State of New Hampshire

Department of Safety

Division of Fire Standards and Training and Emergency Medical Services
Richard M. Flynn Fire Academy
222 Sheep Davis Road, Concord, New Hampshire
Mailing Address: 33 Hazen Drive, Concord, New Hampshire 03305-0002

John J. Barthelmes
Commissioner

Perry Plummer
Director

TRAUMA MEDICAL REVIEW COMMITTEE

COMMITTEE MEETING MINUTES
February 20, 2013

Members Present: Rajan Gupta, MD (Chair); Doreen Gilligan, RN; Amy Matthews, RN; Rick Murphy, MD; Gary Curcio, MD; Peter Hedberg, MD; Lukas Kolm, MD; Laurie Latchaw, MD; Kathy Bizarro; Eric Schelberg, EMTP

Guests: Sue Barnard, RN; Janet Houston; Peg Pedone, RN; Mark Hastings, RN; Nicole Keefe, RN; Brian Nicholson, EMTP; Mary Reidy, RN; Stephen Longbook, RN; Michele Guilfoil, RN; Debra Samaha, RN; Sarah Greer, MD; Sean Elbeg, EMTP

Bureau Staff: Angela Shepard, MD

I. Call to Order

The meeting was called to order by Chair Rajan Gupta at 9:30 am on Wednesday February 20, 2013 at the Richard M. Flynn Fire Academy in Concord, NH. A quorum was present.

Item 1. Introductions All attendees introduced themselves.

Item 2. Minutes

Minutes from the last meeting were provided to all members electronically prior to the meeting. The minutes were accepted without change.

II. Committee Discussion Items

Item 1. Hospital Updates

Angela reminded that Parkland Medical Center had an abbreviated site review earlier in the month. The site review team will provide their report later and the committee will vote on their Level III/IV designation.

Angela reported that she had a positive meeting with some of the ED leadership at Speare earlier this month. Nursing in particular seems committed to pursuing trauma level designation though there is still concern about the surgeon on call requirements. They believe there is still more work to be done to convince the administration that this is an important issue.

Wentworth-Douglass reported that they are very close to submitting their trauma application. Dr. Gupta spoke about how we can attract more hospitals into trauma system participation. Niki Keefe and Sue Barnard both offered to reach out to colleagues at hospitals that have historically shown little interest. Dr. Hedberg shared his experiences with the RTTDC and mentioned that it can be a powerful carrot. Dr. Murphy spoke of the value of mentoring newer hospitals. Dr. Gupta stressed that this may take some financial investment to strengthen the trauma system. The general consensus was that we need to re-evaluate our existing plan to ensure that the

requirements for the small hospitals are achievable and that there is a clear participation benefit for all hospitals.

Item 2. NH Bureau of EMS Report

Angela distributed the EMS Bulletin. She reported that the new Statewide EMS protocols are out and reminded that there were revisions to the Trauma Triage policy.

Dr. Murphy brought up his concerns that the trauma entry in the EMS Bulletin was skewed towards only the highest levels of trauma designation. He worried that it would incorrectly direct EMS providers to bypass the closest hospital to travel to a level I or II trauma facility. Angela said that technically that is what the current policy and trauma plan recommend for severely injured trauma patients. She agreed that ideally the algorithm should incorporate transport time in the decision process. However, there should be some comfort in the fact that the EMS providers do not blindly follow the protocols and policies. Angela explained that these documents are meant to provide freedoms for providers to act in the best interests of their patients. This policy allows them to opt away from the closest facility if the patient's condition warrants immediate transport to a specialty care center. Dr. Murphy said he did not believe that this was how the providers interpreted the protocols. Angela agreed that education on the proper interpretation of protocols in general would be beneficial.

Angela urged that TMRC members take a more active role in the protocol process. The Protocol Committee is a voluntary collaboration of EMS providers, at least one ED physician, and some other stakeholders. They put together the document and provide it to the TMRC for comment. Angela takes the TMRC's comments back to the Protocol Committee. They will generally incorporate those recommendations or some version of them but his is not a given. The draft then goes to the EMS Coordinating Board and Medical Control Board for comments with the Medical Control Board having the final authority to approve the version.

Dr. Murphy asked how we can know that harm is not occurring as a result of this policy that allowsproviders to choose the transport destination. Dr. Gupta said that he would be very disappointed if the Bureau of EMS did not already have a mechanism in place to monitor this. Angela reported that the Bureau did not. She said there is currently no systematic QA or PI process for the EMS system. The Bureau will investigate written, signed complaints against providers but we do not monitor their activities.

Several members of the group discussed that it was important to pursue some form of QI or QA for EMS just as there is for every other health care provider. Brian Nicholson said that many EMS units and EMS Medical Directors do QI with their providers but acknowledged that this depends on the local leadership. Angela asked the committee to consider how we could facilitate the development of some formalized PI processes for the EMS System as we build our own PI program for the Trauma System

III. Old Business

Item 1. Trauma Registry Update

Angela said that several trauma coordinators stayed after the last TMRC meeting to discuss needed characteristics in a potential registry product. Angela has incorporated that feedback

into a requirements list for the RFP. The process continues to move forward though it will be a long course.

Item 2. Planning Next Trauma Conference

Angela reported that the results of the trauma conference planning survey were overwhelmingly in favor of returning to the MVG for this year's trauma conference. There was also strong consensus to host the event on November 15th. A majority of the votes supported holding another pre-conference workshop on the day before the conference. The group then discussed whether we should continue to use the preconference workshop to focus on trauma PI. The consensus was that it was very well received and the audience indicated they would like additional training. It was decided that the workshop would be extended to a full day of PI.

Angela said she plans to ask Shriner's Hospital to be a guest lecturer at this year's conference based on the strong positive feedback she got regarding the exhibit at last year's event. Other members echoed their support of that choice. Angela asked that members interested in planning the upcoming conference please stay after the meeting to discuss specific topic and speaker suggestions.

IV. New Business

Item 1. Parkland Medical Center Review

Angela distributed the site review summary report along with Parkland's updated trauma documents to the TMRC. Parkland applied as an Adult Trauma Level III and Pediatric Trauma Level IV. There were some procedural and documentation issues identified in the original site review last summer. The committee voted to conduct an abbreviated return visit this month to allow Parkland to update their policies and implement those revisions.

Dr. Gupta stated that he was pleased with the hospital-wide commitment to the trauma program and the integration of the QI office into the trauma PIPS process. Dr. Kolm agreed that there was much better cohesiveness within the trauma program. He also pointed out that the transition to a paper trauma flow sheet was very effective in improving many of the documentation issues. Mary Reidy expressed her admiration for the tremendous job that Peg Pedone has done in a very short period of time. Mary suggested that some specific dedicated time between Peg and the trauma medical director can help to strengthen and maintain the positive changes that have been implemented. Angela echoed the praise for Peg and the great improvements made in the trauma program. Tina Legere, CEO of Parkland Medical Center, thanked the TMRC for the time and commitment to their trauma program. She said she was proud of the hospital's performance and was pleased to say that some of the changes within the trauma program were effecting positive changes in other programs as well. The committee had no questions and voted unanimously to grant Parkland Medical Center Adult Trauma Level III and Pediatric Trauma Level IV designation.

Item 2. Trauma Registry and Pediatric Abuse Survey

Angela introduced Deb Samaha from the Injury Prevention Center at Dartmouth. Deb is completing her MPH and as part of that process is doing a field study project with Angela relating to the trauma registry and its ability to capture pediatric abuse data. Deb provided some

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background about how the trauma registry data from DHMC was used to identify infant maltreatment as an injury prevention priority. In the next couple of weeks, trauma coordinators and other ED staff at each hospital will receive an email with a survey link and a data request. These will help us ascertain the current use of trauma registries and identify some capacity issues as well as gauge hospitals' current mechanisms to track pediatric abuse. Each hospital that completes both parts within the deadline will be entered for a drawing to receive two free Trauma System Conference registrations. The TMRC then discussed the possibility of including some of the ICD 9 or ICD 10 995.5 codes for pediatric abuse, specifically Shaken Infant Syndrome. Since any one of the cluster of findings alone may not reach the inclusion criteria, Angela suggested that we consider Shaken Infant Syndrome as an additional inclusion code above what the NTDB utilizes. A few members wondered if it would actually be captured in the registry data since so few people utilize that code because of the need to have abuse substantiated. Angela argued that Shaken Infant Syndrome and pediatric abuse in general is not being tracked well. She agreed that this is an imperfect solution but could provide one additional piece of the data puzzle. Additionally it is important that the TMRC acknowledge the devastation that can result from abusive head trauma even when there aren't accompanying fractures. The consensus of the group was generally positive. This will be considered more when we formalize our state trauma registry inclusion criteria.

Item 3. Goals for Upcoming Year

Dr. Gupta said that he would like to discuss our goals for the trauma system. In the interest of time, he simply outlined his hope that we can establish some formal standing sub-committees specifically addressing Hospital Designation, Education, and Trauma Plan Review. The discussion will be continued at the next meeting.

Item 4. Vote for Vice Chair

Prior to the meeting Dr. Kolm was nominated as Vice Chair for the TMRC by two separate individuals. Dr. Kolm graciously accepted the nomination. The committee unanimously voted for Dr. Kolm as Vice Chair.

V. Public Comment

None

VI. Adjournment

Meeting was adjourned at 11:35. The next TMRC meeting will be Wednesday **April 17, 2013** at 9:30 a.m. at the Richard M. Flynn Fire Academy.

Respectfully submitted;

Angela Shepard, MD, MPH
State Trauma Coordinator
NH Bureau of EMS

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