

NH MEDICAL CONTROL BOARD

**Fire Standards and Training and Emergency Medical Services
Concord, NH**

MINUTES OF MEETING

January 17, 2008

- Members Present:** Donavon Albertson, MD; Tom D'Aprix, MD; Frank Hubbell, DO; Patrick Lanzetta, MD; Jim Martin, MD; Douglas McVicar, MD; William Siegart, DO; John Sutton, MD; Norman Yanofsky, MD; Sue Prentiss, Bureau Chief
- Members Absent:** Chris Fore, MD; Jeff Johnson, MD; Joseph Mastromarino, MD
- Guests:** Steve Erickson, Jeanne Erickson, Doug Martin, Michael Pepin, Steven Achilles, Jonathan Dubey, David Dubey, Chris Dubey, Janet Houston, Kevin Drew, Janet Williamson, Aleda Nichols, Shawn Riley, Doug Martin
- Bureau Staff:** Rick Mason, Director, Vicki Blanchard, ALS Coordinator, Kathy Doolan, Field Services Coordinator, Eric Perry, Education Coordinator, Mike Schnyder, Research and Quality Management Coordinator

I. CALL TO ORDER

Item 1. McVicar welcomed all to the meeting

II. ACCEPTANCE OF MINUTES

Item 1. November 15, 2007 minutes were already approved via email.

Item 2. EMS Community.

Prentiss asked for a moment of silence to remember John Stumpff and Michael Sandoe. Stumpff was a classmate of Prentiss during paramedic school who was recently killed during a medical helicopter mission. Sandoe was a paramedic and former partner of Prentiss. Sandoe died suddenly this week after suffering from chest pain.

A moment of silence was observed.

III. DISCUSSION AND ACTION PROJECTS

Item 1. Nasogastric Tubes Blanchard explained to the board that recently she received a call from an ambulance service that had a patient who needed an interfacility transport. The patient had a capped NG tube, but because our

protocols did not address it, the EMS unit wanted to know if it was okay for a basic to transfer the patient. Blanchard told the Unit she believed it was permissible under our protocols but would double check with the Medical Control Board (MCB). The board concurred.

Item 2: Sedation in the Traumatic Brain Injured Patient

D'Aprix explained that while working on the Traumatic Brain Injury (TBI) protocol the subcommittee reviewed the Traumatic Brain Foundation and American College of Surgeons' recommendations and found that sedation was indicated for the combative patient. The subcommittee wanted guidance from the board as to whether they should consider this.

Discussion: Albertson suggested using fentanyl, as the patient would most likely be in pain and it would not cause irreversible CNS depression, thereby allowing for ruling out organic causes of the combativeness. Sutton stated that historically physicians did not want their patient sedated in order to complete a neurological exam, however all head injured patients now go to CAT scan and the physicians are becoming accustomed to the patients coming in sedated. Sutton would support sedation of the combative head injured patient if kept at a minimal amount; feeling there was a huge range of head injured patients from the intoxicated person with a bump on his head to the severely injured. J Martin suggested adding it as a medical control verbal order; to which McVicar replied that it was difficult to assess combativeness on the other end of the telephone. D'Aprix stated that he wanted to be able to give the providers a tool to help them and prevent them from having to duct tape a patient down for safety. McVicar stated that he did not agree with the suggestion of "a little benzo" – that would not calm down the type of patient D'Aprix describes. Albertson suggested Haldol[®] as it does not cause respiratory depression.

Decision: D'Aprix stated that what he was hearing was that the board supported adding sedation to the TBI protocol. The Protocols Subcommittee will investigate further and provide a draft. McVicar asked for a show of hand for all those in favor. Vote: Unanimously supported.

Item 2. Continuous Positive Airway Pressure (CPAP)

Schnyder presented the MCB a report (see attached) which supported the use of CPAP at the EMT-Basic level and asked the board to consider it.

Discussion: The report stated that 12 states currently had basics using CPAP; McVicar asked Schnyder if he had any information on which states they are and if the providers were actually using the CPAP they were licensed to carry? Schnyder replied that he did not know and that it was relatively new. Martin expressed concern in assessing and distinguishing the CHF patient from the COPD patient, even at the paramedic level. McVicar asked even if the patient was not in CHF but had pneumonia patient or COPD what harm would CPAP be likely to cause? Sutton stated that studies conducting ICUs showed that patients on CPAP required increased nursing care and that mask seals were difficult to obtain/maintain. Sutton expressed concern about the training and particularly about assuring an adequate mask seal. J Erickson stated that the prehospital devices are different from those used in the hospital. They are simpler and obtaining the mask seal was not difficult. Erickson also stated that the EMS

services in her area have been using them without difficulty. Schnyder then pointed out that even if they did not obtain a good seal, they would still be getting 100% oxygen which is what they would receive with a non-rebreather mask. Lanzetta asked if there would be a delay in transporting. Schnyder stated that in his experience, in Delaware, there was no delay in transport. Prentiss stated that perhaps the Board should consider shooting for a middle ground and move CPAP to the Intermediate level. She explained, at this time we have roughly 1000 Intermediates versus 1900 or so Basics. She stated that she meant no disrespect for the Basics but perhaps having a smaller group would enable us to see how it would work. There was a question on CPAP being at the paramedic level in the National Scope of Practice and Prentiss stated that it was a foundation we should not go below but we can go above it. McVicar thought Prentiss's suggestion was a good compromise. Yanofsky stated that he looked at the cost, risks, and benefits. We know the cost, the risks are low and the benefits are high; therefore he would support CPAP at the Basic level. Martin again expressed concern in assessing CHF. Albertson reminded the board that the situation is similar to the era when defibrillators first came out. For this modality the efficacy is high and the risk is low. Albertson stated the board should put this at the Basic level. Prentiss further suggested that it be an option and not a mandate at this time. There are organizations where purchasing a one-time use device at \$60 is a big deal. McVicar then polled the Board members, asking each member to make a comment as to which level they supported. Yanofsky stated he would support the Intermediate level with the intent to move it to the Basic at a later time. Siegart concurred with Yanofsky. D'Aprix supported the Intermediate level and no mandatory requirement. Martin supported Prentiss's suggestion of a stepped approach, starting at the Intermediate and evaluating from there. Hubbell support CPAP at the Basic level. Albertson also stated he would support CPAP at the Basic level but would be happy to see it start with the Intermediates. Sutton and Lanzetta each supported CPAP at the Intermediate level.

Decision: D'Aprix moved "CPAP to the Intermediate level but not as a mandatory piece of equipment." Yanofsky 2nd. Vote: 7 Yes, 1 Abstained. Motion PASSED.

In addition the board asked that the minutes reflect that all members are interested in seeing CPAP eventually at the Basic level, if that additional experience here and nationwide supports it.

Item 3. 2007 Off Label Drug Us

In the past there has been discussion on when to use medications off-label, McVicar stated that in general the board does not put off-label uses for medications into the protocols unless there is a clear advantage and is widely used. It is recognized that many, if not most, medications have off-label uses. McVicar pointed out that pharmacological companies would not have any motivation to add these uses to their FDA approved labeling since they are already enjoying the sales from off-label use, and don't need to pay for the research required for FDA approval, nor assume additional liability.

Discussion: D'Aprix informed the board that intranasal (IN) fentanyl use is off-label as is midazolam. There was a concern for the concentration of midazolam

and IN administration. Currently, D'Aprix noted that when giving an IN medication it is recommended to not give any more than 1 ml per nostril, as any more would just run off into the pharynx. At this time ambulances are carrying midazolam in the 1 mg/ml concentration and protocol calls for 2.5 mg. A 5 mg/ml concentration is available and D'Aprix would like to see ambulances switch to this concentration. In addition he stated they should only carry this concentration to minimize medication errors.

Decision: The board concurred with D'Aprix, Blanchard will follow up with a letter to the hospital pharmacy advising them of this decision.

Additional Discussion: The use of odansetron, granisetron, and dolasetron for routine nausea and vomiting is also an off-label use. There labeled use is for nausea and vomiting in the chemotherapy patient, and calls for a slow IV push.

Discussion: Albertson stated he felt there were no concerns. D'Aprix reminded the group that it is routinely given as a IV push in the ED.

Decision: All agreed there was no concern here, and protocols should not be changed.

Item 4: Nitronox

During the November meeting nitronox was approved at the Intermediate level for pain. At that time a discussion raised concerns regarding nitronox regulators and scavengers. Blanchard and McVicar were to report to the board on whether there were any OSHA regulation regarding scavengers on nitronox regulators.

Discussion: McVicar reported that he could find no OSHA regulation. However some federal internet postings did indicate that there is a concern, and NIOSH does send out warnings to dental offices occasionally. D. Martin stated that he looked into the distributor who sold nitronox regulators for ambulances and found the Matrix Unit which does have the option of adding a scavenger. Additionally, D. Martin's further investigation revealed that there were standards for dental offices with for gas monitoring, however he did not find any prehospital protocols regarding monitoring. Lanzetta wondered if there was a real problem with the residual gas or is it theoretical? McVicar replied that he has seen no proof, and proof would be unlikely as concerns involve chronic exposure. Hubbell asked how often it was used in NH. D Martin stated that it is used a little by Frisbie for hips, knee cap, etc. Prentiss stated we could learn more by going through the EMS hospital coordinators, as they would know who had it, then we could look in TEMSIS and see if they are using. Blanchard pointed out that with Intermediates being able to use it, we may see an increase after the rollout of the 2009 Protocols. Hubbell suggested we put a warning box on the protocol.

Decision: D'Aprix moved that the protocol should reflect a warning box, a scavenger should be used and the ventilation fan should be running while administering nitronox. Vote: Unanimously passed.

Further Discussion: J Dube asked why it would be necessary to have both a scavenger and ventilation fan on. Also he asked, what about those Units that

cannot get a scavenger. McVicar stated clearance was much more efficient with a scavenger. D. Martin stated that in his research Matrix is the only one that makes EMS units and they make scavengers.

Item 5: Protocol Review

Blanchard presented the protocols with the below summary:

General format changes:

- As stated at the last November meeting, because “ALS/Paramedic Intercept” and “IV Establishment” bullets are also in Routine Patient Care they were removed from the individual protocols to reduce redundancy. This resulted in many protocols combining Basic and Intermediate Standing Orders.
- References were added when other standards or scientific evidence for protocol changes were used.
- Most protocols had grammatical and formatting changes made.

Discussion: Hubbell stated that he was concerned with the time and cost of doing a lot of reformatting of the protocols, particularly the references.

Decision: McVicar suggested a publishing meeting be planned to look at how best to manage the changes.

Cardiac Protocols:

- Bradycardia - Adult: Broke out “Symptomatic and Hemodynamically Unstable” from “Symptomatic, but Hemodynamically Stable”
- Bradycardia – Pediatric: added reasons for underlying causes.
- Tachycardia – Adult: Reordered PSVT, WPW and AF/Aflutter for better flowj and added diazepam 5 mg IV under sedation
- Tachycardia – Pediatric: Broke out “Symptomatic and Hemodynamically Unstable” and “Symptomatic, but Hemodynamically Stable” for continuity.
- ACS – Adult: Grammatical changes to the Fibrinolytic Questionnaire Box and Cath Lab Activation box. Changed morphine dose to be consistent with the rest of the document.
- Cardiac Arrest – Adult: Grammatical changes
- Cardiac Arrest – Pediatric: Grammatical changes. Updated the AED bullet to reflect recent approval of AED pads for newborns. Reordered VFib/Pulseless VT and Asystole to be consistent with the Adult protocol.

Discussion: D Martin asked why procainamide was in a range and not a single dose, and was explain because we were following AHA guidelines.

Blanchard asked the Board for a consensus on repeat morphine dosing. Did they want the repeat dose to be in 5 minutes or in 10 minutes?

Decision: The board agreed to a repeat dose of morphine every 10 minutes.

Additional Discussion: D'Aprix further asked, do we want a neonatal morphine dose for pain? Houston added that as the protocol is written now, we could give morphine to a neonate.

Decision: The board voted unanimously to change the pain protocol to reflect that morphine is not to be given to neonates.

Poisoning/Substance Abuse/Overdose

- Adult: Grammatical and formatting changes.
- Pediatric: Added a dystonic reaction bullet same as adult and same as pediatric nausea protocol.

Discussion: None

Eye & Dental and Drowning:

- No major changes.

Discussion: None

Burns

- Merged Adult and Pediatric. The only thing separating them before was the IV for Intermediates with Adult, but now that it was moved to Routine Patient Care the protocol was easily merged.

Discussion: None

Traumatic Brain Injury:

- Grammatical and formatting changes
- In addition see Item 2 above.

Discussion: There was not further discussion

Break

Item 4 TEMSIS Report:

TEMSIS report presented by Schnyder – see attached

Discussion: Albertson questions the validity of the time to complete a report. Schnyder stated that he cut out the real short ones and the real excessive to try for a realistic number. Blanchard stated in her experience, the numbers reflected a realistic number. Albertson stated, if that were so, were there ways to trim things out? Schnyder stated absolutely and they are currently working on it.

Pepin asked if the number of calls in the system represented an overlap of non-transporting units who passed patients off to transporting units. Schnyder stated he would have to look at it closer, but believed it probably did and he would adjust his report.

Decisions: None.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: There was no ACEP report, however Prentiss asked if anyone had seen the ACEP statement regarding physician signatures. D'Aprix stated he had not but would it to be an agenda item for the March meeting. McVicar noted.

Coordinating Board: Achilles inquired as to the status of Mastromarino. Mastromarino is the MCB representative to the Coordinating Board and he has recently been unable to attend meetings. Prentiss stated that she thought his was just very busy. McVicar stated he would give him a call.

There was a copy of the Coordinating Boards draft minutes within the packets received today by the MCB. Achilles further elaborated on the following topics.

What is a patient? After discussion with M. Modigliani we learned that the definition of what is a patient is very vague. Albertson stated that we should have some basic guidance. Achilles pointed out that the only place it really comes up in training is at the basic level, when you learn a person is a patient once you have 'consent'. Furthermore, Achilles asked if they should work together to better define. J Martin stated that yes, the MCB should be in on the decision.

Strategic Planning Retreat: There are plans for a pre-retreat meeting to become oriented to the subject matter like the National Scope of Practice or NHTSA's role in EMS before getting into the nuts and bolts of the strategic planning meeting. He will keep us posted.

Equipment List: The Coordinating Board will be reviewing the required equipment list for the ambulances.

Bureau and Division Update: See attached report.

Discussion: None.

Legislative Update: Prentiss reported that yesterday SB316, expanding the Line of Duty Death Benefit to certain EMS providers, was brought to committee by Senator Burling. The bill passed unanimously. Next it will go to the Finance Committee, to the full Senate and then – if we are successful – it will cross over to the House. Sponsors of the bill are Sen. Burling, Sen. D'Allesandro, and Rep. Welch.

HB1201 which has to do with conducting immunization drills was amended to add protection to the physicians who write the prescription for the drills, in addition because the language currently states "all levels of EMTs" can participate in the immunization drills and our protocols only reflect immunization at the paramedic level, an additional amendment was added reflecting the EMS providers would follow the protocols.

HB1136 is directed at public access defibrillators (PADs). Initially they were going to take out the language regarding training in order to protect the bystander, however it has been amended so that "anticipated responders" will still have training, but bystanders without training will still be allowed to defibrillate should they need to.

NH Trauma System: Sutton reported that the Trauma Medical Review Committee continues to work on a re-write of the NH Trauma Plan which will reflect the reality of New Hampshire. In addition as other states work on their trauma plans we are seeing a move toward a national trauma registry. There are some concerns and issues such as who will enter the data, what software will be used and how will the updates be handled. Sutton explained there is software development occurring which would enable current trauma registry to be uploaded into the National registry, and in fact Dartmouth-Hitchcock is doing so now.

Other Business:

Prentiss asked the board if they wanted to further discuss the issue of unlicensed medical personal, such as ski patrollers. Also is this something we should work on with the Coordinating Board. Hubbell stated yes, and he would love to see it as an agenda item for our next meeting. Achilles stated that the initial step might be to pull together representative from not only ski patrol but also the life guards and other such groups with the MCB and Coordinating Board, with the intent to not change legislation but create dialogue. It was agreed that Achilles, McVicar and Prentiss would look into this further.

V. ADJOURNMENT

Motion by Hubbell, seconded by Albertson to adjourn. Approved. Meeting adjourned at 12:15 PM

VI. NEXT MEETING

March 20, 2008 at the NH Fire Academy, Concord, NH.

Respectfully Submitted,

Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Vicki Blanchard, ALS Coordinator)