



State of New Hampshire

Department of Safety

Division of Fire Standards and Training and Emergency Medical Services

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John J. Barthelmes
Commissioner

Richard A. Mason
Director

MEMORANDUM

TO: NH EMS Unit Leaders
NH EMS Hospital Coordinators
NH EMS Regional Chairpersons

FROM: Sue Prentiss, BA, NREMT-P, CMO, Chief
FST & EMS
Bureau of EMS

RE: Division of Fire Standards and Training & Emergency Medical Services (FST & EMS) – Bureau of EMS Report

DATE: November 2, 2009

On behalf of the New Hampshire Department of Safety, Division of Fire Standards and Training & Emergency Medical Services (FST & EMS) I am pleased to update you on our activities.

As of November 2, 2009, the Bureau licensing numbers are:

| | |
|-------------------|------|
| Apprentice | 15 |
| First Responders: | 225 |
| NH EMT-B | 72 |
| NREMT-B | 2274 |
| EMT-I | 1293 |
| EMT-P | 778 |

TOTAL: 4657

There are 304 (167 transporting and 137 non-transporting) licensed Units. We have 140 I/Cs, including 7 Provisional. Licensed and inspected vehicles to date 440. We have seen a slight increase in the number of vehicles which we attribute to two Massachusetts companies that routinely do business in NH becoming licensed Units, which includes licensing vehicles.

Bureau of EMS Report: We recently received the news that the Licensing Coordinator position will be posted, however, prior to an internal posting, Human Resources needs to see if there are any candidates from the recent layoffs who would be suited for that position. The Field Services staff is doing a great job maintaining a high level of service for licensing in the interim.

Fire Training – Certification – Fire Academy – Emergency Medical Services

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<http://www.nh.gov/safety/divisions/fstems>

With the appointment of Sheri Kelloway as the new counsel for our Division, once again we have picked up the draft rules and begun regular meetings. Attorney Kelloway was our counsel when we first came to the Department and was responsible for the permanent set adopted in 2002. These are being drafted with the work already reviewed by the EMS & Trauma Services Coordinating Board (protocol rules, equipment list, CPR card removal as licensure requirement) There will be time for review and there will be public hearings. I have been working on rules weekly since early August. Kathy Doolan will be taking back over, however, I will remain involved.

I have seen a rise in anonymous complaints being mailed to the Bureau. We have a process for third-party complaints outlined in rule. It is tough to manage because many of them are either personal or they are containing information on a concern that would be an easy clarification, however, the inability for me to contact the person who wrote the letter leaves a void of communication. I have recently addressed this and hope the clarification helps those to understand the right thing to do!

If you are an EMS Unit leader who is applying for a waiver for one of your members please be aware that there are Administrative Rules that address this specifically:

Saf-C 5903.08 Waivers of Unit and Provider License Applications.

- (a) Pursuant to RSA 153-A:10, VI and RSA 153-A:11, V applicants for a unit or provider license may request a waiver of licensure from the commissioner for good cause.
- (b) For this section, "good cause" shall include:
 - (1) Evidence of a prior good faith effort to comply with each requirement for which a waiver is requested;
 - (2) A statement documenting why the unit or provider cannot comply with each requirement for which a waiver is requested, including any financial or other significant hardship resulting from efforts to comply;
 - (3) A statement and supporting documentation that non-compliance with each requirement for which a waiver has been requested shall not prevent the unit or provider from providing adequate care to patients;
 - (4) Reasons why non-compliance with each requirement for which the waiver has been requested is not possible for a given period of time; and
 - (5) A plan for compliance with each requirement within the period requested on the waiver application.
- (c) Requests for waivers shall be submitted in writing to the commissioner.
- (d) The waiver request application from the unit or provider applicant shall include:
 - (1) The full name of the applicant;
 - (2) Current mailing address;
 - (3) Telephone number(s);
 - (4) The specific rule for which the waiver is requested;
 - (5) The reason for requesting the waiver;
 - (6) The hardship that would occur if the waiver was not approved;
 - (7) A plan of compliance with the rule to be waived and the date of compliance; and
 - (8) The signature of the applicant.
- (e) The commissioner shall issue a written approval or denial of a waiver request to the applicant within 60 days of receipt of the request.
- (f) Upon a finding of good cause, the commissioner shall approve a waiver of licensure.
- (g) A waiver of licensure shall be considered as a fulfillment of the licensing requirements only for the period specified in the waiver.
- (h) The commissioner shall deny the waiver request if, after reviewing the material submitted in (d) above, it is determined that:
 - (1) Granting the request shall result in the waiver circumventing the rule for which the waiver was requested;
 - (2) The unit or provider shall be unable to meet the needs of the patient(s) or community; or
 - (3) The health or safety of the patient(s) or community shall be jeopardized.
- (i) A decision by the commissioner to deny a waiver request shall be final.

President Obama's Declaration of a Public Health Emergency has potential implications for EMS that are not being reported as EMS concerns per se in the popular media. The President's declaration puts in motion the government's ability to grant "EMTALA waivers" to hospitals that are unable to manage patient surges in face of influenza. **As of today, we have not had that level of surge in NH and no waivers are pending.** In response to the 2009 H1N1 influenza virus, the Secretary of Health and Human Services, Kathleen Sebelius, first declared a public health emergency under section 319 of the Public Health Service Act, 42 U.S.C. 247d on April 26, 2009.

The Secretary has renewed that declaration twice, on July 24, 2009, and October 1, 2009. There have been no declarations within NH, either of a Public Health Incident or a State of Emergency. This activity is at the national level, however, there could be implications on NH, which would affect your operation, specifically the interfacility transfers of patients as well as patients being transported to temporarily established Acute Care Centers (ACC). Please review the following:

An EMTALA waiver allows hospitals to:

- Direct or relocate individuals who come to the ED to an alternative off-campus site, in accordance with a State emergency or pandemic preparedness plan, for the Medical Screening Exam (MSE)
- Effect transfers normally prohibited under EMTALA of individuals with unstable Emergency Medical Conditions (EMC), so long as the transfer is necessitated by the circumstances of the declared emergency.

By law, the EMTALA MSE and stabilization requirements can be waived for a hospital **only if**:

- The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act ; **and**
- The Secretary of HHS has declared a Public Health Emergency; **and**
- The Secretary invokes her/his waiver authority (which may be retroactive), including notifying Congress at least 48 hours in advance; **and**
- The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.

CMS will provide notice of an EMTALA waiver to covered hospitals through its Regional Offices and/or State Survey Agencies.

Duration of an EMTALA waiver:

- In the case of a public health emergency involving pandemic infectious disease, until the termination of the declaration of the public health emergency; **otherwise**
- In all other cases, 72 hours after the hospital has activated its disaster plan
- In no case does an EMTALA waiver start before the waiver's effective date, which is usually the effective date of the public health emergency declaration.

It has been reported by NASEMSO that Secretary Sebelius has invoked her waiver authority but it appears that this situation is imminent. Should we learn of waivers being granted, specifically for EMTALA , we will notify EMS Units. Again, no activity to date.

Whether or not you are giving the vaccine or getting the vaccine, if your EMS Unit has not already gotten into the loop on H1N1 vaccine for your "first responders with direct patient contact", you need to let us know. The primary distribution plan for the H1N1 vaccine targets hospitals and medical practices. The Immunization Program at NH Department of Health and Human Services (DHHS) communicated with hospitals and requested that their numbers submitted for H1N1 vaccine included local "first responders with direct patient contact". However, in a follow up with the Immunization Program staff at Dept of Health and Human Services it has been decided that EMS Units can apply for and become their own sites to receive the H1N1 vaccine and administer to EMS Providers (first responders with direct patient contact*). That being said, here are your options:

- 1) EMS Units can go to their local hospital and work with them to get vaccinations for their providers (first responders with direct patient contact*)
- 2) EMS Units can apply to receive H1N1 vaccine, run their own clinic and administer the vaccine to their own providers and/or in collaboration with other EMS Units
- 3) You can approach the AHHR you are a part of and discuss with them the option of having an EMS POD, basically an amendment to the plan they have already

If you chose to run your own clinic and vaccinate your own providers (and/or a groups of EMS Units together), then you will need to complete the prerequisites that go along with protocol 5.12. The waiving of prerequisites for that protocol by the Medical Control Board (MCB) was to meet the emerging needs of AHHR and their Points of Distribution (POD). EMS workers, Paramedics and EMT-I (for H1N1 only) practicing under this waiver must work

under the structure of an H1N1 POD established by an AHHR, there must be appropriate medical supervision, screening tools, storage plan etc.

If an EMS Unit wants to do this on their own, like seasonal flu and pneumococcal vaccinations, follow the simple prerequisites so that all are protected and we don't lose this privilege. This information was communicated on September 29, 2009, as well. A reminder, the Immunization Training program is available on www.nhoodle.org

(*According to the Department of Health and Human Services (DHHS), Division of Public Health Services)

Additionally, the Home Care Association (HCA) will be working under a contract with the state, Department of Health and Human Services (DHHS), to administer the large public H1N1 vaccination clinics. They have sent a notice to all EMS Units letting them know that they will be providing this service as well as they are set up to subcontract with EMS Units to provide community based clinics. Reimbursement is part of the subcontract, so people will be paid for their time. Whoever is the subcontracting EMS Unit will need to have met the prerequisites. The handling of vaccine and the medical supervision are very important to have in place and that's a major part, outside of training, that the prerequisites assure. There have been multiple list-serve notices specific to the overall vaccination process. Also available on NHOODLE is an ambulance decontamination video that covers all the key Center for Disease Control (CDC) guidance and the Airborne Pathogens Education training program updated to include H1N1.

As discussed numerous times, there are 15 AHHRs. These groups include EMS, Fire and Police are partners in these regional emergency planning and response models. If you are not engaged with these groups, even just knowing who Point of Contact (POC) is and their information is important. There are resources for planning, response, training and most visibly these days, the PODs. AHHRs would play a major response role in an emergency, statewide or local, as they have Multi-Agency Coordinating Entities (MACES), which were stood up during the ice storm December 2008. Acute Care Centers (ACC's) fall under the AHHRs, in terms of planning and establishment – obviously in close collaboration with the medical community. The link to the AHHR information is:

<http://www.dhhs.state.nh.us/NR/ronlyres/eo7qxcsl7r7zwlqyxi4dig3t6zsbfzr56i53gbyk2pzgik5gkyr2tceo7kq273avosj2u4l7d5zac7xzynghkuwynb/ahhrmap.pdf>

Since last spring our Division has been sharing data and performing surveillance of ILI cases with the staff at DHHS, Division of Public Health (DPH). In order to improve the query, on September 16, 2009, within the TEMSIS system we have added a "yes or no" question above the narrative for ILI presentation. Answering this question will help the Bureau of EMS and Public Health Officials to track the frequency and location of cases and identify any clusters of infection that involve more or sicker patients.

The role of N95 masks has been in the forefront of the healthcare provider's response to H1N1. However, there are serious concerns about the availability and supply chain issues for access to N95s. In response, the CDC has issued a FAQ document regarding the use of N95s. OSHA is planning a soon-to-be released guidance document as well.

CDC: Questions and Answers Regarding Respiratory Protection For Preventing 2009 H1N1 Influenza Among Healthcare Personnel http://www.cdc.gov/h1n1flu/guidelines_infection_control_qa.htm

As for PPE, including N-95's there is training available at www.nhoodle.com/org. Should you suspect an ILI case, prepare accordingly, respiratory protection being the most important for you and your patient. The Airborne Pathogens Education Program (APPE) was developed in collaboration with DHHS, DPH and has been updated to be inclusive of H1N1. Although we recognize there is a shortage of N-95's for all healthcare workers, it remains the best form of respiratory protection. The CDC has come out with the recognition, and its time to think about alternative strategies. Earlier today I sent out a request for EMS Unit leaders to complete a survey about the N-95's, use and availability.

Also available on www.nhoodle.com is a training video on ambulance decontamination. This meets the interim guidance posted by the CDC. You can go to the NASEMSO website for an entire listing of EMS specific information and links :

<http://www.nasemsd.org/Resources/PandemicInfluenza.asp#H1N1InfluenzaA>

Some suggestions in maintaining a day to day response for EMS - if this event, and for that matter any event were to escalate and become prolonged, one can expect the potential for some staffing problems. Below are some suggestions to think about now in dealing with this potential:

Everyday EMS in NH plays an important role as the provider of emergency medical triage, treatment and transport. During a pandemic the community efforts to mitigate the spread of disease may increase the demand for EMS. Understanding this, EMS Units, working with the AHHRs must plan ahead for the possibility that the workforce in particular will need augmentation. This may include the necessity of being flexible with staffing during a Pandemic. The resources named below as well as ones that may become available in a state of emergency in NH should be explored to the extent possible ahead of time. Note, the below list is meant to serve as an incremental approach in accordance to the severity of the situation.

NH RSA 153-A:19 "Mutual Aid" provides the language and authority for EMS Units and Providers to move between communities and assist each other with responses and patient care duties. Although written agreements are not required, they are strongly encouraged. Model language for a Mutual Aid agreement can be found here: <http://www.nh.gov/safety/divisions/fstems/ems/forms.html#prep>.

The Fire Mobilization Plan created by the NH Federation of Fire Mutual Aids, has Fire and EMS Strike Teams and EMS Strike Teams. These assets have been deployed during the ice storms and past flood situations. The local Fire Chief can make this call, whether you are Fire based EMS or not. Local Emergency Management Directors (EMD) should be notified should your personnel resources become limited and requests for assistance outside of your normal Mutual Aid agreement. If you don't know how to get in touch with your local EMD please contact HSEM at 271-2231.

The Metropolitan Medical Response System (MMRS) Team is a federally-funded state asset that can be accessed through the State Emergency Operation Center under ESF-8 by your local EMD.

There are fifteen Medical Reserve Corps (MRC) that are federally-funded, local operated assets here in NH. These groups have volunteers who can be utilized to support public health, medical and other medical responses on a local level. These are local assets. These groups can be activated through the AHHR Multi-Agency Command Center (MACE) and relationships should be pre-established understanding that their primary mission is not EMS, however, when competing for medically trained personal and in a state of emergency, MRC resources could augment some aspects of EMS. Unless licensing standards are altered during a "public health incident" and/or "state of emergency" (which we are NOT in at this time), you are still expected to have two licensed providers to transport a patient. MRC information can be found at:

<http://www.medicalreservecorps.gov/FindMRC.php>

Prior to reaching a point of depleted resources, please consider contacting our office and discussing how to develop these plans as well as other proposals you may have developed based on your local/regional situation.

If your questions are specific to who get vaccinated, contact your local hospital or contact at your AHHR.

The DuoDote education program is complete and was distributed to the I/C's. The kits themselves are currently in distribution. If EMS Units want to stay with Mark-1 Kits, they can purchase them. Additional DuoDote kits can also be purchased.

Field Services (FS) & EMS Awards: With a still-vacant Licensing Coordinator position and Kathy Doolan out on leave for the month of August, Christy Dewey, Shawn Jackson, Liza Burrill and Bill Wood (Preparedness assist to FS!) all stepped up to the plate and things have rolled along with few bumps. The licensing database has been under review and Shawn Jackson has been testing some newly proposed changes to make our Division database more effective and efficient. He has also been part of a review by the Quality Management Section, of an ImageTrend product for licensing recordkeeping, and he sounded truly impressed with this product. More research will be needed to investigate the feasibility of such a purchase by the Division.

Christy Dewey has been covering the Licensing Coordinator position from Concord four days per week. The fifth day of each week is being covered from one of the three field offices that has an assigned FS Staff member, and this has been working out fine, mainly because of the networked phone system that each office now has – to the caller, it is seamless.

The 2009 EMS Awards Program recipients were honored along with the Fire Service Committee of Merit members on October 7, 2009, 6:30p.m. at the Capitol Center for the Arts. This year we are honored to have the NH Association of EMTs as co-sponsors on the David Dow Memorial EMS Provider of the Year Award. This year's recipients are as follows:

- NH EMT Association – David F. Dow Memorial EMS Provider of the Year Award: Bobbie Canada, Brookline Ambulance
- BoundTree Medical – EMS Unit of the Year Award: New London Hospital Ambulance
- Lawrence A. Volz Heroism Award: Bob O'Donnell RN, NREMT-P, Speare Memorial Hospital, and Bobbie O'Donnell, Alec Brenton, Ty Cabone, Devon Thomas, Andrew Kerester, Kyle Sweezey – Lake Rescue and resuscitation on July 16, 2009, Meredith NH
- EMS Educator of the Year: Fran Dupuis NREMT-P, EMS I/C, St. Joseph's Hospital

For more information contact Kathy Doolan at (603)223-4212

Advanced Life Support: The Medical Director's training is wrapping up. We received a draft of the video which we are fine tuning. There were some technical difficulties with some of the audio clips which are being worked on. It is expected to have this project finished within the next few weeks. Once completed we will be distributing the program to all of the hospitals as well as will be wrapped into the Medical Director Training program funded by rural health and will represent the "home state" piece.

The protocol committee has begun meeting for the 2011 NH Patient Care Protocols. This early on, the meetings are spent reviewing comments/suggestions from committee members, as well as those collected by Vicki and Dr. D'Aprix and their relevance to the document. Protocol changes will be made to reflect updates on current standards, such as the forthcoming 2010 AHA Guideline changes, and on evidence based medicine. The changes will then be brought to the Medical Control Board (MCB) in increments throughout the next 12 months or so for their approval.

The ALS section contributed greatly to the Immunization project updates and the availability of the on-line program to assist with access to this education.

Trauma: At the August meeting of the Trauma Medical Review Committee (TMRC) attendees completed their work on the pediatric component of the NH Trauma Plan. As previously reported the concept is that there will be four levels of pediatric hospital standards. All hospitals seeking assignment under the NH Trauma System will be required to meet at a minimum the standards for Level IV pediatric trauma. Hospitals may then elect to seek credentialing at a higher level. Hospitals may have a different level of assignment for adult trauma than pediatric trauma, for example a hospital may be a Level III for adult, but a Level IV for pediatric. The TMRC membership has been sent a draft of the NH Trauma Plan that includes the changes made at the August meeting. Clay Odell is waiting for feedback and anticipating approval of the document at the October TMRC meeting.

The Trauma Imaging Committee has met to consider issues related to x-rays and CT scan studies of trauma patients. The committee will create guidelines to assist medical providers to choose the right study to conduct and

what studies could be deferred if a transfer to tertiary care is anticipated. The committee will also try to overcome technical issues with transferring imaging studies from sending hospitals to the trauma center. The goal is to minimize the need to repeat CT scans. Dr. Steven Birnbaum, a radiologist and radiation safety advocate from Nashua is participating in the project, and will speak about this issue at the Trauma Conference in November.

The Air Medical Transport Utilization Review Committee has completed its work, reviewing six months worth of cases. Clay is processing the data and will present a report to the committee for approval, then present the completed report to the TMRC in October. This topic is also on the agenda for the Trauma Conference.

The 9th Annual NH Trauma System Conference is scheduled for November 18, 2009 at the Inns at Mill Falls in Meredith. Topics in addition to those discussed above include a presentation on damage control surgery by Dr. Michael Rotondo from North Carolina, discussion of the new pediatric component of the NH Trauma Plan, breakout sessions on hospital trauma performance improvement, EMS trauma performance improvement, and regional medical and disaster resources. We will be working with Elliot Hospital for physician CME credits, and will grant nursing and EMS contact hours. The conference is once again the grateful recipient of funding from the NH Department of Health & Human Services, Rural Health & Primary Care Section.

Critical Care Transport Committee: The group participated in an exercise to help develop the “critical thinking” component that the group is considering for the proposed “PIFT” (paramedic interfacility transport) training. The critical thinking exercise would help train providers to make the sometimes difficult decision about whether a patient meets the criteria for the PIFT level or whether the CCT (critical care transport) level is needed. The committee will continue to develop the PIFT scope of practice and curriculum.

Education: the education updates are as follows:

- **2009 EMT-Intermediate Transition Programs:** We have completed seven 2009 Intermediate Transition Instructor Orientations. To date 83% of the eligible licensed instructors have attended one of the orientations. To capture any instructors who were unable to attend previous orientations, an additional instructor orientation session will be held on September 24th.
- **Practical Exam Changes:** As part of the Education Section’s continued efforts to streamline the administration of the BLS practical exams some changes have been made effective September 1, 2009. Most of the items involve the administrative process which will be transparent to the candidates testing. These changes include:
 - The minimum number of candidates to host a practical exam will increase from 10 to 15.
 - Exam results will be reported by Bureau of EMS staff only.
 - Bureau of EMS staff will apply moulage to simulated patient assessment patients.
 - Persons serving as patients at exams must be at least 16 years old.
 - Persons assisting at an exam who are under 18 years of age shall have parent / guardian consent.
 - Candidates and evaluators shall only assume one role at an exam and will not routinely be scheduled to serve as both at an exam.

Other changes that have been made are to the exam documents, excluding the skills sheets. The documents will be easier to read and more clearly labeled.

- **Refresher Season:** The 2009-2010 Refresher Season is now upon us. First responder expirations are September 30th with all other levels falling on March 31st. It is recommended that providers complete their refresher course and practical exam as early as possible. The most up to date list of authorized courses and practical exams can be found in the “Course & Exam Schedule” on our website.
- **NH / VT Instructor Recognition:** The NH Bureau of EMS and Vermont Office of EMS Education & Training sections have partnered to address some cross-border education and training issues. A survey went out to all NH & VT Instructors to solicit interest on recognition / licensure in both states. Essentially
- the goal is to enable authorization of courses in both states which is particularly helpful for refresher training programs for providers who have certification / licensure in both states.

- **Refresher by “Exam-in-Lieu”:** NH accepts the NREMT “Refresher by Exam or Exam-in-Lieu” as an alternative to the traditional refresher training program. The process for NH EMS providers is outlined below:

NH Refresher by “Exam-in-Lieu” Process

- Register to take the CBT Exam (www.nremt.org).
- Complete the CBT Exam for your level of certification.
- Upon successful completion of the CBT exam you will receive notification and re-registration documents from the NREMT.**
- Complete the required NREMT documentation.
- Present a copy of the NREMT documentation to the geographically appropriate Education Specialist (Concord, Gorham, Wilton) who will review the documentation.
- Within 14 days of receipt of proper documentation a “Certificate of Completion” will be issued.
- Submit the NREMT paperwork and the **original** State of NH “Certificate of Completion” to the NREMT.

**** Failure of the Exam will require the candidate to complete the refresher process by traditional methods.****

- **NREMT Electronic Recertification:** The NREMT introduced a new Electronic Recertification process for this refresher season. NH was recently briefed on the process. Although there are some unanswered questions from the NREMT about the process, NH BEMS supports the greater level of efficiency offered by this process. The success of this process hinges on EMS Unit’s training officers having a NREMT account to track their personnel. EMS units are encouraged to appoint one training officer to create an account for their agency. Over the next month or so more information and direction about the process will become available.

Please note, Administrative Rule calls for NH licensed providers to complete a NH authorized refresher training program. A letter to remind all NH EMS providers has been sent to EMS Unit leaders, posted on our website and through the list-serve.

RQM Update:

Data: As of September 14th, 2009 there have been 66,255 TEMSIS runs entered in 2009 with a total since inception of 455,400 runs entered. There are 277 services reporting out of 294* services for a total percent reporting of 94% of services. *The number of services has been controlled for licensed services whose primary function is to conduct education. These services do not provide reportable direct patient care causing them to remain in the “not reporting” category.

TEMSIS/ImageTrend Updates: ImageTrend has made significant progress in the programming updates for Service Bridge (the version of TEMSIS found on desktop computers). The new Service Bridge will look like the updated Field Bridge, version 4.0. It will have more friendly graphics, visual flow and power tools for entering vitals, medications and procedures. We are anticipating that it will get “turned on” for the whole state sometime in November. Prior to that, we began conducting beta tests with one EMS Unit per Region including:

- Region 1: Lebanon Fire Department
- Region 2: DiLuzio Ambulance
- Region 3: Frisbie Memorial Hospital
- Region 4: Center Harbor Fire Department
- Region 5: LinWood Ambulance

Brad Weillbrenner conducted an overview of the new format on Saturday, October 17th, at the North Country EMS Conference. As the best test proceeds we will prepare an update on the progress and work towards solidifying a “turn on” time for the entire state.

TEMSIS/Bureau Updates: Some of you may have noticed small changes to TEMSIS as you are doing your EMS Incident Report (EMSIR) lately. These include:

- >The limiting of report printing formats to just two: 2009 PCR and Billing Report. Likely we will be adding back in three others at some point: the signature printout (for services that don't have Field Bridge/tablets), a comprehensive report that will print every single field for Medical Director and legal purposes, and a QA/review version that will be scrubbed for identifying information (the last two are still being developed).
- >A change in the short Status (1-4) definitions was made to more accurately reflect the protocol definitions.
- >A reordering of the template menu. *Be aware that Interfacility / Transfer has been set as the default at the top of the list.* Transfers are not being captured because they are being entered under a full report template. The result is that transfer data has not been available to support the development of the Critical Care Transport program and to make other informed decisions. Providers will need to pay close attention to the template that they choose, to ensure that the template matches the run situation.
- >A number of default fields have been changed from Not Applicable to Not Recorded. This is a more accurate description in many cases. Note: In particular, the default fields for GCS have been changed to Not Recorded. Now your report will show Not Recorded if you didn't document a specific finding. If Not Applicable is a relevant answer to the field, you will still have that as an answer choice.
- >If services or providers run into any issues in the course of using TEMSIS, please contact us, we can't fix what we don't know about!

There is a new general TEMSIS email account for questions, issues, suggestions, etc.: temsis@dos.nh.gov. The NHOODLE site is now up. There are two courses on the site, and more will be added soon. All providers already have an account. Your username is your NH license number, and your initial sign-in password is also your NH provider number. The site can be found at www.NHOODLE.org check in frequently as we will be adding content.

Upcoming Events: Brad will be conducting a Rescue Service Administrator course on Friday, October 16th at the North Country EMS Conference. In addition, we will be holding a session about quality documentation using TEMSIS and a review of the upcoming format changes to the TEMSIS Service Bridge.

TEMSIS Tip: Don't you hate it when you get all the way through a TEMSIS run form to the Vitals/Treatment tab and you realize you can't remember the run times and have to jump back to the first tab? So did we! Here's a tip we found out: If you are using the Service Bridge, you can pull up your run times while in the vitals/treatment section by hitting F1.

As always, thanks for all that you do and for all your dedication and support for NH EMS. If we can be of assistance, please do not hesitate to call me at (603)223-4212.