NH MEDICAL CONTROL Board

NH Fire Academy
Concord, NH

MINUTES OF MEETING

November 17, 2011

Members Present: Kenneth Call, MD; Tom D'Aprix, MD; Chris Fore, MD; Frank Hubbell, DO; Patrick Lanzetta, MD; Mathurin Malby, MD; James Martin, MD, Douglas McVicar, MD; Jim Suozzi, MD; John Sutton, MD; Norman Yanofsky, MD; Clay Odell, Bureau Chief

Members Absent:: Joseph Leahy, DO

Guests: Mark Lang, Jeffrey Stewart, Michael Pepin, Aaron McIntire, Allay Clark, Janet Houston, Ted White, Mary Ellen Gourdeau, Scott Schuler, Richard Cloutier, Jeanne Erickson, Steve Erickson, Paul Leischner, Sean Ellbeg, Stacy Meier, Don Johnson, Eric Jaeger, Christine Beres, Steve L'Heureux

Bureau Staff: Vicki Blanchard, ALS Coordinator, Chip Cooper, QM & Research Coordinator, Kathy Doolan, Field Services Coordinator, Perry Plummer, Director; Angela Shepard, Trauma Coordinator

I. CALL TO ORDER

D'Aprix called the meeting to order at 09:05.
Introductions were made.

EMS Community:
Chief Odell introduced the new EMS Trauma Coordinator, Angela Shepard, MD. Shepard is a NH native who graduated from Plymouth State College and worked as an ED Tech at Littleton Regional before attending medical school at the University of Maryland. After completing her intern year in Emergency Medicine at Christiana Care, she returned to NH to start a family. She recently completed the Preventive Medicine residency at UMass Worcester and is happy to be working with the hospitals and EMS communities.

II. ACCEPTANCE OF MINUTES

Call moved to accept the September 2011 minutes, Sutton 2nd.
Vote: Passed unanimously.

III. DISCUSSION AND ACTION PROJECTS

Membership

D'Aprix reported that we have two nominations for membership, David Hirsch, MD from Concord Hospital and Region 4; and Ray Kelly, MD from Exeter Hospital and Region 3.

D'Aprix continued to state that with these two nominations he realized that there were no formal guidelines or procedures for nominees. Traditionally, a physician will come to the meetings and show interest. After some time they will be nominated by the region and become confirmed by the board after they have had some time to get to know them. Dr Hirsch would be an example. He has been attending meetings on a regular basis for over a year and has contributed to the Board on numerous occasions, and so, the members of the Board. Thus when put to a vote to rafify his nomination, the Board will not be voting on an unknown individual.

In Dr Kelly's case, he worked with RSI sub-committee briefly and is only known to a few members of the Board.

D'Aprix thought that it would be inappropriate to ask the Board to ratify an individual that is not known to all of the members. He explained the situation to Dr Kelly and they agreed that it would be best if Dr Kelly could come to several meetings, so the the Board could become familiar with him and he could observe our activities to be able to gauge his interest before his nomination is voted upon. We can expect him at the January meeting.

McVicar moved to confirm David Hirsch, MD to the NH EMS Medical Control Board. Call 2nd.
Vote: Unanimously passed.

There was further discussion regarding guidelines for membership. D'Aprix wondered if they should consider by-laws. Perhaps consider the nominees be a medical directors or at least an E.D. physician. McVicar then read RSA: A:5 – I (a) "A minimum of 5 physicians representing different geographic areas of the state who shall be nominated by the councils established under RSA 153-A:6 and confirmed by the board and a physician representative of the trauma medical review committee."

Suozzi stated that he did not think it was advantageous to have only E.D. physicians, as pediatricians or other specialist were good to bring to the board. Sutton concurred, adding that as a volunteer board, they should be encouraging all to participate.

Hubbell asked if there were any problems; D'Aprix stated no, just that with these two nominations he discovered there was no formal process or requirements. nothing written down. After extended discussion, the Board did not feel that formal membership criteria was necessary.

EMS Medication Exchange

D'Aprix explained to the board that one of his small non-transporting EMS units had historically exchanged medications used in the field with the transporting commercial EMS unit. The commercial unit changed and the new one would no longer allow this exchange of medications to occur, stating that they believed that

would be in violation of NH law. D'Aprix discussed the issue with the Board of Pharmacy and after explaining the issues, the board stated that the practice that we have traditionally referred to as "medication exchange" would be viewed as "dispensing medications" which is reserved for a pharmacy, thus "medication exchange" is against the law.

On October 14, 2011 a memo was sent out on the EMS list serve explaining the law to the EMS units. Since that time we have received numerous replies that "medication exchange" is a common practice that is widespread in our state. For many agencies abiding by the letter of the law will impose significant hardships.

Hearing the concerns of our community, Dr D'Aprix and Bureau Chief Odell have asked for an audience with the Board of Pharmacy. They have tentatively scheduled us for their January meeting.

Fore asked if this was mostly non-transporting units at the Intermediate level with medications such as Albuterol and IV supplies, to which the reply was yes.

Martin asked if they could just increase the supply they keep on hand covering them until they could back to the hospital to restock? D'Aprix stated that was a possibility, these medications have extended shelf lives.

Jaeger asked if contracts could be written to "pick up" medications for the non-transporting unit by the transporting unit? Plummer stating that is what has been going on for years, and maybe putting it in writing could solve the problem. He added, the concern with increasing the stock pile was the shelf life and dealing with outdates. Clark from Cannon Mountain stated it is a 45 to 60 minute drive one way to restock, which means his community would be left uncovered for up to 2 or 3 hours. He added there is not, "a Rite Aid around the corner", in the North Country.

Shepard added that we should remember to be thinking does the practice benefit the community? Would the Board of Pharmacy consider "restocking" and not dispensing? Lanzetta added that the system has found the most efficient way to work and we need to explain that when we go to the Board of Pharmacy.

Odell read a portion of the Saf-C 5900 under the medical resource agreement that talked about "supply and control of medications"; he wondered if maybe here was a place they could work it in.

Blanchard stated that since the memo went out on October 14th she has received numerous feedbacks and has developed a list of talking points. She will be sending out a request to the EMS hospital coordinators and EMS leaders to reach out to their local hospital pharmacists of our concerns.

In conclusion, D'Aprix stated we did not have a quick fix but would do our best to work with the Board of Pharmacy to find a solution.

EMS in Non-Traditional Environments

D'Aprix reminded the board that this topic was first brought to them from summer camps, but we realized it expands to athletic events of all kinds.

Odell stated the problem lies in our rules where it states an EMS provider must be licensed, and to be licensed they must belong to an EMS unit that has insurance and a medical resource agreement; and finally they must follow protocols. But we do not have protocols for this type of environment.

Odell continued to state that he finds it conflicting that we have rules that state we must be licensed providers working under a licensed EMS unit, when a horse show can hire a first aide provider to cover the event. In that setting, the first aid provider is not breaking any laws, yet if they hire an EMT, the EMT is breaking the law. He stated, that just doesn't seem reasonable; obviously the EMT is better trained to give first aid then someone having only taken a first aid class.

Additionally, Odell stated that if you were a licensed provider covering first aid and you are working the county fair and you see 20 or 30 people and hand out band aids, we do not want a TEMSIS report for all those band aids; and we do not want a refusal form for all those band aids. It is a complicated issue and he feels a committee is needed to look into it.

D'Aprix agreed that a committee should be formed to look into this more closely. Fore agreed and stated that he has seen this with the Pop Warner football in the Concord area. He added if you were a fire department employee and did this extra coverage under the guise of the fire department and something happened, the fire department would not be covering the provider. McVicar agreed and was glad to see it brought up, but felt that 75% of this belonged with the Coordinating Board and 25% with this board. Chief Clark added that he hoped they addressed search and rescue and Fish and Game. D'Aprix stated yes this would fall under the umbrella of this topic.

In conclusion if you anyone is interested in serving on the committee please see D'Aprix or Odell.

Benchmark Project

Cooper reported to the board that his benchmark committee has met with consultant, Gary Wingrove, and developed 5 initial benchmarks to look at. They are:

1. Aspirin administration for chest pain patients.
2.12 lead acquisition for chest pain patients
3. Blood sugar taken for patients with altered mental status (AMS), strokes, or seizures.
4. Stroke scale taken on stroke patients
5. Pain measurement for patients complaining of pain and/or trauma patients.

Martin asked how chest pain was being determined; ischemic versus pluretic? Cooper explained that it is from the provider's impression and added we have to market that we are looking at these benchmarks.

Cooper continued to state that it will take some time to determine what our standard of care is. For instance, will we learn that 85% of our patients with AMS, seizures, or strokes are getting their blood sugar taken and 15% are not because of this or that? We do not know yet.

Fore asked if quantifying pain changes care; he does not think so.

Cooper then showed some preliminarily numbers he pulled from January 1st until this week:
Aspirin for chest pain: 19.47%
Stroke scale for stroke patients: 10.10%
Blood sugar for AMS: 35.70%
Blood sugar for seizures: 35.62%
Blood sugar for stroke: 32.09%

There was then discussion that the general feeling was the patient were receiving aspirin either before EMS arrival at E911's instruction or the providers were giving it to the patients but not recording it. And the same for the stroke scale and blood sugar readings. He also stated that many put the information in their narrative so it does not show up when he pulls the numbers.

McVicar expressed concerns for publishing the data publically. Cooper stated the goal was to put it on a dashboard. McVicar continued to say that people needed to understand what it was saying and there was no advantage to posting it publically. Lanzetta agreed, we needed to be careful how we disseminate.

Schuler stated that many EMS providers are lax in their documentation and unless there are rules built into TEMSIS they wouldn't do it. Cooper said he could build in rules.

D'Aprix stated that we all agree, at this time, the numbers are skewed; but the efforts of the benchmark committee are a great starting point and we look forward to hearing back from them over time. Odell agreed with D'Aprix and added that it will take some time before it is ready for publication.

EMS for Children 2010 Survey
Houston presented the board with the results of a National EMS for Children survey she participated in. The results were:

On line medical control:
National Results:
BLS: 87% always available
ALS: 91% always available
NH Results:
BLS: 100% always available
ALS: 100% always available

Pediatric protocols available during a call:
National Results:
BLS: 63%
ALS: 90%
NH Results:
All BLS: 72% (Non-Transport BLS: 45%)
All ALS: 95% (Non-Transport ALS: 73%)

ACEP Pediatric Equipment on board the ambulance:
National Results:
BLS: 22% carried all
ALS: 34% carried all

NH Results:
BLS: 78% carried all 35 items
ALS: 54% carried all 67 items

Written interfacility transfer guidelines
National: 69%
NH: 45%

Transfer of medical record:	97%	vs	64%
Defined transfer process:	97%	vs	64%
Defined initiation process (roles):	96%	vs	64%
Transfer of signed consent:	95%	vs	59%
Process for appropriate EMS:	85%	vs	64%
Process for appropriate referral:	79%	vs	59%
Plan to transfer personal belongings:	78%	vs	59%
Give directions & referral contact info:	70%	vs	50%

Written interfacility transfer agreements:
National: 59%
NH: 32%

There was discussion regarding the interfacility transfer of pediatric numbers being low because there are really only a few hospitals they would be transferred to and an agreement is not necessary.

Break

2013 Protocols
Blanchard and Suozzi presented the board with the following changes to the 2013 protocols:

Fever:
Move the acetaminophen and ibuprofen administration to the EMT and Advanced EMT level.

There was discussion regarding the scope of practice and if additional training would be necessary. Odell looked in the Advanced EMT text book and found quite a bit of material for aspirin administration; he thought we would need a transition for acetaminophen and ibuprofen. At this time the request was made to have Eric Perry, Education Coordinator come over to the meeting to discuss the idea of a transition for acetaminophen and ibuprofen administration.

Perry arrived and found that it states, “administration of over the counter medications with medical oversight” on page 52 of the Education Standards. He then continued that it then broke out aspirin and oral glucose specifically.

Odell stated that it is a cost/benefit consideration, and we need to be careful on the slippery slope of expanding scope of practice. Sutton asked if there was an actual rule that stated we have to these transitions. Would it be part of off-line medical control? J Erickson stated that this would not take effect until 2013; couldn't they add it into the RTP before then? Odell answered that philosophically and traditionally in NH if we go above and beyond the scope of practice, we have developed transition programs.

The EMS community in the audience then spoke up: Ted White stated they should make a module on NHOODLE. D'Aprix agreed, NHOODLE would be a solution.

Martin moved to approve the fever protocol with an education module placed on NHOODLE for the providers to complete before using the protocol. McVicar 2nd. Vote: Unanimously passed.

Nausea and Vomiting:
It was suggested to change the IV fluid from 500 mL to 250 mL to be consistent with the shock protocol.

D'Aprix stated that if there was no evidence for changing it, that we should leave it alone as we are striving for evidence based practice. we should not be changing, just to change and suggested we leave it at 500 mL.

No further discussion, the protocol will stay as is, at 500 mL fluid bolus and correct the "consider" statement.

McVicar inquired about the use of the word "consider" under the dystonic reaction bullet; and thought it shouldn't state consider, but to actually treat the patient. Blanchard will correct the protocol.

Newborn Care & Newborn Resuscitation:
To be consistent with the 2010 American Heart Association's guidelines the word "oropharynx then nares" was added to the suctioning sentence.

In regard to Newborn Care: Martin asked where the APGAR scale was. It was stated in Routine Patient Care. It was suggested that we also place the scale on this protocol page as well.

No further discussion, approved as presented with the addition of the APGAR scale to the Newborn Care protocol.

Obstetrical Emergencies
Due to the routine standard of care for all postpartum patients the words, "After placental delivery for postpartum hemorrhage consider: Oxytocin…"

There was discussion regarding the flow of the sentence and it was agreed to just state: "After placental delivery give: Oxytocin…"

There was discussion regarding tocolysis and why preeclampsia and vaginal bleeding are contraindicated. It was agreed to remove them from the contraindications.

No further discussion, approved with the above changes.

Pain:
The Pain protocol had been table after the September meeting and the protocol committee was instructed to investigate the use of benzodiazepines in muscle spasms. Suozzi reported back to the board that there really were no head to head studies on this topic.

Lanzetta stated that the protocol should just stick to narcotics. Fore agreed. D'Aprix stated he did some searching and he could find no clear evidence. He added that he doesn't use it; the patients are in pain and need pain control. The paramedics should treat the pain.

Odell spoke up and stated treating with a narcotic and a little benzo can help in situations of moving the patients. He asked if they would consider adding it under medical control orders? Yanofsky agreed, and stated take it out of the standing orders and add it to the medical control order section.

Schuler stated to the board, "you try moving them down a flight of stairs, help us find a way to them out of the house, they are screaming!" J Stewart added that in addition to getting them out of the house, we must then transfer them down our not-so-smooth NH roads. Every bump and turn sends them screaming again. It isn't just a pain issue but and anxiety issue as well.

McVicar moved to, "strike the bullet for standing orders of diazepam for musculoskeletal spasms and modify the Contact Medical Control section to: 'Benzodiazepine administration in conjunction with narcotic administration for patients with musculoskeletal spasms.'" Hubbell 2nd.
Vote: Passed unanimously.

Finally Suozzi stated that at the September meeting they had begun the conversation of narcotics for headaches and the fact that there is clear literature advocating against narcotics for migraine headaches, in part due to the phenomenon of rebound headaches

A bullet was added to the PEARLS that states it is not recommended for first line treatment of headaches and should be reserved for severe headaches only.

No further discussion, protocol approved with the above changes.

At this time the remaining protocols were tabled until the January meeting, due to the time.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report. Fore reported he was stepping down and they would be looking for a new representative

Bureau and Division Update:
See attached Bulletin
Odell added that he a good brainstorming session with the committee looking at best way to move from EMT-I to AEMT. He stated they are looking at all avenues to move this forward and assist the Intermediates in the conversion.

Hubbell moved that the board formally endorse the move from EMT-Intermediate to Advanced EMT. Fore 2nd.
Vote: Passed unanimously.

Legislative Updates:
No report

Coordinating Board Update:
Suozzi has step down from the Coordinating Board representative and we are in need of a new member to represent us. Several board members are considering it at this time.

Stroke/STEMI Development:
Blanchard reported the STEMI/Stroke Point of Entry Summit as been scheduled for June 5, 2012. Please stay tuned as details are worked out.

TEMSIS Update:
See attached Bulletin

Trauma System:
Shepard stated she has nothing further to add to what is in the Bulletin.

Other Business:
Blanchard referred to the new link on the Bureau of EMS's website with all meeting materials and handouts. They will be using this link in the future and will no longer be printing copies.

ADJOURNMENT

Meeting adjourned at 11:54

VI. NEXT MEETING

January 19, 2012 NH Fire Academy

Respectfully Submitted,

Clay Odell, EMTP, RN, Bureau Chief
Tom D'Aprix, MD, Medical Control Board Chairman.

Prepared by Vicki Blanchard, ALS Coordinator

NH Bureau of EMS-Bulletin

VOLUME 1, ISSUE 6 NOVEMBER-DECEMBER 2011

Message from the Bureau Chief

EMT-I CONVERSION PROCESS: The first meeting of the EMT-I Conversion Task Force was held at the NH Fire Academy on November 9th. There were 45 attendees representing a wide variety of services and different areas of the state. The focus of the first meeting was twofold; first an explanation of the reason the Bureau of EMS has made the decision to adhere to the National Registry requirements for EMT-I's to convert to Advanced EMT's (AEMT). The foundation for that decision is the importance of enhancing the professionalism of EMS by adhering to consistent national guidelines. In order to accomplish that EMT-I's in NH will have to successfully complete the National Registry's cognitive exam for the AEMT level at some point during their next two refresher cycles. As you might guess there was considerable discussion among the members regarding the rationale.

The second focus of the meeting was to begin planning for the development of a number of educational "tools" to be able to reach out to the EMT-I community in NH and help them to pass the exam. It was recognized that this will be a costly process, anxiety producing, and will need to address the learning styles and logistics of a variety of providers. The group brainstormed on a number of ideas to pursue. Bureau staff are now compiling the results of that exercise for the next meeting, at which we will begin to flesh out the plans and assign subcommittees to work on the components.

Any individual who feels that they have something to contribute to the process is welcome to attend future meetings. If you are interested please let me know by email and I'll put you on the membership list. Clay.odell@dos.nh.gov

-Clay Odell,
Bureau Chief of the NH Bureau of EMS

Education Section

Refresher Process Q&A
Thank you to all of the instructor/coordinators and providers who attended the Refresher Process Q&A sessions late summer and early fall. There was positive feedback about the changes and enthusiasm about a whole new outlook on the refresher course itself.

Course Audits
As part of the charge of the Commissioner's Refresher Process Ad Hoc Committee we have moved the financial and human resources previously dedicated to refresher practical exams to course audits. A group of 15 part-time employees were trained to conduct course audits in September. We are happy to report that the auditors are finding what we had hoped they would; excellent EMS education in NH's EMS classrooms. The audit process is still new and a learning process for all of us. Thank you to our I/Cs for working with us through this process.

Instructor Cabinet Update
The Instructor Cabinet continues to meet the first Friday of the even months. They continue to serve as a valuable advisory think-tank on emerging educational trends and system changes. Region 3 recently appointed a new representative; the Cabinet welcomes Kevin Jenckes to the group. Thank you to Richard Murphy Jr., for representing Region 3 on the Cabinet so admirably over the last several years.

Inside this issue:

Research & Quality Management

The TEMSIS system will be upgrading to Version 5 on November 29th. This upgrade will benefit providers with faster loading times, new features, including the addition of a Carbon Monoxide data element and more screen space for viewing the runform. The biggest change will be in the visual layout of the home page. We will be sending out literature describing all of the updates including a link to a test site prior to the transition.

The EMS survey report is in draft form and should be complete and available by the beginning of December. The winning participating services for the medical supplies reimbursement incentive drawing are:

Transport services: Barrington Fire and Rescue: $200
Enfield FAST Squad: $100
45th Parallel: TEMSIS consult with BEMS

Non-Transport Services: Langdon Fire and Rescue: $200
Rindge Fire Department: $100
Lakes Region Mutual Aid: TEMSIS consult with BEMS

Advanced Life Support

PIFT Audits: We currently have 33 approved PIFT EMS units. To date we have conducted 4 PIFT audits. Clinical coordinators have been friendly and cooperative, providing positive experiences throughout our visits. We have found, in general, the PIFT units need assistance getting their quality management programs up and running. We have provided materials and examples to assist in the development and execution of these programs and look forward to our follow up visits to see the progress they have achieved. We will continue to audit each PIFT unit throughout the upcoming months.

STEMI/Stroke Summit: Save the date for June 5, 2012 when we will be hosting a summit to look at point of entry plans for STEMI and stroke patients; more information to come in January.

Protocols: The following protocols will be discussed at the Medical Control Board meeting this month: Newborn Care, Newborn Resuscitation, OB, Seizure, Shock, Smoke Inhalation. The Medical Control Board will be looking at an Extended Care Guideline as well as potential extended protocols for the following: Adrenal Insufficiency, Allergic Reaction, Fever. Copies of these protocols can be found at: http://www.nh.gov/safety/divisions/fstems/ems/boards/documents/mcbmaterials.pdf

Trauma & Emergency Preparedness

Trauma Hospital Participation
St Joseph Hospital has successfully completed the renewal application process and is now recognized as an Adult Trauma Level III and Pediatric Trauma Level III Hospital. Congratulations and keep up the great work!

Four other hospitals are currently in the renewal application process and two hospitals who have not previously been active in the state's trauma system, Speare and Wentworth- Douglas, have recently asked about becoming actively involved.

Emergency Preparedness Conference Planning
Our section is working with the Emergency Preparedness Conference planning committee to create some interesting options for emergency responders. If you haven't been to the June conference before now, this will be the year to attend!

Injury Prevention Stories Needed
If any EMS units are involved in injury prevention efforts in their community, we want to hear about it! Please email Angela Shepard and tell her what your squad is doing. angela.shepard@dos.nh.gov

Field Services

EMS Unit Licenses – Form facelift
December 31, 2011 marks the expiration date for all licensed EMS Units and Wheelchair van-for-hire Company licenses in New Hampshire. Re-application packets have been mailed and along with the packets a new application format is being rolled out.

As with more and more of the Division's forms, the Unit application form is now on-line as an interactive PDF document. This makes the form more legible which is more efficient for data entry and processing. The new form has drop-down boxes with standardized responses. The form should be completed on-line, printed off, dated and signed and then mailed in to the Bureau of EMS for processing. The form lists the required documentation that must be submitted with the completed application.

All license applications will each be reformatted in this same manner over the next few weeks. Until these are each complete, the older versions of paperwork will be accepted so as not to hold up the license application process.