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Oregon Trauma Hospital Resource Standards (Exhibit 4)
RULE ADVISORY COMMITTEE
Monday, July 1, 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
Jennifer Serfin, Good Samaritan Regional Medical Center
Eric Blankenship, St. Charles Health System Bend
Erin Burnham, Oregon Chapter of American College of Emergency Physicians
Heather Wong, Oregon Health & Science University
Kathy Tompkins, Salem Hospital
Mindy Stinnett, Blue Mountain Hospital
Natalie Booker, Legacy Health
Robin Hanson (for Matthew Edinger), Asante Rogue Regional Medical Center
Shawn Rogers, Medix-Clatsop County
Stacey Holmes, Sky Lakes Medical Center
Zach Hittner, Willamette Valley Medical Center
INTERESTED PARTY ATTENDEES
Amy Slater, Salem Hospital
Katie Hennick, Good Samaritan Regional Medical Center
Tracy Holliday, St. Anthony Hospital

Oregon Health Authority Staff	
David Lehrfeld	Public Health Division, EMS & TS
Madeleine Parmley	Public Health Division, EMS & TS
Mellony Bernal	Public Health Division, Health Care Regulation & 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 which is to review proposed changes to Exhibit 4 and OAR chapter 333, divisions 200 and 205 based on the revised Dec. 2023 version of the 2022 ACS, Optimal Care of the Injured Patient.

This is the third of four scheduled RAC meetings.
- June 10 RAC meeting reviewed chapters 1-3.
- June 24 RAC meeting reviewed chapter 4.

- This July 1 RAC meeting reviewed Chapters 5-7.

M. Bernal reviewed meeting conduct information and reminders.

- 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.
- All correspondence entered into the Chat is a matter of public record and can be disclosed.
- 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.
- 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.
- Goal is to have final proposed rules submitted to the PHD rules coordinator by August 12 and hold the public hearing in mid-September.

R. Ford conducted roll call of RAC members.

Exhibit 4 – Chapters 5-7

Madeleine Parmley opened discussion and asked if RAC members had any items, they wished to discuss for Chapter 5.

<u>Chapter 5 – Patient Care Expectations and Protocols</u>

> 5.4 – For the highest level of activation, at least 80 percent of the time, the trauma surgeon must be at the patient’s bedside within 15 minutes (Level I or II trauma centers) or 30 minutes (Level III trauma centers) of patient arrival.

- RAC member indicated that previously trauma surgeon response time included reference to ‘adequate notification from the field.’ RAC member asked if this would still apply, or will a 15-minute response time be required regardless? M. Parmley responded that the Gray Book does not reference ‘adequate notice from field’ and is expected within 15 minutes upon activation for Level Is and IIs; and 30 minutes for others. **Follow-up: The current standard (6-6-2) indicates, "Response time is tracked from patient arrival rather than from notification or activation." This is in congruence with the Orange Book, as well as the Gray Book.**

5.6 – Level I and II trauma centers must have the following protocols for care of the injured older adult:

- Identification of vulnerable geriatric patients
- Identification of patients who will benefit from the input of a health care provider with geriatric expertise.
- Prevention, identification, and management of dementia, depression, and delirium
- Process to capture and document what matters to patients, including preferences and goals of care, code status, advanced directives, and identification of a proxy decision maker.
- Medication reconciliation and avoidance of inappropriate medications
- Screening for mobility limitations and assurance of early, frequent, and safe mobility
- Implementation of safe transitions to home or other health care facility

- RAC member indicated surprise that geriatric protocols are only required for Level I and II trauma centers. It was suggested that some requirement for Level III and IV trauma centers for screening geriatric patients for increased risk of morbidity and mortality and consider transfer to Level I trauma centers where appropriate should be considered.
- RAC member indicated that some of the items are a standard of care (code status and medication reconciliation) and seems odd to imply that those are only required for a Level I or II trauma center. **Follow-up: Requirement was added for Level III and Level IV trauma centers, as this is part of standard patient care.**

5.12 – All trauma centers must have clearly defined transfer protocols that include the types of patients, expected time frame for initiating and accepting a transfer, and predetermined referral centers for outgoing transfers.

- RAC member noted verbiage indicating ‘expected time frame for initiating and accepting transfer’ and concerns about current capacity problems at referral centers, it may be difficult to set a time frame on when the transfer may be accepted.

5.20 - All trauma centers must have treatment guidelines for, at minimum, the following orthopaedic injuries:

- Patients who are hemodynamically unstable attributable to pelvic ring injuries
- Long bone fractures in patients with multiple injuries (e.g., time to fixation, order of fixation, and damage control versus definitive fixation strategies)
- Open extremity fractures (e.g., time to antibiotics, time to OR for operative debridement, and time to wound coverage for open fractures)
- Hip fractures in geriatric patients (e.g., expected time to OR (LI, LII, LIII)

5.21 - In all trauma centers, an orthopaedic surgeon must be at bedside within 30 minutes of request for the following:

- Hemodynamically unstable, secondary to pelvic fracture
- Suspected extremity compartment syndrome
- Fractures/dislocations with risk of avascular necrosis (e.g., femoral head or talus)
- Vascular compromise related to a fracture or dislocation trauma surgeon discretion.

- The attending orthopaedic surgeon must be involved in the clinical decision-making for care of these patients.

- RAC member indicated that for 5.20 and 5.21, the text indicates that the standard applies to <u>all level trauma centers,</u> yet the table shows that the standard does not include level IVs. Clarification is needed. If it is expected that a Level IV trauma hospital is expected to have an orthopaedic surgeon at bedside within 30 minutes, then the table needs to reflect such or change the text accordingly. **Follow-up: Exhibit 4 has been updated to specify trauma center levels or all trauma centers as appropriate.**

5.23 – In all trauma centers, trauma patients requiring ICU admission must be admitted to, or be evaluated by, a surgical service.

- RAC member stated that for this standard that refers to patient ICU admission, it is a required standard for all trauma centers, yet their hospital does not have an ICU. It needs to be clear that the standard applies only if the facility provides the service at the facility.
- RAC member concurred that throughout the document it is confusing when in multiple places it refers to "all trauma centers," but then specifically call out applicable levels in the columns. Additionally, text will call out specific requirements for Level Is and IIs. Consistency is needed to eliminate confusion.
- RAC members via Chat echoed that clarification is needed regarding "all" versus trauma levels identified in column.

5.26 – In all trauma centers, documentation of the final interpretation of CT scans must occur no later than 12 hours after completion of the scan.

- RAC member stated that for Level IV trauma centers it is harder to obtain in-house coverage for night shift radiology starting as soon as 5:00 p.m. As such, it is hard to meet this standard when a trauma comes in after hours. It was suggested that language include a percentage of time that the standard must be met. Example: must be met at least 80% of the time.

<u>Chapter 6 – Data Surveillance and Systems</u>

M. Parmley noted for standard 6.3 current requirements do not require non-ACS verified facilities to submit to TQP. This revised standard would result in an additional expense to trauma centers who do not submit data to TQP. The approximate cost is $20,000 per year for each facility.

6.3 - 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 stated in the Chat, "We are concerned for our non-TQIP participating hospitals that this verbiage will increase the number of trauma entries by expanding the definition of trauma across the state. Currently our activation scheme carves out hip fractures and others that would now be mandatory entries. The NTDB inclusion criteria can be simplified to anyone with a traumatic mechanism that sustains an injury greater than a superficial

contusion or abrasion that is admitted or transferred for any reason, regardless of ISS. This standard would increase trauma volume and have a direct effect on standards proposed in section 4 that require registry and PI staff FTEs based on volume. Furthermore, this verbiage seems to mandate that all Level 1, 2, and 3 trauma centers must participate in TQP, which is associated with a significant cost to these facilities. Several RAC members via Chat concurred via Chat.

- RAC member shared via Chat that this is a significant cost for sites that are not submitting to TQP.
- RAC member commented that the $20,000 fee required for submission does not account for an additional registrar that would be needed to complete all fields. As such, the cost would be significantly higher. RAC member shared historical information the last time inclusion criteria was considered. Examples shared of inclusion criteria that were later retracted based on stress and burden on facilities (hips and trauma transfers with ISS 9 or higher). RAC member further stated that the proposal (inclusion criteria) and the stress and burden on systems is concerning.
- RAC member stated via Chat that reference to NTDS inclusion criteria should be removed and maintain only "state, regional or local criteria." Including NTDS criteria would significantly increase the registry entries as well as staffing requirements which will be unattainable for many trauma centers in Oregon. Including the NTDS will have a significant fiscal impact on Trauma Centers across the State. **Follow-up: All trauma centers, updated standard language to replace National Trauma Data Standard with Oregon Trauma Registry inclusion criteria and Oregon Trauma Registry Data Dictionary data elements index definitions. Level I and Level II trauma centers, removed TQP Data Center and retained current standard language of National Trauma Data Bank.**

<u>Chapter 7 – Performance Improvement and Patient Safety</u>

Madeleine Parmley opened discussion and asked if RAC members had any items, they wished to discuss for Chapter 7.

7.4 – All trauma centers must participate in a risk-adjusted benchmarking program and use the results to determine whether there are opportunities for improvement in patient care and registry data quality.

- RAC member indicated via Chat that adding this criterion would significantly increase the registry entry requirements and staffing requirements which will be unattainable for many trauma centers in Oregon. Including benchmarking such as TQIP will have a significant fiscal impact on Trauma Centers across the State. RAC members concurred via Chat.
- RAC member remarked with similar concerns as 6.3 requiring the addition of significant FTE and registration fees to participate.
- RAC member asked if there are any other risk-adjustment programs that are free of charge or reduced cost? Will the image trend product be able to provide any information for non-TQIP facilities? D. Lehrfeld noted that the risk adjustment TQIP is proprietary. Other types of risk adjustment could be done but the state does not know the exact formulas used by TQIP. The Oregon Trauma Registry will have data tools where simple benchmarks can be built. Risk-adjusted benchmarks are more complicated.

- RAC member asked for clarification whether the intent is that all trauma centers would need to participate in some risk-adjusted benchmarking and that there are no free programs which would result in a cost. M. Parmley noted that TQIP has not been enforced because of the fiscal impact. Other options to consider were ATABs getting together to review; the state providing data where a regionalized committee can look at data and create possible changes. ACS does have other risk-adjusted programs listed on their website that are considered acceptable. RAC members were encouraged to provide feedback on this measure. RAC member indicated that any requirement that results in additional costs and additional staff time will not be feasible for lower-level trauma centers.
- RAC member stated via Chat that they believed ACS provides a fee structure for TQIP for level IV trauma centers. RAC member followed up via Chat that they could not find anything relating to TQIP specific to Level IVs to be able to enroll. D. Lehrfeld responded there is not anything for Level IVs. He further noted that risk-adjusted benchmarking uses data from similarly sized trauma centers and levels and as such formulas wouldn't work since it would be compared to Level III data. **Follow-up: Removed the term 'risk-adjusted' from the standard.**

7.6 - All trauma centers must meet the following trauma multidisciplinary PIPS committee meeting attendance thresholds:

- 60 percent of meetings for the TMD (cannot be delegated to the associate TMD)
- 50 percent of meetings for each trauma surgeon
- 50 percent of meetings for the liaisons (or one predetermined alternate) from emergency medicine, neurosurgery, orthopaedic surgery, critical care medicine, and anesthesia
- 50 percent of meetings for the liaison (or one predetermined alternate) from radiology.

- M. Parmley noted that for this standard regarding multi-disciplinary meeting attendance thresholds, the Trauma Medical Director (TMD) must attend 60% of meetings which cannot be delegated to an association TMD. The standard was previously 50%.
- RAC member commented that the last line indicates that for a Level IV trauma center there must be 50% attendance by medical staff that participate in trauma resuscitation. It was noted that clarification is needed on whether that is each medical staff member or a representative of the medical staff that treat trauma patients. M. Parmley noted that for level IV trauma centers, this would be emergency department physicians including radiology, respiratory, lab. RAC member asked follow-up questions whether the intent is just MDs/Dos or all trauma team staff? M. Parmley indicated that staff will look into further and report back.
- RAC member via Chat suggesting editing to say, "a representative of medical staff."
- **Follow-up: No change to proposed standard. It is expected that Level IV emergency physicians, and surgeons as applicable, attend the multidisciplinary PIPS committee.**

7.7 - In all trauma centers, all cases of trauma-related mortality and transfer to hospice must be reviewed and classified for potential opportunities for improvement. Deaths must be categorized as:

• Mortality with opportunity for improvement
• Mortality without opportunity for improvement

- RAC member stated that currently unexpected mortality with opportunity for improvement is a criterion and asked whether only the two noted above will be considered. **Follow-up: The EMS and Trauma Systems program recognizes this is a change as it does not note "unanticipated." If the mortality was categorized as having an opportunity for improvement, this could cover any unanticipated deaths.**

  7.8 - In all trauma centers, all nonsurgical trauma admissions must be reviewed by the trauma program. As part of secondary review, the Trauma Medical Director must review non-surgical admissions that meet any of the following criteria:

  - No trauma or surgical consultation
  - ISS>9
  - Cases with an opportunity for improvement identified at primary review.

- RAC member stated that the current standard for review of non-surgical admissions allows for an appropriate tool or process such as the Nelson criteria to filter out which cases need reviewed by the TMD. RAC member expressed concern about the proposed standard verbiage 'that meet any of the following criteria' would needlessly clog up the secondary review process with patients admitted for low-level injuries. The ISS greater than 9 criteria alone will likely drive up the review process. This standard would require a ground level fall patient with a non-operative, non-displaced hip fracture and a contusion or abrasion to the hand, face, trunk, abdomen that was admitted would require a secondary review, even if seen by orthopedic surgeon. The use of an appropriate screening tool to evaluate these admissions is an acceptable way to identify which patients warrant additional review. It was suggested that language that allows for the use of such tools be added. RAC members agreed via Chat.
- RAC member agreed with comments regarding need to clear out non-surgical admissions at the level I review.
- **Follow-up: Further clarification from the Gray Book - Nonsurgical admissions with trauma or other surgical consultations, with ISS <9, or without other identified opportunities for improvement may be closed in primary review.**

  7.9 – In all trauma centers, all instances of diversion must be reviewed by the trauma operations committee.

- RAC member asked for clarification whether this is all diversions or just trauma diversions.
- **Follow-up: It is expected that all diversions may have an impact on trauma and as such these diversions must be reviewed by the trauma operations committee.**

M. Parmley noted that RAC members may submit comments in writing following the RAC meeting and staff will take into consideration.

R. Ford noted that comments both during RAC meetings and submitted in writing have been considered by staff who are working on amendments to Exhibit 4 which will be shared at the next meeting. RAC member asked if this document can be shared prior to the RAC meeting to

allow people time to review. R. Ford noted that yes, staff will try and get the revised Exhibit to the RAC in advance of the next meeting.

RAC member shared via Chat that they would appreciate any updates so the material can be reviewed and allow an opportunity to comment on changes. RAC members agreed via Chat.

M. Parmley shared that prior to the Gray Book Level IVs were included; however, the revised Gray Book did not include level IVs and ACS indicated they assumed centers would continue to comply with the Orange Book standards. ACS has indicated they would add back level IVs, but it is unknown when this would occur. Staff decided to use current Level IV criteria and determine how those criteria fit with the Gray Book to draft the current proposed Exhibit 4. Level IV criteria that no longer exists in the Gray Book was removed from Level IV requirements.

RAC member asked whether it is acceptable to have facilities share a QI position, and whether there are any current facilities that do share? M. Parmley indicated that there is nothing in the ACS standards that would mandate that a PI position could only serve a single facility, only that they must dedicate appropriate FTE time based on volume. There are health systems that have a team of registrars that serve multiple facilities.

Next Steps

R. Ford shared the following information:

- Information about the status of the RAC meetings and an overview of discussions will be presented to the State Trauma Advisory Board on July 12.
- The next meeting is scheduled for Monday, July 15, 2024, from 2:00-4:00 p.m. where chapters 8-9 will be considered as well as an updated version of Exhibit 4.
- RAC members were encouraged to send comments about chapters 8-9 prior to the meeting for staff consideration.

Meeting adjourned at 2:50 p.m.