

**ALASKA STATE LEGISLATURE**  
**SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE**

February 10, 2010

1:32 p.m.

**MEMBERS PRESENT**

Senator Bettye Davis, Chair  
Senator Joe Paskvan, Vice Chair  
Senator Johnny Ellis  
Senator Joe Thomas  
Senator Fred Dyson

**MEMBERS ABSENT**

All members present

**COMMITTEE CALENDAR**

SENATE BILL NO. 168

"An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers; and providing for an effective date."

- HEARD AND HELD

SENATE BILL NO. 169

"An Act appropriating \$5,000,000 to the uncompensated trauma care fund; and providing for an effective date."

- SCHEDULED BUT NOT HEARD

**PREVIOUS COMMITTEE ACTION**

BILL: SB 168

SHORT TITLE: TRAUMA CARE CENTERS/FUND

SPONSOR(s): HEALTH & SOCIAL SERVICES BY REQUEST

03/27/09	(S)	READ THE FIRST TIME - REFERRALS
03/27/09	(S)	HSS, FIN
04/08/09	(S)	HSS AT 1:30 PM BELTZ 211
04/08/09	(S)	Heard & Held
04/08/09	(S)	MINUTE(HSS)
02/10/10	(S)	HSS AT 1:30 PM BUTROVICH 205

BILL: SB 169

SHORT TITLE: APPROP: TRAUMA CARE FUND

SPONSOR(S): HEALTH & SOCIAL SERVICES BY REQUEST

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04/08/09	(S)	Heard & Held
04/08/09	(S)	MINUTE(HSS)
02/10/10	(S)	HSS AT 1:30 PM BUTROVICH 205

**WITNESS REGISTER**

SENATOR COGHILL  
Alaska State Legislature  
Juneau, AK

**POSITION STATEMENT:** Sponsor of SB 168.

WARD HURLBURT, Chief Medical Officer  
Department of Health and Social Services  
Director, Division of Public Health  
Anchorage, AK

**POSITION STATEMENT:** Supported SB 168.

DR. FRANK SACCO, Trauma Director  
Alaska Native Medical Center  
Chair, State Trauma Systems Review Committee  
Anchorage, AK

**POSITION STATEMENT:** Supported SB 168.

DR. REGINA CHENAULT, State Chair  
American College of Surgeons Committee on Trauma  
Anchorage, AK

**POSITION STATEMENT:** Supported SB 168.

DAVID HULL, Chair  
Governor's Alaska Council on Emergency Medical Services (ACEMS)  
Fire Chief, North Tongass Fire Department  
Ketchikan, AK

**POSITION STATEMENT:** Supported SB 168.

ROD BETIT, President  
Alaska State Hospital and Nursing Home Association  
Juneau, AK

**POSITION STATEMENT:** Supported SB 168.

MARK JOHNSON, Chief  
Emergency Medical Services (EMS)  
Juneau, AK  
**POSITION STATEMENT:** Supported SB 168.

MARTHA MOORE, representing herself  
Juneau, AK  
**POSITION STATEMENT:** Supported SB 168.

SOREN THREADGILL, retired Chief  
Emergency Medical Services (EMS)  
Anchorage Fire Department  
Anchorage, AK  
**POSITION STATEMENT:** Supported SB 168.

#### **ACTION NARRATIVE**

[1:32:31 PM](#)

**CHAIR BETTYE DAVIS** called the Senate Health and Social Services Standing Committee meeting to order at 1:32 p.m. Present at the call to order were Senators Ellis, Paskvan and Davis.

#### **SB 168-TRAUMA CARE CENTERS/FUND**

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CHAIR DAVIS announced consideration of SB 168.

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SENATOR DYSON and SENATOR THOMAS joined the meeting.

SENATOR COGHILL, sponsor of SB 168, said the bill is pretty simple in its workings; it creates a fund much like a piggy bank, the purpose of which is to get hospitals to try to increase their trauma ratings. It came out of the College of Surgeons report that he read almost two years ago, which revealed that the trauma system in Alaska is not as well coordinated as it could be.

He explained that Alaska put together a voluntary system of trauma care about sixteen years ago, and it has done many things well, but there are things that could be done better. There are currently 24 hospitals in Alaska. There is one Level II trauma center at the Alaska Native Medical Center in Anchorage. Of those 24 hospitals, there are four Level IV trauma centers, none of them in Fairbanks or Anchorage. This bill creates a fund to

incentivize hospitals to move up to a trauma Level II or III. There are two hospitals in Anchorage within reach of a Level II and one in Fairbanks that could easily reach a Level III if the state can help them get their uncompensated care taken care of and provide the right incentives.

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SENATOR COGHILL referred members to the November 2008 Trauma System Consultation report by the American College of Surgeons Committee on Trauma (ACSCOT), which is the report that moved him to start looking more closely at this issue. Page 7 lists the challenges and vulnerabilities of the Alaska trauma system. He said the first hearings on this bill occurred on the House side last year, and since that time he has had two meetings with stakeholders including hospitals, Department of Health and Social Services (DHSS), and others. Their discussions have resulted in some very positive steps. DHSS has made it a priority to improve trauma care in Alaska. They have created a position in the department to oversee it and have hired a person whose responsibilities will include development of a trauma system strategic plan and creation of standards for trauma triage.

However, he pointed out, as the College of Surgeons' report states, "few incentives exist for hospitals to participate in the trauma system." That is where SB 168 comes in. The hospitals have been doing a yeoman's job, but they could do better. The doctors do a yeoman's job, but they have private practices and work in the hospitals on call. Both get credit for doing their jobs very well, but the collaboration between them has not been as good as it could be. He hopes this bill will help them establish a better relationship that will allow them to work together to improve the level of trauma care available.

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SENATOR COGHILL acknowledged that Alaska has a large volunteer base and a lot of people who are unpaid first responders. These volunteers should be commended and supported in any way possible, he said; they invest their lives in helping people from the time of any tragedy until they can reach a hospital, but if their work goes unappreciated at the entrance to the hospital because there is not a good working relationship between the doctors and the hospitals, the system has failed them and the people of Alaska.

SENATOR COGHILL related his own experience with the system when, just over two years ago, his grandson fell and suffered a brain

trauma. The boy was stabilized in Fairbanks and medevaced to Anchorage, but it was almost seven hours from the time he fell until he saw a doctor. His grandson died. He does not blame anyone; everyone was doing the best they could do, but it was just not good enough. He is very motivated to push this issue forward.

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He said the fund is just a piggy bank right now, with no money in it, and asked that the committee forward a \$5 million fiscal note to Finance to fill the fund. That amount is commensurate with the amounts similarly populated states have set aside for uncompensated care. He admitted that he does not know how they are going to come up with that money and said he is open to suggestions. One option is to ask the Department of Health and Social Services to re-identify a portion of the Medicaid "Disproportionate Share" funds, which are intended for uncompensated care. Another, suggested by the House, is to take a portion of the tobacco tax or tobacco settlement money for this purpose; that is general fund money anyway.

SENATOR COGHILL went on to provide a sectional analysis of the bill.

Section 1 provides that the commissioner [of the Department of Health and Social Services] shall establish special designations based on nationally recognized standards and procedures for varying levels of trauma care. In other words, in order to get into the fund, a hospital has to have reached nationally recognized standards for trauma care. He added that he is loath to give the department any more authority to make regulations, but knows of no other way to do it. The good news is that Levels I through IV are very well defined in national standards and are outlined in Alaska statutes.

Section 2(b) creates the fund and states that the fund "consists of money appropriated to it by the legislature." Section 2(c) designates it as uncompensated trauma care money and provides for a review by those committees that already do trauma system review.

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Section 2(d) creates stability in the fund by limiting to 25 percent per year the amount of total assets, including earnings that the commissioner can give to one trauma center.

SENATOR COGHILL said when his grandson fell, they didn't question how much it would cost to get the care he needed, but the care was not available. Alaska can do better. He would rather accomplish that through incentives than directives; it is a better business model, and Alaska's health care situation is much more fragile than some people realize.

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SENATOR ELLIS asked if there will be any distinction between for-profit and non-profit health care facilities.

SENATOR COGHILL said some of that is left to the Department of Health and Social Services, but he does not anticipate that there will be any distinction. He said Providence is most likely to reach a Level II designation, and the regional hospital could establish at least a Level III fairly easily. There are economic considerations because they compete for the same customers, which is another reason he thinks an incentive-based program is best.

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SENATOR THOMAS said he is concerned that there is so much lacking in Alaska's trauma care. He asked if it is due to a lack of insurance coverage for trauma situations.

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SENATOR COGHILL answered that insurance will pay, and Medicaid does pay, but a lot of the uncompensated care is more primary care related, and he thinks the state should first look at uncompensated trauma care. Another part of the issue has to do with the different business models. For example, the Alaska Native Tribal Health Consortium (ANTHC) is a Level II trauma center; they keep paid doctors on staff. Doctors working at the other hospitals have private practices to maintain and are on call for emergency room (ER) work. Their interest is to keep their private practices healthy, so there is a natural tension in the working relationship. He hopes to relieve some of that tension so trauma doctors can afford to be on call more often; this fund will give hospitals a designated uncompensated care package they can count on if they raise their trauma levels, but insurance will still be a huge factor.

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SENATOR THOMAS restated that the problem is more one of having doctors available continuously.

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SENATOR PASKVAN said he thinks the public has a natural expectation that hospitals have the capacity to deal with trauma. He also knows there is a contractual relationship between hospitals and emergency rooms. He asked how this will apply to the separate legal entity that is staffing the emergency room.

SENATOR COGHILL said he does not know, but he thinks they should draw that out in the course of discussion. Those contractual relationships should not be barriers.

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SENATOR ELLIS asked if hospitals break out their uncompensated trauma care from other types of uncompensated care. He said his impression is that for-profit facilities "eat" less uncompensated care; they tend to pass more of the cost on to paying customers.

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SENATOR COGHILL responded that he is not an expert in that field but believes the uncompensated care through disproportionate share is streamed to hospitals when they bill Medicaid and flows fairly equally whether an institution is non-profit or for-profit. Probably the biggest difference is where the money ends up in investment, whether in profit centers or additional care.

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SENATOR DYSON said the uncompensated costs for both for-profit and non-profit hospitals often get shifted to third-party payers and more lucrative portions of the business. Governor Murkowski started an effort to fix that by saying, if government is going to force hospitals to provide uncompensated care in the emergency room, then government should come up with a mechanism to pay for that so they don't have to cost-shift. Unfortunately, he didn't get very far with it.

He said he is very proud of the hospitals in his area, including Providence and Alaska Regional, but a lot of money that comes into Providence does not stay in Alaska. He was surprised that Alaska's hospitals are not equipped to provide a higher level of treatment and, if this bill will provide the incentive for them to do that, he is really in favor of it.

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SENATOR COGHILL said he thinks the profit that hospitals make is due to them, whatever the business model. The fact is that

hospitals in Alaska cannot turn people away from the emergency rooms, and the state has to find a way to pay for it.

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SENATOR COGHILL said the College of Surgeons recommended a mandate, but he doesn't want to go there. This is an incentive and, because of this bill, changes are already being made. Not only has DHSS hired a coordinator, but hospitals have actually begun discussions with each other and with the military, which has trauma doctors who are familiar with trauma in war zones. They are looking at how the military can work with the hospitals and how they will deal with the hand-off. They already have out-of-state doctors coming in to work at some hospitals, so he knows it can be done.

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SENATOR ELLIS asked Senator Coghill where he came up with the \$5 million figure and whether that will increase in future years.

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SENATOR COGHILL said the figure is based on data from other comparable states and what they are doing in uncompensated trauma care. He realizes that the department is going to come in with a neutral position because they don't want to spend any more money; he can appreciate that they are under huge downward pressure, but if the state does less, it will get less.

[2:04:32 PM](#)

WARD HURLBURT, Chief Medical Officer, Department of Health and Social Services; Director, Division of Public Health, said one of the first things he learned when he started in his job last summer was how appreciative people are of Senator Coghill's interest and hard work in this area. One of the major responsibilities of the division has to do with the prevention of unintentional injuries and handling those after they occur.

He said he worked as a physician in Naknek, in Dillingham, Alaska in 1961, where he saw a lot of trauma injuries. After he completed his training as a general surgeon, he spent many years at the Alaska Native Medical Center (ANMC), where a big part of what he did was deal with trauma. Part of the reason for the high incidence of trauma in this state is the lifestyle; the way many Alaskan citizens make a living is hazardous; transportation is hazardous; recreation in the state can also be hazardous.

DR. HURLBURT said when he was with the Alaska Native Health Service after the 1964 earthquake, he was very involved in

planning for the new facility; as part of that planning, they recognized the problem that unintentional injury and trauma play in the lives of Alaska Natives and built a facility that met the standards needed to provide that kind of care.

He stressed that trauma is the biggest killer of Alaskans from birth to age 44; it is third behind cancer and cardiovascular disease as the cause of death of all Alaskans, regardless of age and is the number one killer of Alaska Natives of all ages. The administration has learned about the trauma systems and the categorization of trauma systems through the Alaska Trauma System Review Committee and the Alaska Council on Emergency Medical Services (ACEMS). The American College of Surgeons has taken the lead; they are usually the first specialty to see serious trauma victims, so their professional organization was instrumental in developing Alaska's system.

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He said this is the kind of system that the rest of the country has adopted and accepted, and it has generated improved results. The New England Journal of Medicine, a respected medical journal, compared the mortality outcomes for trauma victims who got to certified trauma facilities and those who did not, and found about a 25 percent difference. There was a lower mortality rate for those trauma victims who were treated in certified trauma facilities.

Alaska is the only state in the country, he said, that does not have a Level I or a Level II trauma center for most of the population. He admitted that Alaska may not have a justifiable need for a Level I trauma center in the near future; the Level I trauma center for Alaska is Harborview Hospital in Seattle at this time. But this is the only state that does not have at least a Level II trauma center for most of its citizens; Anchorage is the largest city in the United States without at least a Level II trauma center.

DR. HURLBURT confirmed that, consistent with the recommendation in the American College of Surgeons 2008 report, they hired a trauma system coordinator named Julie Rabeau last week. She previously worked with Alaska Native Tribal Health Consortium (ANTHC) and as a trauma nurse in Las Vegas. Her mother was a nurse in Kotzebue, and her father was a doctor in Alaska, so she has strong Alaskan roots and a passion for the job. He said they recognize that hospital participation in meeting the criteria is voluntary; they also recognize that the standards must be met by both the physicians and the hospitals. For a Level II trauma

certification, general surgeons must be available in the emergency room within 20 minutes of the call; for Level III, 30 minutes is the standard. Level II also has a higher level of neurosurgical capability. He asserted that it would not make sense for Fairbanks Memorial to go for Level II, but it would make sense and would serve the citizens of that region for them to go for a Level III.

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DR. HURLBURT agreed with Senator Coghill that it would be reasonable for Alaska Regional to go for a Level II, but said it probably would not meet the needs of Anchorage because Regional does not have sufficient capacity. Providence, because of its size and current capabilities, would be better placed as a Level II facility. The administration encourages health care facilities and the physician community to embrace this and seek certification.

There is an interesting example in Tacoma, Washington, where two large competing hospitals, St Joseph and Tacoma General, agreed to work together to create one trauma call system; patients are taken to one or the other depending on a schedule. He said he was very skeptical about it when it started, but it has lasted a number of years now and seems to work. Madigan military hospital at Fort Lewis is also part of that collaboration, although they don't take civilian victims there very often. Anchorage has two large civilian hospitals and a military hospital; if they can do it in Tacoma, he said, they ought to be able to do it in Anchorage.

The position of the administration is neutral. The Governor clearly recognizes and agrees with the need, but there is a preference to do this on a voluntary basis and, in a tight budget year, the \$5 million associated with it in SB 169 is difficult.

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SENATOR THOMAS asked if there are additional costs anticipated in human capital, beyond the \$5 million fund.

DR. HURLBURT said there is some concern among hospitals that if they are designated as trauma centers, they will attract more uncompensated care. There may be some other additional costs, but the major concern he has heard articulated is that of attracting more patients who do not have coverage.

SENATOR THOMAS said if that is case, it is not only a personnel issue, but an insurance issue, which brings up questions such as whether the state should mandate insurance or move toward greater affordability of insurance for individuals in order to remove some of the problem with uncompensated care.

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DR. HURLBURT agreed that is a major concern. He said he sees a report each quarter on the level of profitability of the 15 or 20 largest hospitals in the Northwest. The number two hospital in terms of profitability is generally Sacred Heart, which is a Providence hospital in Spokane, Washington; number one is usually Children's Hospital. Alaska's Providence is not large enough to make it into the report, but he understands that it is the most profitable hospital in the Providence system. He also understands that Alaska Regional is part of the Hospital Corporation of America and is profitable for them, so both are solid financially. They need to be profitable in order to reinvest and return profit to their owners; part of managing a business is making the bottom line. The sisters are quoted as saying "No money, no mission," and they will naturally tend to protect any challenges to their level of profitability.

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SENATOR DYSON asked if the Alaska Native Medical Center will treat non-native patients who need Level I or II trauma care.

DR. HURLBURT said they will take some non-native patients but have only 150 beds, so their ability is limited.

SENATOR DYSON asked if he is correct, that nothing in federal regulation prevents them from doing that.

DR. HURLBURT confirmed that is correct.

SENATOR DYSON asked if the same is true of the military hospitals.

DR. HURLBURT said he does not know that system as well, but thinks that any hospital can take a trauma victim.

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SENATOR PASKVAN said the discussion of how soon surgeons must be available at Level I and Level II facilities assumes a contractual agreement between the hospital and the physicians, and that infers there is a transfer of care out of the emergency room and into the hospital. He asked if that is true.

DR. HURLBURT replied that is basically correct. Level I trauma centers have physicians in-house at all times; Level II centers have anesthesiologists in-house, but not general surgeons or orthopedists. In any hospital, the trauma victim goes first to the emergency room to be seen by the emergency room physician who performs triage, makes an assessment, and then calls for a surgeon as necessary. Generally, the on-call physician sees the patient while still in the emergency room and assumes responsibility at that time.

Regarding the point that ANMC physicians are salaried, yes they are, he said, but when he was a surgeon there he had a full day operating schedule and clinics to do and did trauma care at night. It was somewhat easier there, in that he had colleagues who could pick up the ball from him if he got tied up with a trauma victim, but he did have a day job.

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SENATOR PASKVAN clarified that what he is focusing upon is that it may be troubling to members of the public if they don't understand their emergency room is qualified to handle trauma; he wants to be careful how they use language in this regard. He restated that what they are really talking about is that the emergency room physician performs triage and, while the paperwork may take some time to catch up, there is a transfer of care from the emergency room doctor to the surgeon who is called to address specific issues. It is the timeliness of that transfer of care that reduces the mortality rate that is seen in the difference between designated and non-designated hospitals.

DR. HURLBURT agreed it is very important to recognize that the quality of care is very good in this state, but it has been proven that when hospitals meet the specific criteria for trauma centers, the survival rate is significantly better.

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SENATOR PASKVAN asked what Dr. Hurlburt believes is the best way to get the money where it is needed so that surgeons can be there within 20 or 30 minutes.

DR. HURLBURT said he doesn't know. The study in Tacoma looked at the different specialties and how often they get called in, and then tried to come up with fair compensation based on those call projections. For example, a urologist might not be called in very often, so he would be paid less than would an orthopedist who is called in frequently. There is an expectation in the

country today that doctors should be compensated if they are on call; some hospitals hire physicians especially for that. He said that raises the concern that they could be placing those doctors in competition with the doctors on staff.

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SENATOR THOMAS mentioned information in Representative Coghill's booklet about prevention, and asked if there are statistics to support the success of public education programs.

DR. HURLBURT said yes, they have seen prevention efforts pay off; the trauma mortality rates are lower than they were when he came to Alaska, despite the advent of snow machines and other more dangerous methods of locomotion. But, he said, prevention can mean a lot of different things, like the program "kids don't float," which has reduced the number of drowning fatalities. It also means getting other disciplines involved; he cited the improvements highway engineers have made in the safety of the highway between Anchorage and Girdwood.

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DR. FRANK SACCO, Trauma Director, Alaska Native Medical Center; Chair, State Trauma Systems Review Committee, Anchorage, Alaska, said the committee is made up of doctors, nurses, pre-hospital care workers, and hospital administrators. They meet twice a year to review how Alaska is doing as a trauma system and find ways to improve. Trauma systems arose from the military experience. In that model, there is a pre-planned response. Victims go through several levels of care from the time they are injured; they receive initial care from pre-hospital emergency personnel; they get stabilized; they get moved, and finally they are admitted to the facility where they will receive definitive care. Every person who touches those patients has the right training; each place they go is prepared to give them the optimal care every step of the way. That is the basis for civilian trauma systems; both federal and state governments recognize that. Alaska was one of many states that started down the road toward developing a state trauma system in the early 1990s, when Loren Leman introduced the first bill and decided to make this completely voluntary. In the 15 years since that legislation, only five hospitals out of the 24 acute care facilities have been designated, and four of those are in the native health system.

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DR. SACCO said this is not a red or a blue-state issue; it is a non-partisan issue like fire departments and ambulances. He

admitted that there are a lot of questions about how this can be done, but there are 270 Level II trauma centers around the country and almost all of them are community hospitals, both for-profit and non-profit. Because a lot of states are further along in this process, Alaska has the opportunity to take advantage of what they have already done. This is the level of care people want for themselves and their family members, the kind of care most people think they already have. Some states have waited to do anything until a high-profile incident forced them to react, but he emphasized that this is a huge public health problem that affects almost everybody. He thinks it is a good idea to provide incentives for hospitals to participate, but if that doesn't work, then the State needs to take steps to ensure that Alaska has a trauma system.

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DR. REGINA CHENAULT, State Chair, American College of Surgeons Committee on Trauma, Anchorage, Alaska, said she is a general surgeon, the physician member of the Alaska Department of Administration, Violent Crimes Compensation Board, and a member of the Alaska Trauma Systems Review Committee. She is in the ER a lot, and the fact that Alaska is the only state without a designated trauma hospital for the general public is a great concern for her. It is a public safety threat for everyone in Alaska and, she believes, an ethical issue. She said she works at the Alaska Native hospital, which is a Level II trauma center; their mission is to provide care to the Alaska Natives, and their beds are usually full. She has had the opportunity to provide surgical care in several different places since she came to Alaska in 2003, including Soldotna, Kodiak, Ketchikan, and Anchorage, both in a private setting and at the native hospital, and she stressed that there are people dying who should not be, because the systems are not in place. There is a lot of trauma in the state of Alaska; there are high levels of domestic violence; law enforcement officers are being shot; Alaska has to get this trauma designation program in place so Alaskans can get the same standard of care that the people in the other 49 states are already receiving. An organized approach to trauma care gives everyone a 25 percent better chance of surviving an injury, she said, this is the reason we must pass this bill as soon as possible.

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DAVID HULL, Chair, Governor's Alaska Council on Emergency Medical Services (ACEMS); Fire Chief, North Tongass Fire Department, Ketchikan, Alaska, said he is a practicing paramedic with 35 years of responding to all kinds of emergency calls for

help, and it is from this arena that he approaches the issue. Trauma is any bodily injury from an external force; it can be accidental or intentional. Trauma puts a tremendous burden on families and communities all across Alaska. An average of 400 Alaskans die each year from trauma, and for every death, 11 people are hospitalized. Insurance does not cover all of the costs. A study done in 2004 showed that for trauma patients in Alaska, the economic cost of the hospital stay alone was estimated at over \$73 million; one in four hospital admissions was uncompensated, which puts an additional burden on the state's hospitals and health care system. The trauma system is a predetermined, organized, multi-disciplinary response to managing the care and treatment of severely injured people. The statewide trauma system also provides a framework for disaster preparedness and response. For a severely injured person, the time between an injury and receiving definitive care is the most important predictor of survival. It is commonly known as "the golden hour," but in some places in Alaska, that can be a day or, depending on the weather, a week. The local Emergency management System (EMS) responders across the state have gotten pretty good at getting viable trauma patients to the hospitals; then it becomes the hospitals' and the doctors' responsibility to keep up that good work. Increased hospital participation is necessary for the statewide trauma system to function optimally. The goal of a statewide trauma system is to see every hospital in Alaska become designated as a trauma center at an appropriate level; the ultimate goal of everyone involved however, is to save lives. The Alaska Council on EMS seeks the legislature's support for a fully functioning trauma system, including funding for the development of trauma centers and legislation addressing the issue of incentives for trauma care designation and uncompensated care trauma patients.

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MR. HULL closed by asking the legislators to consider his request to help build a coordinated approach to trauma management.

[2:45:02 PM](#)

ROD BETIT, President, Alaska State Hospital and Nursing Home Association, Juneau, Alaska, stated that hospitals support this legislation. He said Senator Coghill attended their annual meeting in Soldotna this year, and they talked about some of the challenges preventing hospitals from moving forward without legislation like this to help closed the gap on the uncompensated care burden and the availability of physicians. To do this, they have to be assured that physicians with specific

specialties are in the hospital within certain time frames. That is a pretty tall order; these physicians are independent practitioners. He thinks they can get there, but suggested that they amend the language in this bill to give the commissioner the discretion to use the fund to address other economic barriers in addition to uncompensated care.

[2:48:08 PM](#)

SENATOR PASKVAN asked what the position of hospitals would be to increasing the cost of compensated care to help cover the trauma system.

MR. BETIT said that is the typical way of doing things. When costs have to be recovered, either an arrangement is made with a government entity to help offset those costs, or an increase does appear on the payer's bill. Senator Dyson spoke to that earlier in terms of cost shifting. He said he hopes the amount that is not otherwise recoverable will be minimized, but trauma tends to carry with it a larger percentage of patients who don't have full coverage than regular health care does. These costs would not show up in uncompensated care however, because they are to ensure the availability of specially trained physicians within the required 20 or 30 minute window, regardless of whether or not there is a patient.

SENATOR PASKVAN clarified that he was asking if hospitals have considered increasing costs for compensated payers across the board, in order to diffuse the cost of obtaining trauma certification.

MR. BETIT could not speak to that.

[2:51:09 PM](#)

SENATOR COGHILL asked Mr. Betit if he knows what is going on in Congress with regard to trauma payment issues.

MR. BETIT said everything is pretty much up in the air, with all that has been going on with federal health reform lately. He said he will let the committee know if he gets any clarification on that.

[2:52:53 PM](#)

MARK JOHNSON, Chief, Emergency Medical Services (EMS), Juneau, Alaska, said he was involved with Representative Lehman when he got the initial legislation passed in 1992-1993. It provides for state certification of trauma centers using the American College of Surgeons standards. He added that a comprehensive trauma

system plan as defined by the American College of Surgeons and others includes everything from injury prevention through pre-hospital and hospital care, to rehabilitation.

He stated that Alaska has made significant progress on prevention and throughout the EMS and trauma systems. Alaska has one of the most comprehensive trauma registries in the United States; the trauma training courses required for trauma certification, such as trauma nurse training and advanced trauma life support have been readily available to Alaska hospital staff for many years. Certification requires a certain amount of equipment, which is already available in all of the state's facilities; it requires a process for continuing quality improvement, and that is also happening in many of Alaska's hospitals. One obstacle to getting Alaska's trauma system to the desired standard is that emergency departments are trained to provide a certain level of care, but if there is internal bleeding or another situation that requires surgical intervention, they need to have a surgeon on call and readily available. That is where Alaska's system is falling down right now; it is inconsistent.

2:57:30 PM

MR. JOHNSON said this bill is a good step because it creates an incentive, which was lacking in the previous legislation. The American College of Surgeons recommends that every hospital in Alaska should be designated at the appropriate level. Small rural hospitals should be a Level IV, and four of them have already achieved that status; mid-sized hospitals should be a Level III. In the 1990s, his office co-sponsored American College of Surgeons reviews at eight different hospitals in the state, and some came close to passing Level II; the biggest hang-up was the on-call schedule. He pointed out that some of the surgeons who have private practices know the insurance status of patients before they do surgery; if the surgeons are on call for emergencies and get called in the middle of the night, they have no way of knowing if the patient is or is not insured, and roughly a quarter of them turn out not to be. Hopefully, this incentive will be enough encouragement for hospitals, in cooperation with their on-call staff, to provide that care. He pointed out that there could also be some peer pressure brought to bear as hospitals begin to step up, that will encourage other hospitals to do it. He believes that once they achieve certification, they will find it makes their operation as a whole much smoother and more efficient.

3:00:03 PM

MARTHA MOORE, representing herself, Juneau, Alaska, said she supports this bill and would like Bartlett to become a Level II trauma center. She used to work in Mark Johnson's office and had many discussions with hospital staff about this issue. She has heard nurses say they have no idea what to expect when a trauma victim comes into the ER; they should know and be prepared. She has heard paramedics say that taking victims to a trauma center has a whole different feel to them, because a trauma team is there and ready to take over. The hospitals that have achieved certification say that their staff's stress levels are down because they have all trained and practiced the protocols and procedures they will use to deal with trauma victims; they feel confident and prepared. She thinks that if every hospital in the state puts forth the effort to become certified, it will improve care for all Alaskans, and she hopes this bill will be enough incentive for them to do that.

[3:03:11 PM](#)

SOREN THREADGILL, retired Chief of EMS, Anchorage Fire Department, Anchorage, Alaska, said he is the Chair of the Red Cross Disaster Consortium and a member of ACEMS, and he supports this bill. He thinks it will improve Alaska's trauma care, thereby improving patients' outcomes. It is one of the responsibilities of government to take care of its people, especially in this case, when people are not really cognizant of the difference between levels of care; they just expect their hospitals to be able to take care of them.

He said EMS started in the 1960s due to the large number highway traumas. There is fair amount EMS can do at the scene, but definitive care is provided at the hospitals. The ACS review emphasizes the importance of collaboration between EMS, the hospitals, law enforcement, first responders, dispatchers, and the public. If this kind of collaborative system is followed as recommended by ACS, it really will do wonders toward improving Alaska's trauma care.

[3:05:26 PM](#)

CHAIR DAVIS closed public testimony for today. She pointed out that the fiscal notes attached to SB 168 from both the Department of Revenue (DOR) and the Department of Health and Social Services are zero, but SB 169, the \$5 million appropriation bill, is still alive if they wish to consider it at some point.

[SB 168 was held in committee.]

3:07:12 PM

There being no further business to come before the committee,  
Chair Davis adjourned the meeting at 3:07 p.m.