NH MEDICAL CONTROL Board

NH Fire Academy
Concord, NH

MINUTES OF MEETING
September 20, 2012

Members Present:	Kenneth Call, MD; Tom D'Aprix, MD; Chris Fore, MD; David Hirsch, MD; Mathurin Malby, MD; Jim Martin, MD; Douglas McVicar, MD; Jim Suozzi, MD; Norman Yanofsky, MD; Clay Odell, Bureau Chief
Members Absent:	Frank Hubbell, DO; Ray Kelly, MD; Patrick Lanzetta, MD; Joseph Leahy, DO; John Sutton, MD
Guests:	Mark Hastings, Grant Turpin, Michael Pepin, Aaron McIntire, Brain Allard, Rich O'Brien, Jeffrey Stewart, Scott Schuler, Richard Cloutier, Stacy Meier, David Rivers, Janet Houston, Patrick Twomey, Steve Erickson, Chris Stawasz, Ted White
Bureau Staff:	Vicki Blanchard, ALS Coordinator; Kathy Doolan, Field Services Coordinator; Shawn Jackson, Education Coordinator; Perry Plummer, Director; Angela Shepard, Trauma Coordinator.

Welcome
The meeting was called to order at 09:10. The chairman pointed out the new agenda style. At the opening of the meeting the board was short one person for a quorum so the chairman stated they would move onto reports before approving minutes.

Introductions/Disclosures
Introductions were made and no conflicts of interest were announced.

Approval of May and August Minutes
Following item 1 the board had a quorum and proceeded to approve the minutes.

Discussion: None

Decision: McVicar moved to approve the July MCB meeting minutes and the August Special MCB meeting minutes.. Fore 2nd. Vote passed unanimously.

1. Bureau and Division Updates – Odell

Odell referred to the EMS Bulletin (see attached). In addition to the bulletin Odell reported that the bariatric project had been placed on hold as other projects require more immediate attention, but that we could expect to hear more from him on it in the future. Odell also reported that today the Coordinating Board would be reviewing revised Administrative Rules.

Discussion: None

Decision: None

2. Trauma System – Shepard

Shepard handed out a STEMI/Stroke/Trauma Report in addition to the EMS Bulletin (see attached) There will be follow up meetings from the STEMI/Stroke Summit, please see the dates and locations on her report. The Annual Trauma Conference brochures will be available by the end of this meeting; she encouraged all to attend. Finally she announced a Best Practices in Trauma Care Poster contest, to be displayed at the Trauma Conference. Shepard stated that if providers, units, or hospitals had data they wanted to share and did not have the resources to put together a poster, she would be willing to help them, including the printing of the posters.

Discussion: None.

Decision: None.

3. TEMSIS – D'Aprix/Cooper, 10

D'Aprix reported while at a meeting with DHHS in regards to Medicaid billing, it came to light that DHHS was still getting some paper PCRs. DHHS is working on a 2 week summary so we can address this. With the proposed revised Administrative Rules Odell indicated the Bureau will have the ability to impose penalties on the EMS units if they do not comply with the requirement to submit PCRs electronically. Odell added that the revised rules would have disciplinary actions in layers, first a fine of $500, second a 1 year suspension, and third a 5 year license revocation. He added they could go against an individual but truly the EMS unit and its administration would be the ones addressed.

Cooper reported he was working with the Version 3 data set and having some struggles with the airway confirmation and the way they have it set up. It does not work operationally. He will need to talk to the board in the near future to see how or if they want to track it in TEMSIS. He asked the board to be thinking how they would like to track airway confirmation.

Discussion: There was a short discussion regarding circumstances when the Bureau would take action if the revised rules passed. Odell replied that it would be very unlikely a municipality would be put out of business; it is the non-transporting units that are refusing to submit electronically or the private services that are not submitting all runs that he takes issue with. Each case would be looked at individually; if a non-transporting unit in a rural area did not have internet access they would be looked at differently than a that was simply refusing to submit.

Decision: None.

4. Preplanned Medical Standby Event Coverage – D'Aprix/Odell

Odell reported that he was charged by the legislature in HB 1631 to develop a plan which would allow NH licensed provider to provide non-emergency services at social or sporting events. Traditionally this has been "first aid" coverage in a number of venues such as fairs, large concerts, athletic events, auto and motocross races, bicycle races, marathons, summer camps and school. Odell put together a committee including members of the MCB and the Coordinating Board to develop this policy.

D'Aprix added the policy is an attempt to give guidance that will minimize risk and exposure for the provider. The policy is not authorization to perform first aid, nor does it include any educational component, but, what it does is provide advice on topics such as malpractice insurance, documentation, etc. It also points out that once the provider identifies an individual's condition as a potential medical emergency they are to active 911 and begin care under the NH Patient Care Protocols to their level of licensure.

Odell continued by stating these are NON URGENT care cases that under our RSA we do not regulate, this plan differentiates between EMS and non-EMS care. He ended by stating the committee recognized EMS curricula do not include training for evaluation and release of patietns and that anyone who participates in this practice in the preplanned setting should seek additional training.

Discussion: There was a question regarding the validity of a policy and if was it enforceable, which Odell stated it was discussed with the attorney who looked at our rules and other rules such as the nursing rules; and was advised as long as policy does not conflict with RSA or rules it is valid.

There was also discussion regarding the school nursing rules that allow nurses to delegate distribution of medications and could an EMS provider distribute medications if delegated by a nurse. Odell pointed out that we are not bound to their rules, we are bound to our rules, and our rules say EMS providers cannot dispense of medications.

Decision: McVicar moved to accept the Policy on NH Licensed EMS Providers Practicing at Preplanned Medical Standby Coverage Events. Hirsch 2nd. – Vote passed unanimously.

5. Community Paramedicine – Odell

This is a follow up from the July meeting regarding the Community Paramedicine prerequisite protocol. Odell met with the NH Homecare Association after the July MCB meeting. He stated he had a good discussion with them and does not believe there will be any big opposition to this protocol. The VNA is sensitive to competition and EMS must be clear that the concept is to address the patients that fall through the cracks. He gave the example of CHF patients without home follow-up. If EMS can assist with medication reconciliation, take vital signs, and talk to the patient, and report back to the patient's physician, it can reduce re-admissions and thus reduce healthcare cost. He urged the board to pass this.

Discussion: There was confusion with the medical director section between the EMS medical director and the community paramedicine program's medical director; He proposed modifications to clarify that the EMS medical director may delegate to the community paramedicine medical director, but, he or she maintains overall control of the process. It was also make clear that any patient specific discussions should be had with the ordering physician not with traditional online medical Fore developed language to address this which he will send to Blanchard to revise the section.

Decision: Suozzi moved to accept the Community Paramedicine Prerequisite Protocol with Fore's revisions. Malby 2nd. – Vote passed unanimously.

Break– meeting to resume at 10:50

After the break Odell handed out to the board a CD podcast entitled, "EMS Eagles Lightning Round" He stated there is an annual "Gathering of the Eagles" in which Medical Directors from the country's most populous EMS systems meet. He has had a chance to listen to their speeches and finds them very compelling. He found them so compelling that he is planning on attending their next conference, which is in Dallas, Texas this February, on his own funding. He would like to see others from here go as well. In addition to handing out the CDs he announced he had the podcasts available on a thumb-drive and to see Blanchard for copies. Suozzi noted that presentation materials can be found by searching "Gathering of the Eagles" online.

6. EMS for Children Advisory Committee - Houston

Houston from the EMS for Children (EMSC) Program came before the board to request a standing committee be formed to address pediatric specific issues. This committee would provide a forum for pediatric emergency care providers and others with a vested interest in the care of children. Houston envisioned this committee giving guidance to the MCB and EMSC Program on changing practice and national trends in pediatric emergency care. The committee could assist the MCB and EMSC Program in developing pediatric program/policies; and interact with parent advocacy groups and review requests prior to submission to the MCB. The core membership would include: a MCB member, physician with pediatric training, an EMS provider, a nurse with pediatric experience, a Bureau of EMS representative, and an EMSC Program representative. The committee would meet between 4 to 6 times a year; some meeting via Webex.

Discussion: D'Aprix stated that he found value in the standing committee and endorsed it.

Decision: Martin moved to create a standing committee, EMS for Children Advisory Committee, as outlined by Houston. Fore 2nd. Vote passed unanimously.

7. Medication Shortages – How to plan in advance? D'Aprix

In follow up from the July MCB meeting, where the board decided to look at the EMS formulary to develop a plan for future medication shortage, D'Aprix reported he had taken some time to review the formulary and in his opinion the best course of action is to address medication shortages as they arise. He reminded the board that they had a positive working relationship with the Board of Pharmacy.

Discussion: None

Decision: Address with medication shortages as they arise.

8. Protocols - Suozzi/Blanchard

Cardiac Arrest:
Little changes except the waveform capnography was moved up from the P level to the E level and the post resuscitation care was moved out its own protocol.

Discussion: It was questioned why the changes were made in the Adult protocol and not the Pediatric. It was answered it was an oversight and would be corrected.

Decision: Move waveform capnography to the E level in the pediatric protocol and move the pediatric post resuscitation care to the new post resuscitation care protocol.

Post Resuscitation Care:

As stated above, the post resuscitation care was moved out of the cardiac arrest protocol into its own protocol. It was updated with the addition of acquiring a 12 EKG as the first bullet under the E/I level and a link at the P level to an Induced Therapeutic Hypothermia protocol.

Discussion: There was a question regarding fluid resuscitation and why the protocol was limited to 2 liters of fluid. It was explained that with the new shock protocol, if the patient is in hypovolemic shock, the provider would refer to that protocol, which has greater fluid challenges.

Decision: Approved as written.

Induced Therapeutic Hypothermia:
This protocol was developed to match what hospitals are currently doing. This protocol was brought before the MCB in the past and although there is no new prehospital evidence, the protocol committee asks the board, would this cause harm? The protocol committee did not think it would. And will it drive better care in the healthcare system? The protocol committee thinks it will.

Discussion: There was significant discussion that there is still no clear evidence that initiating cooling in the field provides any benefit over initiating it in the hospital setting. All agreed however that there was very likely no harm that could result and they felt strongly that at the very least it would benefit patients in that if initiated by EMS it would likely be continued in the hospital setting where there is strong date to support its use.

Decision: Approved as written.

Congestive Heart Failure (CHF):
The protocol was tabled awaiting new evidence to support the removal of furosemide. There have been no new studies on furosemide, but common practice in-hospital shows it is no longer being used, and the standard of care has moved to CPAP and nitrates; therefore the protocol committee recommends removing furosemide from the protocol and formulary. Additionally, while the protocol was under review the IV nitroglycerin dosing was clarified to give guidance in dosing up to 400 micrograms/minutes, if necessary.

Discussion: There was some discussion of the OPAL study which supported the use of furosemide in CHF; however it was pointed out that the study did not include CPAP and the trend now in emergency departments is CPAP and nitroglycerin.

Decision: The board agreed to remove furosemide and approve the protocol as written.

Routine Patient Care
This protocols greatest change was in the formatting for easier flow and the addition of some charts on ventilation rates, oxygen saturation and end tidal CO2. The few changes made were: removal of the musculoskeletal bullets, as it has its own protocol now; moving the consent for treating minors out into its own protocol; adding bullets for the use of lights and siren; and adding a bullet instructing providers not to immobilize pediatrics in their passenger safety seats.

Discussion: There was a lengthy discussion on the securing of a pediatric in a safety seat. Specifically it was argued that removing the patient from a safety seat and manipulating them onto a long board or KED posed greater risk for harm. As well as the difficulty is securing them then to the cot. Houston reference guidelines that stated a child must be removed from their seat when: the provider has reason to believe there was a spinal injury; need medical monitoring or

attention; damage to the seat was moderate to severe; and/or the seat was not of convertible car seat design.

Decision: Aside from the car seat bullet, the protocol was approved, however the decision was made to send the protocol back to the protocol committee to re-work the passenger safety seat bullet and/or incorporate it into the Pediatric Transport protocol.

Consent for Treatment of a Minor
This was in Routine Patient Care and now relocated into its own protocol.

Discussion: None

Decision: Approved as written.

Patient Status Determinants:
This protocol went through some minor rewording to address immediate care and removing transport decision, as this is addressed in the new Trauma Triage and Transport Decision protocol. And the addition of STEMI Alert and Stroke Alert, as the protocol committee would like to see the use of these terms standardized across the state.

Discussion: Minor discussion regarding the determination of the destination hospital, mode of transport and who should or should not be making those decisions.

Decision: changed the last bullet to read, "The destination hospital *and mode of transport* are determined by the prehospital provider with the highest medical level providing patient care; it should not be determined by *fire*, police, or bystanders.

Trauma Triage and Transport Decision:
This protocol was developed using the 2011 CDC Guidelines for Field Triage of Injured Patients and the NH Trauma Plan. It provides guidance in the decision process for transportation of trauma patients in a flowchart design.

Discussion: There was some suggestion of changing some of the inclusion criteria bullets, but was determined they should stay consistent with the national and state guidelines. A recommendation to change the first pediatric decision bullet from just a level 1 pediatric trauma center to level 1 or 2 was agreed upon. Also a formatting request for the "no" arrows was requested.

Decision: Approve with the addition of the level 2 pediatric trauma center and reformatting of the "no" arrows.

Traumatic Brain Injury:
No major changes, this protocol should have been approved with the other trauma protocols but was tabled due to lack of time.

Discussion: None

Decision: Approved as written.

Tracheostomy Care:

This protocol had little change except for the addition of indications and increased language for oxygen administration.

Discussion: None.

Decision: Approved as written.

The remaining protocols will be tabled until the November meeting: Shock, Refusal of Care, Police Custody, Taser Probe Removal, and Pepper Spray Irrigation.

Call moved to accept the protocols as presented and revised. Martin 2nd. Vote passed unanimously.

9. Other Business – No other business.

Adjournment: 11:58

Next Meeting: November 15 2012 – Fire Academy – Concord, NH

Respectfully Submitted,

Tom D'Aprix, MD, Chairman

Prepared by Vicki Blanchard, ALS Coordinator