

*Reflections on the establishment of*  
**OHIO'S TRAUMA SYSTEM: A 20-YEAR EFFORT**



*by*

SIDNEY F. MILLER, MD, FACS, *Dayton, OH;*  
RICHARD FRATIANNE, MD, FACS, *Cleveland, OH;*  
ROBERT FALCONE, MD, FACS, *Columbus, OH;*  
*and* JAMES HURST, MD, FACS, *Cincinnati, OH*

---

In 1982, the Cleveland Academy of Medicine introduced a resolution to the house of delegates of the Ohio State Medical Association (OSMA) calling for the establishment of a statewide trauma system. On November 1, 2002, a derivative of this proposed statewide system was implemented. This article traces the trials and tribulations of the 20-year crusade to establish a trauma system in Ohio.

#### INITIAL STEPS

As a first step in this process, OSMA's house of delegates reviewed the Cleveland resolution. Although the reference committee to which it was assigned approved the proposal, the members were unprepared to make a decision at that time. Therefore, the resolution was referred to the OSMA council for further evaluation, with a report due back to the delegates the following year.

To help gain a clearer understanding about how neighboring states succeeded in implementing a trauma system, the Ohio Committee on Trauma (COT) invited Charles Wolferth, MD, FACS, Chair of the Eastern Pennsylvania COT, to speak at the American College of Surgeons' Ohio Chapter's trauma breakfast during its 1983 annual meeting. After listening to Dr. Wolferth's presentation, the Ohio COT decided to form a broad-based task force under the aegis of the OSMA.

The task force was charged with evaluating the current status of trauma care and need for an organized trauma system in Ohio. The group met regularly for two years and wrote a set of guidelines, which defined a trauma system based on the

College's *Guidelines for Optimal Care of the Injured Patient*. The task force included representatives of the state chapters of all the surgical societies whose members are involved in trauma care, the Ohio chapter of the American College of Emergency Physicians (ACEP), and the Ohio Hospital Association (OHA). Although most parties agreed on the final draft, the OHA board had questions about the draft and would not approve it.

At the 1984 annual meeting of OSMA, the council recommended that this matter be referred to the OSMA Committee on Trauma and Emergency Care. That committee addressed all the issues that the OHA had raised and revised the task force guidelines; however, the house of delegates defeated the final resolution at its next annual meeting in 1985.

Not to be deterred, the members of the trauma task force considered writing draft legislation for introduction in the Ohio House of Representatives, but the legislature was in the process of debating major revisions in the state's emergency medical system's board, and no elected official would step forward to introduce separate trauma legislation. The trauma bill was reluctantly put on hold after more than four years of intense effort by the Ohio COT, the Ohio chapter of ACEP, and many other dedicated professionals.

In 1982, a rudimentary prehospital EMS program was established in Ohio. The Cleveland Academy of Medicine was in the process of establishing a regional countywide trauma system and trauma registry, and the Columbus area was in the process of establishing a local/regional program for trauma care.

Before the introduction of the Cleveland resolution, EMS training fell under the auspices of the Ohio Department of Education. The state viewed EMS only as a training and licensure issue. The Department of Education EMS advisory panel was composed primarily of EMS personnel and fire chiefs. One of the authors of this article, Dr. Miller, was appointed as a representative from the Ohio COT to provide some voice from the medical community to this EMS panel. During the late 1980s, the state EMS board was moving toward the use of the national registry examination for licensure of EMS personnel throughout the state. Many volunteer EMS groups around the state, particularly in the



**Dr. Miller** is professor of surgery, Wright State University, Dayton, OH, and was Chair of the Ohio COT from 1992 to 1994. Dr. Miller is also a member of the ACS COT.

---

smaller rural programs, opposed use of the national registry examination.

In response to these concerns, the state Senate passed S.B. 98 in 1992. That law established an EMS board under the purview of the Ohio Department of Public Safety. This department took control of the board because it was the only Ohio government agency that provided the legislature with a mechanism to fund the EMS activities—namely, using revenue accrued from fines imposed for failure to obey the seat-belt laws. S.B. 98 established a new EMS board responsible for the organization and delivery of EMS services in the state. It also established a trauma registry, a system of regional physician advisory boards (RPABs) responsible for coordinating regional trauma activities, and a mandate to study and report back to the legislature within two years of enactment of the law on the need for a statewide trauma system. The RPABs and registry were unfunded mandates.

#### NEW FACTORS ARISE

A strongly worded report prepared by the EMS board on the critical need for a statewide trauma system was basically ignored and produced little or no activity in the legislature. In 1997, three factors came to bear on the development of a statewide trauma system: (1) the Chairman of the Ohio COT resided in the state capital for the first time in more than 16 years; (2) the Ohio COT hired a lobbyist to work with and identify an appropriate sponsor for trauma legislation; and (3) the Central Ohio (Columbus) Trauma Foundation became politically active and supplied important pooled data to local newspapers. The press responded to the challenge by calling to the attention of the legislature the need for a statewide trauma system.

Under the leadership of state Rep. Robert Shuck (R) and the Central Ohio (Columbus) Trauma Foundation, a meeting was held to begin planning for the introduction of legislation to establish a statewide trauma system. Representative Shuck presented his perspective on why we were having difficulty achieving passage of effective trauma system legislation. He basically told us that we had been preaching to the choir for the last 10 years by carrying out all of the meeting and planning solely within the medical community. Representative Shuck put together a broad-based coalition not only of representatives from all aspects of the

medical community having a role and interest in trauma care, but of unions, business leaders, and civic activists as well. Regular meetings of the planning group and open citizen forums were conducted throughout the state. Representative Shuck and his staff made an impressive effort in terms of educating themselves about all aspects of trauma care and trauma system development. They held the medical representatives' toes to the fire with regular meetings and expected attendance.

#### A SECOND LAW

In 2000, we achieved passage of another law, H.B. 138. It was the intent of the planning group to develop an inclusive trauma system. Concerns had been voiced during the 10 years of the planning process that a statewide trauma system was just a power grab for patients by the Level I and II centers. This argument permeated every trauma system planning process. Representative Shuck and the planning group were determined to pass legislation that would produce an inclusive system.

One of the issues of significant concern to them was the ability of Level III hospitals to meet ACS guidelines. Because the planning committee and the legislature wanted to avoid a two-tier system, the legislation supported ACS verification for all trauma system hospitals. There were also concerns about relegating the content and charter of trauma hospitals, particularly for Level III hospitals as has been done in some states, to a nonmedical forum such as the legislature with the

**Dr. Fratianne** is professor of surgery, Case Western Reserve University, Cleveland, OH, and was Chair of the Ohio COT from 1978 to 1989.



## LESSONS LEARNED

- Persistence was probably the most important factor in advancing the state trauma system. Indeed, the process did not end with the final product, because it is imperfect, and touch-up legislation will undoubtedly be needed. For instance, a designating authority is still not in place, and the issue of population requirements versus hospital choice of participation in the trauma system remains to be addressed. What will happen in two years, after the grace period to receive ACS verification expires? Will those hospitals that are still unable to turn their desires into reality again be able to get legislative relief from the perceived onerous requirement of ACS verification? These questions remain unanswered.

- Community and legislative leadership is required. A broad-based coalition had to be established. As Representative Shuck so clearly expressed, "The medical community had been preaching to the choir for 18 years and had accomplished very little." We needed an effective lobbyist and standard-bearer in the legislature, as well as a broad-based supportive coalition of trauma care professionals, business, labor, and community and political leaders. This is the group that was needed to guide the effort to get effective legislation in place.

- Effective trauma/COT leadership needs to

be active in the state capital. Traveling 70 to 200 miles on short notice to testify at legislative hearings and to meet with community or business leadership to influence the legislature is a challenge. Having the resources readily available in the state capital was a very significant step toward passage of legislation.

- Monitoring the activities of the legislature requires an effective lobbyist. A lobbyist who can deal effectively with the legislature and become the project manager to get legislation passed is invaluable. Knowing when, how, and with whom to deal in the legislature is most important. Contacting and arranging for effective testimony at hearings and facilitating personal contacts are all-important functions of the lobbyist. Trauma programs and surgeons need to give not only verbal but financial support to the statewide efforts to establish a system.

- Lastly, the close working relationship between the Ohio COT and the Ohio Chapter of the College was an important factor in moving legislation forward. The Ohio COT has a voice in the Ohio Chapter's Council and therefore was easily able to mobilize support from the entire chapter. The chapter's annual meeting's COT breakfast and regular trauma sessions allowed the COT to bring forth issues and gain support of the entire chapter throughout the process.

full potential for possible political manipulation.

Political trade-offs, however, were required for passage of the bill. These trade-offs were particu-



***Dr. Falcone** is associate clinical professor of surgery at Ohio State University, Columbus, OH, and was Chair of the Ohio COT from 1994 to 2000.*

larly related to verification of pediatric trauma centers. The Ohio Pediatric Hospital Association (OPHA), through its members, raised concerns that some of the pediatric hospitals would be unable to meet the two-year deadline required under the legislation for verification. Therefore, a clause was added to the law specifically allowing the Ohio Department of Health (ODH) to craft a one-time, two-year waiver of the ACS verification requirement for pediatric hospitals. This amendment allowed the OPHA and the pediatric hospitals to come on board and support the legislation.

The law clearly defined a trauma patient and mandated that within two years of passage all Category 1 trauma patients must receive definitive treatment at a state-designated and ACS-verified trauma center. A state trauma committee was established under the previous function-

---

ing EMS board with a mandate to develop rules for the implementation of this law.

The new state trauma committee established subcommittees to develop protocols and rules for prehospital care, registry, in-hospital care, and air medical activities under the state program. The committee was mandated to use ACS verification for trauma center identification. Additionally, H.B. 138 mandated that the ODH establish an injury prevention and rehabilitation commission to study these two areas of interest and to report back to the legislature.


The trauma committee promptly identified two deficiencies in H.B. 138 that required corrective legislation. First, the legislation lacked any language related to hospitals with provisional designation. This affected hospitals that had made an institutional commitment to ACS guidelines but had been unable to schedule a verification visit. After November 2002, they would be unable to receive patients and establish the patient database and quality assurance process needed for verification. Additionally, programs that failed ACS reverification visits but had minor correctable deficits and qualified for an ACS focused review would lose state trauma center designation.

The other deficiency in the legislation was the lack of a designating authority. Corrective legislation passed in 2002 that allowed the ODH to review the institutional commitment of a hospital in the process of undergoing initial verification or of the deficiencies identified by the ACS reverification visits and provide provisional designation for a limited time. For hospitals in queue, strict guidelines for the depth of the institutional commitments must be provided to the health department in order to receive provisional status. Additionally, the corrective legislation allowed the ODH to evaluate and determine whether the problems identified in the ACS reverification visit represented significant patient care issues. If not, the law allowed the institution to continue participation as a "trauma hospital" until a focused review occurred. The issue of a state designating authority remains unaddressed.

The state trauma registry is now up and running and initial data were provided on a voluntary basis. However, as of November 3, 2002, when the state trauma system was activated, mandatory participation by all facilities treating trauma pa-

tients was required. Hospitals that did not have ACS verification by that date and had evidence of institutional commitments to the management of trauma patients would be allowed to apply to the ODH for up to a two-year period of provisional status. All trauma patients, as defined by the regulations, must be taken to a state trauma hospital for care. The state trauma committee's performance improvement program will now move forward to validate the improved care provided under this system in the state of Ohio.

So, this article summarizes our experience in creating Ohio's trauma system. The lessons we learned in the process are outlined in the sidebar on page 14.

We hope our experience may be useful to others in the process of establishing their statewide trauma systems. 

***Dr. Hurst** is professor of surgery, University of Cincinnati (OH) College of Medicine, and was Chair of the Ohio COT from 1989 to 1992.*

