NH MEDICAL CONTROL Board

NH Fire Academy
Concord, NH

MINUTES OF MEETING
January 17, 2013

Members Present:	Kenneth Call, MD; Tom D'Aprix, MD; David Hirsch, MD; Ray Kelly, Frank Hubbell, DO; MD; Patrick Lanzetta, MD; Mathurin Malby, MD; Jim Martin, MD; Douglas McVicar, MD; Jim Suozzi, MD; Thomas Trimarco, MD; Clay Odell, Bureau Chief
Members Absent:	Chris Fore, MD; Joseph Leahy, DO; John Sutton, MD
Guests:	Mathew Greenston, Stacy Meier, Jeanne Erickson, Janet Houston, Paul Leischner, Aaron McIntire, Kevin Jenckes, Doug Martin, Gary Zirpolo, Michael Foss, David Rivers, Grant Turpin, Steve Robbins, Steve Erickson, Sue Prentiss, Fred Heinrich
Bureau Staff:	Vicki Blanchard, ALS Coordinator; Rich Cloutier, Field Services, Chip Cooper, Research and Quality Management Coordinator; Shawn Jackson, Education Coordinator; Angela Shepard, Trauma Coordinator

Welcome
The meeting was called to order at 09:15
Introductions were made.

Approval of September Minutes

Discussion: Some typographical errors were pointed out.

Decision: Call moved to approve the September MCB meeting minutes, with corrections. McVicar 2nd. Vote passed unanimously.

1. Bureau and Division Updates:
Odell referred to the EMS Bulletin. (See attached)

- Rollout: We have received much positive feedback.
- New Bureau Staff: Welcomed Rich Cloutier to Field Services. Rich will be filling the vacancy created when Shawn Jackson was promoted to Education Coordinator.
- Preplanned Medical Standby Coverage Plan: The Commissioner has signed the plan; Odell and Blanchard will be working on an introduction training program.
- Administrative Rules: The updated rules have been drafted, unfortunately, our attorney is retiring and we will have to wait until her replacement is hired to finalize.
- Director Plummer: The Director has been temporarily reassigned to Homeland Security and Emergency Management for 4 – 6 months. In the meantime, Jeff Philips will be Acting Director for our Division.

- AEMT: The AEMT continues to move forward; we are still hoping for a mobile testing lab, however at this time we are waiting for the attorneys to iron out the contract.
- D'Aprix stated that some providers were still confused with the AEMT versus EMT-I Scope of Practice with the new protocols. He reminded providers that the EMT-Is can continue to practice at their current level and to refer to Appendix 3 for the specific skills allowed for only those EMT-Is that have transitioned over to AEMT. Odell reminded providers to also read the Preface, as it explains it as well.
- Financial Disclosures: Odell reminded the Board that they had to submit their financial disclosures on a annual basis.

Discussion: None

Decision: None

2. Membership

D'Aprix announced that he has received an official resignation from Norm Yanofsky, MD. He pointed to the dedication in the 2013 Protocols and expressed the Board's appreciation for his many years of service. A dedication plaque was presented. In Yanofsky's absence, Odell accepted the plaque and will deliver.

Discussion: None

Decision: None

3. Trauma Systems:

Shepard reported the following:

- The Trauma Conference held in November 2012 at the Grandview in Wakefield was well received. She plans on returning the conference there next year.
- Shepard continued to report that Dr. Sutton has stepped down as Chairman of the Trauma Medical Review Committee and has been replaced by Dr. Gupta.
- In 2013 she will be reviewing a few more hospitals for their trauma designations.
- The Trauma Plan will be reviewed when the new ACS guidelines are released.

Short Board Study Results:

Shepard reported a survey was distributed to providers about their use of short boards during MVC extrications. 203 completed surveys were returned. Most providers reported using short boards infrequently during MVC extrications that met standard criteria for short board use. In fact 45.9% of respondents indicated they used a short board 0-5% of the time during MVC extrications. Providers feel confident in their ability to apply the device but are unsure it provides effective spinal protection during extrication. Many respondents questioned the value in MVCs stating the lack of evidence to support its use and their concerns that it increases movement of patient.

Discussion: There was a brief discussion, that although the shortboard survey was not scientific, it could be useful in future research.

Decision: None

4. 2013 Protocols

D'Aprix reported that for the first time in the history of the Statewide Protocols they were released on January 1st, with an accompanying rollout video for the providers. At this time he has received much positive feedback.

Discussion: There was discussion on the requirement of the rollout. There is no rule to mandate a protocol rollout; however there is a rule that requires a protocol exam for licensure. Medical Directors and EMS Unit leader can require the rollout. It is the Bureau's belief that it should be the EMS Unit's responsibility to assure all their providers go through the rollout. They can mandate it. There was support from the audience that the Units should mandate. There was also positive feedback for the rollout and the consistent messaging it would provide. Odell thanks the audience for their support and stated that in the future we could work on 3 videos, one for each level.

Cooper recognized the new format and gave Blanchard kudos for the huge amount of work required to format each and every page.

Finally, it was recognized that the New England group (ME, VT, MA, RI, CT, & NH) are looking at regionalizing the protocols and will use NH's as a starting point.

Decision: None.

5. Community Paramedicine

Odell reported that the Community Paramedicine Task Force continues to meet on a monthly basis. It is a group that the Bureau assists in facilitating, yet it is all the members that bring information to the table.

The protocol states that the education will be to National Guidelines, which is college based in which the recommended curriculum will only be released to college institutions. Maine is in agreement with a local college and offering the program for about $2,500 and 200 – 250 hours long. Odell was able to receive a copy of the curriculum, which is an outline of the objectives and not a text book. At the next Task Force meeting the group will go through the curriculum and see how NH can model after it.

Additionally, Odell met with the DHHS regarding their RSA requiring licensing as a home healthcare agency. The law is very clear that anyone caring for a person in their home would require to license, except for physicians. With that understanding, we can move forward to assist EMS units in licensing as such.

Finally, Odell stated that the Community Paramedicine protocol is a prerequisite protocol, however it does not specify who will or will not approve an EMS units, or what the objectives are to meet the prerequisite. We know that we do not want to compete with other home health agencies, but to rather fill the gaps within a community. As we move forward, we will need to put together a panel to approve the units.

Discussion: There was a question as to whether this would require another level of licensure, to which it was answered, no, it would be another credential, like CCT. There was also the question of our licensure falling under DHHS, and would it take the Bureau out of the picture. This too was answered, no; like an RN works under her license regardless of the agency, a paramedic would work under our license.

Decision: None.

BREAK

7. Oxygen Administration by Non-EMS Personnel

The question was posed, with the new AHA guidelines limiting oxygen administration was it still permissible for police, as first responders, to carry and administer oxygen?
Discussion: There was a lengthy discussion from who would provide the training of oxygen administration to which patients should receive it.

Decision: The consensus of the Medical Control Board was that while we would not promote the practice of law enforcement providing oxygen to patients prior to the arrival of EMS providers, for those communities that have decided they want to do it, the practice is probably not harmful in that short period. The Board further felt that if an EMS provider wanted to train law enforcement officers within their town to give oxygen, there is nothing the Bureau would do to prohibit that. The Board did suggest that any education of police officers on how to administer oxygen should include a discussion about the current American Heart Association guidelines that too much oxygen can be harmful, and also a discussion that in a cardiac arrest situation, chest compressions and AED take priority over oxygen administration.

9. On Scene Medical Control

Trimarco stated he rides with his EMS agencies, yet because he is not a licensed EMS provider, if he would like to assist in patient care, the way the protocol is written, he would have to call medical control; yet he is the medical director. It didn't make sense. He wondered how this played out legally.

Discussion: The discussion involved the difference between any physicians on scene versus the EMS Unit's Medical Director. The Medical Director already has a relationship with the Unit, and they all agreed it was okay to ride with the EMS Units. If necessary, it could be added to the MRH. The other issue is defining the role of the Medical Director. In EMS Rule, Medical Direction is defined and the language could be incorporated in the next protocols to make it clearer that EMS Units' Medical Director can participate on EMS calls.

Decision: Modify the protocol in 2013 to include guideline for Medical Directors on scene.

10. Influenza Data

Cooper reported that he has been watching the TEMSIS data on influenza calls. He stated it was difficult because there is not a provider impression, "flu" for the providers to choose. Instead he must do a global search, which turns up any call that includes the word, "flu". So if someone had a "flu shot" and that was documented, it would show up. Then the calls need to be personally reviewed. It is very time consuming. From the data collected they have identified 190 cases of the flu averaging about 15 calls a day, which is actually less than last year at this time.

Discussion: Cooper stated that next year they would have new provider impression fields that will allow them to choose influenza and thereby allow for easier surveillance.

Decision: None.

1. Other Business – At this time the Chairman went around the table and the room and

asked members and visitors if they had any items to be considered for the 2015 Protocol Review.

Suozzi: A Statewide Cardiac Arrest initiative, to include community based, hands on CPR.
Jenckes: Consider for EMTs and AEMTs supraglottic airways for respiratory arrest.
Jenckes: CPAP at the EMT level.
Shepard: Looking for help with putting together Stroke and STEMI system sets.

Finally, D'Aprix thanks Hubbell for becoming the newest MCB member on the Coordinating Board.

Adjournment: 11:22

Next Meeting: March 21, 2013 – Fire Academy – Concord, NH

Respectfully Submitted,

Tom D'Aprix, MD, Chairman

Prepared by Vicki Blanchard, ALS Coordinator