

NH EMS MEDICAL CONTROL BOARD

NH Fire and EMS Academy
Concord, NH

MINUTES OF MEETING

January 15, 2009

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

Members Absent: Donavon Albertson, MD; Joseph Mastromarino, MD; Jeff Johnson; William Siegart, DO;

Guests: Doug Martin, Vice-Chairman, NH EMS Coordinating Board, Steve and Jeanne Erickson, Michael Pepin, Sean Ellbeg, Janet Houston, Jonathan Dubey, Janet Williamson; Gary Zirpolo; Denise Normandin; Nancy Pederzini; Fred Heinrich

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

I. CALL TO ORDER

McVicar welcomed all to the meeting. Introduction were made; members and guests also reported early morning temperatures. (The lowest temperature reported was -25 at Berlin.)

EMS Community. Prentiss sadly reported the recent deaths of John DeWever of Rumney EMS and Bette Stevens of Wilton-Temple-Lyndeborough EMS. Additionally, Prentiss reported that yesterday Micheal Schnyder's father died unexpectedly.

Happier news reports: Michelle and Jeffrey Phillips welcomed their new baby girl, Anne Helen, into this world early this morning. Mom and baby are doing well.

Acceptance of Minutes. Hubbell moved to accept the November 20, 2008 minutes, Yanofsky 2nd.

Vote: Unanimously passed

II. DISCUSSION AND ACTION PROJECTS

Item 1. Communication on Medication Assisted Intubation – follow up

At the November 20, 2008 meeting it was decided to have letters written and sent to the 26 NH hospitals outlining the Medical Control Board's decision against Medication Assisted Intubation.

Discussion: McVicar reported that a draft letter is currently being revised, however it was a little more complicated than we first thought. McVicar listed ideas from the group that he felt should be included. For example at the November meeting Yanofsky stated that the letter should indicate that there could be consequences – both legal and administrative, for both the provider and medical oversight – if a provider were to violate protocol.

Decisions: None.

Item 2. Interfacility Transfer Med training Modules

The 2009 Protocols will require paramedics engaged in interfacility transfers of patients on medications identified by the NH EMS Medical Control Board as posing an increased risk of untoward effects (such as paralytics, some sedatives, and vasoactive agents) to complete a NHBEMS approved education program.

Clay Odell has prepared draft modules for the MCB to approve. These drafts were sent via email to the members for preview. During this meeting the board reviewed the modules as follows:

Discussion: Yanofsky asked if the modules were delivered through NHOODLE, what is the Medical Director's role? Odell explain that the best approach is to have the medical director involved. How the medical director wants to do that is up to each medical director. We will provide the basic material that needs to be covered. The medical director can choose to deliver the material as the instructor, or to delegate the teaching, or to use NHOODLE. That would be up to the each medical director.

Discussion of the purpose of the program was to inform the paramedic of the medications, their indications, contraindications, effects, side-effects, suggested dosing, et cetera. But this is a teaching module and is not intended as any kind of a standing order or protocol. The dosing decision is always made by the transferring physician and the training needs to state this clearly. Training also needs to emphasize discussion with the sending physician on the indications and medications. Additionally, paramedics need to know that some medications are routine dosed off-label, and when the sending physician does so this also needs to be discussed.

This brought up the topic of rebolusing or titrating an existing medication. At the May 2008 meeting the topic of rebolusing was discussed and it was decided that rebolusing would not be allowed, however, since that meeting the protocols have been change to reflect this additional training. Does the board want to reconsider?

Sutton felt that titration and rebolusing had to be allowed, Fore agreed. J Dubey stated that his experience with transferring patients on propofol was that titration was always needed.

Decision on titration and rebolusing: Fore moved to “allow rebolusing and titration of those interfacility medications covered in the MCB approved education modules.” Sutton 2nd.

Vote: Yes 7, No 0, Obtains 1 – motion passed.

Should these training modules apply to pediatric patients?

Sutton stated it should come down to the same as with adults, is the paramedic comfortable with the patient/situation and are they capable of re-establishing an airway. The essence of the discussion was there should be no carveout for pediatric patients.

The board went through the Vasopressin, Propofol and Paralytic Modules. The following changes were to be made:

- Change “observe” to monitor
- More information on the patients you are likely to see on the these medications.
- Remove the malignant hyperthermia bullet on paralytics as the condition is extremely rare and may not exist at all under these conditions. Diverting may not always be the best solution. Instead call medical control.
- Change “agitation” and violent” to use forms of the more standard word “combative”.
- Under paralytics there should be additional indications that the patient is not adequately sedated – such as tearing, tachycardia, or agitation.
- Under propofol remove the side effect bullets “pain at injection site” and “hiccups”.
- D’Aprix reported that he recently read that a new formulation of propofol is not white. It is not yet available, however, in the future we may expect to see it.
- For end-tidal CO2 monitoring, change from suggested to required.

Finally, the board discussed under what orders should the paramedic be working; standing orders; written orders; on-line orders? It was decided that an “order sheet” should be developed for the sending physician.

Decision: The decision to have training modules had already been voted on in November, so no other votes are necessary. The board is to review the remaining modules and send comments to Odell. Final approval in March.

Item 3. CPAP protocol input from Respiratory Therapy Board and TEMSIS study

Prentiss explained that the Board of Respiratory Therapy came to the Bureau of EMS with concerns stemming from an incident involving CPAP use with an obtunded patient. This prompted a look into CPAP use. Jackson presented the board with the finding of a recent study conducted.

TEMSIS Data from January 2008 to June 2008 found 179 reports (PCRs)

- Each report was reviewed, used the writer’s words to determine:
- Was the patient exhausted?
- Did the patient go into cardiac arrest?

- Were there other flags?

Out of the 179 reports 44 were flagged as being possible inappropriate use of CPAP. Of the 44, ~ 8 cases were deemed possibly appropriate but flagging was warranted because the providers gave such poor documentation.

What is being done to correct this? The training module has been updated with emphasis on properly assessing to identify the exhausted patient who should be ventilated via a BVM and not placed on CPAP. Additionally, remedial training has been prepared to be delivered to all NH Paramedics again emphasizing proper patient selection, and that CPAP is not a substitute for BVM.

Discussion: Fore stated that he looked in the Airway Management protocol and under CPAP it has respiratory failure as an indication. It was determined that "failure" should be changed to "distress."

Yanofsky asked as a medical director who does chart review, how he can get a list of who uses CPAP in his area? He was told he could generate a report from Report Writer in TEMSIS. McVicar stated that in general the medical directors are not familiar with Report Writer. It was suggested that Schnyder or Weilbrenner create a report that would allow the medical directors to go in on a regular scheduled basis and monitor CPAP.

There were some questions as to how we were going to monitor for improvement. Prentiss stated that the remedial training would be rolled out within the next few weeks and Intermediates would be rolled out in April 2009 and then we can begin to audit after that. Medical directors may elect to monitor monthly, however, the Bureau of EMS will do quarterly audits.

D Martin wanted the board to come to a consensus to the word, "obtunded". It was decided there would be a side discussion during the break and a definition can be given to Blanchard.

Decision: None.

Break

Item 4. Termination of Resuscitation – NH Standard vs. American Heart Association (AHA) Standard

McVicar acknowledged Normandin and Pederzini, visiting representatives from the American Heart Association.

McVicar explained that the NH protocol on termination of resuscitation does not necessarily reflect the AHA standard on termination of resuscitation. It seems that we are more pro termination of resuscitation than AHA. McVicar explained that while NH does try to follow national standards, there are times when our protocols are crafted to be more specific for NH. McVicar then read text of the specific differences between the AHA standards and the NH protocol.

They were:

- 1.) The AHA recommendations state that the decision to stop efforts "can never be as simple as an isolated time interval". We DO use "a simple isolated time interval": e.g., "No return of spontaneous circulation after 15 minutes of either BLS alone or combined BLS and ALS in the absence of, hypothermia."
- 2.) Our use of the term "BLS alone" would seem to allow CPR without attachment of a defibrillator, even if the rescuer is not exhausted, in a dangerous environment etc.
- 3.) Death can be pronounced in the field in NH without consulting medical control. AHA guidelines explicitly require medical control: "Cessation of efforts in the out-of-hospital setting, following system-specific criteria and under direct medical control, should be standard practice in all EMS systems. (Part 7.2: Management of Cardiac Arrest, IV-62)

Discussion: D'Aprix explained that in 2005 more guidance was given to the providers on when to terminate. The 2009 protocols were further revised to give even more guidance especially on what criteria are practically equivalent to death.

The statement that "BLS alone" could be construed as allowing cessation without attachment of an available defibrillator is not correct since there is BLS CPR training requirement in use of AEDs, and the fact that AEDs are required on all ambulances in NH.

Blanchard stated that in rural areas response times are going to be in excess of 10 or 15 minutes in some cases, which pushes the time of the event, response times, and resuscitation time out to more than 30 minutes.

Fore reminded all that not everywhere in NH is ALS available, and if you are 45 minutes from the hospital, do you want your providers doing CPR all that way?

Prentiss thought we should consider changing the title "When to Stop" to "When-to-Stop Considerations".

J Martin stated that because the protocols have already gone to the publisher, we should leave the protocol as is and revisit for 2011.

Zirpola questioned who was responsible for the body after resuscitation efforts had been terminated? McVicar stated that it was then a police matter and is not part of this issue. Pepin stated that it should be treated the same as an untimely death. McVicar stated they had discussed this in past, it was a police matter not EMS, we do not make police protocols.

Decision: None, will revisit with 2011 protocols.

Item 5: 2009 Protocol Rollout Timetable:

Prentiss reported that a notice was sent to all EMS Unit Leaders advising that the 2009 Protocols would be rolled out in March 2009, and the Intermediate Transitions would be rolled out to the Instructor Coordinators in April 2009.

Hubbell stated that the formatting as been a long process but the protocols will be done by March 1, 2009.

Discussion: Janet Williamson inquired if TMC Books would be producing a pocket size book. Hubbell replied that they would not be shrinking the pages down to a quarter size, as it was too difficult to read. Instead the pages will be divided in half and the full display will take up two facing booklet pages.

McVicar inquired if the IFT programs would be ready by the time the protocols are rolled out; to which Odell stated they would be.

Decision: None

III. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Bureau and Division Update: See attached report.

Prentiss wanted to highlight that during the December ice storm EMS occupied the EOC 12 – 24 per day. They were able to assist EMS agencies throughout the emergency, specifically in obtaining needed equipment. Additionally, through TEMSIS the Fire Marshall's office was able to link CO incidences with E911, the Fire Marshall's reports, TEMSIS and ???.

Finally, Prentiss reminded all that on January 28, 2009 the NH EMT Association, Boundtree, and the Office of Rural Health and Primary Care will be presenting a program on the CPAP Mini-Grants. The program will be held at Police Standards and Training and will be telecast to Whitefield for folks in the North Country.

Critical Care Paramedic: Odell reported that the committee continues to look at two levels of critical care paramedics. The committee will be meeting with Jay Bradshaw, Director of Maine EMS to look at their paramedic interfacility transfer (PIFT) program on January 29th.

McVicar inquired if there was representation from the MCB on the committee. Blanchard stated that D'Aprix, Martin, and Siegart had expressed interest but had not been able to make the meetings. She continues to send them information and stated she would add all the MCB emails to the group to keep them informed.

Martin stated he is planning on attending the next meeting.

Coordinating Board:

D Martin reported that the Coordinating Board is currently working with Prentiss on the Strategic Plan and looking at the Critical Care Paramedic group.

Legislative Update:

Director Mason reported that HB 30 intends to hit each of the dedicated funds in police, fire and EMS for 2 million dollars each. This Mason states, is a significant amount. At a hearing earlier this week, Assistant Commissioner Sweeney, Dr. McVicar and Shawn Murray spoke on behalf of the Department of Safety, Fire and EMS.

The director continued, commenting that currently the fund is maintained from motor vehicle checks at \$8.00 each, whereas the insurance industry will support an increase of \$4.00, or a 50% increase. A bill to increase the fees has not been written as of yet. If the 2 million dollars is cut and the \$4.00 fee increase is made the director does not know at this time just exactly what the impact would be.

Discussion: Yanofsky asked what percentage of our total budget is the 2 million. Mason answered approximately one third. He explained that we are at about 5.4 million and work on "anticipated" revenue.

McVicar asked if there was any usefulness if the MCB sent a letter? Mason replied that the Fire Standard and Training Commission did vote last week to send a letter. Mason thought a letter from all three boards (MCB, Fire Commission, and Coordinating Board) could be useful to the legislators on the committee.

Decision: Yanofsky moved to send a letter expressing concerns with HB30. Fore 2nds. Vote: Passed unanimously.

Prentiss reported on HB 249, which would amend NH hospital law as follows: "Treatment by Emergency Medical Personnel. Hospitals shall not establish their own rules which influence general or specific protocols for paramedics and other emergency personnel when such persons are determining the best course of treatment for a patient, including whether to airlift the patient."

Prentiss encouraged the MCB to oppose HB 249. The current EMS Statute, specifically, RSA 153-A:1 "Declaration Policy and Purpose" addresses the best course of treatment(s) including patient destination, patient care protocols and the collaboration between EMS and Hospitals which would make into law.

Heinrich, Londonderry Fire's EMS director, stated that many believe this bill was brought forth due to an incident between Londonderry Fire and Parkland Hospital. Heinrich wanted the record to show that his research has not been able to find any incidence where Parkland Hospital would not allow one of their patient's to be air lifted. He stated that in fact the opposite is true, Parkland is very supportive of the helicopter and encourages its use. Heinrich ended by saying that the incident in question did not happen as it has been portrayed.

McVicar asked if the Board should send a representative to the hearing? Prentiss stated the MCB, EMT Association, Coordinating Board, Hospital Association should all come forth and speak against the bill. Additionally, Prentiss stated that all should write their representatives.

Decision: None

TEMSIS Report: Can be found within Prentiss's Bureau Report

NH Trauma System: Sutton reported that the Trauma Plan is near completion, needing only a few more components. Additionally, the committee has been approached by the Foundation for Healthy Communities to assist with formulating a statement regarding the

proper imaging requirements for x-rays, CTs, etc. as there are concerns with a lack of exposure limits.

Other Business:

Mason was happy to report that nationally EMS was receiving recognition within the USFA/NFA missions. He read an excerpt from a recent email sent to him from the US Fire Administration. It read, "The United States Fire Administration re-authorization language adds EMS to the USFA/NFA missions. *When and where appropriate*, we will be including EMS in NFA course titles and curriculum exercises and examples in future course developments and revisions. As an example, a management course may be titled, "Management for Fire *and EMS*" and some exercises in the course may be EMS management issues. Just as we don't do "hose and ladders" at the NFA, neither will we be doing hands-on EMS courses because of the differences in EMS protocols in each State / municipality."

Prentiss informed the board that she has been appointed by the National Association of State Directors to the National Registry of EMTs certification review committee.

IV. ADJOURNMENT

Motion by Sutton, seconded by Hubbell to adjourn. Approved. Meeting adjourned at 12:00 PM

VI. NEXT MEETING: March 19, 2009

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

(Prepared by Vicki Blanchard, ALS Coordinator)