RTAB Region 8 Trauma Rotation Subcommittee
313 Northeast 50th Street
Oklahoma City, OK 73105
August 20, 2019 – 5:30 pm

MINUTES

I. CALL TO ORDER AND VOTE TO APPROVE 4/23/2019 MINUTES - David W. Smith, MD

The meeting was called to order by Dr. David Smith at 5:32 pm.

Roll call was taken with the following members present: Dr. David Smith; Dr. Roxie Albrecht; Dr. Chad Borin; Dr. Eric Friedman; Dr. Zachary Hurwitz; and Dr. Thomas Lehman. Dr. John Nalagan arrived at 5:36 pm. Dr. Ross Martin was absent. Dr. Jay Cannon tendered his resignation as a member of the committee.

A motion to accept the minutes as written was made by Dr. Borin and seconded by Dr. Friedman. There was no discussion, and the motion passed 6-0.

II. NEW BOARD MEMBER ELECTION - Ryan Wicks, MD

Dr. Smith introduced Dr. Wicks to the group and stated that with Dr. Cannon's resignation, a position for a surgeon has become available. A motion was made by Dr. Friedman to add Dr. Wicks to the Committee. The motion was seconded by Dr. Borin, and the motion carried 7-0.

III. EMSA STATISTICS - David Howerton

Mr. Howerton asked David Gooshaw to present the report as he prepared it. Mr. Gooshaw provided EMSA trauma patient transport data from April 1st through July 31st of this year. He began with an overview of patient transport destinations by priority over that timeframe. He stated that 280 P-1 patients were transported to OU Medicine and review why four P-1 patients were transported to other destinations. He then discussed the total number of P-2 patient transports and reviewed the most common destinations for those patients as well as the most common reasons for choosing them which were patient choice and protocol. Mr. Gooshaw then reviewed the reasons for choosing the destination as well as whether the patient had P-2 face, hand, neurological, or "Priority 2 Criteria" for OU Medicine, INTEGRIS Baptist Medical Center, Mercy Hospital Oklahoma City, and SSM Health St. Anthony Hospital – Oklahoma City. The Committee stated that this data is the most in-depth that they have seen from EMSA since the inception of the Committee.

IV. TReC REPORTS - Lisa Fitzgerald

Daniel Whipple stated that Ms. FitzGerald is no longer with TReC and that he would speak to the TReC report today that covered May, June, and July 2019. Overall, there were no anomalies for calls received by TReC during that period. During the first month of this report, there was only one refusal of acceptance at the initially contacted facility, but the number of refusals jumped to nine and seven for June and July respectively. Mr. Whipple asked the Committee if they would like to see historical data for comparison, and he will attempt to provide that data at the next meeting.

V. **ACCURATE AND TIMELY REPORTING TO TReC** - Reporting of trauma-related capability and capacity, regardless of call rotation status, to include neuro ICU status.

Dr. Smith state that this business item originated from a conversation with Dr. Curtis Knoles, the Medical Director of TReC, when he requested that TReC be notified in a timely and clear manner of capability and capacity of receiving hospitals, especially in regards to neuro ICU capacity. Dr. Smith stated that there already exists a statewide-communication tool to perform just that task in EMResource.

Mr. Rowdy Anthony and Dr. Roxie Albrecht spoke to the on-call system design how ICU or other in-patient capacity was never a design component of the system, only ED capability and capacity. In-patient capacity may change from the time when a patient transfer is accepted and when the patient arrives at the facility and should not be a reason to refuse a transfer. Dr. Albrecht stated that accepting a patient through TReC was no different than accepting a patient from EMSA. Mr. Anthony further stated that to divert patients from TReC, the facility should show on divert on EMResource and not accept any ambulance-delivered patients. Dr. Albrecht further commented that the system was designed to move the patient from a hospital with limited resources to a hospital where the patient can be evaluated by the required specialists. If in-patient capacity has been reached at the receiving hospital or more injuries are found that cannot be managed at the receiving hospital, the system allows for a second transfer of the patient to another facility in the system that can definitively manage that patient. Mr. Anthony stated that it is incumbent of the receiving hospitals to create a system to move patients through the facility to increase throughput to help effectively manage patient load.

A point was made by Dr. Ryan Fish that patients who are boarded in the ED have an increase in mortality. He also stated that an appropriate communication tool could reduce the number of events where patients are boarded within the ED. Dr. Albrecht stated that the EMSA data shows that up to 50% of patients arriving at a hospital are due to patient choice.

During the discussion, Mr. Whipple stated that Emergency System will be happy to pull data that shows how many P-2 neurological patients are admitted, where they are admitted, or discharged from the Emergency Department. Similar data had been pulled in the past, but a complete analysis was not able to be performed at that. The preliminary data indicated that, as a region, upwards of 60% of P-2 neuro patients transferred into Region 8 from an outside hospital may be discharged home from the ED.

VI. **REGION 8 REGIONAL PLANNING COMMITTEE REPORT OF BURN RESOURCES** – Daniel Whipple, ODSH

- Discussion: Does this Require Rotation Schedule or TReC Communication of Available Resources

Mr. Whipple discussed the Region 8 Regional Planning Committee (RPC) conversation regarding burn patient resources that occurred at yesterday's meeting. Both INTEGRIS Baptist Medical Center (IBMC) and OU Medicine were invited to the meeting as they provide the majority of burn patient care in the city. Unfortunately, IBMC was not represented at the meeting, and there was no action taken. Mr. Whipple gave a brief overview of the burn patient data obtained from the trauma registry and Oklahoma EMS Information System (OKEMSIS) for the calendar year 2018. The data indicated that Hillcrest Medical Center was the single facility that received the most burn patients throughout the year with IBMC receiving the second-most. The Committee will attempt to meet with both facilities again and has also asked for data from surrounding states as well as from the Oklahoma Health Care Authority to better analyze the problem.

VII. **DISCUSSION OF CALL SCHEDULE NOTES AND POSSIBLE VOTE TO APPROVE AMENDMENTS** - Dr. Smith:

- **Notes A & B** - Reflect upon the current improved state of Region 8 neurosurgery and neuro ICU coverage

- **Note B** - Reflect upon the Priority 2 terminology used when discussing hand and maxillofacial injured patients
- **Call Schedule Verbiage** - Modification of all call schedule verbiage based on conclusions of above discussions to reflect the subcommittee's intent for the rotation

Dr. Smith began the conversation by stating that the neurosurgical landscape within Oklahoma City has changed dramatically since the creation of the Committee. In the beginning, there were no hospitals that had the ability to provide neurosurgical coverage twenty-four hours per day. Thanks, in part, to the requirements of comprehensive stroke center, Oklahoma City now has four hospitals that provide twenty-four hour per day neurosurgical coverage: Mercy Hospital Oklahoma City, INTEGRIS Baptist Medical Center; SSM Health St. Anthony Hospital – Oklahoma City; and OU Medicine. There are also other hospitals in the metro area that provide neurosurgery occasionally throughout the week. Due to the increase in neurosurgical coverage, Dr. Smith would like to discuss the possibility of removing neurosurgery as a requirement of the on-call facility. If the change were made, patients would be transported to the closest hospital with neurosurgical coverage. He asked if changing the requirement for the on-call hospital would create a patient-safety hazard or patient-safety benefit.

Dr. Albrecht stated that if, when on-call, a hospital utilizes extra resources to assist with the increased patient volume, that it might cause a safety issue. However, if a hospital does not prepare extra resources for its on-call day, there should be no difference whether a patient is transported to the on-call hospital for neurosurgical needs. Dr. Friedman stated at the beginning of the rotation, his hospital prepared for its on-call days, but that he now sees about the same number of neurosurgical trauma patients whether his hospital is the on-call facility or not; this may be due to health systems desiring to keep patients within the system.

Mr. Anthony stated that in order for this Committee to make this decision, other neurosurgeons, neuro ICU representatives, and administrators need to be in the room to express their opinion. This is needed because hospitals may need to schedule additional call or prepare for additional resources, such as operating suites, be available at all times. Mr. Howerton stated, that as the RTAB Chair, he recommends that those individuals be asked to attend. Dr. Nalagan agreed with the statement and emphasized the need to have neuro ICU staff present at the meeting but feels that the reevaluation of the system makes sense.

Dr. Smith believes that there is an underutilization of resources within Oklahoma City to care for patients and that patient outcomes can be improved with the appropriate utilization of our regional assets. His main goal as Chair is to ensure that the system has the most participation from as many facilities and physicians as we can have every day to serve our patients, because our patients deserve that level of care. In the future, the rotation may not exist because there are resources that can be adequately shared throughout Oklahoma City. The Committee has made great progress as evidenced by the removal of both general surgery and orthopedic specialties from the rotation.

A motion to invite neurosurgeons and hospital administrators to the next meeting to discuss the possibility of removing neurosurgery as a requirement of the on-call rotation and send patients to the closest appropriate facility was made by Dr. Nalagan. The motion was seconded by Dr. Wicks, and the motion carried 8-0.

Regarding note B, there is confusion regarding the verbiage and the practice within Oklahoma City. Dr. Albrecht provided an example of hand-injured patients and how, within the metro, Priority 1 and Priority 2 hand patients are transported to the on-call hospital, but note B on the on-call schedule states that the schedule is for unassigned Priority 2 patients. Dr. Lehman stated that the American College of Surgeons (ACS) does not recognize an isolated hand injury as a Level 1. An example he provided is that a thumb amputation is considered a Priority 2 patient. Dr. Albrecht stated that a

patient who hit his/her thumb with a hammer might qualify as a Priority 1 patient and be transported to OU Medicine due to being a P-1. However, OU Medicine does not have hand services every day, and the patient might need transferred to the on-call hospital. There was some discussion as to what ACS criteria for hand patients are, and Mr. Whipple reminded the group that Oklahoma uses its own patient prioritization tool that designates Priority 1, Priority 2, and Priority 3for isolated injuries. Dr. Lehman agreed with the concept that all hand injuries should be transported to the on-call hospital. There was discussion that all face injuries should also be transported to the on-call hospital, but Dr. Martin was not present to provide his opinion on the matter. Dr. Lehman moved that all hand injuries be transported to the on-call hospital, but Mr. Whipple stated that if the motion is approved, note B will become very cumbersome and difficult to follow as it will state that P-2 neuro and face will go to the on-call hospital, P-1 neuro and face will go to OU Medicine, and all hand injuries will go to the on-call hospital. It will be difficult to apply for TReC and ambulance crews from around the state attempting to transport the patient to the appropriate facility. He suggested that this topic be visited again when the three specialties can be more aligned. There was no second, and the committee consented to discuss the topic again.

VIII. AFFIRMATION - Region 8 Trauma Rotation Subcommittee serves as the finest Oklahoma state model for regional advanced emergency care (RAEC) coordination. We strive to remain collegial, effective and innovative in our service to the state, its citizens and the patients we represent.

Dr. Smith explained how the affirmation will help serve as a guide to the Committee and external stakeholders as to the Committee's goal and functionality. He modified the state with the omission of the words "Oklahoma state" ad soliciting for feedback from the group. There were no negative comments from the group, and the statement will be reflected in the minutes to help guide our future endeavors.

IX. NEXT MEETING

Possible meeting dates proposed for the next meeting are October 1st, October 8th, October 22nd, and October 29th.

X. ADJOURNMENT

A motion to adjourn was made by Dr. Borin and seconded by Dr. Lehman. The meeting adjourned at 7:02 pm.

Approved

David Smith, MD
Chair, Region 8 Trauma Rotation Committee
October 29th, 2019