Oregon Time-Sensitive Medical Emergencies Advisory Committee: Trauma Subcommittee Meeting Summary
2025 Quarter 2 | May 7, 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 (virtual)
Anna LaRosa	Hospital administrator	Present (virtual)
Megan Lundeberg	Trauma surgeon	Present
Steve McGaughey	Pediatric physician	Present
Alexis Moren	Trauma medical director	Present
Victor Walco	EMS provider	Present

1. **Call to Order and Introductions (Madeleine Parmley, Oregon Health Authority Emergency Medical Services Program)** **(Recording timestamp 00:01:45)**
   a. Roll call was conducted.
   b. OHA-EMS staff introduced themselves.
   c. Subcommittee members introduced themselves.
   d. The group went over expectations and norms for participation.
   e. The meeting agenda was reviewed; no changes were requested.

2. **Bylaws and Subcommittee Structure (Madeleine Parmley)** **(Recording timestamp 00:19:45)**
   a. Madeleine introduced members to the bylaws of the Time-Sensitive Medical Emergencies Advisory Committee (TSMEAC). The stroke, cardiac, and trauma subcommittees are embedded within the TSMEAC.
   b. There will be a liaison who leads this subcommittee. The liaison will be a member cross-appointed to the TSMEAC.
   c. Megan Lundeberg asked whether, according to the bylaws, workgroups must be created by the TSMEAC, or if the subcommittee could create workgroups. Dana Selover responded that the subcommittee is likely able to create their own, but it needs to be confirmed. Madeleine Parmley added that the goal longer-term is for the subcommittee to generate their own initiatives and have autonomy to undertake relevant projects.

3. **Regional Roundtable Updates** **(Recording timestamp 00:26:25)**
   a. Anna LaRosa shared that her hospital in Ontario covers rural Malheur county. The local EMS system tends to have basic life support and intermediate providers.
   b. Willy Foster shared that he works in Florence, at a critical access hospital on the Oregon coast that is also a Level III trauma center. The EMS system is strong, with many critical care paramedics, because many patients get transferred to the valley. The trauma

program continues outreach events, such as one on Memorial Day at the dunes. The Area Trauma Advisory Board (ATAB) for region 3 continues to run well.

c. Steve McGaughey shared that this is his first involvement with trauma-specific work. He represents a pediatric Level I trauma center, which primarily receives referrals. His work centers on getting patients transferred in quickly and safely, because pediatric subspecialty coverage outside of the metropolitan area is very limited.
d. Victor Walco shared that Life Flight in Oregon continues to evaluate which areas of the state have limited access to critical care services and gaps in transportation.
e. Megan Lundeberg shared that in ATAB 1, Providence Seaside is applying to become a Level IV trauma facility and Columbia Memorial Hospital is requesting re-categorization as a Level III facility (previously Level IV). This will change the catchment areas on the coast. Clinically, ATAB 1 has discussed interpretation of the Brain Injury Guidelines (BIG) for patients on 81mg aspirin. There is data out of Oregon Health & Science University suggesting that those patients do not necessarily behave like BIG 3 patients on other anticoagulants. The group is also working on implementing the Rib Injury Guidelines into the triage and transfer document that helps guide *in situ* management in the community.
    - Madeleine Parmley added that Columbia Memorial has been approved as a Level III center following their recent survey.
f. Sarah Daniels shared that in ATAB 2, Willamette Valley Medical Center in McMinnville is also planning to move from Level IV to a Level III center. ATAB 2 has raised concerns about a lengthy construction project planned for the bridge that connects Marion and Polk counties, including some full closures that would require substantial detours north or south. The group anticipates possible additional usage of air ambulance services to transport patients during disruptions to ground service. Salem Hospital has been serving as a beta-testing site for Epic's massive transfusion protocol buildout. Salem is also planning a mass casualty incident drill in June involving the local school district and EMS services, with 50+ students volunteering. ATAB 2 has discussed the need to focus on sending patients to Level II facilities when appropriate for management in order to reserve resources available at Level I centers that are drawn on statewide.
g. Alexis Moren shared that Salem Hospital is looking into becoming a National Disaster Medical System center, which would help with repatriation of patients in the event of a mass casualty.
    - Madeleine Parmley asked about communication received from the Oregon Department of Transportation (ODOT) about the bridge construction. Sarah Daniels answered that the upcoming construction was discovered by staff and brought up to the emergency management team at Salem Hospital; hospital staff had a meeting with ODOT shortly thereafter but Sarah is unsure who initiated that discussion. EMS partners in the region have been concerned that outreach was to the hospital first, dependent on dissemination of information from there.
      (The discussion was interrupted temporarily by an evacuation drill in the Portland State Office Building.)
    - Victor Walco added that a similar communication gap occurred with the Dalles bridge closure this past year. Due to the long timeline, EMS and the hospitals were able to become active participants in the discussion, but it would be good feedback for ODOT to hear that agencies and hospitals need input earlier.
h. Jeremy Buller shared that ATAB 7 is also focused on transportation, weighing extended transport time against the potential delay of having a patient initially treated at a less-

resourced facility and requiring subsequent transfer. Weather conditions and smoke are factors, including whether or not air transport is an option. In cases where air crews are available, some hospitals are having extended handoff times. St Charles in Bend is looking at expanding the emergency department, though this is unlikely to happen for the next several years. St Charles is also preparing for an airport drill, held every three years. They have been doing tabletop drills regularly but want to use the airport drill as a chance to stress the system and figure out where gaps are.

i. Matt Edinger shared that in ATAB 5, many individual hospitals have adopted the Brain Injury Guidelines and have been able to keep patients closer to home. Southern Oregon has a large geriatric population (patients 65 years and older) and sees many ground-level falls. Rogue Regional Medical Center is working to refer lower-acuity patients seen post-fall to Jackson County's mobile integrated health unit for fall and risk assessments to mitigate future injuries. This is intended to bridge the gap for patients who do not qualify for home health after hospital admission.

4. **Scoping and 2025 Objectives (Madeleine Parmley)** **(Recording timestamp 00:46:27)**
   a. TSMEAC was established through the EMS Modernization legislation (HB 4081, 2024).
   b. Oregon's trauma system has existed for decades and already accomplishes many of the objectives outlined in EMS Modernization (patient definitions, hospital designations, data system, etc.). Stroke and cardiac systems of care still need to be built out.
   c. The subcommittee formed breakout groups to discuss:
      - What can trauma teach us about how to build statewide systems of cardiac and stroke care?
      - What are the advantages of having a statewide trauma subcommittee? What can the subcommittee work on specifically that will contribute to the statewide landscape?
      - Write a 1-2 sentence description of how you collectively see the purpose of the subcommittee.
      - Name 2-3 projects or work products that the subcommittee can develop using members' subject matter expertise.
   d. Reports from breakout groups:
      - Matt Edinger: The subcommittee can provide guidance to ATABs to standardize process improvement and quality assurance across regions. In the transition to regional time-sensitive emergency boards, the subcommittee can advise on minimum composition for those groups. It may also serve as an avenue for facilities and regions to request clarification on particular issues or processes and receive feedback. Sample projects include standardizing reports to enable benchmarking at different scales (state, region, trauma facility level).
        - Jeremy Buller asked whether clarification could include changing the data dictionary if the group produces a clearer definition than the existing one. Matt answered that it will need to remain consistent with the National Trauma Data Bank dictionary, but could address gray areas outside that scope.
        - Madeleine Parmley asked if the comment about composition of regional boards was directed at trauma specifically or intended for other specialties as well. Matt responded that his group discussed minimum trauma presence on the boards.
      - Megan Lundeberg: Group discussed examining and refining the flow of trauma patients to best utilize trauma system resources, such as avoiding "leap-frogging" Level II facilities to Level I. It will take relationship-building and awareness to change

transfer patterns so that patients go to the closest facility able to meet their clinical needs. The group emphasized facilitating initiatives for clinical practice, specifically empowering hospitals to treat certain injury patterns *in situ*, with rib injuries and non-operative facial fractures as potential areas of focus.

- Anna LaRosa: Group would like to ensure that ATABs receive guidance appropriate to both rural and metro areas, given their different resources and needs. Goals included MCI preparation support to improve readiness for smaller departments, supporting relationship-building between trauma surgeons at specialty centers and rural partners, and recommendations to reduce transfer delays while ensuring EMS providers feel comfortable implementing them. How staffing models (registrars, program managers) are used for other time-sensitive emergencies is an area for potential collaboration with the other TSMEAC subcommittees.

5. **Oregon Trauma Registry Updates (Albert Ramon, OHA EMS Program)** **(Recording timestamp 01:08:10)**
   a. The EMS Program's data team is in the process of implementing the new trauma registry system and is collaborating with the vendor. Training for hospitals is being scheduled and will likely occur in June. Data migration is happening on the back end. Albert thanked the hospitals who filled out the account audit.
   b. Matt Edinger asked whether there have been any updates to the implementation timeline. Albert responded that October 1 is the go-live date.
   c. Sarah Daniels asked whether there would be a chance of losing historical data during the migration process. Albert answered that the risk is relatively low and that no issues have been detected to date. Matt Edinger followed up by asking about Abbreviated Injury Scale 15 data that is currently entered through Smartsheet. Albert responded that its migration similarly has been going well on the back end but remains in progress.

6. **Brain Injury Guidelines Update for Pediatrics (Madeleine Parmley)** **(Recording timestamp 01:14:35)**
   a. Before sunsetting, the State Trauma Advisory Board had worked to support hospitals in adopting the Brain Injury Guidelines criteria for management of patients with traumatic brain injuries. A guidance document and video presentation were created by the EMS Program and endorsed by the board.
   b. Pediatric partners raised concern that while the studies for the BIG criteria were conducted in adults, the guidance documentation produced by the EMS Program did not specify patient age and could mistakenly be applied to pediatrics. An updated document version was recently released to clarify that its intended use is for adults.
      - Steve McGaughey asked whether this change was based on cases or taken as a precautionary measure. Megan Lundeberg answered that in ATAB 1, there were a few cases in which transfer was requested for patients with questionable imaging findings and the sending provider expressed concern that the patients were not immediately accepted. This led to conversations among pediatric and trauma providers at Level I facilities and was raised regionally.
      - Willy Foster asked about the age cutoff. Megan Lundeberg answered that research supports application of BIG for patients 16 years and older.
      - Madeleine added a related pediatric equipment warning on Armstrong Medical Broselow tapes with incorrect information listed in two of the sections.

7. **Key Takeaways (Madeleine Parmley)** **(Recording timestamp 01:21:31)**
    a. Madeleine reviewed the subcommittee's vacancies and needs for geographic representation.
    b. The subcommittee's next meeting will be held August 13, 2025, 0900-1200, in person at the Portland State Office Building.

8. **Public Comment** **(Recording timestamp 01:27:25)**
    a. No public comments were requested.

Meeting adjourned at 1129.

Next meeting:
August 13, 2025, 0900-1200
Portland State Office Building, Room 177
800 NE Oregon Street, Portland, OR, 97232