

BUREAU of EMERGENCY MEDICAL SERVICES

Medical Care Committee

January 28, 2009

Chair: John Scott

Scribe: Karen Chamberlain

Sign-in sheet distributed

Called to order by John Scott at 1pm

Reviewed previous meeting minutes - Dr Meurer made motion, no opposition. Minutes approved.

Introduction of Dr Meurer - appointed by Florida EMS Advisory Council, taking over Dr. Shatz' position on Medical Care Committee. Appreciate this appointment and look forward to working together on projects.

Stemi / Stroke status, How this is developing in the State - New legislative package being worked on, many counties adopted protocols to treat these patients. Evaluations are completed by ESM, determine needs stroke center. EMS makes decisions on appropriate hospital for patient to receive care . Is in practice in Florida for stemi patients. Stroke is mandated to go to approved centers. Discussed stroke centers and their ability to in fact care for these patients, versus some who seem to advertise more capabilities than actually available twenty-four hours a day. EMS requested hospital's put placard of what can and cannot handle, because of the disconnect between ED and EMS on these patients. Administration of some hospitals may not want to advertise capabilities, for various reasons.

Discussed confusion on who is listed as comprehensive vs primary stroke centers.

Noted to have seen a cascade effect of legislative packages of what needs to go where.

Newer, cooling of cardiac patients patient taken to places indicate can cool patient, but in certain facilities already seeing confusion as to question of, then can they cath patient?, only to learn they can't, which places patient in need of another transfer.

OCHA has a posted a capability list, but it is difficult to find. Requested State put list on link of State web site.

Want list of sites to include brief description of primary and comprehensive facility, and differences between the two.

JCAHO seems to have completed a more comprehensive review, rather than OCHA, which seems to have statement of capability list provided by facilities.

EMS / pre-hospital providers should not have to get in middle of destination battles between receiving facilities. Needs clear definition of where to take patient. Medics should not have to determine facility capabilities. May want to address by looking at focus of Rules, and see where falls, then take to OCHA to remedy. Advances in Stroke is they are more dynamic than facilities can keep up with. Ask Advisory Council to include in next Strategic Plan 2010-2012 to include this for guidelines for specialized care and ability to transport patients to those facilities.

Dr Joe Nelson: Discussed Medical Director's writing protocols including appropriate facility for patients. Agrees with disconnect between EMS and hospitals, especially to know about treatments rendered in field.

Need to know about patients even after turn care over. Need to work with AHA to prevent / overcome binding items in EMS in determining patient outcomes. (No one in room from AHA.) Discussed ACLS Guidelines and their development. Suggestion was made to develop best practice guidelines that could be developed and updated regularly, rather than legislative issues, which are difficult to change. Make recommendation for guidelines rather than statute. Needs to be data driven, even though recognize may be difficult to obtain sometimes with limited data on certain issues. Many pre-hospital agencies do not get to meetings and they are probably even more confused. Medical Directors called John Scott because didn't know what direction to take with their patients and were looking for clarity.

Wayne Hodges sits on AHA Task Force. Tallahassee and St Pete working together.

Discussed when see overlap of work by different committees and groups.

John Scott indicated he will bring Legislative language and request AHA Fl Hosp Asso, and Amer Heart Assoc at next meeting. They sometimes draft laws without input from EMS when they are sometimes the most affected by these decisions.

Lisa Creswell at St Pete, and Tallahassee shepherding project. John Gardner on Task Force from Miami-Dade. Suggestion was made, need office specifically addressing the myriad of cardiovascular issues.

John discussed progression of Lisa and Bureau meetings and information sharing. Will contact Lisa to see if can catch up.

Dr Shrank: Promoting kit for EMS week - Very good CPR training in a box. John will bring to Council attention.

Legislators were misinformed about agencies involved, and again EMS not as included as they were intended to be included. Conference calls occurred but even issues such as ability to call stemi based on a 3-lead ECG determination was put forth, which Dr Shrank had to explain was not going to work.

Discussed 12-lead capability for all EMS providers, but still not done. Funding not available, even more so today.

Louis Bowen: Discussed keeping in mind they are seeing increased pediatric strokes, and they are presenting with younger patients with strokes.

One individual indicated they are able to fly patients, 6-months of year, the other portion involves weather issues. If legislation present that would require they have to take 'a' to 'b', and they do not have resources to do so, this places them in a bind! Requested to try to find neutral place to meet to still meet needs of these patients. Still see ground transports certain times of the year. Also discussed, may still be role for transport to local hospital for stabilization then transport, but EMTALA has made process harder.

Dr Joe is Medical Director for Key West Rescue. They have increased patients flown from scenes.

Gave group lot to consider on subject.

Scope of care for Critical Care Paramedics. Educators developed list of criteria addressed in training course (not curriculum). Do not have Critical Care Paramedic in Florida, nor definition of Critical Care Ambulance. If do not have State recognition of training level of training they can not recoup, and are not reimbursed for specialty care transports, which is significantly higher. Want to be able to bill for those services. Wanted minimum standards for Critical Care Paramedics. Seeng many denied payments.

On medical care side patients being transported after couple hour course in part because no standards developed.

Discussed neonatal standards very specific in guidelines, criteria, care, and equipment and supplies.

Draft recommendation has been put out, but have not pushed until resolved Education Committee Instructor project.

Some states have licensed the Critical Care Paramedic. Not looking to do that here. Florida Ambulance Assoc dialoging with this as well. When pay must prove level of care. Often based on who processes claim. Critical Care Paramedic will improve patient care. Financial momentum will assist process.

Clinical competencies for medics. Competencies - some departments have, while others do not. Some are verbalization only. Especially important in airway competency. Seeing some need for additional training in certain situations. More problems getting in to ORs. Some institutions have training that is mobile, although this option can be costly. Once see EMSTARS data back will see areas which needs developed.

Patient / Crew safety issues are two different issues. Patient care involves ways to prevent errors with patients, which involves check/safety mechanisms ie Braslow tape. Develop paper which acknowledges use of these adjuncts. Endorse use of these devices on care side. Request QI/QA Committee to assist in deveoping standards. Would apply to BLS and ALS units. Anyone who performs patient care. Next data point on EMSTARS will include collection which will include pediatric devices.

Crew safety: Personal topic for John. Seen people with no knowledge of air say how he should operate program, when ground issues which are bigger and are at higher risk are not being addressed.

Don't see efforts to secure folks in ambulances. Loose equipment and articles. Holdig child during transport. Running red lights. Would like to see development of crew safety. Should be safety summit. Recognition of ground unit safety ie Ground Safety Day. Introduce to Advisory Council: direction want Committee to go with this issue. Nadine's previous presentation at Advisory Council on ground safety was excellent and valuable. State Strategic Plan 3.10 is about safety. EMS Providers is Lead. Dr Joe-safety may be different committee because felt this one owns patient safety. EMLRC looking at researching safety. May want to look at taking research to common place to look at evidence and develop best practices.

Crew safety will probably only change if Feds change laws. Manufacturer's are already changing ambualnce configurations based on needs and evidence based data.

Suggestion was made that many of Nadine's recommendations do not require laws.

Dr Joe: Would look at protocols-look for opportunities and change a call to cold response instead of lights and sirens, which would help mitigate risk. There have been changes on trucks ie lights, reflective material many are changes private doing into public sector. Some trucks have short half lives because of uses, so updates come fairly quickly. DOT

has 5-point quick release vest requirement, but bunker gear during fires on busy highway, vest flammable. . .

Dr Shrank: Stressed need to be taught in initial courses for EMTs and Paramedics.

Louise Bowen indicated will bring issue to Neonatal network - can bring draft of pedi issues on safety for next meeting.

Tourniquet status being presented by Dr Joe to Medical Director's tomorrow. Will submit protocol and Medical Director's review to Advisory Council.

Dr Joe gave history of tourniquet uses and where request came from including military component. Recommended EMS look at tourniquets. Took to Trauma Surgeons. No formal position paper, but will make recommendation to that committee tomorrow, to include for joint position paper.

Dr Armstrong with input from committee, provided draft protocol for review. Recommended standardized use of this intervention. Controversy is recommendation of a specific device. (needs to be more generic) Dr Joe likes state wide protocol. Likes local control of protocols. (cannot mandate protocols Medical Director uses)

Promote EMS agencies should have Tourniquet protocol and should look like final draft.

Dr Shrank: recommended training for tourniquet as well as training on direct pressure, which still seeing not done correctly. Put more substance into training component about necessary patient needs involved with this kind of patient. Have to be careful of recommended training especially with budget concerns.

Must keep in mind, stopped carrying when inappropriate use in past. May need to look into problems of past.

Thank you again to Dr Meurer and Louise Bowen for contributions.

Dr Joe - add issue of hypothermia post cardiac arrest, but other uses: stroke, neuro in Miami uses for stroke patients, Citrus Co started use last spring - 2008 43% ROSC 27% of those cooled - Of those 27%: 80% walked out of hospital neurologically intact. Seeing comparable stat's in other areas.

Russia does not use bypass but rather cool their patients then rewarm after surger.

Miami: Started in field in October, Notifying hospitals when bring patient. Certain strokes seeing definite improvement. EMS trucks carry cold NS. When see ROSC and BP > 90 start cold NS. Some using Dopamine. Not using for trauma or peds patients at this point.

Discussed hypothermia interventions, including time lines, considering seeing 6-12 hour windows and occasionally longer. Requires strong team concept to be able to do.

Broward county going to hypothermia (80% on board). Several EMS agencies doing pre-hosp cooling of patients. EMS may need to take stronger stand on cooling including taking to hospitals to cool and if they do not continue, will not take there. See worse outcomes if start to cool and then do not carry forward. Some concern about fluids giving these patients because know so fragile to begin with after just ROSC.

John Scott thanked everyone for interest and participation. Meeting adjourned.