THE AMERICAN TRAUMA SOCIETY'S

Trauma Watch

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SPOTLIGHT

Arkansas Board of Health approves budget for new trauma system

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Washington enacts sports concussion law to curb traumatic brain injury

Washington Gov. Chris Gregoire (D) recently signed "the country's most rigorous law protecting young athletes from severe brain injuries," the *Seattle Times* reported.

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Study finds staffing changes help Level I trauma center improve outcomes

A Level I trauma center improved outcomes and efficiency by adding trauma surgeons and physicians assistants to the staff, according to a study in the May *Journal of TRAUMA Injury, Infection, and Critical Care*.

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Texas trauma care providers request additional state funding

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1 Arkansas Board of Health approves budget for new trauma system

The Arkansas State Board of Health earlier this month approved a two-year budget for a new statewide trauma system, noting that the specific provisions may change based on levels of hospital participation, the *Arkansas Democrat-Gazette* reported. The $25 million budget for fiscal year (FY) 2010 and $28 million budget for FY 2011 will be funded through revenue from the recent state cigarette and tobacco tax increases. Specifically, the budget allocates $13.5 million in FY 2010 and $20.3 million in FY 2011 for hospital start-up and sustaining grants, as well as $2.32 million in FY 2010 and $2.5 million in FY 2011 for EMS. According to the director of the state Department of Health's Center for Health Protection, the agency has sent applications to 89 hospitals, including three out-of-state institutions—Christus St. Michael Health System in Texarkana, Texas, and the Level I trauma centers at Memphis-based **Le Bonheur Children's Medical Center** and **Regional Medical Center**; hospitals that choose to participate in the voluntary system must submit an application by July 1. Following a four- to six-week review process, the Department of Health will begin issuing start-up grants, ranging from $1 million for Level I trauma centers to $25,000 for Level IV trauma centers, while specialty centers—such as burn and hand centers—will be eligible for $250,000. Hospitals will then have 12 to 18 months to meet trauma center criteria before undergoing a final review. Meanwhile, acknowledging that Regional Medical Center in Tennessee treats approximately 2,000 Arkansans annually, the Board of Heath allocated $500,000 for the Level I trauma center (Park, 5/9, available through www.nwanews.com).

2 Washington state enacts sports concussion law to curb traumatic brain injury

Washington Gov. Chris Gregoire (D) recently signed "the country's most rigorous law protecting young athletes from severe brain injuries," the *Seattle Times* reported. Under the new law, athletes younger than age 18 who exhibit signs of a concussion must be removed from games of organized sports and may not return to play without approval from a licensed health professional, including certified athletic trainers. In addition, school districts must work with the Washington Interscholastic Activities Association (WIAA) to issue guidelines and educate coaches, parents, and students about the nature and risks of a concussion or head injury. To that end, the WIAA is working with the Brain Injury Association of Washington (BIAWA) to develop an informational packet for parents and students to read and sign at the start of each sports season. The WIAA will also incorporate the new law into its rules clinic, which all coaches are required to attend.

Meanwhile, UW Medicine and Seattle Children's Hospital are launching a sports concussion program—composed of health care providers in rehabilitation medicine, neurological surgery, neuropsychology, sports medicine, and radiology—to help coaches meet the provisions of the new law. Seattle-based **Harborview Medical Center**—a Level I adult and pediatric trauma center—and Seattle Children's Hospital will evaluate and treat athletes who sustain head injuries, providing medical clearance for patients to return to sports, when appropriate. In addition, the program will provide education on prevention and treatment of concussions for parents, athletes, athletic directors, and trainers (Wyrwich, 5/15, available through www.seattletimes.com; UW Medicine/Seattle Children's release, 5/14, available through www.seattlechildrens.org).

➢ IN THE JOURNALS

3 Study finds staffing changes help Level I trauma center improve outcomes

A Level I trauma center improved outcomes and efficiency by adding trauma surgeons and physicians assistants (PAs) to the staff, according to a study in the May *Journal of TRAUMA Injury, Infection, and Critical Care*. For the study, researchers evaluated three groups of trauma patients who were admitted to Denver-based **St. Anthony Central Hospital** and were treated under different staffing models, comparing mortality rates, hospital LOS, and ICU LOS. Group one was composed of 6,365 trauma patients treated between July 1, 1999 and June 30, 2002 when the trauma service was staffed with in-house general surgery residents and attending physicians; group two was composed of 6,599 trauma patients treated between July 1, 2002 and June 30, 2005 when the trauma service was staffed exclusively with a core trauma panel, including general surgeons and trauma surgeons; and group three was composed of 2,333 patients treated between July 1, 2005 and June 30, 2006 when the trauma service was staffed with the core trauma panel, supplemented with PAs.

KEY FINDINGS

- After adjusting for transfers-in, mechanism of injury, injury severity score (ISS), and head injury, overall mortality rates were significantly lower in group one, compared with group two (3.12% vs. 3.82%, p=0.05) as were mortality rates among severely injured patients (11.41% vs. 14.83%, p=0.02).
- The median ICU LOS was significantly lower in group one, compared with group two (3.03 days vs. 3.4 days, p=0.006).
- Overall mortality rates were significantly lower in group three, compare with group two (2.80% vs. 3.76%, p=0.05).
- The mean and median hospital LOS were significantly lower in group three compared with group two (4.32 days vs. 4.69 days, p=0.05, and 3.74 days vs. 3.88 days, p=0.02, respectively).

Commenting on the findings, study authors suggested that the outcomes were strongly tied to improvements in the consistency, coordination, and continuity of care with the addition of a core trauma panel and PAs. Noting that trauma centers' human resources vary widely and change frequently, they recommended further study to determine optimal staffing configurations, particularly for Level I trauma centers (Mains et al., "Staff commitment to trauma care improves mortality and length of state at a Level I trauma center," *Journal of TRAUMA Injury, Infection, and Critical Care*, May 2009, available through www.jtrauma.com).

➢ TRAUMA HEADLINES

4 Texas trauma care providers request additional state funding

The Texas EMS Trauma and Acute Care Foundation (TETAF) and the Texas Hospital Association (THA) earlier this month gathered at the state Capitol to lobby for the Legislature to increase trauma care funding to $125 million annually, the Associated Press reported. Currently, the House and Senate proposed budgets allocate $75 million per year, drawn from repeat traffic violation and drunk driving fines, which were established in 2003 to help offset the cost of uncompensated trauma care. However, according to the TETAF and the THA, $50 million of the driver responsibility program funds intended for the trauma system remain in state accounts each year. Highlighting the need for increased funding, the groups said that Texas hospitals provide $200 million in uncompensated trauma care annually (Shannon, AP/*Dallas Morning News*, 5/12, available through www.dallasnews.com).

5 University Hospital (Ky.) regains neurosurgical coverage

The University of Louisville (U of L) School of Medicine in Kentucky has hired nine neurosurgeons to fill faculty vacancies and staff **University Hospital**'s Level I trauma center, replacing physicians hired by nearby Norton Healthcare's Neuroscience Institute earlier this year, the Louisville *Courier-Journal* reported. The announcement came just one week before May 12, which was the last day the Norton neurosurgeons had agreed to provide coverage for University Hospital. According to the U of L's president, the successful recruitment of the two full-time and seven part-time neurosurgeons ensures that the hospital will maintain Level I trauma center status; the university had been concerned that an unresolved faculty shortage would jeopardize the neurosurgical residency program and force the hospital to divert trauma patients. One of the new full-time neurosurgeons is serving as the interim chair of the neurosurgery department and director of the residency program while the university vets 11 candidates for the permanent position (Ungar, 5/9, 2/28, available through www.courier-journal.com; *Business First of Louisville*, 5/8, available through www.bizjournals.com; UL release, 5/8, available through www.php.louisville.edu).

6 Telemedicine links ambulances to emergency, trauma specialists for triage

According to the CEO of the American Telemedicine Association, most ambulances in major metropolitan areas likely will have mobile video conferencing capabilities within 10 years, enabling emergency and trauma physicians to triage cases remotely, *Hospitals & Health Networks Magazine* reported. The mobile "teletrauma" care concept was pioneered in Tucson, Ariz., where the technology was installed in all 18 city-owned ambulances in 2007, linking to **University Medical Center**, the area's only Level I trauma center. Using a $3 million federal grant, the city built a 227-square-mile wireless infrastructure to support the mobile teletrauma communication system, called ER-Link. According to UMC's director of telemedicine for trauma and critical care, having emergency and trauma physicians triage patients en route to the hospital helps ensure the appropriateness of trauma team activation, which results in efficiency gains and cost savings, as each trauma team activation involves 18 to 20 staff members and costs $5,000. Meanwhile, East Baton Rouge Parish, La., in March began developing a similar system, BR Med-Connect, by installing video conferencing technology in one ambulance, which is linked to Our Lady of the Lake Regional Medical Center's ED through a wireless network. According to the assistant director of EMS, the parish plans to expand the system to seven hospitals using funds from the federal Department of Homeland Security (Versel, May 2009, available through www.hhnmag.com; Dyer, *The Advocate*, 3/13, available through www.2theadvocate.com).

7 Denver Health (Colo.) reverified as Level I trauma center

Denver Health Medical Center was recently reverified for the sixth time as a Level I trauma center by the ACS, demonstrating adequate surgical staffing levels and availability of diagnostic equipment, among other criteria, the *Denver Business Journal* reported. According to hospital officials, the review team specificially praised Denver Health's paramedic division, which responds to more than 80,000 calls and transports approximately 50,000 patients to 12 area hospitals annually. Denver Health is one of two Level I trauma centers in Denver, including **St. Anthony Central Hospital** (5/14, available through www.bizjournals.com).

➢ General Health Care Headlines

8 Consumers Union: Not enough progress on preventable errors

A report recently released by not-for-profit publisher Consumers Union stated that despite an "initial flurry of activity" following the Institute of Medicine's (IOM) 1999 "To Err is Human" report, the nation has since made limited progress against several of the IOM's recommended patient safety reforms, Reuters reported. The IOM's call to reduce medical errors by 50% across five years quickly sparked a number of recommendations for implementing safe medication practices, creating accountability through transparency, measuring medical errors, and raising standards for competency in patient safety. However, Consumers Union asserted that "little progress has been made" toward key reforms, noting that current medical error reporting initiatives mostly involve "voluntary, confidential, or aggregate reporting systems designed to facilitate learning" and have thus "fail[ed] to create external pressure for change"; the mandatory, national public reporting system recommended by the IOM, meanwhile, has not been created. Additionally, the report pointed out that no national entity has been "comprehensively tracking patient safety events or progress in reducing medical harm"; there has been limited hospital adoption of computerized prescribing systems, which are known to prevent medication errors; and "there is no evidence that physicians, nurses, and other health care providers are any more competent in patient safety practices" than they were a decade ago, despite "piecemeal action…by peers and purchasers." Consumers Union estimated that the "frustratingly slow" pace of change has likely led to an increase in the number of patient deaths from medical errors from approximately 98,000 to 100,000 annually, totaling 1 million people across the past decade. In addition, the report noted that medical errors result in significant health care costs, citing an IOM estimate that medical errors cost the U.S. health system between $17 billion and $29 billion per year. As Congressional lawmakers work to craft health reform legislation, the report urged them to focus on patient safety issues, saying that reducing medical harm—including hospital-acquired infections and medication errors—would "provide significant cost savings to help make expanded access to health coverage possible." Saying that "one decade later, we can't say whether we are any better off today than when the IOM first sounded the alarm," the director of the Center for Medical Consumers and an assistant author of the IOM report added that "the time to act is now" (Consumers Union report, May 2009, available through www.safepatientproject.org; Consumers Union release, 5/19, available through www.consumersunion.org; Reuters, 5/19, available through www.reuters.com).

9 Hospitals working to remedy lab tech shortages

Noting that the swine-flu outbreak has focused attention on the growing shortage of hospital lab technicians—which could pose a challenge in the event of a major infectious disease outbreak—the *Wall Street Journal* reported that hospitals and professional organizations are taking steps to fund training programs and recruit more workers. Much like the growing shortage of primary care physicians and nurses, the lab technician shortage poses "a potential threat to the safety and quality of health care," the *Journal* reported, as technicians perform vital tests such as diagnosing myocardial infarction; identifying cancerous tumors; and determining the presence of other diseases by examining blood, urine, and other bodily fluids and tissues. According to the *Journal*, average job vacancy rates for lab technicians are more than 50% in some states. Moreover, U.S. government estimates indicate that 138,000 lab technicians will be needed by 2012 to replace technicians who are expected to retire, but only 50,000 will be trained by then. To function with fewer technicians, some laboratories have changed their work practices, training technicians to perform tests in different areas to accommodate varying workloads. Hospitals also are working to address challenges to lab tech recruitment, such as a lack of awareness about the field, lower salaries compared with nursing jobs that require the same level of education, and the closure of one-third of the lab technician training programs across the country in the last decade.

Using a $3.2 million Department of Labor grant, for example, Minneapolis-based Allina Hospitals & Clinics offers a “fast track” training program for college graduates with a science degree. Meanwhile, Three Rivers Community Hospital in Grants Pass, Ore., partners with a local community college to provide lab training for graduates of the college’s two-year medical lab technician program. Commenting on the shortage, the director of the clinical laboratory sciences program at the University of Minnesota in Minneapolis cautions that techs are “responsible for about 70% to 80% of all diagnostic and treatment decisions made by physicians,” adding “if we disappeared for a day or two, health care would grind to a halt” (Landro, *Journal*, 5/13, available through www.wsj.com).

10 Medicare trustees forecast insolvency by 2017

An annual report released earlier this month by the Medicare Trustees forecasted that Medicare’s Hospital Insurance (HI) Trust Fund will be insolvent by 2017, two years earlier than the trustees predicted last year, *CQ HealthBeat* reported. The economic downturn, in particular, has shortened the time to insolvency, as rising unemployment rates have reduced the number of workers contributing to the fund. However, resumed economic growth is not guaranteed to change the outlook, as the projections assumed that the economy will begin to rebound by the end of this year. Meanwhile the trustees predicted that, without congressional action, Medicare spending will grow faster than workers’ earnings or the overall economy, estimating that 25% of all Medicare Part B beneficiaries will face “sharply higher premiums” in the coming years, which will increase from $96.40 per month currently to $104 per month next year and $120 per month in 2011. In addition, the trustees predicted that the average spending per beneficiary will increase from $11,000 last year to as much as $17,000 in 2018. Moreover, the report noted that Medicare expenditures totaled $468 billion—or 3.2% of the national gross domestic product (GDP)—in 2008, and are expected to account for 11.4% of the GDP in 75 years if no action is taken by Congress to slow growth. Offering potential solutions, the report noted that the fund may be brought into actuarial balance across the next 75 years through changes equivalent to an immediate 134% increase in the payroll tax, an immediate 53% reduction in program expenditures, or a combination of the two.

Commenting on the report, HHS Secretary Kathleen Sebelius called the findings a “wake up call for everyone who is concerned about Medicare and the health of our economy, while noting that the best solution is to “fix what’s broken in the rest of the health care system.” Meanwhile, Treasury Secretary Timothy Geithner added that the Obama administration plans to address the issue through broader health reform efforts to “control runaway growth in both public and private health expenditures”; however, *CQ HealthBeat* added that the theory that health system reform will drive down spending is “an untested hypothesis” (Social Security and Medicare Boards of Trustees 2009 annual report summary, 5/12, available through www.socialsecurity.gov; HHS release, 5/12, available through www.hhs.gov; Pear, *New York Times*, 5/13, available through www.nytimes.com; Goldstein, *Washington Post*, 5/13, available through www.washingtonpost.com; Reichard, *CQ HealthBeat*, 5/12, available through www.cq.com; *AHA News Now*, 5/12, available through www.ahanews.com).

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