

# NH EMS MEDICAL CONTROL BOARD

NH Fire and EMS Academy  
Concord, NH

## MINUTES OF MEETING

March 19, 2009

**Members Present:** Chris Fore, MD; Joseph Mastromarino, MD; Douglas McVicar, MD; William Siegart, DO; John Sutton, MD; Norman Yanofsky, MD; Sue Prentiss, Bureau Chief

**Members Absent:** Donavon Albertson, MD; Tom D'Aprix, MD; Frank Hubbell, DO; Patrick Lanzetta, MD; Jim Martin, MD; Jeff Johnson;

**Guests:** Doug Martin, Vice-Chairman, NH EMS Coordinating Board, Steve and Jeanne Erickson, Maia Rutman, MD; Mathurin Malby, MD; Shawn Riley; Mark Hastings; Janet Williamson; Kevin Drew; Michael Pepin, Sean Ellbeg, Janet Houston, Jonathan Dubey, Janet Williamson; Denise Normandin; Steve L'Heureux, NH BEC, Bruce Cheney, Director, NH BEC

**Bureau Staff:** Rick Mason, Director; Vicki Blanchard, ALS Coordinator; Clay Odell, Trauma Coordinator; Shawn Jackson, Field Services

### I. CALL TO ORDER

McVicar welcomed all to the meeting. Introductions were made.

**EMS Community.** McVicar congratulated Prentiss on her recent election to the Lebanon City Council.

**Acceptance of Minutes.** Sutton moved to accept the January 15, 2008 minutes, Fore 2<sup>nd</sup>.  
Vote: Unanimously approved

### II. DISCUSSION AND ACTION PROJECTS

#### **Item 1. E911 Update**

Steve L'Heureux and Director Cheney from E911 were introduced. L'Heureux began by thanking the Medical Control Board (MCB) for all their support. He reviewed some history between the Bureau of Emergency Communication (NHBECE) and the Bureau of EMS (BEMS). Specifically he pointed out that in 1997 the NHBECE received strong endorsement from the MCB for the Emergency Medical Dispatch system. It is with this

support, medical oversight, and leadership from the MCB that thousands of lives have been impacted.

L'Heureux stated that NHBEC people have expanded their outreach programs and are out every week doing continuing education with EMS, Fire, and Police agencies. He informed the Board that recently they worked with the City of Derry to implement the use of call determinants. Through research of the city's geography, demographics, and call volumes they were able to change how EMS was dispatched. Derry Fire will now run the ambulance and fire apparatus cold on some of the calls, improving safety for the citizens of Derry. In addition L'Heureux stated that he cannot praise Dr. D'Aprix enough for his help with the Manchester Fire Department. L'Heureux, D'Aprix, and the Fire Chief sat down and went through all 311 EMS response subdeterminants and how each should be dispatched and the appropriate response for each. Beginning in April 2009, Rockingham Ambulance, which is contracted to do EMS for the City of Manchester, will also be dispatched to run cold on all Alpha and Beta calls.

L'Heureux continued his update with the news that NHBEC has also been working with the American Heart Association in development of STEMI responses.

L'Heureux stated that working with Dr. D'Aprix proved to be very beneficial in that working with the whole Board could get cumbersome at times, where as having a "go to" representative would be more productive. He would love to see Dr. D'Aprix and/or Dr. Martin as that representative of the MCB, since have both have showed interest in the Emergency Communication center in the past.

L'Heureux also wished to inform the Board that NHBEC would soon be rolling out Version 12.0 of the Medical Priority Dispatch System®. And lastly he would like to ask the MCB for a vote expressing their continued support of E911.

Discussion: Prentiss asked L'Heureux if there were any changes in Version 12.0 that the Board or the Bureau of EMS needed to let the EMS Community know about. L'Heureux stated they are preparing a two page letter explaining the changes, but basically it involves refinement with changes in formatting, colors, and additional data fields. We will be receiving this letter.

McVicar said the Board is certainly very appreciative of all the excellent work E-911 does. He asked what type of a statement NH BEC was looking for from the MCB. L'Heureux recognized that formal "approval" of the EMD protocols was problematic since the MCB has no legal authority under NH law to issue EMD protocols, and is not permitted to revise the protocols that are received from the national organization in Utah. He is thinking of something like the 1997 letter endorsing the EMD work of NHBEC.

Prentiss stated that currently the Coordinating Board was working on the action steps to implement our new Strategic Plan for EMS. The plan does support this suggestion of medical oversight for E911.

Director Cheney commented that he agreed and he very much wants NHBEC to participate and be a part of the Coordinating Board's Strategic Plan. From a management point of view he has no problem with the concept of "approval", and would prefer having medical oversight from the MCB, if they move in that direction, or from another source of medical guidance. McVicar expressed his pleasure at the excellent communication between the two Boards over the long term, and thanked L'Heureux, and Cheney particularly, for coming to MCB meetings over the years to provide updates and answer questions.

D. Martin inquired as to cell phone locators. Cheney stated that incoming cell phone calls are located in one of two ways. The older system -- Phase 1 location -- uses the location of towers that are receiving a call to roughly estimate the location of the

caller. Phase 2 actually uses GPS devices within the cell phones to locate a caller, usually within plus or minus 3 meters. Right now some 60 – 70% of 911 calls are located by GPS. Director Cheney went on to explain how exciting it is to be able to watch on the screens at the PSAP as a caller asking for help and a responding unit draw closer and closer. He told of one case where two women were kidnapped and placed in the trunk of a vehicle. Through Phase 2 localization, 911 operators were able to follow the phone's signal and steer the police directly to the victims.

Decisions: None.

### **Item 2. RSI: 2008 Summary of TEMSIS**

Blanchard reported that in 2008 two new EMS Units have met the prerequisites for rapid sequence intubation (RSI). They are Week's Hospital EMS and Littleton Hospital EMS. This brings the total number of EMS units with RSI protocols to six. In 2008 there were 198 RSI procedures reported in TEMSIS. Of the 198 incidences 7 required a backup airway, and all 7 were successful in managing the patient using the backup device. Finally, there were no cases requiring cricothyrotomy.

Discussion: In Blanchard's presentation D. Martin noted that there was one incident labeled "other" and inquired what it was. Blanchard explained there was one incident where a physician performed RSI in the field.

Decision: None

### **Item 3. Board of Pharmacy Meeting**

McVicar reported to the Board that he and Blanchard attended the NH Board of Pharmacy's monthly meeting yesterday. At the meeting the Board of Pharmacy approved the removal of thiamine and procainamide from and the addition of tetracaine to the EMS drug list. Additionally, the Board approved the ability for paramedics to adjust or rebolus medication during an interfacility transfer providing there are written orders by the sending physician, that the paramedic has had appropriate additional training, and the sending hospital sends the medication with the paramedic, as these are not medications on the approved list and they would not therefore not be carried on ambulances. Lastly, the Board agreed to work with us to develop a best practice for the accountability of controlled substances.

Discussion: None

Decision: None.

### **Item 4. Final Proofreading of 2009 Protocols**

Blanchard reported that she received the final version of the protocols last Friday, March 13, 2009. We had the Protocol Subcommittee and MCB proof the document. D'Aprix divvied up the proofreading into 4 pages per person; as of today all but about 6 or 7 people have responded. Blanchard stated that all corrections were minor formatting or

typos, there were no gross medical errors found. Blanchard stated that Sutton brought up the question of whether we wanted to keep promethazine in the protocols.

Discussion: Sutton stated that in light of the recent lawsuit in Vermont where an intra-arterial injection of promethazine into the arm of a pianist caused the patient to lose her arm he would like to consider removing the medication from the protocols. He stated any search done on the medication brings up warnings. Additionally, it is only found in the Nausea/Vomiting protocol and there are four other anti-emetics for the provider to choose from.

Fore stated since the warnings have come out they do not use it at Concord Hospital. Yanofsky stated he still uses it, but does not see why we need to have it prehospitally. Dr. Rutman stated that she does not use it in pediatrics.

Decision on Promethazine: Sutton moved to omit promethazine from the NH Patient Care Protocols. Fore 2<sup>nd</sup>.

Vote: Yes 6, No 0, Abstaining 1. Motion passes.

Decision: No other decision -- protocols are already approved.

#### **Item 5: 2009 Protocol Rollout Timetable:**

Blanchard stated that she has protocol rollouts scheduled with most of the hospitals in the state. A copy of the rollout schedule is included in Prentiss's Bureau Report. Any questions about Rollouts should be directed to Blanchard.

Discussion: None

Decision: None

#### **Item 6. CPAP Training – final changes:**

Jackson reviewed the history of the CPAP training. Initially the training had been updated following a review performed at the request of the New Hampshire Respiratory Care Practitioners Governing Board. At the January MCB meeting there was question about the use of the subjective word "obtunded" in the training. A subgroup worked on improving the assessment portion of the training, however they ran into difficulty coming to a consensus on terminology which was subject, i.e., that is based on an impression of how a patient feels rather than any measurable value.

Jackson showed some slides which contained wording such as "obtunded", "fatigued", "exhausted", "lethargic", "combative", and "altered mental status". He stated he did research and found that many states use a minimum Glasgow Coma Score (GCS) – often  $GCS \geq 10$  -- as criteria for CPAP use.

Discussion: The Board spent some time discussing how to best describe a patient whose mental status constitutes a contraindication for the use of CPAP. D. Martin did not think the GCS score was practical. Riley stated that he instructs his paramedics that the patient must be able to exhale against the resistance of the CPAP unit, e.g. 10 cm of water. Fore stated that a lot of literature he is familiar with cites altered mental status, and in patients who are not alert enough to interact with the provider it may be safer and more

appropriate to choose an alternative device that is less hands-off. Fore is not against having language that states altered mental status is a contraindication. D. Martin countered with the fact that there were varying degrees of altered mental status; a person who has had three beers could be considered to have "altered mental status". Fore felt that, like everything else, this is a situation where "you just have to use your head." D. Martin reminded the Board that there is a wide range of experience in field providers, and some providers are very menu-driven. McVicar agreed saying that our job is to produce protocols; we can't just replace protocol with instructions to "use your common sense." Prentiss reminded the Board that while ideally we want only evidence-based decisions, it is often the case, as it seems to be here, that there isn't any clear evidenced-based answer. At this point we need to rely on our collective experience.

Odell stated that he does not find the GCS to be a useful tool for EMS providers. But the trauma literature strongly supports use of the motor component alone to stand for the entire GCS. He proposed using the motor component alone as an objective and useful cutoff for CPAP. If the patient can obey verbal commands, CPAP is appropriate. If they only respond to pain (motor subscore  $\leq 5$ ) then they would not be a candidate for CPAP. Fore agrees. Another way to think of this is to use the "AVPU" (Alert/Voice/Pain/Unresponsive) scale, and draw a line between the "V" and the "P". McVicar pointed out that the training contains a slide which describes the proper monitoring of a patient on CPAP by multiple means. So if a patient turns out to not be able to tolerate CPAP after it has been applied, that will quickly become apparent.

**Decision:** Fore moved that to be a candidate for CPAP the patient must be alert or responsive to verbal stimulus and able to follow simple commands prior to application. Yanofsky 2<sup>nd</sup>.

**Vote:** Unanimously approved.

### **Item 7. Intermediate Transition Modules**

Blanchard reported to the Board that the Intermediate Training Modules are completed. She emailed copies of the PowerPoint training modules to MCB members last week for their review. The modules include CPAP, DuoNeb<sup>®</sup>, and Intraosseous Infusion. She explained that the training would occur with NH Licensed Instructor Coordinators. Each instructor would be given a set of course objectives, a lesson plan, guidelines, assessment tools to include quizzes and skill sheets, and a sample PowerPoint presentation. She reported that as of today she has had feedback from D'Aprix. She would like to ask the Board to conditionally approve the modules now with the knowledge that any gross medical errors found as the review goes forward can still be corrected.

**Discussion:** Prentiss stated that the modules can be approved now with corrections by a certain date.

**Decision:** Fore moved to approve the modules today understanding that comments, suggestions or corrections will be taken until April 15, 2009. Sutton 2<sup>nd</sup>.

**Vote:** Unanimously approved.

**Item 8: Interfacility Transfer Med Training Modules**

Odell reminded the Board of their decision to approve transfer medication modules. The modules cover medications that the Board decided were a bit above and beyond the usual scope of practice for paramedics. The Board wanted an education program appropriate for paramedics who may use these medications on Interfacility Transfers (IFT). The modules cover certain paralytics, potent antihypertensives, vasopressors, and propofol. The modules were approved in January and several specific changes were requested by the Board. All those changes have now been made. The final drafts of the modules were sent out to the Board a number of weeks ago. Odell has received some general approval, but no specific criticism or requests for changes, so he assumes all are satisfied with them.

They are now ready to go except for one final question pertaining to the pediatric dose for propofol.

Discussion: Dr. Rutman stated that she does not routinely use propofol in the emergency department. It would be a question appropriate for the PICU people. She will provide Odell with names.

McVicar wants to be clear that these are training modules – not protocol. Our agreement with the Board of Pharmacy – reiterated at their meeting yesterday – is that these medications are kept at the sending hospital, ordered and initiated by physicians at the sending hospital, and if there is any titration or rebolusing to be done it is based on written orders from the sending physician to the paramedic. In this circumstance, the paramedic is to follow those orders, not any protocol from the MCB. This is an unusual type of authority for paramedics, and since it is not written in the Interfacility Transfer Protocols it must be a part of the training modules. Each module must have a slide that clearly explains the authority and states these rules.

There was also discussion of a standard transfer order sheet that could be used by sending hospitals if they wished to use it.

Yanofsky inquired about the returning of transfer forms. It was explained that one of the copies of the transfer form is to be returned to the sending facility. Depending on the area, EMS may return the form, in other areas the receiving hospital will mail it. Prentiss stated it is a topic that is currently being looked at. However, there is nothing in EMS rules that states we have to return the form.

Decision: Odell is to update the pediatric dose of propofol after consulting with DHMC PICU personnel, and to add a slide explaining that the sending facility is responsible for all orders for IFT use of non-approved medication. With these provisions the modules are approved.

**Item 9: Planning for 2011 – 2012 (Medical Control Festival)**

McVicar asked the Board to consider in what direction they wanted to move for the 2011-2012 Edition of NH protocols. Also, were they interested in a planning meeting/festival to solicit input from EMS docs who are not part of the medical control board?

Discussion:

Fore stated that he thought the Trauma Conference in November drew a lot of the people we would like to talk to. So he would suggest holding a planning meeting during the conference. Sutton and Siegart agreed with Fore. We will begin to look into the feasibility of holding a substantial (perhaps 2 hour long) breakout session or a separate event on the day of the November Trauma Conference.

Yanofsky felt getting people together was important. He is also concerned that we get our Intermediates in line with the new education standards. The MCB needs to be involved in this process. Also he would like to see us continue to use TEMSIS for research and targeting improvements in the system.

Fore asked what percentage of EMS runs is being captured in TEMSIS. Prentiss replied around 90%. Additional numbers are in her Bureau Report.

McVicar would like to work on a cardiac system similar to our trauma system. Prentiss pointed out that the Strategic Plan now being developed does include development of specially capable systems to meet specific needs, including cardiac.

McVicar thanked everyone and stated he would continue to include planning on the agenda for future meetings, so members should write down and bring in their ideas.

Decision: None

### III. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

**ACEP:** No report.

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

Additionally, Prentiss reported that Tammy Fortier will be retiring after 20 years of service to the State of New Hampshire on May 7, 2009. Micheal Schnyder has left the Bureau to become a full time physician's assistance student.

**Critical Care Paramedic:** Odell reported the committee had to cancel their last two meetings. One meeting was cancelled due to weather and the other because our guest speaker was called to a legislative budget meeting. We have rescheduled for April 10<sup>th</sup>. At this meeting we will be looking at Maine's PIFT program.

**Coordinating Board:**

Achilles referred to the minutes in the packets. Additionally, he commented that the Strategic Planning was going very well. The subgroup is meeting every other month and making great progress.

Yanofsky asked if the Coordinating Board Agenda could be included in the packet as well. Blanchard said she could ask Kathy Doolan to forward to her. After further discussion the group agreed that the Coordinating Board minutes and agenda would be emailed to the MCB – and vice versa.

**Legislative Update:**

Director Mason updated the Board on legislative issues. He stated that the Fire and EMS fund has already had to give up two million dollars to the state's general fund to help cover the massive budget shortfall caused by the financial crisis. However that

does not necessarily mean we face cuts. The legislature is considering an increase in the fees we charge for copies of motor vehicle records. This money is used to fund Fire Standards and Training and EMS. Mason thinks we will get enough increase to offset the two million dollar cut that we suffered. The Department of Safety is currently watching two bills: HB 2, which is the bill that contains the changes to support HB 1 (the Governor's budget), and HB 540, a narrowly focused bill which raises the fees charged for motor vehicle records. HB 540 could update the current motor vehicle record fee increase from \$7 to \$10.50, and HB 2 could see the fee raised to \$12.00. These prices would be in line with some other New England states.

Prentiss reported that HB 249, which would have amended the NH EMS statute (RSA 151-B) to state "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" was inexpedient to legislate (i.e. killed). The bill as written could have had serious unintended consequences, and we were able to show that its purpose is already covered in existing law.

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

**NH Trauma System:** Sutton reported that the revision of the Trauma Plan is complete and a summary will be presented to the Coordinating Board this afternoon. The Trauma Committee adopted a working approach that allows them to approve the plan and still continue to work on it. Particularly the pediatric section is being improved at this time. The old pediatric section was cumbersome and large and virtually a reprint of the adult with the word "pediatric" substituted for "adult".

Odell reported that since the inception of the air medical program two reviews have been conducted. He has formed a committee of 12+ people to look at it again. It will involve reading over the air medical responses to see if they met the protocol criteria.

Sutton stated that the Trauma Review committee will be working on Trauma Imaging Guidelines, based on a request from some of the acute care hospitals around the state. The idea of the Imaging Guidelines is to prevent double imaging in patients that get transferred, and hopefully to reduce unnecessary radiation exposure.

Finally, with spring upon us, the trauma SIM project will be back out to local hospitals.

**Other Business:**

Houston spoke on briefly about the Primary Seat Belt Law. She stated that the bill made it through the House and is now at Ways and Means Committee for setting fee/fines. After Ways and Means it will go before the Senate. Currently we know there are 10 Senators for the bill and 10 Senators against. There are three that are on the fence. Janet handed out a flyer with the names and contact information of the three Senators and asked all to contact them and ask for their support of the Primary Seat Belt Law.

Fore asked if the Board should write a letter and Houston stated certainly that would be wonderful, but more it is even more important for individual constituents to contact their Senator, especially those Senators identified as fence-sitters.

**IV. ADJOURNMENT**

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

**VI. NEXT MEETING:** May 21, 2009

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

(Prepared by Vicki Blanchard, ALS Coordinator)