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**Southwest Regional Trauma Advisory Board  
Region 3 Education Committee**

Comanche County Memorial Hospital Garden  
Way Conference Room  
3401 W. Gore Blvd., Lawton, Oklahoma  
October 23, 2015

I. CALL TO ORDER: 10:11 A.M. By Bob Swietek, REPC Chair

II. ROLL CALL: Quorum Present:

Bob Swietek	Present	Jefferson County Memorial
Brad Lancaster	Present	Murray County EMS
Tammy Crosswhite	Absent	Fredrick Hospital
JenaLu Simpson	Absent	Medic West
Richie Bohach	Present	Comanche County Memorial EMS
Scott Tanner	Present	Southwest Medical Center
Others attending the meeting:		
Shelby Cunningham	Comanche Memorial Hospital	
Daniel Cunningham	Anadarko Fire EMS	
Sean Oats	State Health Department	
David Graham	State Health Department	

III. INTRODUCTIONS AND ANNOUNCEMENTS: None

APPROVAL OF MINUTES: Minutes presented December 4, 2014. Motion to approve minutes made by Brad LanCaster and seconded by Scott Tanner. Minutes were approved by the four members present.

IV. BUSINESS:

A. Time Sensitive issues: A draft of what the hospitals in region 3 have attested to at this time for Stroke on the table. Bob discussed the hospital attestations for Region 3. It shows two level 1 facilities both in Oklahoma City, Seven level 2's with one being in region 3. That facility is Southwest in Lawton. Richie commented that Comanche County is going through the process to become a level 2. Discussion was that we need to have the same mind set we had with the trauma plan for the distribution of patients. It makes no sense for Murray County ems to transport to Lawton when Norman is closer. Bob brought Jefferson County Memorial Hospitals plan for a template and will work on EMS. Prehospital needs education. Sean stated he sees in the future a plan like the OTEP for Stroke.

The only place in region 3 that does not have a CT scanner is Lindsay Hospital. It is a Department of Corrections Facility. Level 3 hospitals drip and ship patient to higher level of care. Level 4 hospitals are in the system if absolutely necessary. Is there a way you can do an ALS assist for basic services? How do we work with the level 4 hospitals with walk in's that need to be transported. Possible clear benefit of transporting to hospital and having a helicopter started to the hospital. It was also discussed that the facility going ahead and performing a CT scan while waiting for the helicopter. In the discussion they talked about every agency having a written policy and protocol with a hospital to transfer patient to a





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higher level of care. The question was asked if it would be possible to ALS agencies to have some kind of agreement with BLS services to meet up with them enroute to a higher level of care. The general consensus was that you would never get an ALS agency to commit to an agreement like that. They did say that it would be possible as a mutual aid agreement when they had the resources available to assist. The question was asked if we want a hard set time to needle and if so should it start from last known well or from the time EMS was called. The benefit of this plan is we have a template and we have mounds of research to help set a hard time. In the stroke working group one of the Physicians said 6 hours to get the patient to an interventional facility should we use that as a hard time or should we shoot for a shorter time. What if we write into the plan if a prehospital uses a tool and calls a Code Stroke it is expected patient will be is CT within 40 minutes and TPA started within an hour and half or a plan of treatment implemented. The question was asked about education and Sean stated he fully sees training like OTEP for Stroke and STEMI as a tool to take out and educate agencies and facilities on the plan and how it should function. It was also discussed about how facilities have to write plans of correction for not meeting times for Stroke and STEMI if they are not meeting the set times at a certain percentage. Level 1 and Level 2 facilities are required to gather the data on patients they receive and sending back to the transferring facility and agency. The discussion changed to we need to educate the facilities agencies and physicians to the plan and how it should work before we implement the plan or we will end up just like the trauma plan. We need to know where we want to go. Start this at the RTAB's soon because people are bored with Trauma. Sean stated that it seems that the RTAB's participants have no interest or buy in they just show up to hear from the state and meet their state required mandates. He asked to hear from some that have been in the RTAB's for some time their thoughts. The discussion was that when the RTAB's were set up everyone was excited and things got done. Once the plan was written and approved you showed up to hear what was done and no improvement in times has occurred. So we are just showing up to hear what we have done and that it is not working. It was also discussed that the facilities and agencies are held accountable to meeting the plan but the ones that direct patient flow are not being held accountable and nothing is going to changes until they are held accountable. The discussion was brought about that we try and get all the RPC and REPC together and send a unified statement to OTERAC that we recommend accountability at the hospital level to follow the plans. We need to start with the EMS services with the education on the assessment of stroke patient and the hospital levels for stroke so they know which hospital to transport the patient. Educate EMS that they are creating a majority of the problems by not transporting the patient to the appropriate facility first. Who has stroke personnel at your facility? How do we incorporate them into it and not a trauma person to implement the stroke plan? If you have a stroke expert it is their job to promote this. Let's look at working group with Stroke Coordinators and ask them to help develop the education portion and develop the stroke plan for region 3. Also involve the EMS agencies in this region to develop education and stroke plan to include the super rural agencies in the region is the next step. It was discussed that a workable goal for EMS would be a rough skeleton of a prehospital stroke destination plan and a rough outline of a prehospital educational class by February 4<sup>th</sup> RTAB. Brad asked for an email of every standard, protocols everything the state has on the current standards this includes the trauma plan in word. Richie and Brad will head up the working group to work on the prehospital side. Bob and Scott will head up the working group to work on the hospital side of this project. We will send both groups the same information so they are working from the same information. We are looking forward to is a

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- regional response plan that has the regional description in the front and appendices for the trauma, stroke, stemi etc. plans.
- B. Bylaws wording changes were made for OTSIDAC to OTERAC. Question on removing persons from the committee which chair are we talking about. The consensus was the chair of the committee may remove a committee member after 2 or more meetings and advise the RTAB chair that the person has been removed. Motion made by Brad Lancaster and seconded by Richie Bohach. Roll call vote motion passed.
- V. PUBLIC COMMENTS: Sean talked about reading an article in JEMS on Suicide rates within EMS. It stated that 1 in 3 EMT's have considered it and 6% have attempted suicide when the national norm is .5%. He has talked with Dane Libart from the Department of Mental Health and Substance Abuse and asked if this was a project they would be interested in helping us with. Is this something you think is needed? Thoughts on the subject were we have to be careful a lot of people will look for a way to get a check or afraid they will get labeled as something and taken out of the field. We have to do something will not cause them their job. Studies have shown that mandatory critical stress debriefing messes with the normal coping mechanism. Sean has understood that Bob Stewart has started to put together a group of resources through the local Emergency Managers. Sean would like to add on our development list a spot Critical Incident Stress Debrief or Mental Health. It was suggested that we find some people that are trained and willing to help then place them on a call list.
- VI. NEXT MEETING OF REPC – February 4, 2015 at 9:30 A.M.
- VII. ADJOURNMENT: Motion to adjourn by Scott Tanner and seconded by Brad Lancaster at 11:53 A.M.