Hearing on
Strengthening our National Trauma System

Statement of

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Good morning Chairman Pitts, Ranking Member Green, and members of the Subcommittee. My name is David Marcozzi. I am an Associate Professor of Emergency Medicine at the University of Maryland and served as a member of the Committee on Military Trauma Care's Learning Health System and its Translation to the Civilian Sector. The Committee is part of the National Academy of Sciences, chartered by Congress in 1863 to advise the government on matters of science and technology. Thank you for your invitation to testify today. It was an honor to serve on this prestigious Committee under the leadership of Dr. Don Berwick. I want to begin my remarks by pausing to remember those who lost their lives during the recent Orlando mass casualty and thank those who answered the call and responded to that crisis. My sympathies go out to those affected by this tragedy. Additionally, I want to recognize a legendary trauma surgeon and Committee member from New Orleans, Dr. Norm McSwain, who passed away during the drafting of our report. His death was a great loss. Finally, I want to thank the sponsors of this work for mutually supporting a comprehensive deliverable aimed at improving our nation's approach to the delivery of trauma care.

I guess you could say that I have worked on both sides of multiple isles--`as a Senate fellow, in policy as a senior advisor serving in positions at HHS and the White House, under Democratic and Republican administrations, as a practicing emergency physician in Level one Trauma Centers, and as an army doctor. It is these experiences that help shape my remarks.

Right now regardless of time, age or payer, emergency and trauma systems across our nation are diagnosing and treating those who are ill, injured or depressed. Those 2

health delivery systems are inextricably linked. Their care has an impact on the community and population they serve. Appreciating this, I reflected on a prior hearing by the House Oversight and Government Reform Committee on June 22, 2007 in response to the 2006 Institute of Medicine release of 3 reports on the state of our nation's emergency care. Dr. Schwab likely remembers that well, as he was one of the experts testifying that day. Many of the remarks in that hearing are, unfortunately, just as applicable today. At the time, ranking member Tom Davis commented, "Emergency critical care services are in critical condition." He went on "such a fragile, fragmented system holds virtually no surge capacity in the event of a natural disaster or terrorist attack." Representative Cummings who chaired that meeting further remarked, after providing a thorough overview of the challenges facing our nation's emergency care system, "the time for action is long overdue."

Our nation's trauma care systems are vital components of both our nation's health delivery system and our nation's resilience. As the leading cause of death in those under the age of 46, preventing injuries is certainly an optimal strategy but unfortunately people still fall, are involved in motor vehicle accidents, get assaulted, or are shot or stabbed. In addition to those unfortunate daily occurrences of traumatic injury, recent events and remarks by CIA Director Brennan and Secretary of the Department of Homeland Security Johnson strongly compel us to assure that our nation's emergency and trauma systems also stand ready for mass casualties. Coining a phrase from comprehensive federal guidance on how best to respond to terrorist bombings, a robust system needs to be ready to respond *In a Moment's Notice* to injuries. Simply, when that system delivers optimal care, lives are saved. Designing that system to achieve optimal outcomes is also

important economically, as care to victims of trauma totaled $600.5 billion in 2013.

The title of the famous book "Good to Great" allows me to put in context advances in trauma care and highlight findings and two recommendations I hope you will find germane to our discussion today. For we are good in many aspects of trauma care, but we aren't great. An example identified by the Committee of this dichotomy was the finding that approximately 1000 service members died of potentially survivable injuries from 2001-2011 in Iraq and Afghanistan. Here at home, nearly 150 thousand trauma deaths occurred in 2014 – with as many as 30,000 of those deaths preventable with optimal trauma care. That is 400 trauma deaths each day, 80 of which could be saved.

First and foremost, we are good at leadership but we aren't great. There are offices and programs that attempt to address this issue, but those civilian entities have small staffs and little or no funding to influence and improve our nation's emergency and trauma systems. Within the military, the Joint Trauma System's future remains tenuous and it is not currently utilized across all combatant commands. This is a glaring omission by the Department of Defense. In short, there is no single entity within HHS or DOD with the authority and accountability to guide the delivery of optimal trauma care. The Committee concluded that the White House should lead the integration of military and civilian trauma care to establish a national trauma care system and that this initiative would include assigning a locus of accountability and responsibility within HHS and DOD that would ensure the development of common best practices, data standards, research, and workflow across the continuum of trauma care.

The Affordable Care Act could be used as a lever to address these issues, but presently is not. I have heard it said that if you show me your books, I'll tell you your

priorities. In January 13, 2016 the Congressional Research Service released a report entitled the Discretionary Spending Under the Affordable Care Act (ACA) and Table 9 of that report entitled *ACA Discretionary Spending: Emergency Care and Trauma Services* lists the multiple programs authorized to address and improve emergency and trauma care but states "no appropriations were identified" from FY2010 to FY2016 for those authorizations.

Prehospital care has achieved success due to tireless champions for improving that care and lives are saved when we call 9-1-1 due to the efforts of paramedics, emergency medical technicians and physicians. Chief James Robinson, LTC Bob Mabry and COL Russ Kotwal are just three of those champions that worked to shape the recommendations of the Committee dealing with prehospital care. We are good, but we aren't great. EMS remains a patchwork of systems, fragmented and largely isolated from health delivery and health delivery reform efforts. Unfortunately and as dictated by congress, prehospital care is considered only a transport mechanism by HHS, not part of the healthcare delivery system. As a result, we don't have a seamless system that includes the medical care provided before you enter doors of a hospital. The report outlines recommendations to address this issue.

Traumatic injury is non-partisan and the delivery of optimal trauma care is shared responsibility by democratic and republican alike. Both sides of the isle can and should support a system that benefits service members sent into harm's way as well as every American. The report, A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury, presents a vision for a national trauma care system with a bold aim of zero preventable deaths after

injury and minimal trauma-related disability. The Committee's work on this report served as a dedication to those lives cut short because of trauma--whether at a dance club, marathon, on our streets, within our towns, in our schools, at our movie theatres, in our places of worship or work or any other location within our nation or on battlefields overseas. We are good, but we aren't great and we need to be. Thank you and I look forward to your questions.