NH MEDICAL CONTROL BOARD

Plymouth State University
Plymouth, New Hampshire

MINUTES OF MEETING

July 19, 2007

Members Present: Tom D'Aprix, MD; Frank Hubbell, DO; Patrick Lanzetta, MD; Jim Martin, MD; Douglas McVicar, MD; Norman Yanofsky, MD; Sue Prentiss, Bureau Chief

Members Absent: Donavon Albertson, MD, Chris Fore, MD;; Jeff Johnson, MD; Joseph Mastromarino, MD; William Siegart, DO; John Sutton, MD

Guests: Steve Erickson, Jeanne Erickson, Doug Martin, Michael Pepin, Steven Achilles, Jonathan Dubey, David Dubey, Chris Dubey, Janet Houston, Doug Martin, William Taffe, Eileen Clark, Claudia Anderson, Christine Beres, Dave Tauber

Bureau Staff: Rick Mason, Director, Vicki Blanchard, ALS Coordinator, Clay Odell, Trauma Coordinator; Shawn Jackson, Field Services, Mike Schnyder, Research and Quality Management Coordinator

I. CALL TO ORDER

Item 1. McVicar welcomed all to Plymouth. He thanked Plymouth State University and Plymouth Fire Department for their generosity in hosting today's meeting.

McVicar then read a few passages from The History of Plymouth regarding Daniel Webster and Nathaniel Hawthorne whose activities in Plymouth set the stage for the visit of the MCB today.

II. ACCEPTANCE OF MINUTES

Item 1. May 17, 2007 Minutes were distributed, reviewed and approved unanimously without amendments.

Item 2. EMS Community. No news at this time

III. DISCUSSION AND ACTION PROJECTS

Item 1. Appointments: In accordance with RSA: 153-A:5 The NH EMS Regional Councils have given their recommendations for Medical Control Board (MCB) membership. Yanofsky moved to accept the recommendations, Hubbell

2nd. Vote: Unanimous. The Medical Control Board was seated as recommended by the Regional Councils with an expiration date of July 31, 2010. The members are:

Region I: John Sutton, MD and Norman Yanofsky, MD
Region II: Tom D'Aprix, MD and Jim Martin, MD
Region III: Donovan Albertson, MD; Patrick Lanzetta, MD; Joseph Mastromarino, MD; and William Siegart, DO
Region IV: Chris Fore, MD and Douglas McVicar, MD
Region V: Frank Hubbell, DO and Jeff Johnson, MD

Following the appointment of the board, Director Mason presented on behalf of Commissioner Barthelmes a letter officially appointing Dr. McVicar Chairman of the Board and State Medical Director.

Item 2: Rapid Sequence Intubation: As requested at the May MCB meeting, Blanchard presented the board with the education and quality management piece for the NH RSI Program. She handed out a packet consisting of a checklist, application, prerequisites, qualifiers, education modules for both the RSI paramedic and the RSI assistant, student handbooks, evaluation tools and finally the quality management piece.

Blanchard thanked Doug Martin, Jim Midgley and Mike Schnyder for their help in the project.

Blanchard asked that each member take the next 28 days to review the material and send comments to her by August 16th.

Blanchard then explained the educational modules to the members. Specifically she noted that the training was broken down into 5 modules:

- Airway Assessment
- Backup Airways
- Pharmacology
- Malignant Hyperthermia
- RSI: Putting it all Together

The RSI Paramedic would be required to complete all 5 modules along with a written examination, practical skills mastery on all backup airways and a final RSI Megacode for the Medical Director.

The RSI Assistant would be required to complete all modules with the exception of the Pharmacology. The "RSI: Putting it all Together" has a modified version for the assistants, specific to their role in the procedure. Additionally they too will need to pass a written examination, practical skills mastery on all backup airways and an RSI Megacode addressing the assistant's for the Medical Director.

Next Blanchard explained the quality management requirements of the project:

- RSI Qualifiers, a document created for the EMS Units, which would allow them to determine whether they are capable and ready to implement a RSI program.
- The education modules.
- Medical Director's Review using a standardized TEMSIS reporting form based on the "NAEMSP Airway Management Reporting Template's" data points.
- TEMSIS reports and Medical Director's Review Report to be forwarded to the Bureau of EMS and Unit.
- Remediation, if necessary
- Biannual refresher training

There was discussion concerning assistants in areas where an RSI may be performed by an intercepting paramedic. Do they need to be trained, and if so, who would be accountable for their training? McVicar felt this would not be a problem – there is no mandate for training. If the community chose not to train providers as RSI assistants then a single RSI paramedic making an intercept could NOT perform RSI. Therefore unless two RSI paramedics intercept, RSI would not be available to that community. This would be part of the quality management piece that the Medical Director would have to review.

Achilles inquired if it were possible for him to require 2 RSI Paramedics in his service, and not allow RSI by a paramedic and an EMT assistant? Prentiss stated yes, you must meet the minimum, however there is not anything saying you cannot exceed that minimum. McVicar agreed with Prentiss.

There was discussion as to the procedure for approving the education modules. Initially the board planned to review the RSI materials for 30 days and then have a vote via email. However Director Mason informed the board that under rule in the state of NH, a board cannot conduct an official voting procedure via email.

D'Aprix moved, "to accept the document today with a 30 day review; if there are uncomplicated changes, leave those changes up to the discretion of the ALS Coordinator and Director to make." Lanzetta 2nd. Vote: Yes: 5, No: 0, Abstain: 1 – Vote Passes

Introductions: At this time the Chairman asked for forgiveness having inadvertently skipped over the introductions that traditionally begin the meeting. All introduced themselves.

<u>Item 3. Planning the Next Protocol Cycle:</u> Over the past two months members of the MCB polled medical directors from around the State of NH, regarding EMS. They inquired on what was or was not working for them in EMS, as well as feedback on protocols, TEMSIS and RSI. Their results were:

McVicar spoke with Dr. Kernan at Androscoggin, Dr. Mattice from Huggins, Dr. Strang from Franklin, and Dr. Burroughs from Memorial. Overall they had high praise for EMS providers and the job they do. High priorities should be airway, specifically recognizing failed airways. Additionally, two of those EMS Medical Directors said they would like to see the medication list updated. Both were

more interested in removing inappropriate or obsolete medications – "deadwood" – than in adding any specific new meds. Finally, they felt communication to the provider could be improved.

Yanofsky spoke with Dr. Cedeno at Alice Day Peck Memorial Hospital. There is not a whole lot of EMS activity at Alice Day Peck as 911 patients typically go to Dartmouth. Dr. Cedeno feels the system in general is working well. He said he was happy with the protocols and with TEMSIS

Martin spoke with Dr. Wu from Southern New Hampshire Medical Center. Dr. Wu is new to the area and feels NH EMS is good, but feels airway management could use improvement. She likes the protocols but has concerns with RSI. She would like to see TEMSIS reports in a more timely manner.

D'Aprix spoke with Dr. Greenston from Catholic Medical Center. Dr. Greenston felt overall there could be improvement in patient assessment. Dr. Greenston said he is not a fan of pre-hospital RSI. He feels transport times in his area are typically too short for RSI to really be needed. Also his observation is that providers are not always managing airways properly now – and sometimes don't seem to be managing airways at all!

After these comments were heard, McVicar gave the floor to Dr. Hubbell, who spoke of Wilderness Medicine Protocols. He stated that these have flown under the radar for some time now, but the reality was many wilderness people are receiving a class and certification but not a license. These people then go out and practice without a license. He is concerned that this is grossly illegal.

Hubbell also pointed out that many ski patrollers were practicing medicine without a license based on ancient legislation. More and more ski patrols are staffed with licensed providers, especially if they are practicing ALS. But not all are licensed. Lifeguards, similarly, are often not appropriately licensed.

Furthermore, Hubbell pointed out, NH EMS does not have any formalized protocols for wilderness medicine. He stated that there are protocols out there for other states, which people are using in New Hampshire, however they are not necessarily good, nor do they address New Hampshire's needs. He would like to write some wilderness protocols for New Hampshire and have the MCB take a look at them.

D'Aprix asked if we took ski patrol out of the picture, who else were we talking about. Hubbell stated there were thousands out there trained in wilderness medicine -- he trained many of them. Hubbell also sited the case of a paramedic who is currently in trouble for practicing without a license on a college campus.

Lanzetta asked how we differentiate between a certification and licensure. The answer was that a certification is proof of training and competency, whereas a license is legal permission from the state to practice.

McVicar stated that what he was hearing was a serious concern about unlicensed providers. But that would be mainly a Coordinating Board question

not MCB. How does this apply to protocols? Hubbell replied that there is a protocol issue because NH needs to have wilderness medicine protocols.

Achilles stated that he could bring up ski patrol licensure at the Coordinating Board this afternoon.

McVicar suggested that perhaps instead of making it a mandate to license ski patrollers, we might want to consider a collaborative approach. We could go to the ski areas and point out the liability they incur by using unlicensed providers. When they look at it in that light, they might be interested in the help that is available from the Coordinating Board, Bureau of EMS, the department's legal and legislative resources – and from us, the protocol writers.

Achilles asked who else are we talking about. Camp counselors and life guards were added to the list.

Doug Martin asked if there were any lawsuits from such practice. Hubbell spoke of a fatality in Colorado.

Lanzetta asked if we had a wilderness medicine protocol would it require a license to practice? Hubbell answered, "ideally."

At this time it was agreed that Hubbell prepare a draft wilderness protocol and present it to the board when ready.

D'Aprix asked at this time about Tactical EMS protocols, stating there was a Naval Seal provider on Rockingham who belonged to the Central NH Special Ops EMS Unit. This provider would like to see tactical EMS protocols. Prentiss and McVicar pointed out that two years ago the board was approached with the very same topic, at that time it was determined the existing protocols were adequate for what the unit wanted. If this provider thinks the existing protocols don't cover everything that they need, then he is welcome to present his ideas.

At this time McVicar sought protocol planning input from all the members of the board. He said he would like to go around the table and have each member state what he would like to see as the present protocol cycle goes forward.

D'Aprix presented a time table for the 2009 protocols. Starting on August 10, 2007, the protocol subcommittee will meet the second Friday of each month until May. At the May 2008 meeting a draft will be presented to the board, from the May to July meeting the draft will be send out for review and feedback. The July meeting will review the feedback. In September a final draft will be approved and the document will be frozen. This will give us three months to get the rollout, educational material and publishing done. Most of the work anticipated requires tweaking the 2007 protocols and working in the wilderness medicine.

McVicar stated he would like to see each protocol show its source and disclose the quality of its evidence basis. An example is the ACLS "protocols" of the AHA where "Class I" means "based on good-quality prospective, randomized, controlled studies" etc. In discussing this suggestion, Hubbell stated they could footnote the protocols to keep the document clean. It was asked if the

subcommittee needed to go back and do this for all the protocols or protocols that are new or changed. It was generally agreed that it would take a lot of work to go back through the old ones. However it is quite feasible to provide this sort of information for new and updated protocols, and then work on the old ones to the extent possible.

Lanzetta's protocol planning advice was to focus on quality management. Are our protocols making a difference? Since getting retrospective information can be difficult, he suggest picking a topic/diagnosis and following it as protocols change.

Yanofsky wants to see the a review of the Intermediate medication list, particularly nitroglycerin. Nitroglycerin is now on the Vermont's Intermediate medication list and he feels it is a drug that has the potential to make a difference in patient outcomes. The difference in protocols between the two states can make it difficult for the border units.

Martin's protocol planning includes looking into "sign-offs." EMS activity includes a lot of patient encounters that are signed off without transport. He would like to see statewide criteria or guidelines to assist providers in these challenging – and legally dangerous – cases. Examples would include MVC protocols, hypoglycemia easily reversed, etc. These protocols would allow consistency, which would have patient care quality and legal benefits.

Lanzetta suggested looking into treat and release issues. What conditions are amendable?

McVicar outlined very different situations:

1. Patient does not want to go to the hospital
2. EMS says patient does not need to go if he doesn't want to
3. EMS decides not to transport patient to the hospital

We certainly can produce protocols for the first situation, and possibly the second. The third is much more problematic.

Achilles stated we need to define when someone is a patient. There are times when we are called for service but there are no patients. An example given was a third party call, maybe from Ohio, you show up and the patient says they did not call you, they do not want your help and do not give consent. Does a person become a patient once they give consent for treatment? Without consent can anyone be a patient?

D. Dubey stated that the Ambulance Association was working with DHHS on similar issues, including redirecting patients. For example, when EMS arrives on scene, the patient does not need to go the emergency room but does need care from their PCP. EMS could "redirect" the patient to make an appoint with their PCP.

McVicar inquired as to why the Ambulance Association is working with DHHS. Dubey stated because of Medicaid reimbursement.

Jackson stated that JEMS had an article a couple years ago on the topic, he would send it to Blanchard and she will send it out to the board.

Beres stated there are many articles on the topic as well as conference lectures.

Lanzetta stated that nationally there are several pilot programs where "frivolous" calls result in patients not being transported but instead being scheduled for appropriate followed up. Results of these studies are still pending at this time.

Martin stated this discussion brings up another issue. He says he often will receive a radio report for a minor call and in the background he can hear the siren going. Why are they using lights and sirens for minor injuries or illness?

Prentiss stated that the law is very specific that lights and sirens are only to be used in an emergency, and they should not be using them in non-emergencies/ minor cases.

Tauber stated he has had the same argument with students and has been told that the insurance companies are mandating that if a patient is in the ambulance, lights and sirens must be used.

Clark stated that Warren-Wentworth just had a CEVO (certified emergency vehicle operations) course and was told by the Municipal Association, who put on the course, "no lights and siren if there is no emergency."

Prentiss stated that we have member on the Coordinating Board from the Local Government Center (aka Municipal Association) we can ask him to find out what the insurance companies are saying.

Achilles remembered that a group worked on this a couple years ago with the Coordinating Board. He will look up the results of that investigation.

McVicar asked the audience for their input on protocol planning. Beres would like to have Phenergan looked at, as the dose is so small he feels it is useless.

Item 4: TEMSIS: Michael Schnyder, our new Research and Quality Coordinator, was introduced to the board. Schnyder comes to us after having worked on the National NEMSIS project. The board gave a warm welcome.

Schnyder went over the handout attached titled, "Research Section Overview."

Schnyder reported that he pulled the TEMSIS workgroup back together last week and had a very good meeting. He would like to encourage more people to join the group. Clark suggested having some of the meetings in the evenings so volunteer providers would have a opportunity to attend.

Schnyder reported that he found 27 data items in the PCR that can be eliminated. After meeting with the work group, it was decided to keep 4 of those items. As a result we can expect to have 23 less data points in the future.

Tauber asked if the 24 hours reporting requirements were going to be addressed. He felt is was not good for continuity of care and wondered what the board felt.

Martin explained that St. Joseph has a “drop-off form” that is required before the EMS Unit leaves the E.D.

McVicar stated that 2 of the doctors on his phone list for the protocol planning calls stated they were having trouble with delays in receiving TEMSIS reports. One doctor was successful in getting the Units to leave their TEMSIS report 90% of the time, while the other was still struggling.

Lanzetta stated at the least a “drop-off form” should be required, that it did not need to be complicated, it is a part of emergency care delivery. He didn’t see why providers should have any problem with it.

Martin replied that many communities only have one ambulance and want to get that truck back to the town in case another call comes in. They wait and do their TEMSIS report once they are back at their base.

Achilles pointed out that the 24 hour requirement is a rule, and as such would have to be brought before the Coordinating Board, not the MCB.

Prentiss stated that getting the information down should not have to be such a huge problem. She explained that there is a learning curve involved with the change over to TEMSIS, but we should be nearing the downward slope of that curve. One provider should be filling out the report while the another is making the stretcher and cleaning the truck

Taffe pointed out the redundancy of the non-transporting service reporting on the same patient the transporting service picked up from them. The reply was that each unit that provides patient care needs to have a record of what it did.

J Erickson, EMS Hospital Coordinator for Speare Memorial Hospital, stated that at the EMS Hospital Coordinator meetings this topic is much discussed. St. Joseph has, at a local level, required their EMS Unit to provide a TEMSIS report within 4 hours.

D’Aprix stated that in the interest of patient care we physicians need the TEMSIS report when we are seeing the patient. Therefore D’Aprix would like to propose that a report be completed before the Unit leaves the hospital. He asked if it was something Achilles could bring before the Coordinating Board.

Schnyder informed the group that Maine had a statewide standard “drop-off form”. In addition, Imagine Trend created a program that hospitals can use to access and print all the patients delivered to their hospital. The problem with this is they are charging so many cents per report. This is something that we should question with them, as it could be considered a necessity and should not require purchasing.

Schnyder asked the audience to spread the word that he was encouraging input from the providers for any suggestions to improve TEMSIS.

One suggestion was to create a "TEMSIS bulletin board" on the first screen where important messages can be posted for providers – e.g. emergency protocol changes. Schnyder said this would probably be possible.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Coordinating Board: Doug Martin reported the following from the May 2007 Coordinating Board Meeting:

Best Practices: A presentation by Rob Atwater was delivered regarding suggested best practices. A draft was handed out with instructions to review and send comments to Kathy Doolan. They are expecting an update today.

National Registry Recertification: The National Registry is allowing recertifcation by taking the on-line written examination. The Coordinating Board concurred that this should be allowed as a substitute for the refresher program, but providers would still need to meet their continuing education requirements.

Death Benefit SB202: This was briefly discussed, no action taken.

Diversion Summit: Coordinating Board with working with Clay Odell on a diversion summit this September.

J Martin asked if it were possible to get a copy of the Coordinating Board minutes. It was agreed that in the future a draft copy of the previous Coordinating Board minutes would be placed in the MCB packets. (The minutes will be in draft form, as they are not approved until the actual meeting.)

Bureau and Division Update: See attached report.

Director Mason added that in the not-so-distant future Fire Standards and Training and Emergency Medical Services will be changing their email account to a First.MI.Last@nh.gov format. We will also be moving over to a voice over internet protocol (VoIP) phone system with E911; the main telephone numbers 271-4568 and 271-2661 and Fax numbers will not change, however each person will be receiving their own telephone number. Additionally, the field offices will be part of the system, allowing telephone calls to be taken here by the main receptionist. Finally, our physical street name has changed from Sheep Davis Road to Smokey Bear Boulevard. Mason states at this time we do not know the exact number on Smokey Bear Boulevard.

With all of these changes, Mason remarked, "at least it is all being done around the same time, so we only have to change our business cards once!"

Mason, Achilles, McVicar and Prentiss met with Commissioner Barthelmes. They felt they had a very positive visit with the Commissioner and found him to be exceptionally supportive of EMS.

Legislative Update: Director Mason reported on SB202. This is the death benefit bill. It has now gone into law with EMS omitted, however a study committee has been established. Mason has spoken to two lobbyists who state that EMS can still be added to the bill. It is Mason's intent that the Division's position be to get EMS added, he will continue to work with lobbyists David Currier and Doug Patch. He also expected that the Legislative Committee of the NH Association of Fire Chiefs will support the addition of EMS.

NH Trauma System: Sutton not present. Odell stated that the State Trauma Plan revision continues. The administrative section is 95% completed and he expects it to be finalized at their next meeting. The Clinical Standards will be addressed next. This will require expanding the group to reach all interested/affected parties. The Trauma Conference for this year is scheduled for Wednesday, November 28th.

Other Business:
D'Aprix discussed signatures for Medical Necessity Forms. D'Aprix researched their requirements and found that private insurance companies and Medicare do not require these signatures, only NH Medicaid. D'Aprix would like to see routine signing of these forms stopped, he feels it is a waste of the doctor's time. He would like to see the board write a letter to NH Medicaid asking that they comply with CMS and not require these forms.

D. Dubey explained that in the initial billing process the forms are not sent. However in the case of an appeal, not just in Medicaid cases, but also in Medicare cases, it is usually the necessity form which allows the ambulance service to get reimbursed for the services it provided.

The board is now informed of this issue, but has no specific action at this time.

V. ADJOURNMENT

Motion by Martin, seconded by D'Aprix to adjourn. Approved. Meeting adjourned at 11:55

VI. NEXT MEETING

September 20, 2007 at the NH Fire Academy, Concord, NH.

Respectfully Submitted,

Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Vicki Blanchard, ALS Coordinator)