



Oklahoma State Department of Health
Creating a State of Health

**Northeast (2) Regional Trauma Advisory Board
Regional Planning Committee
Jane Phillips Medical Center
3500 E Frank Phillips
Bartlesville, OK 74006
February 11th, 2020 - 10:00 am**

AGENDA

I. Call to Order

II. Welcome and Introductions

III. Roll Call

IV. Approval of Minutes – November 12th, 2019

V. Business

- A. STEMI Plan review, discussion, and possible vote to approve plan
- B. Venomous snake plan review and discussion
- C. EMResource discussion on the needs for the Region and possible vote to send recommendations to the RTAB
- D. Discussion of 2021 trauma system goals for recommendation to the RTAB for planning and implementation by October 2020 and possible vote to approve recommendation.

VI. New Business

VII. Next Meeting

- A. Regional Trauma Advisory Board
Jane Phillips Medical Center
3500 E Frank Phillips
Bartlesville, OK 74006
February 11th, 2020 - 1:00 pm
- B. Oklahoma Trauma and Emergency Response Advisory Council
Oklahoma State Department of Health
1000 Northeast 10th Street
Oklahoma City, OK 73117
February 12th, 2020 – 1:00 pm
- C. Quality Improvement Committee
EMSA – East
1417 North Lansing Avenue
Tulsa, OK 74160
April 21st, 2020 - 10:00 am
- D. Regional Planning Committee
Tri County Technology Center
6101 South East Nowata Road
Bartlesville, OK 74006
May 12^h, 2020 - 10:00 am

VIII. Adjournment

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
Becky Payton (*Secretary*)

Jenny Alexopoulos, DO
Terry R Gerard II, DO
Charles W Grim, DDS, MHSA

R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

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Region 2 RPC Roll Call - 2020

Representative	Attendance
Judy Dyke	
Sarah Kyser	
Rita Johnson	
Kelly McCauley	
Amanda Early	
David Davis	
Steve Smith	
Heidi Gilbert	



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**Northeast (2) Regional Trauma Advisory Board
Regional Planning Committee
Tri County Technology Center
6101 Nowata Road
Bartlesville, OK 74006
November 12th, 2019 – 10:00 am**

DRAFT MINUTES

I. Call to Order

The meeting was called to order by Chairperson Sarah Kyser at 10:08 am.

II. Welcome and Introductions

Steve Newton with Pafford EMS and Bonnie Daniel with Joplin Mercy introduced themselves to the committee.

III. Roll Call

Roll call was taken with all members present.

IV. Approval of Minutes – May 7th, 2019

A motion to approve the minutes as written was made by David Davis and seconded by Judy Dyke. There was no discussion and the motion passed 8-0.

V. Business

A. STEMI Plan review and discussion

The STEMI plan was reviewed. The committee asked for the following to be added to the plan; a review date, page number, and some surrounding hospitals be added to “List of PCI Hospital within or accessible to Region 2”. The plan will be on the next quarter RTAB agenda to be voted on.

B. Venomous snake plan review and discussion

The committee reviewed Region 5’s plan. The committee decided to have a volunteer call the hospitals in the Region to see their capabilities for snake bites. Josh Garde volunteered to call each hospital to gather the information and will bring back to the committee for the next meeting.

C. Preparing for Chemical Emergency plan review and discussion

The committee discussed the need for references instead of a plan. The committee asked for the reference (Poison Control and Chemtrec) to be added to EMResource.

D. 2020 Board Meeting Dates, Times, and Venue Vote

1. February 11th, 2020 at Jane Phillips Medical Center at 10:00 am
2. May 12th, 2020 at Tri County Technology Center at 10:00 am
3. August 11th, 2020 at Jane Phillips Medical Center at 10:00 am
4. November 10th, 2020 at Tri County Technology Center at 10:00 am

A motion to approve the 2020 meeting dates, times, and venue was made by Judy Dyke and David Davis. There was no discussion and the motion passed 8-0.

VI. New Business

VII. Next Meeting

- A. Quality Improvement Committee**
Oklahoma State Department of Health
1000 Northeast 10th Street
Oklahoma City, OK 73117
December 12th, 2019 – 8:30 am

[Board of Health](#)



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- B. Regional Planning Committee
TBA
- C. Regional Trauma Advisory Board
Tri County Technology Center
6101 Nowata Road
Bartlesville, OK 74006
November 12th, 2019 – 1:00 pm
- D. Oklahoma Trauma and Emergency Response Advisory Council
Oklahoma State Department of Health
1000 Northeast 10th Street
Oklahoma City, OK 73117
February 12th, 2020 – 1:00 pm

VIII. Adjournment

A motion to adjourn was made by Steve Smith and seconded by David Davis. The meeting was adjourned at 11:06 am.

Board of Health

Region 2 RPC Vote Call - 2019

Motion:

Motion:

Motion:

Representative	1 st /2 nd	Y	N	1 st /2 nd	Y	N	1 st /2 nd	Y	N
Judy Dyke									
Sarah Kyser									
Rita Johnson									
Kelly McCauley									
Amanda Early									
David Davis									
Steve Smith									
Heidi Gilbert									
Passed		Y	N		Y	N		Y	N

Region 2 RPC Vote Call - 2019

Motion:

Motion:

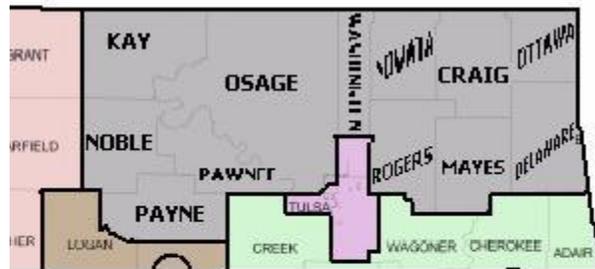
Motion:

Representative	1 st /2 nd	Y	N	1 st /2 nd	Y	N	1 st /2 nd	Y	N
Judy Dyke									
Sarah Kyser									
Rita Johnson									
Kelly McCauley									
Amanda Early									
David Davis									
Steve Smith									
Heidi Gilbert									
Passed		Y	N		Y	N		Y	N

Northeast Oklahoma Regional Time Sensitive Emergency Plan

Region 2

STEMI PLAN



Developed by the Northeast Regional Planning Committee

I. Introduction

Region 2 is committed to the early recognition and treatment of time sensitive emergencies by integrating systems of care for the ST-Elevation Myocardial Infarction (STEMI) patient. This plan will serve as a guide for the care of STEMI patients in Region 2. The goal of this plan is to:

- Develop a STEMI plan that will result in decreased cardiac mortality and morbidity in Region 2.
- Develop the ability to rapidly and accurately identify patients suffering from STEMI and to assure they receive care in a hospital that has a primary percutaneous coronary intervention program (PCI) in place which is capable of providing immediate and comprehensive assessment, resuscitation, intervention, and definitive care.
- Enhance the Region 2 system of STEMI care through quality improvement and data collection initiatives.

II. STEMI Treatment Guideline Recommendations

ACC/AHA STEMI treatment guidelines recommend primary PCI as the preferred reperfusion strategy in patients suffering from a STEMI, if a first medical contact-to-device (FMC-D) time is less than or equal to 90 minutes could be achieved for patients directly transported by emergency medical systems (EMS) to a PCI-hospital or less than or equal to 120 minutes for those who are initially transported to a Non-PCI or STEMI referral hospital.

III. Hospital Classifications

- A. **PCI-Capable Hospital:** A hospital that has the equipment, expertise and facilities to administer percutaneous coronary intervention (PCI), a mechanical means of treating STEMI patients. These PCI-capable hospitals are called STEMI-receiving hospitals because they are well equipped to receive and treat STEMI patients. See Appendix A for the list of PCI-Capable Hospitals in Region 2.
- B. **Non-PCI Hospital:** A hospital that does not have the means to delivery percutaneous coronary intervention (PCI). Non PCI hospitals can: administer clot-busting medicines that meet the health care needs of the STEMI patients; refer STEMI patients to the PCI hospitals, thus the name STEMI PCI referral hospital; and treat STEMI patients with medications when it is not feasible for them to get to a PCI capable hospital for treatment in a timely manner. See Appendix A for the list of Non PCI-Capable Hospitals in Region 2.

IV. AHA EMS Guidelines

Emergency Medical Services (EMS) play an integral role in the Region 2 STEMI plan. EMS personnel must be trained to recognize, treat and transport STEMI patients in a timely manner. In order to accomplish this goal, the following EMS guidelines should serve as best practices in the care and treatment of the STEMI patient in Region 2.

Develop Acute Coronary Syndromes (ACS) Protocols

It is important that all EMS agencies develop standardized ACS protocols. There are several standards, considered quality of care measures that should be instituted on all ACS cases (i.e. immediate administration of oxygen and aspirin). The purpose of an ACS protocol is to rapidly recognize STEMI and other cardiac emergencies, treat with appropriate medications, notify the receiving facility as soon as possible, and provide rapid transportation to a PCI facility when indicated.

Acquire 12 lead ECG Analyses

The ability to rapidly treat a STEMI is predicated on an accurate prehospital assessment to include a 12-lead ECG analysis by EMS providers in the field. The early recognition of a STEMI in the field allows early activation of the PCI facility. All EMS agencies should acquire 12-lead technology and training to the standard of their licensure level.

ECG Transmission

Early hospital notification by EMS personnel of an in-coming STEMI patient significantly reduces the door-to-balloon time. ECG transmission can be via fax, email, special computer, or cell phone. This allows the receiving hospital to activate the cath lab team, have medications ready for administration or for EMS services that have an extended drive time, allow the accepting Physician to give orders prior to arrival. It is recommended that all EMS agencies be able to transmit ECG's to receiving facilities.

Pre-hospital Triage

EMS agencies in Region 2 should be trained to recognize, treat and transport STEMI patients in a timely manner:

- Rapidly identify STEMI patients who call 911 or present to EMS.
- Minimize the time from onset of STEMI to coronary reperfusion.
- Quickly acquire and transmit a 12-lead ECG.
- Rapidly identify the most appropriate hospital destination based on symptom onset time and predicted transport time. EMResource should be utilized as a tool for destination decisions.
- Early activate/notify the hospital prior to the patient arrival.
- Minimize scene time to 15 minutes or less (including a 12-lead ECG).

Procedure for selection of hospital destination:

- Rapid, pre-hospital recognition and appropriate triage of STEMI patients is essential in determining the appropriate hospital destination for these patients.
- It is imperative that EMS agencies are aware of hospital capabilities in their service area. Some hospitals may have STEMI/cath lab availability limited to specific days/times during the week.
- It is recognized that some patients have needs that will only be met at a specific destination hospitals. Therefore, a STEMI patient will often benefit from transport directly to the closest facility with the capability and capacity to provide the appropriate level of STEMI care (PCI Capable Hospital), rather than the closest geographically located, or patient-preferred hospital.
- Hospital bypass and/or air medical transport should be considered to transport the STEMI patient to the appropriate facility within the treatment time guidelines.
- Patient/family request will be honored if the facility is within an established transport distance and has the services/resources to treat the patient.
- EMS providers will use these protocols, based entirely on the best medical interest of the patient, to determine the appropriate destination.

Appendix A – Hospitals in Region 2

- a. PCI Capable Hospitals in Region 2 include:
 - i. Stillwater Medical Center-Stillwater
 - ii. Jane Phillips Medical Center – Bartlesville
 - iii. Integris Grove Medical Center – Grove
 - iv. Integris Grove Medical Center - Miami
 - v. Hillcrest Hospital – Claremore - Claremore
- b. Non PCI Hospitals in Region 2 include:
 - i. Alliance Health Ponca City
 - ii. Hillcrest Hospital Pryor – Pryor
 - iii. Hillcrest Hospital Cushing–Cushing
 - iv. Jane Phillips Nowata Health Center
 - v. Perry Memorial Hospital
 - vi. Blackwell Regional Hospital
 - vii. Cleveland Area Hospital
 - viii. St. Francis Hospital - Vinita
 - ix. Fairfax Community Hospital
 - x. Pawhuska Hospital
 - xi. Willow Crest Hospital

Agreements should be in place so that ALL facilities will work together to implement the Trauma Transfer Guidelines.

1. Level III trauma centers shall have the following
 - a. Written transfer agreements with other providers as a transferring facility.
2. Level IV trauma centers shall have the following:
 - b. Written transfer agreements with either trauma facilities to and expedite the transfer sequence to assure the most appropriate care is rendered to the patients.

Procedure for monitoring hospital status and capability

1. **EMResource™**

The MERC coordinator will generate reports from the EMResource™ for use in monitoring hospital status related to destination. These reports will be provided periodically to the OSHD and made available to the Region 2 QI Committee. Any problems and/or trends identified through review of this data will be addressed by the QI committee directly with the provider and if necessary through referral to the appropriate state level committee.
2. **QI Indicators**

A set of QI Indicators has been developed for use in monitoring hospital status and appropriateness of destination. The Region 2 QI Committee will monitor these indicators. Any problems and/or trends through review of the indicators will be addressed by the QI committee directly with the provider and if necessary through referral to the appropriate state level committee.

Diversion

1. In the event the closest Level I or II facility is on divert for Priority I trauma patients, trauma patients should be rapidly transported to the closest medical facility with the capability and capacity to provide the appropriate level of care as indicated by the patient's injury type and severity.
2. In the event any hospital in the region is on divert status for Priority II patients, those patients will be taken either to the nearest treating facility for stabilization and transfer or to the nearest appropriate Level III trauma hospital if the patient's condition warrants the transfer.
3. Guidelines to determine the possible need for total Emergency Department divert are:
 - a. The Emergency Department cannot handle additional emergencies based on the lack of professional personnel.

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1. Maximum capacity (beds) of the Emergency Department has been met.
2. The hospital does not have capability to care for the patient.
4. Notification of Emergency Department diversion status:
 - a. A written record shall be maintained documenting the date, time started, and time ended of each interval of divert status.
 1. Each hospital shall notify each entity providing emergency medical services, such as ambulance services and hospitals in the catchment area of the divert status.
 2. A hospital on divert can maintain the status for a **maximum** of 2 hours and then the situation must be re-evaluated. If a hospital is continued on divert status for an additional 2 hour time period the MERC coordinator will assess the situation and determine if it is appropriate to continue on divert status.
 3. The EMS system will be updated to show current information.
5. Compliance

Compliance to the above plan will be monitored through QI audits.

Quality improvements

Each facility in the region shall conduct Quality Improvement (QI) activities with regard to their trauma program. Under the auspices of the Medical Director and the Trauma Coordinator each facility will conduct QI activities in accordance with the approved regional QI process.

Communication – EMResource™ component

Introduction

For several years EMResource™ has served as a tool for hospital to display their diversion status in Oklahoma City. Although diversion is still a feature on the EMResource™, we are going to ask that you look at EMResource™ as a communication tool capable of demonstrating resource availability, health alerts and disaster notifications. EMResource™ is now a vital tool that can better enable communication in both routine daily circumstances and during disasters. EMResource™ ability to serve this function is limited by the use of the system by providers.

Usage requirements

ALL providers within Region 2 are required to comply with the guidelines established by the State EMResource™ Joint Advisory Committee and/or the Oklahoma State Department of Health in the

Northeast Regional Trauma Triage and Destination Plan

EMResource™ Manual. In the event that the EMResource™ Manual is updated, the revisions to the EMResource™ Manual override the requirements in this document.

1. Specific usage requirements include but are not limited to
2. Contact information
3. Each provider is responsible to maintain accurate contact information on the EMResource™.
4. Hospitals shall post the telephone number they wish other providers to use when calling patient referrals or reports in this area of EMResource™.
5. Provider status

Each hospital is required to maintain current status on the EMResource™ so that their capabilities or capacity can be readily accessed by other hospitals, EMS agencies and the Trauma Transfer and Referral Center.

Critical Concept: Emergency Departments and Hospitals are considered open unless posted otherwise on EMResource™.

- a. Emergency Department status
 1. This is the specific status of the Emergency Department and is the only status appropriate for diversion of pre-hospital transports. The current ED Status categories are: Open, Total ED Divert, Trauma Divert, CT Divert, ED select, Forced Open, and Closed.
 2. If a facility has not updated their status on the EMResource™ their attempt to divert may be overridden by the pre-hospital provider or the Trauma Transfer and Referral Center.
- b. Hospital Status
 1. This status is specific to the inpatient capability/capacity and is only appropriate for diverting inter-facility transfer patients. The current Hospital Status categories are: Open, Caution, and Closed.
 2. If a facility has not updated their status on the EMResource™ their attempt to divert may be overridden by the Trauma Transfer and Referral Center.
- c. Provider resource availability

This status is for displaying hospital specialty coverage on a real time basis. A customized list of eight specialties has been developed to meet the needs of Oklahoma. The status categories for these coverage areas are:

 1. Yes – coverage is currently available

Northeast Regional Trauma Triage and Destination Plan

2. No – coverage is not currently available
 3. N/A – this service is not offered at this facility
- d. Air ambulance status
- This status is for displaying the current status/availability of air ambulances. The status categories for this status are:
1. Available – the aeromedical resource is currently ready and able to respond to emergency calls.
 2. Call for Status – current conditions necessitate those providers in need of aeromedical transport call to determine resource availability because:
 - i. The aeromedical resource may already be dispatched to a call or be on standby.
 - ii. Local weather conditions may temporarily impact the ability of this aeromedical resource to respond.
 - iii. This aeromedical resource may be temporarily unavailable due to routine service or fueling.
 3. Not Available – the aeromedical resource is currently unable to respond in a timely manner.
 4. In region 2 the air ambulances are required to keep their most accurate status current. They may not leave their status as ‘call for statuses at all times.
- d. System alerts
1. Providers in Region 2 are required to maintain EMResource™ in a manner that enables them to receive alerts in a timely manner. It is suggested that all providers maintain a computer specifically for EMResource™ use 24 hours a day.
 2. If a provider is unable to maintain a computer with EMResource™ displayed 24 hours a day the provider is expected to work with the regional EMResource™ administrator to arrange the delivery of all System Alerts to the text enabled device of designated staff responsible to share the alert information with other on-duty staff.
 3. Compliance with appropriate usage will be monitored through routine MERC drills.
- e. Data reporting

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Providers in Region 2 are required to participate in reporting data supported by the EMResource™ application. This reporting requirement includes but is not limited to:

1. Hospital daily report of bed capacity and ED volume
2. EMS daily report of resources and volume

Monitoring

Appropriate use of EMResource™ will be enforced in the region through the QI process

1. The QI committee will routinely review reports from the Trauma Transfer and Referral Center on diversion of patients and compare the patient diversion list with the list of facility diversion hours generated from the EMResource™.
2. The QI committee will review all cases referred to them for inappropriate use of EMSsystem in any of the listed categories.
3. The regional and/or state EMResource™ administrator will perform periodic drills using EMResource™ and monitor appropriateness of provider response. Reports of these drills will be provided to the RTAB QI committee who will address problems/trends directly with the provider and if necessary through referral to the appropriate state level committee.
4. The QI committee will work with these providers to come into compliance with EMResource™ usage requirements. If these attempts fail the cases will be referred to the State QI committee for further action.

Summary

EMResource™ is a vital communication tool that provides the capability of real time communication among trauma system participants. This ability is limited by provider use of the system. Region 2 supports use of this tool through adoption of these requirements.