

NH EMS MEDICAL CONTROL BOARD

Conway Fire Department
Conway, NH

MINUTES OF MEETING

November 20, 2008

- Members Present:** Tom D'Aprix, MD; Chris Fore, 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; Joseph Mastromarino, MD; Jeff Johnson, MD; William Siegart, DO; John Sutton, MD;
- Guests:** Steve Achilles, Chairman, NH EMS Coordinating Board, Jeanne Erickson, Steve Erickson, Michael Pepin, Jonathan Dubey, Chris Dubey, Kevin Drew, Shawn Riley, Doug Martin, Mark Hastings.
- Bureau Staff:** Vicki Blanchard, ALS Coordinator; Mike Schnyder, Research and Quality Management Coordinator; Clay Odell, Trauma Coordinator

I. CALL TO ORDER

McVicar welcomed all to the meeting; introductions were made.

EMS Community. Prentiss asked for a moment of silence for the 15th anniversary of the loss of N911ME Airmed in the waters of Casco Bay which took the lives of Donald McIntyre, Paramedic/RN and Matthew Jeton, Paramedic.

Acceptance of Minutes. The September 18, 2008 minutes were distributed via email last week for review and approved today without changes.

II. DISCUSSION AND ACTION PROJECTS

Item 1. Medicated Assisted Intubation

In September 2006 the MCB voted to, "not change our protocols to include medicated assisted intubation (MAI) and to conclude it is not a prehospital option at this time." In 2007 we conducted an audit and found 4 cases of MAI. At that time we published an EMS bulletin reminding the EMS community that MAI was not allowed. Blanchard conducted another audit from January 1 – October 31, 2008 and found six more cases of MAI. She presented a summary of these findings today.

The findings were:

Six incidents with four Units involved. Two out of six incidents documented contact with medical control. Five out of six had successful intubation. Five incidents of midazolam use with dosage variations from 0.5 mg to 5 mg.

Discussion: McVicar stated that it was his belief that medical directors were not aware of the EMS bulletin.

To clarify the law, Prentiss read the statute as it applied to on-line medical control, "153-A:2 Definitions XV(b) On-line medical control which exists when pre-hospital providers communicate directly with a physician or the physician designee at a receiving or medical resource hospital. Such direction may be based on the personal preference of the specific on-line physician, but more ideally it is based on protocols for the management of specific problems. This physician assumes responsibility and gives orders for individual patient's care."

D'Aprix stated that our protocols outline the procedures the MCB has approved as the maximum. It is our understanding that the statute means medical control orders should be based on the protocols and not exceed them. Prentiss agreed, but stated that the statute leaves some "wiggle room". D'Aprix suggested tightening up the statute to lessen the wiggle room.

McVicar stated that it may be helpful to have on-line medical control as a cushion or buffer for very, very unusual cases. But he agrees that we need to have our providers to follow protocol. McVicar said there are important reasons to follow protocol. Some of these reasons are:

1. If an on-line medical control doctor orders something that is not protocol, there is no way to assure that the EMS provider has been trained to safely perform the out-of-protocol procedure.
2. We have literature to back up our protocols, and an active process of review and debate prior to approval. We do not know if a medical control order outside of protocol has supporting documentation/literature. Creating protocol on the spur of the moment is inherently dangerous. For example an on-line medical control doctor may not have thought through the differences between doing something in the ED and doing it in the field.
3. McVicar believes most medical control doctors and most paramedics are well-intentioned. But we need to be aware of the possibility of a *folie à deux*, where you have a cowboy medical director and a cowboy paramedic. There are no checks and balances. The protocols, if they are followed, give a substantial measure of protection to the public.
4. Protocols have a layer of quality management through TEMSIS that goes beyond studies in the literature that were done elsewhere. When an EMS provider does a procedure outside of protocol, the extra measure of quality that TEMSIS provides is lost.

Therefore, McVicar stated, It is important for the MCB and BEMS to steer providers towards following protocol as much as possible, and to educate the individual medical control physicians.

Prentiss: Agreed and reminded the board that at this time there was a project in the works to provide a medical director education module, which is specific to NH EMS.

Yanofsky: Pointed out to the board that MAI procedures are high risk for things to go wrong. If they do go wrong, there is a high risk the case would enter the legal system. The individual doctors and medics would then be at grave risk, because without protocol there is little to back them up. If we on the MCB do not enforce the protocols, or at least do what we can to educate our providers, then MCB could, to some extent, be at risk as well. Yanofsky felt the MCB has an obligation to send out this information and state the consequences.

Decisions: Hubbell moved “to have letters sent to all twenty-six hospitals reinforcing the MCB’s position on MAI; to have each MCB member speak with the medical directors of each unit for which a case was identified; and for the Bureau of EMS to contact each Unit involved and inform them of their violation. Additionally, in the future should a provider violate protocol for MAI they will go through an investigative process for protocol violation.” Yanofsky 2nd.

Vote: passed unanimously

Item 2. Rapid Sequence Intubation (RSI) Assistant and Malignant Hyperthermia Training Modules

At the September 2008 MCB meeting copies of updated training modules for the RSI Assistant and Malignant Hyperthermia were distributed to each MCB member to review for approval at the November 2008 meeting.

Discussion: Fore explained that he had taken the Malignant Hyperthermia module and pared it down from 100+ slides to approximately 10 need-to-know slides. Blanchard explained that the assistant’s module was also updated by removing material above and beyond the scope of the assistant.

Decision: Fore moved to approve the updated RSI Assistant and Malignant Hyperthermia training modules.” D’Aprix 2nd

Vote: passed unanimously.

Item 3.Narcotics

Fore explained to the board that a recent incident got him thinking about the controlled substance agreements (aka “narcotic agreements”) and the interactions that occur with their use. First there is an interaction between the pharmacy and the EMS Unit to obtain the narcotic kits, next when the kit is opened there is an interaction with the EMS provider and a patient, finally there is an interaction with the pharmacy to have the narcotics replaced. Fore asked if the group knew of their accountability systems and surmised that each hospital did things a little differently. He wondered if it would be better to attempt to standardize control procedures.

Discussion: The discussion revealed there were numerous ways that narcotics used by NH EMS units were secured, counted and controlled. McVicar noted that the NH Board of Pharmacy is interested in the same questions. He thought that when the Medical Control Board representatives go to their meeting with the Board of Pharmacy in order to ask for agreement on changes to the approved

medications list, we could also address the topic of narcotic security at that time.

Decision: McVicar and Blanchard will discuss controlled substance security procedures with the Board of Pharmacy when they meet, and will report back to the MCB at the January or March 2009 meeting.

Item 4. Pandemic Treat and Release Protocol Task Force

Prentiss explained that in May 2008 there was an attempt to pass a pandemic treat-and-release protocol which was not approved at that time. The idea is to have a protocol ready so that in case of pandemic, EMS personnel could enter homes or provide other treatment without transporting to a hospital. For example, in case of an influenza pandemic, many patients with flu-like symptoms might call EMS. The EMS personnel would enter the home, assess and provide treatment but not transport. This would be an attempt to contain the disease. Prentiss is working on this in conjunction with the NH DHHS. She would like to have representation from the both MCB and the Coordinating Board on a task force which would develop such pandemic protocols.

Discussion: There were questions on liability and how a pandemic is declared. Prentiss replied that the Commissioner of Health and Human Services has some authority to call high level emergencies which loosens up the law, and the Governor can declare a State of Emergency which changes the whole playing field.

McVicar: Stated that isolation is the only proven way to contain an epidemic/pandemic.

Decision: Hubbell, D'Aprix, McVicar, and Fore all expressed interest in the task force. Prentiss will follow up with these physicians.

Item 5. 2009 Protocol Finishing Touches

Digital and Nasotracheal Intubations

D'Aprix reminded the board that at our last meeting we discussed intubation methods and the National Scope of Practice. This prompted D'Aprix to perform several on-line literature searches regarding techniques of prehospital intubation. In general there were no studies or articles pertaining to prehospital digital intubation. Nasotracheal intubation studies were limited (Denver and Dover) and suggested success rate at or around 60%.

The National Scope of Practice includes oral and nasal tracheal intubation at the paramedic level, but not digital tracheal intubation.

Discussion: Blanchard stated that in her research on MAI she found approximately 12 cases of nasotracheal intubation with a 67% success rate. D'Aprix asked if that was acceptable.

McVicar asked the paramedics in the audience if they had any input. Pepin stated that with the advent of CPAP he had not used nasal intubation in a long

time and could foresee it being used even less as the Intermediates begin to use CPAP, and hopefully some day the Basics.

J. Martin stated that he could think of two areas where nasotracheal intubation could be a useful backup if all else failed. First, in trauma; and second, when trismus was involved and RSI was not available. He will vote to not remove nasotracheal intubation.

Yanofsky echoed Martin's remarks, and pointed out that only six services in NH have RSI, leaving the majority of the services without its advantage.

Decisions: Yanofsky moved to keep nasotracheal intubation as a back up. J. Martin 2nd

Vote: Passed unanimous.

D'Aprix moved to remove digital intubation from the paramedic skill set. Hubbell 2nd.

Vote: Yes 4, No 3, motion passed.

Prochlorperazine dosing:

McVicar stated that he had recently had a discussion with some paramedics who pointed out to him that the dose of prochlorperazine allowed in protocol was too low to be effective in many cases. Upon investigation, McVicar found that these paramedics may well be correct. Currently the protocols call for 2.5 mg IV, whereas the standard practice by most emergency medical physicians is 5 – 10 mg IV, which is consistent with the product labeling.

Discussion: No general discussion.

Decision: D'Aprix moved to change the dose of adult prochlorperazine from 2.5 mg to 5 mg – 10 mg. Lanzetta 2nd.

Vote: passed unanimous.

National Scope of Practice and National Education Standards:

Prentiss explained that the National Education Standards will address the educational needs of the National EMS Scope of Practice. Unfortunately, the release of those National EMS Education Standards is now significantly behind schedule. We now expect that they will be released in 2009 -- and then there will be additional waiting time before the publishers actually release textbooks and resources for implementing the education. (There is even more delay expected for any materials that may have cardiac aspects, because publishers will most likely not want to release those until they have seen the new AHA Guidelines, which are not due until 2010.) Prentiss told the board that because of this delay there are a few items in the 2009 protocols which the bureau would like to defer until the 2011 edition of the protocols. All these items are within the Intermediate protocols, and specifically they are nitroglycerin, glucagon, and nitrous oxide (Nitronox®). If the board insists on including these items in the 2009 protocols, the Bureau will have to independently create training modules,

since there will be no national materials for several years. In that case, when the national modules finally do become available, we will have to deal with differences and inconsistencies between the new national modules and the NH modules that we will have started teaching. So, Prentiss recommended deferring these three procedures until 2011 in order to allow for a less confusing and more streamlined move from our old curricula to the new. Prentiss reminded the MCB that nitroglycerin and glucagons are currently approved as medications that the provider can assist the patient in taking, if already prescribed. That would not change.

The Bureau is already committed to CPAP and Intraosseous (I/O) protocols for Intermediates in 2009. These are skills which the MCB has considered important enough to go above the National Scope of Practice Model, so no National Ed Standards will apply. The Bureau is already planning instructional modules for these skills.

Discussion: J Erickson thought that nitroglycerin and glucagon should be included. She feels the providers already have a good understanding of their use because they are assisting with those meds now. McVicar stated that he had heard the same argument coming to an opposite conclusion: Since intermediates are already able to assist with it, there is less rush for a protocol. Med assists to patients who already have a prescription for the medication are safer because the patient's doctor has determined that the medicine is appropriate for that patient, and likely to be needed.

J Dubey did not think we should put it off because of paperwork.

Prentiss and Blanchard emphasized that deferring the protocol items would help to keep the move from old to new education standards as simple as possible.

D Martin stated that they were going to be removing the Nitronox® from their units, as they have found with the addition of fentanyl, they are not using it anymore.

Decision: D'Aprix moved "to synchronize the NH Patient Care Protocols with the pending release of National Educational Standards by deferring Intermediate glucagon, nitroglycerin, and nitrous oxide (Nitronox®) until the 2011 protocols, and to allow CPAP, I/O, and DuoNeb to remain in the 2009 protocols as they are not part of the National Scope of Practice or National Education Standards at the Intermediate level. The CPAP, I/O, and DuoNeb will require transition courses." Lanzetta 2nd.

Vote: passed unanimous.

Interfacility Transfer Medications:

At the September MCB meeting the board voted, "...that 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". Odell presented the following:

NH Protocol enables paramedics to continue medications that are not within their routine scope of practice, during an interfacility transport, provided that the medication was ordered and initiated prior to transport. The paramedic must proactively obtain working knowledge and education of any such medication –through such means as medication manuals or software, discussion with sending clinicians, discussion with medical director, etc. – prior to transporting the patient. Those medications identified by the NH EMS Medical Control Board as posing an increased risk of untoward effects such as paralytics, some sedatives, and vasoactive medications will also require completion of a NHBEMS approved education program. Paramedics must refuse to transport patients that have a level of acuity and/or medication regimen that the paramedic is not comfortable with, and work with the sending facility to acquire optimal staffing (such as sending nursing staff).

Discussion: McVicar questioned if the training modules would be available before the protocol rollout? To which Odell replied that if the MCB would give him a list of the medications he would make sure the training was ready before the protocol rollout.

There was additional discussion regarding NHOODLE, and it was agreed that every effort would be made to have the training available on NHOODLE as soon as possible.

There was concern about getting information out to the hospitals, so the sending physicians were aware that this training would be required. J. Erickson pointed out that the EMS Hospital Coordinators were a very strong group, with a Yahoo Group which allowed information to flow quickly. Blanchard and Odell will make sure the group has the training information available. The protocol rollout will address the training as well.

Odell reminded the board that the Critical Care Transfer Study Committee is working on all of these issues, so that what we are considering now would be a stop gap effort at this time to address these high risk medications until Critical Care Paramedics are available.

Decision: Hubbell moved to approved the above quoted addition to the Interfacility Transfer Protocol. Fore 2nd.

Vote: Yes 6, No 1, motion passes.

2009 Protocol Final Touches:

D'Aprix asked that before the protocols go to the publisher that a couple more items be discussed.

1. Acute Coronary Syndrome protocol 3.2

D'Aprix suggested adding the following statement to the ACS protocol, "Providers should be aware that not all chest pain is cardiac-related. Patient age, history of the present illness and past medical history need to also be considered when assessing a patient complaining of chest pain."

Discussion: D'Aprix explained that some paramedics were giving nitroglycerin and aspirin to any and all patients having chest pain, whether it was cardiac or non-cardiac chest pain. He thought paramedic may be afraid of punitive action if they did not follow the protocol as it was written.

Decision: Fore move to add the above statement to the ACS protocol. Hubbell 2nd.

Vote: Unanimously yes. Motion passed.

2. Special Resuscitation Situations and Exceptions 6.5

D'Aprix questioned if the AHA statement added to the protocol regarding when to stop CPR would create difficult situations pertaining to the custody of the deceased until the deputy medical examiner arrived.

The statement in question is, "EMS are not required to transport every victim of cardiac arrest to a hospital. Unless special circumstances are present, it is expected that most resuscitations will be performed on-scene until return of spontaneous circulation or a decision to cease resuscitation efforts is made based on the criteria listed under "When to Stop". Transportation with continuing CPR is justified if hypothermia is present or suspected. Current AHA guidelines state: "cessation of efforts in the out-of-hospital setting...should be standard practice."

Discussion: McVicar did not think there would be any increased problems with the protocol change. Fore added that most EMS providers still work their arrests and bring them to the hospital. J Martin added that the statement was the first step in getting providers to work the arrests in the field; it was changing philosophy. There was a question as to BLS crews stopping CPR. Blanchard pointed out that under the When to Stop options was: "No return of spontaneous circulation after 15 minutes of either BLS alone or combined BLS and ALS in the absence of hypothermia."

Decision: Do not change.

Intraosseous Lidocaine:

Odell ask the board to reconsider the lidocaine concentration for intraosseous use. The current protocol requires 1%, which was decided based on the articles from "The Journal of Trauma Injury, Infection and Critical Care" and "Prehospital Emergency Care". Odell showed the board where the packet insert for the EZ-IO suggested the use of 2% lidocaine. Odell further explained that paramedics already carry the 2% lidocaine for the cardiac protocols.

Discussion: There was a question as to the volume of 2% versus 1%. It was discovered that both doses were within 1 ml.

Decision: D'Aprix moved to change the wording of the Intraosseous protocol by adding "or 2%" in regards to the lidocaine. Yanofsky 2nd.

Vote: Unanimously passed.

2009 Protocol Approval:

Blanchard asked that the board make a final vote to approve the changes made today to the protocols so that they may be forwarded to TMC Books for formatting.

Discussion: None

Decision: Hubbell moved , "to finalize the 2009 protocols". Fore 2nd.

Vote passed unanimously.

Protocol Rollout Timetable:

Blanchard stated that she anticipated a March 2009 rollout of the protocols.

Discussion: D'Aprix stated he would like to see NHOODLE fully utilized in rolling out the new protocols. D'Aprix said he envisions this as a supplement to, rather than a replacement for face-to-face in-person rollouts. Schnyder stated that NHOODLE would be available for this purpose. However, we will need to decide on a format for delivery -- whether video, PowerPoint with audio, etc. We could also set up a message board for frequently asked questions. Prentiss stated we would also put a tentative release date on our website.

McVicar asked what the procedure would be if we found an error with the formatted document. Hubbell stated he will put the final draft up on a website for a period for people to look at and comment on.

Decision: None needed.

BREAK

III. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Bureau and Division Update: See attached report.

Coordinating Board: Achilles pointed out that draft minutes were in everyone's packet for review. He added that the strategic planning group has been met with Prentiss serving as the facilitator. The group will continue to meet every other month to work on goals and objectives. They expect a final product in one year or less. Additionally, Achilles reported that big items from last meeting included an updated equipment list and the approval of the National Registry in lieu exam.

Finally Achilles reported that the Portsmouth Fire Department was working on an internal Cyanokit procedure. They will share the procedure with the 2011 protocol subcommittee.

Critical Care Paramedic (CCP): Odell reported that the study committee continues to meet and is making progress. No new items to report.

Legislative Update: None

TEMSIS Report:

TEMSIS report presented by Schnyder – see attached.

D Martin inquired if improvements were for hardware or software. Schnyder replied that most of the improvement would be with software. The number one complaint with EMS providers is the time it takes to complete a PCR. His goal is to work on that. Secondly, he will look into replacing the PCs at the hospitals.

J Dubey asked if we could find another provider besides Image Trend. Schnyder replied it would cost hundreds of thousands of dollars to change.

NH Trauma System: Odell reported that the hospital standards have been completed and the new trauma plan should be completed at the February 2009 meeting. They are finishing up verbiage and explanations. He added that they rolled the changes out at the Trauma Conference held two weeks ago where they had great discussion and feedback. After the plan is finalized it will go to the Coordinating Board for final approval.

Other Business: None

IV. ADJOURNMENT

Motion by D'Aprix to adjourn, Yanofsky 2nd. Approved. Meeting adjourned at 11:58 AM

VI. NEXT MEETING

15 January, 2009, NH Fire and EMS Academy, Concord, NH

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

(Prepared by Vicki Blanchard, ALS Coordinator)