Statement of the

American College of Surgeons

To the Subcommittee on Health

Committee on Energy and Commerce

United States House of Representatives

RE: Strengthening Our National Trauma System

Discussion draft – Military, Civilian, and Mass Casualty Trauma Readiness Partnership Act

July 12, 2016

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), we would like to thank the Members of the Health Subcommittee for holding this important hearing. Discussing the role of a nationwide, comprehensive trauma system, and advancing trauma care through partnering our civilian and military trauma providers will have a positive impact on the provision of trauma care in our country. We appreciate this opportunity to provide you with a summary of what the ACS and our Committee on Trauma (COT) have been doing to advance trauma care throughout out the country.

The ACS strongly supports strengthening our nation's trauma care system and looks forward to further reviewing the discussion draft of the Military, Civilian, and Mass Casualty Trauma Readiness Partnership Act. The College is eager to partner with the Energy and Commerce Committee as this legislation works through the legislative process with the goal of developing an integrated civilian/military trauma system that would work toward eliminating preventable death after injury.

The ACS COT was formed in 1922 and has made continuous efforts to improve care of injured patients in our society. Today, our trauma activities are administered through an 83-member Committee, overseeing a field force of more than 3,500 ACS members nationwide who are working to develop and implement meaningful programs for trauma care in local, regional, national, and international arenas. In that light, it has been a priority of the ACS and COT to establish and maintain high-quality and adequately-funded trauma systems throughout the United States and within our Armed Forces. The ACS was a sponsor of the recently released National Academy of Medicine (NAM) report – *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury* – and we are proud that several of our members assisted in the production of that report.

Despite our prevention efforts, 35 million Americans are injured each year and almost 200,000 die after trauma, an average of one person every 3 minutes. According to the Centers for Disease Control and Prevention (CDC), trauma is the leading cause of death for children and adults under age 44 in the United States. Currently, nearly 45 million Americans lack access to the highest level of trauma care within one hour of being injured. Receiving this care within the so-called "golden hour" assures the best possible outcome after a serious injury. Pediatric trauma accounts for almost 60% of all deaths under age 18, yet only 10% of children are treated at specialized pediatric trauma centers due to lack of access. Patients treated in a verified trauma center have a reduction in death rates of at least 25% compared to patients treated in hospitals without immediate trauma care facilities. These facilities include dedicated physicians, nurses, and immediate access to specialized equipment needed for the care of the most severe injuries. Sadly, only 10% of our nation's hospitals are currently equipped to treat severe and life-threatening traumatic injuries. According to the NAM report, an estimated 20% of deaths after injury are potentially preventable with access to the appropriate level of emergency medical services (EMS) response and prompt transport to a verified trauma center.

In addition to being a major public health problem, costs related to trauma rank as the second most costly condition in America, totaling over $670 billion in 2013. This includes medical expenses, lost wages, and lost productivity. Accordingly, we believe that improving access to trauma care and EMS for all Americans will yield immense returns in efficiencies within public health and safety and in overall health care expenditures.

In 2014, the ACS formalized a partnership with the Department of Defense (DoD) Military Health System (MHS) to exchange information and incorporate best practices from both civilian and military health systems. The partnership was charged with the following goals:

- Share information related to the curriculum used to teach military surgical skills through expansion of the ACS Advanced Surgical Skills for Exposure in Trauma course and other programs
- Share information related to existing education offerings of importance to military and surgical communities that are interested in humanitarian and disaster response
- Share information related to validation of the military's *Optimal Resources* handbook
- Share information related to potentially increasing the involvement of military surgeons in the ACS senior leadership program
- Share information related to review of the DoD Combat Casualty Care Research Program
- Share information on relevant research portfolios, including research conducted through the ACS National Trauma Data Bank® and Trauma Quality Improvement Program®
- Share information related to systems-based practice, including dissemination of surgical clinical practice guidelines and development of an optimal resources manual for surgical care

Through this partnership we have increased the capability of military trauma care to develop a well-rounded and comprehensively trained military/civilian trauma surgeon. One of the prime examples of civilian health care advancements derived from the battlefield is the use of tourniquets. Through experience gained in the wars in Iraq and Afghanistan, the military determined that improvised tourniquets were not the most effective, and subsequently came to promote the use of professionally designed tourniquets. When translated to the civilian sector, this advancement prompted both medical first responders and bystanders to use tourniquets to save life and limb during the Boston Marathon bombing and other mass casualty events.

Great lessons have been learned through the exchange of information between the military and civilian trauma care communities but more are yet to be taught. Adequate trauma research funding by governmental agencies, including the Department of Defense, and private industry should become a priority due to the fact that trauma has claimed so many lives and is unfortunately likely destined to claim more. Educating, equipping, and empowering the public, as is being proposed by the ACS supported *Stop the Bleed* campaign, could save additional lives similar to the introduction of bystander cardiopulmonary resuscitation. Failure to take action at this time in our history could have tragic results.

We applaud the Committee for highlighting the critical issue of improving our trauma care system and introducing this legislation. We feel that increasing military civilian partnerships is a critical step toward achieving the goal of zero preventable injury deaths as highlighted in the NAM report. Creating a grant program to assist civilian trauma centers in partnering with military trauma professionals establishes a pathway to provide patients with the highest quality of trauma care in times of peace and in war-time by assuring that our military medical corps is kept in a constant state of readiness for deployment to conflicts, humanitarian needs, or to natural or man-made disasters.

The ACS would recommend amending the section that defines eligibility by removing section (e)(1)(D) which states that trauma centers must demonstrate a need for integrated military trauma care providers to maintain or improve the trauma clinical capability of such trauma center. This requirement could result in a center becoming dependent on military providers, which could be extremely problematic when those providers must deploy. Imbedding trauma care teams into high-volume civilian trauma centers will work to achieve and maintain readiness among military providers and alleviate demand at civilian centers. Additionally, we would recommend that trauma centers that have already established successful partnerships with the US Military are provided an opportunity to bypass a new application and/or are given the highest priority when selecting grant recipients.

The ACS would also suggest that the Committee consider modifying the legislation to incorporate grants to cover trauma systems instead of trauma centers. This would shift focus from single facility-based partnerships to community based partnerships that include practice opportunities in the pre-hospital setting. This will also enhance cooperation and collaboration within communities and may require development of consortia within the local communities in order to apply for the grant. The ACS COT utilizes a regional system consisting of ten regions to cover all 50 states – this could be used as a starting point for establishing a structure to better incorporate military and civilian trauma centers. This would allow military teams to remain close to their home base by having their partnering civilian trauma center in the same region.

Overall, we feel this legislation is a good first step in beginning the conversation on comprehensive trauma care, however, there are several key aspects that must be addressed before we can make substantive progress. First, we need to establish a nationwide commitment to prioritize injury care and to ensure the development of regional systems of care. Currently, the development of systems for injury care is a state or local responsibility, one that is not always prioritized or addressed by state or local government. As a result, viewed at a national level our trauma system is a patchwork that has both areas of excellence and areas of mediocrity, wherein the odds of survival are highly dependent on the geographic location of the incident. There is strong need for guidance at the Federal level that sets the expectation that state and local governments must address the problem of injury as a public health issue.

Further, we need to address the way trauma centers are designated. While this is correctly left to state regulation, all too often state agencies lack the statutory authority and political support to make these oft-times difficult decisions. As a result, there are inappropriate trauma facilities designated in areas where they are not needed and too few in areas where they are lacking. In August of 2015 the ACS COT convened a panel of medical and trauma stakeholders, across a broad spectrum of roles, to establish consensus around the principle that designation of trauma centers should be based on need and not subject to local politics. The ACS COT panel concluded with the following guidelines designed to optimize regional trauma system function:

- The designation of trauma centers is the responsibility of the governmental lead agency with oversight of the regional trauma system. The lead agency must have a strong mandate, clear statutory authority, and the political will to execute this responsibility.

- The lead agency should be guided by the local needs of the region(s) for which it provides oversight. As such, it is the responsibility of physicians, nurses, prehospital health care providers, and their respective organizations to advocate for the interests of the patients and citizens they serve throughout the entire region. The collective interests of these citizens and patients supersede the interests of the providers and their respective organizations.
- Trauma center designation should be guided by the regional trauma plan based upon the needs of the population being served, rather than the needs of individual health care organizations or hospital groups. It is the professional obligation of the surgeons, physicians, nurses, emergency medical services (EMS) providers, and public health professionals to work together to ensure that the patients' needs come first.
- Trauma system needs should be assessed using measures of trauma system access, quality of patient care, population mortality rates, and trauma system efficiency. Possible measures to be considered include:
    - Number of Level I and Level II centers per 1,000,000 population
    - Percentage of population within 60 minutes of a Level I/Level II center
    - EMS transport times
    - Percentage of severely injured patients seen at a trauma center
    - Trauma-related mortality (including close review of deaths felt to be preventable)
    - Frequency and nature of inter-hospital transfers
    - Percentage of time trauma hospitals are on diversion status
- Allocation of trauma centers should be reassessed on a regular schedule based on an updated assessment of trauma system needs.
- The applicability of specific metrics and benchmarks for trauma care resources, as well as the resources available to meet these needs, will vary from region to region; the details of the needs assessment methodology and regional trauma center designation criteria should be derived through a broad-based, locally driven consensus process that is balanced, fair, and equitable.
- An international group of recognized experts, stakeholders, and policymakers should be convened to discuss and plan for optimal future regional trauma system development.

The ACS asks this Committee to adopt language reflective of the COT panel recommendations for how trauma centers are designated and to establish legislative guidelines that ensure trauma systems are structured in a way that serves the needs of the population served and provides a stable system framework that is not subject to variations in the health care market.

The ACS appreciates the Committee's inclusion of data reporting requirements, and specifically mentioning the Trauma Quality Improvement Program (TQIP), a landmark ACS program. The measuring and recording of data is a cornerstone of advancing trauma care. Through the interpretation of trauma data, we can identify key characteristics at a facility that will help to improve patient outcomes on a global scale.

In addition to the goals of this legislation, the ACS believes that funding our trauma systems and centers would be a positive first step toward shoring up struggling trauma programs and developing regionalized systems to meet the needs of all Americans. Without a nationwide system, the goal of zero preventable trauma deaths is not obtainable. This draft legislation is a

starting point in cultivating a system of trauma care that will cover all Americans while working to ensure that our Armed Forces are prepared with a state of readiness in order to limit the loss of life and limb to our armed service members, both domestic and abroad.