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PERMANENT ADMINISTRATIVE ORDER

FILED
04/05/2024 10:45 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

PH 26-2024
CHAPTER 333
OREGON HEALTH AUTHORITY
PUBLIC HEALTH DIVISION

FILING CAPTION: Updated Field Triage Guidelines and Trauma Team Activation Criteria

EFFECTIVE DATE: 10/15/2024

AGENCY APPROVED DATE: 04/05/2024

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RULES:
333-200-0010, 333-200-0080, 333-200-0265

AMEND: 333-200-0010

NOTICE FILED DATE: 12/18/2023

RULE SUMMARY: Amend 333-200-0010
The field triage criteria (Exhibit 2) are amended to align with the revised 2021 National Guideline for Field Triage of Injured Patients, Recommendations of the National Expert Panel on Field Triage. Exhibits 4 and 5 are not being amended but are included for reference. Amendments are only in Exhibit 2 and not in the rule text.

CHANGES TO RULE:

333-200-0010
Definitions ¶

As used in OAR 333-200-0000 through 333-200-0295:¶
(1) "Area Trauma Advisory Board" (ATAB) means an advisory group appointed by the Authority for each established trauma area to represent providers of trauma care and members of the public.¶
(2) "Authority" means the Oregon Health Authority.¶
(3) "Categorization" means a process for determining the level of a hospital's trauma care capability and commitment which allows any hospital which meets criteria to receive trauma patients.¶
(4) "Communications coverage area" means a geographic region representing a primary radio service area for emergency medical communications. When primary service areas substantially overlap they will be considered as one coverage area.¶
(5) "Coordinated care organization" has the meaning given that term in OAR 410-141-0000.¶
(6) "Designation" means a competitive process for determining the level of a hospital's trauma care capability and commitment, allowing the Authority to select a limited number of hospitals which meet criteria to receive trauma patients.¶
(7) "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus, in the

case of a pregnant woman, in serious jeopardy.¶
(8) "Emergency Medical Responder" means a person who is licensed by the Authority as an Emergency Medical Responder.¶
(9) "Emergency Medical Services provider" (EMS provider) means a person who is licensed by the Authority as an Emergency Medical Responder or an Emergency Medical Technician.¶
(10) "Emergency Medical Technician" (EMT) means a person who is licensed by the Authority as an Emergency Medical Technician.¶
(11) "Glasgow Coma Scale" (GCS) means an internationally recognized scoring system for the assessment of head injury severity and degree of coma.¶
(12) "Hospital" has the meaning set forth in ORS 442.015(15).¶
(13) "Injury Severity Score" (ISS) means a method for quantifying the degree of anatomic injury. As described in Baker, S.P., O'Neill B., Haddon W. Jr., et al: The Injury Severity Score, Journal of Trauma, 1974, 14: 187-196.¶
(14) "Level I (regional) trauma hospital" means a hospital which is categorized or designated by the Authority as having met the trauma hospital resource standards for a Level I hospital, as described in Exhibit 4. Level I hospitals manage severely injured patients, provide trauma related medical education and conduct research in trauma care.¶
(15) "Level II (area) trauma hospital" means a hospital categorized or designated by the Authority as having met the trauma hospital resource standards for a Level II hospital, as described in Exhibit 4. Level II hospitals manage the severely injured patient.¶
(16) "Level III (local) trauma hospital" means a hospital categorized or designated by the Authority as having met the trauma hospital resource standards for a Level III hospital, as described in Exhibit 4. Level III hospitals provide resuscitation, stabilization, and assessment of the severely injured patient and provide either treatment or transfer the patient to a higher level trauma system hospital as described in Exhibit 5.¶
(17) "Level IV (community) trauma hospital" means a hospital categorized or designated by the Authority as having met the hospital resource standards for a Level IV hospital, as described in Exhibit 4. Level IV hospitals provide resuscitation and stabilization of the severely injured patient prior to transferring the patient to a higher level trauma system hospital.¶
(18) "Managed health care organization" means a health care provider or a group or organization of medical service providers that provide for the delivery of an agreed upon set of medical or referral services for an enrolled group of individuals and families in a defined geographic area at a fixed periodic rate paid per enrolled individual or family.¶
(19) "Medical direction" means physician responsibility for the operation and evaluation of prehospital emergency medical care performed by emergency care providers.¶
(20) "Off-line medical direction" means the direction provided by a physician to prehospital emergency medical care providers through communications such as written protocols, standing orders, education and quality improvement reviews.¶
(21) "On-line medical direction" means the direction provided by a physician to prehospital emergency medical care providers through radio, telephone, or other real time communication.¶
(22) "Oregon Trauma Registry" means the trauma data collection and analysis system operated by the Authority.¶
(23) "Prehospital response time" means the length of time between the notification of a provider and the arrival of that provider's emergency medical service unit(s) at the incident scene.¶
(24) "Stabilization" means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.¶
(25) "State Trauma Advisory Board" (STAB) means an advisory group appointed by the Authority to represent providers of trauma care.¶
(26) "Trauma patient" means a person who at any time meets field triage criteria for inclusion in the Oregon Trauma System, as described in Exhibit 2 of these rules.¶
(27) "Trauma system hospital" means a hospital categorized or designated by the Authority to receive and provide services to trauma patients.¶
(28) "Trauma system plan" means a document which describes the policies, procedures and protocols for a comprehensive system of prevention and management of traumatic injuries.¶
(29) "Triage criteria" means the parameters established to identify trauma patients for treatment in accordance with the trauma system plan. These criteria are set forth in Exhibit 2.¶
[ED. NOTE: To view tables referenced in rule text, click here to view rule.]
Statutory/Other Authority: ORS 431A.065
Statutes/Other Implemented: ORS 431A.065

EXHIBIT 2
OAR chapter 333, division 200

National Guideline for the Field Triage of Injured Patients

RED CRITERIA

High Risk for Serious Injury

Injury Patterns

- Penetrating injuries to head, neck, torso, and proximal extremities
- Skull deformity, suspected skull fracture
- Suspected spinal injury with new motor or sensory loss
- Chest wall instability, deformity, or suspected flail chest
- Suspected pelvic fracture
- Suspected fracture of two or more proximal long bones (humerus or femur)
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

Mental Status & Vital Signs

All Patients
- Unable to follow commands (motor GCS less than 6)
- RR less than 10 or greater than 29 breaths/min
- Respiratory distress or need for respiratory support
- Room-air pulse oximetry less than 90%

Age 0-9 years
- SBP less than 70 mmHg + (2 x age years)

Age 10-64 years
- SBP less than 90 mmHg **OR**
- HR greater than SBP

Age 65 years or older
- SBP less than 110 mmHg **OR**
- HR greater than SBP

Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

YELLOW CRITERIA

Moderate Risk for Serious Injury

Mechanism of Injury

- High-Risk Auto Crash
  - Partial or complete ejection
  - Significant intrusion (including roof)
    - Greater than 12 inches occupant site **OR**
    - Greater than 18 inches any site **OR**
    - Need for extrication for entrapped patient
  - Death in passenger compartment
  - Child (Age 0-9) unrestrained or in unsecured child safety seat
  - Vehicle telemetry data consistent with severe injury
- Rider separated from transport vehicle with significant impact (e.g., motorcycle, ATV, horse, etc.)
- Pedestrian/bicycle rider thrown, run over, or with significant impact
- Fall from height greater than 10 feet (all ages)

EMS Judgment

Consider risk factors, including:
- Low-level falls in young children (ages 5 years or younger) or older adults (ages 65 years or older) with significant head impact
- Anticoagulant use
- Suspicion of child abuse
- Special, high-resource healthcare needs
- Pregnancy greater than 20 weeks
- Burns in conjunction with trauma
- Children should be triaged preferentially to pediatric capable centers

If concerned, take to a trauma center

Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

AMEND: 333-200-0080

NOTICE FILED DATE: 12/18/2023

RULE SUMMARY: Amend 333-265-0080

The field triage criteria (Exhibit 2) are amended to align with the revised 2021 National Guideline for Field Triage of Injured Patients, Recommendations of the National Expert Panel on Field Triage. Trauma activation criteria in Exhibit 3 have been amended based on changes to the field triage criteria in Exhibit 2 and the American College of Surgeons, Resources for Optimal Care of the Injured Patient (2022 Standards). Exhibits 4 and 5 are not being amended but are included for reference.

CHANGES TO RULE:

333-200-0080
Standards for Area Trauma System Plans ¶

Area trauma system plans shall describe how each of the following standards are met or exceeded. Interpretation and implementation of the standards as set forth in this rule shall be in general accordance with the guidelines of the Resources for Optimal Care of the Injured Patient: Committee on Trauma, American College of Surgeons, 2014. For the purposes of section (4) of this rule, interpretation and implementation of standards shall be in general accordance with the National Guidelines for Field Triage of Injured Patients, Recommendations of the National Expert Panel on Field Triage, 2011; Centers for Disease Control and Prevention, MMWR, January 13, 2012, Vol. 61, No. 1:21. ¶
(1) Communications and Dispatch:¶
(a) System access: Residents and visitors in a communications coverage area shall be able to access emergency medical services by calling 9-1-1 as set forth in ORS 403.115;¶
(b) Dispatch response: Dispatchers for emergency medical care providers shall have protocols which include pre-arrival patient care instructions, and which require the dispatch of the appropriate level of available responding units (basic or advanced life support) based on medical need;¶
(c) Special Resources: All emergency medical services dispatchers shall maintain an up-to-date list of available law enforcement agencies, fire departments, air and ground ambulance services, quick response units that respond to an ill or injured person to provide initial emergency medical care prior to transportation by an ambulance and special responders for extrication, water rescue, hazardous material incidents and protocols for their use;¶
(d) Prehospital/Hospital: Ambulances shall have either a UHF or VHF radio that will provide reliable communications between the ambulance and central dispatch, the receiving hospital, and online medical direction. If the information has to be relayed through the dispatching agency, that agency shall be responsible to relay patient information to the hospital; and¶
(e) Training: There shall be training and certification standards for all tele-communicators that process telephone requests for or dispatch emergency care providers. The authorization to establish these standards is the responsibility of the Department of Public Safety Standards and Training in accordance with ORS 181.640.¶
(2) Responders and Prehospital Response Times:¶
(a) Ambulance Service Areas (ASAs): The existing ASAs shall be described as well as a summary of the ATAB's efforts to promote each county adopting an ASA plan in accordance with ORS 682.062;¶
(b) Prehospital response times: Trauma system patients shall receive prehospital emergency medical care within the following prehospital response time parameters 90 percent of the time:¶
(A) Urban area, an incorporated community of 50,000 or more population - 8 minutes;¶
(B) Suburban area, an area which is not urban, and which is contiguous to an urban community. It includes the area within a 10-mile radius of that community's center. It also includes areas beyond the 10-mile radius which are contiguous to the urban community and have a population density of 1,000 or more per square mile - 15 minutes;¶
(C) Rural area, a geographic area 10 or more miles from a population center of 50,000 or more, with a population density of greater than six persons per square mile - 45 minutes;¶
(D) Frontier area, the areas of the state with a population density of six or fewer persons per square mile and are accessible by paved roads - 2 hours; and¶
(E) Search and rescue area, the areas of the state that are primarily forest, recreational or wilderness lands that are not accessible by paved roads or not inhabited by six or more persons on a year-round basis. - No established prehospital response time.¶
(c) Field command: A uniform policy shall assign responsibility for directing the care of the trauma patient in the prehospital setting in cases of response by multiple providers to assure scene control by the most qualified

responder;¶
(d) Utilization of air ambulance: Protocols for the medical direction, activation and utilization of air ambulance service(s) shall be established;¶
(e) Patient Care Report: All prehospital emergency care providers shall use a patient care report as defined in OAR 333-255-0000; and¶
(f) Utilization of Oregon Trauma System identification bracelet: All prehospital emergency medical care providers shall use the official ~~Authority~~Oregon Health Authority (Authority) numbered trauma system identification bracelet when the patient meets trauma system entry criteria or is entered into the trauma system and notify the receiving trauma hospital of the incoming patient. The prehospital emergency medical care provider shall record the number on the patient's patient care report.¶
(3) Medical Direction and Treatment:¶
(a) Protocols, policies and procedures: Providers in each trauma system area shall function under an effective and coordinated set of off-line prehospital trauma protocols and on-line medical direction trauma policies and procedures which address basic, intermediate and advanced levels of care. Off-line treatment protocols shall clearly describe all treatment and transportation procedures and identify those procedures which require on-line medical authorization. Medical direction policies and procedures must assure consistent area-wide coordination, data collection and area-wide quality improvement responsibility;¶
(b) Hospital status: In the event that on-line medical direction serves two or more categorized or designated hospitals, there shall be a system for medical direction to continuously determine the current status of hospital trauma care capabilities; and¶
(c) Physician qualifications: On-line medical direction physicians must be qualified for this role by virtue of training, experience and interest in prehospital trauma care as demonstrated through emergency medicine and Advanced Trauma Life Support (ATLS) training in accordance with the American College of Surgeons ATLS course.¶
(4)(a) Triage and Transportation: Triage and transportation protocols shall be written to ensure that patients who at any time meet field triage criteria as set forth in Exhibit 2 will be transported directly to a categorized trauma hospital as described under OAR 333-200-0090. The protocols must be based on field triage criteria (Exhibit 2) and identify the following:¶
(A) Which patients are appropriate for transport to a Level I, II, III or IV trauma hospital based on the capabilities of the hospitals in the ATAB;¶
(B) Conditions in which an ambulance may bypass a Level III or IV trauma hospital in order to transport directly to a Level I or II trauma hospital; and¶
(C) Conditions in which air transport should be considered for transport directly to a Level I or II trauma hospital.¶
(b) Triage and transportation protocols shall be followed unless otherwise advised by on-line medical direction or under the following circumstances:¶
(A) If unable to establish and maintain an adequate airway, the patient shall be taken to the nearest hospital to obtain definitive airway control. Upon establishing and maintaining airway control, the patient shall be immediately transferred to a Level I or Level II trauma hospital;¶
(B) If the scene time plus transport time to a Level I or Level II trauma hospital is significantly greater than the scene time plus transport time to a closer Level III or Level IV trauma hospital;¶
(C) If the hospital is unable to meet hospital resource standards as defined in Exhibit 4, when there are multiple patients involved, or the patient needs specialty care; or¶
(D) If on-line medical direction overrides these standards for patients with special circumstances, such as membership in a health maintenance organization, and if the patient's condition permits.¶
(E) Application of paragraphs (B), (C), and (D) of this subsection must not delay definitive medical or surgical treatment.¶
(5) Hospital Resources:¶
(a) Trauma system hospital identification: Either the categorization or designation method of identifying trauma system hospitals as described under OAR 333-200-0090(1), (3) and (4) shall be recommended to the Authority; and¶
(b) Resource criteria: Trauma system hospitals shall meet or exceed the trauma hospital resource standards as set forth in Exhibit 4 and hospital activation criteria as set forth in Exhibit 3. Area criteria that exceed the criteria set forth in Exhibit 4 shall be accompanied by an informational statement of the additional costs that a hospital will incur to meet these standards.¶
(6) Inter-hospital Transfers:¶
(a) Identification of patients: ATAB-wide criteria which meet or exceed any of the criteria set forth in Exhibit 5 of these rules shall be established to identify patients who should be transferred to a Level I or II trauma system hospital or specialty care center.¶
(b) When it is determined that a patient transfer is warranted:¶

(A) The transfer shall take place after the stabilization of the patient's emergency medical condition has been provided within the capabilities of the local hospital, which may include operative intervention; and¶
(B) The transfer to a Level I or II trauma hospital shall not be delayed for diagnostic procedures that have no impact on the transfer process or the immediate need for resuscitation.¶
(c) In all situations regarding an inter-hospital transfer, the decision to retain or transfer the patient shall be based on medical knowledge, experience, and resources available to the patient.¶
(d) The hospital's trauma performance improvement and patient safety process shall monitor all cases meeting inter-hospital transfer criteria. The Authority, through annual reports and site surveys, shall monitor this performance category.¶
(7) Inter-hospital Transfers with Health Maintenance Organizations:¶
(a) Trauma system hospitals shall facilitate the transfer of a member of a health maintenance organization or other managed health care organization when the emergency medical condition of the member permits and no deterioration of that condition is likely to result from or occur during the transfer of the patient. Trauma system hospitals shall transfer a patient in accordance with the provisions of ORS 431~~.611(2)(a) and (b~~A.065(2) and any other applicable laws or regulations.¶
(b) A patient will be deemed stabilized, if the treating physician attending to the patient in the trauma hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.¶
(c) Hospitals or health maintenance organizations may not attempt to influence patients and families, prior to the patient's stabilization, into making decisions affecting their trauma treatment by informing them of financial obligations if they remain in the trauma facility.¶
(d) Health maintenance organizations and non-designated trauma facilities shall report follow-up information to the transferring trauma system hospital and all required data as set forth in the Oregon Trauma Registry data dictionary; and¶
(e) Hospitals or health maintenance organizations that receive or transfer trauma patients shall participate in regional quality improvement activities.¶
(8) Rehabilitation Resources:¶
(a) Capabilities for trauma rehabilitation in each trauma system area and transfer procedures to other rehabilitation facilities shall be described; and¶
(b) Rehabilitation resources for burns, pediatrics, neuro-trauma and extended care shall be included.¶
(9) Quality Improvement:¶
(a) Provisions shall be made for at least quarterly review of medical direction, prehospital emergency medical care and hospital care of trauma cases:¶
(A) Area-wide criteria for identifying trauma cases for audit shall be described and shall include all trauma related deaths;¶
(B) Responsibility for identifying and reviewing all trauma cases meeting audit criteria shall be assigned; and¶
(C) Quarterly reports shall be submitted to the Authority by the ATAB or its representative on confidential forms.¶
(b) The ATAB, STAB, all Area and State Quality Improvement Committee(s) and the Authority shall meet in executive session as set forth in ORS 192.660 when discussing individual patient cases; and¶
(c) No member of any ATAB, the STAB, or any committee, subcommittee or task force thereof, shall disclose information or records protected by ORS 431~~.627 or~~A.090 or ORS 41.675 to unauthorized persons. Any person violating these rules shall be immediately removed by the Authority from membership on any trauma system committee, subcommittee or task force thereof.¶
(10) Education and Research:¶
(a) Trauma training: Trauma system hospitals shall provide or assist in the provision of prehospital trauma management courses to all EMS providers involved in the prehospital emergency medical care of severely injured patients; and¶
(b) Research: In areas with Level I hospitals, clinical and basic research in trauma and publication of results involving surgical and nonsurgical specialists, nurses, and allied health professionals engaged in trauma care, shall be promoted.¶
(11) Prevention:¶
(a) Public education: Public education and awareness activities shall be developed by trauma system hospitals to increase understanding of the trauma system and injury prevention. These activities shall be appropriate to the size and resources of the area; and¶
(b) Development and evaluation: Trauma prevention activities to identify and address area problems shall be supported.¶
(12) Disaster Management: Provisions for addressing triage of trauma system patients to non-trauma hospitals during a natural or manmade disaster must be addressed and include:¶
(a) Implementation and termination of the disaster management plan; and¶

(b) Reporting requirements of the Oregon Trauma Registry and Oregon Trauma Program.¶
[ED. NOTE: To view tables referenced in rule text, click here to view rule.]
Statutory/Other Authority: ORS 431A.065
Statutes/Other Implemented: ORS 431A.060, 431A.065

EXHIBIT 2
OAR chapter 333, division 200

National Guideline for the Field Triage of Injured Patients

RED CRITERIA

High Risk for Serious Injury

Injury Patterns

- Penetrating injuries to head, neck, torso, and proximal extremities
- Skull deformity, suspected skull fracture
- Suspected spinal injury with new motor or sensory loss
- Chest wall instability, deformity, or suspected flail chest
- Suspected pelvic fracture
- Suspected fracture of two or more proximal long bones (humerus or femur)
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

Mental Status & Vital Signs

All Patients
- Unable to follow commands (motor GCS less than 6)
- RR less than 10 or greater than 29 breaths/min
- Respiratory distress or need for respiratory support
- Room-air pulse oximetry less than 90%

Age 0-9 years
- SBP less than 70 mmHg + (2 x age years)

Age 10-64 years
- SBP less than 90 mmHg **OR**
- HR greater than SBP

Age 65 years or older
- SBP less than 110 mmHg **OR**
- HR greater than SBP

Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

YELLOW CRITERIA

Moderate Risk for Serious Injury

Mechanism of Injury

- High-Risk Auto Crash
  - Partial or complete ejection
  - Significant intrusion (including roof)
    - Greater than 12 inches occupant site **OR**
    - Greater than 18 inches any site **OR**
    - Need for extrication for entrapped patient
  - Death in passenger compartment
  - Child (Age 0-9) unrestrained or in unsecured child safety seat
  - Vehicle telemetry data consistent with severe injury
- Rider separated from transport vehicle with significant impact (e.g., motorcycle, ATV, horse, etc.)
- Pedestrian/bicycle rider thrown, run over, or with significant impact
- Fall from height greater than 10 feet (all ages)

EMS Judgment

Consider risk factors, including:
- Low-level falls in young children (ages 5 years or younger) or older adults (ages 65 years or older) with significant head impact
- Anticoagulant use
- Suspicion of child abuse
- Special, high-resource healthcare needs
- Pregnancy greater than 20 weeks
- Burns in conjunction with trauma
- Children should be triaged preferentially to pediatric capable centers

If concerned, take to a trauma center

Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

OREGON HOSPITAL TRAUMA TEAM ACTIVATION CRITERIA

- Confirmed blood pressure less than 90 mmHg at any time in adults, and age-specific hypotension in children aged 0-9 years less than 70 mmHg + (2 x age years)
- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Glasgow Coma Scale less than 9 (with mechanism attributed to trauma)
- Transfer patients from another hospital who require ongoing blood transfusions
- Patients intubated in the field and directly transported to the trauma center
- Patients who have respiratory compromise or are in need of an emergent airway

Emergency physician's discretion

YES

→

Activate Full Trauma Team

Full Trauma Team

- General Surgeon
- Emergency Physician
- Emergency Nurse(s)
- Laboratory
- Radiology
- Respiratory Therapist

Response times from patient arrival:

Level I & II – 15 minutes
Level III & IV – 30 minutes

Oregon Hospital Trauma Team Activation Criteria (continued)

- Glasgow Coma Scale of 9 - 13
- Chest wall instability, deformity, or suspected flail chest
- Suspected fracture of two or more proximal long bones (humerus or femur)
- Suspected spinal cord injury with motor sensory deficit
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Skull deformity, suspected skull fracture
- Suspected pelvic fracture
- Falls from a height greater than 10 feet (all ages)
- High-risk auto crash
  - Partial or complete ejection
  - Significant intrusion including roof: greater than 12 inches occupant site; **OR** greater than 18 inches any site; **OR** need for extrication for entrapped patient
  - Death in passenger compartment
  - Child (age 0-9 years) unrestrained or in unsecured child safety seat
  - Vehicle telemetry data consistent with severe injury
- Pedestrian/bicycle rider thrown, run over, or with significant impact
- Rider separated from transport vehicle with significant impact (e.g., motorcycle, ATV, horse, etc.)

Emergency physician's discretion

Consider risk factors, including:

- Low-level falls in young children (age 0-5 years) or older adults (age 65 years or greater) with significant head impact
- Anticoagulant use
- Suspicion of child abuse
- Special, high-resource healthcare needs
- Pregnancy greater than 20 weeks
- Burns in conjunction with trauma
- Systolic blood pressure (SBP) less than 110 mmHg **OR** heart rate greater than SBP (age 65 years or greater)
- Children should be triaged preferentially to pediatric capable trauma centers

YES

→

Activate Modified Trauma Team

Modified Trauma Team

- Emergency Physician
- Emergency Nurse(s)
- Laboratory
- Radiology

AMEND: 333-200-0265

NOTICE FILED DATE: 12/18/2023

RULE SUMMARY: Amend 333-200-0265

Trauma activation criteria in Exhibit 3 have been amended based on changes to the field triage criteria in Exhibit 2 and the American College of Surgeons, Resources for Optimal Care of the Injured Patient (2022 Standards). Exhibits 4 and 5 are not being amended but are included for reference. Amendments are only in Exhibit 3 and not in the rule text.

CHANGES TO RULE:

333-200-0265
Trauma System Hospital Responsibilities ¶

A trauma system hospital shall:¶
(1) Be responsible for all expenses incurred by the hospital in planning, developing and participating in the trauma system, including attorney fees and costs;¶
(2) Be responsible for all expenses incurred when a re-survey of the hospital is conducted by the ~~Authority~~Oregon Health Authority (Authority) or its designee(s);¶
(3) Comply with all requirements in these rules, all current state and area trauma system standards, and all policies, protocols and procedures as set forth in the approved area trauma system plan;¶
(4) Comply with any reasonable survey process that the Authority may utilize including but not limited to submission of information such as attestations, electronic medical records, and other documents determined necessary by the Authority to evaluate the hospital's trauma program;¶
(5) Meet or exceed the standards for hospital resources as set forth in Exhibit 4 and hospital activation and transfer criteria as set forth in Exhibits 3 and 5;¶
(6) Provide the resources, personnel, equipment and response required by these rules;¶
(7) Provide care to trauma system patients which is consistent with the standards advocated by the Advanced Trauma Life Support Course, American College of Surgeons, Committee on Trauma;¶
(8) Report to the Oregon Trauma Registry all required data as set forth in the Oregon Trauma Registry Abstract Manual for each and every trauma patient as defined in these rules:¶
(a) Data must be reported within 60 days of death or discharge of that patient; and¶
(b) Data shall be submitted in electronic media using a format prescribed by the Authority.¶
(c) The Authority may, at its sole discretion, permit data submission by alternative means where use of the Authority's prescribed format would impose a severe hardship on the reporting institution.¶
(9) Participate in evaluation and research studies as prescribed by the Authority;¶
(10) Record patient resuscitation data using the official state trauma resuscitation flow sheet. If using a form other than the official form, that form must contain at least the same information; and¶
(11) Identify and submit to the Authority the name of the individual that will serve as the Trauma Registrar, Trauma Coordinator or Trauma Program Manager, and Trauma Medical Director. Any changes to persons serving in these roles must be reported to the Authority within 60 days.
Statutory/Other Authority: ORS 431A.065, ORS 431A.085
Statutes/Other Implemented: ORS 431A.060, ORS 431A.065, ORS 431A.085, ORS 431A.090

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

OREGON HOSPITAL TRAUMA TEAM ACTIVATION CRITERIA

- Confirmed blood pressure less than 90 mmHg at any time in adults, and age-specific hypotension in children aged 0-9 years less than 70 mmHg + (2 x age years)
- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Glasgow Coma Scale less than 9 (with mechanism attributed to trauma)
- Transfer patients from another hospital who require ongoing blood transfusions
- Patients intubated in the field and directly transported to the trauma center
- Patients who have respiratory compromise or are in need of an emergent airway

Emergency physician's discretion

YES

→

Activate Full Trauma Team

Full Trauma Team

- General Surgeon
- Emergency Physician
- Emergency Nurse(s)
- Laboratory
- Radiology
- Respiratory Therapist

Response times from patient arrival:

Level I & II – 15 minutes
Level III & IV – 30 minutes

Oregon Hospital Trauma Team Activation Criteria (continued)

- Glasgow Coma Scale of 9 - 13
- Chest wall instability, deformity, or suspected flail chest
- Suspected fracture of two or more proximal long bones (humerus or femur)
- Suspected spinal cord injury with motor sensory deficit
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Skull deformity, suspected skull fracture
- Suspected pelvic fracture
- Falls from a height greater than 10 feet (all ages)
- High-risk auto crash
  - Partial or complete ejection
  - Significant intrusion including roof: greater than 12 inches occupant site; **OR** greater than 18 inches any site; **OR** need for extrication for entrapped patient
  - Death in passenger compartment
  - Child (age 0-9 years) unrestrained or in unsecured child safety seat
  - Vehicle telemetry data consistent with severe injury
- Pedestrian/bicycle rider thrown, run over, or with significant impact
- Rider separated from transport vehicle with significant impact (e.g., motorcycle, ATV, horse, etc.)

Emergency physician's discretion

Consider risk factors, including:

- Low-level falls in young children (age 0-5 years) or older adults (age 65 years or greater) with significant head impact
- Anticoagulant use
- Suspicion of child abuse
- Special, high-resource healthcare needs
- Pregnancy greater than 20 weeks
- Burns in conjunction with trauma
- Systolic blood pressure (SBP) less than 110 mmHg **OR** heart rate greater than SBP (age 65 years or greater)
- Children should be triaged preferentially to pediatric capable trauma centers

YES

→

Activate Modified Trauma Team

Modified Trauma Team

- Emergency Physician
- Emergency Nurse(s)
- Laboratory
- Radiology