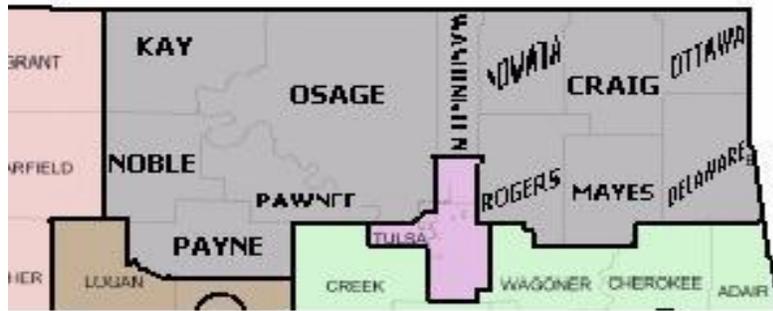


# REGION 2

## TRAUMA PLAN



DEVELOPED BY THE RTAB NE REGIONAL PLANNING COMMITTEE

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# Northeast Regional Trauma Triage and Destination Plan

## TABLE OF CONTENTS

### INTRODUCTION

I.	Goals and Purpose	2
II.	Region Description	2
III.	Trauma Priority Categorization	3
IV.	Categorization of Hospitals See appendix B	
V.	Description of EMS Services See appendix B	
VI.	Trauma Referral Center (TRC)	3

### Pre-Hospital Trauma Destination Component

I.	Procedure for Selection of Hospital Destination	4
II.	Procedure for Monitoring Hospital Status and Capability	6
III.	Air Ambulance Utilization Protocol	6
IV.	Diversion	10

### Inter-Facility Trauma Destination Component

I.	General Principles	10
II.	Hospital Obligations under EMTALA	11
III.	Trauma Team Requirements by Hospital Classification Level (Appendix D)	
IV.	Trauma Program	13
V.	Trauma Team Activation Criteria	15
VI.	Hospital Triage and Transfer Plan	16
VII.	Hospital Transfer Agreements	18
VIII.	Procedure for Monitoring Hospital Status and Capability	19
IX.	Diversion	19
X.	Quality Improvement	20

### COMMUNICATION- EMResource™ Component

I.	Introduction	20
II.	Usage Requirements	21
III.	Monitoring	23
IV.	Summary	23

### APPENDICES:

Appendix A: Northeast RTAB Bylaws (last updated, 2008)

Appendix B: Hospital and EMS Provider Descriptions

Appendix C: Triage Transport and Transfer Guidelines

Appendix D: Trauma Team Requirements and Hospital Classification Level

Appendix E: Advanced Life Support Intercept Protocol

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1

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# Northeast Regional Trauma Triage and Destination Plan

## INTRODUCTION

### III. GOALS/PURPOSE

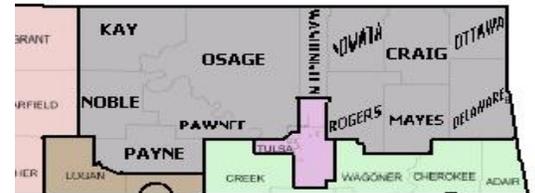
The goals of the regional trauma plan are to:

- A. Assure trauma patients are transported to the most appropriate hospital facility with the available resources and capacity to provide care in a timely fashion.
- B. Support the Pre-Hospital Trauma Triage and Transport Guidelines to effectively reduce trauma morbidity and mortality.
- C. Match a facility's resources with each trauma patient's needs to ensure optimal and cost effective care is achieved.
- D. This plan will not conflict with any rules and/or regulations that are already effective, currently in development or updated in the future. In the event new/updated rules and/or regulations are considered, the Regional Trauma Advisory Board should be included prior to implementation.

### IV. REGION DESCRIPTION

Region 2 consists of the northeastern portion of Oklahoma to include Craig, Delaware, Kay, Mayes, Noble, Nowata, Osage, Ottawa, Pawnee, Payne, Rogers, and Washington counties.

Region 2 encompasses 9,153 square miles with a population of 454,442. It is serviced by (22) ambulance services, (7) Air Ambulance services, 2 Level III trauma hospitals, (14) Level IV trauma hospitals, (4) of which are designated critical access.



### V. TRAUMA PRIORITY CATEGORIZATION

All injured patients must be identified and rapidly transported or transferred to the facility that provides the appropriate level of care based on the clinical need of the patient with specific attention focused on preserving the highest level of care for major trauma patients. A three-tiered system designed to determine appropriate patient hospital destinations for all injured patients considers injury severity, severity risk, time and distance from injury to definitive care and available resources to meet the region's specific needs. Three trauma triage priorities are used in determining the appropriate destination for patients.

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## Northeast Regional Trauma Triage and Destination Plan

### A. **Priority 1 Trauma Patients**

These are patients with blunt or penetrating injury causing physiological abnormalities or significant anatomical injuries. These patients have time sensitive injuries requiring the resources of a Level I or Level II Trauma Center. These patients should be directly transported to a Level I or Level II facility for treatment but may be stabilized at a Level III, Level IV, or Tribal facility, if needed, depending on location of occurrence and time and distance to the higher-level trauma center. If needed these patients may be cared for in a Level III facility if the appropriate services and resources are available.

### B. **Priority 2 Trauma Patients:**

These patients are those that have potentially time sensitive injuries because of a high-energy event or single system injury. These patients do not have physiological abnormalities or significant anatomical injuries and can be transported to a trauma facility with the resources to perform a complete trauma evaluation and medical screening and can care for their injuries.

### C. **Priority 3 Trauma Patients:**

These patients are without physiological instability, altered mentation, neurological deficit, or significant anatomical or single system injury that has been involved in a low energy event. These patients should be treated at the nearest treating facility or the patient's hospital of choice.

## VI. **Categorization of Hospitals See appendix B**

## VII. **Description of EMS Services See appendix B**

## VIII. **TRAUMA TRANSFER CENTER**

The Trauma Transfer and Referral Centers were created in statute (Senate Bill 1554, 2004). They were implemented July 1, 2005. The purpose of these centers is to ensure that trauma patients transported or transferred to facilities in Region 7 or 8 are transported to the facility that provides the appropriate level of care based on the clinical need of the patient in a timely fashion with specific attention focused on preserving the highest level of care for major trauma patients.

Statewide training sessions were held throughout June 2005 to orient all providers to the use of these centers.

Ambulances from Region 2 are required to call into the center prior to delivering a patient to Region 7 or 8 to ensure appropriate destination. Likewise hospitals in Region 2 may call these centers for assistance in identifying the appropriate destination for their trauma patients.

These centers will provide information on resource utilization to the OSDH that will be available to the RTAB for QI purposes.

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Northeast Regional Trauma Triage and Destination Plan  
**PRE-HOSPITAL TRAUMA DESTINATION COMPONENT**

**I. PROCEDURE FOR SELECTION OF HOSPITAL DESTINATION**

It is recognized that some patients have needs that can only be met at specific destination hospitals. Thus, a trauma patient will often benefit from transfer directly to an appropriate hospital with the capabilities and capacity to provide definitive trauma care. This care may not necessarily be at the closest or patient preferred facility and this must be taken into account when treating the patient.

Rapid pre-hospital recognition and appropriate triage of trauma patients using the Oklahoma Model Trauma Triage and Transport Guidelines is essential in determining the appropriate selection of Priority 1, 2, and 3 trauma patients hospital destination (see appendix B).

**These Destinations are:**

**A. ALL PATIENTS:**

1. All trauma patients should be transported to the most appropriate medical facility with the available resources and capacity to provide trauma care in a timely fashion.
2. Those patients with a traumatic arrest or without the inability to secure an airway should be transported to the closest facility.
3. It should be noted that any priority 1 or 2 trauma patient that needs immediate stabilization should be transported to the nearest facility in an effort to expedite care of the trauma patient.
4. Patient preference as well as the time and distance factor to definitive care will be considered for most priority 2 and 3 trauma patients.

**B. General Trauma Patients**

1. **Priority 1 adult and pediatric trauma patients** that meet the state approved trauma criteria should be transported to the closest Level I or II trauma center, to include: OU Medical Center (I-OKC), St John Medical Center (II-Tulsa), St Francis Hospital (II-Tulsa), St John Regional Health (I-MO), Via Christi Medical Center, St Francis Campus (I-KS), and Wesley Medical Center (I-KS) Freeman Health Systems (II-MO), St John Regional Medical Center (II-MO), by the appropriate method of transport.
2. **For those patients that air transport will improve arrival time to a Level I or Level II trauma center, or the patient will benefit from the higher level of care provided by the air ambulance**, air transport should be activated, as defined in Section IX, to ensure rapid transport to the appropriate facility.
3. **In the event air transport is unavailable**, every effort shall be made to arrange for timely ground transport and/or ALS intercept. In the event there will be an

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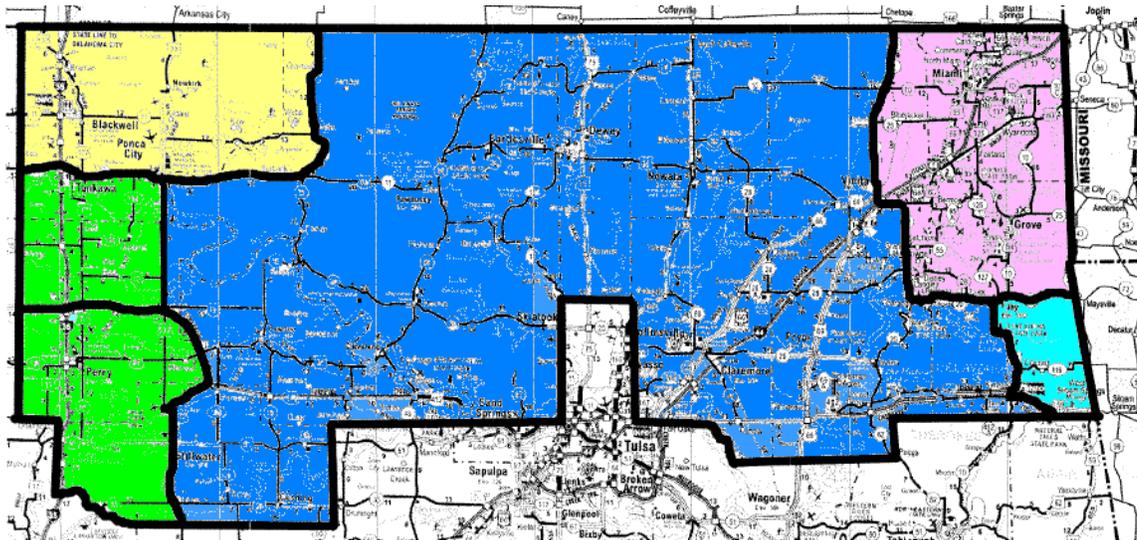
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Northeast Regional Trauma Triage and Destination Plan  
 excessive time delay for transport, the patient may be taken to the closest  
 treating facility for stabilization.

**PRIORITY 1 ADULT AND PEDIATRIC TRAUMA PATIENTS:**

- **West of Hwy 18 & North of Hwy 60** should be transported to Wichita
- **East of Hwy 2 & Hwy 82 and North of Hwy 20** should be transported to Joplin
- **West of Hwy 18 & South of 412** should be transported to Oklahoma City
- **West of Hwy 177** should be transported to Oklahoma City
- **East of Hwy 177** should be transported to Tulsa
- **South of Hwy 20, East of Hwy 59 & south to the Delaware/Adair county line** should be transported to Joplin or Tulsa

The following map helps graphically display the destinations for Priority 2 trauma patients in Region 2.



4. **Priority 2 adult and pediatric trauma** patients should be transported to the appropriate level III or higher facility based on the time/distance factor with preference given to patient desire and the ability to keep the patient in Region
5. **Priority 3 adult and pediatric trauma** patients should be transported to the closest facility or facility of patients' preference based on the time/distance factor with preference given to patient desire and the ability to keep the patient in region 2.

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**C. BURN PATIENTS:**

1. Adults: Refer to Triage & Transport Guidelines–Oklahoma Model Trauma Triage Algorithm.
2. Pediatric patients < 16 years: Refer to Triage & Transport Guidelines–Oklahoma Model Trauma Triage Algorithm.

**II. PROCEDURE FOR MONITORING HOSPITAL STATUS AND CAPABILITY**

**A. 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 2/4/7 CQI Committee. Any problems and/or trends identified through review of this data will be addressed by the 2/4/7 CQI committee directly with the provider and if necessary through referral to the appropriate state level committee.

**B. CQI Indicators**

A set of CQI Indicators has been developed for use in monitoring hospital status and appropriateness of destination. The Region 2/4/7 CQI Committee will monitor these indicators. Any problems and/or trends through review of the indicators will be addressed by the CQI committee directly with the provider and if necessary through referral to the appropriate state level committee.

**III. AIR AMBULANCE UTILIZATION PROTOCOL**

- A. When air transport will improve arrival time to a definitive care facility, the air ambulance service that can provide the quickest transport time should be utilized for all priority I and II trauma patients.
- B. If at any time the patients' condition warrants, i.e. the need for immediate stabilization, establishment of an effective airway, resuscitation, etc., the responders should transport to the closest treating facility.
- C. If a Non-EMS or First Responder activates an air ambulance service, the air service will communicate with local EMS to avoid multiple responses to the incident, to ensure and establish scene safety, to ensure appropriate pre-hospital care at the BLS or ALS level, and to establish a secure landing zone.
  1. "No-Fly" Conditions  
Helicopter utilization is seldom indicated for patients without a chance for survival or without serious injury. The following are other situations in which an air ambulance should not be used:

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## Northeast Regional Trauma Triage and Destination Plan

- a. Patients at a location where time and distance constraints make air transport to the closest appropriate medical facility for the patients injury more time consuming should be transported by ground.
- b. A patient found by local EMS to be in cardiac arrest without return of spontaneous circulation in the field. A witnessed cardiac arrest patient should be transported to the closest appropriate facility with on-going resuscitation efforts.
- c. Priority 3 patients should be transported by ground ambulance.

### 2. "Fly" Conditions

The following are conditions that warrant the use of an air ambulance:

- a. Priority 1 trauma patients that are being transported to a facility in which time and distance constraints make air transport more timely, generally for distances with a transport time greater than 30 minutes by ground ambulance.
- b. Priority 2 trauma patients that are being transported to a facility with a transport time greater than 30 minutes by ground ambulance, based on local resource availability.
- c. The following are conditions that warrant the use of air ambulance even when the patient is within a 30 mile radius of a medical facility:
  - 1) The closest facility is not appropriate for the patients' injury and the appropriate facility is at a distance in which time and distance constraints justify air transport.
  - 2) There are hazardous or impassable road conditions resulting in significant delays for ground transportation.
  - 3) There are multiple patients of a serious nature requiring rapid transport, overwhelming available ground units.
  - 4) Based on information available, the lead rescuer determines a lengthy rescue is required and transportation by ground would extend and delay definitive care.
  - 5) The closest available medical helicopter capable of providing needed services will be utilized to improve survival of all patients being transported to a definitive care facility.
  - 6) If the ETA of the aircraft is more than 10 minutes after the responders have initially treated the patient using standard protocol and the patient is ready for transport, the responders should proceed to the closest pre-existing landing area (PELA site) or to the nearest treating facility if the patients' condition warrants.

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## Northeast Regional Trauma Triage and Destination Plan

### 3. Early Activation / Standby:

After the responders have initially treated the patient using standard protocol and the patient is ready for transport, the responders should proceed to the closest pre-existing landing area (PELA site) or to the nearest treating facility of the patients' condition warrants it.

#### a. Hospital Activation:

When a patient presents by EMS or other means to a hospital, and after primary and secondary assessment, he/she is deemed to be a priority one trauma, then the activation of standby by a flight team should be affirmed. They should not be left on standby for more than 30 minutes.

When a hospital determines that a trauma patient is to be transferred by helicopter the transferring hospital should notify the helicopter service as soon as possible. All pertinent information should be given to the dispatch center so that appropriate flight crew is included on the flight. All precautions for a safe landing/takeoff will be followed by the hospital in an effort to expedite transfer of the patient.

#### b. EMS Activation:

When a dispatch center or ground ambulance service receives a call that meets the following criteria, it is recommended that the air ambulance be "early activated" or placed on ground standby:

- 1) Significant mechanism of injury as defined in the Trauma Triage Algorithm
- 2) Multiple patients
- 3) "Gut Feeling" from the responding crew

\*\*\*\* NOTE: If a Non-EMS/First Responder or bystander activates an air service, the air service will communicate with local EMS at the time of dispatch to avoid multiple responses to the incident. \*\*\*\*

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Northeast Regional Trauma Triage and Destination Plan

4. Landing Zone Parameters
  - a. Free of wires, trees, signs, poles, vehicles, and any other loose debris.
  - b. Ideally, it should be flat and smooth.
  - c. At least 100 X 100 feet square.
  - d. Well defined at night without lights pointed towards the helicopter.
  - e. Area should be secured and clear of all unauthorized personnel.
  - f. The helicopter should be approached with the crew only and care should be taken to avoid the tail rotor.
  - g. The landing zone should remain clear and secure for at least one minute after departure to ensure safe departure of the aircraft from the LZ area.

5. Training

Annual landing zone training shall be completed by all Region 2 EMS services. Individual ambulance services are responsible for contacting an air ambulance service for this training and assuring all employees are compliant with landing zone parameters.

6. EMTALA Clarification

Excerpt from the: State Operations Manual Appendix V - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals In Emergency Cases regarding ground EMS rendezvous with an air ambulance on a hospital helipad:

According to the Interpretative Guidelines, "the following two circumstances will not trigger EMTALA:

- a. The use of a hospital's helipad by local ambulance services or other hospitals for the transport of individuals to tertiary hospitals located throughout the State does not trigger an EMTALA obligation for the hospital that has the helipad on its property when the helipad is being used for the purpose of transit as long as the sending hospital conducted the MSE prior to transporting the individual to the helipad for medical helicopter transport to a designated recipient hospital. The sending hospital is responsible for conducting the MSE prior to transfer to determine if an EMC exists and implementing stabilizing treatment or conducting an appropriate transfer. Therefore, if the helipad serves simply as a point of transit for individuals who have received a MSE performed prior to transfer to the helipad, the hospital with the helipad is not obligated to perform another MSE prior to the individual's

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## Northeast Regional Trauma Triage and Destination Plan

continued travel to the recipient hospital. If, however, while at the helipad, the individual's condition deteriorates, the hospital at which the helipad is located must provide another MSE and stabilizing treatment within its capacity if requested by medical personnel accompanying the individual.

- b. If as part of the EMS protocol, EMS activates helicopter evacuation of an individual with a potential EMC, the hospital that has the helipad does not have an EMTALA obligation if they are not the recipient hospital, unless a request is made by EMS personnel, the individual or a legally responsible person acting on the individual's behalf for the examination or treatment of an EMC."

### IV. DIVERSION

- A. Guidelines to determine the possible need for Emergency Department divert are:
  1. The Emergency Department cannot handle additional emergencies based on the lack of professional personnel.
  2. Maximum capacity of the Emergency department has been met.
  3. The hospital does not have the capability to care for the patient.
- B. Notification of Emergency Department diversion status:
  1. A record shall be maintained documenting the date, time started, and times ended of each interval of divert status.
  2. Each hospital shall notify each entity providing emergency medical services, such as ambulance services and hospitals in the catchment area of the divert status.
  3. The EMResource™ will be updated to show current information.
- C. Compliance:

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

### INTER-FACILITY TRAUMA DESTINATION COMPONENT

#### I. General Principles

The vast majority of injured patients received their total care in the rural hospital, and transfer to a higher level of care is not necessary.

Physicians should assess their own capabilities and those of their institution. This assessment allows for early recognition of patients who may be safely cared for in the local hospital and those who require transfer to an institution that can provide optimal care.

Once the need for transfer is recognized, **arrangements should be expedited and not delayed** for diagnostic procedures that do not change the immediate plan of care.

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EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

10

II. **HOSPITAL OBLIGATIONS UNDER EMTALA**

**EMTALA** - Emergency Medical Treatment and Active Labor Act statute codified at §1867 of the Social Security Act, (the Act) the accompanying regulations in 42 CFR §489.24 (10/01/2005) and the related requirements at 42 CFR 489.20(1), (m), (q), and (r).

EMTALA is also referred to as the “anti-dumping” law.

EMTALA mandates that any individual who presents to the hospital’s dedicated Emergency Department and requests, or has a request made on his/her behalf, for examination or treatment for a medical condition, or a prudent layperson observer would believe, based on the individual’s appearance or behavior, that the individual needs examination or treatment for a medical condition receive: a medical screening examination by a qualified medical person to determine if an emergency medical condition exists or if the patient is in active labor, stabilizing treatment within the facilities capability and capacity and appropriate transfer if needed.

EMTALA Definitions:

- A. **Capability** means the physical space, equipment, staff, supplies, and services (e.g., surgery, intensive care, pediatrics, obstetrics and psychiatry), including ancillary services available at Cleveland Area Hospital.
  
- B. **Capacity** means the ability of a hospital to accommodate an individual requesting or needing examination or the treatment of a Transferred individual. Capacity encompasses the number and availability of qualified staff, beds, and equipment as well as the hospitals past practices of accommodating additional individuals in excess of its occupancy limits.
  
- C. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
  - 1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  - 2. Serious impairment to bodily functions; or
  - 3. Serious dysfunction of any bodily organ or part; or
  - 4. With respect to a pregnant woman who is having contractions:
  - 5. When there is inadequate time to effect a safe Transfer to another facility before delivery; or
  - 6. The Transfer may pose a threat to the health or safety of the woman or the unborn child.

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Northeast Regional Trauma Triage and Destination Plan

- D. **Medical Screening Examination** means the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether or not an Emergency Medical Condition exists or a woman is in Labor. The Medical Screening Examination is an ongoing process, including monitoring of the individual, until the individual is either Stabilized or Transferred.
- E. **Qualified Medical Person** means an individual other than a licensed Physician who:
1. is licensed or certified by the state in which the Hospital is located;
  2. practices in a category of health professionals that has been designated by the Hospital and the Medical Staff Bylaws, or Rules and Regulations, to perform Medical Screening Examinations;
  3. has demonstrated current competence in the performance of Medical Screening Examinations within his/her health profession; and
  4. as applicable, performs the Medical Screening Examination in accordance with protocols, standardized procedures or other policies as may be required by law or Hospital policy. A Qualified Medical Person includes registered nurses, nurse practitioners, nurse midwives, psychiatric social workers, psychologists, and physician assistants. (NOTE: The Oklahoma Nurse Practice Act prohibits registered nurses from conducting a medical screening examination.)
- F. **To Stabilize**  
Means, with respect to an Emergency Medical Condition, to either provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the Transfer of the individual from the Hospital or, in the case of a woman in Labor, that the woman has delivered the child and the placenta.
- G. **Appropriate Transfer** means a transfer to another medical facility only in cases which:
1. the transferring hospital has provided stabilizing treatment within its capacity and capability
  2. the receiving facility has the capability and capacity to accept the patient and has agreed to accept the transfer
  3. the transferring facility sends all the appropriate medical records
  4. the transfer is effected through qualified personnel and transport equipment

**III. TRAUMA TEAM REQUIREMENTS BY HOSPITAL CLASSIFICATION LEVEL**

OSDH – Hospital Trauma Requirements by Level: Appendix D

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12

**IV. TRAUMA PROGRAM**

A well-designed hospital trauma program, utilizing a team approach is crucial for providing optimal care to all trauma patients in Region 2.

All hospitals in Region 2 must establish criteria for the activation of their respective trauma programs and be clearly defined in the institutions policies and procedures. The following are intended as guidelines for each hospital.

- A. The hospital must have a written policy for notification and mobilization of an organized trauma team (Level III) or to the extent that one is available (Level IV). The Trauma Team may vary in size and composition when responding to the trauma activation.
  
- B. Each hospital shall have an established trauma program and designated trauma team that is appropriate for that facilities level of care. The trauma program must include a written commitment letter from the Board of Directors and the medical staff on behalf of the entire facility, which states the facility’s commitment to compliance with the Oklahoma Trauma Care Regulations. Compliance with the above will be evidenced by:
  - 1. Board of Director’s and medical staff letter of commitment
  - 2. Written policies, procedures and guidelines for care of the trauma patient
  - 3. A defined Trauma Team with written roles and responsibilities
  - 4. Appointed Trauma Medical Director with a written job description
  - 5. A written Trauma Performance Improvement Plan
  - 6. Appointed Trauma Program Manager with a written job description
  - 7. Documentation of trauma center representative’s attendance at the Regional Trauma Advisory Committee meetings

**C. Trauma Program Medical Director**

1. **Level III Facility**

The medical director is a board-certified surgeon who leads the multidisciplinary activities of the trauma program. We recommend the director be currently certified by the American College of Surgeons Advanced Trauma Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The trauma director, or his designee, must be actively involved with the trauma system development at the community, regional and state level. The medical director will be responsible for:

Developing a performance improvement process,  
recommending appointment and removal of physicians from the trauma team, patient, and developing treatment protocols for the trauma patients.

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Northeast Regional Trauma Triage and Destination Plan

- 2. **Level IV Facility:** The medical director is a physician who leads the multidisciplinary activities of the trauma program. We recommend the physician director have current verification in ATLS. The physician director is responsible for:

Overseeing the implementation of a trauma specific performance improvement process for the facility, assisting in the development of standards of care, and Assuring appropriate policies and procedures are in place for the safe resuscitation and transfer of trauma patients.

**D. Trauma Coordinator**

- 1. **Level III facility:** Should have an emergency department registered nurse and/or licensed medical professional qualified in the care of the trauma patient, working in the role of a Trauma Coordinator (TC). Working in conjunction with the medical director, the Trauma Coordinator is responsible for organization of the trauma program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. He/she is responsible for working with the trauma team to assure optimal patient care.
- 2. **Level IV facility:** Should have a licensed medical professional qualified in the care of the trauma patient to act as the Trauma Coordinator. Specifically, this person is responsible, with the medical director, for coordinating optimal patient care for all trauma victims.

**E. Composition of the Trauma Team**

The physician leader or mid-level practitioner (PA, ARNP) on the team should be ATLS certified and is responsible for directing all phases of the resuscitation in compliance with accepted standards of care.

- 1. **Level III facility**

Physician, board certified surgeon  
 Trauma Specialists  
 Emergency nursing staff  
 Laboratory & Radiology Technician  
 Ancillary Support Staff – Respiratory therapy, blood bank

The Level III trauma center must have an Emergency Department (ER) staffed so that trauma patients are assured immediate and appropriate initial care. An ER physician deemed competent in the care of the trauma patient shall be available 24 hours/day. This ER physician must be in-house 24 hours/day, immediately available at all times, and capable of evaluating trauma patients and provide initial resuscitation. The ER

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

## Northeast Regional Trauma Triage and Destination Plan

physician will provide team leadership and care for the trauma patient until the surgeon or other specialist arrives to take over care. The ER must have established standards and procedures to ensure immediate and appropriate care for the adult as well as the pediatric trauma patient.

The Level III trauma center must have published on-call schedules and have the following medical specialties immediately available 24 hours/day to the injured patient: General Surgery, Anesthesia, and other medical specialties that may be available in the local area to assist with care of the trauma patient.

A surgical team must be on-call with a well-defined mechanism for notification to expedite transfer to the operating room if the patient's condition warrants.

Clinical support services such as Respiratory Therapy and Radiology technicians shall be available 24 hours/day to meet the immediate needs of the trauma patient. Clinical laboratory services shall have the following services available in-house 24 hours per day: Blood typing and cross matching capabilities, access to sufficient quantities of blood and blood products, microbiology, blood gas and pH determination, alcohol and drug screening and coagulation studies.

### 2. Level IV facility

Physician or Mid-level practitioner

Emergency nursing staff

Laboratory Technician

Ancillary Support Staff

The ER of the Level IV trauma center must be staffed so trauma patients are assured immediate and appropriate initial care. A system must be developed and in place to assure early notification of the on-call practitioner. Adequate number of nurses must be available in-house 24 hours/day to ensure adequate care of the trauma patient.

## V. TRAUMA TEAM ACTIVATION CRITERIA

- A. **FULL ACTIVATION:** In either a Level III or Level IV facility, immediate full activation of the trauma team should occur when any Priority I trauma patient, as defined in the Adult and Pediatric Inter-facility Triage, Transport and Transfer Guidelines (Appendix D), presents to the Emergency Department.

### Plan Approval Dates

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

15

## Northeast Regional Trauma Triage and Destination Plan

- B. **PARTIAL ACTIVATION:** In a Level III or Level IV facility, immediate partial activation of the trauma team should occur when any Priority II or III trauma patient, as defined in the Adult and Pediatric Inter-facility Triage, Transport and Transfer Guidelines (Appendix D), presents to the Emergency Department. After triage and the medical screening examination by the QMP, the patient's injuries should be treated within the accepted standards of trauma care and if necessary full activation of the team may occur.

### VI. HOSPITAL TRIAGE & TRANSFER PLAN

In general, the Level III Trauma Center is expected to provide initial resuscitation of the trauma patient and immediate operative intervention to control hemorrhage and to assure maximal stabilization prior to transfer to a higher level of care institution. In many instances, patients will remain in the Level III trauma center unless the medical needs of the patient require secondary transfer. The decision to transfer will rest with the physician attending the trauma patient.

In general, the Level IV Trauma Center is a licensed, small, rural facility with a commitment to the resuscitation of the trauma patient and written transfer protocols in place to assure those patients needing a higher level of care are transferred appropriately. These facilities may be staffed by a Physician, or a mid-level practitioner (i.e. ARNP or PA), or Registered Nurse. The major trauma patient in this facility will be stabilized and transported to the most appropriate facility for the patients on-going care needs.

#### A. Stabilization Criteria

Regardless of facility trauma level, ALL trauma patients presenting to the hospital will be evaluated by the trauma team and emergency medical conditions will be identified, prioritized, treated and stabilized within the facilities capability and capacity.

In an effort to optimize patient care, rapid assessment of the patient is imperative. When a trauma patient arrives at a destination hospital the trauma team will be activated (either full or partial) and the patient will have an immediate medical screening completed. Depending upon the screening and the needs of the patient any of the following may occur:

1. The patient will be stabilized and then transferred to the most appropriate facility (Priority I or II trauma that is time sensitive),
2. The patient will be stabilized and then admitted to that facility (Priority II or II that is not time sensitive),
3. The patient will be stabilized and transferred to their facility of choice (Priority II that is not time sensitive), or
4. The patient will be treated and discharged to home with appropriate instruction for their injuries (Priority III trauma).

#### Plan Approval Dates

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
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EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

16

**B. Destination Guidelines**

It is recognized that some patients have needs that can only be met at specific destination hospitals. Thus, a trauma patient will often benefit from transfer directly to an appropriate hospital with the capabilities and capacity to provide definitive trauma care. This care may not necessarily be at the closest or patient preferred facility and this must be taken into account when treating the patient.

Rapid pre-hospital recognition and appropriate triage of trauma patients using the Oklahoma Model Trauma Triage and Transport Guidelines is essential in determining the appropriate selection of Priority I, II and III trauma patient hospital destinations (see appendix C of the Pre-Hospital Trauma Destination Plan).

It is recommended that the transfer of Priority I, II and III trauma patients follow the same routing as the Pre-Hospital Destination Plan. This is an effort to provide optimal care in the most appropriate amount of time for the trauma patient. As always, the patient’s choice of facility will be considered when the injuries are not of a time sensitive matter.

**ALL PATIENTS**

1. Those patients with a traumatic arrest or the inability to secure an airway should be transported to the closest facility to the traumatic event.
2. It should be noted that any priority I or II trauma patient that needs immediate stabilization should be transported to the most appropriate facility in or out of state, in an effort to expedite care of the trauma patient.
3. Patient preference as well as the time and distance factor to definitive care will be considered for most Priority II and III trauma patients

**BURN PATIENTS:**

1. Adults: Refer to Triage & Transport Guidelines–Oklahoma Model Trauma Triage Algorithm.
2. Pediatric patients < 16 years: Refer to Triage & Transport Guidelines – Oklahoma Model Trauma Triage Algorithm.

**Neurological Trauma Patients**

1. Priority I adult and pediatric trauma patients should be transported directly to the appropriate Level I or II facility. In-state transfers can be facilitated via use of the Trauma Transfer center.
2. Priority II adult trauma patients should be transported to the appropriate facility in Region 7 or 8, based on the time/distance factor with preference given to patient desire.

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

Northeast Regional Trauma Triage and Destination Plan

3. Priority II pediatric trauma patients should be transported to the most appropriate facility using the Trauma Transfer Center.
4. Priority III adult and pediatric trauma patients should be transported to the closest facility for stabilization before transfer to the appropriate facility.

5. **Air Ambulance Utilization Guidelines**

When air transport will improve arrival time to a definitive care facility, the air ambulance service that can provide the quickest transport time should be utilized for all priority I and II trauma patients.

a. "No-Fly" Conditions

- 1) Helicopter utilization is seldom indicated for patients without a chance for survival or without serious injury. The following are other situations in which an air ambulance should not be used:
- 2) Patients at a location where time and distance constraints make air transport to the closest appropriate medical facility for the patient's injury more time consuming.
- 3) Priority 3 patients should be transported by ground ambulance.

b. "Fly" Conditions

- 1) The following are conditions that warrant the use of an air ambulance:
- 2) Priority 1 trauma patients that are being transported to a facility in which time and distance constraints make air transport more appropriate.
- 3) Priority 2 trauma patients that are being transported to a facility with a transport time greater than 30 minutes by ground ambulance, based on local resource availability.

c. Early Activation/Standby

- 1) When a hospital receives a call that meets the following criteria, it is recommended that the air ambulance be "early activated" or placed on ground standby:
- 2) Significant mechanism of injury as defined in the Trauma Triage Algorithm
- 3) Multiple trauma patients

**VII. HOSPITAL TRANSFER AGREEMENTS**

All hospitals in Region 2 will work collaboratively with other trauma facilities, in and out of state, to develop transfer protocols, written agreements and a well-defined transfer sequence.

Plan Approval Dates

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EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

Northeast Regional Trauma Triage and Destination Plan  
Agreements should be in place so that ALL facilities will work together to implement the Trauma Transfer Guidelines.

Level III trauma centers shall have the following:

Written transfer agreements with other providers as a transferring facility.

Level IV trauma centers shall have the following:

1. Written transfer agreements with other trauma facilities to facilitate and expedite the transfer sequence to assure the most appropriate care is rendered to the patient.
2. Written agreement to provide specialty clinical consultation services via a communication system on a 24-hour basis to include: General surgery, Neurology, Neurosurgery, and Orthopedics.

## VIII. PROCEDURE FOR MONITORING HOSPITAL STATUS AND CAPABILITY

### A. 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.

### B. 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.

## IX. DIVERSION

- A. 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

### Plan Approval Dates

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

19

## Northeast Regional Trauma Triage and Destination Plan

- B. 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 3 trauma hospital if the patients condition warrants the transfer.
- C. Guidelines to determine the possible need for total Emergency Department divert are
1. The Emergency Department cannot handle additional emergencies based on the lack of professional personnel.
    - a. Maximum capacity (beds) of the Emergency department has been met.
    - b. The hospital does not have the capability to care for the patient.
- D. Notification of Emergency Department diversion status:
1. A written record shall be maintained documenting the date, time started, and time ended of each interval of divert status.
    - a. Each hospital shall notify each entity providing emergency medical services, such as ambulance services and hospitals in the catchment area of the divert status.
    - b. 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.
    - c. The EMSsystem will be updated to show current information.
- E. Compliance
- Compliance to the above plan will be monitored through QI audits.

## X. QUALITY IMPROVEMENT

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™

## I. INTRODUCTION

For several years EMResource™ has served as a tool for hospitals to display their diversion status in Oklahoma City. Although diversion is still a feature on the EMResource™, we are

#### Plan Approval Dates

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Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

20

Northeast Regional Trauma Triage and Destination Plan  
 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.

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

- A. Specific usage requirements include but are not limited to:
- B. Contact Information
- C. Each provider is responsible to maintain accurate contact information on the EMResource™.
- D. Hospitals shall post the telephone number they wish other providers to use when calling patient referrals or reports in this area of EMResource™.
- E. 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.

### Plan Approval Dates

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Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

Northeast Regional Trauma Triage and Destination Plan  
Critical Concept: Emergency Departments and Hospitals are considered open unless posted otherwise on EMResource™.

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.
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 that providers in need of aeromedical transport call to determine resource availability because:
  - a. The aeromedical resource may already be dispatched to a call or be on standby.
  - b. Local weather conditions may temporarily impact the ability of this aeromedical resource to respond.
  - c. 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 status’ at all times.

E. **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.

Plan Approval Dates

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

## Northeast Regional Trauma Triage and Destination Plan

### F. **Data Reporting**

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;

### G. **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.

#### Plan Approval Dates

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSsystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

23

Plan Updated: October 6, 2009, November 8, 2011

Bylaw s Updated: October 7, 2008, February 9, 2010, November 8, 2011

# Appendix A

## Northeast Region Trauma Advisory Board Bylaws

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

24

Plan Updated: October 6, 2009, November 8, 2011

Bylaws Updated: October 7, 2008, February 9, 2010, November 8, 2011

# Northeast Regional Trauma Triage and Destination Plan

## **NAME AND GEOGRAPHIC DESCRIPTION**

### Section I. Name

Northeast Regional Trauma Advisory Board

### Section II. Geographic description

Craig, Delaware, Kay, Mayes, Noble, Nowata, Osage, Ottawa, Pawnee, Payne, Rogers and Washington counties.

## **MISSION STATEMENT**

In support of the statewide system, create a regional system of optimal care for all trauma patients, to ensure the right patient goes to the right place in the right amount of time.

## **PURPOSE**

Section I. The purpose of the Regional Trauma Advisory Board (RTAB) is to assist the Oklahoma Trauma System Improvement and Development Advisory Council and Oklahoma State Department of Health with the development and implementation of a formal trauma care system regionally and statewide.

Section II. The Regional Trauma Advisory Board shall be empowered but not limited to:

1. Assessing the current resources and needs within the region respective to Emergency Medical Services (EMS), acute care facilities, rehabilitation facilities, communication systems, human resources, professional education, public education and advocacy.
2. Organizing regional human resources into coalitions and/or alliances, which will be proactive in trauma systems development.
3. Development of Regional Trauma System Development Plan.
4. Development and implementation of Regional Trauma Quality Improvement program.
5. Providing public information and education programs regarding the need for a formal trauma care system.
6. Providing region—specific input to the Oklahoma Trauma System Improvement and Development Advisory Council and Oklahoma State Department of Health concerning trauma care issues.

## **INITIAL STRUCTURE**

The Commissioner of Health shall appoint the first chair of the board who will serve for the first year. This chair will work with the other providers identified for the initial membership rotation to identify the other individuals who will serve the first year.

### **Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
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25

# Northeast Regional Trauma Triage and Destination Plan

## GENERAL MEMBERSHIP

General Membership is composed of representatives from all of the facilities in the region as well as other interested individuals.

Section I. General Medical – Surgical hospitals without a trauma classification and psychiatric hospitals may choose to be general members only, and forego board membership. Hospitals choosing this option must still meet general membership requirements. Hospitals choosing this option understand they will not be able to vote on matters under consideration by the board.

Section II. Ambulance services with transported run volume under 100 per year may choose to be general members only and forego board membership. Ambulance services choosing this option must still meet general membership requirements. Ambulance services choosing this option understand they will not be able to vote on matters under consideration by the board.

Section III. Responsibilities of the General Membership  
The General Members are expected to attend meetings regularly to provide input on topics under consideration by the Board.

Section IV. Committee Service  
General Members may serve on committees, work groups and task forces

Section V. Attendance Expectations

The general members may be subject to licensure action if a member misses two (2) consecutive posted meetings of the scheduled meetings in any year. (75% minimum attendance is required) (Revised October 7, 2008)

## BOARD MEMBERSHIP

Definition of Permanent Member (Revised April 7<sup>th</sup>, 2009)

Section I. Hospital:  
Any Level III facility that is in compliance with Region 2 Bylaws shall be a permanent member of the Board.

Section II. EMS:  
EMS Permanent Members shall be made up of 2 ALS (licensed as Paramedic or Intermediate agencies) and 2 BLS agencies that are in compliance with Region 2 bylaws. The EMS permanent members shall be based on the largest call volume within Region 2 for the most recent completed calendar year. This definition shall become effective for the 2010 Board.

### Plan Approval Dates

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

26

Plan Updated: October 6, 2009, November 8, 2011

Bylaw s Updated: October 7, 2008, February 9, 2010, November 8, 2011

## Northeast Regional Trauma Triage and Destination Plan

The Board at the annual meeting shall approve the selection of permanent and rotating board members for the next year. Prior to the annual meeting, all agencies and facilities are to ensure the board is aware of any licensure or call volume changes.

Board Membership shall be multidisciplinary with broad representatives from the following list of disciplines.

Hospital		Emergency Medical Services
1. Administrator		1. Administrator
2. Business office		2. Non Administrator EMT-B
3. QI practitioner		3. Non Administrator EMT-I
4. Emergency department physician		4. Non Administrator EMT-P
5. Surgeon		5. Business office
6. Trauma nurse coordinator		
6. Trauma registrar		
7. Emergency department nurse		
8. Operating room nurse		
9. Rehabilitation practitioner		
10. Safety officer		

### Section I. Powers and Responsibilities

The Board members are responsible for overall policy and direction of the RTAB.

### Section II. Duties of the Board Members

Board members shall exercise ordinary business judgment in managing the affairs of the organization. In acting in their official capacity as Board Members of this organization they shall act in good faith and take actions they reasonably believe to be in the best interest of the organization and that are not unlawful. In all other instances, the Board Members shall not take any action that they should reasonably believe would be opposed to the organization's best interests or would be unlawful.

Responsibilities of the Board Members include but are not limited to:

1. Conduct the business of the organization
2. Specify the composition of and direct the activities of committees.
3. Consider for approval recommendations from committees.
4. Cause to be prepared and administer the budget, prepare annual reports of the organization.
5. Cause to be prepared grant applications for the organization.
6. Approve, execute and/or ratify contracts made in ordinary course of business of the organization.

#### Plan Approval Dates

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
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27

Northeast Regional Trauma Triage and Destination Plan

7. Make continuous and regular reviews of RTAB matters and business affairs in order to provide information to general membership.

Section III. Number of Board Members

The Board shall consist of no fewer than nine (9) members and no more than twenty (20) members.

Section IV. Actions of the Board

Each Board Member shall be entitled to one (1) vote on each matter submitted to a vote at a meeting of the Board.

A simple majority of the Members present and voting at a meeting at which a quorum is present shall be sufficient to constitute action by the Board.

Section V. Term

The term of the Board Members is one calendar year.

Section VI. Appointments

Member organizations will appoint a representative and an up to two alternate representatives to the board, but will have only one vote. If two alternates are appointed they will be ranked first alternate and second alternate. If more than one representative is present at a meeting, the primary representative holds the voting right if present. If the primary representative is not present the first alternate will hold the voting right. If the primary representative and the first alternate are not present, the second alternate will hold the voting right.

Section VII. Meetings

Meetings of the Board shall be held in accordance with the Oklahoma Open Meeting Act. Meetings of the Board Members shall be held at such times and places as determined by the Board Members. These meetings must be held at least quarterly.

The Board shall not review patient specific information or medical records at these meetings.

Section VIII. Attendance Expectations/Removal of Board Members

1. A representative is automatically removed from the board if more than 1 meeting is missed without arranging for a proxy.
2. Vacancies  
In the event that a representative of a Board Member organization is removed from the board, the effected member organization will be asked to appoint a new member to take the place of the member.
3. Any member organization that subsequently fails to ensure participation by their representative shall be reported to both the *Oklahoma Trauma System*

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

Northeast Regional Trauma Triage and Destination Plan  
*Improvement and Development Advisory Council* and the member organization's  
licensing authority.

Section IX. Proxies

A Board Member wishing to attend a meeting or vote by Proxy must prepare and sign a statement on their institution's letterhead stating their authorization of a specifically named alternate from their institution to attend the meeting and/or cast a vote on their behalf. The proxy can be transmitted or delivered to either the OSDH Trauma Division or the RTAB Secretary up until the time of the meeting. Either the board member or the administrator/director can institute a proxy.

Section X. Quorum

A simple majority of the Board shall constitute a quorum at any meeting.

**OFFICERS**

Section I. The following officers shall be elected from the Board Members: Chair, Vice-chair, Secretary and Treasurer

Section II. The same person shall hold no more than one office.

Section III. The term for officers shall be one year.

Section IV. Nominations

Nominations of candidates for office shall occur at least one month prior to the election.

1. The candidates shall be Board Members.
2. The candidates shall express a willingness to serve.

Section V. Additional Offices

The Board Members may create additional officer positions, define the authority and duties of each such position, and elect persons to fill the position.

Section VI. Attendance Expectations/Removal of Officers

An Officer is automatically removed from office if he/she misses either two (2) consecutive posted meetings or 75% of the scheduled meetings in any year without making arrangements for a proxy to attend.

Section VII. An officer is automatically removed from office if he/she misses more than one meeting in a year without arranging for a proxy.

Section VIII. Vacancies

A vacancy in any office may be filled by the Board for the un-expired portion of the officer's term.

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

**DUTIES OF OFFICERS**

Section I. The Chair shall be the executive officer of the RTAB and shall:

1. Set the agenda and preside at all meetings of the RTAB;
2. Appoint all committee chairs;
3. Sign agreements and contracts after authorization by the Board;
4. Call special meetings when necessary;
5. Ensure that the RTAB is represented at Oklahoma Trauma System Improvement and Development Advisory Council Meetings.
6. Ensure that the RTAB is represented at all other appropriate state and regional meetings;
7. Ensure that the RTAB membership is informed of all appropriate state and legislative activities;
8. Perform other tasks as deemed necessary by the Board Members.

Section II. The Vice-Chair shall perform the duties of the Chair in the absence of the Chair and perform such duties as assigned by the Chair or the Board.

Section III. Duties of the Secretary

1. Ensure dissemination of all notices required by the Bylaws or by the Oklahoma Open Meetings Act.
2. Assure a meeting attendance roster is maintained.
3. Assure a register of the name and mailing address of each member organization is maintained.
4. Ensure minutes are kept of all proceedings of the Board meetings.
5. Manage the correspondence of the organization.

Section IV. Duties of the Treasurer

1. Manage all funds and assets of the RTAB.
2. Monitor monies due and payable to the RTAB.
3. Ensure the preparation of the annual budget and present it to the Board Members for approval.

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

Northeast Regional Trauma Triage and Destination Plan

4. Monitor the financial records of the RTAB and arrange for an independent audit when so directed by the Board Members.

**MEETINGS**

Section I. Meetings of the Board shall be held in accordance with the Oklahoma Open Meeting Act.

Section II. An Annual Board Meeting shall occur each fall. A meeting notice shall be mailed to all member-organizations at least 30 days prior to the meeting. The meeting dates, times and places for the forthcoming year shall be established at the annual meeting.

Section III. Meetings for the forthcoming year shall be posted with the Secretary of State in accordance with the Oklahoma Open Meeting Act prior to December 15. Any changes to the meeting schedule shall be duly noted to the Secretary of State.

Section IV. Notice of the date, time and place of each meeting shall be mailed or e-mailed to each Board Member at least ten (10) days prior to the date of that meeting. The notice of each meeting shall include an agenda of the matters to be considered.

Section V. These meetings must be held at least quarterly.

Section VI. The Board shall not review patient specific information or medical records at these meetings.

Section VII. Members of the General Membership are encouraged to attend these meetings to provide input on topics under consideration by the board.

Section VIII. Special Meetings

Special meetings of the Board may be called by the Chair of the Board, Vice-Chair of the Board, or by any three members of the Board on not less than forty-eight (48) hours notice. Notice of such a meeting must be posted as a special meeting with the Secretary of State. Notice to Board Members can be communicated by mail, e-mail, telegram, telephone, or fax.

***Procedures***

Robert’s Rules of Order will be relied on to resolve any procedural issue not covered in the bylaws.

**COMMITTEES**

Section I. Quality Improvement Committee

1. Each RTAB is required by statute to conduct quality improvement activities.
2. The function of this committee is to decrease death and disability by reducing inappropriate variation in care through progressive cycles of performance review.

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

Northeast Regional Trauma Triage and Destination Plan

3. A multidisciplinary standing committee for Quality Improvement shall be created in each region.
  - A. The minimum recommended membership requirement:
    - i. Physician (preference for ED Physician, Surgeon or EMS Medical Director)
    - ii. Emergency Department Nurse
    - iii. OR Nurse
    - iv. EMT
  - B. Other members for this committee may be identified based upon the need of the region. It is suggested that the membership be kept to 10 members or fewer.
  - C. Other specific disciplines that are not regular members of the committee may be called on to meet specific quality improvement needs.
  - D. A simple majority shall constitute a quorum to conduct business.
  - E. Upon approval by the chair, a committee member is automatically removed from the committee if he/she misses two (2) scheduled meetings in any year.
  - F. Vacancies
    - i. Notice of a vacancy shall be distributed to Board members at least ten (10) days prior to a scheduled meeting.
    - ii. Volunteers/recommendations to fill the vacancy in membership on this committee shall be accepted and voted on at the next scheduled meeting of the Board.
4. Volunteers/recommendations for membership on this committee shall be accepted at the annual meeting, and membership appointments decided by a vote of the board members at the following meeting.
5. Each region shall adopt confidentiality policies for this committee.
6. Minimum Quality Improvement activities shall be defined by the State Medical Audit Committee.
7. The regional committee may identify other activities to monitor based upon regional need.
8. Committee Tenure  
Membership on this committee is for a term of two (2) years. Half of the initial appointments to this committee shall be for a term of one year to ensure staggered terms.

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

## Northeast Regional Trauma Triage and Destination Plan

### Section II. Standing Committees shall be established by a majority vote of the Board

3. Standing committees may include but are not limited to: Hospital Care Committee, Pre-Hospital Care Committee, Injury Prevention Committee, EMS/Hospital Disaster Committee, Trauma Coordinator Committee, Trauma Registry Committee, Finance, Professional Education, Membership, Bylaws, Public Relations, and Research.
4. At least one Board Member shall serve on each standing committee.
5. The Board may recommend the remaining membership on these committees.
6. Each standing committee shall recommend a candidate for chair to be approved by the RTAB Chair.
7. Each person on a committee shall continue to serve on the committee until the next annual meeting of the Board and until his/her successor is appointed unless sooner removed or the committee is dissolved.
8. The Chair of the Board, the Chair of the committee or a majority of the committee may call meetings of a committee. Each standing committee shall meet at least annually.
9. Notice of the committee meetings must be given in accordance with the Oklahoma Open Meetings Act.
10. A majority of the voting persons on the committee shall constitute a quorum.

### Section III. Special Committees

The board may create special, ad hoc, or task force committees based upon the recommendation of the Board Members.

3. Members of these committees are not required to be members of the Board.
4. The Board shall appoint members of these committees.
5. These committees will have no power to act other than as specifically authorized by the Board.
6. The tenure of these committees will be decided by the Board based upon the specific need for the committee.

### Section IV. Committee Resignations, Removal and Vacancies

Any person on a committee may resign from the committee at any time by giving written notice to the chair of the Board, chair of the committee or to the secretary of the Board

#### Plan Approval Dates

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
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33

## Northeast Regional Trauma Triage and Destination Plan

### Section V. Committee Minutes

The Chair of each committee shall prepare complete and accurate minutes of each meeting and promptly forward duplicate originals thereof to the Secretary of the Board.

### Section VI. Action by Committee

Recommendations by committees are to be taken back to the Board for action.

### Section VII. Committee Compensation

Persons serving on a committee shall not receive salaries for their services, but by resolution of the Board a reasonable amount for expenses incurred in attending to authorized duties may be allowed; provided however that nothing herein contained shall be construed to preclude any member of the committee from serving.

## **FINANCES**

### Section I. Deposits

All money received by the corporation shall be deposited with a bank, trust company or other depository, that the Board selects, in the name of the corporation. All checks, notes, drafts and acceptances of the corporation shall be signed in the manner designated by the Board Members.

### Section II. Gifts

1. The Board may accept on behalf of the RTAB any contribution, gift, bequest or legacy that is not prohibited by any laws or regulations in the State of Oklahoma.
2. The Board may make gifts and charitable contributions that are not prohibited by the Bylaws, state law and are not inconsistent with the requirement for maintaining the RTAB's status as an organization exempt from taxation under Section 501(c)(3) of the Internal Revenue code.

### Section III. Conflicts of Interest

1. The Board shall not make a loan to any Board Member or member organization.
2. The Board shall not borrow money from a Board member, a member organization, an employee of a member organization or a family member of a member organization unless:
  - A. The transaction is described fully in a legally binding instrument;
  - B. The transaction is found to be in the best interests of the RTAB after full disclosure of all relevant facts at a scheduled meeting of the Board; and
  - C. Such action requires a 2/3-majority vote of the Board (excluding the vote of any person having a personal interest in the transaction) at a meeting when a quorum is present.

#### Plan Approval Dates

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

34

Northeast Regional Trauma Triage and Destination Plan

- D. Disclosure of intent to undertake such action is declared to the OSDH and the OTSIDAC for approval prior to action.
3. The Board shall not transact business with a Board Member, a member organization, an employee of a member organization or a family member of a member organization unless:
- A. The transaction is described fully in a legally binding instrument;
  - B. The transaction is found to be in the best interests of the RTAB after full disclosure of all relevant facts at a scheduled meeting of the Board; and
  - C. Such action requires a 2/3-majority vote of the Board (excluding the vote of any person having a personal interest in the transaction) at a meeting when a quorum is present.
  - D. Disclosure of intent to undertake such action is declared to the OSDH and the OTSIDAC for approval prior to action.

**PARTICIPATION**

All member organizations are required to participate in RTAB activities. Member organizations who are not currently represented on the Board may meet this requirement by attending meetings at least quarterly to give input to the Board.

Section I. Remote Locations

Individual RTABs may arrange for remote locations to Video Conference or Teleconference into their meetings to facilitate participation by member organizations. It is understood that Board members must attend at the published meeting location to meet the requirements of the Oklahoma Open Meetings Act.

**EMResource™**

The RTAB adopts the policies, standards and definitions recommended by the Oklahoma State Department of Health for the operations of EMResource™. Any recommendations for changes to these documents will be made to the OSDH EMS division for consideration for statewide adoption. Because this is a statewide system, all changes must be made on a statewide basis. Any necessary regional operational procedures will be subject to approval by the RTAB.

**AMENDMENT OF BYLAWS**

The Bylaws may be altered, amended or repealed, and new Bylaws may be adopted by a vote of the Board Members held at a regularly scheduled meeting held in compliance with the Open Meetings Act or at a meeting specially called for that purpose.

Section I. The agenda of any meeting at which the Bylaws are altered, amended or repealed shall include the text of the proposed provisions as well as the text of any existing provisions proposed to be altered, amended or repealed.

**Plan Approval Dates**

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## Appendix B

# Hospital and EMS Provider Descriptions

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
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EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

Plan Updated: October 6, 2009, November 8, 2011

Bylaw s Updated: October 7, 2008, February 9, 2010, November 8, 2011

## Northeast Regional Trauma Triage and Destination Plan

### CATEGORIZATION AND DESCRIPTION OF HOSPITALS SERVING REGION 2

#### A. Hospital Providers within Region 2 include:

1. Level I: **NONE**
2. Level II: **NONE**
3. Level III:
  - a. Jane Phillips Medical Center (JPMC)
  - b. Stillwater Medical Center
4. Level IV:
  - a. Claremore Regional Hospital
  - b. Cleveland Area Hospital
  - c. Craig General Hospital
  - d. Cushing Regional Hospital
  - e. Fairfax Memorial Hospital
  - f. INTEGRIS Baptist Regional Health Center
  - g. INTEGRIS Blackwell Regional Hospital
  - h. INTEGRIS Grove General Hospital
  - i. INTEGRIS Mayes County Medical Center
  - j. Mayes County Medical Center
  - k. Jane Phillips Nowata Health Center
  - l. Pawhuska Hospital, Inc.
  - m. Perry Memorial Hospital
  - n. Ponca City Medical Center
5. Rehabilitation Hospitals: none
6. Non-trauma classified:
  - a. Continuous Care Center of Bartlesville
  - b. Transitions at Cushing – Inpatient Geriatric psych
  - c. Willow Crest Hospital
7. Additional Resources:
  - a. Level I Hospitals:
    - i. OU Medical Center (OUMC) - OKC
    - ii. St Johns Regional Health – Springfield, MO
    - iii. Wesley Medical Center – Wichita, KS
    - iv. Via Christi Medical Center, St. Francis Campus– Wichita, KS
  - b. Level II Hospitals

#### Plan Approval Dates

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EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

37

- Northeast Regional Trauma Triage and Destination Plan
  - i. Freeman Health Systems – Joplin, MO
  - ii. St Francis Hospital – Tulsa, OK
  - iii. St John Medical Center – Tulsa, OK
  - iv. St John Regional Medical Center – Joplin, MO
- c. Adult Burn Specialties
  - i. Baptist Burn Center – OKC
  - ii. Hillcrest Medical Center – Tulsa
  - iii. St John Regional Health – Springfield, MO
  - iv. Via Christi Medical Center, St. Francis Campus– Wichita, KS
- d. Pediatric Burn Specialties
  - i. Hillcrest Medical Center – Tulsa
  - ii. OUMC Children’s Hospital – OKC
  - iii. St John Regional Health – Springfield, MO
  - iv. Via Christi Medical Center, St. Francis Campus– Wichita, KS

**Description of Region 2 EMS provider services by County**

Craig County

1. Mercy Regional of Oklahoma is a Paramedic Service with substations in the region.
  - A. Pawnee County-Cleveland and Wilson Station.
  - B. Osage County- Fairfax.
  - C. Craig County-Vinita.

Delaware County

2. Cleora EMS is a paramedic service with three ambulances covering 75 miles.
3. Grove EMS is a paramedic service with three ambulances covering 210 miles.
4. Jay EMS is a basic service with one ambulance covering 305 miles.

Kay County

5. Blackwell Fire Department Ambulance Service is a basic service with three ambulances covering 400 miles.
6. Newkirk Fire Department EMS is a basic service with two ambulances covering 420 miles.
7. Ponca City Fire Department Ambulance Service is a basic service with five ambulances covering 500 miles.
8. Tonkawa Fire Department Ambulance Service is a basic service with two ambulances covering 440 miles.

Mayes County

9. Mayes Emergency Service Trust Authority is a basic service with three ambulances covering 650 miles.  
Tulsa Life Flight-Rotor Wing in Pryor

Noble County

10. Perry Fire Department EMS is a basic service with three ambulances covering 500 square miles.

**Plan Approval Dates**

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## Northeast Regional Trauma Triage and Destination Plan

### Nowata County

11. Nowata Ambulance Service is a basic service with two ambulances covering 577 miles.

### Osage County

12. Green Country Fire & Rescue is a basic service with one ambulance covering 52 miles.

13. Hominy Medical Trust Authority is a basic service with one ambulance covering 200 miles.

14. Pulse EMS is a paramedic service with 2 ambulances covering 1200 miles.

15. Shidler Ambulance Service is a basic service with one ambulance covering 375 miles.

### Ottawa County

16. Baptist Regional Health Center EMS is a paramedic service with two ambulances covering 700 miles.

17. Integrity EMS is a paramedic substation (Licensed in Region 7) .

18. Quapaw EMS is a basic ambulance service with 2 ambulances covering 200 miles.

### Pawnee County

19. Pawnee Ambulance Service is a basic service with two ambulances covering 500 miles.

### Payne County

20. Air Evac Lifeteam-Cushing

21. Cushing Municipal Ambulance Service is a basic service with three ambulances covering 400 miles.

22. EagleMed-Stillwater

23. Stillwater Fire Department EMS is an intermediate service with 6 ambulances covering 575 miles.

### Rogers County

24. Air Evac Lifeteam-Claremore

25. Oologah-Talala EMS is a paramedic service with two ambulances covering 180 miles.

26. Pafford EMS is a paramedic service with one ambulance covering 495 miles.

### Washington County

27. Bartlesville Ambulance Service is a paramedic service with two ambulances covering 417 miles.

### Out of State Providers

Arkansas City Fire –EMS Department

Arch Air

Air Evac Lifeteam

Eaglemed

### Plan Approval Dates

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EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

39

Plan Updated: October 6, 2009, November 8, 2011

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## Appendix C:

# Triage Transport and Transfer Guidelines

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

40

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# TRAUMA PATIENT TRIAGE DEFINITIONS

## Trauma Triage

Since patients differ in their initial response to injury, trauma triage is an inexact science. Current patient identification criteria does not provide 100% percent sensitivity and specificity for detecting injury. As a result, trauma systems are designed to over-triage patients in order not to miss a potentially serious injury. Under-triage of patients should be avoided since a potentially seriously injured patient could be delivered to a facility not prepared to manage their injury. Large amounts of over-triage is not in the best interest of the Trauma System since it will potentially overwhelm the resources of the facilities essential for the management of severely injured patients.

## Priority 1 Trauma Patients

These are patients with high energy blunt or penetrating injury causing physiological abnormalities or significant single or multisystem anatomical injuries. These patients have time sensitive injuries requiring the resources of a designated Level I, Level II, or Regional Level III Trauma Center. These patients should be directly transported to a Designated Level I, Level II, or Regional Level III facility for treatment but may be stabilized at a Level III or Level IV facility, if needed, depending on location of occurrence and time and distance to the higher level trauma center. If needed these patients may be cared for in a Level III facility if the appropriate services and resources are available.

### Physiological Compromise Criteria:

- Hemodynamic Compromise-Systolic BP <90 mmHg  
Other signs that should be considered include:
  - Sustained Tachycardia
  - Cool diaphoretic Skin
- Respiratory Compromise-RR<10 or >29 Breaths/Minutes  
Or <20 in infant <1 year
- Altered Mentation- of trauma etiology- GCS <14

### Anatomical Injury Criteria

- Penetrating injury of head, neck, chest/abdomen, or extremities proximal to elbow or knee.
- Amputation above wrist or ankle.
- Paralysis or suspected spinal fracture with neurological deficit.
- Flail chest.
- Two or more obvious proximal long bone fractures (upper arm or thigh).
- Open or suspected depressed skull fracture.
- Unstable pelvis or suspected pelvic fracture.
- Tender and/or distended abdomen.
- Burns associated with Priority I Trauma
- Crushed, degloved, or mangled extremity

## Priority 2 Trauma Patients

These are patients with potentially time sensitive injuries due to a high energy event (positive mechanism of injury) or with a less severe single system injury but currently with no physiological abnormalities or significant anatomical injury.

### I. Significant Single System Injuries

- Neurology: Isolated head trauma with transient loss of consciousness or altered mental status but currently alert and oriented.
- Orthopedic: Single proximal and distal extremity fractures (including open) from high energy event, isolated joint dislocations-knee, hip, elbow, shoulder without neurovascular deficits, and unstable joint (ligament) injuries without neurovascular deficits.
- Maxillofacial trauma: Facial lacerations; such as those requiring surgical repair, isolated open facial fractures or isolated orbit trauma with or without entrapments, or avulsed teeth.

# TRAUMA PATIENT TRIAGE DEFINITIONS

## High Energy Event

Patient involved in rapid acceleration deceleration events absorb large amounts of energy and are at an increased risk for severe injury despite normal vital signs on their initial assessment. Five to fifteen percent of these patients, despite normal vital signs and no apparent anatomical injury on initial evaluation, will have a significant injury discovered after a full trauma evaluation with serial observations. Determinates to be considered are direction and velocity of impact and the use of personal protection devices. Motor vehicle crashes when occupants are using personal safety restraint devices may not be considered a high-energy event. Personal safety devices will often protect the occupant from absorbing high amounts of energy even when the vehicle shows significant damage. High Energy Events:

- Ejection of the patient from an enclosed vehicle
- Auto/pedestrian or auto/bike or motorcycle crash with significant impact (> 20 mph) impact with the patient thrown or run over by a vehicle.
- Falls greater than 20 feet for adult, >10 feet for pediatric or distance 2-3 times height of patient
- Significant assault or altercations
- High risk auto crash
  - The following motor vehicle crashes particularly when the patient has not used personal safety restraint devices:
    - Death in the same passenger compartment
    - Rollover
    - High speed auto crash
    - Compartment intrusion greater than 12 inches at occupant site or >18 inches at any site
    - Vehicle telemetry data consistent with high risk injury.

## Medic Discretion

Since trauma triage is an inexact science and patients differ in their response to injury, clinical judgment by the medic at the scene is an extremely important element in determining the destination of all patients. If the medic is concerned that a patient may have a severe injury which is not yet obvious, the patient may be upgraded in order to deliver that patient to the appropriate level Trauma Center. Paramedic suspicion for a severe injury may be raised by but not limited to the following factors:

- Age greater than 55
- Age less than 5
- Extremes of environment
- Patient's previous medical history such as:
  - Anticoagulation or bleeding disorders
  - End stage renal disease on dialysis
- Pregnancy (>20 weeks)

## **Priority 3 Trauma Patients**

These patients are without physiological abnormalities, altered mentation, neurological deficit, or a significant single system injury that has been involved in a low energy event. These patients should be treated at the nearest treating facility or the patient's hospital of choice.

- Example: Same level fall with extremity or hip fracture.

# ADULT PRE-HOSPITAL TRIAGE AND TRANSPORT GUIDELINES

## Oklahoma Model Trauma Triage Algorithm

- INABILITY TO SECURE AIRWAY
- TRAUMATIC ARREST

**YES**

GO DIRECTLY TO NEAREST APPROPRIATE FACILITY

### PHYSIOLOGICAL COMPROMISE CRITERIA

### PRIORITY I

- Hemodynamic Compromise<sup>1</sup>-Systolic BP < 90mmHg  
Or signs that should be considered include:
  - Sustained tachycardia
  - Cool diaphoretic skin
- Respiratory Compromise<sup>2</sup>- RR < 10 or > 29 breaths/minute  
or < 20 in infant < 1 yr
- Altered Mentation of trauma etiology<sup>3</sup>- GCS < 14

**NO** ↓

#### ANATOMICAL INJURY

- Penetrating injury of head, neck, chest abdomen, or extremities proximal to elbow or knee.
- Combination of burns > 10% or significant burns involving face, airway, hands, feet or genitalia without significant trauma transport to regional Burn Center. Burns > 10% with significant trauma transport to trauma center.
- Amputation above wrist or ankle
- Paralysis or suspected spinal fracture with neurological deficit
- Flail chest
- Two or more obvious proximal long bone fractures [upper arm or thigh]
- Open or suspected depressed skull fracture
- Unstable pelvis or suspected unstable pelvic fracture
- Tender and/or distended abdomen
- Crushed, degloved, or mangled extremity

**YES**

INITIATE TRAUMA TREATMENT PROTOCOL

ACTIVATE TRAUMA SYSTEM

**RAPID** transport to the designated Level I,II, or Regional Level III Trauma Center according to the Regional Trauma Plan but may be stabilized at a Level III or IV facility depending on location of receiver and time and distance to the higher level trauma center.

Air Rendezvous may be necessary considering time & distance constraints. If conditions do not permit air transport then consider ALS rendezvous. Stabilization may occur either in the field or at the nearest appropriate facility.

Combination of burns > 10% or significant burns involving face, airway, hands, feet or genitalia *without* significant trauma transport to regional Burn Center. Burns >10% *with* significant trauma transport to trauma center.

**YES**

**NO** ↓

### RISK OF SERIOUS INJURY - SINGLE SYSTEM INJURY

*Patients with potentially time sensitive injuries due to a high energy event (positive mechanism of injury) but currently with no physiological abnormalities or significant anatomical injury, or patients with less severe single system injury.*<sup>4</sup>

- Ejection (partial or complete) of the patient from an enclosed vehicle
- Auto/pedestrian, auto/bike, or motorcycle crash with significant impact (>20 mph) and patient thrown or run over by vehicle
- Falls greater than 20 feet or 2-3 times height of patient
- Significant assault or altercations
- High risk auto crash<sup>5</sup>
- Neurology: Isolated head trauma with transient loss of consciousness or altered mental status but currently alert and oriented
- Orthopedic: Single proximal and distal extremity (including open) from high energy event, isolated joint dislocations-knee, hip, elbow, shoulder without neurovascular deficits, and unstable joint (ligament) injuries without neurovascular deficits.
- Maxillofacial trauma: Facial lacerations; such as those requiring surgical repair, isolated open facial fractures or isolated orbit trauma with or without entrapments, or avulsed teeth.

**YES**

### PRIORITY II

INITIATE TRAUMA TREATMENT PROTOCOL

**PROMPT** transport to the designated Level III Trauma Center or higher depending on location according to the Regional Trauma Plan

**YES**

**NO** ↓

**CONSIDER**<sup>6</sup> Co-morbid factors  
-Gestalt-EMS clinical judgment

**NO**

### PRIORITY III

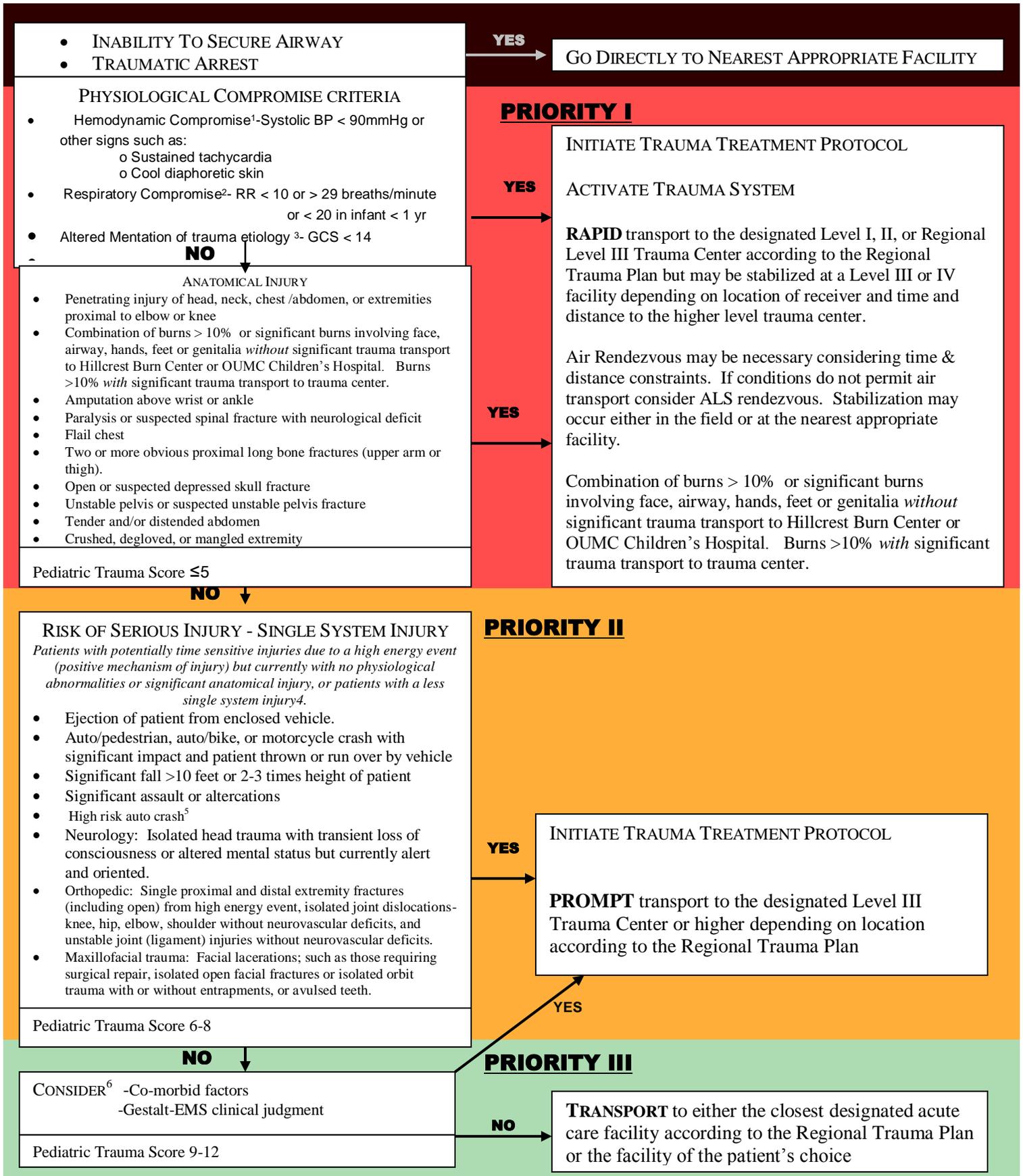
**TRANSPORT** to either the closest Level IV Trauma Center or higher depending on location according to the Regional Trauma Plan or the facility of the patient's choice

**ADULT PRE-HOSPITAL  
TRIAGE AND TRANSPORT GUIDELINES**  
Oklahoma Model Trauma Triage Algorithm

1. In addition to hypotension: pallor, tachycardia or diaphoresis may be early signs of hypovolemia
2. Tachypnea (hyperventilation) alone will not necessarily initiate this level of response.
3. Altered sensorium secondary to sedative-hypnotic will not necessarily initiate this level of response.
4. High Energy Event signifies a large release of uncontrolled energy. Patient is assumed injured until proven otherwise, and multisystem injuries may exist. Determinants to be considered by medical professionals are direction and velocity of impact, use of personal protection devices, patient kinematics and physical size and the residual signature of energy release (e.g. Major vehicle damage). Motor vehicle crashes when occupants are using personal safety restraint devices may not be considered a high energy event because the personal safety restraint will often protect the occupant from absorbing high amounts of energy.
5. The following motor vehicle crashes particularly when the patient has not used personal safety restraint devices:
  - a. Death in the same passenger compartment
  - b. Rollover
  - c. High speed auto crash
  - d. Compartment intrusion greater than 12 inches at occupant site or > 18 inches at any site
  - e. Vehicle telemetry data consistent with high risk of injury
6. Since trauma triage is an inexact science and patients differ in their response to injury, clinical judgment by the medic at the scene is an extremely important element in determining the destination of all patients. If the medic is concerned that a patient may have a severe injury which is not yet obvious, the patient may be upgraded in order to deliver that patient to the appropriate level Trauma Center. EMS provider suspicion for a severe injury may be raised by but not limited to the following factors:
  - Age greater than 55
  - Age less than 5
  - Extremes of environment
  - Patient's previous medical history such as:
    - Anticoagulation or bleeding disorders
    - End state renal disease on dialysis
  - Pregnancy (>20 weeks)

# PEDIATRIC (≤ 16 YEARS) PRE-HOSPITAL TRIAGE AND TRANSPORT GUIDELINES

## Oklahoma Model Trauma Triage Algorithm



Approved : OTSIDAC 02/01/06

Revised: OTSIDAC 08/01/07; 02/06/08, 08/06/08; 02/03/10

Clarification Revision by MAC: 11/19/08

**PEDIATRIC (≤ 16 YEARS) PRE-HOSPITAL  
TRIAGE AND TRANSPORT GUIDELINES**

Oklahoma Model Trauma Triage Algorithm

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  - Age greater than 55
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  - Extremes of environment
  - Patient's previous medical history such as:
    - Anticoagulation or bleeding disorders
    - End state renal disease on dialysis
  - Pregnancy (>20 weeks)

**PEDIATRIC (≤ 16 YEARS) PRE-HOSPITAL  
TRIAGE AND TRANSPORT GUIDELINES**  
Oklahoma Model Trauma Triage Algorithm

<b>Pediatric Trauma Score (PTS)</b>				
<b>Components</b>	<b>+2</b>	<b>+1</b>	<b>-1</b>	<b>Score</b>
Weight	>20 kg (44 lb)	10-20 kg (22-44 lb)	< 10 kg (< 22 lb)	
Airway	Patent *	Maintainable ^	Unmaintainable #	
Systolic (cuff) Or BP (pulses)	> 90 mm Hg Radial	50-90 mm Hg Femoral/Carotid	< 50 mm Hg None palpable	
CNS	Awake, no LOC	Obtunded Some LOC†	Comatose, unresponsive	
Fractures	None	Closed (or suspected)	Multiple open or closed	
Wounds	None	Minor	Major ‡, Burns or penetrating	
<b>TOTAL</b>	<b>Range – 6 to +12</b>			

Score: Possible Range –6 to +12, decreasing with increasing injury severity.

Generally:

- 9 to 12 = minor trauma
- 6 to 8 = potentially life threatening
- 0 to 5 = life threatening
- < 0 = usually fatal

\* No assistance required.

^ Protected by patient but constant observation required for position, patency, or O<sub>2</sub> administration

# Invasive techniques required for control (e.g., intubation).

† Responds to voice, pain, or temporary loss of consciousness.

‡ Abrasions or lacerations

# ADULT INTERFACILITY TRIAGE AND TRANSFER GUIDELINES Oklahoma Model Trauma Triage Algorithm

## **PRIORITY I**

### Anatomy of the Injury

Penetrating injury of the head, neck, torso or groin.

### Abdominal/Pelvic Injuries

- Hemodynamically unstable patient with physical evidence of abdominal or pelvic trauma
- Unstable pelvic ring disruption
- Pelvic fracture with shock or other evidence of continuing hemorrhage
- Open pelvic fracture
- Penetrating wound of abdomen with suspicion of penetration of the peritoneum
- Ruptured hollow viscous

### CNS

- Penetrating Head Injury or Depressed skull fracture
- Open Head Injury
- GCS  $\leq$  10 or deterioration of 2 or more points
- Lateralizing signs
- New neurological deficits
- CSF Leak
- Spinal cord injury with neurological deficits
- Unstable spinal cord injuries

### Chest

- Widened mediastinum or other signs suggesting great vessel injury
- Major chest wall or pulmonary injury with respiratory compromise
- Cardiac injury (blunt or penetrating)
- Cardiac tamponade
- Patients who may require prolonged ventilation
- Suspected tracheobronchial tree or esophageal injury

### Hemodynamic Instability

- Adult SBP consistently  $<90$  following 2 liters of crystalloid
- Respiratory distress with rate  $<10$  or  $>29$

### Major Extremity Injury

- Fracture/dislocation with loss of distal pulses
- Amputation of extremity proximal to wrist or ankle
- Pelvic fractures with hemodynamic instability
- Two or more long bone fracture sites
- Major vascular injuries documented by arteriogram or loss of distal pulses
- Crush Injury or prolonged extremity ischemia

### Multiple System

- Head Injury combined with face, chest, abdominal, or pelvic injury
- Significant injury to two or more body regions
- Combination of burns  $>10\%$  or significant burns involving face, airway, hands, feet or genitalia *without* significant trauma transport to regional Burn Center. Burns  $>10\%$  *with* significant trauma transport to trauma center.

### Secondary Deterioration

- Prolonged mechanical ventilation
- Sepsis
- Single or multiple organ system failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation systems)
- Major tissue necrosis

**YES**

Initiate internal Trauma Treatment Protocol if definitive surgical care and critical care monitoring are available

If definitive surgical care or critical care monitoring are not available then immediate stabilization & transfer to appropriate designated facility according to regional plan. Stabilization may involve surgical intervention prior to transfer. Air transport may be necessary considering time & distance constraints.

**NO**

Proceed to Priority II Interfacility Transfer Criteria

**ADULT INTERFACILITY  
TRIAGE AND TRANSFER GUIDELINES  
Oklahoma Model Trauma Triage Algorithm**

**PRIORITY II**

**Abdominal/Pelvic Injuries**

- Stable pelvic fractures
- Hemodynamically stable isolated abdominal trauma
  - o diffuse abdominal pain/tenderness
  - o seat belt contusions
  - o visceral injuries
- Hemodynamically stable isolated solid organ injuries

**CNS**

- Head Injury with GCS > 10
- Head Injury with Transient loss of consciousness < 5 min
- Head Injury with Transient neurological deficits
- Spinal cord injury without neurological deficits

**Chest**

- Isolated Chest Trauma- pain, mild dyspnea
- Rib fractures, sternal fractures, pneumothorax, hemothorax without respiratory compromise
- Unilateral pulmonary contusion without respiratory compromise

**Comorbid**

- Age <5 or > 55
- Known cardiac, respiratory or metabolic disease
- Pregnancy
- Immunosuppression
- Bleeding disorder or anticoagulants

**Major Extremity Injury**

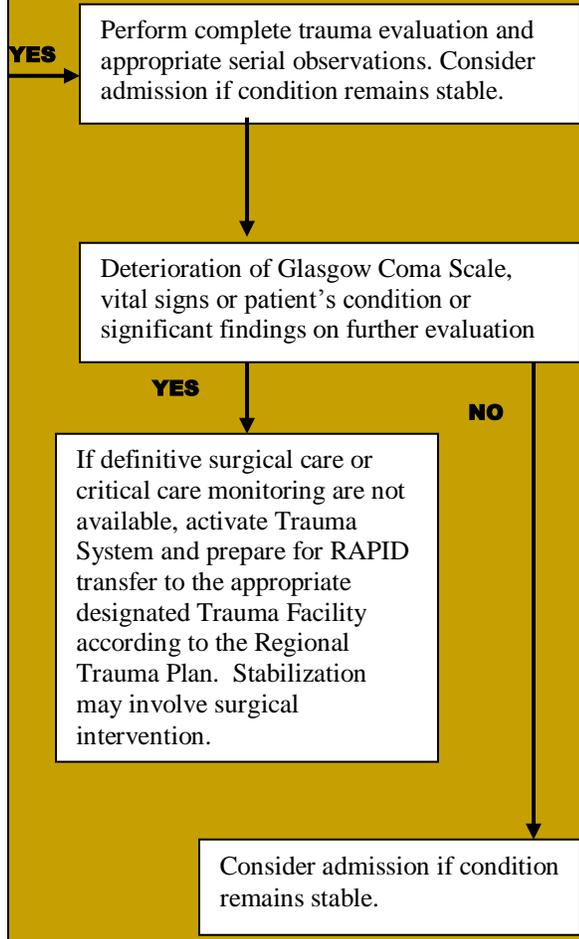
- Single proximal extremity fractures, including open
- Distal extremity fractures, including open
- Isolated joint dislocations-knee, hip, elbow, shoulder without neurovascular deficits
- Unstable joint (ligament) injuries without neurovascular deficits
- Degloving injuries without evidence of limb threatening injury

**Mechanism**

- Ejection of patient from enclosed vehicle
- Adult auto/pedestrian, auto/bike, or motorcycle crash with significant impact and patient thrown or run over by vehicle
- Falls greater than 20 feet
- Significant assault or altercations
- Other “high energy” events based on Paramedic discretion, e.g.: patients involved in motor vehicle crashes with significant vehicular damage and not using personal safety restraint devices

**Other**

- Isolated open facial fractures
- Isolated orbit trauma with or without entrapments, without visual deficits



**NO**

**Priority III**

Perform appropriate emergency department evaluation. Consider discharge or admit if condition remains stable.

Deterioration of Glasgow Coma Scale, vital signs or patient's condition or significant findings on further evaluation: Initiate Trauma Treatment Protocol- Activate Trauma System and prepare for RAPID transfer to the appropriate designated Trauma Facility according to the Regional Trauma Plan if definitive surgical care and critical care monitoring are not available.

# Pediatric Interfacility Triage and Transfer Guidelines Oklahoma Model Triage Algorithm

## PRIORITY I

### Anatomy of the Injury

Penetrating injury of the head, neck, torso or groin.

### Abdominal/Pelvic Injuries

- Hemodynamically unstable patient with physical evidence of abdominal or pelvic trauma
- Unstable pelvic ring disruption
- Pelvic fracture with shock or other evidence of continuing hemorrhage
- Open pelvic fracture
- Penetrating wound of abdomen with suspicion of penetration of the peritoneum
- Ruptured hollow viscous

### CNS

- Penetrating Head Injury or Depressed skull fracture
- Open Head Injury
- GCS  $\leq$  10 or deterioration of 2 or more points
- Lateralizing signs
- New neurological deficits
- CSF Leak
- Spinal cord injury with neurological deficits
- Unstable spinal cord injuries

### Chest

- Widened mediastinum or other signs suggesting great vessel injury
- Major chest wall or pulmonary injury with respiratory compromise
- Cardiac injury (blunt or penetrating)
- Cardiac tamponade
- Patients who may require prolonged ventilation
- Suspected tracheobronchial tree or esophageal injury

### Hemodynamic Instability

- SBP consistently  $<90$  following 20cc/kg of resuscitation fluid
- Respiratory distress with rate of:
  - Newborn:  $< 30$  or  $> 60$
  - Up to 1 yr  $< 24$  or  $> 36$
  - 1-5 yr  $< 20$  or  $> 30$
  - Over 5 yr  $< 15$  or  $> 30$

### Major Extremity Injury

- Fracture/dislocation with loss of distal pulses
- Amputation of extremity proximal to wrist or ankle
- Pelvic fractures with hemodynamic instability
- Two or more long bone fracture sites
- Major vascular injuries documented by arteriogram or loss of distal pulses
- Crush Injury or prolonged extremity ischemia

### Multiple System

- Head Injury combined with face, chest, abdominal, or pelvic injury
- Significant injury to two or more body regions
- Combination of burns  $> 10\%$  or significant burns involving face, airway, hands, feet or genitalia *without* significant trauma transport to Hillcrest Burn Center or OUMC Children's Hospital. Burns  $>10\%$  *with* significant trauma transport to trauma center

### Secondary Deterioration

- Prolonged mechanical ventilation
- Sepsis
- Single or multiple organ system failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation systems)
- Major tissue necrosis

Pediatric Trauma Score  $\leq 5$

**YES**

Initiate internal Trauma Treatment Protocol if definitive surgical care and critical care monitoring are available

If definitive surgical care or critical care monitoring are not available then immediate stabilization & transfer to appropriate designated facility according to regional plan. Stabilization may involve surgical intervention prior to transfer. Air transport may be necessary considering time & distance constraints.

**NO**

Proceed to Priority II Interfacility Transfer Criteria

# Pediatric Interfacility Triage and Transfer Guidelines Oklahoma Model Triage Algorithm

## PRIORITY II

### Abdominal/Pelvic Injuries

- Stable pelvic fractures
- Hemodynamically stable isolated abdominal trauma
  - o diffuse abdominal pain/tenderness
  - o seat belt contusions
  - o visceral injuries
- Hemodynamically stable isolated solid organ injuries

### CNS

- Head Injury with GCS > 10
- Head Injury with Transient loss of consciousness < 5 min
- Head Injury with Transient neurological deficits
- Spinal cord injury without neurological deficits

### Chest

- Isolated Chest Trauma- pain, mild dyspnea
- Rib fractures, sternal fractures, pneumothorax, hemothorax *without* respiratory compromise
- Unilateral pulmonary contusion without respiratory compromise

### Comorbid

- Known cardiac, respiratory or metabolic disease
- Pregnancy
- Immunosuppression
- Bleeding disorder or anticoagulants

### Major Extremity Injury

- Single proximal extremity fractures, including open
- Distal extremity fractures, including open
- Isolated joint dislocations-knee, hip, elbow, shoulder without neurovascular deficits
- Unstable joint (ligament) injuries without neurovascular deficits
- Degloving injuries without evidence of limb threatening injury

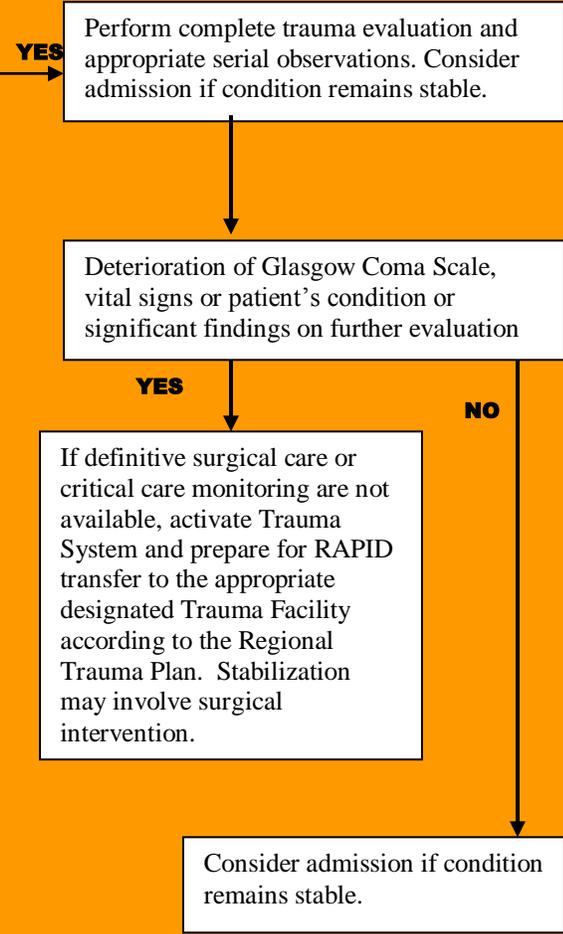
### Mechanism

- Ejection of patient from enclosed vehicle
- Auto/pedestrian, auto/bike, or motorcycle crash with significant impact and patient thrown or run over by vehicle
- Falls greater than 20 feet
- Significant assault or altercations
- Other “high energy” events based on Paramedic discretion, e.g.: patients involved in motor vehicle crashes with significant vehicular damage and not using personal safety restraint devices

### Other

- Isolated open facial fractures
- Isolated orbit trauma with or without entrapments, without visual deficits

Pediatric Trauma Score 6-8



**NO**

## Priority III

Perform appropriate emergency department evaluation. Consider discharge or admit if condition remains stable.  
Pediatric Trauma Score 9-12

Deterioration of Glasgow Coma Scale, vital signs or patient's condition or significant findings on further evaluation: Initiate Trauma Treatment Protocol- Activate Trauma System and prepare for RAPID transfer to the appropriate designated Trauma Facility according to the Regional Trauma Plan if definitive surgical care and critical care monitoring are not available.

Approved : OTSIDAC 02/01/06  
Revised: OTSIDAC 08/01/07; 02/06/08, 08/06/08; 02/03/10  
Clarification Revision by MAC: 11/19/08

## Appendix D

# Trauma Team Requirements by Hospital Classification

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

51

Plan Updated: October 6, 2009, November 8, 2011

Bylaws Updated: October 7, 2008, February 9, 2010, November 8, 2011

Northeast Regional Trauma Triage and Destination Plan

**OKLAHOMA STANDARDS  
HOSPITAL TRAUMA AND EMERGENCY OPERATIVE SERVICES**

This table shows the required components at each classification Level for trauma and emergency operative services as listed at OAC 310:667-59-9.

LEVEL	I	II	III	IV
<b>CLINICAL SERVICES AND RESOURCES</b>				
Organized trauma service	X	X	X	
Organized emergency department	X	X	X	
General surgery	X	X	X	
Anesthesia	X	X	X	
Neurologic surgery	X	X		
Other specialties on call and promptly available:				
Cardiac surgery	X	X		
Cardiology	X	X		
Hand surgery	X			
Infectious disease	X			
Internal medicine	X	X	X	
Microvascular surgery	X			
Obstetric/gynecologic surgery	X	X		
Ophthalmic surgery	X	X		
Oral/maxillofacial surgery	X	X		
Orthopedic surgery	X	X	X	
Otolaryngology	X	X		
Pediatric surgery	X			
Pediatrics	X	X		
Plastic surgery	X	X		
Pulmonary medicine	X	X		

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**Northeast Regional Trauma Triage and Destination Plan**

Radiology	X	X		
Thoracic surgery	X			
Urology and urologic surgery	X	X		

LEVEL	I	II	III	IV
<b>CLINICAL SERVICES AND RESOURCES (continued)</b>				
Operating suite	X	X	X	
Post-anesthesia recovery unit	X	X	X	
Intensive care unit	X	X	X	
Diagnostic imaging including:				
Diagnostic x-ray	X	X	X	
Angiography	X	X		
Ultrasonography	X	X		
Computed tomography	X	X		
Magnetic resonance imaging	X	X		
Neuroradiology	X	X		
Nuclear medicine imaging	X	X		
Clinical laboratory service including:				
Immunochemistry	X	X	X	
Routine chemistry and hematology	X	X	X	
Coagulation	X	X	X	
Blood gas/pH	X	X	X	
Microbiology	X	X	X	
Drug and alcohol screening	X	X	X	
Respiratory therapy	X	X		
Acute hemodialysis	X			
Social services	X	X	X	

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**Northeast Regional Trauma Triage and Destination Plan**

Burn care	X	X	X	
Spinal cord and head injury management	X	X	X	
Rehabilitation services	X	X	X	

LEVEL	I	II	III	IV
<b>PERSONNEL</b>				
Trauma service director	X	X	X	
Trauma coordinator	X	X		
Prevention coordinator	X	X		
Emergency services director	X	X	X	
Surgical director	X	X	X	
Research director	X			
<b>SUPPLIES AND EQUIPMENT</b>				
Emergency department:				
Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, and oxygen	X	X	X	X
Pulse oximetry	X	X	X	
End-tidal CO <sub>2</sub> determination	X	X		
Suction devices	X	X	X	X
Electrocardiograph-oscilloscope-defibrillator-pacer	X	X	X	X
Apparatus to establish central venous pressure monitoring	X	X	X	
Standard intravenous fluids and administration devices including large-bore catheters	X	X	X	X
Sterile surgical sets for:				
Airway control/cricothyrotomy	X	X	X	X
Thoracotomy	X	X	X	

**Plan Approval Dates**

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**Northeast Regional Trauma Triage and Destination Plan**

Vascular access	X	X	X	X
Chest decompression	X	X	X	X
Equipment for gastric decompression	X	X	X	X
Drugs necessary for emergency care	X	X	X	X
Two-way communication with vehicles of emergency transport system	X	X	X	X
Skeletal traction devices including cervical immobilization device	X	X	X	

LEVEL	I	II	III	IV
<b>SUPPLIES AND EQUIPMENT (continued)</b>				
Arterial catheters	X	X		
Thermal control equipment for:				
Patients	X	X	X	X
Infusion of blood, blood products, and other fluids	X	X	X	
Operating suite:				
Cardiopulmonary bypass capability	X			
Operating microscope	X			
Thermal control equipment for:				
Patients	X	X		
Infusion of blood, blood products and other fluids	X	X		
X-ray capability including C-arm intensifier	X	X		
Endoscopes	X	X		
Craniotomy instruments	X	X		
Equipment appropriate for fixation of long-bone and pelvic fractures	X	X		
Post-anesthesia recovery unit:				
Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange	X	X	X	

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

**Northeast Regional Trauma Triage and Destination Plan**

Equipment for the continuous monitoring of intracranial pressure	X	X		
Pulse oximetry	X	X	X	
End-tidal CO <sub>2</sub> determination	X	X	X	
Thermal control equipment for patients and the infusion of blood, blood products, and other fluids	X	X	X	
Intensive care unit:				
Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange	X	X	X	
Cardiopulmonary resuscitation cart	X	X	X	
Electrocardiograph-oscilloscope-defibrillator-pacer	X	X	X	

LEVEL	I	II	III	IV
<b>SUPPLIES AND EQUIPMENT (continued)</b>				
Sterile surgical sets for:				
Airway control/cricothyrotomy	X	X	X	
Thoracotomy	X	X	X	
Vascular access	X	X	X	
Chest decompression	X	X	X	
<b>AGREEMENTS AND POLICIES ON TRANSFERS</b>				
Written policies on transfers	X	X	X	X
<b>QUALITY IMPROVEMENT</b>				
Multidisciplinary trauma committee	X	X		
Quality improvement program including:				
Trauma registry	X	X	X	X
Audit for all trauma deaths	X	X	X	X
Morbidity and mortality review	X	X	X	X
Medical nursing audit, utilization review, tissue review	X	X	X	X

**Plan Approval Dates**

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Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

**Northeast Regional Trauma Triage and Destination Plan**

Regularly scheduled multidisciplinary trauma and emergency operative services review conferences	X	X	X	
Review of prehospital care	X	X	X	
Published call schedules for surgeons, neurosurgeons, and orthopedic surgeons	X	X	X	
Review of the times and reasons for trauma related bypass	X	X	X	
The availability and response times of all on call specialists defined in writing and monitored	X	X	X	X
QI staff with time dedicated to and specific for trauma and emergency operative services	X	X		
<b>CONTINUING EDUCATION</b>				
Provide and document formal continuing education programs for physicians, nurses, allied health personnel, and community physicians	X	X	X	

LEVEL	I	II	III	IV
<b>ORGAN PROCURMENT</b>				
Policies and procedures to identify and refer potential organ donors		X	X	
<b>OUTREACH PROGRAMS</b>				
Consultation	X	X		
Prevention and public education programs	X	X		
<b>RESEARCH PROGRAMS</b>				
Organized trauma and emergency operative services research program directed by a designated research director	X			

**Plan Approval Dates**

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## Appendix E

# Advanced Life Support Intercept Protocol

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
EMSystem	RPC: 2/27/07	RTAB: 1/11/07	OTSIDAC: 08/01/2007

58

Plan Updated: October 6, 2009, November 8, 2011

Bylaw s Updated: October 7, 2008, February 9, 2010, November 8, 2011

**ALS INTERCEPT PROTOCOL FOR REGION 2**

Purpose:

To provide guidelines to Emergency Medical Services personnel on when to request Advanced Life Support (ALS) assistance from neighboring ambulance services.

Policy:

The following will apply to ensure that BLS/ALS assistance requests are managed appropriately.

ALS Assist is defined as any request for an air or ground advanced life support unit to respond to and/or intercept with an EMS Unit for the purpose of providing an advanced level of patient care. A licensed Intermediate or Paramedic level of care should provide ALS Assist.

ALS Assist/intercept requests should be made in any situation where the EMS provider has determined that the patient may be unstable or has life-threatening injuries or illness. Medics should refer to the Oklahoma Trauma Triage and Transportation guidelines for classification of the patient.

Procedure:

1. Consideration must be given as to the location of the EMS unit, and anticipated location of intercept. The decision to request ALS should be made immediately.
2. The location of the intercept shall be decided as soon as possible.
3. Only if it is deemed to be in the best interest of the patient should the patient be transferred from a BLS unit to a ground ALS unit.
4. The ALS provider should be licensed at the Intermediate or Paramedic level or an Air Ambulance.
5. BLS and ALS personnel may elect to request air medical support based on the Regional Trauma Plan. BLS personnel need not wait for an assessment prior to requesting air medical support. Landing zone selection and security shall be coordinated with local resources. Transportation to the closest most appropriate medical facility shall not be inordinately delayed while waiting for air support.
6. A full verbal patient care report shall be given to the ALS personnel upon arrival and a full patient care report will be left with the patient at the hospital.

**Plan Approval Dates**

Pre-Hospital	RPC: 8/18/06	RTAB: 8/18/06	OTSIDAC: 10/4/06
Inter-Facility	RPC: 4/10/07	RTAB: 6/5/07	OTSIDAC: 08/01/2007
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