Trauma System Oversight & Management Committee
Subcommittee Special Needs Work Group
OEMS, 1041 Technology Park Drive
Glen Allen, VA
April 28, 2014
10:00 a.m.

Member Roll Call:	Other Attendees:	OEMS Staff:
Melissa Hall (Chair)*	Shawn Safford (CRMH)**	Paul Sharpe (Staff)
Leonard Weireter (Co-chair)*	Lauren Schmidt (VACEP)	
Maggie Griffin (Inova/Absent)	Melinda Myers (Inova)**	
Andi Wright (CRMH/Absent)	Eugene McGahren (UVA)*	
Amanda Turner (LGH)*	(CHKD Administrator)	
Jeffrey Haynes (VCU)*		
Theresa Guins (EMSC)*		
Allen Williamson (CHKD)*		
Ann Kuhn (CHKD)*		
Sam Bartle (VACEP/VCU)*		
Robin Foster (VCU)*		
Faiqa Qureshi (CHKD)*		
Joel Clingenpeel (CHKD)*		

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
Call to order:	The meeting was called to order at 10:00. The first one hour included debate of what the official composition of this group was. Some were under the understanding that the persons selected during the March Trauma System Oversight and Management Committee (TSO&MC) was the "voting members" of this group. Others were under the impression that the persons identified during the March TSO&MC were an addition to those that had met previously. Ultimately, all who wanted to be considered voting members were considered such. There were first	

	time attendees and alternates to those members chosen during the March TSO&MC meeting.	
Approval of the Agenda:	The agenda was reviewed and approved.	
Review of the Goal for this Group	The goal for this meeting is to again review pediatric specific trauma center designation criteria and move these criteria from Level I designation to a unique pediatric designation. Dr. Bartle requested to know why the pediatric criteria now need to be removed from Level I criteria. Dr. Weireter explained that not all Level I centers manage pediatric patients. Specifically, Sentara Norfolk General Hospital does not manage pediatrics with Children's Hospital of the King's Daughters (CHKD) being co-located on the same campus. A handout with the number of American College of Surgeons (ACS) verified trauma centers was distributed. A second handout, which included the national pediatric trauma criteria using the draft ACS Resources for Optimal Care of the Injured Patient also known as the "Orange Book." These criteria will be used as the base for establishing pediatric trauma criteria for Virginia.  Hand Out 1 ACS Verified Centers 4-28  Hand Out 2 ACS Draft Ped Criteria 4-2 There was one final discussion prior to reviewing each criterion: Dr. Weireter proposed that there be a single level of pediatric designation and that this level mirror the "adult" Level I criteria with the exception of a residency program and research not be required for pediatric designation. There was lengthy discussion on the topic and the group agreed that this did not stop a center from having a residency program or performing research that minimum standards are being set. It was also discussed that due to the smaller volume of pediatric trauma it was a challenge for any single center to perform research as opposed to participate in larger research projects.	**The group agreed that pediatric designation would include all Level I requirements except for having a residency program and performing pediatric trauma research.**
Review of National Criteria (handout #2)	The first item from the handout discussed was the last paragraph on page 1and was edited as shown: The objective is to provide a consistent, objective, and meaningful approach to the designation and verification process. ~~Hospitals seeking pediatric trauma center designation must be physically co-located with a Level I or Level II trauma center. Any hospital that solely treats the pediatric population must meet both the pediatric criteria and at minimum the Level II criteria adjusted for age.~~ **Motion:** was made by Dr. Safford and seconded by Dr. Bartle to delete the stricken language above.	**Motion Passed and language stricken as shown left.**

	Yeas: 8 Nays: 0 Abstentions: 4 Page two including criteria 2.3, 10.1, 10.3, 10.4, 10.5, 10.6, 10.7, and 10.12 were reviewed and discussed. The requirement in 10.1 that requires a pediatric trauma center to admit at least 200 patients annually was discussed and the number of patients being changed to 100 considered. 200 patients were maintained. **Motion:** Adopt all of the criteria mentioned above by Dr. Kuhn and seconded by Dr. Bartle: Yeas: 13 Nays: 0 Abstentions: 0 On page two, criterion 10.9 "there is identifiable pediatric trauma research." **Motion:** to exclude criterion 10.9 was made by Dr. Safford and seconded by Dr. Kuhn: Yeas: 8 Nays: 2 Abstentions: 2 **Motion:** to adopt criteria 10.13, 10.14, 10.15, 10.16, 10.17, 10.18, 10.19, 10.20, 10.25, and 10.27 on page three of the handout. Yeas: 13 Nays: 0 Abstentions: 0 Criteria 10.28 and 10.29 on pages three and four of the draft document which state: 10.28 - A pediatric trauma center must have continuous rotations in trauma surgery for senior residents (PGY3-5) who are part of an Accredited Council for Graduate Medical Education—accredited program.	**Motion passed to except all criteria on page except one as mentioned next.** **Motion to exclude pediatric trauma research passed.** **Motion passed to accept the list of criteria left.** **Motion to strike criteria 10.28 and 10.29 noted left**

	10.29 -At a minimum, these rotations should include residency programs in all the following specialties: general surgery, orthopaedic surgery, and neurosurgery. They may also include support of a pediatric surgical fellowship. **Motion:** by Dr. Kuhn and seconded by Dr. Safford to strike 10.28 and 10.29: Yeas: 7 Nays: 0 Abstention: 7 After further discussion on criteria 10.28 and 10.29 a new motion was made. **Motion:** Dr. Safford moved to strike 10.28 and 10.29 and seconded by Dr. Kuhn: Yeas: 9 Nays: 0 Abstentions: 5 On page four of the draft criteria the following criteria were accepted by the group as is: 10.30, 10.31, 10.32, 10.35. Also on page four, criterion 10.33 which reads: 10.33 - The trauma service should work collaboratively with the pediatric critical care providers ~~although all significant therapeutic decisions must be approved by the trauma service,~~ and the service must be made aware of all significant clinical changes. **Motion:** By Dr. McGahren and seconded by Dr. Haynes to accept criterion 10.33 without the stricken language. Yeas: 13 Nays: 0 Abstentions: 0 Criterion 10.34 which states the following: 10.34 - The surgical director~~, who is board certified in surgical critical care,~~ of the pediatric intensive	**failed to pass.** **Motion to strike criteria 10.28 and 10.29 from the draft document passed.** **Motion to accept 10.33 as amended left passed.**

	care unit must participate actively in the administration of the unit, as evidenced by the development of pathways and protocols for care of surgical patients in the intensive care unit and in unit-based performance improvement. **Motion:** By Dr. Kuhn and seconded by Dr. Haynes to accept criterion 10.34 without the stricken language. Yeas: 14 Nays: 0 Abstentions: 0 Page four, the first element numbered as 2.23[a] (error in numbering by ACS) that states: 2.23[a] - Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating its capability to care for the injured child. **Motion:** To adopt 2.23[a] made by Dr. Kuhn and seconded by Dr. McGahren to accept the ACS language in 2.23[a] and not the South Carolina language. Yeas: 14 Nays: 0 Abstentions: 0 On page four of the draft criteria document criteria 2.23[b] (error in numbering by ACS), 2.24, and 2.25 2.23[b] - The trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body. 2.24 - There must be a pediatric emergency department area, a pediatric intensive care area, appropriate resuscitation equipment, and pediatric-specific trauma PIPS program. 2.25 - Adult trauma centers admitting fewer than 100 injured children younger than 15 years per year, these resources are desirable. These hospitals however, must review the care of all injured children through their PIPS program.	**Motion to accept criterion 10.34 as amended left passed.** **Motion to adopt criterion 2.23[a] passed**

	Motion: Dr. Guins motioned that criteria 2.23[b], 2.24, and 2.25 be added to the adult Level I criteria. The motion was seconded by Dr. Kuhn: Yeas: 14 Nays: 0 Abstentions: 0 On page 5 of the draft criteria items 10.37, 10.38, and 10.39 that all deal with having a trauma peer review committee, its attendance, and composition were included in one motion. **Motion:** Dr. Kuhn moved to adopt criteria 10.37, 10.38, and 10.39 was seconded by Dr. McGahren. Yeas: 14 Nays: 0 Abstentions: 0 Page four criterion 10.40 states: 10.40 - In pediatric trauma centers, the pediatric trauma medical director and the liaisons from neurosurgery, orthopaedic surgery, emergency medicine and critical care medicine must each accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external CME, of which at least 12 hours (in 3 years) must be clinical pediatric trauma care. **Motion:** Dr. McGahren moved that criterion 10.40 be adopted utilizing 10 hours annually or 30 hours of CME in a three year verifiable cycle, which is the same as adult criteria, and that 10 of the 30 hours of CME be pediatric clinically focused. The motion was seconded by Dr. Safford. Yeas: 14 Nays: 0 Abstentions: 0 Criterion 10.41 of the ACS draft document states: The other general surgeons, orthopaedic surgeons, neurosurgeons, emergency medicine physicians and critical medicine care physicians who take trauma call pediatric trauma centers also must be knowledgeable and current in the care of injured patients. This requirement may be met by documenting the acquisition of 16 hours of CME per year on average or by demonstrating participation in an internal educational process conducted by the	**Motion to adopt criterion 2.23[b], 2.24, and 2.25 passed.** **Motion to approve criteria 10.37, 10.38, and 10.39 passed.** **Motion to adopt criterion 10.40 as amended passed**

	trauma program based on the principles of practice-based learning and the PIPS program. **Motion:** By Dr. Kuhn to accept 10.41 and make the same as the adult criteria. The motion was seconded by Dr. McGahren. An amendment to require 10 hours of the CME is pediatric clinically focused. Yeas: 14 Nays: 0 Abstentions: 0 Page six of the ACS draft criteria "Virginia Pediatric Trauma Center Additional Pediatric Criteria" were agreed to leave in the current full Virginia draft Trauma Center Designation Manual. No formal motion was made. Review of the ACS draft pediatric criteria was concluded at this point. **Motion:** Dr. McGahren moved to add a pediatric trauma surgeon to the site review team for pediatric trauma designation visits. The motion was seconded by. Dr. Safford. Yeas: 14 Nays: 0 Abstentions: 0 The next item discussed was criterion 5.9 from the draft 2015 Virginia Trauma Center Designation Manual which states: 5.9 - There shall be in-house 24 hours per day capabilities in general surgery with two separate posted call schedules (one for trauma and one for general surgery). In those instances where a physician may simultaneously be listed on both schedules, there shall be a defined back-up surgeon listed on the schedule to allow the trauma surgeon to provide care for the trauma patient. A PGY4 or PGY5 capable of assessing emergent situations in their respective specialties may fulfill this requirement. The PGY4 or PGY5 shall be capable of providing surgical treatment immediately and provide control and leadership for the care of the trauma patient. **Motion:** By Dr. Haynes and seconded by Dr. Qureshi to include the pediatric trauma surgeon within criterion 5.9 from the Virginia draft manual:	**Motion to adopt criterion 10.41 as amended passed** **Motion to add a pediatric trauma surgeon to the site review team for pediatric designation site visits passed.** **Motion to require pediatric trauma surgeons to meet**

	Yeas: 7 Nays: 3 Abstentions: 4	**the same in-house and call requirements of adult Level I centers failed.**
Summary:	The decision decided during this meeting will be forwarded to the full TSO&MC as recommendations for inclusion to the current draft Virginia Trauma Center Designation Manual. The TSO&MC will have the ability to accept or reject these recommendations. Once the TSO&MC adopts the draft Virginia Trauma Center Designation Manual it then moves to the Emergency Medical Services Advisory Board for adoption. The TSO&MC and the EMS Advisory Board are advisory committees to the Office of Emergency Medical Services and the State Board of Health. Once adopted by the EMS Advisory Board the document will be forwarded to the Office of Emergency Medical Services and the State Board of Health as a recommendation for revised trauma center designation criteria. The State Board of Health is the final promulgating authority for trauma designation criteria.	
Public Comment:	None	
Adjournment:	Meeting adjourned approximately 2:45 p.m.	