

EMSAC MEDICAL CARE COMMITTEE REPORT
1/19/11

GOAL 1: TEAM EFFORT

1. Strategic plan format for meeting agenda
2. We supported the concept of extending the Strategic Plan cycle to 4-5 years
3. Number of groups represented at committee
 - a. Groups represented
 - i. Fire Rescue
 - ii. EMRC
 - iii. Broward Co Trauma Agency
 - iv. Lifeguards
 - v. Fire rescue quality manager
 - vi. EMSTARS
 - b. Group we would like to participate
 - i. Communication Committee PSTs group

GOAL 6: OWNER

4. 6.1 Dispatch system effectiveness: Public Safety Telecommunicator group who are lead on this strategy and there is optimism that measures of 6.1 can be met.
 - a. % PSAPs using nationally recognized EMD system
 - b. Promote utilization of NAACS standards for air medical dispatch
 - c. July 1, 2010 mandatory legislation for certification of public safety telecommunicators (PSTs) includes training minimum 132 hours
 - i. Training programs will be held to standards of application, even if over 132 hours
 - ii. October 1, 2010 mandatory exam to confirm adequate training
 - iii. Certification exam may be utilized as training final exam
 - d. Jim Lanier has a copy of Amber Lee Foundation survey which we need to review and submit
5. 6.2 EMS response time: will require some research and use of Data Committee information, as well as PSAP information.
 - a. Time from PSAP contact to patient contact is data point requested. PST group is lead on this strategy as well.
 - b. Definitions of data on EMSTARS(<=50 agencies submitting) may be a problem here, but we can obtain some preliminary data. Decision was made for all data submitted that best data available would be submitted with description of weaknesses or caveats in data set. This may generate changes in data set in the future.
 - c. Standard models for defining call types will need to be evaluated by Communications Committee. Will review Statute regarding definitions of rural and urban. Will evaluate literature regarding suburban classifications.

- d. Stratify call types/evaluate with EMSTARS categories
 - e. Stratify setting urban/rural/?suburban-(not in statute)
6. 6.3 EMSTAR data points of offload times reflect patient drop off and back in service. This is a start, but will not exactly capture hospital delays.
 - a. This strategy is led by the Data Committee, but Access to Care is a resource and is very interested in this. Will obtain their definition of “diversion” and compare with Trauma Implementation Committee definition. Chief Patterson will work on standardizing the definition, if it is different.
 - b. 6.3 Disaster Committee and John Scott, Joe Nelson with Chief Bixler and Rhonda White are working on organizing Emergency System Status and EM Systems and moving the integration of a statewide system forward. An Advisory Committee has been formed to accomplish this. A motion was made and passed to urge the Bureau of Emergency Preparedness to assign a Project Manager to either institute EM Systems statewide or get compatibility with other systems being utilized. The group was in favor of continuing funding via ASPR, but training and implementation is essential. A survey found that most of trauma centers have system installed, but only a few are using it.
 - c. Access to Care workshop in January was postponed.
 7. 6.41 is owned and led by Medical Care and EMRC and Data Committee are needed for measures. Will work with Dr. Nelson regarding obtaining reports to meet measures based on available information. This data will most likely be a discussion point in developing the next Strategic Plan.
 8. 6.42 is led by the Quality Managers and will need the resource of EMRC and the Stroke Work Group.

A study was done by Broward County on this with data describing Stroke Alert notifications and barriers that need to be overcome for a more efficient and effective system of care.

155 patients with stroke symptoms

 - 39% had stroke alert called and had stroke
 - 41% called with no stroke/tia
 - 19% (30 pts) stroke alert not called

18 pts had strokes
 9. 6.43 is owned by Medical Care Committee and requires trauma alert scene times. Will try to establish whether this data can be better obtained from EMSTARS or the Trauma Registry. It would be optimal to divide these between blunt and penetrating if possible.
 10. 6.44 Challenges to pediatric pre-hospital care are being addressed by EMSC who are the lead in this strategy.
 11. 6.45 is a strategy to determine quality of airway management. The measures in this strategy will require definitions of the data points prior to gathering data. This strategy is led by Medical Care; we have decided to form a work group led by Dr. Lozano to benchmark standard of care in Florida and compare with best practices in the literature. This survey will also include

definitions needed to meet the measures of this strategy. Will also reach out to Dr. Sal Sylvestre who is doing a lot of work in this area.

12. 6.51 measures the number of patients refusing transport. The lead of this goal is the Quality Managers. They expressed concern that all agencies have different protocols regarding this. John Todaro reported that most protocols are on website, so perhaps cataloguing these protocols and evaluating best practices could be a first step. EMSTARS has suggested that a return call for patient who previously refused transport less than 3 hours earlier could be a marker of inefficiency.
13. 6.52 is about trauma alert criteria and is led by Medical Care and Quality Managers with the FCOT and EMRC as resources. This data should be accessible from EMSTARS and the Trauma Registry, so that data requests will be made to be reviewed by both committees.
14. 6.53 and 6.54 are led by Quality Managers and pertain to transport of STEMIs and strokes.
15. 6.55 addresses appropriateness of neonatal and pediatric transport modalities and destinations. The lead of this is EMSC.
16. 6.6 and 6.7 address the QA process of EMS Agencies. Currently there is no standardization or minimal requirements. EMRC is the lead on the strategies to develop minimal requirements for QA and then identify the number of agencies utilizing this template. The number of patient care components measured is another measure required.
 - a. **Error! Reference source not found.** has meeting set with FHA regarding this topic
17. 6.8 is to improve safety of bathing places with the lead being the USLA. Currently the Lifeguard group is housed in FACEMS and seem to be receiving support from this group. The measure of the number of coastal lifeguard agencies operating in Florida has been catalogued, along with which are USLA certified. The other measure of identifying the % of Florida bathing places that are lifeguard protected will be difficult as it is hard to define bathing places in areas with sprawling coastline. Draft legislation for improving regulation and certifying lifeguard agencies was proposed and will be presented to Legislative Committee.

Lifeguard agencies	Public (%)	Dept Fire/Fire R/Emerg svcs	EMT cert Required (%)	MOU Med Director	USLA Certified
48	45 (94%)	15 (31%)	23 (48%)	32 (23%)	33 (69%)

GOAL9: LEAD with STATE EMS MEDICAL DIRECTOR

18. 9.1 Obtain funding and perform a study to determine medical error rate in Florida EMS and determine 3-5 of most serious or frequent errors as baseline Will discuss feasibility with Dr. Nelson.

OTHER ITEMS

1. State Trauma Triage Workgroup evaluating FL Triage criteria vs CDC criteria
 - a. Very similar in content, except for some mechanisms
 - b. Need to include our transfer criteria in comparison
 - c. Evaluation of pediatric issues, age vs weight
 - d. Evaluation elderly criteria
2. Scene amputations: Look at experience in Haiti – Lessons Learned
 - a. John Todaro to arrange talk for CME on this topic
 - b. Will ask UM Group to participate
3. Sacco Triage Criteria
 - a. **Error! Reference source not found.** has agreed to present point counter point at next EMS meetings in January regarding mass casualty triage