Spencer Coggs need to recuse himself from this vote - he's on a board

Mark Miller in for Spencer on this vote only

AGENCY: DHFS

LFB PAPER #: 1167

ISSUE: Grants for Community Health Centers

ALTERNATIVE: 4

SUMMARY:

Alt. 4 maintains current law & saves the program. This is crucial for 16th Street.

BY: Cindy

Rosenzweig motion for a study is a bad idea.

~~No~~ no votes on full bank

ND on Rosenzweig motion

Legislative Fiscal Bureau
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February 28, 2002 Joint Committee on Finance Paper #1167

Grants for Community Health Centers (DHFS)

[LFB Summary of the Governor's Budget Reform Bill: Page 53, #9]

CURRENT LAW

1999 Act 9 (the 1999-01 biennial budget act) created the state community health grant program. In 2002-03, $3.0 million is budgeted for grants to supplement federal funds federally qualified health centers (FQHCs) receive under the Public Health Services Act to support their operations. The program also provides $50,000 annually to a community health center in a first class city (the 16th Street Community Health Center in Milwaukee) and $25,000 to Health-Net of Janesville, Inc.

GOVERNOR

Delete $3,075,000 GPR in 2002-03 and repeal the community health center grant program, effective July 1, 2002.

DISCUSSION POINTS

1. In order to be designated as an FQHC, a health center must meet the following criteria: (a) serve a federally designated health professional shortage area, medically underserved area or a medically underserved population; (b) provide services to all patients regardless of insurance status; (c) use a sliding fee scale for uninsured patients that is based on income status; and (d) operate as a nonprofit corporation governed by a board of directors in which the health center's users constitute a majority of the membership.

2. Under the federal program, health centers are required to bill third-party payers for patients who have coverage so that the federal program funds may be used to serve uninsured

persons. Grantees apply directly to the federal program. Federal funding is not contingent on a state matching contribution.

3. Currently, 14 centers are eligible for the state grant. The amount of each center's grant is determined by each center's proportion of the total federal FQHC grant funding. The table below shows the distribution of federal and state community health center grants in 2001-02.

Community Health Center Grant Program
Fiscal Year 2001-02

Community Health Care Center	Federal Grant	State Grant
Family Health Medical and Dental Center, Wautoma	$737,817	$213,900
N.E.W. Community Clinic, Green Bay	248,399	72,000
Sixteenth Street Community Health Center, Milwaukee	1,463,678	424,350
North Woods Medical Cooperative, Minong	432,852	125,490
Beloit Area Community Health Center, Beloit	647,110	187,590
Northern Health Centers, Inc., Lakewood	374,775	108,660
Health Care for the Homeless, Milwaukee	1,179,459	341,940
Scenic Bluffs Community Health Center, Cashton	692,765	200,850
Bridge Community Health Clinic, Wausau	393,973	114,210
Kenosha Community Health Center, Kenosha	611,224	177,210
Family Health Center, Marshfield	1,589,330	460,770
Milwaukee Health Services, Milwaukee	1,292,752	374,790
Westside Healthcare Association, Milwaukee	227,884	66,060
Lake Superior Community Health Center, Superior	455,914	132,180
Total	$10,347,932	$3,000,000

4. Health centers have used the state grant to hire additional providers and increase the number of patients they serve. The Wisconsin Primary Health Care Association indicates that the centers served 82,317 patients in 1998, before these agencies received the state grant, and 101,726 patients in 2000, the first full year after the state grant funding was available to these agencies. Increases in the federal grant and other revenues may have also contributed to the increase in the number of patients that the centers are able to serve.

5. In addition to expanding access, the health centers have used the state grant to increase the number of examination rooms, extend clinic hours, increase dental care services, employ more bilingual providers and provide translation services, create smoking cessation programs, install case management services and provide more programs for pregnant women, diabetic health care, cardiovascular services and other community care services.

6. Current information on total operating revenues and expenses for the state FQHCs is

not available at this time. According to information compiled by the Wisconsin Primary Health Care Association for 2000, the 13 centers that were eligible for the grants at that time had revenues totaling $67.6 million. This included revenue from third-party payers (59.3%), federal community health center grants (12.7%), foundations and private grants and contracts (9.1%), state community health center grants (4.4%), patient self-pay (4.0%), other state and local contracts (3.7%), other federal grants (1%) and miscellaneous revenues (5.8%). An additional center became eligible in 2002.

7. The amount of funding the state's FQHCs will receive in 2002-03 under the federal program is not known at this time. However, based on current funding proposals before Congress, the Wisconsin Primary Health Care Association estimates that FQHCs in Wisconsin may receive approximately $11 million in that year. If this occurred, the loss of state grant funding for these FQHCs would only be partially offset by the increase in federal funding. In addition, federal law provides that federal grant funding cannot be used to supplant other revenue sources. It would appear, therefore, that FQHCs would have to use any increases in federal funds to support services not currently funded with the state funds.

8. If the Committee adopts the Governor's recommendation to eliminate the grant program, the state's FQHCs would need to reduce the current level of services they provide unless they are able to offset this loss of state funds from other sources.

9. In addition to the $3.0 million annually DHFS distributes to FQHCs, the community health center grant program provides two supplemental grants totaling $75,000 annually. By statute, DHFS is required to annually provide $50,000 to a community health center in a first class city, and $25,000 to Health-Net of Janesville, Inc.

10. While more than one health center would qualify for the $50,000 supplemental grant, the Legislature intended to provide this funding to the Sixteenth Street Community Health Center. The center has used the funding to hire an obstetrics nurse to provide supportive prenatal care and increased prenatal teaching and lactation services. This has increased access to health care for primarily low-income, non-English speaking Hispanic pregnant women.

11. Health-Net of Janesville has used the $25,000 annual grant to increase pediatric services, provide a weekly mental health support group for clinic patients and provide limited emergency dental care.

12. As with the FQHC grant program, if the supplemental grant funding is eliminated, it is unlikely that these two organizations would be able to maintain these expanded services.

13. Because many of the centers have used the grant funding to hire additional providers and expand ongoing services, the Committee could consider phasing out the program over the next two years so that the centers could continue to support some additional services with state funding, while they examine options to find other sources of revenue.

14. For example, the Committee could sunset the program on July 1, 2004, and reduce

funding by $1,025,000 GPR in 2002-03 so that $2,050,000 GPR would be available for state grants in that year ($2,000,000 for FQHCs, $33,300 for the 16th Street Health Clinic and $16,700 for Health-Net). In 2003-04, $1,025,000 GPR would be available for grants ($1,000,000 for FQHCs, $16,700 for the 16th Street Health Clinic and $8,300 for Health-Net). No funding for state grants would be provided in 2004-05 and subsequent years.

15. Another option would be to reduce funding for grants by 50%, beginning in 2002-03, but to retain the program so that $1,537,500 GPR would be provided annually for DHFS to support grants to FQHCs ($1,500,000), the 16th Street Health Clinic ($25,000) and Health-Net ($12,500).

ALTERNATIVES TO BILL

1. Approve the Governor's recommendation to delete $3,075,000 GPR in 2002-03 and repeal the community health center grant program, effective July 1, 2002.

2. Modify the Governor's recommendation by reducing funding for the program in each of the next two years and repealing the program, effective July 1, 2004. Delete $1,025,000 GPR in 2002-03 so that $2,050,000 GPR would be available for grants in 2002-03 ($2,000,000 GPR for grants to FQHCs, $33,300 to the 16th Street Community Center and $16,700 to Health-Net). Modify statutory provisions relating to the program to require DHFS to provide not more than $1,025,000 GPR for grants in 2003-04 ($1,000,000 GPR for FQHCs, $16,700 GPR to the 16th Street Community Center and $8,300 GPR to HealthNet) and to repeal the program, effective July 1, 2004.

Alternative 2	GPR
2001-03 FUNDING	$2,050,000

3. Modify the Governor's recommendation by restoring $1,537,500 GPR in 2002-03 to continue the program at one-half of its current funding level, and deleting the Governor's recommendation to repeal the community health center grant program, effective July 1, 2002. Modify statutory provisions relating to the program to require DHFS to provide not more than $1,500,000 for grants to FQHCs, $25,000 for grants to the 16th Street Community Center and $12,500 for grants to Health-Net, annually, beginning in 2002-03.

Alternative 3	GPR
2001-03 FUNDING	$1,537,500

4. Maintain current law.

Alternative 4	GPR
2001-03 FUNDING	$3,075,000

Prepared by: Carri Jakel

Senator Rosenzweig

HEALTH AND FAMILY SERVICES

Study on Federal Funding for Community Health Centers

[LFB Paper #1167]

Motion:

Move to require DHFS, in consultation with the statewide primary health care association, to conduct a review of federal funding available to health clinics and organizations under section 330 of the Public Health Service Act. Require the study to include: (1) a review of statutory, regulatory and policy requirements for grantees currently supported under the program, as well as organizations that do not currently receive funds; and (2) suggestions for expanding the number of federally qualified health centers in Wisconsin and the number of sites operated by organizations currently funded under the program, and other ways to increase the amount of federal funding for Wisconsin health care clinics. Require DHFS to submit a report to the Joint Committee on Finance and the chief clerk of each house of the Legislature for distribution under section 13.172 of the statutes no later than June 30, 2002.

Note:

Health centers that are designated as federally qualified health centers (FQHCs) are eligible to receive funding under the federal Public Health Services Act. In 2001-02, 14 centers in Wisconsin qualified for the program. Health centers apply directly to the federal government for designation as a FQHC and for grant funds. FQHCs may receive more funding if they can demonstrate that they are expanding the populations they serve through the establishment of new delivery sites. In addition, new centers that receive FQHC designation are eligible for funding. Therefore, federal funding to health care centers in the state could be increased if current centers can demonstrate that they have expanded services, and new centers could achieve federal designation.

This motion would require DHFS, in consultation with the statewide primary health care association, to review the statutory, regulatory and policy requirements for centers currently receiving federal funds, as well as other organizations that may be eligible for funds. The study would include suggestions for expanding the number of federally designated centers in the state and the number of sites operated by current participating centers, and other ways to increase federal funding for health centers. DHFS would be required to submit the results of the study to the Committee and the Legislature no later than June 30, 2002.

MO# 250

	BURKE	Y	N	A
	DECKER	Y	N	A
	MOORE	Y	N	A
	SHIBILSKI	Y	N	A
	PLACHE	Y	N	A
	WIRCH	Y	N	A
	DARLING	Y	N	A
(1)	ROSENZWEIG	Y	N	A
(2)	GARD	Y	N	A
	KAUFERT	Y	N	A
	ALBERS	Y	N	A
	DUFF	Y	N	A
	WARD	Y	N	A
	HUEBSCH	Y	N	A
	HUBER	Y	N	A
	~~COGGS~~ Miller, M.	Y	N	A

AYE 11 NO 5 ABS ____

AGENCY: Department of Health and Family Services

LFB PAPER #: 1168

ISSUE: Statewide Trauma Care System

ALTERNATIVE: A2, B1, 2 & 3

SUMMARY: (A1 is best - but I assume some will want to save GPR by going w/A2)

Alternative A2 modifies the amount necessary to fund the Statewide Trauma Care System.

B1 deletes the statutory deadline of 7/1/02 when the system is to be up and running, since there's no way this will happen.

B2 extends the sunset date for the advisory council from 7/1/02 to 7/1/03.

B3 authorized DHFS to create regional trauma advisory councils.

DHFS is required to promulgate rules to implement the system, including a method by which to classify hospitals as to their respective emergency care capabilities.

Under the DHFS plan, regional trauma advisory councils would be required to

- Develop and evaluate local protocols
- Develop agreements between local providers
- Analyze regional trauma data
- Improve trauma care capabilities
- Develop injury prevention and education strategies
- Educate and train EMS and dispatch providers

A 1999 review indicates that implementation of a trauma care system improves survival rates for seriously injured patients 15-20% over time.

A 1995 study demonstrates that states with trauma care systems have 15.5% lower costs per hospitalized injury episode.

As part of 2001-03 biennial budget, Legislature provided funding and positions for DHFS to implement the trauma care system

- One-time funding of $185,000 in 2001-02; $500,000 in 2002-03 from federal funds received by the DOT
- 2 two-year project positions

For fiscal year 2001-02, WI will receive $3.1 million under the federal section 402 program for traffic safety purposes.

Governor vetoed trauma system funding because he believed the funds were more appropriately used to improve highway safety.

It will not be possible for DHFS to meet the July 1, 2002, statutory deadline for implementing a statewide trauma care system.

WI has been notified that it will receive approximately $19.3 million for bioterrorism preparedness activities; $2.3 million of that to be administered by the Health Resources and Services Administration for regional hospital planning and awareness.

While implementation of a statewide trauma care system would not likely be considered preparation for bioterrorism-related events, but parts of the system could be considered components.

Committee could direct DHFS to use the one-time bioterrorism funding to support parts of the trauma care system, to the extent permissible under federal law and guidelines.

BY: Nicole

March 4, 2002

To: **Members, Joint Committee on Finance**

From: **Bill Bazan, VP, Metro Milwaukee, WHA**
Matt Sande, Director of Legislation, WHA

Re: **Support for Statewide Trauma Care System and Hospital Bioterror Preparedness** [LFB Paper #1168, Support Alternatives A(1), B(1), B(2) and B(3) / Oppose Alternative B(4)]

THE WISCONSIN HEALTH AND HOSPITAL ASSOCIATION FULLY SUPPORTS FUNDING FOR AND IMPLEMENTATION OF A STATEWIDE, REGIONALLY BASED TRAUMA CARE SYSTEM.

Traumatic injuries are the leading cause of death and disability among the 1-44 age group and are recognized as a major public health problem here in Wisconsin. To assist in addressing this problem of treating and caring for victims of trauma, Wisconsin is implementing an inclusive, comprehensive regional trauma care system that integrates all components of patient care, including prevention, out-of-hospital care, acute care, and rehabilitation. The goal of this newly designed system is to match each region's health care resources with the needs of the traumatically injured patient, assuring optimal care and eventual return to his/her community.

In order for this optimal, regional trauma system to be implemented, there is a need for adequate state funding, extension of the sunset date for the state trauma advisory council (STAC), and authority for DHFS to create regional trauma advisory councils. The STAC has identified regional trauma development as the necessary and vital infrastructure of a Wisconsin specific trauma care system in which development, implementation, and evaluation of regional trauma plans can be accomplished effectively.

WHA also supports separate legislation to accomplish the above goals, specifically Assembly Bill 743 which unanimously passed the Assembly and is now in the Senate Health Committee. **AB 743 uses federal funds received by the DOT under the state and community highway safety program.** WHA believes that both these federal highway safety monies and state general-purpose revenues are appropriate funding sources for a state trauma care system.

As necessary for Wisconsin as a statewide trauma care system is, however, the need for hospitals in this state to upgrade their disaster/bioterrorism preparedness is just as urgent. The federal government, through the Health Resources and Services Administration (HRSA), is set to provide Wisconsin $2.3 million for regional hospital planning and awareness as part of a national effort to supplement states' bioterrorism preparedness activities. **WHA strongly opposes the use of these targeted hospital preparedness monies to fund the state trauma care system. Both programs are needed, and one should not be sacrificed for the other.**

WHA strongly encourages your support for a coordinated trauma care system in Wisconsin as well as hospital disaster preparedness. Our motivating factor for this encouragement is the health of the people of Wisconsin. Thank you for your consideration.

Wisconsin Health &
Hospital Association, Inc.

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February 28, 2002 Joint Committee on Finance Paper #1168

Statewide Trauma Care System (DHFS)

[LFB Summary of the Governor's Budget Reform Bill: Page 53, #10]

CURRENT LAW

1997 Act 154, as amended by 1999 Act 9 and 2001 Act 16, requires DHFS to develop and implement a statewide trauma care system by July 1, 2002. DHFS is required to promulgate rules to implement the system, including a method by which to classify hospitals as to their respective emergency care capabilities. Hospitals are required to classify the level of trauma care services they provide within 180 days after the rules are promulgated, and every three years thereafter.

Under the DHFS plan for the system, regional trauma advisory councils, made up of hospitals, providers and other stakeholders, would be required to develop and evaluate local protocols, develop agreements between local providers, analyze regional trauma data, improve trauma care capabilities, develop injury prevention and education strategies and educate and train emergency medical service and dispatch providers.

GOVERNOR

Provide one-time funding of $500,000 GPR and 2.0 GPR project positions in 2002-03, to support activities relating to the development of the statewide trauma care system. Funding would be provided as follows: (a) $80,000 for 1.0 trauma registrar to develop and implement a statewide trauma care database; (b) $80,000 for 1.0 injury education coordinator to develop injury training and education programs and assist with performance improvement activities; (c) $290,000 for grants to regional trauma advisory councils; and (d) $50,000 for regional trauma advisory council meeting expenses.

DISCUSSION POINTS

1. A trauma care system provides a comprehensive approach to triage, treatment, transport and ultimate care of major trauma victims. The National Highway Traffic Safety Administration defines a trauma care system as "a system of health care delivery that combines pre-hospital emergency medical services (EMS) resources and hospital resources to optimize the care, and therefore, the outcome of traumatically injured patients."

2. National studies show that traumatic injury is the leading cause of death for persons under age 44. A number of studies show that implementation of a trauma care system reduces death rates and hospital costs associated with traumatic injuries. A 1999 review of published research on the effectiveness of trauma care systems indicates that implementation of a trauma care system improves survival rates for seriously injured patients 15% to 20% over time. A 1995 study demonstrates that states with trauma care systems have 15.5% lower costs per hospitalized injury episode. According to DHFS, 31 states and Washington D.C. have some type of coordinated trauma care system in place.

3. The impetus for the legislation creating a trauma system in Wisconsin resulted from a 1990 assessment of the state EMS system by the National Highway Safety Administration, which identified the lack of a trauma care system as one of several weaknesses of Wisconsin's EMS system.

4. 1997 Wisconsin Act 154 required DHFS, in conjunction with a Statewide Trauma Advisory Council, to prepare a joint report on the development and implementation of a statewide trauma care system. DHFS was prohibited from promulgating rules to develop and implement a trauma care system until the Joint Committee on Finance approved the report.

5. 1999 Wisconsin Act 9 (the 1999-01 biennial budget act) provided DHFS with $80,000 PR (money from transportation fund transferred to DHFS) and 1.0 PR position, beginning in 2000-01, to develop a statewide trauma care system.

6. On January 25, 2001, DHFS submitted a request to the Joint Committee on Finance for approval of the Wisconsin statewide trauma care system plan. Major components of the plan include: (1) appointing 10 regional trauma advisory councils (RTACs); (2) classifying hospitals according to trauma capabilities and ensuring that no facility would be without direct linkage to a Level I or Level II trauma center; (3) creating a trauma registry containing information on injured patients and fatalities and analyzing the data; (4) establishing guidelines for adult and pediatric trauma triage, interfacility transfers, medical control standards, trauma care education and evaluation and performance improvement mechanisms; (5) standardizing EMS communicator training and certification; and (6) creating education and training programs focused on prevention and control.

7. Because the submitted plan included funding, positions and statutory language, the Co-chairs of the Joint Finance Committee advised DHFS to have the plan drafted as separate

legislation so that the resources and statutory changes could be addressed by the full Legislature.

8. As part of its 2001-03 biennial budget deliberations, the Legislature provided funding and positions for DHFS to implement the trauma care system. The 2001-03 biennial budget bill would have provided one-time funding of $185,000 in 2001-02 and $500,000 in 2002-03 from federal funds received by the Department of Transportation under the state and community highway safety program (Section 402 funds) and 2.0 two-year project positions.

9. Under the federal Section 402 program, states receive funding to reduce traffic accidents and death, injuries and property damage that result from accidents. States are required to submit a highway safety plan before the beginning of each fiscal year. The plan must identify the most serious traffic safety problems. Applicable program areas include alcohol and drug countermeasures, police traffic services, occupant protection and emergency medical services, among others. The Governor of each state is responsible for administering these funds through a state highway agency. For fiscal year 2001-02, Wisconsin will receive $3.1 million under the federal Section 402 program for traffic safety purposes.

10. The Governor vetoed the trauma system funding and positions that would have been provided in the biennial budget bill, in addition to a provision that would have extended the July 1, 2002, sunset date for the Statewide Trauma Advisory Council and created regional advisory councils. In his veto message, the Governor indicated that he believed that the federal funds were more appropriately used to improve highway safety. He also indicated that dedication of these funds to the trauma care system would result in reductions in other highway safety grants, which would be counterproductive.

11. 2001 Assembly Bill 743, which was introduced on January 22, 2002, would provide $185,000 PR in 2001-02 and $500,000 PR in 2002-03 and 2.0 project positions to support development and implementation of the trauma care system. Under the bill, the source of one-time funding for the system would be federal Section 402 funds. The bill would also extend the termination date of the Statewide Trauma Advisory Council, from July 1, 2002 to July 1, 2004, and require DHFS to create regional advisory councils. The Assembly passed the bill unanimously on February 5, 2002.

12. Motor vehicle crashes are the leading cause of injury deaths in Wisconsin. Therefore, there is some justification for using federal highway safety funds to support the development of a statewide trauma care system. Ten states, including Wisconsin, use a portion of their 402 funds to support EMS functions. In Wisconsin, DHFS has applied for and received Section 402 funds ($70,000 in 2001-02) to develop an ambulance report database and conduct EMS medical director training. However, concerns have been raised over whether the Legislature should designate the use of these federal funds.

13. In a January 24, 2002, memorandum to the Secretary of DOT from the National Highway Safety Administration, the federal regional administrator mentioned a number of concerns with the proposed legislation to use the Section 402 funds for the trauma care system, including: (1)

earmarking funds would ignore the highway safety planning process (during the development of Wisconsin's federal 2002 Highway Safety Plan, support for the trauma system was determined to be an ineffective use of the Section 402 funds); (2) state legislation would not be controlling and would be subject to federal approval procedures; (3) in appropriating money from DOT to DHFS, the legislation would abrogate the Governor's responsibility under Section 402 to administer the program through Wisconsin's highway safety agency; and (4) only the portion of the trauma system relating to highway safety would be eligible for the Section 402 funds.

14. Progress on the development of the trauma system has been delayed due to the initial requirement that the Joint Finance Committee approve the report prior to DHFS promulgating rules and the lack of funding and staff resources. The Statewide Trauma Advisory Council continues to meet on a regular basis, and is currently working on identifying membership to regional trauma area councils and their responsibilities. Seven regions have been identified.

15. It will not be possible for DHFS to meet the July 1, 2002, statutory deadline for implementing a statewide trauma care system. In fact, full implementation of a system, as described in the DHFS plan, will involve analysis of injury data and injury prevention education and training activities over several years. For this reason, the July 1, 2002, statutory deadline should be repealed.

16. The regional councils are viewed as a critical component of the system in assessing local capacities and coordinating regional trauma resources. Under the Governor's proposal, $50,000 would be available to cover regional council meeting expenses and $290,000 would be available for grants. DHFS indicates that the grants would be awarded on a request-for-proposal basis for hardware and software for regional data collection and analysis, support staff resources to coordinate regional trauma care, increasing pre-hospital care to the region, home safety inspections, medical director education, public information and education forums and public services announcements on injury prevention.

17. The original DHFS plan identified 10 regions with councils of 30 members each, meeting quarterly with estimated meeting expenses of $5,000 and grants of $29,000 for each region. Given that DHFS currently has identified seven regions, funding could be reduced by $102,000 to maintain the same level of support identified under the plan.

18. While DHFS could proceed with rule-making, implementing a statewide trauma care system without funding or staff to support it would not be effective. Without funding, regional councils would have to voluntarily meet to assess and coordinate trauma care, but would be provided no additional resources to support the system. This could be viewed as a local mandate. In addition, DHFS has not been authorized staff to support the system, implement a statewide database for trauma patients, analyze trauma data, create injury prevention education and training programs and evaluate of the overall system.

19. In light of the constraints on general purpose revenues, the Committee could delete the Governor's provision and repeal the requirement that DHFS implement a system. If the Committee eliminates the requirement that DHFS implement a trauma care system, it could also

reduce DHFS's budget by $80,000 PR annually, beginning in 2002-03 and eliminate the current 1.0 PR trauma care system coordinator position and reduce a corresponding amount of SEG funding in DOT.

20. Alternatively, the Committee could consider other funding sources to support the trauma care system. Since there is a connection between motor vehicle crashes and injuries and deaths, the transportation fund could be considered an appropriate funding source for the trauma care system. One option would be to transfer $398,000 SEG on a one-time basis from the transportation fund to support the system in 2002-03.

21. In December, the projected ending balance in the transportation fund for the 2001-03 biennium was $6,148,700. However, estimates of transportation fund revenues were made in the spring of 2001, and were based on economic projections available at that time. Because of changes in the economy since that time, it is likely that revenues could be much lower. For example, a 0.5% reduction in the consumption of motor vehicle fuel over the biennium would reduce transportation fund revenues by more than $7.2 million.

22. Another option would be to reallocate funding currently budgeted for counties to support services to persons convicted of operating while intoxicated (OWI) offenses. Persons convicted of OWI offenses are assessed a $355 driver improvement surcharge. Counties forward 38.5% of these revenues to the state, which funds several agencies' programs related to alcohol abuse and law enforcement.

23. An estimated $3.6 million in revenues will be available to the state in 2001-02 from the driver improvement surcharge. This funding is distributed to five state agencies: the Departments of Justice, Public Instruction, Health and Family Services, Transportation and the University of Wisconsin. In the 2001-03 biennium, DHFS is budgeted $1.0 million annually from this source.

24. Currently, DHFS allocates this OWI funding to county human services departments and Chapter 51 boards under the intoxicated driver program for treatment of persons convicted of OWI offenses. DHFS has allocated the money to counties to cover costs resulting from deficits in intoxicated driver programs (IDPs) if the counties meet certain criteria. Counties apply for the supplemental funding annually. The funding is allocated based on the availability of, and need for, funding.

25. DHFS has notified counties that the supplemental funding budgeted in 2001-02 for IDP to fund calendar year 2001 costs will not be distributed. Instead, DHFS had anticipated that legislation will be enacted to allow DHFS to use this money and the 2002-03 allocation for underage tobacco enforcement activities.

26. Given the direct correlation between drunk driving and motor vehicle injuries and fatalities (36% of motor vehicle fatalities involved alcohol in 1999), the Committee could consider using $398,000 of the $1,000,000 supplemental funding from the OWI surcharge to fund the trauma

care system in 2002-03. Statutory changes would be needed to allow the IDP funds to be used on a one-time basis for development and implementation of the system. However, the potential use of these funds is considered in LFB Issue Paper #1171 for tobacco enforcement activities. Therefore, using OWI surcharge revenue for the trauma care system would reduce the amount that would be available for either the IDP or tobacco enforcement activities.

27. If no statutory changes are made regarding the use of IDP funds, DHFS will be required to allocate the funding to counties to fund IDP services by the end of the fiscal year.

28. Alternatively, the Committee could delete the Governor's recommendations to provide $500,000 GPR and 2.0 GPR positions for the trauma care system. Funding for the system could still be addressed under the proposed legislation, AB 743, which was recently passed by the Assembly.

29. While the Governor's recommendation to fund the statewide trauma care system would be supported with one-time funds and 2.0 project positions in 2002-03, implementation of the system is seen as an ongoing function by DHFS that could take several years. Further, the two project positions that would be provided are intended to develop the trauma registry, analyze injury data, evaluate the trauma care system, and create and coordinate injury education and training programs. These are viewed as ongoing components of the system. In addition, data would not be available to evaluate until implementation of the system is underway. Therefore, if the requirement that DHFS implement a statewide trauma care system remains, it is likely that DHFS will seek ongoing funding and positions in the future to support the system.

30. If the Committee supports continued development and implementation of a statewide trauma system, the Committee could extend the current July 1, 2002, sunset date for the statewide trauma advisory council to July 1, 2003, so that the Council can continue to meet throughout the development process.

31. The Committee could also include provision that would authorize DHFS to create regional trauma advisory councils. Statutory provisions authorizing the creation of regional councils had been included in the biennial budget bill passed by the Legislature, but was vetoed by the Governor. The Governor's proposal includes grants to regional advisory councils, therefore the intent to authorize DHFS to create regional advisory councils is implied. However, including statutory provisions authorizing their creation would clarify this authority.

32. The Governor included funding for the statewide trauma care system as part of his security initiative. Wisconsin has been notified that it will receive approximately $19.3 million for bioterrorism preparedness activities, including: (a) $16,940,986 to defend against bioterrorism-related events and deal with other public emergencies; and (b) $2,327,920 for regional hospital planning and preparedness. According to correspondence from the U.S. Department of Health and Human Services (DHHS), 20% of the federal funding will be made available to states immediately and the remainder will be released subject to federal approval of a plan submitted by DHFS, due no later than April 15, 2002. The funds must be spent or encumbered by August 30, 2003.

33. According to information provided by DHHS, the $16.9 million must be used for: (a) preparedness planning and readiness assessment; (b) surveillance and epidemiology capacity; (c) laboratory capacity- biologic agents; (d) communicating health risks and health information dissemination; and (e) education and training of public health officials, infectious disease specialists, emergency department personnel and other healthcare providers.

34. The Health Resources and Services Administration (HRSA) is responsible for administering the $2.3 million for regional hospital planning and awareness. HRSA has recently provided guidance as to how the federal funds may be spent.

35. According to the HRSA guidelines, the purpose of the $2.3 million is to upgrade the preparedness of hospitals and collaborating entities to respond to terrorism. This will also allow the health care system to become better prepared to deal with nonterrorist epidemics of rare diseases. This includes development and implementation of regional plans to improve the capacity of hospitals, emergency departments, outpatient centers, EMS systems and other collaborating health care entities for responding to incidents requiring mass immunization, treatment, isolation and quarantine in the aftermath of bioterrorism or other outbreaks of infectious disease.

36. The HRSA program will cover two phases. Phase 1 will consist of state, territorial, regional and municipal efforts to perform a needs assessment of hospital preparedness to respond to a bioterrorist incident and to develop a plan of action, and initial implementation efforts including recruitment and training of EMS personnel and upgrading hospital infrastructures, in areas such as infection control and casualty management. Phase 2 will involve full implementation, including upgrading the ability of hospitals and other health care entities to respond to biological events, to develop a multitiered system in which local health care entities are prepared to triage, isolate, treat, stabilize and refer multiple casualties of a bioterrorist incident. Most of phase 2 funds will be distributed to hospitals and community heath centers. EMS systems and poison control centers may also be funded.

37. While implementation of a statewide trauma care system would not likely be considered preparation for bioterrorism-related events, parts of the system could be considered components of a response to a bioterrorism event, including regional hospital planning and awareness. In addition, at this time, DHFS is considering using the regional area trauma councils as the basis for its regional planning for bioterrorism response. Therefore, the Committee could direct DHFS to use the one-time bioterrorism funding to support parts of the trauma care system, to the extent permissible under federal law and guidelines. Use of the funding for the trauma system would be subject to federal approval.

ALTERNATIVES TO BILL

A. Funding

1. Approve the Governor's recommendation to provide one-time funding of $500,000 GPR and 2.0 GPR project positions in 2002-03 to support activities relating to the development of the statewide trauma care system.

2. Modify the Governor's recommendation to reduce funding by $102,000 GPR in 2002-03 to reflect lower meeting expenses and grant amounts associated with fewer regional area trauma councils than originally proposed under the DHFS trauma system plan.

Alternative A2	GPR
2001-03 FUNDING	- $102,000

3. Delete the Governor's provision. Instead, provide $398,000 SEG in one-time funding from the transportation fund and 2.0 SEG project positions in 2002-03 to support development and implementation of the statewide trauma care system.

Alternative A3	GPR	SEG	TOTAL
2001-03 FUNDING	- $500,000	$398,000	- $102,000
2002-03 POSITIONS	- 2.00	2.00	0.00

4. Delete the Governor's provision. Instead, provide $398,000 PR and 2.0 PR project positions in 2002-03 in one-time funding from OWI surcharge funds to support the development of the statewide trauma care system and reduce funding for IDP programs by $398,000 PR in 2002-03 on a one-time basis.

Alternative A4	GPR	PR	TOTAL
2001-03 FUNDING	- $500,000	$0	- $500,000
2002-03 POSITIONS	2.0	2.0	0.0

5. Delete the Governor's provision.

Alternative A5	GPR
2001-03 FUNDING	- $500,000
2002-03 POSITIONS	- 2.00

6. Delete the Governor's provision. In addition, delete 1.0 PR position and $80,000 PR from DHFS and $80,000 SEG from DOT in 2002-03 to eliminate the current trauma care system coordinator position.

Alternative A6	GPR	PR	SEG	Total
2001-03 FUNDING	- $500,000	- $80,000	- $80,000	- $660,000
2002-03 POSITIONS	- 2.00	- 1.00	0.00	- 3.00

B. Statutory Changes

1. In addition to any of the alternatives under A, eliminate the July 1, 2002, statutory deadline for DHFS to implement a statewide trauma care system.

2. In addition to Alternatives A1, A2, A3 or A4, extend the current statutory sunset date for the statewide trauma advisory council from July 1, 2002 to July 1, 2003.

3. In addition to Alternatives A1, A2, A3 or A4, authorize DHFS to create regional trauma advisory councils.

4. In addition to Alternatives A1, A2, A3, A4 or A5, require DHFS to use the one-time federal bioterrorism funds to support the development and implementation of the statewide trauma system, to the extent allowable under federal law.

5. In addition to A5 or A6, eliminate the requirement that DHFS develop and implement a statewide trauma system.

Prepared by: Carri Jakel

MO# A2; B1, 2, 3, 4

(1)	BURKE	(Y)	N	A
	DECKER	Y	(N)	A
	MOORE	(Y)	N	A
	SHIBILSKI	(Y)	N	A
	PLACHE	Y	(N)	A
	WIRCH	(Y)	N	A
	DARLING	(Y)	N	A
	ROSENZWEIG	(Y)	N	A
(2)	GARD	(Y)	N	A
	KAUFERT	Y	(N)	A
	ALBERS	Y	(N)	A
	DUFF	Y	(N)	A
	WARD	(Y)	N	A
	HUEBSCH	(Y)	N	A
	HUBER	(Y)	N	A
	COGGS	(Y)	N	A

AYE 11 NO 5 ABS ____

AGENCY: Department of Health and Family Services

LFB PAPER #: 1169

ISSUE: Surveillance of Diseases and Potential Threats

ALTERNATIVE: 3 or 5

SUMMARY:

Alternative 3 saves some money by deleting 1 epidemiologist position. See paragraph 19

Alternative 5 deletes the govs recommendation altogether & directs DHFS to use federal bioterrorism funds to the extent permissible under federal law. Only problem with this is it will limit the type of work these folks can do & also, it's a one time grant, so it would be a project position instead of a permanent dedicated state employee.

The Communicable Disease Epidemiology (CDE) section in the DHFS Bureau of Communicable Diseases is currently authorized 8 full-time positions (1 supervisor, 6 epidemiologists and 1 support position).

Primary CDE responsibilities

- Investigating and analyzing communicable disease reports
- Controlling disease outbreaks and exposures
- Maintaining on-call capability and readiness to respond to unanticipated outbreaks

Four of the six epidemiologist are supported with federal funds.

DHFS indicates it does not have the staff to respond to multiple, simultaneous incidents or incidents of large scale.

Because of the ongoing communicable disease workload levels, CDE section is less able to engage in prevention activities

WI has less nonsupervisory, nonsupport, communicable disease control staff per 100,000 residents then MI and MN.

The DHHS has notified WI that the state will receive approx. $19.3 million

- $16,940,986 to defend against bioterrorism-related events and other public health outbreaks, threats and emergencies
- $2,327,920 for regional hospital planning and preparedness

20% of the federal funding will be available immediately and the remainder will be released subject to federal approval of plan submitted by DHFS, due no later than April 15, 2002.

Could direct DHFS to use federal funds to support the positions, to the extent permissible under federal law and guidelines, but responsibilities would be limited to the activities allowable and the period set under federal guidelines (August 30,2003).

BY: Nicole

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February 28, 2002 Joint Committee on Finance Paper #1169

Surveillance of Diseases and Potential Threats (DHFS)

[LFB Summary of the Governor's Budget Reform Bill: Page 54, #11]

CURRENT LAW

The communicable disease epidemiology (CDE) section in the DHFS Bureau of Communicable Diseases is currently authorized 8.0 full-time equivalent (FTE) positions, including 1.0 supervisor, 6.0 epidemiologists and 1.0 support position.

GOVERNOR

Provide $162,900 GPR and 2.5 GPR positions (2.0 epidemiologists and 0.5 program assistant) in 2002-03 to perform surveillance of communicable and infectious diseases and biological and chemical threats to state residents. This item includes $19,500 GPR in one-time funding for workstations and computers.

DISCUSSION POINTS

1. The CDE section monitors and manages outbreaks of infectious diseases of public health significance. There are currently 72 reportable diseases in Wisconsin, of which the CDE section is responsible for 48. Other DHFS staff are responsible for monitoring and managing outbreaks of sexually transmitted diseases, tuberculosis and AIDS/HIV and related diseases.

2. The CDE section is responsible for:

- Investigating and analyzing communicable disease reports from laboratories, clinicians, local public health agencies and others, and following-up as necessary;

- Controlling disease outbreaks and exposures through oversight and direction of local

investigations and control efforts and direct on-sight assistance and situation management, as needed, including maintaining on-call capability and readiness to respond to unanticipated outbreaks and incidents on a 24-hour, 7-day week basis;

- Responding to questions from private clinicians, local public health officials, the media, state and local elected officials and the general public in the event of a disease outbreak or other communicable disease issues;

- Providing technical assistance and training to local public health and clinical staff, including maintenance of state communicable disease information on the internet and statewide seminars;

- Providing ongoing communication with other state agencies, such as the State Laboratory of Hygiene for microbiological testing and the Department of Agriculture, Trade and Consumer Protection for food borne illnesses and rabies;

- Preparing and issuing reports on the prevalence of communicable disease to the federal government, state and local public health agencies and private physicians;

- Developing response capacity for potential bioterrorism incidents, including response to acts by rogue organizations and individuals and early warning for response to disease outbreaks and epidemics from the incursion of newly emerging and/or drug resistant infectious pathogens into the state;

- Managing and performing other projects, such as increasing surveillance of food borne disease outbreaks through genetic testing, preparing the state influenza pandemic preparedness plan and increasing Hepatitis C surveillance and response.

3. Four of the six epidemiologists in the CDE section are supported with federal funds. Two positions are project positions that are funded from grants to support state activities relating to specific threats, one for bioterrorism preparedness activities and one for West Nile Virus surveillance (this position was recently converted from an LTE to a project position upon renewal of the federal grant).

4. The current bioterrorism position is funded from a grant from the federal Centers for Disease Control and Prevention (CDC) to address bioterrorism preparedness. DHFS is currently in the third year of the five-year federal project. This funding has been used to support three epidemiologists, one at DHFS, one in the State Laboratory of Hygiene and one at the Milwaukee Health Department. The grant is being used to increase surveillance and epidemiology, expand laboratory capacity to deal with biological agents and implement the health alert network statewide to connect local health departments, laboratories, hospitals, physicians, emergency management and other health care workers.

5. DHFS has recently been authorized an additional federal position under the CDC

grant to provide assistance to the current DHFS bioterrorism coordinator, epidemiologist position. This position will provide administrative support in managing the project budget, developing and monitoring contracts, preparing reports, arranging training, meetings and teleconferences, distributing materials to local health officials, coordinating with other state organizations and sharing information with other state health departments.

6. In addition, DHFS has recently received approval of a federal grant to support an additional epidemiologist to enhance surveillance of food and waterborne illnesses.

7. The additional federal project positions will increase the total number of positions in the section to 10.0 FTE positions, including 1.0 supervisor, 7.0 epidemiologists and 2.0 support positions.

8. The positions in the bill are part of the Governor's security initiative to increase surveillance of infectious diseases and chemical and biological threats. While these positions would support bioterrorism preparedness activities, they would also increase the Department's capacity to perform surveillance of, and respond to, other types of outbreaks, and increase prevention and outreach activities.

9. Until the recent addition of the federal positions, the number of epidemiologists in the CDE section had not increased for more than ten years. At the same time, workload increased with newly emerging infectious pathogens, growing drug resistance, increased ease of international travel, increased threats of bioterrorism, advances in technology which allow outbreaks, including multi-state outbreaks, to be identified more quickly, and increases in reporting requirements to the federal government and local public health agencies.

10. DHFS indicates that it does not have the staff to respond to multiple, simultaneous incidents or incidents of large scale. For example, during a 1999 outbreak of salmonella in alfalfa sprouts, staff were not able to respond to 15 other communicable disease problems that were occurred over the same time period.

11. More recently, the reaction to September 11, 2001, has heightened awareness of threats from bioterrorism. DHFS received approximately 2,000 anthrax-related calls between October, 2001, and December, 2001. To respond to these calls, DHFS reallocated 48 people within the Division of Health from other activities. DHFS currently receives about three anthrax-related calls each week. Each of these calls must be investigated and followed-up by the section, including talking to local health officials, coordinating laboratory tests and working with police.

12. DHFS indicates that because of the ongoing communicable disease workload levels, the CDE section is less able to engage in prevention activities, such as updating manuals on recognition and treatment of diseases, and providing training to local public and private health workers.

13. DHFS requested 1.0 epidemiologist position and 0.5 program assistant as part of its 2001-03 biennial budget submission to address workload increases and expand the capacity of the

CDE section to respond to communicable disease outbreaks and other public health threats. However, the Governor did not include this request in his budget recommendations.

14. In light of the current state hiring freeze for nonessential positions, the Committee could determine that it is not necessary to fund 0.5 program assistant position for the CDE section at this time. For this reason, the Committee could modify the Governor's recommendation by deleting $25,600 GPR and 0.5 program assistant position in 2002-03 from the bill.

15. However, DHFS argues that providing additional program support would reduce the amount of time epidemiologists spend on administrative and clerical functions, which would enable the epidemiologists to perform more surveillance and response activities and to better prepare the state for potential outbreaks and threats.

16. Information provided by DHFS when it submitted its 2001-03 budget request indicates that Wisconsin had 0.07 nonsupervisory, nonsupport, communicable disease control staff per 100,000 residents. This compared to ratios for surrounding states ranging from 0.11 for Michigan to 0.53 for Minnesota. The Wisconsin ratio does not include the federal project positions assigned to specific types of threats or outbreaks. If the federal project positions are included Wisconsin's ratio would be 0.13.

less then

17. If the Committee approves the Governor's recommendations to provide two additional epidemiologists, Wisconsin's ratio would increase to 0.11 nonsupervisory, nonsupport communicable disease staff per 100,000 residents (or 0.17, including the federal positions). One additional epidemiologist position would increase the ratio to 0.09 (or 0.15 including the federal positions).

18. Based on the recent increases in federal project positions for the CDE section, which brings the state epidemiologist per resident ratio to within those of neighboring states, the Committee could delete the 2.0 GPR epidemiologist positions recommended by the Governor and reduce funding in the bill by $137,300 GPR in 2002-03. However, the federal grants are awarded for limited periods to address specific threats to the state, not to enhance general, ongoing surveillance and response activities. Further, due to the increased awareness of the potential for bioterrorist threats in the aftermath of the September 11, 2001, as well as increases in threats from newly emerging diseases and in the ease with which communicable diseases can spread, the Committee may wish to approve the epidemiologist positions recommended by the Governor.

19. Alternatively, the Committee could delete $68,700 GPR and 1.0 GPR position, and approve 1.5 positions for 1.0 epidemiologist and 0.5 program assistant, as requested by DHFS in its 2001-03 biennial budget request.

20. The U.S. Department of Health and Human Services (DHHS) has notified Wisconsin that the state will receive approximately $19.3 million under the Department of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States Act, 2002, Public Law 107-117. The funding includes: (a) $16,940,986 to

defend against bioterrorism-related events and other public health outbreaks, threats and emergencies; and (b) $2,327,920 for regional hospital planning and preparedness. DHHS has indicated that 20% of the federal funding will be made available to states immediately and the remainder will be released subject to federal approval of a plan submitted by DHFS, due no later than April 15, 2002. The budget period for the supplemental funding ends August 30, 2003, so that the funding will have to be spent or encumbered by that date.

21. DHHS recently provided guidance as to how the federal funds may be spent. The funds may not be used to replace or supplant current state or local expenditures. According to the federal guidelines, the $16.9 million may be used to support the following areas:

a. *Preparedness Planning and Readiness Assessment.* Establishing strategic leadership, direction, assessment and coordination of activities for bioterrorism and other outbreaks of infectious disease and other public health outbreaks;

b. *Surveillance and Epidemiology Capacity.* Enabling state and local health departments to enhance, design and/or develop systems for rapid detection of unusual outbreaks of illness that may be the result of bioterrorism, other outbreaks of infectious disease and other public health threats and emergencies; and assisting state and local health departments in establishing expanded epidemiologic capacity to investigate and mitigate such outbreaks of illness;

c. *Laboratory Capacity -- Biologic Agents.* Ensuring that core diagnostic capabilities for bioterrorist agents are available at all state and major city/county public health laboratories; and enabling state and major city/county laboratories to develop the capacity to conduct rapid and accurate diagnostic and reference testing for selected biologic agents likely to be used in a terrorist attack;

d. *Communicating Health Risks and Health Information Dissemination.* Ensuring that state and local public health organizations develop effective risk communication capacity that provides for timely information dissemination to citizens during a bioterrorist attack, outbreak of infectious disease or other public health emergency or threat including training, printed materials, timely reporting of critical information and effective interaction with the media; and

e. *Education and Training.* Ensuring that state and local health agencies have the capacity to (a) assess the training needs of key public health professionals, infectious disease specialists, emergency department personnel and other healthcare providers related to preparedness for and response to bioterrorism and other outbreaks of infectious disease and other public health threats and emergencies; and (b) ensuring effectiveness of the provision of needed education and training to key target audiences through multiple channels including academic institutions, healthcare professionals, CDC, HRSA and other resources.

22. While it appears that the federal funds could be used to support positions to expand

the capacity of the CDE section to respond to bioterrorist threats and other public health emergencies, funding for the 2.5 positions proposed by the Governor would be subject to inclusion in the DHFS plan and approval by DHHS. In addition, future federal funding is unknown, so any positions funded under the federal grant would be project positions ending August 30, 2003.

23. In light of the constraints on general purpose revenues, the Committee could delete the $162,900 GPR and 2.5 GPR positions in 2002-03, and direct DHFS to use federal funds to support the positions, to the extent permissible under federal law and guidelines. However, any use of the funds to support the positions would be limited to the activities allowable and the period set under the federal guidelines.

ALTERNATIVES TO BILL

1. Approve the Governor's recommendation to provide $162,900 GPR and 2.5 GPR positions in 2002-03 to perform surveillance of communicable and infectious diseases and biological and chemical threats to state residents.

2. Modify the Governor's recommendation to reduce funding by $25,600 GPR and delete 0.5 GPR program assistant position so that $137,300 GPR would be provided to support 2.0 GPR epidemiologist positions.

Alternative 2	GPR
2001-03 FUNDING	- $25,600
2002-03 POSITIONS	- 0.50

3. Modify the Governor's recommendation to reduce funding by $68,700 GPR and delete 1.0 epidemiologist position. Consequently, $94,200 GPR would be provided to support 1.0 epidemiologist and 0.5 program assistant, as requested by DHFS in its 2001-03 biennial budget submission.

Alternative 3	GPR
2001-03 FUNDING	- $68,700
2002-03 POSITIONS	- 1.00

4. Modify the Governor's recommendation to reduce funding by $94,200 GPR and delete 1.5 GPR positions (1.0 epidemiologist and 0.5 program assistant) so that $68,700 GPR would be provided to support 1.0 GPR epidemiologist.

Alternative 4	GPR
2001-03 FUNDING	- $94,200
2002-03 POSITIONS	- 1.50

5. Delete the Governor's recommendation. Instead, direct DHFS to use the federal bioterrorism funds, to the extent permissible under federal law, to support positions to increase the capacity of the state to perform surveillance of and respond to communicable and infectious diseases and biological and chemical potential threats to the state.

Alternative 5	GPR
2001-03 FUNDING	- $162,900
2002-03 POSITIONS	- 2.50

6. Maintain current law.

Alternative 6	GPR
2001-03 FUNDING	- $162,900
2002-03 POSITIONS	- 2.50

Prepared by: Carri Jakel

MO# 5

(1) BURKE	Y	N	A
DECKER	Y	N	A
MOORE	Y	N	A
SHIBILSKI	Y	N	A
PLACHE	Y	N	A
WIRCH	Y	N	A
DARLING	Y	N	A
ROSENZWEIG	Y	N	A
(2) GARD	Y	N	A
KAUFERT	Y	N	A
ALBERS	Y	N	A
DUFF	Y	N	A
WARD	Y	N	A
HUEBSCH	Y	N	A
HUBER	Y	N	A
COGGS	Y	N	A

AYE 16 NO 0 ABS ____