A Review of the NASEM's "A National Trauma Care System" 11 Recommendations

NASEMSO Trauma Committee Statement

Overview

At its core, this is a proposal for a nationalized civilian trauma system that closely coordinates with the military trauma system. A vision for a unified military and civilian trauma system is laudable and worthy of ongoing deliberation to ensure its goals are achievable. The expert committee offered a thoughtful overview of what such a system could look as well as detailed and high-level recommendations for implementation of the model system.

Lack of State Input

As proposed, these recommendations would be a seismic change, politically and fiscally, for the states, including a complete loss of state autonomy. Further, the greatest burdens of such a system would undoubtedly fall on the states to implement and regulate. Yet no state representative or meaningful proxy was on or advised the committee.

This lack of recognition for the central role and burden that states would carry in implementing and regulating the federal civilian system needs to be addressed in our feedback. One need only look to Medicare and Medicaid to see what dilemmas a federalized healthcare system can provide at the state level.

Overarching Concerns

Federalization: NASEMSO will need to internally address the issue of state autonomy vs. federalization, at least as proposed in this publication, before offering its support, neutrality or opposition.

There is language in the publication and its accompanying Report Brief about coordination with states and other trauma organizations, but this language is too vague in light of the overall trajectory and weight of the recommendations. Nothing should be considered implicit in this document when it comes to the role and authority of states.

Central role of ACS within states: NASEMSO should realize that to support the publication is to advocate for the central role of ACS-COT and its programs (TQIP, verification criteria, ATLS, etc.) across all states. It is not unreasonable to conclude that ACS will become the national standard, contrary to language in the recommendations about HHS coming up with standards. ACS is a driver of this initiative and is specifically named throughout the document.

It seems unlikely that a new national 'standard' would be developed that would compromise the core of ACS's long established programs. To this point, ACS-COT has rarely demonstrated a willingness to collaborate or compromise in any meaningful way in its formal relationship with NASEMSO. NASEMSO's attempts to work formally with ACS-COT through signed Memoranda of Understanding are instructive here. Thus, it is reasonable to assume this pattern will continue at a national level where ACS is seen as a (the) key player.

Further, although ACS-COT has been and is a national leader in trauma care resource development, system design and research, its approach and leadership is not fully embraced in most states. In fact, NASEMSO's recent Trauma System State Monograph shows that the majority of states have chosen to

amalgamate state-specific criteria with select ACS-COT requirements instead of wholesale adoption of the ACS-COT model. There are many and varied reasons for this; the point being that there would likely be extreme pushback from states if the ACS-COT is the primary author of a national system that would supersede the need for flexibility across states.

Additional Questions / Concerns

- Does the proposed national civilian system involve rural hospitals? That is, will national standards (ACS-COT) and reporting expectations be applied to rural Level 3, 4, and 5 hospitals? If so, it would be the demise of existing rural trauma systems which are the backbone of care in rural states. This could lead to further health inequity for already disadvantaged areas where level I/II care is not available.
- National standards will result in a decrease in the number of urban trauma centers across the nation (Recommendation 4). Though not completely unwarranted, this goal of ACS-COT will be a political and fiscal burden on states to regulate.
- Funding this vision will require almost limitless resources. States will need a massive initial and ongoing influx of funds if they are to implement and regulate their part of the system. There does not seem to be any upfront acknowledgment of this in the recommendations.

Areas of Encouragement

Many recommendations in this report touch on identified problems in all existing trauma systems. Successful efforts to address the following issues (regardless of the establishment of a formal national trauma system) would provide immense benefit to patients and advance the development of enhanced state systems:

- Rapid adoption of best practices and care guidelines
- National data and reporting system
- National benchmarks
- Integrated real-time registries
- Integration of trauma registries into EHRs
- Assuring competence of our military surgeons during peacetime
- Addressing HIPAA to remove barriers
- Incentives for participation in evidence-based quality improvement programs
- Integrating EMS as healthcare providers
- Integrating military and civilian training for trauma care
- Integrating rehabilitation into the care of the trauma patient from the beginning of care

Moving Forward

Finally, the stated goal of the committee was as follows: “This committee was convened to study and evaluate progress toward better trauma care and outcomes, especially in the military sector; to understand how that progress relates to elements of a learning health system; to recommend how learning and improvement could be even better; and to understand how both trauma care and learning can best be translated between the military and civilian trauma care systems.” Preface, page xiv.

The scope of the work product from the committee significantly exceeds the mandate. The strength of the document lies in those recommendations that specifically address the committee's mandate, while the recommendations regarding the establishment of a national trauma system appear to have been written with neither acknowledgement of the existing systems nor consideration for the practicality of a federalized system.

It might be more realistic and expedient to change the vision of a federalized civilian trauma system to one that coordinates with states to establish baseline standards instead of imposing national standards. In addition, more emphasis should be placed on those recommendations that are possible without a federalized trauma system and which, through collaboration, cooperation and voluntary compromise, could positively impact patient care and promote better alignment of training and research opportunities.