NH MEDICAL CONTROL Board

NH Fire Academy
Concord, NH

MINUTES OF MEETING

July 21, 2011

Members Present:	Kenneth Call, MD; Tom D'Aprix, MD;; Joseph Leahy, DO; Douglas McVicar, MD; Jim Suozzi, MD; Clay Odell, Bureau Chief
Members Absent::	Donavon Albertson, MD; Chris Fore, MD; Frank Hubbell, DO; Patrick Lanzetta, MD; Mathurin Malby, MD; Jim Martin, MD; John Sutton, MD; Norman Yanofsky, MD;
Guests:	David Hirsch, MD, Michael Pepin, Grant Turpin, Jeffrey Stewart, Eric Jaeger, Steve Erickson, Jeanne Erickson, Mark Hastings, Steve L'Heureux, Dave Rivers, Paul Leischner, Ted White, Stacy Meier, Steve Robbins,
Bureau Staff:	Vicki Blanchard, ALS Coordinator, Kathy Doolan, Field Services Coordinator, Perry Plummer, Director

I. CALL TO ORDER

D'Aprix called the meeting to order at 09:12.

D'Aprix noted there was no quorum at this time. Today's meeting will continue with discussions only, recommendations will be made to remainder of the board and votes will be taken next meeting, September 15, 2011.

Everyone in the room introduced themselves.
EMS Community:
None

II. ACCEPTANCE OF MINUTES

Item 1. May 201a Minutes
There were no noted errors in the draft May minutes.

Recommendation: Accept the May minutes as written.

III. DISCUSSION AND ACTION PROJECTS

Item 1.Protocols
Suozzi announced to the Board that Rich Kamin (CT Medical Director) is working with the National Association of State EMS Officials on a project to have an

example protocol for states to use. Ours came up as a possibility. In addition to this, there's talk of working towards regionalizing protocols in New England (CT, NH, VT, RI, ME), MA is a possibility.

Suozzi then presented the board with the following updates for the 2013 NH Patient Care Protocols.

Asthma/COPD/RAD: 3 changes.
1. To keep in line with the AHA Guideline's oxygen saturation recommendation of 94%, the protocol was updated to read:
Attempt to keep oxygen saturation ≥ 94% (90% in COPD).

2. The nebulizer treatment was changed from one dose of DuoNeb (albuterol & ipratropium) followed by up to 4 albuterol treatment to also allowing the choice of 4 DuoNeb treatments. It would read as follows:

Consider albuterol 2.5mg and ipratropium 0.5mg OR Unit dose DuoNeb via nebulizer.
►May repeat albuterol 2.5mg via nebulizer every 5 minutes (4 doses total) OR
►May repeat DuoNeb every 5 minutes (4 doses total)

3. Finally, it is being recommended to move the CPAP up from the Paramedic level to the Intermediate level.

Discussion:
D'Aprix stated that in his practice, he does not give multiple or continuous DuoNeb treatments. Suozzi replied that the decision to make the change was based on a consensus statement from the National Heart, Lung, and Blood Institute. He also stated that he was taught to max out at three doses. Leahy stated that he only gives one treatment; Hirsch stated that at Concord Hospital the pediatricians give 3 treatments. D'Aprix summarized: there is evidence that it is not harmful and is possible helpful.

Recommendation: Accept changes.

Allergic Reaction/Anaphylaxis: 3 changes.
1. Expanded the definition of anaphylaxis to include wide spread hives and GI signs and symptoms.
2. Consider EpiPens only, for safety reason and ease of administration
3. Consider removing IV epinephrine at the Paramedic level.

D'Aprix stated he looked into the cost of EpiPens ($80) and generic ($40), yet an ampule is $0.92 and prefilled syringes are $1.00. D'Aprix continued to state that, yes there is a potential for error, however that is true for all medications. Intermediates and Paramedics are trained to identify their medications and how to administer them.

There was further discussion on additional labeling of the epinephrine. It included suggestions of having the Pharmacies add additional labeling, to the Bureau issuing a labeling template for Units to use. It was pointed out that the label could not obstruct the packaging and questions on if the pharmacy would

take them back if the packaging has been altered? A suggestion was made to make up packets with mini Ziplock bags and put a label on the bag.

Meier asked if there was any evidence that any medication errors had occurred? She added, that for switching to EpiPen only/Prefilled syringe only would be a large financial burger for her agency. Suozzi said he did not have any evidence of inappropriate use/adverse outcomes for EMS in NH, but, that he was aware of errors within the emergency department. Ted White stated that Massachusetts had 20 medication errors and have switched to EpiPens. It was a huge expense to his company.

J Erickson suggested working something into the rollout to emphasize the importance of watching the concentration of the epinephrine.

Recommendation: Keep the epinephrine 1:1,000 choice as is, EpiPens, ampules, and prefilled syringes.

The discussion continued regarding removing epinephrine 1:10,000 for IV administration in anaphylaxis refractory to IM epi. Suozzi stated the issue at hand is, literature says to administer IV epinephrine 1:10,000 over 5 minutes, yet we do not require it on a pump.

D'Aprix and Odell both stated they were not in favor of taking it out of the protocol. In cases of profound shock, we have the option of placing an IO and administering; it maybe the only option. McVicar stated that there are no real studies out there, because it was determined in the 1960s that humans have the unique airway reaction to anaphylaxis in which animals do not.

Recommendation: Keep the IV epinephrine in and add a Red Flag box with instructions on how to administer.

Communication: The sentence referencing recorded lines was updated to, "To contact the destination hospital via telephone use of a direct-recorded line to the Emergency Department is recommended," because not all hospitals' have recorded lines.

Discussion: None

Recommendation: Accept changes.

Hyperthermia: 4 changes.
1. Removed the term "environmental" from the title and added a definition for hyperthermia to include, "elevated temperature due to environmental exposure, pharmacologic agents, or excited (agitated) delirium."
2. Added to the bullet shivering bullet: Discontinue active cooling if shivering, cannot be managed by paramedic providers.
3. Added Midazolam to the Adult protocols and Lorazepam, Diazepam, and Midazolam to the Pediatric protocols.
4. Remove flumazenil.

Discussion: D'Aprix asked that they strike the seizure reference, feeling if the patient went into a seizure, of course the provider would move to the seizure protocol. All were in agreement.

With regard to removing flumazenil, Suozzi explained to the board that since 2005 there have only been 23 total recordings of flumazenil use in TEMSIS and of them, one was a duplicate report and four were mis-documented (likely Furosamide and Fentanyl). Of the remaining 18 uses, the majority of time the indication was used for benzodiazepines, yet, many patients were documented as drowsy but alert and one patient received it after documented seizure activity. There was only one case where it was given appropriately (17 y.o. low SPO2 and decreased mental status after conscious sedation in Dentist's office) however probably still outside of protocol because Versed not given by EMS.

D'Aprix stated that if we remove flumazenil from this protocol, it should be removed from all of the protocols.

Recommendation: Accept changes and remove flumazenil from all the protocols.

Hypothermia: Removed the statement regarding chest compressions ½ - 1/3 the usual rate, as it is not in the AHA Guidelines. Also re-bulleted the Basic section for easier flow.

Discussion: D'Aprix inquired as to the necessity for the severity levels of hypothermia chart within the protocol. The consensus from the board and audience was it was helpful.

Recommendation: Accept changes.

Behavioral Protocol: On hold.

Hyper/hypoglycemia:
Removed IO statement

Recommendation: Return the IO bullet to the protocol.

Item 2 Day Camps:
D'Aprix was approached by a day camp for a Medical Resource Agreement, when he discovered, ENV-Wq 907.01.

"Env-Wq 907.01 Required Health Staffing: Day Camps.

(a) Subject to (b), below, a day camp that is not operated for campers who are physically or mentally disabled shall have, whenever campers are present, a camp staff member who is certified in CPR/FPR and a camp staff member who is:

(1) Certified as an Emergency Medical Technician (EMT);
(2) Certified in Responding to Emergencies;
(3) Certified in First Responder;
(4) Certified in Emergency Response; or
(5) A registered nurse, licensed practical nurse, or physician.

(b) The camp staff member who is certified in CPR/FPR and the camp staff member who qualifies under (a)(1)-(5) may be the same individual."

D'Aprix stated that having EMT's treat at camp grounds, in essence, is treating and releasing. Treating and releasing in not within the NH EMS scope of practice. McVicar stated it is also an issue that the providers are not licensed in that environment and agreed he was concerned with the treating and releasing; wound care is within the scope of practice, but not the release.

Odell then presented the board with a short power point presentation where he reviewed our RSAs and Administrative Rules as it pertained to "Emergency Medical Care Providers", "Emergency Medical Services", "Emergency Medical Service Unit", "Medical Control", "A Patient", and "Protocol." He also gave a list of some possible minor camp issues an EMT might encounter; this list had over 20 items on it, and he pointed out the list could be endless. He also stated that this doesn't just pertain to day camps but also events that go on all over the State every day.

Turpin asked if there were any issues with the way the system was working now. D'Aprix stated, no, but camps are looking for guidance and that we should have a a mechanism to manage minor things such as abrasions, splinters, etc that should not require an ED visit

Odell and D'Aprix pointed out that this in the prevue of both the Medical Control Board and the Coordinating Board and will require committee work.

Recommendation: There is no "short term" fix for this problem, a long term solution will involve cooperation with NH BEMS and NH DES and possibly a protocol that provides guidance in these scenarios. If interested in being a member of the committee please contact D'Aprix.

BREAK

Item 3. Rapid Sequence Intubation (RSI) Standards:

Blanchard reported that the RSI Units met and came up with unified documentation standards for RSI. (see attached)

Suozzi would like an emphasis on pre/post vital signs.

Recommendation: Suozzi will work with Blanchard and Cooper on the vital signs and vote for final acceptance will take place at the September meeting.

Item 4. Lift Assist:

In the interest of time, D'Aprix stated he would like to table this discussion until September, but asked for a quick survey of how people documented their refusals?
J Stewart stated that if the call was initiated by 911 they get a refusal.
Jaeger stated they get a refusal for all patients.

Recommendation: Tabled until September

Item 5. Contraindication to Succinycholine

Hirsch stated that he just completed an RSI refresher for Concord Fire and the question came up of what do you do if the patient has a true contraindication to succinycholine? Hirsch then presented a brief power point listing the various contraindications, then pros and cons for not continuing with the procedure versus continuing with non-depolarizing paralytics.

D'Aprix stated that he was surprised that we hadn't thought of this previously. He added that medicated assisted intubation was not an option for reasons the MCB had previously ruled upon. He felt the non-depolarizing agents were the way to go and would recommend vecuronium as it has the shorter ½ life.

Suozzi agreed and added that it would be a rare occurrence.

McVicar suggested sending Hirsch's power point to the remainder of the board for review and discuss further next meeting.

D'Aprix recognized that during the recent training performed by Concord Fire, they discovered in the Administration Packet the requirement for new paramedics to participate in a "live RSI". He stated that was never the intent of the MCB and asked that it be struck. All were in agreement.

Recommendation: Table until September.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Bureau and Division Update:

See attached.

Odell pointed out that the Interfacility Transfer Protocol will go into effect September 1, 2011. He added that the Bureau intends to make site visits to each of the PIFT units within the first 90 days.

Funding was received for a high fidelity child manikin and some additional money to funds for 2 instructors. It is estimated it will cost approximately $400 to run a training session. EMSC will have scholarships to fund 19 – 20 trainings during the 1st year.

First Responder Oxygen and Vital Sign waivers are moving forward. They have received their first request.

Trauma Coordinator recruitment is ongoing. They have received a couple of qualifying candidates and will move forward with the interview process.

Spine Board Study: This study is failing because it is not being used. Odell is going to regroup, look at it again and perhaps work with a smaller more dedicated group. D'Aprix inquired as to what type of feedback he received from

those who did use it. Odell answered, he hadn't spoken with the units, he had only looked at the data.

Legislative Updates: No Report

Coordinating Board Update:
Suozzi reported that he is stepping down as the representative to the Coordinating Board and is look/asking for a replacement. Odell stated they also needed a member from the MCB on the Trauma Review Committee.

Ad Hoc Committee on Refresher Training: The Coordinating Board had approved the recommendation from the Ad Hoc Committee except for the legislation recommendation, as it is not complete.

Best Practice: The Coordinating Board approved three more Best Practices, they are: Concern for Adult/Elder Well-being; Family-Centered Care: Developing Working Partnerships for Children; and Operating on Limited Access Highways.

Finally Suozzi reported there was a lively PIFT discussion, but in the end, it was approved.

Stroke/STEMI Development:
Blanchard reported that the Bureau continues to participate with DHHS's Stroke committee, additionally, she and Odell would be meeting with the AHA and ECC in August to further discuss Stroke designations as is set forth with the Joint Commission.

Blanchard then presented the board with a portion of Goal #5 of the EMS Strategic Plan (see below):

"**Goal # 5:** Initiate within the EMS & Trauma System the development of specialty care systems in collaboration with NH's medical community and stakeholders

- Research expanding legal authority that addresses legislative initiatives specific to STEMI/Stroke/ Pediatric Medical systems including facility standards and transfer policies
    - ✓ Establish a list of what associations, agencies, should be engaged in a specialty care systems discussion"

Odell then asked specifically, as it pertained to the highlighted bullet and STEMI care, what suggestions the board had for associations and agencies we should engage. The following suggestions were made:

Referring hospitals
Cardiology Association
Neurology
Interventional Radiology

TEMSIS Update:
See within the Bureau Bulletin.
Blanchard pointed out that in their packet were two reports, one on Medication Administration and other on Provider Impression. Did the board find it useful?

D'Aprix stated it was helpful, but it should be emailed out and not waste paper. Blanchard then asked if it necessary to fill their packets with documents that were emailed out ahead of time. The board felt it was a waste of paper and all documents should be emailed. The audience then commented, they would not have an opportunity to see the documents. After a short discussion, it was decided that a page could be created on the BEMS's website with documents for upcoming board meetings which could be available for the public.

Trauma System:
See Bureau Bulletin.

Other Business:
ADJOURNMENT

Meeting adjourned at 12:09

VI. NEXT MEETING

September 15, 2011, Cannon Mountain, Franconia, NH

Respectfully Submitted,

Clay Odell, EMTP, RN, Bureau Chief

Prepared by Vicki Blanchard, ALS Coordinator