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

Perry Plummer
Director

TRAUMA MEDICAL REVIEW COMMITTEE

COMMITTEE MEETING

April 20, 2011
Richard M. Flynn Fire Academy
Concord, New Hampshire

Members Present: John Sutton, MD, Chair, Tony Maggio, EMT, Doreen Gilligan, RN, Richard Murphy, MD, Rajan Gupta, MD (by phone), Gary Curcio, MD, Cherie Holmes, MD, Rob DiLuzio, EMTP (by phone), Kevin MacCaffrie, EMTP

Guests: Sue Barnard, RN, Brian Flynn, RN, EMTP, Janet Houston, Grant Turpin, EMTP, Lynda Paquette, RN, Mary Reidy, RN, John Prickett, RN , Lu Mulla, RN, Roy Jacks, 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 April 20, 2011 at the Richard M. Flynn Fire Academy in Concord, NH. A quorum was present.

Item 1. **Introductions:** At Dr. Sutton's request attendees introduced themselves. Kevin MacCaffrie is the Fire Chief of Londonderry Fire Department and has been appointed by Commissioner Barthelmes to replace Rich O'Brien as the representative of the NH Association of Fire Chiefs.

Item 2. **Minutes**: The minutes from the December 21, 2010 meeting and the February 16, 2011 meeting were distributed for review. There had been revisions of the February minutes recommended. The revisions were accepted and both minutes were approved by vote.

II. Committee Discussion Items

Item 1. **Renewals, Hospital Updates, and Application** Clay presented Mary Reidy with the certificate of approval as a Level III adult trauma hospital as a result of receiving verification as a Level III facility by the American College of Surgeons

Committee on Trauma. A letter of approval will be sent to the President/CEO of Concord Hospital.

Littleton Regional Hospital had a site visit conducted and their application will be brought up for consideration later in the meeting. Catholic Medical Center submitted their application for initial review for a Level III trauma assignment. St. Joseph Hospital submitted their application for renewal but has requested that the site visit be delayed until the Trauma Program Director returns from maternity leave. Clay is still waiting for the application from Southern NH Medical Center.

Clay met last week with the Rural Health Coalition which is composed of the CEO's of the NH Critical Access Hospitals. He discussed the NH Trauma System, particularly the fact that the Level IV criteria was designed for the smaller rural hospitals, and that – on the federal level – CAH's are strongly encouraged to participate in their state's trauma system. He also discussed third party reimbursement for trauma team activations if the hospital is an assigned hospital within the state trauma system.

Clay reported that during the discussion with the CEO's several of them brought up the concern that they would never be able to even apply for Level IV as the likelihood that they would be able to meet the requirement for surgeon arrival within the 30 minute criteria is not realistic. These hospitals by-laws require a one-hour response for the surgeon and there is not much chance of changing that. They asked if the TMRC would consider the reality that those hospitals confront. They are interested in participation if possible.

As previously reported, 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. Despite the changes in staffing in the Bureau as previously discussed Clay commits to making this work.

Dr. Sutton and Dr. Gupta discussed the ACS consideration of type 1 and type 2 deficiencies. This may be a way to become more inclusive, and might prove to be a better way to include some of the smaller hospitals without re-writing the standards or changing the standards. Perhaps this could be a companion document that could change – become stricter – as time moves forward. The ACS has examples of these on their website. Type 2 deficiencies can still result in approval, conditional for a period of time. Dr. Sutton suggested that we could bring the ACS deficiency list to the next meeting for review by the TMRC

Item 2. NH Bureau of EMS Report

Clay reported that the process to recruit and appoint a Division Director was complete. Perry Plummer, Chief of Dover Fire Department has been appointed as Director.

The EMS Coordinating Board is considering a recommendation from the Commissioner's Ad-Hoc Committee on EMS Refresher Training – formed in response to the refresher training scandal last year – to eliminate the requirement for a practical exam as part of the refresher process. The Division is in support of this recommendation. It added complexity and time to the refresher process without adding value. Most states do not have such a requirement. The Coordinating Board will be taking up that issue at their meeting next month.

Clay explained that every two years EMT Basics and Intermediates currently have to take a refresher course and a practical exam. They would still have to take a refresher, but not a state practical exam. He also explained the optional state-approved refresher process of taking a cognitive exam in lieu of a refresher. If an EMT successfully completes an exam-in-lieu, a practical exam is not required under our current rules.

Clay reported that the position of Trauma Coordinator will be posted this week. It will start off be posting in-house first, but will likely be posted to outside candidates as well. Dr. Sutton asked if members of the TMRC would be involved in the selection process. Clay said yes.

Item 3. Vacuum Spine Board Study Clay reported that the project is ongoing. It hasn't been the smoothest start, but that is to be expected. We may consider actually starting the data collection process in June.

Item 4. Telemedicine in Trauma

No report

Item 5. Trauma Conference Dr. Sutton reported that he suggested at the Medical Control Board that we look into combining the trauma conference other issues that pertain to all three boards. There was a positive reception by the MCB. Clay needs to bring the topic up for discussion with the EMS Coordinating Board.

We can explore other venues in addition to the Inn at Mill Falls, but most attendees expressed a preference for that facility. There is still interest in having a meeting for trauma stakeholders on trauma topics, perhaps a good plan would be to have

III. Old Business

None

IV. New Business

Item 1. Littleton Regional Hospital Trauma Assignment Application
Dr. Sutton submitted the summary findings of the Site Visit Committee which conducted an on-site evaluation for LRH's application on April 4, 2011. Site Visit Committee members were Dr. John Sutton, Sue Barnard, Dr. Norm Yanofsky and Clay Odell.

Carlene Whitcomb, RN, the Clinical Director of Outpatient Services at LRH, whose responsibilities include the Emergency Department, participated in this part of the meeting by phone.

The Site Visit Committee noted a number of deficiencies. The committee recognized that LRH had some significant issues with turnover of trauma leadership, some of which was related to health issues. There did not appear to be any functional multi-disciplinary trauma performance improvement program. There was not a clear trauma team activation policy and the hospital stated it had no trauma team activations within the past 12 months, yet a review of the medical records indicated a number of patients who clearly would have met common trauma team activation criteria, and a number of patients whose injuries were substantial enough for transfer to a trauma center.

There are a lot of dedicated people and a great facility. The ED is well equipped and organized for effective trauma care. There is a dedicated pediatric cart with appropriately sized equipment that can be moved from room to room. They face challenges of transport teams, which they appear to handle well, including sending nurses on transports. They have a high rate of nurses with trauma credentials, but they need to work on getting more credentialed. There is commitment by the hospital for nursing training.

None of the reviewers determined any instances of inappropriate care. Prehospital trauma team activation criteria are vague and left to the emergency physician. The written guidelines for trauma team activation are a five tiered response which is very confusing. The trauma team is activated individually by the Ed secretary, but the committee was told that activation of other teams, such as the cardiac arrest team is done by a web based system where all members are notified simultaneously. It would be desirable to have the trauma team activated by the same mechanism.

The activation criteria need to be better defined and then actually used. The trauma flow sheet document that LRH uses seems very good, but the only time they use it is for a trauma activation. Since they haven't done any trauma team activations there were none of these documents to review. The nursing documentation was good, although it was noted that there was not documentation of a follow-up Glasgow Coma Score on any of the nursing documentation.

The consensus of the members was that the organization did not meet the standards for adult Level III and did not specifically address the standards for pediatric Level IV. The feeling was that rather than deny the application at this time it would be useful to hold the application in progress at this time, with reconsideration no more than six months from today. There was a discussion regarding a listing of the deficiencies noted and a process to determine which deficiencies would be Level I deficiencies (major variations from the standards that would not be acceptable) and which would be Level II deficiencies (minor or moderate variations from standards which could be provisionally approved with a plan and timeline to correct the deficiencies). A motion was made and seconded to do so, the motion passed unanimously.

A suggestion was made that the TMRC should make a consultation service available prior to the actual site visit. The consensus was that this idea had considerable merit and we would look into the feasibility of doing it.

Item 2. Clinical Issues Clay brought forward two issues for consideration by the TMRC. He described a common EMS scenario in which a patient for whom a 911 response had occurred has a minimal head injury, but who does not want to go to the hospital. This individual, who is conscious and alert, signs a refusal of care. The good clinician will attempt to give the individual and/or family things to look for that might indicate a worsening head injury. It is not realistic though to expect EMS providers to recall all the appropriate things to look for. Clay distributed an article that looked at Emergency Department head injury discharge instructions as a model for a document that EMS providers could use as an advisory document if they wanted. He asked the group for their input into the document and asked if they wanted to bring the document forward to the Medical Control Board for their review. The consensus of the TMRC was that the documentation would have to be used properly, not as a tool that EMS providers would use to make clinical decisions. The consensus was to ask the Medical Control Board to consider the proposal.

The second issue is for the group to consider developing a generic protocol for hospital ED's to use to rapidly assess head injury patients who are on Coumadin. It has been

recognized that a patient on Coumadin who has a head injury should undergo rapid diagnostic studies (CT scan) to rule out a head bleed, and if an intracerebral hemorrhage is found, prompt reversal of the medication. A companion piece would be to educate EMS providers to be alert for head injury / Coumadin patients and give appropriate pre-arrival notification to the ED. He suggested a sub-committee be established to review the concept.

V. Public Comment

None

VI. Adjournment

Dr Sutton adjourned the meeting at 11:30. The next meeting of the Trauma Medical Review Committee will be Wednesday **June 15, 2011** at 9:30 a.m. at the Richard M. Flynn Fire Academy.

Respectfully submitted:

Clay Odell, EMTP, RN
Bureau Chief, NHBEMS