

**PEDIATRIC COMMITTEE
OF GOVERNOR'S EMS AND TRAUMA ADVISORY COUNCIL (GETAC)
OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES (DSHS)
MEETING MINUTES
May 2012**

Call to Order: Charles Macias, Chair

1. Roll call: Chair

Discussion and possible action on the following items: Committee members

2. Committee liaison reports: Committee members

a. Air Medical: Jorge Sainz: Discussion regarding who has ownership and primarily responsibility of a patient while that patient is transported with dual provider presence (EMS and air crew in same vehicle) if an emergency/ clinical condition arises during transport: usually air crew has more level of expertise but no final resolution was attained. Issue was deferred back to the EMS committee which is where the question originated.

b. EMS: Verne Walker; Met Feb 9 with main topic of need for medical control. Deliberating on a need for language of rules. Cardiac med directors and EMS—requiring national certification. No specific pediatric points of discussion.

c. Education: Charles Jaquith: Feb meeting. Transition course discussion. For recertification, CCMP be removed as a way to recert. Consolidate CE hours from national registry. National has 12 hours. No timeline. Pediatric content.

d. Injury Prevention: Deb Brown: Pediatric specific: strategic plan. Whiskers data base in looking at Texas vs other states. Mechanisms of injury. Address evidence based programs that are working. TX injury prevention program with experts from national level. Motor vehicle collision occupants and drownings. Opportunity for defining the age of pediatrics and applied to this data set.

e. Medical Directors: Juan Juarez: Pediatric specific: tabled discussion on equipment list. Resources issues. Tweaking adult and pediatric guidelines to address resources through centers of excellence. References to special needs. Pharmacies and compound pharmacies for national drug shortages.

f. Stroke: Julie Lewis: Nothing pertinent to pediatric community.

g. Trauma Systems: Sally Snow: Progress towards changes to Rule 157. Performance standards. Trauma registry validation language. Established liaisons but not enough time to address.

h. Regional Advisory Council chairs: Britton Devillier: Assistant director of Medicaid and CHIP for RHCPs (1115 Waiver). Improve outcomes, leverage finance, transition to quality based payment systems. The RHCP regions don't correspond to RAC. No penalty for populations across border. HHSC site posted. Development stage—expect this will be iterative. Regions in process of being redefined. North and south chapters met with members of trauma systems meetings—proposed ideas were put forth.

i. Disaster planning: Bonnie Hartstein: None specific to pediatrics but continue to monitor transportation and transportation planning (safe transfers). Social media usage.

3. EMS for Children State Partnership Update: Anthony Gilchrest (Sally Snow)

- Survey for National Pediatric Readiness for hospitals (original 2001); Multi year quality improvement project. Address existing gaps and allow for benchmarking with QI resources. Interest in insurance industry here in Texas.
- Essential pediatric airway project: neonatal BVM 220 given to requesting agencies, 100 ETCO₂. Still resources available.
- Pediatric Continuing Education program: rural area education. A proposal for Flex grant for critical access hospitals for prehospital providers. Challenge with low cost CE (including nursing)
- On line and off line medical direction surveys. Results. Full presentation.
- Next session will full update on survey (slides) and report on (prehospital protocols)

4. Child Fatality Review Team update: Susan Rodriguez ; No report this meeting

5. Definition of pediatrics for trauma purposes: clinical care, regulatory measures, educational initiatives. Endorsed the general concept of Age less than 15th birthday as a pediatric definition for statistical purposes. For regulatory measures, clinical care recommendations and educational initiatives, age cutoffs for defining pediatrics should not be so restrictive so as to disregard differences in development (physiological, emotional, and sociological) and such differences should be taken into consideration with programming and metrics so as to account for expected variations in these populations. Charles Macias

6. Discussion of pediatric imaging. Penn position statement for children.

Sally Snow and Charles Macias. The following recommendations were offered. Macias is to

1. All CT scans on children should be performed using “pediatric” dose-reduction protocols. Pediatric protocols are available through The Alliance for Radiation Safety in Pediatric Imaging - <http://www.pedrad.org/associations/5364/ig/>. (Bonnie)

2. Imaging modalities that do not use ionization radiation should be used when feasible, e.g. ultrasound instead of CT to evaluate for appendicitis. (Jorge)

3 Avoidance of the use of protocols which automatically result in the performance of multiple CT scans (i.e. head, cervical spine, chest, and abdomen and pelvis) in pediatric trauma patients. (Britt)

4) Avoid further CT imaging once the decision to transfer to definitive care is made, unless the accepting institution specifically requests a scan prior to transfer. If CT imaging is performed prior to transfer, the images should be included in the transfer documentation on disc or some other form of reviewable file. The final radiology report should be forwarded to the receiving facility as via fax or electronic means as soon as possible. Add caveat on transfer delay (Julie and Sally)5)

5. Accepting institution should avoid repeating scans. Consider access to Life Image or similar cloud based translator. (Juan and Deb)

Reminder to consider balance measures (ex. Don't delay definitive care for attempting to obtain low sensitivity imaging)

7. Tracking pediatric specific trauma data and requesting clinically relevant data. Trauma system registry update was presented by the Registry Solutions Workgroup. Trauma Modeling Phase completed and data mapping from current trauma registry to new database elements. Working towards NEMESIS and NTDB standards. Working on a session . Goal for statewide rollout for 3rd quarter 2012. End user ad-hoc reporting both for the committee and for the State Partnership would be explored. Develop a portal on the web for the access. Proposed CDC like public access or AHRQ HCUP data access. June 5 and June 7 and webinar for registry demonstrations.

8. When a facility that is a designated trauma facility changes ownership, the designation does not travel with it. Can reapply (funding eligibility) and be in active pursuit. Apply to stroke facility but active pursuit does not apply because funding eligibility does not apply.

General Public Comment: Guidelines for school will be trained .

Action Items for GETAC: supporting a consideration of caveats of a definition of pediatric trauma (for statistical and reporting purposes)

Announcements