

HB

168

<target><bill>HB 168</bill><subject>HB
168</subject><comm>HFIN26</comm></target>

ALASKA STATE HOUSE OF REPRESENTATIVES



SENATOR JOHN COGHILL

HB 168 Certification and Designation of Trauma Centers

Sponsor Statement 26-LS0437E

This legislation would create a trauma care fund which could reimburse trauma centers for uncompensated or undercompensated services. The bill would create incentives for becoming a certified trauma center but does not force facilities to become certified trauma centers.

Trauma is the leading cause of death for Alaskans between the age of one and forty-four and more than 800 Alaskans are hospitalized each year for spinal cord and brain injuries.

There is a "golden hour" after the injury during which proper treatment and appropriate interventions will potentially save a patient's life and prevent further damage to an injured person. Personal trauma is any bodily injury from an external force including car crashes, shootings, falls, snow machine crashes, and stabbings.

A good trauma system is an organized multidisciplinary response to managing treatment of severely injured people and it spans the full spectrum from prevention and emergency care to recovery and rehabilitation. A trauma system enhances the chance of survival by making sure patients are brought to the most appropriate facility in the most efficient manner and that optimal care is delivered every step of the way. Alaska has many good parts to our trauma response but we must do better.

ALASKA STATE HOUSE OF REPRESENTATIVES



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Session

**(907)-465-3719
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State Capitol
Room 214**

SENATOR JOHN COGHILL

HB 168 Designate Trauma Centers and the Uncompensated Trauma Care Fund

Sectional for Version E

Section 1. AS 18.08.082 currently prescribes by regulation criteria for training programs and for personnel involved in emergency medical services. This section adds a requirement for the commissioner of Health and Social Services establish special designations for varying levels of services offered by a certified trauma center.

Section 2. Establishes a trauma care fund to be used to compensate certified trauma centers for uncompensated trauma care. The fund can accept money appropriated by the legislature, which can include donations, income from the fund, and of the other designated receipts. The commissioner is given authority to establish a special committee for review of the program and limits are set on the distribution of the funds.

Section 3. Would permit the appropriation of unrestricted alcohol beverage taxes to the trauma care fund. The alcohol and other drug abuse treatment and prevention fund. Half of the alcohol beverage taxes are restricted to use in the

Section 4. The bill has an immediate effective date.

FISCAL NOTE

STATE OF ALASKA
2009 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: CS HB 168 (FIN)
 () Publish Date: _____

Identifier (file name): CS HB 168(FIN)-DHSS-IPEMS-04-06-10
 Title: Trauma Care Centers/Fund
 Sponsor: Representative Coghill
 Requester: House Finance Committee
 Dept. Affected: Health & Social Services
 RDU: Public Health
 Component: Injury Prevention/Emergency Medical Services
 Component Number: _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims	5,000.0							
Miscellaneous								
TOTAL OPERATING	5,000.0		*	*	*	*	*	*

CAPITAL EXPENDITURES								
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CHANGE IN REVENUES ()								
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	2,500.0							
1003 GF Match								
1004 GF	2,500.0							
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other-AHFC Receipts								
TOTAL	5,000.0		*	*	*	*	*	*

Estimate of any current year (FY2009) cost: _____

POSITIONS

Full-time								
Part-time								
Temporary								

ANALYSIS: (Attach a separate page if necessary)

CS HB 168 (FIN) creates the trauma care fund to be used to compensate certified trauma centers for practicing at the highest national standards for trauma care. Monies from the Disproportionate Share Hospital (DSH) program can be used as a match to money in the trauma care fund. This would be a 50/50 match.

Prepared by: Co-Chair Rep. Stoltze
House Finance Committee
Co-Chair Rep. Hawker
House Finance Committee

Phone 465-4958
 Date/Time 4/6/2010 12:00PM
 Date 4/6/2010

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number: 2
 Bill Version: CSHB 168(HSS)
 (H) Publish Date: 2/17/10

Identifier (file name): HB168-REV-TRS-2-8-10 Dept. Affected: Revenue
 Title: Uncompensated Trauma Care fund RDU: Taxation and Treasury
 Component: Treasury Division
 Sponsor: Representative Kerttula
 Requester: House Health and Social Services Component Number: 121

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information						
		FY 2011	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
OPERATING EXPENDITURES								
Personal Services								
Travel								
Contractual								
Supplies								
Equipment								
Land & Structures								
Grants & Claims								
Miscellaneous								
TOTAL OPERATING		0.0	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES								
-----------------------------	--	--	--	--	--	--	--	--

CHANGE IN REVENUES ()								
-------------------------------	--	--	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
Other Interagency Receipts								
TOTAL		0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2010) cost: _____

POSITIONS

Full-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Part-time	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Temporary	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: (Attach a separate page if necessary)

This bill establishes a fund to compensate certain certified trauma centers in Alaska for care uncompensated by the person receiving the care or by another source. This fund will be invested within the GeFonsi investment pool. No additional costs have been identified.

Prepared by: Pamela J. Leary, Comptroller
 Division: Treasury Division
 Approved by: Ginger Blaisdell, Director
Administrative Services Division

Phone 465-2300
 Date/Time 2-8-10; 10:01am
 Date 2/8/2010; 8:12pm

CS FOR HOUSE BILL NO. 168(FIN)
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE HOUSE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Kerttula, Lynn, Cissna, Keller, Herron

A BILL

FOR AN ACT ENTITLED

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

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 *** Section 1.** AS 18.08.082 is amended by adding a new subsection to read:

6 (c) The commissioner shall establish special designations in regulation for
7 varying levels of trauma care provided by a certified trauma center that shall be used
8 to set compensation eligibility and amounts under AS 18.08.085. The designations
9 shall be based on nationally recognized standards and procedures.

10 *** Sec. 2.** AS 18.08 is amended by adding a new section to read:

11 **Sec. 18.08.085. Trauma care fund; creation.** (a) The trauma care fund is
12 created. The purpose of the fund is to compensate certified trauma centers in the state
13 that receive a special designation under AS 18.08.082(c).

14 (b) The fund consists of money appropriated to it by the legislature, including

1 donations, recoveries of or reimbursements for awards made from the fund, income
2 from the fund, and other program receipts from activities under this chapter.
3 Appropriations to the fund do not lapse.

4 (c) The commissioner shall administer the fund in accordance with the
5 provisions of this chapter. The commissioner shall spend money from the trauma care
6 fund for the purpose established in (a) of this section.

7 (d) The commissioner shall establish compensation standards under this
8 section. The standards must include funding priorities for trauma centers receiving a
9 special designation under AS 18.08.082(c). The commissioner may seek the advice of
10 a special committee for review of statewide trauma care and compensation standards.

11 (e) The commissioner may not provide more than 25 percent of the total
12 assets, including earnings, of the fund in a fiscal year to one trauma center.

13 * **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

DRAFT

Summary of Trauma Systems and Funding Mechanisms by State

DRAFT

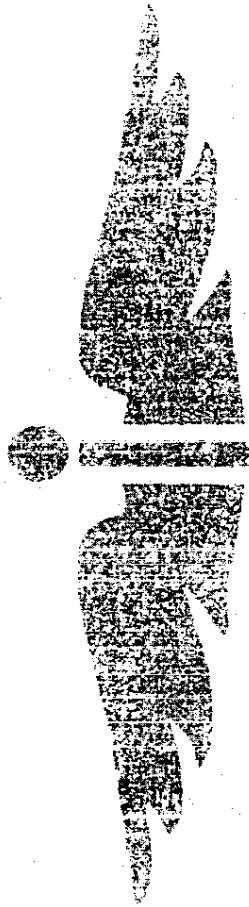
State	ACS Trauma System Control	ACS Big 7 Trauma System	Legislated Trauma System	In State System Funded?	Juvenile on Driving Licenses	Fines/Fees on Other Criminal Penalties	Motor Vehicle Registration/License Renewal	Charitable Gaming	General Revenue Funds	Statewide 911 Calls	Other
Alaska	2008	573	Yes	No							
Alabama	In Discussion		No	No							
Arizona	2007		Yes	Yes			X				
Arkansas	2002*		Yes	Yes			X	X*			
California	In Discussion		No	Yes	X						
Colorado	2006		Yes	No			X				
Connecticut			Yes	Yes							
Delaware	In Discussion		No	Yes	X						
Florida	2009		Yes	No							
Georgia	2003		Yes	Yes			X				
Hawaii			Yes	Yes							
Iowa			No	No							
Idaho	2006		Yes	Yes	X						
Illinois	2008		Yes	No							
Indiana			Yes	Yes	X						
Kansas	2008		Yes	Yes							
Kentucky			Yes	No							
Louisiana	Possible 2009		Yes	No							
Massachusetts			Yes	No							
Maryland			Yes	Yes			X				
Maine			Yes	No							
Michigan			No*	No							
Minnesota	2007		Yes	Yes				X*			Weapons License, ATV registration, Boat registration
Missouri			Yes	Yes			X				
Mississippi			Yes	Yes	X		X				
Montana	1999		Yes	No							
North Carolina	2004		Yes	No							
North Dakota	2008		Yes	No							
Nebraska			Yes	Yes			X				
New Hampshire			Yes	No							
New Jersey	2008		No	No							
New Mexico			Yes	Yes							
Nevada	2004*		Yes	No				X*			
New York			Yes	No							
Ohio	2002*		Yes	Yes		X					
Oklahoma			Yes	Yes	X		X				
Oregon			Yes	Yes							
Pennsylvania	2007		Yes	Yes	X			X			
Rhode Island	2004		No	Yes	X						
South Carolina			Yes	No							
South Dakota			Yes	No							
Tennessee	2008		Yes	Yes			X				
Texas			Yes	Yes	X					X	Southwest Region

*Money to Level I only
 *Marin County (San Rafael, CA)
 *Not a permanent funding source.
 *No Permanent Funding Source
 *Development of System in Progress
 *\$ from General fund, but generated from a hospital license fee of all hospitals & money from Dept of Health
 *Yearly Legislative Appropriation. The surcharges to Pre-Hospital/EMS.
 *Clark County (Las Vegas, NV)
 *Tri-State Trauma Coalition (Cincinnati, OH)
 *Southwest Region

Summary of Trauma Systems and Funding Mechanisms by State

State	ACS Trauma System Certification	ACS BIS Position	Legislative Trauma System	Is that System Funded?	Fines/ Fees on Moving Violations	Fines/ Fees on Other Criminal Infractions	Motor Vehicle Registration License Plates or Driver License Renewal Subsidies	Clearance Funds in the State	General Revenue Funds	Surcharge on Cell Calls	Other
Utah		2002	Yes	Yes	X	X	X				
Virginia		2003	Yes	Yes	X						
Vermont			No	No							
Washington			Yes	Yes	X		X				Surcharge on sale or lease of a new vehicle
Wisconsin			Yes	Minimal							
West Virginia	Post 2009	No	Yes	No					X*		
Wyoming	2004		Yes	No							

*Partial Funding for Trauma Coordinator position and \$50,000 for RTAC development and infrastructure



**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.

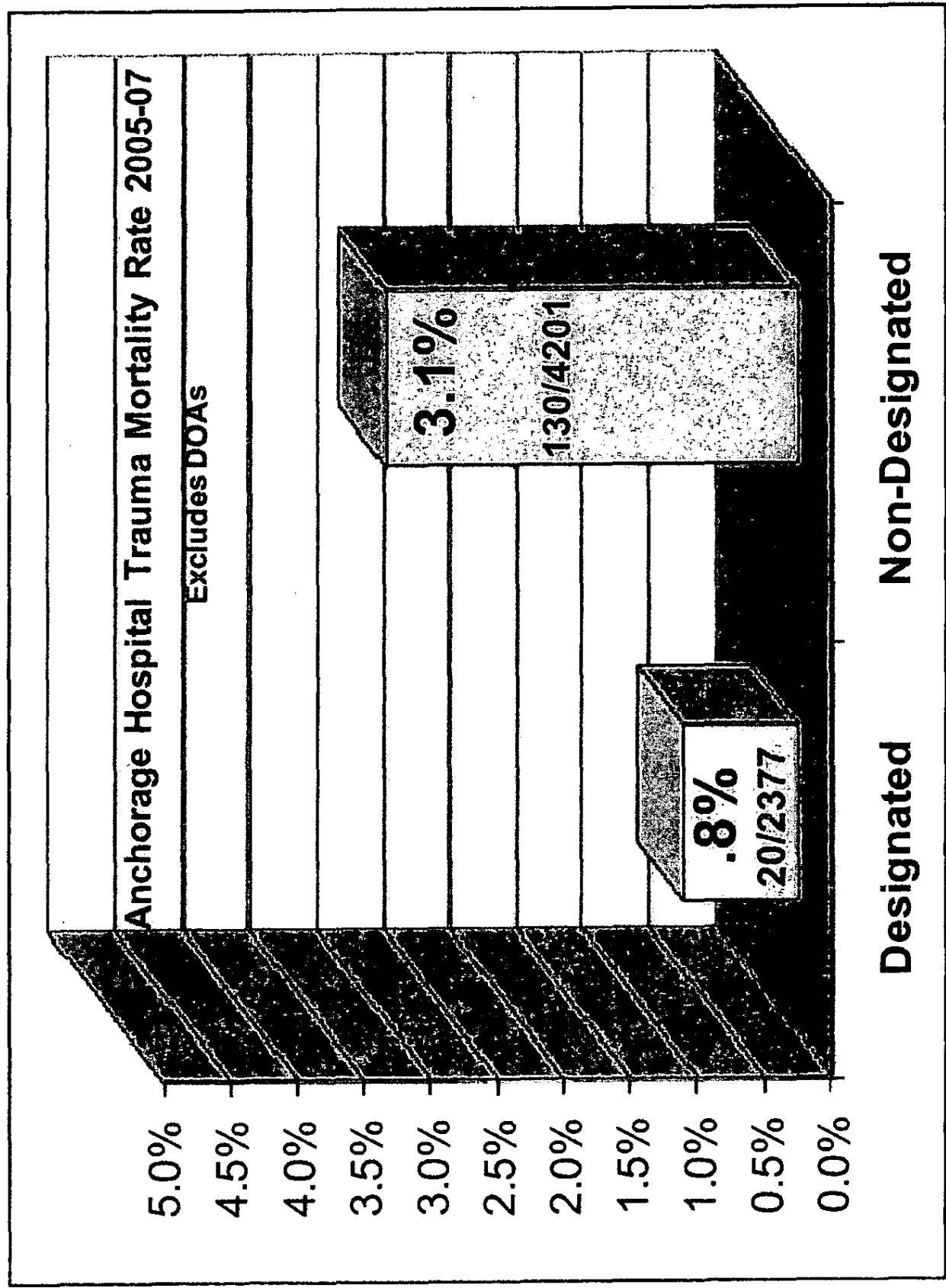
Statutory Authority and Administrative Rules

System Leadership

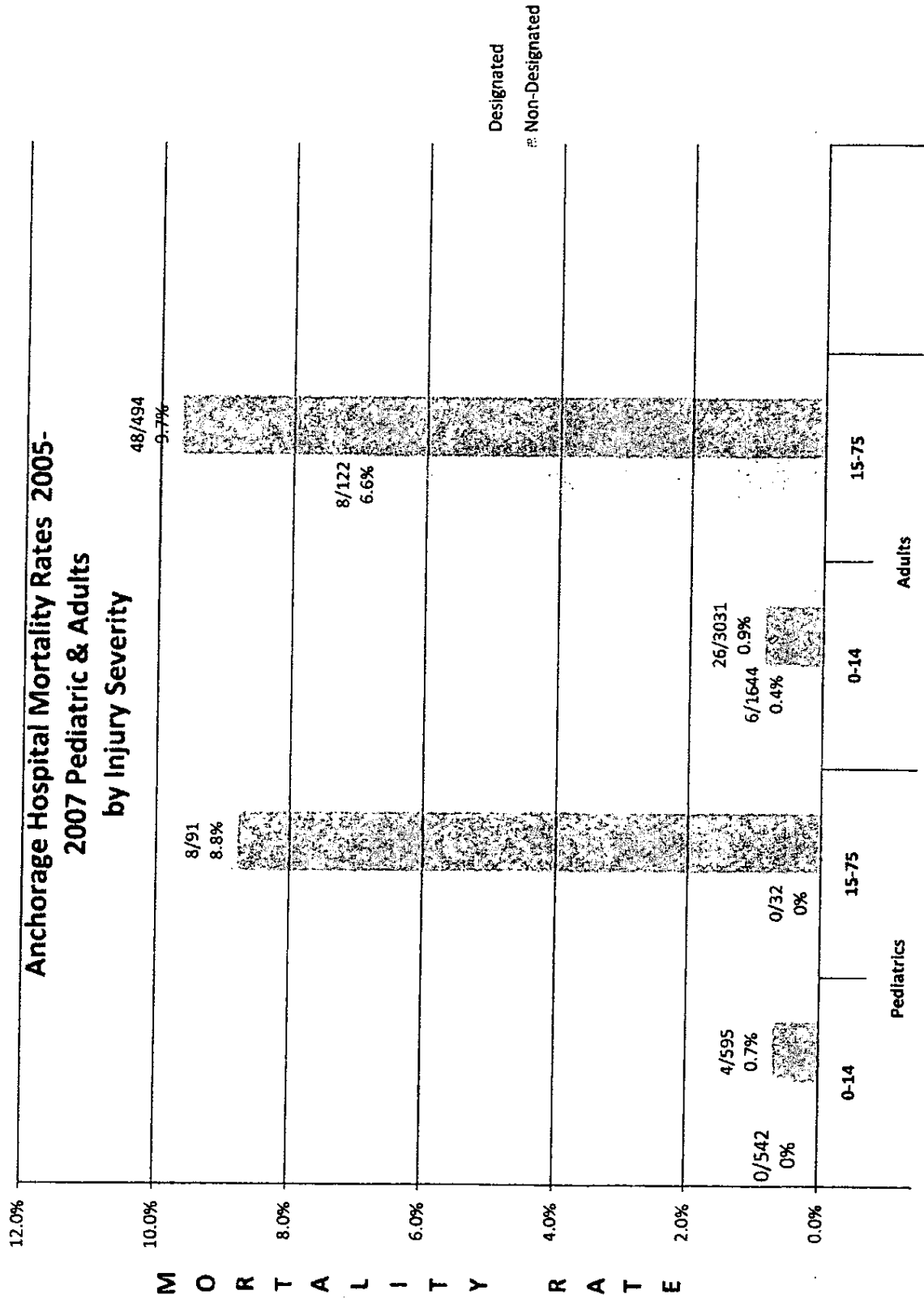
- Form an Alaska Technical Advisory Committee (ATAC) and task it with providing the Alaska Council on Emergency Medical Services (ACEMS) with recommendations regarding the following functions: data systems, trauma system planning, system-wide performance improvement and patient safety, trauma education (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.



Anchorage Hospital Mortality Rates 2005-2007 Pediatric & Adults by Injury Severity





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.

Adopted 4/6/10

26-LS0437/P
Mischel
3/24/10

CS FOR HOUSE BILL NO. 168()

**IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SIXTH LEGISLATURE - SECOND SESSION**

BY

**Offered:
Referred:**

Sponsor(s): REPRESENTATIVES COGHILL, Kerttula, Lynn, Cissna, Keller, Herron

A BILL

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5 provisions of this chapter. The commissioner shall spend money from the trauma care
6 fund for the purpose established in (a) of this section.

7 (d) The commissioner shall establish compensation standards under this
8 section. The standards must include funding priorities for trauma centers receiving a
9 special designation under AS 18.08.082(c). The commissioner may seek the advice of
10 a special committee for review of statewide trauma care and compensation standards.

11 (e) The commissioner may not provide more than 25 percent of the total
12 assets, including earnings, of the fund in a fiscal year to one trauma center.

13 * **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).



ALASKA STATE LEGISLATURE

REPRESENTATIVE BOB HERRON

State Capitol, Room 411, Juneau, AK 99801-1182 (907) 465-4942

HB 168 Designate Trauma Centers and the Trauma Care Fund

Sectional for Version P

Section 1. AS 18.08.082 currently prescribes by regulation criteria for training programs and for personnel involved in emergency medical services. This section adds a requirement for the commissioner of Health and Social Services establish special designations for varying levels of services offered by a certified trauma center.

Section 2. Establishes a trauma care fund to be used to compensate certified trauma centers for trauma care. The fund can accept money appropriated by the legislature, which can include donations, income from the fund, and of the other designated receipts. The commissioner required to establish compensation standards and is given authority to establish a special committee for review of the program and limits are set on the distribution of the funds.

Section 3. The bill has an immediate effective date.

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

Alaska Brain Injury Network
www.Alaskabraininjury.org

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 three hospitals that have been designated by the state. One level II and four level IV centers. Clearly 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.

Review of Alaska Trauma Care by the American College of Surgeons November 2008

The Alaska Department of Health and Social Services (DHSS) recently contracted with the Committee on Trauma of the American College of Surgeons to review trauma care in Alaska. The full report is available on the DHSS website (www.chems.alaska.gov). It notes our strengths and weaknesses and makes recommendations for improving trauma care in our state.

Strengths include: well established injury prevention programs; extensive and creative networks for ground and air medical transport; medical subspecialty availability at three

Anchorage hospitals; and a good relationship with Harborview Medical Center (Level I trauma center) in Seattle.

Deficiencies include the lack of an additional Level II trauma center in Anchorage and the existence of two patterns of trauma care, one for Alaska natives that follows national standards and one for the rest of the state. The review team members noted that among the nontribal hospitals " few of the facilities serving the majority population have made a similar commitment to achieving nationally recognized standards of trauma care". They also noted that there is no statewide trauma plan and no incentive or requirements for hospitals to participate in the system. Additionally, there are few resources at the state level for trauma system management and coordination. Perhaps as important as any of the above, they noted that there seemed to be very little public awareness of trauma system issues.

The review team made 15 priority recommendations. Several involve better organization of state resources and development of a comprehensive statewide trauma plan. The most sweeping recommendation was that all acute care hospitals be required to become designated trauma centers at a level appropriate to their resources and size within two years. They further stated that there should be a second level II trauma center in Anchorage as soon as possible. In addition, an assessment of pediatric trauma care needs should be completed with the goal of developing at least one pediatric trauma center of excellence.

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.

House Bills 168 and 169 have been introduced by John Coghill to encourage hospitals to participate in the trauma system by covering some of the cost of uncompensated trauma care when it is given at designated trauma centers.

The goal of the statewide trauma system is to see every hospital in Alaska 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."

Alaska Statewide Trauma System contact information:

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Committee

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907 729 2732

Julie Rabeau
Trauma Program Manager
Department of Health and Social
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julie.rabeau@alaska.gov

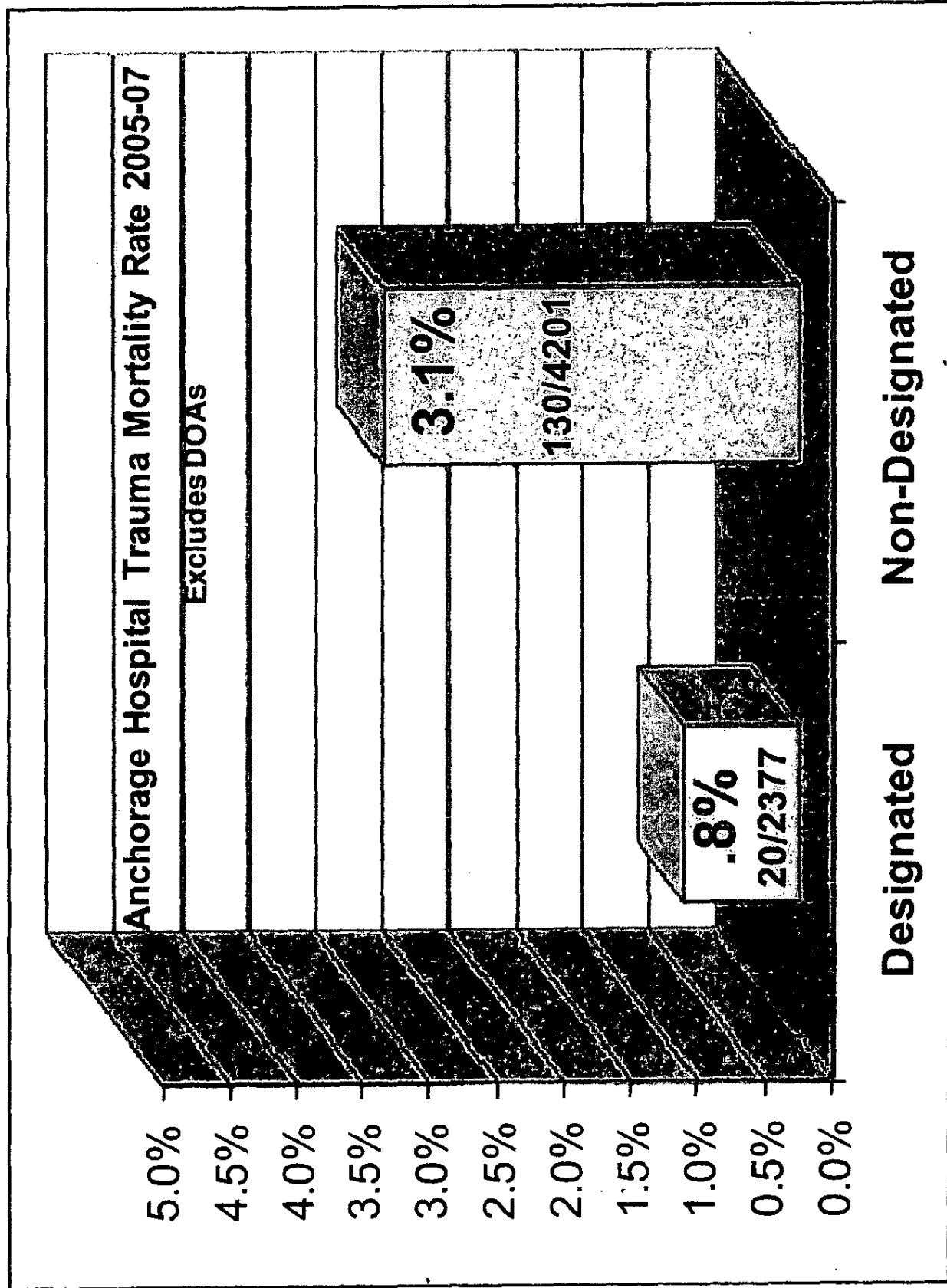
907 334 2175

Mailing Address:

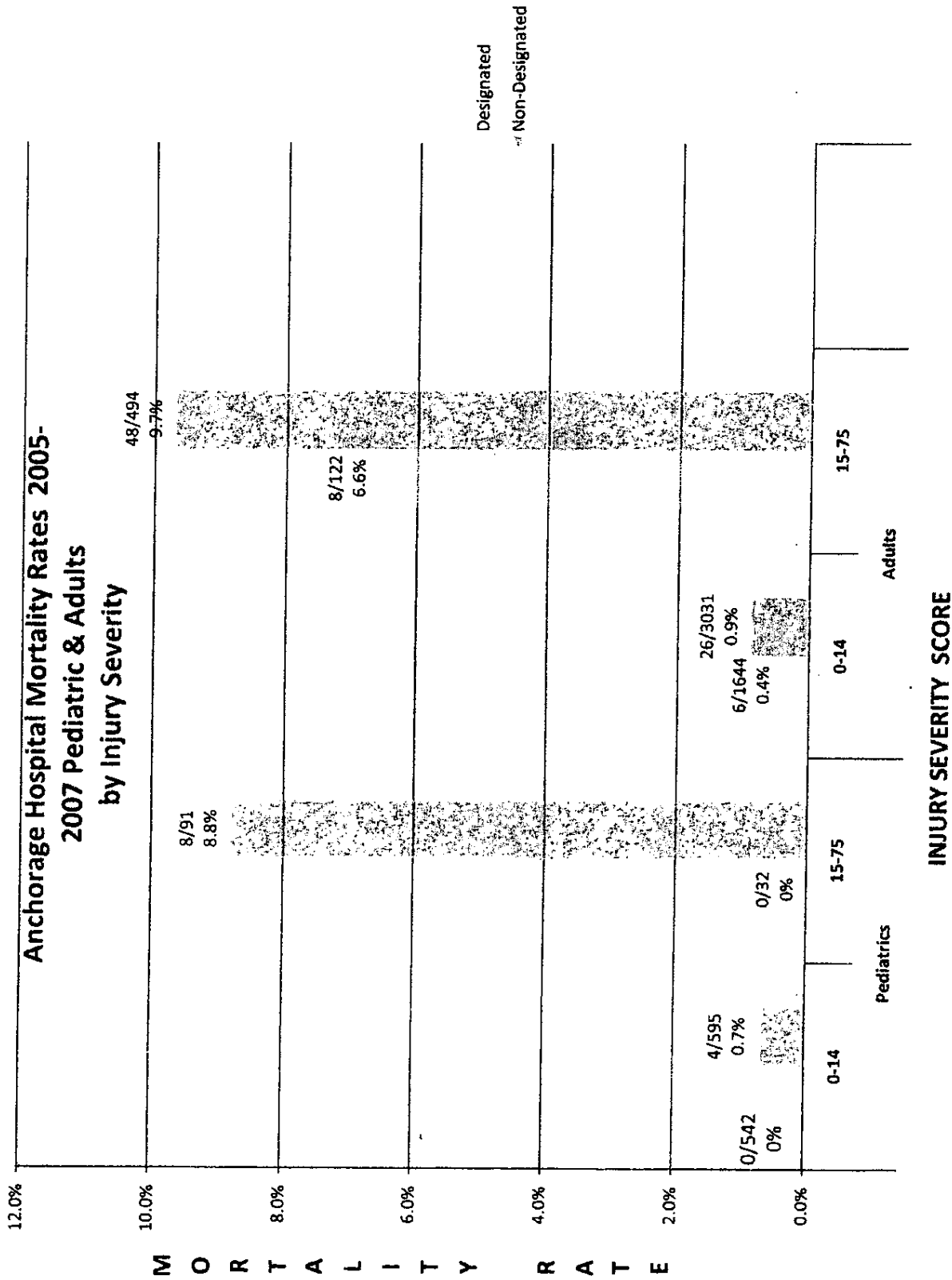
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Division of Public Health Preparedness Program
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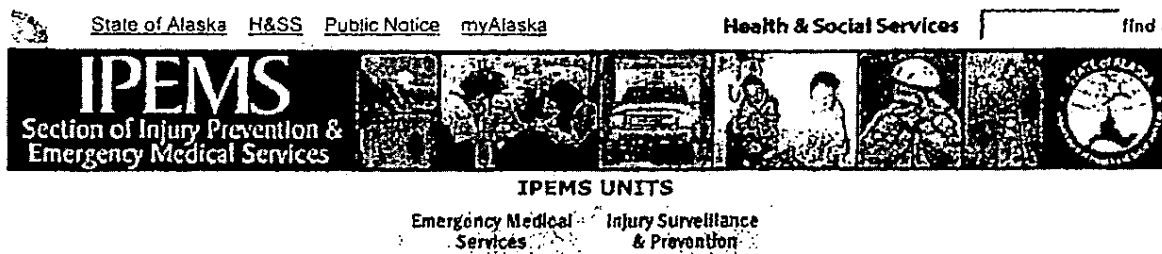
Dr. Frank Sacco, SecMD of General Surgery, Alaska Native Medical Center



Alaska Trauma Hospitals as of April 2009

Name	Designation	Certification date	Certification due
Alaska Native Medical Center (Anchorage)	Level II	November 2006	2009
Mt. Edgecumbe Hospital (Sitka)	Level IV	April 2007	2010
Yukon-Kuskokwim Delta Regional Hospital (Bethel)	Level IV		2010
Sitka Community Hospital (Sitka)	Level IV	January 2007	2010
Norton Sound Regional Hospital (Nome)	Level IV	October 2006	2010

Dr. Frank Sacco, Alaska Native Medical Center



Trauma-Emergency Medical Services System in Alaska

Background:

Alaska's Trauma-EMS System is a work in progress. A great deal has been accomplished since 1992 when the state received the first year of a three-year federal grant specifically targeted toward trauma care system development. Since federal funding has been re-instated, there has been further momentum in enhancing our system.

We currently have a committee the Alaska Trauma System Review Committee that assists the State in the development, enhancement, and evaluation of our Trauma-EMS System.

In 1993 Alaska passed enabling legislation for trauma care system development and accompanying regulations, ([AS 18.08.010-015](#), and [AAC 26.710-745](#)) were adopted in 1996.

Trauma Center Designation:

An important component of Alaska's trauma care system is certified trauma centers. Trauma centers provide an organized and timely response to traumatic injury. What this means in Alaska is:

- The hospital has demonstrated commitment to providing the best trauma care possible by allowing experts to review staffing and qualifications, procedures, protocols and resources;
- The hospital meets state and national standards for providing timely and optimal care for the trauma patient, and;
- The hospital is prepared to treat and transport trauma patients according to Alaska's system-wide plan.

There are four levels of trauma center designation/certification. Alaska has adopted the criteria set forth by the American College of Surgeons Committee on Trauma (ACSCOT). Prior to applying for state certification, Level I, II, and III

American College of Surgeons recommendations for a trauma system:

- [ACS Recommendations Presentation](#)

Trauma Training:

Continuing education training in trauma care for healthcare providers is an important component of a Trauma-EMS System.

Advanced Trauma Life Support (ATLS) Courses are offered periodically throughout the year in Anchorage at the Alaska Native Medical Center (ANMC) and occasionally in other areas of the state. For more information on the ATLS courses at ANMC, contact [Mary Leemhuis, RN](#) at (907) 729-2729; or [Casie Williams, RN](#) at (907) 729-2936. In addition, Providence Alaska Medical Center is providing ATLS courses. Contact [Jeanne Molitor, RN](#) for information.

Basic Trauma Life Support (BTLS) Courses are offered periodically through the EMS Regional offices. [Contact the nearest office](#) for more information.

Trauma Nursing Core Course (TNCC) and Emergency Nursing Pediatric Course (ENPC) are other courses available around the state. For more information contact [Jeanne Molitor, RN](#). For TNCC only contact [Mary Leemhuis, RN](#) or [Margaret \(Rocky\) Carlton, RN](#).

Trauma care continuing medical education training is often available at the State and Regional EMS Symposia. Click [HERE](#) for more information.

Alaska Trauma Registry:

Alaska is very fortunate to have a great

trauma centers must complete an application to ACSCOT and have a verification visit by a team from ACSCOT. Using ACSCOT criteria, Level IV trauma centers are verified by a state team, appointed by the Alaska Division of Public Health.

- **Level I – Regional Resource Center** – Level I Trauma Centers generally serve large cities or population-dense areas. A Level I Trauma Center is responsible for providing leadership in research, professional and community education. There are no Level I Trauma Centers in Alaska because, there are no trauma research and teaching facilities in Alaska.

- **Level II – Regional Trauma Centers** – A Level II Trauma Center provides comprehensive trauma care and serves as a lead trauma facility for a geographical area. A Level II Trauma Center provides educational outreach and prevention programs and assumes responsibility for trauma system leadership. There are emergency physicians and nurses in-house to initiate resuscitation and stabilization, with surgical teams on call and promptly available.

- **Level III – Area Trauma Center** – The Level III Trauma Center provides assessment, resuscitation, emergency surgery, and stabilization and, for the most critically injured patients, arranges for transfer to a Level I or Level II trauma center that can provide further definitive care. A general surgeon must be promptly available and the facility must be involved with prevention and have an active outreach program for its referring communities.

- **Level IV – Local Trauma Stabilization Center** – Level IV Trauma Centers are small rural facilities that provide initial evaluation and assessment of injured patients prior to transfer to a larger referral facility.

For more information, you can download a brochure about [Trauma Center Certification in Alaska](#).

Below are documents/links to assist hospitals interested in seeking Trauma Center Designation.

For the American College of Surgeons, Committee on Trauma (ACSCOT) Level I, II, III verification program visit:
<http://www.facs.org/trauma/verificationhosp.html>

For the pre-review questionnaire for Level I, II, and III verification visit:
<http://www.facs.org/trauma/prq.doc>

To request for a verification visit from ACSCOT visit:
<http://www.facs.org/trauma/sitevisitapplication1006.doc>

source of data through our [Alaska Trauma Registry](#).

Links:

[American College of Surgeons](#) is a scientific and educational association of surgeons founded to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The Committee on Trauma works to improve the care of injured and critically ill patients – before, en route to, and during hospitalization. Their web site has information on trauma center designation and Advanced Trauma Life Support courses.

[American Trauma Society](#) is dedicated to the prevention of trauma and improvement of trauma care. The society is a strong advocate for injury care and prevention and have numerous programs.

[American College of Emergency Physicians](#) promotes the highest standards of patient care through its advocacy and leadership efforts. Their web site has numerous resources on a variety of topics.

[TRAUMA.ORG](#) provides global education, information and communication resources for professionals in trauma and critical care.

Alaska Trauma/EMS List Server

Alaska Trauma/EMS program is pleased to announce the list server that we have developed to disseminate information from the federal and state Trauma/EMS programs. This forum can also be used to improve communication between the facilities and open opportunities for sharing. Please be advised that if you send a message via the list serve it will go to everyone that is a member.

To join this free list, send an e-mail message to:

list.manager@list.state.ak.us

The body of the message should be:

Subscribe ak-trauma

- Level IV Trauma center information
 - o Pre-review Questionnaire (Level IV Trauma Center Checklist) [coming soon]
 - o Level IV, Desirable and Expected Resources/Services
 - o Level IV Request for a verification visit
 - o Performance Improvement for Small Rural Hospitals in Alaska
 - o Performance Improvements Sample meeting minutes

[IPEMS Extraneal Home](#) | [IPEMS Internal](#) | [State of Alaska](#) | [Department of Health & Social Services](#) | [Site Map](#)
[Emergency Medical Services](#) | [Injury Surveillance & Prevention](#)
[Webmaster](#) | [News](#) | [Contact Information](#)
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Uncompensated Trauma Care by State

Arkansas	Tobacco Tax 56 cents Per Pack
Iowa	Tobacco Tax
Oklahoma	Medicaid Enhanced Rates State Trauma Fund \$24 million Vehicle License Fees
Wisconsin	\$1 Increase in Vehicle Registration Fees
Hawaii	\$5 Registration Fee for EMS
Minnesota	General Fund \$10 Failure to Wear Seatbelt Hospital License Fee (Base Fee Plus Per Bed Fee)
South Carolina	Trauma Fund-no Dedicated Funding Considering Surcharge for Seatbelt Violations, Drunk Driving, Alcohol Tax, Gun Tax
Texas	Surcharges on Drunk Driving and Reckless Driving to Trauma Fund
New Mexico	General Fund-Proposed 1% Fee on Home, Rental, Auto Insurance Policies
North Carolina	General Fund-HRSA Bioterrorism and Preparedness Money

Research by Senator Coghill's Office

Kentucky	Proposed 5% Tax on Guns and Ammunition
Kansas	Fees on Moving Violations Line Item
Florida	\$5 Motor Vehicle Violation Fee Vehicle License Fees \$25 Drunk Driving Charge
Rhode Island	\$1 Surcharge on all Violations
Arizona	2.3 Million from DUI and Moving Violations
Massachusetts	Vehicle License Fees
Maine	Vehicle License Fees



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

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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?

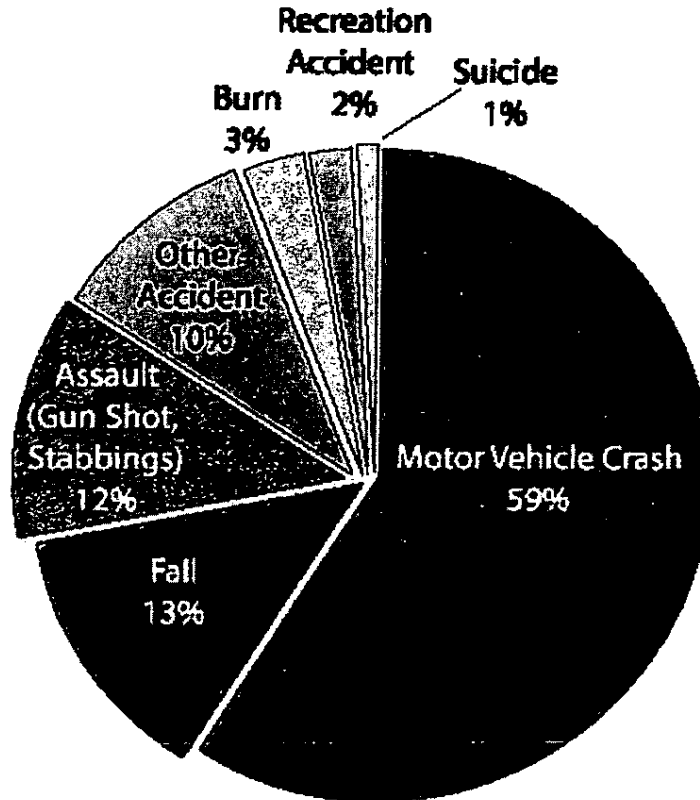
September 11th and Hurricanes Katrina and Rita have raised the profile of trauma centers. But it's not clear how many centers the nation needs. A September 2005 [issue brief](#) by Charles Branas at the University of Pennsylvania notes that the geographic distribution of trauma centers varies widely 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.

Trauma Center Patient Cause of Injury Percent of Patients



Source: National Foundation for Trauma Care.

Tara Lubin contributed reporting to this story.



[\(printer-friendly version\)](#)

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alaska brain injury network

Every 15 seconds someone sustains a traumatic brain injury (TBI) in the U.S.

Thirty years ago, only half of all people with brain injury survived; now 78% survive. This means that many individuals now live with significant disability requiring a full range of services.

Every year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or fatality. The Alaska TBI rate is 28% higher than the national average. The TBI rate in rural Alaska is one of the highest in the nation.

It is estimated that at least 10,000 Alaskans are living with brain injury today.

The Alaska Brain Injury Network, Inc.

(ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury.

ABIN's Board of Directors represent all regions of Alaska and the extended brain injury community – survivors, family members, service providers, health educators, researchers and those who write laws and policy.

ABIN works with their Alaska Mental Health Trust Authority partner boards to advocate for policy changes, programs, and facilities to better serve the brain injury population.

ABIN's staff focuses on early identification, connecting brain injury survivors with services, providing support and education for families, and bringing professional training to Alaska.

The goal for every brain injury survivor is the best possible recovery for a fulfilling and productive life. Achieving that goal requires full range of services close to home. This includes...

- Prevention
- Early identification and intervention
- Access to skilled specialists
- Community-based post injury services
- Continuing rehabilitation
- Brain injury support groups and in-state resources

What you can do...

- **Be aware of the burden of brain injury nationally and to the state of Alaska**
- **Support a TBI Resolution for Brain Injury Awareness Month.**
- **Become familiar with ABIN Priorities in the GF/MH Budget; Prevention, Training, and Resource Navigation**

Upcoming ABIN Priorities

In-state rehab facility – for neurobehavioral beneficiaries.

Brain Injury Waiver - recommendations for the current Medicaid waiver system to accommodate the services needed by brain injury survivors: neuropsychological assessment, cognitive and functional therapy, case management, counseling, home modifications, transportation, respite care, and more.

TBI Screening and early intervention – promotes better recovery and saves money.



www.alaskabraininjury.net
3745 Community Park Loop, Ste 240
Anchorage, AK 99508
(907) 274-2824

Alaska Brain Injury Network, Inc. helps identify, develop, implement, and sustain needed programs and resources that promote prevention and expand treatment and service delivery to Alaskans who experience TBI and their families.

Alaska Brain Injury Network			
Alaska Scorecard and TBI Dashboard – (DRAFT)			
DRAFT #1 – May 22, 2008			
<input type="radio"/> Getting worse	<input type="checkbox"/> Not changing	<input checked="" type="radio"/> Improving	
	5-year Trend	Current Data	Source
SCORECARD: A "scorecard" provides a snapshot of the status of TBI issues in the State of Alaska			
Traumatic Brain Injury Non-fatal Incidence Rates			
TBI rate per 100,000	<input checked="" type="radio"/>	98.6	1.a
Causes			
Falls	<input type="radio"/>	28.7	1.a
Motor Vehicle Transportation Occupant	<input checked="" type="radio"/>	24.7	1.a
Assault	<input checked="" type="radio"/>	12.2	1.a
ATV	<input type="radio"/>	6.5	1.a
Bicycle	<input checked="" type="radio"/>	4.5	1.a
Snowmachine	<input checked="" type="radio"/>	4.4	1.a
Pedestrian	<input checked="" type="radio"/>	3.6	1.a
Sports	<input checked="" type="radio"/>	1.8	1.a
Water Transport	<input type="checkbox"/>	1.3	1.a
Suicide Attempt	<input checked="" type="radio"/>	.8	1.a
Gender			
TBI percentage among males	<input type="checkbox"/>	65.4 %	1.a
TBI percentage among females	<input type="checkbox"/>	33.2 %	1.a
Ethnicity			
Percentage of TBI population that is Alaska Native		34%	1.a
Percentage of TBI population that is White		53%	1.a
Percentage of TBI population that is Other; unknown, Pacific Islander, Hispanic, Black, American Indian, Asian		22%	1.a
Those at highest risk for hospitalization due to TBI (rate per 100,000)			
Males age 80+		301.3	1.a
Females age 80+		217.2	1.a
Males age 70-79		215.7	1.a
Males age 15-19		200.9	1.a
Traumatic Brain Injury Numbers			
TBI hospitalizations/year		640	1.b
TBI deaths/year		150	1.b
Est. TBI-related Emergency Department Visits		2953	2

- 1 Alaska Trauma Registry 2001-2005 – Non-fatal TBI hospitalizations
- 1.a Alaska Trauma Registry 1996-2005 – Non-fatal TBI hospitalizations
- 1.b Alaska Trauma Registry 2006 – Non-fatal TBI hospitalizations
- 2 HRSA TBI Implementation Grant

Alaska Trauma Registry records those who are hospitalized for more than 24 hours. This does not include the number of people who visit the emergency department and are sent home in the same day. This does not include the number of returning service members with traumatic brain injury.

DASHBOARD: A "dashboard" provides a way to see how well an activity is working to affect the TBI population.

○ Getting worse ⇔ Net changing ⊙ Improving

Dashboard: Behavioral Health

TBI and Mental Health	Spot look trend	Current Data	Source
Percentage BH clients screening positive for TBI	⇔	32%	3
TBI and Substance Use			
Alcohol-related TBI 100,000		33%	1
TBI and Suicide			
Percentage of suicide victims with history of TBI		32%	4

Dashboard: Education

Special Education	Spot look trend	Current Data	Source
Number of children in Special Education statewide with TBI diagnosis (2007)	⇔	66	5

Dashboard: Justice

	Spot look trend	Current Data	Source
Percent of incarcerated Alaskans (adults) who are Trust beneficiaries, including those with cognitive disabilities		42%	6

Dashboard: Employment

Vocational Rehabilitation	Spot look trend	Current Data	Source
Number of TBI cases		167	7
Number of TBI cases closed employed		17	7
Number of TBI cases closed with plan for employment		11	7
Average wage at closure		\$12.54	7

Dashboard: Providence

ImpACT Program	Spot look trend	Current Data	Source
Number of baselines (ImpACT)		57	8
Number of student/athletes seen in program (ImpACT)		25	8
Emergency Department	Spot look trend	Current Data	Source
Patients given the diagnosis of "head injury" or "concussion in Emergency Department in 2006		547	8
% of TBI-related ED visits that led to hospitalizations		1%	8
% of ED visits that are Pediatric		15%	8

Dashboard: Alaska Brain Injury Network

TBI Advisory Board	Spot look trend	Current Data	Source
Est. Board Member Volunteer hours/year	⊙	1054	9
Board Member Participation in Quarterly Board Meetings		83%	9
Ex-officio participation in quarterly board meetings		65-80%	9
% of survivors/family members on TBI board		55%	9
% Board Members who give a financial contribution		100%	9
TBI Resource Navigation	Spot look trend	Current Data	Source
Average new consumer contacts per month	⊙	30	9
Average unique visitors/month to ABIN website	⊙	750	9
Number of people on Alaska Brain Matters Listserve	⊙	100+	9

- | | |
|---|--|
| 3 AKAIMS | 7 Division of Vocational Rehabilitation (FY07) |
| 4 Suicide Follow-back Study | 8 Providence Neuroservices |
| 5 http://www.ecd.state.ak.us/stats/ | 9 Alaska Brain Injury Network |
| 6 Trust/DOC Study 07 | |

Statewide Planning: Data

Solution: Case Management

Challenge: Why manage rehabilitation services if they do not exist in state?

Attempt: \$150.0 MHTAAR
\$50.0 GF/MH NOT funded

Need Rehabilitation



Post Acute Rehabilitation

Solution: Post-acute and Residential Rehabilitation

Why build programs if there is not a FUNDING source to pay for the services?

Community providers want to develop brain injury programs

Need FUNDING



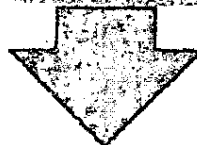
On-Going Supports Funding

Solution: Medicaid Waiver or General Fund

Can't develop waiver application without DATA

Providers cannot build programs without funding source beyond private pay

Need DATA



- With no programs in place to offer continuous follow up service, studies show traumatic brain survivors are more likely to be substance abusers or become jobless or homeless straining other state and city services.

Solution: Action

The existence of brain injury waivers supports the growth of community non-profit brain injury agencies

Case management can be paid through waivers or designating TBI as a targeted population

Data is available through other State's experiences (Rutger's Study)

Rynnieva Moss

From: Christopher Clark [cgcaska@yahoo.com]
Sent: Wednesday, March 11, 2009 8:44 AM
To: Tim Barry; John Bitney; Shannon Devon; Peter Fellman; Linda Hay; Paul Labolle; Karen Lidster; Tom Maher; John Manly; Rynnieva Moss; Jane Pierson; Chris Wyatt
Subject: Daily News editorial: Attracting doctors - Legislature can raise Alaska's stake in competition for docs; Obama right to nix mileage tax

Attracting doctors

Legislature can raise Alaska's stake in competition for docs

Published: March 10th, 2009 06:54 PM
Last Modified: March 10th, 2009 06:54 PM

Alaska's shortage of primary care doctors has been described as grim. A study two years ago found we needed 400 more doctors to provide the same level of care as is available elsewhere in the country. One result is that few doctors will accept the low rates paid by Medicare, the government insurance for those 65 and older. It's a horrible situation for Alaska's senior citizens.

Two bills introduced during this legislative session would help relieve the shortage of doctors and other health care workers, and both are worth passing.

Senate Bill 18 would increase the number of state-subsidized medical students in each class of the WWAMI program operated through the University of Washington. Alaska WWAMI students spend their first year of study at UAA.

These students offer an excellent return – according to the Alaska Physician Supply Task Force study in late 2006, half of Alaska WWAMI students end up practicing in the state, and a few WWAMI students from other states join them.

The state raised the number of Alaska WWAMI students in each class to 20 in 2007.

SB 18 would increase the number by a modest amount, to 24. That's the most UAA can accommodate without incurring expensive overhead costs, said Sen. Bill Wielechowski of Anchorage, the bill's sponsor.

Adding the four students would cost the state little to no money the first year. But by the fourth year, when we would have an additional 16 Alaska students in med school, the state cost is estimated at \$550,000 per year.

A second bill, **SB 139** [by Sen. Donny Olson], calls for the state to pay financial incentives to already-qualified doctors, nurses or other health workers if they take certain jobs in Alaska.

The bill, with a bipartisan group of sponsors, would carry out a plan developed by a group of health care professionals including representatives of the Alaska Primary Care Association and the Alaska State Hospital and Nursing Home Association.

The state would offer financial incentives to as many as 90 workers, from physicians to nurses, to come work in Alaska. Those who take hard-to-fill jobs, or treat a share of uninsured patients or those on Medicare or Medicaid, would get priority.

3/12/2009

Each person would be guaranteed the incentive for three years as long as they kept working here.

The state would either repay part of their student loans or, if the health worker didn't have loans, simply pay them directly. The individual payments would range from \$20,000 per year for nurses, physicians assistants and some others, to \$35,000 for doctors, pharmacists and dentists, to \$47,000 for doctors who accept the hardest-to-fill positions.

The state's cost for three years' worth of incentives would be \$7.5 million.

That sum is large enough to cause concern this year, with a big drop in state revenues anticipated.

But consider this: Forty-four of the 50 states already offer financial incentives to lure health workers. Alaska is not competitive for health care jobs, and people are suffering because of it.

BOTTOM LINE: The Legislature should pass two bills to relieve a critical shortage of health care workers in Alaska.

Not now

Obama right to nix mileage tax

States and the federal government rightly worry that they'll see less revenue to pay for road work as Americans turn to more fuel-efficient vehicles and future technology takes us further from the internal combustion engine.

One solution is a mileage tax, whereby vehicles would be equipped with GPS tracking devices and people would be taxed according to the miles they drive rather than the gallons of gasoline they purchase.

Oregon has already run a pilot program for such a tax, and a federal mileage tax has gained favor in the Democratic Congress despite the opposition of President Obama.

Concerns for revenue and how to pay for road building and maintenance are valid. But the mileage tax is the wrong solution, at least for now.

First, a major shift in transportation tax policy shouldn't be done on the fly in the middle of an economic crisis. There are too many unanswered questions. Among them:

- Is the ability to track people's driving one we want governments to have?
- How does such a tax encourage the use of higher-mileage vehicles? Is the owner of a hybrid getting 35 mpg going to pay the same tax as the owner of a gas-guzzling Hummer?
- Do we really want to charge people more for miles driven during rush hours, a premium that's been suggested in some states?

Raise the gasoline tax if necessary, but let's not be talking about a mileage tax until we've done a lot more research.

BOTTOM LINE: Mileage tax? Maybe down the road. Maybe.

3/12/2009

Daily News

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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

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

no system.

Where do we stand? In 1999, 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

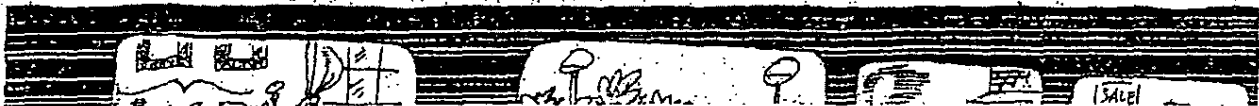
injuries when critical specialties such as neurosurgery and vascular surgery have been unavailable for emergencies, necessitating transfer of some critical patients to Seattle.

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.



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Daily News Opinion

COMPASS: Other points of view

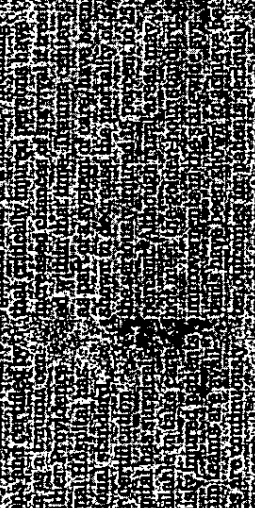
Emergency trauma care needs improvement in Alaska

By Mark S. Johnson
and FRANK SACCO, M.D.
...the state's emergency medical services...



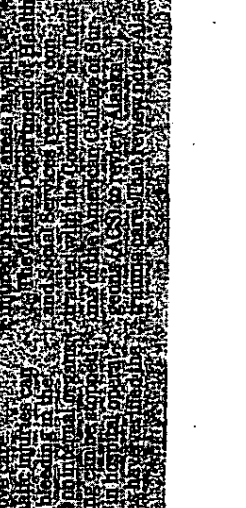
...a shortage of Alaska's emergency services...
...to take care of children, some seriously injured...

...The Anchorage Fire Department has conventional ambulance services...



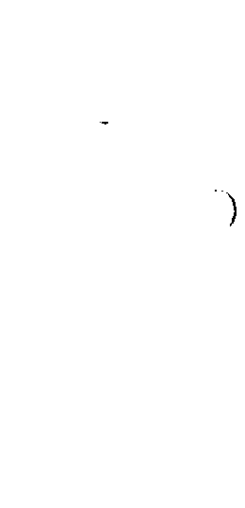
...Among Alaska's handicapped, Alaska's fire department is the only one...

...We hope the program for you...
...happens to you by 11 o'clock...



...In this excellent injury prevention program, extensive and creative...

...The Alaska Native Medical Center...



...The Alaska Native Medical Center...

More Funding Needed To Fight Brain Injuries In Alaska

By Corey Allen-Young, CBS 11 News Reporter
KTVA

Posted:02/26/2009 05:34:33 PM AKST

Known as the silent epidemic, traumatic brain injury here in Alaska is the highest in the country. That's why partnerships are being made statewide to come up with solutions. The key word is solutions as leaders are looking for a permanent fix to decreasing traumatic brain injuries in Alaska. Experiencing a traumatic brain injury can change a life forever. "The recovery process after traumatic brain injury is journey that happens daily and it will continue," said Jill Hodges, of the Alaska Brain Injury Network. With 800 Alaskans being hospitalized or dying and over 10,000 Alaskans currently living with traumatic brain injuries, the consequences could be devastating.

"Yeah it will change your life and everybody else's around you," said Frank Box, who experienced a traumatic brain injury. "It can happen to you while you are walking across the street, you can fall and slip on the ice, or if you are playing a sport or riding a bicycle especially without a helmet, you can also suffer traumatic brain injury," said Christie Artuso, who is the director of the Providence Neuroscience Center. "My brother was a such a vibrant, outgoing person, and for this to happen to him is just unreal," said Duain White, whose brother suffered a traumatic brain injury in an ATV accident.

Taking into account that traumatic brain injuries are the leading cause of death and disability among children and young adults in Alaska, the need to be aware of what exactly can cause an injury is crucial. "We can't do that without the prevention needed and the education needed of our population to tell them about TBI (traumatic brain injury) and to also tell them on how to be healthy," said Don Kashevaroff, who is the CEO of the Alaska Native Tribal Health Consortium. "What we don't have in the state of Alaska is an effective rehabilitative program for people who have been afflicted with a traumatic brain injury can be helped with cognitive therapies, thru rehabilitative therapies to return to a normal functioning life," said Artuso.

Thirty years ago, one half of people who experienced a brain injury survived. Now the number has increased to 78 percent. But officials say the problem in our state is that traumatic brain injury survivors are not getting the services needed for life long living. While people who are victims of traumatic brain injuries do receive initial help there are many questions of what happens next for them. And with money in low supply to provide any additional support, officials say other agencies could be feeling the burden.

With over 10,000 Alaskans currently living with traumatic brain injuries, getting additional care and support is badly needed. "We were just released from the hospital and that was it there was no long term therapy, there was no where to go to offer cognitive therapy, long term physical therapy," said White. "We want to help them maintain their relationships, maintain their families, maintain their lifestyles," said Artuso. "What we need are community and governmental support to do that because currently there is no resources."

Adding more resources is what folks are banking on in helping their loved ones live normal functioning lives. "Is that all we can offer him, is that the best he's going to be doing the rest of his life, its very frustrating," said White. "Treatment, rehabilitation services are essential, they are the key to recovery and sometimes eventual abilities for our brothers or sisters, and family members," said Hodges. With no programs in place to offer continuous follow up service, studies show traumatic brain survivors are more likely to be substance abusers or become jobless or homeless straining other state and city services.

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**Alaska Native
Tribal Health Consortium**

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POSITION PAPER

CONTACT: Valerie Davidson, Senior Director
Legal and Intergovernmental Affairs
Through Pat Jackson, State Liaison for Alaska Native Health
523-0363 – pajackson@anthc.org

DATE: April 8, 2009

RE: HB 168 – State certification and designation of trauma centers and creating the uncompensated trauma care fund
HB 169 – Appropriating \$5,000,000 to the uncompensated trauma care fund

POSITION: Support

ANTHC supports HB 168 and HB 169 as important steps in increasing the trauma care capacity in the state.

The Alaska Native Tribal Health Consortium (ANTHC) is a tribally controlled, non-profit statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally-recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. ANMC is the only Level II Trauma Center in the Indian Health Service/tribal health system nationally. ANMC is also the only Level II Trauma Center in Alaska. The nearest Level I Trauma Center is in Seattle.

Trauma system development is a public health priority. A comprehensive system of trauma care is an essential part of the public safety net. Regionalized trauma systems based on a network of coordinated Trauma Centers designated at the appropriate level improves health outcomes and reduces costs. ANMC, as the highest level designated Trauma Center in the State of Alaska, is the lynchpin for the state's trauma system, and provides the foundation for continued statewide system development.

Trauma Center designations were created as a way to improve outcomes for patients who face extraordinary medical issues. On balance, early and appropriate medical attention to life-threatening health issues reduces overall length of stay in the hospital and reduced complications for many patients. Without trauma care, the costs of health care for trauma patients will be greater, including trauma patients who are Medicaid eligible.

The cost of providing trauma care at ANMC has more than doubled over the past four years and funding has not kept pace. ANMC's Trauma Center simply cannot be maintained at current revenue levels. If ANMC's Trauma Center designation is discontinued because funding levels have rendered the service unsustainable, the hospital faces reductions in staffing. Diversions of patients to non-tribal providers would increase, and because the federal government reimburses 100% of the cost of services provided for Native clients at Native facilities but a smaller percentage at non-tribal providers, there would be an increased cost to the state's general fund budget.

ANTHC supports HB 168 and HB 169 as important steps by the State to encourage and support appropriate trauma care options for Alaskans. Because we are Alaska's only Level II Trauma Center we recommend removing the language in section (d) on Page 2, Line 11, that limits appropriations to any one facility to 25%.

Thank you for your consideration.

ALASKA COUNCIL ON EMERGENCY MEDICAL SERVICES

ACEMS
P.O. Box 110616
Juneau, AK 99811-0616
(907) 465-3027



April 9, 2009

Representative Coghill
Juneau, Alaska

Representative Coghill,

Trauma is any bodily injury from an external force. Trauma puts a tremendous burden on families and communities in Alaska. An average of 400 Alaskans die each year from trauma. For every death, 11 people are hospitalized. One in four hospital admissions is uncompensated which puts an additional burden on the State's health care system. HB 168 is offered to assist in this dilemma.

House Bill 168 provides the DHSS Commissioner authority to establish special designations in regulation for varying levels of trauma care so that a 'Certified Trauma Center' would be eligible to recoup expenses as a result of uncompensated care being rendered. The purpose of the fund is to reimburse certified trauma centers in the state for care uncompensated by the person receiving the treatment or by any other source. HB 169 would then set up the uncompensated trauma care fund that would help cover some of the losses suffered by the trauma center rendering the care.

The Alaska Council on EMS seeks your support for a fully functioning trauma system, including funding for the development of trauma centers and legislation addressing the issue of incentives for trauma center designation and uncompensated care of trauma patients. The added benefit of HB 168, we believe, would be an incentive for more hospitals in the state to become 'Certified Trauma Centers' thereby assisting in the development in a state wide trauma care system.

The American College of Surgeons met 11/08 in Anchorage to assess the States trauma system. The passage of HB 168 & 169 would provide support to address some of the areas that were noted in the report.

Thank you for your support of this critical issue.

A handwritten signature in black ink that reads 'David Hull'.

David Hull, Chair
Alaska Council on Emergency Medical Services

cc Bill Hogan, DHSS Commissioner
Dr. Jay Butler, Chief Medical Officer
Tim Bundy, Section Chief IPEMS

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

Helen Phillips

From: Ben Mulligan
Sent: Monday, April 05, 2010 5:34 PM
To: House Finance Legislation
Subject: Fwd: HB 168 in House Finance

FYI

Begin forwarded message:

From: "Laughlin, Wilda J (HSS)" <wilda.laughlin@alaska.gov>
Date: April 5, 2010 5:29:25 PM AKDT
To: Ben Mulligan <Ben_Mulligan@legis.state.ak.us>, "Sen. John Coghill" <Senator_John_Coghill@legis.state.ak.us>, Rynnieva Moss <Rynnieva_Moss@legis.state.ak.us>, "Rep. Bob Herron" <Representative_Bob_Herron@legis.state.ak.us>, Liz Clement <Liz_Clement@legis.state.ak.us>
Cc: "Streur, William J (HSS)" <william.streur@alaska.gov>, "Lewis, Jill (HSS)" <jill.lewis@alaska.gov>, "Owens, Shelley K (HSS)" <shelley.owens@alaska.gov>, "Hurlburt, Ward B (HSS)" <ward.hurlburt@alaska.gov>
Subject: **HB 168 in House Finance**

This is to let you know that the following representatives from HSS will be available at tomorrow's hearing:

Dr. Ward Hurlburt, Chief Medical Officer and Public Health director, will be testifying for the department.

Bill Streur, Deputy Commissioner for Medicaid and Health Care Policy, will be available for questions.

Both will be in Juneau.

w.

Wilda J. Laughlin

Legislative Liaison, Dept. of Health and Social Services

Phone (907) 465-1613