



Oklahoma State Department of Health
Creating a State of Health

Tulsa (Region 7) Regional Trauma Advisory Board
Hillcrest Medical Center
1120 South Utica Avenue
Tulsa, OK

April 1, 2014 – 1:00 P.M.
Minutes

- I. Call to Order: Meeting called to order at 1:03 P.M.
- II. Roll Call: Roll call by verbal response – Quorum met
- III. Introductions and Announcements: None
- IV. Approval of Minutes – January 7, 2014: Motion made by Bailey Medical Center to approve minutes. Motion seconded by Saint John Medical Center. Roll call vote, motion approved.
- V. Reports:
 - A. Emergency Systems Report: Sean Oats
We have copies of the RTAB pictorial directory in the back if you did not receive on last quarter. We printed enough directories for one for each agency.
Dan Oller presented data from TRec.
- VI. Regional Sub-Committee Report
 1. Regional Planning Committee: None
 2. CQI Sub-Committee: See attached
 - a. In the CQI report you can see that we sent out six good job letters this quarter. We also had one good job letter that was given because of the exceptional documentation of this case.
- VII. Presentation:
 - A. Overview of Trauma Registry and EMS Registry (OKEMSIS) – Dr. Kenneth Stewart
Registry is great to collect data and track your trends. You can customize the variables to meet what you would like to track or look at. Oklahoma Trauma Systems tracks patients with an ISS score of 9 which is low compared to other states. A lot of states do not track patients with an ISS score below 16. Trauma Registry was never meant to be a catch all for trauma. It was set up to improve the care of patients in the trauma system. Once we receive the data there are several different ways we can use this data. Research, Public Health, Performance Improvement are some of the areas we would like to work towards. For more information see attachment or contact Dr. Stewart.



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Sue Watkins asked Dr. Stewart what were some of the biggest issues for the Trauma Registry. He advised it would probably be the turnover of Trauma Registrars. Brandon asked Dr. Stewart if he would address the Hospital Portal. Dr. Stewart stated that we have a hospital portal that will allow the hospital registrar to access the pre hospital records of patients treated at their facility. It has been pretty popular so far. EMS agencies are still required to leave their documentation at the receiving hospital. Dr. Stewart was asked if the portal would allow the EMS agencies to retrieve information from the hospital on patients they transported. The answer was we would have to think about that and check with legal and our HIPPA Privacy Officer.

VIII. Business:

- A. Efficiency Study – Brandon Bowen
I would like to talk with you about a challenge for every region. Senate Bill 1554 makes this an all-inclusive trauma system. These meetings are mandatory to attend. We are continually hearing from all regions we have this trauma thing down when are we expanding into stroke and stemi? We do have a great system but our data shows we still have a four hour delay in getting patients from lower level facilities to definitive care state wide. This is where we need to open dialog and discuss what we can improve on. Regional Planning Committee meetings are open meetings and are where the heavy lifting is done for the Regional Trauma Advisory Boards. Stroke and Stemi have core measures. You can walk into any level four facility in the state and see displays up stating goals for door to balloon time but we don't see a lot about trauma. People will say well the golden hour is not supported. There is no data to support an hour or even two hours. My question is do you need data to know if you get a patient to definitive care faster their outcome will be better? Are we going to wait on someone to give us a benchmark time to know what we are going to aiming for? We are challenging every region to participate in your Regional Planning and maybe have a work group for the Regional Planning to identify your best practices. What do you do when a trauma hits the door? We would really like to see is to your best practices. What is the process from the minute the patient hits the door. What time did they arrive? When were they first seen? When was the decision made to keep the patient or transfer them out? This is what we see in level four facilities. We understand that a lot of trauma is treated in region 7, but maybe sharing some of your best practices with the outlying areas might improve their response and patient care. If we ask a level four facility what their process is for a high acuity trauma patient is and they cannot articulate their process that is the first issue. Another issue could be when the decision is made to transfer the patient when was the call made? What was the ETA given? When did EMS arrive? When did they depart? I feel that by examining these times and when these things occur we can then design a tool to add to our Oklahoma Trauma Education Program Module to address these very things. That can accompany this patient not designed to replace anything you have that works well but assist the facilities that do not deal with high acuity trauma very on a daily basis we give them something that goes right along with the patient and standardized throughout the state of Oklahoma. I think that we can come up with a benchmark time that is not necessarily mandated, but provides a resource or a tool to treat those traumas with a greater sense of urgency. So where do we start?
Mike Paston thinks we have a good start with the DVD. Why aren't the decision makers using this information? Wendy Van Matre asked about discussion of market share how systems work within their system? We have never discussed this and it is a little bit discomfort able but it is reality. Precursor to that question is why does that patient going to you instead of going to the definitive facility in the system. Why do we have so many



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Saint John Owasso thinks that they receive a lot of their patients they transfer because of the Basic services around them know they have some resources. Melissa Kelly is not sure why they do not take them to definitive care. Bruce Kelley says they have a relationship with Saint John Owasso is every morning he gets a report of every patient that is transferred to Saint John whether it is medical or trauma. Also has anyone looked at how many of the patients being transported were brought in by EMS and how many walked in off the street. Mark Kessler from EMSA East brought up that it he does not see the loop closer medics had 20 years ago. Which he sees as medics losing the learning skills of understanding that if they had gone directly to definitive care the outcomes might have been better or giving them an alternative to think about. He also brought up in some of the other services he has been with that they only have one unit and if that unit is out of their service area on a transport for an hour or two their community possibly has no coverage because they are relying on mutual aid. A lot of these smaller services do not understand that sometimes it takes three or four hours to get everything done. Sue asked if they thought the portal would be a good source for that loop closure to drive good decisions in the future.

Maybe a good place to start with this is to look at the agencies destination protocols and see if they are taking patient to the Trauma Center or closest facility. Sometimes it is also the city or community leader saying we have a local hospital that needs the revenue and you have the obligation to stay in your community.

Dr. Sacra discussed about the six to eight percent of trauma patients and come up with a simple patient care record to follow the patient. Judy Dykes made the comment that we should evaluate all level one and two facilities and see how they process priority one patients and develop from the CQI process a tool to send out across the state. Dr. Sacra stated we needed to narrow down the data we are looking at to the true priority one patients. We also need a system in the state that all medical information to include radiological information readily available at the receiving facilities. It was brought up that several states have this available including Arkansas. Dr. Yeary stated that a lot of the transferred in patients presented to the small facility and were not brought in by EMS. Duffy McAnallen suggested that what Saint John or Saint Francis us to call a Trauma Alert distributed out to the field so everyone is following the same criteria. Sue said one facility asked them to give them five steps just five steps and they will follow it every time. Brandon stated we have the information and it is just three steps but we cannot get people to read this. Maybe do a presentation at Medic Update about bypassing the local facilities and transporting patients directly to definitive care. Something we need to address pretty soon is being able to access those studies that are being done. Sometimes even if they send the data it takes longer to upload it than to redo the study itself.

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- IX. Public Comment: None
- X. Next Meeting:
- RTAB- July 1, 2014
Saint John – Broken Arrow
1000 West Boise Circle
Broken Arrow, OK
- RPC – July 1, 2014
Saint John – Broken Arrow
1000 West Boise Circle
Broken Arrow, OK
- CQI – Region 2/4/7 September 11, 2014
Saint John Hospital
1923 South Utica Avenue
Tulsa, OK
- XI. Adjournment: Motion made by Saint John – Owasso and seconded by Hillcrest Hospital to adjourn at 2:43 P.M.