NH MEDICAL CONTROL BOARD
Newington Town Hall
Newington, NH

MINUTES OF MEETING
May 17, 2012

Members Present: Kenneth Call, MD; Chris Fore, MD; Tom D'Aprix, MD; David Hirsch, MD; Ray Kelly, MD; Patrick Lanzetta, MD; Joseph Leahy, DO; Mathurin Malby, MD; Jim Martin, MD; Douglas McVicar, MD; Norman Yanofsky, MD Clay Odell, Bureau Chief

Members Absent: Frank Hubbell, DO; Jim Suozzi, MD; John Sutton, MD

Guests: Jeremy Bouchard, David Goldberg, Stacey Meier, Mary Ellen Gourdeau, Richard Cloutier, David Rivers, Steve Erickson, Jeanne Erickson, Jeffrey Stewart, Ted White, Paul Leischner, Janet Houston, Grant Turpin

Bureau Staff: Vicki Blanchard, ALS Coordinator; Richard 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 09:00.

EMS Community:
EMS Week is next week, May 20 – May 26, 2012; Odell wished everyone a happy EMS Week in advance.

Odell thanked the Town of Newington for hosting our meetings today. Odell also announced that there would be a special lunch meeting to brainstorm on the refresher process at 11:00 for members of the Coordinating Board.

II. ACCEPTANCE OF MINUTES

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

III. DISCUSSION AND ACTION PROJECTS

Nomination Ratification
D'Aprix asked the board to ratifying the previous nomination of Ray Kelly, DO for membership on the MCB. D'Aprix pointed out that Kelly was nominated last fall and since that time he has attended all meetings and contributed valuable commentary.

Discussion: None

Decision: Fore moved that the board accept Ray Kelly as a member of the MCB. McVicar 2nd. Vote: Passed unanimously.

Legislation & EMS at Non-911 Events:
D'Aprix explained to the board and guests that originally HB1631 was voted inexpedient to legislate by the House committee and we thought that meant it was dead. However, at the general house session it was brought to a floor vote with some minor modifications and passed which then meant it had to go to a Senate hearing on May 9th. D'Aprix, Strang, and Plummer testified at the public hearing. D'Aprix expressed concern that the bill as written confused liscensure and certification and that it referred to EMS protocols that don't exist. He proposed that all previous amendments be stricken and proposed new wording as follows: "Develop and implement a plan for individuals possessing a New Hampshire emergency services license to provide non-emergency services at social or sporting events. Such plan shall be developed and implemented by July 1, 2013." He expressed that it was the MCB's intent to develop a framework/protocols to be able to achieve this goal. ,

Subsequently, the committee adopted the new language and it was passed by the Senate. (See attached). D'Aprix is happy with the new wording and feels it gives them a set of minimum standards to work with.

McVicar stated that he thought it was much clearer now.

Odell reported that the committee working on the topic of EMTs working at non-911 events have met several times and have another meeting scheduled the beginning of June. At this time the committee is looking at a prerequisite protocol which would require the EMS provider who wishes to provide standby coverage to have the following components:

1. A NH EMS License
2. Malpractice Insurance
3. Medical Oversight
4. Education
5. The ability to freelance with indemnification from any other EMS Units of which they members

Discussion:
Fore questioned about the insurance; J Erickson stated that many of the EMS providers she knows get insurance through a nursing insurance company. It is believed the company is HPSO, available online.

Odell stated he isn't concerned about an EMS provider putting on a band-aid; but rather, they release someone who should have gone to the hospital. He added that the committee is looking at some of the nursing guidelines that break down circumstances as emergent, urgent, and non-urgent. The EMS provider would only treat and release the non-urgent, anything that rose above that would require the activation of 911.

Yanofsky stated that the medical oversight piece made him nervous. D'Aprix asked him what could the committee do to make him comfortable? Yanofsky stated he didn't want anything to do with it. Lanzetta stated he would be comfortable with his EMS providers because he knows them, but not with some random provider. Lanzetta pointed out that everyone has some sort of oversight, and so should these providers.

Odell asked the audience if it was unreasonable to ask the free lancing provider to have medical oversight? Erickson stated she thought it might be difficult to enlist a physician to provide oversight.

Odell further explained that EMS instructors need to have medical oversight to conduct an EMS course and there does not seem to be a problem with that.

Blanchard stated that once they have the guidelines and education outline, it may be easier to see the medical oversight piece.

Decisions: None.

Disclosures:
D'Aprix suggested that the MCB institute the practice of making financial disclosures at the beginning of each meeting in an effort to keep the MCB beyond reproach with respect to possible financial conflict of interest.

Discussion: No one was opposed to this concept. J Houston stated she recently attended a meeting in Washington D.C. where there was lengthy discussion defining "financial conflict." She will send a summary to D'Aprix.

Decision: Beginning with the July 2012 meeting members will disclose any conflicts of interest.

Acute Coronary Syndrome Protocol
Jeremy Bouchard, EMT-P of Peterborough Fire Department approached the board and explained that Peterborough performs transfers for Monadnock Community Hospital. At this time they are looking into a bypass policy for STEMI patient to go directly to the Catholic Medical Center (CMC), with the initiation of Plavix (clopidogrel) and Angiomax (bivalirudin) in the field.

David Goldberg, cardiologist from CMC, further explained that it is their experience at CMC to have had incredible success with these therapies and will be soon publishing results of its use including EMS activation of the cath lab and bypassing the emergency department. He added that both agents are class 1 therapies.

Discussion:
D'Aprix asked what was the cost of the Angiomax? Goldberg stated CMC would exchange with EMS and as such the net cost to the agency would be zero. D'Aprix then asked if EMS had to buy it upfront, what would it cost them; Bouchard answered, $1,400.00. Plummer stated, it was an upfront cost and even with an exchange of 1:1 to EMS never really recouped the initial outlay, and for companies with multiple trucks, that would be difficult.

D'Aprix stated that he had done some reading on the topic and it seems to clearly benefit patient at higher risks of bleeding complications but long term outcomes seem to be about the same as with heparin.

Turpin asked how use of angiomax/plavix would affects someone who ultimately needs bypass. Goldberg answered they would have to wait 3 or 4 days, but that is standard. He added that at this time their (CMC's) emergency department doctors are providing

Plavix, and he is proposing that we treat in the field the same as they are treating in the emergency department.

McVicar agreed that EMS would like to do what is best, but like with the Cyanokit, there are large financial constraints and that stocking these medications could be cost prohibitive.

Shepard pointed out that not all ambulances have 12 leads, realizing many struggle to just get equipment.

Bouchard pointed out that heparin was in the protocol, but not everyone has it. It could be the same for these medications, not everyone would have to have it. Goldberg added that by putting it in the protocol you are allowing it, if a relationship is in place. He doesn't see a downside.

D'Aprix inquired if Goldberg had any prehospital literature or data; D'Aprix found only one Danish study, but, that their EMS system is markedly different in that physicians provide care in the field. He pointed out that whenever possible, the MCB prefers to use evidence based medicine. Goldberg was not aware of any other literature where angiomax was used in the field. Finally, he stated that by giving heparin, you are restricting him from giving the patient the best possible care; Angiomax goes away quicker than heparin and has less bleeding than heparin.

Yanofsky stated he would like to talk to speak with his cardiology staff at Dartmouth Hitchcock Medical Center (DHMC).

Lanzetta asked who else is using it? Goldberg answered, Portsmouth and DHMC (Yanofsky stated that it is not initiated in the ED at DHMC). Lanzetta stated that their cardiologists at Frisbee cannot universally agree on a single approach. Kelly agreed that he has the same experience at Exeter and that the fact that there is disagreement suggests this is an evolving field.

White asked if there was an avenue for them to do this as a trial? In Massachusetts they have a "special project waiver" that allows them to do trials. NH rules do not allow for trials.

D'Aprix concluded that he got the sense that everyone would like to do further research and discuss with their local cardiologists. He suggests we table until July and learn more. Hirsch asked if there was a list of who was using it now.

Goldberg thanked the board for being able to come before them today.

Decision: Table until July.

Scope of Practice Modules:

Cooper handed out a matrix (see attached) of the scope of practice modules.

Cooper explained to the board that at this time the Education Section is looking at the current scope of practice modules and the future modules with the new National scope of practice being implemented. He said the complexity is making it difficult for staff to keep track of who has had what modules, and even more difficult for providers to know

what they need for licensure. He asked the board to look at the modules listed and determine if they still needed all the modules or could they be combined or condensed? He continued by saying that the plan is to eventually have them all modules online via NHOODLE for people to take, but that will take a lot of work and that the first step is to determine which module will be required

Cooper also stated that he and Blanchard had been discussing the idea of packing the protocol rollout, protocol exam, and scope of practice modules all into one program.

Discussion: None.

Decision: The board is to look at the modules and suggest ones to be eliminated or combined.

Break

Protocol Revisions
Martin and Blanchard presented the following protocol revision for the 2013 NH Patient Care Protocols:

Umbilical Vein Cannulation (UVC)
At this time there are no documented UVC in TEMSIS. When EMS providers are starting lines on newborns they use the IO. A survey was done with other states and we could not find any who were using UVC prehospital and suggest that it be removed from the protocols.

Discussion: None.

Decision: Remove the UVC protocol.

Nasotracheal Intubations

- On step 5 added a recommendation of having the ETCO2 attached to the ETT prior to insertion into the nares to guide placement into the trachea was added.
- All other changes are consistent with orotracheal intubation that was approved at the last MCB.

Discussion: None.

Decision: accept as written.

Rapid Sequence Intubation (RSI)
Mostly small edits, also:

- Added more information under Preparation "SOAPME"
- Added estimated countdown to ETI under each step
- Removed recommendation for Cric pressure. Airway guru, Ron Walls, is no longer recommending it as it's been shown to not reduce aspiration and worsen your view.

Discussion: Malby questioned if anyone was still using lidocaine? Fore answered, sometimes. Others concurred they are still using it.

Yanofsky asked if they could add ketamine. D'Aprix stated he didn't believe the Board of Pharmacy would approve as its use is already very restricted.

Malby stated that with the medication shortages, should we have some alternatives? Yanofsky stated that they are experiencing an etomidate shortage and suggested adding midazolam.

There was a question regarding the contraindications, in that, they were specific to succinylcholine and it should be broken out or put into a red flag box.

Decision: Add midazolam as an alternative to etomidate and put the succinylcholine contraindications in a red flag box.

Suctioning of Inserted Airways
Minor grammatical edits.

Discussion: None.

Decision: Accept as written.

Abuse and Neglect
Mostly grammatical and removed the confusing statement at the end.

Discussion: There is duplication of "NH" in the second bullet under Special Considerations.

Decision: Correct the duplication error under Special Considerations.

Advanced Spinal Assessment
Simplified Motor and Sensory assessment and added a red flagged for high risk MOI

Discussion: There was discussion regarding the first bullet under Cervical flexion, extension and rotation, and the terminology, "No midline pain". The word midline was at question. The board agreed it should just read, "No pain."

Decision: Remove the word, "midline".

Bloodborne/Airborne Pathogens
Minor grammatical edits.

Discussion: None.

Decisions: Accepted as written.

Crime Scene:
Minor grammatical edits.

Discussion: None.

Decision: Accepted as written.

DNR
Blanchard asked that they table this protocol. She recently met with NH Healthy Communities and they have come out with at new POLST (Physician Ordered Life Sustaining Treatment) orders that could affect the protocol. She would like to bring it back to the protocol committee.

Discussion: None

Decision: Tabled.

Immunization
Grammatical changes only.

Discussion: None.

Decision: Accepted as written.

Intraosseous (IO) Access:
- Made the indications the same for both the AEMT and Paramedic level, "Drug or fluid resuscitation of a patient in need of immediate life-saving intervention and unable to rapidly obtain peripheral IV access"
- Adding pediatric IO into AEMT (consistent with National Scope of Practice)
- AEMT level will also be allowed to use 2% lidocaine for this procedure as well.

Discussion: Malby asked why there was not an allowance to wait 2 – 5 minutes after the administration of lidocaine, if appropriate?

Decision: Add time allowance after the administration of lidocaine according to standard practice.

On Scene Medical Personal
Removed last bullet.

Discussion: None

Decision: Accepted as written.

Pediatric Transport
Removed Restraint from the title, grammatical edits, and more detailed explanation of securing a child to cot.

Discussion: There was discuss regarding the new explanation of securing the child to the cot and it was asked if it could be clarified and perhaps add a photograph. Houston stated she had a photo that could be used.

Decision: Reword section mentioned above and add photo.

Response to Domestic Violence:
Grammatical and formatting changes. Removed many of the references.

Discussion: None

Decision: Accepted as written.

Vascular Access
Updated skin prep with chlorhexidine.

Discussion: Houston asked why this was only for adult patients. All agreed it could apply to pediatric.

Decision: Change to Adult and Pediatric procedure.

Final Protocol vote:
Fore moved to accept the protocols as discussed today. Malby 2nd.
Vote: Passed, unanimously.

At this time D'Aprix added that he and Suozzi are involved with the New England EMS Consortium, along with the state EMS medical directors from Maine, Vermont, Rhode Island, Connecticut, Massachusetts. The group is working on developing regional protocols. The idea is to start with NH protocols as the base and try to make a set of protocols that could be used by multiple states. He added that there would be no obligation for NH to use the protocols if the MCB ultimately decided not to participate. But, there is a huge benefit if we ultimately participate in that that we would be able to distribute the workload of protocol development with all other participates and thus be

able to devote time to other endeavors. Ultimately, if this would in New England, the goal then would be a national set of protocols.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Bureau and Division Update:
See attached.

Legislative Updates:
See above.

Coordinating Board Update:
No report. D'Aprix acknowledged that there is no MCB representative on the Coordinating Board at the time. He suggests that until such time as a board member is interested in serving on the Coordinating Board, their minutes be provided to us.

Stroke/STEMI Development:
Shepard passed out a working agenda and flyer of the Summit for people to share/post. She reiterated that the goal was to bring together multidisciplinary group of professionals to look at STEMI and Stroke in New Hampshire and begin to develop a shared vision for the future.

Shepard reminded the board that she need a member from the MCB for the Trauma Review Committee.

TEMSIS Update:
See within the Bureau Bulletin.

Trauma System:
Shepard reported that she secured funding for a trauma registry. The registry will be web based and will be able to link EMS records with outcomes. Initially it will be free, but eventually there will be some cost involved to the users.

The Trauma Conference will be a multiday conference at the Mt View Grand this fall.

ADJOURNMENT

Meeting adjourned at 11:35

VI. NEXT MEETING

July 19, 2012 – Fire Academy – Concord, NH

Respectfully Submitted,

Tom D'Aprix, MD. Chairman, Medical Control Board.
Prepared by Vicki Blanchard, ALS Coordinator