

Medicaid Disproportionate Share Payments

- Medicaid is a joint federal/state partnership with many requirements outlined in federal law.
- One federal requirement is that Medicaid hospital payment rates must take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs (DSH).
- Federal requirements also provide for two limits on DSH expenditures. One limits Medicaid DSH individual hospital payments to the costs of Medicaid services and services to the uninsured less the payments received for those services, and another limits the state's total DSH payments made to all hospitals.
- In order to facilitate the required calculations, each hospital that wishes to participate in the Medicaid DSH program must submit by October 1, of the calendar year preceding the state fiscal year the payment will be made, the Medicare cost report (form 2252) filed for the qualifying year; Medicaid reporting forms for the qualifying year from the *Medicaid Hospital and Long-Term Care Facility Reporting Manual*; and a log for the qualifying year for each patient having uninsured care; the log must be prepared using the *Medicaid Log of Uninsured Care Reporting Form*, the hospital must certify the log as accurate, the log must specify, in sufficient detail for the department to verify uninsured care, Charges, Admissions, Patient days, Any payments made by the patient, or on behalf of the patient by a third party, for services, and Dates of services.
- Federal law mandates three methods of qualifying for Medicaid DSH payments. Those methods are high Medicaid utilization, high low income client utilization, and pediatric outliers DSH payments (which are very insignificant under our current program, and we do pay if necessary). Currently few payments are made utilizing these qualifying standards.
- States can create additional methodologies to pay out DSH as long as those methodologies comply with state and federal law, but the foundation of any payments is still the uncovered Medicaid and uninsured costs.
- The department is currently in the process of revising our Medicaid DSH distribution methodologies as current processes were in place primarily as a Medicaid refinancing tool and have since been rendered obsolete by federal regulations and related appeal decisions. The Department of Law is working with us to identify a methodology we can legally use to target DSH funds towards a particular purpose like trauma centers.
- For 2009, we estimated there was about \$23.8 million in DSH funding available under the state's overall DSH cap that we did not distribute because of a lack of funding. Under current regulation and funding availability, future years would likely look similar.

Alaska's federal allotment for 2010, expressed in terms of federal funds, is \$20,964,262. With our average 61.12% match rate in 2010 that's total allowable DSH expenditures of \$34,300,167 for non-tribal providers.

Following is a list of SFY2010 DSH Payments:

DSH SPEP paid to Providence: \$3,343,719 FFY10
 DSH DET paid to Fairbanks Memorial Hospital: \$1,787,856 FFY10
 DSH DET paid to Bartlett Regional Hospital: \$1,953,050 FFY10
 DSH IMD to API: \$3,584,010 FFY09
 DSH IMD to API: \$9,639,615 FFY10
 Total 2010: \$20,308,250

To the department's knowledge there are no more planned DSH payments for SFY10, which would leave them with approximately \$13,991,917 that they will not spend in 2010.

Alaska Medicaid DSH facility specific limits for 2010 are as follows:

Alaska Psychiatric Institute	16,336,231
Alaska Regional Hospital	5,104,508
Bartlett Regional Hospital	6,727,455
Central Peninsula General Hospital	5,054,361
Cordova Community Medical Center	0
Fairbanks Memorial Hospital	11,807,068
Ketchikan General Hospital	1,881,611
Mat-Su Regional Medical Center	0
North Star Behavioral Health System	0
Norton Sound Regional Hospital	0
Petersburg Medical Center	213,838
Providence Alaska Medical Center	12,307,371
Providence Kodiak Island Medical Center	1,276,910
Providence Seward Medical Center	462,700
Providence Valdez Medical Center	2,074,347
Saint Elias Specialty Hospital	1,529,795
Sitka Community Hospital	0
South Peninsula Hospital	1,134,695
Wrangell Medical Center	0
TOTALS (Not including API)	49,574,659

Information provided by Bill Streur,
 Deputy Commission of HSS and
 director of the Division of Health
 Care Services.

The 2011 Alaska DSH allocation is up in the air because of potential health reform adjustments to the formula from Congressional action. Without health reform, assuming a 4% increase from 2010, and the state's 54.34% FMAP for 2011 the department estimates a 2011 DSH allocation at approximately (21,582,340/.5434) \$39,717,226. The department will probably not have the 2011 facility specific limit calculations completed until approximately July 2010.

TESTIMONY ON SENATE BILLS 168 and SENATE BILL 169
February 8, 2010

ASHNHA represents 27 private, federal, state, and tribal health care facilities located throughout Alaska. The testimony presented here has been approved by ASHNHA's general membership (see detailed member list at bottom of testimony).

ASHNHA's membership supports **SB 168** and its companion bill **SB 169**.

This incentive based approach to increasing trauma treatment capability in Alaska is well reasoned and addresses one key barrier that discourages facilities from seeking trauma designation. A key barrier not addressed by SB 168 is the availability and cost associated with assuring certain physician specialties are on hand to deal with trauma cases. This barrier will continue to limit the ability of hospitals to achieve optimal trauma designation levels unless it too is addressed. In order to solve this problem Alaska's physician community will have to be included in the discussion.

A possible approach might be to broaden Section 18.08.085 to allow the Commissioner of DHSS discretion to use the 'fund' to help offset costs incurred to meet physician staffing requirements necessary to achieve trauma designation. We understand other states are deploying innovative strategies to address the physician staffing challenge which Alaska could possibly learn from and incorporate into this incentive based program if the language of Section 18.08.085 were broader.

ASHNHA supports **SB 168** and **SB 169** and urges their passage from Senate HSS to the next committee of referral at the earliest possible time. Thank you for the opportunity to testify.

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Bartlett Regional Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, North Star Behavioral Health, Wildflower Court Nursing Home.

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Emergency trauma care needs improvement in Alaska

COMPASS: Other points of view

By MARK S. JOHNSON and FRANK SACCO, M.D.

(03/23/09 19:34:23)

Imagine you and your family driving across Anchorage. As you pass through a major intersection, a drunk driver runs a red light and hits your vehicle broadside. In an instant, you and your passengers face a life or death situation. If you're still conscious, you may think, thank God this happened in Anchorage where we have state of the art emergency medical services.

The Anchorage Fire Department has exceptional ambulance services, staffed with well-trained paramedics. Local hospitals have sophisticated emergency departments staffed 24 hours a day with qualified emergency medicine physicians, nurses and support personnel.

You can be confident that you will receive emergency trauma care that compares favorably with care virtually anywhere else in the nation. Right?

Maybe, but maybe not.

Though Alaskans die from injury at the second highest rate in the U.S., there is no statewide system of trauma care. In Anchorage, only the Alaska Native Medical Center has been verified by the American College of Surgeons and certified by the State of Alaska as a trauma center (Level II). Neither Providence nor Alaska Regional Hospital has achieved this national standard.

Trauma center certification means that a hospital has surgical teams readily available to take care of the most seriously injured patients at all times. Backup teams are available and outcomes are continuously reviewed to improve care.

Serious traumatic injuries can produce internal bleeding in the brain, spinal cord or internal organs. Often, this bleeding can be stopped only by surgeons in hospital operating rooms. Studies have verified the "golden hour of trauma," meaning that critically injured persons have increased chances of survival if treated within that time. Trauma centers, as part of a system of care, have been shown to decrease the mortality of the seriously injured 15 percent to 25 percent. Although rural areas may not meet the golden-hour standard, improvements in the statewide systems have been shown to achieve better outcomes for patients seriously injured in remote areas as well.

The Alaska Department of Health and Social Services recently contracted with the Committee on Trauma of the American College of Surgeons (ACS) to review Alaska's trauma care. That review notes Alaska has excellent injury prevention programs, extensive and creative networks for ground and air medical transport, medical specialists in Anchorage and a good relationship with Harborview Trauma Center (Level I) in Seattle.

Among Alaska's deficiencies: Anchorage does not have another Level II trauma center, so there are two systems of trauma care, one for Alaska Natives that follows national standards and another for non-Natives. The team identified no statewide trauma plan and no incentives or requirements for hospitals to participate in the system. State government devotes few resources to coordinating trauma care, and there seems to be very little public awareness of these issues.

The review team recommended requiring all acute-care hospitals to become designated as trauma centers at a level appropriate to their resources and size within two years (Levels II, III or IV). They recommended getting a second level II trauma center in Anchorage as soon as possible, along with a pediatric trauma center. Currently, due to a shortage of Anchorage surgeons willing to take care of children, some seriously injured non-Native children may need to be treated at the Alaska Native Medical Center.

Representative John Coghill Jr. recently introduced House Bills 168 and 169 to create incentives for hospitals to become trauma centers and to offset some of the cost of uncompensated trauma care. The Department of Health and Social Services should be commended for this comprehensive and impartial review of trauma care in Alaska. We urge Alaskans to support these bills and encourage the legislature and Gov. Palin to carefully consider the recommendations in the ACS report.

We hope the scenario above never happens to you but, if it does, let's make sure that the care we expect for our loved ones is available for all Alaskans when we need it.

Mark S. Johnson, MPA, retired as chief of Community Health and Emergency Medical Services for the State of Alaska in 2004. Frank Sacco, M.D., is chairman of the Alaska Trauma Systems Review Committee. The full report on Alaska's trauma care system is available at www.chems.alaska.gov.

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De Fanning, Editor and Publisher, 1971-1983
De Fanning, Editor and Publisher, 1967-1971

OPINION

COMPASS: *Points of view from the community*

Alaska needs a better trauma system

By FRANK SACCO and MARK S. JOHNSON

Alaska is much safer than it was a generation ago. From 1980 to 2004, the unintentional injury death rate dropped more than 50 percent. Without this improvement, an additional 300 Alaskans would have died in 2004. However, Alaska's 2004 rate remained 30 percent above the national average.

We are all aware of the terrible toll of cancer and cardiovascular diseases, but the leading cause of death for people younger than 44 is injury. It remains a major cause of death and disability for all age groups.

For every death approximately three people are left with permanent disabilities.

As with other diseases, prevention is preferable to treatment. Alaska's dramatic reduction in injury deaths is largely attributable to prevention, including use of child restraints and safety belts, reduced rates of drunken driving, and increased use of personal flotation devices. Though prevention is paramount, we also must be prepared to provide the best possible care for those who become injured.

A trauma system is an organized, state-coordinated effort to deliver the full spectrum of care to injured people. The integration of EMS systems, public safety agencies, air medical services and health care facilities ensures that patients receive the most efficient, effective care possible from time of injury through rehabilitation. Trauma systems have been shown to reduce death from injury by as much as 25 percent and are recognized as an integral part of a state's EMS and disaster response system.

According to a 2004 Harris poll, most people want a comprehensive trauma system in their area. Throughout the United States, 83 percent of those surveyed felt a trauma system was as essential as having a fire department and 80 percent were willing to pay extra for it. Interestingly, though 75 percent thought there was a trauma system in their state, only eight states have fully functioning systems and 15 states have



Sacco

no system.

Where do we stand? In 1993, the Alaska Legislature provided authority to the Department of Health and Social Services to verify and certify trauma centers. The statute does not require, or provide incentives for, hospital participation. It does state that no hospital can represent itself as a trauma center unless certified by the state.

Regulations adopted in 1996 require trauma centers to meet standards developed by the American College of Surgeons. Four levels are recognized, from Level I (highest) to Level IV (trauma stabilization facility). There are adequate medical resources to establish Level II trauma centers in Anchorage. In addition, it is feasible to establish Level III and IV centers throughout the state. Because of long transport times, centers of all levels are essential for improving outcomes.

Since the statute and regulations were enacted, only three of 24 eligible hospitals have successfully completed the verification and certification process. (Alaska Native Medical Center — Level II, Yukon-Kuskokwim Regional and Norton Sound Regional Hospitals — Level IV).

Alaska is blessed with exceptional physicians and quality medical resources, but lack of an organized trauma system means that access to timely, quality care cannot be assured. In recent years there have been

Alaska is blessed with exceptional physicians and quality medical resources, but lack of an organized trauma system means that access to timely, quality care cannot be assured.



Johnson

times when critical specialties such as neurosurgery and vascular surgery have been unavailable for emergencies, necessitating transfer of some critical patients to Seattle.

Here are four steps to improve trauma care in Alaska.

1. Residents need to let legislators know that quality trauma care is important.

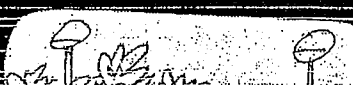
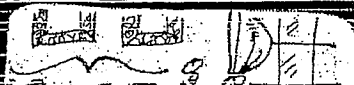
2. The Legislature should put teeth and incentives in the current statute. Successful approaches in other states include requiring trauma center certification at some level as a condition for hospital licensing and limiting medical liability for injuries treated at trauma centers.

3. Tertiary hospitals should ensure availability of critical sub-specialists 24 hours a day, seven days a week.

4. Local EMS and medical providers should organize regional trauma systems and integrate them with the statewide system.

Developing a comprehensive statewide trauma system, and expanding injury prevention efforts, will make Alaska a safer, healthier place to live.

■ Dr. Frank Sacco is chief of surgery at the Alaska Native Medical Center and chairman of the Alaska Chapter of American College of Surgeons Committee on Trauma. Mark S. Johnson was chief of Emergency Medical Services in the Department of Health and Social Services from 1979 until he retired in 2004.



Alaska Statewide Trauma System

Fact Sheet

What is Trauma?

Trauma is any bodily injury from external force. Although many people think of trauma as "accidents", it is better thought of as a disease. Like heart disease and cancer, trauma has identifiable causes and risk factors; and like these conditions, prevention is the best strategy. However, even with the best prevention efforts we still need to be able to take care of the seriously injured. We need to show the same commitment that we brought to cardiac and cancer treatment to trauma care. The seriously injured require timely diagnosis and treatment by health care professionals who are appropriately trained and provided with the necessary resources to reduce the risk of death or permanent disability.

Impact of Trauma in Alaska

Trauma is a tremendous burden on families and communities. In the 1990s, nearly 5,000 Alaskans died from trauma.

- For Alaskans, ages 1 to 44, trauma is the leading cause of death.
- On average, more than 400 Alaskans die from trauma each year. For every injury death, eleven people are hospitalized for trauma-related injuries. For every trauma death that occurs in the hospital, there are an estimated 3 people discharged with permanent disability.
- On average, more than 800 Alaskans are hospitalized each year for central nervous system injury (spinal cord and brain injuries).
- In 2004, motor vehicles were the leading cause of injury death (117), followed by firearm-related injuries (116).
- In 2004, the economic cost of hospital stay alone for trauma patients in Alaska was estimated at over \$73 million. One in four hospital admissions were uncompensated.

Years of Potential Life Lost to Trauma

Death from trauma is tragic at any age. Society's loss is especially great because so many young people die from trauma. The impact can be measured in "years of potential life lost:" the number of years between early death from injury and the average age of death at age 70. Using years of potential life lost, trauma is the leading cause of potential life lost for all Alaskans followed by cancer and heart disease.

What is a Trauma System?

A trauma system is a predetermined, organized, multidisciplinary response to managing the care and treatment of severely injured people. It spans the full spectrum of care; from prevention and emergency care to recovery and rehabilitation. Best practice standards guide each stage of care to ensure that injured patients are promptly transported to and treated at facilities appropriate to their severity of injury and that they receive optimal care at each stage of their treatment.

A statewide trauma system also provides a framework for disaster preparedness and response. As part of its activities, a trauma system coordinates and monitors the

movement and care of severely injured people. Ideally, the trauma system identifies the needs and resources available at any moment and responds to insure optimal care.

Why Have a Trauma System?

For a severely injured person, the time between an injury and receiving definitive care is the most important predictor of survival—the “golden hour.” The chance of survival diminishes with time, despite of the availability of resources and modern technology. A trauma system enhances the chance of survival by making sure that patients are brought to the most appropriate facility in the most efficient manner and that they receive optimal care each step of the way. Trauma systems benefit everybody regardless of income, race, party affiliation or locale. States with mature, comprehensive statewide trauma systems have experienced:

- A 9 percent decrease in motor vehicle crash deaths.
- A 15-20 percent increase in the survival rates of seriously injured patients.
- An increase in productive working years.
- An improvement in statewide disaster preparedness.

Disaster Preparedness

Trauma systems play a vital role in the community response to natural disasters or manmade incidents. Despite concerns over bioterrorism, experience has shown that the vast majority of terrorist attacks will involve explosive devices. We also do know that Alaska will experience major earthquakes in the future. A functioning trauma system is the framework for developing an organized coherent response to these incidents

Alaska's Trauma System

In 1990, state authority for designating trauma centers was created in Alaska. Under this statute hospital participation is entirely voluntary. Criteria were established and the process for designation at Levels I-IV outlined. Since the original legislation there have been only five hospitals that have been designated by the state, one level II and four level IV centers. Clearly, in order to fully realize the benefits of a trauma system, more widespread participation is needed. Alaska's trauma system is ideally an inclusive system, recognizing the vital role that rural communities, hospitals and health care professionals play in the care and management of the trauma patient. Wide-scale involvement is critical to get optimal outcomes for the seriously injured.

The Alaska Trauma Systems Review Committee oversees the statewide trauma system in Alaska. The system addresses four primary components: trauma hospital designation criteria; trauma registry (monitors system performance and provides feedback for improvement); EMS/pre-hospital triage and transport guidelines; and inter-facility (hospital to hospital) transfer guidelines.

Where to Go From Here

- Increased hospital participation is necessary for the statewide trauma system to function optimally.
- There need to be incentives for hospitals to provide the staff and resources required for trauma center designation.

- Legislation to cover the cost of uncompensated trauma care and to limit the medical liability for care given at designated trauma centers are two incentives that have been successful in other states.
- The goal of the statewide trauma system is to see every hospital in Alaska become designated at an appropriate level.
- *Surveys show that the general public overwhelmingly supports having a hospital in their community that is prepared for and capable of effectively managing a seriously injured patient—and are willing to pay for it!

*2005 Harris Interactive poll, "The American Public's Views of and Support for Trauma Systems: A Congressional Briefing."

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TRAUMA CARE IN ALASKA 2008



Treating Trauma

- Like heart disease, cancer or malaria, trauma is best combated with a strategy that addresses prevention, acute care and rehabilitation.

What is Trauma?

- 1966 National Academy of Sciences whitepaper: Accidental Death and Disability: The Neglected Disease of Modern Society”
During this period, more people were dying on our highways each year than during the entire Vietnam conflict.

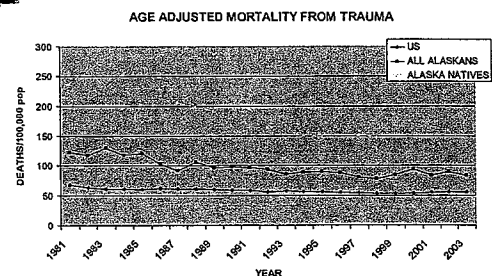
Trauma in Alaska

- Leading cause of death age 1-44
- 400-500 Alaskans die each year
- Over 5000 admitted to the hospital
- Over 1000 with permanent disability
- 800 Alaskans hospitalized with brain or spinal cord injuries

Trauma in Alaska

- Motor vehicle crashes leading cause of death
- Firearm related injuries, second
- 2004 hospital cost for Alaska trauma patients over \$73 million
- ~ 25% over trauma admissions uncompensated

DEATH FROM TRAUMA IN ALASKA



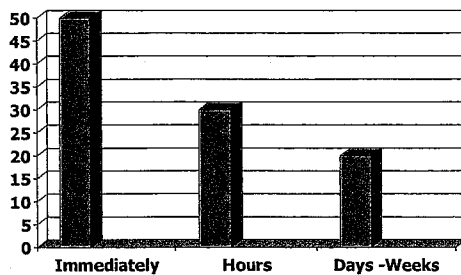
HISTORY OF TRAUMA SYSTEMS

- National Highway Safety Act 1966
- EMS System Act 1973
- Trauma Systems Planning and Development Act 1990
- Skamania conference 1998

Trauma Systems

- ♦ A trauma system consists of hospitals, personnel, and public service agencies with a preplanned response to caring for the injured patient

Death from Trauma



Trauma Systems

- ♦ Facilities (trauma center designation)
- ♦ Personnel (training)
- ♦ Patient transport
- ♦ Triage

Facilities-Trauma Centers

- Level I -Definitive subspecialty care, research
- Level II – Definitive subspecialty care, surgery, ortho, neurosurgery
- Level III- General surgery, ortho, no neurosurgery
- Level IV- Stabilization, limited or no surgical capacity

Personnel

- ATLS
- TNCC
- ETT first responders

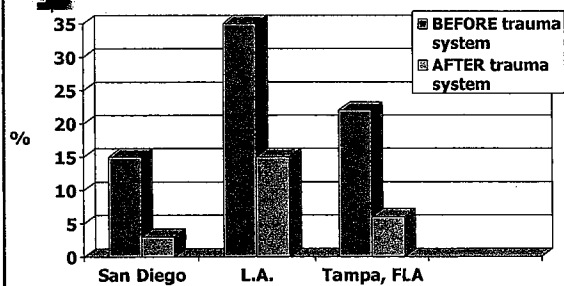
Transport and triage

- Guidelines that take into account local resources and capabilities
- Head Injury Guidelines
- Burn Triage

Trauma Systems

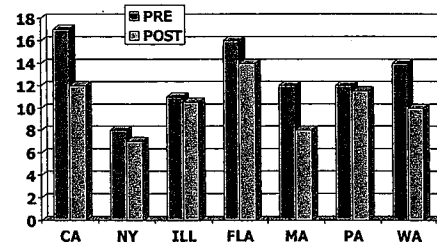
- 15-20% improvement in survival of the seriously injured
- Increase productive working years
- Improve statewide disaster preparedness
- Inclusive systems

Preventable Deaths: The impact of Trauma Systems



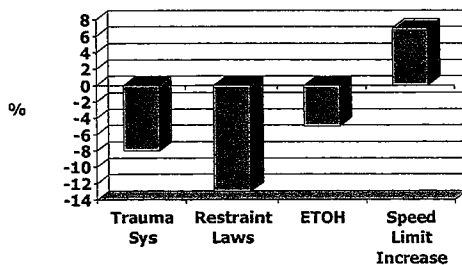
Trauma Systems & crash mortality

Nathens et.al. 2000



Trauma Systems & Crash Mortality

Nathens et.al. 2000



Trauma Centers and Disaster Preparedness

- Trauma centers have usually received the first wave after terrorist attack or natural disaster
- WTC 1993, 2001
- Oklahoma City
- Katrina

Trauma Center and Disaster Preparedness

- Maintain readiness
- Staffed for all types of injury
- Broad communications with regional hospitals and aeromedical resources
- Surge capacity
- Decontamination
- Resources to facilitate patient recovery

Trauma Systems and Disaster Preparedness

- Terrorism- Worldwide explosive attacks cause the majority of deaths and casualties from acts of terrorism
- Economical, readily available

Trauma Systems and the Public

- 2004 Harris poll
- Most people want a trauma system in their area
- 83% felt it was as important as fire department
- 80% were willing to pay extra for it

Trauma Systems and the Public

- 75% of those interviewed "thought" there was a trauma system in their state
- Only 8 states have comprehensive systems
- 15 no system at all
- 27 states including Alaska are "works in progress"

Alaska Trauma System

- 1993 statute- EMS authority for designating trauma centers created
- Hospital participation voluntary
- Standards for trauma center designation follow American College of Surgeons criteria

Alaska Trauma System

- ♦ Verification of compliance by outside reviewers for Level I, II, III
- ♦ In-state review for Level IV

Alaska Trauma Systems Review Committee

- MDs, nurses, admin, and prehospital
- Oversight- Trauma designation
 - EMS/ prehospital triage and inter-facility transfer guidelines
 - Trauma system performance improvement

Alaska Trauma System-14 years later

- Twenty-four hospitals in Alaska
- One level II center - ANMC
- Four level IV centers - NSH - MEH
 - YKHC - SCH
- 8 other reviews or consultations

Alaska Trauma System: Where do we go now ?

- Increasing facility participation is paramount
- "Carrots and sticks"

"Sticks"

- Require participation
- Tie to facility licensing or Medicaid participation

Carrots

- Caps on the medicolegal liability of designated trauma centers taking care of injured patients
- Cover the cost of uncompensated care of trauma patients treated at designated trauma centers

"Carrots"

- Funding of trauma systems.
- Sin Taxes
- Oil revenues- i.e. WY
- Homeland Security

Where do we go now?

Proposed Legislation

- Draft legislation being prepared
- Cap liability of designated trauma facilities at \$500,000 for injury or death
- Creation of a Trauma System Fund—defray the cost of uncompensated care when given at designated trauma centers

Alcohol Screening and Brief Intervention in the Injured Patient:

Injury Prevention in the Hospital and ER

Public Health Impact of Alcohol Use & Abuse

- Alcohol abuse is a preventable public health problem contributing to 100,000 deaths and costing 185 billion dollars annually
- Alcohol misuse has far-reaching implications for the individual drinker, family, workplace, community, and health care system

Alcohol and Injury

What Percent of American Indian and Alaska Native Deaths Are Alcohol-Related?

- ❖ Motor Vehicular—73%
- ❖ Pedestrian—75%
- ❖ Homicide—85%
- ❖ Suicide—84%

Sources: May P, *The Epidemiology of Alcohol Abuse Among American Indians: the Mythical and Real Properties*. The Primary Care Provider, Volume 20, March 1995, Indian Health Service; *Ethnicity and Alcohol-Related Fatalities, 1990-1994*, by Voas RB and Tipetis AS, National Highway Traffic Safety Administration, 1999. Courtesy of D. Wallace

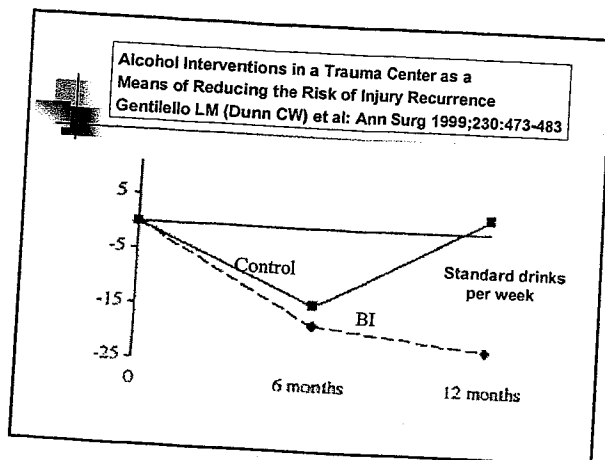
Literature Review

- Prochaska and DiClemente* (1983)
- Bien et al (1993)
- Gentilello* (1999)
- D'Onofrio* and Degutis* (2002, 2005)
- Dischinger* and Soderstrom* (2001)
- Moyer et al (2002)
- Soderstrom* and DiClemente*, (2005)
- Sanddal(s)* and Upchurch*, (2005)
- Schermer*, (2006)

*Assisting the IHS-Tribal ASBI Program

The Spectrum of Alcohol Use: Who Are We Targeting?



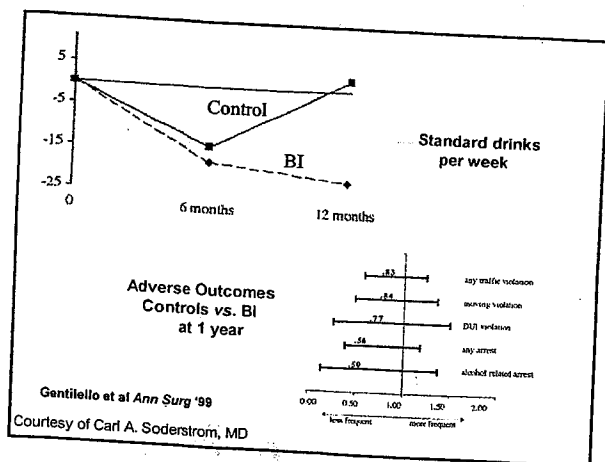


Key Trauma Center Study

Showed beneficial results with a brief intervention in TC patients

- The experimental group demonstrating decreases in drinking at 6 months and at one year
- The control group returned to pre-injury level (or higher) at one year
- The experimental group had a 47% reduction in injuries requiring emergency department care or trauma center admission

Gentilello LM, Rivara FP, Donovan DM, Jurkovich GJ, et al: Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Ann Surg*, 1999;230: 473-483.



R.A. Cowley STC Longitudinal Death Study

- Not offering advice/intervention to STC patients who test positive for alcohol misuse results in significant subsequent higher death rates from injury
- 27,000 patients discharged from the STC and followed for 1.5 to 14.5 years
- A subsequent injury death occurred in 1,631 or (23%) in those who tested toxicology positive at the initial STC admission

Dischinger PC, Mitchell KA, Kufera JA, Soderstrom CA, et al: A longitudinal study of former trauma center patients: the association between toxicology status and subsequent injury mortality. *J Trauma* 2001;51:55-564.

Billings Area Injury Death Study

- 38% of patients with fatal injuries had a previous IHS Service Unit ETOH encounter without prevention counseling within the previous six months
- Injury-Prevention activities should be initiated at the time of any health-system contact in which alcohol use is identified
- Intervention strategies should be developed that convey the immediate risk of death from injury in these patients


Analysis of Prior Health System Contacts as a Harbinger of Subsequent Fatal Injury in American Indians. TL Sanddal, J Upchurch, ND Sanddal and TJ Esposito; *Journal of Rural Health*, 2005

"Prevention Paradox"

- For every known alcohol dependent person there are more than six persons who have alcohol-related problems, but are not dependent
- A majority of this group of non-dependent alcohol user group are in the hazardous and harmful alcohol use group

Personal Communication with Daniel Hungerford, DPH, MS; CDC; May 2006

RESOURCES
FOR
OPTIMAL CARE
OF THE
INJURED
PATIENT
2006



COMMITTEE ON TRAUMA
AMERICAN COLLEGE OF SURGEONS

Prevention

Level I & II - Essential
"Have a mechanism to identify patients who are problem drinkers"

Level I - Essential
"Must have the capability to provide an intervention for patients identified as problem drinkers."

2006 ACS Frequently Asked Questions (FAQ) website in development as of Jan 15, 2007
(facs.org/trauma/faq_answers.htm)

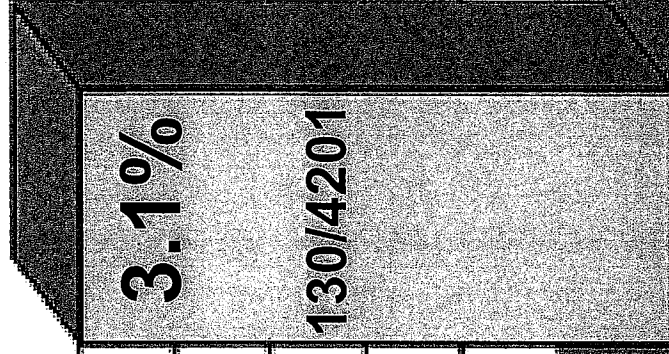
ASBI Documentation and Reimbursement

- Chart Documentation, PCC and HER
- Pre-Screen, Alcohol Screen (AS) & Brief Intervention (BI)
- Coding
- CPT-HCPCS Codes
- H-0049 Screening
- H-0050 Screening and Brief Intervention
- RPMS
- CRS... GPRA
- Billing and Reimbursement
- ICDA Codes

Anchorage Hospital Trauma Mortality Rate 2005-07

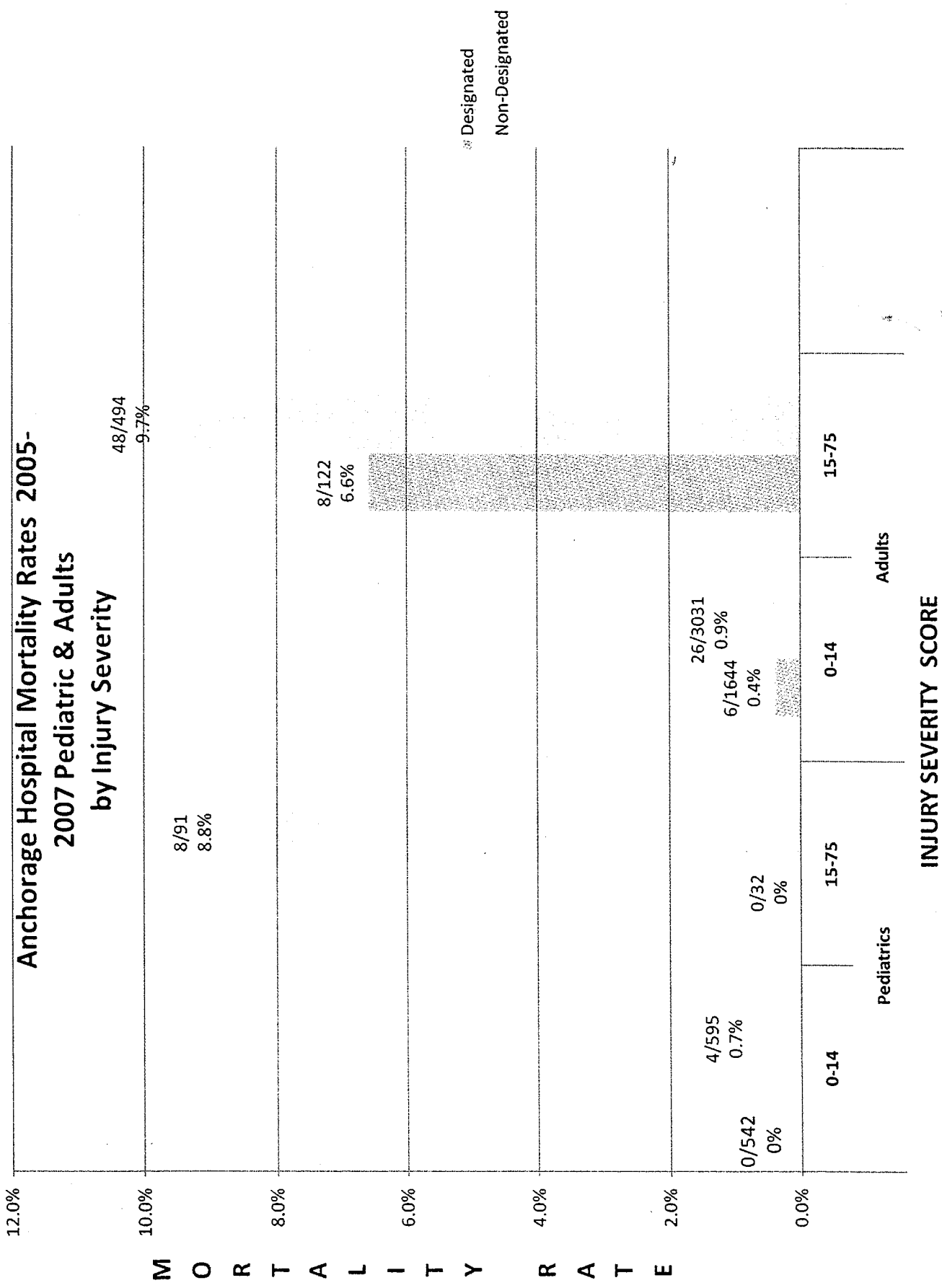
Excludes DOAs

5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%



Designated

Non-Designated





Objectives and Methodology

- The Coalition for American Trauma Care commissioned Harris Interactive to conduct a survey of the public's views of and support for trauma systems.
- Telephone interviews were conducted with a nationally representative sample of 1000 adults aged 18 and over, between November 3rd and 14th, 2004.
- Final data were weighted by age, education, gender, income, and region, where necessary, using 2003 Current Population Survey data to adjust for sampling biases, if any.
- With 1,000 respondents, the sampling error is +/- 3%.



Key Topics

- Knowledge about leading causes of death
- Perceived value of and expectations about trauma centers
- Perceived value of and expectations about trauma systems
- Willingness to support funding of trauma centers and systems
- Disaster preparedness and trauma systems



Harris Interactive Ground Rules For Publicly Released Surveys

- Harris Interactive Inc. has very strong ground rules for surveys which may be publicly released. No other survey firm has stronger rules.
- Our **Five Rules** ensure that our surveys are never used to lead or mislead policymakers or the public. We do not do “hired gun surveys.”
 1. The survey must be fair, balanced and comprehensive.
 2. If the survey is publicly released, the full survey report must be released.
 3. We will not include questions for possible publication about our clients' company or their products or brand names, or the names of their competitors. (The one exception: we sometimes do readership surveys or audience measurement surveys which ask about our clients.)
 4. The survey must not be used to mislead the public, the media, policymakers or anyone else.
 5. We need to review the information that is being released prior to its release in order to check for accuracy.



Overview

- Most Americans are not aware that injury is the leading cause of death for children, youth, and adults under the age of 34.
- After hearing a description of a trauma center, Americans value them highly and appreciate the importance of having one within easy reach.
 - Almost all Americans feel it is extremely or very important to be treated at a trauma center in the event of a life-threatening injury.
 - Nearly nine in ten Americans think it is extremely or very important for an ambulance to take them to a trauma center in the event of a life-threatening injury, even if it is not the closest hospital.
 - Nearly all Americans *believe* that if they had a serious or life-threatening injury, they *would* be taken to the hospital that is best equipped to handle their specific injury in less than 1 hour.
- Majorities of Americans feel that having a trauma center nearby is as important as or more important than having a Fire Department or Police Department.



Overview (cont.)

- After hearing a description of a trauma system, nearly all Americans recognize the importance of having a trauma system in place in their state.
- Large majorities feel that having a trauma system in place is as important as or more important than having State Police or HAZMAT teams.
- About two in three Americans would be extremely or very concerned if they learned that the trauma system in their state did not meet recognized standards. *(However, a 2002 survey of the status of trauma system development conducted by the Health Resources and Services Administration of the U.S. Department of Health and Human Services shows that only 8 states have fully developed trauma systems, 12 states do not have the authority to designate trauma centers, and the rest are in varying stages of partial development.)*
- Americans are willing to spend their own money to have trauma centers and systems in place in their states.
- Generally, Americans have high expectations of their states' trauma centers and systems when it comes to handling natural disasters or terrorist attacks.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

October 13, 2008

Regina Chennault, MD
Frank Sacco, MD
4315 Diplomacy Drive
Anchorage, AK 99508

Via fax: 729-2746

RE: Alaska Trauma System

Dear Drs. Chennault and Sacco:

Thank you, Dr. Chennault for presenting at the ASMA House of Delegates Meeting on Saturday, September 27, 2008.

By consensus the ASMA HOD supported the concept of an appropriate trauma system for Alaska. However, the proposal recommended that there be a \$500,000 cap on all damages for treatment of trauma patients in a state certified trauma center. The HOD recommended that be dropped from your proposal as any cap on economic damages would likely be found unconstitutional in Alaska. Additionally, the HOD also recommended that the proposal be amended to provide for a mechanism to directly compensate physicians for providing treatment for uninsured trauma patients in a state certified trauma center. (This would be for physicians who are not employees of that certified trauma center).

Several individual HOD members also suggested that you may wish to explore Alaska's "Good Samaritan" laws in lieu of any special economic damages caps which, as previously stated, are constitutionally problematic.

Please let me know if I may be of any future assistance.

Sincerely,



By: James J. Jordan, Executive Director
For: The Alaska State Medical Association

CC: John Raster, MD, Speaker of the House
Tom Vasileff, MD, President
J. Ross Tanner, MD, Immediate Past President

**Trauma System Consultation
State of Alaska
Anchorage, Alaska**

**November 2nd -5th , 2008
American College of Surgeons
Committee on Trauma**

PRIORITY RECOMMENDATIONS AMERICAN COLLEGE OF SURGEONS ALASKA TRAUMA SYSTEM REVIEW

November 2-5 2008

Definitive Care Facilities

- Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with American College of Surgeons Committee on Trauma (ACS-COT) verification criteria to meet the existing volume and acuity demands.
- Mandate participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center certification/designation appropriate to their capabilities.
 - Facilities should seek trauma center designation at a level appropriate for their capabilities.
 - Other facilities, such as remote health care clinics, should participate with rapid patient assessment and stabilization and by following guidelines for trauma triage and transfer.
- Study pediatric trauma care needs with the goal of establishing one or more centers of excellence in pediatric trauma care.

Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.

Lead Agency and Human Resources Within the Lead Agency

Develop an appropriate position classification and duty statement for a 1.0 full time equivalent (FTE), permanent trauma system manager that specifies education as a health professional, experience in trauma or emergency health care, and the administrative skills and clinical understanding necessary to support trauma system development.

Trauma System Plan

- Develop a comprehensive trauma system strategic plan consistent with the Health Resources and Services Administration (HRSA) *Model Trauma System Planning and Evaluation* document.

Coalition Building and Community Support

- Develop and disseminate public information about the challenges in providing trauma care and the status of the trauma system in the state for Alaskans.

System Integration

- Ensure that the Injury Prevention and Emergency Medical Services

(IPEMS) Section is engaged in planning with disaster preparedness, emergency management, and public health functions for integration of the trauma system.

Financing

- Provide state funding to hire a fulltime trauma system manager.

Emergency Medical Services

- Develop a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (e.g., load capacity, instrument rating, landing requirements, etc); and to monitor the availability and location of air resources in near real-time.

System Coordination and Patient Flow

- Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).

Disaster Preparedness

- Integrate all components of the trauma system into state and local disaster planning activities.

System-wide Evaluation and Quality Assurance

- Develop an initial set of 3-5 statewide system performance indicators from among the list of nine provided in the Pre-Review Questionnaire.

Trauma Management Information Systems

- Ensure that all elements considered essential to system development, evaluation and performance improvement in the State of Alaska are included and functional in the new trauma registry and are consistent with the National Trauma Data Standard definitions.

Statutory Authority and Administrative Rules

System Leadership

- Form an Alaska Technical Advisory Committee (ATAC) and task it with providing the Alaska Council on Emergency Medical Services (ACEMS) with recommendations regarding the following functions: data systems, trauma system planning, system-wide performance improvement and patient safety, trauma education (Advanced Trauma Life Support [ATLS], Trauma Nurse Core Curriculum [TNCC], Prehospital Trauma Life Support [PHTLS], etc), trauma center review and certification, injury prevention and control, public policy, and research.

• Enact legislation to expand the membership of the ACEMS to represent the trauma system and to include the following members appointed as follows:

- One member, appointed by the Governor, shall represent the Alaska Chapter of the American College of Surgeons Committee on Trauma.
- One member, appointed by the Governor, shall be a general surgeon who routinely participates in the care of injured patients.
- One member, appointed by the Governor, shall represent the Alaska Chapter of the American Academy of Pediatrics.
- One member, appointed by the Alaska Legislature, upon the recommendation of the Speaker of the House of Representatives.
- One member, appointed by the Alaska Legislature, upon the recommendation of the President of the Senate.



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THE WORST: STATES ADDRESS TRAUMA CENTERS' TROUBLES



IN DEPTH STATE HEALTH NOTES

Volume 27, Issue 461

February 20, 2006

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?

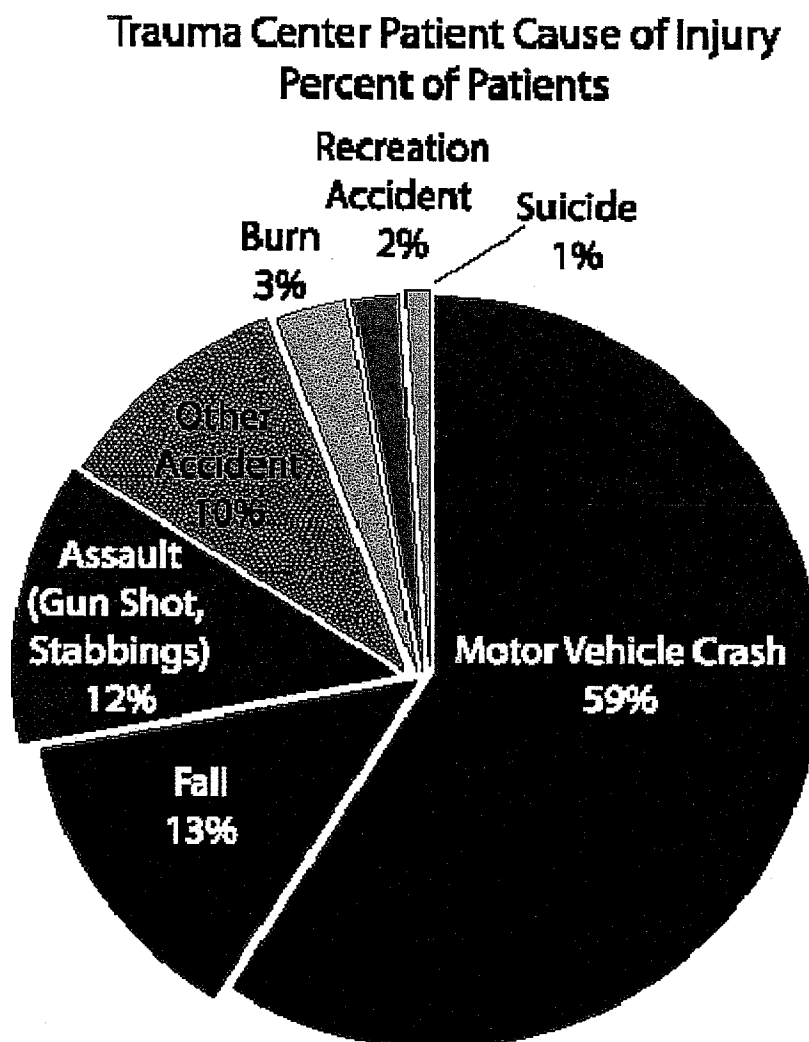
September 11th and Hurricanes Katrina and Rita have raised the profile of trauma centers. But it's not clear how many centers the nation needs. A September 2005 issue brief by Charles Branas at the University of Pennsylvania notes that the geographic distribution of trauma centers varies widely across 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 scarce resources," he wrote.



Source: National Foundation for Trauma Care.

Tara Lubin contributed reporting to this story.



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