State of New Hampshire

Department of Safety

Division of Fire Standards and Training and Emergency Medical Services
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Commissioner

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Director

TRAUMA MEDICAL REVIEW COMMITTEE

COMMITTEE MEETING

February 16, 2011
Richard M. Flynn Fire Academy
Concord, New Hampshire

Members Present: John Sutton, MD, Chair, Amy Matthews, RN, Tony Maggio, EMT, Doreen Gilligan, RN, Rosie Swain, Richard Murphy, MD, Rajan Gupta, MD, Gary Curcio, MD

Guests: Sue Barnard, RN, Mark Hastings, RN, John Leary, RN, Janet Houston, Grant Turpin, EMTP

Bureau Staff: Clay Odell, RN, EMTP

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 16, 2011 at the Richard M. Flynn Fire Academy in Concord, NH.

Item 1. **Introductions:** At Dr. Sutton's request attendees introduced themselves. Dr. Sutton recognized the passing of Estelle MacPhail who was a strong advocate for trauma care in NH back in the 1990's, and participated in the TMRC prior to her retirement. She was a recognized leader in emergency nursing, serving as president of the Emergency Nurses Association. There was a moment of silence in memory of Estelle.

Item 2. **Minutes**: The minutes from the December 21, 2010 meeting were distributed for review. There was not a quorum present at this portion of the meeting, so a vote was not taken at that time. A quorum was present later but no one remembered to bring the minutes back up for a vote. They will be brought forward at the April meeting.

II. Committee Discussion Items

Item 1. **Renewals, Hospital Updates, and Application** Littleton Regional Hospital has submitted their application for renewal. Clay is organizing the site visit committee. Also Southern NH Medical Center has indicated that their application will be sent in soon.

Clay was contacted by Concord Hospital to see what they would have to do to pursue assignment as a Level II trauma hospital. He replied to them that they would have to develop a telemedicine program for neurosurgery similar to the program Elliot Hospital is working on. There is no guarantee however that such a program would be approved. The suggestion of the TMRC is that Concord Hospital should submit their letter of verification from the American College of Surgeons and received NH assignment as a Level III, and they can at any time apply for assignment at a different level.

The NH Department of Health and Human Services, Office of Rural Health and Primary Care, which oversees the Critical Access Hospitals is working with the Bureau of EMS to encourage CAH's that are not currently NH trauma hospital assigned to pursue that designation. There are some federal "Flex Grant" funds to offer the trauma simulation training to these facilities as an encouragement to go through the process.

There was discussion about the membership of the site visit committees for the different levels of assignment. For the Level III or IV it may be useful to develop a checklist for pediatric standards rather than try and recruit a pediatrician. Clay said that other states that credential Level IV facilities usually use a team of two people for a site visit.

Item 2. NH Bureau of EMS Report

Clay mentioned the EMS Bulletin that was sent out to everyone last month, and said if there were any questions please bring them forward. He also mentioned that the process to recruit and appoint a Division Director was ongoing. Jeff Phillips has been appointed as acting Director.

The budget for the Division is not clear at the moment, although the 95% budget submitted to the Governor will have some impact on operations, but no layoffs. The legislature's budget is unknown at this point. The position of Trauma Coordinator is still open and we plan on filling the role. Dr. Sutton asked if the Trauma Coordinator role should include the responsibility for the simulation program. Clay said that was a possibility, and that the Bureau has been supporting a group to learn how to operate the SimMan for both EMS and trauma. Clay also said that it is his hope that we will be able to recruit an RN for the Trauma Coordinator position.

Dr. Gupta brought up the topic of the American College of Surgeons (ACS's) Rural Trauma Team Development Course (RTTDC). He said there was a new version of the RTTDC program available and perhaps it would be a good idea to consider using the RTTDC instead of the NH Trauma Sim program. The course is designed by ACS to be given at the smaller hospitals with the support of a Level I trauma center. Clay said that on the national level there has been funding through the Rural Hospital Flexibility Program for this program. NH has received some of these funds to support the trauma sim program in the past.

NH House Bill 413 will require a legislative study committee to look at the responsibilities of the three NH EMS boards as well as the committee that oversees Emergency Management for redundancies and opportunities to combine the boards if feasible. Clay had testified at a House Committee hearing on this bill that the Department of Safety was not in favor of the legislation, that the 3 EMS boards had separate responsibilities that could not be taken on by other boards, and pointed out that the boards were completely voluntary with no compensation to members. Clay indicated that if this legislation went through, it would establish another committee that will take testimony in the future, then recommend legislation if applicable. If HB 413 were enacted there will be further opportunities for input before any action regarding the boards would be taken.

Janet Houston discussed a booklet that she has been working on with the Bureau that is a guide for hospitals to use to triage the correct level of provider to request for interfacility transport.

Item 3. Imaging Guidelines Project Clay reported that he has been in contact with Rachel Rowe of the Foundation for Healthy Communities about the hospital Chief Medical Officer's group that requested the project. She said the group had discussed the document, they are taking it back to their hospitals and they expressed appreciation for the work. While the TMRC initially offered to do a presentation on the project to the CMOs, the CMOs felt this was not necessary to this time. Clay said the CMO's have significant influence on the practices at their hospitals and hopefully can foster implementation of the Imaging Guidelines.

Item 4. Vacuum Spine Board Study Clay reported that the project has been approved; he and Fred are working on the data collection instrument, and Fred is working with some hospitals regarding data collection within the hospital. He anticipates the study to start March 1st. There are nine services currently in possession of the board who have been requested to use the device on patients to get comfortable with the device prior to the data collection period. Clay says he checked TEMSIS to see if services have been using the device and needs to contact the services again to encourage them to advocate for the project with their staff. So far the use of the device has been slow to start.

Item 5. Telemedicine in Trauma

Dr. Sutton states he sees he issue is that we are trying to tighten up our standards for different levels of trauma hospital participation, but would like to offer the opportunity for hospitals to fix a criteria deficiency for clinical availability of care if it happens sporadically, and telemedicine might be one opportunity to do that. He said that the TMRC can either choose to be rigid like the ACS and say if a deficiency is identified a hospital can either fix it or fail to qualify, or we can establish some guidelines under which telemedicine could fill the void. The easy thing for the TMRC to do would be to disallow any telemedicine program to meet the higher standards. In contemplating the new plan the TMRC felt that a telemedicine would have merit, though not proven. He said if NH was to move to telemedicine it would have to give some guidelines to the site visit committee.

Dr Gupta gave some perspective from the ACS COT which indicated that there is no precedent for it although it has been discussed for rural states. He said he was personally not opposed but would suggest that we keep it limited and focused. He also suggested that rather than grant a hospital a higher level of credentialing if they require telemedicine that they should do it as say a Level III and do a quality improvement process that proves that telemedicine works.

A performance improvement component to the telemedicine program for neurosurgery would be an important part of a telemedicine plan. A hospital would have to PI every use of the telemedicine program and it should be reviewed as part of an ongoing process to determine the effectiveness and safety of the telemedicine program. This is something the TMRC could require as part of an approval process.

Rick Murphy asked if anybody is actually doing telemedicine for neurotrauma. Doreen Gilligan said Elliot Hospital was successful with telestroke, but Dr. Murphy said it is unrealistic to compare telelstroke programs with neurotrauma telemedicine. There are some places that are using it such as Arizona but have not published yet. Dr. Gupta said the EAST group is looking at a study of telemedicine in trauma. Vermont has been doing

telemedicine in trauma for quite some time but none of their studies were based on patient outcomes.

Clay said it is important for the TMRC to look at the NH Trauma System from the 30,000 foot level. We need to take into consideration the motivation for hospitals to actively participate and seek credentialing in the NH Trauma System. It isn't because of any financial incentive the state gives. There is no carrot and no stick. As he has gone out and asked hospital leadership why their hospital has sought a trauma assignment it almost always comes around to intrinsic motivation. In many hospitals it is a hospital culture; they want to prove to their community that they are progressive in the care of the trauma patient. In some hospitals it is a competitive edge. Whatever the motivation is the TMRC should try to embrace it if it drives improvements in trauma care. We need to be very careful and make sure it is safe, but we should not dismiss the potential for telemedicine in neurotrauma care.

There was a discussion regarding EMS triage based on the available resources. If an EMS provider has a patient with a seriously decreased Glasgow Coma Score, what do they do? If a trauma hospital does not have neurosurgery on call the EMS service should bypass the closer hospital to go to a trauma center with neurosurgery on call. This may involve a longer ground transport or utilization of air medical transport. If a hospital had an approved telemedicine program for neurotrauma the patient could be transported to that closer hospital on days when an on call neurosurgeon is not available.

Dr. Sutton said to summarize, we should proceed cautiously but not necessarily await standards to be established by an outside agency.

Item 6. Trauma Conference Clay said he has been discussing the Trauma Conference with the leadership at the Dept. of Health and Human Services Section on Rural Health and Primary care, who have been helping to subsidize the conference for the past several years. It appears as though the federal grant funds that support this program may not be available for 2011. This factor, in conjunction with a decrease in attendance should spur us to consider whether to hold the conference this year.

Does the conference actually reach the decision-makers that we would like to reach? We historically get about 12 physicians who attend, along with many nurses. Unfortunately it seems the majority of these attendees are not in the role of leadership to effect change within their hospital. We also get EMS providers who often express disappointment that the conference is too "hospital oriented".

If we lost the $3500 - $4000 that we usually get from rural health we would have to increase the registration fee. At some point we would encounter the law of diminishing returns and have less people register because the fee goes too high. In 2010 we charged $60, got $3500 in funding from rural health and had $2000 left over that we can roll over to 2011.

Dr. Sutton suggested that we look into either combining the trauma conference with another trauma conference, such as DHMC's trauma conference, or broaden the topic to include the mission of all three of the EMS boards. He will bring up this idea at next month's Medical Control Board meeting. There will be further discussion at the April meeting.

III. Old Business

Clay asked Dr. Gupta about the position on the EMS Coordinating Board from the NH chapter of the American College of Surgeons Committee on Trauma. If there is not interest by the COT then we should work at getting the organization off the list of represented groups under State RSA. Dr. Gupta asked if he could attend some of the meetings to try to determine the level of interest. He is more than welcome to attend and Clay will advise him of the schedule.

IV. New Business

None

V. Public Comment

Tony Maggio announced the first Saturday in May has been designated by the NH Legislature as EMS Provider Recognition Day. The NH Association of EMT's, with assistance by the Bureau will be coordinating an event that day. He also said May 4th is "EMS on the Hill Day" where EMS providers meet with their federal legislators in Washington DC to educate on and advocate for issues involving EMS, such as extending the federal death benefit to EMS providers. He also said May 14-21 is EMS Week and the "Muddy Angels" do a bike ride that week which will begin in Boston and end in Washington DC. For additional information see www.muddyangels.com.

VI. Adjournment

Dr Sutton adjourned the meeting at 11:30. The next meeting of the Trauma Medical Review Committee will be Wednesday **April 20, 2011** at 9:30 a.m. at the Richard M. Flynn Fire Academy.

Respectfully submitted:

Clay Odell, EMTP, RN
Bureau Chief, Acting Trauma Coordinator