Oregon Time-Sensitive Medical Emergencies Advisory Committee: Trauma Subcommittee Meeting Summary
2025 Quarter 3 | August 13, 2025

Slides and recording available upon request.

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

1. **Call to Order and Introductions (Madeleine Parmley, Oregon Health Authority Emergency Medical Services Program, and Jeremy Buller) (Recording timestamp 00:00:43)**
   a. Madeleine introduced Jeremy as the subcommittee's lead and liaison to the main Time-Sensitive Medical Emergencies Advisory Committee (TSMEAC).
   b. Roll call was conducted.
   c. Subcommittee members briefly introduced themselves and OHA-EMS staff were introduced.

2. **EMS Modernization and Legislative Updates (Dana Selover, Oregon Health Authority Health Care Regulation and Quality Improvement) (In Stroke Subcommittee recording)**
   a. All three time-sensitive emergency specialty subcommittees gathered to hear about the next steps after the 2025 legislative session.
   b. House Bill 4081 passed in 2024 and is part 1 of the EMS Modernization plan. House Bill 3572, which would have been part 2, did not pass in 2025. Without the funding of House Bill 3572, OHA-EMS will need to re-prioritize the EMS Modernization objectives using existing resources.

3. **Q2 Subcommittee Summary (Recording timestamp 00:10:31)**
   a. The group approved by consensus the written summary of the previous meeting.

4. **Defining a Trauma Patient (Madeleine Parmley) (Recording timestamp 00:11:20)**
   a. The subcommittee has been asked to review and make recommendations on the trauma patient definition. There is a state standard in rule, but it is subject to discussion.
      - Oregon's state standards for trauma include field triage criteria (Exhibit 2), hospital activation criteria (Exhibit 3), and data inclusion criteria.

- Oregon's standards largely align with the American College of Surgeons (ACS) "grey book" and the National Trauma Data Standard Data Dictionary, with some changes such as spelling out abbreviations.
- Oregon Administrative Rule 333-200-0010 (27) currently states that "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 or the hospital activation criteria as set forth in Exhibit 3."
- In both field triage and hospital activation, there is room for provider discretion.

b. Alexis Moren asked how much leeway the subcommittee would have given that facilities completing ACS verification must comply with ACS standards. Madeleine answered that Oregon only has 5 ACS-verified facilities. State-level requirements can and have been modified to work better for Oregon's non-ACS-verified facilities.
c. To revise the exhibits or the definition as written in rule, a rules advisory committee (RAC) would need to be convened. Victor Walco asked if the exhibits are addenda to the definition. Madeleine answered that Exhibits 2, 3, 4, and 5, as well as the Oregon data inclusion criteria, are mentioned in the rules.
d. Oregon's data inclusion criteria does not include isolated hip fractures, but hip fractures are included for the ACS Trauma Quality Improvement Program (TQIP).
e. Sarah Daniels commented on the disconnect between the inclusion criteria for the National Trauma Data Bank (NTDB) and what the state defines as a trauma patient, despite Exhibit 4 requiring submission to NTDB. This can be difficult for hospitals to follow. Sarah believes it would be clearer for Oregon either to have the same criteria as NTDB or to not require submission to NTDB.
    - Madeleine responded that the RAC for Exhibit 4 had pushed back on just utilizing NTDB, which led to the language change to the Oregon dictionary. RAC members from smaller hospitals provided feedback that it would greatly increase their facilities' workloads if they had to include all NTDB-qualifying incidents.
    - Sarah added that it is not currently possible to benchmark patients, as required by Exhibit 4, if there is variability on which patients are included.
    - Madeleine reminded the group that the current standards are a minimum and hospitals can incorporate extra criteria internally, such as head injury protocols.
f. William Foster asked about delayed trauma patients, ones that were entered into the trauma system based on the results of their workup in the emergency department rather than immediate assessment upon arrival.
    - Madeleine answered that those patients are included if they fit into findings-based activations under Oregon's inclusion criteria. For some, this means the trauma team resources are activated at a delay, while for others, it would not change the course of action but the patients are included in the registry. The RAC that discussed Exhibit 3 could not come to consensus on adding findings-based criteria.
g. Megan Lundeberg mentioned the possibility of adding phrasing "or meets the Oregon inclusion criteria" to the definition in rule to encompass patients with eligibility from workup findings.
h. Jeremy Buller suggested modifying the exclusion criteria to remove specific mention of hip fractures in order to avoid potential misinterpretation since some hospitals must include hip fractures to comply with TQIP.
i. Chris Poulsen asked whether there is a scheduled timeframe or cadence when definitions are re-examined or reconsidered, or if the process is done as needed.

Madeleine answered that the process is ad hoc. The EMS Program initiates changes when there are national updates (usually on cycles of 5-7 years) or if numerous providers find that an element is not working in Oregon's system.

j. Madeleine mentioned that overly specific definitions can be too restrictive. Current setup allows provider discretion. Sarah Daniels supported breadth and wanted to ensure the definitions are not contradictory.
k. Sarah Daniels suggested collecting data on the significance of the criteria change from Oregon to NTDB. Jeremy Buller stated that for his team, about 500-600 patients were added when they moved to the NTDB criteria.
l. Jeremy Buller asked whether the current definition captures delayed activation, retroactive, and cancellations. The group agreed that it does not because it is based on Exhibits 2 and 3, thereby missing patients who may meet other Oregon dataset inclusion criteria such as an Injury Severity Score over 9. This hinges on the difference between 'suspected' injuries and confirmed findings.
m. Jeremy Buller suggested adding "or patients that are entered or will be entered into the Oregon Trauma Registry" to the end of the rule definition to capture. Willy Foster supported. Megan Lundeberg suggested "or meets criteria for inclusion into the Oregon Trauma Registry" as alternate phrasing. Megan also clarified that this is not supposed to make all hip fractures into trauma activations.
n. Jeremy and Madeleine decided to open for public comments specific to this discussion.
    - Nelly Tkachman read off written comments submitted by Katie Hennick. Katie Hennick then verbally commented supporting Jeremy's suggested phrasing change.
    - Kathy Tompkins provided verbal comment on previous discussions of the inclusion criteria revisions in 2016-2017. Kathy mentioned that from a quality improvement perspective, interpretability is a problem for benchmarking. Kathy also suggested a staged rollout if the inclusion criteria are changed to closer match NTDB.
o. Jeremy will present the patient definition at the Time-Sensitive Medical Emergencies Advisory Committee. The TSMEAC may vote to advance this definition to the EMS Advisory Board, or they can request it be brought back to this subcommittee for further review. Implications for potential rulemaking were briefly discussed.

5. Regional Roundtable Updates (Recording timestamp 00:53:30)

a. Megan Lundeberg shared that Area Trauma Advisory Board (ATAB) region 1 met on Monday at Columbia Memorial in Astoria. The group talked about future uses for data given changes in the state registry. They also discussed outreach efforts and education with EMS. They also had a robust discussion on mass casualty response on the coast.
b. Alexis Moren and Sarah Daniels shared that ATAB 2 met about a month ago and worked on troubleshooting upcoming potential EMS issues, including triage following the closure of a bridge in Salem. The Oregon Department of Transportation met with some EMS agencies last week. The bridge will be closed but there will be one-way traffic with a flagger on the bridge to allow any EMS to come through. ATAB 2 is also looking at under- and over-triage to try to identify patterns, and better facilitating trauma transfers coming to Salem's Level II trauma center to mitigate the number that must go north to the Level I facilities in Portland. Salem had a small Mass Casualty Incident (MCI) in June, which allowed them to find areas of improvement in their mass casualty system. It also showed that mass casualty enactments do not demonstrate enough stress to mimic a real event.

c. Chris Poulsen and Willy Foster shared that ATAB 3's emergency departments are stressed and overwhelmed every day, which makes it difficult to conduct drills that are meaningful. The most recent ATAB 3 meetings have included case presentations on patients initially brought to Level III or IV centers, that in retrospect would have been much better served by going straight to a Level II facility. Transferred can be delayed when patients stop at Level III and IV hospitals.
d. ATABs 5 and 6 did not have updates shared at this meeting.
e. Jeremy Buller shared that ATAB 7 is dealing with agency transport issues, but hospital acceptance has not been a problem. St. Charles Bend paused their outreach efforts but will restart now that their survey has been completed.
f. Anna LaRosa shared that ATAB 9's April meeting was cancelled, but they are planning to meet later in August.
g. Victor Walco shared that Mercy Flights now has an additional helicopter, and that Med-Trans has added an aircraft in Klamath Falls which improves regional response.
    - Jeremy Buller shared that even though the Klamath Falls service is only 12 hours, it is being utilized quite efficiently.
    - Madeleine Parmley shared that Good Shepherd in Hermiston is building a hangar on the hospital campus to avoid the 10-minute transit delay to and from the airport.
h. Madeleine Parmley shared that OHA is still actively doing virtual surveys. Providence Seaside will have its new facility onsite initial survey on August 27. Another hospital in the southern part of the state is also talking about applying to be a trauma facility. From 2021, there has been stabilization in staffing and leadership, with a reduction in use of travel nurse staff. This is avoids constant cycles of training and orientation. Feedback on the change to the Smartsheet survey process has been positive.
i. Jeremy Buller also shared that a volunteer EMS agency at the Region 7 Healthcare Coalition is struggling to recruit a new medical director. Other members of the subcommittee had not heard of similar issues with EMS agencies in their area.

6. Oregon Trauma Registry Report (Albert Ramon, OHA EMS Program) (Recording timestamp 01:09:20)

a. The information shared is preliminary as the report is still in progress.
b. There is continued growth and volume across the state, but there are differences based on demographics. There are improvements in record timeliness since the last annual report in 2023. There has been a 50% increase in "missing" data for activation level.
c. Records by trauma center level indicate continuing total volume increase. Total records increased from 22,715 in 2023 to 23,276 in 2024.
    - Victor Walco asked whether this data would reflect changes in the activation criteria; it does not clearly do so because the newest versions of Exhibits 2 and 3 went into effect on October 15, 2024.
    - Alexis Moren asked about dividing the volume of records by region; Albert answered that the final report will have the records broken down by level and region.
d. The financial charges by trauma center level indicate high fluctuation in costs reported from year to year.
    - Jeremy Buller asked why 2019/2020 data was used as a comparator. The last report, released in 2023, used 2019-2020 financial numbers. The 2021-2022 report was not completed, as the staff position to work on the report was vacant. The 2021-2022 report will be done next.

e. ATABs 3, 7, and 9 had larger increases in record volume than other regions. ATAB 5's Level II facility had the largest increase in record volume. Statewide, Level I and II hospitals had overall increase in record volume, while Level IIIs and IVs had overall decrease in record volume. Overall, pediatric patient counts are lower statewide while geriatric patient counts continue to increase, with ATAB 5 and 9 seeing the largest increase in geriatric trauma patients. The final report will include race and ethnicity demographics.
f. Statewide, Oregon Trauma Registry record timeliness — records completed within 60 days of patient discharge — has been much closer to the 80% goal than in 2019-2020. Potential reasons for the seasonal patterns were briefly discussed.
g. Albert shared values on grouped injury mechanism comparisons, and intent of injury values.
    - Chris Poulsen asked to see change-over-time graphs beyond just one year to year if that data is available. Albert responded that data is available from 2017 onwards, so it would be possible to pull.
    - Alexis Moren asked to break the information down by ATAB as well, so regions are better informed in their process improvement efforts. Regions may be able to use one another's help in addressing areas they are struggling.
    - Victor Walco suggested looking at population growth as a cause of increase.
    - The change in "Other transport" injuries is due to a code addition for e-bikes.
h. Albert will be building out region-specific trauma reports for the future.
i. Albert also shared numbers for trauma activations. His focus is the missing data, as there is a steady increase in missing information in the required field. This will be used to inform data quality projects.
j. Albert shared the numbers of pediatric, adult, and geriatric deaths by injury mechanism. This only included those who made it to a hospital to be counted.

7. **Key Takeaways (Jeremy Buller)** **(Recording timestamp 01:34:27)**
    a. Jeremy reviewed the subcommittee's vacancies and needs for geographic representation.
    b. The subcommittee is making a recommendation to change the trauma patient definition.
    c. The subcommittee's next meeting will be held November 5, 2025, 0900-1200, on Zoom.

8. **Public Comment** **(Recording timestamp 01:27:25)**
    a. Public comments were raised earlier in the meeting. No new public comments.

Meeting adjourned at 1144.

Next meeting:
November 5, 2025, 0900-1200
Virtual only on Zoom