Baker (3)

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate has taken up and passed

SS SCS HB 2331 entitled:

AN ACT

To repeal sections 172.800, 191.116, 191.500, 191.515, 191.520, 191.525, 191.743, 192.005, 192.2225, 194.210, 194.255, 194.265, 194.285, 194.290, 194.297, 194.299, 194.304, 195.206, 195.815, 196.866, 196.868, 197.100, 197.256, 197.258, 197.400, 197.415, 197.445, 198.006, 198.022, 198.026, 198.036, 198.525, 198.526, 198.545, 251.070, 301.020, 302.171, 335.230, 335.257, and 660.010, RSMo, and to enact in lieu thereof thirty-seven new sections relating to programs administered by the department of health and senior services, with penalty provisions.

With SA 1 & SA 2

In which the concurrence of the House is respectfully requested.

Respectfully,

Adriane D Crouse

Adriane D. Crouse
Secretary of the Senate

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BY:

SENATE AMENDMENT NO. 1

Offered by Hegeman of Andrew

Amend SS/SCS/House Bill No. 2331, Page 1, Section A, Line 14,

by inserting after all of said line the following:

"135.690. 1. As used in this section, the following terms mean:

(1) "Community-based faculty preceptor", a physician or physician assistant who is licensed in Missouri and provides preceptorships to Missouri medical students or physician assistant students without direct compensation for the work of precepting;

(2) "Department", the Missouri department of health and senior services;

(3) "Division", the division of professional registration of the department of commerce and insurance;

(4) "Federally Qualified Health Center (FQHC)", a reimbursement designation from the Bureau of Primary Health Care and the Centers for Medicare and Medicaid services of the United States Department of Health and Human Services;

(5) "Medical student", an individual enrolled in a Missouri medical college approved and accredited as reputable by the American Medical Association or the Liaison Committee on Medical Education or enrolled in a Missouri osteopathic college approved and accredited as reputable by the Commission on Osteopathic College Accreditation;

(6) "Medical student core preceptorship" or "physician assistant student core preceptorship", a preceptorship for a medical student or physician assistant student that provides

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a minimum of one hundred twenty hours of community-based instruction in family medicine, internal medicine, pediatrics, psychiatry, or obstetrics and gynecology under the guidance of a community-based faculty preceptor. A community-based faculty preceptor may add together the amounts of preceptorship instruction time separately provided to multiple students in determining whether he or she has reached the minimum hours required under this subdivision, but the total preceptorship instruction time provided shall equal at least one hundred twenty hours in order for such preceptor to be eligible for the tax credit authorized under this section;

(7) "Physician assistant student", an individual participating in a Missouri physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant or its successor organization;

(8) "Taxpayer", any individual, firm, partner in a firm, corporation, or shareholder in an S corporation doing business in this state and subject to the state income tax imposed under chapter 143, excluding withholding tax imposed under sections 143.191 to 143.265.

2. (1) Beginning January 1, 2023, any community-based faculty preceptor who serves as the community-based faculty preceptor for a medical student core preceptorship or a physician assistant student core preceptorship shall be allowed a credit against the tax otherwise due under chapter 143, excluding withholding tax imposed under sections 143.191 to 143.265, in an amount equal to one thousand dollars for each preceptorship, up to a maximum of three thousand dollars per tax year, if he or she completes up to three preceptorship rotations during the tax year and did not receive any direct compensation for the preceptorships.

(2) To receive the credit allowed by this section, a community-based faculty preceptor shall claim such credit on his or her return for the tax year in which he or she completes the preceptorship rotations and shall submit supporting documentation as prescribed by the division and the department.

(3) In no event shall the total amount of a tax credit authorized under this section exceed a taxpayer's income tax liability for the tax year for which such credit is claimed. No tax credit authorized under this section shall be allowed a taxpayer against his or her tax liability for any prior or succeeding tax year.

(4) No more than two hundred preceptorship tax credits shall be authorized under this section for any one calendar year. The tax credits shall be awarded on a first-come, first-served basis. The division and the department shall jointly promulgate rules for determining the manner in which taxpayers who have obtained certification under this section are able to claim the tax credit. The cumulative amount of tax credits awarded under this section shall not exceed two hundred thousand dollars per year.

(5) Notwithstanding the provisions of subdivision (4) of this subsection, the department is authorized to exceed the two hundred thousand dollars per year tax credit program cap in any amount not to exceed the amount of funds remaining in the medical preceptor fund, as established under subsection 3 of this section, as of the end of the most recent tax year, after any required transfers to the general revenue fund have taken place in accordance with the provisions of subsection 3 of this section.

3. (1) Funding for the tax credit program authorized under this section shall be generated by the division from a license fee increase of seven dollars per license for

physicians and surgeons and from a license fee increase of three dollars per license for physician assistants. The license fee increases shall take effect beginning January 1, 2023, based on the underlying license fee rates prevailing on that date. The underlying license fee rates shall be determined under section 334.090 and all other applicable provisions of chapter 334.

(2) (a) There is hereby created in the state treasury the "Medical Preceptor Fund", which shall consist of moneys collected under this subsection. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, moneys in the fund shall be used solely by the department for the administration of the tax credit program authorized under this section. Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund. The state treasurer shall invest moneys in the medical preceptor fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

(b) Notwithstanding any provision of this chapter or any other provision of law to the contrary, all revenue from the license fee increases described under subdivision (1) of this subsection shall be deposited in the medical preceptor fund. After the end of every tax year, an amount equal to the total dollar amount of all tax credits claimed under this section shall be transferred from the medical preceptor fund to the state's general revenue fund established under section 33.543. Any excess moneys in the medical preceptor

fund shall remain in the fund and shall not be transferred to the general revenue fund.

4. (1) The department shall administer the tax credit program authorized under this section. Each taxpayer claiming a tax credit under this section shall file an application with the department verifying the number of hours of instruction and the amount of the tax credit claimed. The hours claimed on the application shall be verified by the college or university department head or the program director on the application. The certification by the department affirming the taxpayer's eligibility for the tax credit provided to the taxpayer shall be filed with the taxpayer's income tax return.

(2) No amount of any tax credit allowed under this section shall be refundable. No tax credit allowed under this section shall be transferred, sold, or assigned. No taxpayer shall be eligible to receive the tax credit authorized under this section if such taxpayer employs persons who are not authorized to work in the United States under federal law.

5. The department of commerce and insurance and the department of health and senior services shall jointly promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking

authority and any rule proposed or adopted after August 28, 2022, shall be invalid and void."; and

Further amend the title and enacting clause accordingly.

SENATE AMENDMENT NO. 2

Offered by SNYDER of 2

Amend SS/SCS/House Bill No. 2331, Page 2, Section 172.800, Line 24,

by inserting after all of said line the following:

"190.100. As used in sections 190.001 to 190.245 and section 190.257, the following words and terms mean:

(1) "Advanced emergency medical technician" or "AEMT", a person who has successfully completed a course of instruction in certain aspects of advanced life support care as prescribed by the department and is licensed by the department in accordance with sections 190.001 to 190.245 and rules and regulations adopted by the department pursuant to sections 190.001 to 190.245;

(2) "Advanced life support (ALS)", an advanced level of care as provided to the adult and pediatric patient such as defined by national curricula, and any modifications to that curricula specified in rules adopted by the department pursuant to sections 190.001 to 190.245;

(3) "Ambulance", any privately or publicly owned vehicle or craft that is specially designed, constructed or modified, staffed or equipped for, and is intended or used, maintained or operated for the transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless, or who require the presence of medical equipment being used on such individuals, but the term does not include any motor vehicle specially designed, constructed or converted for the regular transportation of persons who are disabled, handicapped, normally using a wheelchair, or

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otherwise not acutely ill, or emergency vehicles used within airports;

(4) "Ambulance service", a person or entity that provides emergency or nonemergency ambulance transportation and services, or both, in compliance with sections 190.001 to 190.245, and the rules promulgated by the department pursuant to sections 190.001 to 190.245;

(5) "Ambulance service area", a specific geographic area in which an ambulance service has been authorized to operate;

(6) "Basic life support (BLS)", a basic level of care, as provided to the adult and pediatric patient as defined by national curricula, and any modifications to that curricula specified in rules adopted by the department pursuant to sections 190.001 to 190.245;

(7) "Council", the state advisory council on emergency medical services;

(8) "Department", the department of health and senior services, state of Missouri;

(9) "Director", the director of the department of health and senior services or the director's duly authorized representative;

(10) "Dispatch agency", any person or organization that receives requests for emergency medical services from the public, by telephone or other means, and is responsible for dispatching emergency medical services;

(11) "Emergency", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that the absence of immediate medical care could result in:

(a) Placing the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain;

(12) "Emergency medical dispatcher", a person who receives emergency calls from the public and has successfully completed an emergency medical dispatcher course, meeting or exceeding the national curriculum of the United States Department of Transportation and any modifications to such curricula specified by the department through rules adopted pursuant to sections 190.001 to 190.245;

(13) "Emergency medical responder", a person who has successfully completed an emergency first response course meeting or exceeding the national curriculum of the U.S. Department of Transportation and any modifications to such curricula specified by the department through rules adopted under sections 190.001 to 190.245 and who provides emergency medical care through employment by or in association with an emergency medical response agency;

(14) "Emergency medical response agency", any person that regularly provides a level of care that includes first response, basic life support or advanced life support, exclusive of patient transportation;

(15) "Emergency medical services for children (EMS-C) system", the arrangement of personnel, facilities and equipment for effective and coordinated delivery of pediatric emergency medical services required in prevention and management of incidents which occur as a result of a medical emergency or of an injury event, natural disaster or similar situation;

(16) "Emergency medical services (EMS) system", the arrangement of personnel, facilities and equipment for the effective and coordinated delivery of emergency medical services required in prevention and management of incidents occurring as a result of an illness, injury, natural disaster or similar situation;

(17) "Emergency medical technician", a person licensed in emergency medical care in accordance with standards prescribed by sections 190.001 to 190.245, and by rules adopted by the department pursuant to sections 190.001 to 190.245;

(18) "Emergency medical technician-basic" or "EMT-B", a person who has successfully completed a course of instruction in basic life support as prescribed by the department and is licensed by the department in accordance with standards prescribed by sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245;

(19) "Emergency medical technician-community paramedic", "community paramedic", or "EMT-CP", a person who is certified as an emergency medical technician-paramedic and is certified by the department in accordance with standards prescribed in section 190.098;

(20) "Emergency medical technician-paramedic" or "EMT-P", a person who has successfully completed a course of instruction in advanced life support care as prescribed by the department and is licensed by the department in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245;

(21) "Emergency services", health care items and services furnished or required to screen and stabilize an emergency which may include, but shall not be limited to,

health care services that are provided in a licensed hospital's emergency facility by an appropriate provider or by an ambulance service or emergency medical response agency;

(22) "Health care facility", a hospital, nursing home, physician's office or other fixed location at which medical and health care services are performed;

(23) "Hospital", an establishment as defined in the hospital licensing law, subsection 2 of section 197.020, or a hospital operated by the state;

(24) "Medical control", supervision provided by or under the direction of physicians, or their designated registered nurse, including both online medical control, instructions by radio, telephone, or other means of direct communications, and offline medical control through supervision by treatment protocols, case review, training, and standing orders for treatment;

(25) "Medical direction", medical guidance and supervision provided by a physician to an emergency services provider or emergency medical services system;

(26) "Medical director", a physician licensed pursuant to chapter 334 designated by the ambulance service or emergency medical response agency and who meets criteria specified by the department by rules pursuant to sections 190.001 to 190.245;

(27) "Memorandum of understanding", an agreement between an emergency medical response agency or dispatch agency and an ambulance service or services within whose territory the agency operates, in order to coordinate emergency medical services;

(28) "Patient", an individual who is sick, injured, wounded, diseased, or otherwise incapacitated or helpless, or dead, excluding deceased individuals being transported from or between private or public institutions, homes or

cemeteries, and individuals declared dead prior to the time an ambulance is called for assistance;

(29) "Person", as used in these definitions and elsewhere in sections 190.001 to 190.245, any individual, firm, partnership, copartnership, joint venture, association, cooperative organization, corporation, municipal or private, and whether organized for profit or not, state, county, political subdivision, state department, commission, board, bureau or fraternal organization, estate, public trust, business or common law trust, receiver, assignee for the benefit of creditors, trustee or trustee in bankruptcy, or any other service user or provider;

(30) "Physician", a person licensed as a physician pursuant to chapter 334;

(31) "Political subdivision", any municipality, city, county, city not within a county, ambulance district or fire protection district located in this state which provides or has authority to provide ambulance service;

(32) "Professional organization", any organized group or association with an ongoing interest regarding emergency medical services. Such groups and associations could include those representing volunteers, labor, management, firefighters, EMT-B's, nurses, EMT-P's, physicians, communications specialists and instructors. Organizations could also represent the interests of ground ambulance services, air ambulance services, fire service organizations, law enforcement, hospitals, trauma centers, communication centers, pediatric services, labor unions and poison control services;

(33) "Proof of financial responsibility", proof of ability to respond to damages for liability, on account of accidents occurring subsequent to the effective date of such proof, arising out of the ownership, maintenance or use of a

motor vehicle in the financial amount set in rules promulgated by the department, but in no event less than the statutory minimum required for motor vehicles. Proof of financial responsibility shall be used as proof of self-insurance;

(34) "Protocol", a predetermined, written medical care guideline, which may include standing orders;

(35) "Regional EMS advisory committee", a committee formed within an emergency medical services (EMS) region to advise ambulance services, the state advisory council on EMS and the department;

(36) "Specialty care transportation", the transportation of a patient requiring the services of an emergency medical technician-paramedic who has received additional training beyond the training prescribed by the department. Specialty care transportation services shall be defined in writing in the appropriate local protocols for ground and air ambulance services and approved by the local physician medical director. The protocols shall be maintained by the local ambulance service and shall define the additional training required of the emergency medical technician-paramedic;

(37) "Stabilize", with respect to an emergency, the provision of such medical treatment as may be necessary to attempt to assure within reasonable medical probability that no material deterioration of an individual's medical condition is likely to result from or occur during ambulance transportation unless the likely benefits of such transportation outweigh the risks;

(38) "State advisory council on emergency medical services", a committee formed to advise the department on policy affecting emergency medical service throughout the state;

(39) "State EMS medical directors advisory committee", a subcommittee of the state advisory council on emergency medical services formed to advise the state advisory council on emergency medical services and the department on medical issues;

(40) "STEMI" or "ST-elevation myocardial infarction", a type of heart attack in which impaired blood flow to the patient's heart muscle is evidenced by ST-segment elevation in electrocardiogram analysis, and as further defined in rules promulgated by the department under sections 190.001 to 190.250;

(41) "STEMI care", includes education and prevention, emergency transport, triage, and acute care and rehabilitative services for STEMI that requires immediate medical or surgical intervention or treatment;

(42) "STEMI center", a hospital that is currently designated as such by the department to care for patients with ST-segment elevation myocardial infarctions;

(43) "Stroke", a condition of impaired blood flow to a patient's brain as defined by the department;

(44) "Stroke care", includes emergency transport, triage, and acute intervention and other acute care services for stroke that potentially require immediate medical or surgical intervention or treatment, and may include education, primary prevention, acute intervention, acute and subacute management, prevention of complications, secondary stroke prevention, and rehabilitative services;

(45) "Stroke center", a hospital that is currently designated as such by the department;

(46) <u>"Time-critical diagnosis", trauma care, stroke care, and STEMI care occurring either outside of a hospital or in a center designated under section 190.241;</u>

(47) "Time-critical diagnosis advisory committee", a committee formed under section 190.257 to advise the department on policies impacting trauma, stroke, and STEMI center designations; regulations on trauma care, stroke care, and STEMI care; and the transport of trauma, stroke, and STEMI patients;

(48) "Trauma", an injury to human tissues and organs resulting from the transfer of energy from the environment;

[(47)] (49) "Trauma care" includes injury prevention, triage, acute care and rehabilitative services for major single system or multisystem injuries that potentially require immediate medical or surgical intervention or treatment;

[(48)] (50) "Trauma center", a hospital that is currently designated as such by the department.

190.101. 1. There is hereby established a "State Advisory Council on Emergency Medical Services" which shall consist of sixteen members, one of which shall be a resident of a city not within a county. The members of the council shall be appointed by the governor with the advice and consent of the senate and shall serve terms of four years. The governor shall designate one of the members as chairperson. The chairperson may appoint subcommittees that include noncouncil members.

2. The state EMS medical directors advisory committee and the regional EMS advisory committees will be recognized as subcommittees of the state advisory council on emergency medical services.

3. The council shall have geographical representation and representation from appropriate areas of expertise in emergency medical services including volunteers, professional organizations involved in emergency medical services, EMT's, paramedics, nurses, firefighters,

physicians, ambulance service administrators, hospital administrators and other health care providers concerned with emergency medical services. The regional EMS advisory committees shall serve as a resource for the identification of potential members of the state advisory council on emergency medical services.

4. The state EMS medical director, as described under section 190.103, shall serve as an ex officio member of the council.

5. The members of the council and subcommittees shall serve without compensation except that members of the council shall, subject to appropriations, be reimbursed for reasonable travel expenses and meeting expenses related to the functions of the council.

[5.] 6. The purpose of the council is to make recommendations to the governor, the general assembly, and the department on policies, plans, procedures and proposed regulations on how to improve the statewide emergency medical services system. The council shall advise the governor, the general assembly, and the department on all aspects of the emergency medical services system.

[6.] 7. (1) There is hereby established a standing subcommittee of the council to monitor the implementation of the recognition of the EMS personnel licensure interstate compact under sections 190.900 to 190.939, the interstate commission for EMS personnel practice, and the involvement of the state of Missouri. The subcommittee shall meet at least biannually and receive reports from the Missouri delegate to the interstate commission for EMS personnel practice. The subcommittee shall consist of at least seven members appointed by the chair of the council, to include at least two members as recommended by the Missouri state council of firefighters and one member as recommended by the

Missouri Association of Fire Chiefs. The subcommittee may submit reports and recommendations to the council, the department of health and senior services, the general assembly, and the governor regarding the participation of Missouri with the recognition of the EMS personnel licensure interstate compact.

(2) The subcommittee shall formally request a public hearing for any rule proposed by the interstate commission for EMS personnel practice in accordance with subsection 7 of section 190.930. The hearing request shall include the request that the hearing be presented live through the internet. The Missouri delegate to the interstate commission for EMS personnel practice shall be responsible for ensuring that all hearings, notices of, and related rulemaking communications as required by the compact be communicated to the council and emergency medical services personnel under the provisions of subsections 4, 5, 6, and 8 of section 190.930.

(3) The department of health and senior services shall not establish or increase fees for Missouri emergency medical services personnel licensure in accordance with this chapter for the purpose of creating the funds necessary for payment of an annual assessment under subdivision (3) of subsection 5 of section 190.924.

8. The council shall consult with the time-critical diagnosis advisory committee, as described under section 190.257, regarding time-critical diagnosis.

190.103. 1. One physician with expertise in emergency medical services from each of the EMS regions shall be elected by that region's EMS medical directors to serve as a regional EMS medical director. The regional EMS medical directors shall constitute the state EMS medical director's advisory committee and shall advise the department and their

region's ambulance services on matters relating to medical control and medical direction in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245. The regional EMS medical director shall serve a term of four years. The southwest, northwest, and Kansas City regional EMS medical directors shall be elected to an initial two-year term. The central, east central, and southeast regional EMS medical directors shall be elected to an initial four-year term. All subsequent terms following the initial terms shall be four years. The state EMS medical director shall be the chair of the state EMS medical director's advisory committee, and shall be elected by the members of the regional EMS medical director's advisory committee, shall serve a term of four years, and shall seek to coordinate EMS services between the EMS regions, promote educational efforts for agency medical directors, represent Missouri EMS nationally in the role of the state EMS medical director, and seek to incorporate the EMS system into the health care system serving Missouri.

2. A medical director is required for all ambulance services and emergency medical response agencies that provide: advanced life support services; basic life support services utilizing medications or providing assistance with patients' medications; or basic life support services performing invasive procedures including invasive airway procedures. The medical director shall provide medical direction to these services and agencies in these instances.

3. The medical director, in cooperation with the ambulance service or emergency medical response agency administrator, shall have the responsibility and the authority to ensure that the personnel working under their supervision are able to provide care meeting established

standards of care with consideration for state and national standards as well as local area needs and resources. The medical director, in cooperation with the ambulance service or emergency medical response agency administrator, shall establish and develop triage, treatment and transport protocols, which may include authorization for standing orders. Emergency medical technicians shall only perform those medical procedures as directed by treatment protocols approved by the local medical director or when authorized through direct communication with online medical control.

4. All ambulance services and emergency medical response agencies that are required to have a medical director shall establish an agreement between the service or agency and their medical director. The agreement will include the roles, responsibilities and authority of the medical director beyond what is granted in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245. The agreement shall also include grievance procedures regarding the emergency medical response agency or ambulance service, personnel and the medical director.

5. Regional EMS medical directors and the state EMS medical director elected as provided under subsection 1 of this section shall be considered public officials for purposes of sovereign immunity, official immunity, and the Missouri public duty doctrine defenses.

6. The state EMS medical director's advisory committee shall be considered a peer review committee under section 537.035.

7. Regional EMS medical directors may act to provide online telecommunication medical direction to AEMTs, EMT-Bs, EMT-Ps, and community paramedics and provide offline medical direction per standardized treatment, triage, and transport

protocols when EMS personnel, including AEMTs, EMT-Bs, EMT-Ps, and community paramedics, are providing care to special needs patients or at the request of a local EMS agency or medical director.

8. When developing treatment protocols for special needs patients, regional EMS medical directors may promulgate such protocols on a regional basis across multiple political subdivisions' jurisdictional boundaries, and such protocols may be used by multiple agencies including, but not limited to, ambulance services, emergency response agencies, and public health departments. Treatment protocols shall include steps to ensure the receiving hospital is informed of the pending arrival of the special needs patient, the condition of the patient, and the treatment instituted.

9. Multiple EMS agencies including, but not limited to, ambulance services, emergency response agencies, and public health departments shall take necessary steps to follow the regional EMS protocols established as provided under subsection 8 of this section in cases of mass casualty or state-declared disaster incidents.

10. When regional EMS medical directors develop and implement treatment protocols for patients or provide online medical direction for patients, such activity shall not be construed as having usurped local medical direction authority in any manner.

11. The state EMS medical directors advisory committee shall review and make recommendations regarding all proposed community and regional time-critical diagnosis plans.

12. Notwithstanding any other provision of law to the contrary, when regional EMS medical directors are providing either online telecommunication medical direction to AEMTs, EMT-Bs, EMT-Ps, and community paramedics, or offline medical

direction per standardized EMS treatment, triage, and transport protocols for patients, those medical directions or treatment protocols may include the administration of the patient's own prescription medications.

190.176. 1. The department shall develop and administer a uniform data collection system on all ambulance runs and injured patients, pursuant to rules promulgated by the department for the purpose of injury etiology, patient care outcome, injury and disease prevention and research purposes. The department shall not require disclosure by hospitals of data elements pursuant to this section unless those data elements are required by a federal agency or were submitted to the department as of January 1, 1998, pursuant to:

(1) Departmental regulation of trauma centers; or

(2) [The Missouri brain and spinal cord injury registry established by sections 192.735 to 192.745; or

(3)] Abstracts of inpatient hospital data; or

[(4)] (3) If such data elements are requested by a lawful subpoena or subpoena duces tecum.

2. All information and documents in any civil action, otherwise discoverable, may be obtained from any person or entity providing information pursuant to the provisions of sections 190.001 to 190.245.

190.200. 1. The department of health and senior services in cooperation with hospitals and local and regional EMS systems and agencies may provide public and professional information and education programs related to emergency medical services systems including trauma, STEMI, and stroke systems and emergency medical care and treatment. The department of health and senior services may also provide public information and education programs for informing residents of and visitors to the state of the

availability and proper use of emergency medical services, of the designation a hospital may receive as a trauma center, STEMI center, or stroke center, of the value and nature of programs to involve citizens in the administering of prehospital emergency care, including cardiopulmonary resuscitation, and of the availability of training programs in emergency care for members of the general public.

2. The department shall, for trauma care, STEMI care, and stroke care, respectively:

(1) Compile [and], assess, and make publicly available peer-reviewed and evidence-based clinical research and guidelines that provide or support recommended treatment standards and that have been recommended by the time-critical diagnosis advisory committee;

(2) Assess the capacity of the emergency medical services system and hospitals to deliver recommended treatments in a timely fashion;

(3) Use the research, guidelines, and assessment to promulgate rules establishing protocols for transporting trauma patients to a trauma center, STEMI patients to a STEMI center, or stroke patients to a stroke center. Such transport protocols shall direct patients to trauma centers, STEMI centers, and stroke centers under section 190.243 based on the centers' capacities to deliver recommended acute care treatments within time limits suggested by clinical research;

(4) Define regions within the state for purposes of coordinating the delivery of trauma care, STEMI care, and stroke care, respectively;

(5) Promote the development of regional or community-based plans for transporting trauma, STEMI, or stroke patients via ground or air ambulance to trauma centers,

STEMI centers, or stroke centers, respectively, in accordance with section 190.243; and

(6) Establish procedures for the submission of community-based or regional plans for department approval.

3. A community based or regional plan for the transport of trauma, STEMI, and stroke patients shall be submitted to the department for approval. Such plan shall be based on the clinical research and guidelines and assessment of capacity described in subsection [1] 2 of this section and shall include a mechanism for evaluating its effect on medical outcomes. Upon approval of a plan, the department shall waive the requirements of rules promulgated under sections 190.100 to 190.245 that are inconsistent with the community-based or regional plan. A community-based or regional plan shall be developed by [or in consultation with] the representatives of hospitals, physicians, and emergency medical services providers in the community or region.

190.241. 1. Except as provided for in subsection 4 of this section, the department shall designate a hospital as an adult, pediatric or adult and pediatric trauma center when a hospital, upon proper application submitted by the hospital and site review, has been found by the department to meet the applicable level of trauma center criteria for designation in accordance with rules adopted by the department as prescribed by section 190.185. Site review may occur on-site or by any reasonable means of communication, or by any combination thereof. Such rules shall include designation as a trauma center without site review if such hospital is verified by a national verifying or designating body at the level which corresponds to a level approved in rule. In developing trauma center designation criteria, the department shall use, as it deems

practicable, peer-reviewed and evidence-based clinical research and guidelines including, but not limited to, the most recent guidelines of the American College of Surgeons.

2. Except as provided for in subsection [5] 4 of this section, the department shall designate a hospital as a STEMI or stroke center when such hospital, upon proper application and site review, has been found by the department to meet the applicable level of STEMI or stroke center criteria for designation in accordance with rules adopted by the department as prescribed by section 190.185. Site review may occur on-site or by any reasonable means of communication, or by any combination thereof. In developing STEMI center and stroke center designation criteria, the department shall use, as it deems practicable, [appropriate] peer-reviewed [or] and evidence-based clinical research [on such topics] and guidelines including, but not limited to, the most recent guidelines of the American College of Cardiology [and], the American Heart Association [for STEMI centers, or the Joint Commission's Primary Stroke Center Certification program criteria for stroke centers, or Primary and Comprehensive Stroke Center Recommendations as published by], or the American Stroke Association. Such rules shall include designation as a STEMI center or stroke center without site review if such hospital is certified by a national body.

3. The department of health and senior services shall, not less than once every [five] three years, conduct [an on-site] a site review of every trauma, STEMI, and stroke center through appropriate department personnel or a qualified contractor, with the exception of trauma centers, STEMI centers, and stroke centers designated pursuant to subsection [5] 4 of this section; however, this provision is not intended to limit the department's ability to conduct a

complaint investigation pursuant to subdivision (3) of subsection 2 of section 197.080 of any trauma, STEMI, or stroke center. [On-site] Site reviews shall be coordinated for the different types of centers to the extent practicable with hospital licensure inspections conducted under chapter 197. No person shall be a qualified contractor for purposes of this subsection who has a substantial conflict of interest in the operation of any trauma, STEMI, or stroke center under review. The department may deny, place on probation, suspend or revoke such designation in any case in which it has [reasonable cause to believe that] determined there has been a substantial failure to comply with the provisions of this chapter or any rules or regulations promulgated pursuant to this chapter. Centers that are placed on probationary status shall be required to demonstrate compliance with the provisions of this chapter and any rules or regulations promulgated under this chapter within twelve months of the date of the receipt of the notice of probationary status, unless otherwise provided by a settlement agreement with a duration of a maximum of eighteen months between the department and the designated center. If the department of health and senior services has [reasonable cause to believe] determined that a hospital is not in compliance with such provisions or regulations, it may conduct additional announced or unannounced site reviews of the hospital to verify compliance. If a trauma, STEMI, or stroke center fails two consecutive [on-site] site reviews because of substantial noncompliance with standards prescribed by sections 190.001 to 190.245 or rules adopted by the department pursuant to sections 190.001 to 190.245, its center designation shall be revoked.

4. (1) Instead of applying for trauma, STEMI, or stroke center designation under subsection 1 or 2 of this

section, a hospital may apply for trauma, STEMI, or stroke center designation under this subsection. Upon receipt of an application [from a hospital] on a form prescribed by the department, the department shall designate such hospital[:

(1) A level I STEMI center if such hospital has been certified as a Joint Commission comprehensive cardiac center or another department-approved nationally recognized organization that provides comparable STEMI center accreditation; or

(2) A level II STEMI center if such hospital has been accredited as a Mission: Lifeline STEMI receiving center by the American Heart Association accreditation process or another department-approved nationally recognized organization that provides STEMI receiving center accreditation.

5. Instead of applying for stroke center designation pursuant to the provisions of subsection 2 of this section, a hospital may apply for stroke center designation pursuant to this subsection. Upon receipt of an application from a hospital on a form prescribed by the department, the department shall designate such hospital:

(1) A level I stroke center if such hospital has been certified as a comprehensive stroke center by the Joint Commission or any other certifying organization designated by the department when such certification is in accordance with the American Heart Association/American Stroke Association guidelines;

(2) A level II stroke center if such hospital has been certified as a primary stroke center by the Joint Commission or any other certifying organization designated by the department when such certification is in accordance with the American Heart Association/American Stroke Association guidelines; or

(3) A level III stroke center if such hospital has been certified as an acute stroke-ready hospital by the Joint Commission or any other certifying organization designated by the department when such certification is in accordance with the American Heart Association/American Stroke Association guidelines] at a state level that corresponds to a similar national designation as set forth in rules promulgated by the department. The rules shall be based on standards of nationally recognized organizations and the recommendations of the time-critical diagnosis advisory committee.

(2) Except as provided by subsection [6] 5 of this section, the department shall not require compliance with any additional standards for establishing or renewing trauma, STEMI, or stroke designations under this subsection. The designation shall continue if such hospital remains certified or verified. The department may remove a hospital's designation as a trauma center, STEMI center, or stroke center if the hospital requests removal of the designation or the department determines that the certificate [recognizing] or verification that qualified the hospital [as a stroke center] for the designation under this subsection has been suspended or revoked. Any decision made by the department to withdraw its designation of a [stroke] center pursuant to this subsection that is based on the revocation or suspension of a certification or verification by a certifying or verifying organization shall not be subject to judicial review. The department shall report to the certifying or verifying organization any complaint it receives related to the [stroke] center [certification of a stroke center] designated pursuant to this subsection. The department shall also advise the complainant which organization certified or verified the [stroke] center and

provide the necessary contact information should the complainant wish to pursue a complaint with the certifying or verifying organization.

[6.] 5. Any hospital receiving designation as a trauma center, STEMI center, or stroke center pursuant to subsection [5] 4 of this section shall:

(1) [Annually and] Within thirty days of any changes or receipt of a certificate or verification, submit to the department proof of [stroke] certification or verification and the names and contact information of the center's medical director and the program manager [of the stroke center]; and

(2) [Submit to the department a copy of the certifying organization's final stroke certification survey results within thirty days of receiving such results;

(3) Submit every four years an application on a form prescribed by the department for stroke center review and designation;

(4) Participate in the emergency medical services regional system of stroke care in its respective emergency medical services region as defined in rules promulgated by the department;

(5)] Participate in local and regional emergency medical services systems [by reviewing and sharing outcome data and] for purposes of providing training [and], sharing clinical educational resources, and collaborating on improving patient outcomes.

Any hospital receiving designation as a level III stroke center pursuant to subsection [5] 4 of this section shall have a formal agreement with a level I or level II stroke center for physician consultative services for evaluation of stroke patients for thrombolytic therapy and the care of the patient post-thrombolytic therapy.

[7.] 6. Hospitals designated as a trauma center, STEMI center, or stroke center by the department[, including those designated pursuant to subsection 5 of this section,] shall submit data [to meet the data submission requirements specified by rules promulgated by the department. Such submission of data may be done] by one of the following methods:

(1) Entering hospital data [directly] into a state registry [by direct data entry]; or

(2) [Downloading hospital data from a nationally recognized registry or data bank and importing the data files into a state registry; or

(3) Authorizing a nationally recognized registry or data bank to disclose or grant access to the department facility-specific data held by the] Entering hospital data into a national registry or data bank. A hospital submitting data pursuant to this subdivision [(2) or (3) of this subsection] shall not be required to collect and submit any additional trauma, STEMI, or stroke center data elements. No hospital submitting data to a national data registry or data bank under this subdivision shall withhold authorization for the department to access such data through such national data registry or data bank. Nothing in this subdivision shall be construed as requiring duplicative data entry by a hospital that is otherwise complying with the provisions of this subsection. Failure of the department to obtain access to data submitted to a national data registry or data bank shall not be construed as hospital noncompliance under this subsection.

[8.] 7. When collecting and analyzing data pursuant to the provisions of this section, the department shall comply with the following requirements:

(1) Names of any health care professionals, as defined in section 376.1350, shall not be subject to disclosure;

(2) The data shall not be disclosed in a manner that permits the identification of an individual patient or encounter;

(3) The data shall be used for the evaluation and improvement of hospital and emergency medical services' trauma, stroke, and STEMI care; and

(4) [The data collection system shall be capable of accepting file transfers of data entered into any national recognized trauma, stroke, or STEMI registry or data bank to fulfill trauma, stroke, or STEMI certification reporting requirements; and

(5)] Trauma, STEMI, and stroke center data elements shall conform to [nationally recognized performance measures, such as the American Heart Association's Get With the Guidelines] national registry or data bank data elements, and include published detailed measure specifications, data coding instructions, and patient population inclusion and exclusion criteria to ensure data reliability and validity.

[9. The board of registration for the healing arts shall have sole authority to establish education requirements for physicians who practice in an emergency department of a facility designated as a trauma, STEMI, or stroke center by the department under this section. The department shall deem such education requirements promulgated by the board of registration for the healing arts sufficient to meet the standards for designations under this section.

10.] 8. The department shall not have authority to establish additional education requirements for physicians who are emergency medicine board certified or board eligible

through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department of a facility designated as a trauma center, STEMI center, or stroke center by the department under this section. The department shall deem the education requirements promulgated by ABEM or AOBEM to meet the standards for designations under this section. Education requirements for non-ABEM or non-AOBEM certified physicians, nurses, and other providers who provide care at a facility designated as a trauma center, STEMI center, or stroke center by the department under this section shall mirror but not exceed those established by national designating or verifying bodies of trauma centers, STEMI centers, or stroke centers.

9. The department of health and senior services may establish appropriate fees to offset only the costs of trauma, STEMI, and stroke center [reviews] surveys.

[11.] 10. No hospital shall hold itself out to the public as a STEMI center, stroke center, adult trauma center, pediatric trauma center, or an adult and pediatric trauma center unless it is designated as such by the department of health and senior services.

[12.] 11. Any person aggrieved by an action of the department of health and senior services affecting the trauma, STEMI, or stroke center designation pursuant to this chapter, including the revocation, the suspension, or the granting of, refusal to grant, or failure to renew a designation, may seek a determination thereon by the administrative hearing commission under chapter 621. It shall not be a condition to such determination that the person aggrieved seek a reconsideration, a rehearing, or exhaust any other procedure within the department.

190.243. 1. Severely injured patients shall be transported to a trauma center. Patients who suffer a STEMI, as defined in section 190.100, shall be transported to a STEMI center. Patients who suffer a stroke, as defined in section 190.100, shall be transported to a stroke center.

2. A physician, physician assistant, or registered nurse authorized by a physician who has established verbal communication with ambulance personnel shall instruct the ambulance personnel to transport a severely ill or injured patient to the closest hospital or designated trauma, STEMI, or stroke center, as determined according to estimated transport time whether by ground ambulance or air ambulance, in accordance with transport protocol approved by the medical director and the department of health and senior services, even when the hospital is located outside of the ambulance service's primary service area. When initial transport from the scene of illness or injury to a trauma, STEMI, or stroke center would be prolonged, the STEMI, stroke, or severely injured patient may be transported to the nearest appropriate facility for stabilization prior to transport to a trauma, STEMI, or stroke center.

3. Transport of the STEMI, stroke, or severely injured patient shall be governed by principles of timely and medically appropriate care; consideration of reimbursement mechanisms shall not supersede those principles.

4. Patients who do not meet the criteria for direct transport to a trauma, STEMI, or stroke center shall be transported to and cared for at the hospital of their choice so long as such ambulance service is not in violation of local protocols.

190.245. [The department shall require hospitals, as defined by chapter 197, designated as trauma, STEMI, or stroke centers to provide for a peer review system, approved

by the department, for trauma, STEMI, and stroke cases, respective to their designations, under section 537.035. For purposes of sections 190.241 to 190.245, the department of health and senior services shall have the same powers and authority of a health care licensing board pursuant to subsection 6 of section 537.035.] Failure of a hospital to provide all medical records and quality improvement documentation necessary for the department to implement provisions of sections 190.241 to 190.245 shall result in the revocation of the hospital's designation as a trauma center, STEMI center, or stroke center. Any medical records obtained by the department [or peer review committees] shall be used only for purposes of implementing the provisions of sections 190.241 to 190.245 and the names of hospitals, physicians and patients shall not be released by the department or members of review [committees] teams.

190.257. 1. There is hereby established the "Time-Critical Diagnosis Advisory Committee", to be designated by the director for the purpose of advising and making recommendations to the department on:

(1) Improvement of public and professional education related to time-critical diagnosis;

(2) Engagement in cooperative research endeavors;

(3) Development of standards, protocols, and policies related to time-critical diagnosis, including recommendations for state regulations; and

(4) Evaluation of community and regional time-critical diagnosis plans, including recommendations for changes.

2. The members of the committee shall serve without compensation, except that the department shall budget for reasonable travel expenses and meeting expenses related to the functions of the committee.

3. The director shall appoint sixteen members to the committee from applications submitted for appointment, with the membership to be composed of the following:

(1) Six members, one from each EMS region, who are active participants providing emergency medical services, with at least:

(a) One member who is a physician serving as a regional EMS medical director;

(b) One member who serves on an air ambulance service;

(c) One member who resides in an urban area; and

(d) One member who resides in a rural area; and

(2) Ten members who represent hospitals, with at least:

(a) One member who is employed by a level I or level II trauma center;

(b) One member who is employed by a level I or level II STEMI center;

(c) One member who is employed by a level I or level II stroke center;

(d) One member who is employed by a rural or critical access hospital; and

(e) Three physicians, with one physician certified by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) and two physicians employed in time-critical diagnosis specialties at a level I or level II trauma center, STEMI center, or stroke center.

4. In addition to the sixteen appointees, the state EMS medical director shall serve as an ex officio member of the committee.

5. The director shall make a reasonable effort to ensure that the members representing hospitals have geographical representation from each district of the state

designated by a statewide nonprofit membership association of hospitals.

6. Members appointed by the director shall be appointed for three-year terms. Initial appointments shall include extended terms in order to establish a rotation to ensure that only approximately one-third of the appointees will have their term expire in any given year. An appointee wishing to continue in his or her role on the committee shall resubmit an application as required by this section.

7. The committee shall consult with the state advisory council on emergency medical services, as described in section 190.101, regarding issues involving emergency medical services."; and

Further amend the title and enacting clause accordingly.