Division of Advocacy and Health Policy

Statement Of:
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Before The:
House Committee On Oversight And Government Reform

Hearing On:
The Lack Of Hospital Emergency Surge Capacity: Will the Administration's Medicaid Regulations Make It Worse?

May 5, 2008

Introduction
Chairman Waxman, Ranking Member Davis, Representatives McHenry & Foxx from my home state, Distinguished Members of the Committee and guests, thank you for the opportunity to appear before you today to discuss the impact the proposed Medicaid regulations would have on trauma center preparedness.

My name is Dr. Wayne Meredith and I serve as Professor and Chairman of Surgery at Wake Forest University Baptist Medical Center. I am a trauma surgeon and have devoted my career to caring for victims of traumatic injury, teaching our next generation of trauma surgeons, and also to building the best possible system of trauma care delivery. I currently serve as Medical Director of Trauma Programs for American College of Surgeons, and was a founding Board member for the National Foundation for Trauma Care, an organization that seeks to secure the economic viability of America's trauma centers.

Wake Forest University Baptist Medical Center, one of the nation's preeminent academic medical centers, is an integrated health care system that operates 1,154 acute care, rehabilitation and long-term care beds, outpatient services, and community health and information centers. Baptist Medical Center has 20 subsidiary or affiliate hospitals and operates more than 100 outreach activities throughout the region, including satellite clinics, health fairs and consulting services. It provides a continuum of care that includes primary care centers, outpatient rehabilitation, dialysis centers, home health care and long-term nursing centers.

Although its primary service area is a 26-county region in northwestern North Carolina and southwestern Virginia, Wake Forest University Baptist Medical Center in the past year has served patients from 98 (of 100) North Carolina counties, all 50 states, the District of Columbia and Puerto Rico, and several foreign countries. Wake Forest University Baptist Medical Center's component institutions carry out a joint mission of patient care, education, research and community service.

Wake Forest University Baptist Medical Center is one of six Level I Trauma Centers in the state of North Carolina, and is the first trauma center in the state that has been verified by the American College of Surgeons as a Level I Adult and Pediatric Trauma Center. This is the region's only Level 1 service.

Between 2800-3000 trauma and burn patients (85% blunt/ 15% penetrating) are admitted to the trauma center each year from a large catchment area of Western North Carolina, Southern Virginia and Eastern Tennessee. This large population base allows for an unusual combination of a very busy trauma center in a city of a manageable size.

What is Trauma?

Trauma is a major public health problem. It is the leading cause of death for children, youths, and adults under the age of 34. It kills more Americans than strokes and AIDS combined and yet less than 10% of hospitals have a trauma center and only 8 states have fully developed trauma systems.

All trauma care is emergent but not all emergency care is trauma. Emergency rooms and departments treat ill and injured people, while trauma centers handle the most severe, life-threatening blunt force and penetrating injuries. Emergency medical technicians (EMTs) transport complex injury victims meeting predefined triage criteria past local hospitals to trauma centers where a sophisticated and highly trained interdisciplinary team of health care professionals are immediately available to provide the services needed to save that person's life and prevent further disability or physical deterioration. Trauma centers dedicate extensive staff, physician and faculty resources around the clock, so that seriously injured patients have the best possible chance of survival. Seriously injured victims treated in trauma centers have a 25% lower risk of death. The availability of trauma centers to care for these patients is the most effective treatment strategy for the number one killer of citizens under the age of 44 and a major cause of death and disability for all ages.

A Level I Trauma Center has a full range of specialists and equipment available 24-hours a day and admits a minimum required annual volume of severely injured patients. Additionally, a Level I Trauma Center has a program of research, is a leader in trauma education and injury prevention, and is a referral resource for communities in neighboring regions through community outreach.

The Level I Trauma Center must have a program for substance abuse screening and provide brief intervention to patients as appropriate.

A Level II Trauma Center usually works in collaboration with a Level I Center but may be the only tertiary resource in a rural state such as Montana or Wyoming. It provides 24-hour availability of all essential specialties, personnel and equipment. There are no minimum volume requirements. These institutions are not required to have an ongoing program of research or a surgical residency program but must have an injury prevention program as well as conduct substance abuse screening.

A Level III Trauma Center does not have the full availability of specialist except surgery and orthopedics in most states, but does have the resources for the emergency resuscitation, stabilization, emergent surgery, and intensive care of most trauma patients. A Level III Trauma Center has transfer agreements with Level I and/or Level II Trauma Centers to assure back-up resources for the care of patients with severe injuries. The Level III Trauma Center has an injury prevention program.

In many, but not most states, trauma centers participate in coordinated systems of trauma care delivery to ensure that patients are transported to the right place at the right time. The development of trauma systems is more advanced in some states than others. I am proud that North Carolina has one of the most advanced trauma care systems in the nation. The ACS and other trauma organizations are dedicated to ensuring continued development of coordinated trauma care delivery systems in all states.

Golden Hour – Getting Right Patients to Right Place at Right Time Saves Lives

The golden hour is the first 60 minutes after the occurrence of a major multi-system trauma. It is widely believed that the victim's chances of survival are greatest if he or she receives specialized trauma care within the first hour. Trauma care delivery arose out of our experience in treating battlefield injuries in Vietnam and has grown and developed tremendously since that time.

I have had the great privilege of treating well over ten thousand patients over the years who survived and overcame life-threatening injuries. Just a small sampling of those patients include:

- Greg Thomas, aged 40 was riding his bicycle when he was hit by a car and severely injured. He arrived at our trauma center in shock and activated at a Level I. His injuries included a flailing chest, pelvic fractures and his left leg had to be amputated. Even though he is disabled, Greg still celebrates life and visits the trauma center every year to say thank you.

- Josh Brown was being a good Samaritan and stopped to help someone change their tire when he was stabbed in the neck. He arrived hypertensive and losing blood but because we had a 24/7 team waiting, he was immediately treated and able to be discharged within a short period of time.

- Jason Hong was a student at Wake Forest University. His parents lived in Winston-Salem and owned a convenience store. Jason was working at the store one night, when the store was robbed and he was shot in the thigh. The bullet hit one of his main arteries in his leg and Jason was losing enormous amounts of blood. Fortunately for Jason, he was brought immediately to the trauma center at Baptist. We were able to staunch his hemorrhage before he bled to death and repair his injured artery and vein using a section of vein harvested from his other leg. We also had to incise the injured leg to release the pressure that was building in it. If we were not able to treat him in time, Jason would have lost his leg or even worse, died. But not only did Jason survive, he was inspired to become a doctor. Jason has been a student at Wake Forest University School of Medicine at the Bowman Gray Campus and has now graduated from medical school and will become a surgery resident beginning July 1.

Trauma Center Preparedness Needs Improvement

Trauma centers must be prepared to respond on a minutes notice for every day traumatic injuries, as I have just described, and for catastrophic, natural disaster and terrorist attacks. When examining the level of preparedness for terrorist attack among our nation's trauma centers, it is essential to highlight that on 9/11, St. Vincent's Medical Center in Manhattan, (which is a Level I trauma center) had a surge

of 848 patients from the World Trade Center attack, of whom 450 were seen in the first two hours. Are all of our nation's trauma centers prepared for that kind of surge? Unfortunately, the answer is a resounding no.

In the 2006 *U.S. Trauma Center Preparedness for Terrorist Attack in the Community Report*, the National Foundation for Trauma Care, in conjunction with the Centers for Disease Control, found that many of our nation's trauma centers are not fully prepared for a terrorist attack. The *Trauma Center Preparedness Report* identified only seven highly prepared trauma centers and numerous trauma centers with below average preparedness scores five years after 9/11. To put this in more stark terms, of the 175 surveyed trauma centers, the average overall preparedness score was 74 out of 100— that would constitute C- if we were grading our average level of preparedness.

The *Trauma Center Preparedness Report* identified key factors of high level preparedness, including most significantly, higher funding amounts from multiple sources. Lower funding amounts for trauma centers generally resulted in lower preparedness scores. The Report provided numerous recommendations for improvement in preparedness for our nation's trauma centers including ensuring adequate funding for trauma centers based on their proximity to hazards and threats. Implementation of all the critical recommendations made in the Report requires a significant expenditure of human and fiscal resources.

Scarcity of Resources for Trauma Care

Saving people from the brink of death, whether from every day trauma or due to a terrorist attack, is a costly and resource intensive but absolutely necessary endeavor. For us to fulfill that obligation for all trauma victims, our trauma care delivery system has several basic requirements, all of which must be met:

Coordinated Trauma Systems. We must have coordinated, integrated, fully developed and fully funded trauma systems at the state and local level to ensure critically injured patients are taken to the right place at the right time. Unfortunately, federal funding for trauma systems has been extremely limited over the past decade and was eliminated entirely last year.

Trauma Surgeons, Nurses and other Caregivers. We must have enough trauma and other subspecialty surgeons, nurses and other caregivers who are available 24/7 for all who need their specialized care. Unfortunately, high malpractice insurance and other challenges are leading to a severe shortage of current and future trauma surgeons and other subspecialties providing trauma care including neurosurgery - and orthopedic surgery subspecialties. Only about half of the nation's trauma surgery residencies are filled.

Trauma Centers. Trauma centers, and the hospitals in which they are housed, must have sufficient resources to provide trauma services to all victims of traumatic injury, regardless of their ability to pay. Unfortunately, federal funding for hospital preparedness keeps declining and there is currently no federal funding to directly support trauma centers for their core mission and uncompensated care costs,

and no means by which the federal government can help to prevent a trauma center closure or downgrade.

Preparation for all Kinds of Trauma. We must be prepared for all kinds of trauma:

- For trauma we see everyday—victims of car crashes, gun shots, construction accidents and the like.
- For catastrophic events—the bridge collapse in Minneapolis, or the pedestrian bridge at the Speedway outside of Charlotte, or the bus full of children flying off the bridge in Atlanta, or the carnage at Virginia Tech.
- For natural disasters from which traumatic injury results—for hurricanes, earthquakes and tornados.
- And, as we learned so well on September 11, we must be prepared for terrorism by whatever means, including by blast attack.

The delivery of trauma care requires money to pay for all of what I've just described. It requires fair and reasonable Medicaid reimbursement to ensure that safety-net hospitals have sufficient resources with which to maintain their trauma centers. It requires full funding of the federal trauma systems planning program. It also requires full funding for the Hospital Terrorism Preparedness Program and Hospital Partnership Grants. And, it requires directed funding to trauma centers to help defray the costs of core mission activities and uncompensated care, provide emergency funding to prevent closures or downgrades, and enable the infusion of federal funding in the event of a natural disaster or terrorist attack.

Threat to Trauma Care Delivery by Medicaid Regulations

Trauma centers are funded and supported by their hospitals, most often safety net public or non-profit hospitals whose mission it is to care for all, regardless of their ability to pay. Across the nation, the costs of practicing medicine and delivering trauma care have steadily increased. Meanwhile, the reimbursements to trauma centers and physicians from health plans, managed care, Medicare, Medicaid, and safety net programs for the uninsured have steadily decreased and are now gravely threatened by the Medicaid regulations. And somehow, in all of this chaos, our obligation to be prepared for a terrorist blast attack has grown exponentially.

The annual cost of running our trauma center at Baptist Medical Center is approximately $4.5 million. This is the cost for us to be prepared for the approximately 1600 trauma patients we care for each year and does not include our uncompensated care costs. The expected loss to Baptist if the Medicaid regulations are not stopped by the Congress is $36 million per year. The only funding our region—which is comprised of Baptist Medical Center, one Level II trauma center, one Level III trauma center, 26 hospitals, and 17 EMS agencies—receives for all-hazards preparedness is approximately $2 million from the State of North Carolina which is largely derived from the federal Hospital Preparedness Grant Program. The numbers speak for themselves.

Baptist Medical Center is not alone in facing the challenges of funding our trauma center. If the Medicaid regulations go into effect, North Carolina hospitals would lose a collective $387 million per year. The hardest hit among them by the Medicaid regulations are those eight safety-net hospitals which serve as Level I and II trauma centers and operate the air ambulance services in their region.

According to the National Foundation for Trauma Care, since 2000, at least 19 hospitals across the nation have closed their trauma service and a number have downgraded levels. How many more closures and downgrades might we have if the Medicaid regulations are allowed to go into effect? I don't really know and I don't want to find out the hard way. The patients I described earlier depended on me and Baptist Medical Center to save their lives. We are all depending on you to ensure our nation's trauma centers have the ability to treat all trauma victims in the future.

The Congress should complete final enactment of H.R. 5613, the Dingell-Murphy legislation, to stop the Medicaid cuts and protect the ability of safety-net hospitals with trauma centers to maintain this critical public health function. The Congress should also enact and fully fund the National Trauma Center Stabilization Act, H.R. 5942, recently introduced by Representatives Edolphus Towns, Michael Burgess, Chairman Waxman, and Marsha Blackburn. I am grateful for their leadership and championship of this vital legislation.

Conclusion and Recommendations

Mr. Chairman and Committee Members, I commend you for holding this hearing today. To summarize what needs to be done to ensure our nation's trauma care delivery system is ready and able to care for all victims of traumatic injury and be prepared for terrorism and everyday trauma, I respectfully provide the following recommendations for your consideration:

1. Stop the Medicaid cuts and enact H.R. 5613, the Dingell-Murphy bill, which passed the House with overwhelming support.

2. Fully fund the Trauma Systems Planning Program to ensure maintenance and further development of coordinated trauma care delivery systems in all states.

3. Enact and fully fund H.R. 5942, the Towns-Burgess-Waxman-Blackburn, legislation to provide federal funding for the core mission, uncompensated care and emergency needs of trauma centers.

4. Fully fund the Hospital Preparedness Program and the Hospital Partnerships Grants to ensure the highest possible level of preparedness funding for all hospitals, and most particularly for trauma centers.

Thank you for the opportunity to testify before you today.

Revised October 28, 2011