MEDICAL CONTROL COMMITTEE

Wednesday, February 25, 1998

MINUTES

Members Present:	**Others Present:**
Ed DesChamps, MD, Chairman	Doug Warren
John Sorrell, MD	Chris Cothran
Carol Baker, MD	Frank Trenery
Richard Rogers, MD	Steve Shelton, MD
Doug Norcross, MD	Anthony Horton
Bill Gerard, MD	Vickie Myers
	George Rice
	Mark C. Wilson, MD
	Jeremy Clifton
	Lanny Bernard
	Anthony Bostick, MD
	T. Greg Robinson
	Otis Speight, MD
	Joe Fanning
	Phyllis Beasley

REVIEW OF MINUTES FROM 11/19/97

Dr. DesChamps, Chairman, asked if anyone had revisions to the minutes from November 19, 1997. There were no comments. A motion was made to accept the minutes as written. The motion was seconded. The motion passed.

DRUG LIST REVISIONS

Addition of Amyl Nitrate/Lily Cyanide kit/Special Purpose drug list:

Dr. Baker requested the addition of amyl nitrate to the drug list based on the number of industries in the Greenville area which produce toxic products, such as cyanide.

Dr. Norcross asked if the MCC wanted to start approving specific drugs for poisoning, which could be a large number.

Mr. Fanning expressed staff concerns about the growing size of the drug list and the need for EMTs to have knowledge of each of these drugs. There was discussion about having a core drug list with specialty optional drugs.

Dr. Sorrell made a motion to create a third category of drugs called special use or special purpose to be allowed by the medical control physician who is responsible for the training and QI for those drugs. Dr. Baker seconded the motion. The motion passed.

By consensus the MCC agreed to hold another meeting in about six months to review special purpose drugs for that list. Staff will send out a request for those drugs prior to that meeting.

Dr. Baker made a motion to adopt the Lily Cyanide kit as a special purpose drug (in lieu of amyl nitrate). The motion was seconded. The motion passed.

Racemic epinephrine:

The request for Racemic epinephrine came from the Upstate. It is a change of route. Racemic epinephrine is supplied in inhalator/nebulizer bottles containing either 7.5, 15 or 30 ml and is used in the treatment of croup.

Dr. Baker made a motion to approve Racemic epinephrine, a change of route. Dr. Rogers seconded the motion. The motion passed.

Heliox:

The request for the addition of Heliox came from the Upstate/Dr. Baker. Dr. Baker explained that the principle of using Heliox is that there is less dense molecules, thus making it easier to breathe. It has many uses, but it's best use is for tracheal inflammation. It can be used in the field to "buy time" till other treatments can be rendered. It is cheap and non-toxic. It's only downside is that it is not FDA-approved, but as Dr. Gerard explained, it is standard of care.

A motion was made by Dr. Baker to add Heliox to the state drug list. Dr. Rogers seconded the motion.

There was some discussion about Heliox being another drug for which there are other substitutes and that addition of Heliox would compound the problem of the large number of drugs being required for EMTs to be responsible for.

A vote was taken. There were five opposed and one abstention (Dr. Baker). The motion did not pass.

Zantac:

A request was made from the Low Country/Dr. Sorrell to add Zantac as an interfacility drug.

There was again discussion about the number of drugs being added to the list. Dr. Gerard suggested that the MCC develop an interfacility template, which would allow the sending physician to send a patient on any drug as long as the EMT did not have to manipulate or in any

way change dosages on the drug. The template would include information such as the name of the drug, side effects, measures to counter side effects, who to contact if there is a problem and a place for the signature of the responsible sending physician. Dr. Norcross emphasized that these drugs would be used for transport only and would not be administered or manipulated by the EMT.

There was discussion about the fact that there are many different types of drugs (IV H2 antagonists) which may be used by patients needing transport. **Dr. Baker made a motion to approve the use of IV H2 antagonists (Zantac, Pepcid, etc.) as interfacility drugs. The motion was seconded. The motion passed.**

Dr. Gerard agreed to develop a template for the transport of any interfacility drug for presentation at the next MCC meeting. Dr. Sorrell emphasized that clarification would need to be made clear that the sending medic is responsible for any of those drugs.

Meperidine HCL (Demerol):

This drug was presented by Dr. Sorrell for the Low Country.

Discussion was raised about why Demerol is needed on the drug list if morphine is already approved. **A motion was made by Dr. Sorrell to add Demerol. The motion was seconded by Dr. Rogers. A vote was taken. All were opposed.**

Promethazine HCL (Phenergan):

A change in use of Phenergan was requested by Dr. Sorrell for the Low Country. The request for Phenergan was made to counteract the effect of Demerol (which had also been requested). Since Demerol was not approved, the request for Phenergan was tabled.

Nitroglycerin intravenous:

Nitroglycerin intravenous was requested as an interfacility drug, change of use, by Dr. Sorrell for the Low Country.

MCC members expressed concerns about adding this change of use of nitroglycerin to the drug list for use by all paramedics. Dr. Baker said that EMT's should be able to adjust the dose on long transports.

Dr. Norcross said that the Committee's two options are to 1) put the drug on the interfacility list so they can adjust the drug, or 2) put it on the drug list so everyone has to know the drug.

Dr. Sorrell asked that the Committee defer the request for nitroglycerin until the interfacility template is developed.

Dr. Baker asked that the MCC look at the current interfacility list for other such drugs that could be used with the proposed template.

Potassium Chloride:

A change in use of Potassium Chloride was requested by Dr. Sorrell for the Low Country. Dr. Sorrell explained that the request was made in order to allow the EMT to correct levels of potassium in case this had not been done prior to transport.

Dr. Sorrell said that he felt that the risk/benefit ratio was too high.

After discussion, the MCC declined to vote and passed on consideration of this drug.

Discussion on Lidocaine:

Dr. DesChamps explained that a question had arisen about the loading dose of Lidocaine Hydrochloride listed in the "Special Notes/Restrictions" versus AHA standards. Richard Harrison asked about the difference in the drug list loading dose (decreased by 50% for patients in CHF, shock or over 70 years of age) versus AHA standard of not reducing the loading dose for patients over age 70, but reducing the maintenance drip by half.

Dr. DesChamps recommended that the "Special Notes/Restrictions" in the drug list be revised to read "In certain instances, dosages may be reduced and there are many acceptable ways to do this." A motion was made to adopt this statement. The motion was seconded. The motion passed.

PILOT PROJECT: CRITICAL CARE EMT-P

Dr. Steve Shelton presented the proposed pilot project on behalf of Rural/Metro EMS provider. The project requests the ability to train their paramedics in selected portions of the Critical Care Paramedic curriculum to include training the following special skills: Titrate medication drips with titration parameters; ventilator adjustments; intra-aortic balloon pump adjustments; invasive cardiac pacemaker adjustments. The proposed project would also allow those paramedics to transport patients with vercuronium bolus; Midazolam bolus; Norepinephrine drip; and Phenylephrine drip; PEEP valves; intra-aortic balloon pumps; and invasive cardiac pacemakers.

Dr. Shelton stated that there is a need for this type of training because of the number of critical patients being transported interfacility, but that hospitals are downsizing their staffs and cannot always send a physician or nurse to accompany the patients. This program would fill that manpower gap.

Dr. Norcross said that he can see how it would be important where there is not the personnel to transport, but on the other hand it might be a way out for hospitals not to use their skilled personnel.

Mr. Fanning asked how many of the MCC members have studied the need for this program? Dr. Sorrell questioned how far paramedic training can go before it oversteps the boundaries of nursing.

Mr. Fanning said he thought this type of project would have to go before the DHEC Board because it is a medical practice issue. Dr. Norcross said that he wanted to hear what the Board of Medical Examiners and Nursing Board think about this type of project/training.

Dr. DesChamps asked Dr. Shelton to look at Maryland, Ohio, and North Carolina and determine what the legal/governmental processes were to allow that training and to get a copy of their curricula.

It was decided that a joint subcommittee of Medical Control Committee and the Training Committee would review this request and the process and medical practice implications. Members of the MCC who will serve on this subcommittee are: Dr. Sorrell, Dr. Baker, and Dr. Norcross.

No further action will be taken on the pilot project request until a report is received by the subcommittee.

AUTOMATIC EXTERNAL DEFIBRILLATORS (AED)

Mr. Fanning reported that the Board of Medical Examiners met to address the issue of the use of AED's by 40-hour first responders and laypersons. The Board determined that, yes, use of the AED can be allowed by two groups:

a) persons with relatives that may have a heart problem, but a prescription for an AED must be written by a physician and the family members must have training in the use of AED and in CPR and the physician must ensure that the training has been received and must inform the local EMS about the existence and potential use of the AED.

b) public safety personnel such as fire departments. These groups must have training in the use of the AED and must have medical control which conducts quality improvement and must allow supervision of the use of AED's by the local EMS.

George Rice requested that the MCC "allow the use of AEDs by emergency response personnel in arenas throughout areas of the state where they are working as part of the EMS chain of survival. There are many EMS services throughout the state that have been working for several years to train volunteer firefighters, police officers and other emergency responders as first responders. Many systems throughout the state have trained these people to the 40-hour level course as outlined by NHTSA. The public has a greater expectation of EMS than they had six or seven years ago. In addition, the position of the Heart Association came out in 1992. It is now 1998 and to meet the expectations of the public, and to decrease the instances of mortality among

people who have incurred sudden cardiac arrest in rural areas; I would ask that based on what we have presented to the Board of Medical Examiners and also based on the position of the National Academy of Emergency Physicians, the state of North Carolina and other states that we go ahead and move forward and allow systems (first responders are a part of the EMS systems) to use AED's, provided there is medical direction, quality assurance, quality control and that they receive the training as outlined by the NHTSA EMT curriculum in using the AED."

There was discussion by the MCC about the fact that the Board of Medical Examiners will require physician supervision, though not necessarily EMS medical control physician supervision.

A motion was made in support of getting the AED's out for use as requested by George Rice. The motion was seconded by Dr. Rogers.

Dr. Sorrell also added to the motion that EMS medical control physicians get involved with AED users. Dr. Gerard added to the motion that we should develop a model AED QI program.

The motion passed.

NEW EMT-P CURRICULUM

Chris Cothran made a presentation explaining the new EMT-P curriculum which is nearly ready for consideration for adoption by states. The proposed curriculum revision will soon be delivered to NHTSA. South Carolina will need to review the curriculum and decide what we want to do.

The new curriculum includes extensive training in many new areas including:

- Illness and injury prevention
- General principles of pathophysiology
- Therapeutic communications
- Life span development
- Clinical decision making
- Abuse and assault
- Challenged patient
- Acute interventions of the home care patient
- Operations

The clinical internships of the new curriculum will far exceed what we require today. The final paramedic curriculum is estimated to be between 1000 and 1200 hours including field and clinical time.

Mr. Cothran also mentioned that the EMT-I project will also be completed soon. As yet there is no textbook for the new curriculum.

Mr. Cothran said that the change in the curriculum will affect the scope of practice of EMT-P's and may also affect the admission criteria.

Mr. Cothran said that the MCC can review the proposed curriculum on-line at <www.pitt.edu\~paramed\>.

REPORT ON RSI PILOT PROJECT

A subcommittee met after the last MCC meeting and reviewed all the RSI charts for Lancaster County EMS. The subcommittee had questions about the aggressiveness of the intubations on the medical cases. The subcommittee determined, however, that no inappropriate charts were kicked out in review.

After discussion, the MCC determined that the QI process could be "tweaked" to include more charts for all intubations and possible intubations. Dr. Sorrell asked about the number of charts. Lancaster County EMS responded that over the six month review time there were about 30 charts and now there are about 40.

Dr. Gerard stated that the subcommittee is in favor of continuing the pilot project for another six months. Dr. DesChamps asked if the project should still be restricted to this service and Dr. Baker responded "yes." It was determined that the same subcommittee would review more charts again in six months.

Dr. Gerard stated that Dr. Bianco had called to state that he was against the continuance of the RSI pilot project.

Dr. Norcross made a motion to extend the RSI pilot project at Lancaster County EMS until the first Medical Control Committee meeting six months from this date. The motion was seconded by Dr. Sorrell. The motion passed.

TRAUMA

Ms. Beasley reported that the process to begin redesignations had started. Letters had been sent to the first group of ten hospitals asking for review dates.

Dr. Norcross mentioned that the third site reviewer's training workshop had just been completed and many new physicians were trained. **Dr. Norcross made a motion (to amend a motion at a previous MCC meeting) to require the inclusion of an emergency physician on all redesignation site review teams. The motion was seconded. The motion passed.**

With no further business, the meeting was adjourned.

(The Medical Control Committee will meet again in May 1998.)

MEDICAL CONTROL COMMITTEE

Third Floor Training Room

Heritage Building

May 28, 1998

11:00 a.m.

Members Present	Others Present
Ed DesChamps, MD, Chairman	Joe Fanning
Bill Gerard, MD	Alonzo Smith
Steve Shelton, MD	Paul Lucas
Doug Norcross, MD	Richard Miller
John Sorrell, MD	Renee Callan
Carol Baker, MD	Dave McDonald
Richard Rogers, MD	Teke Washington
Eric Weinstein for Joe Bianco, MD	Todd Jackson
Ron Fuerst, MD	Scott Lesiak
	Chris Cothran

The meeting was called to order by Dr. DesChamps. He informed the committee that Paul Lucas is new director at Lowcountry Regional EMS. Dr. DesChamps asked that the committee review the minutes of the February 25, 1998, Medical Control committee meeting (MCC). **Dr. Sorrell stated a change needed to page 3 paragraph 2 the word "medic" to "physician". Dr. DesChamps asked for a ruling on the minutes with changes to be implemented. All were in favor, the minutes were accepted.**

Structure of Medical Control and Trauma System Committees- Dr. Norcross

Dr. Norcross stated that how position are appointed on the Trauma System Committee needs to be reviewed. He stated that currently the chairman is to be a Level I trauma director who serves on the Medical Control Committee (MCC). He explained that sometimes there is not a Level I trauma surgeon to fill this position. Dr. Norcross made the following suggestions for restructure of the Trauma System Committee;

PURPOSE:	**Unchanged**
GOALS:	**Unchanged**
MEETING FREQUENCY:	**Unchanged**
NUMBER OF MEMBERS:	**Unchanged**
QUORUM:	**Unchanged**

TYPE OF POSITION:	
Chairman	**Should be a member of Medical Control Committee appointed by Medical Control Committee chairman.**
Medical Control Committee Chairman	**Unchanged**
Level III surgeon	**Should be appointed by the SC Chapter of the American College of Surgeons Committee on Trauma**.
Level III emergency physician	**Should be appointed by the SC Chapter of the American College of Emergency Physicians.**
Level III nurse	**Should be appointed by the SC Emergency Nurses Association.**
Representative of SC Hospital Assoc.	**Unchanged.**
Level III trauma registrar	**Trauma Association of SC**
EMS regional director	**Appointed by the SC EMS Advisory Council.**
Pediatric specialist	**Should be appointed by the SC Chapter of the Academy of Pediatrics (candidate should have interest in pediatric emergency medicine)**
Level II emergency physician	**Should be appointed by the SC Chapter of the American College of Emergency Physicians.**
Level I trauma nurse coordinator	**Trauma Association of SC**
Level I emergency physician	**Should be appointed by the SC Chapter of the American College of Emergency Physicians.**
On-line medical control physician from a non-designated hospital	**Should be appointed by the Chairman of the Advisory Council.**
Rep. from SC College of Emergency Physicians EMS Committee	**Should be appointed by the SC Chapter of the American College of Emergency Physicians.**
Level I trauma surgeon	**Should be representative from the SC Committee on Trauma**
EMS Field representative	**Should be appointed by the chairman of the Advisory Council.**
MEMBERS APPOINTMENT:	**Delete**
LENGTH OF TERM:	**At the discretion of the organization represented by the members**.
OTHER PROCEDURES:	
Agenda Items:	**Unchanged**
Ad Hoc Committees:	**Unchanged**

Minutes:	**Unchanged**
Designations/Predesignations:	**Delete**

Dr. Norcross made a motion to approve the changes to the guidelines of the Trauma System Committee. Dr. Sorrell seconded the motion. Dr. Fuerst abstained. The motion passed.

The guidelines for the Medical Control Committee were unanimously accepted with the following change;

LENGTH OF TERM: **"at the discretion of the organization represented by the members."**

Report from Critical Care Paramedic Subcommittee - Dr. Sorrell

Dr. Sorrell stated that Mobile Care Ambulance Service and Rural Metro have each submitted a pilot project request for a critical care transport course. He stated the subcommittee met and decided that skills and training from this course would be beneficial to EMTs. He explained that the subcommittee will meet again to decide which skills should be included in a standard curriculum. The subcommittee discussed allowing the local medical control physician to determine which of the skills in the curriculum would be used by his paramedics. The subcommittee will report their findings at the next MCC meeting.

Presentation of Interfacility Drug Template- Dr. Gerard

Dr. Gerard stated that he and Dr. Shelton are going to meet and review the current drug list, after which, they will submit their recommendations to other medical control physicians for further input. They will report their findings at the next Medical Control Committee meeting for final approval.

Drugs to be removed from State Approved Drug List and added to Special Purpose Drug List

Dr. DesChamps stated that it was suggested that a core and optional/local drug list be developed. He explained that all EMT-Ps will be tested on their knowledge of core and optional/local drugs during initial certification and at the National Registry level. However, EMT-Ps will only be tested on core drugs for recertification. The committee reviewed the current drug list and made the following changes:

Core Drugs	**Optional/Local Drugs**
Adenosine/*Adenocard*	Aspirin (Children's chewable)
Albuterol Sulfate/*Ventolin/Proventil*	Diltiazem Hydrochloride/*Cardiazem*
Atropine Sulfate	Dobutamine Hydrochloride/*Dobutrex*
Bretylium Tosylate/*Bretylol*	Flumazenil/*Romazicon*
Calcium Gluconate	Heparin Lock Flush

Activated Charcoal USP	Ibuprofen/*Motrin, Advil, Pedi-Profen*
50% Dextrose/*D50W*	Labetalol/*Normodyne, Trandate*
Combination Dextrose/Sodium Chloride/	Nalbuphine Hydrochloride/*Nubain*
5% Dextrose in 0.45% Sodium chloride (D51/2NS)	Oxytocin/*Pitocin*
5% Dextrose in Water/*D5W*	Nitrous Oxide (50%) & Oxygen (50%)/ *Nitronox*
Diazepam/*Valium* **C IV**	Proparacaine Hydrochloride/ *Ocu-Caine(Alcaine)*
Diphenhydramine/*Benadryl*	Promethazine/*Phenergan* (Note: change Special Notes/Restrictions: to stocked on vehicle)
Dopamine Hydrochloride/*Intropin*	
Epinephrine/*Adrenalin*	
Furosemide/*Lasix*	
Glucagon USP	
Syrup of Ipecac	
Lorazepam/*Ativan* **C IV**	
Morphine Sulfate/ ***C II***	
Naloxone/*Narcan*	
Nitroglycerin	
Procainamide Hydrochloride	
Lactated Ringers (LR)	
0.9% Sodium Chloride/*Normal Saline*	
Sodium Bicarbonate	
Terbutaline Sulfate/*Brethine*	
Thiamine	

Dr. Norcross informed the committee that during a previous MCC meeting there was a suggestion of adding the Lily Cyanide Kit to a special purpose drug list. He asked the committee to consider adding the Lily Cyanide Kit to the local/optional list. The committee agreed but stated that the list should be changed to the Special Purpose Drug List.

Mr. Smith asked the committee to consider adding Promethazine*/Phenergan* to the Special Purpose Drug List since it can be administered by paramedics. The committee unanimously agreed, and added Promethazine*/Phenergan* as a special purpose drug. Dr. DesChamps stated that the MCC will met again to review and make additions to the Special Purpose Drug List. (See attached Special Purpose Drug List).

Dr. Weinstein asked if Magnesium Sulfate Infusion should be added as a core drug on the basis of anticonvulsant in preeclampsia. Dr. DesChamps stated that this could be better addressed during the meeting to review or make additions to the drug list. The committee agreed. *Note: Add to agenda on next MCC meeting.*

Medical Control Physician's Workshop- Dr. Gerard

Dr. DesChamps informed the committee that Dr. Gerard, Dr. Sorrell, Dr. Baker and Dr. Rogers have been asked to review the recertification process of medical control within the Medical Control Physician's Workshop and submit a recommendation(s) for improvement.

Dr. Gerard stated that before a recommendation can be made three topics should be addressed; the adequateness of the initial course, if there should be a recertification process and if there should be a requirement for online medical direction. Dr. Baker added that the minimum qualifications to become a medical control physician should also be addressed.

Dr. Fuerst recommended to the committee that refresher continuing medical education courses to allow recertification in ACLS and ATLS would be beneficial.

Dr. Gerard stated that if continuing medical education courses are developed, they should be focused statewide. He explained that this would allow medical control physicians to gain more focused and accurate information/ training on the new/revised skills, equipment and drugs offered within the state.

Dr. Fuerst asked if credit could be given toward a self study continuing medical education course.

Dr. Gerard responded that self study should be permitted. He explained that this could be done if a summary guide of minutes from past Medical Control Committee minutes and a question and answer sheet were developed.

Dr. Baker asked who would develop the test.

Dr. DesChamps stated that a committee of Medical Control Members would be formed to create the study guide and test.

Dr. Baker added that the test should be updated yearly and a Medical Control Bulletin should be distributed to medical control physicians informing them of new drugs, equipment and changes made in South Carolina. She also suggested that every two years medical control physicians would have to take an open book test, in conjunction to attending a minimal number of EMS related continuing medical education courses.

Dr. Weinstein stated that credit for continuing medical education courses could be gained from either teaching a course or attending a Medical Control meeting.

Dr. Fuerst asked how would initial certification affect current medical directors.

Dr. DesChamps explained that they would be grand fathered into the program over a 4 year period. He added that this would require credit for continuing medical education courses to be obtained in hours.
Mr. Fanning informed the committee that credit hours have been established but only for courses offered on a half day or less basis. He added that if courses, initial or refresher are scheduled for a full day, the current rate of obtaining hourly credit will have to be revised. Mr. Fanning suggested with the help of the American College of Emergency Physicians, a subcommittee be formed to develop a refresher course.

Dr. DesChamps agreed and stated that the subcommittee should be comprised of 1 or 2 Medical Control Committee members, 1 or 2 members from the American College of Emergency Physicians, and representatives from DHEC-EMS staff (Alonzo Smith and Phyllis Beasley).

The committee agreed and decided to form a subcommittee to discuss the qualifications to become a medical director, the requirements to maintain medical director status, the continuing medical education course and the recertification/refresher process. The subcommittee will be comprised of 1 or 2 Medical Control Committee members, 1 or 2 members from the American College of Emergency Physicians, a representative from the EMT Association, a representative from the Rural Health Association and representatives from DHEC-EMS staff (Alonzo Smith and Phyllis Beasley). This committee will met and make a recommendation at the next Medical Control Committee meeting.

Dr. DesChamps asked the committee for a recommendation(s) on the requirements of online medical control physicians.

Dr. Weinstein informed the committee that the American College of Emergency Physicians has a program established for online medical control physicians. He explained that each person must watch a 10 minute video, and read a 20 minute guide about to what an online medical control physician's responsibilities are and what state and local protocols have to be followed.

The committee asked that Dr. Weinstein to develop a poster to be placed by the radio for local online medical control and make a presentation at the next Medical Control Committee meeting.

The NHTSA Report and Recommendations

The committee agreed to hold this report until presentations/recommendations have been made from Dr. Weinstein regarding online medical control and the Medical Control Physicians Workshop subcommittee.

Note: Staff add Dispatch retreat as an agenda item for next MCC meeting.

Field Death Pronouncements

Dr. DesChamps stated that several medical directors have asked if there is any precedence/protocols that would allow paramedics the authority not to administer resuscitation or to pronounce someone dead on the scene. He recommended to the committee that guidelines/protocol should be developed to allow paramedics this option under specific circumstances.

Dr. Sorrell informed the committee that currently there is a Do Not Initiate Policy.

Note: Staff is to get journal article regarding Do Not Initiate Policy, the policy from Greenville and Charleston, the ACLS standing order, and trauma literature from Dr. Norcross.

The committee elected Dr. Fuerst to work with staff on gathering any and all information regarding the aforesaid.

Mr. Fanning stated that the EMS for Children bill outlines what is required of an EMS system with an impact on pediatrics. He added that the request for federal funding had to be removed to allow the bill to pass this year. Mr. Fanning explained that he would prefer funding to be included on this bill even if it would not be approved until next year. He stated that he would inform the committee as additional information is received.

Note: Phyllis poll committee in the next couple of months for next meeting date.

The meeting was adjourned by Dr. DesChamps.

MEDICAL CONTROL COMMITTEE

MINUTES

October 22, 1998

Members Present:	Others Present:*
Ed DesChamps, MD, Chairman	Mark Reynolds, MD
Doug Norcross, MD	Aline Greene, RN
John Sorrell, MD	Jay Hamm, RN
Robert Malanuk, MD	Renee Callan
William Gerard, MD	David Miller, RN
Richard Rogers, MD	Ryon Watkins
Carol Baker, MD	

*The roster of ***Others Present*** is incomplete. The Medical Control Committee attendance list was not signed by visitors and the list was composed by memory.

MINUTES FROM 5/28/98

The first item on the agenda was the review/discussion of the minutes from the last Medical Control Committee meeting on May 28, 1998. Dr. Gerard asked that the minutes be corrected to add Lidocaine to the list of core drugs in the minutes. Dr. Sorrell made a motion to approve the minutes with the additional listing of Lidocaine. Dr. Rogers seconded the motion. The motion passed.

NEW PEE DEE EMS DIRECTOR

Dr. Richard Rogers introduced Ryon Watkins, the new Director for the Pee Dee Regional EMS located in Florence.

TRAUMA SYSTEM COMMITTEE

Dr. Doug Norcross, Chairman of the Trauma System Committee (TSC), began the review of actions taken by the TSC.

Trauma Center Redesignation Recommendations:

Hilton Head Hospital

Dr. Norcross presented a brief summary of the site report of Hilton Head Hospital, including the concerns that QI was being conducted, but not always documented properly and that physician issues were not being addressed in the Trauma Committee. **He made the motion that the**

Medical Control Committee approve Hilton Head Hospital under Redesignation Option #2 (that the hospital be redesignated as a trauma center, but with the understanding that the hospital will correct the problems noted and report them to the Committee within 90 days. The hospital has the important essential items, but needs some minor changes/improvements. After 90 days, the evidence submitted by the hospital of effort(s) to correct the problems will be reviewed and the hospital will be placed in either redesignation category 1 or 3) and the hospital is required to document in 90 days a process in which medical staff issues will be brought to its Trauma Committee. The motion was seconded by Dr. Sorrell.

There was then discussion by Dr. Malanuk about how the hospital will provide the required information. Dr. Norcross explained that the hospital will be required to present a written explanation of how it has remedied the problem. He also said that there was discussion at the TSC about patient care issues, but that the redesignation process was developed only to look at the hospitals' QI programs and the redesignation method cannot be changed in the middle of the process.

The motion passed.

Georgetown County Memorial Hospital

Dr. Norcross then briefly explained that the review team's findings at Georgetown County Memorial Hospital indicated a QI program that was thorough and well documented. He noted that the team's only recommendations were that the hospital develops a defined trauma alert protocol, possibly a tiered system. **Dr. Norcross made a motion to approve the TSC's recommendation that Georgetown County Memorial Hospital be redesignated as a Level III trauma center under redesignation option #1 (To designate the hospital as a trauma center. The hospital has everything required and is designated with no question or problems.). Dr. Sorrell seconded the motion. The motion passed.**

Bon Secours St. Francis Xavier Hospital

Dr. Norcross reviewed the TSC recommendations for Bon Secours Hospital. Dr. Mark Reynolds, team leader at the review, arrived and reaffirmed Dr. Norcross' statements. Dr. Reynolds said that the team found that the hospital should have a stronger Trauma Committee and stronger documentation. Dr. Norcross made a motion to accept the TSC recommendation that Bon Secours St. Francis Xavier Hospital be redesignated as a Level III trauma center under Option #2 (**that the hospital be redesignated as a trauma center, but with the understanding that the hospital will correct the problems noted and report them to the Committee within 90 days. The hospital has the important essential items, but needs some minor changes/improvements. After 90 days, the evidence submitted by the hospital of effort(s) to correct the problems will be reviewed and the hospital will be placed in either redesignation category 1 or 3**). **The problems to be corrected are: 1) to document that there is a mechanism in process in which other committees will report their findings to the**

Trauma or Critical Care Committee and 2) that the QI process allows for review of patients admitted to nonsurgical services to ensure that it was appropriate that the lack of general surgical involvement was appropriate. Dr. Sorrell seconded the motion. The motion passed.

Dr. Norcross reiterated his concerns on the overregulation of the trauma center redesignation process. He said that after all the hospitals have undergone redesignation, the TSC would look at the redesignation process and make changes. He said that the process does not allow for the individual issues seen at the Level III hospitals.

Structure of TSC:

Dr. Norcross explained that at the last TSC meeting concerns were raised about the lack of Level II representation on the committee. Changes had been made by the MCC at its last meeting regarding terms and appointments, but the TSC felt that there should be more representation by Level II trauma centers, since there were now three designated Level II centers. There had been discussion about the size of the Committee getting too large to meet quorum, but the TSC still asked that the MCC consider adding two Level II positions. **Dr. Norcross made a motion that two Level II positions be added to the Trauma System Committee: a Level II surgeon, appointed by the SC Committee on Trauma; and a Level II Trauma Nurse Coordinator, appointed by the Trauma Association of South Carolina. Dr. Rogers seconded the motion. The motion passed.**

The question was raised about how the changes passed by the MCC would be implemented. Ms. Beasley explained that the method she planned on using was to send letters to the current TSC members notifying them of the changes and asking them to contact the appropriate organization if they wished to retain their seat. Then letters would be sent to the appointing organizations telling them who currently holds the positions and asking them for their appointments. All the letters would contain dates in which the information was needed.

Dr. Robert Malanuk questioned the preponderance of positions which would be appointed by the South Carolina Chapter of Emergency Physicians and whether that was an equitable way to select emergency physician representation. He expressed concern that by using this method of appointment, there may not be good geographic representation of emergency physicians. He suggested that the appointments be made by the regional medical directors. Dr. William Gerard said that he did not know another way, or organization, that could be used.

Dr. Norcross suggested that the appointing organizations who are responsible for more than two positions be asked to consider the geographical diversity of their appointees.

Dr. Gerard also added that he felt that the TSC, as well as other meetings, should be rotated to different areas of the state. There was further discussion on this suggestion, but no resolution.

Dr. Norcross said that he was most comfortable with the organizations making the final decisions

on appointments to the TSC. Dr. DesChamps added that the MCC would have final say on the appointments.

Trauma Association of South Carolina (TASC) Proposed Workshop:

Jay Hamm, RN, president of TASC, explained that during the redesignation process several problems have been noted regarding registry data input and a general understanding of the registry and QI process. He said that all the trauma centers are putting in the data differently. Victor Grimes of DHEC EMS and TASC will be working together to develop an all-day Trauma Registrar's Workshop and the Trauma Committee will be sending letters to all the hospitals "strongly recommending" attendance by at least one representative. The workshop will be presented sometime after the first of the year and may be offered several times during the year.

CRITICAL CARE PARAMEDIC PILOT PROJECT

Dr. John Sorrell, chairman of the Critical Care Paramedic subcommittee, reviewed the findings and recommendations of the subcommittee. He said that the subcommittee felt that it would be better to allow the curriculum to be used as a pilot project, rather than attempting to implement it statewide at this point. The subcommittee had reviewed the list of skills for approval and had determined **that all should be conducted only with on-line medical control**. The skills which would be used include:

- maintain and adjust temporary internal pacemaker as required by patient condition
- Rapid Sequence Intubation (RSI) with retrograde intubation as a secondary intubation technique
- Needle and surgical crichothyroidotomy
- Foley catheter placement
- Arterial blood gas collection and analysis via I-Stat machine
- All aspects of ventilator operation to include initiation and adjustments in accordance with on-line medical control
- Perform and interpret 12-lead EKG's
- Transport and monitor Swan-Ganz catheters. In the event the catheter tip displaces into the right ventricle have the ability to withdraw catheter back into right atrium only with on-line medical control
- Able to transport and monitor patients with ICP devices
- Umbilical venous line placement
- Arterial line placement.

Dr. Sorrell also said that the subcommittee asked for written criteria for the certification and recertification of skills.

Dr. Sorrell made a motion that the Critical Care Paramedic Project be allowed, but limited to the two services which made initial application (Mobile Care Ambulance Service and

Rural Metro) and limited to the skills which were approved by the subcommittee (see above).

Dr. DesChamps suggested approving the pilot project, then asking the subcommittee to meet again and come back with an approved certification process for a skills checklist and competency checks.

There was much discussion about the differences in the amount of skills which will be used. Dr. Sorrell said that Rural Metro didn't want to be as comprehensively involved in the project as Mobile Care Ambulance and that they just wanted to pick certain skills to implement in their project. He said that each service should be able to decide how much of the curriculum to use, as long as the skills used fell under the "*approved*" list.

The motion was amended to add that at the next meeting, the MCC must approve the skills checklist and the competency checks and will expect formal reports every six months after the program is started. Dr. Rogers seconded the motion. Dr. Norcross asked for a clarification. He said that one of his concerns was a potential problem with the Nursing Board. Dr. Sorrell reported that the subcommittee said that the skills could be performed **in an ambulance** without nursing board approval. A vote was then taken. **The motion passed with abstentions from Dr. Baker and Dr. Sorrell.**

Dr. Sorrell said that the subcommittee also recommended that CME's be awarded for the Critical Care Paramedic course. Alonzo Smith asked if the course had been approved by the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS). *Mr. Smith also said that he could get a copy of NC's critical care protocols for use here.*

Mr. Fanning asked that Mr. Smith check to see if any legislative changes were necessary in NC to implement this program.

TRAUMA CENTER SITE REVIEWERS AGREEMENT

Dr. Norcross asked to return quickly to one trauma topic that needed MCC approval. He presented a document that had been developed by DHEC which would require signatures by trauma center reviewers verifying that: [1] they have no conflict of interest, [2] professional or monetary affiliation with, [3] do not live or work in the same county as, or [4] have not provided trauma consultation services for the hospital being reviewed. He presented a second document, for information only, that had been developed with could be used by hospitals and trauma consultants which delineated the role and involvement of consultants. Both documents had been suggested for development much earlier by Dr. Richard Bell, when he was serving on the Medical Control Committee.

Dr. Norcross made a motion to adopt the proposed document "Site Reviewers Agreement." Dr. Gerard seconded the motion. The motion passed.

WORKSHOP REVISION SUBCOMMITTEE REPORT

Dr. DesChamps reviewed the summary report of the Workshop Revision Subcommittee (see attached). Dr. Malanuk questioned the requirement listed on the summary that (re: recertification)

- After initial certification at the main Medical Control Physician Workshop, the physician should attend a meeting such as another Medical Control Physician Workshop, a Medical Control Committee meeting, or a regional information meeting.

Dr. Malanuk questioned whether requiring annual physical attendance at a meeting was a punitive requirement. Dr. DesChamps said that the interpretation was wrong; the subcommittee meant to give the physician a choice between physically attending an approved meeting or workshop or participating in a written subject and test (to be developed later). Dr. DesChamps said that the requirements should be clearly worded to say that **any one** of these options could serve as recertification. He said that the subcommittee will be asked to develop the subjects to be used as CME's.

Dr. Baker suggested that the subcommittee could develop regional meetings and the same information could be distributed there.

Dr. Sorrell made a motion to accept the Workshop Revision Subcommittee's recommendations with the clarification of attendance requirements and CME tests, effective the year 2000, and have an informational meeting for medical control physicians at the EMS Symposium (in February of 1999). Dr. Baker seconded the motion. The motion passed.

It was decided also that the Subcommittee should start developing CME topics and try out regional updates.

INTERFACILITY DRUG TEMPLATE

Dr. Baker raised the question, "If a service never does interfacility transports, does the medical control physician have to teach the interfacility drugs?" Dr. DesChamps responded that if the MCC decides to adopt the proposed interfacility drug template, then the interfacility drug list will no longer be used and services will be able to transport any drug using the template.

Mr. Fanning asked Mr. Smith and Dr. DesChamps to check with the DHEC Board to make sure that there is no problem with using the template an eliminating the interfacility drug list.

Dr. Norcross asked if there were any interfacility drugs that the EMT's were adjusting. The answer was NO.

A question was raised about who would fill out the interfacility form? The Committee agreed

that the sending physician or nurse would complete the form. Another question was raised about whose responsibility it would be to teach about and understand the drug. The Committee agreed that it was the EMT's responsibility to ask questions.

Dr. Sorrell stated that on the form it should be noted in bold that "**the EMT cannot change or stop the drug.**" He said that the form should also include a section with basic guidelines concerning the drug.

Dr. Malanuk suggested adding more lines for any adverse effects of the drug. Dr. Sorrell suggested taking off the section for indications and adverse effects and adding a section for "*special considerations.... call if.....*"

Dr. Baker expressed concern about EMS services which may not have pumps for transporting some of the drugs. Dr. Sorrell said in that case, the sending facility should decide if it is worth the risk to "drip in" the drug.

Dr. Malanuk expressed his opposition to the form.

Dr. Baker suggested leaving off the section on "*indications, adverse effects and observations*" and using a broader permission form.

The suggestion was also made to add a disclaimer at the bottom that the physician or nurse is responsible for the patient; the EMT can only monitor the drug or discontinue it with on-line medical control. It should also be added that EMT's are not allowed to adjust drugs, even with on-line medical control. The suggestion was made that a phrase like "*all drugs are provided for the benefit of the patient at the request of the sending physician*" should be added.

The Committee agreed by consensus to approve the template in concept. Staff will adapt the template and fax it out for approval.

Dr. Norcross said that the contact physician listed on the form should not be limited to the sending hospital; the form should also allow contact with the receiving hospital.

There was discussion about the best way to get out the information about the new form. The Committee agreed that the form and an introductory letter should be sent to hospital administrators, the chiefs of hospital medical staffs, and the directors of nursing. The Committee also agreed that in the cover letter sent with the form, there should be a section on how the form is to be used and the changes related to it. There should also be a note added to the form that interfacility drugs can only be transported by paramedics.

NEW PROCESS FOR COMPLAINT INVESTIGATIONS

Mr. Smith presented a flow sheet outlining a new, definitive process for the investigations of complaints against services or EMTs. (See attached) He explained the different types of

complaints the office receives and how they are classified. Part of the new procedure included the development of a Peer Advisory Committee (PAC). Mr. Smith explained that staff felt that the decision making process would be fairer if a Committee determined the results of an investigation. The PAC would be composed of [1] the state medical director, [2] the four regional training coordinators (less the coordinator who served in the region being investigated), [3] a field paramedic (selected by the EMS Directors Association), and [4] one regional medical director. Mr. Smith also said that the Committee structure has been discussed, but not finalized.

Dr. Norcross clarified that letters would be sent to the director of the service (or services in cases in which the EMT works for multiple services) for which the EMT works at the time of the violation.

The Committee agreed that the process should be changed to say that the Division Director can accept the PAC recommendation, or refer the decision back to the PAC for amendments (in the next to the last step).

Dr. Sorrell added that in the third flow step down, if an investigation is warranted, then a letter should also be sent to the service's medical director, as well as the service director, in cases which involve a patient care issue.

Dr. Norcross said that non-EMS issues such as crimes should bypass the PAC and go directly from the legal department to revocation.

Dr. DesChamps asked if any of the regional medical directors would have a problem with serving on this committee on a rotational basis. The consensus was that would be okay.

TRAINING AND COMPLIANCE POLICY MANUAL

Mr. Smith passed out a newly-developed training and compliance policy manual and asked the Committee members to take it back with them and review it, particularly the areas regarding medical direction and training.

RAPID SEQUENCE INDUCTION INTUBATION (RSI)

Dr. Gerard said that he had not been able to get information on the project from Lanny Bernard. *It was agreed that this subcommittee needs to meet before the next MCC meeting.*

CRICOTHYROTOMY PILOT PROJECT

Dr. DesChamps noted that a brief review of the current pilot projects had been conducted. The cricothyrotomy project had been approved in the mid-1980's for Spartanburg EMS and later for MUSC. He said that this pilot project had fallen between the cracks. Dr. Norcross said that he

thought that no more than one or two crichs had been performed in the past 12 years. He also added that if the state is going to allow RSI, then services need to be able to perform cricothyrotomies.

Dr. Gerard said that he had read research that indicated that cricothyrotomies are not necessary because of the other airway options. Dr. DesChamps added that cricothyrotomies are in the new paramedic curriculum as an optional skill.

Dr. Norcross stated that regardless of the data, there are times when there is nothing else to do and it is quicker than retrograde intubation.

Dr. DesChamps stated that the pilot projects have fallen between the cracks and that there should be an ongoing file of each project and regular reports to the MCC. Dr. Baker suggested that the services must reapply for pilot project status every several years.

Dr. DesChamps said that staff should write the services with current pilot projects and ask for data for the last several years. Dr. Sorrell suggested that the Committee can't set times for the projects because they are all different, as far as the scope of the projects. Dr. Norcross said that a time limit should be set on an individual basis to reauthorize each project.

The Committee agreed by consensus that a letter should be sent to all services currently participating in a pilot project (cricothyrotomy, D50W, and TPA) to ask for the data on their projects for the last several years. Dr. Sorrell said that a decision on the performance of cricothyrotomies should be made at the next meeting. *Dr. Gerard said that he would send a copy of his review article on cricothyrotomies.*

C-SPINE PROTOCOLS

Information on C-spine protocols was passed out for discussion at the next Medical Control Committee meeting.

FIELD DEATH PRONOUNCEMENTS

Copies of Charleston's and Columbia's field death protocols were submitted at the meeting. Staff agreed to copy these and send them out to all MCC members for further discussion. Dr. Sorrell clarified that the discussion on field death pronouncements was for the purpose of developing a generic state-approved protocol. **The Committee agreed by consensus that this state-approved protocol should be developed.**

AMBULANCE RUN REPORT (ARR) ISSUES

Dr. DesChamps brought up the issue of the need for a place for a signature by the patient on the ARR for instances in which a patient refuses treatment. He suggested that a separate generic form should be developed for use in these instances.

Dr. Gerard said that there are several definitions on the ARR which need to be addressed and clarified by DHEC (i.e. false calls, no transport, etc.). *Dr. Gerard agreed to put together a list of questions for DHEC to answer, then to address those issues to the EMS Advisory Council.*

Dr. DesChamps said that a meeting in early December, prior to the EMS Advisory Council would be scheduled, if possible.

MEDICAL CONTROL COMMITTEE

MINUTES

December 3, 1998

Members Present:	Others Present:
Ed Deschamps, MD, Chairman	**Mark Krawiel**
John Sorrell, MD	**Brett Patton**
Richard Miller, MD	**Richard Boyer, MD**
Bill Gerard, MD	**Kelly Hawsey**
Richard Rogers, MD	**Cliff Staggs, MD**
Doug Norcross, MD	**Lisa Evert, RN**
Bob Malanuk, MD	**Jan Kuhn, RN**
	Ryon Watkins
	Al Futrell
	John Arnold, RN
	Paul Lucas
	Helene Gerrald, MD
	Barbara Bryant, RN
	David Mearns, MD

MINUTES FROM 10/22/98

The first item on the agenda was the review/discussion of the minutes from the last Medical Control Committee meeting on October 22, 1998. **A motion was made to accept the minutes as presented. The motion was seconded by Dr. Sorrell. All were in favor. The motion passed.**

TRAUMA SYSTEM COMMITTEE REPORT

Beaufort County Memorial Hospital

Dr. Norcross informed the Committee that Dr. Russell Jaicks was the team leader for this site review, Dr. Weaver was the emergency physician and Kim Nathan was the critical care nurse on this team.

Dr. Norcross review the Redesignation Options 1-3:

1. To designate the hospital as a trauma center. The hospital has everything required and is designated with no question or problems.

2. To designate the hospital as a trauma center, but with the understanding that the hospital will correct the problems noted and report them to the Committee within 90 days. The hospital has the important essential items, but needs some minor changes/improvements. After 90 days, the evidence submitted by the hospital of effort(s) to correct the problems will be reviewed an the hospital will be placed in category 1 or 3.

3. This hospital will lose its designation at this time, since it has a number of major deficiencies and the hospital must submit a new application at the next application cycle in order to be reconsidered.

Dr. Norcross stated that the review team reported that Beaufort County Memorial Hospital has an excellent general and surgical response to trauma. During the review no problems were found and Redesignation Option # 1 was recommended. **Dr. Norcross made a motion to redesignate Beaufort County Memorial Hospital as a Level III trauma center under Redesignation Option #1 with final approval to be made by the Advisory Council. Dr. Gerard seconded the motion. All were in favor. The motion passed.**

Palmetto Baptist Hospital

Dr. Norcross stated that Dr. Richard Miller was the team leader for this site review. This team suggested adding radiology as a part of the trauma team. No problems were found during and redesignation under Option #1 was recommended. **Dr. Norcross made a motion to redesignate Palmetto Baptist Hospital as a Level III trauma center under Redesignation Option #1 with final approval to be made by the Advisory Council. Dr. Sorrell seconded the motion. All were in favor. The motion passed.**

Aiken Regional Medical Center

Dr. Norcross reported that he lead the team for this site review. He stated that Aiken Regional Medical Center has an outstanding QA process. During the review he recommended that death reviews are documented. **Dr. Norcross made a motion to redesignate Aiken Regional medical Center as a Level III trauma center under Redesignation Option #2 with final approval to be made by the Advisory Council. After 90 days, the hospital must provide documentation that mortality reviews are being conducted. The motion was seconded by Dr. Rogers. All were in favor. The motion passed.**

Trident Regional Medical

Dr. Norcross stated that Dr. Mark Reynolds was the team leader for this review. During the review it was recommended that there be documentation of trauma alerts and documentation of "loop closure" on the issue of the delay of anesthesia. **Dr. Norcross made a motion to redesignate Trident Regional Medical Center as a Level III trauma center under**

Redesignation Option #2 with final approval to be made by the Advisory Council. After 90 days, the hospital must submit documentation that they have implemented a trauma alert protocol and document "loop closure" on the issue of the delay of anesthesia. The motion was seconded by Dr. Gerard. All were in favor. The motion passed.

Allen Bennett Memorial Hospital

Dr. Norcross informed the Committee that he was the team leader for this site review. He stated that this service receives very little trauma, however the QA process in place works for them. Dr. Miller explained that Allen Bennett Hospital is a satellite hospital, but they do want to participate in the trauma system. **Dr. Norcross made a motion to redesignate Allen Bennett Memorial Hospital as a Level III trauma center under Redesignation Option #1 with final approval to be made by the Advisory Council. Dr. Gerard seconded the motion. All were in favor. The motion passed.**

Conway Hospital

Dr. Norcross informed the Committee that Dr. Thomas Ashley was the team leader for this review. Dr. Steve Shelton was the emergency physician and Naquita Richardson was the critical care nurse on this team.

Dr. Norcross stated the site reviewers found that there were no minutes from the 1997 Critical Care Committee (CCC) meetings. In 1998 the CCC met five times and only three meetings were documented (minutes). Dr. Norcross added that the review team found that the reviews of deaths or transfers were not consistent. Dr. Norcross explained that, from discussion at the earlier Trauma System Committee, the team leader felt that the hospital's trauma QI is a "work in progress." Dr. Norcross stated that Dr. Ashley's recommendation is because Conway Hospital has not adhered to the state required audit filters, redesignation should be made under Option #3.

Dr. Miller asked when could Conway reapply. Dr. Norcross responded that an application can be resubmitted in January 1999.

Dr. Malanuk made a motion that Dr. Miller and Dr. Norcross review the redesignation process of Conway Hospital and redesignation be deferred until a recommendation is submitted.

Dr. Norcross explained that because he accepts patients from Conway Hospital he would have to refrain from the review. Dr. Miller accepted the request.

Dr. Sorrell said that a decision on Conway's redesignation should be given today.

Dr. Helene Gerrald, Medical Director of Conway Hospital, stressed that the state's audit filters are used but have been developed into an in-house form. She submitted the hospital's audit filter

review form with the corresponding numbers from the state's form. Dr. Gerrald stated that Conway Hospital's medical and administrative staff is aware that consistency is required when documenting the committee minutes.

Dr. DesChamps asked for a ruling on the motion before the committee. **Dr. Sorrell seconded the motion. All were opposed. The motion was declined.**

Dr. Miller suggested redesignation under Option # 2 with a full site review in 90 days.

Dr. Sorrell asked if the problems should be specified. Dr. Norcross responded that the hospital should be notified that a site review team will be sent to review the QI process as a whole.

Dr. Sorrell made a motion that Conway Hospital should be redesignated under Redesignation Option #2. After 90 days a full site review will examine the hospital's QI program. Dr. DesChamps seconded the motion.

Discussion ensued.

Dr. Sorrell amended the motion to include the redesignation of Conway Hospital as a Level III trauma center under Redesignation Option #2. After 90 days, a full site review team, led by Dr. Richard Miller, will return to review the hospital's QA program, specifically the documentation issues. The motion was seconded by Dr. DesChamps. All were in favor. The motion passed.

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) PILOT PROJECT - LAURENS CO. EMS

Dr. David Mearns gave a comprehensive review of the CPAP to include a demonstration of the mask and head gear, use of the adjustable PEEP valve and practical equipment and the project's proposed documentation procedures.

Dr. DesChamps asked if use would be restricted to Paramedics. Dr. Mearns responded that use of the CPAP would be restricted to Paramedics.

Dr. Miller asked what is a fail safe when intubation is needed.

Dr. Norcross stated that a protocol needs to be established to set time limits for treatment and nonresponsiveness. Dr. Mearns responded that after five minutes of no response to the CPAP, the Paramedic should revert to normal intubation protocol.

There was discussion about having a control group. Dr. Mearns expressed concern that there would be legal problems in using CPAP for some patients and not for others.

Dr. Miller made a motion to approve the Continuous Positive Airway Pressure (CPAP)

Pilot Project in Laurens County EMS. The use of the CPAP is restricted to the Paramedic level and a "bail out" time is defined as an option.

Dr. DesChamps amended the motion to include formal reports of the CPAP Pilot Project to be submitted every six months to the DHEC -EMS.

Dr. Norcross asked that in addition to the other requirements, SATS be used as a guideline.
Dr. Miller withdrew the motion.

Dr. Miller made a motion to approve the implementation of the pilot project with the requirement that formal reports are submitted to the Medical Control Committee every six months, a DHEC staff member will attend the training of the EMT's in this program, the use of the CPAP is restricted to paramedics, but all EMT's will receive training, the programs "bail out options" will be defined, determine if SATS will be used as a guideline and a definition of when the therapy (by use of the CPAP) has failed, what other measures will be taken. **Dr. Sorrell seconded the motion. All were in favor. The motion passed.**

TRAUMA SYSTEM ISSUES-FEES, EMERGENCY PREPAREDNESS, THE REDESIGNATION PROCESS

Dr. Norcross stated that the Trauma System Committee determined that the fee schedule for Level III trauma center reviews should be a set amount of $500.00, to be paid by the hospital. It was also decided that members of a Level III trauma center site review would be voluntary and would not receive a stipend. All monies would be maintained by the DHEC-EMS Trauma System Coordinator.

Mr. Fanning stated that he would research the legalities of receiving such funds.

Dr. Norcross stated to the Committee that the trauma centers and the trauma system should have an active role with emergency preparedness. He informed the Committee that Dr. Eric Weinstein will inquire with the Local Emergency Preparedness Council (LEPC) as to what specific actions the trauma centers can take to improve their role with emergency preparedness.

Dr. Norcross stated that the designation/redesignation process has been problematic. The Trauma System Committee (TSC) will review the process after all site reviews have been completed. The TSC is considering a five year formal review with emphasis on patient care rather than focusing solely on the QA process.

RSI REPORT/STATUS OF PILOT PROJECTS

Dr. Gerard asked to postpone this report until the next meeting; no Lancaster County EMS people came to the subcommittee meeting. The committee agreed.

CRICOTHYROTOMY PILOT PROJECT - LIFE REACH

Ms. Kelly Hawsey of Life Reach at Providence Hospital reported to the committee that Providence Hospital is requesting approval for participation in the Life Reach Cricothyrotomy Pilot Project. Ms. Hawsey distributed a handout to the Committee that described the service, the need for the program, equipment and functions; cost effectiveness, the procedure etc.

Dr. Norcross asked if it were true that one half of the service's transports are trauma; even with Palmetto Richland's helicopter service. Ms. Hawsey answered "***yes***." Dr. Norcross stated that at Meducare only 2 cricothyrotomies have been done in the past 10 years and he cautioned that it is difficult to keep skills up in this situation.

The question was asked if RSI were available. Ms. Hawsey said that the policy is that surgical cricothyrotomies would be used as a last ditch effort after other means have been exhausted.

The question was asked about how cricothyrotomies would be taught? Ms. Hawsey answered, by didactic and manikins.

Dr. Norcross stated that he does not want to see cricothyrotomies performed statewide at the EMS level until RSI is approved statewide. Mr. Smith stated that the total statewide scope of practice needs to be reviewed and changes made. Dr. Sorrell stated that he felt that cricothyrotomies should be made a local option for medical control, and, short of that, a motion should be made to approve this pilot project.

Dr. Norcross made a motion to allow Life Reach to participate in this pilot project, using the training and guidelines set from Meducare. Meducare and the Medical Control Committee will address the issue of RSI and cricothyrotomies for a statewide optional skill at the next meeting. Dr. Rogers seconded the motion. All were in favor. The motion passed.

12-LEAD EKG FOR EMT-B

Dr. Staggs, Aiken County's Medical Control Director, informed the Committee that Aiken County EMS has been utilizing 12-lead capability for approximately three years. He stated that the problem that exists is that a paramedic must be present to conduct the 12-lead. Aiken County is requesting that EMT-B's and EMT-I's be trained in the use of 12-lead EKGs for transmission to the ED physician. He explained that training would consist of a four hour course covering: the review of anatomy and physiology of the cardiovascular system, equipment familiarization, practice acquiring the 12-lead and practice transmitting EKG.

Dr. Norcross asked if use of the 12-lead would be restricted to Aiken? Dr. Staggs stated that this would be for statewide use.

Mr. Smith felt that this would be a change in the scope of practice. He recommended reconsidering the use of the 12-lead. He stated that this may cause confusion in the EMT

community and that regulations prohibit the use of 12-lead EKGs by EMT's other than paramedics.

Dr. Norcross made a motion to add 12-lead EKG's and pulse oximeter to device list at next revision. The motion was seconded by Dr. Rogers. All were in favor. The motion passed.

Staff: Look at all noninvasive therapeutic devices which may be added to the device list when the device list is up for revision.

REVISED INTERFACILITY DRUG FORM

Mr. Smith informed the Committee that the DHEC Legal Department stated that it feels comfortable with this Committee making medical recommendations and approved the Interfacility Drug Transport Form.

Ms. Beasley stated that a DHEC form number may be required for this form before it is distributed.

Dr. Sorrell asked if form would apply for more than one drug? Dr. DesChamps asked Ms. Beasley to revise the form to accommodate three or four drugs.

Dr. Sorrell asked the wording (in bold) be changed to read:

> *the EMT-Paramedic transporting this patient is not allowed to adjust drugs, even with on-line medical control. The EMT-P may only monitor or discontinue the drug and should notify the on-line medical control.*

A motion was made to approve the Interfacility Drug Transport Form with changes to be made. The motion was seconded. All were in favor. The motion passed.

FIELD DEATH PRONOUNCEMENT PROTOCOL

Dr. DesChamps suggesting using Charleston's field death pronouncement protocol as a guideline to develop the state-approved protocol. He explained that this protocol would not be a mandated policy. Dr. DesChamps asked the Committee to review the handout and offer suggestions/approval.

Dr. Norcross suggested deleting *and there is any possibility that life exists or can be restored*.

Dr. Sorrell asked that the word *Ambulance Run Report* be changed to the *Patient Care Form*.

The Committee unanimously agreed to adopt the Charleston field death pronouncements (with changes to be made) and add it to the state approved protocols. Also the form would be put into algorithm form.

C-SPINE PROTOCOL

Dr. DesChamps asked the Committee to review the flowchart of Spinal Immobilization Protocol.

Dr. Norcross recommended removing the "negative" course of action and adding point five, Loss of Consciousness.

The Committee unanimously agreed to adapt the C-Spine Protocol (with changes to be made) and add it to the state approved protocols.

UMBILICAL CORD CANNULATION

Mr. Smith informed the Committee that a question was asked if EMT's could perform umbilical cord cannulations. Mr. Smith stated that it is not listed in the state curriculum as a skill but it is listed in PALS.

Dr. Sorrell stated that this skill does not need to be added.

The committee unanimously agreed.

MEDICAL CONTROL COMMITTEE RETREAT

Dr. DesChamps stated that a questionnaire was distributed to the Medical Control Committee members regarding a two day retreat (away form Columbia to work on things such as (but not limited to) Trauma, Critical Care Paramedic, Medical Control Physician Workshop revision, RSI and Pilot Projects.

Dr. Norcross asked that an agenda be set beforehand.

The Committee agreed.

Dr. Norcross asked for representation from other committees. Mr. Fanning asked that if other committees are represented, specific members should be invited.

Dr. DesChamps asked that members complete their questionnaire and return it along with suggested agenda items to Ms. Beasley.

MEDICAL DIRECTOR TOPICS

Dr. DesChamps informed the Committee that during the National Association of EMS Directors meeting, various informative topics were discussed. Dr. DesChamps stated that most of the topics were/are being discussed in the Medical Control Committee.

Dr. Sorrell requested approval of a Toxicology Box (Tox Box). This box includes a cyanide kit, etc. Dr. Sorrell stated that he would submit a request/documentation to Ms. Beasley for the "***drug meeting.***"