OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 200

EMERGENCY MEDICAL SERVICES AND TRAUMA SYSTEM

333-200-0000
Purpose
The purpose of these rules is to establish the procedures and standards for the development and maintenance of a comprehensive statewide trauma system as set forth under ORS 431.575 through 431.671.
Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.575 – ORS 431.671

333-200-0010
Definitions
As used in OAR 333-200-0000 through 333-200-0295:
(1) "Area Trauma Advisory Board" (ATAB) means an advisory group appointed by the Authority for each established trauma area to represent providers of trauma care and members of the public.
(2) "Authority" means the Oregon Health Authority.
(3) "Categorization" means a process for determining the level of a hospital's trauma care capability and commitment which allows any hospital which meets criteria to receive trauma patients.
(4) "Communications Coverage Area" means a geographic region representing a primary radio service area for emergency medical communications. When primary service areas substantially overlap they will be considered as one coverage area.
(5) "Coordinated Care Organization" has the meaning given that term in OAR 410-141-0000.
(6) "Designation" means a competitive process for determining the level of a hospital's trauma care capability and commitment, allowing the Division to select a limited number of hospitals which meet criteria to receive trauma patients.
(7) "Division" means the Public Health Division of the Oregon Health Authority.
(8) "Emergency Medical Condition" means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus, in the case of a pregnant woman, in serious jeopardy.
(9) "Emergency Medical Services Agency" (EMS Agency) has the meaning given that term in OAR 333-265-0000.
(10) "Emergency Medical Responder" means a person who is licensed by the Division as an Emergency Medical Responder.
(11) "Emergency Medical Services Provider" (EMS Provider) means a person who is licensed by the Division as an Emergency Medical Responder or an Emergency Medical Technician.
(12) "Emergency Medical Technician" (EMT) means a person who is licensed by the Division as an Emergency Medical Technician.
(13) "Glasgow Coma Scale" (GCS) means an internationally recognized scoring system for the assessment of head injury severity and degree of coma.
(14) "Hospital" has the meaning set forth in ORS 442.015(15).
(15) "Hospital Catchment Area" means a geographic region representing a primary service area for hospitals. When primary service areas substantially overlap they shall be considered as one catchment area.
(17) "Level I (Regional) Trauma Hospital" means a hospital which is categorized or designated by the Division as having met the trauma hospital resource standards for a Level I hospital, as described in Exhibit 4. Level I hospitals manage severely injured patients, provide trauma related medical education and conduct research in trauma care.
(18) "Level II (Area) Trauma Hospital" means a hospital categorized or designated by the Division as having met the trauma hospital resource standards for a Level II hospital, as described in Exhibit 4. Level II hospitals manage the severely injured patient.
(19) "Level III (Local) Trauma Hospital" means a hospital categorized or designated by the Division as having met the trauma hospital resource standards for a Level III hospital, as described in Exhibit 4. Level III hospitals provide resuscitation, stabilization, and assessment of the severely injured patient and provide either treatment or transfer the patient to a higher level trauma system hospital as described in Exhibit 5.
(20) "Level IV (Community) Trauma Hospital" means a hospital categorized or designated by the Division as having met the hospital resource standards for a Level IV hospital, as described in Exhibit 4. Level IV hospitals provide resuscitation and stabilization of the severely injured patient prior to transferring the patient to a higher level trauma system hospital.
(21) "Managed Health Care Organization" means a health care provider or a group or organization of medical service providers that provide for the delivery of an agreed upon set of medical or referral services for an enrolled group of individuals and families in a defined geographic area at a fixed periodic rate paid per enrolled individual or family.
(22) "Medical Direction" means physician responsibility for the operation and evaluation of prehospital emergency medical care performed by emergency care providers.
(23) "Off-Line Medical Direction" means the direction provided by a physician to prehospital emergency medical care providers through communications such as written protocols, standing orders, education and quality improvement reviews.
(24) "On-Line Medical Direction" means the direction provided by a physician to prehospital emergency medical care providers through radio, telephone, or other real time communication.
(25) "Oregon Trauma Registry" means the trauma data collection and analysis system operated by the Division.
(26) "Prehospital Response Time" means the length of time between the notification of a provider and the arrival of that provider's emergency medical service unit(s) at the incident scene.
(27) "Stabilization" means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.
(28) "State Trauma Advisory Board" (STAB) means an advisory group appointed by the Authority to represent providers of trauma care.
(29) "Trauma Patient" means a person who at any time meets field triage criteria for inclusion in the Oregon Trauma System, as described in Exhibit 2 of these rules.
(30) "Trauma System Hospital" means a hospital categorized or designated by the Division to receive and provide services to trauma patients.
(31) "Trauma System Plan" means a document which describes the policies, procedures and protocols for a comprehensive system of prevention and management of traumatic injuries.
(32) "Triage Criteria" means the parameters established to identify trauma patients for treatment in accordance with the trauma system plan. These criteria are set forth in Exhibit 2.
[ED. NOTE: Exhibits referenced are not included in rule text. Click here for PDF copy of exhibit(s).]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.611

333-200-0020
Objectives of the Trauma System
The objective of the statewide trauma system is to reduce deaths and disabilities which result from traumatic injuries by:
(1) Identifying the causes of traumatic injuries and recommending, promoting, and coordinating prevention activities;
(2) Developing a statewide trauma system plan to assure timely, quality, definitive care through coordinated identification, transportation and treatment of trauma patients:
(a) The statewide trauma system plan shall be composed of seven area plans; and
(b) Each area trauma system plan shall consist of policies, procedures, and protocols which address each of the following trauma system components:
(A) Communication and dispatch;
(B) Responders and prehospital response times;
(C) Medical direction and treatment;
(D) Triage and transportation;
(E) Hospital resources;
(F) Inter-hospital transfers;
(G) Rehabilitation;
(H) Quality improvement;
(I) Education and research;
(J) Prevention; and
(K) Disaster management.
(3) Adopting the standards, policies and procedures necessary to unify area trauma system plans into a statewide trauma system; and
[Publications: Publications referenced are available from the agency.]
State Trauma Advisory Board Functions
(1) The STAB is established in accordance with ORS 431.580.
(2) The STAB shall:
(a) Advise the Division with respect to the development of a comprehensive emergency medical services and trauma system including meeting the objectives established in OAR 333-200-0020;
(b) Advise the Division on the adoption of rules, policies, and procedures regarding the trauma system;
(c) Analyze data related to prevention of injuries, monitoring of the trauma system and recommend improvements where indicated; and
(d) Suggest improvements to the emergency medical services and trauma system.
(3) In satisfying its duties described in section (2) of this rule, the STAB shall:
(a) Make evidence-based decisions that emphasize the standard of care attainable throughout the state and individual communities; and
(b) Seek the advice and input of coordinated care organizations or other managed care organizations.
(4) The Division shall seek the advice of the STAB concerning the approval of area trauma system plans and approval of subsequent protocols for major modifications.
(5) A majority of the members of the STAB shall constitute a quorum in order to conduct business.
(6) Official action taken by the STAB requires the approval of the majority of the members.

State Trauma Advisory Board Appointments
(1) The STAB shall consist of a minimum of 17 members. These members shall represent each of the seven ATABs. A STAB member may also be a member of an ATAB.
(2) Members of the STAB shall be chosen in accordance with the provisions of ORS 431.580.
(3) Appointment for STAB members shall be as follows:
(a) Terms shall be for four years;
(b) Vacancies shall be filled by the Authority in concurrence with the Governor;
(c) Members may be reappointed but may not serve consecutive terms;
(d) With the exception of Level I trauma hospitals, members may not be appointed from the same trauma hospital in consecutive terms; and
(e) A member serves at the pleasure of the director of the Authority.
(4) The STAB may recommend to the Authority that:
(a) Membership be expanded to improve coordination of the trauma care system; and
(b) Provider specialty positions are considered for board appointment.
(5) A public member who has an economic interest in the provision of emergency medical services or trauma care may not be appointed to serve on the STAB.
333-200-0040
Trauma System Areas
The Division has established seven trauma system areas utilizing county lines, zip codes, township and range, and roads for the purpose of developing, implementing and monitoring the trauma system and not for the purpose of restricting patient referrals. The trauma system areas are illustrated in Exhibit 1 and are:
(1) Area 1: Clackamas County; Clatsop County; Columbia County; Multnomah County; Tillamook County (except zip codes 97122, 97135 and 97149); Washington County; and Yamhill County (zip codes 97115, 97119, 97123, 97132, 97140 and 97148 only);
(2) Area 2: Benton County; Lincoln County; Linn County; Polk County; Marion County; Tillamook County (zip codes 97122, 97135 and 97149 only); and Yamhill County (except zip codes 97115, 97132 and 97148);
(3) Area 3: Coos County; Curry County (zip codes 97450, 97465, and 97476 only); Douglas County; and Lane County;
(4) Area 5: Curry County (zip codes 97406, 97415 and 97444 only); Jackson County; and Josephine County;
(5) Area 6: Gilliam County; Hood River County; Sherman County; and Wasco County (except zip codes 97001, 97057 and 97761);
(6) Area 7: Crook County; Deschutes County; Grant County; Harney County; Jefferson County; Klamath County; Lake County; Wasco County (zip codes 97001, 97057 and 97761 only); and Wheeler County; and
(7) Area 9: Baker County, Malheur County, Morrow County; Umatilla County; Union County; and Wallowa County.
[ED. NOTE: Exhibits referenced are not included in rule text. Click here for PDF copy of exhibit(s).]
Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.609

333-200-0050
Area Trauma Advisory Board Functions
(1) Area Trauma Advisory Boards (ATAB) are established in accordance with ORS 431.613;
(2) Each ATAB shall:
(a) Act as liaison between the providers and general public in their area and the STAB and the Division for exchanging information about trauma system issues and developing an area-wide consensus;
(b) Advise the STAB and the Division on the adoption of rules, policies and procedures regarding area trauma system plans;
(c) Recommend to the Division an area trauma system plan which meets the standards and objectives of these rules;
(d) Participate in the promotion and function of the implemented area trauma system plan by making recommendations to the Division and the area trauma care providers; and
(e) Provide an annual report to the Division which describes a review and any recommended modifications of the area trauma system plan.
333-200-0060
Area Trauma Advisory Board Appointments
(1) Each ATAB shall consist of at least 15 members who shall be broadly representative of the trauma area as a whole.
(2) Appointments to the ATABs shall be in accordance with the provisions of ORS 431.613.
(3) Terms of appointment for ATAB members shall be as follows:
(a) Terms shall be for a period of three years;
(b) Vacancies shall be filled by appointment by the Authority in concurrence with the Governor;
(c) Members may serve unlimited terms at the discretion of the Division; and
(d) Members are subject to removal with cause by the Division.
(4) ATABs may recommend to the Division that:
(a) Membership be expanded in order to improve coordination of the area trauma system; and
(b) Provider specialty positions are considered for ATAB appointments.

333-200-0070
Approval of Area Trauma System Plans
(1) Each ATAB shall recommend to the Division an area trauma system plan and, when deemed necessary by the Division or the ATAB, modifications to the plan.
(2) Area trauma system plans shall meet the minimum standards established in OAR 333-200-0080.
(3) The Division may grant waivers from one or more standards contained in OAR 333-200-0080, in an area trauma system plan if the ATAB can demonstrate, or the Division finds that compliance with such standards is inappropriate because of special circumstances which would render compliance unreasonable, burdensome or impractical. Such waivers may be limited in time or may be conditioned as necessary to protect the public welfare.
(4) The Division shall seek the advice of the STAB concerning the approval of area trauma system plans and approval of subsequent proposals for major modifications.
(5) All approved area trauma system plans shall be considered the standard of care for the area covered by the plan.
(6) Each ATAB shall review its area trauma system plan at least once every five years and submit to the Division:
(a) A copy of the plan; and
(b) A description of any proposed changes including a statement about why such changes are necessary.

333-200-0080
Standards for Area Trauma System Plans
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. For the purposes of section (4) of this rule, interpretation and implementation of standards shall be in general accordance with the Guidelines for Field Triage of Injured Patients, Recommendations of the National Expert Panel on Field Triage, 2011: Centers for Disease Control and Prevention, MMWR, January 13, 2012, Vol. 61, No. 1:

(1) Communications and Dispatch:
(a) System Access: Residents and visitors in a communications coverage area shall be able to access emergency medical services by calling 9-1-1 as set forth in ORS 403.115;
(b) Dispatch Response: Dispatchers for emergency medical care providers shall have protocols which include pre-arrival patient care instructions and which require the dispatch of the appropriate level of available responding units (Basic, Intermediate or Advanced Life Support) based on medical need;
(c) Special Resources: All emergency medical services dispatchers shall maintain an up-to-date list of available law enforcement agencies, fire departments, air and ground ambulance services, quick response units that respond to an ill or injured person to provide initial emergency medical care prior to transportation by an ambulance and special responders for extrication, water rescue, hazardous material incidents and protocols for their use;
(d) Prehospital/Hospital: Ambulances shall have either a UHF or VHF radio that will provide reliable communications between the ambulance and central dispatch, the receiving hospital, and online medical direction. If the information has to be relayed through the dispatching agency, that agency shall be responsible to relay patient information to the hospital; and
(e) Training: There shall be training and certification standards for all tele-communicators that process telephone requests for or dispatch emergency care providers. The authorization to establish these standards is the responsibility of the Department of Public Safety Standards and Training in accordance with ORS 181.640.

(2) Responders and Prehospital Response Times:
(a) Ambulance Service Areas (ASAs): The existing ASAs shall be described as well as a summary of the ATAB’s efforts to promote each county adopting an ASA plan in accordance with ORS 682.062;
(b) Prehospital Response Times: Trauma system patients shall receive prehospital emergency medical care within the following prehospital response time parameters 90 percent of the time:
   (A) Urban area, an incorporated community of 50,000 or more population — 8 minutes;
   (B) Suburban area, an area which is not urban and which is contiguous to an urban community. It includes the area within a 10-mile radius of that community's center. It also includes areas beyond the 10-mile radius which are contiguous to the urban community and have a population density of 1,000 or more per square mile — 15 minutes;
   (C) Rural area, a geographic area 10 or more miles from a population center of 50,000 or more, with a population density of greater than six persons per square mile — 45 minutes;
   (D) Frontier area, the areas of the state with a population density of six or fewer persons per square mile and are accessible by paved roads — 2 hours; and
   (E) Search and rescue area, the areas of the state that are primarily forest, recreational or wilderness lands that are not accessible by paved roads or not inhabited by six or more persons on a year round basis. — No established prehospital response time.
(c) Field Command: A uniform policy shall assign responsibility for directing the care of the trauma patient in the prehospital setting in cases of response by multiple providers to assure scene control by the most qualified responder;
(d) Utilization of Air Ambulance: Protocols for the medical direction, activation and utilization of air ambulance service(s) shall be established;
(e) Prehospital Care Report Form: All prehospital emergency care providers shall use a patient care report form as defined in OAR 333-255-0000; and
(f) Utilization of Oregon Trauma System Identification Bracelet: All prehospital emergency medical care providers shall use the official Public Health Division numbered Trauma System Identification Bracelet when the patient meets trauma system entry criteria or is entered into the Trauma System and notify the receiving trauma hospital of the incoming patient. The prehospital emergency medical care provider shall record the number on the patient's prehospital care report.

(3) Medical Direction and Treatment:
(a) Protocols, Policies and Procedures: Providers in each trauma system area shall function under an effective and coordinated set of off-line prehospital trauma protocols and on-line medical direction trauma policies and procedures which address basic, intermediate and advanced levels of care. Off-line treatment protocols shall clearly describe all treatment and transportation procedures and identify those procedures which require on-line medical authorization. Medical direction policies and procedures must assure consistent area-wide coordination, data collection and area-wide quality improvement responsibility;
(b) Hospital Status: In the event that on-line medical direction serves two or more categorized or designated hospitals, there shall be a system for medical direction to continuously determine the current status of hospital trauma care capabilities; and
(c) Physician Qualifications: On-line medical direction physicians must be qualified for this role by virtue of training, experience and interest in prehospital trauma care as demonstrated through emergency medicine and Advanced Trauma Life Support (ATLS) training in accordance with the American College of Surgeons ATLS course.

(4)(a) Triage and Transportation: Triage and transportation protocols shall be written to ensure that patients who at any time meet field triage criteria as set forth in Exhibit 2 will be transported directly to a categorized trauma hospital as described under OAR 333-200-0090. The protocols must be based on field triage criteria (Exhibit 2) and identify the following:
(A) Which patients are appropriate for transport to a Level I, II, III or IV trauma hospital based on the capabilities of the hospitals in the ATAB;
(B) Conditions in which an ambulance may bypass a Level III or IV trauma hospital in order to transport directly to a Level I or II trauma hospital; and
(C) Conditions in which air transport should be considered for transport directly to a Level I or II trauma hospital.
(b) Triage and transportation protocols shall be followed unless otherwise advised by on-line medical direction or under the following circumstances:
(A) If unable to establish and maintain an adequate airway, the patient shall be taken to the nearest hospital to obtain definitive airway control. Upon establishing and maintaining airway control, the patient shall be immediately transferred to a Level I or Level II trauma hospital;
(B) If the scene time plus transport time to a Level I or Level II trauma hospital is significantly greater than the scene time plus transport time to a closer Level III or Level IV trauma hospital;
(C) If the hospital is unable to meet hospital resource standards as defined in Exhibit 4, when there are multiple patients involved, or the patient needs specialty care; or
(D) If on-line medical direction overrides these standards for patients with special circumstances, such as membership in a health maintenance organization, and if the patient's condition permits. 

(E) Application of paragraphs (B), (C), and (D) of this subsection must not delay definitive medical or surgical treatment.

(5) Hospital Resources:

(a) Trauma System Hospital Identification: Either the categorization or designation method of identifying trauma system hospitals as described under OAR 333-200-0090(1), (3) and (4) shall be recommended to the Division; and

(b) Resource Criteria: Trauma system hospitals shall meet or exceed the trauma hospital resource standards as set forth in Exhibit 4 and hospital activation criteria as set forth in Exhibit 3. Area criteria that exceed the criteria set forth in Exhibit 4 shall be accompanied by an informational statement of the additional costs that a hospital will incur to meet these standards.

(6) Inter-hospital Transfers:

(a) Identification of Patients: ATAB-wide criteria which meet or exceed any of the criteria set forth in Exhibit 5 of these rules shall be established to identify patients who should be transferred to a Level I or II trauma system hospital or specialty care center.

(b) When it is determined that a patient transfer is warranted:

(A) The transfer shall take place after the stabilization of the patient's emergency medical condition has been provided within the capabilities of the local hospital, which may include operative intervention; and

(B) The transfer to a Level I or II trauma hospital shall not be delayed for diagnostic procedures that have no impact on the transfer process or the immediate need for resuscitation.

(c) In all situations regarding an inter-hospital transfer, the decision to retain or transfer the patient shall be based on medical knowledge, experience and resources available to the patient.

(d) The hospital's trauma performance improvement and patient safety process shall monitor all cases meeting inter-hospital transfer criteria. The Division, through annual reports and site surveys, shall monitor this performance category.

(7) Inter-hospital Transfers with Health Maintenance Organizations:

(a) Trauma system hospitals shall facilitate the transfer of a member of a health maintenance organization or other managed health care organization when the emergency medical condition of the member permits and no deterioration of that condition is likely to result from or occur during the transfer of the patient. Trauma system hospitals shall transfer a patient in accordance with the provisions of ORS 431.611(2)(a) and (b) and any other applicable laws or regulations.

(b) A patient will be deemed stabilized, if the treating physician attending to the patient in the trauma hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

(c) Hospitals or health maintenance organizations may not attempt to influence patients and families, prior to the patient's stabilization, into making decisions affecting their trauma treatment by informing them of financial obligations if they remain in the trauma facility.

(d) Health maintenance organizations and non-designated trauma facilities shall report follow-up information to the transferring trauma system hospital and all required data as set forth in the Oregon Trauma Registry Data Dictionary; and

(e) Hospitals or health maintenance organizations that receive or transfer trauma patients shall participate in regional quality improvement activities.

(8) Rehabilitation Resources:
(a) Capabilities for trauma rehabilitation in each trauma system area and transfer procedures to other rehabilitation facilities shall be described; and
(b) Rehabilitation resources for burns, pediatrics, neuro-trauma and extended care shall be included.

(9) Quality improvement:
(a) Provisions shall be made for at least quarterly review of medical direction, prehospital emergency medical care and hospital care of trauma cases:
   (A) Area-wide criteria for identifying trauma cases for audit shall be described and shall include all trauma related deaths;
   (B) Responsibility for identifying and reviewing all trauma cases meeting audit criteria shall be assigned; and
   (C) Quarterly reports shall be submitted to the Division by the ATAB or its representative on confidential forms.

(b) The ATAB, STAB, all Area and State Quality Improvement Committee(s) and the Division shall meet in executive session as set forth in ORS 192.660 when discussing individual patient cases; and

(c) No member of any ATAB, the STAB, or any committee, subcommittee or task force thereof, shall disclose information or records protected by ORS 431.627 or 41.675 to unauthorized persons. Any person violating these rules shall be immediately removed by the Division from membership on any trauma system committee, subcommittee or task force thereof.

(10) Education and Research:
(a) Trauma Training: Trauma system hospitals shall provide or assist in the provision of prehospital trauma management courses to all EMS Providers involved in the prehospital emergency medical care of severely injured patients; and

(b) Research: In areas with Level I hospitals, clinical and basic research in trauma and publication of results involving surgical and nonsurgical specialists, nurses, and allied health professionals engaged in trauma care, shall be promoted.

(11) Prevention:
(a) Public Education: Public education and awareness activities shall be developed by trauma system hospitals to increase understanding of the trauma system and injury prevention. These activities shall be appropriate to the size and resources of the area; and

(b) Development and Evaluation: Trauma prevention activities to identify and address area problems shall be supported.

(12) Disaster Management:
Provisions for addressing triage of trauma system patients to non-trauma hospitals during a natural or manmade disaster must be addressed and include:
(a) Implementation and termination of the disaster management plan; and
(b) Reporting requirements of the Oregon Trauma Registry and Oregon Trauma Program.
[ED. NOTE: Exhibits referenced are not included in rule text. Click here for PDF copy of exhibit(s).]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.609 & 431.611

333-200-0090
Trauma Hospital Approval and Categorization
(1) The Division 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.
Approval will be renewed every three years if the hospital submits an application for renewal,
and if the Division's review finds that the hospital continues to meet the prescribed standards in
Exhibit 4.
(2) Upon determining the level of a hospital’s trauma care capability and whether prescribed
hospital resource standards have been met in accordance with OAR 333-200-0080, the Division
shall categorize a trauma system hospital as a Level I, Level II, Level III or Level IV trauma
hospital. A trauma hospital may also be categorized as a Level I or Level II Pediatric Trauma
Center and must meet prescribed pediatric trauma care standards in Exhibit 4. The Division may
accept ACS verification in accordance with OAR 333-200-0250.
(3) For area trauma system plans prescribing categorization of hospitals, the Division shall
approve all hospitals which meet the standards of the area trauma system plan.
(4) For area trauma system plans prescribing designation of hospitals, the Division shall approve
selected hospitals which meet the standards of the area trauma system plan. The Division shall
select hospitals based on the assessment that the best interests of the patients of the area are
served by the particular applicant and expected patient volume. Competing applicants shall be
judged on the on-site survey assessments of which hospital(s) provides the highest quality of
compliance with the standards in Exhibit 4.
(5) A trauma system’s hospital categorization may be transferable to a successor operator if the
successor provides written acknowledgment that the successor will comply with all of the
responsibilities and obligations imposed upon the transferor and under these rules including
probationary status, and the successor agrees to be substituted in pending proceedings regarding
the approval status. The Division may decline, at its discretion, to transfer approval if it
reasonably believes the successor cannot meet the standards, rules, policies or protocols set forth
in the approved area plan.
(6) A trauma system hospital may, without cause, terminate its trauma system hospital status
upon 90-days written notice to the Division and the ATAB’s list of interested parties.
[ED. NOTE: Exhibits referenced are not included in rule text. Click here for PDF copy of
exhibit(s).]
Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.609, 431.611 & 431.627

333-200-0235
Trauma Hospital Application
(1) Application for a hospital to be categorized as a Level I, II, III or IV trauma hospital shall be
submitted in writing on a form prescribed by the Division.
(2) The application process shall provide for at least 60 days in which to complete and submit
proposals to the Division with all supporting information and documents.
(3) The Division’s evaluation of the application shall include:
(a) A review of the hospital’s proposal by the Division or survey team; and
(b) An onsite survey by the Division and survey team of the hospital.
(4) The application shall become the property of the Division and upon completion of the
approval process is not subject to disclosure in accordance with ORS 431.627.
(5) The applicant shall have the right to withdraw its application at any time prior to dispositive
action by the Division.
(1) In accordance with OAR 333-200-0235, the Division shall conduct an on-site survey using a survey team composed of persons selected by the Division.
(2) No person may serve as a member of the survey team that has any actual or potential personal, organizational or financial conflict of interest in the hospital under consideration.
(3) The Division shall provide the proposed list of survey team members to the applicant prior to conducting a survey. An applicant wishing to contest a member of the survey team shall provide written notice to the Division within 10 calendar days of receiving the proposed list. The written notice must identify concerns and provide information that demonstrates a clear and convincing basis for the concern.
(4) The quality of each hospital’s compliance with the standards set forth in Exhibit 4 shall be evaluated during an on-site survey. Members of the survey team shall:
   (a) Evaluate medical records, staff rosters and schedules, minutes from quality improvement committee meetings, and other documents relevant to trauma care;
   (b) Evaluate equipment and premises;
   (c) Conduct informal interviews with hospital personnel; and
   (d) Report the findings and interpretations of the survey to the Division.
(5) During an on-site survey, administrative staff, faculty, medical staff, employees and representatives are prohibited from having any contact with any survey team member, except as directed by the Division. A violation of this provision may be grounds for immediate termination of the survey.
(6) The Division may review, inspect, evaluate, and audit patient trauma discharge summaries, trauma patient care logs, trauma patient care records, trauma quality improvement committee minutes and other documents relevant to trauma care of any hospital at any time to verify compliance with trauma system standards as set forth in these rules. The confidentiality of such records shall be maintained by the Division in accordance with state law.
(7) Information gathered during an on-site survey by the survey team including oral and written reports and deliberations shall be confidential in accordance with ORS 431.627(3).
(8) A written report of the on-site survey findings will be provided to the applicant only within 60 days of completing the on-site survey and shall be confidential in accordance with ORS 431.627(3).

[ED. NOTE: Exhibits referenced are not included in rule text. Click here for PDF copy of exhibit(s).]

333-200-0250
Hospitals Seeking Verification from American College of Surgeons
(1) Notwithstanding OAR 333-200-0235 and OAR 333-200-0245, a hospital seeking verification from the American College of Surgeons (ACS) shall submit the following information to the Division:
   (a) Notification of intent to seek verification;
(b) Notification of the date and time of the site visit to be conducted by ACS;
(c) A copy of the ACS Preview Review Questionnaire; and
(d) Any additional information necessary to determine compliance with state specific standards.

(2) A Division representative shall be present at the verification site visit and may request additional information to determine compliance with state specific standards.

(3) In accordance with OAR 333-200-0295, the Division shall provide a written report of the on-site survey findings and a corrective action plan shall be submitted by the hospital, if applicable.

(4) A hospital shall submit a copy of the ACS verification report to the Division upon receipt.

(5) The Division may accept ACS verification if the verification is recognized by the Division as addressing the ACS trauma system standards and any additional state standards identified in these rules.

Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.609, 431.611 & 431.627

333-200-0255
Waivers

(1) The Division may grant waivers from standards that are established in OAR 333-200-0080, OAR 333-200-0265 or Exhibit 4. Such waivers may be limited in time or may be conditioned as the Division considers necessary to protect the safety and welfare of the public.

(2) If a hospital seeks a waiver to the Division’s rules, it must submit a request in writing that includes, at a minimum, the following information:
   (a) The specific rule for which a waiver is requested;
   (b) The special circumstances relied upon to justify the waiver;
   (c) Any alternatives that were considered and the reasons those alternatives were not selected;
   (d) How the proposed waiver will maintain or improve patient health and safety without jeopardizing patient health and safety; and
   (e) The proposed duration of the waiver.

(3) After reviewing the written request, the Division shall issue its decision in writing.

(4) Applicants may not implement any waiver request until approved in writing by the Division.

[ED. NOTE: Exhibits referenced are not included in rule text. Click here for PDF copy of exhibit(s).]

Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.611

333-200-0265
Trauma System Hospital Responsibilities

A trauma system hospital shall:

(1) Be responsible for all expenses incurred by the hospital in planning, developing and participating in the trauma system, including attorney fees and costs;

(2) Be responsible for all expenses incurred when a re-survey of the hospital is conducted by the Division or its designee(s);

(3) Comply with all requirements in these rules, all current state and area trauma system standards, and all policies, protocols and procedures as set forth in the approved area trauma system plan;

(4) Meet or exceed the standards for hospital resources as set forth in Exhibit 4 and hospital activation and transfer criteria as set forth in Exhibits 3 and 5;
(5) Provide the resources, personnel, equipment and response required by these rules;
(6) Provide care to trauma system patients which is consistent with the standards advocated by the Advanced Trauma Life Support Course, American College of Surgeons, Committee on Trauma;
(7) Report to the Oregon Trauma Registry all required data as set forth in the Oregon Trauma Registry Abstract Manual for each and every trauma patient as defined in these rules:
   (a) Data must be reported within 60 days of death or discharge of that patient; and
   (b) Data shall be submitted in electronic media using a format prescribed by the Division.
   (c) The Division may, at its sole discretion, permit data submission by alternative means where use of the Division's prescribed format would impose a severe hardship on the reporting institution.
(8) Participate in evaluation and research studies as prescribed by the Division;
(9) Record patient resuscitation data using the official state trauma resuscitation flow sheet. If using a form other than the official form, that form must contain at least the same information; and
(10) Identify and submit to the Division the name of the individual that will serve as the Trauma Registrar, Trauma Coordinator or Trauma Program Manager, and Trauma Medical Director. Any changes to persons serving in these roles must be reported to the Division within 60 days.

[ED. NOTE: Exhibits referenced are not included in rule text. Click here for PDF copy of exhibit(s).]
[Publications: Publications referenced are available from the agency.]
Stats. Implemented: ORS 431.609, 431.611 & 431.623, 431.627

333-200-0275
Division Responsibilities
When requested, the Division shall provide statistical reports in formats prescribed by the Division in consultation with the STAB, to the STAB and ATAB Quality Improvement Committees within 90 days of the close of the calendar quarter following receipt of the data submitted pursuant to OAR 333-200-0265(7).
Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.611

333-200-0285
Violations
(1) No person, emergency medical service, medical clinic, or hospital shall by any means advertise, assert, represent, offer, provide or imply that such person, service, clinic or hospital is a trauma system hospital or has the capabilities for providing treatment to trauma patients beyond the status for which the approval has been granted.
(2) No trauma system hospital shall in any manner advertise or publicly assert that its trauma approval affects the hospital's care capabilities for non-trauma system patients, nor that the approval should influence the referral of non-trauma system patients.
(3) Where a hospital is greater than three months in arrears in reporting required trauma patient data, the Division may contract with an independent data collection and abstraction service to perform the data collection. The Division shall assess the trauma system hospital for all costs associated with such collection of required data.
333-200-0295

Enforcement

(1) Following an on-site survey, a member of the survey team may conduct an exit conference with the applicant or his or her designee. During the exit conference, a survey team member shall:

(a) Inform the applicant or designee of the preliminary findings of the survey; and
(b) Give the person a reasonable opportunity to submit additional facts or other information to the surveyor in response to those findings.

(2) Following the survey, a determination shall be made and Division staff shall prepare and provide the applicant or his or her designee specific and timely written notice of the findings. An applicant shall have 30 days from receipt of the survey report to request a reconsideration of the categorization.

(3) If during a survey, the survey team documents non-compliance with trauma rules or laws, the deficiencies will be identified in the survey report and the laws alleged to have been violated and the facts supporting the allegation.

(a) A corrective action plan must be mailed to the Division within 45 to 60 calendar days from the date the survey report was received by the applicant.

(b) The Division shall prescribe the time frame an applicant has to correct all deficiencies. The time frame shall be based on the seriousness of the deficiencies and whether any deficiencies affect patient safety.

(c) The Division may determine that a focused review is necessary within one year of the date of the on-site survey in order to determine that the deficiencies identified in the survey report have been corrected.

(4) Upon receipt of the Division’s written survey report, an applicant shall be provided an opportunity to dispute any findings including identified deficiencies. If an applicant desires an informal conference to dispute the survey findings, the applicant shall notify the Division in writing within 10 calendar days after receipt of the written survey report. The written request must include a detailed explanation of why the applicant believes the findings are inaccurate.

(5) The Division shall determine if a corrective action plan is acceptable. If the plan of correction is not acceptable to the Division, the Division shall notify the applicant in writing or by telephone:

(a) Identifying which provisions in the plan the Division finds unacceptable;

(b) Citing the reasons the Division finds them unacceptable; and

(c) Requesting that the plan of correction be modified and resubmitted no later than 30 calendar days from the date the letter of non-acceptance was received by the applicant.

(6) The Division may re-survey a trauma system hospital, immediately suspend or revoke a trauma system hospital approval or place a hospital on probation under any of the following circumstances:

(a) Substantial failure, for any reason, of a hospital to comply with these rules, all current state and area trauma system standards, and all policies, protocols and procedures as set forth in the approved area trauma system plan; or

(b) Submission of reports to the Division that are incorrect or incomplete in any material aspect.
(7) Except as set forth in OAR 333-200-0285(3), occasional failure of a trauma system hospital to meet its obligations will not be grounds for probation, suspension or revocation by the Division if the circumstances under which the failure occurred:
(a) Do not reflect an overall deterioration in quality of and commitment to trauma care; and
(b) Are corrected immediately by the hospital.
(8) Failure of a trauma system hospital to timely and accurately report to the Division all data required by rule or statute is grounds for suspension or revocation as a trauma hospital.
(9) A hospital which is dissatisfied with the decision of the Division regarding revocation, suspension, or probation in section (6) or (8) of this rule may request a contested case hearing pursuant to ORS chapter 183.

Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.609, 431.611 & 431.627

333-200-0300
Applicability
(1) A trauma hospital categorized as a Level I, Level II, Level III or Level IV trauma hospital as of January 1, 2016 shall comply with the resource standards prescribed in Exhibit 4 no later than January 1, 2017.
(2) An area trauma system plan shall include revised triage and transportation standards in accordance with OAR 333-200-0080(4) no later than January 1, 2017.
[ED. NOTE: Exhibits referenced are not included in rule text. Click here for PDF copy of exhibit(s).]
Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.611

DIVISION 205

TRAUMA SYSTEM HOSPITAL DESIGNATION IN TRAUMA AREA # 1

333-205-0000
Purpose
These rules establish standards for the approval and designation of Level I trauma system hospitals in Trauma Area #1. These rules establish standards in addition to OAR 333-200-0000 through 333-200-0295. For all standards addressed in both OAR 333-200-0000 through 333-200-0295 and OAR 333-205-0000 through 333-205-0050, the rules contained in OAR 333-205-0000 through 333-205-0050 shall apply.
Stats. Implemented: ORS 431.575 – 431.635

333-205-0010
Designation
(1) The designation method of selecting Level I trauma system hospitals shall be implemented in accordance with the provisions of OAR 333-200-0090(1) and (4), OAR 333-200-0235, and OAR 333-200-0245.
(2) Written notification of the trauma system hospital designation shall be provided to the applicant by the Division. An applicant shall have 30 days from the receipt of notification of non-designation to file a request with the Division for reconsideration.
Stats. Implemented: ORS 431.609, 431.611 & 431.627

333-205-0020
Hospital Resource Criteria
Trauma system hospitals shall meet or exceed the standards for Hospital Resources as set forth in OAR 333-200-0090, Exhibit 4.
[ED. NOTE: Exhibits referenced are not included in rule text. Click here for PDF copy of exhibit(s).]
Stats. Implemented: ORS 431.609, 431.611 & 431.627

333-205-0040
Number of Facilities
(1) The Division shall designate a sufficient number of Level I trauma system hospitals to assure resources within ATAB 1 are routinely available to treat at least four major trauma patients within a 90-minute time period. Major trauma means serious injury caused by external forces which results in death or an injury severity score of 16 or greater, a three day hospital length of stay, or requires intensive care admission or major surgical procedure within six hours of hospital admission.
(2) The Division shall designate a maximum of two Level I hospitals and shall not designate any Level III or Level IV hospitals in Clackamas, Multnomah and Washington Counties.
Stats. Implemented: ORS 431.609, 431.611 & 431.627

333-205-0050
Hospital Designation Criteria
(1) The Division shall utilize criteria as set forth in OAR 333-200-0090(4) and may, in addition, utilize the following criteria for selecting trauma system hospitals:
   (a) Locations of major trauma incidents; and
   (b) Geographical barriers which impede air or ground transportation.
(2) The Division shall consider the information contained in Resources for Optimal Care of the Injured Patient: Committee on Trauma American College of Surgeons, 2014, when interpreting the standards for the purpose of designating trauma system hospitals. This publication is not adopted as part of these rules.
[Publications: Publications referenced are available from the agency.]
Stats. Implemented: ORS 431.609, 431.611 & 431.627