



Standards Minutes: July 17, 2018

Mission - To ensure that every child in Tennessee receives the best pediatric emergency care in order to eliminate the effects of severe illness and injury.

Vision - To be the foremost advocate for children throughout the continuum of care in Tennessee and the nation.

[X] MEETING [] CONFERENCE CALL

<p>Time: 9 am <u>Central Time Zone</u> - Call to Order</p>	<p>PLACE: WILLIAMSON COUNTY EOC, 304 BEASLEY DRIVE FRANKLIN, TN 37064</p>
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MINUTES OF PREVIOUS MEETING: Previous Meeting Date Minutes: Approved Not Approved Distributed prior to Meeting Not Submitted – Not Completed

PRESENT:
Standards Voting: Alicia Duck, Brittany Stover, Yvette DeVaughn, Marisa Moyers, Kevin Brinkmann, Lee Blair, Katherine Hall, Kara Adams, Seth Brown, Samir Shah
Non-Voting: Christy Cooper, Kate Copeland, Beckye Dalton, Jennifer Dindo, Dawn Morrow, Debe Newton, Deena Kail, Oseana Bratton, Anissa Revels, John Wright, Michele Walsh, Cristina Estrada, Amber Greeno, Mollie Triplett
Guests: Tom Rouoth, Donna Russell
Staff: Rhonda Phillippi
State Liaisons: Kyonzte Hughes-Toombs, Ann Reed, Rob Seesholtz,

Overall Lead/ Time Allotted	Topic	Summary / Decisions
Kevin Brinkmann, MD	Welcome and Establish quorum	Quorum established Purpose of meeting is to review and revise PECF Proposed Trauma Rules.
		Document reviewed and identified areas for further discussion. See attachment below.



<p>Adjourn ADJOURNMENT: [] AM [X] 2PM RECORDED BY: RPhillippi APPROVED BY: Standards Committee on 1/8/19</p>		
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PECF Proposed Trauma Rules:

The following rules in the sections listed below would be reorganized into the new section 1200-08-30-.03-(2)-(d) ADMINISTRATION:

1200-08-30.03-(2)-(a)-7-(v) ADMINISTRATION and it's subsection – delete and add into below – “ **(v)** Each CRPC shall submit Trauma Registry data electronically to the state trauma registry on all closed patient files at least quarterly for CoPEC and/or the Board to analyze. **(v)-(l)** Data shall be transmitted to the state trauma registry in accordance with the state trauma rules. Failure to submit data may result in the delinquent facility's necessity to appear before the Board for any disciplinary action it deems appropriate.”

1200-08-30-.03-(2)-(c) ADMINISTRATION – delete and add into below – “Have an organized trauma training program by and for staff physicians, nurses, allied health personnel, community physicians and pre-hospital providers;”



1200-08-30-.03-(2)-(c) ADMINISTRATION – delete and add into below – *“Establish within its organization a defined pediatric trauma program for the injured child. The pediatric trauma director shall be a pediatric surgeon, board certified/board eligible in pediatric surgery, with demonstrated competence in care of the injured child. The director shall have full responsibility and authority for the pediatric trauma program.”*

1200-08-30-.03-(2)-(f)-8. ADMINISTRATION – delete and add into below – *“the pediatric trauma committee chaired by the director of the pediatric trauma program with representation from pediatric surgery, pediatric emergency medicine, pediatric critical care, neurosurgery, anesthesia, radiology, orthopedics, pathology, respiratory therapy, nursing and rehabilitation therapy. This committee shall assure participation in a pediatric trauma process improvement. There must be documentation of the subject matter discussed and attendance at all committee meetings. Periodic review should include mortality and morbidity, mechanism of injury, review of the EMS system locally and regionally, specific care review, trauma system review, and identification and solution of specific problems including organ procurement and donation;”*

1200-08-30-.03-(2)-(f)-9. ADMINISTRATION – delete and add into below – *“a full-time equivalent trauma registrar for each 500-750 trauma patients per year is required to assure high-quality data collection;”*

1200-08-30-.05-(4)-(c) ESSENTIAL FUNCTIONS– delete and add into below – *“A Comprehensive Regional Pediatric Center shall be qualified and competent as a pediatric trauma program and satisfy the requirements in Table 1. A CRPC may fulfill this requirement by having written agreements with another CRPC that meets the State’s criteria for level I trauma or an Adult Level I trauma center within the same region.”*

New section 1200-08-30-.03-(2)-(d) ADMINISTRATION

1. A Comprehensive Regional Pediatric Center shall be qualified and competent as a pediatric trauma center.
2. A CRPC shall fulfill this requirement by either being ACS verified or state designated as pediatric trauma center and having a pediatric trauma program with the following requirements:
 - a. A pediatric trauma medical director who shall be a pediatric surgeon, board certified/board eligible in pediatric surgery, with demonstrated competence in care of the injured child. The director shall have full responsibility and authority for the pediatric trauma program and shall meet the following requirements:
 - i. 36 hours of category I external trauma/critical care CME every 3 years or 12 hours each year, and attend one national meeting whose focus is pediatric trauma or critical care;
 - ii. Participates in call;
 - iii. Has the authority to manage all aspects of trauma care;
 - iv. Authorizes trauma service privileges of the on-call providers;
 - v. Works in cooperation with nursing administration to support the nursing needs of trauma patients;
 - vi. Develops treatment protocols along with the trauma team;
 - vii. Coordinates performance improvement and peer review processes;
 - viii. With the assistance of the hospital administration and the trauma program coordinator, be involved in coordinating the budgetary process for the trauma program;



- ix. Trauma Medical Director or designated pediatric trauma surgeon that participates in the Committee on Pediatric Emergency Care
 - x. Participates in regional and national trauma organizations; and
 - xi. Retains a current ATLS certification and participates in the provision of trauma-related instruction to other health care personnel.
- b. Current Board certified/board eligible pediatric surgeons on the trauma service and must have current ATLS certification. A CRPC shall be involved in local/regional EMS agencies/hospitals and/or personnel and assist in trauma education, performance improvement, and feedback regarding care A Trauma Program Leader who shall:
- i. Have experience in Pediatric Emergency and/or Critical Care Nursing;
 - ii. Have a defined job description and organizational chart delineating roles and responsibilities
 - iii. Be provided the administrative and budgetary support to complete educational, clinical, administrative and outreach activities for the trauma program; and
 - iv. Show evidence of educational preparation with a minimum of 12 hours internal or external of trauma related continuing education per year. This shall include attending one national meeting within a 3-year trauma program designated cycle.
- c. A CRPC shall submit Trauma Registry data electronically to the state trauma registry on all closed patient files at least quarterly for CoPEC and/or the Board to analyze.
- i. Data shall be transmitted to the state trauma registry in accordance with the state trauma rules. Failure to submit data may result in the delinquent facility's necessity to appear before the Board for any disciplinary action it deems appropriate.
 - ii. A CRPC shall have a full-time equivalent trauma registrar for each 500-750 trauma patients per year to assure high-quality data collection.
- d. The pediatric trauma program must annually admit 200 or more pediatric trauma patients younger than 15 years of age. These admissions may include inpatient or 23-hour observations, but should exclude patients admitted for drowning, poisoning, foreign bodies, asphyxiation or suffocation without presence of injury, patients who are dead on arrival to the facility or other pediatric patients excluded as per the most recent version of the *Resources for Optimal Care of the Injured Patient* by the American College of Surgeons Committee on Trauma.
- e. A CRPC shall have a pediatric trauma committee chaired by the pediatric trauma medical director with designated representation from pediatric general surgery and liaisons to the trauma program from pediatric emergency medicine, pediatric critical care, neurosurgery, pediatric anesthesia, pediatric radiology, pediatric orthopedics, and pediatric trauma program leader y, The pediatric trauma committee shall meet at least quarterly. Members or designees shall attend at least 50% of meetings.
- i. This committee shall assure participation in a pediatric trauma process improvement program with the following requirements / responsibilities:
 - 1. Administration shall provide resources to support the trauma process improvement program (PIPS).
 - 2. A performance improvement coordinator shall be designated with dedicated time for this responsibility.
 - 3. The trauma registry is essential to the performance improvement and patient safety program (PIPS) and shall be used to support the PIPs process.
 - 4. Identify process and outcome measures;
 - 5. Shall have a morbidity and mortality review of trauma patients.
 - 6. Maintain a Trauma Bypass/Diversion log:
 - a. Trauma bypass/diversion shall not exceed 5%.



- b. Pediatric surgery on-call shall be involved in bypass/diversion decisions.
 - c. All bypass/diversions shall be reviewed.
 - 7. Document and review response/consult times for pediatric surgeons, neurosurgeons, pediatric anesthesia, and pediatric orthopedists, all of whom must demonstrate 80% compliance with facility determined timed guidelines
 - 8. Monitor team notification times. For highest level of activation trauma, the pediatric attending surgeon must be present within 15 minutes of patient arrival 80% of the time.
 - 9. Review pre-hospital trauma care to include patients dead on arrival.
 - 10. Review times reasons and appropriateness of care for transfer of injured patients.
 - 11. Demonstrate that action taken as a result of issues identified in the Process Improvement Program created a measurable improvement. Documentation shall include where appropriate: (1) problem identification, (2) analysis, (3) preventability, (4) action plan, (5) implementation, and (6) reevaluation.
 - 12. Evaluation of Operational Process Improvement (evaluation of systems issues) shall occur to address, assess, and correct global trauma program and system issues, correct overall program deficiencies to continue to optimize patient care.
 - f. The CRPC shall have clearly defined graded activation criteria.
 - i. Criteria for the highest level of activation
 - ii. n shall be clearly defined and evaluated by the pediatric trauma committee.
 - iii. For the highest level of activation, the trauma team (trauma Chief resident (post-graduate year training 3/4/5) or Pediatric Emergency Physician shall be immediately available and the pediatric trauma attending available within 15 minutes of patient arrival 80% of the time.
 - g. The CRPC shall have an injury prevention program which:
 - i. Shall have an organized and effective approach to injury prevention and must prioritize those efforts based on trauma registry and epidemiologic data.
 - ii. shall have a full time injury prevention coordinator dedicated to the trauma program to ensure community and regional injury prevention activities are implemented and evaluated for effectiveness.
 - iii. shall implement at least two programs that address one of the major causes of injury in the community.
 - iv. shall screens for alcohol and drug abuse in admitted patients.
 - h.
3. CRPC Trauma Center Verification/Designation:
- a. A CRPC that is an American College of Surgeons verified Level I Pediatric Trauma Center shall continue to meet the trauma requirements for this designation.
 - b. A CRPC can that is state designated as pediatric trauma center A CRPC with a pediatric trauma program that is part of the regional pediatric trauma system with an American College of Surgeons verified Level I Pediatric Trauma Center or Adult Level I Trauma Center with Pediatric Verification shall be verified by the following process.
 - i. Following self-designation as a CRPC, a trauma designation site visit shall be conducted at the facility every three years beginning one year after the promulgation of these rules.
 - ii. CRPC trauma program designation. Approved above by standards 7/17/18
 - 1. The CRPC trauma program designation team shall consist of the following team members:



- a. A pediatric trauma medical director or a pediatric general surgeon who has previously been a trauma medical director from an out-of-state pediatric trauma center who shall serve as team leader.
 - b. A pediatric general surgeon from an in-state ACS Level I pediatric trauma center or from a CRPC with a verified pediatric trauma program.
 - c. An in-state trauma program manager / trauma nurse coordinator from an in-state ACS Level I pediatric trauma center or from a CRPC with a verified pediatric trauma program.
2. The team shall be appointed by the following organizations:
 - a. The Tennessee Committee on Pediatric Emergency Care shall assist in identifying the out-of-state surgeon.
 - b. The EMSC program manager, in consultation with the executive committee of the Tennessee Committee on Pediatric Emergency Care, shall select the in-state members of the site visit team.
 3. The CRPC trauma program verification team shall:
 - a. Advise the CRPC of an upcoming verification team visit at least sixty days prior to the visit. After the CRPC receives notice of the upcoming verification site visit, it shall prepare all materials the team requests for submission.
 - b. Conduct a visit to ensure compliance for the requirements of a CRPC with a trauma program.
 - c. Conduct an exit interview with the CRPC at the conclusion of the verification visit communicating the following:
 - i. The presence of deficiencies;
 - ii. The CRPC's strengths and weaknesses; and
 - iii. Recommendations for improvements and correction of deficiencies.
 - d. Submit a site visit report within sixty days of completion of the site visit. A copy of this report shall be submitted to the Board, the Chief Executive Officer of the CRPC, the CRPC Trauma Director and the CRPC trauma program manager / trauma nurse coordinator.
 4. If the CRPC trauma program verification team does not cite deficiencies and the CRPC is in compliance with all requirements set forth in these rules, then the CRPC shall be reevaluated three years from the site visit.
 5. If during the visit the CRPC trauma program verification team identifies deficiencies, the CRPC shall have a period not to exceed 60 days to correct deficiencies.
 - a. If the deficiencies are not deemed to have been corrected by either off-site or on-site review by the team, then the CRPC shall present an explanation to the BOARD at it's next scheduled meeting. The Board will further evaluate for any disciplinary action it deems appropriate.
 6. The CRPC shall bear all costs of a CRPC trauma program verification team visit.

*Surgeons on staff and availability requirements are already defined in the pediatric emergency department/trauma personnel in 1200-08-30-.03-(2)-(f)

*Trauma related equipment, other CRPC support staff, laboratory and radiology requirements as listed in the rules and tables.

4. Other additions / changes to PECF Rules for Trauma:
 - a. DEFINITIONS



- i. ACS
- ii. ATLS
- iii. PECF - Hospital facilities that provide pediatric emergency and trauma services...
- iv. FAST
- b. ADMINISTRATION – changes as above
- c. ADMISSIONS, DISCHARGES and TRANSFERS
 - i. 1200-08-30-.04-(2)-(d)-3. transports children to the most appropriate facility in their region for emergency and trauma care. Local destination guidelines for EMS should assure that in regions with 2 Comprehensive Regional Pediatric Centers, or 1 Comprehensive Regional Pediatric Center and another facility with Level 1 Adult Trauma capability, that seriously injured children are cared for in the facility most appropriate for their injuries. – make note to review and change as needed
- d. ESSENTIAL FUNCTIONS
- e. TABLES
 - i. FAST – under Miscellaneous Equipment or other

TCAC Outline for Reference

- 1. Definitions
- 2. Requirements
 - a. Trauma Registry Requirements
 - b. Levels of Care
 - i. Hospital Organization
 - 1. Trauma Program
 - 2. Surgical Services
 - 3. Emergency Department Services
 - 4. Surgical Specialty Availability In-house 24 hours a day
 - 5. Surgical Specialty Availability from inside or outside the hospital
 - 6. Non-Surgical Specialty Availability in-hospital 24 hours per day
 - 7. Non-Surgical Specialty Availability on call from inside or outside the hospital
 - ii. Special Facilities/Resources/Capabilities
 - 1. Emergency Department Personnel
 - 2. Emergency Department Equipment
 - 3. PICU
 - 4. PICU Equipment
 - 5. Post-anesthetic recovery room (PICU is acceptable)
 - 6. Acute Hemodialysis capability
 - 7. Organized burn care
 - 8. Acute spinal cord management capability or written transfer agreement with a hospital capable of caring for a spinal cord patient.



9. Acute head injury management capability or written transfer agreement with a hospital capable of caring for a spinal cord patient.
 10. Radiologic Special Capabilities
 11. Organ donation protocol
 - iii. Operating suite special requirements
 - iv. Clinical Laboratory Services available 24 hours a day
 - v. Trauma Medical Director
 - vi. Attending General Surgeon on the Trauma Service
 - vii. Trauma Program Manager / Trauma Nurse coordinator
 - viii. Trauma Registrar
 - ix. Programs for Quality Assurance
 1. Medical Care Education
 2. Trauma Process Improvement
 3. Operational Process Improvement (Evaluation of System Issues)
 4. Trauma Bypass/Diversion Log
 - x. System Development
 - xi. Injury Prevention
 - xii. Institutional Commitment
 - xiii. Activation Criteria
 - xiv. Disaster Preparedness
3. Designation
 4. Verification
 5. All designated Adult and Pediatric Trauma Centers as well as CRPC's shall participate in the collection of data for the Trauma Registry and in the review of the Trauma Registry.
 6. All designated Adult and Pediatric Trauma Centers as well as CRPC's shall record and report the payor source for patient care on patient discharge. Final payment data shall be classed as self-pay, commercial insurance, Medicare, Medicaid, or workers compensation.
 7. Revocation and Suspension