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Oregon Trauma Hospital Resource Standards (Exhibit 4)
RULE ADVISORY COMMITTEE
Monday, July 15, 2024
2:00 PM – 4:00 PM

RAC MEMBER ATTENDEES
Angie Short, Good Shepherd Hermiston
Danielle Meyer, Hospital Association of Oregon
Heather Wong, Oregon Health & Science University
Jennifer Serfin, Good Samaritan Regional Medical Center
Jeremy Buller (for Eric Blankenship), St. Charles Bend
Kathy Tompkins, Salem Hospital
Matthew Edinger, Asante Rogue Regional Medical Center
Mindy Stinnett, Blue Mountain Hospital
Shawn Rogers, Medix-Clatsop County
Stacey Holmes, Sky Lakes Medical Center
Susan Steen, Oregon Health & Science University
Zach Hittner, Willamette Valley Medical Center
INTERESTED PARTY ATTENDEES
Amy Slater, Salem Hospital
Joey Van Winckel, Salem Health
Katie Hennick, Good Samaritan Regional Medical Center
Misty Wadzeck, Peace Harbor Medical Center
Ruth Miles, Salem Health
Shelley Campbell, Legacy Health Systems
Stefanie Boen, Adventist Health Columbia Gorge
Timbra Burrup, St. Alphonsus Ontario/Baker City

Oregon Health Authority Staff	
David Lehrfeld	Public Health Division, EMS & Trauma Systems
Madeleine Parmley	Public Health Division, EMS & Trauma Systems
Mellony Bernal	Public Health Division, Health Care Regulation & Quality Improvement
Rachel Ford	Public Health Division, EMS & Trauma Systems

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 fourth and final scheduled RAC meeting. This meeting will review chapters 8-9, changes to Exhibit 4 based on previous RAC discussions, Oregon Administrative Rule 333-200 and 205, and Statement of Need and Fiscal Impact.

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 8-9

R. Ford provided a brief overview of previous RAC meetings where the following chapters of the Gray Book were considered:

- 6/10/24: RAC Meeting 1 - Chapters 1-3
- 6/25/24: RAC Meeting 2 - Chapter 4
- 7/01/24: RAC Meeting 3 - Chapters 5-7

Madeleine Parmley opened discussion and asked if RAC members had any items they wished to discuss for Chapters 8-9.

RAC members offered no comments nor had any questions.

Exhibit 4 – Proposed Updates

R. Ford shared the following changes to Exhibit 4 after consideration of feedback from RAC members from previous RAC meetings:

- 2.6: Changed language to reference ‘annual admits’ instead of ‘care for.’
- 2.8: Changed language to reflect that it is recommended that a Level II and III trauma center TMDs has active membership in at least one regional, state, or national trauma

organization and attendance at least one meeting during the verification cycle rather than required.

- The following tags were amended to clarify the standards that applied to which level of trauma hospital: 4.2, 4.4, 4.14, 4.16, 4.35, 5.17, 5.20, 5.21, 5.22, 5.27
- 4.12: The acronym "OTA" was removed and the term spelled out - Orthopedic Trauma Association
- 4.21 & 4.22: Further language was added to clarify that a contingency plan must address any sporadic gaps in coverage due to vacations, conference attendance, etc.
  - RAC member asked for purposes of 4.21 and 4.26 whether any grace would be given to hospitals that are actively trying to recruit for necessary coverage to meet the required standard. It was noted that for remote trauma centers, it is difficult to obtain 24/7 coverage. Concerns were further expressed that this is a type I deficiency, and the standard is a big lift given current hospital staffing deficiencies especially surgical specialties in rural areas. Staff responded that based on language in Gray Book, it would be interpreted that any "sporadic gaps in coverage must be addressed with a contingency plan." Staff further noted that the intent with the language is about communication and having transfer plans in place with other facilities who have the necessary expertise when there are gaps in coverage.
  - RAC members concurred via Chat writing the following:
    - It was discussed that there should be a contingency plan for recruiting issues. It would be helpful if that was spelled out instead of just "etc."
    - Communities may need to hire multiple plastic surgeons to maintain coverage. There is also an unknown fiscal impact on this.
    - This will have significant financial impact to trauma centers to compensate providers for their continuous coverage. **Response:** Modified 4.21: Level I trauma centers must have continuous availability of surgical expertise listed in the standard, and Level II trauma centers must have surgical expertise available. For Level I trauma centers, sporadic gaps in coverage due to vacation or conference attendance must be addressed with a contingency plan. Modified 4.22: Level I trauma centers must have continuous availability of ophthalmology. For Level I trauma centers, sporadic gaps in coverage due to vacation or conference attendance must be addressed with a contingency plan. Level II trauma centers must have ophthalmology available.
- RAC member inquired about standard 4.25 which requires a level I and II trauma center to have replantation capability continuously available or to have in place a triage and transfer process with a replant center. RAC member stated they are not aware of any Level II center that have a replant center which is a specific specialty service and questioned the appropriateness of including level II centers in this standard. Triage and transfer processes must be in place regardless of whether a patient needs a reattachment.
- 4.31 & 4.35: Replaced references to 'NTDS' with 'Oregon Trauma Registry' inclusion criteria.
  - RAC member indicated via Chat that it is confusing to have a different inclusion criteria for state and national standards. Uploading TQP requires following NTDB inclusion criteria.

- 4.32: Changed the requirement that there must be at least one CAISS registrar for all trauma centers to reflect only a Level I or other trauma centers seeking ACS verification.
- 5.6: Amended to require all trauma level centers to have protocols for the care of the injured older adult versus just Levels I and II.
- 5.22: Amended to require that Level IV trauma centers that provide surgical services must also have an OR booking policy that specifies targets for timely access to the OR based on level of urgency and includes access targets for a range of clinical trauma priorities
- 6.3: Replaced the term 'NTDS' with 'Oregon Trauma Registry' inclusion criteria which will apply to all trauma centers and for Level I and Level II centers removed reference to the TQP Data Center and retained National Trauma Data Bank.
  - RAC member asked whether isolated hip fractures from ground level falls would continue to be excluded from registry entry. M. Parmley clarified that the proposal is to maintain the current Oregon Trauma Registry criteria, which excludes isolated hip fractures. David Lehrfeld further noted that the EMS program will revisit Oregon Trauma Registry inclusion criteria, as well as Exhibit 5.
- 7.4: Removed reference that all trauma centers must participate in a 'risk-adjusted' benchmarking program and replaced with all trauma centers must participate in a benchmarking program.

Questions and suggested changes that were discussed previously and were not changed include the following:

- 2.7: Level IV requirement to hold quarterly multidisciplinary PIPs committee meetings.
  EMS & Trauma Systems Program response: Addressing concerns past six months is too late to take any definitive correction action even with small patient volume.

- 2.10: Documentation that 0.5 FTE spent on TPM activities.
  EMS & Trauma Systems Program response: Measures of compliance include roles and responsibilities of the TPM, CE certificates or transcripts, and proof of membership in trauma organizations.

- 2.11: Request to keep 'TPM in collaboration with TMD' language.
  EMS & Trauma Systems Program response: The standard language includes 'in conjunction' which is the same as saying 'in collaboration.'

- 3.5: New requirement for point-of-care ultrasound available 24 hours per day and accessible for patient care within 15 minutes.
  EMS & Trauma Systems Program response: The Focused Assessment with Sonography in Trauma (FAST) exam per ATLS protocol is performed immediately after the primary survey. This is the initial imaging test of choice for trauma care in the United States and is part of the ATLS protocol developed by ACS.

- 4.30: Mid-level provider requirement to have ATLS.
  EMS & Trauma Systems Program response: 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.

- 4.33: Question about months of experience needed to take registry staff courses.
  EMS & Trauma Systems Program response: A minimum of six months experience with AIS (abbreviated injury scale) either in a trauma registry or coding of injury cases is required.
- 5.4: Question about adequate notification from the field.
  EMS & Trauma Systems Program response: 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.

- 7.6: Question about Level IV participation in multidisciplinary PIPS.
  EMS & Trauma Systems Program response: It is expected that Level IV emergency physicians, and surgeons as applicable, attend the multidisciplinary PIPS committee.
  - RAC member asked how locum providers will be required to participate in multidisciplinary PIPS committee meetings. Quite a few locums are used and their availability to participate in those meetings is very limited, and it is not anticipated that their availability can be increased. Are locums included in that standard? D. Lehrfeld remarked that ACS does not address this. Surveyors know how to perform surveys, know the hospitals, and know what will be helpful or not and should not be an issue.

- 7.7: Question about whether there is no longer unanticipated mortality.
  EMS & Trauma Systems Program response: 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: Question about the criteria for secondary review.
  EMS & Trauma Systems Program response: Nonsurgical admissions with trauma or other surgical consultations, with ISS<9, or without other identified opportunities for improvement may be closed in primary review.
  - RAC member noted that their current process is to look at all non-surgical admits that did not have a surgical consultation, and the Nelson criteria is used to further discard cases. As written, this standard does not leave room for the Nelson criteria to be used. RAC member noted that they participate in TQP and as such have an expanded definition for what constitutes a trauma. The criteria (ISS > 9) will increase the amount of TMD review that may not be needed. Since there is additional language, "cases with an opportunity for improvement identified at primary review," it was requested that the program consider increasing the ISS requirement or removing it. **Response:** Modified to the following: “As part of secondary review, the Trauma Medical Director must review non-surgical admissions according to the criteria in the Nelson Criteria for Nonsurgical Admission.”

- 7.9: Question about diversions.

EMS & Trauma Systems Program response: 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.

OAR 333-200 and 205 – Proposed Changes

M. Bernal reviewed minor changes to the rule text, primarily housekeeping in nature, with RAC members. Changes included:

For OAR chapter 333, division 200:

- Corrected references to Oregon Health Authority and OHA;
- 0010 – Added reference to AEMT, EMT-Intermediate and Paramedic to definition of EMS provider and added cross references to appropriate Exhibits.
- 0020, 0080 – Updated the ACS Resources for Optimal Care of Injured Patient to reflect the 2022 Standards as revised in December 2023.
- 0040 – Corrected zip code errors for Area 1.
- 0090 – Clarified that if the Authority finds that a trauma hospital does not meet prescribed standards in Exhibit 4, it will follow the processed outlined in 0295.
- 0250 – Clarified that the Authority will provide a written report of survey findings for state specific standards.
- 0266 – Reference to the Oregon Trauma Registry (OTR) Abstract Manual was updated to OTR Data Dictionary and section (10) referring to the use of the state trauma resuscitation flow sheet was removed.
- 0285 – Clarified that the reporting requirement is calculated from the date of patient discharge.
- 0295 – Clarified that a trauma hospital may be subject to suspension or revocation for failing to comply with the data reporting required after the OHA has utilized an independent data collection and abstraction service pursuant to the rules.

For OAR chapter 333, division 205:

- Corrected references to Oregon Health Authority and OHA;
- Updated statutory references; and
- Updated the ACS Resources for Optimal Care of Injured Patient to reflect the 2022 Standards as revised in December 2023.

RAC members had no comments on the revisions proposed to OARs 333-200 and 205.

Statement of Need and Fiscal Impact

M. Bernal reviewed the Statement of Need and Fiscal Impact (SNFI) with RAC members. The SNFI identifies possible impacts the proposed rule changes will have on equity in Oregon as

well as the possible fiscal and economic impact on persons or businesses affected by the proposed rule changes.

- Need for rule was reviewed and includes reference to alignment with the revised ACS Resources for Optimal Care of the Injured Patient.

- Documents relied upon include the Gray Book and ORS chapter 431A.

- The program acknowledged that more data analysis is necessary to determine whether the ACS resource standards lead to significantly better out comes for Black, Indigenous and People of Color. It was further noted that the program intends to perform post hoc linkage between the Oregon Trauma Registry data and the REALD-SOGI repository to develop robust equity metrics related to hospital trauma care and outcomes within the next two to four years.
    - RAC members had no comments on racial equity impact statement.

- Fiscal impacts to trauma centers by level were noted as follows:

  For all trauma centers (I, II, III, and IV):
  - Staff who have a registry role in data abstraction and entry, injury coding, ISS calculation, data reporting or data validation must participate in an ICD-10 course or an ICD-10 refresher course every five years.
  - Availability 24/7 of point-of-care ultrasound within 15 minutes

  For Level I and Level II trauma centers:
  - Increased response times for the following:
    - Conventional radiography within 15 minutes
    - Computed tomography (CT) within 15 minutes

  - Continuous availability of the following:
    - Cardiothoracic surgery
    - Vascular surgery
    - Hand surgery
    - Plastic surgery
    - Obstetrics and Gynecologic surgery
    - Otolaryngology
    - Urology
    - Ophthalmology

  - Continuous availability of medical specialists including cardiology, gastroenterology, internal medicine or pediatrics, infectious disease, nephrology, and pulmonary medicine.

  - Availability of medical specialists including pain management (with expertise to perform regional nerve blocks), physiatry, and psychiatry.

  For Level I, Level II, and Level III trauma centers:

- At least 0.5 FTE dedicated performance improvement personnel when the annual volume of registry patients exceeds 500. At least 1.0 FTE when annual volume is at least 1,000 patients. It is unknown how many trauma centers have dedicated PI personnel so unable to estimate costs.

- Requirement that the trauma program manager maintain membership in a national or regional trauma organization. Estimated cost between $125-$1,500/year.

For Level III trauma centers:

- Continuous availability of internal medicine

For Level IV trauma centers:

- Conventional radiography within 30 minutes
- CT 24 hours per day and within 30 minutes

RAC member inquired whether the OHA needed to identify the value of the financial impact or is it to identify whether there is or is not a financial impact. M. Bernal responded that if OHA, or members of the RAC, are aware of verifiable costs, or even estimated costs, then the SNFI should reflect such. If it is difficult to ascertain costs based on not knowing whether hospitals currently meet a requirement or not, have staff in place, etc. than actual values are not required.

- Impacts to the OHA, local governments and the public are not anticipated.
- There is no cost of compliance effects on small businesses as trauma centers are not considered small business (50 or fewer employees).

Next Steps

M. Bernal shared the following information on next steps:

- Staff will consider the comments shared today and consider whether additional changes are needed.
- Final proposed rule text will be shared with the Public Health Division's, Administrative Rule's Coordinator no later than August 16, 2024.
- A Notice of Proposed Rulemaking Hearing will be posted in the September 1, 2024 Oregon Bulletin.
- On or after September 16, a public hearing will be held to obtain oral public comments. The final date will be determined in coordination with the PHD Administrative Rules Coordinator who serves as the public hearing's officer.
- The deadline to receive written comments will be on or after September 23, 2024. Date is determined based on public hearing date.
- Goal is to file final rules by October 15, 2024 with an effective date of July 1, 2025.

Staff thanked RAC members for their participation.

Meeting adjourned at 3:00 p.m.