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TRAUMA CARE SYSTEMS PLANNING AND DEVELOPMENT ACT OF 2003

JUNE 9, 2003.—Ordered to be printed

Mr. GREGG, from the Committee on Health, Education, Labor, and Pensions, submitted the following

R E P O R T

[To accompany S. 239]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 239) to amend the Public Health Service Act to add requirements regarding trauma care, and for other purposes, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

CONTENTS

		Page
I.	Purpose and need for legislation	1
II.	Summary	2
III.	History of legislation and votes in committee	3
IV.	Explanation of bill and committee views	3
V.	Cost estimate and unfunded mandate statement	4
VI.	Regulatory impact statement	6
VII.	Application of law to the legislative branch	6
VIII.	Section-by-section analysis	6
IX.	Changes in existing law	7

I. PURPOSE AND NEED FOR LEGISLATION

The purpose of the "Trauma Care Systems Planning and Development Act of 2003" is to assist State governments in the development, implementation, and improvement of statewide and regional systems of trauma care. By providing incentives to States to establish well-coordinated systems, severely injured individuals can receive specialized, high quality care as rapidly as possible following their injury. Experience has proven that death and disability for severely injured patients are both reduced dramatically when de-

finitive care is provided within the so-called "golden hour" following their injury.

Trauma is the leading killer of Americans up to age 34. Every year, more than 150,000 Americans die from traumatic injuries, many of which result from motor vehicle collisions, violence and falls. Given the events of September 11, 2001, and the nation's renewed focus on enhancing disaster preparedness, it is critical that the Federal Government increase its commitment to strengthening Title XII programs governing trauma care system planning and development.

Survival among severely injured patients requires specialist care delivered promptly and in a coordinated manner. Care begins at the scene of injury, continues through emergency transport to the trauma center, intensive care unit, hospital floor, and ultimately to rehabilitation. Optimal acute care depends on technical expertise and coordination between teams of providers, including first responders, trauma center teams, acute care and rehabilitative care teams.

A trauma care system is an organized approach to facilitating and coordinating a multidisciplinary system response to severely injured patients. It is inclusive of injury prevention, emergency department care, surgical interventions, intensive and general surgical in-hospital care, rehabilitative services, along with social services and support groups that enable the patient to return to society at the most productive level possible.

Research has shown that functioning trauma systems can prevent death and disability resulting from trauma. For example, the establishment of an effective trauma system in San Diego County, CA was credited with reducing the proportion of preventable fatalities out of all deaths from 13.6 percent to 2.7 percent. It is estimated that at least 25,000 deaths due to trauma can be prevented every year through the proper preventive, acute and rehabilitative care that trauma care systems can provide.

Trauma care and emergency medical services systems are an integral component of our nation's health and public health infrastructure and an important public safety resource in all States. Throughout the U.S., trauma systems face ongoing and increasing challenges of both natural and man-made disasters.

Strong Federal support for Title XII and the goals of the "Trauma Care Systems Planning and Development Act" will help States and communities in need of improved infrastructure to provide effective and efficient care to severely injured patients.

II. SUMMARY

This legislation reauthorizes Title XII of the Public Health Service Act for a period of 5 years; doubles the funding available for trauma system development under Parts A–C of Title XII for fiscal year 2004, from $6 million to $12 million; and authorizes $750,000 for fiscal year 2004 and fiscal year 2005 for the IOM study under Part E.

First, the "Trauma Care Systems Planning and Development Act of 2003" improves the collection and analysis of trauma patient data with the goal of improving the overall system of care for these patients; second, at this time of increasing pressure on State budgets, the bill provides some relief to States in their matching re-

quirements; third, the legislation provides a self-evaluation mechanism to assist States in assessing and improving their trauma care systems; fourth, it authorizes an Institute of Medicine (IOM) study on the state of trauma care and trauma research; and finally, it doubles the funding available for this program to allow additional States to participate.

III. History of Legislation and Votes in Committee

The "Trauma Care Systems Planning and Development Act of 1990," (PAL. 101–590) which created Title XII of the Public Health Service Act (PHS), was enacted to improve trauma care systems nationwide. From 1992 to 1994, the Health Resources and Services Administration (HRSA) administered the Federal funds to execute the responsibilities specified in the Act. The program's authority expired in 1995 and funding was discontinued. Title XII was reauthorized in 1998 for fiscal year 2000 through fiscal year 2002 in PAL. 105–392, the "Health Professions Partnership Act of 1998" and funding re-initiated in fiscal year 2001.

During the first session of the 108th Congress, S. 239, the Trauma Care Systems Planning and Development Act of 2003, was introduced January 29th, 2003, to reauthorize the program. The Committee on Health, Education, Labor, and Pensions reported the bill favorably without amendment on February 12, 2003.

IV. Explanation of Bill and Committee Views

The bill has a variety of provisions, the explanation of and committee views on which follow below:

The Clearinghouse on Trauma Care and Emergency Medical Services was authorized in previous legislation but never established at the Department. As a result, the committee collapsed clearinghouse functions into the general trauma care program.

The bill adds a provision to an existing program for improving trauma care in rural areas that would increase coordination of State trauma systems with EMS operations in rural areas of the State. In rural areas, the barriers to coordination between first responders and State trauma systems may be greater. The committee expects that this change to the existing program will help to overcome some of those barriers.

The bill reduces the States' contribution to the Federal matching requirement. It is hoped that this reduction will provide some relief to States and encourage more States to further develop their trauma care systems. The committee believes that although the Federal Government should provide assistance in ensuring the availability of quality trauma care for Americans, each State should be responsible for developing and maintaining a trauma care system that is tailored to its own needs. The revised matching requirement sustains the policy that the State investment in trauma care exceed the Federal contribution.

It is critical that State trauma care systems coordinate well with other State-based health emergency systems, such as the bioterrorism and hospital preparedness systems. The bill adds a requirement for such coordination with State preparedness efforts.

The bill requests an Institute of Medicine report on the status of the nation's trauma care and trauma care systems. The committee

expects that this report will be important in properly evaluating trauma care systems and identifying priorities for trauma research in the future.

The bill updates and revises the existing provision for the Secretary, acting through the Director of the NIH, to establish a comprehensive program of trauma research.

V. Cost Estimate and Unfunded Mandate Statement

U.S. Congress,
Congressional Budget Office,
Washington, DC, March 13, 2003.

Hon. Judd Gregg,
Chairman, Committee on Health, Education, Labor, and Pensions, U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for S. 239, the Trauma Care Systems Planning and Development Act of 2003.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Alexis Ahlstrom.

Sincerely,

Douglas Holtz-Eakin,
Director.

Enclosure.

S. 239—Trauma Care System Planning and Development Act of 2003

Summary: S. 239 would amend the Public Health Service Act to reauthorize the emergency services and trauma care programs administered by the Health Resources and Services Administration (HRSA). Those programs include grants to states for the development of trauma care systems, an emergency care residency training program, and a traumatic brain injury demonstration project. S. 239 also would require HRSA to contract for a study on trauma care and trauma research.

Assuming the appropriation of the necessary amounts (including annual adjustments for anticipated inflation), CBO estimates that implementing S. 239 would cost $4 million in 2004 and $71 million over the 2004–2008 period. The legislation would not affect direct spending or receipts.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 239 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—					
	2003	2004	2005	2006	2007	2008
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law:						
Estimated Authorization Level [1]	13	10	10	0	0	0
Estimated Outlays	10	11	10	7	2	1
Proposed Changes: [2]						
Estimated Authorization Level	0	13	13	23	23	24
Estimated Outlays	0	4	10	15	20	22

	By fiscal year, in millions of dollars—					
	2003	2004	2005	2006	2007	2008
Spending Under S. 239:						
Estimated Authorization Level [1]	13	23	23	23	23	24
Estimated Outlays	10	15	20	22	23	23

[1] The 2003 level is the amount appropriated for that year for the Trauma/Emergency Medical Systems program.
[2] Including adjustments for anticipated inflation, the estimated outlay changes would total $71 million over the 2004–2008 period. Without such adjustments, the five-year total would be $68 million.

Basis of estimate: S. 239 would reauthorize three trauma-related programs and would require HRSA to contract for a study on the current state of trauma care. Assuming the appropriation of the necessary amounts, CBO estimates that implementing S. 239 would cost $4 million in 2004 and $71 million over the 2004–2008 period.

HRSA currently administers grants to states for the planning, development, and improvement of trauma centers and systems and maintains a clearinghouse on trauma care. S. 239 would authorize the appropriation of $12 million in 2004 and such sums as necessary through 2008 for those activities.

The planning grant part of that program provides federal matching payments to funds spent by states. Under current law, the federal government does not require contribution of state funds in the first year, but requires a matching payment of $1 for every $1 of state spending in the second year, and a $3 for every $1 subsequently. Under the bill, states would receive grants without the contribution of their own funds for the first two years. In the third year, the federal government would provide a matching payment of $1 for every $1 of state spending. In subsequent years, the federal government would provide a matching payment of $1 for every $2 of state spending.

State participation under the current, less-generous program is very high. States in 2002 were not required to contribute any matching funds, and used grant monies from HRSA to do needs assessments and to plan for future uses of grant money. Although states will have to contribute $1 for every $1 they receive in federal grants under current law in 2003, HRSA believes that state participation in 2003 will be similar to the level in 2002. Since the bill would provide for a more-generous program (i.e., lower state-matching requirements), we expect that participation would remain high under S. 239.

The authorization level for 2004 under S. 239 for this program would be almost four times higher than the 2003 appropriation level of $3.5 million. Based on current state spending for the planning grant program and on discussions with HRSA about strong interest by states for participation in this program. CBO estimates that state contributions toward these grants would be sufficient to obligate the proposed level of appropriation in S. 239. Based on historical spending patterns for this program, CBO estimates that implementing this provision would cost a little less than $4 million in 2004 and $48 million over the 2004–2008 period.

S. 239 also would reauthorize a residency training program in emergency medicine for the 2004–2008 period. The bill would authorize $400,000 each year for grants to public and private nonprofit entities for the development of residency programs with an emphasis on treatment and referral of domestic violence cases.

CBO estimates that implementing this provision would cost $2 million over the 2004–2008 period.

Under current law, HRSA is administering a demonstration project that provides grants to states to improve access to health and other services in brain injury cases. S. 239 would reauthorize this program and remove its designation as a demonstration project. The bill would authorize such sums as necessary. Based on historical spending for the demonstration program and assuming the appropriation of the necessary amounts, CBO estimates that implementing this provision would cost $3 million in 2006 and $20 million over the 2006–2008 period. (This provision would have no effect on discretionary spending in 2004 or 2005 because the program is authorized through 2005 under current law.)

S. 239 would require the Secretary of Health and Human Services to contract with the Institutes of Medicine or a similar entity to conduct a study on trauma care. The bill would authorize the appropriation of $750,000 in both 2004 and 2005. Based on spending for similar activities, CBO estimates that implementing this provision would cost $1.5 million over the 2004–2006 period.

Intergovernmental and private-sector impact: The bill contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments. The bill would reauthorize and increase authorized funding for a grant program designed to improve the quality of trauma care systems. States that choose to apply for those grants would have to provide matching funds, but any costs they incur would be voluntary.

Estimated prepared by: Federal Costs: Alexis Ahlstrom; Impact on State, Local, and Tribal Governments: Leo Lex; and Impact on the Private Sector: David Auerbach.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

VI. Regulatory Impact Statement

In accordance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the committee has determined that there will be minimal increases in the regulatory burden imposed by this bill.

VII. Application of Law to the Legislative Branch

The committee has determined that there is no impact of this law on the Legislative Branch.

VIII. Section-by-Section Analysis

Section 1. Short title

"Trauma Care Systems Planning and Development Act of 2003".

Section 2. Findings

This Section makes certain findings regarding the cost and burden of trauma and the importance of trauma care systems.

Section 3. Amendments

This Section reauthorizes the current grant program to enable a State to develop, implement, and maintain statewide trauma care

systems. This Section collapses the duties of the Clearinghouse into the general program description and authorizes the Secretary, acting through HRSA, to promote the reporting and collection of trauma data in a consistent, standardized manner and strikes it from its original position in the statute. This Section also eliminates authorization for the Clearinghouse on Trauma Care and Emergency Medical Services.

This Section authorizes the Secretary to make grants for programs for improving trauma care in rural areas. Grants are authorized to increase coordination of emergency medical services (EMS) in rural areas with statewide trauma systems, under existing rural grant programs.

The Section requires matching funds for fiscal years subsequent to first fiscal year of payments. The Section amends the requirement of State matching funds in the following manner: first fiscal year—no match; second fiscal year—$1 State: $1 Federal; third fiscal year—$1 State: $1 Federal; fourth fiscal year—$2 State: $1 Federal; and fifth fiscal year—$2 State: $1 Federal.

Section 3 promotes standardized trauma data collection requirements under the trauma care component of the State plan for EMS and promotes coordination with State disaster emergency planning and bioterrorism hospital preparedness planning under the trauma care component of the State plan for EMS. Section 3 also requests the Secretary to update the model trauma care plan.

This Section authorizes the appropriation of $12,000,000 for fiscal year 2004 and such sums as may be necessary for fiscal years 2005 through 2008.

This Section requests an Institute of Medicine study on the state of trauma care and trauma research and authorizes $750,000 for fiscal years 2004 and 2005 for such study.

IX. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TRAUMA CARE SYSTEMS PLANNING AND DEVELOPMENT ACT OF 2003

* * * * * * *

TITLE XII—TRAUMA CARE

Part A—General Authority and Duties of Secretary

* * * * * * *

SEC. 1201. ESTABLISHMENT.

(a) IN GENERAL.—The Secretary*, acting through the Administrator of the Health Resources and Services Administration,* 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, 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;

[(3)**]** *(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**]**

[(4)**]** *(5)* sponsor workshops and conferences*; and*

(6) promote the collection and categorization of trauma data in a consistent and standardized manner.

(b) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The Secretary *acting through the Administrator of the Health Resources and Services Administration,* may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).

[(c) ADMINISTRATION.—The Administrator of the Health Resources and Services Administration shall ensure that this title is administered by the Division of Trauma and Emergency Medical Systems within such Administration. Such Division shall be headed by a director appointed by the Secretary from among individuals who are knowledgeable by training or experience in the development and operation of trauma and emergency medical systems.**]**

* * * * * * *

[SEC. 1202. CLEARINGHOUSE ON TRAUMA CARE AND EMERGENCY MEDICAL SERVICES.

[(a) ESTABLISHMENT.—The Secretary shall by contract provide for the establishment and operation of a National Clearinghouse on Trauma Care and Emergency Medical Services (hereafter in this section referred to as the "Clearinghouse").

[(b) DUTIES.—The Clearinghouse shall—

[(1) foster the development of appropriate, modern trauma care and emergency medical services (including the development of policies for the notification of family members of individuals involved in medical emergencies) through the sharing of information among agencies and individuals involved in planning, furnishing, and studying such services and care;

[(2) collect, compile, 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 of the unique needs of rural areas;

[(3) provide technical assistance relating to trauma care and emergency medical services to State and local agencies; and

[(4) sponsor workshops and conferences on trauma care and emergency medical services.

[(c) FEES AND ASSESSMENTS.—A contract entered into by the Secretary under this section may provide that the Clearinghouse charge fees or assessments in order to defray, and beginning with fiscal year 1992, to cover, the costs of operating the Clearinghouse.]

SEC. [1203.] *1202.* ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.

(a) IN GENERAL.—* * *

* * * * * * *

(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) * * *

(B) * * *

* * * * * * *

(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; [and]

(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.

* * * * * * *

SEC. 1212. REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.

(a) NON-FEDERAL CONTRIBUTIONS.—

(1) IN GENERAL.—The Secretary may not make payments under section 1211(a) unless the State involved agrees, with respect to the costs described in paragraph (2), to make available non-Federal contributions (in cash or in kind under subsection (b)(1)) toward such costs in an amount equal to—

(A) for the second fiscal year of such payments to the State, not less than $1 for each $1 of Federal funds provided in such payments for such fiscal year; [and]

[(B) for any subsequent fiscal year of such payments to the State, not less than $3 for each $1 of Federal funds provided in such payments for such fiscal year.]

(B) for the third fiscal year of such payments to the State, not less than $1 for each $1 of Federal funds provided in such payments for such fiscal year;

(C) for the fourth fiscal year of such payments to the State, not less than $2 for each $1 of Federal funds provided in such payments for such fiscal year; and

(D) for the fifth fiscal year of such payments to the State, not less than $2 for each $1 of Federal funds provided in such payments for such fiscal year.

* * * * * * *

(b) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—With respect to compliance with subsection (a) as a condition of receiving payments under section 1211(a)—

(1) a State may make the non-Federal contributions required in such subsection in cash or in kind, fairly evaluated, including plant, equipment, or services; *and*

(2) the Secretary may not, in making a determination of the amount of non-Federal contributions, include amounts provided by the Federal Government or services assisted or subsidized to any significant extent by the Federal Government**[**; and**]**.

[(3) the Secretary shall, in making such a determination, include only non-Federal contributions in excess of the amount of non-Federal contributions made by the State during fiscal year 1990 toward—

[(A) the costs of providing trauma care in the State; and

[(B) the costs of improving the quality and availability of emergency medical services in rural areas of the State.**]**

SEC. 1213. REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

(a) TRAUMA CARE MODIFICATIONS TO STATE PLAN FOR EMERGENCY MEDICAL SERVICES.—* * *

(1) * * *

(2) * * *

(3) subject to subsection (b), contains *nationally recognized* standards and requirements for the designation of level I and level II trauma centers, and in the case of rural areas level III trauma centers (including trauma centers with specified capabilities and expertise in the care of the pediatric trauma patient), by such entity, including standards and requirements for—

(A) the number and types of trauma patients for whom such centers must provide care in order to ensure that such centers will have sufficient experience and expertise to be able to provide quality care for victims of injury;

* * * * * * *

(5) subject to subsection (b), contains *nationally recognized* standards and requirements for medically directed triage and transport of severely injured children to designated trauma centers with specified capabilities and expertise in the care of the pediatric trauma patient;

(6) **[**specifies procedures for the evaluation of designated**]** *utilizes a program with procedures for the evaluation of* trauma centers (including trauma centers described in paragraph (5)) and trauma care systems;

(7) provides for the establishment and collection of data *in accordance with data collection requirements developed in consultation with surgical, medical, and nursing specialty groups, State and local emergency medical services directors, and other trained professionals in trauma care* from each designated trauma center in the State of a central data reporting and analysis system—

(A) to identify the number of severely injured trauma patients *and the number of deaths from trauma* within regional trauma care systems in the State;

* * * * * * *

(F) to identify patients transferred within a regional trauma system, including reasons for such transfer *and the outcomes of such patients*;

* * * * * * *

(9) provides for appropriate transportation and transfer policies to ensure the delivery of patients to designated trauma centers and other facilities within and outside of the jurisdiction of such system, including policies to ensure that only individuals appropriately identified as trauma patients are transferred to designated trauma centers, and to provide periodic reviews of the transfers and the auditing of such transfers that are determined to be appropriate;

(10) coordinates planning for trauma systems with State disaster emergency planning and bioterrorism hospital preparedness planning;

[(10)**]** *(11)* conducts public education activities concerning injury prevention and obtaining access to trauma care; and

[(11)**]** *(12)* with respect to the requirements established in this subsection, provides for coordination and cooperation between the State and any other State with which the State shares any standard metropolitan statistical area.

(b) CERTAIN STANDARDS WITH RESPECT TO TRAUMA CARE CENTER AND SYSTEM.—

(1) IN GENERAL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees that, in carrying out paragraphs (3) through (5) of subsection (a), the State will adopt standards for the designation of trauma centers, and for triage, transfer, and transportation policies, and that the State will, in adopting such standards—

(A) take into account national standards **[**concerning such**]** *that outline resources for optimal care of the injured patient*;

* * * * * * *

(D) beginning in fiscal year **[**1992**]** *2004*, take into account the model plan described in subsection (c).

* * * * * * *

(3) APPROVAL BY SECRETARY.—The Secretary may not make payments under section 1211(a) to a State if the Secretary determines that—

(A) in the case of payments for fiscal year **[**1991**]** *2004* and subsequent fiscal years, the State has not taken into account national standards, including those of the American College of Surgeons, the American College of Emergency Physicians and the American Academy of Pediatrics, in adopting standards under this subsection; or

(B) in the case of payments for fiscal year **[**1992**]** *2004* and subsequent fiscal years, the State has not, in adopting

such standards, taken into account the model plan developed under subsection (c).

(c) MODEL TRAUMA CARE PLAN.—Not later than 1 year after the date of the enactment of the Trauma Care Systems Planning and Development Act of [1990, the Secretary shall develop a model plan] *2003, the Secretary shall update the model plan* for the designation of trauma centers and for triage, transfer and transportation policies that may be adopted for guidance by the State. Such plan shall—

* * * * * * *

SEC. 1214. REQUIREMENT OF SUBMISSION TO SECRETARY OF TRAUMA PLAN AND CERTAIN INFORMATION.

(a) TRAUMA PLAN.—

(1) IN GENERAL.—For fiscal year [1991] *2004* and subsequent fiscal years, the Secretary may not make payments under section 1211(a) unless, subject to paragraph (2), the State involved submits to the Secretary the trauma care component of the State plan for the provision of emergency medical services *that includes changes and improvements made and plans to address deficiencies identified.*

(2) INTERIM PLAN OR DESCRIPTION OF EFFORTS.—For fiscal year [1991] *2004*, if a State has not completed the trauma care component of the State plan described in paragraph (1), the State may provide, in lieu of a completed such component, an interim component or a description of efforts made toward the completion of the component.

* * * * * * *

SEC. 1215. RESTRICTIONS ON USE OF PAYMENTS.

(a) IN GENERAL.—The Secretary may not, except as provided in subsection (b), make payments under section 1211(a) for a fiscal year unless the State involved agrees that the payments will not be expended—

(1) subject to section 1233, for any purpose other than developing, implementing, and monitoring the modifications required by section 1211(b) to be made to the State plan for the provision of emergency medical services[.]*;*

* * * * * * *

[SEC. 1216. REQUIREMENT OF REPORTS BY STATES.

[(a) IN GENERAL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees to prepare and submit to the Secretary an annual report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for—

[(1) securing a record and a description of the purposes for which payments received by the State pursuant to such section were expended and of the recipients of such payments; and

[(2) determining whether the payments were expended in accordance with the purpose of the program involved.

[(b) AVAILABILITY TO PUBLIC OF REPORTS.—The Secretary may not make payments under section 1211(a) unless the State involved agrees that the State will make copies of the report described in subsection (a) available for public inspection.

[(c) EVALUATIONS BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall evaluate the expenditures by States of payments under section 1211(a) in order to assure that expenditures are consistent with the provisions of this part, and not later than December 1, 1994, prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report concerning such evaluation.]

SEC. 1216. [RESERVED].

* * * * * * *

SEC. 1222. REPORT BY SECRETARY.

Not later than October 1, [1995] *2006*, the Secretary shall report to the appropriate committees of Congress on the activities of the States carried out pursuant to section 1211. Such report shall include an assessment of the extent to which Federal and State efforts to develop systems of trauma care and to designate trauma centers have reduced the incidence of mortality, and the incidence of permanent disability, resulting from trauma. Such report may include any recommendations of the Secretary for appropriate administrative and legislative initiatives with respect to trauma care.

* * * * * * *

SEC. 1232. FUNDING.

[(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out parts A and B, there are authorized to be appropriated $6,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 2002.]

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out parts A and B, there are authorized to be appropriated $12,000,000 for fiscal year 2004, and such sums as may be necessary for each of the fiscal years 2005 through 2008.

(b) ALLOCATIONS OF FUNDS BY SECRETARY.—

(1) GENERAL AUTHORITY.—For the purpose of carrying out part A, the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under subsection (a).

(2) RURAL GRANTS.—For the purpose of carrying out section [1204] *1202*, the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under subsection (a).

* * * * * * *

[Part E—Miscellaneous Programs]

PART E—MISCELLANEOUS PROGRAMS

SEC. 1251. RESIDENCY TRAINING PROGRAMS IN EMERGENCY MEDICINE.

(a) IN GENERAL.—* * *

* * * * * * *

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated

$400,000 for each of the fiscal years [1993 through 1995] *2004 through 2008*.

* * * * * * *

SEC. 1252. STATE GRANTS FOR [DEMONSTRATION] PROJECTS REGARDING TRAUMATIC BRAIN INJURY.

(a) IN GENERAL.—* * *

* * * * * * *

SEC. 1254. INSTITUTE OF MEDICINE STUDY.

(a) IN GENERAL.—The Secretary shall enter into a contract with the Institute of Medicine of the National Academy of Sciences, or another appropriate entity, to conduct a study on the state of trauma care and trauma research.

(b) CONTENT.—The study conducted under subsection (a) shall—

(1) examine and evaluate the state of trauma care and trauma systems research (including the role of Federal entities in trauma research) on the date of enactment of this section, and identify trauma research priorities;

(2) examine and evaluate the clinical effectiveness of trauma care and the impact of trauma care on patient outcomes, with special attention to high-risk groups, such as children, the elderly, and individuals in rural areas;

(3) examine and evaluate trauma systems development and identify obstacles that prevent or hinder the effectiveness of trauma systems and trauma systems development;

(4) examine and evaluate alternative strategies for the organization, financing, and delivery of trauma care within an overall systems approach; and

(5) examine and evaluate the role of trauma systems and trauma centers in preparedness for mass casualties.

(c) REPORT.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to the appropriate committees of Congress a report containing the results of the study conducted under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $750,000 for each of fiscal years 2004 and 2005.

* * * * * * *

PART F—INTERAGENCY PROGRAM FOR TRAUMA RESEARCH

SEC. 1261. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health (in this section referred to as the "Director"), shall establish a comprehensive program of [conducting basic and clinical research on trauma (in this section referred to as the "Program"). The Program shall include research regarding the diagnosis, treatment, rehabilitation, and general management of trauma.] *basic and clinical research on trauma (in this section referred to as the "Program"), including the prevention, diagnosis, treatment, and rehabilitation of trauma-related injuries.*

[(b) PLAN FOR PROGRAM.—

[(1) IN GENERAL.—The Director, in consultation with the Trauma Research Interagency Coordinating Committee estab-

lished under subsection (g), shall establish and implement a plan for carrying out the activities of the Program, including the activities described in subsection (d). All such activities shall be carried out in accordance with the plan. The plan shall be periodically reviewed, and revised as appropriate.

[(2) SUBMISSION TO CONGRESS.—Not later than December 1, 1993, the Director shall submit the plan required in paragraph (1) to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, together with an estimate of the funds needed for each of the fiscal years 1994 through 1996 to implement the plan.]

(b) PLAN FOR PROGRAM.—The Director shall establish and implement a plan for carrying out the activities of the Program, taking into consideration the recommendations contained within the report of the NIH Trauma Research Task Force. The plan shall be periodically reviewed, and revised as appropriate.

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(d) CERTAIN ACTIVITIES OF PROGRAM.—The Program shall include—

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(4) the authority to make awards of grants or contracts to public or nonprofit private entities for the conduct of basic and applied research regarding traumatic brain injury, which research may include—

(A) the development of new methods and modalities for the more effective diagnosis, measurement of degree of brain injury, post-injury monitoring and prognostic assessment of head injury for acute, subacute and later phases of care;

(B) the development, modification and evaluation of therapies that retard, prevent or reverse brain damage after [acute head injury] *traumatic brain injury*, that arrest further deterioration following injury and that provide the restitution of function for individuals with long-term injuries;

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[(D) the development of programs that increase the participation of academic centers of excellence in [head] *traumatic* brain injury treatment and rehabilitation research and training; and

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[(g) COORDINATING COMMITTEE.—

[(1) IN GENERAL.—There shall be established a Trauma Research Interagency Coordinating Committee (in this section referred to as the "Coordinating Committee").

[(2) DUTIES.—The Coordinating Committee shall make recommendations regarding—

[(A) the activities of the Program to be carried out by each of the agencies represented on the Committee and the amount of funds needed by each of the agencies for such activities; and

[(B) effective collaboration among the agencies in carrying out the activities.

[(3) COMPOSITION.—The Coordinating Committee shall be composed of the Directors of each of the agencies that, under subsection (c), have responsibilities under the Program, and any other individuals who are practitioners in the trauma field as designated by the Director of the National Institutes of Health.]

[(h)] *(g)* DEFINITIONS.—For purposes of this section:

(1) The term "designated trauma center" has the meaning given such term in section 1231(1).

(2) The term "Director" means the Director of the National Institutes of Health.

(3) The term "trauma" means any serious injury that could result in loss of life or in significant disability and that would meet pre-hospital triage criteria for transport to a designated trauma center.

(4) The term "traumatic brain injury" means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to trauma. The Secretary may revise the definition of such term as the Secretary determines necessary, after consultation with States and other appropriate public or nonprofit private entities.

[(i)] *(h)* AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years [2001 through 2005] *2004 through 2008*.

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