



# Oklahoma City Area Regional Trauma Advisory Board Oklahoma County

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Two Year Terms:  
2015-2016

**OU Medical Center  
Oklahoma City, OK  
October 13<sup>th</sup>, 2015**

**12:30 PM RTAB Meeting  
11:00 AM ED Managers Meeting**

- I. Call to Order: Meeting called to order @ 12:35 PM by Chair David Howerton.
- II. Welcome and Introductions
- III. Roll Call: Quorum met
- IV. Stroke and STEMI Update: Dr. Cathey
  - A. Update moved up in agenda due to time constraints of Dr. Cathey.
  - B. Hospital Stroke Classification Draft Numbers: Will be distributing full copies to the RTABs within the next few weeks.
    1. On September 11, 2015, Stroke Rules went into effect. The rules required every licensed facility in Oklahoma to attest their stroke classification level (I, II, III, or IV).
    2. Great success in facility response: Classification responses have been received from 138 of 147 facilities. The remaining 9 facilities have been contacted several times and classification is expected soon. These remaining facilities will most likely be classified as level IV and will not require TPA.
    3. 3 Level I Stroke Centers: OUMC, Mercy OKC, and Saint John's Medical Center
    4. 9 Level II Stroke Centers
    5. 55 Level III Stroke Centers: Can give TPA but do not typically keep the stroke patient.
    6. 80 Level IV Stroke Centers - The majority of these facilities do not give TPA. A few will have TPA and decide when to administer the medication. These facilities will not administer TPA all of the time.
    7. OKC Stroke Facilities
      - a. Level I: OUMC, Mercy OKC
      - b. Level II: INTEGRIS Baptist, INTEGRIS Southwest, and St. Anthony's
      - c. Level II: Mercy El Reno, INTEGRIS Canadian Valley, St. Anthony's Shawnee, Mercy Hospital Logan County, Heart Hospital North, Heart Hospital South, and Alliance Health Midwest City
      - d. Level IV: A full report can be received from Eddie Sims at the OTERAC discussion.
  - C. Issues Noticed To Date:
    1. Wrong stroke checklists for TPA administration are being used around the state: FDA has changed indications and contraindications for TPA administration. Forms have not been updated with new guidelines.
    2. Approximately 80 Level 4 Stroke Centers: Some do not want to administer TPA while others do. Those who do, want to do so occasionally on their own terms.
    3. The Trauma System has taught EMS not to stop at nearby hospitals that cannot provide definitive care. Stroke protocols do not follow the same plan. Closer facilities are able to administer TPA. Air is being utilized for transport of stroke patient secondary to belief the patient might get transferred.
    4. Tribal Hospitals: There is a need to convince SE Tribal Hospitals (Choctaw and Talihina) that it is too far for the acute stroke patient to go to another hospital for treatment. These facilities need to find a way to administer TPA at their facility.
  - D. Ricky Smith at Mercy has stated they are already seeing a positive impact in the Mercy Health System as far as the stroke system: patient's being transferred earlier and better earlier stabilization.
- V. Approval of Minutes – July 14th, 2015: Motion made by Tela Brown representing INTEGRIS Southwest for approval of minutes. Motion seconded by Brian Bottom representing EMSA – West. Roll call vote with motion passed unanimously.
- VI. Treasurer's Report – Chair David Howerton: Account balance is \$1461.47 after a deduction of \$2.00 for a paper fee. Chair David Howerton has spoken to Sean Oats about moving to electronic statements in order to save the \$2.00 fee for unnecessary paper statements.
- VII. Reports and Updates
  - A. OSDH Emergency Systems Report: Sean Oats
    1. Introduction of EMS Administrators: Jennifer Woodrow, Lori Hogan, and Robert Irby. Jennifer Woodrow is the new Region 8 EMS Administrator. Robert Irby is responsible for EMS education and licensure for all of Oklahoma.
    2. The next OTERAC meeting will be held at Metro Tech on December 2, 2015 at 1:00 PM.

3. OKEMIS: Every EMS Agency is required to be Version 3 compliant by January 1, 2016. For all EMS agencies who do not think they will be compliant or would like extra training, Martin Lansdale is OSDH point of contact for OKEMIS training.
  4. Trauma Registry: Agencies who have not submitted their 2015 data need to contact Dr. Stewart to address the issue.
  5. Open Comment Period for EMS Rules is ongoing. A hyperlink will be included in the Region 8 recap email. You may use this link to comment on the proposed rules.
  6. The Emergency Systems Data Report from July to September 2015 is included in the member packet. Please review and contact Sean Oats with any questions.
  7. OSDH is working on the 2016 RTAB Pictorial Directory's 3rd publication. Jennifer Woodrow will be taking pictures for the directory after the meeting.
- B. CQI Subcommittee Report: Sean Oats
1. A vertical timeline is a small summary of the cases that the local CQI Committee is seeing. Region 8's local CQI Committee is Region 6 and Region 8 combined.
  2. Three cases from the local CQI 3rd quarter review were presented. Violations of the Regional Trauma Plan found include delay in definitive care secondary to unnecessary testing, patient transfers to a higher level of care when the initial facility is capable of handling the injuries, and delay of acceptance to the time of EMS contact. A good job letter was sent to a facility for recognizing an injury, determining it was beyond their capability to treat, and quickly transferring the patient to a trauma center.
- C. Trauma Rotation Subcommittee Report: No report at this time.
- D. Regional Planning Subcommittee Report
1. Brad Smith - Waiting to get stroke protocols to implement a state regional plan for region 6 and 8.
  2. Eddie Sims - Region 6 did a survey to find out resources available within the region. Proposal made for Region 6, Region 8, and a couple of stroke coordinators from OSAC to work together to form a regional stroke plan. Meeting is anticipated in 2-3 weeks.
- E. TREC Report: Sean Oats
1. 1672 patients have gone through the TReC system from Jan. 1, 2015 to date. Breakdown of patients:
    - a. 44 Priority III patients (low energy events, stable vital signs, no major anatomical injuries or physiological compromise)
    - b. 1013 Priority II patients (high mechanism of energy, single system, stable vital signs)
    - c. 615 Priority I (multisystem, unstable vital signs, massive anatomical injuries)
  2. Patients transferred within Region 8: 10 Priority III, 201 Priority II, 119 Priority I
  3. If your facility is on call, encourage them to take the patient load that they have agreed upon.
  4. The majority of present RTAB members agreed they would like quarterly TReC reports to be presented at RTAB meetings. David Howerton would like to see a breakdown of priority I patients to include POV (Privately Owned Vehicle), EMS transport, and pediatric. David will bring the breakdown of EMSA transport numbers to present at quarterly RTAB meetings as well. He also calls notice to EMS services dropping off patients at the periphery of the city and then those facilities must transfer to appropriate facility further inside the city. Sean will ask for requested information in the next TReC report.

## VIII. Business

- A. Vote for RTAB positions: slate Roll Call Vote passed unanimously
1. Cindy Moore as Treasurer
  2. CQI subcommittee members: Liz Webb and Lindsey Henson
- B. Roll Call Vote for 2016 Board Meeting Dates, Times and Venues: a slate Roll Call Vote passed unanimously for the following meeting dates, times, and venues:
1. January 12, 2016 at 12:30 PM – Mercy Hospital Oklahoma City
  2. April 12, 2016 at 12:30 PM – INTEGRIS Southwest Medical Center
  3. July 12, 2016 at 12:30 PM – McBride Clinic Orthopedic Hospital
  4. October 11, 2016 at 12:30 PM – OU Medical Center
- C. Chair David Howerton
1. Medical Control Board Protocol
    - a. New spinal restriction protocol in place that will allow field crew to omit patients from back boarding.
    - b. The C-collar protocol will stay in place.
    - c. There are still criteria that will require patients to be placed on backboard, such as age.
    - d. The majority of the patients will be placed on a backboard to move them to cot. The patient will then be removed from backboard and transported to facility.
    - e. A company is working on developing a poster to be placed in the ED for a point of reference for physicians with questions/concerns regarding the protocol. David Howerton will make contact with facilities and posters will be distributed by the nurse managers.
    - f. Dr. Albrecht urged facilities to educate nursing staff to receive these patients without negative interactions with the medics.
    - g. Protocol goes into effect on December 1<sup>st</sup>.
  2. OU Children's Hospital Priority II Trauma
    - a. 210 patients have been brought directly to the Children's Hospital's Level II System.
    - b. They are currently seeing decreased amounts of over and under triage.
    - c. Splitting up a family is an issue noted within the system.
  3. resQCPR
    - a. resQCPR requires the use of a rescue pump instead of hands to administer CPR. The device does both active compression and active decompression. Active decompression of the chest is accomplished by pulling above neutral causing a negative intrathoracic pressure. The negative intra-thoracic pressure causes an increase in pre-load of the heart. Increased cerebral blood flow and good blood pressures during cardiac arrest are being seen with use of this device.

- b. Intra-arrest wakefulness has been noted with use of the rescue pump. While in use, eye opening, gag reflex, and non-purposeful movement have been seen in patients. When device is stopped, patients return immediately to arrest. A sedation protocol for intra-arrest wakefulness is in place that calls for either restraints or sedation with Versed.
- c. Studies out of Minnesota show that patient outcomes are very favorable.
- d. Contact David or Bryan for any questions about the device.
- e. Device is FDA approved to be cleaned and placed back in apparatus.
- f. At this time, there are no policies to hold over EMS crew for continuation of CPR with the rescue pump. Average EMSA drop time for cardiac arrest at the facility is approximately 45-60 min during which time the device may be used.
- g. Rate of compression needs to be decreased to 80 with a device from 110 with manual decompression.
- h. Brian Bottom of EMSA - The rocking of the unit on rough city streets may cause a decrease in quality of compressions at which time manual compressions may be initiated. Once the unit stabilizes on better roads at consistent speeds, the rescue pump may be reinitiated with good results. Capnography readings of 36mmHg have been obtained with device on scene decreasing to 12 mmHg when switching to manual compressions. Once use of device reinitiated, readings returned to 36-38 mmHg. On city streets it is difficult to maintain balance and safety but once transporting on highways/interstate with a more stable platform, the device is very effective.

IX. Public Comment

- A. Eddie Sims: follow up from OTERAC meeting
  - 1. The focus of the last OTERAC meeting was improvement of patient transport and time to definitive care for STEMI and acute strokes.
  - 2. Pros and Cons of different ways to accomplish improvement in patient transport and time to definitive care for STEMI and acute strokes:
    - a. In stroke legislation, there is a requirement for a stroke registry. However, there is not a stroke registry meaning the requirement is not being enforced. A possible solution is to have the STEMI and Stroke registry added to the Trauma Registry. Legislative action is a requirement for this to happen. AHA is thought to be making a proposal at the next legislative session.
    - b. STEMI and stroke are not covered by protected CQI. Therefore, the process that we use for trauma will not work for STEMI and stroke. A possible solution is to make the meetings closed executive meetings. This would allow CQI meetings to be held without legislation, improving quality of stroke and STEMI.
    - c. Each RTAB has been asked to develop a stroke and STEMI transport protocol to be incorporated into the transport plan for the state. Hopes are that plans will be completed by the end of the year or early next year.
    - d. Dr. Cathey and Mr. Sims have been asked to attend an OSAC meeting. OSAC is a group from AHA who have been working on stroke for 12-13 years. The next meeting is October 28, 2015 at 3:30 PM. Information from OTERAC will be taken and presented to OSAC. OSAC has a lot of expertise and ideas and OTERAC would like them to be a part of a solution.
    - e. Next OTERAC work group for STEMI and stroke will be on November 3, 2015 at 12:30 PM with stroke being addressed first and STEMI second.
    - f. Mr. Sims encouraged members to be involved at their own level in the work groups and OSAC and to work on regional planning. He also asked members to be prepared for changes in the stroke registry and CQI over the next 1-2 years.
    - g. At this point, there is no legislation requiring hospitals to be categorized for STEMI or registration.
- B. Genentech - TJ Richards and Michele Steele:
  - 1. Genentech makes TPA, the medication that is used to treat stroke acutely.
  - 2. Genentech would like to assist facilities in any way they can with the improvement of stroke care.
  - 3. Education and in-services are available to any facility in need.
  - 4. Particular for Region 8, resources are available for tele-stroke hubs to educate other facilities.
- C. Cardene offered assistance and information with effectively transporting stroke patients.

X. Next Meeting:

- A. RTAB: January 12, 2016 at 12:30 PM at Mercy Hospital in OKC.
- B. RPC – Brad Smith will schedule next RPC once stroke material is together.
- C. CQI – Will be scheduled at the same time RPC is scheduled.

XI. Adjournment – Motion made to adjourn at 1:25 PM.