Oregon Time-Sensitive Medical Emergencies Advisory Committee: Trauma Subcommittee Meeting Summary
2025 Quarter 4 | November 5, 2025

Slides and recording available upon request.

Appointed Subcommittee Members		
Name	**Position**	**Attendance**
Jeremy Buller	Nurse	Present
Sarah Daniels	Nurse	Present
Matt Edinger	Patient advocate / educator / injury prevention coordinator	Present
Willy Foster	Emergency medicine physician	Present
Anna LaRosa	Hospital administrator	Present
Megan Lundeberg	Trauma surgeon	Present
Steve McGaughey	Pediatric physician	Absent
Alexis Moren	Trauma medical director	Present
Chris Poulsen	EMS supervising physician	Present
Victor Walco	EMS provider	Absent

1. **Call to Order (Jeremy Buller)** **(Recording timestamp 00:01:00)**
   a. Roll call was conducted.
   b. OHA-EMS staff introduced themselves.

2. **Patient Definition** **(Recording timestamp 00:08:30)**
   a. David Lehrfeld introduced the topic. The American College of Surgeons (ACS) releases a set of field triage criteria, which is a prospective tool. They also release the National Trauma Data Standard (NTDS), which is a retrospective tool.
      - ACS updates its field triage roughly once every decade, while the NTDS is updated yearly. Instead of adopting the national standard in rule and changing it yearly, Oregon has a workgroup that meets frequently to discuss state-level changes.
      - Hip fractures were removed from the inclusion criteria in Oregon. However, hospitals that participate in ACS's Trauma Quality Improvement Program (TQIP) do include hip fractures in their data.
   b. Matthew Edinger added that the other purpose of Exhibit 2 is to help guide EMS services to the appropriate trauma facility in the area once they have identified someone as a trauma patient.
   c. Willy Foster asked whether there are any major aspects being missed now outside of hip fractures in how Oregon's data standard differs from the national standard.
      - Oregon's trauma database predates the national trauma data standard.
      - In the national standard, one must have injuries that make them a trauma patient. NTDS does not consider field triage; its only consideration is retrospective.
      - In the Oregon data standard, if someone is marked a trauma patient, they remain that way even if they are ultimately diagnosed with a different cause for their injuries (such

as stroke). This allows Oregon's trauma program to understand the real under- and over-triage rates.
    - Hip fractures were adopted nationally after Oregon decided to exclude them.
    - The national dataset is more consistent if looking only at injuries, not at activations.
d. Several members asked about the potential implications of changing to align with NTDS.
    - ACS guidelines do not include Level IV hospitals, which are over half the trauma hospitals in Oregon.
    - Level IV facilities generally have higher geriatric populations, so there would be a large increase in their trauma volume that comes with the inclusion of isolated proximal femur fractures, for which they likely do not have the staff capacity.
e. The hip fractures were included nationally because there is significant evidence of improved outcomes for patients who have their hip fracture pinned within 72 hours.
f. Megan Lundeberg mentioned that changing the inclusion criteria may change the flow of care around the state for hip fractures. Many non-trauma hospitals, especially in the Portland metro area, provide orthopedic care and already have sufficient systems in place to get patients treated quickly.
g. Matthew Edinger mentioned that Oregon's data standard acts as the minimum that every center should capture. This protects the smaller hospitals that don't have much capacity for data entry, then the centers that participate in TQIP have to use the expanded NTDS.
h. One quirk of inclusion criteria is that a patient may not have enough injuries to be a trauma patient at the first hospital, but if they are transferred to a trauma hospital, they are then included as a trauma patient, though there is not trauma record on them from the first hospital. This makes it difficult to track the throughline of care for quality improvement.
i. Sarah Daniels asked whether there has been consideration of inputting partial data for uninjured patients to still get the over-triage information without requiring full abstraction.
    - Peter Geissert shared that the main issue with a short form would be the validation rules, but it could be developed in a way that only certain rules apply. It would be a challenge but may be possible.
j. Chris Poulsen asked whether there could be a flow change in which EMS traffic is diverted when a hip fracture is suspected.
    - Members of the group chimed in that this could be changed with the regional Area Trauma Advisory Board (ATAB) plan rather than through inclusion criteria. Similar adjustments are in place already for orthopedic injuries in central Oregon and obstetric and neurosurgical patients in southern Oregon.
    - State criteria act as a "floor" onto which the regions and EMS agencies can build.

3. Q2 Subcommittee Summary (Recording timestamp 00:43:49)

a. The group approved by consensus the written summary of the previous meeting.

4. Regional Roundtable Discussion (Recording timestamp 00:44:30)

a. Alexis Moren updated that ATAB 2 is working on transfers to Level II centers that can support patient's injuries, rather than sending them to Level I centers. They are also working on over- and under-triage with the new system. Sarah Daniels added that new construction in the region will start in 2026. Salem Hospital is also working through the change in the trauma registry, including the slowdown and backlogs of charts.
b. Megan Lundeberg shared that ATAB 1 is looking at the catchment areas and transfers, especially now that there are two Level IV facilities and a Level III facility on the coast.

ATAB 1 hospitals are also dealing with the delays due the registry; the Level I facilities are concerned that TQIP delays may impact their ACS verification as a trauma center.

c. Willy Foster shared that his Level III center in Florence might have to drop to Level IV due to changes in regulations that the medical director cannot have a co-director.
d. Matthew Edinger shared that they are also slowing down from the registry. From ATAB 5 perspective, there was a lot of gearing up for regional time-sensitive emergency boards, but since the second part of the EMS Modernization bill did not pass, the plans look a bit different regarding changes to regional meetings. Matt is looking forward to suggestions from the state on how they can regionally restructure.
e. Jeremy Buller shared that St. Charles is planning to implement a new prehospital communication platform, Tiger Connect, for EMS agencies to give report to the hospital more efficiently than radio, in Quarter 1 of 2026. The St. Charles Bend ED is getting a new blood fridge, and they are hiring a performance improvement nurse to start in January.
f. Chris Poulsen shared that the volume of EMS calls continues to increase; volume and throughput issues have been compounded by emergency department boarding. Willy Foster asked about the changes since the Crisis Assistance Helping Out On The Streets (CAHOOTS) mobile crisis intervention ceased operations earlier this year; Chris answered that subjectively, the EMS transports changed fairly minimally as the calls for service largely shifted from CAHOOTS calls to the Lane County Mobile Crisis Team.
g. Jeremy Buller also mentioned that Bend Fire has a SOS Safety for Seniors program to do home assessments for fall risks. Willy Foster shared that their EMS Mobile Integrated Health community paramedic program does these assessments too.

5. Oregon Trauma Registry (Peter Geissert) (Recording timestamp 00:57:20)

a. Peter and the data team are tracking all issues through Smartsheet. There are 32 outstanding requests, 5 are in progress, 4 were identified as good topics to discuss with the data workgroup, 62 have been completed, and 3 were cancelled.
b. Legacy data migration: there is a lot of work going into testing and ensuring that previous data is moving into the new system correctly.
    - The data team has to verify everything, even things that cannot be seen.
    - There is an outstanding request for ImageTrend for the export mappings; it seems like it is not in a readily accessible format that they can show us.
    - There is also a request in with the vendor regarding NTDB inclusion criteria setup so that the data team can test it, since it is not visible. The triggers are not transparent.
c. Access levels:
    - The data team acknowledges that some users need access to multiple hospitals, and this has been delayed.
    - There is a known issue with the visibility of the user list to hospital administrators, with a workaround which is not a long-term solution. The data team has been trying to get clarity on how to move forward with this.
    - Many accounts were reset for security. Users needing different access level permissions are asked to fill out a support request form.

6. 2026 Goals (Recording timestamp 01:10:00)

a. Several members expressed that their primary focus is getting the data clean and valid in the trauma registry. This must happen before data analysis projects can proceed.

b. Jeremy Buller proposed a workgroup to help get the data elements fixed in the trauma registry. This was approved by the subcommittee.
   - This should be a small group of mainly front-end users. The work will need to be done in phases.
c. Megan Lundeberg suggested work around reducing unnecessary patient transfers. One conversation is adopting the modified Brain Injury Guidelines which eliminate aspirin from the highest-risk (BIG 3) criteria. OHSU has incorporated this, and it makes sense to extend that into the community. The Rib Injury Guidelines (RIG) and isolated facial fractures were also discussed as potential topics.
   - The group approved a workgroup to focus on transfers.
d. Matthew Edinger asked whether any decisions made by the subcommittee would ultimately have to be adopted by the EMS Advisory Board (EMSAB). Madeleine Parmley clarified that it would depend on the recommendation. Ultimately, this group is comprises the experts on trauma, so its decisions will likely be deferred to unless the higher-level groups anticipate additional impacts, such as fiscal implications.

7. Administrative Updates (Madeleine Parmley) (Recording timestamp 01:27:20)
a. Madeleine shared that recruitment efforts are ongoing for both committee and board seats.
b. Due to fiscal constraints and budgetary considerations, all meetings in 2026 will be held virtually. Subcommittees will meet at different times to help reduce the burden on staff.
c. Madeleine shared a new resource called Basecamp for document management.

8. Public Comment (Recording timestamp 01:39:50)
a. Mindy Stinnett provided verbal comment requesting information on data entry trainings. Peter Geissert responded that the EMS Program data team is working to make recorded trainings publicly available. [December 2025 update: recordings are now available.]
b. Sue Steen provided verbal comments regarding the Oregon Trauma Registry Inclusion Criteria, specifically the use of prospective versus retrospective data. She raised the question of which approach offers greater value for reporting, analysis, and injury prevention. She highlighted hip fractures as an example, questioning about how many patients with hip fractures may remain at hospitals that lack the capacity to treat them promptly. This delay in care could contribute to the high mortality rate in this population. Looking ahead to 2026, Sue emphasized the importance of collecting data that offers meaningful insights into mechanisms of injury across the state. This information could help identify areas for system improvement and guide prevention efforts.
c. Nelly Tkachman read off written comment submitted by Heather Wong about contributing registrars to the workgroup focused on addressing registry issues.

9. Key Takeaways (Jeremy Buller) (Recording timestamp 01:46:56)
a. The subcommittee set up two workgroups to work on trauma registry data and transfers.
b. The subcommittee's next meeting will be held February 10, 2025, 0900-1200, on Zoom.

Meeting adjourned at 1104.

Next meeting:
February 10, 2026, 0900-1200
Virtual only on Zoom