

01/20/10 EMS Advisory Council / Medical Care Committee

Dr. Meurer is in Haiti so John Scott chaired meeting.  
Meeting Daytona Beach, Ocean Center Room 201C at 1:00pm.  
John Scott called meeting to order.

Sign-in sheet was distributed. Previous meeting minutes were approved.

John Scott updated the group on meeting format, and requested (agenda, meeting minutes, and contributions to include the State Strategic Plan) information.

Discussed report that will go to State Surgeon General with 08-10 Strategic Plan objective accomplishments. Individuals were encouraged to submit information they feel are pertinent to this report to Dr. Meurer or John Scott.

There is more scrutiny being placed on the meetings and their content. This places an emphasis on value of meetings and accomplishments obtained during them, many that are carried forth to multiple individuals and organizations to incorporate into their practice.

The group reviewed/discussed the 2008-2010 Strategic Plan objectives:

Note: Many of the objectives have portions that will roll over for the 10-12 Plan, see Plan update (\*Please obtain from Julie Bacon).

#### 5.1 Measure and identify opportunities for improvement of dispatch system effectiveness

There will be interaction between this Committee and Communication Committee (which has combined communication and dispatch since they had many of the same issues and challenges)

Dispatcher certification is in Senate and will likely go thru this year. Amber Lee Act assisted with this effort. The Advisory Council sent letter of endorsement in support of Bill (when requested by Mr. Lee at last Advisory Council meeting).

It was noted the very small rural communities may have difficulty obtaining the certification and may need assistance.

An additional challenge going forward may be the issue of jurisdiction, as a majority fall under Sheriff's organizations, which has law enforcement focus. (It was noted group appreciate all law enforcement training, efforts and cross cooperation but medical dispatch may have better fit with medical direction, i.e., the Medical Director's). There are many challenges involved with Dispatcher training and everyone is especially aware the diversity of 911 calls. (Is there data on percentage of types of calls? Non-medical: fire (home, office, auto), MVC, unusual odors (requiring investigation), shots fired, fights, domestic disturbances, robberies, etc...

5.2 Measure and identify opportunities for improvement in the area of EMS response time (from 911 call to patient contact)

This roll over included more specifics of focus areas fro committee

This requires link to EMSTARS and their data (including definitions).

This requires involvement from Access to Care Committee

5.3 Changes to EMSTARS Data Dictionary and Disaster Response Tracking System to be able to capture EMS off load and diversion times

Chief Patterson discussed the importance of true/honest data collection. Also discussed Canadian Services have scan cards they utilize for real time data. (It was noted all are aware Florida is quite a ways away from this)

EMSTARS has Data Dictionary that does define terms.

Note: Less than 50% of agencies are utilizing EMSTARS

One suggestion was the addition of field for when turn over care, which could then be shared with hospitals. Competitive hospitals may want to have better times, hence motivation for improved data than their competitors.

(Note: The group drifted from report but pertinent to Committee)

Committees are organizing the way they conduct meetings. We are transitioning to an organized, Strategic Plan Goals and specific objectives format. This will allow a more focused agenda, rather than what may be perceived to be focusing on the crisis occurring at a particular meeting.

Dr. Nelson expressed a serious concern with EMSsystems (which is in transition from phase one to phase two during February). EMSsystems is supposed to involve 1/3 EMS, 1/3 Hospitals, and 1/3 Emergency Management. EMSsystem was selected by Emergency Management but has only one EMS person on Steering Committee, and he feels strongly they need additional EMS experienced individuals involved with this project.

The EMSsystems contract coordinator is Bob Smith. Group all agreed EMSsystems, especially in light of integration with EMS, needs to update the involved Committees and constituency groups as well as attend next meetings.

EMSsystems attended the Office of Trauma July meetings. The vendor demonstrated product but have left many unaware of progress in their 2-year period of implementation.

Dr. Byers discussed delays with EMSTARS. Regions are customizing certain fields, and she is uncertain of the validity of data collection. The understanding was EMSystems would provide data including issues such as diversion time.

Steve McCoy from State gave history of EMSystems, acknowledging some areas of Florida have been utilizing system for years while other areas may not be as aware of system.

Dr. Nelson indicated EMSTARS should be model for EMSystems, since has proven success.

Concern was expressed that EMSystems appears to not be having dialog/interaction with key involved parties/constituencies.

Chief Patterson graciously offered to assist with this issue and reach out to Florida Emergency Preparedness Association for information and to express our concerns.

Chief Bixler and Steve McCoy were requested to ask for update as well (from Bureau).

5.4 Measure and identify opportunities for improvement effectiveness of on-site EMS treatment

Dr. Nelson gave an update from EMRC, which includes increase committee members.

Steve McCoy: EMRC meeting in March. They have a list of action items and have preliminary data. Individuals within the committee reviewed and agreed to assigned objectives.

Dr. Nelson agreed to provide Medical Care Committee with paragraph about creation of EMRC for the 08-10 report.

Stroke care was discussed: There was a CDC Study out of Atlanta but thus far have not seen the report of their survey (protocols and outcomes). John Scott will follow up on this and if he is able to obtain this information it will be included in the 08-10 report.

5.5 Measure and identify opportunities for improvement for appropriate transport destination

There was extensive discussion of the Primary vs. Comprehensive Stroke Centers, the differences between them, and the decision to take a patient to one or the other. Dr. Lazano indicated Medical Directors are close to consensus statement on Stroke Centers, and it's not necessarily all about the t-PA. There is evidence that patients who exhibit stroke symptoms, even when they fall out of the time window, do better at Stroke Centers. If a unit has the ability to provide this then it may be the better decision, but if the patient is unable to be delivered to a Stroke Center (i.e., those patients that have elected to live in very rural areas) then the unit takes them to closest appropriate facility. Some felt issues are clear while others felt may not be clear.

There was discussion of trauma being more defined because there is an Office of Trauma at a State level. Cardiovascular and stroke patients do not have this beneficial department, and their

ability to focus on specific issues necessary for ongoing care of these patients (provided by studies and data, etc.).

Dr. Nelson discussed Cardiac Arrest Network, which is similar to the STEMI way of providing patient care and interventions. Dr. Nelson also noted the sepsis patients as an identified group of patients who may also require more timely interventions in the future.

The Medical Care Committee is purposely proactive on issues so as to be cautious of going forward with recommendations that may end up being unfunded mandates!

Julie Bacon discussed pediatric/neonatal issues and understanding of where gaps are. At present they are gathering data, including which hospitals have certain capabilities. They are doing a regional resources report. This will greatly assist in learning where need training or equipment, etc.

Angel expressed a need for outcome data to know what is effective, and this is crucial to what Medical Directors need to know.

There was also discussion of hospital competition and the factor this plays in patient care delivery. Dr. Nelson discussed the systems of care network, and the good things being accomplished with telemedicine. John Scott expressed this may be more of an interfacility project)

2010-2012 Plan: Add Medical Directors to 6.5.1

Member of audience requested information from Dr. Nelson as he was concerned about negative perceptions of EMRC and the decisions that committee will provide.

Dr. Nelson discussed committee, and positive perceptions will occur when EMRC provides useful data, which they were unable to ascertain previously. They have a large enough data base to provide this feedback. Is it oversight vs. data feedback? This is an information highway. EMRC will be establishing benchmarks and best practices based on blinded case studies (all records are blinded for identifying information prior to committee review). EMRC is not looking to police EMS but rather a beneficial opportunity for EMS. Dr. Nelson acknowledged need to educate EMS about committee activities although this will be self-resolving once information is disseminated.

5.6 Develop a standard Quality Improvement/Quality Assurance (QI/QA) template for use by all EMS provider agencies in conjunction with the state plan

Note: 6.8 Provides Lifeguards integration into EMS (absorbed into FACEMS)

Their input will be invaluable in light of Florida has the highest percentage of drowning of any State. (The group is aware and acknowledge Florida's higher amount of pools, lakes, ponds, and land surrounded by water)

Dr Byers requested discussion of on-scene amputations. Miami-Dade has protocol which includes individual who can perform. Felt issue is more complicated now that Dr. Shatz left State, as well as liability issues. John Scott requested data on how often seen, and particulars addressed. This would be sent to Trauma Committee and once position paper provided would be sent to Medical Directors, and then Medical Care Committee. Dr. Nelson agreed on need to develop position paper. There was general discussion of issues by those in attendance.

Meeting adjourned 2:30pm by John Scott

Note: Advisory Council update: Terminology definitions should sent to Chief Mooreland for clarification (Define: 'time of patient contact to delivery of care' from Medical Care Comm discussion.)

Note: Todd Mechler will assist with EMSsystems, and invite them to join conference call.