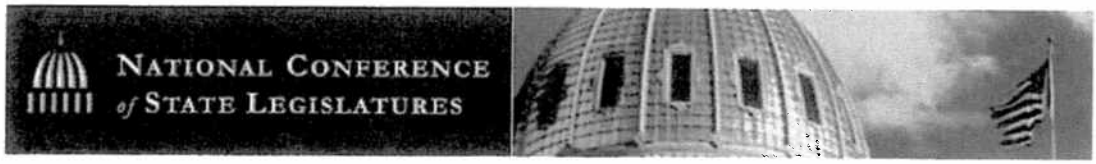

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PREPARING FOR THE WORST: STATES ADDRESS TRAUMA CENTERS' TROUBLES

By Christina Kent

Victims of traumatic events are at least 25 percent more likely to live if they're taken to a certified trauma center than if they are taken to a non-trauma center, according to a carefully controlled, nationwide study in the Jan. 26 *New England Journal of Medicine*.

That finding could give a boost to state legislators who are scrambling to find new sources of funds for the centers, which provide care for the most expensive conditions in the nation. In January, the Agency for Healthcare Research and Quality reported that trauma disorders have become, for the first time, the most expensive condition to treat. According to the agency's Medical Expenditure Panel Survey, trauma-related disorders cost the nation $71.5 billion in 2003 – topping the cost of treating heart conditions ($68 billion), cancer ($48 billion), mental disorders ($47 billion), and cardiopulmonary disease and asthma ($46 billion).

Trauma centers differ from general hospital emergency departments in that they provide, on a 24/7 basis, teams of trauma surgeons, plastic surgeons and other specialists who can deal with the most severe injuries within the "golden hour" – the early period of trauma where skilled intervention may mean the difference between life and death or life-long disability. The centers are capable of dealing with the most severe, life-threatening injuries, including blunt force wounds, multiple internal injuries, burns, broken bones and severe shock.

"Trauma is the number one killer of people aged one to 40," said Dr. J. Wayne Meredith, chairman of the American College of Surgeons' trauma committee. "One of the most prominent tools to prevent those deaths is the trauma system."

The nation's approximately 600 regional trauma centers – which also are often public and teaching hospitals – collectively lose $1 billion a year, according to Connie Potter, executive director of the National Foundation for Trauma Care. And they're facing growing pressure from rising health-care costs, increases in the number of un- and underinsured patients, and physicians' growing unwillingness to provide on-call trauma care, which many regard as underpaid and highly risky (because of possible malpractice lawsuits).

A 2004 report by the Foundation says that, without corrective action, the current rate of closures among the nation's trauma centers will increase, and 10 percent to 20 percent will close within three years.

Preventing Closures

States play an enormously important role in providing trauma care. Not only do they pass legislation authorizing state agencies to design trauma systems, but they strive to keep the trauma centers functioning by channeling to them special funding streams.

Since car crashes are the number one cause of trauma (see chart), many states elect to help pay for trauma care by imposing fines on individuals who are convicted of drunken or reckless driving, or who lose their driver's

license. Some states also use revenues from tobacco, alcohol or firearms taxes, while others tax auto insurance or fine persons convicted of illegal drug distribution.

A number of states are currently considering legislation to shore up their trauma centers; some bills would address the crisis in getting physicians to provide on-call trauma care by increasing their reimbursement.

In New Mexico, HB 356 and SB 356, introduced at the behest of Gov. Bill Richardson, would provide $6 million to create a trauma system fund. Of that amount, $4 million would go to support trauma services at the University of New Mexico hospital and $2 million would go to strengthen the trauma system throughout the state.

In Hawaii, the Legislature is considering HB 3142, which states that Hawaii's "extreme isolation and limited physician re-supply capability renders Hawaii uniquely vulnerable to natural disasters that may occur in a mid-Pacific environment." The bill would create a fund to reimburse the state's only trauma center for documented un- or under-compensated care (including supplemental funding for treatment given to Medicaid beneficiaries). The fund would draw money from state surcharges, the state's environmental response revolving fund, as well as any funds that are separately appropriated by the Legislature or granted by Congress (as long as they don't place an obligation upon the Legislature to continue the purpose for which the federal funds are made available).

In Florida, HB 1697 and HB 497 were signed into law in 2005 after first being vetoed by the governor, who reportedly had concerns about the way the funds were to be distributed. The first bill is expected to raise as much as $4.7 million annually for the state's trauma centers by increasing the penalties for motorists who cause serious injuries (they now will be charged $500) or fatalities ($1,000) in traffic accidents.

The second bill will provide new funding for in-state trauma care by increasing the fine for running a red light from $60 to $125. Florida's 20 trauma centers incur an annual net loss of $96 million, said Amy Maguire, director of the Alliance to Save Florida's Trauma Care. The funds will be distributed to the hospitals based on their state of "readiness" (e.g., how many physicians are on call), and the severity and volume of injuries treated.

Pennsylvania, which has one of the oldest trauma systems in the nation, is considering a bill (HB 502) that would seek to retain trauma providers by increasing their reimbursement. The bill notes that many high-risk health-care providers and institutions in the state are being paid less than Medicare rates by private insurers. "[H]igh-risk health-care providers and institutions may leave this Commonwealth or close down if the low reimbursements continue," the bill states. It would require insurers to pay 25 percent more than the Medicare fee to high-risk providers (defined as those who pay malpractice premiums in one of the four highest classes) for providing covered treatment to trauma patients at a state-accredited Level 1 or 2 trauma center – or the provider's "usual and customary charge," whichever is less.

If states play the primary role in creating trauma centers, the federal government historically also has contributed. For years, the Health Research and Services Administration's (HRSA) Trauma/Emergency Medical Services program provided grants to states to help them plan trauma systems. But the federal FY 2006 budget zeroed out funds for that program. It had been funded at about $3.4 million a year since 2001, Potter said, and grants to individual states had averaged about $40,000 per state.

Both Potter and Meredith were highly critical of the fact that the program was eliminated. "Having a federal agency that supports trauma care is critical," Meredith said. "It's the catalyst, the grist of the mill." Trauma costs the nation billions of dollars a year, he noted. "Spending $3 to $4 million to keep that on track seems like a pretty good investment to me." Repeated calls to HRSA for comment were not returned.

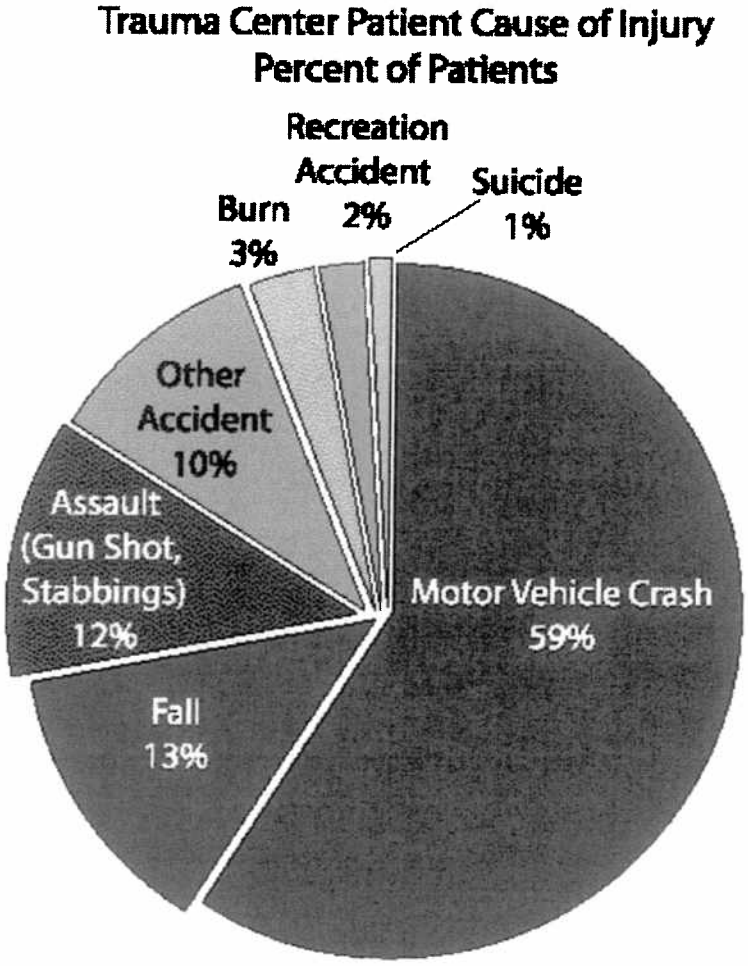
How Many?

September 11th and Hurricanes Katrina and Rita have raised the profile of trauma centers. But it's not clear how many centers the nation needs. A September 2005 issue brief by Charles Branas at the University of Pennsylvania notes that the geographic distribution of trauma centers varies widely across states and regions. Branas and colleagues calculated that 84.1 percent of the U.S. population has access to a Level 1 or 2 trauma center within one hour. (Level 1 and 2 trauma centers provide the most sophisticated care; Level 3 centers transport the most severely wounded patients to a Level 1 or 2 center.)

The Northeast has the greatest access, followed by the West, the Midwest, and the South. About 36.7 million people – most of whom live in rural areas – do not have access within one hour, Branas found.

A significant proportion of people could reach a trauma center within the "golden hour" by crossing state lines, Branas pointed out. As of 2005, 47 states had protocols to enhance interstate cooperation during mass casualty incidents, but just 31 states had standardized protocols for border crossing of day-to-day trauma patients.

Policymakers who are trying to evaluate their trauma systems can measure how long it takes their state's residents to reach a trauma center, in comparison to national norms, Branas suggested. This would enable policymakers to "more realistically allocate scare resources," he wrote.



Tara Lubin contributed reporting to this story.

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