Reps. Dunn and Trahan's Request for Information – Pandemic and All-Hazards Preparedness Act (PAHPA)
Response from the Trauma Center Association of America (TCAA)

Question 1: The Trauma Center Association of America (TCAA)
Question 2: *Point of Contact Information*
Question 3: *Point of Contact Information*

Question 4: Suggestions for the following US government programs:
Check:

- National Disaster Medical System (NDMS)
- Military and Civilian Partnership for Trauma Readiness Grant Program

Question 5: Elaborate on topics that were chosen:

Every day, trauma centers across the United States care for some of the most critically ill patients of all ages. Traumatic injury remains the leading cause of death and disability for people under age 46, [1], and more than 3 million older Americans are treated in emergency departments for non-fatal fall injuries. [2]. While trauma centers manage this steady patient volume without fanfare, they are also continuously preparing for the next emergency or disaster. Recognizing the essential role trauma centers play in national preparedness, Congress has repeatedly authorized and funded programs designed to help them maintain a constant state of readiness. Because access to highly specialized trauma centers offers the best chance of survival when individuals experience devastating traumatic injuries, [3], we urge Congress to strengthen and expand these successful programs, including MISSION Zero and the National Disaster Medical System (NDMS).

The Trauma Center Association of America (TCAA) appreciates the opportunity to provide feedback on this request for information regarding the Pandemic and All-Hazards Preparedness Act (PAHPA).

As noted, trauma centers are a critical part of our nation's readiness strategy in the event of an emergency or disaster, either natural or man-made. These facilities operate with specialized equipment and teams on hand to treat patients with severe and potentially life-threatening injuries, including falls, motor vehicle crashes, gunshots, and assaults. For most levels of care, [4], operating rooms must be readily available for trauma surgeons and their teams. Lower-level trauma centers must have trained staff that are prepared to stabilize and transfer these critically ill patients to higher-level facilities.

Among the programs within PAHPA, we wish to focus our comments on suggested improvements to the Military and Civilian Partnership for Trauma Readiness Grant Program (also known as MISSION Zero) and NDMS.

The MISSION Zero program stems from the June 2016 National Academy of Sciences, Engineering, and Medicine (NASEM) report entitled, *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury*. [5]. In the report, NASEM recommended that the United States adopt an overall aim for trauma care of "zero preventable deaths after injury," and sets forth elements of system redesign that would provide military personnel with real-world training and experience at civilian trauma centers. Following the report, Congress created the MISSION Zero grant program via the Military Injury Surgical Systems Integrated Operationally Nationwide to Achieve ZERO Preventable Deaths Act or "MISSION Zero Act," which was authorized by the Pandemic

and All-Hazards Preparedness and Advancing Innovation Act of 2019. Its authorization, unfortunately, lapsed in September 2023, and we thank Reps. Kathy Castor and Richard Hudson for their legislation that would reauthorize the program (H.R. 2414) through fiscal year (FY) 2029.

We appreciate that Congress has repeatedly funded the program over the last few years. We are convinced that the funding provided by the MISSION Zero Act will allow us to continue to save lives and help trauma centers manage and recover from workforce shortages of essential providers. Additionally, MISSION Zero allows military trauma providers to maintain their clinical skills while they are not deployed, ensuring that our nation's Armed Forces benefit from high-quality and state-of-the-art trauma care while on the battlefield. This is especially critical given that research estimates that only about ten percent of military general surgeons meet readiness criteria. [6]. In fact, this issue was cited at a May 2025 Senate Committee on Armed Services hearing, where members of the Committee expressed concern about the readiness of military surgeons and emphasized the importance of ensuring they remain sufficiently "busy" during peacetime.

Twenty-five trauma centers from 16 states – including Florida – have established and set up MISSION Zero programs. Among surveyed military providers (physicians, nurses, corpsmen, technicians, etc.) who participated in a MISSION Zero deployment, 75 percent reported that their shifts at a civilian trauma center were busier, more in-depth/complex, and more trauma-focused than at their military treatment facility. Accordingly, 91 percent of providers rated themselves as "very prepared" or "moderately prepared" to care for severely injured trauma patients after working at a civilian trauma center through MISSION Zero. Before entering MISSION Zero, only 29 percent of providers felt "very prepared" or "moderately prepared" to care for severely injured trauma patients. As one provider reported, "I see more trauma and critical care patients at my civilian trauma center in 1 month than my associate Military Treatment Facility sees all year." These data points reinforce that military-civilian trauma partnerships provide enormous value for providers' ability to respond to the next war, emergency, or disaster.

Relatedly, the NDMS is a critical part of our nation's health care infrastructure that supports state and local governments' response to emergencies and disasters. Additionally, should it be needed, it would also support the Armed Forces and the Department of Veterans Affairs in caring for injured service members during an armed conflict. Both MISSION Zero and the NDMS are vital programs that would ensure trauma systems across the country are ready to respond in the event of emergencies, disasters, or wartime.

As Congress considers reauthorizing PAHPA, and with it, MISSION Zero and NDMS, we offer the following suggestions to improve both programs.

First, we suggest that Congress expand the MISSION Zero program by (1) increasing its authorization amount from $11.5 million to $25 million, (2) increasing the grant award per grantee cap, and (3) modifying the cap on the number of maximum MISSION Zero grantees from 20 to 50. Through these recommendations, Congress can ensure that existing programs can expand while other trauma centers can develop their own programs, thereby allowing their community to benefit from MISSION Zero through improved trauma care. Second, as Congress considers reforms to NDMS, we urge it to consider ways to ensure partnering trauma centers can maintain a proper readiness posture, including by supporting them by providing adequate resources for trauma centers who choose to voluntarily partner with NDMS. Ensuring that trauma centers maintain their skills and readiness is a resource-intensive task and with additional resources, Congress can ensure that NDMS will be adequately equipped to handle any surges in trauma care.

TCAA looks forward to working with both of you to ensure our health care infrastructure, including trauma centers, remain ready to respond to our country's next emergency or disaster.

[1] The National Academies of Science, Engineering, and Medicine, *A national trauma care system: Integrating military and civilian trauma systems to achieve zero preventable deaths after injury* (2016), https://nap.nationalacademies.org/read/23511/chapter/5#44.
[2] Curtis S. Florence, et. al., *Medical Costs of Fatal and Nonfatal Falls in Older Adults*, 66 J. Am. Geriatric Soc'y 693 (Mar. 7, 2018), https://pubmed.ncbi.nlm.nih.gov/29512120/.
[3] Ellen J. MacKenzie, et.al., *A National Evaluation of the Effect of Trauma-Center Care on Mortality*, 354 N. Eng. J. Med. 366 (Jan. 26, 2006), https://www.nejm.org/doi/full/10.1056/nejmsa052049.
[4] *Resources for Optimal Care of the Injured Patient (2022 Standards)*, Am. College of Surgeons (Dec. 2023), https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/.
[5] The National Academies of Science, Engineering, and Medicine, *A national trauma care system: Integrating military and civilian trauma systems to achieve zero preventable deaths after injury* (2016), https://nap.nationalacademies.org/read/23511/chapter/5#44.
[6] Michael Dalton, et. al., *Analysis of Surgical Volume in Military Medical Treatment Facilities and Clinical Combat Readiness of US Military Surgeons*, 157 JAMA Surgery 43 (2021), https://jamanetwork.com/journals/jamasurgery/fullarticle/2785414.

Question 6: Policy suggestions that do not fit within one of the currently authorized programs or initiatives from #1

Recent emergencies and disasters emphasize the need for a robust public health response when a pandemic, emergency, or mass casualty event arises. In these situations, trauma centers are often the hub for care, and Congress must ensure that trauma systems, which include trauma centers, emergency transport services, and post-acute care providers, have the tools they need to maintain this readiness. Accordingly, we offer the following recommendations to Congress on how to improve trauma system readiness.

First, Congress should support the grant programs authorized by the Improving Trauma Systems and Emergency Care Act (the "Trauma Grants") which is part of the Consolidated Appropriations Act, 2023. The Trauma Grants would allow the Administration for Strategic Preparedness and Response (ASPR) to award grants for trauma centers to strengthen coordination and communication, develop approaches to improve emergency medical and trauma system access, establish evidence-based practices, and conduct activities to support clinical research. Funding would also improve trauma care in rural areas through grants for research and demonstration projects that focus on developing innovative technology, training and education, transportation, prehospital care, and other priorities, greatly benefiting underserved rural communities which often lack access to high-quality trauma care. These grants are essential to promoting ready access to trauma care for all, and we appreciate that the Appropriations Committees funded two of the Trauma Grants at $2 million for FY 2026. We hope Congress will support the funding of these important grants in future years, and reauthorize it when its authorization ends in FY 2027.

Second, Congress should consider promoting the use of telemedicine platforms among trauma centers. During a severe traumatic injury, lower-level trauma centers serve as a care facility to stabilize the patient before they are transferred to a level one or two trauma center. These lower-level trauma centers may not have specialized professionals who can assist in the stabilization of the patient.

Accordingly, the use of tele-ICU and tele-trauma services can improve access to time-sensitive and life-saving interventions in remote areas. We encourage Congress to advance policies that promote the use of telemedicine among trauma systems.

Third and finally, given trauma care professionals' unique responsibility in our nation's readiness posture, we urge Congress to invest in policies that ensure the stability of the trauma care workforce. Like in other areas of the health care industry, trauma centers have been battling with workforce shortages exacerbated by the rising costs of education and burnout. Accordingly, there is now a shortage of acute care surgeons in the U.S., with an estimated 79 percent of hospitals being considered short-staffed by researchers. [1]. It is therefore essential that Congress continue to advance policies that invest in the recruitment, education, and training of the trauma workforce, particularly in emergency surgery, pediatric trauma care, nursing, emergency medical systems (EMS), and critical care.

We would be honored to work alongside you in further consideration of these recommendations. Thank you for your leadership in updating and advancing this vital piece of legislation. Please feel free to reach me, Jennifer Ward, President of TCAA, at jennifer@traumacenters.org, with any questions or concerns.

[1] Patrick Murphy, et al., *Understaffed and overworked: The stark reality of acute care surgeon staffing in the United States, an Eastern Association for the Surgery of Trauma multicenter study*, 99 J. of Trauma and Acute Care Surgery 560 (2025), https://journals.lww.com/jtrauma/abstract/2025/10000/understaffed_and_overworked__the_stark_reality_of.9.aspx.

Question 7: Views on if any of the current programs or initiatives are duplicative to already existing efforts.

N/A

Question 8: Your top three priorities for the 2026 PAHPA reauthorization in order of preference.

1. Reauthorizing, reforming, and increasing funding for the MISSION Zero program.
2. Ensuring adequate incentives for trauma centers to partner with NDMS.
3. Advancing the Trauma Grants and ensuring they are funded and reauthorized.