TRAUMA CENTER ASSOCIATION OF AMERICA

2099 Pennsylvania Ave., NW
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October 15, 2010

The Honorable Kathleen Sebelius
Department of Health and Human Services
Agency for Health Care Research and Quality
Attention: Nancy Wilson -- Room 3216
540 Gaither Road
Rockville, MD 20850

Re: National Health Care Quality Strategy and Plan -- Comments on Behalf of the Trauma Center Association of America (TCAA)

Dear Secretary Sebelius:

The Trauma Center Association of America (TCAA) respectfully submits these comments regarding the National Health Care Quality Strategy and Plan ("National Quality Strategy").

General Background: Trauma Care and Trauma Centers

Trauma -- defined as a blunt force or penetrating serious and body altering physical injury -- is the leading cause of death for children and adults under the age of 44. It is estimated to be the third most expensive medical condition to treat at $100 billion annually in the United States, just behind the cost of treating mental illness at $142 billion and heart disease at $123 billion, and more costly than treating cancer, lung disease, hypertension and kidney disease. Trauma kills more Americans than stroke and AIDS combined and yet less than 10% of hospitals have a trauma center and only 8 states have fully developed trauma systems.

All trauma care is emergent but not all emergency care is trauma. Emergency rooms and departments treat ill and injured people, while trauma centers handle the most severe, life-threatening blunt force and penetrating injuries. Emergency medical technicians (EMTs) transport complex injury victims meeting predefined triage criteria past local hospitals to trauma centers where a sophisticated and highly trained interdisciplinary team of health care professionals are immediately available to provide the services needed to save that person's life and prevent further disability or physical deterioration. Trauma centers dedicate extensive staff, physician and facility resources around the clock, so that seriously injured patients have the best possible chance of survival.

Getting a trauma victim to a trauma center right away is necessary to save his or her life. The golden hour is the first 60 minutes after a traumatic injury. It is widely believed that the victim's chances of survival are greatest if he or she receives critical and specialized trauma care within the first hour. Trauma centers must be prepared for all types of trauma, whether

on a small or large scale, including everyday traumatic injuries (such as victims of car crashes, falls, assaults, construction and farming accidents), catastrophic events (such as the bridge collapse in Minneapolis or the mass shootings at Virginia Tech), natural disasters and terrorist events.

The trauma system operates best when it is coordinated, integrated, fully developed and fully funded at the state and local level in order to ensure that critically injured patients are taken to the right place at the right time. This includes mutual aid agreements between adjacent States to ensure the seamless delivery of trauma services.

The availability of specialized trauma centers to care for victims of traumatic injury has a close correlation with improvements in mortality and other quality measures. In addition, stabilization of patients suffering traumatic injury is ordinarily the beginning, not the end, of their interaction with the health care system. Many traumatic injuries lead to the need for lengthy and potentially expensive recuperative and rehabilitative services. Trauma Center services improve the efficiency of this subsequent care by reducing the utilization of subsequent services.

The National Study on Costs and Outcomes of Trauma, published December 2007 in the Journal of Trauma; Injury, Infection and Critical Care, by Ellen Mackenzie, et al established that “the risk of death is 25% lower when care is provided in a regional, Level I trauma center than when it is provided in a non-trauma center hospital” (J Trauma, December 2010, Supplement, pp. 1). This study also documented improvements in one-year physical functioning associated with trauma care for patients with severe lower extremity injuries. Further research indicates that mortality increases 3.8 times if the severely injured patient is treated initially at a non-trauma hospital instead of bypassing that facility for initial resuscitation at a Level I Trauma Center (J Trauma, Nirula, Maier, et al, September 2010; pp 595-601). Previous studies of States with developed trauma systems versus those without showed a “risk-adjusted odds of death demonstrated a significant protective effect (a 20% reduction), … for the Oregon patients in the later period (1990-1993), when Oregon had an established trauma system and Washington was still functioning under an ad hoc process…" (J Trauma, Mullins Richard J., Mann, Clay, et al; April 1998, pp 609-618).

Principles to Ensure Universal Access to Trauma Care Services

The promotion of quality improvement was addressed by the Affordable Care Act (ACA) not only related to the importance of wellness, disease prevention and management, but also related to the availability of trauma care and emergency medical research, as evidenced by the inclusions of Sections 3504 and 3505 in the Quality Title III of the ACA. The ACA recognized that acute traumatic injury and emergency medical conditions will continue to occur, despite the best prevention efforts, and that quality and availability of care and treatment for them must be assured.

Accordingly, in articulating the National Quality Strategy and in implementing the quality provisions in the ACA, trauma and emergency care research should be given appropriate recognition, particularly in light of the substantial costs of treating traumatic

injuries noted earlier. Further, while implementing efforts to realign reimbursement toward better utilization of health care services, care must be taken in this process to recognize the readiness costs of trauma centers and the highly specialized physicians required to staff them as well as to avoid inadvertently diminishing access to trauma care services by infringing reimbursement for trauma center and trauma physician specialist costs. In addition, systemic issues need to be addressed so that trauma services can be provided on a universal access basis.

The TCAA has advocated throughout the national discussion on health care reform and implementation for several essential components – adequate insurance coverage and reimbursement for trauma center and physician specialists providing trauma care, additional funding borne by all payers for the readiness costs of 24/7 capability for trauma services, greater systemic funding that enables states to continue and expand their critical role in coordinating trauma care service delivery, and an increased federal role in supporting the states in mutual aid agreements and other innovative approaches to enable a borderless approach to ensuring the availability of trauma services. TCAA was very pleased with the inclusion in Sections 3504 and 3505 of the Affordable Care Act of a $100 million authorization for trauma center grants, $100 million authorization for trauma service availability grants, reauthorization of the Trauma Systems Planning Act at $24 million including the Regionalization of Emergency Care Pilot Program, and a directive to the Secretary of HHS to promote emergency medical care research, including adult and pediatric trauma research. It is essential that the National Quality Strategy address these key components as they were included in the Quality Title III of the ACA.

Further, with regard to systemic coordination, victims of traumatic injury depend upon a coordinated trauma system to ensure they are quickly treated by the appropriate trauma center qualified and able to provide the necessary trauma services to save their life or prevent permanent disability. The health care delivery system must recognize two essential components to ensuring universal access and availability of trauma care for all trauma victims: (1) ensuring the future availability of trauma care services requires a greater federal investment in state development and maintenance of coordinated trauma systems; and (2) the federal government needs to play a stronger role toward building a borderless overlay and coordination of trauma care services between state trauma systems.

Recommendations Regarding the Development of a National Health Quality Strategy and Plan

The TCAA has reviewed the Department of Health & Human Services initial thinking regarding a National Health Quality Strategy and Plan and offers the following specific recommendations:

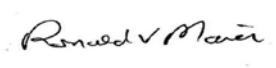
- *Access should be identified as a discrete component of the Framework for a National Quality Strategy.* HHS has initially proposed that the issue of access to care be subsumed within the subject heading of "Better Care". TCAA would recommend that access to the entire continuum of health services be considered

as a separate component from the other elements identified under the heading (quality, safety, reliability, active engagement of patients and families and the best possible care at all stages of health/disease). With more than 20 trauma center closures and a number of trauma center level downgrades over the past decade, ensuring access to trauma care is fundamental to improvements in quality and outcomes. And, as a general proposition, access to care is a fundamental threshold issue that precedes considerations of better care and warrants separate emphasis.

- *Improving Trauma Care should be an initial priority.* As discussed above, improvements in the provision, access and availability of trauma services have an immense potential to improve health outcomes, efficiency and patient-centeredness of care. What is fundamentally required is an approach that promotes systemic capability and coordination whereby patients suffering traumatic injury are routed to the proper level of care sophistication (e.g. appropriate level of trauma center versus emergency department) and whereby trauma care is better integrated into the entire continuum of care. In addition, while trauma triage guidelines have been developed for adult victims of traumatic injury, there remains lacking a similar set of trauma triage guidelines and essential quality metrics for pediatric victims of traumatic injury.
- *The goals of the national strategy should include improving the management of acute medical conditions, such as trauma, as well as chronic illness.* HHS' initial thinking on the goals of a national quality strategy articulates the need to dramatically reduce the occurrence and improve the management of chronic illness through strong partnerships and clear accountability across providers, patients and communities. This is an excellent goal, but it is every bit as relevant in the context of acute injury, particularly traumatic injury. In addition to injury prevention efforts, traumatic injury care can benefit immensely from improvements in the continuity of care that is provided across the spectrum of involved providers and sites of care. In light of the ACA's specific inclusion of trauma care in the Quality Title III of ACA, acute medical conditions such as trauma care should be afforded equal emphasis as a quality improvement goal.

We appreciate very much the opportunity to provide these comments in support of HHS' efforts to develop a strong National Health Care Quality Strategy and Plan.

Sincerely,



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