

NH EMS MEDICAL CONTROL BOARD

Fire Standards and Training and Emergency Medical Services
Concord, NH

MINUTES OF MEETING

May 15, 2008

- Members Present:** Tom D'Aprix, MD; Ned LeBlanc, MD; Jim Martin, MD; Douglas McVicar, MD; William Siegart, DO; John Sutton, MD; Norman Yanofsky, MD; Sue Prentiss, Bureau Chief
- Members Absent:** Donavon Albertson, MD; Chris Fore, MD; Frank Hubbell, DO; Patrick Lanzetta, MD; Joseph Mastromarino, MD
- Guests:** Steve Achilles, Chairman, NH EMS Coordinating Board, Jeanne Erickson, Steve Erickson, Michael Pepin, Jonathan Dubey, David Dubey, Chris Dubey, Janet Houston, Kevin Drew, Dave Tauber, Steve Achilles, Todd Robinson, Matthew Leavitt
- Bureau Staff:** Rick Mason, Director; Vicki Blanchard, ALS Coordinator; Kathy Doolan, Field Services Coordinator; Mike Schnyder, Research and Quality Management Coordinator; Clay Odell, Trauma Coordinator; Brad Weillbrenner, Research Program Specialist.

I. CALL TO ORDER

McVicar welcomed all to the meeting, and asked for all in the room to introduce themselves. Ned LeBlanc is sitting in for Jeff Johnson who could not attend.

EMS Community. Prentiss reported that last Saturday, May 10, 2008, the Fisher Cats Baseball Team held EMS Day and sold over 100 tickets to raise money for the David Dow Memorial Fund.

Brad Weillbrenner was introduced. Brad is a research program specialist, who will work with the day-to-day operations of TEMSIS.

Finally, Prentiss reported that the North Country EMS office had opened in Gorham.

Acceptance of Minutes. D'Aprix moved to accept the March 20, 2008 minutes, Martin 2nd.

Vote: Unanimously passed

II. DISCUSSION AND ACTION PROJECTS

Item 1. Medical Control Physicians:

Prentiss informed the board that there is Rural Health Grant funding available to create a training module for new or visiting emergency department physicians. At this time, not all physicians who work in emergency departments are emergency medicine board-certified. Even certified emergency physicians are often not knowledgeable about public safety radio procedures, EMS levels of licensure and corresponding scope of practice, or NH EMS Protocols.

Prentiss proposes to develop a guide which would include a CD or DVD and guidebook. This would be done through a consulting group with media specialization.

Discussion: Martin thought it was a good idea. McVicar inquired if there was any way we could be sure docs take the module. D'Aprix stated he did not see how we -- the MCB and the state -- could make them take it, but the hospitals could. Prentiss added that New York State has done something similar which has been successful and gives consistency throughout the state. Yanofsky asked about the timeframe for this project, and Prentiss said DVDs could be available as soon as fall or winter.

Decisions: No formal decision required. From the discussion it is apparent the board likes and supports the concept.

Item 2: Kentucky and Protocols

Prentiss informed the board that the Medical Director from Kentucky had contacted her to inquire about permission to adopt the NH Patient Care Protocols for use in Kentucky as their first statewide EMS Protocols. Kentucky EMS would to tweak it some, add their name to it and cite us. Prentiss noted that the content belonged to the Medical Control Board, and that the credit statement should reflect that.

Discussion: No discussion

Decision: McVicar inquired if there were any objections. There were no objections.

Item 3. Pandemic Planning

Prentiss reported that there were new Federal regulations regarding pandemic planning which all states are being asked to respond to. NH Fire Standards and Training and Emergency Medical Services (FSTEMS) has been involved in these efforts and is looking to work EMS providers into the document. Specifically, Prentiss would like the board to approve a treat and release protocol specific to pandemic instances. This would not be for routine use, but only in case of a legally declared state of emergency in New Hampshire (RSA 4). The plan would facilitate keeping people safely at home.

Discussion:

- McVicar pointed out that this is a huge change from what the public would normally do in a health emergency. All planning will have to take that problem into account.
- Yanofsky asked what is the authority for the specific criteria chosen. For example why 104°?
- McVicar stated that the proposed protocol is based on how we do things now, but that level of care may not be available. The plan needs to address the CDC Pandemic Severity Index, plus local information such as how many people are in the hospitals, call volume, and EMS and hospital staffing. McVicar stated he did not believe the Board could make all the necessary changes at this meeting. He said approval of the existing document on a temporary basis with the understanding that it will be rewritten could be considered as a timely solution for a deadline issue. Prentiss did not feel that would be advisable.

Decision: Prentiss will work with McVicar to re-configure the protocol

Item 4. Transfer Algorithm

Odell updated the board on the transfer algorithm project. Last meeting he came to the board asking for assistance in fine tuning an algorithmic tool for physicians to use when transferring patients. Specifically, matching EMS personnel and resources with patient needs, as physicians often ask for a paramedic or highest level of care, when the patient does not need it. Lanzetta, McVicar and Martin helped Odell fine tune the algorithm.

Odell walked the board through the algorithm. He explained that this would not be a mandated procedure, but a template that he would like to see endorsed by the Medical Control Board. If the board did endorse, he would ask that they write a letter to NH hospitals presenting the concept and explaining the need for it.

Discussion:

- Yanofsky inquired why pain management was not included, to which Odell replied that several had made that comment, and that he is planning to add an additional bullet for ongoing pain management under the paramedic level.
- D'Aprix stated that he liked the look and the color coding. He asked that they ensure that it aligns with the current NH Patient Care Protocol 7.0 Interfacility Transfers.
- Tauber pointed out that in NH there is no licensing level for critical care paramedics. Having a critical care level would expand the decision tree and help smaller hospitals make the most critical transfers more quickly.
- D'Aprix requested to add a bullet under the critical care team to address sedated patients.

Decision: Martin moved to approve and endorse the transfer algorithm with the following changes: add a bullet under the paramedic level for ongoing pain control and for an additional bullet to be added to under the critical care team to read, "unstable patient requiring sedation and or ongoing paralysis." Sutton 2nd.

Vote: Yes 6, No 1. Motion approved.

Item 5. Critical Care Paramedic

Odell explained to the board, that during the review of the Interfacility Transfer Protocol 7.0 it became complicated when we got to the unstable critical patient. Nationally, Critical Care EMS is evolving. We would like to take a closer look at this and would ask the board for support in establishing a Critical Care EMS subcommittee with board representation.

Discussion:

- McVicar stated that the Coordinating Board should be involved in this. And if rule changes were needed, only the Coordinating Board could do it.

Decision: Odell and Blanchard will establish a subcommittee with representation from the Medical Control Board, Coordinating Board, and other interested parties.

Item 6. Diltiazem: Blanchard presented the board with a recent issue regarding diltiazem. Our protocols and ACLS specify that diltiazem is to be administered by bolus over 2 minutes. In the fall of 2006, the manufacturers of diltiazem discontinued the use of "Lyo-ject" packaging, resulting in some EMS units now using the "ADD-Vantage" system, which requires mixing the powdered med in a small IV bag and then drawing the medication from the mixed bag. However, the "ADD-Vantage" vial of diltiazem states on its label, "not for bolus." Blanchard asked the board if they would make a statement permitting the off-label use of diltiazem by bolus even though packaged in the "ADD-Vantage" system.

Discussion:

- McVicar pointed out that the FDA packaging information for "ADD-Vantage" diltiazem, states that "The initial dose of Diltiazem Hydrochloride Injection should be 0.25 mg/kg actual body weight as a bolus administered over 2 minutes" and contradicts itself at the top of the page where it says in large type "Not For Bolus". We need to know which is correct. Although the drug diltiazem is obviously safe for bolus administration, there may be inactive ingredients such as preservatives, buffers, etc. in the "ADD-Vantage" material that may not be safe for bolus administration.

Decision: Blanchard to contact the manufacturer and find out if this particular packaging cannot be given by bolus, and if not, why not.

Item 5 Cyanide Poisoning Follow Up:

At the March MCB meeting the board requested a TEMSIS report on the use of cyanide kits in NH. Weillbrenner delivered the requested report. Data available through TEMSIS show 91 calls which were identified as "smoke inhalation." Of these 91, there was one possible candidate for the Cyanokit. There were no uses of the Lilly kit, nor the Cyanokit.

Discussion:

- McVicar asked are we going to keep the Lilly kits (cyanide kits) or not? Since this is a costly item, we should know who is stocking cyanide kits
- D'Aprix observed that from the TEMSIS data one could say that we do not need the Lilly kit, but advocates we keep it anyway. To which McVicar replied that he would like to eliminate the Lilly kit. He feels the Cyanokit is the better choice since we would like to encourage people to move toward earlier treatment, which has support in the literature, for example the Rhode Island studies. He feels the dangers and complexities inherent in the Lilly kit tend to raise barriers against its use, and particularly against presumptive, early use.
- D'Aprix inquired about the costs. The Cyanokit is around \$700 and the Lilly kit around \$300, with the Cyanokit having a longer shelf life.
- Tauber stated that OSHA requires industries with cyanide to have a cyanide kit. What we are likely to see is the industry having the kit, not the ambulance unit.
- D'Aprix suggested phasing out the Lilly kit slowly to allow for expiration of present units. This would mean leaving it for 2009 but eliminating it in the 2011 protocols. We should also send an advisory to EMS, hospitals, fire services and industry stating that when replacing an outdated cyanide kit the Medical Control Board endorses replacing it with a Cyanokit. The advisory should also state that after January 2011 EMS providers will not be permitted to use the Lilly kit.

Decision: Leave the protocol as is for 2009 and take action to request fire departments, the Fire Marshall's office, EMS Units, hospital EMS coordinators and cyanide-using industries to replace outdated Lilly kits with the Cyanokit, and to notify them that as of January 2011 the Lilly kit will be out of the protocols.

Item 6 Surgical Airways Follow Up:

Schnyder reported to the board that a literature search proved a number of references to prehospital cricothyrotomies including evidence of their low rate of performance and a 31% complication rate, as well as proposed standards. A TEMSIS search revealed two cricothyrotomies over the past years – both failed. One was with a dilatation system and the other surgical. It is Schnyder's recommendation that the board endorse commercially available devices over the "home grown" kits.

Prentiss reminded all that at the last meeting the new scope of practice was reviewed and it was found that surgical cricothyrotomy was not included. She spoke with Dan Manz who was Principal Investigator for the NHTSA National EMS Scope of Practice Model. Dan's response is summed up as follows: that cricothyrotomy was a high risk, low frequency skill; however, we could go above and beyond the national scope as long as we accept the responsibility of the training.

Discussion:

- Siegert thought eliminating "home grown" kits was a good idea, but there is also a lot of variation among the commercial kits.

- McVicar reminded the group that the original advice from the protocol subcommittee was to use commercially available kits over homemade kits.
- Prentiss stated that if the board requires a commercial kit, it will need to go to the Coordinating Board to adjust the equipment list.
- Sutton suggested omitting entirely, stating the literature outcomes are questionable, no matter what kit is used. Additionally, it is difficult to maintain the training.
- D'Aprix suggested removing the surgical crics since they are not included in the National Scope of Practice.
- McVicar asked that the board not endorse a particular commercial brand, but specify generically the type of procedure it approves.
- D'Aprix suggested specifying needle dilatation with examples of specific products.
- Leblanc inquired why would we take out jet insufflation, as it is especially good in pediatrics.
- Sutton stated that jet insufflation required pressures of 50 psi and Prentiss noted that most ambulance do not have that capability.
- D'Aprix noted that there were three items on the table. The board agreed to vote on each individually.

Decision:

- To eliminate surgical airways (defined as techniques requiring scalpel incision and dissection to gain access.)
Vote: Yes 6 – No 0: Surgical airway eliminated.
- Martin moved: Approval of cricothyrotomy limited to only age-appropriate commercial devices using technique of needle and guide-wire followed by dilatation. Siegart 2nd.
Vote: Unanimous vote to pass.
- Decision on jet insufflation for pediatrics deferred. Will be decided at July meeting after additional research by BEMS staff.
Vote: Unanimous vote to defer.

Item 7. Protocols

Blanchard and D'Aprix presented the Board with a power point of the protocols reviewed and revised as follows:

- Airborne/Bloodborne Pathogens: Complete re-write incorporating updated standards from the Center of Disease Control and OSHA.
- Abuse and Neglect: Reporting procedures section added. The reporting section strengthened by adding language from applicable NH RSA.
- Response to Domestic Violence: Rewritten to heighten awareness of the potential dangers associated with domestic violence calls, and provider safety considerations. Reference section added.
- DNR: Clarified the duties of the Durable Power of Attorney for Healthcare. Clarified revocation of a DNR. Procedures section made more descriptive.
- Pediatric Restraint: Updated with the latest recommendations from the Position Statement of Association of Air Medical Services, "Improved

Restraint Usage for Infant and Pediatric Patients in Ground Ambulances through Education and Policy Development, “ which included 5 point restraints and isolette recommendations.

- Interfacility Transfers: Grammar and clarification editing.
- Consent: Section added to Routine Patient Care.

Discussion: Blanchard presented the following questions to the board:

- Does the board want to approve the language now in the draft protocol – but not in the current 2007 Protocols – to allow rebofus of medications that were given in the hospital? This has been suggested, for example regarding propofol and paralytics during interfacility transfers
 - D’Aprix stated that we should not leave rebofusing in the protocol.
 - Tauber pointed out that in NH there is no licensing level for critical care paramedics and the current Interfacility Transfer protocol does not allow for rebofusing of medications or adjusting drip rate. He thinks this procedure is needed.
 - McVicar commented that the original intent from the Board of Pharmacy was that the transfer medications were not carried by EMS, and were not subject to routine readjustment while enroute.
 - J Erickson inquired if allowing particular medications to be adjusted under medical control would be an option.
 - McVicar feels that if EMS providers are going to be titrating a medication it should be on their approved medication list.
 - Tauber pointed out that to rebofus a sedated intubated patient is not the same as RSI, since the patient is already intubated. It is a much lower level of skill, just a matter of maintaining the sedated state, and probably safer than doing so in a patient whose airway is not controlled.
 - Yanofsky agreed that Tauber had a good point, but stated that to do the right thing is to put the medications in question on the approved list and provide appropriate training. Yanofsky does not feel we should attempt to avoid this responsibility by allowing “rebofus” as a blanket procedure.
 - Martin stated this is a patient care issue; we should not compromise care in the process of trying to solve hospital administrative problems. If the patient is on a paralytic they need to have an RN on board as well.
 - There was discussion regarding critical care paramedics and whether they might have the ability to rebofus such patients. Prentiss pointed out that the critical care medic level is not defined by either NHTSA or the National Registry. She also noted that at this time the critical care courses do not have validated testing. However she reminded the group that we just committed to looking further at a critical care level for NH.
 - D’Aprix suggested the board not approve any specific medication list at this time, but look into approval by classes of medications.

- Yanofsky added that most of the medications that are used in Interfacility transports do not need adjustments enroute. If investigation reveals that just a handful would be useful, maybe we should add them to the list.
- Broaden list of approved crystalloids for intermediates in interfacility transfer setting. All agreed.
- The protocol subcommittee would like to see continuous CO₂ monitoring as a required procedure for all intubated patients starting in 2011.
 - McVicar thought it was a realistic proposal. The MCB would have to notify the Coordinating Board which is currently revising the equipment list.
 - Achilles stated that while he agreed it was a good idea, he wondered if it was the standard of care within the hospital? If it is not, then it is going to be difficult to mandate it for the field. The MCB must be sure to have the validation.
 - Martin addressed this point, saying that the patient in the back of an ambulance moving down the road is much different than a patient in a stationary room in the hospital.
- The Coordinating Board's Equipment List Committee is looking at eliminating the drug reference guide from the required list of equipment. The Protocols Subcommittee disagree and would like the support of the Medical Control Board in keeping it
 - Achilles asked what was a reason behind the suggested removal. The reply was that it didn't fit in the drug box, often got lost, and that many medics carry their own anyway.
 - D'Aprix pointed out that ambulances are expected to use it for transfer as a guide.
 - The discussion by the MCB supported the usefulness of this reference. Every ED has one or more; doctors and nurses use them all the time. McVicar therefore asked the Coordinating Board representatives at the meeting to transmit the message that the MCB supports keeping the drug reference guide on the required equipment list.

Decisions:

Yanofsky moved to accept the protocol changes with the following exceptions:

- Rebolus of medications during interfacility transfers is not approved, and will be removed from the draft.
- Interfaculty Transfer Medication. If specific additions to the med list are requested for Interfacility transfer, we will look into adding them. We will consult the Board of Pharmacy to see if they have changed their opinion re approval of medication by class.
- Equipment Changes: Make announcements this fall that as of January 2011 we will require continuous CO₂ monitoring for all intubated patients, and will be eliminating the Lilly kit from the Cyanide protocol.

Sutton 2nd.
Vote: Unanimously approved.

III. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

Coordinating Board: Achilles reported that the Strategic Planning Retreat will be scheduled for August and will be held at the Fish and Game Building. Don Bliss will be the facilitator.

Equipment list: Achilles will bring forward the Board's request regarding the drug reference guide.

The board continues to work on ski patrol and, "What is a patient?"

Cyanide Kit: Achilles reported that one of his officers did research on cyanide poisoning. In Portsmouth they are going to be getting a cyanide gas detector and get the hospital to get the Cyanokits. They will be coming up with a guideline for the detector and will share it when it is done.

ACEP: No report.

Bureau and Division Update: See attached report.

Legislative Update: HB1136, the Death Benefit bill, is in study committee. Prentiss stated it is really important for the legislators on the study committee to hear from the 4000+ providers.

TEMSIS Report:

TEMSIS report presented by Schnyder – see attached

NH Trauma System: Sutton reported that the Trauma Medical Review Committee is nearing the completion of the Revision to the Trauma Plan and hope it will be completed in the next meeting or two. In the plan they are building in appropriate educational programs, which may test a hospital's commitment to participate. Another important source of changes in the update is the need to keep in line with the latest American College of Surgeons standards.

Plans for the annual trauma conference are underway.

The simulations project is going well with a couple of sessions already held at Memorial Hospital, and more sessions planned for Littleton and AVH this summer. Rural Health and Primary Care have funds for additional instructors. Recently FSTEMS acquired a second Sim Man with Homeland Security monies and will be setting him up in a Simlab at the Fire Academy.

Other Business:

Prentiss reported on north country obstetric initiatives. On June 5, 2008, a meeting will take place in Whitefield between the North Country hospitals and

area OBs to discuss the potential impact on EMS. They will try to define to determine ways to prepare for the situation.

IV. ADJOURNMENT

Motion by Yanofsky, seconded by Sutton to adjourn. Approved. Meeting adjourned at 12:10 PM

VI. NEXT MEETING

17 July 2008, Portsmouth Hospital, Portsmouth, NH

Respectfully Submitted,
Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Vicki Blanchard, ALS Coordinator)