

Statement on Trauma Center Designation Based Upon System Need

Regional trauma system implementation has been shown to improve mortality and reduce complications. The number, level, and location of trauma centers are critical elements of trauma system function and disaster response. The importance of controlling the allocation of trauma centers, as well as the need for a process to designate trauma centers based upon regional population need, has been recognized as an essential component of trauma system design since the 1980's. Despite this recognition, few trauma systems are able to operationalize these concepts, especially when faced with real or potential challenges from powerful health care institutions or providers. Without both a strong mandate and clear statutory authority that is backed by a transparent and fair process, lead agencies for many trauma systems have been unable to make potentially controversial decisions, and in some cases have abdicated their responsibility regarding trauma center designation. When this situation occurs, trauma center designation becomes driven by the needs and ambitions of individual health care organizations or hospital groups rather than the needs of injured patients within the region. When changing economic fortunes determine the desirability of trauma center designation, trauma centers may opt in or out of the system based upon their own perceived gains without consideration for the needs of the populations served. The result is a situation in which the resources available for the care of injured patients change with the economic tide.

Recent changes in health care economics have made trauma center designation generally more desirable and certain areas have developed a perceived oversupply of high-level trauma centers, with potentially adverse effects on cost and efficiency of patient care. History has shown that changes in health care economics can also make trauma center designation less desirable and as a result, some trauma centers drop high-level designation despite demonstrated population need; a scenario that played out frequently in the 1990's. Both outcomes are detrimental to the long-term stability of a regional trauma system and to the population it serves.

The issue is not simply that the "proliferation" of new trauma centers is bad—quite the contrary. It is far more common for regions to lack access to trauma care because no high-level designated trauma centers are located nearby; a need that can best be filled by encouraging "proliferation" of new trauma centers in the appropriate places. The problem arises when a lead agency lacks the ability to limit growth of new trauma centers to areas of need, and passively allows health care organizations and hospital groups to establish new trauma centers in areas that yield an economic advantage, while ignoring areas of true need. Such uncontrolled growth of trauma centers, some of which may lack long-term commitment, has potential to undermine the quality of trauma care within a region; on one hand creating areas of oversupply and adverse competition while ignoring underserved areas entirely.

In order to best serve the needs of injured patients through optimization of regional trauma system function, the American College of Surgeons Committee on Trauma supports the following:

- The designation of trauma centers is the responsibility of the governmental lead agency with oversight of the regional trauma system. The lead agency must have a strong mandate, clear statutory authority, and the political will to execute this responsibility.
- The lead agency should be guided by the local need of the region(s) for which it provides oversight. As such, it is the responsibility of physicians, nurses, prehospital providers and their respective organizations to advocate for the interests of the patients and citizens they serve throughout the entire region. The collective interests of these citizens and patients supersede the interests of the providers and their respective organizations.
- Trauma center designation should be guided by the regional trauma plan based upon the needs of the population being served, rather than the needs of individual health care organizations or hospital groups. It is the professional obligation of the surgeons, physicians, nurses, EMS providers and public health professionals to work together to ensure that the patients' needs come first.
- Trauma system needs should be assessed using measures of trauma system access, quality of patient care, population mortality rates and trauma system efficiency. Possible measures to be considered include:
 - Number of level I and level II centers per 1,000,000 of population
 - Percentage of population within 60 minutes of a level I/level II center
 - EMS transport times
 - Percentage of severely injured patients seen at a trauma center
 - Trauma related mortality
 - Frequency and nature of inter-hospital transfers
 - Percentage of time trauma hospitals are on diversion status
- Allocation of trauma centers should be re-assessed on a regular schedule, based upon an updated assessment of trauma system needs.
- The applicability of specific metrics and benchmarks of need for trauma care resources, as well as the resources available to meet these needs will *vary* from region to region; the details of the needs assessment methodology and regional trauma center designation criteria should be derived through a broad-based *locally* driven consensus process that is balanced, fair, and equitable.
- An international group of recognized experts, stakeholders, and policy makers should be convened to discuss and plan for optimal future regional trauma system development.