NH EMS MEDICAL CONTROL BOARD

Manchester Fire Department – Central Station

MINUTES OF MEETING

September 17, 2009

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

Members Absent: Donavon Albertson, MD; Patrick Lanzetta, MD; Joseph Mastromarino, MD; William Siegart, DO; John Sutton, MD; Jeff Johnson;

Guests: Doug Martin, Mathurin Malby, MD, Jeanne Erickson, Steve Erickson, Michael Pepin, Nancy Pederzini, Denise Normandin, Steven Achilles, Janet Houston, Kelley Sweeney, Kimberly Ender MD, Doug Devine, Eric Schelberg, Tim McGinley, Jonathan Dubey, Steve L'Heureux

Bureau Staff: Vicki Blanchard, ALS Coordinator; Chip Cooper, Quality Management and Research Coordinator; Kathleen Doolan, Field Services Coordinator, Clay Odell, Trauma Coordinator;

I. CALL TO ORDER

McVicar welcomed all to the meeting. Introductions were made around the room.

EMS Community. None

Acceptance of Minutes. D'Aprix moved to accept the July 16, 2009 minutes as circulated, Fore 2nd.
Vote: Unanimously approved

II. DISCUSSION AND ACTION PROJECTS

Item 1. Influenza A (H1N1) 2009 Monovalent Vaccine
McVicar began with a preface to the flu discussion. He said the language for naming flu is confusing. The flu that has spread around the world this year, whose incidence is now increasing more rapidly, is a new virus that most people have no immunity to. It goes by several different names including "swine flu", or more accurately "Swine-Origin Influenza A (H1N1)", or "2009 H1N1 flu", or "Pandemic H1N1/09". Most people seem to be calling it "H1N1", which is fine, as long as we know that technically most flu is classified as H1N1, including most seasonal flu, and the 1918 killer epidemic flu. Whatever we want to call the new flu, it is important to keep separate in our minds this year's "2009 H1N1 [swine] flu", and the regular seasonal flu. Immunizations for the two types of flu are different – and EMS providers and hospital workers need to get both! Although the 2009 H1N1 flu spreads rapidly and seems to be infecting many more people than the familiar

seasonal flu, there is a silver lining in the cloud since the symptoms are milder and the disease is less lethal than the average seasonal flu. We also need to be aware of yet another type of flu, the H5N1 influenza also known as the "Avian Flu" or "Bird flu". This infects fowl and has very limited transmission to humans, but of those unfortunate humans who have gotten the H5N1 flu up to 60% died. So there would be a great danger to public health if H5N1 flu were to mutate into a disease that could spread like a regular seasonal flu – or even worse, like 2009 H1N1 flu.

Prentiss then spoke. She stated that she would like to break up her discussion into three separate pieces: 1) Seasonal flu immunizations by paramedics, 2) 2009 H1N1 flu immunizations by paramedics, and 3) flu immunizations by EMT-Intermediates. Prentiss first addressed the Paramedic level. Since 2004 in NH we have had a training program for paramedics to administer certain immunizations. Since 2005 we have had a Protocol with prerequisites (Protocol 5.12) to allow paramedics to participate in immunization clinics for seasonal flu and pneumococcus. The prerequisites were put in place so that a department or unit could not set up a clinic without proper training, medical oversight and orders, and proper documentation. This should not be considered overly restrictive; it is similar to any other health agency that provides immunization services.

Prentiss continued, the NH Bureau of EMS has had available since 2004 an EMS Vaccine training program, which must be taught by a registered nurse (RN). We have now provided this training using our distance learning modality, www.NHOODLE.org. This training program is the same module available on our website. In NHOODLE Jeanne Erickson, RN, EMT-I, IC, presents the whole program in a video format. EMS providers may go onto the website, watch the training, take an exam and then be given a certificate of completion which includes 1.25 CEU. This is a key tool for "just in time" training. It also can be used by other healthcare professionals through a guest log-in.

Prentiss explained that with the increased demand for vaccinators the 19 All Health Hazards Regions (AHHR) in NH have asked if EMS can assist. Prentiss would like to suggest that the Medical Control Board keep the prerequisite structure as is for the regular seasonal vaccine clinics. But when the 2009 H1N1 flu vaccine becomes available, the prerequisites – except for the training – should be lifted to allow Paramedics to work in clinics set up by hospitals, public health agencies and other organizations that would provide the necessary organizational structure. In other words, paramedics will not be setting up any 2009 H1N1 flu clinics, only helping out in clinics set up by others.

Discussion: Sweeney stated that she was active in the AHHR in the Conway area and Conway Fire has offered to immunize all the EMS providers in the area. Prentiss noted that the 2009 H1N1 flu distribution guidelines target healthcare providers, first responders with direct patient contact, and this includes EMS. The vaccine will be distributed to the hospitals. How the hospitals in turn distribute their vaccine stock will be up to them, and certainly a hospital could chose to make a Fire Department one of their vaccination sites.

J Martin asked if this would mean that these paramedic immunization providers would be outside the purview of their medical directors. Prentiss answered yes, when working at an organized site they would be under someone else. Sweeney added that any 2009 H1N1 flu site must have medical oversight on scene. Hubbell asked who was assuming

the liability. Prentiss stated the structure of the AHHR is set up with physicians who are going to take that role. Hubbell wanted it to be noted that he was making a point of liability exposure to the doctors and they should look at riders above and beyond their usual insurance. McVicar stated that having EMS providers working in this way actually provides a degree of protection for EMS Medical Directors. McVicar further noted that vaccine cases are not regular malpractice or liability cases, but are processed through the much more favorable vaccine courts under special laws. Hubbell replied that the lawyers have found a way to get around that. Prentiss said no EMS Medical Directors would be forced to sign off on vaccination clinics. Prentiss further noted that for several years now paramedics in NH have been doing seasonal flu immunizations without a problem.

Prentiss stated that Dr. Montero had just informed her last night at six o'clock that 2009 H1N1 flu vaccine would be given to first responders and that it would be distributed through the hospitals.

Decisions: Hubbell moved that for the administration of 2009 H1N1 flu vaccine in an established All Health Hazard Region Point of Distribution (POD) or supervised medical environment, the prerequisite for the NH Patient Care Protocol 5.12 be waived with the exception of the training requirement. Fore 2nd.

Vote: Passed unanimously.

Item 2 Flu Emergency Planning for EMS.

Prentiss then noted that she has had multiple requests from All Health Hazard Regions as well as fire chiefs to allow EMT Intermediates to administer 2009 H1N1 flu vaccine. Fore pointed out that the necessary skills – administering an intramuscular injection and following sterile procedure – are ones that the EMT-Intermediates already possess. The issue is recognizing contraindications and potential problems, but within the immunization center there is framework for recognition of these issues. In addition the required training program would also cover this. J. Martin noted that since the clinic itself would be responsible for all aspects of the immunization program, and the intermediates would function only to administer IM injections, it is very important to notify the clinic administrators of the narrow scope of practice of EMT-Intermediate vaccinators. J Martin asked how the training of the Intermediates would be verified. Prentiss replied that each provider would have a certificate showing that they had successfully completed the training. They would present that certificate to be eligible to work.

Prentiss notes that Vermont allows paramedics and intermediates to vaccinate – but does not prescribe any training.

Decision: Hubbell moved that we allow NH licensed EMT-Intermediates to administer the 2009 H1N1 Flu vaccine in an established All Health Hazard Region Point of Distribution (POD) or supervised medical environment, after they have completed the EMS Vaccine training. Fore 2nd.

Vote: Passed unanimously.

Prentiss asked the board to consider the development of a treat-and-release guideline for influenza. Specifically she would like the board to establish a subcommittee of board members to work with her on formulating the guidance, both operational and clinical, for a 2009 H1N1 Flu assessment and treatment. This protocol would include the decision to transport to a hospital emergency department, another medical facility, or to not transport at all. Prentiss said that only a couple of states have tried to do this, but so far she is not aware of anyone who has produced a model that is both operational and clinical. Pennsylvania has an operational guideline and Maryland has a clinical one. She will be traveling to Little Rock, Arkansas for an EMS Director's Meeting and will be working with other states on this topic. Additionally, because of the urgency of flu planning and the fact that the MCB's next meeting will not be until November, she asked the board to vote to formulate guidance that could be ratified at the next meeting. This would allow for it to be fluid and change as the needs dictate.

Discussion: McVicar commented that since the information about 2009 H1N1 Flu is changing every week, and since Director Mason has determined [that under RSA 91-A, the NH "right-to-know" law] we cannot legally vote via the email, Prentiss's proposal is reasonable. There is nothing to prevent the board from giving its counsel through email. The Prentiss added that by allowing this vote the members could be given the draft guideline along with a time table, appropriate to the degree of emergency, that would specify the deadline for submitting comments and an effective date of the final protocol.

Houston inquired if E911 was screening for flu-like symptoms. L'Heureux replied: that there is an available brief interrogation that can be used for flu-like symptoms. All the information is tracked and downstreamed to providers. It was used for 3 months last spring and is ready to go again when Dr. Montero decides to "flip the switch." A different tool that is also ready to go is Priority Dispatch Protocol 36. A US Department of Transportation 911 task force in 2007 developed the material in Protocol 36. This protocol is flexible and adjusts to different World Health Organization levels of epidemic severity. After a comprehensive interrogation the emergency communicator would provide appropriate instructions (e.g. "The ambulance is on the way" "The ambulance will be there when they can" or "We are going to turn you over to someone who will give you information about treating this at home.") NH Bureau of Emergency Communication personnel all received training on Protocol 36 last April and are prepared to do it again. Protocol 36 would be implemented on orders of the NH DHHS. Prentiss pointed out that the planning process has not yet created the alternative treatment resources that Protocol 36 would point to. That work is moving ahead rapidly.

D Martin said that EMS will need parameters, for example: does EMS give a patient a nebulizer and IV fluids and leave that patient at home, or do they assess and send somewhere. McVicar responded that he wanted to limit discussion at this time to the procedure for producing and communicating guidance as a potential epidemic flares. The specific content of that guidance could change rapidly and hopefully could be adopted from national expert standards. D Martin said he had understood that we were looking for a protocol today. Prentiss stated that right now we were only looking for a procedure capable of producing a protocol in an emergency.

Hubbell stated that this work is profoundly important; we can expect mass hysteria if a major flu epidemic unfolds. J Martin inquired as to once a protocol was approved or ratified, how and when would it go into effect, and who would educate the providers. Prentiss answered that we would most likely do just-in-time training on the NHOODLE

website. She foresees two ways for the switch to be flipped: the Commissioner of Health and Human Service or the Commissioner of Safety declare a State of Emergency, or the Governor declares the same. She stated it is a moving target right now. Yanofsky, Hubbell and McVicar stressed the important of educating the public, so that the public knows what we are doing and appreciates the service, and is prepared to deal with the inevitable mistakes that will occur.

McVicar polled the board members as to the procedure they favored for getting this protocol done. The group would like to have the drafting done by a small ad hoc subcommittee, and ultimately submitted to the full board before final approval.

Decision: D'Aprix moved to approve the concept of a treat-and-release protocol for epidemic influenza, with details to be developed by a subcommittee made up of McVicar, Hubbell, Fore, D'Aprix, and D. Martin working with Prentiss provided that it is ratified at our next meeting. Fore 2nd.
Vote: Passed unanimously.

Item 3 Sepsis Prehospital Protocol - vasopressors
Malby spoke to the board regarding early treatment of septic patient. Specifically, he stated that his paramedics are using a field lactate analyzer enabling them to identify patients with early sepsis.
Discussion: D'Aprix stated that the first line treatment is fluids with or without lactate levels. Vasopressors come later. Malby replied there are subsets of patients who could need more – for example a long extrication type patient; a bariatric patient on the 3rd floor. "Is this worth looking into?", he asked. McVicar found this idea interesting and added that he did not think providers needed a special protocol to test lactate levels. Hubbell agreed that this was interesting and would like to have a study done and look at the data. Fore thought it might be infrequent enough to be a matter for online medical control. D'Aprix stated that the protocol committee was going to be looking into a general 'shock' protocol and will make this topic part of the discussion. Malby agreed to participate in this discussion.
Decision: None

Item 4 RSI Summary for first half of 2009
Blanchard reported the number of RSIs performed in the first half of 2009. (See attached)
Discussion: None
Decision: None

Item 5 Extended Care EMS
Hubbell reported from the perspective of the whole world. From that perspective we are doing more and more in EMS; things are becoming more complex and when you are in remote areas you may be the only one to provide care, "you are it." The development of these protocols has been going on for decades. Military experience and third world experience provide a great deal of information. The techniques are very effective and very practical, but also very poorly known in conventional US medicine and EMS. Hubbell feels that NH should have an extended care protocol. The need does come up right here in NH. He reminded us of the ice storms of 1998 and 2007, and stated the potential is great and we should take another look at it. He did not think it would be a good idea to require another level of licensure. There should be extended care certification a provider could obtain. He identified two groups that are "flying under the

radar" in NH right now, providing lots of care without necessarily having proper training. One group is unlicensed rescue groups, and the other is ski patrols, whose members are often unlicensed.

Discussion: Prentiss commented that operationally, not clinically; this is already within the new EMS Strategic Plan which actually is to be discussed at the Coordinating Board meeting this afternoon. They will be researching when and what should be licensed with the Bureau of EMS. The Strategic Plan will be a formalized structure that once in place will help address this type of item. Achilles added that based on Hubbell's commentary, we should look at the geography within our own organization. Achilles feels that there are many patients here in NH who may require EMS care for more than one hour. He would like to think of this as extended care and not "wilderness" care. He agrees with Hubbell that this should be a training level, not a licensure level.

McVicar reminded the board that Albertson spoke at our July meeting, as he has at other times in the past, about the broad concept of extended scope of practice. Albertson cited 14 extended scope of practice areas, for example, event medicine, tactical medicine, and industrial medicine. "Extended Care" as Hubbell and Achilles are using the term probably encompasses several of Albertson's 14. In any case, Albertson's thought was that the MCB and the Coordinating Board should look at all of these, prioritize them, and tackle them one at a time. McVicar cautioned the group that based on NH experience with the critical medic program, making these areas of care available will require significant time and resources.

Prentiss read the action steps that support the Strategic Plan. Achilles said that the Strategic Planning process could provide a "roadmap" for getting extended care done. Prentiss wants to avoid a separate process that would be redundant. She estimated that a timetable might be a year or two. Hubbell noted that he has been working on this issue at the national level to prevent national mandates. He will stand by to help NH as our process goes forward.

Decision: None

Item 6 Protocol Subcommittee

D'Aprix provided the group with a summary of the first monthly meeting of the 2011 Protocol Subcommittee. The meeting addressed a long list of ideas, a majority of which were derived from the protocol rollouts this spring. Members were assigned specific protocols to review. On this cycle there are many protocols that probably do not need revision unless new information comes out. Examples include "Communication Failure" and "Apparent Life-Threatening Event". This should shorten the review time significantly this year. The Subcommittee will be able to do a number of the required revisions right away, this will leave time towards the end of the cycle for the Cardiac protocols which must await the release of the new AHA Guidelines.

Discussion: Fore asked if the protocol committee is going to review whether corticosteroids should be used in the field at all, to which D'Aprix stated, yes they would. D'Aprix then showed a special supplement of the Journal of Emergency Medicine, which has just arrived and is devoted to management of acute asthma. He noted that there is no recommendation for prehospital steroids, the only recommendation for IV methylprednisolone (Solu-Medrol®) is in patients with respiratory failure or impending respiratory failure, and the dose in that case is between 40 mg and 80 mg for an adult. He feels this demonstrates that our new 62.5 mg dose is adequate and there is no need

to give any more. Blanchard said she received two phone calls from out of state about this dosage reduction. Utah has apparently already made a similar decision, and Connecticut is considering it. McVicar noted that providers were very interested in this particular issue and said that when the time comes to discuss it for the 2011 Protocol cycle we must make sure we get the word out. D'Aprix noted that another issue of some interest is a possible increase in the permitted dose of fentanyl.
Decision: None.

Item 7 Intracycle Protocol Changes
Tabled until November meeting.

Item 8 Medical Control Consultation
McVicar solicited ideas to discuss at the Medical Control Consultation to be held during an afternoon breakout session of the Annual Trauma Conference. Board members generally support this process, but did not suggest specific questions to ask. Fore suggested a reprise of the talk we presented several years ago about the legal liability attached to medical control.

Decision: Each MCB member is to call their contacts via the "buddy list" inviting them to the Trauma Conference and Medical Control Consultation.

III. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Bureau and Division Update: Detailed discussion can be found within Prentiss's Bureau Report. Sue would like to thank Rockingham Ambulance and Manchester Fire Department for the invitation to come to Manchester for this September's Medical Control Board meeting.

Prentiss took this opportunity to address anonymous complaints to the Bureau. She stated that per RSA 153A:13, if someone complains but does not tell her who you are, she cannot help.

Finally, Prentiss reminded the board that the NH Fire and EMS Awards ceremony will be held on Wednesday, October 7, 2009 at the Capital Center of the Arts in Concord, NH.

Critical Care Paramedic: Detailed discussion can be found within Prentiss's Bureau Report. Odell additionally reported that the committee continues to meet monthly and is drilling down through the differences between a critical care transfer versus a paramedic interfacility transfer (PIFT). They have looked at working in critical thinking exercises as part of the training. He feels the curriculum is now approximately 75% completed.

Odell added that one of the items the committee is working on is administration of blood products during a transfer. The committee cannot find anything that states a paramedic cannot give blood products during a transfer. They have searched the rules, the Red Cross, the blood banks, and have come up empty handed, and are beginning to wonder if this widespread belief is actually a myth. He posed the question to the board and audience, does anyone know where that idea came from that paramedics could not transfer blood?

Medical Control Physician Training Video: Received the draft video. There were some problems with the audio in some section, which Brad Weilbrenner is working on. It is expected to have the program complete within a few weeks. It will then be distributed to the hospitals.

Coordinating Board: Achilles reported the Strategic Plan is "the big thing" the board is working on, and it is still on track. Additionally they are reviewing what is a best practice, and what is the most useful way to present best practices. Finally, Achilles reported his third term will be coming to an end this winter, but due to other commitments he has decided to step down today. They will be voting on an interim chairman this afternoon.

Legislative Update: None

TEMSIS Report: Detailed discussion can be found within Prentiss's Bureau Report. Cooper added that through funding at Rural Health an online medical direction program is available at www.medicaldirctoronline.com. The physician signs in with his/her license number, it is free to NH Physician and $300 for outside doctors.

NH Trauma System: Detailed discussion can be found within Prentiss's Bureau Report. Odell added that Sutton was not here today because he is off getting married! He also stated that the pediatric component is complete and incorporated into the document. It will receive its final approval at the next Trauma Medical Review meeting. These changes will be available at the Trauma Conference on November 18, 2009 in Meredith, NH.

Other Business:

IV. ADJOURNMENT

Motion by D'Aprix moved to adjourn, Yanofsky 2nd. Motion passed unanimously.

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

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

(Prepared by Vicki Blanchard, ALS Coordinator)

NH Bureau of EMS
RSI Summary for the Medical Control Board – September 17, 2009
January 1 – June 30, 2009

Total number of patients: 95

Agencies:
DHART, Derry FD, Concord FD, Weeks Medical Center, Littleton Hospital, Frisbee Memorial Hospital

Male: 53
Female: 42

A: 61
B:25
C:1
D:3
E:0
F: 5

Back Up Airway required 4 times (2 combi-tubes, 2 KINGs). No failures, no crics.

Exeter Hospital Paramedic Intercept just approved this month.

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: September 14, 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 to Manchester Fire Department's Emergency Operations Center for their City. I am pleased we were able to make it out on the road once this fall and pleased that you could join us! Listed below is an update on our activities.

As of September 14, 2009, the Bureau licensing numbers are:

Apprentice	16
First Responders:	265
NH EMT-B	73
NREMT-B	2290
EMT-I	1272
EMT-P	773
TOTAL:	**4689**

There are 305 (167 transporting and 138 non-transporting) licensed Units. We have 139 I/Cs, including 8 Provisional. Licensed and inspected vehicles to date 429.

Bureau of EMS Report: We are awaiting word on the request to Governor and Council to upgrade the Licensing Coordinator's job classification. We will keep everyone posted. In the interim the Field Services staff. with the assistance of Christy Dewey, have been holding down the fort. Kathy Doolan just returned from a medical leave during August, welcome back Kathleen!

With the appointment of Sheri Kelloway as the new counsel for our Division, once again we have picked up the draft rules and begun regular meetings. Attorney Kelloway was our counsel when we first came to the Department and was responsible for the permanent set adopted in

2002. A deadline of January 1, 2010 has been scheduled for the final drafts to be on her desk to prepare for filing. These are being drafted with the work already reviewed by the EMS & Trauma Services Coordinating Board (protocol rules, equipment list, CPR card removal as licensure requirement). There will be time for review and there will be public hearings. I have been working on rules weekly since early August, Kathy Doolan will be taking back over, however, I will remain involved.

I have seen a rise in anonymous complaints being mailed to the Bureau. We have a process for third-party complaints outlined in rule. It is tough to manage because many of them are either personal or they are containing information on a concern that would be an easy clarification, however, the inability for me to contact the person who wrote the letter leaves a void of communication. I have recently addressed this and hope the clarification helps those to understand the right thing to do!

NH EMS Response to Swine-Origin Influenza A (H1N1) & Preparedness: As has been widely reported, the state is preparing for an upswing in the frequency of H1N1 cases this fall and early winter. We have already worked to make the Immunization training program available on-line through NHOODLE (www.nhoodle.org or www.nhoodle.com). This program has been available since 2004 in the classroom setting. As under the published protocol with prerequisites, it is available for working as part of a team at an H1N1, seasonal flu and/or pneumococcal vaccination clinic. The Immunization Program information is located at:

http://www.nh.gov/safety/divisions/fstems/ems/advlifesup/prereq.html

This has been available for the paramedics, and I will be asking the Medical Control Board to authorize the provision of H1N1 vaccinations by EMT-Intermediates. Remember, initially it was set up for regular clinic activity. Although the educational content will stay the same, I will be requesting modifications to some of the prerequisites for the purposes of dealing with H1N1 and the need for vaccinators. Also available on NHOODLE is an ambulance decontamination video that covers all the key Center for Disease Control (CDC) guidance and the Airborne Pathogens Education training program updated to include H1N1. Soon weekly to daily reports with updated clinical guidance for EMS will be distributed via the list-serve. As you already know, EMS workers, first responders with DIRECT patient contact will be eligible for the H1N1 vaccine. Hospitals will most likely serve as the distribution points for the key target groups including EMS, first responders with DIRECT patient contact. I am awaiting final confirmation from Dr. Montero. Therefore, you should check with those entities to learn more about the schedule and accessibility.

The Duodote education program is finally complete and posted on the web as well as distributed to the I/Cs. The kits themselves will be distributed shortly. If EMS Units want to stay with Mark-1 Kits, they can purchase them. Additional Duodote kits can also be purchased.

Field Services & EMS Awards: With a still-vacant Licensing Coordinator position and Kathy Doolan out on leave, Christy Dewey, Shawn Jackson, Liza Burrill and Bill Wood (Preparedness assist to FS) all stepped up to the plate and things have rolled along with few bumps. The licensing database has been under review and Shawn Jackson has been testing some newly proposed changes to make our Division database more effective and efficient. He has also been part of a review by the Quality Management Section, of an ImageTrend product for licensing recordkeeping, and he sounded truly impressed with this product. More research will be needed to investigate the feasibility of such a purchase by the Division.

First Responder (FR) Level Providers that are due to expire in 2009 will lapse on September 30th, if not relicensed. All Unit Heads, and FR Providers, are reminded to submit applications in a timely fashion in order to remain licensed and able to provide EMS in New Hampshire. Waivers for anyone who will not have their National Registry card back in time to relicense are available upon request by the Leader of the Provider's affiliated Unit. The waivers are processed in a timely manner, but they do take time….PLEASE keep this in mind as we approach September 30th.

The 2009 EMS Awards Program recipients will be honored along with the Fire Service Committee of Merit members on October 7, 2009, 6:30p.m. at the Capitol Center for the Arts. This year we are honored to have the NH Association of EMTs as co-sponsors on the David Dow Memorial EMS Provider of the Year Award. This year's recipients are as follows:

- NH EMT Association – David F. Dow Memorial EMS Provider of the Year Award: Bobbie Canada, Brookline Ambulance
- Bound Tree Medical – EMS Unit of the Year Award: New London Hospital Ambulance
- Lawrence A. Volz Heroism Award: Bob O'Donnell RN, NREMT-P, Speare Memorial Hospital, and Bobbie O'Donnell, Alec Brenton, Ty Cabone, Devon Thomas, Andrew Kerester, Kyle Sweezey – Lake Rescue and resuscitation on July 16, 2009, Meredith NH
- EMS Educator of the Year: Fran Dupuis NREMT-P, EMS I/C, St. Joseph Hospital

For more information contact Kathy Doolan at (603) 223-4200.

Advanced Life Support: The Medical Director's training is wrapping up. We received a draft of the video which we are fine tuning. There were some technical difficulties with some of the audio clips which Brad is working on. We expect to have this project finished within the next few weeks. Once completed we will be distributing the program to all of the hospitals as well as will be wrapped into the Medical Director Training program funded by rural health and will represent the "home state" piece.

The protocol committee met last week for the 2011 NH Patient Care Protocols. The meeting was spent reviewing comments/suggestions from committee members, as well as those collected by Vicki and Dr. D'Aprix and their relevance to the document. Protocol changes will be made to reflect updates on current standards, such as the forthcoming 2010 AHA Guideline changes, and on evidence-based medicine. The changes will then be brought to the Medical Control Board (MCB) in increments throughout the next 12 months or so for their approval.

The ALS section contributed greatly to the Immunization project updates and the availability of the on-line program to assist with access to this education.

Trauma: At the August meeting of the Trauma Medical Review Committee (TMRC) attendees completed their work on the pediatric component of the NH Trauma Plan. As previously reported the concept is that there will be four levels of pediatric hospital standards. All hospitals seeking assignment under the NH Trauma System will be required to meet, at a minimum, the standards for Level IV pediatric trauma. Hospitals may then elect to seek credentialing at a higher level. Hospitals may have a different level of assignment for adult trauma than pediatric trauma. For example, a hospital may be a Level III for adult, but a Level IV for pediatric. The TMRC membership has been sent a draft of the NH Trauma Plan that includes the changes

made at the August meeting. Clay Odell is waiting for feedback and anticipating approval of the document at the October TMRC meeting.

The Trauma Imaging Committee has met to consider issues related to x-rays and CT scan studies of trauma patients. The committee will create guidelines to assist medical providers in choosing the right study to conduct and what studies could be deferred if a transfer to tertiary care is anticipated. The committee will also try to overcome technical issues with transferring imaging studies from sending hospitals to the tertiary care center. The goal is to minimize the need to repeat CT scans. Dr. Steven Birnbaum, a radiologist and radiation safety advocate from Nashua is participating in the project, and will speak about this issue at the Trauma Conference in November.

The Air Medical Transport Utilization Review Committee has completed its work, reviewing six months' worth of cases. Clay is processing the data and will present a report to the committee for approval, then present the completed report to the TMRC in October. This topic is also on the agenda for the Trauma Conference.

The 9th Annual NH Trauma System Conference is scheduled for November 18, 2009 at the Inns at Mill Falls in Meredith. Topics in addition to those discussed above include a presentation on damage control surgery by Dr. Michael Rotondo from North Carolina, discussion of the new pediatric component of the NH Trauma Plan, breakout sessions on hospital trauma performance improvement, EMS trauma performance improvement, and regional medical and disaster resources. We will be working with Elliot Hospital for physician CME credits, and will grant nursing and EMS contact hours. The conference is once again the grateful recipient of funding from the NH Department of Health & Human Services, Rural Health & Primary Care Section.

Critical Care Transport Committee: The CCT Study Committee met on August 27th. The group participated in an exercise to help develop the "critical thinking" component that the group is considering for the proposed "PIFT" (paramedic interfacility transport) training. The critical thinking exercise would help train providers to make the sometimes difficult decision about whether a patient meets the criteria for the PIFT level or whether the CCT (critical care transport) level is needed. The committee will continue to develop the PIFT scope of practice and curriculum.

Education:

- **2009 EMT-Intermediate Transition Programs:** We have completed seven 2009 Intermediate Transition Instructor Orientations. To date 83% of the eligible licensed instructors have attended one of the orientations. To capture any instructors who were unable to attend previous orientations, an additional instructor orientation session will be held on September 24th.

- **Practical Exam Changes:** As part of the Education Section's continued efforts to streamline the administration of the BLS practical exams some changes have been made effective September 1, 2009. Most of the items involve the administrative process which will be transparent to the candidates testing. These changes include:

  - The minimum number of candidates to host a practical exam will increase from 10 to 15.
  - Exam results will be reported by Bureau of EMS staff only.
  - Bureau of EMS staff will apply moulage to simulated patient assessment patients.

- Persons serving as patients at exams must be at least 16 years old.
- Persons assisting at an exam who are under 18 years of age shall have parent / guardian consent.
- Candidates and evaluators shall only assume one role at an exam and will not routinely be scheduled to serve as both at an exam.

Other changes that have been made are to the exam documents, excluding the skills sheets. The documents will be easier to read and more clearly labeled.

- **Refresher Season:** The 2009-2010 Refresher Season is now upon us. First responder expirations are September 30th with all other levels falling on March 31st. It is recommended that providers complete their refresher course and practical exam as early as possible. The most up to date list of authorized courses and practical exams can be found in the "Course & Exam Schedule" on our website.

- **NH / VT Instructor Recognition:** The NH Bureau of EMS and Vermont Office of EMS Education & Training sections have partnered to address some cross-border education and training issues. A survey went out to all NH & VT Instructors to solicit interest on recognition / licensure in both states. Essentially the goal is to enable authorization of courses in both states which is particularly helpful for refresher training programs for providers who have certification / licensure in both states.

- **Refresher by "Exam-in-Lieu":** NH accepts the NREMT "Refresher by Exam or Exam-in-Lieu" as an alternative to the traditional refresher training program. The process for NH EMS providers is outlined below:

NH Refresher by "Exam-in-Lieu" Process

- Register to take the CBT Exam (www.nremt.org).
- Complete the CBT Exam for your level of certification.
- Upon successful completion of the CBT exam you will receive notification and re-registration documents from the NREMT.**
- Complete the required NREMT documentation.
- Present a copy of the NREMT documentation to the geographically appropriate Education Specialist (Concord, Gorham, and Wilton) who will review the documentation.
- Within 14 days of receipt of proper documentation a "Certificate of Completion" will be issued.
- Submit the NREMT paperwork and the **original** State of NH "Certificate of Completion" to the NREMT.

** **Failure of the Exam will require the candidate to complete the refresher process by traditional methods.****

- **NREMT Electronic Recertification:** The NREMT introduced a new Electronic Recertification process for this refresher season. NH was recently briefed on the process. Although there are some unanswered questions from the NREMT about the process, NH BEMS supports the greater level of efficiency offered by this process. The success of this process hinges on EMS Units' training officers having a NREMT account to track their personnel. EMS units are encouraged to appoint one training officer to

create an account for their agency. Over the next month or so more information and direction about the process will become available.

RQM Update:

Data: As of September 14th, 2009 there have been 66,255 TEMSIS runs entered in 2009 with a total since inception of 455,400 runs entered. There are 277 services reporting out of 294* services for a total percent reporting of 94% of services. *The number of services has been controlled for licensed services whose primary function is to conduct education. These services do not provide reportable direct patient care causing them to remain in the "not reporting" category.

TEMSIS/ImageTrend Updates: ImageTrend has made significant progress in the programming updates for Service Bridge (the version of TEMSIS found on desktop computers). The new Service Bridge will look like the updated Field Bridge, version 4.0. It will have more friendly graphics, visual flow and power tools for entering vitals, medications and procedures. We are anticipating that it will get "turned on" for the whole state sometime in November. Prior to that, we will be conducting pilot tests with a number of different types of services in different regions to identify and resolve any bugs. Brad Weilbrenner will conduct an overview of the new format on Saturday, October 17th, at the North Country EMS Conference.

Tap Chart will be available to services starting in early October. Tap Chart is a modification of the field bridge that allows you to use a Microsoft OS PDA/cell phone to capture patient care information and signatures in the field. The devices are much more affordable than a Tablet ($3000-4000) at around $350, and you can get a replacement warranty if it gets destroyed.

TEMSIS/Bureau Updates: Some of you may have noticed small changes to TEMSIS as you are doing your EMS Incident Report (EMSIR) lately. These include:

>The limiting of report printing formats to just two: 2009 PCR and Billing Report. Likely we will be adding back in three others at some point: the signature printout (for services that don't have Field Bridge/tablets), a comprehensive report that will print every single field for Medical Director and legal purposes, and a QA/review version that will be scrubbed for identifying information (the last two are still being developed).

>A change in the short Status (1-4) definitions was made to more accurately reflect the protocol definitions.

>A reordering of the template menu. *Be aware that Interfacility / Transfer has been set as the <u>default</u> at the top of the list*. Transfers are not being captured because they are being entered under a full report template. The result is that transfer data has not been available to support the development of the Critical Care Transport program and to make other informed decisions. Providers will need to pay close attention to the template that they choose, to ensure that the template matches the run situation.

>A number of default fields have been changed from Not Applicable to Not Recorded. This is a more accurate description in many cases. Note: In particular, the default fields for GCS have been changed to Not Recorded. Now your report will show Not Recorded if you didn't document a specific finding. If Not Applicable is a relevant answer to the field, you will stall have that as an answer choice.

>If services or providers run into any issues in the course of using TEMSIS, please contact us, we can't fix what we don't know about!

There is a new general TEMSIS email account for questions, issues, suggestions, etc.: temsis@dos.nh.gov .

The NHOODLE site is now up. There are two courses on the site, and more will be added soon. All providers already have an account. Your username is your NH license number, and your initial sign-in password is also your NH provider number. The site can be found at www.NHOODLE.org. Check in frequently as we will be adding content.

Upcoming Events: Brad will be conducting a Rescue Service Administrator course on Friday, October 16th at the North Country EMS Conference. In addition, we will be holding a session about quality documentation using TEMSIS and a review of the upcoming format changes to the TEMSIS Service Bridge.

TEMSIS Tip: Don't you hate it when you get all the way through a TEMSIS run form to the Vitals/Treatment tab and you realize you can't remember the run times and have to jump back to the first tab? So did we! Here's a tip we found out: If you are using the Service Bridge, you can pull up your run times while in the vitals/treatment section by hitting F1.

As always, thanks for all that you do and for all your dedication and support for NH EMS. Hope you had a nice summer and I am looking forward to the fall! If we can be of assistance, please do not hesitate to call me at (603) 223-4212.