

IDAHO EMSPC MEETING MINUTES

November 18, 2011

A meeting of the Idaho Emergency Medical Services Physician Commission was held on this date at Oxford Suites, 1426 S. Entertainment Ave., Boise, ID 83709.

Members Present:

Curtis Sandy, M.D.
Eric Chun, M.D.
James Alter
Keith Sivertson, M.D.
Maurice Masar, M.D.
Murry Sturkie, D.O.

Member's Position:

State Board of Medicine
Idaho Fire Chiefs Association
Citizen Representative
Idaho Hospital Association
Idaho Association of Counties
American College of Emergency Physicians, Idaho Chapter

Members Absent:

Adam Deutchman, M.D.
David Kim, M.D.
Sarah Curtin, M.D.

Member's Position:

American College of Surgeons Committee on Trauma
Idaho Medical Association
Idaho EMS Bureau

Vacant Seats:

American Academy of Pediatrics, Idaho Chapter
Citizen Representative

Others Present:

Bill Aresenault
Brandon Erickson
Chris Stoker
Dave Reynolds
David Jackson
Diana Hone
Gary Showers
Gary Voss
Jan Peterson
Janna Nicholson
Jill Hiller
Kat Wood
Kevin Bollar
Larry Garey
Marc Essary
Matt Conklin
Randy Howell
Randy Sutton
Season Woods
Todd Jinkins
Vicki Eld
Wayne Denny
Wendy Walther

Other's Position:

Wildland Fire
Meridian Fire
Idaho EMS Bureau Standards & Compliance Section Manager
Moscow Ambulance
Nampa Fire
Idaho EMS Bureau Administrative Assistant
Jerome City Fire
Eagle Fire
BLM
Payette County Paramedics
Cascade Rural Fire/EMS
BLM
INL Fire
Jerome City Fire
Idaho EMS Bureau Licensing Supervisor
Life Flight Network
Boise Fire
West End Fire
Idaho EMS Bureau Education & Exams Specialist
US Forest Service
Donnelly EMS
Idaho EMS Bureau Chief
DHW - Medicaid

Chairman Sturkie called the meeting to order at 8:39 a.m.

Approval of Minutes from 9-16-11

Commissioner Masar, Idaho Association of Counties, moved and Commissioner Chun, Idaho Fire Chiefs Association, seconded the motion to accept the draft minutes as submitted.

Motion passed unanimously.

Statewide Protocol Subcommittee Report

The Statewide Protocol Subcommittee continues to work on developing and formatting statewide protocols using the North Carolina protocols as a template. Commissioner Sandy reported that challenges continue to be getting them to fit on single page, standardizing the verbiage and formatting. The subcommittee has been working in groups and individually. They have a retreat planned for February where they hope to finalize all the protocol drafts and have them ready for review at the EMSPC meeting on February 10, 2012. Another retreat is scheduled for April where they hope to work on the procedures. The Commission will have to determine distribution methods and allowances or methods for variance or exemptions by agencies.

Medical Director Education Subcommittee Report

Commissioner Alter reported the subcommittee recommends holding regional meetings rather than a major workshop. They would like to focus on an area of need such as new medical directors or a specific region. They recommend having two presentations in the same day: one in the afternoon and one in the evening. The subcommittee requested EMS Bureau help with budget allocations, securing facilities, identifying and scheduling presenters, advertising, registration, preparing materials and tracking participants. They recommend keeping the format simple, focus on regional problems and not try to rehash the “medical director handbook”. They would like to schedule a “pilot” meeting sometime in the spring, perhaps in an area where help has been requested. Invite both Administrators and Medical Directors.

The Planning Guide from the 2008 workshops needs to be updated. Commissioner Sandy reported that it would probably cost about \$5000 to edit and reprint an Idaho version of the medical director handbook he worked on with North and South Dakota

Training Equipment Requirement Report from EMSAC

The minimum equipment requirements listed in the EMS Bureau’s Education Standards Manual for training programs to teach the new curriculum were discussed at the September EMSPC meeting. The concerns were to be taken to the EMS Advisory Committee (EMSAC) Education Subcommittee for further review at their October meeting. Season Woods reported that the subcommittee discussed it briefly but did not have time to make any decisions because their priority item was to revise the BLS exam. The equipment requirements will be a future agenda item. It was noted that the Education Standards Manual is currently a policy document until it is incorporated by reference in rule, which would make it law rather than policy. The education rules are not going before the legislature this year; therefore, there is time to work this out even though new curriculum courses have started. Commissioner Sandy expressed his hope that now that the exam skill sheets are available, their content would be reflected in some of the required equipment for the classes.

Agency Equipment Waiver Process

New minimum equipment lists went into effect last July 2011. They have flexibility built in to them but occasionally the Bureau will receive a waiver request that may need physician input since the medical director making the request may feel a bureau employee who is a paramedic or EMT does not have the knowledge base to override their recommendation. Marc Essary asked if the Commission wants to be consulted or if it is okay

for the EMSPC Chair to take care of it. Commissioners felt the Chairperson could handle it and at their discretion bring the matter before the entire EMSPC when necessary.

Emergency Medical Dispatch (EMD) and Emergency Communication Commission (ECC)

The EMSPC discussed the need for standards and medical oversight for emergency medical dispatching throughout 2008. The EMSPC sent a letter to the ECC in April 2009 expressing their opinion that EMD is a key component of EMS and offered support or input in the ECC's effort to develop statewide standards for 9-1-1 and EMD. The EMSPC was informed by ECC that they agreed EMD was important, that it was in their strategic plan to develop standards and the PSAP subcommittee was working on it. However, when they were asked to attend EMSPC meetings to give an update, they said they had nothing to update. Recently a new chairman has taken over and he informed Commissioner Sandy that they have never talked about EMD and they are not going to. He said members of this committee do not feel comfortable passing standards their bosses may not want. They feel this is a medical decision and they do not feel comfortable making these standards.

The EMSPC still feels strongly about the importance of EMD. After further discussion it was determined that the Commission should write another letter to the ECC and offer assistance.

Commissioner Sandy, State Board of Medicine, moved that the EMS Physician Commission (EMSPC) send a letter to the Emergency Communication Commission (ECC) regarding the importance of developing statewide standards for emergency medical dispatch (EMD) and offer assistance with the development. A carbon copy is to be sent to the Governor's Office. Commissioner Chun, Idaho Fire Chiefs Association, seconded. Motion passed unanimously.

Micron Variance for Calcium Gluconate Gel

Dr. Timothy Phillips presented Micron Technology's request to continue their variance to use calcium gluconate gel. He reported that in 2010-2011 it was used in 6 cases by their EMTs. All the cases were reviewed by Dr. Phillips. He did not see any inappropriate use in those 6 cases. All cases occurred because they were in known hydrofluoric acid areas. In the last several years most of the exposures are coming from residual amounts of hydrofluoric acid left in pipes and in the tools they are dismantling rather than being exposed to large amounts.

Commissioner Sivertson, Idaho Hospital Association, moved to approve the continuation of the waiver for the use of calcium gluconate gel by EMTs at Micron Technology, Inc. for the period of two years. Commissioner Masar, Idaho Association of Counties, seconded. Motion passed unanimously.

2012 Standards Manual Changes

➤ Airway Management Data Collection

Commissioners were informed that the Department of Health and Welfare recently issued a policy that Survey Monkey can no longer be used. They have authorized use of Key Survey, however only four (4) licenses are available for the entire department; therefore, long term data collection through a survey will no longer be possible. If the Commission desires to collect data in the future, a different method will have to be determined.

Commissioners did not feel the language in Section IX of the Standards Manual needed to be changed at this time. The Bureau will re-explore what data elements are available in PERCS. The separate data collection tool was implemented because some of the elements the Commission wanted to see for airway management were

not NEMSIS elements. Perhaps NEMSIS elements can be found that would fit the current need rather than creating a new tool. Chairman Sturkie noted that the information was very informative and did help the Commission make decisions.

➤ **Medical Supervision Plan Submission Requirements**

Because of changes made to the 2012-1 EMSPC Standards Manual removing the requirement to submit medical supervision plans annually (See pages 8 and 13), a change may need to be made to the EMSPC Rule 16.02.02.400.07. This will be addressed at the February meeting for possible rule change in 2013 to resolve the conflict.

➤ **Epinephrine Auto Injector**

Commissioners agreed to change Epinephrine Auto Injector to an X floor skill for new level EMTs rather than an optional module (OM) because it is in the new curriculum EMT Instructional Guidelines.

➤ **Scope of Practice Effective Date**

It was recommended to make the effective date of the Standards Manual and therefore the Scope of Practice a hard date of July 1 each year rather than sine die of the legislature.

The need to have transition time for scope of practice was discussed again and it was agreed that the varying transition time lines apply to licensing but do not have to be listed in the EMSPC Standards Manual for the scope of practice grid. The new level scope of practice will become effective July 1, 2012. Providers will be able to follow the new level scopes of practice when they become licensed at the new curriculum license levels and are credentialed and authorized by their medical director to use the new skills.

Commissioner Sivertson, Idaho Hospital Association, moved to make the effective date of the EMS Physician Commission Standards Manual effective July 1st every year. Commissioner Chun, Idaho Fire Chiefs Association, seconded.
Motion passed unanimously.

Commissioner Masar, Idaho Association of Counties, moved to remove the paragraph referring to personnel transitioning to the scope of practice in Section VIII. Commissioner Alter, Citizen Representative, seconded.
Motion passed unanimously.

➤ **Grid Layout**

Commissioners liked the new layout of the scope of practice grid with all levels in view across the page.

EMR Hemorrhage Control - Tourniquet

Commissioner Sivertson stated that the most basic and effective skills for field providers are to open an airway and stop external hemorrhaging; therefore, he is a big proponent of approving tourniquets at the lowest level possible, if it does not create a hardship in terms of curriculum and testing.

Season Woods reported that tourniquet is in the education for EMT, but at the EMR level it is left to local discretion. It says to follow your local protocol and medical direction to make those decisions at the EMR level. National Registry has removed Tourniquet from the EMR practical exam because it is left to the discretion of the states. The education could be copied from EMT for EMR use. The Bureau is in the process of updating the BLS exam and could easily take the EMT skill sheet and make it part of the EMR practical. Bleeding Control and Shock is one of the optional testing stations at the EMT level. If you make it an optional module, it could be tested at the EMR level since it is testable at the EMT level.

Commissioner Sivertson, Idaho Hospital Association, moved to make Hemorrhage Control – Tourniquet part of the floor for new curriculum EMR-2011 and 2,OM for old curriculum EMR/FR94s. Commissioner Masar, Idaho Association of Counties, seconded.

Commissioner Sivertson reiterated that if one looks at the EMR and the chain of survival where they arrive first on scene, the two skills that will impact patient outcome the most are opening an airway and stopping external hemorrhage. So let's give them the skills to do that with. Certainly a follow-on ALS unit next on scene can remove the tourniquet. There is no prohibition to removing the tourniquet if it is not needed.

Commissioner Masar noted that military statistics show that it saves more lives than it hurts. He supported making it a part of the floor.

Kevin Bollar noted that a study reported in the current PTLIS guidelines found about a 92% survival rate in comparison to 10% prior to tourniquet implementation. The complication rate as a result of applying tourniquets was less than 2%.

Motion passed unanimously.

Commissioner Sivertson asked that Impedance Threshold Devices be discussed at the February meeting.

Automated Transport Vent (ATV)

➤ ATV Clarification

Commissioner Chun researched ATVs for the Commission as requested at the September meeting. He found that the technology varies greatly, just like cell phones have evolved over the years, making it hard to compare one to another. The cost ranges from about \$4000 up.

He found that the language on line 14 of the Scope of Practice (SoP) grid “Demand Valve – Manually triggered ventilation” is probably outdated and misleading. Commissioners agreed to add “flow restricted” to this line so it reads: “Demand Valve – Manually triggered, flow restricted, ventilation”.

There seems to be some confusion about lines 47 and 48 of the SoP also. EMT-2011s and AEMT-2011s will be allowed to use ATVs for non-intubated patients only. This means they will only use the vent that attaches to a mask so they do not have to use hand squeezing. Only Paramedics will be able to use ATVs for intubated patients.

➤ Concern about ALS billing if ATV becomes a BLS skill

Wendy Walther from Medicaid attended the meeting to answer EMSPC concerns about billing when skills become BLS rather than ALS in the scope of practice. She responded that yes, if a skill is available at the lower level, even if only as an optional module, it is billed at the lower rate even when it is performed by a higher level provider. Medicaid pays according to the Physician Commission scope. If the SoP says something is a BLS skill, Medicaid reimburses for it at the BLS rate no matter what level of provider performs that skill on that particular run.

So the question with the ATV is an EMT-2011 can only use a vent that attaches to a mask, it is still a BLS skill (line 47). The ATV is just a device that helps ventilate the person, instead of one person squeezing the bag, the machine does it. This is different from what an ALS provider can do on line 48. AEMT-2011 and Paramedics can use ATVs on an intubated patient, which makes it an ALS skill. A paramedic would put the patient who is intubated on a ventilator to do the tidal volumes, the respiratory rate, etc. That patient is intubated so it is ALS.

Wendy requested that perhaps a liaison from the Commission work with her at Medicaid to clarify what is BLS and what is ALS on an annual basis. Commissioner Sivertson agreed to do this.

The Medicaid reimbursement discussion continued. Chairman Sturkie asked, “If an ALS provider is in back of a BLS rig, can BLS agency bill for ALS skill?” Audience member Janna Nicholson stated that EMS rule states they have to transfer the patient to the ALS rig where ALS procedures could then take place. Wendy stated that Medicaid has no restrictions in their rule about ALS providers in BLS rigs. Medicaid rule says you can bill for level of service that was provided even if it was in a BLS ambulance.

Commissioners also discussed reimbursement when BLS rendezvous with ALS. Can the BLS segment get reimbursed separately from the ALS segment? Wendy responded that each agency should bill for their segment of the call. The BLS agency can be reimbursed for their part of the run and the ALS agency can be reimbursed for their part of the run.

What happens when different level agencies combine into one agency license (tiered response system licenses), can they still get reimbursed for the separate parts of the run when transfer from a BLS unit to an ALS unit occurs? One (1) chart, two (2) separate transport vehicles. Wendy said she would have to use a modifier to show that it was not a duplicate and each piece would have to come in with a different Health Insurance Claim Form (HCFA).

Removal of AEMT Orotracheal Intubation as an OM

The Commission voted to remove Orotracheal Intubation as an optional module from the AEMT scope of practice at the September 2011 meeting. There was some concern expressed by providers in the field that not enough people were in attendance to discuss it and asked that it be reviewed again. Correspondence from Back Country Medics was reviewed and Kevin Bollar from INL testified about their need to maintain an airway. He also noted that skill maintenance at the paramedic level is difficult too so why penalize AEMTs.

Commissioner Sivertson explained that because AEMTs have never been allowed to use drug assisted intubation, they have been restricted to intubating the near or soon to be dead. Every time the Commission has looked at this issue, the outcome of AEMT intubated patients has been uniformly fatal. This is not a reflection on the provider; it is a reflection on the condition of a patient that can be intubated without sedation by an AEMT. Commissioner Chun was of the similar opinion and stressed that maintenance of competency is a real issue.

The EMSPC is interested in interventions that actually move the needle toward patients surviving to be able to go home and be a meaningful member of the family. Commissioner Sivertson noted that large systems in other states, with resources Idaho cannot even imagine, are saying that even Paramedic intubations are not improving outcomes, let alone those that can be intubated by an AEMT without medications. In Idaho paramedics cannot be placed in every rural area to do drug assisted intubations; therefore, to get best results agencies should focus on the use of supraglottic airways and bag valve mask intubation. An AEMT putting an endotracheal tube into the trachea of these patients is not moving the needle toward better outcomes.

Commissioners were still of the opinion that there are better alternatives available now for use without medication. These alternatives were not available when the Commission first allowed intubation at the AEMT level. Therefore, as of July 1, 2012, Intubation – Orotracheal will not be an optional module for Advanced EMTs in Idaho.

EMT-2011 / AEMT-85 Options

➤ ILS Administrator Survey

The EMS Bureau surveyed ILS agency administrators to see what their plans are for transitioning their AEMT-85 personnel to the new AMET-2011 level. Chris Stoker presented the results: 46% said they planned to transition their personnel, 42% were uncertain, 5% said no, and 7% failed to respond. A copy of the full survey results can be obtained from the Bureau if interested.

Issues and Options being considered for the EMT-2011 / AEMT-85 situations:

- EMT-2011 transferring care to the AEMT-85**
- Allow an AEMT-85 to take the EMT-2011 Transition Course to acquire the missing skills but remain as AEMT-85. This would require a dual license.**
- EMT-2011 use of Supraglottic Airway and IV as Optional Modules. If approved, would this carry additional continuing education requirements at the EMT-2011 level?**

13 state medical directors responded to a quick survey asking about this. 7 are currently allowing EMTs to administer advanced airways as an optional module, 2 others are considering adding the skill. 2 states currently allow EMTs to administer IVs, 1 other state is considering adding this skill. 1 state currently allows both.

- If an AEMT-85 reverts to EMT-2011 by taking the EMT-2011 Transition Course and if EMT Supraglottic Airway and IV optional modules are approved, these reverting AEMT-85s would qualify for the optional modules without additional training.**

Audience member asked, "If you allow EMT-2011s to have supraglottic airway and IV as optional modules, what would be the reason for keeping I-85s?" Chairman Sturkie answered that when the decision was made to go with the National Scope of Practice Model there was significant concern about what would happen to I-85s. Therefore, at that time a commitment was made by the Bureau and Commission to maintain the I-85 until they went away, either by transition or attrition. If these OMs are allowed, that would mean those skills would continue at the EMT/BLS level forever, rather than only existing at the ILS/ALS levels.

Development of OM curriculum was discussed with Commissioners feeling the educational standard should be set and then let the medical directors develop the curriculum from the Advanced EMT curriculum.

Commissioner Sivertson asked if anyone was aware of any science that suggests outcomes are improved by airway and IVs at the EMT level. He was also concerned about confusion among AEMTs since the Transition Guidelines have already been distributed without these options. Commissioner Sivertson felt that only so much change can be pushed on a system at a time and perhaps the state has too much going on right now. He felt the EMSPC should delay considering this until next year or longer. However, Commissioner Sandy felt that since everyone is going through change right now it would be a good time to go ahead and do this. He suggested include it along with everything else because it might make a difference in their decisions about transition.

Wayne Denny asked that the Bureau be given an opportunity to discuss different options further, to look at planning, lay out a time line and discuss this again at the February EMSPC meeting. Chairman Sturkie noted that would put any changes out until the next Standards Manual in 2013. It was noted that the first transition deadline date for AEMTs is March 2014, so there is time.

Commissioner Sivertson emphasized that during this scope of practice transition, regardless of the level of licensure, it is incumbent on the providers and medical directors to make sure that the receiving provider can provide equal to or same level of care as the transferring provider. Skip the titles; can the receiving provider do what needs to be done, is it in their scope? Bureau Chief Denny said that medical directors may have to turn off

some skills until everyone gets up to speed. Yes a skill may be in the BLS scope but cannot be performed because the rendezvousing ILS service cannot support that skill.

Teleconference audience member asked “Will authorizing the EMT to do supraglottic devices and IV access, which is at this time an advanced skill, change the license of the organization from ILS to BLS? This could cause financial changes to organizations that are only supported by billing. They would no longer be able to bill for advanced calls.” Chairman Sturkie referred to the Medicaid response earlier that changes in skills could change reimbursement to agencies, but the reimbursement rates have gone up, and licensure level should not be a factor in reimbursements.

One of the other options under consideration is allowing AEMT-85s to take EMT-2011 transition course and add the new EMT-2011 skills to the AEMT-85 scope? Originally the promise was that AEMT-85s would be frozen at the I-85 skill level. Commissioner Masar said that in talking to several I-85s they want to do this. They are people that have been AEMT-85s for 20 years and eventually are going to retire. Before they retire they would like to continue and adding the EMT-2011 skills would help greatly with transfer of care issues. Commissioner Masar felt this is a good idea.

An audience member asked if the Commission was trying to make it undesirable to maintain I-85 or not. He felt it was silly to do both: let AEMT-85s take EMT-2011 transition to pick up those skills and/or give EMT-2011 IV and Airway as OMs. Wayne Denny replied that a lot of people would agree, but there is a pride component that comes along with the title “Advanced” EMT because of the additional training and effort to become one. Marc Essary also noted that these ideas came up as a compromise to try to help I-85s after discussing transition options with them at the road show meetings this fall. If this body believes that those skills need to exist in rural Idaho, then we are considering enabling them through two different avenues. The key is whether those skills are crucial to rural Idaho. Some feel they will not be available in the future, if these two options go away, because not enough people will become the new AEMT-2011.

Commissioner Sivertson asked for a diagram to show each AEMT-85 option: What are the implications and time frame for each decision? What does it take to get there?

This topic will be discussed further at the February 10, 2012, EMSPC meeting.

Commissioner Sandy wants to look at operationally specific scopes of practice, to include specifically over the counter medications for special teams. This topic will be on the February 2012 agenda.

Optional Module (OM) - PERCS Reporting Requirement

The agencies that are wanting access to optional modules but are still having problems with their PERCS reporting feel submitting paper patient care reports (PCR) for the optional module (OM) calls is too cumbersome and still not feasible. Problems with reporting software was discussed again at length.

Randy Howell with Boise Fire requested the NEMESIS data field requirements be reviewed and updated again. He hopes unnecessary data fields can be identified and eliminated, simplifying reporting.

Originally the EMSPC decided to collect data on OMs so in the future OM usage could be evaluated to determine if they are effective, appropriate, and/or necessary. The Commission still feels collecting data on OMs is important for this reason. Commissioner Sivertson stated that the EMSPC mindset to introduce OMs was to create flexibility for agencies that did not have access to ALS. Since the smaller agencies are not having

problems with reporting and the larger agencies that are having the problem with reporting have access to ALS, he was not very open to reversing the philosophy requiring OM reporting.

However, Commissioner Chun expressed his dissatisfaction that OM approval is not being granted because of data collection when OM usage could improve patient care. He feels they are not the highest risk type of care or training, so why wouldn't the Commission want to relax things, especially because there are other higher levels of care that are far beyond the optional modules which are not restricted. It was noted that the agencies are gathering the data; their exports just cannot be validated yet. They could run a report and submit it in another form.

If the reporting requirement were relaxed the onus would be placed on the medical director and the EMSPC would have no leverage for quality. It would require a more involved medical director including if an investigation event occurred with a provider using an optional module.

Since collection of data is not the issue, perhaps it could be submitted in a different form.

Commissioner Sivertson, Idaho Hospital Association, moves that organizations currently unable to submit via PERCS must report Optional Module data annually, by July 31, through a Microsoft Excel spreadsheet. The spreadsheet will have fields defined by the EMS Bureau. This shall be deemed sufficient for reporting requirements for optional modules. This method of reporting shall expire June 30, 2014. Commissioner Chun, Idaho Fire Chiefs Association, seconded. Motion passed unanimously.

Agencies can apply for optional module approval now and do the training. However, they cannot use the skills until the new standards manual goes into effect July 1, 2012, if they are not currently able to report through PERCS or an Idaho validated export.

Sivertson moved to adjourn.

Adjournment 4:21 pm

Murry Sturkie, Chairman
Idaho Emergency Medical Services Physician Commission