NH MEDICAL CONTROL Board

NH Fire Academy
Concord, NH

MINUTES OF MEETING

May 19, 2011

Members Present:	Kenneth Call, MD; Tom D'Aprix, MD; Mathurin Malby, MD; Jim Martin, MD; Douglas McVicar, MD; Jim Suozzi, MD; John Sutton, MD; Norman Yanofsky, MD; Clay Odell, Bureau Chief
Members Absent::	Donavon Albertson, Chris Fore, MD; Frank Hubbell, DO; Patrick Lanzetta, MD; MD; Joseph Leahy, DO
Guests:	Jeanne and Steve Erickson, Kevin Jenckes, Stacy Meier, Beverly Tufts, Judy Weatherwax-Knight, Janet Houston, Mechael Pepin, Steve Robbins, Jason Grey, Mark Hastings, Grant Turpin, David Hirsch, MD, Richard Cloutier, Michael Mulhern, Roland Vaillancourt, Patrick J. Twomey, Ted White, Chuck Hemeon, Stephen :'Heureux, Raymond E. Leavitt, Jr, Eric Schelberg
Bureau Staff:	Vicki Blanchard, ALS Coordinator, Chip Cooper, QM & Research Coordinator, Kathy Doolan, Field Services Coordinator, Shawn Jackson

I. CALL TO ORDER

D'Aprix called the meeting to order at 09:00.

EMS Community:
Odell welcomed every to EMS Week and wanted to recognize ACEP for their support of EMS. Additionally, Odell pointed out that the slide show before the meeting was of the 3rd Annual EMS Provider Recognition Day, held on May 7th, the first Saturday in May.

Odell advised the audience that that the email that was circulated regarding the repeal of the refresher practical exam is for this afternoon with the Coordinating Board and not this morning with the Medical Control Board.

II. ACCEPTANCE OF MINUTES

Martin moved to accept the March minutes with the spelling corrections noted. McVicar 2nd.Vote: Passed unanimously

III. DISCUSSION AND ACTION PROJECTS

Prehospital Lactate Levels and Zofran ODT

Tabled due to the absence of Dr. Kelly

2011 Protocol Errors/Additions

Interfacility Transfers

D'Aprix explained to the board that following last March's meeting, the Interfacility Transfer Committee met along with members of the Coordinating Board to address concerns from several agencies and facilities that the proposed protocol might be too restrictive and could adversely impact patient care. The proposal from that ad-hoc committee involves a "safety valve" that would allow for a patient who would otherwise require a CCT level transport to be transported by a PIFT crew if delay would negatively impact patient care.

The board was given a handout with addition language to be added to the Interfacility Transfer Protocol 7.0. See below:

"The MCB strongly encourages the use of paramedics specially trained for the type of patient/condition being transported but, recognizes that a CCT crew may not always be available.
As a measure of last resort, in cases where CCT paramedics are unavailable AND delay in transfer would have a significant negative impact on patient outcome, other transport arrangements may be initiated provided that:

1 - Sending facility makes an exhaustive effort to send additional personnel.

2-The NH Bureau of EMS, and Unit EMS Medical Director are notified within 48 hours and appropriate TEMSIS and IFT documentation is completed by the EMS Unit and the sending physician/institution.

3 – All interventions are within the scope of practice of the transporting paramedic and vehicle."

Malby inquired about the reporting form; D'Aprix stated that we would modify the IFT form Cooper had developed.

McVicar like the language and stated that it was a great model and clearly stated the principals of the IFT protocol.

Martin expressed concern for the Milford Medical Center, a stand alone emergency department, stating it could cause a problem in the rare instance of a patient requesting a transport by their local squad that was not trained to the PICT or CCT level.

D'Aprix noted that Milford Medical Center came up in discussions of the ad-hoc committee and that it was the committee's feeling that since it was an ED as opposed to an urgent care, that it should be held to the same standards as other ED's though out the state.

McVicar moved to accept the new language. Yanofsky 2nd.
Vote: Yes 6, No 1, motion passed.

Left Ventricular Assisted Devices (LVADS)

D'Aprix stated that he had received communication that the Catholic Medical Center (CMC) was putting in LVADs and circulating a protocol. He advised them

that it was the role of the Medical Control Board to write and approve protocols. He then explained to the board and audience that the devices might have a continuous flow and thus the patient might not have any palpable pulse even if the device were operating correctly. It is important that providers NOT do CPR on these patients, as they can dislodge the cannula placed in the heart. D'Aprix suggested that we place the following language in protocol 6.11:

"1. CPR is generally not recommended for ventricular assist device (VAD) patients unless the VAD is not functioning. This can be assessed by auscultating for typical VAD sounds (usually a continuous "hum").

2. Patients should almost never be pronounced dead at the scene, particularly if there is any doubt about whether the device is functioning or not.

3. Most current LVADs generate continuous rather than pulsatile flow. Thus, most patients will not have a palpable pulse and mean arterial pressure can only be measured with a Doppler device and cuff.

4. Given the potential complexities in their management, providers should contact the patient's care team prior to transport to help assist in management. If the presenting problem is LVAD related, transport to the implanting facility, if reasonable, is indicated."

J Suozzi moved to accept the motion, Sutton 2nd.
Vote: Unanimously passed.

Additionally, it was agreed that the protocol committee should look at a new LVAD protocol for the 2013 edition of the protocols.

2013 Protocols

Suozzi reported that the protocol committee has reconvened to begin the 2 year protocol cycle review. The first two meetings were spent discussing the general management of the document. The committee strongly felt they should have more control of the document. It is difficult making changes, sending them off the publisher, then having to proof read again, etc. The committee feels that they have the capability of publishing the document themselves.

The committee also spent quite a bit of time discussing the layout of the document and agreed to divide it out into protocols, policies, and procedures.

D'Aprix stated that it was his belief that the content belonged to the Bureau of EMS, but the format belonged to TMC Books as they had volunteered to develop the format for the Bureau. J Martin stated that he was in support of the committee publishing the document.

Blanchard and D'Aprix stated that they were very grateful for the work TMC Books and Dr Hubble had done on the document in previous years..

Protocol changes:

- Adrenal Insufficiency: No significant changes. Corrected typos.
- Air Medical Transport: Added "both adult and pediatric" under Clinical Conditions, to be consistent with the NH Trauma plan and "STEMI" under Notes to be consistent with the ACS protocol.
- ALTE: Change the opening paragraph under Notes to be clearer that patients who present with an ALTE should be transported because there could be serious underlying conditions. There was discussion regarding the grammar in the new paragraph, which Houston agreed to correct. Additionally, the board directed the committee to bold the bullet that stated to call medical control if parent/guardian refuses transport.
- Communication Failure: A new bullet was added to document any communication failures.
- Allergic Reaction/Anaphylaxis: Suozzi reported that the group discussed the administration of IV epinephrine and the difficulty in drawing up 1mg (from the 10 mg prefilled syringes) and pushing it over 5 minutes in an ambulance. Cooper ran a report to see how often IV epinephrine has been given for allergic reaction/anaphylaxis and reported that there were only 4 cases out of 3973, and out of the 4, only 1 was severe. The committee agreed to remove IV epinephrine from the anaphylaxis protocol. Suozzi would like the board to take the next 2 months and look at some literature and studies the committee has referenced and discuss further at the July meeting. He added that there are other states that have removed IV epinephrine. Additionally, some places have gone to EpiPens only, but understands the financial difficulties that could cause. Yanofsky would like to see the literature; because he sees it used in the hospital and believes it saves lives. There was further discussion regarding the cost of EpiPens and speed in which they can be given over drawing up an ampule. Yanofsky suggested changing the protocol, that the 1st dose is the EpiPen.

The Board agreed to table allergic reaction/anaphylaxis and agreed to the other changes.

EMT Intermediate Transitions:

Blanchard created in-house EMT Intermediate Transition modules for glucagon, nitrous oxide, and nitroglycerin. The programs were distributed to the MCB prior to the meeting. D'Aprix felt the glucagon program could be shortened up. McVicar had some questions on the nitroglycerin slides.

It was agreed that board members should forward comments to Blanchard. Then Blanchard, D'Aprix, and McVicar will meet to make modification.

J Erickson asked when they would be available. D'Aprix responded, after they meet and make the modification; Blanchard will then work on rolling them out to the Instructor Coordinators.

Break

After the break Odell introduced Perry Plummer, the new Director for the Division of Fire Standards and Training & Emergency Medical Services. Plummer stated that he looked forward to working closely with the MCB and would try to regularly attend the MCB meetings.

Documentation Standards

Cooper stated that providers do not have a consistent way of documenting in TEMSIS, so it makes it difficult to query the data. Cooper is in the process of putting together a Data Advisory Committee, which would meet monthly to determine data sets and work on benchmarks. He has identified 24 different stake holders. A consultant, Gary Wingrove, will be brought in to help them get started. Wingrove is an expert in the field.

Cooper pointed out that once services know what we are looking for, that their documentation tends to improve. Cooper suggested starting with RSI and determining what standards we want. Another area to look at is aspirin administration; when he looked at the current data, only 25% of patients with chest pain got aspirin from EMS. E911 may direct the patient to take aspirin prior to EMS, but EMS is not documenting it the "prior to arrival" choice. Blanchard agreed to work with Cooper and reconvene the RSI committee to assist the new Data Advisory Committee.

McVicar asked if there was a function that could audit at the end to be sure items were filled out. Cooper stated that there is a validity score function that he could modify; an example being aspirin documentation and chest pain patients, but first he needs to know what we want document.

Finally, Cooper solicited for a medical director for the committee.

Best Practices – Head Injury Instructions

Odell reported to the board that he and Yanofsky had devised an evidence based (from CDC) instruction tool for patients with head injuries that refuse transport on behave of the Trauma Medical Review Board. He asked if it could be considered as a best practice. Odell handed out copies of the head injury instruction form along with a copy of the CDC's head injury discharge form. The board made some suggested changes to Odell's form, such as removing the term concussion, because EMS would not diagnose a concussion.

The board agreed on the form and then further discussed whether it would be in protocol or a best practice. There was also discussion on other refusals of transport and instruction forms for them, such as diabetics. There was concern that if the document was left as a "best practice" concept that would allow variability in the information that was presented to patients. And even if some agencies might chose not to do it.

McVicar suggested that they pilot the head injury instruction form as a best practice for this protocol cycle, and then consider putting it in protocols for 2013.

The board agreed to put it into a best practice along with a bulletin from the Medical Control Board, supporting the document, but that the opening paragraph needed to be changed to something to the effect of, "your were offered transportation but refused it…"
D'Aprix agreed to draft the paragraph, then put it on letterhead and mention it in the bulletin.

Sutton asked if the Coordinating Board needed to see it. Odell stated this was a clinical issue for the Medical Control Board to decide.

First Responder Expanded Scope

Odell gave a history of the First Responder; in the past under local option some First Responders were taught oxygen administration and vital signs. (It has never been in the D.O.T. curriculum) Then when we went to statewide protocols, we allowed those who were trained under local option to obtain a waiver to continue to practice. If you took a new first responder course, you did not get the additional training, nor the waiver. The North Country people have come to Odell and requested that they allow them to continue to train their first responders to give oxygen and take vital signs. They cited the fact that there are many areas where the first responders are waiting for an ambulance to get on scene for more than a half an hour, and oxygen could potentially be life saving. Additionally, Odell added the changes in the new EMS scope of practice and new education standards do include oxygen administration and vital signs at the first responder level. He asked that the MCB approve oxygen administration and vital signs at the first responder level, under a waiver, until the new education standards are rolled out.

There was discussion regarding oxygen saturation levels in the protocols for cardiac patients and whether that would influence the first responders. J Erickson stated that the indications for oxygen are clearly addressed in the new education standards.

McVicar moved to support oxygen administration and vital signs at the first responder level. Suozzi 2nd.
Vote: Unanimously passed.

Extended Care Protocols

Blanchard reported the Extended Care Protocol committee met on April 21st, below is a summary of their meeting:

Definition of Extended Care:
"These protocols shall be followed whenever the patient is in a remote, nontraditional EMS environment; when implementation is approved by an online Medical Control Physician; or when extended evacuation will be detrimental to the patient."

Who would use this protoco?l:
Any organized team that regularly responds to provide medical care (mountain rescue groups) and current EMS Units/Providers in circumstances as defined Extended Care

Would these providers be considered "good samaritans?":
No, it is not happenstance

How would protocols apply?:

- Those in the team that provide care will require training and certification
- Individual providers will need to be licensed to practice
- Units will need to license as non-transporting Units

- Protocols will include additional bullets with extended care medical control option
- TEMSIS reporting would be required

There were questions regarding how the Mt. Rescue groups would be brought on board. Turpin, committee member, stated that the committee had a member from Fish and Game as well as the Mt. Rescue folks; he is bringing the information back to them.

Stoke/STEMI Survey
Blanchard presented the board with the results of the Stroke/STEMI survey (see attached). D'Aprix stated that the information should be forwarded to the hospitals and hospital coordinators.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report

Bureau and Division Update:
See attached.
Odell also solicited for nominations for the EMS awards; deadline is June 1st.
Cooper added that the Bureau is hosting an EMS Management Course; it is June 3,4,5,10, &17. Please pass the word, there are still open slots. Ideally, Cooper would like to get participation from the North Country folks. It will be held at the Fire Academy, with free lodging in the dorms. The cost of the program is $75.

Legislative Updates:
No report

Coordinating Board Update:
Suozzi stated that today the Coordinating Board will be looking at the Ad Hoc Committee's on the refresher process recommendations, and specifically the topic of whether or not to remove the practical exams from refreshers.

Suozzi also reported that the best practice document was moved onto the front page of the EMS state website to make it more accessible. Additionally, K Doolan went with Blanchard to all the protocol rollouts and gave a short presentation of the best practice document, to help get the word out.

Finally, Suozzi informed the board that his term on the Coordinating Board is up and he is not able to continue. He solicited for another volunteer.

Critical Care Paramedic Task Force:
See above.

Stroke/STEMI Development:
See above.

TEMSIS Update:
Cooper reported that the EMS Medical Director online training has only had 3 participants. He reminded the board it was free and had approved CEU. He

encouraged the board to participate. He will put it out on the list serve again, as a reminder.

TEMSIS survey: The pilot survey has been completed; it was useful for identifying some technical glitches and working them out. Cooper will be sending out a letter next week letting Unit heads know the survey is coming and how to prepare for it.

Trauma System:

Odell reported that besides working on the head injury instruction form, the Medical Trauma Review Committee has been working at the hospital level on a way to assess patients with head injuries who are on blood thinners. They should be going through a rapid evaluation track and given immediate reversal medication if indicated. The committee is looking at this as well as indicators for EMS to notify the hospital and will come up with a protocol. D'Aprix pointed out that there is a new anticoagulant (Predaxa) which cannot be monitored or reversed. It is easier for the patient to take, but more difficult for the emergency department to manage in the case of head injuries.

Additionally, Odell stated that the Bureau is in the process of recruiting a new Trauma Coordinator.

Other Business:

Meier invited the Board to have their September meeting at Cannon Mountain. The board accepted the invitation.

ADJOURNMENT

Meeting adjourned at 11:55

VI. NEXT MEETING

July 21, 2011 location TBA

Respectfully Submitted,

Clay Odell, EMTP, RN, Bureau Chief

Prepared by Vicki Blanchard, ALS Coordinator