TRAUMA CENTER
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TESTIMONY BEFORE THE

HOUSE COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

"Examining Public Health Legislation to Help Patients and Local Communities"

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Chairman, Trauma Center Association of America (TCAA)

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Statement

Chairman Upton, Ranking Member Pallone, Chairman Pitts, Ranking Member Green, and members of the Committee, thank you for holding this hearing on examining public health legislation to help patients and local communities, and for inviting the Trauma Center Association of America (TCAA) to speak. TCAA is a non-profit, 501(c)(6) association representing trauma centers and systems across the country and is committed to ensuring access to life-saving trauma services.

TCAA, along with our advocacy partners, the American Trauma Society (ATS); the America Association for the Surgery of Trauma (AAST); the American College of Surgeons (ACS); the American College of Emergency Physicians (ACEP); American Burn Association (ABA); the American Association of Neurological Surgeons (AANS); College of Neurological Surgeons (CNS); Emergency Nurses Association (ENA); Society of Trauma Nurses (STN); American Academy of Orthopaedic Surgeons (AAOS) and the Eastern Association for the Surgery of Trauma (EAST) are on the forefront of providing trauma and emergency care to millions of Americans, and it is out of that commitment that we submit these comments for your consideration.

As organizations that care deeply about access to trauma and emergency care, we would like to thank you for passing the *Trauma Systems and Regionalization of Emergency Care Reauthorization Act* (H.R. 4080) last session and express our strong support for the passage of this vital legislation again this session. We would also like to thank Dr. Burgess and Representative Green for their continued leadership in recognizing the importance of these systems of care in saving lives.

Trauma Care Saves Lives

Trauma is a major public health issue. In the United States, approximately 35 million people are treated every year for traumatic injuries[i] -- constituting one hospitalization every 15 minutes. Traumatic injury is the leading cause of death under age 44[ii]. At an annual cost of $67.3 billion, trauma is the third most expensive medical condition (behind only heart disease ($90.9billion) and cancer ($71.4billion).[iii]

The "value" proposition for trauma care is well documented. The care provided by trauma centers, including specialist physicians, nurses and their entire trauma teams, has a dramatic and cost-effective impact on patients' subsequent quality of life. In fact, trauma care is more cost effective than many other interventions, including dialysis for kidney failure.[iv] Victims of traumatic injury treated at a Level I trauma center are 25% more likely to survive than those treated at a general hospital. Unfortunately, 45 million Americans lack access to major trauma centers within the "golden hour" post injury when chances of survival are greatest. For those severely injured in motor vehicle crashes[v], initial triage to a non-trauma center increases the risk of death within the first 48 hours by at least 30%.[vi] Compared against the two higher cost medical conditions, significantly more adult patients are treated for trauma (26.4 million) than are treated for heart disease (22.5 million) or cancer (15.3 million) at a substantially lower cost per patient[vii].

The Trauma Systems and Regionalization of Emergency Care Reauthorization Act

The Trauma Systems and Regionalization of Emergency Care Reauthorization Act would reauthorize two important grant mechanisms, the Trauma Care Systems Planning Grants Program and the Regionalization of Emergency Care Pilots Program, each authorized at $12 million per year. The Trauma Care Systems Planning Grants support state and rural development of trauma systems. The Regionalization of Emergency Care Pilots Program funds pilot projects to design, implement, and evaluate innovative models of regionalized emergency care. *The Trauma Systems and Regionalization of Emergency Care Reauthorization Act* would also direct states to update their model trauma care plan with the input of updated stakeholders one year after enactment.

Unfortunately, in 2015, we still lack effective regionalized care systems for infectious disease like Ebola or even for cardiac or stroke patients. The vast majority of hospitals addressing patients with these significant events also serve as our nation's regional trauma centers. These hospitals must have the tools and capabilities to care for all their patients with emergent, time sensitive and life-threatening conditions -- whether Ebola, trauma or stroke. The funding to

support these hospitals must follow and support their willingness to provide care to the sickest Americans in their greatest hour of need.

On June 25, 2014, the House passed *The Trauma Systems Regionalization of Emergency Care Reauthorization Act* (H.R. 4080). However, the Senate was not able to pass H.R. 4080 before the end of the 113th Congress. Thus, it is up to the 114th Congress to take up these important programs. On behalf of the trauma and emergency care community, thank you again for your leadership and we urge your continued efforts to reauthorize these vital programs.

The Access to Life-Saving Trauma Care for All Americans Act

In addition to the Trauma Care Systems Planning Grants and Regionalization of Emergency Care Pilots there are two other programs contained in the Public Health Service Act (PHSA) set to expire this year and need to be addressed by Congress. The Access to Life-Saving Trauma Care for All Americans Act would reauthorize these vital programs to prevent more closures and improve access to trauma care. The Trauma Care Center Grants are authorized at $100 million per year in an effort to prevent more trauma center closures by supporting their core missions, curtailing losses from uncompensated care and providing emergency awards to centers at risk of closing. Also, the Trauma Service Availability Grants authorized at $100 million per year are channeled through the States to address shortfalls in trauma services and improve access to and the availability of trauma care in underserved areas.

In addition, the Interagency Program for Trauma Research is in need of reauthorization. This program is designed to facilitate collaboration across the National Institutes of Health on trauma research. Of course there is no specific Institute that encompasses trauma and the very nature of trauma care crosses several of the Institutes. In 2010, NIH convened a Roundtable on Emergency Trauma Research which identified key research priorities and barriers. Priorities include focusing on the timing, sequence, and the time sensitivity of traumatic injury and treatment effects, assessing the effect of development and aging on postinjury response, and the need to understand why there are regional differences in outcomes after injury. Barriers to

research include a limited number of trained investigators and experienced mentors, limited research infrastructure and support and regulatory hurdles. The Roundtable concluded that the science of emergency trauma care would be advanced by facilitating the following:

> " (1) development of an acute injury template for clinical research; (2) developing emergency trauma clinical research networks; (3) integrating emergency trauma research into Clinical and Translational Science Awards; (4) developing emergency care-specific initiatives within the existing structure of NIH institutes and centers; (5) involving acute trauma and emergency specialists in grant review and research advisory processes; (6) supporting learn-phase or small, clinical trials; (7) performing research to address ethical and regulatory issues; and (8) training emergency care investigators with research training programs."

Reauthorization of the Interagency Program for Trauma Research is imperative to achieve these goals.

PHSA Trauma Programs Designed to Improve Patient Outcomes, and Save Lives and Costs:

All of the PHSA Trauma and Emergency Programs are designed to ensure the availability and effective use of trauma care to save lives, costs and improve patient outcomes. Trauma can happen to anyone, any time and anywhere. As demonstrated by the numerous lives saved during the Boston Marathon bombing and other recent mass casualty events by getting the severely injured to a Level I or II trauma center during the "golden hour." From 1990-2005, 30% of trauma centers closed in large part due to the high level of uncompensated care they provide. Access to timely trauma care has improved in some parts of the nation, but remains unavailable to millions of Americans.

Trauma will continue to occur, despite our best prevention efforts. Unfortunately, access to trauma care is threatened by losses associated with the high cost of treating severely injured patients, including those unable to pay for their care, as well as a growing shortage of trauma related physicians (e.g. trauma, neurological and orthopaedic surgeons) who rely upon trauma centers for the costs of trauma call coverage.

The PHSA trauma programs must be reauthorized because federal investments in trauma systems and centers are essential to improve patient outcomes and provide downstream cost savings. The availability of specialized trauma centers and their effective use through coordinated trauma systems has a close correlation with improvements in mortality and other quality measures. As noted earlier, seriously injured victims treated in Level I trauma centers have a 25% lower risk of death.

The immediate availability of emergency medical personnel and timely access to major trauma and burn centers is essential to saving lives. But lack of trauma care access -- especially in rural areas -- is more often the reality in the United States. Physical distance can be a significant barrier to transporting emergent patients quickly and effectively after first responders have arrived. For example, an accident scene in Mexican Hat, the closest medical facility with a trauma unit was 117 miles away. Five of the victims were treated at this level IV trauma center. The closest level I trauma unit was 190 miles away in Flagstaff, Arizona, and two individuals were treated there and 10 individuals were treated as far as 230 miles away at a level II trauma unit in Grand Junction, Colorado, and three were treated 360 miles away in Salt Lake City, Utah, at a level I trauma unit. Not all of the patients survived. The outcome from a survivable injury should not be a matter of chance.

The public's expectation that trauma care will always be available to them wherever they reside or travel, just as it was on that tragic day in Mexican Hat, has yet to be met. The challenges facing trauma centers, trauma systems and physicians who treat our must vulnerable patients are profound.

Access to Trauma Care is Essential for All Americans

These programs are critical to the efficient delivery of services through trauma centers and the highly specialized trauma teams that staff them, as well as to the development of regionalized

systems of trauma and emergency care that ensure timely access for injured patients to appropriate facilities. A modest investment can yield substantial returns in terms of cost efficiencies and saved lives.

The combination of market pressures and reduced reimbursement, as well as a growing shortage of on-call specialists, could result in additional closures, particularly in rural areas where they are needed the most. Trauma centers typically do not reconstitute once closed, and it takes years to re-establish or develop a new one. It is imperative that federal policy makers address this looming crisis before it deteriorates further.

The PHSA trauma and emergency care programs address the need to improve trauma care by providing seed money to the States to develop and enhance their trauma systems, enhance the availability of services in all geographic locations and to provide support for the existing trauma center infrastructure. Reauthorization of these programs will help to prevent trauma center closures and will drive the development of more efficient regionalized systems of emergency care and transport and enhance trauma research and our ability to most effectively save lives. A modest investment by Congress can yield immense returns in efficiencies, economies of scale and improvement in public health and safety.

Conclusion

On behalf of our trauma and emergency care community, we call upon the Congress to reauthorize these vital programs. Specifically, we urge Congress to reauthorize the Trauma Care Systems Planning Grants; Regionalization of Emergency Care Pilots; Trauma Care Center; Trauma Research and Trauma Service Availability Grants this year. Reauthorization will ensure that support for these vital programs will be able to continue.

Again, thank you for holding this hearing and prioritizing trauma and emergency care as a priority at the beginning of the 114th Congress. Your acknowledgement of the need to ensure that these systems are available to all Americans is greatly appreciated, and we thank you again for your leadership and commitment to these crucial programs. TCAA and our advocacy

partners welcome the progress that has already been made and look forward to working with you. Please contact, Jennifer Ward, RN, BSN, MBA President of the Trauma Center Association of America at (575) 525-9511, if you have any questions or need further information.

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[i] National Trauma Institute. www.nationaltraumainstitute.com. San Antonio, TX.

[ii] Injury Prevention & Control: Trauma Care. www.cdc.gov/traumacare. Centers for Disease Control and Prevention, Atlanta, GA.

[iii] Soni, A. Top 10 Most Costly Conditions among Men and Women, 2008: Estimates for the U.S. Civilian Noninstitutionalized Adult Population, Age 18 and Older. Statistical Brief #331. July 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://meps.ahrq.gov/mepsweb/data_files/publications/st331stat331.shtml.

[iv] MacKenzie EJ, et al. the Value of Trauma Center Care. *J Trauma* 2010; 69: 1-10.

[v] Haas B, Stukel T, Gomez D, et al. The mortality benefit of direct trauma transport in a regional trauma system: A population based analysis. *Trauma Acute Care Surg* Volume 72, Number 6, 2011; MacKenzie EJ, Rivara FP, Jurkovich GJ, et al. A national evaluation of the effect of trauma center care on mortality. N Engl J Med. 2006; 354; 366-378

[vi] Haas B, Stukel T, Gomez D, et al. The mortality benefit of direct trauma transport in a regional trauma system: A population based analysis. *Trauma Acute Care Surg* Volume 72, Number 6, 2011.

[vii] Ibid. Mean expenditures per person on most costly conditions among men and women, adults age 18 and older, 2008. For trauma related disorders: $2,475 for women and $2635 for men; for heart disease $3,723 for women and $4,363 for men; and for cancer $4,484 for women and $4,873 for men.