ACS AMERICAN COLLEGE OF SURGEONS

June 28, 2022

The Honorable Anna G. Eshoo
Chairwoman
Energy and Commerce Subcommittee on Health
U.S. House of Representatives
272 Cannon House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Ranking Member
Energy and Commerce Subcommittee on Health
U.S. House of Representatives
272 Cannon House Office Building
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Guthrie:

On behalf of the more than 84,000 members of the American College of Surgeons (ACS), thank you for conveying your commitment to improving public health by convening a hearing on "Investing in Public Health: Legislation to Support Patients, Workers, and Research." As the Subcommittee examines a slate of important public health bills, ACS' comments will focus on trauma care and the *Improving Trauma Systems and Emergency Care Act* (H.R. 8163).

The ACS is a scientific and educational association of surgeons, founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. Since its inception in 1922, the ACS Committee on Trauma (COT) has worked tirelessly to transform trauma care and continues to play a pivotal role in advocacy and education efforts, leveraging trauma center and trauma system resources, creating best practices, providing outcome assessment, and prioritizing continuous quality improvement. Prior to the creation of the COT, there was no organized approach to the care of injured patients—injury prevention campaigns, prehospital care, trauma centers, blood banks, trauma registries or quality improvement programs, uniform trauma education, providers dedicated to emergency medicine or trauma surgery, and coordination of disaster response did not exist. None of the components of what is today considered a trauma system existed. Robust trauma systems and the teams who treat trauma patients have never been more critical to our health care system. It is though this lens that ACS has been working to leverage knowledge and best practices to incorporate the lessons learned from the response of the COVID-19 pandemic into a robust, national infrastructure to support our preparedness for future events and strengthen existing delivery of trauma care.

ACS appreciates the objective in H.R. 8163 to reauthorize trauma grant programs and improve the provision of trauma care as well as the intent to better coordinate medical services during a public health emergency via the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response. However, we would like to work with the Subcommittee to strengthen the language to ensure our nation meets this necessary and laudable goal.

Traumatic injury in the United States is the most common cause of death for children and adults younger than 45 years and the leading cause of potential life lost before the age of 75.[1] Trauma systems are designed to deliver optimal trauma care for injured patients, informed

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[1] https://wisqars.cdc.gov/data/lcd/

by best evidence and accessible to all injured patients regardless of circumstance. While there are exemplary regional trauma system models that have demonstrated robust access to high-quality trauma care, there is broad variability in the quality, continuity, and access to trauma care.[2] This leaves many Americans at increased risk for death and disability resulting from injury. It is estimated that 20% of trauma-related deaths could be prevented if optimal care was available to everyone.[3]

Effective daily trauma care requires timely access to a system with optimal resources for pre-hospital interventions, initial evaluation and imaging, operative care, intensive care, post-injury care, rehabilitation, and recovery (to include social and mental health services). With life-threatening injury, time is of the essence. This reality underscores the need to implement a robust system of injury care that reaches every community in the U.S. Disparities in trauma care are well documented and seen in both rural and urban areas.[4] Racial and ethnic differences in access to trauma care are also associated with disparities in geographic access to trauma centers.[5] The COVID-19 pandemic further illuminated health inequity in communities across America as it revealed gaps in our public health emergency preparedness system, as well as a health care infrastructure unable to meet the ongoing demand for care.[6]

The COVID-19 pandemic also put a spotlight on our medical infrastructure and demonstrated that it was not prepared to handle the severity nor scale of the disease. To mount an effective response to any future pandemic or mass casualty event and move our trauma system forward, ACS envisions a National Trauma and Emergency Preparedness System (NTEPS) that provides situational awareness of the resources and surge capacity of the entire health care system, as well as the ability to level load the system to match patients with appropriate resources and specialty expertise. We believe this system should be built on the framework of an interconnected network of Regional Medical Operations Coordination Centers (RMOCCs), which are local/regional organizations that bring together emergency management, public health, and acute medical care systems to balance the distribution of resources and patients in the acute health care system. RMOCCs operate daily to support the movement of patients for routine but time-sensitive emergencies (e.g., injury, heart attack, and stroke) and can rapidly scale up to serve as the coordinating entity for the health care sector during a mass casualty event, essentially functioning the "air traffic control towers" for inclusive coordination of the health and medical response in affected areas across all health care partners. Additionally, RMOCCs enable real-time reporting of critical information, such as emergency medical services and transportation resources, hospital bed capacity, essential logistic availability (e.g., personal protective equipment and ventilators), and patient volume and acuity.[7]

ACS believes a trauma system model that links together the local, state, and regional health systems with a common data network and drives performance improvement, readiness, and research is critical to achieving optimal, accessible care for daily injuries and mass population

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[2] https://pubmed.ncbi.nlm.nih.gov/26517780/
[3] https://pubmed.ncbi.nlm.nih.gov/26816061/
[4] https://pubmed.ncbi.nlm.nih.gov/32195996/
[5] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2727264
[6] https://jamanetwork.com/journals/jama/fullarticle/2775687
[7] https://pubmed.ncbi.nlm.nih.gov/17161107/

events, leading to a more unified approach that reduces death and disability from injury and disease. **As such, ACS urges to Congress to establish an NTEPS model with essential elements and functions such as public health readiness, standards, performance improvement, research, and public outreach. Doing so will promote universal and equitable access to high quality trauma care across the U.S. and support public health readiness and coordination of care during major events.**

Thank you again for your commitment to improving public health and strengthening trauma systems. We look forward to working with you to improve ensure optimal care for injured patients. If you have any questions, please contact Emma Zimmerman at ezimmerman@facs.org.

Sincerely,

Patricia L. Turner, MD, MBA, FACS
Executive Director

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