MINUTES

Meeting notice was posted with the Oklahoma Secretary of State on December 4th, 2019 at 2:51 pm and amended on January 23rd, 2020 at 11:08 am. Meeting notice was physically posted at OSDH at 9:00 am February 13th, 2020 and at the meeting location on February 18th, 2020.

I. Call To Order
The meeting was called to order by Chair Eddie Sims at 11:05 am.

II. Welcome and Introductions
There were no introductions.

III. Roll Call
Roll call was taken with the following members present: Julia Day, Daniel King, and Eddie Sims. Jason Likens arrived at 11:23 am. Celesa Green was not present.

IV. Approval of Minutes – August 20th, 2019
A motion to accept the minutes was made by Julia Day and seconded by Daniel King. There was no discussion, and the motion passed 3-0.

V. Business
A. Regional Trauma and Stroke Capability Survey discussion
Daniel Whipple stated that there are currently six entities that have not submitted the survey: Chandler Ambulance; CHG Cornerstone Hospital of Oklahoma – Shawnee; Mercy Hospital Logan County; Pafford EMS of Oklahoma (El Reno); SSM Health St. Anthony Hospital – Shawnee; and United EMS Lincoln County. Mr. Sims asked if those entities could be contacted again regarding the survey as large portions of the region have not provided information. Heather Yazdanipour stated that she will also be able to include the request at the Healthcare Coalition meeting on March 3rd, 2020.

B. Discussion, consideration, possible actions, and vote to approve updates of the Region 6 Trauma Plan
There was no action taken on this item as it depended on action from business item A.

C. Discussion, consideration, possible action, and vote to approve Bylaw language regarding multiple Board or General Members being represented by one individual.
Mr. Sims stated that there may be instances where one individual may represent more than one licensed entity, and the bylaws do not clearly address this. It was asked that Mr. Whipple prepare draft language and present it at the next RPC meeting. Language
Central (6) Regional Trauma Advisory Board
Regional Planning Committee
Microsoft Teams
https://teams.microsoft.com/l/meetup-join/19%3ameeting_YzgxMzcxYjYtZjlkOC00ZWI2LTlkZWEtZmIzYzU3MzE5YTQ3%40thread.v2/0?context=%7b%22Tid%22%3a%22%3a%229a307864-3e98-4f08-b90a-728b62cf32c5%22%2c%22Oid%22%3a%22463c8334-e408-4d1d-b4eb-52f4b934efe4%22%7d
August 18th, 2020 – 11:00 am

AGENDA

I. Call To Order

II. Welcome and Introductions

III. Roll Call

IV. Approval of Minutes – February 18th, 2020

V. Business
A. Regional Trauma and Stroke Capability Survey discussion – Eddie Sims
B. Discussion, consideration, possible action, and vote to approve updates of the Region 6 Trauma Plan – Eddie Sims
C. Discussion, consideration, possible action, and vote to approve Bylaw language regarding multiple Board or General Members being represented by one individual – Eddie Sims
D. Discussion, consideration, possible action, and vote to create strategic plan to reduce the number of Priority 1 patients delivered by ambulance to Level III and Level IV trauma centers by three percent and reduce the length of stay at the initial facility of transferred patients with Injury Severity Score of 16 or greater by three percent. – Eddie Sims

VI. New Business
(for matters not reasonably foreseen at least 48 hours in advance of the meeting)

VII. Next Meetings
A. Central (6) Regional Trauma Advisory Board
   August 18th, 2020 – 1:00 pm
B. Combined Region 6/8 Quality Improvement Committee
   October 13th, 2020 – 10:30 am
C. Central (6) Regional Planning Committee
   November 17th, 2020 – 11:00 am

VIII. Adjournment
suggestions included that each license holder be entitled to one vote as well as that each licensed entity serving on the Board be entitled to one vote.

Mr. Whipple also suggested that the language regarding Board and General Member organizations and representatives be reviewed and amended throughout the document to better define whether a licensed entity or its representative is accountable for certain items.

VI. New Business
(for matters not reasonably foreseen at least 48 hours in advance of the meeting)

VII. Next Meetings
A. Central (6) Regional Trauma Advisory Board
INTTEGRIS Canadian Valley Hospital
1201 Health Center Parkway
Yukon, OK 73099
February 18th, 2020 – 1:00 pm

B. Combined Region 6/8 Quality Improvement Committee
Mercy Hospital I-35
2017 West I-35 Frontage Road
Edmond, OK 73013
April 14th, 2020 – 10:30 am

C. Central (6) Regional Planning Committee
Gordon Cooper Technology Center
1 John C. Bruton Drive
Shawnee, OK 74804
May 19th, 2020 – 11:00 am

D. Oklahoma Trauma and Emergency Response Advisory Council
Oklahoma State Department of Health
1000 Northeast 10th Street
Oklahoma City, OK 73117
June 10th, 2020 – 1:00 pm

VIII. Adjournment
A motion to adjourn was made by Julia Day and seconded by Jason Likens. The meeting adjourned at 11:38 am.

Approved

Eddie Sims, Chair
Region 6 Regional Planning Committee
August 18th, 2020
REGION 6 TRAUMA PLAN

Developed by the RTAB Central Regional Planning Committee
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Central Oklahoma Region 6 Trauma Plan

Pre-hospital Trauma Destination Component

I. GOALS/PURPOSE
The goals of the regional trauma destination plan are to:
   A. Assure trauma patients are transported to the most appropriate facility with the available resources and capacity to provide care in a timely fashion;
   B. Support the Trauma Triage and Transport Guidelines to effectively reduce trauma morbidity and mortality;
   C. Match a facility’s resources with each trauma patient’s need to ensure optimal and cost effective care is achieved; and
   D. This plan will not conflict with any rules and/or regulations that are in place now, that may be 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. MISSION STATEMENT
In support of the statewide system; create a regional system of optimal care for all trauma patients to ensure the right patient goes to the right place in the right amount of time.

III. DESCRIPTION
Region 6 consists of the central portion of Oklahoma and includes the following counties: Canadian, Cleveland, southeastern Kingfisher, Lincoln, Logan, McClain, and Pottawatomie.

   It is serviced by twelve (12) ambulance services and two (2) Level III trauma hospitals. There are seven (7) Level IV trauma hospitals, of which three (3) are designated as Critical Access Hospitals. There is one (1) hospital in the region without a trauma designation.

IV. 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 considers injury severity, severity risk, time and distance from injury to definitive care, and available resources to meet the region’s specific needs.

   It is imperative that all pre-hospital and hospital medical providers use this system and language. Three trauma triage priorities are used in determining the appropriate destination for patients. It is noted that all of region 6 will adopt the use of these priorities and include them in their internal training processes.
Central Oklahoma Region 6 Trauma Plan

A. **Priority 1 Trauma Patients:**
These are patients with blunt or penetrating injury causing physiological abnormalities or significant anatomical injuries. These patients have time sensitive injuries requiring the resources of a Level I or level II Trauma Center. These patients should be directly transported to a Level I or Level II facility for treatment but may be stabilized at a Level III 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.

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 injuries that have been involved in a low energy event. These patients should be treated at the nearest facility or the patient’s hospital of choice.

V. **CATEGORIZATION OF HOSPITALS**
A. Hospital Providers in Region 6 include:
1. Level I: None
2. Level II: None
3. Level III:
   a. INTEGRIS Canadian Valley Hospital (Yukon)
   b. Norman Regional (Norman)
4. Level IV
   a. CHG Cornerstone Hospital of Oklahoma – Shawnee (This facility functions as a Long Term Acute Care Facility.)
   b. Mercy Hospital Logan County, Inc. (Guthrie)
   c. Prague Community Hospital (Prague)
   d. Purcell Municipal Hospital (Purcell)
   e. Stroud Regional Medical Center (Stroud)
   f. SSM Health St. Anthony Hospital – Shawnee
5. General Medical Surgical Hospitals that are not Trauma Classified:

VI. **DESCRIPTION OF EMS SERVICES**
Region 6 is an area that encompasses six (6) counties and covers approximately 4261.5 square miles. It is served by twelve (12) ambulance services.
Central Oklahoma Region 6 Trauma Plan

A. Ground Ambulance Services:
   1. **Canadian County:**
      Two (2) Paramedic services cover the Region 6 portion of Canadian County with seven (7) total units of which an average of two (2) are routinely staffed, covering 1,210 square miles of the county.
   2. **Cleveland County:**
      Cleveland County is served by one (1) Intermediate service and one (1) Paramedic service. The Intermediate services covers the southern 96 square miles of the county with three total ambulances, two (2) of which are routinely staffed, and the Paramedic service covers the Norman and Moore areas with twenty (20) ambulances.
   3. **Lincoln County:**
      Lincoln county is 1,090 square miles covered by one (1) Paramedic service and two (2) Basic service. There are nine (9) total ambulances, of which six (6) are routinely staffed.
   4. **Logan County (including southeastern Kingfisher County):**
      Logan County is covered by two (2) Basic ambulances services with nine (9) units, of which six (6) are routinely staffed, that cover 406 square miles of these counties.
   5. **McClain County:**
      One (1) Intermediate and one (1) Paramedic Service cover McClain County with eight (8) units, of which six (6) are routinely staffed, covering 825 square miles of the county.
   6. **Pottawatomie County:**
      One (1) Paramedic ambulance service covers Pottawatomie County with ten (10) units, of which six (6) are routinely staffed, covering 825 square miles of the county.

For all of Region 6, there are a total of 66 ground units of which 23 are routinely staffed.

B. There are no Rotor Wing Air Ambulance services *based* in Region 6.

   Air Ambulance services *accessible* to Region 6 are:
   1. Air Evac Lifeteam – Ada
   2. Air Evac Lifeteam – Cushing
   3. Air Evac Lifeteam – Kingfisher
   4. Air Evac Lifeteam – Stillwater
   5. Air Kids One
   6. Mediflight – Chickasha
   7. Mediflight – Seminole
   8. Mediflight – Stillwater
   9. Survival Flight – OKC
   10. Tulsa Life Flight – Tulsa
Central Oklahoma Region 6 Trauma Plan

VII. **TReC – TRAUMA REFERRAL CENTER**

The Trauma Referral Center was created by statute (Senate Bill 1554, 2004), and it was implemented on July 1st, 2005. The purpose of the center 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 6 are required to call into the center prior to entering Region 7 or 8 in order to ensure appropriate destination. Likewise, hospitals may call the center for assistance in identifying the appropriate destination for their trauma patients.

The center will provide information on resource utilization to the OSDH that will be available to the Region 6 RTAB for Quality Improvement purposes.

VIII. **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 transport directly to an appropriate hospital with the capability 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 patient hospital destinations.

These destinations are:

**ALL PATIENTS:**

A. Those patients with a traumatic arrest or the inability to secure an airway should be transported to the trauma-designated facility closest to the traumatic event.

B. It should be noted that any priority 1 or 2 trauma patient that needs immediate stabilization may be transported to the trauma-designated facility closest to the traumatic event in an effort to expedite care.

C. Patient preference, as well as time and distance, will be considered for most Priority 2 and 3 trauma patients.
D. All trauma patients should be directly transported to the closest trauma designated facility with the capability and capacity to provide definitive care for the patient based on injury type and severity.

**General Trauma Patients**

A. Priority 1 adult and pediatric trauma patients that meet the state-approved trauma criteria should be transported to OU Medicine via the appropriate method of transport. For Priority 2 adult and pediatric trauma patients transported into Region 8 from the south, Norman Regional Hospital may be utilized. For those patients outside of an area 30 minutes from OU Medicine, 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 trauma designated facility for stabilization.

B. Priority 2 adult and pediatric patients

All priority 2 pediatric patients that are transferred and transported into Region 8 shall now be taken to The Children’s Hospital at OUMC.

a. In Pottowatomie County, Priority 2 trauma patients will be transported to whichever is closest:
   i. Norman Regional (Porter Campus), or
   ii. The closest Level III in Region 8 using the Trauma Referral Center.

b. In Lincoln County, Priority 2 trauma patients will be transported to whichever is closest:
   i. Stillwater Medical Center, or
   ii. The closest Level III in Region 7 or 8 using the Trauma Referral Center.

c. In Logan County, Priority 2 trauma patients will be transported to whichever is closest:
   i. St. Mary’s Regional Medical Center or INTEGRIS Bass Baptist Health Center in Enid,
   ii. Stillwater Medical Center, or
   iii. The closest Level III in Region 8 using the Trauma Referral Center.

d. In Canadian County, Priority 2 trauma patients will be transported to INTEGRIS Canadian Valley Hospital or the closest Level III or higher facility in Region 6 or 8 using the Trauma Referral Center.

e. In McClain County, Priority 2 trauma patients will be transported to the closest Level III or higher facility with the capability and capacity for definitive care:
   i. Grady Memorial Hospital Authority in Chickasha, or
   ii. Norman Regional (Porter Campus), or
   iii. The closest Level III in Region 8 using the Trauma Referral Center, or
   iv. Mercy Hospital Ada.
Central Oklahoma Region 6 Trauma Plan

f. In Cleveland County, Priority 2 trauma patients will be transported to:
   i. Norman Regional (Porter Campus), or
   ii. The closest Level III in Region 6 or 8 using the Trauma Referral Center.

Neurological Trauma Patients
A. Priority 1 and 2 adult and pediatric trauma patients should be transported directly to the
   appropriate facility in Region 6, 7, or 8 via use of the Trauma Referral Center.
B. Priority 3 adult and pediatric trauma patients should be transported to the closest trauma
   designated or patient preference facility in Region 6.

Burn Patients
A. Adults: Refer to Triage and Transport Guidelines – Oklahoma Model Trauma Triage
   Algorithm.
B. Pediatric patients <16 years: Refer to Triage and Transport Guidelines – Oklahoma Model
   Trauma Triage Algorithm.

IX. 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 OSDH
   and made available to the Region 6 CQI Committee. Any problems and/or trends identified
   through review of this data will be addressed by the 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 shall be developed for use in monitoring hospital status and
   appropriateness of destination. The Region 6 CQI Committee will monitor these indicators.
   Any problems and/or trends through review of the indicators will be addressed by the CQI
   committee directly with the provider, and, if necessary, through referral to the appropriate
   state level committee.

X. HELICOPTER UTILIZATION PROTOCOL
Purpose: Appropriate utilization of air ambulance resources by Region 6 providers.
A. “No Fly” Conditions
   1. Helicopter utilization is seldom indicated for patients without a chance for survival or
      without serious injury. The following are other situations in which an air ambulance should
      not be used:
      a. Patients at a location where time and distance constraints make air transport to the
         closest appropriate medical facility for the patient’s injury more time consuming should
         be transported by ground. This is when ground transport is expected to take less than
         30 minutes.
Central Oklahoma Region 6 Trauma Plan

b. Priority 3 patients should be transported by ground ambulance.
c. Cardiac arrest without return of spontaneous circulation in the field.

B. “Fly” Conditions

1. The following conditions warrant the use of an air ambulance:
   a. Priority 1 trauma patients that are being transported to a facility in which time and
time and distance constraints make air transport more efficient.
   b. Priority 2 trauma patients that are being transported to a facility with a ground
transport time greater than 30 minutes, based on lack of local resources.

2. The following are conditions that warrant the use of an air ambulance even when the
patient is within 30 minutes of a medical facility:
   a. The closest trauma designated facility is not appropriate for the patient’s injury
   b. Hazardous or impassable road conditions resulting in significant delays for ground
transportation.
   c. There are multiple patients of a serious nature requiring rapid transport,
overwhelming available ground units.
   d. Based on information available, the lead rescuer determines a lengthy rescue is
required and transportation by ground would extend and delay definitive care.
   e. The closest available medical helicopter will be utilized, with consideration given to air
response time to the scene, to improve survival of all patients being transported to a
definitive care facility.

3. 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 patient’s condition
warrants.

4. Early Activation / Standby: 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, or
   b. Multiple patients, or
   c. The responding crew’s index of suspicion.

**** NOTE: If an air ambulance is requested by anyone other than the local EMS agency,
then the air ambulance will establish communication with the local EMS agency
immediately. ****

C. 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 square feet 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 not be approached unless escorted or directed by the aircrew, 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.

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

E. **EMTALA:** There are concerns regarding air utilization and rendezvous with a local ground transport at a helipad upon a medical facility’s property. This is addressed in Appendix B.

**XI. 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; or
   2. Maximum capacity of the Emergency Department has been met; or
   3. The hospital does not have the capability to care for the patient.

B. Compliance:
   1. If a hospital goes on Emergency Department divert, then the MERC or his/her designee will make re-evaluation, on a 2-hour basis, for continuation.
   2. The MERC or his/her designee has the authority at any time to deny or discontinue Emergency Department divert based upon the needs of the community.
   3. The MERC or his/her designee also has the authority to place ambulance services on a rotating basis to avoid over-saturation of any one given facility.
   4. Update of the EMResource™ will be made accordingly.
   5. All providers are to update their status on the EMResource™ every 24 hours. All EMS providers will utilize the Trauma Referral Center to prevent re-routing related to diversion status of hospital in Regions 7 and 8. The Level III hospitals within Region 6 should be utilized when geographically appropriate prior to transporting into Region 7 or 8 if possible. If the Level III facility is unable to accept the patient, the Trauma Referral Center will be contact.
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Inter-Facility Trauma Destination Component

I. General Purpose
A well-designed trauma program within the hospital is crucial to the success of providing optimal care to the trauma patient in Region 6. A written commitment on behalf of the entire facility devoted to the organization of trauma care is vital. Therefore, all hospital in Region 6 shall establish criteria for the activation of their respective trauma systems. These criteria shall be clearly noted in each institution’s trauma policy. The following is intended to serve only as a general guideline for the hospitals as each hospital is unique.

II. Level III Trauma Hospital
A. A Level III Trauma Center is an acute care facility with the commitment, medical staff, personnel, and specialty training necessary to provide initial resuscitation of the trauma patient. It shall establish and maintain a hospital trauma service with a trauma service director which can also be the emergency services director. Patients will remain in the Level III trauma hospital 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. A 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. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its resources. For the Level III trauma hospital, the suggested composition of the trauma team for severely injured patients may include:
   1. Emergency Physician
   2. Emergency Charge RN
   3. Emergency RN
   4. Laboratory
   5. Radiology
   6. Respiratory Therapy

C. The Level III trauma center must have an emergency department staffed so those trauma patients are assured immediate and appropriate initial care. An emergency medicine physician who is deemed competent in the care of the trauma patient shall be available 24 hours per day. This emergency physician must be in-house 24 hours/day, immediately available at all times, capable of evaluating trauma patients, and providing initial resuscitation. The emergency 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 must...
Central Oklahoma Region 6 Trauma Plan

participate in the trauma PI process. There should be an adequate number of RNs staffed for the trauma resuscitation area in-house 24 hours/day.

D. The Level III trauma center must also have published on-call schedules and have the following medical specialists immediately available 24 hours/day to the injured patient:
   1. General Surgery notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process;
   2. Anesthesia must be promptly available with a mechanism to ensure notification of the on-call anesthesiologist; and
   3. Emergency services, with a designated physician director.

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

F. Clinical support services such as Respiratory Therapy personnel and Radiological technicians shall be available 24 hours/day to meet the immediate needs of the trauma patient. Written policy should exist delineating the prioritization/availability of the CT scanner for trauma patients. The use of Tele-radiology is acceptable.

G. Within the Level III trauma hospital, clinical laboratory services shall have the following services available in-house 24 hours/day:
   1. Access to a community central blood bank and adequate storage facilities;
   2. Sufficient quantities of blood and blood products should be maintained at all times. Blood typing and cross-match capabilities must be readily available;
   3. Standard analysis of blood, urine, and other body fluids including:
      a. Microbiology,
      b. Blood gas and pH determinations,
      c. Alcohol screening is required and drug screening is highly recommended, and
      d. Coagulation studies.
   4. A Level III trauma facility shall have the following:
      a. Written transfer agreements with other providers as a transferring facility, and
      b. A helipad.

III. Level IV Trauma Hospital

A. Level IV trauma centers are generally licensed, small, rural facilities with 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. A Level IV trauma facility shall have an emergency services department with an emergency physician or a licensed mid-level practitioner and nursing personnel on-duty 24 hours/day. A registered nurse not designated as a physician extender shall be immediately available to respond to the emergency department from within the hospital.

B. Again, the team approach is optimal in the care of the multiple injured patients. The Level IV trauma center must have a written policy for notification and mobilization of an organized
Central Oklahoma Region 6 Trauma Plan

trauma team to the extent that one is available. The trauma team may vary in size and composition. The physician leader or licensed mid-level practitioner on the trauma team is responsible for directing all phases of the resuscitation. Suggested composition of the trauma team includes, if available:

1. Physicians or licensed mid-level practitioners,
2. Emergency RN,
3. Laboratory, and

C. The emergency department of a Level IV trauma center must be staffed so trauma patients are assured immediate and appropriate initial care. A system must be developed to assure early notification on the on-call practitioner. An adequate number of nurses must be available in-house 24 hours/day. The nurse may perform other patient care activities within the hospital when not needed in the ED.

D. The Level IV trauma facility shall have the following clinical services available for immediate consultation via a communications system:

1. General surgery,
2. Infectious disease,
3. Neurosurgery,
4. OB0GYN, and

E. The Level IV trauma center must have written transfer agreements with other trauma facilities in the region. A policy must be in place to facilitate and expedite the transfer sequence to assure the most appropriate care is rendered. Agreements should be in place so that all facilities will work together to implement the Trauma Transfer Guidelines. These guidelines indicate which patients should be considered for transfer and what procedures to follow to ensure the most expedient safe transfer of the patient.

IV. Criteria for activation of the Trauma Team

A. Immediate activation of the trauma system (Full Team Resuscitation) should occur when you have:

1. Glasgow Coma Scale (GCS) < 10;
2. Systolic Blood Pressure < 90 mmHg;
3. Respiratory Rate < 10 or > 30/min;
4. RTS < 11;
5. PTS < 9;
6. Penetrating injury to the head, neck, torso, or extremities above the elbows or knees;
7. Flail chest;
8. Two or more proximal long bone fractures;
9. Pelvic fracture;

Approved by OTSIDAC February 1, 2006
Revised by RTAB April 21, 2009; February 03, 2010; May 18, 2011; November 17, 2015, May 21, 2019
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10. Limb paralysis;
11. Amputation proximal to the wrist or ankle;
12. Body surface burns > 5% (second or third degree) or burns associated with other traumatic or inhalation injury;
13. Trauma transfer that is intubated or receiving blood; or
14. Children under 12 with any of the historical flats outlined below:
   a. Ejection from vehicle;
   b. Death in same passenger compartment;
   c. Extrication time greater than 20 minutes;
   d. Rollover MVC;
   e. High speed auto crash greater than 40 MPH;
   f. Auto deformity greater than 20 inches of external damage or intrusion into the passenger compartment greater than 12 inches;
   g. Pedestrian thrown or run over; or
   h. Motorcycle crash greater than 20 MPH or separation of rider from bike.

V. Inter-facility Transfers

In an effort to optimize the 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 PARTIAL or FULL), and the patient will undergo immediate medical screening. Depending upon the screening results and the needs of the patient, any of the following may occur:

A. The Priority 1 or Priority 2 time-sensitive patient will be stabilized and then transferred to the most appropriate facility in Region 7 or 8 utilizing the Trauma Referral Center (TReC);
B. The Priority 2 patient that is not time sensitive will be stabilized and then admitted to that facility when care needed is within the scope of the facility, or transferred to the most appropriate facility utilizing the TReC; or
C. The Priority 3 patient will be stabilized and:
   1. Admitted, or
   2. Transferred to their facility of choice, or
   3. Treated and discharged to home with appropriate instructions for their injury.

It is recommended that the transfer of Priority 1, Priority 2, or Priority 3 trauma patients follow the same routing as the Pre-Hospital Destination Plan when possible. However, the TReC may be contacted to expedite location of the most appropriate facility. Once the need for transfer is recognized, diagnostic tests should be limited to decrease time at the transferring facility. This is an effort to provide optimal care in the most appropriate amount of time for the trauma patient. Upon stabilization of the patient, transport should be by the quickest means of
transport available. It is, however, the expectation that facilities with the capability and capacity to treat patients at their facility will not initiate a transfer. As always, the patient’s choice of facility will be considered when the injuries are not of a time sensitive nature.

VI. EMResource™ Usage

A. 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™’s ability to serve this function is limited by the use of the system by providers.

B. Usage Requirements

Within Region6, all providers are required to comply with the guidelines established by the State EMResource™ Joint Advisory Committee and/or the Oklahoma State Department of Health in the EMResource™ Manual. In the event that the EMResource™ Manual is updated, the revisions to the EMResource™ Manual override the requirements in this document.

Specific usage requirements include, but are not limited to:

1. Contact Information

a. Each provider is responsible to maintain accurate contact information on the EMResource™.

b. Hospitals shall post the telephone number they wish other providers to use when calling patient referrals or reports in this area of EMResource™.

2. 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 Referral Center.

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

a. Emergency Department Status

i. 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.

ii. 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 Referral Center.
b. Hospital Status
   i. 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.
   ii. If a facility has not updated their status on the EMResource™, their attempt to divert may be overridden by the Trauma Referral Center.
   iii. Critical Concept: Emergency Departments and Hospitals are considered open unless posted otherwise on EMResource™.

c. Provider Resource Availability
   This status is for displaying hospital specialty coverage on a real time basis. A customized list of eight specialties has been developed to meet the needs of Oklahoma. The status categories for these coverage areas are:
   i. Yes – Coverage is currently available
   ii. No – Coverage is not currently available
   iii. N/A – This service is not offered at this facility.

d. Air Ambulance Status
   This status is for displaying the current status/availability of Air Ambulances. The status categories for this status are:
   i. Available – The aeromedical resource is currently ready and able to respond to emergency call.
   ii. Call for Status – Current conditions necessitates that provider in need of aeromedical transport call to determine resource availability because:
      i. The aero-medical resource may already be dispatched to a call or be on standby;
      ii. Local weather conditions may temporarily impact the ability of this aeromedical resource to respond; or
      iii. This aeromedical resource may be temporarily unavailable due to routine service or fueling.
   iii. Not Available – The aeromedical resource is currently unable to respond in a timely manner.

   In Region 6, 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.

3. System Alerts
   a. Providers in Region 6 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™ 24 hours a day.
   b. 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™
Central Oklahoma Region 6 Trauma Plan

Administrator to arrange delivery of all System Alerts to the text enabled device of designated staff responsible to share the alert information with other on-duty staff.

4. Data Reporting

Providers in Region 6 are required to participate in reporting data supported by the EMResource™ application. This reporting requirement includes, but is not limited to:

a. Hospital Daily Report of bed capacity and ED volume;

b. EMS Daily Report of resources and volume.

C. Monitoring

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

b. The CQI committee will routinely review reports from the Trauma Referral Center on diversion of patients and compare the patient diversion list with the list of facility diversion hours generated from the EMResource™.

c. The CQI committee will review all cases referred to them for inappropriate use of EMResource™ in any of the listed categories.

d. 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 to work with these providers to come into compliance with EMResource™ usage requirements. If these attempts fail, the cases will be referred to the State CQI committee for further action.

D. 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 6 supports use of this tool through adoption of these requirements.
Appendix A

Oklahoma Trauma Patient Definitions and Triage Algorithms
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 to not 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 per minute
  or <20 in infant <1 year of age
- Altered Mentation of trauma etiology – GCS <14

Anatomical Injury Criteria

- Penetrating injury of the head, neck, chest/abdomen, or extremities proximal to elbow of 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 1 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.

**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 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 but not limited to the following factors:

- Age greater than 55
- Age less than 5
- Extremes in environment
- Patient’s previous medical history such as:
  - Anticoagulation or bleeding disorders
  - End stage renal disease or 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 levels fall with extremity or hip fracture.
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 restraint 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)
**PHYSIOLOGICAL COMPROMISE CRITERIA**

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

**ANATOMICAL INJURY**

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

Pediatric Trauma Score < 5

**RISK OF SERIOUS INJURY — SINGLE SYSTEM INJURY**

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

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

Pediatric Trauma Score 6-8

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**PRIORITY I**

**INITIATE TRAUMA TREATMENT PROTOCOL**

**ACTIVATE TRAUMA SYSTEM**

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

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

Combinations 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.

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**PRIORITY II**

**INITIATE TRAUMA TREATMENT PROTOCOL**

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

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**PRIORITY III**

**TRANSPORT to either the closet Level IV Trauma Center or higher depending on location according to the Regional Trauma Plan or facility of the patients choice**

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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
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 restraint 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

<table>
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<th>Components</th>
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<th>+1</th>
<th>-1</th>
<th>Score</th>
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<td>10-20 kg (22-44 lb)</td>
<td>&lt;10 kg (&lt;22 lb)</td>
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<td>Airway</td>
<td>Patent *</td>
<td>Maintainable ^</td>
<td>Unmaintainable #</td>
<td></td>
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<tr>
<td>Systolic (cuff) or BP (pulses)</td>
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<td>50-90 mmHg Femoral/Carotid</td>
<td>&lt;50 mmHg None palpable</td>
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<td>Obtunded Some LOC †</td>
<td>Comatose, unresponsive</td>
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</tr>
<tr>
<td>Fractures</td>
<td>None</td>
<td>Closed (or suspected)</td>
<td>Multiple open or closed</td>
<td></td>
</tr>
<tr>
<td>Wounds</td>
<td>None</td>
<td>Minor</td>
<td>Major‡, Burns, or penetrating</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>Range -6 to +12</td>
</tr>
</tbody>
</table>

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

Generally:

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

* No assistance required
^ Protected by patient but constant observation required for position, patency, or O₂ administration
# Invasive techniques required for control (e.g. intubation)
† Responds to voice, pain, or temporary loss of consciousness
‡ Abrasions or lacerations
### 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 <= 10 or deterioration of 2 or more points
- Lateralizing signs
- New neurological deficits
- CSF Leak
- Spinal cord injury with neurological deficits
- Unstable spinal cord injuries

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

### Hemodynamic Instability
- SBP consistently <90 following 20cc/kg of resuscitation fluid
- Respiratory distress with rate <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

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

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**PRIORITY I**

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

**NO**
Proceed to Priority II Interfacility Transfer Criteria

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

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
Perform complete trauma evaluation and appropriate serial observation. Consider admission if condition remains stable.

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.

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.
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 <= 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 tamponade
- Patients who may require prolonged ventilation
- Suspected tracheobronchial tree or esophageal injury

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

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

Multiple System
- Head injury combined with face, chest, abdominal, or pelvic injury
- Significant injury to two or more body regions
- Combination of burns > 10% or significant burns involving face, airway, hands, feet or genitalia without significant trauma transport to 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)

Pediatric Trauma Score <5
**Abdominal/Pelvic Injuries**
- Stable pelvic fractures
- Hemodynamically stable isolated abdominal trauma
  - diffuse abdominal pain/tenderness
  - seat belt contusions
- Visceral injuries
- Hemodynamically stable isolated solid organ injuries

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

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

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

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

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

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

**Pediatric Trauma Score 6-8**

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**PRIORITY II**

**YES**

Perform complete trauma evaluation and appropriate serial observation. Consider admission if condition remains stable.

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

**YES**

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.

**NO**

Consider admission if condition remains stable.

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**PRIORITY III**

**NO**

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 B

EMTALA Clarification
Central Oklahoma Region 6 Trauma Plan

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

**Emergency Medical Condition:**
A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse)
• such that the absence of immediate medical attention could reasonably be expected to result in:
  1. Placing the health of the individual or, with respect to a pregnant woman, the health of a woman and her unborn child in serious jeopardy;
  2. Serious impairment of bodily functions, or
  3. Serious dysfunction of any bodily organ or part; or
B. With respect to a pregnant woman who is having contractions:
  1. That there is inadequate time to affect a safe transfer to another hospital before delivery; or
  2. 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.

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.
Central Oklahoma Region 6 Trauma Plan

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 Hospital Property or Premises*, 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.
Appendix C

Advanced Life Support Intercept Protocol
Central Oklahoma Region 6 Trauma Plan

ALS INTERCEPT PROTOCOL FOR REGION 6

I. Purpose:

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

Policy:

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

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

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

II. Procedure:

A. 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.
B. The location of the intercept shall be decided as soon as possible.
C. 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.
D. The ALS provider should be licensed at the Intermediate or Paramedic level or an Air Ambulance.
E. 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.
F. 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.
Appendix D

Interfacility Transfer Agreements
Inter-facility Transfer Agreements

The Oklahoma Central Regional Trauma Advisory Board has developed a regional resource list for reciprocal transfers returning to the region (See appendix E.) Hospitals should have a policy and transfer agreements in place in accordance with the OSDH Hospital Standard 310:667-59-9 (4B) which states: The facility shall have a transfer agreement with a hospital capable of providing trauma care for severely injured patients. This agreement shall include reciprocal provisions requiring the facility to accept return transfers of patients at such time as the facility has the capability and capacity to provide needed care. Reciprocal agreements shall not incorporate financial provisions for transfers.
## Central Oklahoma Region 6 Trauma Plan

<table>
<thead>
<tr>
<th>Type</th>
<th>FacilityName</th>
<th>County</th>
<th>Phone</th>
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<tr>
<td>Ambulatory Surgery Center</td>
<td>Guthrie Surgical Center</td>
<td>Logan</td>
<td>(405) 282-9000</td>
<td>324 East Oklahoma Avenue</td>
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<tr>
<td>Mental Health Ctr</td>
<td>Central OK Community Mental Health</td>
<td>Cleveland</td>
<td>(405) 360-5100</td>
<td>909 East Alameda</td>
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<tr>
<td>Home Care Agency</td>
<td>CareTeam of OKC</td>
<td>Cleveland</td>
<td>(405) 364-5273</td>
<td>3625 W Main #108</td>
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<tr>
<td>Home Care Agency</td>
<td>Caring Hearts Services, Inc.</td>
<td>Cleveland</td>
<td>(405) 213-7327</td>
<td>330 W. Gray St., Ste 100-5</td>
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<tr>
<td>Home Care Agency</td>
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<td>Home Care Agency</td>
<td>Doctors Park Home Health</td>
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<td>(405) 878-4753</td>
<td>2205 North Kickapoo, Suite 2</td>
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<td>Cleveland</td>
<td>(405) 447-8700</td>
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<td>Home Care Agency</td>
<td>Gentiva Health Services</td>
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<td>(918) 968-9543</td>
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<td>Home Care Agency</td>
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<td>(405) 527-0027</td>
<td>519 W. Delaware</td>
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<td>Home Care Agency</td>
<td>Heartland Home Health Care &amp; Hospice</td>
<td>Pottawatomie</td>
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<td>Home Care Agency</td>
<td>Legend Care Pharmacy</td>
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<td>Home Care Agency</td>
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<td>Home Care Agency</td>
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<td>Home Care Agency</td>
<td>Park View Hospital Home Health</td>
<td>Canadian</td>
<td>(405) 262-6877</td>
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<td>Home Care Agency</td>
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<td>(405) 258-0035</td>
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<td>Home Care Agency</td>
<td>Synergy HomeCare, LLC</td>
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<td>(405) 310-4020</td>
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<td>Hospice, Class A</td>
<td>Angelic Family Hospice, L.L.C.</td>
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<td>(405) 275-8300</td>
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<td>Hospice, Class A</td>
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<td>Hospice, Class A</td>
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<td>(405) 579-8565</td>
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<td>Cleveland</td>
<td>(405) 329-2290</td>
<td>226 W. Gray, Ste 200</td>
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Approved by OTSIDAC February 1, 2006
Revised by RTAB April 21, 2009; February 03, 2010; May 18, 2011
# Central Oklahoma Region 6 Trauma Plan

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<tr>
<td>Hospice, Class A</td>
<td>Life's Journey Hospice, LLC</td>
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<td>(918) 968-4870</td>
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<td>Hospice, Class A</td>
<td>Mays Hospice Care, Inc</td>
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<td>Hospice, Class A</td>
<td>Mercy Hospital El Reno</td>
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<td>(405) 258-0040</td>
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<td>Hospice, Class A</td>
<td>Russell-Murray Hospice, Inc.</td>
<td>Canadian</td>
<td>(405) 262-3088</td>
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<td>Specialized Hospital: Psych</td>
<td>Griffin Memorial Hospital</td>
<td>Cleveland</td>
<td>(405) 321-4880</td>
<td>900 East Main Street</td>
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<td>Specialized Hospital: Rehab</td>
<td>J. D. McCarty Center for Children</td>
<td>Cleveland</td>
<td>(405) 321-4830</td>
<td>2002 East Robinson</td>
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<td>PPS-Psychiatric</td>
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<td>Cleveland</td>
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<td>PPS-Rehabilitation</td>
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<td>(405) 321-1700</td>
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<td>PPS-Rehabilitation</td>
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<td>Swing Bed</td>
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<td>Swing Bed</td>
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<td>(405) 273-2240</td>
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<td>Outpatient Therapy, PT/SP</td>
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<td>Lincoln</td>
<td>(918) 968-2656</td>
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<td>Outpatient Therapy, PT/SP</td>
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<td>(405) 573-0121</td>
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<td>Outpatient Therapy, PT/SP</td>
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<td>Outpatient Therapy, PT/SP</td>
<td>Select Physical Therapy</td>
<td>Cleveland</td>
<td>(405) 321-1469</td>
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CENTRAL REGIONAL TRAUMA ADVISORY BOARD
BYLAWS
Counties: Canadian, Cleveland, Lincoln, Logan, McClain, Pottawatomie

NAME AND GEOGRAPHIC DESCRIPTION
Section 1. Name:
Central Regional Trauma Advisory Board

Section 2. Geographic description:
Canadian, Cleveland, Lincoln, Logan, McClain, Pottawatomie.

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

PURPOSE
Section 1. The purpose of the Regional Trauma Advisory Board (RTAB) is to assist the Oklahoma Trauma and Emergency Response Advisory Council (OTERAC), the Oklahoma State Department of Health (OSDH) with the development and implementation of a formal trauma care system regionally and statewide.

Section 2. The Regional Trauma Advisory Board shall be empowered but not limited to:
   a. Assessing the current resources and needs within the region respective to Emergency Medical Services (EMS), acute care facilities, rehabilitation facilities, communication systems, human resources, professional education, public education and advocacy
   b. Organizing regional human resources into coalitions and/or alliances, which will be proactive in trauma systems development.
   c. Development of Regional Trauma System Development Plan.
   d. Development and implementation of Regional Trauma Quality Improvement program.
   e. Providing public information and education programs regarding the need for a formal trauma care system.
   f. Providing region—specific input to the OTERAC and Oklahoma State Department of Health concerning trauma care issues.
   g. Establishing and coordinating regional planning and networking activities with the Oklahoma City Region.

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

Approved OTERAC: 01/13/2005
RTAB Revisions: 05/18/2010; 08/17/2010; 06/26/2013; 08/18/2015; 05/17/2016; 05/21/2019
GENERAL MEMBERSHIP

General Membership is composed of licensed ambulance services and hospitals, representatives from all of the organizations that regularly service the region as well as other interested individuals as approved by the Board. Each General Member organization is responsible for appointing representatives authorized to act on behalf of the organization. Examples of General Members include:

a. Hospital
   - Non-acute care hospitals will serve as general members.
   - Any new acute care hospital will serve as general member initially until a rotation is established and approved by the board.

b. EMS
   - When not serving as a board member, member organization will serve as general member.
   - A new organization will serve as general member during the initial year of licensure and be placed into the upcoming board member rotation schedule.

c. A representative of the Emergency Medical Services for Children (EMSC)
d. A representative of the Medical Emergency Response Center (MERC)
e. A representative of the Trauma Referral Center (TReC).

Section 1. Responsibilities of the General Membership:
The General Members are expected to attend meetings regularly to provide input on topics under consideration by the Board. General Members are expected to disseminate information from Board Meetings to its organization.

Section 2. Committee Service:
General Members may serve on committees, work groups, and task forces.

Section 3. Attendance Expectations:
The General Members are expected to attend at 100% of regularly scheduled meetings.
   a. Each General Member organization may send a proxy to attend in place of the authorized representative.
   b. Rescheduled meetings and special meetings are not considered to be regularly scheduled.

BOARD MEMBERSHIP

Representation Appointment to the Board will rotate between the member organizations in the region based upon an approved rotation schedule to be determined by the Board.

The rotation schedule will be operated as follows for the individual provider type:

a. Hospital
   - All acute care hospitals will serve as permanent members.
CENTRAL REGIONAL TRAUMA ADVISORY BOARD
BYLAWS

Counties: Canadian, Cleveland, Lincoln, Logan, McClain, Pottawatomie

- A new acute care hospital will serve as general member during the initial calendar year of licensure and be placed into the upcoming rotation schedule as permanent member.
- Non-acute care hospitals will serve as general members.

b. EMS
- The four organizations with licenses held within Region 6 that have the highest call volumes, as reported to OKEMSIS in the previous calendar year, will serve as permanent board members.
- All other organizations will serve as board members in alternating terms.
- When not serving as a board member, the organization will serve as general member.
- Any new organization will serve as general member during the initial year of licensure and be placed into the upcoming rotation schedule.

c. Physician
- TeamHealth will serve as a permanent member.

Ideally Board Membership will be multidisciplinary with broad representation from the following list of disciplines.

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<tr>
<th>Hospital</th>
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<tr>
<td>1. Administrator</td>
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<tr>
<td>2. Business office</td>
<td>2. Non-Administrator EMT</td>
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<td>3. QI practitioner</td>
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<td>3. Emergency department physician</td>
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<td>4. Surgeon</td>
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<td>5. Trauma nurse coordinator</td>
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<td>7. Emergency department nurse</td>
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<td>8. Operating room nurse</td>
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<td>9. Rehabilitation practitioner</td>
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<td>10. Safety officer</td>
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Section 1. Powers and Responsibilities:
The Board Members are responsible for overall policy and direction of the RTAB.

Section 2. Duties of the Board Members:

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

a. Conduct the business of the organization  
b. Specify the composition of and direct the activities of committees  
c. Consider for approval recommendations from committees  
d. Cause to be prepared and administer the budget, prepare annual reports of  
   the organization  
e. Cause to be prepared grant applications for the organization  
f. Approve, execute and/or ratify contracts made in ordinary course of business  
   of the organization  
g. Make continuous and regular reviews of RTAB matters and business affairs in  
   order to provide information to general membership

Section 3. Number of Board Members
The Board shall consist of no fewer than nine (9) members and no more than twenty  
(20) members.

Section 4. Actions of the Board
Each Board Member shall be entitled to one (1) vote on each matter submitted to a  
vote at a meeting of the Board. A simple majority of the Members present and voting at a meeting at which a  
quorum is present shall be sufficient to constitute action by the Board.

Section 5. Term
The term of the Board Members is two calendar years with staggered terms.

Section 6. Appointments
Board Members shall be appointed by the respective member organizations  
according to the established membership structure and rotation. Each Board Member  
organizations will appoint a representative and an alternate to the board, but each  
Board Member organization will have only one (1) vote each meeting. If both primary  
and alternate member are present at a meeting, the representative who responds to  
the Roll Call shall hold the voting right.

Section 7. Meetings
Meetings of the Board Members shall be held at such times and places as  
determined by the Board Members.

Section 8. Proxies
A Proxy for attendance and voting at a meeting must be initiated by the authorized  
representative, or the member organization administrator. This must be a signed  
statement on the represented organization’s letterhead or email stating the  
authority of a specifically named substitute from that organization to attend and
vote on their behalf. The proxy shall be delivered to the RTAB meeting prior to Calling to Order, and shall be retained with the roll call. A proxy shall only be valid at the meeting for which it is executed.

Section 9. Attendance Expectations/Removal of Board Members
   a. A Board Member is automatically removed from the Board if an authorized representative or proxy misses any regularly scheduled meeting in any year without:
      i. arranging for a proxy, or
      ii. if a meeting is missed by a Board Member or their proxy, The authorized representative of the member organization may request consideration for excused absence at the following RTAB meeting only. A request must be made to the RTAB Chair for placement as an agenda item, by contacting Emergency System staff at least fourteen (14) days prior to the meeting. The Board will then vote either to excuse or deny the absence.
   b. Vacancies resulting from a Board Member’s removal for not adhering to the attendance policy shall be replaced by another member organization that is next in line for rotation.
   c. Any member organization that subsequently fails to ensure participation by their representative shall be reported to both the Oklahoma Trauma and Emergency Response Advisory Council (OTERAC) and the member organization’s licensing authority.
   d. Any removed member will no longer carry the authority to vote, nor be listed as a Board Member for the remainder of the appointed term.

Section 10. Quorum
   A simple majority of the Board shall constitute a quorum at any meeting.

OFFICERS
   Section 1. The following officers shall be elected from the Board Members: Chair, Vice-chair, and Secretary.

   Section 2. The same person shall hold no more than one office.

   Section 3. The term for officers shall be two years.

   Section 4. Nominations of candidates for office shall occur at least one month prior to the election.
      a. The candidates shall be Board Members.
Section 5. Additional Offices
The Board Members may create additional officer positions, define the authority and duties of each such position, and elect persons to fill the position.

Section 6. Attendance Expectations/Removal of Officers
An Officer is automatically removed from office if he/she fails to maintain membership as defined by Board Membership Section 9: Attendance Expectations/Removal of Board Members.

Section 7. Vacancies
A vacancy in any office may be filled by the Board for the un-expired portion of the officer’s term.

**DUTIES OF OFFICERS**

Section 1. The Chair shall be the executive officer of the RTAB and shall:
   a. Set the agenda and preside at all meetings of the RTAB
   b. Appoint all committee chairs
   c. Sign agreements and contracts after authorization by the Board
   d. Call special meetings when necessary
   e. Ensure that the RTAB is represented at OTERAC Meetings
   f. Ensure that the RTAB is represented at all other appropriate state and regional Meetings
   g. Ensure that the RTAB membership is informed of all appropriate state and legislative activities
   h. Perform other tasks as deemed necessary by the Board Members

Section 2. The Vice-Chair shall perform the duties of the Chair in the absence of the Chair and perform such duties as assigned by the Chair or the Board.

Section 3. Duties of the Secretary:
   a. Ensure dissemination of all notices required by the Bylaws or by the Oklahoma Open Meetings Act
   b. Assure a meeting attendance roster is maintained
   c. Assure a register of the name and mailing address of each member organization is maintained
   d. Ensure minutes are kept of all proceedings of the Board meetings.
   e. Manage the correspondence of the organization.
MEETINGS

Section 1. Meetings of the Board shall be held in accordance with the Oklahoma Open Meeting Act.

Section 2. An Annual Board Meeting shall occur each fall. A meeting notice shall be mailed to all member-organizations at least 30 days prior to the meeting. The meeting dates, times and places for the forthcoming year shall be established at the annual meeting.

Section 3. Meetings for the forthcoming year shall be posted with the Secretary of State in accordance with the Oklahoma Open Meeting Act prior to December 15. Any changes to the meeting schedule shall be duly noted to the Secretary of State.

Section 4. Notice of the date, time, and place of each meeting shall be mailed or e-mailed to each Board Member at least ten (10) days prior to the date of that meeting. The notice of each meeting shall include an agenda of the matters to be considered.

Section 5. These meetings should be held at least quarterly.

Section 6. The Board shall not review patient specific information or medical records at these meetings.

Section 7. Members of the General Membership are encouraged to attend these meetings to provide input on topics under consideration by the board.

Section 8. Special Meetings
Special meetings of the Board may be called by the Chair of the Board, Vice-Chair of the Board, or by any three members of the Board on not less than forty-eight (48) hours’ notice. Notice of such a meeting must be posted as a special meeting with the Secretary of State. Notice to Board Members can be communicated by mail, e-mail, telegram, telephone, or fax.

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

COMMITTEES
Section 1. Quality Improvement Committee
a. Each RTAB is required by statute to conduct quality improvement activities.

b. The function of this committee is to decrease death and disability by reducing inappropriate variation in care through progressive cycles of performance review. A multidisciplinary standing committee for Quality Improvement shall be created in each region.
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Minimum membership requirement:
  i. Emergency Department Physician
  ii. Emergency Department Nurse
  iii. Paramedic
  iv. EMT, Intermediate, or Advanced EMT
  v. Quality Improvement Practitioner

c. Other members for this committee may be identified based upon the need of the region. It is suggested that the membership be kept to 10 members or fewer.
d. Other specific disciplines that are not regular members of the committee may be called on to meet specific quality improvement needs.
e. A simple majority shall constitute a quorum to conduct business.
f. Upon approval by the Committee Chair, a committee member may be removed from the committee if he/she misses two (2) consecutive scheduled meetings and shall be removed after he/she misses three (3) consecutive scheduled meetings.
g. The chair of the RTAB may attend the QI committee as an ad-hoc representative.
h. Vacancies and recommendations for committee membership:
  i. Notice of either a vacancy or request for committee membership shall be distributed to Board members at least ten (10) days prior to a meeting.
  ii. Volunteers/recommendations to fill the vacancy in membership or new request for membership on this committee shall be accepted and voted on at the next meeting of the Board.
i. Each region shall adopt confidentiality policies for this committee.
j. The Quality Improvement Committee shall recommend minimum Quality Improvement activities to be defined and approved by the Regional Trauma Advisory Board.
k. The regional committee may identify other activities to monitor based upon regional need.
l. Committee Tenure:
   Membership on this committee is for a term of two (2) years. Half of the initial appointments to this committee shall be for a term of one year to ensure staggered terms.

Section 2. Standing Committees shall be established by a majority vote of the Board
a. Standing committees may include but are not limited to:
   Hospital Care Committee, Pre-Hospital Care Committee, Injury Prevention Committee, EMS/Hospital Disaster Committee, Trauma Coordinator Committee, Trauma Registry Committee, Finance, Professional Education, Membership, Bylaws, Public Relations, and
b. At least one Board Member shall serve on each standing committee.

c. The Board shall affirm Standing Committee members.

d. Each person on a committee shall continue to serve on the committee until the next annual meeting of the Board and until his/her successor is appointed unless sooner removed or the committee is dissolved.

e. The Chair of the Board, the Chair of the committee or a majority of the committee may call meetings of a committee. Each standing committee shall meet at least annually.

f. Notice of the committee meetings must be given in accordance with the Oklahoma Open Meetings Act.

g. Upon approval by the Committee chair, a committee member may be removed from the committee if he/she misses two (2) consecutive scheduled meetings.

h. A majority of the voting persons on the committee shall constitute a quorum.

Section 3. Special Committees

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

a. Members of these committees are not required to be members of the Board.

b. The Chair shall recommend the members of these committees to be affirmed by the Board.

c. These committees will have no power to act other than as specifically authorized by the Board.

d. The tenure of these committees will be decided by the Board based upon the specific need for the committee.

e. Upon approval by the committee Chair, a committee member may be removed from the committee if he/she misses two (2) consecutive meetings.

Section 4. Committee Resignations, Removal and Vacancies

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

Section 5. Committee Minutes

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

Section 6. Action by Committee

Recommendations by committees are to be taken back to the Board for action.
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Section 7. Committee Compensation
Persons serving on a committee shall not receive salaries for their services, but by
resolution of the Board a reasonable amount for expenses incurred in attending to
authorized duties may be allowed; provided however that nothing herein contained
shall be construed to preclude any member of the committee from serving;

FINANCES
Section 1. Deposits
All money received by the corporation shall be deposited with a bank, trust company
or other depository, which the Board selects, in the name of the corporation. All
checks, notes, drafts and acceptances of the corporation shall be signed in the
manner designated by the Board Members.

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

Section 3. Conflicts of Interest
a. The Board shall not make a loan to any Board Member or member
   organization.
b. The Board shall not borrow money from a Board member, a member
   organization, an employee of a member organization or a family member of
   a member organization unless:
   i. The transaction is described fully in a legally binding instrument
   ii. The transaction is found to be in the best interests of the RTAB after
       full disclosure of all relevant facts at a scheduled meeting of the
       Board
   iii. Such action requires a 2/3-majority vote of the Board (excluding the
        vote of any person having a personal interest in the transaction) at a
        meeting when a quorum is present.
   iv. Disclosure of intent to undertake such action is declared to the OSDH
       and the OTERAC for approval prior to action.
c. The Board shall not transact business with a Board Member, a member
   organization, an employee of a member organization or a family member of
   a member organization unless:
   i. The transaction is described fully in a legally binding instrument;
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ii. The transaction is found to be in the best interests of the RTAB after full disclosure of all relevant facts at a scheduled meeting of the Board

iii. Such action requires a 2/3-majority vote of the Board (excluding the vote of any person having a personal interest in the transaction) at a meeting when a quorum is present.

iv. Disclosure of intent to undertake such action is declared to the OSDH and the OTERAC for approval prior to action.

PARTICIPATION
All member organizations are required to participate in RTAB activities and meet attendance expectations.

Section 1. Remote Locations
Individual RTABs may arrange for remote locations to Video Conference or Teleconference into their meetings to facilitate participation by member organizations. It is understood that Board members must attend at the published meeting location to meet the requirements of the Oklahoma Open Meetings Act.

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

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

Section 1. The Bylaws shall be reviewed/revised biennially by the Central (6) Regional Planning Committee.
Section 2. The notice of any meeting at which the Bylaws are altered, amended or repealed shall include the text of the proposed revisions, either within the agenda or as an attachment to the agenda sent out to members in advance of the meeting.