

# EMSAC General Session Meeting Minutes

October 21, 2010

## **COMMITTEE MEMBER ATTENDEES:**

Vicki Armbruster, Volunteer Third Service  
Ken Bramwell, Emergency Pediatric Medicine Physician  
Denise Gill, Idaho Association of Counties  
Mark Johnson, Private Agency  
David Kim, Idaho Chapter of ACEP  
Scott Long, Idaho Fire Chiefs Association  
Mike McGrane, Air Medical  
Tom McLean, EMT-Paramedic  
Travis Myklebust, EMS Instructor  
Michelle Priestley, EMT Basic  
Gary Showers, Advanced EMT-A  
Murry Sturkie, DO, Idaho Medical Association  
Pat Tucker, Consumer  
Mark Zandhuisen, Career Third Service

## **COMMITTEE MEMBERS ABSENT:**

Joe Cladouhos, Idaho Hospital Association  
Gary Gilliam, Third Service Non-Transport  
Dennis Godfrey, County EMS Administrator  
Robert Hansen, Fire Department Based Non-Transport  
Lloyd Jensen, Idaho Chapter of the American Academy of Pediatricians  
Catherine Mabbutt, Board of Nursing  
Bill Morgan, Committee on Trauma of the Idaho Chapter of ACS

## **VACANT MEMBER SEATS**

## **EMS STAFF ATTENDEES:**

Michele Carreras	Barbara Freeman
Kay Chicoine	Dia Gainor
John Cramer	Tara Knight
Wayne Denny	Dean Neufeld
Marc Essary	Tawni Taylor
Tom Fogg	Season Woods

## **OTHER ATTENDEES:**

Bill Arsenault, Wildland Fire Rescue	Dave Reynolds, Moscow Fire Department
Tony Balukoff, Life Flight Network	Lynette Sharp, Air Idaho Rescue
Justin Dillingham, Life Flight Network	Melonie Skiftun, Donnelly Ambulance
Barb Pyle, Donnelly Ambulance	

Discussion	Decisions/Outcomes
<b>Minutes and General</b>	
<p>New Members introduced:  Mark Zandhuisen, Career Third Service Member;  Joe Cladouhos, Idaho Hospital Association;  Bill Morgan, Committee on Trauma of the Idaho Chapter of ACS.</p> <p>Gary Gilliam and Scott Long's terms are expiring in October 2010</p>	<p>Next meeting dates:  Feb 3, 2011  June 29-30, 2011  October 20, 2011 –  Feb 16, 2012</p> <p>Minutes approved.</p>
<b>EMS Bureau Update</b>	
<p>Wayne Denny discussed the recent Bureau reorganization and consolidation of remote offices into the Boise location. The changes were facilitated by the opportunity for more square footage in the basement of the LBJ building. The Idaho Falls and the Lewiston positions were moved to Boise resulting in decreased costs for travel and lease as well as gains in workflow efficiencies.</p> <p>Wayne discussed the new organization chart. Changed a part time admin assistant to a full time technical records specialist (TRS2). Changed a management analyst from full time to part time. The TRS2 position will support the education and exams, investigator, and licensure positions.</p>	
<b>Investigation Update</b>	
<p>Tawni Taylor discussed the recent requirement to input data into the National Practitioners Data Base. Tawni reviewed the history of the database from the U.S. Dept of Health and Human Services, Health Resources and Services Administration (HRSA)</p> <p>1986 - Healthcare Quality Improvement Act  1988 - Development of the <u>National Practitioner Databank</u> (NPDB) begins  1990 - First reports are submitted  1995 - More than 100,000 reports submitted  1996 - HIPAA directs development of a <u>Healthcare Integrity &amp; Protection Databank</u> (HIPDB)  1999 - NPDB/HIPDB combined &amp; begin operating on the Internet  2000 - NPDB Turns 10 Years Old (Over 3.2 million queries are processed that year)  2010 - Data Bank Expands / Section 1921 of the Social Security Act</p> <p>The Data Bank implements Section 1921 on March 1, 2010 to include all healthcare practitioners, not just physicians nurses and dentists, as well as healthcare entities</p> <p><b>Why was the NPDB developed?</b></p> <ul style="list-style-type: none"> <li>A nationwide increase in medical malpractice litigation.</li> <li>To assist licensing boards uniformly identify, discipline &amp; disclose unprofessional behavior, incompetency &amp; adverse actions.</li> <li>To restrict the ability of health care providers to move undetected between states after adverse actions.</li> </ul> <p><b>Why is reporting important?</b></p>	

Reporting certain adverse information is required by law.

It fosters quality in health care delivery.

It assists the health care community in making sound employment, credentialing, and licensing decisions.

A failure to report can expose the public to practitioners who are unfit to provide patient care.

What is reportable to the NPDB? (Under Section 1921).

State licensure actions taken as a result of formal proceedings (Idaho = Peer Review).

The proceeding must be held by a state licensing or certification authority, peer review organization, or private accreditation entity that maintains defined rules, policies, or procedures for such a proceeding.

Any adverse action, including revocation or suspension of a license, reprimand, censure, restriction, or probation (retain with conditions).

Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the state or jurisdiction.

Any other loss of the license, whether by operation of law, voluntary surrender, denial or withdrawal of initial or renewal application, or otherwise.

Any negative action or finding that is publicly available information.

Formal or official actions, such as the revocation, suspension, or probation of a license, or a reprimand or censure.

Any other loss of, or the loss of the right to apply for or renew, a license, certification agreement, or contract for participation in government health care program, whether by operation of law, voluntary surrender, or non-renewal (excluding non-renewals due to nonpayment of fees, retirement, or change to inactive status), or otherwise.

Any other negative action or finding that is publicly available information.

### **How is the NPDB used?**

Primarily an alert or flagging system to enable a comprehensive review of a healthcare practitioner/entity credentials.

Should be considered with other relevant data when evaluating credentials.

Provides a brief report of the adverse action and directs the entity to the source for further information - state / agency that took the action.

Additional Resources:

[www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov)

NPDB and HIPDB Guidebooks, Interactive Training, FAQs and Brochures, Comparison Charts and Fact Sheets, Statistics, Annual Reports, Instructions for Reporting and Querying.

Customer Service Center - 1-800-767-6732

### **Idaho Subjects reported to the NPDB/HIPDB**

1996 – 2010: 37 Subjects (10 Paramedic, 8 AEMT, 18 EMT, 1 EMR).

Revoked (14), Suspended (5), Probation (3), Deny Initial (4), Deny renewal (3), Voluntary Surrender (1), Reprimand (1), Criminal Conviction (20). 9 of the 37 Idaho subjects had their EMS licenses reinstated. Of those who were not reinstated some become an agency administrator, agency driver, husband of an active volunteer EMT or moved to a bordering state.

### **EMS Investigations**

Open Investigations    Total Cases

FY05	0	13
FY06	0	10
FY07	0	13
FY08	0	22
FY09	0	38
FY10	6	35
FY11 to Date	11	20

The investigations in 2010 resulted in 17 open cases with issues about education (8), unlicensed EMS service (5), disqualifying crime (2), patient care (2).

### **Discussion**

Are agencies or individuals notified when a complaint is made? No. First there is an initial look to see if there is any substantive issues/evidence or does the Bureau have jurisdiction.

Does the Bureau have subpoena authority? Not at this time. Only entity that has subpoena is the Board of Health and Welfare and they don't have a vehicle to transfer the records to the Physician Commission. It would take a statutory change to give the EMSPC subpoena authority. Records are useful in validating cases. There are some other routes for obtaining records such as having the family request records.

It would be highly desirable to be able to obtain records in a timely manner. Otherwise the investigation is compromised. The Bureau doesn't want to be in the situation of not being able to take action because of the inability to obtain records. Possibly the EMSPC chair could meet with the public health officer to discuss.

### **Licensure Subcommittee Report**

Currently all agency licenses expire annually in September. The Bureau is implementing a new approach that will divide the license renewals over a 11 month period (December is the exempted month) with more oversight and individual involvement of Bureau staff to assist the agencies with inspections, medical supervision plans and other issues. The starting point is in eastern Idaho and will be grouped geographically.

### **Education Subcommittee Report**

#### Education and Exam Rules Task Force (ERTF)

The subcommittee reported the (ERTF) activity this year. Several subject matter experts have been invited to the meetings from the board of education, CoAEMSP, NREMT, and NAEMSE. Tawni Taylor will present investigation issues that focus on education programs. The subcommittee's role in this project will be discussed at the February meeting.

#### Optional Modules (OM)

The Optional Modules (OM) are available and on the website – [healthandwelfare.idaho.gov/EMSEdu](http://healthandwelfare.idaho.gov/EMSEdu). The report described requirements and the application process to obtain a password to access the OMs.

The agency requirements for OM training is to be currently licensed, reporting to PERCS, and submitting an annual report regarding OM use with the agency license renewal application. Some of the reporting will come through PERCS. Not yet determined if it will be reported separate or as part of the medical supervision plan.

The medical direction requirements for OM training is to have a current medical supervision plan (MSP) on file with the EMS Bureau, submit an addendum to the current MSP for optional modules, and the credential licensed EMS personnel in use of the optional module skills and interventions.

Only an agency administrator or an agency medical director can request OM training. The agency needs to meet the requirements as stated above, apply to the EMS Bureau, obtain a user name and password for the EMSEdu website from the EMS Bureau, complete the class, submit the documentation, and credential personnel by the medical director.

The modules are password protected and limited to the OMs requested in the application and MSP. The agency administrator or medical director will have access to teaching materials.

#### Discussion

The question was raised about why it is necessary to block access to the OMs. It would be helpful for decision making about applying and implementing OM skills to be able to review the material. Security makes sense for the exam, but lesson plans should be available for decision making with caveats about requirements for applying and obtaining approval for usage of the OM.

### Grants Subcommittee Report

Presented by Travis Myklebust.

The subcommittee was informed of a irregularity in the calculation of available collections for the FY2011 grant cycle. The collections at the cutoff date of June 30 was less than the amount entered into the database calculations. The preferred solution was to retain the awards and use 15 months of collections instead of 12 months leaving the FY2012 somewhat less than usual. In effect, the Bureau has used \$324, 565 of FY2012 collections to pay for FY2011 awards.

The subcommittee discussed a few areas of the FY2012 application that needed clarification such as a checkbox for a remount or the option to not include radio or gurney with a vehicle award.

More definitive information about PERCS compliance is also needed. Even if the proposed rules are not approved, PERCS compliance could still be used in the grants scoring (in place of the migrant/visitor score which is becoming difficult to determine and may be irrelevant).

Dr. Kim asked about the extrication equipment discussion in the subcommittee. Are there more opportunities for funding extrication equipment?. Yes – through Office of Highway Safety (OHS - \$141,000 for vehicle equipment this year.) If there are other robust fund sources, maybe it is a good idea to restrict awards in the EMS dedicated III fund. There was lengthy discussion in the subcommittee about items that might have alternate funding including communications (radios) equipment.

The caps for vehicles will remain in place without changes.

A motion to recommend accepting the 80/20 split as is for next year's grant cycle was seconded (Mark Zandhuisen) and carried. (80% for vehicles, 20% for equipment).

A motion to recommend leaving the current price cap on all transport, non-transport and remount vehicles as is was seconded (Gary Showers) and carried.

### **Air Medical Subcommittee**

Mike McGrane presented the report. The subcommittee worked on phrasing a nondiscrimination policy requirement in the proposed new rule.

The subcommittee concluded that it has been very difficult to provide “live” Landing Zone Training (LZT) training every other year to all providers. Enhancements to on line training to supplement the “live” training were considered and will be explored further in the February meeting.

The subcommittee discussed restoring the Air Medical Safety Forum that was responsible for developing LZT and will reorganize in February after the next EMSAC meeting.

Appropriate utilization-remote transports of minor illness/injury was considered but was not viewed as a huge problem. It can be an opportunity for education and outreach. May be appropriate if there is limited access to other care.

Michele spoke about the challenges of utilizing the air med rotation in SW Idaho with 5 helicopters covering a 100 mile radius and also referred to the policies that have been implemented at StateComm to assure that the closest helicopter is dispatched.

### **EMSC Subcommittee Report**

Kenny Bramwell presented.

The subcommittee will assist the EMSPC to make the current pediatric guidelines into state-wide protocols.

The Rescue Me conference in Boise promises to have a good enrollment and a lot of interest.

The Bureau has received a good response from the agency and hospital surveys.

The pursuit of an EMSC logo is on-going.

Training with the Idaho Simulation Network (ISN) and the Critical Access Hospitals (CAH) in northern Idaho was well received. The cost was \$24,000 for 4 hospitals. The cost is mostly travel and equipment. Rachael Alter will include funding in next years budget for more training to additional Critical Access Hospitals.

Pat Tucker proposed a project to increase outreach and education to improve the survival rate of trauma and cardiac arrest pediatric victims. She presented her research regarding the use of AEDs and will continue to obtain more research specific to Idaho about AED use and ways to implement this outreach.

Currently it appears that many AEDs don't have pediatric paddles. Rachael will be able to ascertain better when the survey results are analyzed. This might be a consideration for EMSC funding to improve pediatric patient care.

### **Other Business**

Murry Sturkie requested ideas and feedback about how to define “the practice of EMS”.