NH EMS MEDICAL CONTROL BOARD

Division of Fire Standards and Training & Emergency Medical Services
Richard M. Flynn Fire Academy
Concord, NH

MINUTES OF MEETING (Approved)
March 19, 2015

Members present: James Suozzi-Chair; Kenneth Call, David Hirsch, Frank Hubbell, Joseph Leahy, Douglas McVicar, Joshua Morrison, John Seidner, Brian Sweeney, Thomas Trimarco; Trevor Eide (membership pending)

Members absent: Patrick Lanzetta and Harry Wallus
Mathurin Malby and Jonathan Vacik - both have resigned and have not yet been officially replaced

Guests: Jeffrey Stewart, Aaron McIntire, Jeanne Erickson, Steve Erickson, Joel Coelho, MaryEllen Gourdeau, Christopher Gamache, Andrew Merelman, Bruce Goldthwaite, Janet Houston, Mark Hastings, Richard Riley, Rick Murnik, Thomas Greig, Stacy Meier, Brian Nicholson, Paul Leischner, Chuck Hemeon, Nick Stadlberger, Patrick Twomey, Stephanie Locke, David Rivers, Pamela Drewniak, Eric Jaeger, Jason Grey, and Grant Turpin

Bureau staff: Director Deborah Pendergast, Bureau Chief Nick Mercuri, Deputy Chief Jon Bouffard, Captains: Vicki Blanchard, Chip Cooper, Kathy Higgins-Doolan, and Shawn Jackson; and Field Representative (Investigations) Richard Cloutier, and Todd Donovan

NOTE: "Action items" are in bold red.

Welcome

The meeting was called to order at 9:07AM. A quorum was determined to be present.

Introductions / Disclosures

Introductions were made. Chair Suozzi gave a membership update:

- Jonathan Vacik resigned and will be replaced by Michelle Nathan, from Catholic Medical Center.

- Mathurin Malby resigned and will be replaced by Trevor Eide, from Frisbie Memorial Hospital. The MCB has a certificate for Dr. Malby who has served on the board for 7 years.

January 15, 2015 Minutes

Frank Hubbell made a motion to approve the minutes from the January 15, 2015 MCB meeting, with edits made in Item 8(pain mgt./pediatric); seconded by John Seidner; motion passed unanimously.

Item 1

Bureau/Division Updates – Bureau Chief Nick Mercuri

The next newsletter will be coming out very soon.

Law Enforcement Provider – emergency rules are now in effect, creating a new level of licensure for law enforcement providers. Nick met with the Chiefs of Police Association on this subject; some plan on participating right away while others need more time to study the rule. Chip Cooper has completed preparatory work in TEMSIS, and Vicki Blanchard has completed the training part. A press release will be coming out very soon. Law enforcement providers will be required to have an MRH.

Mobile Integrated Healthcare (MIH) – The rule was filed, and the Joint Legislative Committee (JLC) sent it back with some slightly different wording. More work was done, and now the Dept. of Health and Human Services (DHHS) has the rule, but we do not know if it has been filed yet; once it is filed, the 90-120 day clock will start.

Leglislation:

HB 130 – the "Blue Light Bill": This bill has passed the House with some slight amendments and will now move over to the Senate by the end of March.

HB 196 – ambulance markings: This bill requires out-of-service ambulances to remove all ambulance related markings so as not to confuse people.

Grants:

Trauma System – The Trauma Medical Review Committee asked that the statewide trauma system be evaluated. An RFP (request for proposal) was posted on Monday. Several groups provide this service, including the American College of Surgeons. It is hoped that the results of the evaluation can be used as a strategic plan.

Ebola and infection control – The State received about 1 million dollars; about 30% has been earmarked for EMS. Discussions are on-going with DHHS, with an emphasis on infection control in general. This grant could be spent on equipment and/or training modules.

EMS System Evaluation – The National Highway Traffic Safety Administration (NHTSA) was here in 1990, and it is hoped that we will have an opportunity to

have them come back in, though it will probably not be for a year or more. Like the trauma system evaluation, it is hoped that this can also be used as a strategic plan.

Item 2

Coordinating Board update – Dr. Frank Hubbell

Dr. Hubbell summarized the last meeting, held on January 15, 2015; here is the link to the minutes from that meeting:
http://www.nh.gov/safety/divisions/fstems/ems/boards/coordinating/cbminutes.html
The next meeting of the Coordinating Board is this afternoon at 1:00PM. (March 19, 2015)

Item 3

Trauma Medical Review Committee update – Dr. Kenneth Call

Dr. Call summarized the last meeting held on February 18, 2015; here is the link to the minutes from that meeting:
http://www.nh.gov/safety/divisions/fstems/ems/boards/traumamedicalreview/trauma_minutes.html
The next TMRC meeting is on April 15, 2015, from 9:30 – 11:00AM at the Richard M. Flynn Fire Academy, Classroom 2.

Item 4

TEMSIS update – Captain Chip Cooper and Todd Donovan

Quality improvement:

Click to see a copy of the CQI Projects Presentation given by Captain Cooper and Todd Donovan. Continued improvements in data collection will lead to improvements on a much broader scale. **Dr. McVicar suggested that an article on the success of aspirin administration in NH be sent to *The Union Leader*.**

Other items of interest:

- We will not be able to participate with CARES, a cardiac arrest registry, because there is no money available to pay the $15,000/year cost. Other tracking means will be examined.
- The Elite transition will not occur until the end of this year.

Item 5

Education Section update – Captain Shawn Jackson

A report was submitted, the contents of which are as follows:

Our implementation of the NREMT's National Continued Competency Program pilot continues to move forward. We have convened a stakeholders' group to determine what the topics for the State/Local requirements will be. "Local" content was divided into two categories – mandatory and flexible (optional suggestions). Mandatory content that was identified by the group included:
Documentation (to improve the quality of data that we receive and make our protocol and other decisions based upon),
Skills reviews (ie: IO, ECG, CPAP, Glucometers, IV Pumps, other service-specific equipment, etc.),
Advanced Spinal Assessment/Spinal Motion Restriction (Dr. Wallus and others have been seeing expanded applications for the protocol indicating a misunderstanding of the protocol on the part of many providers)

Trauma System Triage/Trauma Team Activation/Air Medical Activation (dependent upon local needs – different trauma centers have different activation criteria, transport decisions, etc.)

The EMT-Intermediate to AEMT Transition pass rates continue to be well above the national average – our candidates are still enjoying a 64% first-time pass rate and a 75% overall pass rate. EMT-Intermediate providers are reminded that the deadline to Transition is March 31, 2016 for even-year expirations and March 31, 2017 for odd-year expirations.

The deadline for EMT-Basics to transition to the EMT level is this March for odd-year expirations and next March for even-year expirations. An email communication was sent on October 8, 2014 to all of the currently licensed EMT-Basics (202 providers) expiring 3/31/2015 for whom we do not have a record of a transition course in our files, explaining the need to take a transition course or that they would run the risk of being downgraded to EMR. The same notification was mailed out to those Providers with the relicensing packet sent via US Mail. A final email was sent out to the remaining 103 Providers on March 3, 2015. These Providers were also called via telephone on this date to remind them that action was required. Many had completed the Transition Course out-of-state or were letting their certification lapse anyway.

The Education Section has worked with the eLearning Group to develop the Glucometry Scope of Practice Course for NHOODLE. This program will still need to be delivered in conjunction with a licensed EMS Instructor/Coordinator, but is still in the beta-testing phase

Item 6

Drug Diversion – Jeffrey Stewart

Click on the following link to see the Drug Diversion Sub-Committee report, submitted by Mr. Stewart.

Item 7

Protocols – Vicki Blanchard

A written report was submitted, the contents of which are as follows:

Bradycardia – Pediatric

- For calcium channel blocker overdoses, added calcium gluconate (10% solution) 100mg/kg with a maximum 3000mg/dose; may repeat in 10minutes to mirror Bradycardia – Adult.

CPAP

- Following the PEGASUS recommendation, CPAP was added to the Asthma/Bronchiolitis/Croup protocol.
- It is recommended if a pediatric mask is not available and a small adult mask will fit on an older pediatric patient, the AEMT or Paramedic may use it. The CPAP protocol was updated to add the following bullet to the Contraindications list:
    - Pediatric patient who is too small for the mask to fit appropriately.

Asthma/Bronchiolitis/Croup

- The final version of the Asthma/Bronchiolitis/Croup protocol was presented. No changes were made, only formatting since the January meeting.

Tachycardia – Pediatric

- No changes.

Exception Protocol

- No Changes

Extended Care Guidelines

- No Changes

Routine Patient Care

- New Emergency Medical Dispatch section added to the beginning of the protocol.
- A fluid bolus for dehydrated patients without shock was added under Circulation.
- Links to the Trauma Triage and Transport Decision and Air Medical Transport policies were added under Transport Decision.

Mass/Multiple Casualty Triage:

- Updated to the SALT (Sort, Assess, Lifesaving Interventions, Treatment/Transport) system. SALT is part of the CDC – sponsored project based upon best evidence and designed to develop a national standard for mass casualty triage.

Bariatric Triage, Care & Transport

- New Policy developed for identifying bariatric patients, dispatching information, medical treatment, transporting, and destination hospitals.
- This is an umbrella policy in general; at the local level, where the caches are stored, detailed plans are in development.

Trauma Triage and Transport Decision

- Glasgow Coma Scale score changed from <9 to ≤13.
- In previous versions of the protocols the Glasgow Coma Scale (GCS) score for the Trauma Triage and Transport Decision algorithm was set at <9; this was a reflection of the over triage use of air medical transports. As our trauma system has matured, the Trauma Medical Review Committee recommended changing the GCS score to ≤13 to reflect the CDC recommendations.

Inter-facility Transfers

- Updated the driver portion to include any licensed EMS provider.
- At the AEMT level included mediations within their scope of practice
- Removed incomplete EMTALA language that caused much confusion in the past.
- Updated the term transferring physician to transferring physician/provider, as mid-level providers are also transferring patients.

Mobile Integrated Healthcare

- Change the name from Community Paramedicine
- Complete re-write of the protocol. The old protocol was prescriptive; the new protocol focuses on a community needs analysis for healthcare gaps and a plan to fill that gap, including staffing plan, patient interaction plan, training plan, quality management and data collection, as well as documentation. This is a prerequisite protocol and will require approval from the State before implementation.

Tourniquet Application

- New procedure. The application of a tourniquet has been included in the protocols for a number of cycles, however, since the Boston bombing and lessons learned, a tourniquet application procedure has been developed for best patient outcomes.

Supraglottic Airway:

- The KING, Combitube, and LMA protocols have been combined into one Supraglottic Airway Procedure. The new procedure includes both single lumen devices, such as the KING, iGel, or LMA Supreme and double lumen devices such as the Combitube. The procedure is for EMTs, AEMTs and Paramedics. In the past LMA was only for AEMTs and Paramedic, but with the release of the newer LMAs the Protocol Committee recommends EMTs also be able to use the devices if trained to do so.
- Combitube device to be removed in the 2017 protocols.

Percutaneous Cricothyrotomy Procedure:

- Reintroduced to the protocols. This protocol was removed in the 2011 protocols and per the May 2014 MCB meeting vote, returned for the 2015 version.

- There was a lengthy decision regarding training and credentialing of paramedics in both the percutaneous cricothyrotomy method as well as the surgical cricothyrotomy method (surgical cricothyrotomy procedure was approved at the November 2014 MCB meeting).

Discussion items:
1. Percutaneous Cricothyrotomy is within the Paramedic's scope of practice, however due to the high risk low frequency nature of the procedure, the board felt the training and approval should involve the EMS Unit's Medical Director.
2. Surgical Cricothyrotomy is not within the Paramedic's scope of practice and therefore the procedure would require a Scope of Practice model in order for Paramedics to be licensed.
Per the vote at the September 2014 MCB Meeting, "Cricothyrotomy: …allowing both surgical and percutaneous crics in the protocol and allow the EMS Unit and Medical Director choose which is right for their service."
With the decision left to the Medical Director on which procedure to use, it seemed inappropriate to require all Paramedics to go through a Surgical Cricothyrotomy Scope of Practice module, if their Medical Director decided on the use of the Percutaneous device. It was then determined that the Surgical Cricothyrotomy Procedure could become a Prerequisite protocol, that way only those EMS unit using that procedure would be required to go through the training, that was not within their scope of practice.

Motion: *Tom Trimarco moved to accept the Percutaneous Cricothyrotomy procedure as written and move the Surgical Cricothyrotomy procedure to a Prerequisite Protocol." John Seidner 2nd.* ***Vote: Yes****, Seidner, Hirsch, Call, Sweeney, Suozzi, Leahy.* ***No****: none;* ***Abstained****: Hubbell and McVicar.*

AEMTs formulary for Pediatrics
Blanchard reminded the board that the scope of practice for AEMTs allowed them to administer medications within their formulary to pediatrics. The 2015 protocols have been updated to this. She asked, if the board wanted EMT-I to be able to administer medications to pediatric or only those providers who have transitions to AEMTs.

Motion: *Dr. Hirsch moved, only the AEMTs and not the EMT-Is may administer medications to pediatric patients, per the AEMT protocols." Dr. Seidner 2nd. The vote passed unanimously.*

Odansetron IV route of AEMTs
Gary Zirpolo explained to the board that Odansetron OTD was over $20 a tablet from his medical resource hospital's pharmacy and they would not be supplying it to his ambulance. He inquired if the board would vote to allow AEMTs to give it via IV?

There was a discussion regarding the different routes odansetron may be given, including, not only the dissolving tablet, but also by mouth (PO) with the IV solution. The board was not inclined to move the mediation to the IV route as the PO route was available.

Motion: *Dr. Hirsch moved to add PO route of administration of odansetron to the Nausea and Vomiting protocol. Dr. Seidner 2nd. The vote passed unanimously.*

Fentanyl dose:
Blanchard pointed out that with the exception of the pain protocol, the dosing range for fentanyl throughout the protocols is 25 -100 mg (the Pain Protocol is 25 -75 mg), and she asked, for consistency, if the board would change the dose in the Pain Protocol to 25 – 100 mg.

Motion: *Hubbell moved to change the fentanyl dose in the Pain Protocol to 25 – 100mg, Seidner 2nd. Vote passed unanimously.*

Item 8

Preset medical devices that do not require any interventions for EMS – Vicki Blanchard

Blanchard explained that we routinely get calls inquiring if an EMT can transport a patient, usually to home or an appointment, who has a medical device that does not require any intervention by EMS, such as insulin pumps, PCA pumps, and ventilators with home healthcare managers. She asked if the board would put out a bulletin regarding transport.

The board agreed that something should be put in Routine Patient Care about self-managed or caretaker managed devices.

Motion: *Mr. Hubbell moved and Dr. Seidner 2nd to add to Routine Patient Care, "Non emergent medical transports from home or a medical facility with self or caretaker managed devices is an EMT-B level skill. Caretaker must travel with the patient if it is not a self-managed device."*
The vote passed unanimously.

Item 9

Lorazepam – Vicki Blanchard

Blanchard informed the board that the NH Directors of Pharmacy had a discussion last week regarding the expiration and storage of lorazepam, and the fact that the only formula available needs to be refrigerated. As a result, any EMS unit without a refrigerator would need to use a substitute.

The board had a brief discussion, stating that midazolam and diazepam were both still available and there is no need for any action at this time.

Item 10

BiPap – Brian Nicholson (postponed until the next meeting)

Item 11

Future of Cardiac Arrest – Chair Suozzi

Due to the fact that there are going to be significant changes in the adult cardiac arrest protocol, there will be a separate roll out for it. **This summer, a cardiac arrest "summit" will be held to get all of the stakeholders together; a cardiac arrest registry will be considered.**

Item 12

Topics ad libitum

There was a discussion regarding who needed to be present during an RSI procedure; the protocol currently requires 2 RSI paramedics or 1 RSI paramedic and 1 RSI assistant. The board and members of the audience agreed that a licensed paramedic would have enough knowledge to assist an RSI paramedic during the RSI procedure. The protocol was amended to read, "This procedure is only to be used by paramedics who are trained and credentialed to perform RSI by the NH

Bureau of EMS. One RSI paramedic and one RSI assistant or non-RSI paramedic must be present."

Chair Suozzi thanked the Protocol Committee for their hard work.

Adjournment

Motion *to adjourn at 12:05PM made by Dr. Suozzi and seconded by Dr. Hubbell; passed unanimously*

Next meeting: Thursday, May 21, 2015 at 9:00AM / Richard M. Flynn Fire Academy, Dormitory Building/Classrooms 5 & 6

Future meetings: July 16, September 17, and November 19, 2015

Respectfully submitted,
James Suozzi, DO, Chairperson

Prepared by:
June Connor
Administrative Assistant I
june.connor@dos.nh.gov