

NH EMS MEDICAL CONTROL BOARD

NH Fire and EMS Academy
Concord, NH

MINUTES OF MEETING

May 21, 2009

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

Members Absent: Frank Hubbell, DO; Joseph Mastromarino, MD; William Siegart, DO; Jeff Johnson;

Guests: Steve and Jeanne Erickson, Mathurin Malby, MD; Douglas Devine, Tim McGinley, Matthew Leavitt, Todd Robinson, Chuck Hemeon, Sean Ellbeg, Shawn Riley; Mark Hastings; Janet Williamson; Michael Pepin, Janet Houston, Jonathan Dubey, Denise Normandin; Steve L'Heureux, Aaron McIntire, Dr. Joeseeph Leahy

Bureau Staff: Rick Mason, Director; Vicki Blanchard, ALS Coordinator; Clay Odell, Trauma Coordinator;

I. CALL TO ORDER

McVicar welcomed all to the meeting. Introductions were made.

EMS Community. Prentiss wished all an excellent EMS week. She acknowledged the NH EMS providers for their outstanding respond during the H1N1 crisis. Additionally, Prentiss stated that three NH providers, Doug Martin, Paramedic and Vice Chairman of the Coordinating Board, Micheal Kennard, Paramedic and Program Coordinator for the NH Bureau of EMS's Education Section; and Jennifer Frenette, President of the NH EMT Association, are all riding their bicycles with the Muddy Angels from New York City to Roanoke, Virginia to the National EMS Memorial Service.

Acceptance of Minutes. Fore moved to accept the March 19, 2009 minutes, Yanofsky 2nd.

Vote: Unanimously approved

II. DISCUSSION AND ACTION PROJECTS

Item 1. Pandemic Flu Readiness

McVicar stated it was very gratifying that after all the meetings and planning he has been participating in, how well we reacted to the H1N1 situation. He felt New Hampshire was ready and learned a few new things as well.

Prentiss stated that for all the planning that occurred it was nice to actually follow the plan. She stated this was a real time exercise where we were able to let EMS know current guidelines through NHOODLE's "Just in Time Training". Please see Sue's Report at the end of the minutes "NH EMS Response to Swine-Origin Influenza A(H1N1)" for complete details.

Discussion: J Martin asked if any providers were given oseltamivir phosphate (TAMIFLU®)? To which Prentiss responded, "not that she was aware of." Then Martin asked where would he get it if he needed to? Prentiss stated that should a patient need oseltamivir phosphate, they would get it through a prescription from their physician. She added that the state did not get to the next stage of the pandemic plan where medications would be released from the national stockpile. Martin felt there was a step missing in the plan for those patients/staff exposed and in need of the treatment prior to the extent needed to release the national stockpile. McVicar replied that there was a system in place which monitors the infectivity and severity, and if appropriate levels were met there should be enough medication to treat these people. Fore stated Concord had a problem getting oseltamivir phosphate for the two patients they had. This was because physicians were writing scripts prophylactically causing none to be available for the sick people. It was agreed too many prophylactic prescriptions were written.

Additional discussion included McVicar explaining that he participated in a table top exercise which he found very helpful and learned that although they followed national guidelines, the biggest mistake was not establishing lines of communications with regional and state agencies.

Prentiss added that Massachusetts published clinical guidelines for EMS. Prentiss went through the NH Patient Care Protocols covering flu-like signs and symptoms and felt the protocols were very sufficient for this event. However this raised the question of what to do in more serious situations that could occur. Could the MCB change, update, or create new protocol if there were an event which produced new treatment recommendations from the CDC, and which the State endorsed? Fore stated that this was a tough question because there could be hundreds of scenarios, from asteroid strikes to the flu. McVicar added that it was impossible to try and anticipate and create protocol in advance for every situation, however we can create a notification tree to quickly establish treatment recommendations if when any such events occurred.

Decisions: None.

Item 2. Protocol Rollouts

Blanchard has been personally doing rollouts of the new protocols throughout the state. She reported the following protocol rollout summary

- Blanchard traveled 4580 miles doing rollouts from March 23, 2009 – May 18, 2009!
- She visited 23 hospitals
- She presented to over 450 providers. (The goal was attendance by at least one provider from each unit.)

General Comments and Suggestions for the 2011 Protocols:

- When to Stop:
 - Initially issues with “When to Stop” but changed she changed her approach to answer the questions before they were raised
 - Should have notation for known organ donors
 - There were questions with billing on when to stop
- Stroke Scale box in TEMSIS says Cincinnati or LA
- EMT-Intermediates and pumps. The interfacility protocol allows pumps, but only to give crystalloids.
- Tetracaine and proparacaine: Should limit number of times given, due to caustic effects if too much. Blanchard reiterated during her rollouts that these agents were to be used to facilitate the introduction of the Morgan lens.
- Smoke Inhalation Protocol for 2011 especially with CyanoKit
- End Tidal CO2 Monitoring/Capnography for Basics using the blind insertion airway
- Allow feeding tubes for Basics making transfers, especially if not running
- Repeat doses: use the term “total of” instead of “repeat” it makes it much clearer.
- Lily Kit: There was a concern if we remove from protocol and industry is still carrying it, what do the providers do?
- CPAP: Allowing nitropaste instead of sublingual or IV NTG after the device is secured

Discussion: McVicar responded by stating these were all great suggestions for consideration of the 2011 edition of the protocols. Blanchard is to present these suggestions to the Protocol Subcommittee when they reconvene.

Protocol Items for possible immediate action:

Pain Protocol 2.10. The current version of the protocol states the paramedic may consider for pain control one of the following...ketorolac, morphine, fentanyl, or nitronox... There was an overwhelming and widespread concern during the rollouts that the protocol allows only one medication to be given for pain control. Following are some examples of the concerns:

- Example: ketorolac and morphine for kidney stones were formerly routinely given, as one was an NSAID the other an opiate.
- Transport times > 45 minutes in many locations and not enough medication
- Nitronox ® then morphine for pain is routine for extremity injuries

McVicar stated he did not think it was their original intent to include ketorolac in the list, as it is not an opiate and not subject to cumulative overdosing. Fore and D'Aprix agreed with McVicar that that was not it was the original intent. D'Aprix suggested the following:

1. There should be no issue with given ketorolac with one of the opiates.
2. Do we want providers flipping back and forth between fentanyl and morphine? He does not see a need for this. It could be dangerous.
3. Nitronox ® would be okay if your start your pain management with it, then move onto an opiate, but not vice versa.

Fore agreed with D'Aprix and stated that as far as the opiates were concerned, the provider should just pick one.

Yanofsky also agreed, stressing that in the case of Nitronox ® it must be used first.

D'Aprix moved, "to strike the "OR" after ketorolac. The paramedic may choose either morphine or fentanyl but not both. Nitronox ® may be used only if the patient has not already received an opiate. The updated protocol would read:

Paramedic Adult Standing Orders

Unless the patient has altered mental status or multi-systems trauma, the paramedic may consider for pain control:

- Ketorolac*: 15 – 30 mg IV or 30 – 60 mg IM (no repeat)
[Consider as first line in renal colic. Avoid Ketorolac in patients with NSAID allergy, aspirin sensitive asthma or known peptic ulcer disease.]

One of the following opiates:

- Morphine*: 1-5 mg IV/IM every 10 minutes to a total of 15 mg titrated to pain relief and systolic BP is greater than 100 **OR**
- Fentanyl*: 25-50 micrograms slow IV, 50 micrograms IM, every 5 minutes up to a total of 150 micrograms IV/IM or 1.4 micrograms/kg IN,
- For hypoventilation from opiate administration by EMS personnel, administer naloxone 0.4 mg SQ/IV/IM/IN/ETT as needed.

If the patient has not already received an opiate the paramedic may consider:

- Nitronox**: (Patient must be able to self-administer this medication)
(Contraindicated in abdominal pain, pneumothorax, head injured, or diving emergency patients).
- Nausea: Refer to Nausea Protocol 2.13.

Paramedic Pediatric Standing Orders

- Fentanyl* 0.5 micrograms/kg IV/IM every 5 minutes. May be repeated up to a total of three doses, OR
- Morphine* 0.1 mg/kg IV every 5 minutes. May be repeated up to 3 doses.

Sutton 2nd the motion.

Vote: Passed Unanimously.

Tachycardia Protocol 3.1:

Fore pointed out under Atrial Fibrillation/Flutter there was no longer a bullet for a beta block, similar to the one under PSVT.

Fore moved to change the Tachycardia Protocol to add the bullet, “metoprolol 5 mg over 2 – 5 minutes; may repeat every five minutes to a max of 15 mg as needed to achieve a ventricular rate of 90-100,” after the diltiazam bullet under atrial fibrillation/flutter. The new protocol would read:

For atrial fib, atrial flutter, consider:

- diltiazem 0.25 mg/kg IV over 2 minutes (Note contraindication: WPW); may repeat once in 15 minutes at 0.35 mg/kg. Consider infusion 5-15 mg/hour, **OR**
- metoprolol 5 mg over 2 – 5 minutes; may repeat every five minutes to a max of 15 mg as needed to achieve a ventricular rate of 90-100.”

D'Aprix 2nd the motion.

Vote: Passed Unanimously.

Cricothyrotomy Protocol 5.6

The current protocol requires “age appropriate commercial devices using technique of needle and guide-wire followed by dilatation.” It appears that the only device that meets this description currently available is the device called the Melker kit which fits this description. There are other commercial devices available; however they do not meet the “needle and guide-wire followed by dilatation” criteria. Additionally, the vehicle equipment list requires two devices per truck. The cost of these devices is approximately \$200 a piece.

Blanchard explained that during the rollouts it was pointed out to her by many of the Unit leaders that they had either the ‘Quick-Trach®’ or ‘Nu-Trake®’ currently on their trucks. These devices were chosen over the Melker kit for their simplicity. Because of these expressed concerns Blanchard performed a non-scientific poll, from which she was only able to find 5 units that actually carried the Melker kits. Finally, Blanchard did a data search through TEMSIS, the following results were found:

TEMSIS report on Cricothyrotomies:

May 15, 2007 – May 20, 2009: Where Needle or Surgical Cricothyrotomies was selected under procedures and a narrative search: 2 Cases were found:

1. Quick-Trach®– Unsuccessful
2. Quick-Trach®– Successful

Discussion: Fore stated that he too was approached by his Unit leaders with the same concerns. He thought it might be reasonable for them to use what they had until they expired or used.

J Dubey stated that these devices were a huge expense to the ambulance services, carry an expiration date, cannot be returned once expired, and they are hardly ever used and so they end up getting thrown out. He would like to suggest that only one be required per truck.

J Martin stated that Dubey had a valid point and he was concerned with the technique.

Sutton pointed to the data retrieved from TEMSIS: only two cases in two years were reported with a 50% success rate. He added it was a complex skill that is hard to maintain and different on a manikin than a person.

McVicar stated that this had been discussed at least twice before the final approval of the protocols, and that the Board has expressed serious concerns for safety. The technique is in fact seldom used and not always successful. He would like to propose that we plan and intend to eliminate cricothyrotomies in 2011 and to allow providers to continue to use the devices they have and are trained to use until then.

Lanzetta stated that if the intent was to eliminate in 2011, then do it now.

Yanofsky asked if the TEMSIS report included DHART data, to which Blanchard replied that it did not. She add, at the last MCB meeting she gave the 2008 RSI report, which did include DHART, and did not have any documented cricothyrotomies.

Sutton asked if we need to change the language with the “open technique”. Dubey responded tat he would like to see the board take “guide-wire” out of the language and limit the number per truck to one. Yanofsky commented that the number of kits on the required equipment list was a Coordinating Board question not MCB, but they could make recommendations.

D’Aprix moved to change the Cricothyrotomy Protocol to read “age appropriate commercial device.”

Sutton 2nd the motion.

Vote: Passed unanimously.

At this time Dubey asked if he could comment on the EMT-Intermediate transition Train-the-Trainer. He stated he took the training with included CPAP, Intraosseous, and albuterol / ipratropium (DuoNeb®), which is as was stated in the March 2009 minutes. However, during his training he was told he would also have to teach the original three Intermediate transition modules: Cardiology, Pharmacology, and Laryngeal Mask Airway. He did not think that was the original intent. J Erickson stated that the requirement was to demonstrate competence, for example by taking the post-quiz, not to reteach the whole module.

McVicar stated that this was not a topic for the MCB but rather for the Coordinating Board.

In continuance of the protocols, D’Aprix stated that for 2011 we should investigate the using weight-based dosing for children who extend beyond the end of the length-based resuscitation (Broselow®) tape. Specifically in his catchment area there were two cases where children were taller than the and therefore given an adult dose of solumedrol resulting in an overdose and clinical hyperglycemia.

J Martin stated he was in favor of discussing weight-based dosing for adults as well as children.

McVicar stated we will place this on the July agenda. This will give board members a chance to investigate these questions in depth.

No additional decisions.

Item 3. Workplan and Timetable for 2011 Protocols

D'Aprix stated that initially he thought to keep maintain the timetable status quo, ie. aim for release in January 2011. But after further consideration, he thought that to get the full 24 months of use out of the current edition we might perhaps want to aim for an April 2011 release. Additionally, thinking ahead to the number of needed changes, he did not see many, nor particularly large changes. Hopefully, therefore the editing process should not be cumbersome. He would like to limit the number of meetings of the Protocols Subcommittee to eight, starting in September 2009.

Discussion: McVicar had concerns with an April 2011 rollout, in that it would likely start to creep ahead, and we would find ourselves in August. D'Aprix said we could aim for January, which would give us a buffer period so that if we were a few months late we would still end up with at least an April rollout. One issue we will have to face is the anticipated release of the new AHA Guidelines November 2010. This could potentially delay our release for a few months.

Decision: None.

Item 4.STEMI System

McVicar referred the "NH Cardiac STEMSI System EMS Organizational Meeting" handout (see end of minutes), to the AHA guidance on STEMI system development published in Circulation in 2007

Discussion: Dr. Malby had a concern with item #5 which proposes a 30 – 45 minute limit on time to cath lab. In particular his providers (at Frisbie Memorial Hospital) are involved in a system to bypass a closer hospital and go to Portsmouth. The time issue is important because there is a difference at different hospital between time to the door of the cath lab and time to balloon. Malby thought it this type of decision should be left open to each Unit.

McVicar stated that the EMS shouldn't have to do all the work here, like we did for the trauma system. Instead American Heart Association and the various cardiology groups are already starting to work on a system for the state.

Prentiss read from RSA 153A: ..." provide safe transportation to the most appropriate treatment center prepared to receive the sick or injured person..." stating that this language would support the development of a STEMI System. The Board needs to talk about appropriate staffing for transferred.

Fore stated that EKG transmission is a "big bug-a-boo". Another problem will be getting all the competing cardiology groups to play nice when an EMS Unit drives by hospital A for hospital B.

J Martin questioned the statement that transmission of EKGs "wouldn't be an issue". That would imply that paramedics would be making this call in the field. Lanzetta felt that the implication was that computerized readings were reliable. He was not sure all would be willing to accept that.

Yanofsky stated that they use the EKG readings and thinks they are "terrific". The false alerts that he knows about were due to paramedics misinterpreting the language of the

computer's report. J Martin, Yanofsky and McVicar agreed that a system that relied on computer readings would need the support of the cardiologists and the willing to accept a certain small percentage of false positives.

McVicar stated he had spoken to a cardiologist at another (unnamed) big hospital. This particular cardiologist stated they accept the computerized EKG reading. They look at the EKG when the patient rolls and if it turns out that an intervention is not needed, then so be it. No problem. So the cardiologists may actually be ahead of us on this point.

Lanzetta stated that Region 3 has a working model that we need to look at McVicar agreed with Lanzetta, that the group should look at Region 3, as well as a "hot stretcher" program being used at Lakes Region Hospital.

Yanofsky asked how many hospitals are providing cath labs and Normandin answered eight. He then asked how many had 24 hour availability and was told five.

Normandin of the AHA, said she is working to convene all stake holders, talking to the appropriate hospitals, and feels EMS is key to patients receiving treatment with the 90 minute window. EMS providers are well trained and need to be empowered.

Lanzetta suggested asking each Region what they doing and are there issues. The planning level could be the Region

Lastly, Prentiss stated that it sounded like the group wanted to approach this process by picking the "low-hanging fruit." She felt that this is fine. But advised the MCB to be sure they communicate closely with the Coordinating Board which is moving through a long-term planning process for EMS.

Decision: None.

Item 5: Planning for 2011 - 2012:

McVicar asked members of the Board for their thoughts looking forward to the next edition (2011 – 2012) of the protocols.

Discussion: The following two items were suggested for now:

1. Consider changing drug dosing to weight based.
2. Fore brought up therapeutic hypothermia after post arrest return of spontaneous circulation. It may be a long way off. But Fore says several centers are doing it now. Examples include Elliot, CMC, St Joseph, Concord, Dartmouth. McVicar pointed out that NAEMSP has issued a statement saying that there is not enough evidence to support prehospital hypothermia at this time. But he still thinks it would be a worthwhile discussion to have.

Decision: None

Break

III. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Bureau and Division Update: See attached report.

Additionally, Prentiss announced that Richard “Chip” Cooper has been offered and accepted the position of Research and Quality Management Coordinator.

Critical Care Paramedic: See Prentiss’s report. Odell added that the group did meet with Jay Bradshaw, Director of Maine EMS. We found their curriculum to be very good and will incorporate it into ours when we are at that stage. Maine’s biggest difficulty lay in the gray area between a PIFT call and critical care call, with “stable” being the determining factor. Knowing that “stable” is so subjective the committee is looking at having a critical thinking process which would help the provider recognize their own limitations.

Coordinating Board:

In the absence of Coordinating Board Chairman and Vice Chair, the board was referred to the draft minutes of the Coordinating Board which were sent out via email to the MCB earlier in the week. Additionally, J Dubey reported on the behalf of the Coordinating Board that they are working on not requiring CPR cards as part of licensure as it is already required for certification.

Legislative Update:

Director Mason stated that our budget prospects were looking up a bit. He was asked to submit three budgets; 1: a maintenance budget, 2: 100% budget of this year, and 3: a 97% budget of this year. The Governor went along with the maintenance budget. The biggest item that was eliminated was a new fire truck, but Mason said “we will be okay.” He believes the Senate will vote on the budget sometime this week. With a maintenance budget we will be able to maintain all of the programs we have had in the past, which is good news.

Mason again reminded the Board that the Fire and EMS Fund 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 damaging 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 in the short term. 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.

Finally, Mason reported that the Superintendent of the National Fire Academy came to New Hampshire for guidance in including EMS in their titles. He was interested in the

New Hampshire experience since we went through this when EMS moved over from Health and Human Services.

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

NH Trauma System: Sutton reported that two months ago the new Trauma Plan was accepted by the Coordinating Board with the expectation that the pediatric portion would be forthcoming. They decided the pediatric portion would be an equal but separate chapter of the plan. Currently the group is working on this chapter, along with Janet Houston and others with a special interest in care of children, which is nice.

In addition a review committee has been formed that is reviewing airmedical cases for a six month period. Currently they have reviewed two months of cases. Their preliminary impression is that the existing guidelines are too stringent, and may prevent the helicopter from being called when it should be. It is Sutton's hope to expand the evaluation criteria and hold those accountable who did not call and should have.

Odell continues his work with the Trauma SIM training.

Doreen Gilagill has been appointed the Coordinating Board representative.

Finally, Sutton reported that happily there seems to be a renewed interest in the membership with the table being full with 20 people.

Other Business:

Blanchard reported that she received a request from Colorado Springs for permission to use some of the components of our new protocols.

Sutton wanted to know more specifically what they are taking and are they citing NH?

McVicar proposed that Blanchard ask out of state agencies wishing to use our protocols for an acknowledgment. Also since we occasionally need to make changes for safety reasons and to correct errors, that the link be provided to our web page that lists protocol changes.

Decision: Unanimously approved McVicar's proposal

Mason reported to the Board that he would be participating in the "Relay for Life" for cancer research for the American Cancer Society June 5 – 6. Any donations would be greatly appreciated

IV. ADJOURNMENT

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

VI. NEXT MEETING: July 16, 2009, location to be announced.

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

(Prepared by Vicki Blanchard, ALS Coordinator)

MEMORANDUM

TO: NH EMS Medical Control Board
NH EMS & Trauma Services Coordinating Board

FROM: Sue Prentiss, BA, NREMT-P, CMO, Chief
FST & EMS
Bureau of EMS

RE: Division of Fire Standards and Training and Emergency Medical Services (FST & EMS) – Bureau of EMS Report

DATE: May 20, 2009

On behalf of the New Hampshire Department of Safety, Division of Fire Standards and Training and Emergency Medical Services (FST & EMS) I would like to welcome you back to the Division Headquarters for our May 2009 meeting. I would also like to wish you all a Happy EMS Week and take this opportunity once again thank you for all the work you do for the NH EMS Community. Listed below is an update on our activities.

As of May 20, 2009, the Bureau licensing numbers are:

Apprentice	17
First Responders:	267
NH EMT-B	72
NREMT-B	2124
EMT-I	1240
EMT-P	745
TOTAL:	4465

There are 298 (164 transporting and 136 non-transporting) licensed Units. We have 126 I/Cs, including 7 Provisional. Licensed and inspected vehicles to date 425.

Bureau of EMS Report: During EMS Week our staff is attending events throughout the state including Portsmouth, New London, Peterborough, Brookline, Milford, Nashua, Brentwood and Rochester. We are also following the NH members of the National EMS Memorial Bike Ride, Jennifer Frenette, Doug Martin and Mike Kennard. Tony Maggio from Barrington EMS rode with the group over the weekend. Updates from Mike Kennard are posted on the list-serve. This is not only a week to celebrate what good work EMS does, but to honor those lives lost in the line of duty – thank you Muddy Angels.

We are looking at changing the Epping Office to a part-time status and basing Karen Louis, and coverage for the Seacoast and Central aspects of NH, out of the Concord office. Epping Fire, for many years has been gracious enough to provide space for a staff member to work out of their station for only the costs of our equipment, communications, etc. We have been paying for a storage area for equipment but have no room for support staff, which the other Field Offices

that have an Educational Specialist do. Karen continues to do good work for her areas and the Bureau, however, with the centralization of the training records and the difficulty presented when you are not routinely with staff support have us seriously evaluating the situation. There would be NO change in service to the Seacoast in particular, just the routine base of operations. We would, Epping Fire Department willing (which they are), like to keep a space available for part-time operations, like I do with the Lebanon Field Office. We will also save some money, but that is not the primary reason. Will keep you posted.

Mike Schnyder resigned and has become a full-time student again. He is enters Physician's Assistant School on June 11, 2009. We have made an offer to the top candidate and are working out some of the terms. As you know Tammy Fortier retired after 20 plus years of state service, 17 with the Bureau. We are preparing to post her position.

NH EMS Response to Swine-Origin Influenza A (H1N1): FST & EMS has been engaged with the state's response to H1N1 situation since April 25, 2009 (yes, I returned from a week away to this!). Since that time the Director and I have participated in 3 Department Head meeting with Governor Lynch, met with the Commissioner and coordinated the following activities:

- Used the list-serve to update EMS on the situation, sometimes daily, including clinical considerations and manpower planning for a protracted response to this situation.
- Collaborated with DHHS on the review of the "Interim CDC" guidance for EMS and First Responders, and ultimately endorsed this and forwarded it along to EMS Units.
- Used our Website to set-up a "most current" happenings section on the front page with important links to guidance documents and information on the All Health Hazards Region information.
- Updated its Airborne Pathogens Protection educational module, which has been available on the website since 2005. In addition a version of the PowerPoint presentation with audio was developed and placed on NHOODLE in the "Just-in-Time" training section.
- Posted an ambulance disinfection video that meets the CDC requirements on NHOODLE.

The intensity of the situation has shifted, however the importance has not. Using some grant funds through HSEM – Hospital Bio Terrorism, I am bringing on a person on a temporary basis to help finalize the EMS Pandemic Flu Operations Guidance document I developed last year. This person will complete the peer review, and will conduct Regional EMS Pandemic Flu Operations training in each EMS Region over the summer. As noted in Vicki's report, we are ramping up the Immunizations Training also. All efforts focused on next flu season and what it might bring.

Advanced Life Support: Vicki was fortunate enough to travel to 23 hospitals around the Granite State during the awakening of springtime to deliver the 2009 NH Patient Care Protocol Rollout(s). The rollouts were quite a success having Vicki introduce the changes to over 450 providers. As expected there were questions to be answered and suggestions for change. All of the ideas and comments have been recorded and will be brought forward to the Medical Control Board for further consideration in the 2011 Protocols.

We continue to work with Jon Politis on the Medical Directors' Training project. Currently we are putting the final touches on the scripts and collecting images for the presentation. I invite anyone who has EMS shots or picturesque photographs that they are willing to share for this project to email them to me. vicki.blanchard@dos.nh.gov.

Now more than ever we are planning to re-introduce the Immunization program AKA: EMS Vaccine Program this summer. I am currently updating the material to include the H1N1 information and establishing a network to more efficiently deliver the training. Please stay tuned. Having more Paramedic level services trained prior to next flu season is a priority and many more are interested now in light of H1N1.

Clay and Vicki continue to work with the Critical Care Transfer Committee. See the Trauma Report for further information.

With the EMT-I changes in the 2009 Protocols Vicki has been working closely with Eric Perry, not only on the development of the models but on the rollout to I/Cs. More to follow in the Education report.

Education Section Update: Highlights from Education below:

- **Alternative Refresher Program (ARP):** To date, eight ARP programs have been authorized and a majority of them are currently in progress. Four of the programs are being held in Region IV, three in Region II, and one in Region I. The feedback from instructors about this new format has been mostly positive and the Education Section continues to work with the instructors to make improvements to the process.
- **National EMS Education Standards:** There is a level of uncertainty with the timeline to implement the National EMS Education Standards. NH was originally targeting April 2010 to start implementation, but it appears we would be significantly ahead of the rest of the nation, which in theory sounds great, but would leave us without adequate educational support materials, textbooks and potentially certification exams. 2010 was truly an optimistic target and it now appears that 2011 is a more realistic target.
- **2009 EMT-Intermediate Transition Programs:** We have completed six 2009 Intermediate Transition Instructor Orientations. There were 110 instructors eligible to take the program with 73 attending. This is a much higher percentage of attendance than most of our instructor offerings. We are in the process of scheduling an additional two programs, one summer, one fall.
- **Summer Projects:** The non-refresher season time of April to August is when the Education Section takes time to catch up on projects, work on the administrative process for courses and exams as well as preparing for the busy fall season. Examples of this summer's projects are as follows:
 - Full review of EMT-Basic station scenarios. The two new scenarios have been in use for a full year and we will be reviewing the comments from our Exam Coordinators, Instructors and Candidates.
 - Reviewing the Bleeding, Wounds and Shock skills station for the First Responders to evaluate the need of adding tourniquets to the skills station.
 - Creating minimum requirements for practical exam personnel (patients, assistants, etc.).
 - Creating an annual calendar with dates of key instructor programs that take place throughout the year such as; I/C Enrichments, New Instructor Orientation, PEETE Instructor Orientation, etc..
 - Creating an evaluator newsletter to keep our BLS evaluators current on any exam changes or administrative process.

- Planning two additional 2009 Intermediate Transition Instructor Orientation Programs.

Research and Quality Management (RQM)/TEMSIS: Brad has been doing a great job holding down the fort in the Research & Quality Management Section with the Coordinator's vacancy. One item very important to this section is that grant funding from Highway Safety. I am the point person between Highway Safety, the Office of Information Technology (OIT) and our Counsel. The funds have come through the Governor and Council Process to Safety, now we are working on the complexities of the contract with ImageTrend, which will need to go to Governor and Council.

The RQM Section has been hosting "Rescue System Administrator" programs. To date there have been 3 classes with a total of 29 participants. These have been mostly heads of Units and/or local QM contacts. The program is divided into two sessions. The first session focuses on the TEMSIS platform and how to administer TEMSIS such as, how to get providers into or out of TEMSIS, re-setting passwords and customizing certain settings to suit the service to include auto call numbering. The second session aims at querying the service's TEMSIS data and placing the data into Excel and formatting it so that is easy to use and understand. This includes the use of a training query, an accompanying Excel template, and pivot tables. Query building and Excel formulas are also discussed.

We have been working with the Department of Health and Human Services (DHHS) on Swine-Origin Influenza A (H1N1) surveillance since April 26, 2009. To date we have completed and submitted 23 reports (not including Rockingham Regional Ambulance addenda) Date Range: 4/26/09 - 5/18/09 Total number of records reviewed from the queries: 875.

Since the first of the year, we have 49,012 records entered into TEMSIS with a total since going on-line of 401,000,000. Throughout the next few months the RQM section, specifically Brad, will be working on:

- NHOODLE
- Finish up Rescue Service Administrator Programs
- Continuing to work with services to start reporting to TEMSIS
- Continuing to work with services using third party reporting software to report to TEMSIS
- Working with services to establish Quality Management programs

Trauma System Report: At the May meeting of the Trauma Medical Review Committee (TMRC), attendees began working on the pediatric component to the NH Trauma Plan. The EMS for Children Program under Janet Houston had drafted a document for consideration by the TMRC. Following considerable discussion the TMRC reaffirmed plans to have pediatric care as a third section of the NH Trauma Plan. The first two sections of the NH Trauma Plan were approved by the Emergency Medical and Trauma Services Coordinating Board at the April 2009 meeting. The TMRC hopes to have the pediatric section completed by the end of summer.

The Air Medical Transport Utilization Review Committee met on April 22, 2009. The group reviewed cases from April and May of 2008. The committee reviewed flight records and EMS Patient Care Reports from TEMSIS. The group suggested that future meetings include EMS reports that were not in TEMSIS and trauma registry data. The next meeting is scheduled for June 3, 2009.

Based on a request from the NH Hospital Association, the TMRC has established a subcommittee to consider issues related to imaging studies for trauma patients. The intent of this project is to establish guidelines that hospitals may use regarding what kinds of imaging studies (plain film x-rays and CT scans) are recommended for certain categories of trauma patients.

The NH Trauma Sim Program has been to Cheshire Medical Center this season and is working on some dates with LRGHealthcare in Laconia and Parkland Medical Center in Derry.

Doreen Gilligan, RN has been nominated by the TMRC as that Board's representative to the Emergency Medical and Trauma Services Coordinating Board. Doreen is the Clinical Coordinator for Emergency Services at Lakes Region General Hospital and serves as the trauma nurse representative on the TMRC.

At the April meeting, the Critical Care Study Committee (CCT) had an opportunity to meet with Jay Bradshaw, Director of EMS for the State of Maine to discuss that state's experience developing a training program for paramedic interfacility transport, which they call PIFT. The committee met last week to further discuss the Maine model, and to determine what kind of conditions a PIFT level provider would be able to handle versus a true critical care transport provider. The group discussed developing a decision tree document to delineate PIFT vs. CCT. Once that task is done and approved the group would begin to develop an educational program. The group discussed the need to add a critical thinking skills component to the training, as they anticipate there will never be a "black and white" division between PIFT and CCT.

Field Services (FS): With the Licensing Coordinator (LC) position vacant, the remaining Field Services Staff has jumped into action and, on a rotating basis, are covering the Licensing "desk" at the main office. Christy Dewey, the Division's part time PEETE Coordinator and Licensing back-up, has been able to schedule three days each work week to fill-in and keep the ball rolling. On her days away from the office, Shawn Jackson, Liza Burrill and Kathy Doolan are taking care of the LC duties. Although, because of the coverage by multiple staff members, there may be a slower response to some matters, all licensing issues are well in hand and moving along. We all agree that we are grateful to Tammy Fortier for not retiring from this position during the height of the re-licensing "season".

The LC direct phone number (223-4218) remains intact and operational with voice mail if someone is not at the desk when a call is received. All email is being automatically forwarded so that nothing will be missed, and notifications have gone out over the Bureau's List Serve and via email auto response.

We are hoping to have this position filled by the middle of this summer.

All other Field Services responsibilities are being maintained and we look forward to answering all requests that come to us. As always, the Field Services Staff is available for inquiries and assistance if operational questions arise from EMS Providers and Unit Leaders. Asking questions ahead of time is much better than being counseled after a violation has occurred.

As always, thanks for all that you do and for all your dedication and support for NH EMS. If we can be of assistance, please do not hesitate to call me at (603)223-4212.

NH Cardiac STEMI System EMS Organizational Meeting "The Riverside Meeting" 18 Sept 08, Conway, NH

Steve Achilles Norm Yanofsky Don Albertson Dave Strang Doug Martin Doug McVicar
Chief Solomon, Conway Fire

- 1) System should be regional, but in place throughout the state.
 - 2) Level of planning should be the EMS squad. The planning should follow specific guidelines, not caprice.
 - 3) Creating and issuing the guidelines, and creating corresponding EMS protocols is the role of the MCB.
 - 4) No need for levelization. EMS should not attempt certification of centers analogous to that of the NH Trauma System.
 - 5) One doctor reported that at this institution the prevailing belief is that any patient who can be in cath lab within 30 - 45 minutes should go directly to the lab. If the time is greater than that, the patient should go to the nearest hospital for a full strength lytic. After that, transfer to the lab becomes less time dependent. [Note: We should follow AHA guidelines* as much as possible. - McV]
- 1 MCB policy should be immediately to encourage 12 lead EKG capability with computer interpretation. The current state of computer diagnosis of MI is good enough that we don't have to worry about transmission of the tracing to a remote site.
 - 2 The next step is to email this outline to the MCB to get the process going. Then we need to begin meeting with other organizations and individuals. Some suggestions include: cardiologists from interventional centers willing to receive patients, the many sending hospitals, transfer and 911 ambulance services, and Reed Brozen representing DHART, a potential asset.

* <http://circ.ahajournals.org/cgi/content/full/116/2/217>