OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 200

EMERGENCY MEDICAL SERVICES AND SYSTEMS

333-200-0010 Definitions
As used in OAR 333-200-0000 through 333-200-0090:
(1) "Area Trauma Advisory Board" (ATAB) means an advisory group appointed by the Division for each established trauma area to represent providers of trauma care and members of the public.
(2) "Categorization" means a process for determining the level of a hospital's trauma care capability and commitment which allows any hospital which meets criteria to receive trauma patients.
(3) "Communications Coverage Area" means a geographic region representing a primary radio service area for emergency medical communications. When primary service areas substantially overlap they will be considered as one coverage area.
(4) "Designation" means a competitive process for identifying the level of a hospital's trauma care capability and commitment which selects a limited number of hospitals which meet criteria to receive trauma patients.
(5) "Division" means the Public Health Division of the Oregon Health Authority.
(6) "Emergency Medical Condition" means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus, in the case of a pregnant woman, in serious jeopardy.
(7) "Emergency Medical Services Agency" (EMS Agency) has the meaning given that term in OAR 333-265-0000(15).
(8) "Emergency Medical Technician" (EMT) means a person who is licensed by the Division as an Emergency Medical Technician.
(9) "First Responder" means a person who is licensed by the Division as an Emergency Medical Responder.
(10) "Glasgow Coma Scale" (GCS) means an internationally recognized scoring system for the assessment of head injury severity and degree of coma.
(11) "Hospital" has the meaning set forth in ORS 442.015(13).
(12) "Hospital Catchment Area" means a geographic region representing a primary service area for hospitals. When primary service areas substantially overlap they shall be considered as one catchment area.
(14) "Level I (Regional) Trauma Hospital" means a hospital which is categorized or designated by the Division as having met the hospital resource standards for a Level I hospital, as described
in Exhibit 4. Level I hospitals manage severely injured patients, provide trauma related medical education and conduct research in trauma care.

(15) "Level II (Area) Trauma Hospital" means a hospital categorized or designated by the Division as having met the hospital resource standards for a Level II hospital, as described in Exhibit 4. Level II hospitals manage the severely injured patient.

(16) "Level III (Local) Trauma Hospital" means a hospital categorized or designated by the Division as having met the hospital resource standards for a Level III hospital, as described in Exhibit 4. Level III hospitals provide resuscitation, stabilization, and assessment of the severely injured patient and provide either treatment or transfer the patient to a higher level trauma system hospital as described in Exhibit 5.

(17) "Level IV (Community) Trauma Hospital" means a hospital categorized or designated by the Division as having met the hospital resource standards for a Level IV hospital, as described in Exhibit 4. Level IV hospitals provide resuscitation and stabilization of the severely injured patient prior to transferring the patient to a higher level trauma system hospital.

(18) "Managed Health Care System" means a business enterprise, e.g., health maintenance organization, which contracts with organizations, individuals, or government programs to provide for the delivery of an agreed upon set of medical or referral services for an enrolled group of individuals and families in a defined geographic area at a fixed periodic rate paid per enrolled individual or family.

(19) "Medical Control" means physician responsibility for the operation and evaluation ofprehospital emergency medical care performed by emergency care providers.

(20) "Off-Line Medical Control" means the direction provided by a physician to prehospital emergency medical care providers through communications such as written protocols, standing orders, education and quality improvement reviews.

(21) "On-Line Medical Control" means the direction provided by a physician to prehospital emergency medical care providers through radio, telephone, or other real time communication.

(22) "Oregon Trauma Registry" means the data collection and analysis system operated by the Division.

(23) "Response Time" means the length of time between the notification of a provider and the arrival of that provider's emergency medical service unit(s) at the incident scene.

(24) "Stabilization" means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

(25) "State Trauma Advisory Board" (STAB) means an advisory group appointed by the Division to represent providers of trauma care.

(26) "Trauma Patient" means a person who at any time meets criteria for inclusion in the Oregon Trauma System, as described in Exhibit 2 of these rules.

(27) "Trauma System Hospital" means a hospital categorized or designated by the Division to receive and provide services to trauma patients.

(28) "Trauma System Plan" means a document which describes the policies, procedures and protocols for a comprehensive system of prevention and management of traumatic injuries.

(29) "Triage Criteria" means the parameters established to identify trauma patients for treatment in accordance with the trauma system plan. These criteria are set forth in Exhibit 2.

[Publications: The publication(s) referred to or incorporated by reference in this rule are available from the agency.]

[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]
Objectives of the Trauma System

The objective of the statewide trauma system is to reduce deaths and disabilities which result from traumatic injuries by:

(1) Identifying the causes of traumatic injuries and recommending, promoting, and coordinating prevention activities;

(2) Developing a statewide trauma system plan to assure timely, quality, definitive care through coordinated identification, transportation and treatment of trauma patients:

(a) The statewide trauma system plan shall be composed of seven area plans; and

(b) Each area trauma system plan shall consist of policies, procedures, and protocols which address each of the following trauma system components:

(A) Communication and dispatch;

(B) Responders and response times;

(C) Medical control and treatment;

(D) Triage and transportation;

(E) Hospital resources;

(F) Inter-hospital transfers;

(G) Rehabilitation;

(H) Quality improvement;

(I) Education and research;

(J) Prevention; and

(K) Disaster management.

(3) Adopting the standards, policies and procedures necessary to unify area trauma system plans into a statewide trauma system; and


Standards for Area Trauma System Plans

Area trauma system plans shall describe how each of the following standards are met or exceeded. Interpretation and implementation of the standards as set forth in this rule shall be in general accordance with the guidelines of the Resources for Optimal Care of the Injured Patient: Committee on Trauma, American College of Surgeons, 2006. For the purposes of section (4) of this rule, interpretation and implementation of standards shall be in general accordance with the Guidelines for Field Triage of Injured Patients, Recommendations of the National Expert Panel on Field Triage, 2011; Centers for Disease Control and Prevention, MMWR, January 13, 2012, Vol 61, No. 1:

(1) Communications and Dispatch:
(a) System Access: Residents and visitors in a communications coverage area shall be able to access emergency medical services by calling 9-1-1 as set forth in ORS 401.720;

(b) Dispatch Response: Dispatchers for emergency medical care providers shall have protocols which include pre-arrival patient care instructions and which require the dispatch of the appropriate level of available responding units (Basic, Intermediate or Advanced Life Support) based on medical need;

(c) Special Resources: All emergency medical services dispatchers shall maintain an up-to-date list of available law enforcement agencies, fire departments, air and ground ambulance services, quick response units that respond to an ill or injured person to provide initial emergency medical care prior to transportation by an ambulance and special responders for extrication, water rescue, hazardous material incidents and protocols for their use;

(d) Prehospital/Hospital: Ambulances shall have either a UHF or VHF radio that will allow communications with the base hospital and their dispatch agency as set forth in OAR 333-255-0070(2)(q). If the information has to be relayed through the dispatching agency, that agency shall be responsible to relay patient information to the hospital; and

(e) Training: There shall be training and certification standards for all tele-communicators that process telephone requests for or dispatch emergency care providers. The authorization to establish these standards is found in ORS 401.735 and is the responsibility of the Department of Public Safety Standards and Training.

(2) Responders and Response Times:
(a) Ambulance Service Areas (ASAs): The existing ASAs shall be described as well as a summary of the ATAB’s efforts to promote each county adopting an ASA plan in accordance with ORS 682.205;

(b) Response Times: Trauma system patients shall receive prehospital emergency medical care within the following response time parameters 90 percent of the time:
   (A) Urban area, an incorporated community of 50,000 or more population -- 8 minutes;
   (B) Suburban area, an area which is not urban and which is contiguous to an urban community. It includes the area within a 10-mile radius of that community's center. It also includes areas beyond the 10-mile radius which are contiguous to the urban community and have a population density of 1,000 or more per square mile -- 15 minutes;
   (C) Rural area, a geographic area 10 or more miles from a population center of 50,000 or more, with a population density of greater than six persons per square mile -- 45 minutes;
   (D) Frontier area, the areas of the state with a population density of six or fewer persons per square mile and are accessible by paved roads -- 2 hours; and
   (E) Search and rescue area, the areas of the state that are primarily forest, recreational or wilderness lands that are not accessible by paved roads or not inhabited by six or more persons on a year round basis. -- No established response time.

(c) Field Command: A uniform policy shall assign responsibility for directing the care of the trauma patient in the prehospital setting in cases of response by multiple providers to assure scene control by the most qualified responder;

(d) Utilization of Air Ambulance: Protocols for the medical control, activation and utilization of air ambulance service(s) shall be established;

(e) Prehospital Care Report Form: All prehospital emergency care providers shall use a patient care report form in accordance with the policy regarding prehospital forms as set forth in OAR 333-255-0070(2)(r); and
(f) Utilization of Oregon Trauma System Identification Bracelet: All prehospital emergency medical care providers shall use the official Public Health Division numbered Trauma System Identification Bracelet when the patient meets trauma system entry criteria or is entered into the Trauma System, and that number shall be recorded on the patient's prehospital care report.

(3) Medical Control and Treatment:

(a) Protocols, Policies and Procedures: Providers in each trauma system area shall function under one set of off-line prehospital trauma protocols and one set of on-line medical control trauma policies and procedures which address basic, intermediate and advanced levels of care. Off-line treatment protocols shall clearly describe all treatment and transportation procedures and identify those procedures which require on-line medical authorization. Medical control policies and procedures must assure consistent area-wide coordination, data collection and area-wide quality improvement responsibility;

(b) Hospital Status: In the event that on-line medical control serves two or more categorized or designated hospitals, there shall be a system for medical control to continuously determine the current status of hospital trauma care capabilities; and

(c) Physician Qualifications: On-line medical control physicians must be qualified for this role by virtue of training, experience and interest in prehospital trauma care as demonstrated through emergency medicine and Advanced Trauma Life Support training in accordance with the American College of Surgeons curriculum.

(4) Triage and Transportation: Triage and transportation protocols shall be written which assure that patients who at any time meet triage criteria as set forth in these rules in Exhibit 2 will be transported directly to a Level I or Level II trauma hospital as described under OAR 333-200-0090(1) unless otherwise advised by on-line medical control or under the following circumstances:

(a) If unable to establish and maintain an adequate airway, the patient shall be taken to the nearest hospital to obtain definitive airway control. Upon establishing and maintaining airway control, the patient shall be immediately transferred to a Level I or Level II trauma hospital;

(b) If the scene time plus transport time to a Level I or Level II trauma hospital is significantly greater than the scene time plus transport time to a closer Level III or Level IV trauma hospital;

(c) If the hospital is unable to meet hospital resource standards as defined in Exhibit 4, when there are multiple patients involved, or the patient needs specialty care;

(d) If on-line medical control overrides these standards for patients with special circumstances, such as membership in a health maintenance organization, and if the patient's condition permits; and

(e) Application of subsections (b), (c), and (d) of this section must not delay definitive medical or surgical treatment.

(5) Hospital Resources:

(a) Trauma System Hospital Identification: Either the categorization or designation method of identifying trauma system hospitals as described under OAR 333-200-0090(1) through (3) shall be recommended to the Division; and

(b) Resource Criteria: Trauma system hospitals shall meet or exceed the standards for hospital resources as set forth in Exhibit 4 and hospital response criteria as set forth in Exhibit 3. Area criteria that exceed the criteria set forth in Exhibit 4 shall be accompanied by an informational statement of the additional costs that a hospital will incur to meet these standards.

(6) Inter-hospital Transfers:
(a) Identification of Patients: ATAB-wide criteria which meet or exceed any of the criteria set forth in Exhibit 5 of these rules shall be established to identify patients who should be transferred to a Level I or II trauma system hospital or specialty care center. 
(b) When it is determined that a patient transfer is warranted:
   (A) The transfer shall take place after the stabilization of the patient's emergency medical condition has been provided within the capabilities of the local hospital, which may include operative intervention; and 
   (B) The transfer to a Level I or II trauma hospital shall not be delayed for diagnostic procedures that have no impact on the transfer process or the immediate need for resuscitation. 
(c) In all situations regarding an inter-hospital transfer, the decision to retain or transfer the patient shall be based on medical knowledge, experience and resources available to the patient. 
(d) The hospital's trauma performance improvement process shall monitor all cases meeting inter-hospital transfer criteria. The Division through annual reports and site surveys shall monitor this performance category. 

(7) Inter-hospital Transfers with Health Maintenance Organizations: 
(a) Trauma system hospitals shall facilitate the transfer of a member of a health maintenance organization or other managed health care organization when the emergency medical condition of the member permits and no deterioration of that condition is likely to result from or occur during the transfer of the patient. Trauma system hospitals shall transfer a patient in accordance with the provisions of ORS 431.611(2)(a) and (b) and any other applicable laws or regulations. 
(b) A patient will be deemed stabilized, if the treating physician attending to the patient in the trauma hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved. 
(c) Hospitals or health maintenance organizations may not attempt to influence patients and families, prior to the patient's stabilization, into making decisions affecting their trauma treatment by informing them of financial obligations if they remain in the trauma facility. 
(d) Health maintenance organizations and non-designated trauma facilities shall report follow-up information to the transferring trauma system hospital and all required data as set forth in the Oregon Trauma Registry Abstract Manual; and 
(e) Hospitals or health maintenance organizations that receive or transfer trauma patients shall participate in regional quality improvement activities. 

(8) Rehabilitation Resources: 
(a) Capabilities for trauma rehabilitation in each trauma system area and transfer procedures to other rehabilitation facilities shall be described; and 
(b) Rehabilitation resources for burns, pediatrics, neuro-trauma and extended care shall be included. 

(9) Quality improvement: 
(a) Provisions shall be made for at least quarterly review of medical control, prehospital emergency medical care and hospital care of trauma cases:
   (A) Area-wide criteria for identifying trauma cases for audit shall be described and shall include all trauma related deaths; 
   (B) Responsibility for identifying and reviewing all trauma cases meeting audit criteria shall be assigned; and 
   (C) Quarterly reports shall be submitted to the Division by the ATAB or its representative on confidential forms.
(b) The ATAB, STAB, all Area and State Quality Improvement Committee(s) and the Division shall meet in executive session as set forth in ORS 192.660 when discussing individual patient cases; and
(c) No member of any ATAB, the STAB, or any committee, subcommittee or task force thereof, shall disclose information or records protected by ORS 431.627 or 41.675 to unauthorized persons. Any person violating these rules shall be forthwith removed by the Division from membership on any trauma system committee, subcommittee or task force thereof.
(10) Education and Research:
(a) Trauma Training: Trauma system hospitals shall provide or assist in the provision of prehospital trauma management courses to all First Responders and EMTs involved in the prehospital emergency medical care of severely injured patients; and
(b) Research: In areas with Level I hospitals, clinical and basic research in trauma and publication of results involving surgical and nonsurgical specialists, nurses, and allied health professionals engaged in trauma care, shall be promoted.
(11) Prevention:
(a) Public Education: Public education and awareness activities shall be developed by trauma system hospitals to increase understanding of the trauma system and injury prevention. These activities shall be appropriate to the size and resources of the area; and
(b) Development and Evaluation: Trauma prevention activities to identify and address area problems shall be supported.
(12) Disaster Management:
(a) Integration: All counties in a trauma system area shall have a medical component in their disaster plan, which shall include any non-trauma system hospitals and appropriate mutual aid agreements; and
(b) Review: There shall be a mechanism in place for ongoing review of the medical component of the county disaster plan.
[Publications: The publication referred to in this rule is available from the agency.]
[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]

333-200-0090
Trauma Hospitals
(1) The Division shall accredit trauma system hospitals by levels of care capability as defined by the criteria contained in Exhibit 4 and by any criteria contained in the approved area plan. Accreditation will be renewed every three years if the hospital submits an application for reaccreditation, and if the Division's review finds that the hospital continues to meet the prescribed standards in Exhibit 4.
(a) The application process shall provide for at least 60 days in which to complete and submit proposals to the Division with all supporting information and documents;
(b) The Division's evaluation of hospital applications:
(A) Shall include a review of the hospital's proposal by the Division or on-site survey team;
(B) Shall include a survey of the hospital by an on-site survey team. This team shall be composed of persons selected by the Division; and
(C) The on-site survey teams shall evaluate the quality of each hospital's compliance with the standards in Exhibit 4 by:
(i) Evaluating medical records, staff rosters and schedules, quality improvement committee minutes and other documents relevant to trauma care;
(ii) Evaluating equipment and premises;
(iii) Conducting informal interviews with hospital personnel; and
(iv) Reporting the findings and interpretations of the survey to the Division.
(c) The Division may grant exemptions from one or more standards that are established in OAR 333-200-0080 if the applicant can prove, or the Division finds that compliance with such standards is inappropriate because of special circumstances which would render compliance unreasonable, burdensome or impractical. Such exemptions or variances may be limited in time or may be conditioned as the Division considers necessary to protect the public welfare;
(d) When selecting on-site survey team members the Division shall consider concerns for conflict of interest when the applicant can demonstrate a clear and convincing basis for concern. These concerns include but are not limited to past or potential financial or personal gain, past or potential employment, or gain from the use of confidential information. Concerns accompanied by the proof upon which the applicant relies shall be submitted to the Division, in writing, within 10-working days of the Division's announcement of proposed on-site survey team members;
(e) The applicant's administration, faculty, medical staff, employees and representatives are prohibited from having any contact with any on-site survey team member, except as directed by the Division. A violation of this provision may be grounds for excluding that applicant;
(f) Information gathered by the on-site survey team, their oral and written reports and deliberations shall be held confidential by the Division;
(g) The Division will provide a written report of its on-site survey results to the applicant hospital only. Hospital survey reports shall be held confidential by the Division;
(h) Each hospital application shall become the property of the Division and shall become public record at the end of the accreditation process, subject to the laws and rules applicable to public records; and
(i) The applicant shall have the right to withdraw its application at any time prior to dispositive action by the Division.
(2) For area trauma system plans prescribing categorization of hospitals, the Division shall accredit all hospitals which meet the standards of the area trauma system plan.
(3) For area trauma system plans prescribing designation of hospitals, the Division shall accredit selected hospitals which meet the standards of the area trauma system plan. The Division shall select hospitals based on the assessment that the best interests of the patients of the area are served by the particular applicant and expected patient volume. Competing applicants shall be judged on the on-site survey assessments of which hospital(s) provides the highest quality of compliance with the standards in Exhibit 4.
(4) The notification of trauma system hospital accreditation shall be made by certified letter from the Division. An applicant has 30 days from the receipt of the announcement of non-accreditation to file a request with the Division for reconsideration.
(5) A trauma system hospital shall:
(a) Be responsible for all expenses incurred by the hospital in planning, developing and participating in the trauma system, including attorney fees and costs;
(b) Be responsible for all expenses incurred when a re-survey of the hospital is conducted by the Division or its designee(s);
(c) Comply in all material respect with these rules, all current state and area trauma system standards, and all policies, protocols and procedures as set forth in the approved area trauma system plan;

(d) Provide the resources, personnel, equipment and response required by these rules;

(e) Provide care to trauma system patients which is consistent with the standards advocated by the Advanced Trauma Life Support Course, American College of Surgeons, Committee on Trauma; 1999.

(f) Report to the Oregon Trauma Registry all required data as set forth in the Oregon Trauma Registry Abstract Manual for each and every trauma patient as defined in these rules, within 90 days of death or discharge of that patient. Data shall be submitted in electronic media using a format prescribed by the Division. The Division may, at its sole discretion, permit data submission by alternative means where use of the Division's prescribed format would impose a severe hardship on the reporting institution;

(g) Participate in evaluation and research studies as prescribed by the Division; and

(h) Record patient resuscitation data on the official state trauma resuscitation flow sheet. If using a form other than the official form, that form must contain at least the same information.

(6) The Division shall provide statistical reports in formats prescribed by the Division in consultation with the STAB, to the STAB and ATAB Quality Improvement Committees within 90 days of the close of the calendar quarter following receipt of the data submitted pursuant to subsection (5)(f) of this rule.

(7) Accreditation under sections (4) and (5) of this rule may be transferable to a successor operator if the successor provides a written acknowledgment that the successor will comply with all of the responsibilities and obligations imposed upon the transferor under these rules including terms of probationary status, and that successor agrees to be substituted in pending proceedings regarding the accreditation status. The Division may decline, at its discretion, to transfer accreditation if it reasonably believes the successor cannot meet the standards, rules, policies or protocols set forth in the approved area plan.

(8) No person, emergency medical service, medical clinic, or hospital shall by any means advertise, assert, represent, offer, provide or imply that such person, service, clinic or hospital is a trauma system hospital or has the capabilities for providing treatment to trauma patients beyond the status for which the accreditation has been granted.

(9) No trauma system hospital shall in any manner advertise or publicly assert that its trauma categorization or designation affects the hospital's care capabilities for non-trauma system patients, nor that the categorization or designation should influence the referral of non-trauma system patients.

(10) The Division may review, inspect, evaluate, and audit patient trauma discharge summaries, trauma patient care logs, and trauma patient care records, trauma quality improvement committee minutes and other documents relevant to trauma care of any hospital at any time to verify compliance with trauma system standards as set forth in these rules. The confidentiality of such records shall be maintained by the Division in accordance with state law.

(11) The Division may re-survey a trauma system hospital, to immediately revoke or suspend a trauma system hospital accreditation or to place a hospital on probation under any of the following circumstances:

(a) Substantial failure, for any reason, of a hospital to comply with these rules, all current state and area trauma system standards, and all policies, protocols and procedures as set forth in the approved area trauma system plan;
(b) Submission of reports to the Division that are incorrect or incomplete in any material aspect;
(c) Except as set forth in sections (12) and (13) of this rule, occasional failure of a trauma system hospital to meet its obligations will not be grounds for revocation, suspension, or probation by the Division if the circumstances under which the failure occurred:
(A) Do not reflect an overall deterioration in quality of and commitment to trauma care; and
(B) Are corrected immediately by the hospital.
(d) Failure of a trauma system hospital to timely and accurately report to the Division all data required by rule or statute is grounds for suspension or revocation as a trauma hospital.
(12) Where a hospital is greater than three months in arrears in reporting required trauma patient data, the Division may contract with an independent data collection and abstraction service to perform the data collection. The Division shall assess the trauma system hospital for all costs associated with such collection of required data.
(13) A hospital which is dissatisfied with the decision of the Division regarding revocation, suspension, or probation in section (10) of this rule may request a contested case hearing pursuant to ORS 183.310 to 183.550.
(14) A trauma system hospital may without cause terminate its trauma system hospital status upon 90-days written notice to the Division and the ATAB's list of interested parties.
[ED. NOTE: The Exhibit(s) referenced in this rule is not printed in the OAR Compilation. Copies are available from the agency.]
Stat. Auth.: ORS 431.611
Stats. Implemented: ORS 431.609, 431.611 & 431.627