State Trauma Advisory Board Quarterly Meeting Minutes
2022 Quarter 4 | October 14, 2022
Chair Ron Barbosa, MD | Vice Chair Rhonda Fischer, RN

Appointed Board Attendance

Y	Ron Barbosa, MD	Level 1 Trauma Surgeon
Y	Mac Cook, MD	Level 1 Trauma Surgeon
Y	Daniel Sheerin, MD	Level 1 or 2 Orthopedic Surgeon or Neurosurgeon
N	Justin Sales, MD	Level 1 Emergency Medicine Physician
Y	Heather Wong, RN	Level 1 Trauma Program Manager Nurse
N	Travis Littman, MD	Level 2 Trauma Surgeon
VACANT	VACANT	Level 2 Trauma Nurse Coordinator
Y	Rhonda Fischer, RN	Level 3 Trauma Nurse Coordinator
Y	Abigail Finetti, BSN, RN	Level 4 Trauma Nurse Coordinator
VACANT	VACANT	Urban Area Trauma Hospital Administration
N	April Brock, MSN	Rural Area Trauma Hospital Administration
Y	Michael Lepin, Paramedic	Rural Area Emergency Medical Services Provider
VACANT	VACANT	Public Safety Answering Point Representative
Y	Aaron Ott	Public Member
N	Joel Carmody	Public Member
N	Jim Cole, Paramedic	EMS Committee Representative

Oregon Health Authority Attendance

Dana Selover, MD; David Lehrfeld, MD; Stella Rausch-Scott, EMT; Peter Geissert; Rebecca Long, P; Leslie Huntington, P; Madeleine Parmley, RN; Rachel Ford; John Crabtree; Robbie Edwards; Kimberley Aubrey; Yesenia Rosario; Justin Hardwick; Veronica Seymour; Andy Nunes; Mellony Bernal; Nick May

Public Attendance

Kali Dubois, Misty Wadzeck, Kim Fletcher, Danny Freitag, Frank Ehrmantraut, Matthew Edinger, Pamela Halbrook, Jamie Diercks, Tara Buhr, Emily Weber, Kathy Tompkins, Ashley Watson, Stephen Long, Carrie Allison, Katie Hennick, Thomas Gregan, Megan Lundeberg, Susan Steen, Ethan Lodwig ,Mindy Stinnett, Leslie Engelgau, Linda Sheffield, Renae Mefferd, Joey Van Winckel, Peter Rosenberg, Emily Weber, Matt Philbrick, Jean Benson, Jeremy Buller, Anthony Huacuja, Daniel Hull, Randi Saucier, Melissa Levesque, Timbra Burrup, Kali Dubois, Judi Gabriel, Peter Rosenberg, Lauri Martinich, David R, Lucas Bradshaw, Karla Rutherford, Tiffany O'Byrne, Andrea Greenlaw, Libby Windell, Bet Martin, Thomas Gregan, Brittany

Tagliaferro-Lucas, Randi Saucier, William Scott

Call to Order/ Membership - Ron Barbosa

The meeting was called to order. A quorum was met. The agenda was presented, and no changes were requested.

Committee Appointed membership annual training is due December 31, 2022.
OHA - HR - 2022 Required Courses Overview for Partners/Providers - PDF

DAS – CHRO – 2022 Preventing Discrimination and Harassment
OHA - DAS - 2021-22 Overview of Oregon Ethics Law
ODHS/OHA - ISPO - 2022 Information Security and Privacy Awareness Course for Partners/Providers
ODHS/OHA - ISPO - 2022 Information Security and Privacy Awareness - Policy & Agreement

OHA is continuing to improve the meeting conduct and providing more inclusive and equitable meetings platform processes.
Attendees may see:

- Practice inclusive and accessible intros
- Invite and model use of pronouns
- Share name and role first time
- State your name every time you speak

Oregon Health Authority has the resources to provide:

Activated automatic speech recognition, or ASR, via Zoom. These computer-generated captions appear within the Zoom window.

If a attendee would prefer Communication Access Real Time Translation, or CART, provided by a professional captioner or American Sign Language Interpretation, they will need to contact the meeting organizer at least 1 full business day before the meeting.

Changes for meeting communication include:

Introduce yourself the first time you speak:

- My name is:
- I am a (title) in the (department/unit):
- My pronouns are: (optional)
- I am a person with (skin color, hair color):
- I am wearing:
- My background (space behind me) is:

You are not expected to share:

- Age

- Disability
- Ethnicity
- Gender
- Marital status
- National origin
- Race
- Religion
- Sexual orientation

OHA will continue to build upon making all attendees have the tools and resources needed and will adjust the communication for those to attend.

Action Items	Appointed committee members need to complete the annual training by December 31st 2022. OHA - HR - 2022 Trainings for Partners/Providers ONLY https://www.oregon.gov/das/HR/Documents/CreateUpdateEELAccount_JA.pdf

Review/Approve Minutes - Ron Barbosa

2022 Quarter 3 STAB meeting minutes were reviewed and a motion to accept was requested. Aaron Ott motioned to approve the minutes and Amy Slater seconded. The motion passed.

Case Presentation – Mac Cook, MD

Dr. Mackenzie Cook, OHSU, presented a transferred case from Mid-Columbia Medical Center of a single, self-inflicted gunshot wound to the head. Patient was transferred to OHSU with a neurological consult and was decided this patient had poor neurological exam and had a poor prognosis.

Points of discussion:

- No discussion of survivability / goals on call – should there be?
- What is the role of a level III/IV trauma in comparable situations?
- Associated financial cost: *Combining transport costs with hospital charges, each futile transfer was estimated to cost US $56,396*

2021 EAST PODIUM PAPER

Futile trauma transfers: An infrequent but costly component of regionalized trauma care

Craig Follette, DO, Bachar Halimeh, MBBS, Annelise Chaparro, MS, Alan Shi, MS, *and* **Robert Winfield, MD, FACS**, *Kansas City, Kansas*

Discussion:
In smaller ER's, they keep around medics and police around for assistance. They look at Trauma centers above them for guidance. It can be difficult.

Mac Cook: Prognostication being so difficult, it is one of the big factors. A second challenge is caring for trauma patients as well as dozen other patients in the waiting room.
Level 1 and Level 2 Trauma Centers are supposed to be a trauma resource for the state.

Jennifer Serfin: Suggested providing trainings and education to present end of life discussions. Emergency providers can have a quick, 5 min conversation and say, "What are your expectations with your life? And would you tolerate a level of disability that's going to be caused by this injury?"

Linda Sheffield: Level 4, states telemedicine would be the answer to a situation like this. Consult with neuro via telemedicine robot

Pamela Halbrook: From a level 4, the feedback is that they have a difficult time having neurosurgeon get on the phone, to confirm the futility. In addition, family has a difficult time taking the "futility" discussion from a non-neurosurgeon. The initial shock, "do everything" mentality is strong and hard to overcome.

Heather Wong: What is the ability of smaller centers to support this type of patient who is a potential organ donor that can go directly to Cascade Life Alliance for recovery?

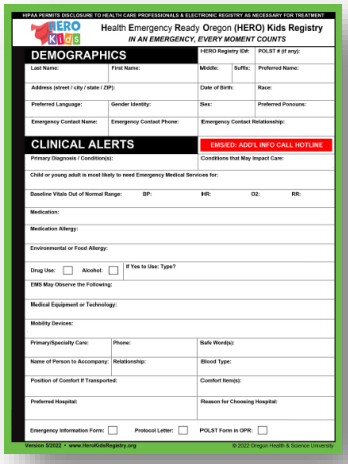
Rhonda Fisher: They have improved with telemedicine for stroke but has not seen it happen with any trauma scenario. Is that an option to put a telemedicine robot and have an assessment take place?
Ron Barbosa: Arizona has done the most work on telemedicine and most of their telemedicine is oriented around preventing transfers for minor injuries and there's many more of those that are done as opposed to preventing transferring of the lethally injured. What is the statues of telemedicine in Arizona?

Mac Cook: Statues of telemedicine in Arizona is unknown. Pre-pandemic, 4-5 years ago in California, there was a medical patient, and they utilized a virtualized U doctor who came in to say your loved one is going to pass.

Zoom has many logistical benefits, but one of the challenges is the end-of-life conversations are emotionally charged and difficult.

Amy slater: Some of these patients could be cared for at level two's, freeing up some of the capacity at the level ones for patients that that as level two are trying to get to level one but can't or have long

delays so a question to the Level three and four folks out there is: Do you ever give consideration to level twos for those patients that they can manage at theirs, relieving some of that transfer capacity availability to level ones? Abigail Finetti: Supporting the threes and fours and knowing what they're capable of is important. A trauma surgeon or neurosurgeon is needed to help with end-of-life discussions with families. It can be as flexible as having the physician get on speaker phone with the families. Fours needed to be supported in that moment with the patients and down the line when they look at the charts.	
Action Items	Workgroup: Create hospital education and support resources for patients that will include goals of care. Mac Cook Abigail Finetti Ron Barbosa Misty Wadzeck Tiffany O'Byrne

Hero Kid Registry – Brittney Tagliaferro-Lucas and Rachel Ford
Rachel Ford and Brittney Tagliaferro- Lucas presented Health Emergency Ready Oregon (HERO) Kids is a collaborative project between the Oregon Center for Children and Youth with Special Health Needs and Oregon EMSC. HERO Kids will provide real-time information to EMS and ED providers. HERO Kids is for any Oregon child or young adult through age 26. It is a no-cost, voluntary system. Registration opened September 12, 2022 and the system launched October 3, 2022. EMS and Emergency Department rooms have access to the form.    HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT HERO KIDS Health Emergency Ready Oregon (HERO) Kids Registry IN AN EMERGENCY, EVERY MOMENT COUNTS DEMOGRAPHICS CLINICAL ALERTS EMS/ED: ADD'L INFO CALL HOTLINE

ACTION	www.herokidsregistry.org

Rule Update – Madeleine Parmley & Rachel Ford

Rachel Ford provided an overview of the Exhibit 2 (Guidelines for Field Triage of Injured Patients) and Exhibit 3 (Hospital Trauma Team Activation Criteria) Rule Advisory Committee held on October 4, 2022.

- RAC members invited to participate included EMS agency owners and operation officers, trauma program medical directors, trauma program managers, trauma nurse coordinators, the hospital association, State EMS Committee and State Trauma Advisory Board members, and community partners.
- The field triage of injured patients' guidelines is used by EMS providers to make patient care decisions. The history of the development of the field triage guidelines and the American College of Surgeons (ACS) review process which included emergency medical services feedback was reviewed.
  - 1976: ACS Optimal Resources Document – first guidance
  - 1987: ACS develops Field Triage Decision scheme
    - Updates through expert consensus in 1990, 1993, 1999
  - 2006: CDC leads multidisciplinary panel
    - Evidence-based review
    - Published in the MMWR in 2009
  - 2011: CDC Expert Panel revision: Minor updates
    - Oregon adopted 2011 version in 2013

The ACS conducted five systematic reviews including using the motor Glasgow Coma Scale (GCS) vs. total GCS; circulatory measures; respiratory measures; mechanism of injury and special considerations; and overall guideline performance. Via Chat, Madeleine Parmley shared the following link, where additional details can be found on evidence base: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9323557

- In April and June 2021, an expert panel was convened to consider changes to the field triage guidelines. A steering committee was created and considered input from the expert panel, created a draft guideline, and coordinated obtaining feedback from stakeholder organizations as well as the expert panel until all comments, suggestions, and feedback were addressed.
- The structure and format of the field triage guideline were changed to better align with flow of information to EMS and with how the guidelines were used. Criteria have been consolidated into two categories – High risk for serious injury and moderate risk for serious injury.
  - New criteria added in the high risk for serious injury category:
    - Under injury patterns, active bleeding requiring a tourniquet or wound packing with continuous pressure
    - Under mental status and vital signs, criteria have been broken into four categories with new criteria noted below. (The criteria noted below identifies new criteria only and not the complete list.)
      - All patients:
        - Motor GCS of less than 6
        - Respiratory distress or need for respiratory support
        - Room-air pulse oximetry of less than 90%
      - Ages 0 to 9 years

        - Systolic blood pressure less than 70mm Hg plus 2 times age in years
    - Ages 10 to 64 years
        - Heart rate greater than systolic blood pressure
    - Ages 65 and older
        - Heart rate greater than systolic blood pressure
- New criteria added in the moderate risk for serious injury category:
    - Under mechanisms for injury:
        - Extrication for entrapped patient
        - Child (ages 0 to 9) unrestrained or in unsecured child safety seat
        - Rider separated from transport vehicle; examples include motorcycle, horse, and ATV
        - For all ages a fall from height greater than 10 feet
    - Under the EMS judgement section, new factors that the ACS panel felt important to consider but lacked evidence base included:
        - Anticoagulant use
        - Special, high resource healthcare needs
        - Pregnancy greater than 20 weeks

R. Ford noted that the EMS and Trauma Systems Program is proposing to adopt Exhibit 2 in its entirety. It was further noted that during the RAC meeting, EMS RAC members asked clarifying questions and were generally not concerned with implementing the revised field triage criteria.

Madeleine Parmley provided an overview of proposed changes to the Hospital Trauma Team Activation Criteria (Exhibit 3) which are based on the proposed changes to the field triage criteria (Exhibit 2). Changes to Exhibit 3 including new and updated criteria to bring into alignment with Exhibit 2 and a new findings-based section was added at the request of trauma medical directors. Changes to Exhibit 3 under Full Trauma Team Activation include:

- Added age specific vital signs in alignment with Exhibit 2;
- The GCS motor response of less than six was noted to be better for the same indicator than a total GCS scoring;
- Added room-air pulse oximetry of less than 90%;
- Clarified skull deformity, suspected skull fracture;
- Clarified respiratory distress or need for respiratory support;
- Clarified suspected pelvic fractures;
- Added crushed, degloved, mangled or pulseless extremity;
- Added amputation proximal to ankle or wrist; and
- Added active bleeding requiring a tourniquet or wound packing with continuous pressure.

Under Modified Trauma Team Activation, the following changes were made:

- Removed total GCS score;
- Added a fall from height greater than ten feet for all ages;

- Added under high-risk auto crash – Child (age 0-9 years) unrestrained or in unsecured child safety seat;
- Auto versus pedestrian language was revised to 'Rider separated from transport vehicle with significant impact (e.g., motorcycle, ATV, horse, etc.)
- Previous co-morbid factors were added to modified activation including:
    - Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact
    - Anticoagulant use
    - Suspicion of child abuse
    - Special, high-resource healthcare needs
    - Pregnancy greater than 20 weeks
    - Burns in conjunction with trauma
    - Children should be triaged preferentially to pediatric capable centers

A new section on Findings-based Criteria was added. If no trauma team activation has occurred, consider activation or consult based on the following positive findings:

- Any intracranial hemorrhage
- More than two unilateral rib fractures or bilateral rib fractures
- Pneumothorax, hemothorax, or lung contusion
- Any skull base fracture or depressed skull fracture
- Any hemoperitoneum
- Any grade III or above solid organ injury
- Unstable pelvic fracture requiring transfusion
- Femur fracture or any open fracture
- Complex pelvic fracture or acetabular fracture
- Vertebral fractures or findings concerning for spinal cord injury
- Carotid artery, vertebral artery, or significant vascular injury
- Burns that require intubation and/or transfer to a burn center

The following next steps:

- Additional RAC meeting scheduled for November 1, 2022 from 10:30-12:00pm
- Submit final proposed rules to Public Health Division's rule coordinator to file proposed rulemaking hearing notice
- Proposed rules will be posted in the Oregon Bulletin along with public hearing date and public comment period deadline
- Notify interested parties
- Respond to public comments
- File final rules

Discussion:

Rhonda Fischer inquired whether the summary of the changes just discussed were recommendations of the Exhibit 2 and Exhibit 3 RAC including recommended changes under the new "Gray Book." Dr. Lehrfeld clarified that the proposed changes shared were changes suggested by the EMS and Trauma Systems and program that were shared with the RAC. It was noted that a significant amount of material has been sent to the program that must be reviewed and considered further. R. Fischer acknowledged questions in the Chat and stated as both a STAB member and program manager, in conducting their own research of their own data, a significant increase in volume specifically with the BP over 110 for those over 65 but not with significant increase in injury. R. Fischer further noted that the article seems to address just prehospital - is there another link for the hospital-based team response?

Amy Slater inquired whether the information shared by the RAC to the program would be considered at the November 1, 2022 RAC meeting. Dr. Lehrfeld noted that information is being collated and considered further.

Stella Rausch-Scott noted that ATAB members are requesting confirmation of receipt of letters identifying suggested changes to the proposed exhibits. M. Parmley noted via Chat that the EMS & Trauma Systems program has received responses from RAC members and ATABS 2, 5, and 7.

Mellony Bernal thanked STAB members for their patience and acknowledged that the program has received comments from ATABs and others on the proposed rules which the program will be considering further. It was further noted that after the November RAC meeting, the program will consider further the best forum to receive additional feedback from the STAB and State EMS Committee. When filing proposed draft rules, there will be a public hearing scheduled along with a public comment period where interested parties can share comments, concerns, or support.

Via Chat, the following questions were asked –

- Dr. Barbosa – what is meant by "vehicle telemetry data consistent with severe injury?" Dr. Lehrfeld responded AACN predicts 20% chance of ISS greater than 16.
- Ethan Lodwig – Have any other states extrapolated the ACS field triage guideline, to the hospital trauma activation level guidelines? and Jeremy Buller – Has the OHA pulled state date to estimate hospital impact? In response to Dr. Barbosa and E. Lodwig, Dr. Lehrfeld noted that the guidelines have just been released and there are no nationwide or statewide data on these guidelines. The changes are incremental and thus incremental changes to trauma demographics are expected. It was noted that based on the past two times trauma activation criteria have been changed, there has been no significant impact.
- Dr. Lehrfeld noted that one of the lead researchers on the revised field triage guidelines is Dr. Craig Newgard from OHSU. Dr. Newgard will be present at the next RAC meeting to share information and answer questions.

Amy Slater inquired about the correct process and forum to discuss questions that are appearing in the Chat. Dr. Lehrfeld responded that he is happy to field questions and noted that the answer in terms of volume remains unchanged – it is not known how these changes will impact trauma triage, but it is not

expected to be significant. It was further noted that the RAC is the forum to request changes to the proposed rules. There will be a public comment period when the final draft rules are filed where members of the public and other interested parties may submit comments and request changes.

Carrie Allison via Chat noted that the proposed changes will represent a massive increase in patients triaged into the trauma system just considering even the single criteria of SBP <110 in patients >65. C. Allison asked via Chat, have these proposed criteria been validated at either the national or state level, and is there a statewide undertriage problem that these new criteria are intended to address? C. Allison further stated via Chat that Dr. Newgard's article states that the FTGs are not intended to be applied to in hospital activation criteria. Can OHA speak to how the decision was made to take the FTGs in a direct line fashion to create the new Exhibit 3 guidelines? Dr. Lehrfeld responded that the RAC has also shared that point and the EMS and Trauma Systems Program will be looking at the data.

Heather Wong via Chat agreed with comment shared by C. Allison that there will be a huge increase in full activations not to mention transfers to higher level trauma centers.

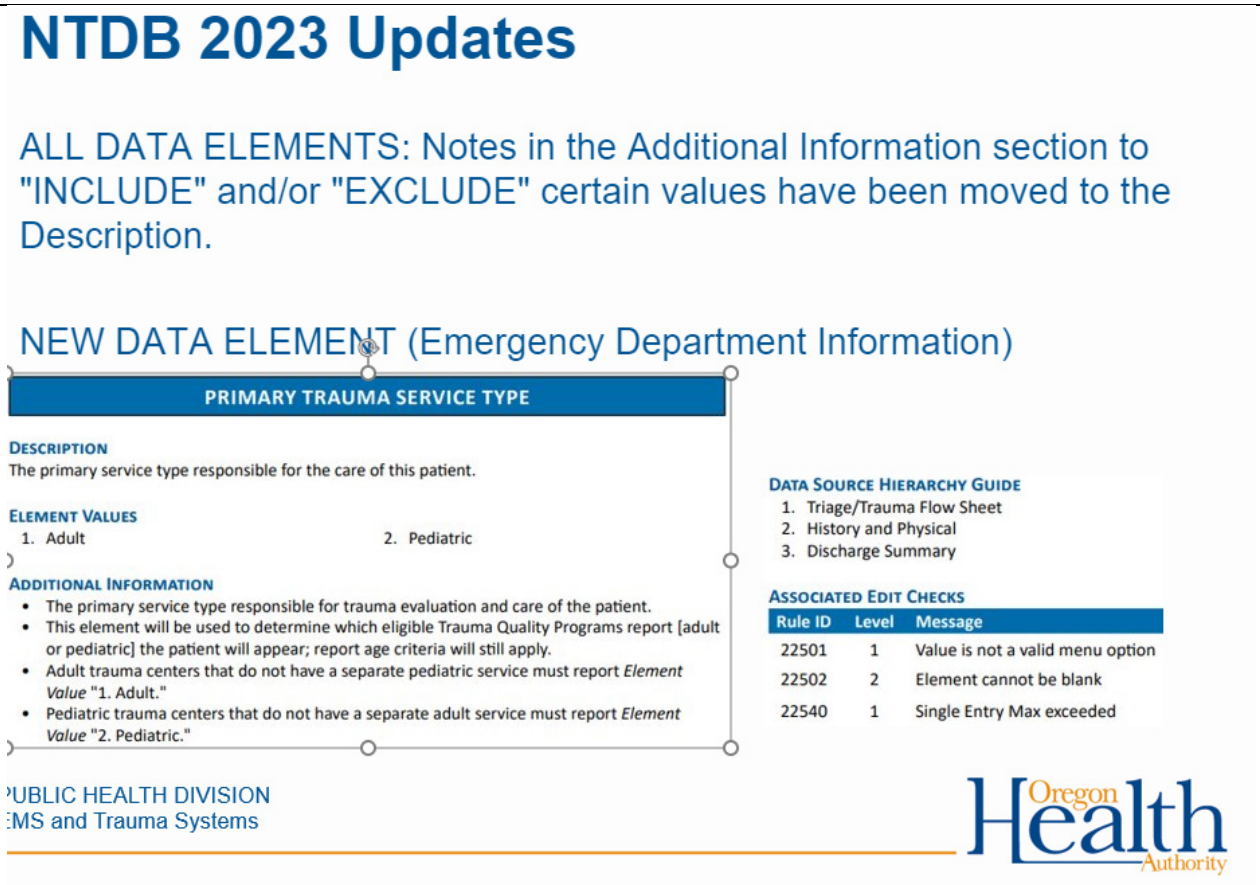
Kathy Tompkins via Chat asked why were the 2021 field triage guidelines not included in the 2022 grey book? She further stated that as a RAC member, she disagrees with the statement that general comments were made during the meeting, and they are very concerned about the impact of the changes.

Libby Windell via Chat asked why is the state attempting to implement the field triage guidelines as the in-hospital activation criteria? It specifically states in paragraph 4 of that paper that "the guideline is intended for use in civilian 911 EMS systems and is not intended to guide mass casualty events or in hospital trauma team response. It was further stated in the chat that these proposed changes will cripple the system and add a large volume of full traumas in minimally injured people.

Heather Wong inquired whether STAB members can provide feedback on Exhibits 2 and 3? S. Rausch-Scott noted that for purposes of this meeting, the program is providing an update on the proposed rule that was shared with the RAC. There will be a public comment period for interested persons to comment further. S. Rausch-Scott reiterated that the program thanks members for their patience as the program continues to work through the new RAC requirements due to passage of legislation.

ACTION	

OTR Data – Andey Nunes



NTDB 2023 Updates:

Pre-Existing Condition element updates

- Retired:
  - Angina Pectoris
  - Mental/Personality Disorders (replaced by new data elements)
- New:
  - Bipolar I/II Disorder
  - Major Depressive Disorder
  - Other Mental/Personality Disorders
  - Post-Traumatic Stress Disorder
  - Schizoaffective Disorder
  - Schizophrenia

The presentation will be attached to the minutes for reference.

Committee updates – Matt Philbrick and Jim Cole
EMS for Children – Matt Philbrick Continue to work on the weighbased response from EMS crews. The EMS for Children Committee is recruiting for three open positions.

EMS Committee – Jim Cole
Reviewed Exhibit 2 and Exhibit 3. Created a workgroup to review data and come up with ideas to improve EMS care. Reviewed EMR relicensing decrease presentation.

HOSCAP to Oregon Capacity System – Nick May
Nick May, OHA Health Security and Response Program presented the Oregon Capacity System that will replace HOSCAP. This health care tracking system is intended to support medical reserve core during disaster. Time sensitive information about diseases and how active things are transferred. Hospital capacity numbers list. OC System is intended to reduce the burden of reporting on hospital staff. Oregon Capacity System (OCS) Resources: https://oregoncapacity.com/request-ocs-access https://oregoncapacity.com/learn-more

ATAB Updates - ATAB Representatives
ATAB 1: Change in leadership as the chair is stepping down. Still recruiting for positions that represent the coastal communities. ATAB 2: Is meeting next week. Continuing to look at data and will discuss hybrid meetings. ATAB 3: No Response ATAB 5: Reviewing the data that is collected and required in the ATAB 5 plan. Recruiting for vacant positions and starting to look at STB classes. ATAB 6: Continuing to recruit for vacancy. Discussing data that the group would like to focus on. Preparing for a Disaster training drill at both hospitals and with multiple agencies. ATAB 7: Reviewing the hospital surge and taking place in the region. Reviewing ways to support education in the outlying hospitals. ATAB 9: Continuing discussions around auto-acceptance policies with hospitals. Having issues with transferring patients and having to send them farther than their support is able to transfer to.

Director Update – David Lehrfeld
Staffing update: posted position for the manager of EMS Trauma. • EMS & Trauma systems Program Mgr. position recruitment, open until Oct. 30 • Patient movement workgroup • Rules present and future • Trauma Rules and Exhibit 2-4 State Quarter report is linked for review.

Public Comment - Ron Barbosa
Public comment was listed in the Exhibit 2 and Exhibit 3 discussion.

Meeting was adjourned