Oklahoma State Department of Health
Creating a State of Health

Southwest (3) Regional Education Planning Committee
Great Plains Technology Center
4500 Southwest Lee Boulevard
Lawton, OK 73505
September 5th, 2019 – 10:00 am

MINUTES

I. Call to Order
The meeting was called to order by Chair Brad Lancaster at 10:00 am.

II. Roll Call
Roll call was taken with the following members present: Brad Lancaster, Beth Malone, JenaLu Simpson, Bob Stewart, Rachel Talley, Tyler Walters, and Alicia Webster. Scott Tanner was absent.

III. Introductions and Announcements
Dan McLeod was introduced as new member of the committee to be voted on for approval at the October 3rd Regional Trauma Advisory Board (RTAB) meeting.

IV. Approval of Minutes – March 7th, 2019
A motion to approve the March 7th, 2019 minutes as written was made by Bob Stewart and seconded by JenaLu Simpson. There was no discussion and the motion passed 7-0.

V. Business:

A. Review and possible vote to approve amended Region 3 Trauma Plan to move to RTAB for review and approval
Members reviewed the amended Region 3 Trauma Plan with additional recommended amendments made on the attached proposed Region 3 Trauma Plan. Other points of discussion during the review included the following:

- Trauma classification and current capabilities of Grady Hospital Memorial Authority were clarified after identification of recent EMS transport diversions. Beth Malone requested she be notified in the event of any EMS divert. Members noted that EMS can override a hospital divert for critical patients and that any continued issues should be reported to the Quality Improvement Committee for review.
- The need to update information found in the Description of EMS Services section was identified. Members discussed the relevancy of the current information listed and determined descriptions should only include the agency licensure level, number of staffed ambulances, number of available ambulances, and number of staffed substations with staffed and available ambulances at that location. A survey will be handed out at the October 3rd RTAB to determine the current identified regional resources. Any information not obtained from the October 3rd survey will be taken from the OSDH annual EMS survey.
- Members discussed the usefulness of EMResource for hospitals and EMS agencies and how to improve the tool to make it relevant and a better resource for Region 3. Dan Whipple encouraged members to participate in the EMResource Workgroup with the next meeting scheduled for September 20th, 2019 at the OSDH beginning at 1:00 pm.
- Members discussed how to best include out of state resources into the trauma plan to meet the goal of getting the right patient to the right place receiving the right treatment in the right amount of time.

A motion to approve the proposed Region 3 Trauma Plan to move to the RTAB for review and approval was made by Beth Malone and seconded by JenaLu Simpson. There was no discussion and the motion passed 7-0.

B. Review and possible vote to approve amended Region 3 Bylaws to move to RTAB for review and approval

Members reviewed the amended Region 3 Bylaws with additional recommended amendments made on the attached proposed Region 3 Bylaws. Other points of discussion during the review included the following:

- The need to draft bylaw language and define a process of determining Board rotation as defined by Attachment A was identified. Specific instruction is needed to address appointment and removal of Board Members due to attendance, reestablishing and maintaining a Board Member ratio of 50% EMS and 50% Hospital, rotation for corporations who hold multiple licenses, and Board Member representation by town or county. Jennifer Woodrow will email the current rotation to members for consideration and discussion at the next REPC.
- Members discussed attendance requirements, enforcement of those requirements, and the need to increase current attendance while ensuring the appropriate member representation. The committee agreed to add a standing agenda item to review current member attendance for discussion at the upcoming RTAB and possible recommendation for licensure action.
- Possible updates may be needed for the Quality Improvement section regarding membership term and election of Chair.

A motion to approve the proposed amended Region 3 Bylaws to move to the RTAB for review and approval was made by Beth Malone and seconded by Tyler Walters. There was no discussion and the motion passed 7-0.

C. 2020 Committee Meeting Dates Discussion

1. February 6th, 2020 at Great Plains Technology Center – 9:00 am
2. April 2nd, 2020 at Great Plains Technology Center – 9:00 am
3. August 6th, 2020 at Great Plains Technology Center – 9:00 am
4. October 1st, 2020 at Great Plains Technology Center – 9:00 am

Members reviewed the proposed 2020 dates with no discussion.

D. Discussion on proper utilization of regional resources for interfacility transfers

Brad Lancaster discussed developing an educational piece for hospitals and EMS agencies that would center on how hospitals can better work with their respective EMS agencies to better prioritize transfers. Mr. Lancaster called for a working group to be formed comprised of EMS and hospital members to identify the current problems and to suggest solutions for those problems. The committee will then determine a scope to build an educational piece around that will be presented to the Oklahoma State Department of Health for approval. Members discussed problems encountered on both the EMS and hospital side to include wearing down of EMS crews, no clear cut definition of an emergency transfer, and backing up of patients in the hospital setting due to inability to transfer. Members appointed to this working group included Brad Lancaster, JenaLu Simpson, Beth Malone, and Dr. Phillip Sloan with Dan McLeod appointed as Chair. The working group will report to the REPC at the February 6th, 2020 meeting.

E. AHA Rural EMS Stroke Triage Algorithm discussion

Alicia Webster presented a proposed EMS Stroke Triage Algorithm for review and requested members provide input on what might be missing and how to improvement the document. Members suggested the algorithm include a fibrinolytic checklist/screen noting the inability to receive TPA effects appropriate transport destination. It was also suggested that the word "consider" be added in front of "transport to the closest EVT capable center" to allow other factors to be taken into consideration in determining transport destination. The Committee recognized the importance of using assessment tools to assist in delivering patients to the appropriate facility improving patient outcomes. The Committee determined the regional stroke plan needs to be amended to reflect changes in clinical practice guidelines regarding last known well times.

VI. New Business

There was no new business.

VII. Next Meeting

A. Quality Improvement Committee
Comanche County Memorial Hospital
3401 West Gore Boulevard
Lawton, OK 73505
September 5th, 2019 – 11:00 am

B. Regional Education Planning Committee
Great Plains Technology Center
4500 Southwest Lee Boulevard
Lawton, OK 73505
October 3rd, 2019 – 9:00 am

C. Regional Trauma Advisory Board
Great Plains Technology Center
4500 Southwest Lee Boulevard
Lawton, OK 73505
October 3rd, 2019 – 10:30 am

VIII. Adjournment

A motion to adjourn the meeting was made by JenaLu Simpson and seconded by Tyler Walters. The meeting adjourned at 12:17 pm.

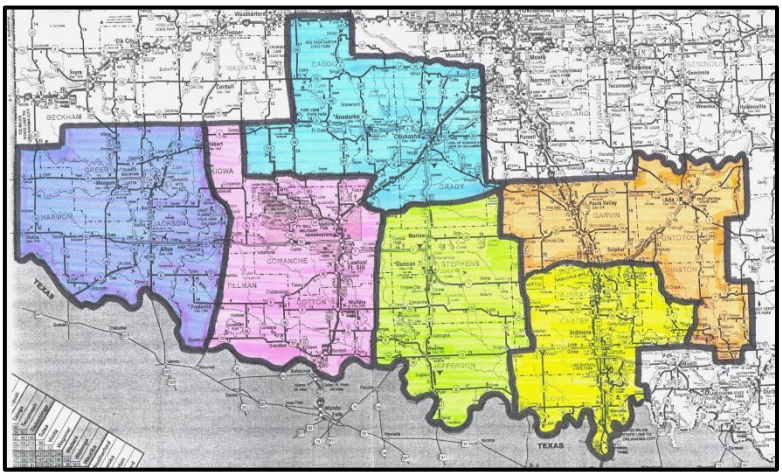
Approved

X _____

Brad Lancaster, Chair
Southwest (3) Regional Education Planning Committee
October 3rd, 2019

Region 3 Trauma Plan

Developed by the RTAB SW Regional Planning Committee



Approved RTAB 05/04/2006 Revised 06/10/2008, 06/26/2009, 11/03/2011, 08/03/2017
Approved OTSIDAC: 03/02/2005

Southwest Regional Trauma Plan
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Inter-Facility Trauma Destination Component

Southwest Regional Trauma Plan

INTRODUCTION

I. GOALS / PURPOSE

The goals of the regional trauma destination plan are to:

A. Assure trauma patients are 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 Trauma Triage and Transport Guidelines to effectively reduce trauma morbidity and mortality.

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

D. This plan will not conflict with any rules and/or regulations that are in place now maybe 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 3 consists of the southwest portion of Oklahoma and includes the following counties: Caddo, Carter, Comanche, Cotton, Garvin, Grady, Greer, Harmon, Kiowa, Jackson, Jefferson, Johnston, Love, Murray, Pontotoc, Stephens, and Tillman.

Region 3 encompasses 13,249 square miles with a population of 444,513. It is serviced by 32~~29~~ ambulance services, ~~six~~five (5~~6~~) Level 3 trauma hospitals, and ~~fourteen~~ thirteen (13~~14~~) Level 4 trauma hospitals of which nine (9) are designated critical access, two (2) Federal, and two (2) psychiatric hospitals.

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.

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 or Level II Trauma Center. These patients should be directly transported to a Level I or Level II facility for treatment but may be stabilized at a Level III or

Level IV facility, if needed, depending on location of occurrence and time and distance to the higher-level trauma center. If needed these patients may be cared for in a Level III facility if the appropriate services and resources are available.

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 injuries 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 (20199~~07~~ Data)

Hospital Providers in Region 3 include:

A~~1~~. Level I: None

B~~2~~. Level II: None

C~~3~~. Level III:

1. Comanche County Memorial Hospital (Lawton)
2. Duncan Regional Hospital, Inc. (Duncan)
3. Grady Memorial Hospital Authority (Chickasha)
4. ~~Jackson County Memorial Hospital (Altus)~~ Mercy Hospital Ada (Ada)
5. Mercy ~~Memorial Health Center~~ Hospital Ardmore, Inc. (Ardmore)
6. ~~Valley View Regional Hospital (Ada)~~

D~~4~~. Level IV: General Med-Surgical Hospitals

1. Elkview General Hospital (Hobart)
2. ~~Lindsay Municipal Hospital (Lindsay)~~Jackson County Memorial Hospital Authority (Altus)
3. ~~Memorial Hospital & Physician Group (Frederick)~~Lindsay Municipal Hospital (Lindsay)
4. ~~Paul's Valley General Hospital (Paul's Valley)~~
5. ~~5~~. Southwestern Medical Center (Lawton)

E. Level IV: Critical Access Hospitals

1. Arbuckle Memorial Hospital Authority (Sulphur)
2. Carnegie Tri-County Municipal Hospital (Carnegie)
3. Harmon Memorial Hospital (Hollis)
4. ~~Healdton Mercy Hospital (Healdton)~~
5. ~~5~~. Jefferson County Hospital (Waurika)
5. Mangum Regional Medical Center (Mangum)
6. Mercy Health Love County (Marietta)
7. Mercy Hospital Healdton, Inc. (Healdton)

8~~6~~. Mercy Hospital Tishomingo (Tishomingo)

9~~7~~. ~~Quartz Mountain Medical Center (Mangum)~~The Physicians'Hospital in Anadarko (Anadarko)

F. Federal Hospitals
1. Chickasaw Nation Medical Center (Ada)
2. Lawton Indian Hospital PHS (Lawton)

E. Psychiatric Hospitals:
1. Jim Taliaferro Community Mental Health Center (Lawton)
2. Rolling Hills Hospital, LLC (Ada)

V. TReC: TRAUMA TRANSFER CENTER

Oklahoma City, Region 8: (888) 658-7262
Tulsa, Region 6: (866) 778-7262

The TReC: 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.

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

Ambulances from Region 3 are required to call into the center prior to entering Regions 7 or 8 in order to ensure appropriate 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 3 RTAB for Quality Improvement purposes.

VI~~I~~. EMResource™ Usage

A. Introduction

For several years EMResource™ has served as a tool for hospitals to display their diversion status in Oklahoma City. Although diversion is still a feature on the EMResource™, we are going to ask that you look at EMResource™ as a communication tool capable of demonstrating resource availability, health alerts and disaster notifications. EMResource™ is now a vital tool that can better enable communication in both routine daily circumstances and during disasters. EMResource's™ ability to serve this function is limited by the use of the system by providers.

B. Usage Requirements

Within Region 3 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:

1. Contact Information
   a. Each provider is responsible to submit~~maintain~~ accurate contact information on the EMResource™.

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

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

Critical Concept: Emergency Departments and Hospitals are considered open unless posted otherwise on EM Reso-u-rce™–.

a. Emergency Department Status

i. This is the specific status of the Emergency Department and is the only status appropriate for diversion of pre-hospital transports. The current ED Status categories are: Open, Total ED Divert, Trauma Divert, CT Divert, ED select, Forced Open, and Closed.

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

b. Hospital Status

i. This status is specific to the inpatient capability/capacity and is only appropriate for diverting inter-facility transfer patients. The current Hospital Status categories are: Open, Caution, and Closed.

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

iii. Critical Concept: Emergency Departments and Hospitals are considered open unless posted otherwise on EMResou-rce™–.

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

d. Air Ambulance Status
This status is for displaying the current status/availability of Air Ambulances. The status categories for this status are:

i. Available At – the aero-medical resource is currently ready and able to respond to emergency calls.

ii. ~~Call for Status~~ Delayed At – current conditions necessitate that providers in need of aero-medical transport call to determine resource availability because:

1) The aero-medical resource may already be dispatched to a call or be on standby.
2) Local weather conditions may temporarily impact the ability of this aero-medical resource to respond.
3) This aero-medical resource may be temporarily unavailable due to routine service or fueling.

iii. ~~Not Available~~ Unavailable – the aero-medical resource is currently unable to respond in a timely manner.

iv. Limited Availability

~~iv.~~ In region 3 the air ambulances are required to keep their most accurate status current. They may not leave their status as "~~call for status~~Delayed At" at all times.

3. System Alerts

a. Providers in Region 3 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.

b. If a provider is unable to maintain a computer with EMResource™ displayed 24 hours a day, the provider is expected to work with the regional EMResource™ 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.

4. Data Reporting
Providers in Region 3 are required to participate in reporting data supported by the EMResource™ application. This reporting requirement includes but is not limited to:

a. ~~Hospital Daily Report of bed capacity and ED volume~~OSDH Monthly Bed Survey;

b. ~~EMS Daily Report of resources and volume~~OSDH Monthly EMS Report;

c. MCI Drills.

C. Monitoring

1. Appropriate use of EMResource™ will be enforced in the region through the QI process

2. 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™.

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

4. 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.

D. CQI 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.

E. 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 3 supports use of this tool through adoption of these requirements.

VIII. HELICOPTER UTILIZATION PROTOCOL

Purpose - Appropriate utilization of air ambulance resources by Region 3 providers.

A. "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 for the patients injury more time consuming should be transported by ground. This is generally within 30 minutes of the destination facility.
   b. Priority 3 patients shall be transported by ground ambulance.
   c. Cardiac arrest without return of spontaneous circulation in the field.

B. "Fly" Conditions:
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 timelier, generally for distances with a transport time greater than 30 minutes by ground ambulance.
   b. Priority 2 trauma patients that are being transported to a facility with a transport time greater than 30 minutes by ground ambulance, based on local resource availability.

C. The following are conditions that warrant the use of an air ambulance even when the patient is within a 35 mile radius of a medical facility:
   a. The closest facility is not appropriate for the patient's 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.

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Approved OTSIDAC: 03/02/2005

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: Simultaneous dispatch of the air ambulance should be utilized to the fullest extent when appropriate and in the best interest of the patient.

1. Hospital Activation:

When a patient presents by EMS or other means to a hospital, and after primary and secondary assessment he/she is deemed to be a priority one trauma, then the activation of standby by a flight team should be affirmed. They should not be left on standby for more than 30 minutes.

When a hospital determines that a trauma patient is to be transferred by helicopter the transferring hospital should notify the helicopter service as soon as possible. All pertinent information should be given to the dispatch center so that appropriate flight crew is included on the flight. All precautions for a safe landing/takeoff will be followed by the hospital in an effort to expedite transfer of the patient.

2. EMS Activation:

When a dispatch center or ground ambulance service receives a call that meets the following criteria, it is recommended that the air ambulance be "early activated" or placed on ground standby:

a. Significant mechanism of injury as defined in the Trauma Triage Algorithm
b. Multiple patients
c. "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.
8. Aircraft and ground crew communications will remain in effect for 2 minutes after departure.

H. Training:

All ambulance service personnel on an annual basis should complete Landing zone training. Each individual ambulance service can contact an air ambulance service for this training.

EMTALA

There are concerns regarding air utilization and rendezvous with a local ground transport at a helipad upon a medical facility's property. This is addressed in (**Appendix C**).

Southwest Regional Trauma Plan
PRE-HOSPITAL TRAUMA DESTINATION COMPONENT

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 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 hospital destination for Priority 1, 2, and 3 trauma patients. (See **Appendix B** of the Pre-Hospital Trauma Destination Plan). The appropriate resource for the optimal care of the injured patient may not be available at the closest facility or the facility of patient preference. Transport to a facility with the appropriate capabilities should occur in a timely fashion.

These Destinations are:

A. ALL PATIENTS:

1. All trauma patients should be transported/transferred to the most appropriate medical facility with the available resources and capacity to provide trauma care in a timely fashion.

2. Those patients with a traumatic arrest or the inability to secure an airway should be transported to the closest facility to the traumatic event for stabilization and transfer.

3. It should be noted that any priority 1 or 2 trauma patient that needs immediate stabilization should be transported to the nearest facility in an effort to expedite care of the trauma patient.

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

5. In the event of a disaster, or Public Health emergency that requires assets or coordination outside the normal local and mutual aid response, the MERC will be activated. Activation of the MERC will temporarily suspend these procedures to ensure proper distribution of patients. The intent is to alleviate the possibility of overwhelming the nearest facility and to apply a coordinated, unified response to a catastrophic event. All patient transports associated with the event will be coordinated through the MERC

B. GENERAL TRAUMA PATIENTS:

1. Priority 1 adult and pediatric trauma patients that meet the state approved trauma criteria should be transported to OU Medi~~cal Center~~ cine or Medical City Denton, ~~or~~ Medical City Plano, or United Regional Hospital via the appropriate method of transport. For those patients **outside** of an area **30 minutes** from ~~OUMC~~a definitive care facility, **air transport** should be activated, as defined in Section IX, as soon as possible to ensure rapid transport to the appropriate facility.

Approved RTAB 05/04/2006 Revised 06/10/2008, 06/26/2009, 11/03/2011
Approved OTSIDAC: 03/02/2005

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.

~~2. Priority 2 adult and pediatric trauma patients **WEST of Hwy 54** should be transported to Jackson County Memorial Hospital. **(Dark Purple)**~~

~~3. Priority 2 adult and pediatric trauma patients **between Hwy 183 and Hwy 65 in Comanche, Cotton, and Tillman counties** should be transported to Comanche County Memorial Hospital. Southwest Medical Center may be utilized to stabilize a patient. Parts of Tillman, Cotton, Jefferson Counties, may consider Jackson County Memorial Hospital, and United Regional Health Care in Texas. **(Light Purple)**~~

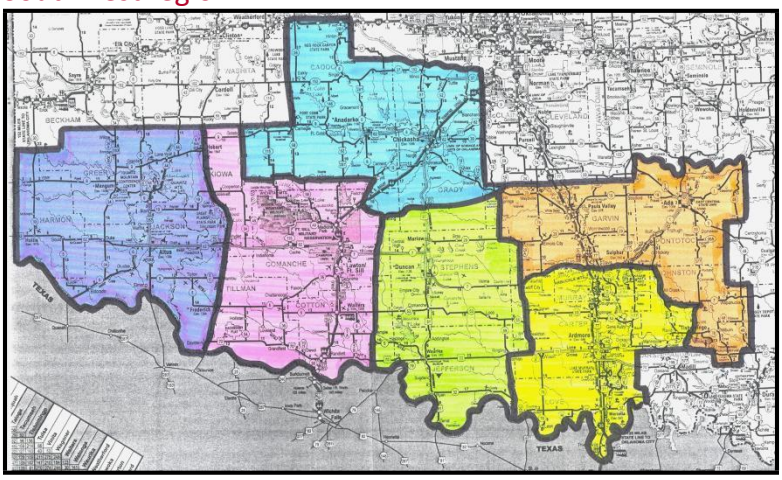
~~4. Priority 2 adult and pediatric trauma patients **between Hwy 65 and Hwy 76 in Stephens, Jefferson, and Grady (north to Rush Springs) counties** should be transported to Duncan Regional Hospital. Parts of Jefferson Counties, may consider United Regional Health Care in Texas. **(Golden Rod)**~~

~~5. Priority 2 adult and pediatric trauma patients **between Hwy 76 and Hwy 9 in Murray, Carter, Love, Johnston counties (north to Hwy 7)** should be transported to Mercy Memorial Health Center in Ardmore. **(Yellow)**~~

~~6. Priority 2 adult and pediatric trauma patients **East of Hwy 76 and north of Hwy 7 in Garvin, Johnston, Pontotoc, and Murray counties** should be transported to Valley View Hospital in Ada. Parts of these counties may consider Norman Regional Health System and McAlester Regional. **(Brown)**~~

~~7. Priority 2 adult and pediatric trauma patients **East of Hwy 54 and West of Hwy 76 in Grady, Caddo, and Kiowa counties** should be transported to Grady Memorial Hospital in Chickasha or Oklahoma City via the TReC. **(Blue)**~~

~~The following map graphically displays the destinations for Priority 2 trauma patients in the Southwest region.~~



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2. Priority 2 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.

Priority 2 single system pediatric trauma being transported or transferred into region 8 should be taken to The Children's Center at OU Medicine.

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

~~9. Priority 2 single system pediatric trauma being transported or transferred into region 8 should be taken to The Children's Center at OUMC.~~

C. NEUROLOGICAL TRAUMA PATIENTS:

1. Priority 1 adult and pediatric trauma patients should be transported directly to the appropriate facility in Oklahoma City via use of the Trauma Transfer center.

2. Priority 2 adult trauma patients should be transported to the appropriate facility in Lawton or Region 8 based on the time/distance factor with preference given to patient desire and the ability to keep the patient within Region 3.

3. Priority 2 pediatric trauma patients should be transported to The Children's Center at ~~OUMC~~OU Medicine,
Oklahoma City using the Trauma Transfer Center.

4. Priority 3 adult and pediatric trauma patients should be transported to the closest facility for stabilization before transfer to the appropriate facility within the region or Oklahoma City.

D. BURN PATIENTS:

1. Adults: Refer to Triage & Transport Guidelines – Oklahoma Model Trauma Triage Algorithm.
2. Pediatric patients < 16 years: Refer to Triage & Transport Guidelines – Oklahoma Model Trauma Triage Algorithm.

II. QI INDICATORS

A set of QI Indicators has been developed for use in monitoring hospital status and appropriateness of destination. The Region 3 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.

I. GOALS / PURPOSE

The goals of the regional Interfacility Trauma destination plan 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 Inter-Facility Trauma Triage and Transport Guidelines to effectively reduce trauma morbidity and mortality.

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

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

E. Each licensed medical facility shall have trauma policies, procedures, and plans that are consistent with OAC 310:667, subchapter 59.

II. TRAUMA CENTER PROGRAM

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

A. **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.

B. **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 a mid-level practitioner (i.e. ARNP or PA), or Registered Nurse. The major trauma patient in this facility will be stabilized and transported to the most appropriate facility for the patients on-going care needs.

C. **Trauma Program:**
There must be a written commitment letter from the Governing 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. Board of Director's and medical staff letter of commitment;
2. Written policies, procedures, and guidelines for the care of the trauma patient;
3. Appointed Trauma Medical Director with a written job description;
4. A written Trauma Performance Improvement plan;
5. Appointed Trauma Program Manager with a written job description;
6. Documentation of the trauma center representative's attendance at the Regional Trauma Advisory Boards meetings.

III. TRAUMA TEAM COMPOSITION

The team approach is optimal in the care of the multiply 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 in a Level III facility will have been ATLS trained at least one time. In a Level IV facility ATLS training is recommended but trauma training through the RTTDC (Rural Trauma Team Development Course) is acceptable.

Suggested composition of the trauma team includes:

Level III:

Physicians trained in Trauma Care
Specialists
Laboratory Technicians
Nursing trained in Trauma Care
Auxiliary Support staff

Level IV:

Physician or Mid-level Practitioner trained in Trauma Care
Nursing personnel trained in Trauma Care
Laboratory Technicians
Auxiliary staff

Compliance with the above will be evidenced by the following:

A. Written resuscitation protocols that adhere to the principles of ATLS protocol, 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.

Approved RTAB 05/04/2006 Revised 06/10/2008, 06/26/2009, 11/03/2011
Approved OTSIDAC: 03/02/2005

B. Medical Director:

The Trauma Center must have a physician director of the trauma program. The Director at a Level III facility shall be either a Surgeon or an Emergency Room physician trained in Trauma Care and is appointed by the medical staff. Through the Quality Improvement Program, the Director shall have responsibility for all trauma patients and administrative authority for the hospital's Trauma Program. The Director must have been trained in ATLS protocols.

C. Trauma Program Manager:

All trauma centers must have a Trauma Program Manager, usually a full-time Registered Nurse, who is responsible for the organization of services and systems necessary for a multidisciplinary approach to providing care to injured patients. The TPM, in particular, assumes day-to-day responsibility for process and performance improvement activities as they relate to nursing and ancillary staff and assists the Trauma Director in carrying out the same functions for the physicians. This person may also serve as the Trauma Registrar.

D. Trauma Registrar:

The Trauma Registrar is an important member of the trauma team. Although the registrar's all come from diverse backgrounds, ideally they should work directly with the trauma team and report to the TPM. It is important to acknowledge that high-quality data begin with high-quality data entry, and it is the Trauma registrar who is responsible to perform this task.

IV. HOSPITAL TRIAGE AND TRANSFER PLAN:

A well-designated trauma program within the hospital is crucial to the success for providing optimal care to the trauma patients in Region 3. A written commitment on behalf of the entire facility devoted to the organization of trauma care is vital. Therefore, all hospitals in the region should establish criteria for activation of their respective trauma programs and 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 will include:

1. Emergency Physician(s)
2. Emergency Room Nurses
3. Laboratory
4. Radiology
5. 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, 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:

1. General Surgery
2. Orthopedics
3. Anesthesia
4. Emergency Services
5. 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:

1. Blood typing and cross matching capabilities
2. Access to sufficient quantities of blood and blood products
3. Microbiology
4. Blood gas and pH determination
5. Alcohol and drug screening
6. Coagulation studies.

All Level III trauma centers shall have the following:

1. Written transfer agreements with other providers as a transferring facility
2. A Helipad.

B. LEVEL IV TRAUMA CENTER

Again, team approach is optimal in the care of the multiple injured patients. The Level IV trauma center must have a written policy for notification and mobilization of an organized 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:

1. Physician or Licensed Mid-level practitioner knowledgeable in ATLS,
2. Emergency Room Nurse trained in Trauma care,
3. Laboratory
4. Radiology
5. Ancillary personnel as needed

The ER of the Level IV trauma center must 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 available in-house 24 hours/day to ensure adequate care of the trauma patient.

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

1. General surgery
2. Neurology
3. Neurosurgery
4. Orthopedics

The Level IV facility should 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.

V. 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 following the approved Oklahoma Trauma Triage Algorithms. These may be found in Appendix B of the Pre-Hospital Trauma Destination Plan.

In a Level III or Level IV facility, PARTIAL ACTIVATION of the trauma tem should occur when a patient presents to the ER with a priority 2 or priority 3 injuries. After triage by the appropriate personnel the patient should be treated appropriately for the injury and if necessary the full activation of the team should occur.

VI. 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 will be activated (either full or partial) 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:

A. The Priority 1 or Priority 2 trauma patient will be stabilized and then transferred to the most appropriate facility,
B. The Priority 2 trauma patient with a time-sensitive injury or Priority 3 patient will be stabilized and then admitted or transferred to an appropriate facility,
C. The Priority 2 non-time sensitive patient will be stabilized and admitted or transferred to their facility of choice, or
D. The Priority 3 trauma patient will be treated and discharged to home with appropriate instruction for their injuries.

It is recommended that the transfer of Level II and Level 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. The patients' choice of facility will be considered when the injuries are not of a time sensitive matter.

In accordance with the American College of surgeons, **"Once the need for 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."**

In-Route Ambulance Diversion:
If a trauma patient's condition deteriorates in route and the ambulance crew cannot stabilize the patient, the patient will be transported to the closest facility. The transporting EMS must make every effort to contact the facility via radio prior to arrival, and report the patients' condition, reason for diversion, pertinent medical information, and estimated time of arrival. The transporting EMS will provide to the facility any pertinent files accompanying the patient upon arrival.

VII. PROCEDURE FOR SELECTION OF INTERFACILITY TRANSFER DESTINATIONS

A. 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 hospital destination for Priority 1, 2, and 3 trauma patients. (See appendix B of the Pre-Hospital Trauma Destination Plan). The appropriate resource for the optimal care of the injured patient may not be available at the closest facility or the facility of patient preference. Transport to a facility with the appropriate capabilities should occur in a timely fashion. Interfacility transfers will follow the same pattern as the optimal Pre-Hospital Destinations as outlined in **section VII**.
B. For all unassigned trauma patients the TReC should be utilized when the patients need exceeds the capability and capacity of the facility. (See section VIII)

VIII. TRAUMA TRANSFER 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 trauma patients transported or transferred to facilities in Region 7 (Tulsa) or 8 (Oklahoma City) are transported to the facility that provides the appropriate level of care based on the clinical needs of the patient. This is to ensure the highest level of care for major trauma patients.

Ambulances from Region 3 are required to call into the TReC prior to entering Regions 7 or 8 in order to ensure appropriate destination. Likewise, hospitals may call TReC 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 3 RTAB for Quality Improvement purposes.

IX. PROCEDURE FOR MONITORING HOSPITAL STATUS AND CAPABILITY

A. EMResource™

The MERC coordinator will generate reports, from the **EMResource™**, upon request, for use in monitoring hospital status. These reports will be provided periodically to the ~~OSHD~~ OSDH and made available to the Region 3 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 3 CQI Committee will monitor these indicators. Any problems and/or trends through review of the indicators will be addressed by the CQI committee directly with the provider and if necessary through referral to the appropriate state level committee.

X. HELICOPTER UTILIZATION PROTOCOL

A. Purpose: To appropriately utilize air ambulance resources by Region 3 providers,

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

C. "Fly" Conditions:

1. Priority 1 trauma patients that are being transported to a Level 1 Trauma Center with an injury that is time sensitive for the patients' survival
2. Priority 2 trauma patients with unstable vital signs and are in need of immediate transport to a Level 1 or Level 2 Trauma Center. The mechanism of injury or physiological condition is such that the patients' condition is time sensitive in accordance with the Oklahoma Trauma Triage Algorithms and Protocols.

XI. QUALITY IMPROVEMENT

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

XII. DIVERSION

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

A. Maximum capacity of the Emergency department has been met.
B. The hospital does not have the capability to care for the patient.
   1. The EMSystem will be updated to show current information.

XIII. AMENDMENT OF TRAUMA PLAN

The Soutwest Regional Trauma Plan shall be reviewed/revised annually by the Southwest Regional Education and Planning Committee.

Approved RTAB 05/04/2006 Revised 06/10/2008, 06/26/2009, 11/03/2011
Approved OTSIDAC: 03/02/2005

Appendix A

EMS Provider Descriptions

Southwest Regional Trauma Plan
DESCRIPTION OF EMS SERVICES

Region 3 is a large area encompassing 17 counties and covering approximately 16,295 square miles that is serviced by 321 ambulance services and 135 air transport services.

CADDO COUNTY:

1. **Apache** Ambulance~~EMS~~ is a Basic Service staffed with 2 First Responders, 2 Basics, 3 Intermediates, and 0 Paramedics
2. **Anadarko Fire** Department **EMS** is an Intermediate Service staffed with 4 First Responders, 7 Basics, 13 Intermediates and 1 Paramedics.
   They have 2 routine units and 3 total units and cover 240 square miles.
3. **Carnegie** ~~Tri-County Hosp~~EMS is a Basic Service staffed with 2 First Responders, 6 Basics, 3 Intermediates and 4 Paramedics.
   They have 3 routine and 3 total units and cover 12754~~0~~ square miles.
4. ~~**Cyril EMS-Cyril** is a Basic Service staffed with 0 First Responders, 0 Basics, 2 Intermediates and 2 Paramedics. They have 1 routine unit and 2 total units and cover 170 square miles.~~

45~~.~~ **Medic West LLC** has a substation located in Hinton which may be staffed with 1 Paramedic Unit.

CARTER COUNTY:

56~~.~~ **Southern Oklahoma Ambulance Service** is a Paramedic service staffed with ~~2 First Responders,~~ 192 ~~Basics~~ EMTs, 17 ~~Intermediates~~Advanced, and 218 Paramedics. They have 6 routine and 8 total units ~~and~~ covering 833 square miles with 1 substation located in Healdton with 1 staffed and 1 available unit.

COMANCHE COUNTY:

76~~.~~ **Comanche County Memorial Hospital EMS~~Ambulance~~** is a Paramedic Service staffed with 0 First Responders, 13 Basics, 3 Intermediates and 18 Paramedics.
They have 3 routine units and 6 total units and cover 500 square miles.

8. ~~**CCMH – EMS- Elgin** is a Basic level service staffed with 0 First Responders, 1 Basic, 1 Intermediate and 1 Paramedic. They have 1 unit and cover 290 square miles.~~

79~~.~~ ~~**CCMH –**~~ **Cache EMS** is a Basic level service~~substation~~, which may be staffed with one unit,

810~~.~~ **Kirk's Emergency Service** is a Paramedic Service staffed with 0 First Responders, 6 Basics, 3 Intermediates and 11 Paramedics. They
have 3 routine units and 6 total units that cover 500 square miles.

911~~.~~ **Reynolds Army Community Hospital ~~EMS~~** is a Paramedic Service.

COTTON COUNTY:

1012~~.~~ **Cotton County** currently has no licensed ambulance service within the county limits. It is currently covered as needed by the next closest available ambulance service. There is approximately 350 square miles uncovered area in this county.

GARVIN COUNTY:

1113~~.~~ ~~**City of**~~ **Lindsay EMS** is ~~a Basic~~an Intermdiate Service staffed with 0 First Responders, 8 Basics, 3 Intermediates and 12 Paramedics. They have 2 routine units and 3 total units that cover 420 square miles.

124~~.~~ **Paul's Valley ~~Gen Hosp EMS~~ Ambulance Authority** is a Basic Service. ~~staffed with 1 First Responders, 7 Basics, 4 Intermediates and 5 Paramedics.~~
~~They have 2 routine and 3 total units that .~~ covering 450 square miles.

135~~.~~ **Stratford ~~EMS~~Response Area** is a Basic Service. ~~staffed with 4 First Responders, 3 Basics, 3 Intermediates and 0 Paramedics. They have 1 routine unit and 2 total units and cover 320 square miles.~~

146~~.~~ **Elmore City EMS** is a basic level Service staffed with 2 Paramedics, 3 Intermediates, and 2 basics with 2 First Responders. They have on routine unit and 1 non staffed backup unit and cover 250 square miles.

GRADY COUNTY:

157~~.~~ **Chickasha Fire Department EMS** is an Intermediate Service staffed with 3 First Responders, 9 Basics, 18 Intermediates and 12 Paramedics. They have 2 routine units and 3 total units and cover 26 square miles. They are a 522 district.

168~~.~~ **Rush Springs Fire/EMS** is a Basic Service staffed with 9 First Responders, 9 Basics, 2 Intermediates and 0 Paramedics. They have
2 routine units and 2 total units and cover 345 square miles.

Approved RTAB 05/04/2006 Revised 06/10/2008, 06/26/2009, 11/03/2011
Approved OTSIDAC: 03/02/2005

179. **Tuttle Fire/-EMS** is an Intermediate service.

~~20. **Mediflight Air Ambulance** is an air unit which responds with one Paramedic and one flight nurse.~~

GREER COUNTY:

1821. **Greer County Special Ambulance Service ~~EMS~~** is an Intermediate Service staffed with 8 First Responders, 4 Basics, 4 Intermediates and 1 Paramedics.

They have 3 routine units and 4 total units and cover 960 square miles. They are a 522 district.

HARMON COUNTY:

1922. **Southwest Oklahoma Ambulance Authority** is a Basic Service staffed with 2 First Responders, 4 Basics, 1 Intermediates and 1 Paramedics. They have 2 routine units and 3 total units and cover 538 square miles. They are a 522 district.

JACKSON COUNTY:

203. **Jackson County EMS** is an Intermediate Service staffed with 1 First Responders, 8 Basics, 2 Intermediates and 9 Paramedics. They have 2 routine units and 3 total units and cover 780 square miles. They are a 522 district.

~~24. **Eldorado EMS** is a Basic Service staffed with 0 First Responders, 5 Basics, 0 Intermediates and 0 Paramedics. They have 1 unit and cover square 210 miles.~~

JEFFERSON COUNTY:

215. **Waurika ~~Voluntary Ambulance~~ EMS** is a Basic Service staffed with 5 First Responders, 3 Basics, 1 Intermediates and 0 Paramedics. They have 2 units and cover 2000 square miles.

JOHNSTON COUNTY:

226. **Johnston County EMS** is a Basic Service staffed with 1 First Responders, 1 Basics, 6 Intermediates and 0 Paramedics. They have 3 units and cover 636 square miles.

KIOWA COUNTY:

~~27. **Mountain View Gotebo Ambulance** is a Basic Service staffed with 6 First Responders, 4 Basics, 0 Intermediates and 0 Paramedics. They have 1 unit and cover 450 square miles. They are a 522 district.~~

~~28. **Kiowa County District 3** is a Basic Service staffed with 4 First Responders, 7 Basics, 5 Intermediates and 0 Paramedics. They have 1 routine and 2 total units and cover 450 square miles.~~

239. **Sinor EMS – ~~-~~Hobart** is an ~~Intermediate~~ Basic Service staffed with 1 First Responder, 4 Basics, 4 Intermediates, and 3 Paramedics.

They have 2 units that cover 305 square miles.

~~30. **Lone Wolf EMS** is a Basic level service staffed with 2 First Responders and 1 Basic, 0 Intermediates, and 0 Paramedics~~

LOVE COUNTY:

2431. **Mercy Health Love County** is a Paramedic Service staffed with 0 First Responders, 4 Basics, 0 Intermediates and 8 Paramedics. They have 2 routine units and 4 total units and cover 480 square miles. They are a 522 district.

MURRAY COUNTY:

2532. **Murray County EMS** is a ~~Paramedic~~ Basic Service staffed with 0 First Responders, 8 Basics, 2 Intermediates and 9 Paramedics.

They have 2 routine and 3 total units and cover 400 square miles. They are a 522 district.

PONTOTOC COUNTY:

2633. **Chickasaw Nation EMS** is a Basic Service staffed with 0 First Responders, 3 Basics, 4 Intermediates and 6 Paramedics. They have 2 routine units and 3 total units and cover _ square miles.

2734. **~~Valley View~~Mercy Hsopital Ada EMS** is a Paramedic Service ~~staffed with 0 First Responders, 0 Basics, 5 Intermediates and 20 Paramedics. They have 3 routine units and 5 total units and cover 714 square miles.~~

STEPHENS COUNTY:

2835. **American Medical Response – Duncan** is a Paramedic Service staffed with 0 First Responders, 3 Basics, 2 Intermediates and 14 Paramedics. They have 2 routine units and 6 total units and cover 400 square miles.

2936. **American Medical Response – Marlow** is a Paramedic Service staffed with 0 First Responders, 3 Basics, 2 Intermediates and 14 Paramedics. They have 1 unit and cover 1500 square miles.

307. **Velma Community Ambulance** is a Basic Service staffed with 10 First Responders, 5 Basics, 0 Intermediates and 0 Paramedics. They have 1 unit and cover 238 square miles.

TILLMAN COUNTY:

319. **Grandfield Ambulance Service** is a Basic Service staffed with 0 First Responders, 2 Basics, 2 Intermediates and 0 Paramedics. They have 2 units and cover 350 square miles.

328. **Tillman County EMS** is a Basic Service staffed with 3 First Responders, 5 Basics, 1 Intermediates and 2 Paramedics. They have

2 routine units and 3 total units and cover 900 square miles.

AIR SERVICES

1. AirEvac Lifeteam – Ardmore, OK
2. AirEvac Lifeteam – Ada, OK
3. AirEvac Lifeteam – Altus, OK
4. AirEvac Lifeteam – Decatur, TX
5. AirEvac Lifeteam, Duncan, OK
6. AirEvac Lifeteam – Elk City, OK
7. AirEvac Lifeteam – Weatherford
8. Air-Evac Lifeteam – Wichita Falls, Texas
9. Apollo MedFlight – Amarillo, TX
10. CareFlight - Denton
11. CareFlight – Grand Prairie, TX
12. Survival Flight – Altus, OK
13. Survival Flight – Lawton, OK

~~1. Air Evac Lifeteam – Paul's Valley, OK~~
~~2. Air Evac Lifeteam – Lawton, OK~~
~~3. Air Evac Lifeteam – Elk City, OK~~
~~4. EagleMed – Ardmore, OK~~
~~5. Medi Flight – Chickasha, OK~~

Approved RTAB 05/04/2006 Revised 06/10/2008, 06/26/2009, 11/03/2011
Approved OTSIDAC: 03/02/2005

Appendix B
Trauma Triage Algorithm

TRAUMA PATIENT
TRIAGE DEFINITIONS

Trauma Triage

Since patients differ in their initial response to injury, trauma triage is an inexact science. Current patient identification criteria does not provide 100% percent sensitivity and specificity for detecting injury. As a result, trauma systems are designed to over-triage patients in order not to miss a potentially serious injury. Under-triage of patients should be avoided since a potentially seriously injured patient could be delivered to a facility not prepared to manage their injury. Large amounts of over-triage is not in the best interest of the Trauma System since it will potentially overwhelm the resources of the facilities essential for the management of severely injured patients.

Priority 1 Trauma Patients

These are patients with high energy blunt or penetrating injury causing physiological abnormalities or significant single or multisystem anatomical injuries. These patients have time sensitive injuries requiring the resources of a designated Level I, Level II, or Regional Level III Trauma Center. These patients should be directly transported to a Designated Level I, Level II, or Regional Level III facility for treatment but may be stabilized at a Level III or Level IV facility, if needed, depending on location of occurrence and time and distance to the higher level trauma center. If needed these patients may be cared for in a Level III facility if the appropriate services and resources are available.

Physiological Compromise Criteria:

Hemodynamic Compromise-Systolic BP <90 mmHg

Other signs that should be considered include:

- Sustained Tachycardia
- Cool diaphoretic Skin

Respiratory Compromise-RR<10 or >29 Breaths/Minutes

Or <20 in infant <1 year

Altered Mentation- of trauma etiology- GCS <14

Anatomical Injury Criteria

Penetrating injury of head, neck, chest/abdomen, or extremities proximal to elbow or knee.
Amputation above wrist or ankle.
Paralysis or suspected spinal fracture with neurological deficit.
Flail chest.
Two or more obvious proximal long bone fractures (upper arm or thigh).
Open or suspected depressed skull fracture.
Unstable pelvis or suspected pelvic fracture.
Tender and/or distended abdomen.
Burns associated with Priority I Trauma
Crushed, degloved, or mangled extremity

Priority 2 Trauma Patients

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

I. Significant Single System Injuries

Neurology: Isolated head trauma with transient loss of consciousness or altered mental status but currently alert and oriented.

Orthopedic: Single proximal and distal extremity fractures (including open) from high energy event, isolated joint dislocations-knee, hip, elbow, shoulder without neurovascular deficits, and unstable joint (ligament) injuries without neurovascular deficits.

Maxillofacial trauma: Facial lacerations; such as those requiring surgical repair, isolated open facial fractures or isolated orbit trauma with or without entrapments, or avulsed teeth.

TRAUMA PATIENT
TRIAGE DEFINITIONS

High Energy Event

Patient involved in rapid acceleration deceleration events absorb large amounts of energy and are at an increased risk for severe injury despite normal vital signs on their initial assessment. Five to fifteen percent of these patients, despite normal vital signs and no apparent anatomical injury on initial evaluation, will have a significant injury discovered after a full trauma evaluation with serial observations. Determinates to be considered are direction and velocity of impact and the use of personal protection devices. Motor vehicle crashes when occupants are using personal safety restraint devices may not be considered a high-energy event. Personal safety devices will often protect the occupant from absorbing high amounts of energy even when the vehicle shows significant damage. High Energy Events:

Ejection of the patient from an enclosed vehicle
Auto/pedestrian or auto/bike or motorcycle crash with significant impact (> 20 mph) impact with the patient thrown or run over by a vehicle.
Falls greater than 20 feet for adult, >10 feet for pediatric or distance 2-3 times height of patient
Significant assault or altercations
High risk auto crash

- The following motor vehicle crashes particularly when the patient has not used personal safety restraint devices:
  - Death in the same passenger compartment
  - Rollover
  - High speed auto crash
  - Compartment intrusion greater than 12 inches at occupant site or >18 inches at any site
  - Vehicle telemetry data consistent with high risk injury.

Medic Discretion

Since trauma triage is an inexact science and patients differ in their response to injury, clinical judgment by the medic at the scene is an extremely important element in determining the destination of all patients. If the medic is concerned that a patient may have a severe injury which is not yet obvious, the patient may be upgraded in order to deliver that patient to the appropriate level Trauma Center. Paramedic suspicion for a severe injury may be raised by but not limited to the following factors:

Age greater than 55
Age less than 5
Extremes of environment
Patient's previous medical history such as:

- Anticoagulation or bleeding disorders
- End stage renal disease on dialysis

Pregnancy (>20 weeks)

Priority 3 Trauma Patients

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

Example: Same level fall with extremity or hip fracture.

ADULT PRE-HOSPITAL
TRIAGE AND TRANSPORT GUIDELINES
Oklahoma Model Trauma Triage Algorithm

INABILITY TO SECURE AIRWAY
TRAUMATIC ARREST

YES → GO DIRECTLY TO NEAREST APPROPRIATE FACILITY

PRIORITY I

PHYSIOLOGICAL COMPROMISE CRITERIA

- Hemodynamic Compromise[1]-Systolic BP < 90mmHg
  Or signs that should be considered include:
  - Sustained tachycardia
  - Cool diaphoretic skin
- Respiratory Compromise[2]- RR < 10 or > 29 breaths/minute or < 20 in infant < 1 yr
- Altered Mentation of trauma etiology[3]- GCS < 14

YES → INITIATE TRAUMA TREATMENT PROTOCOL

ACTIVATE TRAUMA SYSTEM

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

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

NO ↓

ANATOMICAL INJURY

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

YES → 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.

NO ↓

PRIORITY II

RISK OF SERIOUS INJURY - SINGLE SYSTEM INJURY

Patients with potentially time sensitive injuries due to a high energy event (positive mechanism of injury) but currently with no physiological abnormalities or significant anatomical injury, or patients with less severe single system injury.[4]

Ejection (partial or complete)of the patient from an enclosed vehicle
Auto/pedestrian, auto/bike, or motorcycle crash with significant impact (>20 mph) and patient thrown or run over by vehicle
Falls greater than 20 feet or 2-3 times height of patient
Significant assault or altercations
High risk auto crash [5]
Neurology: Isolated head trauma with transient loss of consciousness or altered mental status but currently alert and oriented
Orthopedic: Single proximal and distal extremity (including open) from high energy event, isolated joint dislocations-knee, hip, elbow, shoulder without neurovascular deficits, and unstable joint (ligament) injuries without neurovascular deficits.
Maxillofacial trauma: Facial lacerations; such as those requiring surgical repair, isolated open facial fractures or isolated orbit trauma with or without entrapments, or avulsed teeth.

YES → INITIATE TRAUMA TREATMENT PROTOCOL

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

NO ↓

CONSIDER[6] -Co-morbid factors
-Gestalt-EMS clinical judgment

YES / NO

PRIORITY III

TRANSPORT to either the closest Level IV Trauma Center or higher depending on location according to the Regional Trauma Plan or the facility of the patient's choice

Approved : OTSIDAC 02/01/06
Revised: OTSIDAC 08/01/07; 02/06/08, 08/06/08; 02/03/10
Clarification Revision by MAC: 11/19/08

1. In addition to hypotension: pallor, tachycardia or diaphoresis may be early signs of hypovolemia
2. Tachypnia (hyperventilation) alone will not necessarily initiate this level of response.
3. Altered sensorium secondary to sedative-hypnotic will not necessarily initiate this level of response.
4. High Energy Event signifies a large release of uncontrolled energy. Patient is assumed injured until proven otherwise, and multisystem injuries may exist. Determinants to be considered by medical professionals are direction and velocity of inpact, use of personal protection devices, patient kinematics and physical size and the residual signature of energy release (e.g. Major vehicle damage). Motor vehicle crashes when occupants are using personal safety restraint devices man not be considered a high energy event because the personal safety restraint will often protect the occupant from absorbing high amounts of energy.
5. The following motor vehicle crashes particularly when the patient has not used personal safety restraint devices:
   a. Death in the same passenger compartment
   b. Rollover
   c. High speed auto crash
   d. Compartment intrusion greater than 12 inches at occupant site or > 18 inches at any site
   e. Vehicle telemetry data consistent with high risk of injury
6. Since trauma triage is an inexact science and patients differ in their response to injury, clinical judgment by the medic at the scene is an extremely important element in determining the destination of all patients. If the medic is concerned that a patient may have a severe injury which is not yet obvious, the patient may be upgraded in order to deliver that patient to the appropriate level Trauma Center. EMS provider suspicion for a severe injury may be raised by but not limited to the following factors:

   Age greater than 55
   Age less than 5
   Extremes of environment
   Patient's previous medical history such as:
   - Anticoagulation or bleeding disorders
   - End state renal disease on dialysis

   Pregnancy (>20 weeks)

PEDIATRIC (16 YEARS) PRE-HOSPITAL TRIAGE AND TRANSPORT GUIDELINES

Oklahoma Model Trauma Triage Algorithm

INABILITY TO SECURE AIRWAY
TRAUMATIC ARREST

YES → GO DIRECTLY TO NEAREST APPROPRIATE FACILITY

PHYSIOLOGICAL COMPROMISE CRITERIA

Hemodynamic Compromise[1]-Systolic BP < 90mmHg or other signs such as:
- o Sustained tachycardia
- o Cool diaphoretic skin

Respiratory Compromise[2]- RR < 10 or > 29 breaths/minute or < 20 in infant < 1 yr

Altered Mentation of trauma etiology [3]- GCS < 14

YES → **PRIORITY I**

INITIATE TRAUMA TREATMENT PROTOCOL

ACTIVATE TRAUMA SYSTEM

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

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

Combination of burns > 10% or significant burns involving face, airway, hands, feet or genitalia *without* significant trauma transport to Hillcrest Burn Center or OUMC Children's Hospital. Burns >10% *with* significant trauma transport to trauma center.

NO

ANATOMICAL INJURY

Penetrating injury of head, neck, chest /abdomen, or extremities proximal to elbow or knee

Combination of burns > 10% or significant burns involving face, airway, hands, feet or genitalia *without* significant trauma transport to Hillcrest Burn Center or OUMC Children's Hospital. Burns >10% *with* significant trauma transport to trauma center.

Amputation above wrist or ankle

Paralysis or suspected spinal fracture with neurological deficit

Flail chest

Two or more obvious proximal long bone fractures (upper arm or thigh).

Open or suspected depressed skull fracture

Unstable pelvis or suspected unstable pelvis fracture

Tender and/or distended abdomen

Crushed, degloved, or mangled extremity

YES →

Pediatric Trauma Score ≤5

NO

PRIORITY II

RISK OF SERIOUS INJURY - SINGLE SYSTEM INJURY

Patients with potentially time sensitive injuries due to a high energy event (positive mechanism of injury) but currently with no physiological abnormalities or significant anatomical injury, or patients with a less single system injury4.

Ejection of patient from enclosed vehicle. Auto/pedestrian, auto/bike, or motorcycle crash with significant impact and patient thrown or run over by vehicle Significant fall >10 feet or 2-3 times height of patient Significant assault or altercations

High risk auto crash[5]

Neurology: Isolated head trauma with transient loss of consciousness or altered mental status but currently alert and oriented.

Orthopedic: Single proximal and distal extremity fractures (including open) from high energy event, isolated joint dislocations-knee, hip, elbow, shoulder without neurovascular deficits, and unstable joint (ligament) injuries without neurovascular deficits.

Maxillofacial trauma: Facial lacerations; such as those requiring surgical repair, isolated open facial fractures or isolated orbit trauma with or without entrapments, or avulsed teeth.

YES →

INITIATE TRAUMA TREATMENT PROTOCOL

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

Pediatric Trauma Score 6-8

NO

PRIORITY III

CONSIDER[6] -Co-morbid factors
-Gestalt-EMS clinical judgment

YES →

Pediatric Trauma Score 9-12

NO → **TRANSPORT** to either the closest designated acute care facility according to the Regional Trauma Plan or the facility of the patient's choice

Approved : OTSIDAC 02/01/06
Revised: OTSIDAC 08/01/07; 02/06/08, 08/06/08; 02/03/10
Clarification Revision by MAC: 11/19/08

1. In addition to hypotension: pallor, tachycardia or diaphoresis may be early signs of hypovolemia
2. Tachypnia (hyperventilation) alone will not necessarily initiate this level of response.
3. Altered sensorium secondary to sedative-hypnotic will not necessarily initiate this level of response.
4. High Energy Event signifies a large release of uncontrolled energy. Patient is assumed injured until proven otherwise, and multisystem injuries may exist. Determinants to be considered by medical professionals are direction and velocity of inpact, use of personal protection devices, patient kinematics and physical size and the residual signature of energy release (e.g. Major vehicle damage). Motor vehicle crashes when occupants are using personal safety restraint devices man not be considered a high energy event because the personal safety restraint will often protect the occupant from absorbing high amounts of energy.
5. The following motor vehicle crashes particularly when the patient has not used personal safety restraint devices:
   a. Death in the same passenger compartment
   b. Rollover
   c. High speed auto crash
   d. Compartment intrusion greater than 12 inches at occupant site or > 18 inches at any site
   e. Vehicle telemetry data consistent with high risk of injury
6. Since trauma triage is an inexact science and patients differ in their response to injury, clinical judgment by the medic at the scene is an extremely important element in determining the destination of all patients. If the medic is concerned that a patient may have a severe injury which is not yet obvious, the patient may be upgraded in order to deliver that patient to the appropriate level Trauma Center. EMS provider suspicion for a severe injury may be raised by but not limited to the following factors:

   ~~Age greater than 55~~
   Age less than 5
   Extremes of environment
   Patient's previous medical history such as:
   - Anticoagulation or bleeding disorders
   - End state renal disease on dialysis

   Pregnancy (>20 weeks)

Pediatric Trauma Score (PTS)				
Components	**+2**	**+1**	**-1**	**Score**
Weight	>20 kg (44 lb)	10-20 kg (22-44 lb)	< 10 kg (< 22 lb)	
Airway	Patent *	Maintainable ^	Unmaintainable #	
Systolic (cuff) Or BP (pulses)	> 90 mm Hg Radial	50-90 mm Hg Femoral/Carotid	< 50 mm Hg None palpable	
CNS	Awake, no LOC	Obtunded Some LOC†	Comatose, unresponsive	
Fractures	None	Closed (or suspected)	Multiple open or closed	
Wounds	None	Minor	Major ‡, Burns or penetrating	
TOTAL			**Range – 6 to +12**	

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

Generally:
9 to 1 = minor trauma
6 to 8 = potentially life threatening
0 to 5 = life threatening
< 0 = usually fatal

* No assistance required.
^ Protected by patient but constant observation required for position, patency, or O_2 administration
# Invasive techniques required for control (e.g., intubation).
† Responds to voice, pain, or temporary loss of consciousness.
‡ Abrasions or lacerations

Approved : OTSIDAC 02/01/06
Revised: OTSIDAC 08/01/07; 02/06/08, 08/06/08; 02/03/10
Clarification Revision by MAC: 11/19/08

ADULT INTERFACILITY
TRIAGE AND TRANSFER GUIDELINES
Oklahoma Model Trauma Triage Algorithm

PRIORITY I

Anatomy of the Injury
Penetrating injury of the head, neck, torso or groin.

Abdominal/Pelvic Injuries
- Hemodynamically unstable patient with physical evidence of abdominal or pelvic trauma
- Unstable pelvic ring disruption
- Pelvic fracture with shock or other evidence of continuing hemorrhage
- Open pelvic fracture
- Penetrating wound of abdomen with suspicion of penetration of the peritoneum
- Ruptured hollow viscous

CNS
- Penetrating Head Injury or Depressed skull fracture
- Open Head Injury
- GCS <= 10 or deterioration of 2 or more points
- Lateralizing signs
- New neurological deficits
- CSF Leak
- Spinal cord injury with neurological deficits
- Unstable spinal cord injuries

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

Hemodynamic Instability
- Adult SBP consistently <90 following 2 liters of crystalloid
- Respiratory distress with rate <10 or > 29

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

Multiple System
- Head Injury combined with face, chest, abdominal, or pelvic injury
- Significant injury to two or more body regions
- Combination of burns > 10% or significant burns involving face, airway, hands, feet or genitalia *without* significant trauma transport to regional Burn Center. Burns >10% *with* significant trauma transport to trauma center.

Secondary Deterioration
- Prolonged mechanical ventilation
- Sepsis
- Single or multiple organ system failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation systems)
- Major tissue necrosis

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

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

NO → Proceed to Priority II Interfacility Transfer Criteria

Approved : OTSIDAC 02/01/06
Revised: OTSIDAC 08/01/07; 02/06/08, 08/06/08; 02/03/10
Clarification Revision by MAC: 11/19/08

ADULT INTERFACILITY
TRIAGE AND TRANSFER GUIDELINES
Oklahoma Model Trauma Triage Algorithm

PRIORITY II

Abdominal/Pelvic Injuries
- Stable pelvic fractures
- Hemodynamically stable isolated abdominal trauma
  - o diffuse abdominal pain/tenderness
  - o seat belt contusions
  - o visceral injuries
- Hemodynamically stable isolated solid organ injuries

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

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

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

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

Mechanism
- Ejection of patient from enclosed vehicle
- Adult auto/pedestrian, auto/bike, or motorcycle crash with significant impact and patient thrown or run over by vehicle
- Falls greater than 20 feet
- Significant assault or altercations
- Other "high energy" events based on Paramedic discretion[4], e.g.: patients involved in motor vehicle crashes with significant vehicular damage and not using personal safety restraint devices

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

YES → Perform complete trauma evaluation and appropriate serial observations. Consider admission if condition remains stable.

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

YES → If definitive surgical care or critical care monitoring are not available, activate Trauma System and prepare for RAPID transfer to the appropriate designated Trauma Facility according to the Regional Trauma Plan. Stabilization may involve surgical intervention.

NO → Consider admission if condition remains stable.

NO

Priority III

Perform appropriate emergency department evaluation. Consider discharge or admit if condition remains stable.

Deterioration of Glasgow Coma Scale, vital signs or patient's condition or significant findings on further evaluation: Initiate Trauma Treatment Protocol- Activate Trauma System and prepare for RAPID transfer to the appropriate designated Trauma Facility according to the Regional Trauma Plan if definitive surgical care and critical care monitoring are not available.

Approved : OTSIDAC 02/01/06
Revised: OTSIDAC 08/01/07; 02/06/08, 08/06/08; 02/03/10
Clarification Revision by MAC: 11/19/08

Pediatric Interfacility Triage and Transfer Guidelines Oklahoma Model Triage Algorithm

PRIORITY I

Anatomy of the Injury

Penetrating injury of the head, neck, torso or groin.

Abdominal/Pelvic Injuries

- Hemodynamically unstable patient with physical evidence of abdominal or pelvic trauma
- Unstable pelvic ring disruption
- Pelvic fracture with shock or other evidence of continuing hemorrhage
- Open pelvic fracture
- Penetrating wound of abdomen with suspicion of penetration of the peritoneum
- Ruptured hollow viscous

CNS

- Penetrating Head Injury or Depressed skull fracture
- Open Head Injury
- GCS <= 10 or deterioration of 2 or more points
- Lateralizing signs
- New neurological deficits
- CSF Leak
- Spinal cord injury with neurological deficits
- Unstable spinal cord injuries

Chest

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

Hemodynamic Instability

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

Major Extremity Injury

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

Multiple System

- Head Injury combined with face, chest, abdominal, or pelvic injury
- Significant injury to two or more body regions
- Combination of burns > 10% or significant burns involving face, airway, hands, feet or genitalia *without* significant trauma transport to Hillcrest Burn Center or OUMC Children's Hospital. Burns >10% *with* significant trauma transport to trauma center

Secondary Deterioration

- Prolonged mechanical ventilation
- Sepsis
- Single or multiple organ system failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation systems)
- Major tissue necrosis

Pediatric Trauma Score ≤ 5

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

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

NO → Proceed to Priority II Interfacility Transfer Criteria

Approved : OTSIDAC 02/01/06
Revised: OTSIDAC 08/01/07; 02/06/08, 08/06/08; 02/03/10
Clarification Revision by MAC: 11/19/08

Pediatric Interfacility Triage and Transfer Guidelines Oklahoma Model Triage Algorithm

PRIORITY II

Abdominal/Pelvic Injuries
- Stable pelvic fractures
- Hemodynamically stable isolated abdominal trauma
  - o diffuse abdominal pain/tenderness
  - o seat belt contusions
  - o visceral injuries
- Hemodynamically stable isolated solid organ injuries

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

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

Comorbid
- Known cardiac, respiratory or metabolic disease
- Pregnancy
- Immunosupression
- Bleeding disorder or anticoagulants

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

Mechanism
- Ejection of patient from enclosed vehicle
- Auto/pedestrian, auto/bike, or motorcycle crash with significant impact and patient thrown or run over by vehicle
- Falls greater than 20 feet
- Significant assault or altercations
- Other "high energy" events based on Paramedic discretion[4], e.g.: patients involved in motor vehicle crashes with significant vehicular damage and not using personal safety restraint devices

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

Pediatric Trauma Score 6-8

YES

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

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

YES

If definitive surgical care or critical care monitoring are not available, activate Trauma System and prepare for RAPID transfer to the appropriate designated Trauma Facility according to the Regional Trauma Plan. Stabilization may involve surgical intervention.

NO

Consider admission if condition remains stable.

NO

Priority III

Perform appropriate emergency department evaluation. Consider discharge or admit if condition remains stable.

Pediatric Trauma Score 9-12

Deterioration of Glasgow Coma Scale, vital signs or patient's condition or significant findings on further evaluation: Initiate Trauma Treatment Protocol- Activate Trauma System and prepare for RAPID transfer to the appropriate designated Trauma Facility according to the Regional Trauma Plan if definitive surgical care and critical care monitoring are not available.

Approved : OTSIDAC 02/01/06
Revised: OTSIDAC 08/01/07; 02/06/08, 08/06/08; 02/03/10
Clarification Revision by MAC: 11/19/08

Appendix C
EMTALA Clarification

I. EMTALA Regarding Helipad Usage

There have been some concerns of possible EMTALA violations when using a hospitals helipad to transfer a patient from a ground ambulance to an air ambulance. The following two (2) circumstances will not trigger EMTALA. (Excerpt from the State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases)

A. The use of a hospital's helipad by local ambulance services or other hospitals for the transport of individuals to tertiary hospitals located throughout the state does not trigger an EMTALA obligation for the hospital that has the helipad on its property when the helipad is being used for the purpose of transit as long as the sending hospital conducted the Medical Screening Exam (MSE) prior to transporting the individual to the helipad for medical helicopter transport to a designated recipient hospital. The sending hospital is responsible for conducting the MSE prior to transfer to determine if an Emergency Medical Condition (EMC) exists and implementing stabilizing treatment or conducting an appropriate transfer. Therefore, if the helipad serves simply as a point of transit for individuals who have received an MSE performed prior to the transfer to the helipad, the hospital with the helipad is not obligated to perform another MSE prior to the individuals continued travel to the recipient hospital. If, however, while at the helipad the individual's condition deteriorates, the hospital at which the helipad is located must provide another MSE and stabilizing treatment within its capacity if requested by medical personnel accompanying the individual.

B. If as part of the EMS protocol, EMS activates helicopter evacuation of an individual with a potential EMC, the hospital that has the helipad does not have an EMTALA obligation if they are not the recipient hospital, **unless a request** is made by EMS personnel, the individual, or a legally responsible person acting on the individuals behalf for the examination or treatment of an EMC.

II. EMTALA EMERGENCY DEPARTMENT DEFINITIONS & DESCRIPTIONS

Situations may occur in which patients are diverted to other healthcare facilities provided EMTALA is followed.

Emergency Medical Treatment and Active Labor Act ("EMTALA") refers to Sections 1866 and 1867 of the Social Security Act, 42 U.S.C. Section 1395dd, which obligates hospitals to screening, treatment, and transfer of individuals with emergency medical conditions or women in labor. It is also referred to as the "anti-dumping" statute and COBRA.

Emergency Medical Condition:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
   a. Placing the health of the individual or, with respect to a pregnant woman, the health of a woman and her unborn child in serious jeopardy;
   b. Serious impairment of bodily functions, or

c. Serious dysfunction of any bodily organ or part; or

2. With respect to a pregnant woman who is having contractions:
   a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
   b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses number and availability of qualified staff, beds, equipment, and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

- Such as Emergency Department beds are filled, patients are backed up in the Emergency Department waiting room, and there are no other beds or personnel available to provide appropriate care for the patients.

Capabilities of a medical facility or main hospital provider means the physical space, equipment, supplies, and services (e.g. trauma care, surgery, intensive care, pediatrics, obstetrics, burn unit, neonatal unit, or psychiatry), including ancillary services available at the hospital. The capabilities of the hospital's staff mean the level of care that the hospitals personnel can provide within the training and scope of their professional licenses. For off-campus departments, the capability of the hospital as a whole is included. The obligations of the hospital provider must be discharged within the hospital as a whole. However, the hospital is not required to locate additional personnel or staff to off-campus departments to be on-call for possible emergencies.

Under no circumstances will an Emergency Department patient who has an emergency medical condition be transferred to another facility because of inability to pay for services or based on any illegal form of discrimination (national origin, race, gender, religion, etc.). Prior to any Emergency Department transfer, the Emergency Department staff will comply fully with EMTALA. A transfer form is to be used for patients who are transferred to a different acute care facility.

If a patient Comes to the Hospital Property or Premises and has an emergency medical condition, the hospital must provide either: (a) further medical examination and treatment, including hospitalization, if necessary, as required to stabilize the medical condition within the capabilities of the staff and facilities available at the hospital; or (b) a transfer to another more appropriate or specialized facility.

- **Comes to the Emergency Department** with respect to an individual presenting for examination and treatment for what may be an emergency medical condition means that the individual is on the hospital property and premises. An individual in a non-hospital owned ambulance on hospital property or premises is considered to have come to the hospitals Emergency Department.

Appendix D

Advanced Life Support Intercept Protocol

Approved RTAB 05/04/2006 Revised 06/10/2008, 06/26/2009, 11/03/2011
Approved OTSIDAC: 03/02/2005

Southwest Regional Trauma Plan

ALS INTERCEPT PROTOCOL FOR REGION 3

Purpose:

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

Policy:

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

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

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

Procedure:

1. Consideration must be given as to the location of the EMS unit, and anticipated location of intercept. The decision to request ALS should be made immediately.
2. The location of the intercept shall be decided as soon as possible.
3. Only if it is deemed to be in the best interest of the patient should the patient be transferred from a BLS unit to a ground ALS unit.
4. The ALS provider should be licensed at the Intermediate or Paramedic level or an Air Ambulance.
5. BLS and ALS personnel may elect to request air medical support based on the Regional Trauma Plan. BLS personnel need not wait for an assessment prior to requesting air medical support. Landing zone selection and security shall be coordinated with local resources. Transportation to the closest most appropriate medical facility shall not be inordinately delayed while waiting for air support.
6. A full verbal patient care report shall be given to the ALS personnel upon arrival and a full patient care report will be left with the patient at the hospital.

Approved RTAB 05/04/2006 Revised 06/10/2008, 06/26/2009, 11/03/2011
Approved OTSIDAC: 03/02/2005

SOUTHWEST REGIONAL TRAUMA ADVISORY BOARD
BYLAWS

NAME AND GEOGRAPHIC DESCRIPTION

Section I. Name: Southwest Regional Trauma ~~Regional~~ Advisory ~~Council~~Board

Section II. Geographic description, the following counties are included in the Southwest Regional Trauma Advisory Council:

Caddo	Greer	Love
Carter	Harmon	Murray
Comanche	Jackson	Pontotoc
Cotton	Jefferson	Stephens
Garvin	Johnston	Tillman
Grady	Kiowa	

MISSION STATEMENT

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

PURPOSE

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

Section II. The Regional Trauma Advisory Board shall be empowered but not limited to:

1. Assessing the current resources and needs within the region respective to Emergency Medical Services (EMS), acute care facilities, rehabilitation facilities, communication systems, human resources, professional education, public education and advocacy.

2. Organizing regional human resources into coalitions and/or alliances, which will be proactive in trauma systems development.

3. Development of Regional Trauma System Development Plan.

4. Development and implementation of Regional Trauma Quality Improvement program.

5. Providing public information and education programs regarding the need for a formal trauma care system.

6. Providing region—specific input to the Oklahoma Trauma and Emergency Response Advisory Council and the Oklahoma State Department of Health concerning trauma care issues.

MEMBERSHIP

Membership is composed of representatives from all of the facilities in the region as well as other interested individuals.

Section I. Responsibilities of the Membership
The Members are expected to attend meetings regularly to provide input on topics under consideration by the Board.

Section II. Committee Service
Members may serve on committees, work groups and task forces.

Section III. Attendance Expectations
The Members are expected to have 100% attendance every quarter annually. If a Member misses a meeting, they will be reported to their licensure authority for action.

Section IV. Exceptions involving emergencies may be considered on a case by case basis by a unanimous vote by the Board.

BOARD MEMBERSHIP

Representation will rotate between the member organizations in the region based upon the approved rotation schedule (attachment A); but will maintain a ratio of approximately:

50% Hospital representative's
50% EMS representatives

Board Membership should be multidisciplinary with broad representatives from the following list of disciplines.

Hospital		Emergency Medical Services
1. Administrator		1. Administrator
2. Business office		2. Non Administrator EMT-B
3. QI practitioner		3. Non Administrator EMT-I
4. Emergency department physician		4. Non Administrator EMT-P
5. Surgeon		5. Business office
6. Trauma nurse coordinator		
7~~6~~. Trauma registrar		

8~~7~~. Emergency department nurse		
9~~8~~. Operating room nurse		
10~~9~~. Rehabilitation practitioner		
11~~0~~. Safety officer		

Member organizations will appoint a representative and an alternate to the board but will have only one vote.

Section I. Powers and Responsibilities
The Board members are responsible for overall policy and direction of the RTAB.

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

1. Conduct the business of the organization.
2. Specify the composition of and direct the activities of committees.
3. Consider for approval recommendations from committees.
4. Cause to be prepared and administer the budget, prepare annual reports of the organization.
5. Cause to be prepared grant applications for the organization.
6. Approve, execute and/or ratify contracts made in ordinary course of business of the organization.
7. Make continuous and regular reviews of RTAB matters and business affairs in order to provide information to general membership.

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

Section IV. Actions of the Board

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

Section V. Term

The term of the Board Members is one calendar year.

Section VI. Appointments

Board members shall be appointed by the respective member organizations according to the established membership structure and rotation.

Section VII. Meetings

Meetings of the Board shall be held in accordance with the Oklahoma Open Meeting Act. Meetings of the Board Members shall be held at such times and places as determined by the Board Members. These meetings must be held at least quarterly.

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

Section VIII. Attendance Expectations/Removal of Board Members

1. A Member is automatically removed from the Board if he/she misses a scheduled and posted meeting in any year without arranging for a proxy. In the event a board member is removed due to not meeting the attendance expectations, the agency or facility CEO and or Director will be notified of their representatives' removal from the Board. If the board member believes that they missed a scheduled meeting due to extenuating circumstances, that member shall notify the RTAB Chair and the RTAB Chair will determine if the absence was acceptable.

2. Vacancies
   In the event that a Board Member is removed from the board, the effected member organization will be removed from the current rotation and the next provider on the rotation will assume their position. The Chair of the Board will notify both providers of the change.

3. Any member organization that fails to ensure participation by their representative shall be reported to both the *Oklahoma Trauma and Emergency Response Advisory Council* and the member organization's licensing authority.

Section IX. Proxies

In the event that a board member or their alternate is unable to attend a board meeting, they may attend a meeting or vote by Proxy. They must prepare and send~~ign~~ a statement on their institution's letterhead or by email stating their authorization of a specifically named alternate from their institution to attend the meeting and/or

cast a vote on their behalf. The proxy should be transmitted to **both** the *OSDH Trauma Office* and the *RTAB Secretary* at least 24 hours before the posted meeting time. A proxy shall only be valid at the meeting for which it is executed.

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

OFFICERS

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

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

Section III. The term for officers shall be one year.

Section IV. Nominations
Nominations of candidates for office shall occur at least one month prior to the election.

1. The candidates shall be Board Members.

2. The candidates shall express a willingness to serve.

Section V. Additional Offices
The Board Members may create additional officer positions, define the authority and duties of each such position, and elect persons to fill the position.

Section VI. Attendance Expectations/Removal of Officers
An Officer is automatically removed from office if he/she misses a posted meetings of the scheduled meetings in any year without making arrangements for the alternate or a proxy to attend.

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

DUTIES OF OFFICERS

Section I. The Chair shall be the executive officer of the RTAB and shall:

1. Set the agenda and preside at all meetings of the RTAB;

~~2. Appoint all committee chairs~~

~~3.~~2. Sign agreements and contracts after authorization by the Board;

~~4.~~3. Call special meetings when necessary;

~~5.~~4. Ensure that the RTAB is represented at Oklahoma Trauma and Emergency Response Advisory Council, OTERAC.

~~6.~~5. Ensure that the RTAB is represented at all appropriate state and regional meetings;

~~7.~~6. Ensure that the RTAB membership is informed of all appropriate state and legislative activities;

~~8.~~7. Perform other tasks as deemed necessary by the Board Members.

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

Section III. Duties of the Secretary

1. Ensure dissemination of all notices required by the Bylaws or by the Oklahoma Open Meetings Act.
2. Assure a meeting attendance roster is maintained.
3. Assure a register of the name and mailing address of each member organization is maintained.
4. Ensure minutes are kept of all proceedings of the Board meetings.
5. Manage the correspondence of the organization.

~~Section IV. Duties of the Treasurer~~

~~1. Manage all funds and assets of the RTAB.~~

~~Monitor monies due and payable to the RTAB~~.

~~2. Ensure the preparation of the annual budget and present it to the Board Members for approval.~~

~~3. Monitor the financial records of the RTAB and arrange for an independent audit when so directed by the Board Members.~~

SOUTHWEST REGIONAL TRAUMA ADVISORY BOARD
BYLAWS

MEETINGS

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

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

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

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

Section V. These meetings must be held at least quarterly.

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

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

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

PROCEDURES

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

COMMITTEES

Section I. Quality Improvement Committee

1. Each RTAB is required by statute to conduct quality improvement activities.

2. The function of this committee is to decrease death and disability by reducing inappropriate variation in care through progressive cycles of performance review.

3. A multidisciplinary standing committee for Quality Improvement shall be created in each region.

   A. Minimum membership requirement:

      i. Emergency Department Physician

      ii. Surgeon

      iii. Emergency Department Nurse

      iv. OR Nurse

      v. EMS Medical Director

      vi. EMT

      vii. Air Ambulance Provider

   B. Other members for this committee may be identified based upon the need of the region. It is suggested that the membership be kept to 10 members or fewer.

   C. Other specific disciplines that are not regular members of the committee may be called on to meet specific quality improvement needs.

   D. A simple majority shall constitute a quorum to conduct business.

   E. Upon approval by the chair of the committee, a committee member ~~is automatically~~ may be removed from the committee if he/she misses ~~two (2) consecutive scheduled meetings or 25~~50% of the regularly scheduled meetings in any year.

   F. Vacancies

      i. Notice of a vacancy shall be distributed to Board members at least ten(10) days prior to a scheduled meeting.

      ii. Volunteers/recommendations to fill the vacancy in membership on this committee shall be accepted and voted on at the next scheduled meeting of the Board.

4. Volunteers/recommendations for membership on this committee shall be accepted at the annual meeting, and membership appointments decided by a vote of the board members at the following meeting.

5. Each region shall adopt confidentiality policies for this committee.

6. Minimum Quality Improvement activities shall be defined by the Quality Improvement Committee and approved by the Board ~~State Medical Audit Committee~~.

7. The regional committee may identify other activities to monitor based upon regional need.

8. Committee Tenure
   Membership on this committee is for a term of two (2) years. Half of the initial appointments to this committee shall be for a term of one year to ensure staggered terms.

Section II. Regional Education and Planning Committee

1. The purpose of this committee is meet regional needs through strategic planning; creating, reviewing, and amending regional plans; and creating educational components to further regional goals.
2. Suggested membership should be nine members with a make-up of four members from hospitals, four members from EMS agencies, and a member from the Regional Medical Response System (RMRS).
3. The committee shall elect a Chair.
4. The Chair of the Board, the Chair of the committee, or a majority of the committee may call meetings of a committee. The committee will meet at least annually.
5. Each member shall continue to serve on this committee until the next annual meeting of the Board and until his/her successor is appointed unless sooner removed, the member resigns, or until the Committee is dissolved.
6. Upon approval by the chair of the committee, a committee member may be removed from the committee if he/she misses 50% of the regularly scheduled meetings.

Section III. Standing Committees shall be established by a majority vote of the Board

1. Standing committees may include but are not limited to: Hospital Care Committee, Pre-Hospital Care Committee, Injury Prevention Committee, EMS/Hospital Disaster Committee, Trauma Coordinator Committee, Trauma Registry Committee, Finance, Professional Education, Membership, Bylaws,

Public Relations, and Research.

2. At least one Board Member shall serve on each standing committee.

3. The Board may recommend the remaining membership on these committees.

4. Each standing committee shall elect a Chair.

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

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

7. Upon approval by the chair of the committee, a committee member ~~is automatically~~ may be removed from the committee if he/she misses ~~two (2) consecutive scheduled meetings or~~ 50~~25~~% of the regularly scheduled meetings in any year.

8. Notice of the committee meetings must be given in accordance with the Oklahoma Open Meeting Act.

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

Section IV~~II~~. Special Committees
The board may create special, ad hoc, or task force committees based upon the recommendation of the Board Members.

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

2. The Board shall appoint members of these committees.

3. Upon approval by the chair of the committee, a committee member ~~is automatically~~ may be removed from the committee if he/she misses ~~two (2) consecutive scheduled meetings or 25~~50% of the regularly scheduled meetings in any year.

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

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

Section ~~I~~V. Committee Resignations, Removal and Vacancies
Any person on a committee may resign from the committee at any time by giving written notice to the chair of the Board, chair of the committee or to the secretary of the Board.

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

Section VII. Action by Committee
Recommendations by committees are to be taken back to the Board for action.

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

FINANCES

Section I. Deposits

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

Section II. Gifts

1. The Board may accept on behalf of the RTAB any contribution, gift, bequest or legacy that is not prohibited by any laws or regulations in the State of Oklahoma.

2. The Board may make gifts and charitable contributions that are not prohibited by the Bylaws, state law and are not inconsistent with the requirement for maintaining the RTAB's status as an organization exempt from taxation under Section 501(c)(3) of the Internal Revenue code.

Section III. Conflicts of Interest

1. The Board shall not make a loan to any Board Member or member organization.

2. The Board shall not borrow money from a Board member, a member organization, an employee of a member organization or a family member of a member organization unless:

   A. The transaction is described fully in a legally binding instrument;

   B. The transaction is found to be in the best interests of the RTAB after full disclosure of all relevant facts at a scheduled meeting of the Board; and

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

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

3. The Board shall not transact business with a Board Member, a member organization, an employee of a member organization or a family member of a member organization unless:

A. The transaction is described fully in a legally binding instrument;

B. The transaction is found to be in the best interests of the RTAB after full disclosure of all relevant facts at a scheduled meeting of the Board; and

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

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

PARTICIPATION

All member organizations are required to participate in RTAB activities. Member organizations who are not currently represented on the Board may meet this requirement by attending meetings at least quarterly to give input to the Board.

EMRESOURCE™

The RTAB adopts the policies, standards and definitions recommended by the Oklahoma State Department of Health for the operations of EMResource™. Any recommendations for changes to these documents will be made to the OSDH EMS division for consideration for statewide adoption. Because this is a statewide system, all changes must be made on a statewide basis.

Any necessary regional operational procedures will be subject to approval by the RTAB.

AMENDMENT OF BYLAWS

The Bylaws may be altered, amended or repealed, and new Bylaws may be adopted by a vote of the Board Members held at a regular or specially called meeting for the purpose of altering, amending or repealing the Bylaws.

Section 1. The Bylaws shall be reviewed/revised biennially by the Southwest Regional Education and Planning Committee.

Section I. The notice of any meeting at which the Bylaws are altered, amended or repealed shall include the text of the proposed provisions as well as the text of any existing provisions proposed to be altered, amended or repealed.