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Oregon Trauma Hospital Resource Standards (Exhibit 4)
RULE ADVISORY COMMITTEE
Monday, June 10, 2024
2:00 PM – 4:00 PM

RAC MEMBER ATTENDEES
Amy Hanifan, Oregon Fire Chiefs Association – EMS Section
Angie Short, Good Shepherd Hermiston
Danielle Meyer, Hospital Association of Oregon
Erin Burnham, Oregon Chapter of American College of Emergency Physicians
Jennifer Serfin, Good Samaritan Regional Medical Center
Eric Blankenship, St. Charles Health System Bend
Heather Wong, OHSU
Kathy Tompkins, Salem Hospital
Mackenzie Cook, OHSU
Matthew Edinger, Asante Rogue Regional Medical Center
Sabrina Riggs, Oregon State Ambulance Association
Shawn Rogers, Medix-Clatsop County
Stacey Holmes, Sky Lakes Medical Center
Susan Steen, Doernbecher Children's Hospital
Zach Hittner, Willamette Valley Medical Center
INTERESTED PARTY ATTENDEES
Amy Slater, Salem Hospital
Clif Dodson, Providence Hood River Memorial Hospital
Judi Gabriel, Good Shepherd Health Care System
Katie Hennick, Good Samaritan Regional Medical Center
Tracy Holliday, St. Anthony Hospital
Ruth Miles, Salem Health
Joey Van Winkel, Salem Health West Valley Hospital

Oregon Health Authority Staff	
Madeleine Parmley	Public Health Division, EMS & TS
Mellony Bernal	Public Health Division, Health Care Regulation and Quality Improvement
Rachel Ford	Public Health Division, EMS & TS

Welcome, Housekeeping and Agenda Review
Mellony Bernal introduced self and welcomed attendees to the Oregon Trauma Hospital Resource Standards (Exhibit 4) Rule Advisory Committee meeting. The purpose of this meeting is to consider changes to OAR chapter 333, divisions 200 and 205 and Exhibit 4 based on the 2022, American College of Surgeons, Resources for the Optimal Care of the Injured Patient.

- The agenda was reviewed.
- Persons participating in the virtual meeting were instructed to identify themselves by typing their name and organization into the Chat and identify themselves as a RAC member or member of the public.
- RAC meetings are not subject to the public meetings law. Public members may listen to the discussion but may not participate. It was noted that members of the public were welcome to submit comments or questions for consideration at the conclusion of the RAC meeting by emailing Mellony Bernal, Madeleine Parmley and Rachel Ford and email addresses were shared via Chat.
- RAC members were instructed to use the Chat feature to indicate if they wanted to speak by typing the word "Comment." RAC members who did not want to speak but wanted staff to consider information were asked to type into the Chat “For the Record” and include the information they wished to share.
- It was noted that information shared in the Chat is a matter of public record.
- Meeting notes from the meeting will be drafted and shared with RAC members via email and will also be posted on the EMS Rulemaking Activity webpage.
- After the RAC process has concluded, there will be an opportunity for persons to provide oral public comments at a public hearing or to send written comments during the public comment period. Information about the notice of proposed rulemaking and public hearing will be shared by email and posted on the EMS Rulemaking Activity webpage.

Roll call of RAC members and RAC members introduced themselves.

Rules Advisory Committee Overview and Scope

Overview

M. Bernal noted the following:

- State agencies convene RACs for a variety of reasons including when the legislature passes laws that require rules be adopted or revised, in order to clarify process or intent, and occasionally at the request of community partner feedback to change rules.
- RAC members include persons and communities that are most likely to be affected by the proposed rules including representation from facilities, special interest groups, and associations.
- The EMS and Trauma Systems Program drafts the rule text and convenes the RAC to seek input and suggestions on the rule text and consider possible changes, concerns, issues, etc. Additionally, the RAC will review the Statement of Need and Fiscal Impact (SNFI) which also includes a statement on how the proposed rules may affect racial equity in Oregon.
- Considering information provided by the RAC, the EMS and Trauma Systems Program will finalize proposed rule text and submit notice of proposed rulemaking to the Secretary of State along with the SNFI.
- A public hearing will be scheduled where persons can present oral testimony or submit written comments. The EMS and Trauma Systems Program will review and consider the testimony and comments received and determine whether additional changes to the rule are necessary based on those comments.

- The EMS and Trauma Systems Program will finalize rule text and determine effective date and file permanent rulemaking notice with the Secretary of State's office.

Scope

- The scope of this RAC is to seek input and suggestions on the amendments to existing rules under OAR 333-200, 205 and Exhibit 4.
- The RAC will consider the proposed amendments including the possible fiscal and economic impact on affected parties.
- The RAC will consider what effect, if any, the proposed rules may have on racial equity in Oregon.

Estimated Timeline

The estimated timeline was shared noting that dates may change based on the progress of the RAC.

- Four meetings are planned between June and July
- Final proposed rule language submitted to Rules Coordinator by 8/12
- Post in the September 1 Oregon Bulletin
- Public hearing on or after September 15
- Written comment deadline on or after September 21
- File final permanent rules on or after October 15
- Rules to go into effect July 1, 2025

Exhibit 4 History and Revisions

Rachel Ford provided historical facts about the Oregon Trauma System:

- In 1982, Dr. Daniel K. Lowe conducted a retrospective analysis of 762 severely injured patients admitted to 23 hospitals in a six-county area, including Portland and the surrounding rural areas. The patients had been transported from the scene of the injury to the nearest hospital, without regard to the hospital's capabilities. The outcomes for 16 percent of the injured patients were considered "inappropriate" for the severity of the patient's injury.
- In 1983, Senators Starkovitch and Kitzhaber introduced Senate Joint Resolution 23 calling on the state to develop a plan for a statewide trauma system.
- In 1984, the Oregon Trauma Plan was completed. It included standards for prehospital trauma care, trauma center triage criteria, trauma center designation, system-wide quality assurance, research, and injury prevention.
- In 1985, the Oregon Legislature passed Senate Bill 147 that created the statewide trauma system.
- In September 1985, Governor Atiyeh signed the bill, making Oregon one of the few states in the nation to approach trauma care in a systematic manner. The legislation is codified as Oregon Revised Statutes (ORS) 431A.050. The administrative rules are set forth as Oregon Administrative Rules (OAR) Chapter 333, Division 200 and Division 205.
- In 2018, Exhibit 4 was updated using the American College of Surgeons Resources for the Optimal Care of the Injured Patient 2014 Standards – also known as the orange book. And it is referenced in OAR 333-200-0080: "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…"

- On April 1, 2024, the OHA EMS & Trauma Systems Program sent an email invitation seeking persons to serve on the Exhibit 4 Rule Advisory Committee (RAC). Those who were interested in participating were asked to submit their name or the name of a representative and email address no later than April 14, 2024. On April 17, 2024, the persons selected to serve as RAC participants were notified. All persons that expressed interested in serving on the RAC were selected. In May, RAC members received a set of documents including the rule, exhibit, scope, meeting agenda, rulemaking process, and rule # overview.
- The proposed changes to Exhibit 4 are largely aligned with the American College of Surgeons Resources for the Optimal Care of the Injured Patient 2022 Standards (also known as the 'Gray Book'.) The program will work with the RAC to consider possible changes to the proposed rule and then after completion of the RAC meetings, a public hearing will be scheduled to obtain public input on the draft.
- The Exhibit 4 Table proposed changes document is overwritten to reflect the 2022 standards.
    - Red font indicates proposed changes; the crossed-out numbers and words have been updated or removed.
    - Starting at page 26, there is a list of the current standards with notes on whether they are covered by a new standard or removed.
    - The proposed standards have been streamlined from 21 chapters to 9 chapters.
- Staff will not go through each standard, rather will identify specific standards that need to be discussed. The RAC will be given the opportunity to share comments and ask questions for each chapter.
- The goal is to share proposed updates based on RAC feedback at the July 15, 2024, RAC meeting.

Exhibit 4 - Chapters 1 – 3

Madeleine Parmley introduced self and reviewed standards for discussion. It was noted that the 'Gray Book' will be referred to for purposes of interpretive guidance and additional information for each of the standards. Additionally, Level IV requirements have been added since ACS did not include level IV trauma hospitals in the 2022 standards. The Level IV requirements align with the 'Orange Book.'

RAC member inquired which version of the Resources for Optimal Care of the Injured Patient would be used. It was noted that the revised December 2023 version is being used. This version is available on the website: https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/. RAC member inquired about language used in the administrative rule text and staff noted that it will review further and update accordingly.

Chapter 1 – Institutional Administrative Commitment

RAC members did not have any comments related to Chapter 1.

Chapter 2 – Program Scope and Governance

The following standards were discussed:

2.6 - Adult trauma centers that care for 100 or more injured children younger under 15 years of age must have the following additional:
• Pediatric emergency department area
• Pediatric intensive care area
• Appropriate resuscitation equipment, as outlined in the pediatric readiness toolkit.

Discussion:

- RAC member noted that previous text reflected 'annual admits' and now the language has been changed to "care for" implying that all children cared for in the emergency room. This number can vary wildly. M. Parmley noted that despite the language used, per the guidance in the 'Gray Book', this standard is applicable to programs that ***admit*** injured children but are not seeking pediatric verification. And under 'measures for compliance' it states ***admission*** data for the reporting period.
- RAC member via Chat requested that the current language of 'annual admits' be retained instead of changing to "cared for" and stated that over time with increasing trauma volumes the language may place some hospitals at risk of not meeting the new requirement, especially given the added "suspected child abuse" to the trauma entry criteria (Exhibit 3).
- RAC member requested the program consider, at completion of the process, splitting out trauma hospitals by level so that it is clear which standards apply to each level of hospital.
- RAC member via Chat concurred with recommendation to breakout requirements by level
- RAC member commented that historically there has been a lot of confusion around use of term "admit" and whether that meant admitted to the hospital (e.g., from emergency department to inpatient unit) or patients that were "admitted" to the trauma registry. Language should be reconsidered for clarity.
- RAC member indicated via Chat similar concerns stated above.
- RAC member via Chat supported clarifying language 'cared for.'
- RAC member asked, relating to pediatric intensive care areas, is it about the area being designated in the emergency room versus the requirement for a pediatric intensive care department or unit? M. Parmley responded based on the 'Gray Book' it is interpreted to mean a PICU as the book calls a specific 'pediatric emergency department area' and a 'pediatric intensive care area' whether on a pediatric floor or wherever there is this specialized area for intensive care of pediatric patients. Follow-up question was if the hospital 'cares for' not necessarily 'admits' more than 100 pediatric patients, would they be required to have a PICU? M. Parmley reiterated that the 'Gray Book' measure of compliance is for admission data for the reporting period and not trauma entries.

2.7 – All trauma centers must have a trauma multidisciplinary PIPS committee chaired by the TMD or an associate TMD which meets at minimum of quarterly.

Discussion:

- RAC member noted as it relates to Level IV trauma hospitals, will they be held to a quarterly requirement if trauma volumes are low, or can it be adjusted based on patient load?

- M. Parmley noted this was added for clarification based on information in the 'Orange Book' that these meetings should occur at least quarterly. Addressing concerns past six months is too late to take any definitive correction action even with small patient volume. RAC member expressed concern that if there are no actions to report, then a quarterly meeting should not be necessary, especially given the number of that are required to attend these meetings.

2.8 – In all trauma centers, the TMD must fulfill the following requirements:

- Hold current board certification or board eligibility in general surgery or pediatric surgery by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), or Royal College of Physicians and Surgeons of Canada (RCPS-C)
- Serve as the director of a single trauma program
- Be credentialed to provide trauma care
- Hold current Advanced Trauma Life Support (ATLS®) certification
- Participate on the trauma call panel
- Provide evidence of 36 hours of trauma-related continuing medical education (CME) during the verification cycle. For pediatric TMD, 9 of 36 hours must be pediatric-specific CME
- In Level I trauma centers, the TMD must hold active membership in at least one national trauma organization and have attended at least one meeting during the verification cycle
- In Level II or III trauma centers, the TMD must hold active membership in at least one regional, state, or national trauma organization and have attended at least one meeting during the verification cycle.

Discussion

- RAC member noted that the program must define how long the survey cycle is and that it is prorated for those centers with shorter survey cycles (annual requirement). This should be done throughout the document. M. Parmley responded that one year is not a survey cycle rather a probationary period. A survey cycle is three years (OAR 333-200-0090,) although there have been extraordinary circumstances where the cycle has been longer (i.e., COVID, rearranging survey schedule.)
- RAC member inquired about the reference to the Level II or III trauma center TMD holding active membership in at least one regional, state, or national trauma organization and whether membership in the ATAB would count towards the state or regional trauma organization? M. Parmley noted further follow-up on this question would be needed give changes due to EMS modernization.
- RAC member via Chat agreed with need to clarify state and regional membership which may be very difficult for level III and IV trauma centers to meet with the changes to ATABs and STAB.
- RAC member concurred with above response specific to requirement for trauma program managers.
- RAC member recommended that level IV trauma centers not be included in this requirement due to language that single trauma medical director cannot cover more than one facility. RAC members concurred via Chat. M. Parmley responded that this requirement does not

apply to level IV trauma centers – it only applies to I, II and III. RAC member noted confusion about how the table is formatted and staff agreed to look at further.

2.10 - In Level I, II, and III trauma centers, the Trauma Program Manager must fulfill the following requirements:

- Have 1.0 full-time equivalent (FTE) commitment to the trauma program
- Provide evidence of 36 hours of trauma-related continuing education (CE) the verification cycle
- Hold current membership in a national or regional trauma organization

In Level II and III trauma centers, at least 0.5 FTE of the TPM's time must be spent on TPM-related activities. The remaining time must be dedicated to other roles within the trauma program.

In Level IV trauma centers, a proportionate FTE Trauma Coordinator must be employed for trauma centers with less than 250 patients per year.

Discussion:

- RAC member asked about how a trauma center will show that at 0.5 FTE was spent on TPM related activities? M. Parmley responded that the measures of compliance in the 'Gray Book' identify roles and responsibilities of the TPM, CE certificates or transcripts and proof of membership in trauma organizations. Job descriptions and internal documents identifying how positions are allotted to responsibilities would be reviewed to determine if the standard is met.

2.11 – In all trauma centers, the trauma TPM must have a reporting structure that includes the TMD and they are to assume at minimum, the following leadership responsibilities in conjunction with the TMD and/or hospital administration:

- Oversight of the trauma program
- Assist with the budgetary process for the trauma program
- Develop and implement clinical protocols and practice management guidelines
- Provide educational opportunities for staff development
- Monitor performance improvement activities in conjunction with a PI coordinator (where applicable)
- Service as a liaison to administration and represent the trauma program on hospital and regional committees to enhance trauma care
- Have oversight of the trauma registry

Discussion:

- RAC member remarked that previously, there was a discussion about keeping the language 'the TPM in collaboration with TMD.' A lot of trauma centers use this language to ensure that there is active involvement in peer review. Several RAC members via Chat concurred using the language "collaboration with."

<u>Chapter 3 – Facilities and Equipment Resources</u>

The following standards were discussed:

3.4 - Level I and II trauma centers must have an adequate supply of blood products available. Level III trauma centers must have an adequate supply of red blood cells and plasma available.

Discussion:

- RAC member asked for clarification on what counts as an adequate supply of blood and whether this is determined on a case-by-case basis based on geography. M. Parmley responded yes and acknowledged it may change on daily basis based on the facility.

3.5 - In Level I and II trauma centers, the following services must be available 24 hours per day and be accessible for patient care within the time interval specified:

- Conventional radiography—15 minutes
- Computed tomography (CT)—15 minutes
- Point-of-care ultrasound—15 minutes
- Interventional radiologic procedures—1 hour
- Magnetic resonance imaging (MRI)—2 hours

In Level III and IV trauma centers, the following services must be available 24 hours per day and be accessible for patient care within the time interval specified:

- Conventional radiography—30 minutes
- CT—30 minutes
- Point-of-care ultrasound—15 minutes

Discussion:

- M. Parmley noted that a new change is the requirement of point of care ultrasound. Although many emergency departments utilize this procedure, not all do. This would necessitate that some facilities purchasing equipment and training providers on how to utilize. The increased cost is unknown as the OHA does not know how many facilities already have this equipment, or how many providers are trained to utilize the equipment. RAC member noted that this service is usually performed by emergency department physicians and sometimes general surgeons. Level III and IV trauma centers may not have available staff on hand with relevant training to perform the service. This may impose a burden on some physicians and facilities in Level III and IV trauma centers. Maintaining the skills necessary would also be difficult.
- RAC member asked whether ultrasound was a standard of care. M. Parmley noted that this is not always the case. Facilities may have the equipment but not have providers that are knowledgeable in utilizing the equipment. Further discussion ensued regarding ACS verification of trauma centers and Oregon state verification. ACS verifies trauma level I, II, and III. RAC member asked whether a trauma center can be state verified as a level I, II, III without ACS verification. Another RAC member stated that in Oregon Level I trauma centers must be ACS verified. **Follow-up: OAR 333-200-0090 specifies under section (1) that the Authority shall approve trauma system hospitals by levels of care capability as defined by the standards contained in Exhibit 4 and by any criteria contained in the approved area plan. Section (2) further states that the Authority shall categorize a trauma system hospital as a Level I, II, III or IV trauma hospital and that the Authority**

***may* accept ACS verification in accordance with OAR 333-200-0250. OAR 333-200-0250 states that a hospital seeking verification from ACS must submit information to the Authority and that the Authority may accept ACS verification if the verification is recognized by the Authority has addressing the ACS trauma system standards and any additional state standards identified in rule.**

- RAC member asked for clarification on what is meant by "accessible for patient care" considering previous standards refer to have staff available within a certain period of time. Example – proposed standard states that a Level I or II trauma center must have conventional radiography available within 15 minutes – does this mean the image must be taken within 15 minutes or that someone is available within 15 minutes to conduct the service. Also, clarification on whether all level IVs are currently required to have CT capability. M. Parmley responded that based on clarifying information from the 'Gray Book,' "accessible for patient care" implies that the necessary human resources and equipment are available within the time specified. The time interval refers to the time between initial request and initiation of the test/procedure. This does not mean that every test must be completed within the interval specified. Timeliness depends on patient need. Review of perceived delays in imaging that might have affected patient care are a component of the PIPS program.
- RAC member asked via Chat whether all level IV trauma centers currently have CT scanners or is this something that would have to be implemented. M. Parmley responded that all level IV trauma centers have CT scanners.
- RAC member expressed uneasiness about this standard based on recent changes to Exhibit 2 – Field Triage Criteria which added additional language for the number of patients that will meet trauma entry criteria and may be prioritized over other patients. It was expressed that for this trauma center, patient volume is expected to increase, and it is unknown how this may impact CT availability from 30 minutes down to 15 minutes. Additional discussion needs to take place in facilities to try and consider what this impact may be.

3.8 - In Level I and II trauma centers, cardiopulmonary bypass equipment must be immediately available when required, or a contingency plan must exist to provide emergency cardiac surgical care.

Discussion:

- RAC member asked for clarification on the definition of "immediately" if the by-pass is already in use. M. Parmley remarked that per the 'Gray Book,' the contingency plan must address the need for immediate transfer of patients with time-sensitive cardiovascular injuries. So, if the equipment was encumbered is there a contingency plan in place for transferring that patient to emergency services in that situation.

RAC member via Chat state that they would strongly encourage very clear language around admit numbers versus registry entries, as this terminology impacts several rules and has long been a source of confusion. Several additional RAC members concurred via Chat.

RAC member via Chat recommended keeping the language that the "Trauma Program must involve multiple disciplines and transcend normal departmental hierarchies" (currently found in 5-4.)

Next Steps
M. Bernal shared that the next meeting is scheduled for Monday, June 24, 2024 from 2 – 4 p.m. Reminder emails will be sent to RAC members and the goal is to have meeting notes completed and shared prior to the next meeting. R. Ford noted that the registration link will be the same for all four RAC meetings and re-reregistration is not necessary. If anyone is having any technical difficulties with registering, please contact R. Ford at rachel.l.ford@oha.oregon.gov.

Meeting adjourned at 3:12 p.m.