NH MEDICAL CONTROL Board

NH Fire Academy
Concord, NH

MINUTES OF MEETING
July 19, 2012

Members Present:	Kenneth Call, MD; Chris Fore, MD; Tom D'Aprix, MD; Frank Hubbell, DO; Ray Kelly, MD; Joseph Leahy, DO; Mathurin Malby, MD; Jim Martin, MD; Jim Suozzi, MD; Norman Yanofsky, MD; Clay Odell, Bureau Chief
Members Absent:	David Hirsch, MD; Patrick Lanzetta, MD; Douglas McVicar, MD; John Sutton, MD
Guests:	Micheal Pepin, Chuck Hemeon, Aaron McIntire, Jeremy Bouchard, Paul Robidas, Scott Schuler, Richard Cloutier, Jeffrey Stewart, Janet Houston, Sue Prentiss, Dave Rivers, Steve Erickson, Jeanne Erickson, Doug Martin
Bureau Staff:	Vicki Blanchard, ALS Coordinator; Kathy Doolan, Field Services Coordinator; Shawn Jackson, Education Coordinator; Perry Plummer, Director; Angela Shepard, Trauma Coordinator.

I. CALL TO ORDER

D'Aprix called the meeting to order at 09:00, introductions were made and no conflicts of interest were announced.

EMS Community:
Odell welcomed Shawn Jackson as the new Education Coordinator.
D'Aprix informed the Board that Dr. Hirsch would not be here today, as his wife just delivered a new son.

II. ACCEPTANCE OF MINUTES

Item 1. May 2012 Minutes
Call moved to approve May 2012 minutes as written, Yanofsky 2nd.
Vote: Passed unanimously.

III. DISCUSSION AND ACTION PROJECTS

Lights & Siren Update
M Pepin reported that at this time the Best Practice Committee planned on presenting to the Coordinating Board this afternoon an updated Lights and Siren Best Practice that would include letters from Primex and the Local Government Center stating that they do not mandate how services uses lights and sirens. Pepin further went on to state that the

committee would like to work with the Instructor Coordinators (I/Cs) to roll this information into the refresher programs.

Discussion: Suozzi stated that he felt this was a good first step, however he cautioned Pepin that more current National Standards are now available and they should consider updating.

Plummer added that educating the I/Cs and rolling the information into the refreshers is only one way to get the information out there. Educating the Professional Fire Fighters, Fire Chiefs, and Service Heads would also be beneficial. The more we can get the information out there the better. D'Aprix inquired what happened when this was brought before the Fire Chief. Plummer replied that ½ or so said it made sense, ¼ wanted more information, and ¼ needed more convincing.

C Hemeon stated that Derry FD uses call determinants; he looks at every run and consistently the call determinants are 92 – 95% accurate. Additionally if a crew decides to run lights and sirens from the scene to the hospital it is required that they document why.

D'Aprix stated that the best practice document should not just lights/siren use to the scene but from it as well

Decision: MCB supports the addition of a section in the Lights and Siren Best Practice regarding the use of lights and siren from the scene to the hospital.

Excited Dilirium:
D'Aprix questioned if the current protocols had for behavioral emergencies allowed for administration of enough medication to properly manage patients with excited delirium.

D'Aprix stated that historically the MCB does tries to avoid intra-cycle changes to the protocols, but, can do so in events where there is a significant safety concern.

Leahy stated that he has recently experienced numerous patients in Nashua with excited delirium from bath salts. He stated there is not a lot of literature but has found the Northern New England Poison Center protocol helpful. His concern is for the providers in the back of an ambulance with these patients. He feels the current Behavioral Emergencies protocol is not sufficient enough to properly care for these patients.

Discussion:
There was some discussion regarding police tazing the patients and transporting them to the hospital. Schuler stated that tazer do not work for these patients. He continued to state that the problem with the current protocol is that you need to call medical control if you want to give more medication and depending on the doctor on the other end of the line, you may not get it.

Suozzi suggested sending out a bulletin regarding bath salts and changing the dosing options for the Behavior Emergencies protocol.

Decision: Leahy moved to change the dosing in the Behavioral Emergencies protocol for excited delirium to:

- Midazolam 5mg IV/IM every 10 minutes as needed.

- If agitation continues after the second dose of midazolam, then consider:
    - Haloperidol 10 mg IM every 10 minutes.
- Contact medical control if more than 10 mg of versed or 20 mg of haloperidol is needed.

Vote: Passed unanimously.

D'Aprix stated he would write a bulletin. Suozzi added that the protocol committee was going to be meeting with Police Standards and Training and they would educate them as well.

Diltiazem

D'Aprix explained that there was no maximum dose for diltiazem bolus in the NH Patient Care Protocols, yet physicians typically give maximums of 20-25 mg. There have been several instances of hypotension from large doses of diltiazem. Some bolus doses have been as high as 70mg. He continued to state that he could not find any clear cut data or standard as to a maximum dose but wondered if the MCB would consider an inter-cycle change to the protocols with a maximum dose of 20 mg?

Discussion: The general discussion among the board was that none of the MCB physicians give doses greater than 20mg even if the 0.25 mg/kg suggests a larger dose. Most started with a small dose of 5mg or 10mg and titrated as needed.

Decision: Suozzi moved to change diltiazem bolus to a maximum of 20mg throughout the protocols and send out an inter-cycle protocol bulletin. Yanofsky 2nd.
Vote: Unanimously passed.

Bivalirudin for AMI in Prehospital Setting

D'Aprix reminded the board of the heated discussion held in May regarding bivalirudin. Since that time board members have been able to return to their hospitals and do some research on their own. D'Aprix's literature review found:

1. There is no proof starting bivalirudin before angioplasty has any benefit.
2. There is no data for prehospital use of bivalirudin.

D'Aprix suggest that the board not consider bivalirudin in the prehospital setting.

Discussion:
Yanofsky stated that he also looked into this further and found that the administration of heparin does not prohibit the use of bivalirudin, as had been suggested, so he does not find any gain.

Fore stated that he and Hirsch spoke to interventional cardiology at their facility and found that there is little agreement amongst cardiologists as to what agent is best to use for PCI for STEMI.

Decision: Fore moved to not approve the request for bivalirudin, as there is not enough evidence to support its use at this time. Yanofsky 2nd.
Vote: Unanimously passed.

Medication Shortages:

Odell spoke of the medication shortages being experienced throughout the country and pointed out that although we do not have a significant problem, there are problems in other states. He would like to see the MCB take a proactive role in preparing for possible

future shortages. He continued by stating they could add medications within a drug class, but if it is not on the formulary it will need to be approved by the Board of Pharmacy. Other states have looked at extending expiration dates or compounding pharmacies to create the medication. He brings it to the board for discussion.

Discussion: Yanofsky stated it has been a huge issue for his region with anitemetics. D'Aprix stated that shortages seem to vary locally. it varies regionally. Others reported shortages as well.

Fore stated that he found it interesting that since the shortages they have starting giving more oral medication instead of IV. That is a possibility for the ambulance depending on the onset times.

Discussion continued surrounding the idea of expanding the EMS formulary to allow for alternative agents to be used.

Decision: The protocol committee and MCB will go through each protocol and consider alternative medication then work with the Board of Pharmacy to expand the formulary accordingly.

Break

Exception Rule

A question was posed to the bureau about administration of factor replacements for hemophiliacs. If the patient has it with them could EMS administer it? We've had similar issues with other medications / medical conditions in the past and looked at individualized protocols, etc. Not only would this potentially be cumbersome, but, we simply can't do this given the way our protocols are adopted in rule.

D'Aprix looked into how other states handle similar situations and found a potentially workable solution from Massachusetts. They refer to it as the "Exception Rule" The text is as follows:

• "The Statewide Treatment Protocols represent the best efforts of the EMS physicians and pre-hospital providers of the Commonwealth to reflect the current state of out-of-hospital *emergency medical care*, and as such should serve as the basis for such treatment.

• We recognize, though, that on occasion good medical practice and the needs of patient care may require deviations from these protocols, as no protocol can anticipate every clinical situation. In those circumstances, EMS personnel deviating from the protocols should only take such actions as allowed by their training **and** only in conjunction with their on-line medical control physician.

• Any such deviations must be reviewed by the appropriate local medical director, but for regulatory purposes are considered to be appropriate actions, and therefore within the scope of the protocols, unless determined otherwise on Department review by the State EMS Medical Director. "

There was great interest in this concept but also concern about possible abuse. D'Aprix reports that the "exception rule" had been in MA protocols for about 6 years and their

medical director reports that it had only been used a handful of times and there were no cases in which it seemed to have been abused. MA Medical Director

Yanofsky and Fore felt there were two items to address:
1. Assisting patients with their prescribed medication
2. Using medications in the formulary and within a provider's scope of practice for emergencies not addressed in protocol.

Jackson pointed out that it works well for providers when they are calling medical control and the doctor knows the scope of practice of the provider, but many times they do not know our scope of practice.

J Erickson suggested the Protocol Committee review and present a NH version of the "exception rule" at the next meeting

Decision: Table, Protocol Committee will look at and bring back suggestions.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

Bureau and Division Update:
Odell announced that the Bureau would be hosting Bariatric Transport Brainstorming session on July 25th from 10:00 AM – 12:00 PM. He notes in that in some resource poor areas it has become a big problem. He encouraged interested services/providers to join the braining storming session. Call-in information has been sent to the EMS list serve.

Transition courses: The EMT-I to AEMT transition course is moving along nicely. The curriculum has been developed and is available; dates for rollout sessions for the I/Cs have been sent out.

Field Services Position: The position vacated by S Jackson since his promotion will soon be posted. A change in the supplemental job description will include language for this position to be the lead investigator in investigation.

EMS Management Course: The course will be held November 2, 3, 4, 9, and 16. Last year's course was a big success and we look forward to having it again this year.

Trauma Conference: The trauma conference will be November 15 & 16th at the Mt. View Grand.

Additional information can be found in the EMS Bulletin (attached).

Odell ended by asking the opinion of the MCB regarding a hospital's authority to limit EMS. As an example he stated, if a hospital or medical director was not comfortable with EMS having IV nitroglycerin and they will not allow them to have it. Is that okay with the MCB? Is it okay if they purchase it elsewhere? Or glucagon; the up front cost is expensive at over $80 a dose. Is it okay that the hospital not supply it, but still allow them to purchase it if they chose to carry it?

D'Aprix stated that a Medical Resource Hospital (MRH) could determine which medications, if any, they would provide that are on the EMS formulary. The purpose for

multiple agents within one category is to allow for variability from one MRH to another based on that facility's formulary.

Odell further reminded the board that the move to statewide protocols was to remove some regional variability.

Jaeger asked if there was a mechanism to prohibit them? D Martin answered that he believed that restriction could come from the MRH but that it would have to be written explicitly.

D'Aprix posed the question, "Is it the general opinion of this board; if a medication (except Prerequisite medications) is in protocol, then an appropriately licensed unit/provider should be allowed to use it?" All affirmed, "yes".

Community Paramedicine

Odell stated the Bureau is proposing a prerequisite protocol in which EMS agencies can partner with other healthcare agencies to address healthcare gaps within their communities. He added that community paramedic is developing nationwide.

The EMS Units will need to meet certain criteria and Bureau would have oversight. An example being used throughout the nation is CHF and re-admissions: if patients are re-admitted within a certain timeframe after dx of CHF, then insurers Medicare will not reimburse the hospital for the second visit. However it might be possible to use paramedics within their community to assess these patients at home. There is evidence that has shown that this process can reduce re-admissions.

Hubbell asked wasn't this what visiting nurses did? Odell stated that was a good question; there are patients out there that currently do not meet the criteria for visiting nurses or home healthcare; the paramedic visits would be episodic care and not long care. It isn't case management and is not meant to compete with the visiting nurses and other home healthcare agencies. Hubbell stated that he thought it would be perceived as competing. Odell agreed and stated that he was working with the Hospital Association to alleviate this perception.

Schuler stated that gap analyses have been performed in certain areas of the state and in those areas the home healthcare folks have been involved and welcome the help of paramedics. He added that a gap analysis at the 45th parallel is going to be different than one for Manchester. He liked the protocol because it allowed for variation.

Odell stated he hoped the MCB would approve the protocol and let Units move forward. Jaeger agreed with Odell and added that this is happening nationally.

Further discussion was tabled so that members could have time to review the process

Coordinating Board Update:

No report.

EMS at Non-911 Events

Odell stated that the committee continues to work on the policy regarding EMS providers at Non-911 events. There next meeting is tentatively scheduled for August 16th.

STEMI/Stroke:
Shepard reported the 1st Annual STEMI/Stroke Summit was a success and received positive feedback. There were approximately 110 attendances, with 94 actually signing in; 20 out of the 26 hospital attended along with12 EMS agencies and a few other interested parties. Our next steps are to set up a series of regional discussions to work on the development of a statewide system. She added that several states are developing statewide systems including Missouri, which last year introduced a STEMI/Stroke/Trauma point of entry plans. D'Aprix stated that he attended the Summit and found there was great interest.

TEMSIS Update:
See within the Bureau Bulletin.

Trauma System:
Shepard reported that she secured funding for a trauma registry. The funding is working its way through the Governor and Council

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

Special Resuscitation Situations & Exceptions
The definition of SIDs was update to Sudden Unexplained Infant Death (SUID) and included all unexplained deaths of infants less than 12 months of age. Additionally a bullet was added, at the request of the Medical Examiner's Officer, that if possible to record the carbon monoxide levels of the rooms where SUID are found.

When to stop section was updated to include instructions for continuation of care for patients with recurrent V Fib or V Tach and instruction for hypothermic patients, and finally a bullet stating if resuscitation is terminated during transport to proceed to the receiving hospital without lights or sirens.

In the section determining death in the field, the bullet that stated to leave the body in place was replaced with a bullet that allowed the body to be moved with collaboration between law enforcement and medical examiner. Additionally language as to the jurisdiction of a dead body were added for clarification. The ME does not need to be involved for hospice patient

The MCI section was removed and a reference to the MCI protocol was added.

The LVAD section was removed and a new LVAD protocol will be developed.

Discussion: There was some discussion as to the legality of stopping CPR and transporting a dead body to the hospital. Suozzi explained that the question was asked directly to Kim Fallon of the Medical Examiners Office and it was determined that it was okay.

Decision: Approve as written.

Do Not Resuscitate (DNR)
A new section on POLST was added

Discussion: Suozzi pointed out that the Comfort-focus Care section was incorrect.

Decision: Approved with the correction made to the Comfort-focus Care section.

Thoracic Injuries
No new changes

Discussion: None

Decision: Accept as written

ADJOURNMENT

Meeting adjourned at 12:05

VI. NEXT MEETING

September 20, 2012 – Fire Academy – Concord, NH

Respectfully Submitted,

Tom D'Aprix, MD, Chairman

Prepared by Vicki Blanchard, ALS Coordinator