOSE AND SUMMARY

H.R. 8163, the “Improving Trauma Systems and Emergency Care Act of 2022,” reauthorizes grants to improve trauma care readiness and coordination and to support trauma care and emergency medical services. The bill directs the Secretary of the Department of Health and Human Services (HHS), acting through the Assistant Secretary for Preparedness and Response (ASPR), to support the efforts of States and consortia of states to coordinate and improve emergency medical services and trauma care during declared emergencies. The bill also expands eligibility and revises grants for improving emergency medical services and trauma in rural areas and competitive grants for improving regional emergency medical and trauma systems.

II. BACKGROUND AND NEED FOR LEGISLATION

Managing care for traumatic injuries requires enhanced coordination and support among health care providers and support personnel in order to save lives and reduce mortality. Unintentional injury is the leading cause of death for people under age 44 and the fourth leading cause of death of all age groups in the United States.1 It is estimated that the annual burden of trauma care is approximately $670 billion in the United States when accounting for total medical expenditures and lost productivity from trauma-related injuries.2

As noted by the National Academies for Sciences, Engineering, and Medicine in a 2016 report, “recognizing the best strategy to reduce the considerable burden associated with trauma is to prevent injuries from occurring in the first place, the delivery of optimal trauma care when injuries do occur is a critical means to preventing unnecessary death and disability.”3 The National Academies estimated that “of the 147,790 U.S. trauma deaths in 2014, as many as 20 percent—or about 30,000—may have been preventable after injury with optimal trauma care.”4

Approximately 46.7 million Americans do not live within 60 minutes of a Level I or Level II trauma center—often referred to as the “golden hour” following traumatic injury during which there is the

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4 Id.
highest likelihood that prompt medical treatment can prevent death.\(^5\) Residents without access to trauma centers often live in rural areas that lack inclusive systems of care.\(^6\)

For these reasons, the provisions included in H.R. 8163 are intended to enhance access to trauma care, improve coordination among trauma systems, and provide resources for rural access to trauma services. As noted by Dr. Kevin Croston, the Chief Executive Officer of North Memorial Health, who testified in support of H.R. 8163 before the Subcommittee on Health on June 29, 2022, the grants authorized by this bill “represent and support a core function of an ideal trauma system: coordination.”\(^7\) The grants included in the bill are intended to help trauma systems develop best practices, not only for their own patients, but also to facilitate the dissemination of those best practices to similar trauma systems throughout the country to improve care overall.

The 2016 National Academies report on a national trauma care system provided a series of recommendations on how to improve trauma care and reduce trauma-related mortality. These recommendations included creating a vision for a national trauma care system with national-level leadership that would help better coordinate care and establish processes and tools for disseminating trauma knowledge. H.R. 8163 helps further these goals to integrate and improve the United States’ trauma care system to save lives following traumatic injury.

III. COMMITTEE HEARINGS

For the purposes of section 3(c) of rule XIII of the Rules of the House of Representatives, the following hearing was used to develop or consider H.R. 8163:

The Subcommittee on Health held a hearing on June 29, 2022, entitled “Investing in Public Health: Legislation to Support Patients, Workers, and Research.” The Subcommittee received testimony from the following witnesses:

- Kirsten Bibbins-Domingo, Ph.D., M.D., M.A.S., Professor of Epidemiology and Biostatistics and the Lee Goldman, M.D. Professor of Medicine, University of California, San Francisco;
- Kevin Croston, M.D., CEO, North Memorial Health;
- Tanika Gray Valbrun, Founder and President, The White Dress Project;
- Michael D. Shannon, Executive/President of Government Solutions, IPTalons, Inc.;
- Desiree Sweeney, CEO, NEW Health; and
- Leslie R. Walker-Harding, M.D., F.A.A.P., F.S.A.H.M., Ford/Morgan Endowed Professor Chair Department of Pediatrics/Associate Dean, University of Washington; Chief Academic Officer/Senior Vice President, Seattle Children’s Hospital.

IV. COMMITTEE CONSIDERATION

H.R. 8163, the “Improving Trauma Systems and Emergency Care Act of 2022,” was introduced on June 21, 2022, by Representative

\(^5\) Charles Branas et al, Access to Trauma Centers in the United States, JAMA (June 1, 2005).
\(^6\) Id.
\(^7\) House Committee on Energy and Commerce, Testimony of Kevin Croston, M.D., Chief Executive Officer, North Memorial Health, Hearing on Investing in Public Health: Legislation to Support Patients, Workers, and Research, 117th Cong. (June 29, 2022).
Tom O'Halleran (D–AZ) and was referred to the Committee on Energy and Commerce. Subsequently, on June 22, 2022, the bill was referred to the Subcommittee on Health.

On September 14, 2022, the Subcommittee on Health met in open markup session, pursuant to notice, to consider H.R. 8163 and four other bills. During consideration of the bill, an amendment in the nature of a substitute (AINS), offered by Representative Eshoo (D–CA), was agreed to by a voice vote. Upon conclusion of consideration of the bill, the Subcommittee on Health agreed to report the bill favorably to the full Committee, amended, by a voice vote.

On September 21, 2022, the full Committee met in open markup session, pursuant to notice, to consider H.R. 8163 and 23 other bills. An AINS, offered by Representative O'Halleran, was agreed to by a voice vote. Upon conclusion of consideration of the bill, the full Committee agreed to a motion on final passage offered by Representative Pallone, Chairman of the Committee, to order H.R. 5585 reported favorably to the House, amended, by a roll call vote of 55 yeas to 1 nays.

V. COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list each record vote on the motion to report legislation and amendments thereto. The Committee advises that there was one record vote taken on H.R. 8163, including a motion by Mr. Pallone ordering H.R. 8163 favorably reported to the House, amended. The motion on final passage of the bill was approved by a record vote of 55 yeas to 1 nays. The following are the record votes taken during Committee consideration, including the names of those members voting for and against:
Bill: **H.R. 8163**, the "Improving Trauma Systems and Emergency Care Act"

Vote: Final Passage

Disposition: AGREED TO by a roll call vote of 55 yeas to 1 nays

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VI. OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portion of the report.

VII. NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Pursuant to 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

The Committee has requested but not received from the Director of the Congressional Budget Office a statement as to whether this bill contains any new budget authority, spending authority, credit authority, or an increase or decrease in revenues or tax expenditures.

VIII. FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

IX. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to enhance access to trauma care, improve coordination among trauma systems, and provide resources for rural access to trauma services.

X. DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 8163 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111–139 or the most recent Catalog of Federal Domestic Assistance.

XI. COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

XII. EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 8163 contains no earmarks, limited tax benefits, or limited tariff benefits.
XIII. ADVISORY COMMITTEE STATEMENT

No advisory committee within the meaning of section 5(b) of the Federal Advisory Committee Act was created by this legislation.

XIV. APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

XV. SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 designates that the short title may be cited as the “Improving Trauma Systems and Emergency Care Act.”

Sec. 2. Trauma care reauthorization

Section 2 amends section 1201 of the Public Health Service Act to direct the Assistant Secretary for Preparedness and Response to support the efforts of states and consortia of states to coordinate and improve emergency medical services and trauma care during a public health emergency. This support may include developing, issuing, and updating guidance, as appropriate, to support the coordinated medical triage and evacuation to appropriate medical institutions based on patient medical need; identification and dissemination of performance metrics; and other activities as appropriate to optimize a coordinated and flexible approach to the emergency response and medical surge capacity of hospitals, other health care facilities, critical care, and emergency medical systems.

Section 2 also amends section 1202 of the Public Health Service Act to award grants to eligible entities for the purpose of carrying out research and demonstration projects to support the improvement of emergency medical services and trauma care in rural areas.

Section 2 also amends section 1204 of the Public Health Service Act to award pilot grants to trauma centers, such as a consortium of level I, II, or III trauma centers designated by applicable State or local agencies, in order to improve situational awareness and emergency medical and trauma system access and for other purposes.

Section 2 also amends section 1232(a) of the Public Health Service Act to reauthorize this provision from 2023 to 2027.

XVI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT
TITLE XII—TRAUMA CARE

PART A—GENERAL AUTHORITY AND DUTIES OF SECRETARY

SEC. 1201. ESTABLISHMENT.
(a) IN GENERAL.—The Secretary shall, with respect to trauma care—
   (1) conduct and support research, training, evaluations, and demonstration projects;
   (2) foster the development of appropriate, modern systems of such care through the sharing of information among agencies and individuals involved in the study and provision of such care;
   (3) collect, compile, analyze, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing trauma care and emergency medical services and, in so doing, give special consideration to the unique needs of rural areas and medically underserved areas;
   (4) provide to State and local agencies technical assistance to enhance each State's capability to develop, implement, and sustain the trauma care component of each State's plan for the provision of emergency medical services; and
   (5) promote the collection and categorization of trauma data in a consistent and standardized manner.
(b) TRAUMA CARE READINESS AND COORDINATION.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall support the efforts of States and consortia of States to coordinate and improve emergency medical services and trauma care during a public health emergency declared by the Secretary pursuant to section 319 or a major disaster or emergency declared by the President under section 401 or 501, respectively, of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Such support may include—
   (1) developing, issuing, and updating guidance, as appropriate, to support the coordinated medical triage and evacuation to appropriate medical institutions based on patient medical need, taking into account regionalized systems of care;
   (2) disseminating, as appropriate, information on evidence-based or evidence-informed trauma care practices, taking into consideration emergency medical services and trauma care systems, including such practices identified through activities conducted under subsection (a) and which may include the identification and dissemination of performance metrics, as applicable and appropriate; and
   (3) other activities, as appropriate, to optimize a coordinated and flexible approach to the emergency response and medical surge capacity of hospitals, other health care facilities, critical care, and emergency medical systems.
(c) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).
SEC. 1202. [ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.] GRANTS TO IMPROVE TRAUMA CARE IN RURAL AREAS.

(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for the purpose of carrying out research and demonstration projects with respect to improving the availability and quality of emergency medical services in rural areas—

(1) by developing innovative uses of communications technologies and the use of new communications technology;

(2) by developing model curricula, such as advanced trauma life support, for training emergency medical services personnel, including first responders, emergency medical technicians, emergency nurses and physicians, and paramedics—

(A) in the assessment, stabilization, treatment, preparation for transport, and resuscitation of seriously injured patients, with special attention to problems that arise during long transports and to methods of minimizing delays in transport to the appropriate facility; and

(B) in the management of the operation of the emergency medical services system;

(3) by making training for original certification, and continuing education, in the provision and management of emergency medical services more accessible to emergency medical personnel in rural areas through telecommunications, home studies, providing teachers and training at locations accessible to such personnel, and other methods;

(4) by developing innovative protocols and agreements to increase access to prehospital care and equipment necessary for the transportation of seriously injured patients to the appropriate facilities;

(5) by evaluating the effectiveness of protocols with respect to emergency medical services and systems; and

(6) by increasing communication and coordination with State trauma systems.

(b) SPECIAL CONSIDERATION FOR CERTAIN RURAL AREAS.—In making grants under subsection (a), the Secretary shall give special consideration to any applicant for the grant that will provide services under the grant in any rural area identified by a State under section 1214(d)(1).

(a) IN GENERAL.—The Secretary shall award grants to eligible entities for the purpose of carrying out research and demonstration projects to support the improvement of emergency medical services and trauma care in rural areas through the development of innovative uses of technology, training and education, transportation of seriously injured patients for the purposes of receiving such emergency medical services, access to prehospital care, evaluation of protocols for the purposes of improvement of outcomes and dissemination of any related best practices, activities to facilitate clinical research, as applicable and appropriate, and increasing communication and coordination with applicable State or Tribal trauma systems.

(b) ELIGIBLE ENTITIES.—

(1) IN GENERAL.—To be eligible to receive a grant under this section, an entity shall be a public or private entity that provides trauma care in a rural area.

(2) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to eligible entities that will provide
services under the grant in any rural area identified by a State
under section 1214(d)(1).
(c) REQUIREMENT OF APPLICATION.—The Secretary may not make
a grant under subsection (a) unless an application for the grant is
submitted to the Secretary and the application is in such form, is
made in such manner, and contains such agreements, assurances,
and information as the Secretary determines to be necessary to
carry out this section.
(d) REPORTS.—An entity that receives a grant under this section
shall submit to the Secretary such reports as the Secretary may re-
quire to inform administration of the program under this section.

SEC. 1204. [COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR
EMERGENCY CARE RESPONSE.] PILOT GRANTS FOR
TRAUMA CENTERS.

(a) IN GENERAL.—The Secretary, acting through the Assistant
Secretary for Preparedness and Response, shall award
not fewer
than 4
multiyear contracts or competitive grants to eligible en-
tities to support pilot projects [that design, implement, and evaluate]
to design, implement, and evaluate new or existing innovative
models of regionalized, comprehensive, and accountable [emerg-
cy care] emergency medical and trauma systems, and improve
access to trauma care within such systems.
(b) ELIGIBLE ENTITY; REGION.—In this section:
(1) ELIGIBLE ENTITY.—The term “eligible entity” means—
(A) a State or a partnership of 1 or more States and 1
or more local governments; or
(B) an Indian tribe (as defined in section 4 of the In-
dian Health Care Improvement Act) or a partnership of 1
or more Indian tribes.
(A) a State or consortia of States;
(B) an Indian Tribe or Tribal organization (as defined in
section 4 of the Indian Self-Determination and Education
Assistance Act);
(C) a consortium of level I, II, or III trauma centers des-
ignated by applicable State or local agencies within an ap-
plicable State or region, and, as applicable, other emer-
gency services providers; or
(D) a consortium or partnership of nonprofit Indian
Health Service, Indian Tribal, and urban Indian trauma
centers.
(2) REGION.—The term “region” means an area within a
State, an area that lies within multiple States, or a similar
area (such as a multicounty area), as determined by the Sec-
retary.
(3) EMERGENCY SERVICES.—The term “emergency services”
includes acute, prehospital, and trauma care.
(c) PILOT PROJECTS.—The Secretary shall award a contract or
grant under subsection (a) to an eligible entity [that proposes a
project] to design, implement, and evaluate [an emergency
medical and trauma system that—] a new or existing emergency
medical and trauma system. Such eligible entity shall use amounts
awarded under this subsection to carry out 2 or more of the fol-
lowing activities:
(1) [coordinates] Strengthening coordination and communication with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop [an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;] approaches to improve situational awareness and emergency medical and trauma system access.

(2) [includes] Providing a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to support patient movement to ensure that the patient is taken to the medically appropriate facility (whether an initial facility or a higher-level facility) in a timely fashion.

(3) [allows for] Improving the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions.

(4) [includes a consistent] Supporting a consistent region-wide prehospital, hospital, and interfacility data management system that—

(A) submits data to the National EMS Information System, the National Trauma Data Bank, and others;
(B) reports data to appropriate Federal and State databanks and registries; and
(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant health outcomes of hospital care.

(5) Establishing, implementing, and disseminating, or utilizing existing, as applicable, evidence-based or evidence-informed practices across facilities within such emergency medical and trauma system to improve health outcomes, including such practices related to management of injuries, and the ability of such facilities to surge.

(6) Conducting activities to facilitate clinical research, as applicable and appropriate.

(d) APPLICATION.—

(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

(2) APPLICATION INFORMATION.—Each application shall include—

(A) an assurance from the eligible entity that [the proposed] the applicable emergency medical and trauma system system—

(i) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office or Tribal entity);

(ii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;
(iii) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

(iv) includes a categorization or designation system for special medical facilities throughout the region that is integrated with transport and destination protocols;

(v) includes a regional medical direction, patient tracking, and resource allocation system that supports day-to-day emergency care and surge capacity and is integrated with other components of the national and State emergency preparedness system; and

(vi) addresses pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children and adolescents.

(B) for eligible entities described in subparagraph (C) or (D) of subsection (b)(1), a description of, and evidence of, coordination with the applicable State Office of Emergency Medical Services (or equivalent State Office) or applicable such office for a Tribe or Tribal organization; and

[(B)] (C) such other information as the Secretary may require.

(e) REQUIREMENT OF MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant was made, to make available non-Federal contributions (in cash or in kind under paragraph (2)) toward such costs in an amount equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

(2) NON-FEDERAL CONTRIBUTIONS.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a medically underserved area (as defined in section 330(b)(3)).

(g) REPORT.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

(2) the system characteristics that contribute to opportunities for improvement, including recommendations for how to
improve the effectiveness and efficiency of the program (or lack thereof);  
(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;  
[(4) the State and local legislation necessary to implement and to maintain the system;]  
[(5)] (4) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers[; and];  
[(6)] (5) recommendations on the utilization of available funding for future regionalization efforts[, ] and  
(6) any evidence-based or evidence-informed strategies developed or utilized pursuant to subsection (c)(5).  
[(h) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g).]  
(h) DISSEMINATION OF FINDINGS.—Not later than 1 year after the completion of the final project under subsection (a), the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report describing the information contained in each report submitted pursuant to subsection (g) and any additional actions planned by the Secretary related to regionalized emergency care and trauma systems.

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PART C—GENERAL PROVISIONS REGARDING PARTS A AND B

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SEC. 1232. FUNDING.

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out parts A and B, subject to subsections (b) and (c), there are authorized to be appropriated $24,000,000 for each of fiscal years 2010 through 2014; and 2023 through 2027.

(b) RESERVATION OF FUNDS.—If the amount appropriated under subsection (a) for a fiscal year is equal to or less than $1,000,000, such appropriation is available only for the purpose of carrying out part A. If the amount so appropriated is greater than $1,000,000, 50 percent of such appropriation shall be made available for the purpose of carrying out part A and 50 percent shall be made available for the purpose of carrying out part B.

(c) ALLOCATION OF PART A FUNDS.—Of the amounts appropriated under subsection (a) for a fiscal year to carry out part A—  
(1) 10 percent of such amounts for such year shall be allocated for administrative purposes; and  
(2) 10 percent of such amounts for such year shall be allocated for the purpose of carrying out section 1202.

(d) AUTHORITY.—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall transfer authority in administering grants and related authorities under such parts from
the Administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.