Northwest (1) Regional Planning Committee
REGULAR MEETING
Tuesday, April 27, 2021 – 9:00 a.m.

Location of Meeting: Microsoft Teams
https://teams.microsoft.com/l/meetup-join/19%3ameeting_NDAxZmZlMmQtNDE1My00NmZkLTg0YTgtYTBkNDI3OGE2Yjgy%40thread.v2/0?context=%7b%22Tid%22%3a%229a307864-3e98-4f08-b90a-728b62cf32c5%22%2c%22Oid%22%3a%22463c8334-e408-4d1d-b4eb-52f4b934efe4%22%7d
Join by Phone: +1 405-898-0717 United States, Oklahoma City (Toll)
Conference ID: 318 235 457#

There is no physical meeting location. All Advisory Council Members are participating remotely via the Microsoft Teams platform shown above. Advisory Council Members are:
Jamie McAlister, Chair, Rodney Baker, Joshua Boden, Vanessa Brewington, Tamara Fischer, Emily Powell, Derek Vermillion, Valerie Schultz, Grant Wadley

AGENDA

I. Call to Order……Jamie McAlister, Chair

II. Roll Call……Jamie McAlister, Chair

III. Introductions and Announcements……Jamie McAlister, Chair

IV. Approval of Minutes – November 13, 2020……Jamie McAlister, Chair

V. Business
A. Discussion, consideration, possible action and vote to approve recommendation to the RTAB for planning and implementation of 2021 trauma system goals……Jamie McAlister, Chair

VI. New Business (For matters not reasonably anticipated 48 hours prior to the meeting)

VII. Next Meetings
A. Regional Trauma Advisory Board
April 27, 2021 – 10:30 am
B. Quality Improvement Committee
April 27, 2021 – 12:00 p.m.
C. Oklahoma Trauma and Emergency Response Advisory Council
June 2, 2021 – 1:00 p.m.
D. Regional Planning Committee
July 28, 2021 – 9:00 a.m.

VIII. Closing, Adjournment, and Dismissal

**If the audio is disconnected at any point during the meeting, Board Members will attempt to rejoin. The meeting will reconvene upon reconnection using the same platform and access codes. If unable to restore connections for a maximum of 15 minutes the meeting will be adjourned.*

Northwest (1) Regional Planning Committee
Microsoft Teams
https://teams.microsoft.com/l/meetup-join/19%3ameeting_ZjMwZDA5MDktMTY0Mi00Yzk2LWJiZDEtZWI3NjY2OWRjZjNj%40thread.v2/0?context=%7b%22Tid%22%3a%229a307864-3e98-4f08-b90a-728b62cf32c5%22%2c%22Oid%22%3a%22463c8334-e408-4d1d-b4eb-52f4b934efe4%22%7d
November 13th, 2020 – 9:00 am

MINUTES

There is no physical meeting location and the following members are participating remotely using the Microsoft Teams teleconferencing platform: Rodney Baker, Joshua Boden, Vanessa Brewington, Tamara Fischer, Jamie McAlister, Emily Powell, Derek Vermillion, Valerie Schultz, and Grant Wadley.

The meeting notice was filed with the Oklahoma Secretary of State on November 5th, 2020 at 8:39 am. The meeting notice/agenda was posted on the Oklahoma State Department of Health website for the Region 1 RTAB on November 6th, 2020.

I. Call to Order – Chair Jamie McAlister
The meeting was called to order by Chair Jamie McAlister at 9:07 am.

II. Welcome and Introductions – Chair Jamie McAlister
There were no introductions made.

III. Roll Call – Chair Jamie McAlister
Roll call was taken with the following members present: Joshua Boden, Vanessa Brewington, Tamara Fischer, Jamie McAlister, and Emily Powell. The following members were absent: Rodney Baker, Derek Vermillion, Valerie Schultz, and Grant Wadley.

IV. Approval of Minutes – July 28th, 2020 – Chair Jamie McAlister
A motion to approve the minutes as written was made by Tamara Fisher and seconded by Joshua Boden. There was no discussion and the motion passed 5 – 0.

V. Business

A. Discussion, consideration, possible action and vote to approve draft Region 1 Stroke Plan for recommendation to the RTAB – Chair Jamie McAlister
Jennifer Woodrow noted that she requested the plan several times but had not receive a revised draft stroke plan. Tamara Fischer also stated she did not have the draft plan. Ms. Woodrow will send the first draft plan with the committee's recommendations for changes for Ms. Fischer to revise and return to be presented at the next meeting for approval. Ms. Woodrow noted that Valerie Schutlz and Ms. Fischer agreed to review the plan to ensure compliance with the approved Oklahoma State Stroke Systems Advisory Council (OSSSAC) guidelines.

B. Discussion, consideration, possible action and vote to approve amended Region 1 Trauma Plan for recommendation to the RTAB – Chair Jamie McAlister
Jamie McAlister presented recommended changes to the Region 1 Trauma Plan. Jennifer Woodrow noted that she had updated the Trauma Plan with facility name changes and current numbers regarding population and EMS descriptions. Members reviewed the trauma plan for additional needed changes with all agreed upon changes noted on the attached Region 1 Trauma Plan. Members reviewed proposed changes recommended by the Region 1 Medical Emergency Response Center (MERC) that included deletion of the following:

- The MERC or his/her designee has the authority at any time to deny or discontinue Emergency Department divert based on the needs of the community.
- 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.

Members asked who will manage these items if the MERC will not. The decision was made to bring the discussion and question to the RTAB to resolve. Members also discussed the need to combine the Description of EMS Services and Appendix A and, due to frequent changes, not include staffing numbers. These changes will be brought back to the next meeting for approval. Emily Powell discussed the need to possibly reevaluate trauma level designations to address Level IV Trauma Centers that do not have the capability to provide immediate stabilization. Dan Whipple noted that there are organizations such as the American College of Surgeons Committee on Trauma that use five different levels of trauma centers and the OTERAC Systems Improvement and Development workgroup will be looking to see if there is a need to possibly amend the current nomenclature for trauma center classification.

Northwest (1) Regional Planning Committee
Microsoft Teams
https://teams.microsoft.com/l/meetup-join/19%3ameeting_ZjMwZDA5MDktMTY0Mi00Yzk2LWJiZDEtZWI3NjY2OWRjZjNj%40thread.v2/0?context=%7b%22Tid%22%3a%229a307864-3e98-4f08-b90a-728b62cf32c5%22%2c%22Oid%22%3a%22463c8334-e408-4d1d-b4eb-52f4b934efe4%22%7d
November 13th, 2020 – 9:00 am

MINUTES

C. Discussion, consideration, possible action and vote to approve amended Region 1 Bylaws for recommendation to the RTAB – Chair Jamie McAlister
Members reviewed the Region 1 Bylaws and discussed the addition of the following:
Section II. Standing Committees:
10. The Trauma Plan shall be reviewed/revised biennially by the Northwest (1) Regional Planning Committee.
AMENDMENT OF BYLAWS
Section 2. The Bylaws shall be reviewed/revised biennially by the Northwest (1) Regional Planning Committee.
Due to Region 1 Bylaw requirements, the amended language will be added to the next meeting agendas and distributed to members two weeks in advance for approval at the next RPC and RTAB meetings.
A motion to approve the changes shown on the attached Region 1 Trauma Plan and the above Region 1 Bylaw amendments was made by Joshua Boden and seconded by Emily Powell. There was no discussion and the motion passed 5-0.

D. Discussion, consideration, possible action and vote to approve draft letter to send to the stroke coordinators of licensed hospitals regarding proposed stroke algorithm and need to provide education to EMS agencies for recommendation to the RTAB – Chair Jamie McAlister
Jamie McAlister presented the draft letter for review. Tamara Fischer stated the letter included stroke education resources from the American Heart Association and OSSSAC and was developed to send to hospitals for the purpose of providing stroke education to EMS agencies and hospital staff. Jennifer Woodrow suggested that the letterhead be changed from Okeene Municipal to the approved Region 1 RTAB letterhead and noted that the algorithm for rural stroke care was developed and approved by OSSSAC and not the Regional Planning Committee. Tamara Fischer will make the suggested changes and send to Jennifer Woodrow to be placed on the agenda for approval at the next meeting. Members approved of the letter and suggested changes with the decision made to wait to send until after approval of a regional stoke plan. The decision was also made for the letter to be signed by Jamie McAlister as the acting RTAB Chair.

E. Discussion, consideration, possible action and vote to approve 2021 Meeting Dates, Times, and Venue – Chair Jamie McAlister
- January 26th, 2021 beginning at 9:00 am at the High Plains Technology Center
- April 27th, 2021 beginning at 9:00 am at the High Plains Technology Center
- July 27th, 2021 beginning at 9:00 am at the High Plains Technology Center
- October 26th, 2021 beginning at 9:00 am at the High Plains Technology Center

Jamie McAlister presented the proposed 2021 meeting dates, times, and venues. A motion to approve the above proposed meeting dates, times, and venues was made by Joshua Boden and seconded by Emily Powell. There was no discussion and the motion passed 5-0.

VI. New Business – Chair Jamie McAlister
(For matters not reasonably anticipated 48 hours prior to the meeting)
There was no new business.

VII. Next Meeting – Chair Jamie McAlister

A. Regional Trauma Advisory Board
Microsoft Teams
October 27th, 2020 – 10:30 am

B. Quality Improvement Committee
Microsoft Teams
October 27th, 2020 – 12:00 pm

C. Oklahoma Trauma and Emergency Response Advisory Council
Oklahoma Department of Health
1000 Northeast 10th Street
Oklahoma City, OK 73117
As Called – 1:00 pm

Northwest (1) Regional Planning Committee
Microsoft Teams
https://teams.microsoft.com/l/meetup-join/19%3ameeting_ZjMwZDA5MDktMTY0Mi00Yzk2LWJiZDEtZWI3NjY2OWRjZjNj%40thread.v2/0?context=%7b%22Tid%22%3a%229a307864-3e98-4f08-b90a-728b62cf32c5%22%2c%22Oid%22%3a%22463c8334-e408-4d1d-b4eb-52f4b934efe4%22%7d
November 13th, 2020 – 9:00 am

MINUTES

D. Regional Planning Committee
High Plains Technology Center
3921 34th Street
Woodward, OK 73801
January 26th, 2021 – 9:00 am

Jamie McAlister announced the next meeting dates with no discussion.

VIII. Adjournment – Chair Jamie McAlister

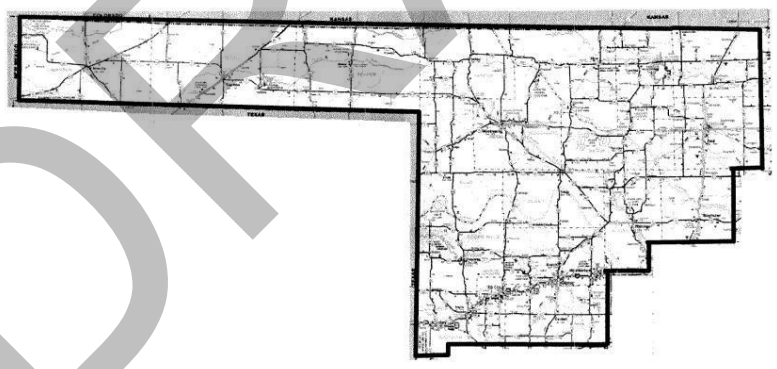
A motion to adjourn was made by Joshua Boden and seconded by Emily Powell. The meeting adjourned at 10:16 am.

Approved

_____
Jamie McAlister, Chair
Region 1 Regional Planning Committee
April 27th, 2021

Region 1 Trauma Plan

Developed by the RTAB NW Regional Planning Committee



Plan Approval Dates:
Pre-Hospital RTAB: 07-18-2006 OTSIDAC: 08-02-2006 RTAB: 11/13/2020
Inter-facility RTAB: 03-27-2007 OTSIDAC: 08-01-2007
EMResource™ RTAB: 05-23-2006 OTSIDAC: 08-02-2006
OTSIDAC Revision to Trauma Triage Algorithm Guidelines: February 2, 2010

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I. GOALS / PURPOSE

The goals of the regional trauma pre-hospital destination/inter-facility transfer plans are to:

A. Assure trauma patients are stabilized and transported to the most appropriate hospital facility with the available resources and capacity to provide care in a timely fashion.

B. Support the Pre-Hospital/Inter-Facility Trauma Triage and Transport Guidelines to effectively reduce trauma morbidity and mortality.

C. Match a facility's resources with each trauma patient's needs to ensure optimal and cost effective care is achieved.

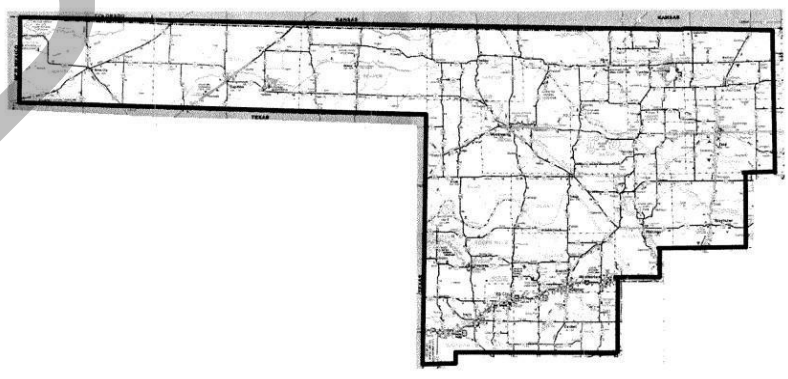
D. This plan will not conflict with any rules and/or regulations that are currently in place, or may be written or changed in the future. In the event new rules and/or regulations are considered, the RTAB should be included in that dialogue prior to implementation.

II. REGION DESCRIPTION

Region 1 consists of the northwest portion of Oklahoma and includes the following counties: Alfalfa, Beaver, Beckham, Blaine, Cimarron, Custer, Dewey, Ellis, Garfield, Grant, Harper, Kingfisher, Major, Roger Mills, Texas, Washita, Woods and Woodward.

Region 1 is the largest region in Oklahoma and encompasses ~~21,334~~ 21,232 square miles with a population of ~~232,461~~238,148. Region 1 has common borders with four states: Colorado, Kansas, New Mexico and Texas.

It is serviced by 4~~0 3~~ ambulance services, two (2) Level III T~~t~~rauma ~~hospitals~~Centers, ~~and eighteen (~~178~~)~~ L~~l~~evel IV T~~t~~rauma ~~hospitals~~ Centers, of which ~~seven (~~147~~)~~ are designated C~~c~~ritical ~~a~~Access Hospitals, and ~~and~~ three~~one~~ (3~~1~~) P~~p~~sychiatric ~~facility~~Hospital. ~~and one (1) Long Term Acute Care hospital.~~



III. TRAUMA PRIORITY CATEGORIZATION

All injured patients must be identified and transported/transferred to the facility that provides the appropriate care based on the clinical needs of the patient. This should be done in a timely fashion with specific attention focused on preserving the highest level of care for major trauma patients. A three-tiered system designed to determine the appropriate hospital destination for all injured patients considers injury severity, severity risk, time and distance from injury to definitive care, and available resources to meet the region's specific needs. This three-tiered system is outlined in Appendix BC and 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.

1. **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, Level II, or designated Level III Trauma Centers with 24/7 in house ED physicians, 24/7 general and orthopedic surgeon availability. These patients should be directly transported to a Level I, Level II, or designated Level III facility for treatment, but may be stabilized at any 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 receive definitive care in a Level III facility if the appropriate services and resources are available. (e.g. orthopedic, vascular, or maxillofacial surgery).

2. **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.

3. **Priority 3 Trauma Patients:**

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

IV. CATEGORIZATION OF HOSPITALS

A. Hospital Providers in Region 1 include: (~~2008~~ 2020 Information). For the latest information regarding facility capabilities, refer to EMResource™.

1. **Level I:** None
2. **Level II:** None
3. **Level III:**
   a. INTEGRIS Bass Baptist Health Center (Enid)
   b. St. Mary's Regional Medical Center (Enid)

4. **Level IV:**
   ~~l. Sayre Memorial Hospital (Sayre)~~
   a. ~~INTEGRIS Clinton Regional Hospital~~ AllianceHealth Clinton (Clinton)
   b. ~~Woodward Regional Health Center~~ AllianceHealth Woodward (Woodward)
   c. Beaver County Memorial Hospital (Beaver)
   d. Cimarron Memorial Hospital (Boise City)
   e. Cordell Memorial Hospital (Cordell)
   f. Fairview ~~Hospital~~ Regional Medical Center Authority (Fairview)
   g. Great Plains Regional Medical Center (Elk City)
   h. Harper County Community Hospital (Buffalo)
   i. Memorial Hospital of Texas County Authority (Guymon)
   j. ~~Kingfisher Regional Hospital~~Mercy Hospital Kingfisher (Kingfisher)
   k. ~~Watonga Municipal Hospital~~ Mercy Hospital Watonga (Watonga)
   l. Newman Memorial Hospital, Inc. (Shattuck)
   m. Okeene Municipal Hospital (Okeene)
   n. Roger Mills Memorial Hospital (Cheyenne)
   o. Seiling Municipal Hospital ~~Authority~~ (Seiling)
   p. Share ~~Memorial Hospital~~ Medical Center (Alva)
   q. Weatherford Regional Hospital, Inc. of Weatherford, Oklahoma (Weatherford)

~~5. Long Term Acute Care Facilities:~~
~~a. INTEGRIS Bass Pavilion~~

6. **Psychiatric Hospitals:**
   a. Northwest Center for Behavioral Health (Ft. Supply)
   b. INTEGRIS Meadow Lake – pediatric & adolescent (Enid)
   ~~a.~~c. St. Mary's Resilience Behavioral Health (Enid)

7. **Other Facilities:**
   a. ~~USPHS Indian Hospital~~Clinton Indian Health Center (Clinton)

b. Oklahoma Veterans Center (Clinton)

B. Out of Region Hospital Resources:

1. **Level I:**
   a. ~~Via Christi Regional Medical Center~~Ascension Via Christi St. Francis~~(St. Francis Campus)~~, Wichita, KS
   b. OU ~~Medical Center~~Medicine, Oklahoma City, OK
   c. University Medical Center Health System, Lubbock, TX
   d. Wesley Medical Center, Wichita, KS
2. **Level II:**
   a. St. John Medical Center, Inc., Tulsa, OK
   b. St. Francis ~~Medical Center~~ Hospital, Inc., Tulsa, OK
3. **Level III:**
   a. Northwest Texas Healthcare System, Amarillo, TX

V. DESCRIPTION OF EMS SERVICES

Region 1 is a very large area encompassing 18 counties (Population ~~232,461~~238,148) and covering approximately 21,232~~334~~ square miles that is serviced by 40~~2~~ ambulance services and seven (7) ~~two~~ air transport service~~s with three bases~~.

A. Ground Ambulance Services: (2020~~08~~ Information). For current information, refer to the EMS Registry available at:
http://www.ok.gov/health/Protective_Health/Emergency_Medical_Services/

1. Alfalfa County:
   One (1)~~2~~ Basic ambulance service~~s~~ cover~~s~~ Alfalfa County with four (4) routine units covering the 866~~81~~ square miles of the county.
2. Beaver County:
   One (1) Basic ambulance service covers Beaver County with two (2) routine units covering the
   1,815~~8~~ square miles of the county.
3. Beckham County:
   Three (3)~~2~~ Basic ambulance services ~~and 1 intermediate ambulance service~~ cover~~s~~ Beckham County with five (5) routine units that cover the 90~~4~~2 square miles of the county.
4. Blaine County:
   Blaine County is covered by three (3)~~4~~ Basic ambulance services with four (4)~~11~~ routine units that cover~~ing~~ the
   92839~~9~~ square miles of the county.
5. Cimarron County:
   Cimarron County is covered by two (2) Basic ambulance services with three (3) routine

units that
cover the 1,8353541 square miles of the county.

6. Custer County:

Custer County is covered by three (3) ~~Intermediate~~ Basic ambulance services, one (~~and~~ 1) ~~Basic~~ Intermediate ambulance service, and one (1) Advanced ambulance service with nine (9)~~10~~ routine units that cover the 9891,002 square miles of the county.

7. Dewey County:
   Dewey County is covered by three (3)~~4~~ Basic services with six (6)~~8~~ routine units that cover the
   999~~1,002~~ square miles of the county.
8. Ellis County:
   Ellis County is covered by one (1) Basic ambulance service with two (2)~~3~~ routine units that cover the
   1,232 square miles of the county.
9. Garfield County:
   Garfield County is covered by one (1) Paramedic ambulance service and one (1) Basic ambulance ~~S~~service with five (5)~~6~~ routine units that cover the 1,058~~60~~ square miles of the county.
10. Grant County:
    Grant County is covered by three (3)~~2~~ Basic ambulance services with three (~~a total of~~ 3)~~4~~ routine units that cover the 1,00~~1~~4 square miles of the county.
11. Harper County:
    Harper County is covered by two (2) Basic ambulance services with two (~~a total of 2) routine~~4 units that cover the 1,039~~41~~ square miles of the county.
12. Kingfisher County:
    Kingfisher County is covered by two (~~1~~2) Paramedic ambulance services and one~~,~~ (1) Intermediate ~~and 1 Basic~~ ambulance service ~~cover Kingfisher County~~ with four (4)~~5~~ routine units that cover the 898~~906~~ square miles of the county.
13. Major County:
    Major County is covered by one (1) ~~-~~Basic Ambulance service with two (2)~~3~~ routine units that cover the
    955~~8~~ square miles of the county.
14. Roger Mills County:
    Roger Mills County is covered by one (1) Basic ambulance service with one (1)4 ~~-~~ routine unit~~s~~ that cover~~s~~ the 1,141~~6~~ square miles of the county.
15. Texas County:
    Texas County is covered by one (1) Intermediate ambulance service and two (2)~~3~~ Basic ambulance services with seven (7) routine units that cover the 2,041~~9~~. square miles of the county.
16. Washita County:
    Washita County is covered by two (~~-~~2)~~3~~ Basic ambulance services with two (2)~~5~~ routine units that cover the 1,003~~9~~ square miles of the county.
17. Woods County:
    Woods County is covered by three (3) Basic ambulance services with four (4)~~6~~ routine units that cover the 1,287~~90~~ square miles of the county.
18. Woodward County:

Woodward County is covered by one (1) Basic ambulance service with six (6)~~5~~ routine units that cover the 1,242~~6~~ square miles of the county.

B. Air Ambulance Services

1. Air Evac Lifeteam, based in Elk City, OK (AE21); Kingfisher, OK (AE131); Weatherford, OK (AE122); and Woodward, OK (AE70), provides rotor wing service to Region 1.
~~1.~~
2. Apollo MedFlight, based in Amarillo, TX, provides fixed wing service to Region 1.
3. Air MD LLC dba: Life Save, ~~Midwest Life Team~~ based in Liberal, KS, provides fixed wing service to Region 1.
~~4.~~ Eagle Med – Kansas, based in ~~Guymon, Oklahoma and Stillwater, Oklahoma (EagleMed8) (Stillwater is~~
~~5.~~4. ~~in Region 2 but provides Air Service to Region 1).~~Wichita, KS, provides fixed wing service to Region 1.~~Eaglemed has one Fixed Wing Aircraft (EagleMed21) located in Yukon, Oklahoma that can service all Regions.~~

VI. TRAUMA TRANSFER AND REFERRAL CENTER (TReC)

The Trauma Transfer and Referral Centers were created by statute (Senate Bill 1554, 2004) and they were implemented on July 1, 2005. The purpose of these centers is to ensure that trauma patients transported or transferred to facilities in Region 7 or 8 are transported to the facility that provides the appropriate level of care based on the clinical needs of the patient. This should be done in a timely fashion with specific attention focused on preserving the highest level of care for major trauma patients. On April 1, 2010, TReC was consolidated to a single call center in Region 7. TReC is located in the Tulsa 911 center and serves the entire State of Oklahoma.

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

Ambulances from Region 1 are required to call into the center prior to entering Regions 7 or 8 in order to ensure appropriate patient destination. Likewise, hospitals may call these centers for assistance in identifying the appropriate destination for their trauma patients.

These centers will provide information on resource utilization to the OSDH that will be available to the Region 1 RTAB for Quality Improvement purposes.

PRE-HOSPITAL DESTINATION PROTOCOLS

I. PROCEDURE FOR SELECTION OF HOSPITAL DESTINATION

It is recognized that some patients have needs that can only be met at specific destination hospitals. Thus, a trauma patient will often benefit from transfer directly to an appropriate hospital with the 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 Trauma Triage and Transport Guidelines is essential in determining the appropriate hospital destination for Priority 1, 2, and 3 trauma patients (see appendix B).

These Destinations are:

ALL PATIENTS:

1. All trauma patients should be rapidly transported to the closest medical facility with the capability and capacity to provide the appropriate level of care as indicated by the patient's injury type and severity.

2. Patients with a traumatic arrest or the need to secure an airway should be transported to the closest facility to the traumatic event.

~~3.~~ Any priority 1 ~~or 2~~ trauma patient who needs immediate life saving treatment or intervention~~stabilization~~ should be transported to the nearest facility ~~with the capability and capacity to provide definitive care~~for stabilization.

~~4~~3. Patient preference as well as the time and distance should factor into where definitive care will be considered for most Priority 2 and 3 trauma patients.

GENERAL TRAUMA PATIENTS:

General trauma patients who meet the State of Oklahoma approved trauma criteria should be transported using the following guidelines. General geographic and transportation borders have been used as boundaries for these transportation designations. These boundaries are used as guidelines and it is understood that there are sites in the region that based on time and distance may need to be transported into a different border area.

1. Priority 1 adult and pediatric trauma patients that meet the state approved trauma criteria should be transported to the nearest Level I~~1~~ or II~~2~~ T~~t~~rauma C~~c~~enter.

    a. OU Medicine ~~Medical Center~~ will be the appropriate center for the majority of Region 1.

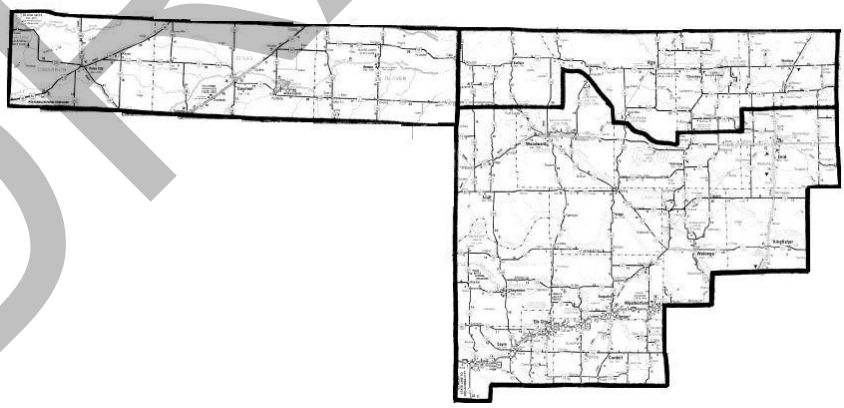
    b. Cimarron, Texas and Beaver counties *may* transport to University Medical Center Health Systems in Lubbock, Ascension Via Christi ~~Regional Medical Center~~ Saint Francis or Wesley Medical Center in Wichita, and OU Me~~dicine Medical c~~enter in Oklahoma City.

    c. Harper, Woods, Alfalfa and Grant counties *may* transport to Ascension Via Christi Saint Franc~~is Regional Medical Center~~ or Wesley Medical Center in Wichita, Kansas.

    d. The appropriate method of transport for those patients **outside** of an area **45 minutes** from the appropriate center should activate **air transport** as defined in Section IX, as soon as possible to ensure rapid transport to the appropriate facility.

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

    Region 1 Priority 1 Trauma Patient Destinations:



2. Priority 2 trauma patients that meet the state approved trauma criteria should be transported using the following guidelines:

    a. 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. Additionally, Priority 2 patients should be transported to a facility with the capability and capacity to provide definitive care.

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

c. All single system Priority 2 Pediatrics being transferred or transported into Region 8 will now go directly to The Children's Hospital at OU Medicine~~C~~.

3. Priority 3 adult and pediatric trauma patients should be transported to the nearest appropriate treating facility or the facility of patient preference.

NEUROLOGICAL TRAUMA PATIENTS:

1. Priority 1 adult and pediatric neurological trauma patients.

   a. The majority of Priority 1 neurosurgical trauma patient in Region 1 will go to Oklahoma City via use of the TReC.
   b. Cimarron, Texas, and Beaver counties should transport to ~~the Northwest Texas Healthcare System in Amarillo, Texas.~~ University Medical Center Health Systems in Lubbock, Texas; ~~,~~ Ascension Via Christi Saint Fran~~cis Regional Medica~~l Center or Wesley Medical Center in Wichita, Kansas; and OU M~~e~~dicine ~~al center~~ in Oklahoma City, Oklahoma.
   c. Harper, Woods, Alfalfa and Grant counties should transport to Ascension Via Christi Saint Francis ~~Regional Medical Center~~ or Wesley Medical Center in Wichita, Kansas.
   ~~d. Adult Priority 1 neurological trauma patients may also be transported to St. Mary's Medical Center in Enid if neurosurgical services are available at the time.~~

2. Priority 2 adult trauma patients should be transported to the appropriate facility in Enid or Oklahoma City based on the time/distance factor with preference given to patient preference and the ability to keep the patient within Region 1.

3. All single system Priority 2 Pediatrics being transferred or transported into Region 8 will now go directly to The Children's Hospital at OU Medicine~~C~~.

4. Priority 3 adult and pediatric trauma patients should be transported to the closest facility for evaluation.

BURN PATIENTS:

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

2. Pediatric: Combination of burns > 10% or significant burns involving face, airway, hands, feet, or genitalia *without* significant trauma, transport to Alexander Burn Center at Hillcrest Medical Center ~~Burn Center~~ or OU Medicine~~MC~~ Children's Hospital. Burns >10% *with* significant trauma, transport to trauma center.

II. PROCEDURE FOR MONITORING HOSPITAL STATUS AND CAPABILITY

A. EMResource™

The Medical Emergency Response Center (MERC) C~~c~~oordinator will generate reports from the EMResource™ for use in monitoring hospital status related to destination. These reports will be provided periodically to OSDH and made available to the Region 1 ~~C~~Quality Improvement (QI) 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. Quality Improvement (QI) Indicators

A set of QI Indicators has been developed for use in monitoring hospital status and appropriateness of destination. The Region 1 ~~C~~QI Committee will monitor these indicators. Any problems and/or trends through review of the indicators will be addressed by the ~~C~~QI committee directly with the provider and, if necessary, through referral to the appropriate state level committee.

III. ALS INTERCEPT (Ground)

A. Purpose: Appropriate utilization of ground ambulance resources by Region 1 providers.

This differs from other mutual aid requests that may occur during a mass casualty incident or other catastrophe. For the purposes of this protocol, an ALS Intercept occurs when a BLS unit requests assistance for an emergent patient. This support is to be rendered if the ALS unit is available and will not put the ALS response area at risk.

B. Conditions of use

BLS units should request ALS units for the purposes of:

1. Airway and respiratory interventions
2. Circulatory Support
3. Other life-sustaining interventions beyond the scope and practice of BLS crewmembers.

BLS units should not request support from ALS units for the purposes of non-emergency transports of the trauma patients, as this will tax resources of supporting agencies. As such, it is only when a BLS unit is transporting Priority 1 and 2 patients should an ALS intercept be considered.

Additionally, the BLS unit should consider location, time constraints, and distance when considering a ground or air unit for support and transportation.

ALS agency or ALS units that can provide ALS intercepts should support requests for intercepts and assistance in the following circumstances:

1. Crew is available for response
2. Adequate time is received for the request to meet the BLS crew before arrival at a receiving facility.
3. Any safety concerns such as hazardous material, violence, weather, and traffic are addressed or within acceptable margins.

IV. HELICOPTER UTILIZATION PROTOCOL

A. Purpose

Appropriate utilization of air ambulance resources by Region 1 providers.

B. "No Fly" Conditions:

Helicopter utilization is seldom indicated for patients without a chance for survival or without serious injury. The following are other situations in which an air ambulance should not be used:

a. Patients at a location where time and distance constraints make air transport to the closest appropriate medical facility more time consuming should be transported by ground. This is generally within 45 minutes of the destination facility.

b. Priority 3 patients should be transported by ground ambulance.

c. Cardiac arrest without return of spontaneous circulation in the field.

C. "Fly" Conditions:

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

   a. Priority 1 trauma patients that are being transported to a facility in which time and distance constraints make air transport more timely, generally for distances with a transport time greater than 45 minutes by ground ambulance.

   b. Priority 2 trauma patients that are being transported to a facility with a transport time greater than 45 minutes by ground ambulance, based on local resource availability.

2. The following are conditions that warrant the use of an air ambulance even when the patient is within a 45 minutes of a medical facility:

   a. The closest facility is not appropriate for the patients' injury and the appropriate facility is at a distance in which time and distance constraints justify air transport.

   b. There are 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.

D. The **closest available** medical helicopter will be utilized to improve survival of all patients being transported to a definitive care facility.

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

F. 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:

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

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

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

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

I. EMTALA:
There are concerns regarding air utilization and rendezvous with a local ground transport at a helipad upon a medical facilities property. This is addressed in Appendix C.

V. DIVERSION

Guidelines to determine the possible need for total Emergency Department divert are: The Emergency Department cannot handle additional emergencies based on the lack of professional personnel.

1. Maximum capacity (beds) of the Emergency Department has been met.
2. Maximum capability (staff) of the Emergency Department has been met.

Notification of Emergency Department diversion status:

1. Each hospital will notify the MERC or his/her designee of the diversion status and a written record shall be maintained documenting the date, time started, and time ended of each interval of divert status.

2. Each hospital shall notify each entity providing emergency medical services, such as ambulance services and hospitals in the catchment's area of the divert status.

3. The EMResource™ will be updated to show current information.

Compliance:

1. If a hospital goes on Emergency Department divert, then the MERC or his/her designee will re-evaluate every 2 hours for continuation of diversion.
2. The MERC or his/her designee has the authority at any time to deny or discontinue Emergency Department divert based on 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.

INTER-FACILITY TRANSFER PROTOCOLS

I. TRAUMA CENTER PROGRAM

Each hospital shall have a designated Trauma Team that is appropriate for that facilities level of care. It is important to incorporate all facilities in trauma planning and implementation, as well as, in the planning of transfer protocols.

Level III Trauma Center:

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

Level IV Trauma Center:

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

Trauma Program:

Each hospital shall provide the level of Trauma Services for which the facility is licensed in accordance with the Hospital Standards of Oklahoma Administrative Code 310:667. It is important to incorporate all facilities in trauma planning and implementation, as well as, in the planning of the transfer protocol.

There must be a commitment letter from the Hospital Board and the Medical Staff on behalf of the entire facility, which states the facility's commitment to compliance with the Oklahoma Trauma Care Regulations. A trauma program must be established and recognized by each organization and evidenced by:

1. Hospital Board and Medical Staff commitment to trauma care.
2. Written policies and procedures for the care of the trauma patient.
3. A defined Trauma Team with written roles and responsibilities.
4. Appointed Trauma Medical Director with a written job description.
5. A written Trauma Performance Improvement plan.
6. Appointed Trauma Program Manager (coordinator) with a written job description.
7. Documentation of the trauma center representative's attendance at the Regional Trauma Advisory Boards meetings.

II. TRAUMA TEAM

The team approach is optimal in the care of the injured patient. The trauma center must have a written policy for notification and mobilization of an organized trauma team (in a Level III facility) or to the extent that one is available (Level IV facility). The Trauma Team may vary in size and composition when responding to trauma activation. The physician leader or the mid-level practitioner on the trauma team should have ATLS or possess equivalent training for care of the trauma patient and is responsible for directing all phases of the resuscitation.

Suggested composition of the trauma team includes:

Level III:

a. ED Physicians
b. Physician Specialists
c. Laboratory Technicians
d. Nursing
e. Auxiliary Support Staff

Level IV:

a. Physician or Mid Level Practitioner
b. Nursing
c. Laboratory Technicians
d. Auxiliary Staff

Compliance with the above will be evidenced by:

There will be written resuscitation protocols that adhere to the principles of ATLS guidelines, and a written trauma team criteria activation policy. This policy should include physiologic, anatomical, and mechanism of injury protocols in accordance with the Oklahoma Trauma Triage Algorithms and protocols.

Medical Director:

The Trauma Center should have a physician director for the trauma program. The physician should be responsible for working with all members of the trauma team, and overseeing the implementation of a trauma specific performance improvement plan for the entire facility. Through this process, he/she should have the overall responsibility for the quality of trauma care rendered at the facility. The director should assist in the development of standards of care and assure appropriate policies and procedures are in place for the safe resuscitation and transfer of trauma patients. The physician director should have ATLS or possess equivalent training for care of the trauma patient

Trauma Program Manager (Coordinator):

All Level III trauma centers must have a Registered Nurse working in the role of the Trauma Program Manager (TPM). In conjunction with the Medical Director, the TPM is responsible for organization of the program and all necessary systems for the multidisciplinary approach throughout the continuum of trauma care. He/she is responsible for working with the trauma team to assure optimal care and will liaison with local EMS personnel, the RTAB, and other trauma centers.

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

III. HOSPITAL TRIAGE AND TRANSFER PLAN:

A well designed trauma program within the hospital is crucial to the success for providing optimal care to the trauma patients in Region 1. A written commitment on behalf of the entire facility devoted to the organization of trauma care is vital. Therefore, all hospitals in the region will establish criteria for the activation of their respective trauma programs and these criteria will be clearly defined in each institutions trauma policy. The following are intended as guidelines only for each hospitals policy as each and every hospital is unique in the way it serves its stakeholders.

A. LEVEL III TRAUMA CENTER

A team approach is optimal in the care of the trauma patient. As noted above, the trauma team should consist of those individuals that can expedite care for the trauma patient. In a Level III facility this should include:

i. Emergency Physician(s)
ii. Emergency Room Nurses
iii. Laboratory
iv. Radiology
v. Respiratory Therapy

The Level III trauma center must have an Emergency Department (ER) staffed so that trauma patients are assured immediate and appropriate initial care. An ER physician deemed competent in the care of the trauma patient shall be available 24 hours/day. This ER physician must be in-house 24 hours/day, immediately available at all times, and capable of evaluating trauma patients and provide initial resuscitation. The ER physician will provide team leadership and care for the trauma patient until the surgeon or other specialist arrives to take over care. The ER must have established standards and procedures to ensure immediate and appropriate care for the adult as well as the pediatric trauma patient. The medical director of the ER must participate in the trauma PI process.

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

i. General Surgery
ii. Anesthesia
iii. Other medical specialties that may be available in the local area to assist with care of the trauma patient.

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

Clinical support services such as Respiratory Therapy and Radiology technicians shall be available 24 hours/day to meet the immediate needs of the trauma patient. Written policies should exist delineating the prioritization/availability of the CT scanner for trauma patients. The use of tele-radiology is an acceptable practice in the Level III facility.

Clinical laboratory services shall have the following services available in-house 24 hours per day:

i. Blood typing and cross matching capabilities
ii. Access to sufficient quantities of blood and blood products
iii. Microbiology
iv. Blood gas and pH determination
v. Alcohol and drug screening
vi. Coagulation studies.

All Level III trauma centers should have the following:

i. Written transfer agreements with other providers as a transferring facility
ii. Available Helipad.

B. LEVEL IV TRAUMA CENTER

The team approach is optimal in the care of trauma patients. The Level IV trauma center must have a written policy for notification and mobilization of an organized trauma team to the extent that one is available. The team may vary in size and composition depending on the logistics of the facility. The physician leader or 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:

i. Physician or Licensed Mid-level practitioner
ii. Emergency Room Nurse
iii. Laboratory
iv. Radiology
v. Ancillary personnel as needed

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

The Level IV trauma center should have the following clinical services available for consultation via a communication system on a 24-hour basis:

i. General surgery
ii. Neurology
iii. Neurosurgery
iv. Orthopedics

The Level IV facility 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 to the patient. Agreements should be in place so that ALL facilities will work together to implement the Trauma Transfer Guidelines.

IV. CRITERIA FOR ACTIVATION OF THE TRAUMA TEAM

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

a. Glasgow Coma Scale (GCS) < 10
b. Systolic blood pressure < 90 mmHg (adult)
c. Respiratory rate < 10 or > 30/min
d. Penetrating injury to the head, neck, torso, or extremities above the elbows or knees
e. Flail chest
f. Two or more proximal long bone fractures
g. Pelvic fracture
h. Limb paralysis
i. Amputation proximal to the wrist or ankle
j. Body surface burns > 5% (second or third degree)
k. Burns associate with other traumatic or inhalation injury
l. Trauma transfer patient that is intubated or receiving blood
m. Children under 12 with any of the following criteria
n. Ejection from vehicle
o. Death of same passenger compartment
p. Extrication time greater than 20 minutes
q. Rollover MVC
r. High-speed auto crash greater than 40 mph
s. Auto deformity greater than 20 inches of external damage or intrusion into passenger compartment greater than 12 inches
t. Pedestrian thrown or run over
u. Motorcycle crash greater than 20 mph or separation of rider from the bike.

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

V. INTER-FACILITY TRANSFERS

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

1. The patient will be stabilized and then transferred to the most appropriate facility (Priority I or Priority II trauma that is time-sensitive), if appropriate staff and resources are available, stabilization may require surgical intervention, all Priority I patients that are admitted at a level III or IV hospital will have automatic CQI by the RTAB,
2. The patient will be stabilized and then admitted to that facility (Priority II that is not time-sensitive or Priority III),
3. The patient will be stabilized and transferred to their facility of choice (Priority II that is not (time-sensitive), or
4. The Priority III trauma patient will be treated at the closest acute care hospital or the hospital of patient's choice. The patient will be treated and discharged to home with appropriate instruction for their injuries (Priority III trauma).

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

In accordance with the ATLS guidelines of the American College of Surgeons, "Once the need to transfer is recognized, arrangements should be expedited and not delayed for diagnostic procedures that do not change the immediate plan of care for the patient."

VI. PROCEDURE FOR SELECTION OF HOSPITAL DESTINATION

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

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

VII. 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 OSDH and made available to the Region 1 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. QI Indicators

A set of QI Indicators has been developed for use in monitoring hospital status and appropriateness of destination. The Region 1 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.

VIII. HELICOPTER UTILIZATION PROTOCOL

A. Purpose

Appropriate utilization of air ambulance resources by Region 1 providers.

B. "No Fly" Conditions:

Helicopter utilization is seldom indicated for patients without a chance for survival or without serious injury. The following are other situations in which an air ambulance should not be used:

i. Patients at a location where time and distance constraints make air transport to the closest appropriate medical facility more time consuming should be transported by ground. This is generally within 45 minutes of the destination facility.

ii. Priority 3 patients should be transported by ground ambulance.

iii. Cardiac arrest without return of spontaneous circulation in the field.

C. "Fly" Conditions:

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

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

ii. Priority 2 trauma patients that are being transported to a facility with a transport time greater than 45 minutes by ground ambulance, based on local resource availability.

D. The following are conditions that warrant the use of an air ambulance even when the patient is within a 45 minutes of a medical facility:

i. The closest facility is not appropriate for the patients' injury and the appropriate facility is at a distance in which time and distance constraints justify air transport.

ii. There are hazardous or impassable road conditions resulting in significant delays for ground transportation.

iii. There are multiple patients of a serious nature requiring rapid transport, overwhelming available ground units.

iv. 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 aircraft should be utilized to improve survival of all patients being transported to a definitive care facility.

IX. DIVERSION

A hospital on divert can maintain that status for a **maximum** of 2 hours and then the situation should be re-evaluated. If it a hospital is continued on divert status for an additional 2 hour time period the Medical Emergency Response Center (MERC) coordinator in conjunction with the Regional Medical Director will assess the situation and determine if it is appropriate to continue on divert status and activate the MERC if deemed necessary.

X. QUALITY IMPROVEMENT

Each facility in the region shall conduct Quality Improvement (QI) activities with regard to their trauma program. Under the auspices of the Medical Director and the Trauma Program Manager each facility will conduct QI activities in accordance with the approved regional QI process.

EMResource™ Usage

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.

Usage Requirements

Within Region 1 all providers are required of to comply with the guidelines established by the State *EMResource™ Joint Advisory Committee* and/or the Oklahoma State Department of Health in the *EMResource™ Manual.* In the event that the *EMResource™ Manual* is updated, the revisions to the *EMResource™ Manual* override the requirements in this document.

Specific usage requirements include but are not limited to:

Contact Information

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

Provider Status

Each hospital is required to maintain current status on the EMResource™ so that their capabilities or capacity can be readily accessed by other hospitals, EMS agencies and the Trauma Transfer and Referral Center.

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

Emergency Department Status

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.
If a facility has not updated their status on the EMResource™ their attempt to divert may be overridden by the pre-hospital provider or the Trauma Transfer and Referral Center.

Hospital Status

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

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:
Yes – Coverage is currently available.
No – Coverage is not currently available.
N/A – This service is not offered at this facility.

Air Ambulance Status

This status is for displaying the current status/availability of Air Ambulances. The status categories for this status are:
Available – the areomedical resource is currently ready and able to respond to emergency calls.
Call for Status – current conditions necessitate that providers in need of aeromedical transport call to determine resource availability because:
The aeromedical resource may already be dispatched to a call or be on standby.
Local weather conditions may temporarily impact the ability of this aeromedical resource to respond.
This aeromedical resource may be temporarily unavailable due to routine service or fueling.
Not Available – the aeromedical resource is currently unable to respond in a timely manner.
In region 1 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.

System Alerts

Providers in Region 1 are required to maintain EMResource™ in a manner that enables them to receive alerts in a timely manner. It is suggested that all providers maintain a computer specifically for EMResource™ use 24 hours a day.
If a provider is unable to maintain a computer with EMResource™ displayed 24 hours a day the provider is expected to work with the regional EMResource™ administrator to arrange the delivery of all System Alerts to the text enabled device of designated staff responsible to share the alert information with other on-duty staff.
Compliance with appropriate usage will be monitored through routine MERC drills.

Data Reporting

Providers in Region 1 are required to participate in reporting data supported by the EMResource™ application. This reporting requirement includes but is not limited to:
Hospital Daily Report of bed capacity and ED volume;
EMS Daily Report of resources and volume;

Monitoring

Appropriate use of EMResource™ will be enforced in the region through the QI process
The CQI committee will routinely review reports from the Trauma Transfer and Referral Center on diversion of patients and compare the patient diversion list with the list of facility diversion hours generated from the EMResource™.

The CQI committee will review all cases referred to them for inappropriate use of EMResource™ in any of the listed categories. The regional and/or state EMResource™ administrator will perform periodic drills using EMResource™ and monitor appropriateness of provider response. Reports of these drills will be provided to the RTAB CQI committee who will address problems/trends directly with the provider and if necessary through referral to the appropriate state level committee. The CQI committee will work with these providers to come into compliance with EMResource™ usage requirements. If these attempts fail the cases will be referred to the State CQI committee for further action.

Summary

EMResource™ is a vital communication tool that provides the capability of real time communication among trauma system participants. This ability is limited by provider use of the system. Region 1 supports use of this tool through adoption of these requirements.

Appendix A

EMS Provider Descriptions

DESCRIPTION OF EMS SERVICES

EMS Providers within Region 1 include: 2008 Information. For current information go to: http://www.ok.gov/health/Protective_Health/Emergency_Medical_Services/

Alfalfa County

Alfalfa County EMS is a Basic Service with one (1)~~1~~ Emergency Medical~~First~~ Responder~~s~~, 1~~8~~3 ~~Basic~~ EMTs, nine (~~and~~ 9)~~1~~ ~~-~~ Advanced/Intermediate EMTs, and two (2) Paramedics.

~~*Helena EMS is a Basic Service with 2 First Responders, 6 Basic EMTs, 6 Intermediate EMTs and 1 Paramedic.*~~

Beaver County

Beaver County EMS is a Basic Service with three (3)~~6~~ Emergency Medical~~First~~ Responders, ~~and~~ 11~~12~~ ~~Basic~~ EMTs, and three (3) Advanced/Intermediate EMTs.

Beckham County

Elk City Fire Department EMS is a Basic Service with nine (9) Emergency Medical Responders, 18 EMTs, four (4) ~~1~~ Advanced/Intermediate EMTs, and 11~~4~~ Paramedics.

Erick Ambulance ~~Service~~ is a Basic Service with four (4)~~11~~ Emergency Medical~~First~~ Responders, five (5)~~6 Basic~~ EMTs, one (1) Advanced/Intermediate EMT, and one (1)~~2~~ Paramedic~~s~~.

Sinor EMS (Sayre) is a~~n~~ Basic~~Intermediate~~ Service with one (1) Emergency Medical Responder, one (~~2~~1) ~~Basic~~ EMT~~s~~, and one (1) ~~-~~Advanced/Intermediate EMT ~~and 1 Paramedic~~.

Blaine County

Canton-Longdale EMS is a Basic Service with six (6)~~7~~ ~~Basic~~ EMTs.

Okeene Ambulance is a Basic Service with two (2)~~3~~ Emergency Medical~~First~~ Responders, six (6) ~~5 Basic~~ EMTs, two (2)~~-~~ Advanced/Intermediate EMTs, and one (1) Paramedic.

~~*Parkview Ambulance (Geary EMS) is a Basic Service with 8 Basic EMTs and 1 Paramedic.*~~

Watonga EMS is a Basic Service with one (1)~~4~~ Emergency Medical ~~First~~ Responder~~s~~, 10~~5~~ ~~Basic~~ EMTs, one (1)~~3~~ Advanced/Intermediate EMT~~s~~, and three (3)~~4~~ Paramedics.

Cimarron County

Cimarron County EMS is a Basic Service with two (2) Emergency Medical Responders, four (4)~~8~~ ~~Basic~~ EMTs, two (2)~~1~~ Advanced/Intermediate EMTs, ~~-~~and one (~~3~~ 1) Paramedic~~s., and 1 First Responder.~~

Keyes EMS is a Basic Service with six (6)~~8~~ ~~Basic~~ EMTs, two (2) Advanced/Intermediate EMTs, and two (2) Paramedics.

Custer County

Butler EMS is a Basic Service with six (6) ~~Basic~~ EMTs ~~and 1 Intermediate EMT~~.

Cheyenne-Arapaho Tribes EMS is an Intermediate Service with four (4)~~1~~ Emergency Medical~~First~~ Responders, one (1) EMT~~-~~, four (4) Advanced/~~6~~ Intermediate EMTs, and seven (7) Paramedics.

Lifeguard Ambulance Service Weatherford is an Advanced Service with eight (8) EMTs, two (2) Advanced/Intermediate EMTs, and eight (8) Paramedics.

Sinor EMS Clinton is a~~n Intermediate~~ Basic Service with four (4)~~2 First~~ Emergency Medical ~~-~~Responders, five (5)~~4~~ ~~Basic~~

EMTs, two (2) Advanced/Intermediate EMTs, and six (6) Paramedics.

Sinor EMS Thomas is a Basic Service with one (1) Emergency Medical Responder, two (2) EMTs, and one (1) Advanced/Intermediate EMT.

~~with 8 EMTs, 2 Advanced/Intermediate EMTs, and 8 Paramedics~~

~~*Sinor EMS* (Weatherford) is an Intermediate Service with 5 Basic EMTs and 7 Paramedics.~~

Dewey County

Community Ambulance Service is a Basic Service with nine (9) Emergency Medical~~3 First~~ Responders, eight (8)~~6 Basic~~ EMTs, one (1) Advanced/Intermediate EMT, and one (1) Paramedic.

Leedey Ambulance Service is a Basic Service with three (3)~~4 Basic~~ EMTs, one (1) Advanced/Intermediate EMT, and two (2)~~1~~ Paramedics.

~~*Taloga Ambulance Service* is a Basic Service with 12 First Responders, 8 Basic EMTs and 1 Paramedic.~~

Vici-Camargo EMS is a Basic Service with four (4) Emergency Medical~~5 First~~ Responders and six (~~,~~ 6)~~3 Basic~~ EMTs~~, 1 Intermediate EMT and 3 Paramedics~~.

Ellis County

Ellis County EMS is a Basic Service with one (1) Emergency Medical~~20 First~~ Responder~~,s and~~ eight (8)~~17 Basic~~ EMTs, nine (9) Advanced/Intermediate EMTs, and five (5) Paramedics.

Garfield County

Life EMS is a Paramedic Service with eight (8)~~6 Basic~~ EMTs, five (5) Advanced/~~7~~ Intermediate EMTs, and 12~~4~~ Paramedics~~. and 8 Specialty Care.~~

Miller EMS – Garfield County is a Basic Service with one (1) Emergency Medical Responder and nine (9) EMTs.

Grant County

Medford Ambulance ~~Service~~ is a Basic Service with two (2) Emergency Medical ~~First~~ Responders, four (4)~~6 Basic~~ EMTs, and one (1) Advanced/Intermediate EMT~~ and 2 Paramedics~~.

Miller EMS is a Basic Service with one (1) Emergency Medical Responder, seven (7) EMTs, and six (6) Paramedics.

Pond Creek Fire Department Ambulance is a Basic Service with~~ 13 First Responders, 12~~ seven (7) ~~Basic~~ EMTs~~, 5 Intermediate EMTs~~ and five (~~5~~)~~1~~ Paramedics.

Harper County

Buffalo EMS District is a Basic Service with two (2) Emergency Medical ~~9 First~~ Responders, three (3)~~8 Basic~~ EMTs, and two (2) Advanced/Intermediate EMTs. ~~and 1 Paramedic.~~

Laverne EMS is a Basic Service with six (6) Emergency Medical~~5 First~~ Responders, eight (~~ and~~ 8)~~7 Basic~~ EMTs, and one (1) Advanced/Intermediate EMT.

Kingfisher County

~~*Cashion Fire Department* is a Basic Service with 8 First Responders and 10 Basic EMTs.~~

Kingfisher Ambulance (City of)~~Service~~ is an Intermediate Service with ~~10 Basic EMTs,~~ 16 Advanced/Intermediate EMTs

and four (4)3 Paramedics.
Life EMS of (Hennessey) is a Paramedic Service with six (6) Basic EMTs, seven (7) Advanced/Intermediate EMTs, and 14 Paramedics.
Miller EMS – Kingfisher is a Paramedic Service with six (6) EMTs and six (6) Paramedics.

Major County

Major County EMS is a Basic Service with three (3) Emergency Medical1 First Responders, 4 Basic11 EMTs, eight (8)7 Advanced/Intermediate EMTs, and 12 Paramedics.

Roger Mills County

Roger Mills Ambulance is a Basic Service with 17 First Responders, 104 Basic EMTs, three (53) Advanced/Intermediate EMTs, and five (5)4
Paramedics.

Texas County

Goodwell Ambulance Service is a Basic Service with three (3) Emergency Medical Responders, three (3) 6 Basic EMTs, and two (1 Intermediate EMT and 2) Paramedics.
Guymon Fire Department Ambulance is an Intermediate Service with seven (7) Emergency Medical3 First Responders, eight (14 Basic8) EMTs, 4 Intermediate EMT, and
163 Paramedics.
Hooker Municipal Ambulance is a Basic Service with two (2)4 Emergency MedicalFirst Responders and six (6)7 Basic EMTs.
Texhoma Ambulance Service is a Basic Service with 2 First Responders, 5 Basic EMTs and 2 Intermediate EMTs.

Washita County

Burns Flat Ambulance is a Basic Service with three (3) Emergency FirstMedical Responders, three (8 Basic3) EMTs, two (2)9 Advanced/Intermediate EMTs, and one (1) Paramedic.
Cordell Ambulance is a Basic Service with four (4) Emergency Medical2 First Responders, eight (and 8)6 Basic EMTs, one (1) Advanced EMT, and two (2) Paramedics.
Sentinel City Ambulance is a Basic Service with 2 First Responders and 7 Basic EMTs.

Woods County

Alva Ambulance is a Basic Service with four (4)6 Basic EMTs, six (and 6)1 Advanced/Intermediate EMTs, and one (1) Paramedics.
Freedom Volunteer Fire & Ambulance is a Basic Service with one (1) Emergency Medical Responder, four (4) Basic EMTs, and one (1) Advanced/Intermediate EMT.
Waynoka Ambulance is a Basic Service with three (3)4 Emergency Medical RespondersFirst Responders and five (5) 2

~~Basic~~ EMTs.

Woodward County

Woodward County EMS is a Basic Service with one (~~2~~1) Emergency Medical~~First~~ Responder~~s~~, ~~6 Basic~~10 EMTs, seven (7) Advanced/~~4~~ Intermediate EMTs, and three (3)~~8~~ Paramedics.

AIR SERVICES

Air Evac Lifeteam Elk City
Air Evac Lifeteam Kingfisher
Air Evac Lifeteam Weatherford
Air Evac Lifeteam Woodward
Air MD, LLC dba: Life Save
Apollo Medflight
Eaglemed - Kansas ~~– Elk City and Woodward~~
~~*OK EagleMed* – Guymon and Stillwater~~
~~*OK Midwest Lifeteam* – Liberal, KS~~