Oklahoma County Region (8)
Regional Trauma Advisory Board
Trauma Rotation Committee

313 Northeast 50th Street
Oklahoma City, OK 73105

August 7th, 2018 – 5:30 pm

MINUTES

MEMBERS:
Jay P. Cannon, MD, Chair
P. David Hunter, MD, Vice-Chair
Roxie Albrecht, MD
Chad Borin, DO
Eric Friedman, MD
Thomas P. Lehman, MD
S. Ross Martin, DMD
Juan Nalagan, MD
David W. Smith, MD

STAFF:
David Howerton, RTAB Chair
Brad Smith, PA
Grace Pelley, OSDH
Daniel Whipple, OSDH

INVITED GUESTS:
INTEGRIS:
John Adams
Tela Brown, ER Director, Southwest Med. Ctr.
Ryan Fish, MD, Medical Director, Baptist ER
Tim Johnsen, President, INTEGRIS Baptist
OU Medicine:
Charles Spicer, President/CEO
Rowdy Anthony, MBA, RN
Michael D. Martin, MD
Richelle Rumford, Trauma Pgm Mgr
Kris Wallace, RN, President, OUMC
Mercy Hospital:
Karyl James, MSN, RN, CNO
St. Anthony Hospital
Joe Hodges, President, SSM
Tammy Powell, President, St. Anthony
Kersey Winfree, MD
Oklahoma County Medical Society
Jana Timberlake, Executive Director
Jeffrey Goodloe, MD - EMSA

I. **Call to Order – Jay P. Cannon, MD**
The meeting was called to order by Dr. Cannon at 5:33 pm. Roll call was taken with the following members present: Dr. Jay Cannon; Dr. David Hunter; Dr. Chad Borin; Dr. Eric Friedman; Dr. Ross Martin; Dr. David Smith. Dr. Thomas Lehman arrived at 5:37 pm. Members not present were Dr. Roxie Albrecht and Dr. Juan Nalagan.

Dr. Cannon asked Grace Pelley to introduce two guests tonight. Ms. Pelley introduced LaWanna Halstead, Vice-president of Patient Quality Initiatives at the Oklahoma Hospital Association, and Marva Williamson, Trauma Fund Coordinator at the Oklahoma State Department of Health, and Kathy O'Dell, ED Director at St. John Medical Center in Tulsa.

Dr. Cannon introduced Dr. Zachary Hurwitz, a hand surgeon from the Mercy system.

II. **Acceptance of minutes – March 6th, 2018**
A motion to accept the minutes was made by Dr. Friedman and seconded by Dr. Hunter. The motion passed 6-0.

III. **NEDOCS – Improving EMS/Hospital Communication – Kathy O'Dell, DNP, RN, CEN, NEA-BC, Director of Emergency and Trauma Services, St. John Medical Center, Tulsa**

Ms. O'Dell provided a brief overview of her work experiences to include that of a paramedic and a nurse with a Doctorate in Nursing Practices with her thesis being about patient throughput and a work history at both St. John Medical Center (SJMC) in Tulsa and Parkland Hospital in Dallas. She discussed how ED overcrowding is essentially a supply and demand problem. Negatives of ED overcrowding include a 5% increase in mortality, increased hospital costs, increased hospital length of stays, increased risk of medication errors, and decreased patient satisfaction scores. She further emphasized that ED overcrowding is not just an ED problem, and that it involves action from the entire hospital. The National Emergency Department Overcrowding Score (NEDOCS) is tool using a linear regression model that helps predict ED overcrowding. She provided a current example of EMResource showing St. John Medical Center and its NEDOCS score. NEDOCS is a tool that uses common terminology and scoring to demonstrate internally and externally the "busy-ness" of an ED and serves as the framework for a comprehensive hospital surge plan. She provided an example of the Dallas-Ft. Worth metropolis and how the hospitals there utilize NEDOCS. She stressed the information provided on EMResource is only as accurate as the data elements recorded to calculate the score. She then explained how a comprehensive surge plan should use NEDOCS and at least one other hospital-defined variable and explained a few options that SJMC utilizes for its plan. The data for SJMC ED divert hours were presented for the time before the implementation of NEDOCS/surge plan and after; ED divert hours decreased from over fifty hours pre-implementation to under ten hours per month for the remainder of the year. Even during the flu epidemic in 2018, SJMC utilized ED divert less than ten hours that month. Ms. O'Dell proposed that in order to move forward, all hospitals contact OSDH to request the use of NEDOCS on EMResource, that each hospital create a surge plan that complements NEDOCS, and that the EMResource Steering Committee be implemented to suggest changes to that platform statewide. Ms. O'Dell then mentioned how EMResource includes and automatically calculates NEDOCS for a facility, and this ability can cost upwards of $20,000 if a hospital had to purchase a system to do that on its own. It is the recommendation of Ms. O'Dell that all Level I, II, and III trauma centers utilize NEDOCS; at this time all Level I and II trauma centers utilize NEDOCS.

Ms. Pelley stated that over the last four months, more than 27,000 ambulance patients were delivered to the hospitals participating in the call rotation. NEDOCS can help provide a common language and frame of reference to all hospitals as a communication tool as there has been difficulty with that historically. Within the handouts, she also provided an example of how NEDOCS functions within EMResource and references to articles where NEDOCS was implemented and its functionality.

A discussion about which hospitals currently use EPIC Electronic Medical Record (EMR) and those facilities include INTEGRIS hospitals, Mercy Hospital Oklahoma City, and St. Anthony Hospital. Currently OUMC does not utilize EPIC EMR. Dr. Hunter asked a question about how to get hospitals using EPIC to begin implementation of this tool. Ms. Pelley stated that it is imperative that hospitals realize that the solution includes an "all hospital" approach rather than just an ED solution; hospitals that want to begin using NEDOCS must contact OSDH to have that feature activated in EMResource.

Dr. Cannon stated that the system must continue to evolve in order to be successful. He requested that the assembled representatives take this information their hospital leadership. It was further explained how a similar score represents the same feeling of "busy-ness" regardless of hospital size and capability. A question was raised about whether EPIC can automatically interface with EMResource; at this time it is believed that this is not possible, but by speaking with the vendor a bridge may be able to be created in order to automatically populate the required information within EMResource. There was further discussion of how the surge plan complements the NEDOCS score and the use of that complementing duo has been enacted at SJMC to include moving "hold" patients from the ED to non-traditional locations throughout the hospital and the hiring of new float employees to care for those patients once they have been moved from the ED. In closing, Ms. O'Dell stated that over the course of twelve months SJMC has decreased the amount of ED divert hours by 92% and the transfer center has decreased its divert time by 82%, and this has provided a greater return on investment. Ms. Halstead recommended that the presentation be given at both the Greater Oklahoma City and Tulsa Area Hospital Associations.

IV. EMSA Statistics – David Howerton

Mr. Howerton was not present, and the EMSA data was not presented.

V. TReC Reports – Cathy Smith and Lisa Fitzgerald

Ms. FitzGerald provided data that showed how the number of TReC facilitated transfers show an increase in the call volume over this last period and a decrease in the number of transfer refusals by receiving facilities. Dr. Watson asked if there has been any change in the number of patients transported to the on-call hospital since the implementation of revised destination procedures. Ms. FitzGerald did not have specific data to answer that but stated that there has been much better cooperation since that change.

VI. Draft Trauma Rotation Committee Bylaws – Daniel Whipple, OSDH

Ms. Pelley stated that there has been no continuity plans for the future, and the draft bylaws were created to have a framework about the mission of the group and its functionality. Ms. Pelley requested that the members review the draft bylaws and provide input to Daniel Whipple so that he may incorporate recommendations for approval by the committee.

VII. Hospital Ophthalmology Trauma Services – Daniel Whipple, OSDH

This item was tabled until the next meeting, but a brief discussion was had about the need to identify facilities with ophthalmology services in order to get patients needing those services to the right facility in the right time. It was mentioned that even if a hospital has an ophthalmologist on call, the facility itself may not have the equipment needed to the repair. Ms. Fitzgerald stated that this service and plastics has been something requested by sending providers frequently. Dr. Smith expressed his concern about why anyone is requesting plastic surgery services rather than focusing on the injury itself.

VIII. Review Definition of "Unassigned Patient" – Daniel Whipple, OSDH

Dr. Cannon explained that despite the Region 8 Trauma Plan containing a definition of "unassigned patient" there have been questions raised about what that truly means. Dr. Smith commented that there are many communities with only one hospital, and that facility has an affiliation with a larger health system. He further stated that if that patient is transferred from that health system to the on-call hospital that is not affiliated with the sending hospital, the

patient may have difficulty in obtaining follow-up care in their hometown and at an increased financial burden to the patient. He recommends that if a patient is at a facility with an affiliation to a larger hospital that the patient is transferred to that larger network facility if it has the capability and capacity to do so. Ms. Pelley asked what he believes is the cause of the difficulty with the patient receiving follow-up care. Dr. Smith believes that it is much easier for that follow-up care to be facilitated within network rather than attempting to coordinate resources between health systems. Ms. FitzGerald explained that TReC is designed for patients without a preference for a definitive care hospital and occasionally this is discussed with the sending provider. Dr. Smith stated that he believes the individuals contacting TReC do not understand how the system is supposed to work and feels that the TReC call takers need to introduce a line of questioning about assigned and unassigned patients in order to act as a gatekeeper for the definitive care hospital. Dr. Smith stated that he is requesting the committee to vote on the definition of unassigned patient and to have TReC introduce questions to determine whether a patient is assigned or unassigned. Several examples were discussed of how a patient may receive certain treatment modalities at a hospital of one health system and be treated at another health system's hospital for an unrelated injury. Ms. Pelley stated that the system was designed so that TReC was to be used for patients without a hospital preference and for EMResource to be updated as hospital statuses change in order for patients to be placed at the closest appropriate facility.

Dr. Smith moved that the Trauma Referral Center introduce questions to determine whether a patient is assigned or unassigned by using the approved definitions contained within the Region 8 trauma plan; Ms. Pelley recommended that the motion be to recommend this action to OSDH. Dr. Friedman seconded the motion, and it passed 7-0.

Dr. Borin moved that Ms. FitzGerald provide a report at the next Trauma Rotation Committee meeting about the progress of this change. Dr. Smith seconded the motion. The motion passed 7-0.

IX. Miscellaneous

X. Next Meeting

It was recommended that the next meeting be held December 4th, 2018.

XI. Adjournment

Dr. Friedman motioned to adjourn, and it was seconded by Dr. Martin. The meeting adjourned at 6:55 pm.

Approved

Jay P Cannon, MD 12/4/2018

Jay P. Cannon, MD
Chair, Region 8 Trauma Rotation Committee
December 4th, 2018