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Oregon Trauma Hospital Resource Standards (Exhibit 4)
RULE ADVISORY COMMITTEE
Monday, June 24, 2024
2:00 PM – 4:00 PM

RAC MEMBER ATTENDEES
Angie Short, Good Shepherd Hermiston
John Moorehead (for 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, Oregon Health & Science University
Kathy Tompkins, Salem Hospital
Mackenzie Cook, Oregon Health & Science University
Matthew Edinger, Asante Rogue Regional Medical Center
Mindy Stinnett, Blue Mountain Hospital
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
Judi Gabriel, Good Shepherd Health Care System
Katie Hennick, Good Samaritan Regional Medical Center
Michelle Renault, ATAB 6 Co-Chair, Hood River 9-1-1
Ruth Miles, Salem Health

Oregon Health Authority Staff	
David Lehrfeld	Public Health Division, EMS & TS
Madeleine Parmley	Public Health Division, EMS & TS
Rachel Ford	Public Health Division, EMS & TS

Welcome, Housekeeping and Agenda Review
Rachel Ford introduced self and welcomed attendees to the Oregon Trauma Hospital Resource Standards (Exhibit 4) Rule Advisory Committee meeting. This is the second of four scheduled RAC meetings. R. Ford reviewed meeting conduct information, reminders, and agenda.

- 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.
- 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.

R. Ford conducted roll call of RAC members.

Overview of June 10, 2024 Meeting

R. Ford provided a brief overview of the June 10, 2024 RAC meeting.

- Chapters 1 through 3 of the proposed changes to Exhibit 4 that may result in a fiscal impact to trauma hospitals were reviewed as well as additional items posed by RAC members.
- Discussions and suggested changes are being considered and an update of Exhibit 4 will be shared at the last RAC meeting scheduled for July 15, 2024.
- It was acknowledged that staff have also received written comments that will be considered.

Exhibit 4 – Chapter 4

Madeleine Parmley 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. In addition, only standards that will result in a fiscal impact to trauma centers will be reflected on the slides.

Chapter 4 – Personnel and Services

The following standards were discussed:

> **4.12** –Trauma centers must have an orthopaedic surgeon who has completed an OTA-approved fellowship or has met the alternate training criteria.

Discussion:

- RAC member via Chat indicated that "OTA (Orthopedic Trauma Association) should be expanded in the definition for clarity."

4.20 - In all trauma centers, the patient-to-nurse ratio in the ICU must be 1:1 or 2:1, depending on patient acuity as defined by the hospital policy for ICU nursing staffing.

Current practice notes no more than 2:1. This may or may not present an issue as the standard notes it will depend on hospital policy for ICU nurse staffing.

Discussion:

- RAC members had no comments.
- **Follow-up in response to question about hospital nurse staffing law – HB 2697 that passed during the 2023 legislative session prescribes minimum nurse to patient staffing ratios. For the ICU, the minimum nurse to patient ratio is 2:1.**

4.21 - Level I and II trauma centers must have continuous availability of the surgical expertise listed below:

• Cardiothoracic surgery
• Vascular surgery
• Hand surgery
• Plastic surgery
• Obstetrics Gynecology surgery
• Otolaryngology
• Urology

Current practice states the surgical expertise must be "available" which would not mandate 24/7 coverage. Continuous availability would require 24/7 coverage by these medical specialties. The increased cost is unknown.

Discussion:

- RAC member asked about 24/7 coverage whether it was acceptable to have a contingency plan in place to transfer patients to another location for some of the surgical expertise (i.e., hand and plastic surgery) which is allowed in other elements of the standards or will 24/7/365 be expected? It was noted that some trauma centers have limited hand and plastics coverage. M. Parmley noted that the Gray Book references only sporadic gaps in coverage due to vacation, conference attendance, etc. must be addressed with a contingency plan. Transfer agreements are not mentioned for purposes of this standard.
- RAC member noted that recruiting in their region for hand specialty was going to be extremely difficult and if 24/7/365 was required they would not be able to meet the standard.
- Question posed by RAC member regarding cardiothoracic versus cardiovascular surgeons seeking clarification based on the different roles. Additionally, it was asked what the timeline is to recruit and fill these positions to be able to meet the standard. M. Parmley responded that effective dates for compliance have not been determined yet as the program continues to seek information from RAC members. **Follow-up: per the standard, a Level I and II trauma center must have continuous availability of cardiothoracic surgery, a surgeon who operates on anything in the chest, i.e., heart, lungs, esophagus, trachea.**
- RAC member stated that they are hesitant to agree with such a change if the fiscal impact cannot be determined. The RAC member agreed that this standard would be very challenging given sporadic gaps that would *not* be due to vacations or conferences and there is a lack of community need for these specialized services. There are good plans in

place for contingencies including patient transfer. It was requested that the RAC consider what specialties are appropriate to have 100% of the time and what could be changed to optional or less than continuous coverage.

- RAC member via Chat agreed with previous statements that adding contingency planning is needed to allow for recruiting issues.
- RAC member via Chat asked, "What is the response time for these coverages?" David Lehrfeld responded via Chat response times are only mandated for general surgery, ortho, and neuro.

4.22 - Level I and II trauma centers must have continuous availability of ophthalmology.

Current practice states that ophthalmology must be available, which does not mandate 24/7 coverage. Continuous availability would require 24/7//365 coverage by this medical specialty. The increased cost is unknown. Similar language about contingency plans for sporadic gaps in coverage for vacation or conference attendance was acknowledged.

Discussion:

- RAC member noted that their trauma center does have ophthalmology coverage 24/7 however not all ophthalmologists are comfortable with all procedures (e.g., globe rupture) and so some complex cases are referred out. RAC member asked if other trauma centers are experiencing similar issues with non-operative ophthalmologists. Additional RAC member responded via Chat agreement that they also transfer due to complexity.
- RAC member responded via Chat that this would fall under similar concerns noted previously.
- RAC member stated agreement with the standard as written.

4.26 - Level I and II trauma centers must have all of the following medical specialists:

- Cardiology*
- Gastroenterology*
- Internal medicine or pediatrics*
- Infectious disease*
- Nephrology*
- Pain management (with expertise to perform regional nerve blocks)
- Physiatry
- Psychiatry
- Pulmonary medicine*

An asterisk (*) denotes services that must be continuously available.

Level III trauma centers must have internal medicine continuously available.

The asterisk items that require continuously available could require additional staff. The increased cost is unknown.

Discussion:

- RAC member shared that for the "pain medicine" availability, they currently have anesthesiologists who are regional specialists that are on staff and available. RAC member

asked if the expectation is that trauma centers staff pain boarded specialists or can an anesthesiologist fill this role? M. Parmley noted that per the Gray Book, it states that it must be someone "with expertise to perform regional nerve blocks."

4.30 – In all trauma centers, trauma and/or emergency department advanced practice providers who are clinically involve in the initial evaluation and resuscitation of trauma patients during the activation phase must have current ATLS certification.

Discussion:

- RAC member indicated their trauma center has mid-level providers providing triage in the emergency room and do not necessarily provide direct care. If a trauma and triage is identified, the patient goes into the care of an emergency physician. Are these mid-level providers also required to have ATLS even though they are not providing direct care rather triage? RAC member noted that currently their mid-level providers are not required to take ATLS, and it would be a big expenditure to increase the number of providers that are ATLS certified.
- Staff will consider this question further and provide follow-up information. **Follow-up: Any independent practitioner on the trauma call panel, who is not board certified in emergency medicine or general surgery, must have ATLS to provide clinical care for trauma patients.**

4.31 – In all trauma centers, there must be at least 0.5 FTE dedicated to the trauma registry per 200–300 annual patient entries. The count of entries is defined as all patients who meet NTDS inclusion criteria, and those patients who meet inclusion criteria for hospital, local, regional and state purposes.

Combined adult and pediatric programs (Level I/II adult trauma center with Level II pediatric trauma center) may share resources, but someone must be identified as the lead pediatric registrar.

Discussion:

- RAC member via Chat recommended retaining the current language of "annual admissions" vs "annual entries" as this wording change will have a significant impact on the smaller hospitals. It was recommended that language should instead speak to FTE requirements to ensure that trauma registrar staffing is sufficient to complete data entry within 60 days of patient discharge. Additionally, remove the "NTDS inclusion criteria" and retain the inclusion criteria for hospital, local, regional and state purpose. (Adding NTDS inclusion criteria will significantly increase the number of patients entered in the registry and will have a significant financial and staffing impact on all organizations and may prevent some from participating as a trauma hospital which will lead to inequality in members of their communities). This is especially true if the proposed language in 4.32 and 4.33 is included. **Follow-up: Current Oregon Trauma Registry inclusion criteria includes every patient where there was a field activation, hospital trauma team activation, or trauma consult. Current criteria include all entries and admissions.**
- RAC member indicated that the current inclusion criteria does not align with the NTDS, and they asked whether these criteria were going to be considered for change which would change the number of inclusion entries and registry needs. As written, there would be a

Commented [RF1]: Lehrfeld said he emailed Mellony about this and would pull together a statement. Mellony - would it be possible to ask him to have that drafted ASAP so can include in minutes?

Commented [MB2R1]: Have not received an email. @Lehrfeld David P - Please draft statement so I can incorporate into minutes. We need this right away.

Commented [PJ3R1]: Current standard 15-2 requires they collect data in compliance with the NTDS. Our Inclusion criteria already require them to include all entries. We already count those in their trauma volumes. NTDS doesn't increase their volumes. Our inclusion criteria do.

Commented [mcb4R1]: @Lehrfeld David P @Parmley Madeleine J @Rachel Ford - In follow-up to IM message from David to me about whether we changed OTR inclusion criteria with Exhibit 4 last time: I am not aware of any changes to inclusion criteria that took place during any previous RAC process, however, I understand that the inclusion criteria are set forth in the "OTR Abstract Manual" as described under OAR 333-200-0265(8). There is also a reference in rule to the OTR "data dictionary" under 333-200-0080(7)(d) - not sure if those are supposed to be the same thing or not. Any changes that occurred happened within the program, not part of the RAC process. The last revision to the data dictionary appears to be in 2019. The last action on Exhibit 4 appears to be a filing in September 2018 when CME hours were reduced to align with ACS.

Can someone please let me know if the "data dictionary" and the "abstract manual" are the same document so I can amend the rules for alignment?

Commented [LP5R1]: The change in wording from "admissions" to "entries" should have virtually no effect on the FTE or workload of the trauma registrars in Oregon. The Oregon trauma registry predates the national registry and we have always used a different standard that includes ALL trauma patients and not the nation standard that is ONLY admissions, transfers or death. This new national standard is just catching up to where Oregon has been right from the beginning.

significant fiscal impact. D. Lehrfeld responded that the inclusion criteria are not part of Exhibit 4 so are currently not under consideration. RAC member noted that there is an impact based on the language used in 4.31 that is specific to the NTDS that could be quite significant. It would impact trauma volumes and as such the number of registrars needed to input data. Additional RAC members concurred via Chat with the above comment.

- RAC member stated agreement and indicated that it needs be cleared up now whether to include the criteria or not given other standards (e.g., 6.3). This will have a huge financial impact for trauma centers, including changing the language from annual admissions to annual entries and the 60-day entry requirement. RAC member concurred via Chat.
- RAC member noted that it is a requirement for level III and level IVs, and this will hold level IVs to the standard to follow the NTDS inclusion criteria on top of the state criteria. Level IVs would then have a huge increase, not necessarily in admissions, but entries that will require more staff, registry staff and PI staff. Need to review this carefully.
- RAC member via Chat indicated that in all trauma centers, trauma registry data must be collected in compliance with the National Trauma Data Standard (NTDS) inclusion criteria and data element definitions and must have been submitted to the TQP Data Center in the most recent call for data.
- RAC member indicated via Chat that this standard will impact level III trauma centers as well.

4.32 - In all trauma centers, at least one registrar must be a current Certified Abbreviated Injury Scale Specialist (CAISS).

Combined adult and pediatric programs (Level I/II adult trauma center with Level II pediatric trauma center) may share the CAISS certified registrar to meet this requirement.

Currently, according to the Association of the Advancement of Automotive Medicine (AAAM) website, there are only four certified registrars in the state. The cost for taking the certification exam is $350. The increased cost would impact 4 Level II facilities and 10 Level III facilities.

Discussion:

- RAC member via Chat asked whether everyone requires their registrars to be within the state? It was noted that their trauma center employs a number of remote registrars that are across the U.S. M. Parmley clarified that the information from the AAAM was for informational purposes only and that there is no requirement that the register be located within the state.
- RAC member noted that the cost to take the exam may only be $350; however, there is a phenomenal amount of studying and prerequisites that are required and is a huge lift to get a trauma registrar certified. The fiscal impact is therefore much greater than $350. RAC members concurred via Chat.

4.33 - In all trauma centers, all staff members who have a registry role in data abstraction and entry, injury coding, ISS calculation, data reporting, or data validation for the trauma registry must fulfill all of the following requirements:

- Participate in and pass the Association of the Advancement of Automotive Medicine's (AAAM's) Abbreviated Injury Scale (AIS) course or an equivalent local course for the version used at your center.
- Participate in a trauma registry course that includes all of the following content:
  - Abstraction
  - Data management
  - Reports/report analysis
  - Data validation
  - HIPAA
- Participate in an ICD-10 course or an ICD-10 refresher course every five years.

The current requirement is for all trauma registrars to complete these courses within 12 months of being hired. The new requirement does not note a deadline for course completion. In addition, it requires a refresher course every five years. The number of current registrars that would be impacted by this requirement is unknown, and therefore the increased cost is unknown.

Discussion:

- RAC member noted that a financial impact is already being experienced by their ACS verified trauma center due to this standard. Example shared of the onboarding of registrars with 20 plus years of experience.
- RAC member noted that as a PIPs coordinator, they run their own reports for data validation, etc. Question was posed whether it would be required that they meet this standard in order to run those reports? M. Parmley responded that the Gray Book does not specify and only speaks to Trauma Registry staff.
- RAC member via Chat indicated it was their understanding the trauma registrars must have 12 months experience in order to attend the AAAM course. RAC member via Chat concurred and asked if there was a plan for how to mentor new abstractors? **Follow-up: A minimum of six months experience with AIS (abbreviated injury scale) either in a trauma registry or coding of injury cases is required; one year or more is suggested, not required.**

4.35 - In all trauma centers, there must be at least 0.5 FTE dedicated performance improvement (PI) personnel when the annual volume of registry patient entries exceeds 500 patients. The count of entries is defined as all patients that meet NTDS inclusion criteria, and those patients who meet inclusion criteria for hospital, local, regional, and state purposes.

When the annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1.0 FTE PI personnel.

- This is a new position requirement for Level I, II, and III facilities.
- This would impact 4 Level II and 3 Level III facilities.
- The cost could range from $350,000 to $700,000 for facilities that do not currently have the required staffing.

Discussion:

- RAC member stated that requiring NTDS inclusion criteria is going to be a significant lift for level III trauma centers.
- RAC member via Chat recommended retaining the current language of "annual admissions" vs "annual entries" as the wording change will have a significant impact on the smaller hospitals. Additionally, the NTDS inclusion criteria should be removed and retain the inclusion criteria for hospital, local, regional and state purpose. Adding NTDS inclusion criteria will significantly increase the number of patients entered in the registry and will have a significant financial and staffing impact on all organizations and may prevent some from participating as a trauma hospital which will lead to inequality in members of their communities. RAC members concurred via Chat.
- RAC member asked if the responsibility can be split between more than one person? D. Lehrfeld commented that the ACS is trying to be more explicit about the duties of the trauma registrar. Depending on size of program there may be dedicated PI staff. He further stated that the language around entries versus admissions is to ensure trauma centers are looking at the quality of care being provided. D. Lehrfeld indicated that they will consider these comments, run data and determine if changes are necessary.
- RAC member stated via Chat, in order to understand the true fiscal impact, will depend on whether the NTDS inclusion criteria will be added. It is hard to know the impact until that is addressed.
- RAC member asked about the estimated $350,000-$700,000 for a 1.0 FTE or 0.5 FTE to meet the standard. M. Parmley responded that this is an estimate based on the total number of facilities that would be impacted and need to obtain additional staff. **Follow-up: This estimated total is based on the total number of facilities that may need additional staffing to meet the requirement.**
- RAC member stated via Chat that the cost as posted would be financially challenging for most organizations.
- RAC member via Chat indicated that there needs to be a broader discussion on what OHA inclusion criteria will be and how those criteria will affect these standards.
- **Follow-up: The change in wording from "admissions" to "entries" is not expected to increase volume because the Oregon standards includes all trauma registry entries. This could impact Level II and Level III facilities that do not already have dedicated PI FTE as noted in standard 4.35.**

M. Parmley asked RAC members if there were other standards they wished to discuss.

4.6 - In Level I and II trauma centers, the emergency department director must be board-certified or board-eligible in emergency medicine or pediatric emergency medicine.

In Level I and II trauma centers, physicians who completed primary training prior to 2016 and are board-certified in a specialty other than emergency medicine or pediatric emergency medicine may serve as the emergency department director.
In Level III trauma centers, the emergency department director must be board-certified or board-eligible.

<u>Discussion:</u>

- RAC member stated that there should be no exception that an emergency department director must be board-certified or board-eligible in emergency medicine or pediatric medicine.

Additional comments:
- RAC member stated that they had spent more time reviewing the Gray Book and shared that it is hard to understand the intent of each standard without the additional information explanation from the Gray Book and RAC member encouraged that this additional information be included moving forward. RAC member remarked that the additional information will help when needing to seek support from administration and should be adopted into the Exhibit 4.
  - RAC member via Chat agreed with above comment and stated that it would be helpful to include the additional information language in the final version of Exhibit 4.
  - Additional RAC members concurred.
- RAC member indicated via Chat that it is important to note that if hospitals cannot meet the standards that increase the financial burden on hospitals, then there will be a direct impact that will negatively impact those members of vulnerable populations.
- RAC member agreed that a discussion regarding potentially adopting the NTDS criteria is needed.

M. Parmley shared that staff are looking for RAC members input on Level IV standards and how they might align with revised standards under consideration. The proposed Level IV standards remain the same as currently written. It was noted that the state standards do not necessarily align directly with the ACS as some other states do.

Next Steps

R. Ford shared the following information:
- The next meeting is scheduled for Monday, July 1, 2024 from 2:00-4:00 p.m. where chapters 5-7 will be considered. An email with agenda will be forwarded to RAC.
- Information about the status of the RAC meetings will be presented to the State Trauma Advisory Board on July 12.
- The last meeting is scheduled for July 15 where chapters 8-9 will be discussed along with proposed changes to Exhibit 4 table.
- The filing dates for the Notice of Proposed Rulemaking and the public hearing date are not finalized and will depend on progress of the RAC discussions.
- **Follow-up: The RAC will also need to review the Statement of Need and Fiscal Impact which also includes an equity impact statement.**

R. Ford noted that the registration link will be the same for the remaining RAC meetings and re-registration 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 2:55 p.m.