

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH

CHAPTER 667. HOSPITAL STANDARDS

SUBCHAPTER 59. CLASSIFICATION OF HOSPITAL EMERGENCY SERVICES

310:667-59-1. General

(a) All hospitals that treat emergency patients shall identify the extent of the stabilizing and definitive emergency services they provide. For each of the clinical areas listed in OAC 310:667-59-7 for which a hospital provides emergency services, the hospital shall designate which classification level of service it provides.

(b) All hospitals shall participate in the state-wide trauma and stroke registries—registry and shall submit data on stroke and trauma related injury and illness to the Department as required. Hospitals shall submit data on the other emergency medical services they provide as required by the Department as the data collection tools to capture this information become available.

310:667-59-3. Inspections and deemed status

(a) All hospitals required to have a license are subject to inspection by Department staff in accordance with OAC 310:667-1-4.

(b) The Commissioner shall designate representatives to verify a hospital's emergency services are accurately classified for trauma and emergency operative services Levels II, III and IV, and all other classified emergency services. Survey teams for facilities providing trauma and emergency operative services at Levels II and III shall include a physician. If it is determined a hospital does not meet the requirements for a service to be classified at the Level reported on the Emergency Medical Services Classification Report (ODH Form 911), the Department shall classify that service at the next lowest Level where all requirements are met.

(c) Hospitals holding current verification as a Level I or Level II trauma center issued after an on-site review of their trauma services by a verification team from the American College of Surgeons Committee on Trauma (ACS COT) shall be deemed to meet the classification requirements for Trauma and Emergency Operative Services listed in OAC 310:667-59-9(c) or OAC 310:667-59-9(d). Such hospitals shall be classified by the Department as providing definitive trauma and emergency operative services at either classification Level I or Level II as reported by the ACS based on the provisions of this Subchapter.

(d) The services provided by hospitals classified at Level II for Trauma and Emergency Operative Services may be verified by either ACS COT surveyors or other representatives deemed qualified by the Commissioner.

(e) Only hospitals holding current verification as a Level I trauma center after an on-site review of their trauma services by a verification team from the ACS COT according to the standards at OAC 310:667-59-9(d) shall be classified at Level I for trauma and emergency operative services.

(f) The Department may grant Primary Stroke Center classification to hospitals holding current verification as a Primary Stroke Center issued after an on-site review of their emergency stroke services by a verification team from The Joint Commission. Such classification shall

also be granted to hospitals that meet the requirements of a Primary Stroke Center as specified at OAC 310:607-59-20 and verified by Department staff.

310:667-59-5. Notification

(a) Each hospital shall notify the regional emergency medical services system control when treatment services are at maximum capacity and that emergency patients should be diverted to another hospital (divert status). If the hospital is located in an area in which no regional emergency medical services system control is active, the hospital shall notify each entity providing emergency medical services, such as ambulance services, in their catchment area. Each hospital shall maintain written records documenting the date and time of the start and end of each interval of divert status.

(b) Each hospital shall develop and maintain written criteria that describe the conditions under which any one or all of the hospital's emergency services are deemed to be at maximum capacity.

(c) A hospital classified at Level I or Level II for Trauma and Emergency Operative Services or as a Primary Stroke Center shall notify the Department in writing or by facsimile or other electronic means within twenty-four (24) hours of the complete loss of verified status as a Level I or Level II trauma center by ACS COT, or as a Primary Stroke Center by the Joint Commission.

(d) A hospital shall notify the Department in writing or by facsimile or other electronic means within twenty-four hours (24) if it is unable to provide any classified emergency medical service at the current classified level, such as through the unavailability of professional personnel or required equipment which is beyond the scope of the facility's normal divert protocols. If such an interruption of service is expected to be brief and the hospital notifies the Department promptly, at the discretion of the Commissioner, it may not be necessary to permanently reclassify the service to a lower Level.

(e) A hospital may request a permanent change in classification for any classified emergency medical service by notifying the Department in writing and submitting a new Emergency Medical Services Classification Report (ODH Form 911) at least thirty (30) days prior to the effective date of the change.

310:667-59-20. Classification of emergency stroke services [NEW]

(a) **Secondary Stroke Facility.** A Secondary Stroke Facility shall provide services with at least a licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician on site twenty-four (24) hours a day. A hospital shall be classified as a Secondary Stroke Facility if it meets the following requirements:

(1) **Clinical services and resources.** No diagnostic, surgical, or medical specialty services are required.

(2) **Personnel.** A physician, licensed independent practitioner, registered nurse, licensed practical nurse, or intermediate or paramedic level emergency medical technician shall be on site twenty-four (24) hours a day. In the absence of a physician, licensed independent practitioner, registered nurse, or paramedic level emergency medical technician, at least one of the practitioners on duty shall have received training in advanced life support techniques

and be deemed competent to initiate treatment of the emergency stroke patient.

(A) If the facility is licensed as a General-Medical Surgical Hospital it shall also meet the personnel and staffing requirements at OAC 310:667-29-1 and any other applicable parts of this Chapter.

(B) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Psychiatric, it shall also meet the personnel and staffing requirements at OAC 310:667-33-2 and any other applicable parts of this Chapter.

(C) If the facility provides emergency medical services and is licensed as a Specialized Hospital: Rehabilitation, it shall also meet the personnel and staffing requirements at OAC 310:667-35-3 and any other applicable parts of this Chapter.

(D) If the facility provides emergency medical services and is licensed as a Critical Access Hospital, it shall also meet the personnel and staffing requirements at OAC 310:667-39-14 and any other applicable parts of this Chapter.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Seizure control agents;

(B) Thiamine and glucose for intravenous administration; and

(C) Antipyretics and procedures for reducing body temperature when necessary.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) The facility shall have a written agreement with a hospital classified as a Primary Stroke Center, or with a board certified, board eligible, or residency trained neurologist, or group of neurologists to provide immediate consultative services for stroke patients twenty-four (24) hours a day. Such services shall include providing instructions for the initiation of appropriate therapy and/or patient transfer.

(b) **Primary Stroke Center.** A Primary Stroke Center shall provide emergency medical services with an organized emergency department. A physician shall be on call and immediately available to respond to the emergency department and nursing staff with special capability in emergent stroke care shall be on site twenty-four (24) hours a day. A hospital shall be classified as a Primary Stroke Center if it meets the following requirements:

(1) **Clinical services and resources.**

(A) **Emergency services.** A physician deemed competent in the care of the emergent stroke patient and credentialed by the hospital to provide emergency medical services shall be on call and immediately available to respond to the emergency department and nursing personnel with special capability in emergent stroke care shall be on site twenty-four (24) hours a day.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall also comply with the requirements of OAC 310:667-29-1 through OAC 310:667-29-2.

(ii) For a hospital licensed as a critical access hospital,

emergency services shall also comply with OAC 310:667-39-14.

(B) **Stroke Team.** A stroke team shall be identified in writing and shall be on site or immediately available to respond to the emergency department:

(i) Stroke team members shall have at least annual training in the care of the stroke patient;

(ii) Response time standards for the stroke team shall be established and monitored;

(iii) Standard practice protocols for the care of the stroke patient shall be in place, including appropriate administration of an FDA-approved thrombolytic agent within sixty (60) minutes of the arrival of the patient at the emergency department.

(C) **Diagnostic imaging.** The hospital shall have diagnostic x-ray and computerized tomography services available twenty-four (24) hours a day. A radiologic technologist and computerized tomography technologist shall be on duty or on call and immediately available twenty-four (24) hours a day. A single technologist designated as qualified in both diagnostic x-ray and computerized tomography procedures by the radiologist may be used to meet this requirement if an on call schedule of additional diagnostic imaging personnel is maintained.

(i) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(ii) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(D) **Clinical laboratory service.** The hospital shall have clinical laboratory services available twenty-four (24) hours a day. All or part of these services may be provided by arrangements with certified reference laboratories provided these services are available on an emergency basis twenty-four (24) hours a day. At least the following shall be available:

(i) Standard analysis of blood, urine, and other body fluids to include routine chemistry and hematology testing;

(ii) Cerebrospinal fluid, cell count, white blood cell differential, protein, glucose, Gram stain, and antigen testing when appropriate;

(iii) Coagulation studies;

(iv) Blood gas/pH analysis; and

(v) Drug and alcohol screening.

(vi) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 23 of this Chapter.

(vi) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in Subchapter 39 of this Chapter.

(2) **Personnel.**

(A) **Emergency services director.** The medical staff shall designate a physician credentialed to provide emergency medical care as emergency services director.

(B) **Neurologist.** A physician board certified, board eligible, or residency trained in neurology shall be available for consultation

on site or immediately available by telephone or other electronic means twenty-four (24) hours a day.

(3) **Supplies and equipment.** In addition to the requirements at OAC 310:667-59-9(a)(3), the hospital shall have the following equipment and supplies on site, functional, and immediately available:

(A) Seizure control agents;

(B) Thiamine and glucose for intravenous administration;

(C) Antipyretics and procedures for reducing body temperature when necessary;

(D) Sterile procedure trays for lumbar puncture and measurement of intracranial pressure; and

(E) Thrombolytic agents for treatment of acute nonhemorrhagic stroke.

(4) **Agreements and policies on transfers.**

(A) The hospital shall have written policies defining the medical conditions and circumstances for those emergency patients which may be retained for treatment in-house, and for those who require stabilizing treatment and transfer to another facility.

(B) If the facility does not have a board certified, board eligible, or residency trained neurologist, or group of neurologists on staff to provide immediate consultative services for emergent stroke patients twenty-four (24) hours a day, the facility shall have a written agreement with a hospital, or a board certified, board eligible, or residency trained neurologist, or group of neurologists to provide such services for emergent stroke patients on a twenty-four (24) hours basis. Such services shall include providing instructions for the initiation of appropriate therapy and/or patient transfer.

(5) **Quality Improvement.** The hospital shall ensure an appropriate quality improvement process is in place to monitor and evaluate the care provided to the critically ill stroke patient, and to provide regular feedback to emergency medical service agencies and referring hospitals on the optimal care of the critically ill stroke patient.