

IDAHO EMSPC MEETING MINUTES

November 15, 2013

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

Members Present:

Mark Urban, M.D.
Murry Sturkie, D.O.
Brian O'Byrne, M.D.
James Alter
Veronica Mitchell-Jones
Maurice Masar, M.D.
Paul Johns, M.D.
Eric Chun, M.D.
Keith Sivertson, M.D.
Ian Butler-Hall, M.D.
Curtis Sandy, M.D.

Member's Position:

American Academy of Pediatrics, Idaho Chapter
American College of Emergency Physicians, Idaho Chapter
American College of Surgeons Committee on Trauma
Citizen Representative
Citizen Representative
Idaho Association of Counties
Idaho Bureau of Emergency Medical Services & Preparedness
Idaho Fire Chiefs Association
Idaho Hospital Association
Idaho Medical Association
Idaho State Board of Medicine

Members Absent:

Member's Position:

Vacant Seats:

None

Others Present:

Bill Aresenault
Chris Stoker
Dave Reynolds
David Jackson
Dean Neufeld
Diana Hone
Hans Ohme
Jan Peterson
Jill Hiller
Kelland Wolf
Kevin Bollar
Kody Dribnak
Les Eaves
Mark Zandhuisen
Melonie Skiftun
Mikel Walker
Randy Sutton
Season Woods
Wayne Denny

Other's Position:

Wildland Fire / U.S. Forest Service
Idaho Bureau of EMS & Preparedness - EMS Section Manager
Moscow Fire Department
Nampa Fire Department
Idaho Bureau of EMS & Preparedness - Licensing Supervisor
Idaho Bureau of EMS & Preparedness - Records Lead
McCall Smokejumpers
Idaho Bureau of Land Management
Cascade Rural Fire & EMS
Wood River Fire & Rescue
INL
Idaho Bureau of EMS & Preparedness - EMS Field Coordinator
Clearwater County Ambulance
Bonner County EMS
Donnelly Ambulance
Madison Fire Department
West End Fire & Rescue
Idaho Bureau of EMS & Preparedness - EMS Field Coordinator
Idaho Bureau of EMS & Preparedness - Bureau Chief

Chairman Sandy called the meeting to order at 9:00 a.m. The Commission welcomed Dr. Paul Johns as the new commissioner representing the Idaho Bureau of EMS & Preparedness. 100% attendance with all seats filled was accomplished at this meeting.

Commissioner Sturkie, American College of Emergency Physicians, Idaho Chapter, moved to move into closed executive session to review confidential material in accordance with Idaho Code § 67-2345(1)(b&f). Commissioner Alter, Citizen Representative, seconded the motion. Motion passed unanimously.

Commissioner Sturkie, American College of Emergency Physicians, Idaho Chapter, moved to come out of executive session. Chairman Sandy, Idaho State Board of Medicine, seconded the motion. Motion passed unanimously.

Open meeting called to order at 10:05 a.m.

License Action Report

Commissioner Butler-Hall, Idaho Medical Association, moved to accept actions taken in closed session on 2013-27, 41, 43-51. Commissioner Chun, Idaho Fire Chiefs Association, seconded the motion. Motion passed unanimously.

Approval of Minutes from 9-14-12

Minutes were accepted as is by unanimous consent.

Medical Director Education Subcommittee Report / Budget 2014

Commissioner Butler-Hall and Commissioner Johns volunteered to join the Medical Director Education Subcommittee. The subcommittee was tasked to develop a “Welcome Packet” for new EMS medical directors, especially for rural Idaho. Limit to 15-20 pages. Introduce the EMS Bureau, the website, and the bare-bones basics. Perhaps supplement and simplify the Medical Supervision Development Guide.

Commissioners want to continue the evening medical supervision workshops because the personal interface is positive, well received, and appreciated. Therefore, the tentative budget would include \$1000 for the Statewide Protocol Workgroup meeting in February and \$6000 for 2 or 3 Medical Supervision Workshops. Suggested target area for next workshops: East Idaho – Rexburg, Salmon, Challis, Idaho Falls, Clark County area.

Medical Supervision Plan (MSP) Subcommittee Report

This quarter’s medical supervision answers that were collected during agency renewals were furnished to the commissioners. The medical supervision question discussed at the last meeting will be changed on the agency renewal application after the first of the year for the next licensing cycle.

The draft credentialing article, that will be included in the Bureau newsletter, was presented to the commissioners. Commissioner Sturkie suggested that the need to be re-credentialed when there is a

change in medical directors or agencies be added. Commissioner Sivertson suggested a sample credentialing card be created and posted to the website. Perhaps the card would also list the OMs for that level that could be checked off. It would need a date and signature/initial field.

Time-Sensitive Emergency (TSE) Workgroup Update

Wayne Denny reported that the TSE System Workgroup for trauma, stroke, and heart attack, will meet for the last time next week. The Department of Health and Welfare was directed by House Concurrent Resolution 10, in 2013, to draft legislation for a time-sensitive emergency system for all three emergency types in response to efforts by the Healthcare Quality Planning Commission (HQPC) to create a trauma system. The draft legislation has been completed with several ad hoc subcommittees working with the legislation language, funding, defining regions, etc., and they will begin to build concepts for rules. Frequently Asked Questions and the Executive Summary may be found on their website at www.tse.idaho.gov. It is proposed that there be a 17 member state board appointed by the governor similar to the EMS Physician Commission and regional advisory committees (RAC). EMS, hospitals, rehab, etc., will all funnel in through the RACs. Education, quality improvement, technical assistance will be primary components of the RACs. One benefit of a TSE System will be the ability to look at data across the state and when we see that one region has a lower mortality rate for a procedure, those best practices can be shared with the other regions.

The workgroup is hoping that either the Idaho Hospital Association or Idaho Medical Association will champion the legislation before the legislature. At this time there are three (3) pieces of legislation; one for the system, one for funding, and one for reporting.

Commissioner Sivertson noted that the EMSPC does not have a seat on the board even though EMS medical directors direct the most patients across the state. He also noted that the language includes physicians and registered nurses, but not physician assistants. Commissioner Sivertson acknowledged that everyone thinks this is a good idea but expressed concern that the regulatory burden on the hospitals be minimized, that detailed funding be secured, that there is a lack of a carrot for participation, that the proposed regions do not follow existing referral patterns that have evolved over time, and he did not understand how the RACs would be involved with recruitment and retention of EMS personnel.

Further discussion included uncompensated care, the ability to bill for trauma activation as one carrot for some hospitals, that actual patient flow patterns were not considered for creation of the regions, and that there is no EMS medical director representative at all. Chairman Sandy also pointed out a loop that needs to be closed: the board contains representatives from the RACs but the RACs cannot be composed without the board.

Regional Medical Direction

The possible need for representation of EMS medical direction at the TSE RAC level as a resource for the region was discussed. Regional medical direction would be a resource that would affect the education of medical directors and perhaps raise the bar for EMS medical direction. Commissioners felt this would be especially beneficial in the rural areas, but not as needed in the more populated areas where they are more organized already. The topic will remain on future agendas for further discussion.

Agency OM Usage Report

This information continues to be update from the license renewals and inspections. It is self-reported and not validated. Out of the 192 agencies renewed so far this year only 35 report any OM usage. It appears that many adopt them but do not use them.

Wildland Fire Update

Dean Neufeld reported that the Great Basin and the Northern Rockies coordinators, along with the Idaho Department of Lands, collaborated and put language in their contracting books this year to require entities, if they wanted to get paid, to submit the Idaho Bureau of EMS forms, either the Limited Request for Recognition or the Planned Deployment form. Therefore, there was a lot more activity and a lot more formal preregistration.

It was noted that “Limited Recognition” is not a license; it is simply protection from any administrative action by the Bureau. Providers are denied recognition if they do not have a license in another state. National Registry of EMTs certification alone is not a license to practice.

Dean provided commissioners with a report of “Limited Recognition Authorization Activity for 2013.” The report does not show Idaho personnel who were working on a fire site under the direction of their Idaho EMS agency. It only shows those that were working on a fire under a Medical Unit Leader. The report indicates that the vast majority of providers that are part of a wildland fire medical unit are brought in from out of state.

The Bureau has been invited to Missoula to orient all of their medical unit leaders to the Idaho processes and expectations.

Emergency Medical Dispatch (EMD)

Chairman Sandy reviewed a letter sent by the EMS Physician Commission to the Emergency Communications Commission (ECC) in 2009 about the great benefit that dispatch centers using EMD are to EMS and the possible establishment of EMD standards by the Public Safety Answering Points (PSAP) subcommittee. The PSAP listed several reasons why they were not going to work on EMD standards at that time. The last communication with ECC was in 2011.

Commissioner Sivertson, Idaho Hospital Association, moved to send a letter to the Emergency Communications Commission (ECC) to inquire about the current state of EMD standards and reaffirm EMS Physician Commission’s desire to work with them. Commissioner O’Byrne, American College of Surgeons Committee on Trauma, seconded. Motion passed unanimously.

Statewide Protocol Rollout

- *Rollout*

They were published July 1, 2013. All EMS agencies and medical directors were sent a booklet for review printed on the polyester durable paper. The Bureau has received a lot of good feedback. Dean reported that a significant number of medical directors have embraced them and felt that having them available was a load off of their minds because they would not have to spend significant amounts of research and development time. They felt strongly about the protocols being supported by the EMSPC. The overall feedback has been very supportive and encouraging. Some

wanted more detail in a few areas. Chairman Sandy noted that the protocols were not meant to educate so some of those details will not be included. The subcommittee is collecting the feedback and will meet in February to review the suggestions and problems noted. The intention is to prepare an updated version each year. The booklets were designed so that single pages may be replaced when needed.

A protocol for the appropriate use of lights and sirens in regards to transport and response will be developed due to the recent ambulance crashes in Idaho.

- *Procedures*

Dean reported that only nine (9) Procedures were included in this edition. The full range of Procedures listed in the Legend were not included in this edition because they were not all standardized with an established flow yet. Dean also felt there was a need for further discussion to determine if the Procedures should be published in a separate booklet from the Protocols; or, with the availability of commercial procedure books, is there a need for an Idahoized procedure book since procedures are pretty generic. Commissioner Sivertson suggested referencing an on-line source for procedures that is kept current.

The procedures that were included in this edition were the ones where the EMSPC had a specific optional module (OM) requirement to follow EMSPC protocols and procedures. Therefore, if a medical director adopts those OMs, they are required to extract the corresponding protocols and procedures from the EMSPC Statewide Protocols, even if they are not adopting the protocols in their entirety.

The main purpose for the Procedures Legend listing was to identify all the procedures referenced in the protocols by level of scope of practice.

- *Agency Adoption*

If agencies want to adopt the EMSPC protocols, the medical director signs the front cover sheet and submits it to the Bureau to be included in their record. They can use some or all of the protocols. They still need Destination and SafeHaven protocols of their own.

During the annual agency inspection the field coordinator asks if the protocols on file at the Bureau are current. The Bureau tracks the date protocols were last submitted, or the date the EMSPC protocols were adopted.

If an agency wants to make changes to the EMSPC protocols for their own use, then the protocols would no longer be endorsed by the Commission. The EMSPC copy write would be removed and the protocols would be the sole responsibility of the agency medical director.

- *Spinal Immobilization*

Commissioners reviewed “EMS Spinal Precautions and the Use of the Long Board” position statement from the National Association of EMS Physicians and American College of Surgeons Committee on Trauma and Chapter 2 “Prehospital Cervical Spinal Immobilization After Trauma” from the Congress of Neurological Surgeons.

Chairman Sandy reported that the Position Statement is quite mild compared to the original NAEMSP statement which is quite abrupt. In the world of EMS, one side says backboards are bad and harming patients, period. This position statement puts it more in the middle saying they may not provide that much benefit, they are not really sure if patients should actually be immobilized, but they “may” be used in some situations. It uses **NEXIS** criteria to list those that do not need immobilization on a backboard.

States across the country are determining if they accept the recommendations of this Position Statement or not. The big question is, “What is considered spinal immobilization, or spinal motion restriction, or spinal protection? What is that actually defined as?”

Chairman Sandy reviewed the position paper recommendations and then asked what the Idaho EMSPC immobilization protocol should eventually look like? Currently we have not specified what spinal immobilization means. It is a procedure that we have not put in to place.

Commissioner Sivertson, Idaho Hospital Association, moved to support the National Association of EMS Physicians (NAEMSP) and American College of Surgeons Committee on Trauma (ACSCOT) “EMS Spinal Precautions and the Use of the Long Board” Position Statement. Commissioner Butler-Hall, Idaho Medical Association, seconded. Motion passed unanimously.

Commissioner Sivertson stated that this Position Statement needs to be distributed to all of the emergency departments in the state as a recommended policy of the Idaho EMS Physician Commission.

Commissioner Sivertson stated that at some point a distinction has to be made between the use of a backboard for spinal immobilization and the use of a backboard as a lifting or transferring mechanism. It was noted that some agencies don’t have backboards at all. They have gotten rid of them and only use a scoop. Others will still use the backboards as they were meant to be used, as an extrication device, and then roll the patient off on to the stretcher where they are maintained with logroll precautions only.

The commission asked that the Position Statement be posted on the website and go out in the next Bureau newsletter. Commissioner Chun noted that medical practice often lags for years beyond the evidence that supports it. He felt the Position Statement needs to be sent to the hospitals and try to direct it to the surgeons since NEXIS has been out for close to 10 years. A cover letter will be drafted and the Position Statement will be sent to the EMSPC’s represented associations, the Idaho Athletic Trainers Association, and EMS agency administrators and medical directors who will be encouraged to take it to their referring hospitals.

The Commission acknowledges that it will take time and training to change the paradigm. There are a lot of variables associated with this topic. There will be push-back from EMS and hospitals because back boarding has been taught for so long. Even when a new concept is taught properly field personnel may not apply it properly.

- *National Association of State EMS Officials (NASEMSO)*

Chairman Sandy reported that all states are moving to statewide protocols and they liked ours.

2014 Standards Manual Update

The topic of optional module (OM) training hours not being used for continuing education (CE) credit for license renewal was discussed again at length. This has been a controversial subject with several varying aspects being discussed at previous meetings. The controversy stems from AEMT CE renewal hour requirements being significantly more than EMTs, even with the addition of several AEMT skills to the EMT scope of practice as OMs.

Commissioner Sivertson reiterated that it is the responsibility of the agency and medical director to make sure that the continuing education within the agency is sufficient to maintain knowledge and proficiency of all skills, including OMs.

Commissioner Sivertson, Idaho Hospital Association, moved to remove the sentence: “Hours used to train OM skills may not be used towards continuing education hours for personnel license renewal.” from page 14, paragraph 4, Section VIII, of the current 2014-1 Standards Manual draft. Commissioner Chun, Idaho Fire Chiefs Association, seconded. Motion passed unanimously.

Patient care response data reporting as one of the OM usage requirements was discussed. (Page 14) **Commissioner Sivertson, Idaho Hospital Association, moved to extend the date for the alternate reporting method in Section VIII.1.a. to June 30, 2016. Commissioner Chun, Idaho Fire Chiefs Association, seconded.**

Further discussion followed.

Commissioner Sivertson, Idaho Hospital Association, amended the motion to include changing the language of Section VIII.1.a. to read: “If an agency has not been able to obtain PERCS validation, they must report optional module data with each agency license renewal application. This method of reporting shall expire June 30, 2016.” Commissioner Johns, Idaho Bureau of EMS and Preparedness, seconded. Motion passed unanimously.

Extracting OM data from PERCS has been found to be very cumbersome and not accurate because they are not “required” fields; therefore, OM usage is not always entered fully and correctly. The OM usage report supplied to the Commissioners is generated by the alternate collection method from agency renewal reporting, not from PERCS data. However, agencies that are PERCS compliant do not have to report optional module usage by this alternate method in addition to their PERCS reporting.

Commissioner Chun, Idaho Fire Chiefs Association, moved to accept the edited 2014-1 EMSPC Standards Manual as final. Commissioner Masar, Idaho Association of Counties, seconded. Motion passed unanimously.

The need for the ability to use Lidocaine at the EMT and AEMT level when performing Intraosseous on a conscious patient was discussed.

Commissioner Sivertson, Idaho Hospital Association, moved to push this discussion to the Protocol Subcommittee to work it out. Commissioner Butler-Hall, Idaho Medical Association, seconded.

Motion passed unanimously.

Approve Pending Rule Docket for 2014 changes.

Commissioner Chun, Idaho Fire Chiefs Association, moved to approve Pending Rule Docket 16-0202-1301 to change the Standards Manual edition to 2014-1, effective July 1, 2104.

Commissioner Sivertson, Idaho Hospital Association, seconded.

Motion passed unanimously.

Cardiac Arrest Registry to Enhance Survival (CARES) Registry

Chairman Sandy brought the CARES Registry to the Commission because he feels that someone at the State level needs to be looking at the data collected. He encouraged EMS agencies and hospitals to sign up and submit their data. The goal would be to track and improve Idaho's prehospital cardiac arrest survival rate and to determine how many patients actually received dispatcher CPR. This may impact the ECC's need to work on EMD, as discussed earlier.

Chairman Sandy asked that information about the CARES Registry be included in the next Bureau newsletter to make EMS agencies aware that it is out there and encourage them to participate and submit data. CARES is working to enable state data repositories, such as PERCS, to be able to dump directly in to the CARES database through NEMSIS criteria.

Randy Howell agreed that the report is a pretty cool tool and there are not that many fields to complete.

New EMS Agency Licensure Rule – Minimum Equipment Lists

Chris Stoker reported that the Bureau is updating the Minimum Equipment Standards in connection with the new EMS Agency Licensure Rules this upcoming legislative session. He wanted to point out the role the EMSPC will play in the ability for agencies to modify their required minimum equipment based on their need and license type.

16.01.03.500.03. Modifications to an EMS Agency's Minimum Equipment List. An EMS agency's minimum equipment list may be modified upon approval by the Department. Requests for equipment modifications must be submitted to the Department and include clinical and operational justification for the modification and be signed by the EMS agency's medical director. Approved modifications are granted by the Department as either an exception or an exemption.

04. Review of an Equipment Modification Request. Each request from an EMS agency for equipment modification will be reviewed by either the EMS Advisory Committee (EMSAC), or the EMS Physician Commission (EMSPC), or both. The recommendations from EMSAC and EMSPC are submitted to the Department which has the final authority to approve or deny the modification request.

- a. A modification request of an operational nature will be reviewed by EMSAC;
- b. A modification request of a clinical nature will be reviewed by the EMSPC; and
- c. A modification request that has both operational and clinical considerations will be reviewed by both.

The new "Minimum Equipment Standards for Licensed EMS Services" edition 2014, version 1, is incorporated by reference into the new rule. The new model for minimum equipment will be specific for each agency according to their service type, clinical level and operational declarations.

Many of the quantity requirements have been removed. The rule states: **16.01.03.500.01. Equipment and Supplies.** Each EMS agency must maintain sufficient quantities of medical care supplies and devices specified in the minimum equipment standards to ensure availability for each response.

NASEMSO – Statewide Implementation of an Evidence-Based Guideline – Project Update

The Bureau is expecting to receive the project plan shortly, but had nothing new to report at this time.

NASEMSO Meeting Report

Chairman Sandy reported on a few things discussed at the NASEMSO Medical Director Council meeting in Nashville in September. One of the up and coming topics, besides spinal immobilization, was Narcan for law enforcement use. States are being petitioned to allow police officers to carry Narcan for overdose situations.

Chairman Sandy reported that many of the state EMS medical directors wish they had a governing body such as the Idaho EMS Physician Commission to work with.

The Medical Director Council discussed the Hartford Consensus document. After the Sandy Hook school shooting a conference was held in Hartford, Connecticut, with tactical powers such as fire/rescue departments, military, law enforcement, FBI, etc. They came up with a consensus document which basically says that EMS can no longer stage in a hostile environment; that EMS agencies and fire departments need to develop programs to send medical personnel into a hostile environment to render medical care. They are to work with police officers to try to get people in as soon as they can. Local EMS personnel are concerned about receiving proper training, including firearms, if they are going to be expected to be a “SWAT medic.”

Strategic Plan

Focus and long term goals:

TSE – look at regional medical direction

Medical Director Education

Protocols

EMS physician definition in code – recognition of our profession and may help with immunity

Upcoming meetings:

- February 6th will be Protocol Subcommittee retreat the day before the February 7th EMSPC meeting in Boise. Those not on this subcommittee may be asked to help with Peer Review on the 6th.
- May 9th at CSI in Twin Falls
- August 8th in Boise
- November 14th in Boise

Adjournment 3:58 pm

Curtis Sandy, Chairman
Idaho Emergency Medical Services Physician Commission