NH MEDICAL CONTROL Board

NH Fire Academy
Concord, NH

MINUTES OF MEETING

March 15, 2012

Members Present: Kenneth Call, MD; Chris Fore, MD; Tom D'Aprix, MD; David Hirsch, MD; Frank Hubbell, DO; Joseph Leahy, DO; Jim Martin, MD; Douglas McVicar, MD; Jim Suozzi, MD; John Sutton, MD; Norman Yanofsky, MD Clay Odell, Bureau Chief

Members Absent: Patrick Lanzetta, MD; Mathurin Malby, MD

Guests: Jeffrey Stewart, Aaron McIntire, Chuck Hemeon, Stephen Robbins, Stacy Meier, Eric Jaeger, Sean Ellbeg, Doug Martin, Grant Turpin, Mark Hastings, Jeanne Ericson, Steve Ericson, Chad Miller, Sue Prentiss, Scott Schuler, Paul Robidas, Paul Leischner, Patrick Twomey; Janet Houston

Bureau Staff: Vicki Blanchard, ALS Coordinator, Richard Cooper, QM & Research Coordinator, Kathy Doolan, Field Services Coordinator, Angela Shepard, Trauma Coordinator.

I. CALL TO ORDER

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

EMS Community:
Odell reported that in the past 24 hours there were two crashing involving emergency vehicles. One crash was in Nashua involving an ambulance versus a pickup truck; all minor injuries. The second in Windham where Fire and EMS went through an intersection and it appears the opticon changed back and a police vehicle preceding through an intersection was struck. No major injuries in the Windham accident.

II. ACCEPTANCE OF MINUTES

Item 1. November 2011 Minutes
Fore moved to approve January 2012 minutes as written, Leahy 2nd.
Vote: Passed unanimously.

III. DISCUSSION AND ACTION PROJECTS

Medication Exchange

D'Aprix reported that he and Blanchard met again with members of the NH Board of Pharmacy. After taking into consideration the comments given to them by the EMS community and listening to our presentation at their January 2012 meeting they reversed their decision. EMS providers may resume exchange of non-controlled medication as necessary between transporting and non-transporting EMS units as long as there is an agreement to do so between both agencies.
Discussion: None

Decision: None

Legislation:
Odell reported on a number house bills effecting EMS.

HB 1441: was deemed Inexpedient to Legislate (ITL). This was the bill to remove the requirement to use TEMSIS.

Discussion: Odell stated that with the ITL, the committee has asked that the Bureau of EMS conduct a town meeting to comment on TEMSIS and ways to improve it. The town meeting will be in April or May.

Decision: None.

HB 1631: was deemed Inexpedient to Legislate (ITL). This was the bill that would allow unlicensed EMTs to practice at non-911 events. Both the Medical Control Board and the EMS Coordinating Board sent letters in opposition of HB 1631; Dr. D'Aprix, Director Plummer, and Dr. Strang all testified against the bill and asked that they allow us to develop our protocol.

SB 402: relative to the adoption of policies for the management of concussion and head injury in youth sports, which includes assessing and determining return to play.

Discussion: Houston stated that she has reviewed the bill and the language. She has a proposed amendment that would strengthen the language to say that it is not EMS's role to determine if a patient should return to play. She handed out the suggested language to the board (see attached). Houston continued to add that 35 states have or are pushing to have this same legislation passed.

Odell stated that there is an assessment tool out there, SCAT (Standard Concussion Assessment Tool). This tool could be used, so the potential is there for us to do it, but we are not there yet. He further added that the Department of Safety is neutral on this bill.

Fore stated that the Concord School District had policies and procedures for return to play. Houston commented that some areas are more stringent than others.

D'Aprix stated he supported Houston's suggested amendment. McVicar stated he, too, liked the proposed changes.

Decisions: McVicar moved to endorse the proposed changes as written. Fore 2nd. Vote: Passed unanimously.

HB 1179: regarding an increase in penalty for assaulting health care worker was also found Inexpedient to Legislate.

Discussion: Fore asked what it meant to, "Inexpedient to Legislate", Odell explained that it means it was found to be not advisable or not judicious.

EMS at non-911 Events:

D'Aprix reported that the committee on EMS at Non-911 Events has met twice so far. Most of the meetings were organizational and brainstorming but the following had been agreed upon:

1. Only licensed providers under an EMS unit can practice at these events.
2. The tentative protocol would only apply to scheduled, non-911 where coverage is organized ahead of the event. These would not apply for a 911 initiated call.
3. The provider would only be responsible for patients brought to their attention. There attendance at the event is not for injury/illness surveillance.
4. If the patient's condition exceeds the new protocol the 911 system is to be initiated.
5. There will be a carve out for the provider working under medical direction direct medical supervision - such as at events with medical tents where a physician is present. In these cases the EMS provider can perform beyond the scope of this protocol as deemed appropriate by the physician organizing the care.

He further reported that with the brainstorming issues have been uncovered such as:

- Consent to treat if parents aren't at the event.
    - How much effort to contact the parents? What if we can't contact parents?
- How do you release a minor?
    - The coach?
    - Their friends?
- How are we going to document these encounters?
    - It doesn't warrant a TEMSIS report?
    - Is a simple list appropriate?
    - Should there be a subset in TEMSIS?
- What items do we would we include the protocol?
- Then there is the issue of EMS providers in schools; whose auspices are they working:
    - School physician?
    - Protocols?

D'Aprix concluded that the committee has sorted some things out but there is a lot more work to do.

Discussion: Jaeger stated that he saluted the committee for the work being done. He stated that his unit covers the Special Olympics at UNH and he has providers not associated with his EMS unit which would like to volunteer but cannot the way things are written now. He asked that the committee keep them in mind.

Houston stated camps and other places will hold onto a child's prescriptions and ask that the EMS provider dispense the medication; this is outside the scope of practice for the provider. Hubbell stated that the American Camper's Association has a standard that allows for dispensing of medications, which he believes makes it legal. D'Aprix stated the committee has not resolved how to tackle summer/day camps yet. Odell pointed out that there are homes for the developmentally disabled where non-health care providers are dispensing medication; there is training out there for this. McVicar liked the idea of a training module, adding that invested parents know all about their children's medications, but an EMT may not.

In conclusion, D'Aprix stated he would take these suggestions to the committee and report back.

Decision: None.

Item 4. 2011 RSI Report
Blanchard reported the 2011 RSI numbers. (See attached report.)

Discussion: There was a question as to why Frisbie's numbers were so high. D Martin stated that it was looked at in past and it is the socioeconomic make up of the area such that patients often wait to contact EMS very late in the course of their illness and thus tend to be very sick. Cooper concurred stating when looked at in the past it was relative.

J Martin inquired about the consistency in collecting data. Blanchard responded that there were some specific documentation guidelines in the updated RSI packet that providers should be aware of. Hirsch added that it was difficult to pull consistent data.

Decision: None.

Video Recording of Patient Encounters:
Odell stated that he was approached by a DHMC attorney regarding video taping of trauma resuscitations. The attorney discovered that is was against the law and was considering legislative change. Odell thought it was something we should look at and think about. We could record patient encounters for quality improvement. He stated he has seen new devices that attach to the ear similar to a phone's Bluetooth device for recording. If this is the time to change the legislation, should the board be involved?

Discussion: J Martin stated that it is very often that we find technology is faster than the legislative system. He was concerned would attorneys use it against us. D'Aprix stated that there was a difference between real time streaming and recording. Streaming cannot be retrieved for later use but could be used for real-time telemedicine-type care. Fore stated that Vermont was doing something

similar with telemedicine, and the problem is with consent. He agreed though, from a quality management stand point it would be fantastic. He would love to be able review an RSI recorded in the field.

D Martin inquired was it just video or audio as well; reminding the group of the days of the old LifePaks that audio recorded. Odell stated that there are at least 2 laws; one on audio, which is questionable if it is legal; and the other on video. Meier stated her husband is a police officer; he can video but not audio without consent. She can see video recordings as an effective tool, but worries about law suits and attorneys taking things out of context.

Odell stated protection from discovery might help us. Miller stated that is would be very important to have it protected from discovery. D'Aprix added that while it might be protected, meaning you don't have to share it, should someone do so, it then could be used as evidence.

Schuler stated he could see it used for risk management; with only one provider and one patient in the back of an ambulance, it is one person's word against another on what takes place. It could be a form of protection.

Odell asked if the board was interested in participating with DHMC if they go forward with legislative change? McVicar stated there was no consensus here today, but would monitor the process.

Decision: None.

Protocol Revisions

Suozzi and Blanchard presented the following protocol revision for the 2013 NH Patient Care Protocols:

Drowning/Submersion Injuries

Changed the resuscitation consideration to reflect water temperature.

- If water temperature is estimated to be less than 43^{o}F and submerged:
  - less than 90 minutes—initiate full resuscitation
  - greater than 90 minutes – consider not initiating resuscitation or termination of efforts
- If water temperature is estimated to be greater than 43^{o}F and submerged:
  - less than 30 minutes—initiate full resuscitation
  - greater than 30 minutes - consider not initiating resuscitation or termination of efforts

It was noted that the Paramedic section should be for both Advanced EMT and Paramedic.

Decision: Blanchard to update P to A/P and otherwise, approved as written.

Eye/Dental Injuries

Added milk to one of the agent to soak an avulsed tooth into.

Discussion: None.

Decision: Pass as written.

Septic Shock – New Protocol
This is a new protocol. This protocol will allow up to 4 liters of fluid. Additionally, there is a box for identifying septic shock which includes criteria for the serum lactate device, which some EMS units are carrying now.

Discussion: Sutton stated while looking at the Identification box that it has everything to consider except white count, which cannot be done in the field. Fore asked if there was any thought to weight based fluid management, 2 mL/kg? Suozzi stated this follows ACEP recommendations, as written.

There was further discussion to the confusion between the Advanced EMTs giving up to 4 liters of fluid and the Paramedic section. It was decided to edit the Paramedic section.

Decision: Change second bullet in Paramedic section to change “consider“ to, “continue up to 4,000 mL IV fluid and consider:”.

Shock Adult/Pediatric
Changes were made to bleeding control. Under the Advanced EMT a list of physiological signs shock was added. Finally, under the Paramedic section added phenylephine to be consistent with other protocols.

Discussion: D’Aprix stated there is good evidence that when appropriately used, tourniquets do not lead to tissue damage and he suggested moving it up in the order of treatment modalities. Hirsch added that the hemostatic dressings are really for the NON extremity areas.

J Martin stated that there should be some reference to not over resuscitating the patients and causing pulmonary edema and that we should remind provider to frequently monitor lung sounds. McVicar suggested adding a red flag box. Schuler added that most research refers to mean arterial pressure and would like to see it added to the protocol.

Sutton felt that like septic shock, different kinds of shock required different treatments. Fore suggested the types of shock and treatment be broken out.

Decision: Move tourniquets up and send back to protocol committee to break out types of shock and treatment.

Smoke Inhalation Adult/Pediatric:
No protocol change, added a red flag box regarding SpO2 and CO monitoring inaccuracies.

Discussion: It was noted a formatting error for the first sentence under A/P. D'Aprix questioned the intent of the first bullet in the red flag box and suggested it be reworded.

Decision: Reformat first sentence in A/P and reword first bullet in red flag box.

Break: 15 minute break was taken

Stroke
Only change was to add the wording consistent with the American Heart Association, "last time seen normal."

Discussion: McVicar commented on the graphics used and if there was confusion with the normal versus un-normal face. The consensus was the images were clear in what they were meant to convey.

Decision: None, approved as written.

Airway Management Adult/Pediatric
A new protocol for airway management.
A bullet that allows for the supraglottic airway to be consider as one of the primary airway was included.

Discussion: Schuler stated that he read or heard that literature is suggesting the KING LT use showed a decrease in carotid perfusion. Several studies have suggested this but as there is no concrete data as of yet. Therefore no change indicated.

Decision: None, approved as written.

Airway Management Procedure:
Blanchard explained that up until this point all protocols reviewed were protocols. The remainder of the protocol document were procedure or policies. This airway management procedure is the same as in the past with an added bullet regarding supraglottic airways being an acceptable alternative to the endotracheal tube.

Discussion: None.

Decision: None, approved as written.

Gum Elastic Bougie
Removed the first bullet and made links to referencing protocols.

Discussion: D'Aprix asked if this was on the required equipment list. It is not.

Decision: None, approved as written.

Combitube or Easy Tube:
Suozzi explained that the committee reverted back to breaking out the supraglottic airway devices due to the fact that we were recognizing each procedure separately.

Added Indications and Contraindications, quantitative waveform capnography and securing with commercial airway device.

Discussion: Fore questioned the burn contraindication, stating the provider may need to try something. D'Aprix suggested changing contraindications to "relative" contraindications. McVicar felt they were all relative, but Jaeger stated he perceives it to mean "shall not" if it falls under "contraindications".

Decision: Add "relative" to contraindications for all supraglottic airway procedures.

Continuous Positive Airway Pressure (CPAP)- New procedure
This is a new procedure.

Discussion: Fore suggested getting rid of the Altered Mental Status bullet. D'Aprix suggested there be a red flag to use caution with a patient who has signs of hypercarbia relative to the use of benzodiazepines.

Decision: Remove the Altered Mental Status bullet and create a red flag box cautioning against benzodiazepine use with patients with signs of hypercarbia.

KING LT
Same as the old procedure with the addition of a size chart.

Discussion: There was a question to the contraindication of less than 4 feet. It was determined that the bullet was left over from the 2007 procedure; before there were pediatric sized KING LTs

Decision: Remove bullet contraindicating less than 4 feet and add “relative” to contraindications.

Laryngeal Mask Airway (LMA)
Size chart added.

Discussion: It was noted that the obesity and pregnancy bullet was inadvertently left in the document twice and that it should be broken out. J Martin suggested changing the wording regarding “bagging” to specify bag-valve-mask.

Decision: Break out the obesity and pregnancy bullet. Under #7 change ventilating to “ventilation using bag-valve-mask.

Orotracheal Intubation
Added a chart for the classification of laryngoscopy views.

Discussion: Some formatting errors were pointed out.

Odell pointed out #11 that mandates quantitative waveform capnography devices; which would require a change in administrative rule. It was suggested to change the word “required to “it is the standard of care” in that section.

There was some out cry from the audience stating this had been coming since the 2009 protocols and people were made aware of it and had purchased devices. Odell stated that it was brought to his attention that waveform capnography did not make it into the required equipment list even though the intent was that it should have been there.

Hirsch stated that he had a service that did not have the device and he told them they could not intubate until they have one; in the meantime they could use their KING LT. Odell questioned Hirsch to ask if he had a paramedic unit without the device, he should tell them they cannot intubate? Hirsch stated, “yes”. Odell continued to say we cannot mandate this if it is not in administrative rule. He strongly suggested they change it to read it is a standard of care and not required. McVicar stated that the protocols were in administrative rule, so they did not need to change the language.

Decision: Hirsch moved to keep the protocol as written to require quantitative waveform capnography for intubated patients. Vote: Passed unanimously.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Bureau and Division Update:
See attached.
Odell referred everyone to the first topic regarding changing the name of our Transition modules to the NH Scope of Practice Modules, due to the confusion it was causing with the National Registry's use of the term Transition Modules. We have chosen to change the names of our programs.

Odell informed the group that Eric Perry left the Bureau after 7 years of great service and thanked him for all of his work. The job description for the Education Coordinator had some changes made to it; it is over at Human Resources right now awaiting approval of the changes. Once it is approved he will be listing the position. In the meantime, Chip Cooper will be overseeing the Education Section.

Community Paramedicine: Odell stated he was developing a task force to assist the EMS units that are interested in the paramedicine. Those units include the 45th parallel, Androscoggin Valley Hospital, Frisbie Memorial Hospital, and AMR. The task force will look at if we need to modify the licensing rules, what type of protocol will be followed, and how will medical direction be handled, amongst other things.

Moving Bariatric Patients: Odell stated he was approached by the Plymouth folks regarding moving bariatric patients. He acknowledges that there are only a couple of units in the state with the capability. He said that he would be looking for a best practice for moving these patients in the absence of a bariatric unit.

Short boards/KEDS: Odell reminded everyone that the short board has always been hammered home in every EMT class, to the point that it is one of the practical exam pieces. It has been held up as a standard of care, yet in reality it is used far less than it should be, according to the standard. He has assigned Shepard to devise a survey to be handed out at the Sunapee Conference, IC seminar, and North Country Conference, to poll people in its use.

At this time Shepard handed out a draft survey and people took a few minutes to look it over. It was decided to take the last question and break it out into 2 questions.

Legislative Updates:
See above.

Coordinating Board Update:
No report.

Stroke/STEMI Development:
Save the date: June 5, 2012 for the STEMI/Stroke Summit. Registration form will be available on NHOODLE's Resource Center in the near future.

TEMSIS Update:
See within the Bureau Bulletin.

Trauma System:
See within the Bureau Bulletin.
Shepard added that the Annual Trauma Conference will be held this fall, please stay tuned.

Other Business:
Blanchard reminded the audience that the Bureau Bulletin had the link to the new Protocol Blog and encouraged people to check it out.

ADJOURNMENT

Meeting adjourned at 11:55

VI. NEXT MEETING

May 17, 2012 - TBA

Respectfully Submitted,

Tom D'Aprix, MD - Chairman

Prepared by Vicki Blanchard, ALS Coordinator