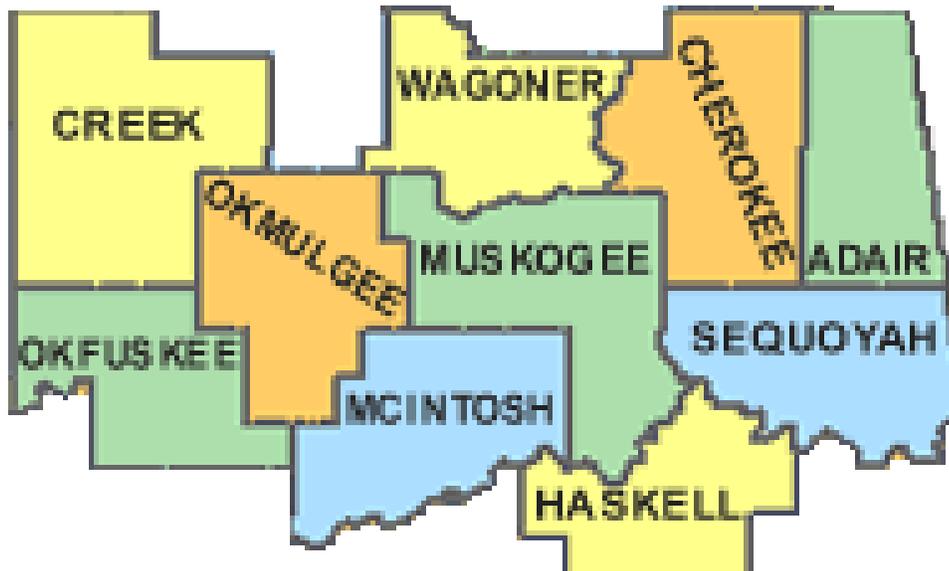


# Region 4 Trauma Plan



Developed by the EC RTAB Regional Planning Committee

*Plan Approval Dates:*

*Prehospital RTAB: 07/20/2006 OTSIDAC: 08/02/2006*  
*Interfacility RTAB: 07/19/2007 OTSIDAC: 08/01/2007*  
*EMResource™ RTAB: 07/20/2006 OTSIDAC: 08/02/2006*  
*Plan Modified by OTSIDAC February 4, 2009(Burn Clarification)*  
*Plan Modified by RTAB on March 19, 2009 - Oct 27, 2011*

# EAST CENTRAL REGION 4 TRAUMA PLAN

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### *Plan Approval Dates:*

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## Introduction

### I. GOALS / PURPOSE

The goals of the regional trauma destination 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 in place now maybe written or changed in the future. In the event new rules and/or regulations are considered the RTAB should be included in that dialogue prior to implementation.

### II. REGION 4 DESCRIPTION

Region 4 consists of the northeast and some central portions of Oklahoma and includes the following counties: Adair, Cherokee, Creek, Haskell, McIntosh, Muskogee, Okmulgee, Sequoyah, and Wagoner.



Region 4 encompasses 6,228 square miles with a population of 380,605 residents. It is serviced by 14

ambulance services, zero(0) Level 2 trauma hospitals, two(2) Level 3 trauma hospitals, and fourteen (14) Level 4 trauma hospitals of which zero (0) are designated critical access.

### III. TRAUMA PRIORITY CATEGORIZATION

All injured patients must be identified and transported/transferred to the facility that provides the appropriate care based on the clinical needs of the patient. This should be done in a timely fashion with specific attention focused on preserving the highest level of care for major trauma patients. A three-tiered system designed to determine the appropriate hospital destination for all injured patients

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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.

### 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 Tribalfacility, 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.

## IV. CATEGORIZATION OF HOSPITALS See

List in Appendix A

## V. TRAUMA TRANSFER CENTER

The Trauma Transfer and Referral Centers were created by statute (Senate Bill 1554, 2004) and they were implemented on 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 needs of the patient. This should be done 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 4 are required to call into the center prior to entering Regions 7 or 8 in order to ensure appropriate destination. Likewise, hospitals may call these centers for

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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 Region 4 RTAB for Quality Improvement purposes.

### 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.

#### *Plan Approval Dates:*

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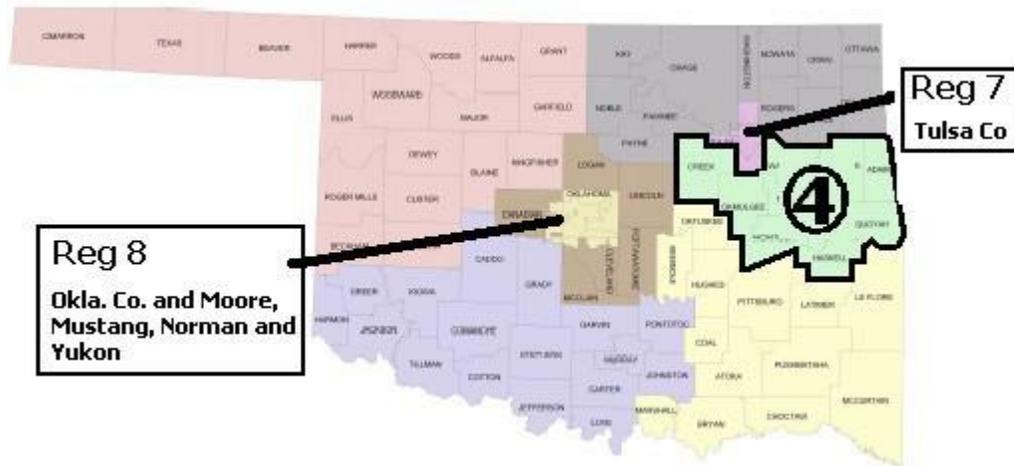
*EMResource™ RTAB: 07/20/2006 OTSIDAC: 08/02/2006*

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### B. GENERAL TRAUMA PATIENTS:



1. Priority 1 adult and pediatric trauma patients should be transported directly to the appropriate facility in Region 7 & 8 via use of the Trauma Transfer center. For those patients **outside** of an area **30 minutes** from the appropriate facility in Region 7 or 8, **air transport** should be considered as defined in Section IX, as soon as possible to ensure rapid transport to the appropriate facility.

If air transport is unavailable ground transport and/or ALS intercept can be utilized for transport. In the event there will be an excessive time delay for transport the patient may be taken to the closest treating facility for stabilization.

2. Priority 2 adult and pediatric trauma patients should be transported to the appropriate facility in Muskogee or Tahlequah or appropriate out-of-area Level 3 or equivalent facility with appropriate capability/capacity to care for the patient, based on the time/distance factor with preference given to patient desire and the ability to keep the patient within Region 4.
3. Priority 3 adult and pediatric trauma patients should be transported to the nearest treating facility or the facility of choice.

### C. NEUROLOGICAL TRAUMA PATIENTS:

1. Priority 1 adult and pediatric trauma patients should be transported directly to the appropriate facility in Region 7 or 8 via use of the Trauma Transfer center.

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2. Priority 2 adult trauma patients should be transported to the appropriate facility in Muskogee or Region 7 or 8 based on the time/distance factor with preference given to patient desire and the ability to keep the patient within Region 4.
3. Priority 2 pediatric trauma patients should be transported to the appropriate facility in Region 7 or 8 using the Trauma Transfer Center.
4. Priority 3 adult and pediatric trauma patients should be transported to the nearest treating facility or the facility of choice.

### D. BURN PATIENTS:

1. Adult: 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.
2. Pediatric: 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.
3. Priority 1 trauma patients complicated with burns will be transported to the appropriate facility in Region 7 or 8 utilizing the Trauma Transfer Center.

## 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 Region 2/4/7 CQI committee directly with the provider and if necessary through referral to the appropriate state level committee.

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### III. HELICOPTER UTILIZATION PROTOCOL

Purpose: Appropriate utilization of air ambulance resources by Region 4 providers.

#### A. "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:

1. 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. This is generally within 30 minutes of the destination facility.
2. Priority 3 patients should be transported by ground ambulance.
3. Cardiac arrest without return of spontaneous circulation in the field.

#### B. "Fly" Conditions:

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

1. Priority 1 trauma patients that are being transported to a facility in which time and distance constraints make air transport more timely, generally for instances with a transport time greater than 30 minutes by ground ambulance.
2. 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 an 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.

#### D. 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.

#### E. 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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### E. 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.

#### 1. 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.

#### 2. 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:

- a. Significant mechanism of injury as defined in the Trauma Triage Algorithm
- b. Multiple patients
- c. "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. \*\*\*\*

### F. Landing Zone Parameters:

1. Free of wires, trees, signs, poles, vehicles, and people
2. Landing zone is flat, smooth, and clear of debris
3. The landing zone should be at least 100 x 100 feet square in size
4. The landing zone should be well defined at night without lights pointed towards the helicopter
5. The area should be secured and free of all loose debris as well as clear of all unauthorized personnel
6. The helicopter should be approached with the crew only and care should be taken to avoid the tail rotor
7. The landing zone should remain clear and secure for at least one minute after departure for safety reasons.

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### G. Training:

Landing zone training should be accomplished by all ambulance services on an annual basis. Each individual ambulance service contact an air ambulance service for this training.

### H. EMTALA

There are concerns regarding air utilization and rendezvous with a local ground transport at a helipad upon a medical facilities property. This is addressed in Appendix C. Region 4 recognizes area and ground ambulances can rendezvous at air hospital properties without triggering EMTALA, unless a request is made by EMS.

## 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.

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## **Inter-facility Trauma Destination Component**

### **I. General principles**

The vast majority of injured patients receive 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 recognitions 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.

### **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, trauma care, intensive care, pediatrics, obstetrics and psychiatry), including ancillary services, that the hospital provides. Capabilities of staff of a facility mean the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses. This includes coverage available through the hospitals on call roster.
- 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.

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- C. **Central Log** means a log maintained by the hospital on each individual who comes to the Dedicated Emergency Department(s) or any location on the Hospital Property seeking emergency assistance and the disposition of each individual.
- D. **Comes to the Emergency Department** means an individual who:
1. Presents at 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;
  2. Presents on hospital property other than a dedicated Emergency Department, and requests or has a request made on his/her behalf for examination or treatment for what may be an Emergency Medical Condition, or a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;
  3. Is in a ground or air ambulance owned and operated by the hospital for the purposes of examination or treatment for a medical condition at the hospital's dedicated emergency Department, unless the ambulance is operated
    - a. Under community-wide E M S protocols that direct the ambulance to transport the individual to another facility (e.g., the closest available facility); or
    - b. At the direction of a Physician who is not employed or affiliated with the hospital that owns the ambulance; or
    - c. Is in a non-hospital owned ground or air ambulance that is on hospital property for presentation for examination or treatment for a medical condition at the hospital's dedicated Emergency Department.
- E. **Dedicated Emergency Department** means any department of the hospital (whether located on hospital property or off-campus) that meets at least one of the following requirements:
1. It is licensed by the State in which the hospital is located under applicable State law as an emergency room or emergency department;
  2. It is held out to the public (by name, posted signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
  3. During the immediately preceding calendar year, it provided (based on a representative sample) at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
- F. **Department of the Hospital** means the hospital facility or department that provides services under the name, ownership, provider number, and financial and administrative control. For purposes of EMTALA, Department of the hospital does not include a skilled nursing facility, home health agency, rural health clinic, free-standing ambulatory surgery center, private physician office, or any other provider or entity that participates in the Medicare program under a separate provider number.

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### **G. Emergency Medical Condition means:**

1. 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:
  - a. 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;
  - b. Serious impairment to bodily functions; or
  - c. Serious dysfunction of any bodily organ or part; or
  - d. With respect to a pregnant woman who is having contractions:
    - i. When there is inadequate time to effect a safe transfer to another facility before delivery; or
    - ii. The transfer may pose a threat to the health or safety of the woman or the unborn child.

**H. Hospital** means a hospital that has entered into a Medicare provider agreement, including a critical access or rural primary care hospital.

**I. Hospital Property** means the entire main hospital campus, including areas and structures that are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the CMS regional office, to be part of the main hospital's campus. Hospital property can include the parking lots, sidewalks, and driveways on the main hospital campus. It does not include private businesses, residences or public streets.

**J. Inpatient** means an individual who is admitted to the hospital for bed occupancy for purposes of receiving inpatient services with the expectation that he/she will remain at least overnight and occupy a bed, even though the individual may be later discharged or transferred to another facility and does not actually use a hospital bed overnight.

**K. Labor** means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman is in true labor unless a physician certified that, after a reasonable period of observation, the woman is in false labor.

**L. 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.

**M. On-Call List** means the list of physicians who are "on-call" after the initial medical screening examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.

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- N. Outpatient** means an individual who has begun to receive outpatient services as part of an encounter, other than an encounter that triggers the EMTALA obligations. An “encounter” is a direct personal contact between an outpatient and a physician or qualified medical person who is authorized by state law to order or furnish services for the diagnosis or treatment of the outpatient.
- O. Physician** means:
1. A doctor of medicine or osteopathy;
  2. A doctor of dental surgery or dental medicine;
  3. A doctor of podiatric medicine; or
  4. A doctor of optometry, each acting within the scope of his/her respective licensure and clinical privileges.
- P. Physician Certification** means the written certification by the treating physician ordering a transfer and setting forth, based on the information available at the time of transfer, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of a woman in labor, to the unborn child, from effecting the transfer.
- Q. Qualified Medical Person** means an individual other than a licensed Physician;
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.)
- R. Signage** means the signs posted by the hospital in the dedicated Emergency Department(s) and in a place or places likely to be noticed by all individuals entering the dedicated Emergency Department(s) (including the waiting room, admitting area, entrance, and treatment areas) that inform individuals of their rights under EMT
- S. Stabilized** means, with respect to an emergency medical condition, that no material deterioration of the condition is likely within reasonable medical probability, 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 delivered the child and the placenta. An individual will be deemed stabilized if the treating physician has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.
- T. 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.

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- U. Stable for Discharge** means a determination by the treating physician, within reasonable clinical confidence, that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care with the discharge instructions. For the purpose of discharging an individual with psychiatric condition(s), the individual is considered to be stable for discharge when he/she is no longer considered to be a threat to him/her or to others.
- V. Stable for Transfer** means:
1. A determination by the treating physician, with reasonable clinical confidence, that an individual is expected to leave the hospital and be received at the second facility, with no material deterioration in his/her medical condition; and
  2. The treating physician reasonably believes the receiving facility has the capability to manage the individual's medical condition and any reasonably foreseeable complication of that condition. In the case of an individual who has a psychiatric condition(s), the individual is stable for transfer when he/she is protected and prevented from injuring himself/herself or others.
- W. Transfer** means the movement (including the discharge) of an individual outside the hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead or who leaves the facility against medical advice or without being seen.
- X. Triage** is a process to determine the order in which individuals will be provided a medical screening examination by a physician or qualified medical person. Triage is **not** the equivalent of a medical screening examination and does not determine the presence or absence of an emergency medical condition.

### III. Region Description

Region 4 consists of the following counties: Adair, Cherokee, Creek, Haskell, McIntosh, Muskogee, Okmulgee, Sequoyah, and Wagoner.

Encompassing 6,228 square miles; 380,605 persons reside in the region.

*See Appendix A for specific resources.*

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*EMResource™ RTAB: 07/20/2006 OTSIDAC: 08/02/2006*

*Plan Modified by OTSIDAC February 4, 2009(Burn Clarification)*

*Plan Modified by RTAB on March 19, 2009 - Oct 27, 2011*

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### IV. Categorization of Hospitals

#### A. Level III Trauma Centers

A Level III trauma center is a licensed acute care facility with the commitment, medical staff, personnel and specialty training necessary to provide initial resuscitation of the trauma patient. Generally, a 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 referral to a higher level of care. 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 a patient rests with the physician attending the trauma patient. All Level III trauma centers will work collaboratively with other trauma facilities to develop transfer protocols and a well-defined transfer sequence.

#### B. Level IV Trauma Centers

Level IV trauma centers are generally licensed; small, rural facilities with a commitment to the resuscitation of the trauma patient and written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred. The major trauma patient will be resuscitated and transferred. At least one of the practitioners on duty shall have received training in advanced life support techniques and be deemed competent to initiate treatment of the emergency patient.

### V. Trauma Program

There must be 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. A trauma program must be established and recognized by the organization. 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. A written Trauma Performance Improvement Plan
5. Appointed Trauma Service Director with a written job description
6. Appointed Trauma Program Coordinator with a written job description, and
7. Documentation of the trauma center's representative's attendance at the Regional Trauma Advisory Board meetings.

#### A. Performance Improvement

The key elements in trauma system improvement include evaluation, measurement and improvement of performance. The goal is to decrease variation in care and improve patient outcomes. Compliance with the above may be evidenced by:

1. Review of compliance with Regional EMS Triage Guidelines and Protocols
2. Written Trauma Team Activation Criteria.

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## EAST CENTRAL REGION 4 TRAUMA PLAN

3. Compliance with the principles of ATLS.
4. Peer Review of all trauma deaths to determine timeliness and appropriateness of care and preventability of death
5. Review of trauma related morbidities for appropriateness of care and preventability
6. Nursing Audit (Clinical review of nursing documentation and quality of care rendered to trauma patients)
7. Review of timeliness and appropriateness of all transfers out

### **B. Trauma Registry**

All trauma centers will participate in the statewide trauma registry. Compliance is required through hospital licensure, which will be monitored by Trauma Registry and Hospital licensure staff.

### **C. Trauma Service Director – Level III**

The medical staff shall designate a surgeon as trauma service director. In this Instance, the physician is responsible in working with all members of the trauma team, and overseeing the implementation of a trauma specific performance improvement plan for the entire facility. Through this process, he/she should have overall responsibility for the quality of trauma care rendered at the facility. The director must be given administrative support to implement the requirements specified by the Oklahoma Trauma Plan. The director should assist in the development of standards of care and assure appropriate policies and procedures are in place for the safe resuscitation and transfer of trauma patients. The physician director should have current verification in ATLS.

### **D. Trauma Program Coordinator (TPC) – Level III**

The trauma center should have a designated trauma coordinator such as a Registered Nurse working in the role of the Trauma Program Coordinator. The trauma center must have a person to act as a liaison to the regional evaluation process the administrative functions required by the trauma program. In conjunction with the Medical Director, the TPC is responsible for organization of the program and all necessary systems for the multidisciplinary approach throughout the continuum of trauma care. He/she is responsible for working with the trauma team to assure optimal care and will liaison with local EMS personnel, the RTAB, and other trauma centers.

The TPC will also develop a methodology for which activation of the trauma team is accomplished in their facility. The activation may be either full or partial depending upon the severity of the trauma patients' injuries.

### **E. TRAUMA TEAM**

The team approach is optimal in the care of the injured patient. Policies should be in place describing the roles of all personnel on the trauma team and define different levels of trauma team activation. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its resources. The physician leader or the mid-level practitioner on the trauma team should be ATLS certified or the equivalent, and should be responsible for directing all phases of the resuscitation in

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*Plan Modified by OTSIDAC February 4, 2009(Burn Clarification)*

*Plan Modified by RTAB on March 19, 2009 - Oct 27, 2011*

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compliance with ATLS protocol. Suggested composition of the trauma team for severely injured patients may consist of:

1. ER Physician
2. Surgeon(s) on call for ER
3. ER Registered Nurses
4. Designated ER staff
5. House Shift Supervisors
6. Respiratory Therapists
7. Ancillary Support Staff (Lab, X-Ray, EKG)

### F. TRAUMA TEAM ACTIVATION CRITERIA GUIDELINES

1. Full trauma team activation should include the notification and mobilization of the entire trauma team as defined by the hospital, prior to the arrival of the trauma patient.
2. Partial trauma team activation should include the notification and mobilization of ER physician and ER Registered Nurse. Other team members will be notified and mobilized as needed.

In either a Level III or Level IV facility, immediate activation of the trauma system (FULL ACTIVATION) should occur when you have any of the following:

- Glasgow Coma Scale (GCS) < 10
- Systolic blood pressure < 90 mmHg
- Respiratory rate < 10 or > 30/min
- Penetrating injury to the head, neck, torso, or extremities above the elbows or knees
- Flail chest
- Two or more proximal long bone fractures
- Pelvic fracture
- Limb paralysis
- Amputation proximal to the wrist or ankle
- Body surface burns > 5% (second or third degree)
- Burns associated with other traumatic or inhalation injury
- Trauma transfer patient that is intubated or receiving blood
- Children under 12 with any of the following criteria:
  - ▶ Ejection from vehicle
  - ▶ Death of same passenger compartment
  - ▶ Extrication time greater than 20 minutes

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#### **EAST CENTRAL REGION 4 TRAUMA PLAN**

- ▶ Rollover MVC
- ▶ High-speed auto crash greater than 40 mph
- ▶ Auto deformity greater than 20 inches of external damage or intrusion into passenger compartment greater than 12 inches
- Pedestrian thrown or run over
- Motorcycle crash greater than 20mph or separation of rider from the bike.

In a Level III or Level IV facility, PARTIAL ACTIVATION of the trauma team should occur when a patient presents to the ER with a Priority II or Priority III injury. After evaluation by the appropriate personnel the patient should be treated appropriately for the injury and if necessary full activation of the team may occur.

#### **G. Level III Trauma Center**

The facility must have an emergency department staffed so those trauma patients are assured immediate and appropriate initial care. The emergency physician must be in-house 24 hours/day, immediately available at all times, and capable of evaluating trauma patients and provide initial resuscitation. The emergency medicine physician will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The medical director for the department, or his designee, must participate with the Multidisciplinary Trauma Committee and the trauma PI process. There should be an adequate number of RN's staffed for the trauma resuscitation area in-house 24 hours/day. There should be a written plan ensuring nurses maintain ongoing trauma specific education (ACLS, PALS, TNCC, ENPC).

Level III trauma centers must have published on-call schedules and have the following medical specialties immediately available 24 hours/day to the injured patient:

- General Surgery
- Orthopedics
- Anesthesia
- Emergency Services
- Other medical specialists 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. Written policies should exist delineating the prioritization/ availability of the CT scanner for trauma patients. The use of tele-radiology is an acceptable practice in the Level III facility.

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Clinical laboratory services shall have the following services available in-house 24 hours/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
- Coagulation studies.

### H. Transfer Protocols – Level III

The Level III trauma center will have transfer agreements in place with other appropriate trauma centers, as well as all specialty referral centers (such as burn, pediatrics, spinal cord injury and rehabilitation). Additionally, transfer protocols may be written with all referral facilities in the immediate service area. All facilities will work together to develop transfer guidelines indicating which patients should be considered for transfer, and procedures to assure the most expedient, safe transfer of the patient. The transfer agreements must include a feedback loop so the primary provider has a good understanding of patient outcome and assures this information becomes part of the trauma registry. All designated facilities will agree to provide services to the trauma patient regardless of their ability to pay. Every effort should be made to repatriate the trauma patient to his/her local community hospital or provider hospital as appropriate.

### I. Emergency Department (Level IV)

The facility must have an emergency department staffed so trauma patients are assured immediate and appropriate initial care. The on-call practitioner must respond to the emergency department based on local written criteria. A system must be developed to assure early notification of the on-call practitioner. Compliance with this criterion must be documented and monitored by the Trauma Performance Improvement process. Adequate numbers of nurses must be available in-house 24 hours/day, to meet the need of the trauma patient. The nurse may perform other patient care activities within the hospital when not needed in the emergency department. It is anticipated that a Level IV trauma center may have limited availability of the following services:

- Respiratory Therapy Services
- Radiology Services
- Clinical Laboratory Services

**If any of these services are available, the facility should make them available to the trauma patient as necessary and within the capabilities of the facility.**

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### J. Transfer Protocols – Level IV:

The Level IV trauma center should have written transfer agreements with appropriate within their service area. A policy must be in place to facilitate and expedite the transfer sequence to assure the most appropriate care is rendered to the patient.

## VI. INTER-FACILITY TRANSFER GUIDELINES

In an effort to optimize patient care and deliver the trauma patient to the most appropriate destination, 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 undergo immediate medical screening. Depending upon the results and the needs of the patient, any of the following may occur:

- A. The patient will be stabilized and then transferred to the most appropriate facility. (Priority I trauma or Priority II trauma that is time-sensitive) A complete set of x-rays or CT are not necessary for the patient to be deemed Level I or Level II trauma. These tests should be limited to decrease time at transferring facility. The purpose of the transferring facility is to stabilize the patient for transport via the quickest means of transport available,
- B. The patient will be stabilized and then admitted to that facility (Level II that is not time-sensitive or Level III),
- C. The patient will be stabilized and transferred to the facility of his or her choice, as appropriate. (Priority II or III that is not time-sensitive),
- D. The patient will be treated and discharged to home with appropriate instruction for their injuries (Level III trauma).

It is recommended that the transfer of Priority 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.

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## **COMMUNICATION COMPONENT**

### **EMResource™ Usage**

#### **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 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.

#### **I. Usage Requirements**

Within Region 4 all providers are required of 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.

Specific usage requirements include but are not limited to:

##### **A. Contact Information**

1. Each provider is responsible to maintain accurate contact information on the EMResource™.
2. Hospitals shall post the telephone number they wish other providers to use when calling patient referrals or reports in this area of EMResource™.

##### **B. 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™.**

##### **1. Emergency Department Status**

- a. 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.

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- b. 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.
2. Hospital Status
- a. 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.
  - b. 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.

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

3. 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:

- a. Yes – Coverage is currently available.
- b. No – Coverage is not currently available.
- c. N/A – This service is not offered at this facility.

4. Air Ambulance Status

This status is for displaying the current status/availability of Air Ambulances. The status categories for this status are:

- a. Available – the aeromedical resource is currently ready and able to respond to emergency calls.
- b. Call for Status – current conditions necessitate those providers in need of aeromedical transport call to determine resource availability because:
  - 1) The aeromedical resource may already be dispatched to a call or be on standby.
  - 2) Local weather conditions may temporarily impact the ability of this aeromedical resource to respond.
  - 3) This aeromedical resource may be temporarily unavailable due to routine service or fueling.
- c. Not Available – the aeromedical resource is currently unable to respond in a timely manner.
- d. In region 5 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.

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### C. System Alerts

1. Providers in Region 4 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.

### D. Data Reporting

Providers in Region 4 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;

## III. Monitoring

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

- A. The CQI 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™.
- B. The CQI committee will review all cases referred to them for inappropriate use of EMResource™ in any of the listed categories.
- C. 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 CQI committee who will address problems/trends directly with the provider and if necessary through referral to the appropriate state level committee.

The CQI 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.

## IV. 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 4 supports use of this tool through adoption of these requirements.

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# Appendix A

## EMS and Hospital Provider Descriptions

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## EAST CENTRAL REGION 4 TRAUMA PLAN

### DESCRIPTION OF EMS SERVICES

EMS Providers within Region 4 include:

#### ADAIR COUNTY

1. **Stillwell Ambulance** is an Intermediate Service staffed with 1 Emergency Medical Responders, 6 Basics, 15 Intermediates and 4 Paramedics. They have 4 total units and cover 569 square miles.
2. **Westville EMS** is a Basic Service staffed with 6 Emergency Medical Responders, 4 Basics, 6 Intermediates and 3 Paramedics. They have 3 total units and cover 275 square miles.

#### CHEROKEE COUNTY

3. **Tahlequah City Hospital EMS** is a Paramedic service staffed with 2 Emergency Medical Responders, 4 Basics, 3 Intermediates, and 15 Paramedics. They have 3 total units and cover 1000square miles.
4. **Cherokee Nation EMS** is a Paramedic service staffed with 0 First Responders, 17 Basic, 7 Intermediates, and 28 Paramedics. They have 8 total units and cover 1000 square miles.
5. **Eagle Med-Tahlequah** is a Paramedic Substation of Eaglemed based in Oklahoma City. This service is staffed with 0 Emergency Medical Responders, 0 Basic, 0 Intermediates, 1 Basic, 7 Paramedics and 4 RNs. They have 1 total unit and covers 800square miles.

#### CREEK COUNTY

6. **Creek County Emergency Ambulance** is an Intermediate Service staffed with 3 Emergency Medical Responders, 14 Basics, 9 Intermediates and 18 Paramedics. They have 5 total units and cover 900 square miles.
7. **Mannford Volunteer Ambulance** is a Basic Service staffed with 0 Emergency Medical Responders, 7Basic, 0 Intermediate and 2 Paramedic - They have 1 unit and cover 54 square miles.

#### HASKELL COUNTY

8. **Southwest EMS** has a Paramedic Substation under Southwest EMS-Wilburton and is staffed with a Paramedic. They have 1 unit and covering 577 square miles.

#### MCINTOSH COUNTY

9. **Checotah EMS** is an Intermediate Service staffed with 0 First Responders, 2 Basics, 7 Intermediates and 2 Paramedics. They have 3 total units that cover 360 square miles.
10. **Integrity EMS** has a Paramedic Substation licensed under Integrity in Broken Arrow. The substation is in Eufaula
11. **ParaMed** has an intermediate substation licensed under ParaMed in McAlester. The substation is in Eufaula.

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### MUSKOGEE COUNTY

12. **Muskogee County EMS** is an Intermediate Service staffed with 0 Emergency Medical First Responders, 24 Basics, 27 Intermediates and 52 Paramedics. They have 20 total units and cover 917 square miles.
13. Air Evac Lifeteam-Muskogee is an paramedic licensed air ambulance based in Muskogee
14. Rocky Mountain Air dba Tulsa Life Flight is a paramedic licensed air ambulance in Keifton

### OKMULGEE COUNTY

15. **Okmulgee EMS County EMS** is a Basic Service staffed with 1 Emergency Medical Responders, 13 Basics, 5 Intermediates and 13 Paramedics. They have 6 units and cover 700 square miles.

### SEQUOYAH COUNTY

16. **Pafford EMS- Sallisaw** is a Paramedic Substation. They have 2 total units and cover 674 square miles.
17. **Pafford EMS-Vian** is a Paramedic Substation with 1 unit.

### WAGONER COUNTY

18. **Wagoner EMS** is an Intermediate Service staffed with 0 Emergency Medical Responders, 5 Basics, 4 Intermediates and 13 Paramedics. They have 2 total units and cover 354 square miles.
19. **Coweta Fire Dept** is a Basic Service staffed with 7 Emergency Medical First Responders, 20 Basics, 1 Intermediates and 1 Paramedics. They have 2 units and cover 200 square miles.

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### DESCRIPTION OF HOSPITAL PROVIDERS

Hospital Providers in Region 4 include:

1. Level 1: None
2. Level 2: None
3. Level 3:
  - Muskogee Regional Medical Center (Muskogee) (Voluntary reduction to Level IV Facility, See Plan Addendums)
  - MRMCA Approved for Level III Status-January 2010. Addendum Letter to be removed.
  - Tahlequah City Hospital (Tahlequah)
4. Level 4:
  - Bristow Medical Center (Bristow)
  - Continuous Care Centers of Tulsa at Sapulpa (Sapulpa)
  - Drumright Regional Hospital (Drumright)
  - Epic Medical Center, formerly Community Hospital-Eufaula
  - George Nigh Rehabilitation Center/OUHSC (Okmulgee)
  - George Nigh Long Term Acute Care Facility (LTAC)
  - Haskell County Hospital (Stigler)
  - Henryetta Medical Center (Henryetta)
  - Memorial Hospital – Adair County Health Center (Stilwell)
  - Okmulgee Memorial Hospital (Okmulgee)
  - Sequoyah Memorial Hospital (Sallisaw)
  - St. John Sapulpa (Sapulpa)
  - Wagoner Community Hospital (Wagoner)
  - Muskogee Community Hospital (open March 2009)
5. Tribal Facility
  - Cherokee Nation-W.W. Hastings-Tahlequah
6. Psychiatric Hospitals: None
7. Out of Region Resources include:
  - Priority 1
    - a. OU Medical Center, Oklahoma City using the Trauma Transfer and Referral Center
    - b. Saint Francis Hospital, Tulsa using the Trauma Transfer and Referral Center
    - c. St. John Medical Center, Tulsa using the Trauma Transfer and Referral Center

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### Priority 2 –

- a. Stillwater Medical Center
- b. Claremore Regional Hospital
- c. McAlester Regional Medical Center
- d. Unity Hospital, Shawnee
- e. Region 7 (Tulsa) hospitals using the Trauma Transfer and Referral Center
- f. Washington Regional, Fayetteville, Arkansas
- g. Sparks, Ft. Smith, Arkansas
- h. St. Edwards, Ft. Smith, Arkansas

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*EMResource™ RTAB: 07/20/2006 OTSIDAC: 08/02/2006*

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*Plan Modified by RTAB on March 19, 2009 - Oct 27, 2011*

# Appendix B

## Trauma, Triage and Transport Guidelines

*Plan Approval Dates:*

*Prehospital RTAB: 07/20/2006 OTSIDAC: 08/02/2006*

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*EMResource™ RTAB: 07/20/2006 OTSIDAC: 08/02/2006*

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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 do 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)

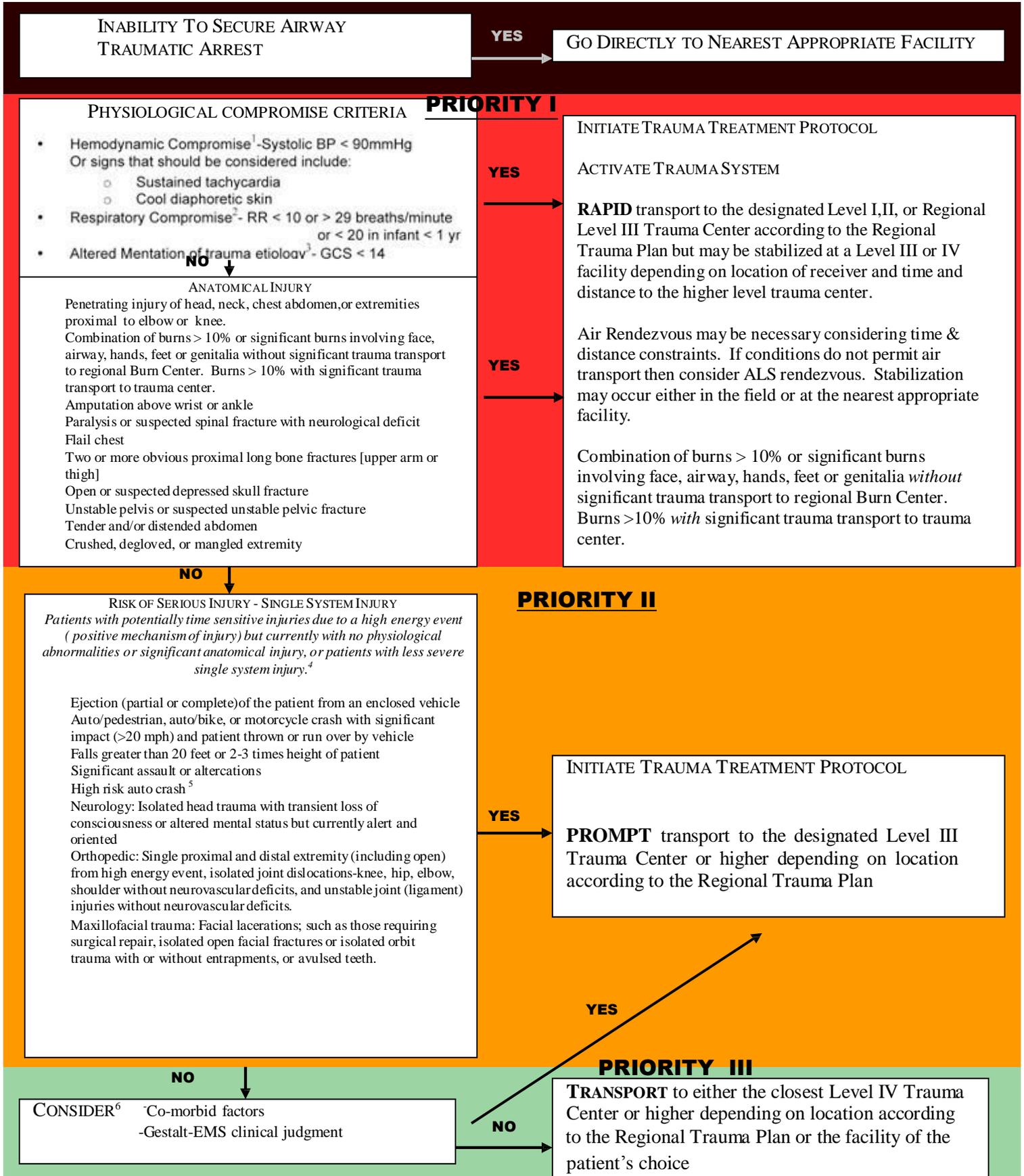
## Priority 3 Trauma Patients

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



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

**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

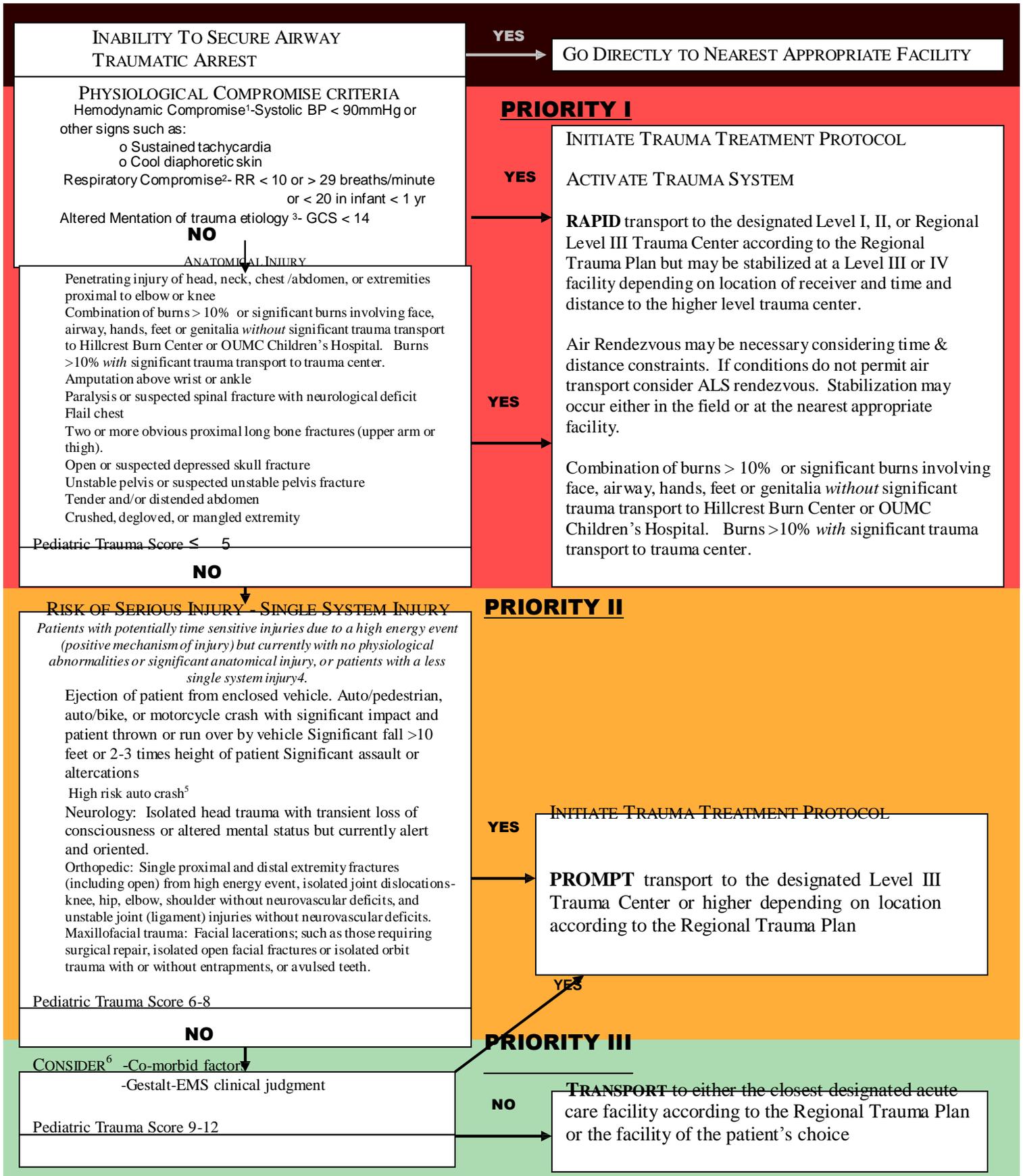
Patient's previous medical history such as:

- 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

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

### Oklahoma Model Trauma Triage Algorithm

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  - 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  
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 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 1 = 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**

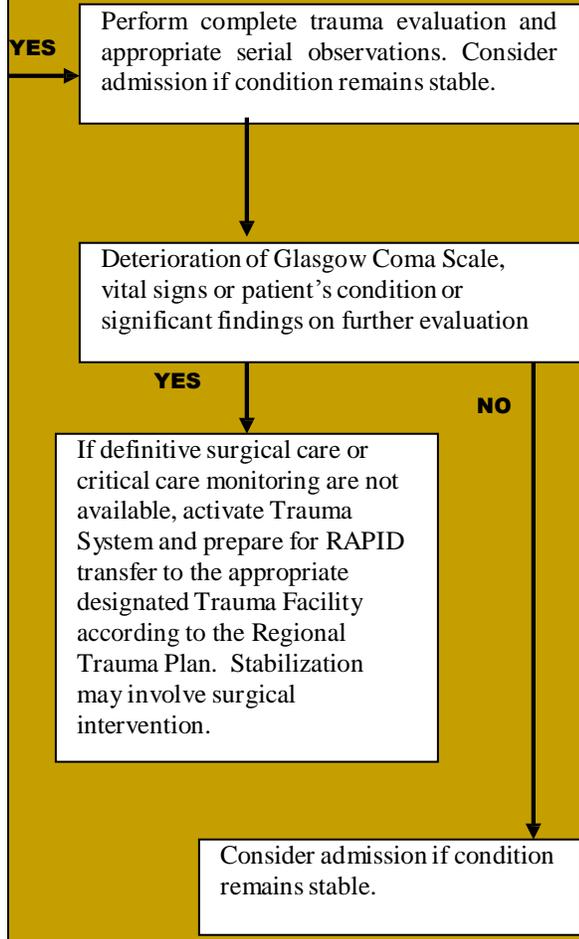
- Single proximal extremity fractures, including open
- Distal extremity fractures, including open
- Isolated joint dislocations-knee, hip, elbow, shoulder without neurovascular deficits
- Unstable joint (ligament) injuries without neurovascular deficits
- Degloving injuries without evidence of limb 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<sup>4</sup>, 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**

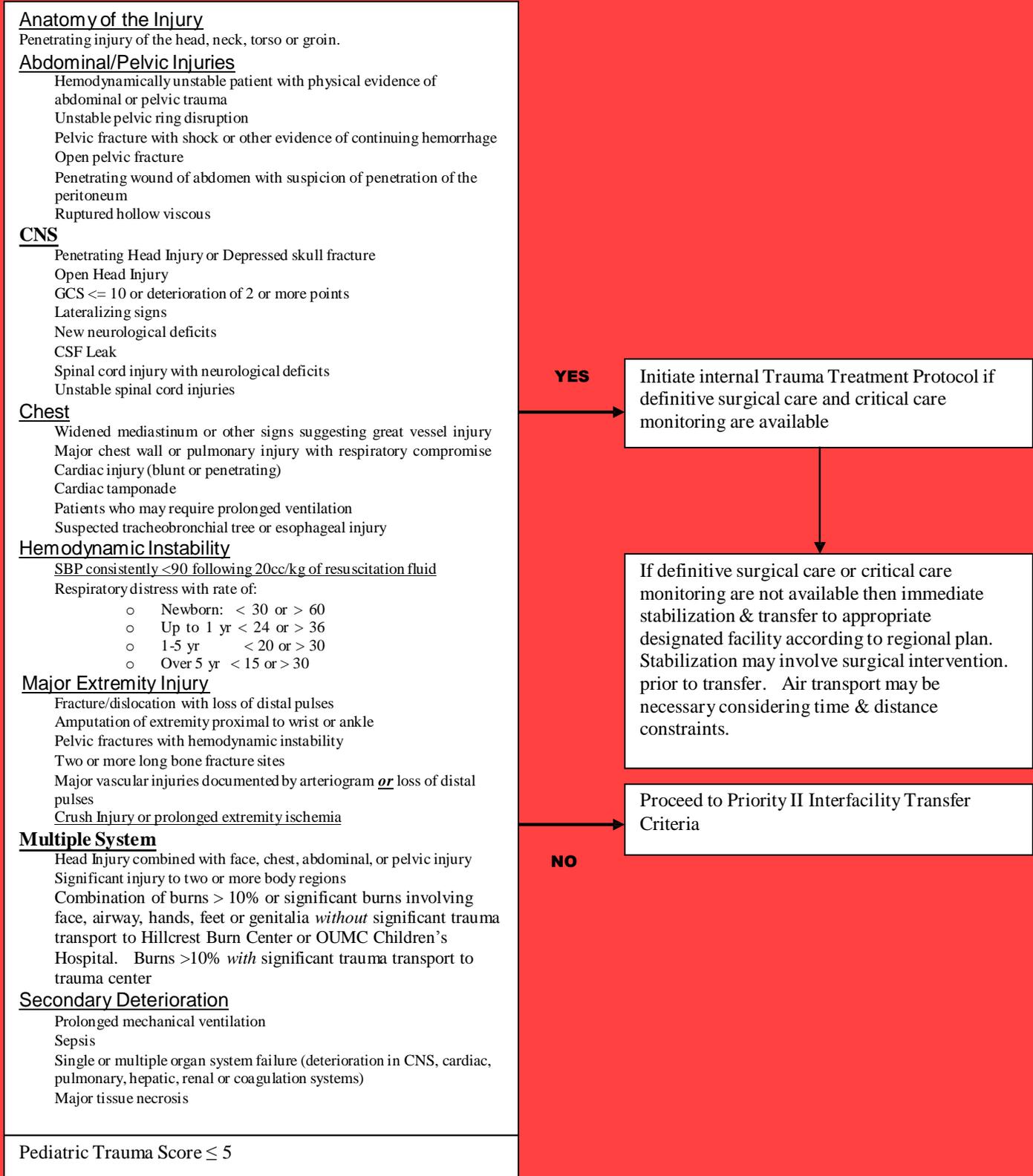
**Priority III**

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



# 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<sup>4</sup>, 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

**YES** Perform complete trauma evaluation and appropriate serial observations. Consider admission if condition remains stable.

Deterioration of Glasgow Coma Scale, vital signs or patient's condition or significant findings on further evaluation

**YES**

**NO**

If definitive surgical care or critical care monitoring are not available, activate Trauma System and prepare for RAPID transfer to the appropriate designated Trauma Facility according to the Regional Trauma Plan. Stabilization may involve surgical intervention.

Consider admission if condition remains stable.

**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.

# Appendix C

## EMTALA Clarification

*Plan Approval Dates:*

*Prehospital RTAB: 07/20/2006 OTSIDAC: 08/02/2006*

*Interfacility RTAB: 07/19/2007 OTSIDAC: 08/01/2007*

*EMResource™ RTAB: 07/20/2006 OTSIDAC: 08/02/2006*

*Plan Modified by OTSIDAC February 4, 2009(Burn Clarification)*

*Plan Modified by RTAB on March 19, 2009 - Oct 27, 2011*

## **EMTALA CLARIFICATION**

### **I. EMTALA Helipad Usage**

There have been some concerns of possible EMTALA violations when using a hospital's helipad to transfer a patient from a ground ambulance to an air ambulance. The following two (2) circumstances will not trigger EMTALA. (Excerpt from the State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases)

- 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 Medical Screening Exam (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 Emergency Medical Condition (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 an MSE performed prior to the transfer to the helipad, the hospital with the helipad is not obligated to perform another MSE prior to the individuals' continued travel to the recipient hospital. If, however, while at the helipad the individuals' 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.

### **II. EMTALA EMERGENCY DEPARTMENT DEFINITIONS & DESCRIPTIONS**

Situations may occur in which patients are diverted to other healthcare facilities provided EMTALA is followed.

**Emergency Medical Treatment and Active Labor Act ("EMTALA")** refers to Sections 1866 and 1867 of the Social Security Act, 42 U.S.C. Section 1395dd, which obligates hospitals to provide medical screening, treatment, and transfer of individuals with

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## East Central Trauma Triage and Destination Plan

emergency medical conditions or women in labor. It is also referred to as the “anti-dumping” statute and COBRA.

### **Emergency Medical Condition:**

1. 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:
  - a. Placing the health of the individual or, with respect to a pregnant woman, the health of a woman and her unborn child in serious jeopardy;
  - b. Serious impairment of bodily functions, or
  - c. Serious dysfunction of any bodily organ or part; or
2. With respect to a pregnant woman who is having contractions:
  - a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

**Capacity** means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses number and availability of qualified staff, beds, equipment, and the hospital’s past practices of accommodating additional patients in excess of its occupancy limits.

- Such as Emergency Department beds are filled, patients are backed up in the emergency Department waiting room, and there are no other beds or personnel available to provide appropriate care for the patients.

**Capabilities** of a medical facility or main hospital provider means the physical space, equipment, supplies, and services (e.g. trauma care, surgery, intensive care, pediatrics, obstetrics, burn unit, neonatal unit, or psychiatry), including ancillary services available at the hospital. The capabilities of the hospital’s staff mean the level of care that the hospital’s personnel can provide within the training and scope of their professional licenses. For off-campus departments, the capability of the hospital as a whole is included. The obligations of the hospital provider must be discharged within the hospital as a whole. However, the hospital is not required to locate additional personnel or staff to off-campus departments to be on-call for possible emergencies.

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## East Central Trauma Triage and Destination Plan

Under no circumstances will an Emergency Department patient who has an emergency medical condition be transferred to another facility because of inability to pay for services or based on any illegal form of discrimination (national origin, race, gender, religion, etc.). Prior to any Emergency Department transfer, the Emergency Department staff will comply fully with EMTALA. A transfer form is to be used for patients who are transferred to a different acute care facility.

If a patient Comes to the Hospital Property or Premises and has an emergency medical condition, the hospital must provide either: (a) further medical examination and treatment, including hospitalization, if necessary, as required to stabilize the medical condition within the capabilities of the staff and facilities available at the hospital; or (b) a transfer to another more appropriate or specialized facility.

**Comes to the Emergency Department** with respect to an individual presenting for examination and treatment for what may be an emergency medical condition means that the individual is on the hospital property and premises. An individual in a non-hospital owned ambulance on hospital property or premises is considered to have come to the hospital's Emergency Department.

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# Appendix D

## Advanced Life Support Intercept Protocol

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## East Central Trauma Triage and Destination Plan

### **ALS INTERCEPT PROTOCOL FOR REGION 4**

#### Purpose:

To provide guidelines to Emergency Medical Service 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.

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