MINUTES
NORTH CAROLINA OFFICE OF EMERGENCY MEDICAL SERVICES
ADVISORY COUNCIL

Injury Committee
Department of Health and Human Services
Division of Health Service Regulation
Office of Emergency Medical Services

Brown Building
Dorothea Dix Campus

Raleigh, NC 27603
August 9, 2011
9:30 a.m.

Members Present
Mr. F. Wayne Ashworth, Chairman
Mr. Bob Bailey
Ms. Kathy Dutton
Dr. Steven Landau
Mr. Carl McKnight
Dr. Donna Moro-Sutherland
Mr. Tony Seamon, Jr.
Dr. Brent Myers

Members Absent
Dr. William K. Atkinson
Dr. Michael Chang
Dr. Herbert Garrison

Staff Members Present
Mr. Danny Allen
Ms. Diane Gervais
Ms. Regina Godette-Crawford, Chief
Ms. Gloria Hale
Ms. Beth Diaz
Ms. Nadine Pfeiffer
Ms. Susan Rogers
Dr. Michael Thomason
Ms. Julie Williams
Mr. Allen Johnson
Dr. Roy Alson

Others Present
Mr. Ronnie Cashwell
Mr. Dereck Willis
Mr. Keith Lovin
Mr. Bradley Dean
Mr. John Sharp
Ms. Gail Kluttz
Mr. Dale Hill
Dr. Hervy Kornegay, Jr.
Ms. Shannon Barkwell
Ms. Candi VanVleet
Mr. Gordon A. Joyner
Dr. Rashid M. Janjua

(1) Purpose of the Meeting: The Committee met to receive an update on the EMS for Children (EMSC) program as well as an update on the rural trauma program. The Committee also will receive information on Carolinas Medical Center Northeast's Level III trauma center state designation renewal and the upcoming Level III state designation renewal for Cleveland Regional Hospital.

(2) Actions of the Committee:

Mr. Ashworth called the meeting to order at 9:30 a.m.

(a) Motion was made by Mr. Bailey seconded by Dr. Moro-Sutherland and approved that:

RESOLVED: The Injury Committee minutes of the May 10, 2011 meeting are approved.

(b) Motion was made by Mr. Bailey, seconded by Dr. Myers and approved that:

RESOLVED: A subcommittee be formed to further explore EMS reporting responsibilities of suspicions of child abuse and neglect to DSS. The committee should include members from EMS, Law Enforcement, and DSS.

Explanation: During final edits of the State Child Fatality Prevention Team's report on EMS' response to child emergencies with fatal outcomes due to child abuse and neglect, SIDS, and toxins, two significant findings were discovered 1) lack of documentation which suggests that EMS providers are not reporting suspicions of child abuse and neglect to DSS, and 2) resuscitation efforts are sometimes being made on pediatric patients with obvious signs of death. Both of these findings are in conflict with written state EMS standards of care.

Other Actions of the Committee:

Ms. Gloria Hale reported to the Committee on the ED Preparedness for Pediatrics Survey, which is now closed, that a 98% response rate was achieved. A temp will be hired to analyze the data and assist in the development of reports.

During the May 10, 2011 Injury Committee meeting, Ms. Hale was asked by Mr. Bailey to drill down through the EMSC performance measures survey on pediatric equipment and supplies on transport vehicles to find missing equipment. Ms. Hale reported to the Committee today the top three items missing, were 1) transcutaneous cardiac pacemakers with pediatric pads/cables 2) 5.5 millimeter endotracheal tubes and 3) end-tidal CO2 detector devices with pediatric capability.

Ms. Gloria Hale also reported to the Committee that the NC EMSC program recently applied for an additional $13,000 from the federal EMSC program that became available to all State EMSC Partnership programs. If awarded, the funds will be used to acquire neonatal/infant circuits or filter lines for use with the 12 lead AED monitors with end tidal CO2 detection capability that are to be purchased through the OEMS Lead the Wave project.

Ms. Gloria Hale reported final edits are being made on the State Child Fatality Prevention Team's report on EMS' response to child emergencies with fatal outcomes which looked at EMS response to child fatalities due to child abuse and neglect, SIDS, and toxins. There were two significant findings 1) lack of documentation which suggests that EMS providers are not reporting suspicions of child abuse and neglect to DSS. In 46% of suspected homicides, only 1/3 of the suspected cases were reported to the hospital and there was no indication DSS was ever informed and 2) resuscitation efforts are sometimes being made on pediatric patients with obvious signs of death. Both of these findings are in conflict with written state EMS standards of care. The full report will be available on the web in the coming weeks.

Ms. Hale shared three significant findings with the Committee from the Child Fatality Prevention Team report. First, it was noted by the team that in approximately 1/3 of SIDS death, resuscitation was performed despite EMS policy which states in obvious signs of death that CPR and ALS treatment be withheld (as per NCCEP

guidelines). Excessive resuscitation could create artifacts that may confound the autopsy findings. Second, according to the study, law enforcement was not notified in every case where a child was non-responsive or had a life threatening injury. Notification to law enforcement would ensure an investigation could be done in a timely manner. However, law enforcement was present for 95% of the toxin cases that resulted in death, but only 77% of homicides by parent or caregiver and 75% of the SIDS deaths. Lastly, the study showed that EMS documented the scene information and/or statements that were made on scene in 77% to 95% of the cases across all three categories. Reports and charts from this study will be available soon and will be made public.

Ms. Beth Diaz reported to the Committee that she, Dr. Shayne Martin of Wake Forest University Baptist Medical Center, Ms. Nadine Pfeiffer and Mr. Matt Womble of the Office of Rural Health and Community Care are presently reviewing other states' methods of involving all their hospitals to report data that can be used to develop a system in which time sensitive/critically ill patients can be moved from rural areas. The goal is to create an inclusive trauma system in North Carolina.

Ms. Diaz also reported that she is in the process of promoting the RTTDC (Rural Trauma Team Development Course). The RTTDC was developed to help rural hospitals with the development of their trauma teams. Ms. Diaz is currently working with the ACS on the release of the 3rd edition of the RTTDC. The goal of the course is to improve the quality of care in the community by developing a timely, organized, and rational response to the care of the trauma patient, as well as a team approach that addresses the common problems in the initial assessment and stabilization of the injured. The purpose is to increase the efficiency of resource utilization and to improve the level of care provided to the injured patient in the rural environment.

Finally, Ms. Diaz reported to the committee on the continuing progress of the OEMS, in conjunction with the Performance Improvement Center, for the ability to allow for all hospitals to have access to PRCs (patient care records) through the PIC Credentialing Information System.

Ms. Pfeiffer reported to the Committee that the Carolinas Medical Center-North East trauma Level III renewal designation site visit was completed on July 29. This was a State only visit and the full report will be available at the next Injury Committee meeting in November. Presently, the OEMS is preparing for a second State renewal designation of a trauma Level III facility, Cleveland Regional Medical Center. The site survey team is in place, and the visit is scheduled for November 2, 2011.

Ms Pfeiffer also reported to the Committee of the success of the electronic submission of the RFP by Carolinas Medical Center-North East. All involved are pleased with the new method of submission and found it to be very easy.

Ms. Pfeiffer also gave an update on the initial trauma designations for Cape Fear Valley Medical Center and Gaston Memorial Hospital. Cape Fear Valley Medical Center is still working towards a Level III Trauma Designation. Their partial RFP has not yet been received; however, they have submitted items that raised question on policies that were not finalized. Discussion has been engaged in finalizing these policies; as soon as questions are answered the OEMS will be recommending triage and destination plan revisions. The next step will be an onsite consultation visit which may be early spring 2012.

Gaston Memorial Hospital's Trauma Level III designation site visit is scheduled for December 8, 2011. The full RFP from Gaston should be received by the OEMS in early September. Since there has been a change in OEMS Medical Directors, Gaston Memorial has requested to meet with Dr. Winslow to be sure they are on target with his expectations. Involved parties anticipate a successful site visit in December.

With no further business, the meeting was adjourned at 10:15 a.m.

Minutes submitted by Susan Rogers.