PUBLIC HEALTH DIVISION
Office of the State Public Health Director
Tina Kotek, Governor

Oregon Health Authority

800 NE Oregon Street, Suite 465
Portland, OR 97232
Voice: (971) 673-1222
FAX: (971) 673-1299
TTY: 711

DATE: April 1, 2024

TO: Hearing Attendees and Commenters –
Oregon Administrative Rules chapter 333, division 200 –
"Updated Field Triage Guidelines and Trauma Team Activation Criteria"

FROM: Brittany Hall, Hearing Officer and Administrative Rules Coordinator

cc: Dana Selover, Section Manager
Health Care Regulation and Quality Improvement

SUBJECT: Presiding Hearing Officer's Report on Rulemaking Hearing and Public Comment Period

---

Hearing Officer Report

Date of Hearing: January 17, 2024, via Microsoft Teams

Purpose of Hearing: The purpose of this hearing was to receive testimony regarding the Oregon Health Authority (OHA), Public Health Division, EMS and Trauma Systems (EMS & TS) program's proposed permanent amendments to Exhibit 2 (National Guideline for the Field Triage of Injured Patients) and Exhibit 3 (Oregon Hospital Trauma Team Activation Criteria) in Oregon Administrative Rules chapter 333, division 200. These exhibits have been updated to align with the revised, 2021 National Guideline for Field Triage of Injured Patients and the 2022 Resources for Optimal Care of the Injured Patient.

Pursuant to ORS 431A.050 and 431A.060, the EMS & TS program is responsible for the development of a comprehensive statewide trauma system which includes the development of state trauma objectives and standards, hospital designation, and the criteria and procedures utilized in designating hospitals. The EMS & TS program is also responsible for identifying the standards that must be addressed in ambulance service area plans which includes triage and transportation protocols.

The 2021 National Guideline for Field Triage of Injured Patients was developed by a national expert panel led by the American College of Surgeons with support from the National Highway Traffic Safety Administration, the Health Resources and Services Administration's Maternal and Child Health Bureau, and the EMS for Children Program. The national expert panel included EMS clinicians, EMS physicians, emergency

physicians, EMS medical directors, experts in EMS training and education, EMS and trauma system administrators, researchers, and others.

In addition, the EMS & TS program is responsible for the development and amendment of Hospital Trauma Team Activation Criteria. The 2022 Resources for Optimal Care of the Injured Patient detail the principles regarding resources, performance improvement patient safety processes, data collection, protocols, research, and education for trauma centers. Standard 5.3 Levels of Trauma Activation was the primary reference for amendments to the current Exhibit 3.

Hearing Officer: Brittany Hall

Testimony Received: Two individuals provided testimony at the hearing. Oral testimony was followed by submission of written comments by one of the individuals.

Other Comments: Five individuals or organizations submitted written comments to OHA within the period allotted for public comment, which closed at 5:00 PM on January 22, 2024. Written comments are attached to this report as **EXHIBIT 1.**

In oral testimony, OHA heard that that while the terminology, 'trauma system entry,' is widely accepted in Oregon, EMS has historically struggled with the difference between EMS entering a patient in the trauma system versus the hospital and nowhere in the rules or Exhibit 2 is 'trauma system entry' identified. It was recommended that the OHA provide more clarity on when a patient should be considered a trauma system entry or not, including putting a trauma band on a patient. This would be especially helpful for rural providers who perhaps don't have as much education and training.

In oral testimony and written comments, OHA heard requests for changes to specific areas within Exhibit 2:

1. Recommendation that criteria for both Age 10-64 years (SBP less than 90 mmHg) and Age 65 years and older (SBP less than 110 mmHg) be moved from the "red criteria" section to the "yellow criteria" section under the "EMS judgment" box for EMS to consider in their overall assessment and determination.
    a. It was also recommended that "two consecutive blood pressures be noted to warrant trauma activation" "to demonstrate a pattern as opposed to a one time reading that could perhaps be an outlier."
2. Concern was also expressed that under the updated Exhibit 2, "patients over the age of 65, with a systolic blood pressure of less than 110, presenting with a traumatic injury pattern, will have to be transported by EMS to the *highest-level trauma center in the region*." It was noted in written comments that "many people over the age of 65 have comorbidities, such as cardiac disease, which result in systolic blood pressure rates between 90 and 110, as a direct consequence of pharmaceutical intervention."
    a. It was recommended that the criteria in Exhibit 2 be aligned with that which is contained in Exhibit 3 pertaining to hospital activation criteria. "This would require that any adult with confirmed systolic blood pressure

of less than 90 be the triggering criteria, and that transported to ‘a trauma center,’ rather than the ‘highest level trauma center in the region.’”

3. Recommendation that “suspicion of child abuse” be removed from the yellow criteria section altogether or a clear and detailed definition for it be provided. Further recommendation requested that “suspicion of child abuse” be removed from Exhibit 2 and “instead be assessed in a hospital setting with more appropriate resources” rather than being “addressed in a time sensitive environment like pre-hospital.”
4. Recommendation that “special, high-resource healthcare needs” be removed from the yellow criteria section altogether or a clear definition for it be provided.
5. Within the “red criteria” section under “Mental Status and Vital Signs” a request that “clarification be added to allow vitals on baseline oxygen and furthermore to place this under an EMS judgement, which would be based on their assessment and allow room for patients who otherwise have a baseline saturation less than 90%.”
    a. It was recommended to consider “pre-existing conditions which may cause saturations of less than 90 percent, and to transport patients experiencing trauma to ‘a trauma center,’ rather than the ‘highest trauma center in the region.’”

Written comments submitted as follow-up to oral testimony further recommended that the proposed changes to Exhibit 2 above are mirrored in Exhibit 3 where applicable.

OHA heard in written comments the concern that “the changes to Exhibit 2 would result in more patients being considered trauma patients, without improving patient care. In geographic areas where EMS will be required to bypass Level III, IV and possibly Level II trauma centers, the drive time for EMS will increase and result in delayed care to others in need.”

OHA heard in written comments the concern that the “proposed changes to the criteria will result in a significant increase of trauma volumes at rural hospitals for patients who do not require trauma-level resources, and without any significant improvement in quality outcomes of these patients.”

OHA heard in written comments the recommendation to add back “EMS Provider” discretion in Exhibit 3, in addition to keeping the newly added “emergency physician’s” discretion. It was noted that Exhibit 2 references “EMS Judgment” so “it is imperative to add this back to Exhibit 3 to maintain the alignment between the two exhibits.”

OHA heard in written comments the concern about the impact that the proposed changes will have on hospital resources and staffing, stating that “the projected increase in trauma volumes would have challenging impacts on hospitals from a resource, financial, and staffing perspective.” Further comments noted concern that “changes to Exhibit 3 will result in hospital trauma activation that could bypass other patients needing triage.”

OHA heard in written comments that the proposed changes “are not supported by an analysis of Oregon’s state trauma data” and that “using national data to drive statewide changes neglects regional context.”

Agency response:
In 2021, the American College of Surgeons (ACS) introduced the National Guidelines for the Field Triage of Injured Patients. An expert panel was convened by the American College of Surgeons Committee on Trauma, and included EMS clinicians, EMS physicians, emergency physicians, trauma surgeons, pediatric surgeons, nurses, EMS medical directors, experts in EMS training and education, EMS and trauma system administrators, researchers, and representatives from stakeholder organizations. For the last 30 years, these guidelines have been widely adopted by trauma systems in the U.S., including Oregon, with the goal that the most seriously injured patients get transported to the most clinically appropriate trauma centers.

In response to specific changes to criteria in Exhibit 2:

- Red Criteria – Mental Status and Vital Signs – Move systolic blood pressure [SBP] activations for age 10-64 (SBP less than 90mm Hg) to the Yellow Criteria and clarify that a minimum of two consecutive readings must be noted to warrant trauma activation

A SBP of less than 90mm Hg for <u>all patients</u> is currently required in Exhibit 2 which has been effective since 01/01/2013. The current Exhibit 2 directs EMS to take these patients *preferentially* to the highest level of care within the trauma system. The proposed changes to Exhibit 2 do not change this intent and specifies that patients *should* be transported to the highest-level trauma center not 'must.' Since current rule already requires trauma activation for age 10-64 with a SBP less than 90 mm Hg, and hospitals already must activate a full trauma team for these patients under the current Exhibit 3, the OHA does not support any change to the final rules.

- Red Criteria – Mental Status and Vital Signs – Move systolic blood pressure [SBP] activations for age 65 or greater (SBP less than 110mm Hg) to the Yellow Criteria and clarify that a minimum of two consecutive readings must be noted to warrant trauma activation

Any physiologic derangement measured in the vital signs should be repeated to ensure it was measured correctly. A SBP of less than 110mm Hg for adults 65 or greater is currently a criterion that warrants special patient or system consideration. As prescribed by rule, these patients must be transported to a trauma center or hospital capable of conducting a timely and thorough assessment and initial management of the injury. In the article, 2021 National Guideline for the Field Triage of Injured Patients by Newgard, et al., it was noted that undertriage is highest among older adults and that the threshold for possible shock in the older adult needed to be changed, based on this evidence-based research which included systematic reviews of the field triage literature. As such the OHA supports aligning with national evidence-based recommendations and keeping criterium in the red criteria. OHA notes that the intent in terms of transportation to a

trauma center has not changed from the existing exhibit, which specifies that patients *should be* transported to the highest-level trauma center available within the geographic constrains of the regional trauma system.

- Red Criteria – Mental Status and Vital Signs – Move Room-air pulse oximetry to the yellow criteria under EMS judgement and change text to incorporate the consideration of pre-existing conditions which cause saturations of less than 90% and to allow vitals on baseline oxygen.

While there may be those whose underlying obstructive pulmonary disease causes oxygen saturation readings less than 90% at baseline, it should be noted that these patients are being evaluated as trauma patients, based on mechanism of injury, as well as any physiologic derangement, and these patients can have decreased resilience to overcoming physical insult than those without these underlying diseases. The OHA therefore does not support the recommendation.

- Yellow Criteria – EMS Judgement – Remove reference to suspicion of child abuse as well as special, high resource health care needs for add definitions of these terms.

Child abuse is defined by Centers for Medicare & Medicaid Services, Centers for Disease Control and Prevention, and ACS, as well as the National EMS Education Standards. Providing a definition is therefore not necessary.

Special high-resource healthcare needs were reviewed by the expert panel, convened by ACS, and noted that special healthcare needs related to comorbidities, such as ventilator dependence or ventricular assist devices, may require the resources and expertise of trauma centers. Defining what constitutes a special high-resource healthcare needs could be limiting and not inclusive of all conditions or situations, and this allows discretion by EMS in making that determination in transporting these trauma patients. The OHA supports alignment with national evidence-based recommendations in the proposed rules.

- Exhibit 3 – Full Activation – Move SBP activation to modified and reference to a minimum of two sequential readings.

The current Exhibit 3 includes the SBP activation criteria so this is not a change. SBP is also included in the ACS criteria for full trauma team activations. As mentioned previously, any physiologic derangement measured in the vital signs should be repeated to ensure it was measured correctly.

- Exhibit 3 – Modified Activation – Add back EMS provider judgement

Exhibit 3 is a hospital trauma team activation criteria document and directs the trauma team with regards to full or modified trauma team activation criteria. This is in keeping with ACS levels of trauma team activation criteria as well. Since it is hospital resources that are being utilized, the trauma team should be the determinants of its use.

In response to the remarks that the adoption of the new Field Triage Guidelines (FTGs), Exhibit 2, as well as Exhibit 3, Oregon Hospital Trauma Team Activation Criteria, could harm rural trauma hospitals and the patients they serve, by taking away from the expertise and judgement in the field, as well as hospital staff and result in increased costs, OHA notes there has been no evidence of this impact in the last two years with trauma systems across the U.S. having already adopted the new FTGs. Additional remarks were that it would cause overtriage which would increase the number of patients that would be considered trauma patients without improving care. OHA notes that although there has been some change in language to align the new Exhibit 2 FTGs with the new proposed Exhibit 3, there are only a few additions, resulting in essentially minimal change.

OHA notes that EMS judgement will still be utilized in discerning patient transport destination and it will be based on patient assessment and the urgency to get the patient to the required resources. It is noted that OHA currently has 26 Level IV trauma facilities and approximately 60% of those facilities have no other nearby trauma centers, resulting in EMS transporting those patients to those facilities regardless of acuity, unless air medical is called to the scene to transfer to a higher level of care. OHA expects EMS to continue to utilize professional judgement on trauma patient status and transport decisions to be based on the condition of the patient.

With respect to the comment about 'trauma system entry' terminology, while not every state uses a unique trauma patient identification, Oregon does. Pursuant to OAR 333-250-0310(5)(b)(A) and (B), Oregon issues a trauma band which signifies a patient's entry into the Oregon trauma database. EMS applies field triage criteria (Exhibit 2) to the injured patient. If the patient meets triage criteria they are “entered” into the trauma system. EMS places a trauma band on the patient and notifies the receiving hospital of the trauma. The hospital uses Exhibit 3 to determine a full or modified response, and then activate the trauma team accordingly. Whether a trauma band is placed in the field or in the hospital, the hospital trauma registrar enters the patient data into the Oregon Trauma Registry (OTR).

EXHIBIT 1

Providence Health & Services
4400 N.E. Halsey St., Building 2
Suite 599
Portland, OR 97213
www.providence.org/oregon

January 18, 2024

Mellony Bernal
800 NE Oregon St.
Portland, OR 97232

Re: Notice of Proposed Rulemaking for OAR chapter 333, division 200 – "Updated Field Triage Guidelines and Trauma Team Activation Criteria"

Dear Mellony Bernal,

Providence Health & Services proudly serves as Oregon's largest health care provider, including eight hospitals, 90 clinics, comprehensive behavioral health services, and a range of elderly care services. Within Providence Oregon, we have two Level III trauma centers, including Providence Medford Medical Center (PMMC) and Providence Hood River Memorial Hospital (PHRMH) within Area Trauma Advisory Boards (ATABs) 5 and 6.

The Oregon Health Authority (OHA) has proposed rules to permanently amend Exhibit 2 (EMS Field Triage Criteria) based on the *2021 National Guideline for Field Triage of Injured Patients* and Exhibit 3 (Hospital Trauma Team Activation Criteria) based on the *2022 Resources for Optimal Care of the Injured Patient*. As currently written, Providence has concerns about the proposed amendments, and appreciates the opportunity to provide reasoning for these concerns and share recommendations.

Providence's Recommended Changes to the Proposed Rules:

Given the concerns outlined above, there are three specific areas where we are requesting changes within **Exhibit 2**, including:

1) **Within the "Red Criteria" Section under the "Mental Status & Vital Signs" box:**
    a. We recommend that criteria for both Age 10-64 years ("**SBP less than 90 mmHg**") and Age 65 years or older ("**SBP less than 110 mmHg**") be moved from the "red criteria" section to the "yellow criteria" section under the "EMS judgment" box. As currently proposed, these criteria would lead to significant over-triage as a mandatory inclusion. However, we recognize the recommendations of the American College of Surgeons (ACS) guidelines and the needs of the geriatric population; therefore, we recommend moving these criteria from the "red criteria" section to the "yellow criteria" section (under "EMS Judgment") for EMS to consider in their overall assessment and determination.

2) **Within the "Yellow Criteria" section under the "EMS Judgment" box:**
    a. As currently proposed, "**Suspicion of child abuse**" has been added to the "yellow criteria" (moderate risk for serious injury) section. There is no definition provided of what "suspicion of child abuse" means, and our major concern is that the ambiguity

presents challenges in interpretation and operationalization. We recommend either removing "suspicion of child abuse" from the yellow criteria section altogether, or providing a clear definition.

3) **Within the "Yellow Criteria" section under the "EMS Judgment" box:**
   a. As currently proposed, "**Special, high-resource healthcare needs**" has been added to the "yellow criteria" (moderate risk for serious injury) section. There is no definition provided of what "special, high-resource healthcare needs" means, and our major concern is that the ambiguity presents challenges in interpretation and operationalization. We recommend either removing "special, high-resource healthcare needs" from the yellow criteria section altogether, or providing a clear definition.

Given that Exhibit 3 has been developed to align with Exhibit 2, we recommend that the proposed changes above to Exhibit 2 are mirrored in Exhibit 3. We recommend keeping the existing criteria for full and modified activations similar to current state as it is also in alignment with the ACS criteria for the highest level of activations.

Providence's Concerns to the Proposed Rules:

- **Increase in trauma volumes without improvement in patient outcomes**: OHA's proposed changes to the criteria will result in a significant increase of trauma volumes at rural hospitals for patients who do not require trauma-level resources, and without any significant improvement in quality outcomes of these patients.

    - **Using national data to drive statewide changes neglects regional context:** There has been no analysis of Oregon state trauma data to support the decision to increase the requirements for full-team activations, nor has data been shared that supports a concern for system-wide under-triage in Oregon. Adopting these new activation criteria will have a significant increase in overall trauma patients and in over-triage rates for minimally-injured patients that will be unsustainable for hospitals to manage, leading to delays in diagnosis and treatment of non-trauma patients and potentially causing significant patient safety concerns in the non-trauma population. Additionally, based on the proposed Exhibit 2, in geographic areas where EMS will be required to bypass Level III, IV and possibly Level II trauma centers, our highest level trauma centers will be overwhelmed with patients who could be appropriately cared for at lower levels. This increases the difficulty for lower level trauma centers to find accepting facilities for critical patients that truly do need higher levels of care, and is extremely concerning as we are already having difficulty securing accepting facilities.

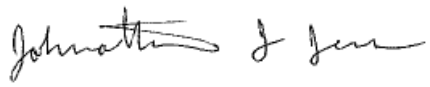
- **Impact on hospital resources and staffing:** As Oregon hospitals are currently operationalizing the hospital staffing bill (HB 2697) passed in 2023, which requires implementing new workflows and additional staffing resources in order to meet new staffing ratios and meal/rest break requirements, it is expected that the projected increase in trauma volumes would have challenging impacts on hospitals from a resource, financial, and staffing perspective. Additionally, the local landscape is an essential component when viewing the trauma system as

a whole; adding unnecessary health care costs to our most vulnerable populations in Oregon is not equitable.

- As an example, our Providence Medford Medical Center conducted data analyses of trauma activation volumes and identified that the proposed criteria changes would significantly increase the number of patients categorized as "trauma patients" by about 160 patients/year, growing current volumes of 250-300/year to 450-500/year. In our analyses, it was found that most of the new trauma activation volume would be generated from predominantly low-injury severity scores related to falls or isolated orthopedic/hip injuries. Our concern is that the proposed criteria changes would hinder our longstanding goal of ensuring seriously injured patients are transported to the most clinically-appropriate trauma centers, and instead contribute to over-triage that will be unsustainable for facilities to manage.

We respectfully request that OHA consider the challenges and recommendations outlined above in response to the proposed criteria changes. We hope that our continued partnership will continue to result in a trauma system that is sustainable, equitable, and efficient. Thank you for allowing us to provide input and feedback.

Respectfully,



Johnathan Jones, RN, BSN
Clinical Trauma Coordinator
Providence Health & Services – Oregon

AdventistHealth Tillamook

Administration

1000 Third Street
Tillamook, OR 97141
P: 503-815-2260
F: 503-842-3062
AdventistHealthTillamook.org

Mellony Bernal
800 NE Oregon St.
Portland, OR 9723

Re: *Notice of Proposed Rulemaking for OAR chapter 333, division 200 – "Updated Field Triage Guidelines and Trauma Team Activation Criteria"*

Dear Mellony,

Adventist Health Tillamook is a 25-bed critical access Level IV trauma center serving Tillamook County. Adventist Tillamook also operates the largest hospital-based ambulance service in the state of Oregon with four stations located throughout Tillamook County.

First and foremost, Adventist Tillamook appreciates all the effort that has been put forth by the Oregon Health Authority (OHA) in addressing many needed updates to the Field Triage Guidelines (EMS Field Triage Criteria) and Trauma Team Activation Criteria (Hospital Trauma Team Activation Criteria). As Adventist Health Tillamook is in a rural area with limited resources, we have concerns regarding some of the proposed rules that would permanently amend Exhibit 2 and Exhibit 3.

Since Adventist Health Tillamook owns our ambulance service, we have a vested interest in the pre-hospital criteria and the following concerns regarding some of the proposed changes to Exhibit 2:

1) Within the *RED CRITERIA* under "Mental Status and Vital Signs" we would like you to consider moving the systolic blood pressure (SBP) activations for AGE 10-64 (SBP less than 90 mmHg) and Age 65 years or greater (SBP less than 110 mmHg) to the YELLOW CRITERIA box. Our concern is that if left unchanged, this activation will result in a significant number of over-triaged patients. Secondly, we would like to suggest that this blood pressure be part of a sequence to demonstrate a pattern as opposed to a one time reading that could perhaps be an outlier. We would recommend that two (2) consecutive blood pressures be noted to warrant trauma activation.
2) Within the *RED CRITERIA* under "Mental Status and Vital Signs" we have two(2) concerns regarding the wording "Room-air pulse oximetry less than 90%". The First concern is that this does not take into consideration the number of patients that live with a baseline saturation in the 80s, predominately our COPD population. Secondly, it implies that saturation on room air MUST be assessed, even if the patient's baseline is with additional oxygen, thereby guaranteeing that a low saturation will be noted once oxygen has been removed again triggering an unnecessary over-triage. We would like to suggest that clarification be added to allow vitals on baseline oxygen and furthermore to place this under an EMS judgment, which would be based on their assessment and allow room for patients who otherwise have a baseline saturation less than 90%.
3) Within the *YELLOW CRITERIA* box under "EMS Judgment" we have concerns regarding "Suspicion of child abuse". There are many forced consequences that come from the implication of child abuse and therefore should not be taken lightly or addressed in a time sensitive environment like pre-hospital. We would recommend that this be dropped from Exhibit 2 and instead be assessed in a hospital setting with more

appropriate resources. If it is decided that this must be left in place, then we would recommend providing an in-depth clarification and a detailed definition to what "suspicion of child abuse" means.

4) Within the *YELLOW CRITERIA* box under "EMS Judgment", the risk factor "Special, high resource healthcare needs" is vague and does not provide insight as this can imply many different things. We would suggest either removing this all together or providing a clear definition with parameters to help direct our pre-hospital crews.

It is our understanding that these proposed changes have been suggested to better align communication and flow between Exhibit 2 and Exhibit 3. In maintaining that alignment, we have the following recommendations for Exhibit 3.

1) Within the *FULL TRAUMA TEAM CRITERIA*, we would again reference the previously mentioned issue from Exhibit 2 - #1 and suggest that the "Blood Pressure" activation be moved to the *Modified Trauma Team Activation* box. Furthermore, we would again believe that this be two(2) or more sequential blood pressures noted to trigger an activation. Again, if left unchanged, our concern is that the over-triaging of patients will significantly tax our trauma system and burn-out our resources, thus causing the opposite effect of improving the efficiency of the program.
2) It is noted that "EMS Provider" has been removed and in exchange "Emergency physician's discretion has been added. In the field, EMS assessment and experience is invaluable and since we rely so heavily on their judgment it would be unreasonable take that privilege away from them. We would highly recommend keeping the Emergency Physician's discretion and adding back EMS discretion as well. Since the new proposed Exhibit 2 references "EMS Judgment" we believe it is imperative to add this back to Exhibit 3 to maintain the alignment between the two exhibits you are attempting to achieve.

Adventist Health Tillamook thanks you for acknowledging our concerns and suggestions outlined above in response to the proposed changes to Exhibit 2 and Exhibit 3. We believe that our recommendations with your other proposed changes will lead to a more improved, efficient, and fluid trauma response and system.

Thank you for your time and allowing us to provide feedback.

Sincerely,

Eric Swanson, MBA, FACHE, NRP
President

Frederick A. Foss, Jr. MD FACS
Trauma Program Director

Anthony Huacuja, RN
Trauma Program Coordinator

Hospital Association of Oregon

January 22, 2024

Oregon Health Authority
Public Health Division
800 NE Oregon Street
Portland, OR 97232

Submitted electronically to: publichealth.rules@odhsoha.oregon.gov

Re: Proposed Administrative Rules - Updated Field Triage Guidelines and Trauma Team Activation Criteria

Mellony Bernal:

The Hospital Association of Oregon appreciates the opportunity to comment on the proposed rules for chapter 333, division 200 relating to Emergency Medical Services and Trauma Systems. The Oregon Health Authority (OHA) has proposed rules to permanently amend Exhibit 2 (EMS Field Triage Criteria) based on the *2021 National Guideline for Field Triage of Injured Patients* and Exhibit 3 (Hospital Trauma Team Activation Criteria) based on the *2022 Resources for Optimal Care of the Injured Patient*. We write to provide comments on the following important topics.

The adoption of these changes could harm rural trauma hospitals and the patients they serve. We are hearing from hospitals that the proposed changes take away from the expertise and judgment in the field and throughout the hospital staff and would increase costs.

We are concerned that the changes to Exhibit 2 would result in more patients being considered trauma patients, without improving patient care. In geographic areas where EMS will be required to bypass Level III, IV and possibly Level II trauma centers, the drive time for EMS will increase and result in delayed care to others in need. We are also concerned that the highest-level trauma centers will need to serve an increasing number of patients who could be appropriately and efficiently cared for at other hospitals.

We are also concerned that changes to Exhibit 3 will result in hospital trauma activation that could bypass other patients needing triage. Adopting the new activation criteria will have a significant increase in overall trauma patients and over triage for minimally-injured patients. This does not appear to be patient-centered, and it will have an impact on hospital resources and staffing needs.

4000 Kruse Way Place
Building 2, Suite 100
Lake Oswego, Oregon, 97035

Phone: 503.636.2204
Email: info@oregonhospitals.org
Web: oregonhospitals.org

Our understanding is these proposals are not supported by an analysis of Oregon's state trauma data. We are unaware of an analysis by the Oregon Health Authority that would support the need for these changes or support that the changes would improve patient care.

We request that OHA consider the challenges outlined above. Thank you for reviewing our comments.

Thank you,

Danielle Meyer
Director of Public Policy
Hospital Association of Oregon

4000 Kruse Way Place
Building 2, Suite 100
Lake Oswego, Oregon, 97035

Phone: 503.636.2204
Email: info@oregonhospitals.org
Web: oregonhospitals.org

HALL Brittany A

From: Whitley Sullivan <sullivan@pwlobby.com>
Sent: Monday, January 22, 2024 3:20 PM
To: Public Health Rules
Cc: Mark Long; aeaston@samhealth.org
Subject: Samaritan Comments on Updated Field Triage Guidelines and Trauma Team Activation Criteria

Good afternoon, please accept the below comments on behalf of Mark Long, who represents Samaritan Health Services. Please let me know if you need any additional information.

"My name is Mark Long. I am the Vice-President of Regulatory Affairs at the Pac/West Lobby Group. I write today on behalf of Samaritan Health Services, Inc. (Samaritan). Samaritan is a nonprofit network of hospitals, clinics and health services caring for more than 265,000 residents in the mid-Willamette Valley and central Oregon Coast. Samaritan works together to provide innovative medicine and world-class quality in a way that supports the values of the communities we serve. Thank you for the opportunity to provide written feedback on the Updated Field Triage Guidelines and Trauma Team Activation Criteria, which were discussed at the remote hearing that occurred on Wednesday, January 17, 2024.

We understand that Oregon Health Authority (OHA), Public Health Division (Division) is proposing to permanently amend Exhibits 2 and 3 of Oregon Administrative Rules Chapter 333, Division 200 relating to Emergency Medical Services and Trauma Systems. We further understand that the changes are inspired by the revised, 2021 National Guideline for Field Triage of Injured Patients and the 2022 Resources for Optimal Care of the Injured Patient.

Our specific concerns are related to the updated field triage criteria located in Exhibit 2 of OAR Chapter 333 Division 200. Under the updated Exhibit, patients over the age of 65, with a systolic blood pressure of less than 110, presenting with traumatic injury pattern, will have to be transported by EMS to the *highest-level trauma center in the region*. Many people over the age of 65 have comorbidities, such as cardiac disease, which result in systolic blood pressure rates between 90 and 110, as a direct consequence of pharmaceutical intervention.

This will necessarily result in EMS providers having longer transport times; taking them outside of their local community, so they can provide fewer rides. This will also unnecessarily substantially burden higher level trauma centers, further straining scarce hospital resources. Moreover, these patients will be taken out of their local communities to receive their trauma care, resulting in discharge challenges for their families.

We believe that the better course of action would be to align the criteria in Exhibit 2, with that which is contained in Exhibit 3, which pertains to hospital activation criteria. This would require that any adult with confirmed systolic blood pressure of less than 90 be the triggering criteria, and that transported to "a trauma center," rather than the "highest level trauma center in the region."

We are additionally concerned that the triggering criteria for patients at all ages to be transported to a trauma center is room air pulse oximetry less than 90 percent, under the revised Exhibit 2. Simply put, this should not apply to *all patients*. This is because there are some patients who have comorbidities, such as those requiring at home oxygen, or chronic obstructive pulmonary disease (COPD) that have baseline saturations of less than 90 percent. We recommend considering pre-existing conditions which may cause saturations of less than 90 percent, and to transport patients experiencing trauma to "a trauma center," rather than the "highest trauma center in the region."

Both collectively, and in isolation, these modifications will significantly increase the volume of trauma patients take by EMS to Level 1 and Level 2 trauma centers throughout the state. This will necessarily result in unnecessary burden on those facilities, resulting in a decreased capacity to accept transfers of high acuity trauma patients who actually need the care provided at Level 1 and Level 2 trauma centers.

If you have any questions, do not hesitate to contact Samaritan's Trauma Program Manager Katie Hennick via phone at 541-768-5231, or via email at khennick@samhealth.org. "

WHITLEY SULLIVAN
Director of Rural Development and Housing

PAC/WEST LOBBY GROUP

PO Box 12518 |Salem, OR 97309
PO Box 221 | Hermiston, OR 97838
541-720-6581 | pwlobby.com
sullivan@pwlobby.com

From: John Heiser
To: Public Health Rules
Subject: Notice of Proposed Rulemaking
Date: Saturday, January 6, 2024 10:15:31 AM

I would like to comment on the proposed rule change. I am the Medical Director for all of the Fire Agencies in Yamhill County. Each year these Agencies transport many trauma patients to either Salem or WVMC. I am hearing from the Trauma Coordinators at both facilities that these proposed changes will significantly affect their hospitals. I review many trauma entries every year. Mostly because the Medics did not enter a patient. I have not seen any cases where a patient would have benefitted from the new criteria. The concern for my Agencies would be that they would have to transport red criteria patients to Salem versus WVMC as it is a higher level Trauma Center in our geographic area. This would do 2 things. First it would potentially be a longer transport and second it may overwhelm Salem with extra patients. The Medics I supervise have a good sense of who would benefit from taking a patient to a higher level Trauma Center in our area. I feel the current Trauma Entry criteria are working well and that you should not change something that is not broken.

Sincerely,

John Heiser MD,FACEP