

**Congress of the United States**  
**Washington, DC 20515**

March 21, 2016

The Honorable Tom Cole  
Chairman  
Subcommittee on Labor, Health and Human  
Services, Education and Related Agencies  
Committee on Appropriations  
2358-B Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Rosa DeLauro  
Ranking Member  
Subcommittee on Labor, Health and Human  
Services, Education and Related Agencies  
Committee on Appropriations  
1016 Longworth House Office Building  
Washington, D.C. 20515

Dear Chairman Cole and Ranking Member Delauro:

As Members of Congress who value the critical role trauma centers and systems play in treating victims of traumatic injury, including victims of terrorist attacks and other mass casualty incidents, we respectfully request inclusion of \$28 million in the Fiscal Year 2017 Labor, Health, Education Appropriations bill for the trauma and emergency care program. The multiple attacks in Paris and the recent homegrown terrorist attack in San Bernardino amplify the need to ensure that should further attacks occur on U.S. soil, our trauma system and our trauma centers will be ready and able to care for the victims.

As was seen in the response to the Boston Marathon bombing in April 2013, the immediate availability of emergency medical personnel and timely access to six major trauma and three verified burn centers was essential to saving lives. The low death count relative to the attack in Boston was not luck -- it was due to the close proximity of multiple specialized trauma and burn centers, emergency medical practitioners at the scene, and prior investments and training in disaster preparedness and response.

Unfortunately, Boston is an exception. Many areas of the nation, including some major metropolitan centers, would be overwhelmed by a major attack. On April 19, 1995, a truck bomb consisting of more than 4,000 lbs. of ammonium nitrate was detonated outside the Alfred P. Murrah federal building located in Oklahoma City, Oklahoma. Immediate deaths number 163 and 3 were pronounced dead on arrival at local hospitals. Eighty-three immediate survivors were hospitalized, and, subsequently, 46 died. Most survivors sustained minor injuries caused by flying/falling debris. The most frequent type of injury was soft tissue trauma. The truck bomb that detonated also resulted in several secondary fires. Ten casualties suffered thermal burns. Today, there is only one Level I trauma and burn center in the state of Oklahoma. The Level I trauma center in Seattle serves Washington, Idaho, Alaska, and Montana. Other areas of the nation are underserved as well.

In states with an established trauma system, patients are 20 percent more likely to survive a traumatic injury. However, because of economic instability in supporting trauma care centers, at least 21 have closed during the past decade, including St. Vincent's in Manhattan, which treated 848 patients on September 11, 2001.

As we grapple with the tragedies of the Navy Yard, Boston Bombing, Sandy Hook, Tucson, Paris, Aurora, and other mass casualty events, we can't assume that trauma care will miraculously be there -- we need to make sure that it is.

Trauma care is a prudent federal investment. Victims of serious traumatic injury have a 25 percent reduction in mortality if they receive care from a major trauma center. Yet, 45 million Americans lack access to a major trauma center within the "golden hour." Trauma remains the leading cause of death under age 45, more than AIDS and stroke combined.

The trauma and emergency care programs in the Public Health Service Act are designed to maintain and improve access to trauma care services as part of a well-designed trauma care system for victims of every day trauma and mass casualty events. These programs should be funded to ensure that all Americans have access to lifesaving trauma care where and when they need it. A modest investment can yield substantial returns in terms of cost efficiencies and saved lives.

The \$28 million trauma and emergency care request would include funding for these four grants which have not been funded with a breakdown as follows:

- \$11 million for Trauma Care Center Grants: Historically authorized at \$100 million per year for federal grants to trauma centers to provide operating fund to maintain their core missions, compensate for losses from uncompensated care and provide emergency awards to centers at risk of closure.
- \$11 million for Trauma Service Availability Grants: Historically authorized at \$100 million per year channeled through the States to address shortfalls in trauma services and improve access to and the availability of care.
- \$3 million for Trauma Systems Planning Grants: Historically authorized at \$24 million per year for Trauma Care Systems Planning grants to support state development of trauma systems.
- \$3 million for Regionalization of Emergency Care Pilots: Historically authorized at \$24 million for pilot projects to design, implement and evaluate innovative models of regionalized emergency care systems. Coordinated emergency medical and trauma systems within a region are critical for improving patient health outcomes, including for patients suffering a stroke, heart attack, or other cardiac emergencies where time is of the essence in treatment.


Last year, the House of Representatives overwhelmingly passed the "The Trauma Systems and Regionalization of Emergency Care Reauthorization Act (H.R. 648)" by 382-15 and "The Access to Life-Saving Trauma Care for All Americans Act" (H.R. 647) by 389-10. Collectively, these bills reauthorize the grant programs listed above through 2020.

As your Subcommittee makes difficult choices around prioritizing the most prudent federal investments, we urge you to provide \$28 million to implement the trauma and emergency



programs contained in Sections 1201-4, 1211-22, 1231-32, 1241-46 and 1281-2 of the Public Health Service Act. We thank you for your consideration of this request.

Sincerely,



Michael C. Burgess, M.D.



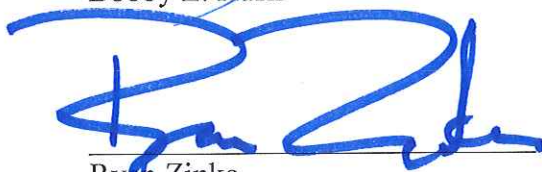
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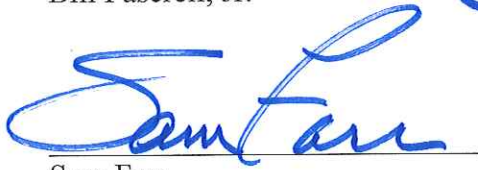
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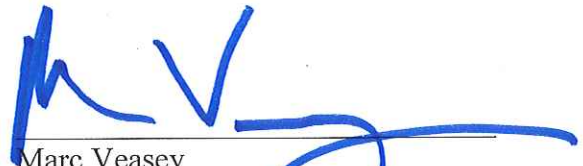
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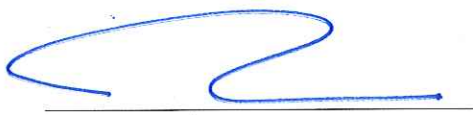
  
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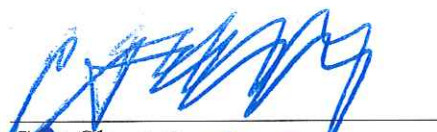
  
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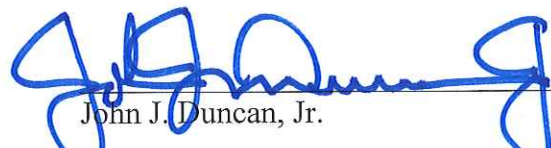
  
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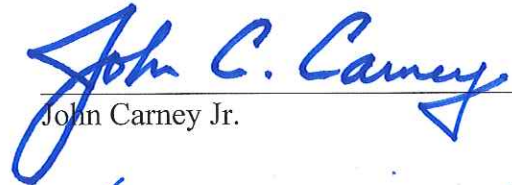
  
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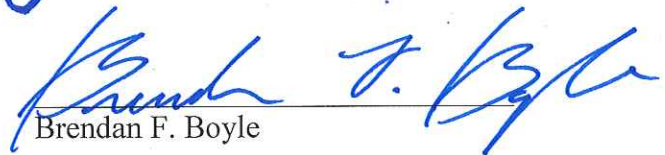
  
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