



# State of New Hampshire

## Department of Safety

Division of Fire Standards and Training and Emergency Medical Services  
Richard M Flynn Fire Academy  
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John J. Barthelmes  
*Commissioner*

Richard A. Mason  
*Director*

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### TRAUMA MEDICAL REVIEW COMMITTEE COMMITTEE MEETING

February 18, 2009  
Richard M. Flynn Fire Academy  
Concord, New Hampshire

**Members Present:** John Sutton, MD, Chair, Richard O'Brien, EMTP, Jim Paquette, EMTP, Rosie Swain, Doreen Gilligan, RN, Cheri Holmes, MD

**Guests:** Janet Houston, Mary Reidy, RN, Kurt Lucas, Sue Barnard, RN, Dick Cooper, EMTP, Noreen LaFleur, RN, Lynda Paquette, RN, John Prickett, RN,

**Bureau Staff:** Clay Odell, EMTP, RN

#### I. Call to Order

The meeting of the Trauma Medical Review Committee was called to order by Chairman John Sutton at 9:30 am on Wednesday February 18, 2009 at the Richard M. Flynn Fire Academy in Concord, NH

**Item 1. Introductions:** At Dr. Sutton's request attendees introduced themselves.

**Item 2. Minutes:** The minutes from the December, 2008 meeting had been approved via email vote of the TMRC members that were present. Clay asked if there were any errors that needed corrections. There were none.

#### II. Committee Discussion Items

**Item 1. State Budget Considerations** Clay reported the impact on the Division of Fire Standards and Training and EMS, of the efforts to reconcile the state budget. The Division is not funded through the general fund. There is a dedicated fund that supports the Division, as well as the Office of Emergency Management and the Fire Marshall's Office. This year the NH Legislature has appropriated two million dollars from that fund to go back to the general fund. This represents nearly 50% of the total revenue of the fund.

It is not clear at this time what impact this budgetary move will have on the Division and on the NH Trauma System. One issue may be a restriction of part-time instructors. Dr.

Sutton asked what staffing the Division gives to the NH Trauma System. Clay replied that the Bureau supports trauma research via TEMSIS, and EMT's education related to trauma, but the primary support is the position of Trauma Coordinator.

Janet Houston said that she had read Governor John Lynch's speech regarding the State budget where he said that he would consider sunsetting all Boards and Commissions, then the individual boards would have to justify their reinstatement as a board. The rationale behind this move appears to be to reduce the costs involved with duplication of effort. Janet asked if there had been any consideration of that within the Division yet. Clay replied that he had spoken to EMS Bureau Chief Sue Prentiss very briefly about that. There was some concern that EMS has three different boards which might appear to be excessive, but there is enough specialization within the boards that Clay feels confident that the case could be made to retain the three boards. If the issue comes up Clay will be in touch with TMRC members to discuss the issue.

**Item 2.           Seat Belt Law**   Dr. John Sutton indicated that House Bill 383 was approved by the House Transportation Committee 11 to 6, and is being heard on the House floor this morning. He said last time the bill passed the transportation committee and then stalled in the House. A committee was created to study the issue determine the best ways to facilitate increased seat belt usage, and the outcome of that process is the current bill.

Sue Barnard said that if NH passes a seatbelt law the State would get \$3.7 million dollars from the federal government. She asked if any of that would go to the trauma system. Dr. Sutton replied that a case could be made for trauma to tap into that fund. He also mentioned that many states use funds from seat belt violations to help fund the trauma system. It would be nice if NH would use some of those funds to help fund the expenses of a statewide trauma registry. Clay will look into that and advise stakeholders as information becomes available.

**Item 3.           Air Medical Transport Utilization Review**   Clay said he had a very good response to his request for participation in the 2009 AMT UR. He has been working on setting up a scientifically valid study and developing the data collection tool. He has been communicating with the air medical programs to recruit their participation in the review. He has been looking into the technical issues of enabling the meetings to be conducted by telephone or web. He will contact all the individuals who expressed interest to give them an update on the status of the project. He anticipates initiating the meetings in late March to early April.

### **III. New Business**

**Item 1.           Imaging Guidelines** At the December meeting Rachel Rowe of the Foundation for Healthy Communities presented a request to the TMRC. She was representing the Medical Directors of all acute care hospitals in NH that has discussed the utility of developing guidelines for the imaging of trauma patients, and is seeking input from the TMRC for their expertise. The TMRC agreed to participate.

The TMRC discussed how to proceed with this project. Dr. Sutton said that one approach would be to consider two levels to approach the project. One would be if a facility was going to do a CT scan of a particular area what are the technical requirements for that CT scan. Examples of standards for trauma imaging might include: For a potential traumatic brain injury a non-contrast head CT would be indicated, while a CT for potential abdominal trauma should include the pelvis and

should utilize IV contrast. The second level would be to provide guidelines for what imaging studies are appropriate for certain trauma conditions. It is not feasible to provide an algorithm for every conceivable injury a CT might be considered for, but it might be possible to provide suggestions or guidelines for appropriate imaging for conditions found. For example if a cervical spine fracture is discovered during assessment a CT scan of the complete axial spine is warranted.

Another issue that goes along with this project is the ability of one hospital to send images to another. Dr. Sutton said that often a CT image will be sent with the patient with the axial cuts but no sagittal or AP reconstructions, which requires DHMC to do the CT again which is a waste of resources and causes increased x-ray exposure. Other members indicated that including the reconstructions in the disc sent with the patient was often not feasible as it is a time consuming (30 – 40 minutes) task. In that case it would be a significant advantage to be able to send and receive this information via the internet. The problem appears to be that the hospitals are on different systems. The systems all use the PACS filmless radiology technology, but the software that provides the infrastructure (such as Epic Medical Systems or Allscripts Medical Software) is not able to communicate with other systems. The medical directors of the acute care hospitals should be implored to help resolve this difficulty.

There should be a statement/disclaimer at the beginning of this project that indicates if a trauma patient presents to a community hospital, and clinical judgment indicates that the patient will be transferred promptly to tertiary care, further imaging should be at a minimum and should only be to make the patient more stable. This imaging could include ultrasound of the abdomen to evaluate for abdominal bleeding that could lead to profound hypotension. Other examples might include AP chest x-ray, and/or a pelvis plain film for a patient with a clinical indication of a pelvis fracture or hypotension with a suspicion of a pelvis fracture.

Clay will solicit members of the TMRC and interested parties to participate in a subcommittee. He will contact Patt Sampson about getting the involvement of Dr. Birnbaum from Southern NH Medical Center, who has done a lot of work on this topic.

**Item 2. Representation on the NH Emergency Medical and Trauma Services Coordinating Board** Clay advised at the last meeting that Dr. Sutton's third three-year term representing the TMRC on the EMSCB has expired. According to state law a member of the EMSCB cannot have more than three consecutive terms. Clay asked anyone who is interested in serving in this role to let him know. Janet Houston said as a member of the EMS Coordinating Board she would like to see more representation by the hospitals on that board, so any TMRC members who represent hospitals are encouraged to seek the nomination.

#### **IV. Old Business**

**Item 1. Revision of NH Trauma Plan** The group worked on and completed the prehospital clinical standards section of the document. Clay will implement the changes discussed at the meeting and send the document out to attendees for comments. If there are no objections to the document Clay sends out, it will be considered approved. As this is the last section to undergo revision, Clay will do one last review of the entire document for spelling and grammatical mistakes, then submit the document to the NH Emergency Medical and Trauma Services Coordinating Board for review at the March 19<sup>th</sup> meeting. Clay asked any TMRC members or regular guests that wanted to support the adoption of the NH Trauma Plan to attend the Coordinating Board meeting.

John Prickett told the group that this revision has served to re-energize the trauma service at Lakes Region General Hospital, particularly the performance improvement and patient safety program.

**Item 2. Pediatric Trauma Considerations** Dr. Sutton said that he didn't want a separate NH Pediatric Trauma Plan document, particularly one that merely substituted the word "pediatric" in the adult document. He presented a draft of "Interfacility Pediatric Trauma and Critical Care Consultation or Transfer Guidelines" which he found in his files but doesn't recall its source. He said the document has criteria for pediatric trauma triage. The group discussed whether a similar document should be added to the appendix of the trauma plan.

Janet Houston said that she has been considering what level of pediatric care the NH Trauma System should have in its plan. The majority of hospitals in NH don't have any in-patient pediatric capabilities, so the assessment of the hospital would apply only to the ED. Hospitals that do have pediatric inpatient facilities don't necessarily have critical care capabilities for children. Janet will make contact with clinical leadership at Elliot Hospital Pediatric ED and the trauma service medical director at Concord Hospital for their input.

The primary consideration for pediatric trauma is a properly equipped emergency department that is capable of resuscitating seriously injured children when needed, are proficient at early recognition of those patients who need to be transferred to a pediatric trauma center, and can mobilize a rapid transport of the patient.

Clay announced a letter of nomination has gone to Commissioner Barthelmes to appoint a pediatric surgeon to the TMRC, Dr. Laurie Latchaw from Dartmouth-Hitchcock Medical Center.

## V. Public Comment

Clay announced that the SBIRT Conference (Screening and Brief Intervention and Referral to Treatment) will be occurring upstairs in Classroom 2 of the Fire Academy starting at noon. SBIRT is a program that identifies emergency department patients who have an alcohol or substance abuse component to their ED visit. SBIRT-trained providers (nurse, physician, social worker) initiate a brief counseling visit with the patient and provide information about how to access resources such as alcohol counseling. SBIRT is a program that has been scientifically validated and is supported by several groups such as ACEP, ENA and ACS. This conference was coordinated by the Trauma Coordinator's Group and funded by Dartmouth-Hitchcock Medical Center. It is a train-the-trainer program and all 26 acute care hospitals in NH were invited to send a representative.

Dr Sutton announced that DHMC was reviewed by the American College of Surgeons verification committee and found to have no criteria deficiencies for adult Level I trauma. They are awaiting official notice of verification. There was one criteria deficiency for pediatric level I. DHMC currently has one emergency physician with credentials in pediatrics and two are required. DHMC is currently advertising for a second Pedi ED MD. Dr. Sutton reports that the ACS agreed that once DHMC has secured a second practitioner they will submit the paperwork to ACS and receive verification as a Level I pediatric trauma center.

## **VI. Adjournment**

Dr Sutton adjourned the meeting at 11:30. He advised the group that the next regular meeting of the Trauma Medical Review Committee will be Wednesday **April 15, 2009** at 9:30 a.m. at the Richard M. Flynn Fire Academy.

**Respectfully submitted:**

**Clay Odell, EMTP, RN  
Trauma Coordinator**