TRAUMA CENTER ASSOCIATION OF AMERICA

TALKING POINTS FOR TCAA LOBBY DAY
June 2012

What is Trauma Care?

- Trauma care is delivered at specialized hospitals known as ***trauma centers*** that are distinguished by the *immediate* availability of *specialized* personnel, equipment and services to *treat* the most severe and critical injuries.
- Trauma care includes ready-to-go teams that perform immediate surgery and other necessary procedures for people with serious or life-threatening injuries, for example, due to a car crash, bad fall or gun shot.
- Only 1 in 10 hospitals serve as a trauma center. Emergency rooms treat ill and injured people; trauma centers handle the most severe, life-threatening, blunt force and penetrating injuries.

Trauma Care Saves Lives:

Trauma is a major public health issue:

- 35 million people are treated annually for trauma -- one hospitalization every 15 minutes.
- Trauma is the leading cause of death under age 44, more than AIDS and stroke combined.
- At $67.3 billion, trauma is the 3rd most costly medical condition.

The "value" proposition for trauma care is well documented:

- Risk of death for a severely injured trauma at Level I Center is 25% less than at a non-trauma center.
- For those severely injured in car crashes, initial triage to a non-trauma center increases the risk of death within the first 48 hours by at least 30%[i].
- More adults with trauma are treated at a lower cost per patient than heart disease or cancer.
- Trauma center care is more cost effective than many other interventions, including renal dialysis.

Threats to Trauma Care Access:

The federal government has NOT made necessary investments in trauma, leaving a fragile trauma system to falter. This looming crisis in access to trauma care must be fixed before further deterioration.

- 45 million Americans already lack access to Level I trauma centers within the "golden hour".
- From 1990-2005, 30% of trauma centers closed, disproportionate impacting vulnerable patients.
- 15% of trauma patients are uninsured.
- The primary reason for trauma center closure is a lack of funding.

Trauma centers and physicians need reliable, stable, sufficient and predictable trauma reimbursement, which does not currently exist. Cost pressures on hospitals and physicians may lead to more closures.

- Trauma centers can get paid a "trauma activation fee" but only for: (i) outpatients that are (ii) critically injured and (iii) transferred by ambulance. There is no inpatient DRG for trauma.

- There are no CPT codes for trauma physicians. Trauma centers routinely pay $1,500 to $5,000 per day in "on-call pay". 60% of Level I and II trauma centers report inadequate on-call coverage.
- Of total expenditures for trauma, Medicare covers 20% for men and 32% for women.

Solutions:

The combination of market pressures and reduced reimbursement, as well as a growing shortage of on-call specialists, may result in a "perfect storm" of closures. Trauma centers typically do not reconstitute once closed, and it takes years to reestablish or develop a new one. More closures must be prevented.

Short-Term Solutions:

- Funding should be provided for the Public Health Service Act trauma and regionalization of emergency care programs; and
- Study how to ensure access to trauma care and develop reimbursement strategies that promote trauma care that is widely accessible, sustainable and cost-effective.

Intermediate Solutions:

- Fix current reimbursement problems for trauma centers --
    - Remove pre-notification and critical care diagnosis requirements;
    - Create trauma specific DRGs for inpatients; and
    - Require Medicaid to pay activation fee or otherwise support trauma services.
- Determine a mechanism to compensate trauma physicians such as an enhanced update.

Long-Term Solutions:

- Model and test long-term alternative trauma payment models that would incentivize high quality outcomes and cost-effectiveness of care while providing a more stable and predictable funding mechanism for trauma centers and specialist physicians.

[i] 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.