

Trauma System Oversight & Management Committee
OEMS, 1041 Technology Park Drive
Glen Allen, VA
December 5, 2013
10:00 a.m.

Members Present:	Other Attendees:	OEMS Staff:
Ajai Malhotra, Chair	Dallas Taylor	Paul Sharpe
Mindy Carter	Linda Taylor	
Keith Stephenson	Allen Williamson	
Maggie Griffen		
Emory Altizer		
Amanda Turner		
Don Kauder		
Dan Munn		
Timothy Novosel		
Martin O'Grady		
Elton Mabry		
J. Forrest Calland		
Michael Aboutanos		
Greg Stanford		
Stanley Heatwole		
Theresa Guins		
Susan Ward		
Melinda Myers		
Lisa Wells		
Lou Ann Miller		
Raymond Makhoul		
Valeria Mitchell		
Kathy Butler		
LeAnna Harris		
Melissa Hall		
Sherry Mosteller		
Beth Broering		
Andi Wright		
Bryan Collier		

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
Call to order:	The meeting was called to order at 10:00 a.m.	
Approval of Past Minutes	The minutes from the September 5, 2013 were posted and distributed in advance. The previous meeting's minutes were	The 9/5/2013 minutes

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	approved without correction.	were approved.
	This meeting was extended in time and primarily dedicated to review the draft Trauma Center Designation Manual. The format of this meeting, beginning with the 12/4/2013 meeting, is to allow each trauma manual workgroup to present its key items needing full committee consideration prior to publishing a final draft designation manual.	 Draft Designation Manual
Administrative Workgroup Continued from 12/4/2013– Andi Wright (CRMH):	<p>The administrative workgroup were responsible for the following areas: Designation description, organizational commitment, program leadership, trauma team alert, clinical capabilities, electronic medical records, patient follow-up / transfer process, TSO&MC attendance, and the designation application related criteria.</p> <p>Continuing discussion from 12/4/2013 meeting on Section 1.10.a the trauma registrar FTE requirements. Ms. Wright distributed a handout (see right) with proposed language addressing the registrar and additional an additional FTE to meet the needs of performance improvement, outreach, and other similarly required trauma service activities. Ms. Wright will update the draft designation manual based on the discussion of this topic over the two days of meetings.</p> <p>On page 35 of the draft document Section 2.06.b discusses the need for the Emergency Department (ED) physician to remain within the ED at all times and not provide coverage to other areas of the hospital. The committee discussed and came to consensus that this should be a critical level criterion for Level III centers also.</p> <p>For Section 2.08 which lists the medical and surgical clinical specialties and their response requirements. The list will be revised to consolidate specialist that are currently in other criteria. The determination to define “promptly” and apply it throughout the designation manual affects this section also.</p>	 Wright Handout
Special Needs Workgroup – Melissa Hall (MWH):	<p>The special needs workgroup were responsible for evaluating the needs of the pediatric, geriatric, and bariatric trauma patient needs. This group also addressed the issue of re-implantation. The primary area of focus has been on the pediatric trauma patient.</p> <p>Discussion began with Dr. Guins (EMSC) updating the Committee on the EMSC committee special called meeting to review the draft designation manual on 12/2/2013. Dr. Guins distributed a summary (see right) of the discussions from the 12/2/2013 EMSC committee. The following motion was made and passed during the EMSC committee meeting and is being provided to the TSO&MC:</p> <p><i>The EMS for Children Committee recommends to the State Trauma Systems Management and Oversight Committee that the Level II Pediatric Trauma Center Designation as proposed in the draft document be removed. We support the development of one level of Pediatric Trauma Center that meets the criteria for Level I designation as described in the draft document.</i></p> <p>The topic of pediatric designation was discussed at length. Limiting pediatric designation to Level I only was generally accepted. Discussion whether to update the designation manual to include a pathway for a free standing pediatric hospital to meet current Level I designation criteria versus creating an additional pediatric specific level of designation i.e. Level IP. The unintended consequence of creating an additional pediatric specific designation level would be to take away the ability of four existing level I centers being able to provide pediatric care.</p>	 EMSC Mtg Summary  Draft 12/2/13 EMSC Minutes

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	<p>After significant discussion about addressing pediatric designation the special needs workgroup will be updating the draft designation manual removing pediatric specific language and reviewing existing Level I language to assure there is a pathway for pediatric hospital designation as a level I trauma center. Additional pediatric stakeholders will be asked to assist in reviewing and developing language to meet the needs of pediatric trauma patients.</p> <p>Definition of a pediatric patient: To assist with matters of trauma triage and consistency when performing site reviews a pediatric patient is defined as a person up to the age of 14 years 364 days (15 and over is adult). It was understood some centers may need to make modifications at their institutions related to the cut-off ages of patients managed within their trauma service.</p>	<p>The TSO&MC and five workgroups agreed to make all suggested edits to the draft designation manual by 1/31/2014. If on time, staff committed to have a revised clean draft designation manual by the 3/2014 meeting.</p> <p>For purposes of the Virginia trauma system a pediatric patient is all person under the age of 15.</p>
<p>Educational / Credentialing Workgroup – Valeria Mitchell (SNGH):</p>	<p>The education / credentialing workgroup were responsible for evaluating the designation manual criteria related to trauma medical director (TMD), physician and mid-level credentials, education, and continuing medical education (CME), outreach, injury prevention, and EMS outreach and education.</p> <p>The first criteria addressed were Section 1.04.x and xi that identify the CME requirements for TMDs. The committee decided to change the CME requirements for Level III TMDs to 30 hours of CME and striking the option of the TMD attending a national meeting in lieu of CME.</p> <p>Section 1.04.xii the later part of this criterion identifies an alternative education program (self-learning / Web based learning program) to obtaining 30 hours of CME. The draft designation manual had the alternative program stricken. There was discussion on the topic including reviewing the national guidance, comments from the one center that utilizes this process, and how the determination was made to strike this language.</p> <p>MOTION: A motion was made to remove the self-learning program from Section 1.04.xii in the draft designation manual. Motion passed.</p> <p>Section 1.04.xii physician CME; the Committee discussed whether Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) courses were allowed to be counted as CME. After discussion and debate it was determined that ACLS and PALS do not count towards meeting physician CME related to trauma designation criteria.</p> <p>Section 3.06.c and d that discusses orthopedic surgeons CME and Advanced Trauma Life Support (ATLS) certification requirements. Historically, these criteria have been listed as optional (-O-) The question was posed why the criteria were stricken. Staff and committee members responded with the fact that as a regulatory document it should only state what criteria are required and not optional items.</p>	<p>The TSO&MC and five workgroups agreed to make all suggested edits to the draft designation manual by 1/31/2014. If on time, staff committed to have a revised clean draft designation manual by the 3/2014 meeting.</p> <p>Motion Passed to eliminate the self-learning / Web based learning program from the draft designation manual.</p>

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<p>Performance Improvement Workgroup – Kathy Butler (UVA):</p>	<p>The performance improvement (PI) workgroup were responsible for evaluating the designation manual criteria related to performance improvement content and research.</p> <p>Ms. Butler advised that the PI criteria could be found on pages 48 and 49 of the draft designation manual and invited comment.</p> <p>Section 5.03.a that addresses the trauma PI plan; within the interpretive guidance the Committee determined that rehabilitation be removed from the PI plan because the majority of rehabilitation is managed by another facility or in the outpatient environment.</p> <p>Within the same section the Committee determined that the criterion should be increased from a non-critical to critical criterion.</p> <p>There was discussion on what the language describing the use of “state recommended audit filters” within the PI program should be. There was discussion about removing this language. Staff noted that while reviewing the national standard a list of audit filters was developed. The lists of filters are those items that the ACS states should be monitored within a trauma service’s PI program. Staff also shared that this is a frequent question received and a frequent area of concern during site review visits. Staff will provide the list of audit filters to the Trauma PI Committee.</p>	<p>The TSO&MC and five workgroups agreed to make all suggested edits to the draft designation manual by 1/31/2014. If on time, staff committed to have a revised clean draft designation manual by the 3/2014 meeting.</p> <p>Loop Closure: The list of PI Filters were e-mailed to Dr. Calland and are attached here.</p> <div style="text-align: center;">  <p>PI Audit Filters</p> </div>
<p>Other criteria in draft designation manual discussed not covered during workgroup sessions.</p>	<p>There was discussion whether ED physicians should be required to be board certified in emergency medicine. Also discussed was the existing language related to non-boarded ED physicians need to maintain current ATLS and the language stating that the ED physician must be board certified in emergency medicine except in rare instances when the physician has had long-term practice in emergency medicine.</p> <p>The Committee discussed that ED physicians do not need to be board certified in emergency medicine, but should be boarded in some medical specialty.</p> <p>Staff asked the Committee to take a position on item IV.c.iii of the Administrative Guidelines. This item discusses the management of non-critical deficiencies. The current process states that a non-critical deficiency noted during two consecutive site reviews would be managed during the second review as a critical deficiency.</p> <p>The alternative / national management of non-critical deficiencies is that a center may receive three non-critical deficiencies and not be required to address the deficiencies. Upon receiving a fourth non-critical deficiency during a site review visit that non-critical deficiencies would be managed as critical deficiencies.</p> <p>There was lengthy discussion and a divide on the potential use of the national method. The final determination by the</p>	

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	<p>Committee was to maintain the current process of managing non-critical deficiencies.</p> <p>Section 4.07.a.ii and iii which discuss the credentials of the Intensive Care Unit Surgical Director. There was lengthy discussion on this criterion. No changes noted.</p>	
<p>Committee Composition</p>	<p>The Chair introduced the topic of the TSO&MC composition. The Current committee has grown in size and there are requests for additional members. The large size of the Committee can cause challenges with accomplishing tasks and following proper committee management based on the EMS Advisory Board Bylaws and State requirements.</p> <p>Staff was asked to review and present items from the bylaws that are applicable to the need to re-evaluate the Committee’s composition. Staff presented the following from the bylaws:</p> <ul style="list-style-type: none"> • The TSO&MC will maintain an inclusive system – more components of the system may be needed. • The membership will provide continuity of the committee – the current membership includes an alternate for each trauma center and examples of how this breaks continuity were shared. • Committees will be limited to 10 – Staff currently prepares Committee seating for 34, the official Committee roster is supposed to be 19, and seating for 39 is projected for 2014. • Alternates are not allowed – the current committee composition is based on alternatives by naming hospitals as members rather than persons. • Proxy votes are not permitted – technically proxy votes are not occurring, frequently persons not in attendance are represented. • Sub-committees may be established to accomplish the work of the Committee – there is no requirement that sub-committees be comprised solely of Committee members. • Committee members shall adhere to the conflict of interest requirements of the <i>Code of Virginia</i> § 2.2-3100 – this includes the requirement for members to submit the required conflict of interest documents. • Meetings will be conducted per Robert’s Rules of Order (RRoO) – examples of how infrequently the Committee follows RRoO was provided. • The Committee shall adhere to the Freedom of Information Act (specifically the conduct of open public meetings) – examples of how FOIA is not followed were presented. • The Chair in consultation with the Executive Committee will annually appoint a diverse geographic representation of the “system.” – This has not been occurring due primarily to the fact that the other bullet items are not being followed. Representation of the system should be interpreted to include all aspects of the system and not exclusively trauma centers. • The Chair will pay special attention to minimize the financial obligation to the Commonwealth – The OEMS will need to secure an outside facility with the projected growth of the Committee in 2014. Also, Committee size affects lodging, per-diem, and travel. <p>The Chair and staff shared that this issue has been discussed with the EMS Advisory Board Executive Committee and discussed at VDH/OEMS. It was requested that a decision be reached by the March 2014 TSO&MC meeting as this would allow the designation manual to be completed by the existing committee, allow time to make adjustments to regional council contracts, and the effective date of a new committee composition could coincide with the July 1st membership changes of the Advisory Board including change in the TSO&MC Chair position.</p>	<p>Loop Closure: Dr. Calland asked if a copy of the bylaws and the bullet list used by Staff were distributed. A link to the bylaws is prominently posted on each agenda. In addition an e-mail to the committee identifying a reference for each bullet item was sent on 12/7/2013 and is attached below.</p> <div style="text-align: center;">  <p>Composition Bullet References</p> </div> <p>OEMS staff was directed to draft a proposed committee composition to be finalized at the March</p>

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	<p>The committee was offered the opportunity to lead in the development of a new committee composition. After discussion the Committee requested OEMS staff develop a recommendation to be available by the March 2014 TSO&MC meeting.</p>	<p>2014 meeting.</p>
<p>Inclusive Trauma System in Virginia and Assessment of Needs (ITSAN) Committee</p>	<p>With Dr. Robert's departure from the Committee the Chair discussed what should be done about the ITSAN committee that he was to chair. The Chair and staff discussed in lieu of reappointing a chair to this subcommittee that it may be beneficial to have an outside party perform this evaluation. Few state systems, seven, have a process of limiting trauma center designation. The Committee agreed to this plan.</p> <p>The Chair and Staff propose initiating an ACS State Trauma System Assessment and ask this body to address the questions to be answered by the ITSAN committee and other trauma system related issues. Staff request that the assessment not begin until later in 2014 when available resources at OEMS will be less strained and funding can be requested for the next fiscal year budget. Staff will submit the request for approval (a.k.a RAP) and attempt to have the approval in place by the March 2014 meeting.</p> <p>Staff also request that a TMD and TPM liaison be identified to assist with the assessment. Other states experiences are that this is a very labor intensive process that needs stakeholder involvement.</p>	<p>Staff will submit a RAP requesting approval by VDH Exec Mgmt. for the funding needed for an ACS state review. An update will be provided at the March 2014 meeting.</p>
<p>Adjournment:</p>	<p>The meeting adjourned approximately 3:45 p.m.</p>	

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