Ensuring Access to Life-Saving Trauma Services Now and in the Future

Trauma Care Saves Lives:

Trauma is a major public health issue. In the United States, approximately 35 million people are treated every year for traumatic injuries -- which includes one hospitalization every 15 minutes. Traumatic injury is the leading cause of death under age 44. And, at an annual cost of $67.3 billion, trauma is the 3rd most costly medical condition (behind heart disease ($90.9b) and cancer ($71.4b)). Currently, falls comprise 38% of mechanism of injury, motor vehicle/traffic injuries account for 28%, and firearms and cut/pierce combine for 9.

The "value" proposition for trauma care is well documented. While there are significant costs to trauma team readiness and activation, trauma center care is more cost effective than many other interventions, including dialysis for kidney failure. The risk of death for a severely injured trauma patient treated at Level I Center is 25% less than in a non-trauma center hospital. For those severely injured in motor vehicle crashes, initial triage to a non-trauma center increases the risk of death within the first 48 hours by at least 30%. Compared against the two other higher cost medical conditions, there are significantly more adult trauma patients treated (26.4 million) than heart disease (22.5 million) or cancer (15.3 million) at a substantially lower cost per patient.

Limited Access to Trauma Care:

The importance of getting the severely injured to a Level I or II trauma center within the first "golden hour" is well known, and was evidenced in the response to the victims of the Tucson and Aurora tragedies. Yet, 45 million Americans lack access to Level I trauma centers within the golden hour. While a few trauma centers are opening in isolated areas where the payer mix is strong, in most areas of the nation, trauma centers struggle to keep their doors open. From 1990-2005, 30% of trauma centers closed, with a disproportionate adverse impact on access for vulnerable populations. A significant contributor for trauma center closure is lack of funding -- 15% of trauma patients are uninsured. A fragile trauma system is faltering.

Unique and Complex Nature of Trauma Care:

All health events that are both emergent and life-threatening share certain characteristics. They are time sensitive, such that getting the right patient to the right place in the right amount of time can make the difference between life, death or serious disability. There is a differentiated system for movement of such patients to the appropriate medical destination regardless of insured status or ACO assignment. And, there are substantial fixed costs of ensuring readiness of 24/7 life-saving care. Proximate and timely access to specialized centers of care can greatly impact patient outcome. For trauma, there are additional attributes that are unique and complex:

- Traumatic injury frequently implicates multiple organs and systems. Care for complex multisystem injuries requires multidisciplinary readiness and capabilities of numerous surgical specialties and emergency physicians and other specialized nurses and respiratory therapists. Trauma surgeons manage trauma care, beyond surgery, including in the intensive care unit.

- Traumatic injury is extremely unpredictable in nature and duration. There is substantial variability in an entire acute care episode of acute trauma care and rehabilitation due to the uniqueness of every injury. The outcome of a trauma patient can greatly depend upon an underlying medical condition prior to injury. Planned and unplanned readmissions are a matter of routine for severely injured trauma patients.
Trauma disproportionately affects children, young adults, and the very old. The majority of traumatic injury affects people under the age of 45 who are children or wage earners. They are more likely to be uninsured or underinsured. The frail elderly are increasingly at risk of traumatic falls.

Trauma can happen to anyone, anytime, and anywhere. Prevention of other imminently life threatening diseases reduces costs as there are fewer patients to treat (e.g. lowering risk of cardiac disease reduces the number of cardiac events). However, no matter how much is invested in trauma prevention, there remain high fixed costs of readiness for any patients, even if the number of trauma patients is reduced.

To ensure access for all Americans to high quality life-saving trauma care, trauma centers and specialist physicians need reliable, stable, sufficient and predictable funding and reimbursement. The current fee for service model of payment is not well suited to promoting high quality, access and value and is out of date.

Trauma centers (hospitals) receive a "trauma activation fee" for the initial resuscitation period (1-2 hours) for a trauma patient. Medicare and some commercial payers recognize and pay for this code. However, the code’s value is limited in that it requires pre-notification by EMS or a transferring hospital and currently applies only to outpatients. It does not account for approximately 15% of the patients that are brought in by private vehicle. It penalizes trauma centers for meeting the standard of care regarding throughput. There is no modifier or specific DRG for the higher costs of trauma care during the inpatient stay or that reflects the higher severity of or resource intensity for trauma patients.

Specialist physicians are reimbursed by Medicare for specific procedures, rather than incentivizing the appropriate care for the patient, which may or may not involve surgery. There is no CPT code for trauma and no modifier to recognize the more intensive services provided to trauma patients. Higher medical liability exposure and the lack of reimbursement for uncompensated care renders critical surgical specialists increasingly unavailable to provide trauma care, further destabilizing the trauma system. Trauma centers routinely pay $1,500 to $5,000 per day in "on-call pay" to ensure specialist availability.

Federal Commitment to Trauma Care Should be Strengthened and Reimbursement Evaluated:

The continued development of a regionalized trauma care system is important to achieving the dual goals of ensuring access to an appropriate level of care in a cost-effective manner. The combination of market pressures and reduced reimbursement, as well as a growing shortage of on-call specialists, may result in a "perfect storm" of closures. Trauma centers typically do not reconstitute once closed, and it takes years to reestablish or develop a new one. It is imperative that federal policy makers address this looming crisis before it deteriorates further:

Fund Trauma Grant Programs: Funding should be provided for the trauma and regionalization of emergency care programs in the Public Health Service Act to stabilize the trauma care system.

Fix Existing FFS Reimbursement: Current reimbursement for trauma centers should be improved, such as by removing the pre-notification and critical care diagnosis requirements for use of the 68X code and expanding it to inpatients; creating a DRG modifier or add-on for trauma patients or DRGs specific to trauma; and providing a mechanism to compensate trauma physicians.

Evaluate New Value Based Trauma Center Payment Model: Other models of payment should be evaluated, such as an episode based payment model, specifically designed for the unique and unpredictable nature of care provided by trauma centers. A new model could encompass: 1) incentivizing the movement of the right patient to right level of trauma care; 2) metrics that drive quality and value, but take into consideration the unpredictable and inconsistent nature of trauma care; and 3) payment that recognizes readiness at varying levels of care as well as the particular acuity and severity of injury of the trauma patient and intensity of treatment.