DATE: October 22, 2024

TO: Hearing Attendees and Commenters –
Oregon Administrative Rules chapter 333, divisions 200 and 205 –
"Trauma Hospital Categorization and Resource Standards"

FROM: Brittany Hall, Hearing Officer and Administrative Rules Coordinator

cc: Dana Selover, Section Manager
Health Care Regulation and Quality Improvement

SUBJECT: Presiding Hearing Officer's Report on Rulemaking Hearing and Public Comment Period

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Hearing Officer Report

Date of Hearing: September 17, 2024, via Microsoft Teams

Purpose of Hearing: The purpose of this hearing was to receive testimony regarding the Oregon Health Authority (OHA), Public Health Division, EMS and Trauma Systems (EMS & TS) program's proposed permanent amendments to Oregon Administrative Rules in chapter 333, divisions 200 and 205; replacement of Exhibit 4 in entirety relating to trauma hospital categorization and resource standards; and modification of Exhibit 1 for purposes of clarifying trauma systems and zip codes served.

In accordance with ORS 431A.060, OHA is responsible for the development of a comprehensive statewide trauma system which includes the development of state trauma objectives and standards, and the criteria and procedures utilized in categorizing and designating trauma hospitals. OHA is directed to categorize hospitals according to trauma care capabilities using standards modeled after the American College of Surgeons (ACS), Committee on Trauma Standards (COT). In March 2022, the ACS, COT Verification Review Subcommittee published the revised, Resources for Optimal Care of the Injured Patient, 2022 Standards (revised December 2023) and as such OHA has amended the rules adopting these latest standards and replaces Exhibit 4 in entirety

to align with the revised standards for trauma centers categorized as a Level I, II, III, or IV.

OHA is also proposing changes to clarify processes and procedures and correcting errors.

Hearing Officer: Brittany Hall

Testimony Received: Three individuals provided testimony at the hearing.

Other Comments: Four individuals or organizations submitted written comments to OHA within the period allotted for public comment, which closed at 5:00 PM on September 23, 2024. Written comments are attached to this report as **ATTACHMENT 1**.

In oral testimony and written comments, OHA heard concerns about the proposed amendments to Exhibit 4, Standard 4.5 that indicates that Level III facilities require a "Board-certified or board-eligible anesthesiologist" as a liaison. This is in contradiction to Section 4.5 of the 2022 American College of Surgeons, Committee on Trauma Standards (ACS standards) that indicate that "In Level III trauma centers, certified registered nurse anesthetists (CRNAs) who are licensed to practice independently my serve as the anesthesia liaison."

Agency response: The OHA thanks the respondents for their comments regarding CRNAs serving as the trauma liaison in Level III trauma centers. Exhibit 4, Standard 4.5 has been amended to include CRNAs as liaisons to the multidisciplinary trauma peer review committee as follows:

4.5	The trauma program must have the following designated liaisons: … LIII: • Board-certified or board-eligible emergency medicine physician • Board-certified or board-eligible orthopedic surgeon • Board-certified or board-eligible anesthesiologist or certified registered nurse anesthetist • Board-certified or board-eligible neurosurgeon (applies only to LIII-N) • Board-certified or board-eligible ICU physician

In written comments, OHA heard concern about the proposed amendments to Exhibit 4, Standard 2.8 that state "In Level IV trauma centers, the TMD [trauma medical director] ***is*** a physician practicing emergency medicine…." Written comments request a verbiage change in order to better clarify the intent of the standard, stating that Standard 2.8 should be reworded to "In Level IV trauma centers, the TMD ***may be*** a physician practicing emergency medicine…." This change would "allow Level IV centers with an available surgeon to appoint said surgeon as their TMD or allow them to use an ED [emergency department] physician when the don't have an available/appropriate surgeon for the role."

Agency response: The OHA thanks respondents for their careful consideration of the language used in Standard 2.8. The OHA has amended this standard to clarify that the Trauma Medical Director may be a physician that is currently board certified or board eligible in general surgery or pediatric surgery as follows:

2.8	In all trauma centers, the TMD must fulfill the following requirement: … In Level IV trauma centers, the TMD is a physician that is currently board certified or board eligible in general surgery or pediatric surgery, or may be a physician practicing emergency medicine, responsible for coordinating the care of injured patients, verifies continuing medical education (CME) of personnel, and has oversight of the trauma quality improvement process. The TMD is clinically involved with trauma patient management and responsible for credentialing of trauma team members.

In written comments, OHA heard the following requests:

1. That OHA delay the effective date of July 1, 2025 to allow hospitals the time to implement these rule changes.
2. That OHA include references or text of the standard from the "Resources for Optimal Care of the Injured Patient, 2022 Standards (revised December 2023)" in Exhibit 4 where appropriate.
3. That OHA streamline the process and reduce the administrative burden on Level I and Level II trauma centers regarding data submission. Exhibit 4, Standard 6.3 requires Level I and Level II trauma centers to submit their data to the National Trauma Data Bank every year, while the rules also require hospital trauma centers to participate in the Oregon Trauma Registry. Some data fields are different, and this creates a reporting burden.

Agency response: In response to the request that the OHA delay implementation of these rules, the OHA has amended the rule so that a trauma system hospital must comply with the revised Exhibit 4 standards on or before October 1, 2025. The other changes reflected in this rule filing will be effective November 1, 2024, including the amendments to Exhibit 1.

Reference to "Resources for Optimal Care of the Injured Patient, 2022 Standards (revised December 2023)" is already included in the rule text under OARs 333-200-0020, 333-200-0080, and 333-205-0050. As such, adding the reference to Exhibit 4 is considered unnecessary. The OHA Trauma Program largely aligns with this standard and modifications have been made to Exhibit 4 to reflect the needs of the Oregon trauma system.

Lastly, regarding the request to streamline data reporting and reduce administrative burden for Level I and II trauma centers, no changes are being considered. Current administrative rules already require Level I, II and III trauma centers to submit data to the National Trauma Data Bank (NTDB) in accordance with the National Trauma Data Standard. The revised Standard 6.3 removes Level III trauma centers from this requirement. The Rule Advisory Committee (RAC), which was convened to consider these rule changes, requested that language be added requiring that trauma registry data be collected in compliance with the Oregon Trauma Registry and Oregon Trauma Registry Data Dictionary. The OHA believes that any changes to the data collection requirements would need to be further discussed in a RAC.

From: Parmley Madeleine J
To: Clifton Dodson (Visitor)
Cc: Anderson, Tiffany C; Wiseman, Richard C; Elliott, Carly A; Gilbert, Khia; Mellony Bernal
Subject: RE: CRNAs as liaisons
Date: Wednesday, September 18, 2024 7:24:43 AM

Hi Clif,

Thank you for your comments. These will be forwarded to be included in public comment.

Regards,

Madeleine Parmley, BSN, RN
Trauma Program Coordinator
OREGON HEALTH AUTHORITY
Public Health Division
EMS & Trauma Systems
Cell: 503-891-0464
Madeleine.J.Parmley@oha.oregon.gov

From: Dodson, Clifton A <Clifton.Dodson@providence.org>
Sent: Tuesday, September 17, 2024 3:41 PM
To: Parmley Madeleine J <MADELEINE.J.PARMLEY@oha.oregon.gov>
Cc: Anderson, Tiffany C <Tiffany.C.Anderson@providence.org>; Wiseman, Richard C <Richard.Wiseman@providence.org>; Elliott, Carly A <Carly.Elliott@providence.org>; Gilbert, Khia <Khia.Gilbert@providence.org>
Subject: CRNAs as liaisons

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Hello Madeleine,

I hope you've had a relaxing summer. My anesthesia liaison reached out to me yesterday regarding information she received from the Oregon Association of Nurse Anesthetists (ORANA). It seems to pertain to the OHA's work on redoing Exhibit 4 and pertains to CRNAs not being allowed to be liaisons to the trauma department at Level III centers. Specifically, the change is to Exhibit 4 (11-3-3) "A qualified anesthesia provider must be designated as the

liaison to the trauma program." But this would change to, "The trauma program must have the following designated liaisons: Board-certified or board-eligible anesthesiologist."

As you may have inferred, my liaison is a CRNA. In fact, my entire anesthesia staff consists entirely of CRNAs. We would be unable to fulfill this requirement if enacted. Further, the change is counter to the ACS language under Grey Book 4.5 - Specialty Liaisons to the Trauma Service, "For Level III Trauma Centers: In states where certified registered nurse anesthetists (CRNAs) are licensed to practice independently, they may serve as the anesthesia liaison." It goes on to say that even in states where CRNAs can't practice independently, they can still serve as liaison is there is no anesthesiologist on staff.

Surely, I am not the only Level III center that operates with a whole CRNA anesthesia staff. This simple change in seemingly innocuous language will have far reaching implications for many Level III centers, I am certain. Please advise.

V/r,
Clif

Clif Dodson, BSN, RN, TCRN, CEN, CPAN (He/Him/His)
Trauma Clinical Program Coordinator I Trauma Registrar I ED-Trauma Clinical Educator
Emergency Department
Providence Hood River Memorial Hospital – 810 12th Street, Hood River, OR 97031
clifton.dodson@providence.org
Phone: office (541) 387-8909 / cell (503) 737-9533

We prepare and train for the uncommon, so that when it arrives, it is not the unknown.

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September 23, 2024

OHA, Public Health Division
Brittany Hall, Administrative Rules Coordinator
800 NE Oregon Street, Suite 930
Portland, Oregon 97232

Thank you for the opportunity to comment on The Oregon Health Authority (OHA), Public Health Division, Emergency Medical Services and Trauma Systems Program's proposed amendments to Oregon Administrative Rules in Chapter 333, Divisions 200 and 205 for Trauma Hospital Categorization and Resource Standards. It is our understanding that OHA is directed to categorize hospitals according to trauma care capabilities using standards modeled after the American College of Surgeons, Committee on Trauma Standards (ACS standards).

Unfortunately, the proposed amendments appear to deviate from the ACS standards, as well as establishing a more restrictive provision than the current rules. In particular, in current Chapter 333, Division 200, Rule Section 11-3-3, it indicates that, for Level III and IV facilities, a "qualified anesthesiology provider" must be the liaison to the trauma program. Under the existing rules, a "qualified anesthesiology provider" includes a Certified Registered Nurse Anesthetist (CRNA). Proposed Chapter 333, Division 200, Rule Section 4.5 indicates that Level III facilities require a "Board-certified or board-eligible anesthesiologist" as liaison. This change will have a dramatic impact on Level III facilities across the state.

Furthermore, Section 4.5 of the 2022 ACS standards indicates that "***In Level III trauma centers, certified registered nurse anesthetists (CRNAs) who are licensed to practice independently may serve as the anesthesia liaison"*** (emphasis added). As you are no doubt aware, CRNAs have been licensed to practice independently for over 20 years in the State of Oregon.

We respectfully request that you add the 2022 ACS standard language regarding CRNAs in Level III trauma centers to the proposed amendments to OAR Chapter 333, Division 200, Rule Section 4.5. Thank you for your consideration. If you have any questions, please contact our lobbyist, Shaun Jillions (shaun@jillionsgroup.com).

Sincerely,

Andrea Hargis
President, Oregon Association of Nurse Anesthetists

From:	Edinger, Matthew
To:	Parmley Madeleine J; Mellony Bernal
Cc:	Public Health Rules
Subject:	Exhibit 4 Verbiage Clarification Concern
Date:	Friday, September 13, 2024 9:47:05 AM
Attachments:	image001.png

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Good morning, Madeleine and Mellony!

I just received an email from a Level IV with a clarification question that probably warrants a verbiage change in the upcoming Exhibit 4 changes.

In the old Exhibit 4, Standard 5-5-2 states that the TMD for a Level IV the "TMD ***is*** a physician practicing emergency medicine". (Emphasis mine). I believe the intent was to set a minimum standard so that Level IV facilities with minimal surgical capabilities weren't required to have a surgeon be the TMD.

In the new Exhibit 4, this verbiage was copied and pasted from the standard above, but I believe a verbiage change is in order to better clarify the intent of the standard.
Standard 2.8 should be reworded to state that "In Level IV trauma centers, the TMD ***may be*** a physician practicing emergency medicine…" (Emphasis again mine).
This would clearly allow Level IV centers with an available surgeon to appoint said surgeon as their TMD or allow them to use an ED physician when they don't have an available/appropriate surgeon for the role.

Let me know what you think.
Thanks!
-Matt

Matt Edinger MHA, RN
(He/Him)
Trauma PI Coordinator
Trauma Services
Asante Rogue Regional Medical Center
Phone: (541) 789-4729 | In House Ext: 14729 | **Mobile:** (858) 633-6317
Fax: (541) 789-4721
Email: Matthew.Edinger@asante.org

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Hospital Association of Oregon

September 23, 2024

Oregon Health Authority
Public Health Division
800 NE Oregon Street
Portland, OR 97232

Submitted electronically to: publichealth.rules@odhsoha.oregon.gov

Re: Proposed Rules - Trauma Hospital Categorization and Resource Standards

Mellony Bernal:

The Hospital Association of Oregon appreciates the opportunity to comment on the proposed rules for Chapter 333 relating to Trauma Hospital Categorization and Resource Standards. The Oregon Health Authority (OHA) has proposed rules to permanently amend Exhibit 4 (Oregon Trauma Hospital Resource Standards), Divisions 200 and 205, and Exhibit 1 (Oregon Trauma System Area Map). We are appreciative of OHA's rulemaking process. The transparency and responsiveness of OHA staff through this rulemaking process was exceptional.
We write to provide comments on the following important topics.

Effective Date
OHA's goal is to file the final rules by October 15, 2024, with an effective date of July 1, 2025. OHA noted fiscal impacts from the proposed rule changes to hospital trauma centers, but it is difficult to ascertain the exact costs. Hospital trauma centers need time to meet the requirements and get staff in place, among other implementation efforts. We request a delayed effective date.

- ***Request:*** We request that OHA delay the effective date to allow hospitals the time to implement these rule changes.

Resources for Optimal Care of the Injured Patient
OHA is directed to categorize hospitals according to trauma care capabilities using standards modeled after the American College of Surgeons (ACS) Committee on Trauma Standards (COT). In March 2022, the ACS COT Verification Review Subcommittee published the revised, Resources for Optimal Care of the Injured Patient, 2022 Standards (revised December 2023). As such, OHA has amended the rules adopting these latest standards and is revising Exhibit 4 to align with the revised standards for trauma centers categorized as a Level I, II, III, or IV. During the rules advisory committee meetings OHA referenced the Resources for Optimal Care of the Injured Patient, 2022 Standards (revised December 2023) when clarifying required elements in Exhibit 4. We request that OHA include the text of the standard or a reference to the standard in Exhibit 4.

4000 Kruse Way Place
Building 2, Suite 100
Lake Oswego, Oregon, 97035
Phone: 503.636.2204
Email: info@oregonhospitals.org
Web: oregonhospitals.org

- ***Request:*** We request that OHA include references or text of the standard from the "Resources for Optimal Care of the Injured Patient, 2022 Standards (revised December 2023)" in Exhibit 4, OAR Chapter 333, Division 200, Oregon Trauma Hospital Resource Standards, where appropriate.

Exhibit 4, OAR Chapter 333, Division 200, Oregon Trauma Hospital Resource Standards
2: Program Scope & Governance
2.8 The rule requires that the Trauma Medical Director in a Level IV trauma center must be a physician practicing emergency medicine. The rule does not allow a surgeon to serve as the Trauma Medical Director. We request that surgeons also be allowed to be the Trauma Medical Director in a Level IV trauma center.

- ***Request:*** We request that OHA revise 2.8 as follows:
  In Level IV trauma centers, the TMD may be a **surgeon or** a physician practicing emergency medicine, responsible for coordinating the care of injured patients, verifies continuing medical education (CME) of personnel, and has oversight of the trauma quality improvement process.

6: Data Surveillance and Systems
6.3 Requires Level I and Level II trauma centers to submit their data to the National Trauma Data Bank every year in a timely fashion so that it can be aggregated and analyzed at the national level. In addition, the rules require hospital trauma centers to participate in the Oregon Trauma Registry. However, some data fields are different. This creates a reporting burden. We request that OHA streamline the process and reduce the administrative burden.

- ***Request:*** We request that OHA streamline the process and reduce the administrative burden.

We request that OHA consider the comments outlined above. Thank you for reviewing our comments.

Thank you,

Danielle Meyer
Senior Public Policy Advisor
Hospital Association of Oregon

About the Hospital Association of Oregon

Founded in 1934, the Hospital Association of Oregon (HAO) is a mission-driven, nonprofit trade association representing Oregon's 61 hospitals. Together, hospitals are the sixth largest private employer statewide, employing more than 70,000 employees. Committed to fostering a stronger, safer, more equitable Oregon where all people have access to the high-quality care they need, the hospital association supports Oregon's hospitals so they can support their communities; educates government officials and the public on the state's health landscape and works collaboratively with policymakers, community based organizations and the health care community to build consensus on and advance health care policy benefiting the state's 4 million residents.

4000 Kruse Way Place
Building 2, Suite 100
Lake Oswego, Oregon, 97035

Phone: 503.636.2204
Email: info@oregonhospitals.org
Web: oregonhospitals.org