

# NH EMS MEDICAL CONTROL BOARD

Conway Fire Department  
Conway, NH

## MINUTES OF MEETING

September 18, 2008

**Members Present:** Donavon Albertson, MD; Tom D'Aprix, MD; Frank Hubbell, DO; Mederic LeBlanc, MD (for Jeff Johnson); Patrick Lanzetta, MD; Jim Martin, MD; Douglas McVicar, MD; John Sutton, MD; Norman Yanofsky, MD; Sue Prentiss, Bureau Chief

**Members Absent:** Chris Fore, MD; Joseph Mastromarino, MD; William Siegart, DO;

**Guests:** Steve Achilles, Chairman, NH EMS Coordinating Board, Jeanne Erickson, Michael Pepin, Chief Dan Andrus; Matt Leavitt; Sean Ellbeg, Janet Houston, Jonathan Dubey, Chris Dubey, Kevin Drew, Dave Tauber, William Riley, Kelley Sweeney, Doug Martin.

**Bureau Staff:** Vicki Blanchard, ALS Coordinator; Mike Schnyder, Research and Quality Management Coordinator; Clay Odell, Trauma Coordinator; Eric Perry, Training Coordinator; Liza Burrill, Field Services Representative

### I. CALL TO ORDER

McVicar welcomed all to the meeting, and asked for all in the room to introduce themselves. McVicar then introduced David Tauber, member of the Conway Fire Department.

David Tauber welcomed all, he explained parking and restroom locations.

**EMS Community.** Prentiss sadly reported the untimely death of Allan Bryant. Bryant was the Director of Groveton EMS and a member of the Groveton Fire Department as well as a past student of Dave Tauber's. A moment of silence was observed.

**Acceptance of Minutes.** The July 17, 2008 minutes were approved with one change. Dr. Sutton was not in attendance. D'Aprix moved to accept with the change. Yanofsky 2<sup>nd</sup>.

Vote: Unanimously passed

## II. DISCUSSION AND ACTION PROJECTS

### Item 1. Intramuscular Fentanyl

At the July 17, 2008 meeting a vote to add intramuscular (IM) administration of fentanyl was tabled until S. Riley and Blanchard could find additional information of the pharmacokinetics regarding the dosage and absorption of IM fentanyl.

Discussion: McVicar reported that according to the “22<sup>nd</sup> Edition of the Nursing Drug Handbook”, that adult dose 50 -100 mcg IM with an onset of 7 – 15 minutes, and duration of 1 – 2 hours. According to Baxter Manufacturer: adult dose up to 150 mcg, with onset of action 7 – 8 minutes, and duration of 1 – 2 hours.

Decisions: Sutton moved to add IM administration of fentanyl, 50 mcg IM q10 min up to a total of 150 mcg. Martin 2<sup>nd</sup>.

Vote passed unanimously

### Item 2. Equipment Survey Results

In July Blanchard sent out an equipment survey. To date 91 EMS units have responded out of 299. Of the 91 units, 50 are ALS. Blanchard passed out a document showing the responses from the survey. Those numbers are below:

Device	Yes	No	Device	Yes	No
ED	74	17	AED	42	8
12 Lead	42	49	12 Lead	36	14
CPAP	57	34	CPAP	44	6
Contin			Contin		
CO2	39	52	CO2	31	19
Cyanide	0	91	Cyanide	0	50
Autopulse	3	88	Autopulse	3	47
Vent	9	82	Vent	7	43
Commer.			Commer.		
IO	43	48	IO	36	14
Pumps	38	53	Pumps	30	20
Commer			Commer		
Cric	43	48	Cric	41	9

For all units responding

For the 50 ALS units responding

Blanchard further explained that of the 50 responding ALS units to the Commercial IO question, 36 units have commercial IOs and of those 36 units, 30 of them are using the EZ-IO®. Additionally, Blanchard pointed out that of for the commercial cricothyrotomy kits, the most popular was the QuickTrach®.

Discussion: There was a brief discussion as to how the Bureau could get more units to respond to the survey. Yanofsky asked if it could be included in the ambulance inspection. Members were reminded that most of this equipment is not require and therefore would not be on the inspection list. J Dube expressed concern that the survey could be a first step towards additional mandated

equipment. McVicar noted that these fears could introduce a selection bias into the survey data. Prentiss stated establishing mandates was never the goal of the survey. The items of equipment included on the survey were items that were frequently discussed at MCB meetings, and in other EMS forums, so this information is of broad interest for many members of the EMS community.

Decision: Blanchard would check with Field Services on ideas to improve the survey response.

### **Item 3. RSI Audit**

Blanchard performed an RSI audit on the six EMS units who have met the prerequisites to perform RSI. Please see the summary document at the end of these minutes.

Discussion: None

Decision: None

### **Item 4. RSI Assistant and Malignant Hyperthermia Training Modules**

Blanchard explained that Concord and Derry Fire each just completed the RSI Assistant program. Through this training the RSI Assistant program was tested for the first time. It was found that the RSI Assistant and the Malignant Hyperthermia modules had more information than necessary. With the help of Dr. Fore, Kevin Drew, and Chuck Hemeon, the modules were updated to make them more concise and user friendly.

Blanchard passed out copies of the updated RSI Assistant and Malignant Hyperthermia training modules. She asked the MCB members to review the modules over the next two months and bring back comments or suggestions to the November meeting. At the November meeting the updated modules will be placed on the agenda for final approval.

Discussion: No discussion

Decision: No decisions necessary.

### **Item 5. 2009 Final Protocol Review**

The 2009 Patient Care Protocols were approved at the July meeting. Following their approval the protocols were sent out for review. The review consisted of sections given to each member of the MCB and the whole document went out for peer review. Following this review the following items were brought forward:

**Scope of Practice Name Change**

The National Scope of Practice has introduced new names for prehospital providers. They are as follows:

Current

First Responder  
Emergency Medical Technician (EMT) – Basic  
EMT – Intermediate  
EMT-Paramedic

New

Emergency Responder  
EMT  
Advanced EMT  
Paramedic

Blanchard asked the Board if this was the time to address the name changes for the protocol.

Discussion: Prentiss explained to the all present that the new names would not be ready to go for change until after the National Education Standards are finalized.

Perry stated that it could occur between the 2009 and 2011 protocols.

Decisions: The Preface of the protocols will contain a statement regarding the name changes; however the protocols will not reflect that change at this time.

**Standardizing of the Protocols:**

Blanchard introduced this chart illustrating changes made across the whole protocol document.

Inconsistencies	Change to
mL or ml	ml
SBP, systolic BP, BP	Systolic BP
10mg	10 mg
prn	as needed
mcg	micrograms
g, gm	grams
>	greater than
cc	ml
IVP, IV push, IV	IV

Discussion: Hubbell disagreed with some of the changes which seemed unnecessary in cases of widely known abbreviations. Further he questioned whether the work of making small changes was justified. D Martin pointed out that most of the changes were consistent with the Institute of Safe Medical

Practices (ISMP) recommendations. J Dube wondered if the dosing units could be printed in a serifed font for clarity.

The consensus from the board was to make the changes recommended by the protocol committee.

Other places in the protocol were updated to reduce redundancy, and to improve consistency and grammar.

Decision: Leave as is.

**Vagus Nerve Stimulator (VNS):**

The VNS bullets in the Seizure protocols were updated to reflect better direction when encountered when treating a seizing patient with a VNS.

Discussion: None

Decision: None

**Activated Charcoal:**

The bullet for activated charcoal for the poisoning protocols was changed from "Consider activated charcoal 25 – 50 gm PO" to: "Consider activated charcoal 25 – 50 grams PO if ordered by poison control or medical control."

This change was made after the American Academy of Clinical Toxicology presented a position statement on charcoal administration which in essence stated single-dose activated charcoal should not be administered routinely in the management of poisoned patients.

Discussion: None

Decision: Leave in new change.

**Epinephrine Infusions for Anaphylaxis:**

During the peer review we discovered that the adult protocol provided for an epinephrine infusion in refractory anaphylaxis. There is no corresponding pediatric protocol. The committee proposes that the Board add an epinephrine infusion to the pediatric anaphylaxis protocol.

Discussion: The question was raised whether we really even needed an epinephrine infusion for adult or pediatric. A poll of the Board revealed that only a couple of physician had ever done it for Anaphylaxis. Albertson pointed out that there were provisions to administer IV epinephrine 1:10,000 if patient was refractory to subcutaneous or intramuscular administration of epinephrine.

Decision: Albertson moved to removed epinephrine infusion from the adult anaphylaxis protocol and not add it to the pediatric. Yanofsky 2<sup>nd</sup>.

Vote: Unanimously yes. Motion passed.

**Interfacility Transfer Intermediate Crystalloids:**

In the interfacility transfer protocol under “Stable Patient with Low Risk of Deterioration” there was concern because Lactated Ringers, a potassium containing solution, is included. Yet EMT-Intermediates, who are approved to handle this class of transfers, do not administer IV potassium. Therefore a clarifying statement from the MCB is needed for this section of the protocol.

Discussion: The amount of potassium in Lactated Ringers is quite low. One suggestion was to reword the statement to permit: “Any crystalloid infusion not containing added potassium (i.e. 0.9% NaCl, 0.45% NaCl, D5W, Lactated Ringers).” However much more concentrated premixed potassium solutions are in use in some areas.

Decision: Sutton moved that the bullet be changed to “any crystalloid infusion containing less than 10 mEq/liter of potassium” . D’Aprix 2<sup>nd</sup>.

Vote: Unanimously passed.

**Scope of Practice Changes:**

Items on the scope of practice were updated to reflect the new protocols. While reviewing the protocols it was realized that under intubation there were procedures outlined for oral and nasal intubation but not digital so it was removed from the scope of practice. This brought forth a discussion pertaining to various intubation techniques.

Discussion: Tauber voiced concern for not being able to use digital intubation in some trauma calls. Other voiced pros and cons of nasal intubations.

Decision: Yanofsky moved that the Scope of Practice change from “nasal and oral endotracheal intubation” to “tracheal intubation”. Sutton 2<sup>nd</sup>.

Vote: Unanimously passed.

**Medication List:**

The 2009 Medication List was reviewed by the Board. Blanchard pointed out that thiamine and procainamide were removed from the list as they were no longer in protocol.

Discussion: It was asked if tetracaine could be added to the list. The manufacturer requires proparacaine to be refrigerated. McVicar pointed out that for practical purposes, that recommendation is often not followed. A problem squads are having is that not all hospitals have proparacaine in their formulary.

Decision: Martin moved to added tetracaine to the approved medication list and included in the eye protocol. D’Aprix 2<sup>nd</sup>.

Vote: Yes 8 , No 1. Motion passed.

**Interfacility Transfer Medications:**

D'Aprix suggested that propofol and paralytics be carved out of the transfer protocol to require additional personnel. He notes that they are high risk medications that often require adjustment of the rates for ongoing paralysis. Additionally, it was pointed out that we require our RSI paramedics to go through extensive training to administer paralytics, where as most of the paramedics doing transfer have not had the training necessary for these medications.

Discussion: Yanofsky asked where the Critical Care Paramedic Study Committee is at this time. Odell stated we are in the beginning stages and would not be ready for more than a year or two to bring forth specific recommendations.

The discussion continued to training and staffing needs during transfers, particularly the question of whether to send a nurse with these patients. It was apparent during the discussion that available and practical levels of staffing were very dependent on whether the transfer was coming from a rural or urban hospital. Compared to more northern and rural regions, southern areas and larger hospitals could more easily obtain a nurse with experience in paralytics or propofol.

Decision: Sutton moved, "that there be no exceptions to the transfer medication list, however there should be an introductory statement that contained education and knowledge of medications. If this education and knowledge has not been obtained then that paramedic is ineligible for the transfer". Albertson 2<sup>nd</sup>.

Vote: Yes 7, No 1, Abstained 1. Motion passed.

**Materials still outstanding:**

Lastly Blanchard pointed out that two protocols remain uncompleted: the Commercial Cricothyrotomy Protocol and JCAHO consistent language for minimal restraints. Blanchard would send out via email these sections when completed.

**Break**

At the return from break McVicar asked Pepin to introduce Dan Andrus, the new Fire Chief for Concord Fire Department. Andrus comes to Concord from Utah, and has special expertise and interest in EMS. All welcomed Chief Andrus

Conway Fire Chief, Steve Solomon, joined the meeting at this time and he was introduced. All thanked Chief Solomon for his hospitality in hosting our EMS Board Meetings.

### **Item 6. 2009 EMS Long Range Planning**

Achilles reported that the EMS Coordinating Board/MCB Planning Retreat was held on August 14, 2008. Bullets highlighting the meeting were available in everyone packets. Achilles did not want to go through each bullet but stated he had put together a subcommittee to work on goals and objectives. He will change his agenda to address these goals and objectives. Achilles also stated that he planned to push to implement as many of these as possible and not wait on them.

Discussion: None

Decisions: None

### **III. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS**

**ACEP:** No report.

**Bureau and Division Update:** See attached report.

**Coordinating Board:** D Martin stated that the Coordinating Board would be going over the equipment list today. He at this time wanted to solicit advice from the MCB on a short list of items.

Pediatric Traction Devices: Houston pointed out that on a national level it was considered to be required. Discussion revealed at this time it is not a required piece of equipment. It is fairly expensive and rarely would be used. Some felt an adult device could be readily manipulated to fit a child. Others stated they had used the pediatric version in the past.

Decision: Do not add to the required equipment list.

Activated Charcoal and Aspirin: At this time activated charcoal is a required medication for the ambulances. Protocols no longer include activated charcoal under standing order, instead they require orders from poison control or medical control to administer. The committee studying the equipment list would like to remove activated charcoal from the required list. Units would still have the option of keeping it on their trucks, it just would not be required. On the flip side, aspirin which is a standing order in protocol, is not required equipment. The committee would like to see aspirin be a required medication.

Decision: The MCB unanimously consented that aspirin should be a required medication. The MCB decision made earlier in the day already answers the question about activated charcoal.

NG Tubes: The committee wanted guidance with NG tube requirements. Currently there were many sizes required, some of which are very difficult to

obtain and very uncommonly used. One service noted it was required to carry more sizes of NG tubes than its Medical Resource Hospital has.

Decision: Consider reviewing the national standard and decreasing the number of sizes required.

**Critical Care Paramedic (CCP):** Odell reported that the CCP Study Committee had met twice since July. The committee comprises about 18 members with good representation of NH EMS. We are in need of some physicians. Some physicians have expressed interest and have just not been able to make the meetings. We will continue to keep them informed. Additionally, a Yahoo Group has been formed as an open communication forum for the committee.

As a first step the committee divided up the United States with each member taking 3 states. Each state was researched for CCP. It was found that the vast majority of them did not a level of CCP. There were however 4 states that had some promising programs. We put together a subcommittee to look more closely at these 4 states, and to study their programs and report back at our next meeting.

Early discussions with the group decided 2 levels of CCP seemed appropriate. The first level, a lower level, would include training a little higher than the current standard curriculum, and would be appropriate, for example, for the transport of most STEMI patients. The second level would be the true critical care paramedic. We will be looking at accreditation modules, education, renewal, competencies, and performance improvement. In addition, like the RSI Units, we will look for unit commitment with a CCP supervisor, and a medical director working directly with the unit. It may or may not necessarily be an emergency physician. Additionally we will be looking at a robust quality management component.

Our next meeting will be held on October 31, 2008, 10 AM, NH Fire and EMS Academy. McVicar asked members of the Board and others in the room who might be interested in getting involved to contact Odell.

Discussion: Sweeney wanted to know what would happen to those individuals who are now certified by the UMBC CCEMTP (University of Maryland, Baltimore County, Critical Care Emergency Medical Transport Program). Odell stated the committee would be looking at their curriculum and there would probably be some grandfathering. Albertson asked if the propofol and paralytic issues discussed earlier would be answered with the lower of the two contemplated CCP levels. Odell stated that he saw those procedures at the higher level.

**Legislative Update:** None

**TEMSIS Report:**

TEMSIS report presented by Schnyder – see attached.

**NH Trauma System:** Sutton reported that the 8<sup>th</sup> annual Trauma Conference was to be held on November 12<sup>th</sup> in Meredith. This year the conference will review the updated trauma plan and its effect. It will also cover the use of the National Trauma Database.

Sutton further reported that the Trauma Review Committee continued to work on the plan. He felt it was a more workable and friendly plan with improved standards that will help the State of New Hampshire.

Albertson asked if Dartmouth Hitchcock Medical Center was getting patients that should have been treated at the transferring facility? Sutton said that was very much the case, but that it seemed to be an unfortunate reality. However this issue is difficult to track accurately. For example it seems that some days certain facilities may have an appropriate specialist, some days they do not. Why not? Albertson stated that he could see the lack of surge capacity as being a big problem in the future. Sutton replied that they have been struggling for years to get people to submit data. There could now be an opportunity with the proposed data registry. Then we can get a state report and look into it deeper.

**Other Business:** None

#### **IV. ADJOURNMENT**

**Motion** by Sutton, seconded by Hubbell to adjourn. Approved. Meeting adjourned at 12:25 PM

#### **VI. NEXT MEETING**

20 November 2008, NH Fire and EMS Academy, Concord, NH

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

(Prepared by Vicki Blanchard, ALS Coordinator)

**RSI Audit Summary**  
Vicki Blanchard  
Advanced Life Support Coordinator

There are now 6 EMS Units in New Hampshire who have completed the prerequisites required to perform RSI:

Concord Fire Department  
Dartmouth Hitchcock Advanced Response Team (DHART)  
Derry Fire Department  
Frisbie Memorial Hospital EMS  
Littleton Regional Hospital  
Weeks Medical Center

The audit consisted of verifying various elements of the RSI prerequisite. The following areas were reviewed:

1. The Provider Experience Criteria:

- Provide written proof for each paramedic the following:
- ≥ 2 years as a paramedic
- ≥ 5 field tubes (not including performed while a student)

Field tube evidence was verified through PCR's and training records from operating room tubes. Years as a paramedic were verified through the NH Bureau of EMS licensing database.

2. Training Requirements:

- Provide proof of training through course completion roster signed by Medical Director

Evidence of the training was verified through rosters and statements from the medical directors.

3. Quality Management:

- A. How many patients, who need to be intubated, arrived at the hospital successfully intubated over the past 12 months (July 2007 – July 2008)?
  - 1. How many patients should have been intubated?
  - 2. How many received rescue airway devices?
  - 3. How many patients, who needed to be intubated, were:
    - a. In cardiac arrest?
    - b. Live patients?
    - c. Could have qualified for RSI?

Two units were asked to supply the quality management evidence. The EMS Coordinator/Director of each unit supplied a report of the above.

In summary: One unit had 61 patients intubated with 32 of those intubation being done by RSI. The second unit had 31 patients intubated with 9 being done by RSI. One unit identified one patient which "probably did not require RSI, but the patient was a known EMS provider and emotions were a factor". The other unit stated that there where no patients who may have benefited from RSI who did not receive it. There was one patient who required a rescue airway (combi-tube) which was placed successfully.

In conclusion, all EMS Units were very cooperative with the audit. Strengths were in training, weakness were found in documentation. Plans have been put forth to better utilize TEMSIS for improve documentation in the future.

# Research and Quality Management Section Report 9/10/2008

<b>Total Number of Reports:</b>	312,025	(From 1/05 through 9/10/08)
<b>2006</b>	100,738	
<b>2007</b>	112,483	(Increase of 12%)
<b>2008</b>	82,959	Through 9/10/08

<b>Average Time to Complete a Report</b>	
<b>2006</b>	<b>26.7 minutes</b>
<b>2007</b>	<b>25.9 minutes</b>
<b>2008</b>	<b>24.9 minutes</b>
<b>Since 6/11/08</b>	<b>24.6 minutes*</b>
*No statistical difference from rest of 2008	

### Overview of TEMSIS :

- The RQM Section is continue to work on getting non-TEMSIS agencies on-board. This has included a number of agencies in the Southwest portion of the State that are currently (or will be) using FireHouse for the data collection software.
- We are recollecting unused FieldBridge software licenses for redistribution to agencies that have made a commitment to TEMSIS. The purpose is to supplement agencies that may be on the verge of needing an extra unit because of call volume increases.
- We received word from the Highway Safety Agency that New Hampshire received the full \$500,000 award for the Federal 408 grant. If you remember, FSTEMS requested \$125,000 of that money for improvements to the TEMSIS system. We will be meeting with them to confirm the shared amount and deliverables for the project.
- ImageTrend continues to push forward with the next major software release. We have not received an official launch date, but it should be coming this year.
  - We have received word that this next version will include a revamp of the Report Writer portion of the system. As a result, we have put off work (possibly temporarily) on the TEMSIS to Excel program.
- Upcoming Research and Quality Management work:
  - Our focus will remain on how to improve the TEMSIS system.
  - We are progressing forward with the online distance learning product (NHOODLE) and will perform testing this Fall.
    - This will include some work on foundational quality management courses for all provider levels.