

MEDICAL CONTROL MEETING

Minutes

January 16, 1995

<u>Members Present</u>	<u>Others Present</u>
Debra Perina, M.D. Chairman	Michael Stein, M.D.
Doug Norcross, M.D.	Albert M. Futrell
Ed DesChamps, M.D.	Alonzo W. Smith
Bob Malanuk, M.D.	Doug Warren
John Sorrell, M.D.	Joe Fanning
Richard Bell, M.D.	Phyllis A. Beasley
William C. Gerard, M.D.	Don Whiteley
	Thomy Windham
	Judy Jones, R.N.
	Lisa R. Clark
	Lawton Salley, M.D.

Dr. Perina opened the meeting with the minutes of the last meeting held on November 2, 1994. She asked if there was any old business left to discuss. There was none. **The minutes stood approved as written.**

Richland Memorial's Designation Review

The committee reviewed Richland Memorial's reply for the Trauma System Designation. Ms. Beasley passed out handouts to the committee for their response. Dr. Sorrell asked Mr. Fanning if staff was satisfied with their proposal for designation. He requested that Ms. Beasley give a brief review of the nine requirements needed. Mr. Fanning expressed concern regarding the ability of the trauma director to authorize decisions over specific areas, ex: (SICU, Acting upon QA Findings). Dr. Bell responded that the contract was not crystal clear on this issue, yet he felt that the concern Mr. Fanning has might be true only with those that are non-trauma patients. In reference to trauma patients he has direct authority. Mr. Fanning asked for example, if Dr. Bell as director of the SICU has the authority to move an individual out of SICU to an existing bed. He responded positively. Dr. Sorrell asked Dr. Bell if he had full support of the hospital in carrying out these duties. Dr. Bell said he felt the hospital had become more aware of the responsibilities concerning trauma and the need for this authority. Before the committee began final decision making, Mr. Fanning commented that past protocol has always been for the hospital in question to leave the room so a vote can take place. **Dr. Norcross made a motion to approve Richland for Level I Designation. The motion was seconded, and passed.** Dr.

Perina stated that the motion would have to be approved by the EMS Advisory Committee and the Board of DHEC, but that would basically be a formality.

Dr. Perina shared with the committee that she had officially resigned as the states EMS Director, and relocated to Raleigh and is presently on the faculty of the Univ. of N.C's. Residency Program. She has agreed to assist with the Myrtle Beach Medical Control Workshop and continue to serve on the EMS-Committee and Medical Control committee until her replacements are secured.

Paramedics outside the prehospital environment

The next topic of discussion was the role of paramedics outside the prehospital EMS environment. Mr. Fanning had contacted the State Board of Nursing and State Medical Board to get clarification on exactly what they saw the role of the paramedic entailing. They were unable to attend this meeting, yet promised to assist the committee. Both are in the Dept. of Labor, which are a certification and licensure organization.

Mr. Whiteley presented New Mexico and Florida's protocol involving paramedics functioning outside the prehospital setting. Mr. Whiteley said he spoke with Mr. Travis, Coordinator of Training for EMS in Florida. Their regulations do not specifically limit the role of paramedics to the prehospital setting; instead their guidelines allow them to work in the hospital setting and be called paramedics. Handouts were given to committee members to review the program currently in place that allows Florida's paramedics to administer immunizations in county public health units, while being under the direct supervision of the medical director, either by on scene supervision or by radio. It is Florida's interpretation that they are able to do this under the statute related to the medical practice act.

Mr. Whiteley spoke with Kevin Hinson, in reference to New Mexico. Mr. Hinson was unsuccessful in sending the information for the committee to review, but like Florida, they also allow their paramedics to work outside the prehospital setting. Mr. Whiteley asked the committee to reflect upon the Red River Project, where that environment has few physicians so therefore they use physician extenders. Though, Red River is a pilot project and is continuously changing, it is viewed as a progressive and intensive program. The nurses in New Mexico lobbied for the rights for paramedics to work in the hospitals.

The committee voiced a concern over the liability factors. Mr. Whiteley referred the members to Item 6 on the last page of their handout. Mr. Fanning didn't see any liability for the prehospital EMS providers. Mr. Fanning and Dr. Perina concurred: the prehospital EMS medical control physician liability was not affected under such circumstances. Mr. Sandy Hunter said from the paramedics' perspective, insurance is based on call numbers per year not on the type of situations. Dr. Perina said we still have to hear from the Department of Labor, involvement with the Board of Medical Examiners and Nursing. Dr. Sorrell suggests that Mr. Fanning give a proposal to the Nursing Board and get their view on paramedics performing outside the

prehospital setting.

Dr. Bell inquired about a letter sent out by Mr. Alonzo Smith to the different regions requesting input for "new trends" in paramedic roles. Mr. Smith had not received adequate feedback so the committee requested a follow-up letter be sent to collect their comments. Most agreed that if paramedics meet all certification requirements they should not be limited to the prehospital setting. There was a concern from Dr. Malanuk about the field of nursing and how that would affect their occupation. Nursing homes, prisons, and hospitals were discussed as settings for paramedic employment. Dr. Stein felt that the issue should be addressed specifically to whether or not they could work in emergency rooms and that they should be able to perform those duties for which they are trained. Dr. Bell was hesitant to endorse that idea. He felt that the education process for medical control physicians would need to be enhanced so that they would be totally aware of their responsibility before pursuing that objective. Dr. Norcross reminded the committee that medical control physicians are required to attend a medical control physician workshop.

Ms. Judy Jones from MUSC told the committee that paramedics are allowed to perform in the hospital emergency room under their qualifications, yet have to be referred to as a multi-skilled worker, under hospital regulation, drawn from the State Board of Nursing. Hospital licensure comes from DHEC. If DHEC approves of having paramedics in the hospital setting then that leaves an avenue open for opportunities. **Dr. Sorrell made a motion to present a proposal to the Dept. of Labor after concurring with the Nursing Board that medics be allowed to perform under regulation. (with current responsibilities) outside the prehospital environment. Dr. DesChamps seconded the motion. At this point Mr. Futrell iterated that in the past there has been an unwritten protocol to contact the Attorney Generals Office and request their views on the matter and then have those views referred to the DHEC Board. At this point the motion was withdrawn and Mr. Fanning recommended that the motion Dr. Sorrell made be amended to read: "Request clarification from Attorney Generals Office on the proposal that paramedics be allowed to perform those functions exactly as written under state regulation outside the prehospital environment." Dr. Sorrell agreed and amended his motion. The motion was seconded, and passed.**

Interfacility Transport Protocols

Dr. Perina altered the agenda and proceeded to discuss "other business items". Mr. Hunter then discussed the Gusto Pilot Project, and the issue of transporting patients with a blood pressure reading requirement of every five minutes. Mr. Hunter requesting an adjustment to read every 20-30 minutes after initial reading. **Dr. Norcross made a motion to require a blood pressure reading at 20 - 30 minutes once initial pressure is taken. Dr. Sorrell suggested that the motion read "no more than 30 minutes between blood pressure readings after initial reading. Dr. Norcross amended his motion as suggested. Dr. Malanuk seconded the motion.**

Mr. Fanning relayed to the committee a request from Bill East of Midlands EMS that physicians put their signature on the ALS run report, but the committee decided against the request. Dr. Bell asked about the results of the survey that Mr. Smith had mailed out concerning paramedics.

Central Line Drug Administration

Dr. Norcross addressed the issue of administering drugs during interfacility transport through a central line. Following the drug approved list, he felt paramedics should have that authority. Dr. Perina reminded the committee that paramedics are trained in monitoring not administering. **Dr. DesChamps made a motion that paramedics be allowed to monitor any central line that is already in place with an external port be used for any activity that are normally allowed through peripheral lines for which paramedics are already trained.** After considering breaking sterility and other problems such as the uncertainty of how long that line might have been in or what purpose it had been used, **Dr. DesChamps withdrew his motion and Dr. Perina tabled the discussion until the next Medical Control Meeting where the agenda would also include a discussion on medications.**

Recertification of Paramedics

There was a discussion on the recertification of paramedics which had been previously initiated by Dr. Sorrell at a prior meeting. There was some clarification on exactly what steps the paramedic has to accomplish to receive certification.

Paramedics are required to be working with an EMS provider, though there is not a minimum time limit in which they have to meet. Dr. Norcross asked what the reasoning for DHEC to require employment before issuing certification when all other criteria have been met. Mr. Futrell offered prior knowledge of a decision made by the Advisory Council making it necessary for paramedics to be employed as a criterion. Dr. Sorrell felt that this was assurance of medical control involvement. Dr. Sorrell reminded Mr. Futrell that even if the paramedic received his certification while employed he was not obligated to remain employed to obtain his certification for three years. The discussion also included individuals that desire only to teach compared to those that want to work in the field. The Department of Transportation has issued a request for proposal for a National Standard EMS Blueprint that is being developed to clarify the role or curriculum of paramedics.

Dr. Sorrell asked about the status of the DNR Regulation that was in the process of legislation. Mr. Futrell explained to the committee that at this time we were awaiting the next step which would be the board meeting that was scheduled February 9. Mr. Fanning relayed to the committee that materials would be submitted to the Medical Control Committee at the next meeting of the status of the "Do Not Resuscitate Order".

Legislation for Pediatric Commitment

Mr. Futrell told the committee about a meeting he had with Mr. Govan who has initiated legislation that would establish an EMS for children function in DHEC. There was much discussion on the handouts that Mr. Futrell submitted to the committee for comment. Most members asked if there was a chance of negative response by the house, causing an adverse reaction to the objective and goals of the EMS-Childrens' Grant. It was decided after much discussion that the committee would extend an invitation to Mr. Govan to talk about the best avenue to pursue to achieve a positive outcome. At this time, **Dr. Perina made a motion to adjourn.**

EMS Medical Control Committee

Minutes

Heritage Building

May 12, 1995

Members Present	Others Present
Douglas Norcross, M.D.	Al Futrell
Ed DesChamps, M.D., Chairman	Don McCown
Richard Bell, M.D.	Doug Warren
Carol Baker, M.D.	Susan Breen
John Sorrell, M.D.	Phyllis Beasley
Marni Bonnin, M.D.	Al Smith
Bill Gerard, M.D.	Joe Fanning
	Don Whiteley

Dr. DesChamps, Chairman, called the meeting to order and asked for review and approval of the minutes of the last meeting. The minutes were approved by consensus of those present.

Susan Breen presented the results of the recent visit by the site team at the Orangeburg Regional Medical Center. She stated that Dr. Stein was the site team leader, with Dr. Larry Raney, emergency department physician at MUSC Hospital, and Judy Jones, trauma nurse coordinator at MUSC Hospital. Ms. Breen said that the purpose of the site visit was to review the areas noted for correction or improvement by the Medical Control Committee when the Orangeburg Medical Center was last up for review. She stated that the team met with members of the staff of the hospital to include the surgeons who had made a commitment to their role in the trauma center. While the deficiencies noted in the last review were carefully reviewed, the medical records of selected trauma patients were also reviewed. The team found very positive results in all of the areas reviewed, to include the medical records. The hospital staff was especially commended for their quality assurance program -- both their process and the activities indicated in the minutes of the committees. The site team found no real problems, and only suggested that the emergency department physicians' portion of the patient's medical record could be improved. They recommended that the hospital be designated as a level III trauma center.

There was some discussion regarding the question of commitment of the hospital, especially the surgeons. There was some discussion that perhaps the surgeons were not seeing trauma patients, but

were suggesting prompt transfer out. The protocols for care and referral of patients at a level III trauma center were discussed. The group agreed that certain types of trauma patients with obvious evidence of needing level I trauma care should be promptly transferred without waiting for the surgeon -- when they might be at the level I facility before they could see the local surgeon. It was also discussed that the actual practice of most level III hospitals appeared to be over triage to the level I facilities. This can be improved by review at the level I with feedback to the level III. The data from the trauma register can also be used to review and research the practice and extent of inappropriate triage.

Dr. Norcross made a motion to approve the Orangeburg Regional Medical Center as a Level III trauma center without any reservations. Dr. Baker seconded the motion. The motion was approved with one abstention.

Ms. Breen then reported on all the new applications expected this year for trauma center designation. These included: Kershaw County Medical Center, Carolinas Hospital System, McLeod Regional Medical Center, Toumey Regional Medical Center, Laurens County Hospital, Self Memorial Hospital, and Roper Hospital - North. All of these facilities have requested an extension of the April 30 application deadline.

Staff also reported that this calendar year is the time for review for redesignation of trauma centers. However, because of the heavy load of new trauma center designations and development of the trauma plan(s) there is not sufficient staff to support a redesignation process this year. Designation of new trauma centers and development of trauma systems and plans are the central objectives of a trauma grant which supports the present trauma system activities.

The next agenda item was the annual review of request for new drugs or changes in the administration of presently approved drugs. The first request was for Thiamin to be added to the prehospital drug list. **After some discussion it was decided by consensus that Thiamin should be approved for pre-hospital use as outlined in the attached, provided that the administration as requested is consistent with the information in the Physician's Desk Reference.**

Mr. Smith then presented the request for change in use of Terbutaline sulfate. He said that this drug was previously approved to be administered via handheld nebulizer. However, when Albuterol sulfate was approved, the committee felt that Terbutaline should only be administered Sub Q. Especially since data has shown Albuterol to be more effective and also the drug of choice. **Dr. Bonnin made a motion than Terbutaline not be approved for administration via handheld nebulizer drug. The motion was seconded by Dr. Gerard. The motion passed.** The committee requested that staff send out a letter to Dr. James Hightower, M.D. at SRP explaining the committee's decision.

A request for Vecuronium Bromide was presented, but the request was for nurses to utilize the drug in the prehospital setting. **The committee noted in discussion that though approval is not needed**

by the committee for nurses to administer Vecuronium Bromide, it should be noted that it is not approved for administration by paramedics.

Aminophylline was then presented in a request for approval for inter-facility transport. **Dr. Baker made a motion that it be approved as requested (See attached). The motion was seconded by Dr. Bonnin. The motion passed. Dr. Gerard abstained.**

Mr. Smith then presented some questions surrounding paramedic course administration. One question was who was the physician in charge of the paramedic course. Although the local medical control physicians must provide medical control for a paramedic student the course medical director should be responsible for the paramedic students during the course, especially the clinicals.

Mr. Warren said that there is a written policy in the Low Country region that says the student has 10 days to get a new medical control physician if the present medical control physician withdraws support. He said that the regional medical director is the director of all courses for the region.

The Committee agreed by consensus that the regional medical director is in charge of all advanced life support training activities within the region. They agreed that the regional medical director could appoint a designee, but that the regional medical director is still ultimately responsible. They agreed that the director of such a course must also have attended a medical control physician's workshop.

Dr. DesChamps requested that Dr. Sorrell, Doug Warren, and Al Smith develop a proposal/policy to resolve the questions and problems regarding the acceptance and rejection of students. Policies will be developed regarding the removal of a student from a course, and the conditions for acceptance into a course.

Dr. Norcross suggested that the committee needs a legal opinion on personnel issues for paramedic courses for the regions. Which personnel are responsible for the students in paramedic courses? Is it the medical director who sends the EMT to the course or is it the regional medical director?

Mr. Warren suggested that the state office of EMS establish a registry for Paramedics and other EMTs that contains information on the removal, reprimand or other limitations placed on an EMT as the result of misconduct, inappropriate procedures, etc.

Dr. Norcross next presented the idea of allowing patients with chest tubes in place to be transported within the state.

Dr. Gerard suggested that there is a need for state protocols and training for field procedures. He suggested that a short one page protocol be developed for each procedure. He suggested that protocols should be in place to provide procedures that might be necessary in situations of

complications. Doctors Gerard and Baker suggested that additional training will be needed for paramedics to be able to manage chest tubes.

Mr. Futrell suggested that a document should be developed that can make the procedures necessary for maintenance of chest tubes a necessary part of in-service training.

Dr. Norcross noted that both North Carolina and Georgia apparently have no concern regarding transport of the patient with chest tubes.

Dr. DesChamps suggested that a list be developed to mail out to the field that will provide instructions for paramedics transporting patients with chest tubes. He requested that Dr. Norcross develop this information, using others as he needed.

Discussion of central venous lines then followed. It was then suggested that a procedural list be developed. It would include procedures for chest tubes, N.G. tubes, arterial lines, central lines, peripheral lines, foley catheters, etc.

Doug Warren volunteered to assist Dr. Norcross in developing this list. **Dr. Norcross agreed to have a proposed device list for the committee to approve at its next meeting.**

Al Smith then gave a brief report on what the training committee is doing. The things approved recently by the committee include: the new EMT/B curriculum, requirements that lead EMT instructors be a paramedic, that students entering the EMT course after July 1 have a high school or GED, and that calculators or calipers be no longer allowed at exams. He said that staff is working on the EMT/B basic written and practical exams and the policy guide. Also, staff is conducting instructor updates through June 1995.

The subject of expanded functions and/or workplace for paramedics was next discussed. Dr. Sorrell suggested that it is the consensus that under the present set of legislation and guidelines the paramedic can do anything he is trained to do as long as he has medical control.

Dr. Norcross said that the responsibility of the possible additional functions of the paramedic should be taken off the medical control physician. He said that a paramedic should be defined as working for an Emergency Medical Service for those things they are trained to do. He said it didn't seem that it should be in the purview of the medical control committee to be responsible or concerned for what the paramedic does outside this setting.

It was suggested that we need to define paramedic, what a paramedic should do. Any procedure done outside this definition should be done as a layperson -- not with the credentials of a paramedic. The position of the committee should be that a paramedic should function only as a paramedic as enabled by legislation.

Dr. Sorrell suggested then that paramedics are not trained to do health screening.

Dr. Norcross suggested that the Department of Labor, Licensing and Regulation and Hospital Association be notified of this position, that is not assuming the additional medical control responsibility. He said that information should be sent to all medical control physicians for ambulance services.

It was suggested that we write a letter to the Board of Medical Examiners LLR and let them know our position on what the Paramedic can and can't do and what is going on now in this area. That the paramedic is certified by DHEC and serving under direct/indirect medical control and should not do anything new.

Dr. Sorrell, Dr. Baker and Joe Fanning were asked to draw up a statement explaining our position for presentation at the next committee meeting.

Next, Joe Fanning announced that Dr. DesChamps had been selected as the state Medical Director for Emergency Medical Services. He has been a part of the committee since it's organization and very involved since that time. It was hoped that Dr. Perina could have been present to conduct this meeting to allow the group to acknowledge her contributions. Dr. DesChamps and Joe Fanning presented a paper which she had developed (attached) which stated a number of objectives she felt should be addressed in the near future.

Dr. DesChamps requested that staff study the activities of other states to see what they were doing in these areas. Dr. DesChamps also suggested that a Long Range Planning Committee be developed composed of Marni Bonnin, M.D., Bill Gerard, M.D., and Ed DesChamps, M.D. This committee should develop a list of ideas for where EMS should be a few years from now.

The Workshop for Medical Control Physicians was discussed. It was agreed that some modifications might be made in the present orientation to make it better. However, **it was suggested that an additional workshop (maybe annual) be added for those physicians which have already been through the orientation.**

The committee revisited the drug list to agree that lidocaine jel should be approved as a lubricant for insertion of tubes.

Dr. Gerard was requested to present a report on Emergency Preparedness. He suggested that a standard set of state protocols should be developed for patient treatment. Then all EMS personnel coming from outside the disaster area could be instructed to follow the state protocols and standing orders. He suggested that a list of persons willing to be team members for situations within the state should be developed.

Dr. Gerard was asked to revise the guidelines/protocols/standing orders etc. to assist in implementing functioning disaster teams.

It was suggested that the resources of the trauma centers and other organizations and protocols in the state trauma plan also be utilized.

The committee tried to set a date for the next meeting, but it was agreed that the members should be polled for the best meeting day in the last week of July or the first week in August.

Revised 08-07-95

MEDICAL CONTROL COMMITTEE

Minutes

August 2, 1995

<u>Members Present:</u>	<u>Others Present:</u>
Dr. Ed DesChamps, Chairman	Joe Fanning
Dr. Bob Malanuk	Phyllis Beasley
Dr. John Sorrell	Dr. Raghaven Chari
Dr. Carol Baker	Kelli Latimer, RN
Dr. Douglas Norcross	Alonzo Smith
	Doug Warren
	Judy Jones, RN

Minutes from 5/12/95

Dr. DesChamps opened the meeting by asking for approval/discussion of the minutes from the last meeting of May 12, 1995. Mr. Fanning asked for clarification on two points of discussion included in the minutes. 1) What did Dr. Norcross mean by "the committee needs a legal opinion on personnel issues for paramedic courses for the regions (Page 3, Paragraph 7)?" Dr. Sorrell responded that he remembered the discussion as being related to liability issues such as determining whether the EMS service or the teaching institution is responsible for the students' actions. *Staff agreed to review the tapes of the last meeting for clarification.*

2) Mr. Fanning asked if the development of written protocols for training meant protocols for all field procedures (Page 4, Paragraph 2). Dr. DesChamps said that it was his understanding that the development of such written protocols was meant for all specialized or new procedures. Dr. Norcross has put together protocols for procedures which are not included in any other training curriculum and he emphasized that the procedures should be included only if they are new procedures. Mr. Smith suggested changing Page 4, Paragraph 2, Sentence 2 to "He suggested that a short one page protocol be developed for each procedure especially in situations of complications.

Dr. Norcross made a motion to accept the above changes in the minutes. Dr. Sorrell seconded the motion. The motion was approved.

Pilot Project Proposal: TPA Field Study

The next item on the agenda was to hear a pilot project proposal for TPA (activase) field study. The project was proposed and explained by Dr. Raghaven Chari. A pilot project to use eminase in instances of cardiac problems was approved several years ago. However, when Kershaw County's new emergency services director was hired, she found that the eminase, which requires constant cold storage, had not been properly stored, thereby affecting the efficacy of the drug. She destroyed the old eminase and Dr. Chari now seeks to revive the pilot project using TPA which does not require specialized storage. Dr. DesChamps asked if all other procedures for the use of TPA remain the same as they were with eminase. Dr. Chari stated that the only difference is that TPA initial dosage is changed. Dr. Norcross asked again if the only change in the pilot project was the drug and its appropriate dosage. Dr. DesChamps asked if the project required on-line medical control. Dr. Chari's response to both questions was "yes." Dr. Baker asked if Dr. Chari was using it for a specific transport time. Dr. Chari responded "yes, unless perhaps the transport time is 10 minutes or less away."

Dr. Baker made a motion to approve the pilot project with a change to TPA. The motion was seconded by Dr. Malanuk. Dr. Norcross added, "assuming there are no other changes."

Dr. Malanuk then asked the length of the project. Dr. Chari responded that it will be a year-long project. The motion was approved. Dr. DesChamps affirmed that time evaluations will be included in the EMS quarterly report on the project.

Proposed Changes in the Ambulance Run Report

At this time, since Mr. Smith was unavailable for discussions on the drug dosage item on the agenda, the Committee then addressed the agenda item related to proposed changes in the ambulance run report. Mr. Fanning introduced the proposed changes. He said that staff would be reviewing the changes over the next few days. He asked the Committee to also consider whether a box indicator should be added to indicate where the run report is left, whether in the ICU or ER. The Committee should also consider the field triage and assessment information section. Is there anything else that should be added? This was a general suggestion by a physician to staff.

Dr. Sorrell commented that in advanced procedures reconstruction of a call is difficult unless times are included for each procedure. He stated that IV information has the option for including times, but everything else should also, especially intubations and re-intubations.

Dr. Miller commented that at Greenville, their nursing flow sheet is being revised to include a box chart to indicate the victim's position in the car, and/or where the car hit the tree.

Dr. Norcross said that an appropriate addition would be the ACS triage decision scheme. He

then stated, however, that this probably would not be practical because each service has its own criteria. Dr. Norcross' main concern is the ability to track trauma transport destinations with the ambulance run report and trauma registry.

Mr. Fanning said that the second sheet of the ARR would be revised, probably next time. There have been comments on the fact that the second sheet is outdated. Dr. Sorrell stated that the ambulance run report is used for two types of runs: short, emergency runs and the longer interhospital or convalescent transports. He said that the second sheet of the run reports should have enough space to record times for procedures on the lengthier runs. Dr. DesChamps agreed that the ARR is not geared to complicated trauma or cardiac calls. Mr. Warren added that there should be a box for whether defibrillations are manual or automatic. Dr. Miller commented that EMS should write brief procedures, rather than long narrative and thus save space on the run report. There was also discussion on the section indicating anatomical injuries. Dr. Baker said that there should be checks next to a list of specific mechanism of injuries to save space. Mr. Fanning thanked the Committee for its comments and said that they would be taken into consideration for changes to the ambulance run report.

Staff Updates

The next agenda items was staff updates. Mr. Fanning said that Dr. Caughman Taylor, the pediatric representative, is unable to participate on the Committee. He has suggested Dr. Robert Hubbard, also with the Dept. of Pediatrics of USC, as his replacement. His nomination is being confirmed.

Dr. Norcross asked if a new Pee Dee regional medical control physician has been hired. Mr. Fanning said that they are still looking.

Ms. Beasley explained that trauma grant funding has been rescinded and that staff is working to secure funding to continue the work of the trauma staff. EMSC funding is probably secure through September 30, 1996. Ms. Beasley reported that the second draft of the pediatric trauma center criteria are ready to go to the Trauma System Committee. She also reported that the application processes for six hospitals are continuing.

The discussion of trauma grant staffing, led Dr. Malanuk to ask about the use of the South Carolina trauma registry. He stated that 3 out of 4 Level I trauma centers are not using it. Mr. Fanning said that the registry was geared more toward the Level III trauma centers. Dr. Malanuk said that he is considering purchasing Tri-Analytics trauma registry because Baptist has not been able to have SCTAR produce reports which they need. Mr. Fanning explained that the SCTAR software is being updated every year. He also volunteered to have Doug Bennett, trauma registry staff person, assist Dr. Malanuk's staff in producing their reports.

Subcommittee Reports: Workplace/Role of the Paramedic

The next item to be discussed was the subcommittee reports. The first issue was the "workplace/role of the paramedic." Dr. Sorrell and Dr. Baker drafted a letter to be sent out explaining the legal role of EMTs in areas other than the traditional "field" settings. Mr. Fanning presented a memo from the DHEC Legal Office which summarized their opinion of the legal roles of the EMT. He asked that the Committee keep this memo confidential. He said that, in summary, the memo reiterated the Committee's thoughts that an EMT may operate only in the pre-hospital setting. Mr. Fanning stated that, earlier, it had been suggested that staff write the Board of Medical Examiners for their opinion. However, Mr. Fanning said that the concern over the role of the paramedics is really DHEC's and the Medical Control Committee's concern and the Board of Medical Examiners should be informed of any actions/opinions that are formulated by DHEC.

The Committee determined that the following two sentences from the legal opinion should be incorporated into the draft letter: "Therefore, it appears that an EMT's certification to perform certain medical procedures while acting in his capacity as an ambulance attendant would not be broad enough to allow him to perform those same duties in a private industry setting. In fact, under § 40-47-260, it may be that an EMT performing medical procedures in a private industry setting may be subject to a penalty for practicing medicine without a license". The Committee agreed that would be an important comment which should be included and added in the fourth paragraph of the draft letter. The Committee also agreed that the last sentence of the fourth paragraph should be rewritten to "If an EMT works outside of the scope of EMS, it is the EMT's responsibility to assure that he is under the auspices of another State agency which regulates health care."

In the course of the discussion, it was mentioned that since the skills of the basic EMTs are being increased and will require medical control, then the state should also consider certifying first responders.

Dr. Norcross also requested that, as the regulations are being revised, that the wording of the law be changed from "ambulance attendant" to "certified EMT."

Dr. DesChamps asked the committee about the distribution of the letter. The list of certified personnel kept at the Division of EMS is not reliable since addresses are changed frequently. The Committee decided that the letter should be sent to all currently certified intermediate and advanced EMTs, all new basic EMTs, EMS services and medical control physicians.

Questions from EMTs who are already working in a hospital setting should be referred to the hospitals' lawyers. Ms. Jones commented that EMTs can be approved by the Board of Nursing to work in the hospital if the job duties are listed, training is certified and approval from the Board of Nursing is sought.

The Committee also determined that the letter should come from Mr. Fanning as Director of the Division of EMS and the Medical Control Committee.

Dr. Sorrell made a motion to adapt the draft letter with the suggested changes incorporated and to send this letter to new basic EMTs, intermediate EMTs, advanced EMTs, EMS services and medical control physicians. *The suggestion was made that, before being mailed, the letter should be presented to the EMS Advisory Council.* The motion was seconded by Dr. Norcross. The motion was passed.

Subcommittee Reports: Procedural List/Protocols for Specialized Procedures

Next under subcommittee reports, the Committee addressed procedural list/protocols for specialized procedures. Dr. Norcross presented his draft document which provides information on new medical devices which EMS services may encounter during an interhospital transport. It includes information on the device name and trade names, usage, restrictions, training level needed and any important points.

Dr. Sorrell suggested that the Committee members should take the list home for review and consultation, as well as for suggestions for further devices and procedures for presentation at the next Medical Control Committee. *Dr. Norcross suggested that the list be presented to the Advisory Council and EMS regions.*

Referring to which procedures/devices should be included in this document, Dr. Baker stated that any procedure/device that is taught in the core curriculum should not be included in this document. This document will serve as a supplement to the training curriculum. Dr. Sorrell questioned if this list was inclusive, and if a device is not listed in this document, an EMS crew could not transport. The answer by general consensus was "yes." Mr. Warren suggested adding transport ventilators. Dr. Sorrell suggested adding the Morgan lens which is used for eye irrigation.

The Committee determined that this nearly complete draft document should be sent to Advisory Council members for review at its next meeting and that the Medical Control Committee will seek the Advisory Council's approval to develop the final draft with no further reviews, in order to complete it and distribute it out into the field in a timely fashion.

Subcommittee Reports: National EMS Education and Practice Blueprint

Next, the Committee reviewed the recommendations for the National EMS Education and Practice Blueprint. Mr. Smith presented copies of the Blueprint and advised the Committee that all future curriculum changes and development will be based on this national guide. It provides nationwide long range training objectives. The Division of EMS is currently using it as the base document for the revision of the intermediate and paramedic programs.

Mr. Fanning commented that this document will be of use in long range planning. Dr. DesChamps questioned how the curriculum for intermediate EMTs will be changed, in light of the recent changes for basic EMTs. He cited North Carolina's Intermediate Advanced EMT which is considered a cardiac curriculum. He suggested that the Medical Control Committee make recommendations for the intermediate training and other course structures to the Training Committee.

Dr. DesChamps asked the Committee to review the document at their convenience and think of suggestions for the future direction of EMS training.

Subcommittee Reports: Acceptance/Rejection of Students in ALS Training

The Committee then addressed the issue of policies on the acceptance/rejection of students in ALS training. Dr. DesChamps asked Mr. Warren, who had been working with Dr. Sorrell, to present their information/recommendations. Mr. Warren stated that currently intermediates and paramedics are trained by the technical colleges and must be affiliated with a service and have the approval of the service director and medical control physician to be certified. This was put into place because, originally, there was a limited amount of training available and admission to the program was more carefully controlled. The requirement for endorsement by the service directors was initiated to cover liability and workman's compensation issues.

Mr. Warren and Dr. Sorrell were charged with looking at possible modifications of the current policies or suggest new policies. Mr. Smith, Thomy Windham, Mr. Warren, and Dr. Sorrell agreed that anyone going into an advanced level of training needs experience, although experience is difficult to obtain and is not a guarantee of ability. They recommend that the requirement for experience needs to stand. The requirement for affiliation is a problem. By signing the application, the service director is accepting financial commitment for insurance purposes. The technical colleges offer student insurance. If the requirement for affiliation is changed, the student would have to provide insurance coverage independently or purchase it through the training agency, but it would broaden the number of persons eligible for training. This would change the process to training someone before they seek employment rather than having them seek employment before receiving the training. It would take some of the burden of cost off the counties and place more of the burden on the individual seeking training. The biggest problem comes from the larger services that require their EMTs to get the advanced training and pay for that training, and the EMTs have no interest in being in the class. The students who do well are the ones who pay for the training themselves and are motivated or those who must compete within a service to get the training. From the standpoint of the provider, if they have a ready pool of trained paramedics to choose from, the service can devote its resources to other needs. The training institution would have to develop a better application screening process, if students are accepted without the requirement for service affiliation. There would need to be a method to more accurately predict the student's success. It would put the

burden of the student's clinical training on the regional medical control director. The student would not be certified until he/she passes the registry exam and is hired by or affiliated with a service. In the current system many people have found ways to circumvent the system. In the Lowcountry, military people who know they will be leaving the service soon, go to a county service director and convince them to sign the application.

Dr. Norcross asked if the liability insurance would have to be maintained by the student or employer. Mr. Warren responded that student liability is available through the training institution and is not very expensive. The Committee then agreed that applicants already affiliated with a service should have priority in the application process. Mr. Warren added that there is nothing in the current policy which would allow regions to reject applicants, other than their test scores.

Dr. Baker recommended that the Committee accept these suggestions and ask the Training Committee to develop more specific admission criteria. This system should put control of course admission back in the regions and not with the services.

Dr. DesChamps asked about removal of students from an ongoing course if there were problems. Mr. Warren said that they would have to review the issues such as disruptive behavior, use of intoxicants, abuse of skills, which might cause a student to be dismissed from the course. A statewide statement on causes for expulsion would have to be agreed upon.

Dr. Sorrell stated that the best thing about a change in policy would be that the control for training is put back with the regions and the training institution would be more like a university that sets admission standards and enforces them. There was then extensive discussion about the current admission to advanced training and the suggested revisions. Mr. Futrell said that the only students this would affect would be those who lose sponsorship. He also stated that if the program is opened up to people who are nonaffiliated, the clinical component of the program will be changed drastically. The premise of the clinical component has been that EMTs are brought up through the field and have had experience before they set foot in the class. Mr. Fanning suggested that the admission criteria address this.

Dr. Malanuk stated that it seemed that all the rules were being changed for a few people who, for whatever reason, could not meet current admission policy. He suggested that if someone were not eligible under the current rules, there should be an appeals procedure. Dr. DesChamps added that regional medical control physicians should be involved in this decision, since they are responsible for those students. Dr. Sorrell suggested that staff ask the directors how they would feel about these change; he doesn't think they would stay with the current system.

Dr. DesChamps then suggested that they table the discussion and send their recommendations to the Training Committee for their input. Dr. Baker again suggested that strong consideration be given to increasing the involvement of the regional medical control physician in admitting

students to the program. Mr. Futrell stated that the original guidelines for accepting students into allied health training included guidelines for the interview and acceptance procedures. Those original guidelines should be reviewed again because they required an interview and had an appeals process. The next Training Committee meeting was scheduled for August 10.

Subcommittee Reports: Long Range Planning

The next topic was long range planning. A handout was submitted with a list of topics suggested for long range planning which include: procedures to be considered for statewide non-pilot; changes needed on the ARR; procedures to be added to curriculum; centralized medical control; and statewide continuous quality improvement.

Dr. DesChamps added that, using ARR data, Dr. Bonnin and Dr. Gerard wanted information on attempts on IVs and attempts at endotracheal intubations and intraosseous infusion. Discussion began with Dr. Malanuk asking what is being done with the ARR data currently being keyed in. Dr. DesChamps suggested that EMS inspections should be run more like QI; for example monitoring run times and identifying problems when inspections are conducted. Mr. Fanning stated that ARR reports should be produced similarly to the trauma registry reports. *The question was raised about what kinds of reports can be produced immediately from the 1994 ARR data? Mr. Fanning said that staff would produce some reports from 1994 ARR records and will be mailed to Medical Control Committee members before the next meeting. He also asked the Committee to come up with ideas for reports from the ambulance run reports.* Dr. Sorrell suggested that when response and scene times are examined, they should only be evaluated for medical signals such as chest pain, shortness of breath, cardiac arrest, unconsciousness and trauma since these are the types of calls in which time is most important. Times should also be broken down into urban and rural.

The issue of revision of guidelines, protocols and standing orders was postponed until the next meeting when Dr. Gerard can present this item.

Subcommittee Reports: Questions on Drug Dosages (Albuterol)

The next item on the agenda was questions on drug dosages, specifically Albuterol. Questions had been raised about the pediatric dosage of Albuterol. During the initial approval phase the DHEC Legal Office and Medical Control Committee gathered data to support a pediatric dose as being the "standard of care" and used the current drug dose in the state-approved drug list which comes from the Physician's Desk Reference.

Dr. Baker volunteered to gather research papers and data supporting the adult dosage for pediatric patients. Mr. Futrell said that staff will hold the drug list addendum until this information is gathered. Dr. Baker then asked the Committee if it would support the pediatric dosage as being a maximum single dose of 5 mg or 1cc in normal saline (NS) for all age groups,

only with medical control orders.

Dr. Norcross made a motion to include the pediatric dosage of Albuterol in the state-approved drug list as being a maximum single dose of 5 mg or 1 cc in NS, used only with on-line medical control orders. The motion was seconded and passed.

Recommendation for the next meeting was Sept. 12 or 13, or during the last two weeks of September. (Later information negated these dates because those are the dates of the ACEP conference.) The Committee would then meet again in the first part of December. The Committee decided to reserve Wednesday, March 13 for a possible Medical Control Committee meeting at the EMS symposium.

With no further discussion, the meeting was adjourned.

MEDICAL CONTROL COMMITTEE

Wednesday, September 20, 1995

MINUTES

Members Present:	Others Present:
Dr. Ed DesChamps, Chairman	Al Futrell
Dr. Doug Norcross	Joe Fanning
Dr. Carol Baker	Phyllis Beasley
Dr. Bill Gerard	Dr. Eric Weinstein
Dr. Bob Malanuk	Judy Jones
Dr. Robert Hubbird	Susan Breen
	Debbie Hession
	Thomy Windham
	Doug Warren

Dr. DesChamps opened the meeting with a review of the minutes from the August 2, 1995 meeting. Dr. Norcross made a motion to accept the minutes as written. Dr. Baker seconded the motion. The motion was approved.

REVISION OF ALBUTEROL

The next item on the agenda was a review/discussion of the revision of Albuterol for the state-approved drug list. A copy of the revision from the last Medical Control Committee meeting was reviewed (see attached). Dr. Baker opened the discussion by stating that studies she had reviewed had not indicated any adverse effects of administering higher dosages of nebulized Albuterol to pediatric patients.

Dr. Hubbird, the new pediatric representative on the Committee, who is a pediatric intensivist, stated that no drugs are completely safe for any age child, but presented copies of the doses from two standards of care references of pediatric intensive care (Rogers). Their doses are .03ml per kilo and a new textbook from emergency medicine shows the same dosage; they are using .15 mg per kg per dose. The article said that for anyone over two years old use 1 cc. If there is not a long EMS run and the dosage is going to be repeated every 20 minutes, it will not hurt the child. He said that it would be possible to use 0.5 cc for up to 6 years of age and 1 cc for older children, or 1 cc. for any child over age 2; the bottom line is that it will not matter.

Dr. DesChamps asked if the Committee wanted to leave the on-line medical control requirement, or go by standing order? Dr. Gerard made a motion to remove the requirement for on-line medical control in administering pediatric dosages of Albuterol. Dr. Hubbird seconded the motion. Before taking a vote, the Committee began discussion about the dosage. Dr. Norcross

asked if the Committee was changing the medical control requirement, or the dosage. There was general agreement that the dose would be changed, also and Dr. DesChamps suggested that, then, a motion be made first to change the dose. Dr. Baker asked if anyone would have a problem with going up to 1 cc. in the adult population, and what about dosages for children under 2? The current drug list does not allow for administering Albuterol at all for children under 2. Dr. DesChamps asked if administering Albuterol to children under 2 was a standard practice; Dr. Hubbird responded "yes." Dr. Hubbird said that the dosage for that age would have to be changed to a mg or kg basis. Dr. Baker asked Dr. Hubbird if there is a maximum dosage he uses for that age range. Dr. Hubbird said no, but there you generally do not administer less than 1/4 cc. to anyone, except a preemie. He said if the child is under 2, you can give up to 1 cc.

Dr. Hubbird recommended for children under 2, per medical control, a dosage of 0.25cc to 0.5cc. Dr. DesChamps asked for clarification that if a child is under 2 years of age, on-line medical control would be required to initiate any dosage of Albuterol. The consensus was that on-line medical control should be required for children under age 2. The Committee then agreed to set the dosage by two age groups, ages 2 and older, and under age 2.

Dr. Gerard consolidated his earlier motion to include an amendment by Dr. Baker with the committee's agreement on dosage and age breakdowns. He made a motion to change the dosages to: Patients ≥ 2 of age a dosage of 5 mg. to a maximum dosage of 1cc with no on-line medical control required; and patients ages <2 a maximum dosage of 0.5 cc with on-line medical control. Dr. Norcross seconded the motion. The motion passed.

Report on the Revision of the State Approved Standing Orders, Protocols

Dr. Gerard explained that he had collected copies of protocols from several EMS services including Greenwood, Greenville, Charleston and Richland. He contacted a number listed in an emergency medicine magazine for a copy of protocols developed by Texas emergency physician. Dr. Gerard passed out this document of algorithms for the Medical Control Committee to review and make comments on. Dr. DesChamps asked the Committee members to send their comments to Dr. Gerard or to EMS staff. Dr. Gerard stated that the state's current protocols haven't been revised in a long time and are also written in sentence form which is more difficult to read than algorithms.

EMS Advisory Council Reports

Letter regarding roles/workplaces of EMTs: Dr. DesChamps reported that the EMS Advisory Council had approved the letter with the addition of phrase "They must be employed by, *or acting as an agent of*, a licensed emergency medical service, and are subject to the system's training and recertification requirements." They also changed the sentence: "EMTs are authorized to practice in "field" settings, rescue operations, emergency and convalescent transportation, *and special stand-by events (e.g. football games and rodeos)*. The letter will be

sent to all certified paramedics, intermediate EMTs, newly certified basic EMTs, ambulance services, medical control physicians, and, by request of the EMS Advisory Council, all hospital administrators.

Mr. Fanning also passed out an article addressing this issue especially with mobile health care units, for information only.

Device List: The Committee's proposed device list was presented to the Advisory Council for information and input only. Dr. Norcross suggested that the Committee review the list at this time for changes and the Committee agreed. (The revised device list is attached.)

The Committee agreed to make a change in the introduction page to state that the equipment addressed in this list is equipment that "is in place at the time of the arrival of the EMT." Thus, the first sentence of the introduction will read "The purpose of this manual is to denote medical devices not specifically covered in EMS training which may be transported by EMS personnel *and which is in place at the time of arrival of the EMT.*"

The Committee then addressed the page on transport ventilators. Mr. Warren commented that transport ventilators are put in by EMTs during transport. Dr. Norcross commented that, then, transport ventilators should be added to the paramedic curriculum. There was much discussion about the variance in accuracy and dependability of transport ventilators. *Dr. Baker suggested that a subcommittee be developed to address the issues surrounding transport ventilators and training needs. Dr. Norcross and Dr. Hubbard volunteered to serve on this subcommittee, and Dr. DesChamps asked that this subcommittee "dovetail" with the Equipment and Standards Committee.* Dr. Norcross agreed to take transport ventilators out of the device list, with the understanding that it will be discussed in the future. Dr. DesChamps stated that he would like for this issue to be on the next agenda and asked that Doug Warren report on how this ventilator is being used in the field and if primary initiation of this equipment is by paramedics.

The Committee reviewed each equipment recommendation and made the following changes:

<u>Surgical Drains:</u>	no changes;
<u>Urethral/Suprapubic Catheter:</u>	no changes;
<u>Percutaneous Drainage Tubes:</u>	no changes;
<u>Nasogastric/Orogastric Tubes:</u>	Add in Restrictions/Training Level that basic and intermediate EMTs can transport only; paramedics may transport and may manipulate/replace;
<u>Surgically Placed Gastrointestinal Tube:</u>	Add in Restrictions: Feedings should be discontinued prior to transport
<u>Tube Thoracostomy/Chest Tube:</u>	Add in Usage: Tube usually attached to a device which establishes and maintains a vacuum in the pleural space <i>or a one-way valve (e.g. Heimlich valve).</i> The issue of training that EMTs receive related

	<p>to chest tubes was brought up.</p> <p>Dr. Norcross stated that chest tubes are essential, particularly in trauma transports and exposure to chest tubes should be a required in-service.</p> <p>Mr. Futrell stated that this could be put in the curriculum as information only.</p> <p>Dr. Norcross also suggested that when this device list is sent out to the field, Division of EMS could ask the services to in-service all the items in the list.</p> <p>Dr. Baker added that a cover letter should be drafted for the device list emphasizing the importance of in-servicing this information and emphasizing important points about each device.</p> <p>Dr. Norcross then said that the list should be treated like the drug list.</p>
<u>Arterial Lines:</u>	<p>Add in Usage: Catheter placed into an artery for monitoring of blood pressure, for easy sampling of blood <i>or for s/p radiographic or invasive procedures</i>. Add in Training Level: <i>Paramedics Only</i>. Add in Important Points: <i>Apply pressure to site for a minimum of 15 minutes if dislodged, and contact medical control. Observe for signs of hematoma or bleeding.</i></p>
<u>Automatic Internal Cardiac Defibrillator (AICD):</u>	<p>Change Important Points: <i>Presence of device has only minimal potential shock and no effect on cardiac resuscitation</i></p>
<u>Percutaneously Placed Central Venous Catheters:</u>	<p>Add to Device: The intention of this is not to include Swan-Ganz catheters. Add to Restrictions: <i>Paramedics</i> may continue medications.. <i>Intermediates and Basics</i> may transport IV fluids in place only (no medications). Change Training Level: <i>All levels</i>.</p>

At this point in the discussion, Dr. Norcross pointed out that in the section on Percutaneously Placed Central Venous Catheters, under Restrictions, he had added a point saying "May NOT initiate new medications through line without direct on-line medical control." He stated that he believed that this issue needed discussion by the Committee. Mr. Fanning asked that the Committee address this issue separately from the overall changes in the device list. Dr. Norcross then made a motion to allow paramedics to administer drugs approved for EMS use through

previously placed percutaneously or surgically implanted central venous lines under direct on-line medical control. Dr. Baker seconded the motion. Dr. DesChamps asked for discussion. Dr. Malanuk asked for clarification if medical control contact must be made in arrest situations. The Committee affirmed that on-line medical control is a requirement in all situations for using medication in the lines. Dr. DesChamps then asked if the lines could be used only for adults or for all patients. The Committee clarified that it would be all patients. Dr. Baker stated that the clarification should be made that the lines should be used for other medication only if no other option is available. Dr. Norcross asked to amend his motion to read "to allow paramedics to administer drugs approved for EMS use through previously placed percutaneously or surgically implanted central venous lines *should no other option be available*. (Take out the need for on-line medical control.) The Committee then discussed whether local medical control should be asked to develop their own protocols or standing orders about using medications in these lines. Dr. Norcross then amended his motion again to read "paramedics may administer medications through previously placed percutaneous central venous lines when no other option is available *under direct on-line medical control or standing protocol*. The motion was seconded. The motion was approved. The Committee returned to the explanations regarding the percutaneously placed central venous catheters.

<p><u>Percutaneously Placed Central Venous Catheters:</u></p>	<p>Change Important Points:</p> <ol style="list-style-type: none"> 1) If line becomes dislodged, apply pressure to control bleeding and contact medical control. 2) If used for monitoring, may require infusion of heparin solution under pressure, <i>paramedics only</i>, (see Arterial Lines). 3) Prevent air embolus. 4) <i>For medication administration: prevent air embolus; maintain stringent sterile technique; flush bolus medication with double the usual amount of fluid (compared to peripheral flush)</i> <p>Add under Restrictions (the motion from above): <i>Paramedics may administer medications through previously placed percutaneous central venous lines when no other option is available under direct on-line medical control or standing protocol.</i></p>
<p><u>Completely Implantable Venous Access Port:</u></p>	<p>Change Training Level: <i>All levels.</i></p> <p>Under Restrictions: Capitalize "MAY NOT BE ACCESSED* BY EMS PERSONNEL." Delete "May not initiate new medications via</p>

	<p>this device during transport." Add "<i>Paramedics may administer medications through previously placed lines when no other option is available under direct on-line medical control or standing protocol.</i>"</p>
<u>Implantable Central Venous Catheters:</u>	<p>Under Restrictions: Change to "<i>Paramedics may administer medications through previously placed lines when no other option is available under direct on-line medical control or standing protocol.</i>"</p>
<u>Epidural Catheters:</u>	<p>Change Training Level to: <i>All levels.</i> Add to Important Points: <i>If catheter accidentally dislodged, apply sterile pressure dressing and contact medical control.</i></p>
<u>Peritoneal Dialysis Catheters:</u>	<p>Add under Restrictions: <i>If catheter actively in use at time of transport a physician, nurse or individual actively involved in patient dialysis..</i> Add under Important Points: <i>If catheter accidentally dislodges, apply sterile pressure dressing and contact medical control.</i></p>
* Access refers to the puncturing of skin	

Dr. DesChamps reiterated that the list would be put in final format and sent to EMS Advisory Council. The Advisory Council would be asked that the list be made available to all services and that in-service would be required. Dr. Norcross asked that this list be treated like the drug list and new devices be added annually, possibly in July. For the first six months, however, new devices may be added as needed. Mr. Futrell stated that a letter would be sent to the field with this list and explanation.

Testing of EMTs Who Receive Recertification Through In-service Training

The next item on the agenda was a discussion on the issue of the testing of EMTs who receive their recertification through in-service training. Mr. Futrell had explained that DHEC EMS regulations allows for recertification through either a refresher course and test or an approved in-service program and test. The regulation allows for the testing of in-service students to be waived by the service's medical control physician if the physician certifies that the EMT is "knowledgeable, proficient, and capable of performing the duties of an emergency medical technician." When the regulation was first passed, the law required that the Div. of EMS provide a study to assess the usefulness of the written examination required by the Department for the recertification of EMTs. However, at the time the study was required very few of the in-service

students had taken the written exam. The medical control physicians were waiving both practical and written tests. At the present time, more EMTs have and are completing the in-service recertification program and a study or testing of that program could be equitably conducted.

Dr. DesChamps stated that the Div. of EMS is now in its third round of recertifications through in-service training which have been awarded without being tested by the state. He is concerned about the quality control issues related to recertifications by in-service training. Mr. Warren had asked the Training Committee to address this issue. Dr. Gerard, representing the Training Committee, reported that the Committee is determining what type of exam should be used and how it should be administered. The Training Committee has not determined the details of this procedure such as who would administer it and when it would be administered. The Committee did decide that it should be a "spot/pop" exam and based on data, not skills.

Staff Reports

Mr. Fanning reported that press conferences in four parts of the state were held to inform the public about the new DNR regulations. The Division of EMS has had lots of calls and requests for DNR forms.

Mr. Grimes passed out a list of proposed QI reports from ambulance run report data (see attached). Ms. Jones asked if it would be possible to get a comparison of the accuracy of Revised Trauma Scoring from earlier times to current times since the trauma system has been developed further. Dr. Norcross asked if the Committee could get a report showing how many trauma patients are being transported initially to non-trauma center hospitals, broken down by RTS of 0-≤8 and 9-10.

Mr. Futrell suggested that advanced procedures when performed by basic EMTs should be required key entry. The suggestion was made that prisoners be used for key entry. Mr. Futrell added that electronic field key entry was starting at many services. Dr. Norcross asked if false calls should be monitored; if there is a problem with false or cancelled calls. Mr. Grimes stated that over 10% of the calls statewide are false calls. Mr. Fanning said that he would bring up this issue with the EMS directors and report back to the Medical Control Committee. He then asked the Committee to send staff any further suggestions or comments.

Report on Trauma and EMSC

Ms. Beasley reported that the second year approval for EMSC was received the last week. Training with support from this grant will continue. The Protocol/Equipment Subcommittee will meet the first week of October and will developed recommended pediatric protocols and guidelines for pediatric ambulance equipment. Ms. Breen reported that applications for trauma center designation have been received from Carolinas Hospital System and Roper North and

McLeod's was due the afternoon of the meeting. Tuomey and Self have application deadlines of November 30; and Kershaw County Hospital's deadline is October 30. The public hearing for this state trauma plan is later this afternoon. The Lowcountry regional trauma plan hearing is September 25. The other regions have not completed their regional plans.

With no further discussion, the meeting was adjourned.

MEDICAL CONTROL COMMITTEE

MINUTES

December 13, 1995

<u>Members present:</u>	<u>Others present:</u>
Ed DesChamps, Chairman	Joe Fanning
Robert Hubbard, M.D.	Phyllis Beasley
William Gerard, M.D.	Alonzo Smith
Richard Rogers, M.D.	Al Futrell
John Sorrell, M.D.	Richard Campbell
Dan Phillips, M.D.	Doug Warren
Carol Baker, M.D.	Jeff Ward
Bob Malanuk, M.D.	Eric Weinstein, M.D.
	Phil Clarke
	Jim Sullivan
	Thomy Windham
	Susan Breen
	Don Whiteley
	Rodney Bowman
	Debbie Hession
	Howell Youmans
	Ed Allen
	Connie Godowns, RN
	Sam Kini, M.D.

Dr. DesChamps opened the meeting by introducing the two newest members of the Medical Control Committee: Dr. Dan Phillips the new S.C. ACEP representative replacing Dr. Marni Bonnin and Dr. Richard Rogers, the new Pee Dee Regional Medical Control Physician, replacing Dr. DesChamps.

Dr. DesChamps asked for review and approval of the minutes. He noted that at the last EMS Advisory Council meeting a motion was made to change the name of the "Device Manual" to "Invasive/Implanted Device Manual." The minutes were approved by consensus of the Committee.

12-LEAD EKG

The first item on the agenda was a review/approval of pilots projects submitted for 12-lead EKG and discussion of the use of 12-lead EKG. Dr. DesChamps noted that five services had applied for 12-lead EKG pilot projects: Greenville, McCormick, Marion, Beaufort, Aiken. Additionally, Kershaw County has already been approved to use 12-lead EKG in its pilot project. The Committee has been asked to address the use of 12-lead EKG without the use of thrombolytics in these projects. The pilot projects had been requested so that the services could purchase this equipment with grant-in-aid funds. 12-lead EKG is currently not approved for purchase with those funds. Dr. DesChamps asked the Committee to also address the issue of whether the Committee wants to pursue 12-lead EKG as pilot project status or as an optional capability for all services.

Drs. Baker, Phillips, Gerard, and Sorrell expressed their approval for accepting 12-lead EKG as an optional capability. Their comments included the fact that Greenville has been using them for a couple of years (not knowing that it had to be approved as a pilot project) and found it to be very effective and helpful without harming the patient and being noninvasive. Dr. Baker said that with 12-lead EKG, they generally do not repeat an EKG in the ER. Dr. Sorrell stated that there was no way it could harm the patient, but questioned whether the medics would interpret the results or send them to the ER. Dr. Baker stated that it is not interpreted on the scene.

. Dr. Baker made a motion that the Committee adopt 12-lead EKG as an optional field procedure. Dr. Phillips seconded the motion. Discussion ensued. Mr. Smith stated that some of the services applying for the pilot project are also requesting the use of thrombolytics. He said that the Committee needs to make it clear that their motion is to approve 12-lead EKG for diagnostic use only. Dr. Baker agreed that it should be stressed that the motion is for approving 12-lead EKG for diagnostic purposes only. A vote was taken and the motion passed.

Mr. Smith asked for clarification on how the motion was approved. The Committee agreed that the use of 12-lead EKG is a local issue, that each service should be responsible for its own training. Jeff Ward from Greenville County EMS proceeded to explain how they developed their training program for 12-lead EKG. He stated that their EMTs spend 16 hours of training with an EKG technician in the hospital.

In response to a question by Dr. Weinstein, the Committee agreed that the training would be locally run and would not be added to the curriculum. Dr. DesChamps advised that the 12-lead EKG pilot projects which have been submitted should be kept on file in the Division of EMS for review by other services as they develop their training programs.

Mr. Fanning asked if it were the intent of the Committee's motion that the local medical control physician is the one who would request to use 12-lead EKG. The Committee agreed. Mr. Ward asked for clarification about the process to begin the program. He asked if there were some

other procedure that services must go through for approval. Dr. DesChamps said that the motion must still go before the Advisory Council, but that the Committee's motion gives approval for local use of 12-lead EKG. Mr. Fanning said that the use of 12-lead EKG, without thrombolytics, has been approved by the Medical Control Committee, pending Advisory Council approval, for those services who submitted pilot projects. Ms. Beasley commented that she felt that the confusion was that it appeared that Mr. Fanning was saying that the medical control physicians who have already submitted a pilot project must also send a letter to the Division of EMS requesting to use 12-lead. *Mr. Fanning asked that any other services, not approved today, send a letter to the Division of EMS stating that they wished to use this procedure.* Mr. Fanning said that the physician would then sign a document stating something to the effect that he understood the implications for using 12-lead EKG, to include the need to develop training. Dr. Sorrell agreed that it was not necessary to develop definitive training guidelines by the state, that the local physician will develop the training procedure.

Dr. Malanuk stated that the Committee should be cautious in ensuring that they are not setting a standard of care that would make smaller services that choose not to use 12-lead liable. Mr. Fanning reiterated that this would be called an optional field procedure and the standard for training would be set by the local medical control physician.

After this discussion, Dr. DesChamps summarized the action of the Committee by saying that the use of 12-lead EKG, without thrombolytics, has been approved for the services which submitted pilot projects and any other service wishing to use 12-lead should submit a letter notifying the Division of EMS of their intent. *Dr. Baker asked if a letter would be sent to all services of this decision (once it is approved by the EMS Advisory Council).* *Mr. Fanning agreed that a letter would be sent.* Dr. Phillips asked about the request to also use aspirin which was included in at least one pilot project. Dr. DesChamps stated that the use of aspirin or other drugs with 12-lead is an issue that should be referred to the February or March meeting in which all new additions to the drug list would be addressed.

Dr. Sorrell asked if this determination were any relation to requests to use AEDs. Dr. DesChamps stated that AEDs were taken off pilot project status. Mr. Fanning said that for services to purchase AEDs with grant-in-aid, they must state that they have a plan to teach first responders, a plan to train their EMTs, and that they have a plan for paramedic backup. We like for them to let us know at the state level that they have it. Dr. Baker asked about pulse oximetry: that the Committee has never talked about it and can it be bought with grant-in-aid. Mr. Fanning explained that pulse oximetry can be purchased with grant-in-aid because it was determined that it did not involve additional training. Dr. Baker stated that these differences are confusing. Mr. Fanning explained that the determinations were based on whether the equipment required additional extensive training of the EMTs. Equipment that required additional skills or training had to be considered as a pilot project and could not be purchased with grant-in-aid money. Mr. Clark from Aiken said that he has a problem with the state making requirements such as those with AED to purchase the equipment when equipment purchased with local money has no such

requirements. There was much discussion about the validity of the Division's requirements to purchase AEDs. Mr. Fanning explained the basis for the Division's requests and asked that he contact his office for further discussion on these type issues at a later time.

Mr. Allen of Beaufort asked if the supplemental equipment, such as cellular phones to transmit the readings, requested in the 12-lead EKG pilot project has been approved with this motion.

Mr. Fanning responded that he believed that the equipment would be approved, but Mr. Allen should contact his office after the meeting.

TRANSPORT VENTILATORS

Dr. Weinstein passed out information on the features and types of ventilators preferred by the service of which he is medical control. Mr. Warren stated that he knew of at least 60 ventilators that are in service throughout the state, most of which are used for interhospital transport. He reiterated the concern that if a patient needed ventilating and other care at the same time, and a ventilator was not available on the truck, and there was only one EMT in the back of the truck, the patient has to do without either the ventilation or the other care. Dr. DesChamps questioned whether the ventilators are kept in the ambulances and applied by the paramedics. Mr. Warren stated that one of the services he knew kept their one ventilator at the hospital and used it on whichever truck needed it.

Dr. Baker expressed the concern about the standard efficiency of the ventilator and that it is a very invasive device. She felt that there should be some kind of evaluation done on the ventilators. Dr. Malanuk stated that Dr. Norcross (who was not present) was going to prepare some information on ventilators. The issue of training came up and Mr. Warren explained that most of the training is provided by sales reps. Drs. Hubbard and Phillips said that in cases where transport ventilators are used in their services, respiratory therapists are sent in the ambulances. *Dr. Sorrell asked that a subcommittee look at the issues surrounding the use of transport ventilators. Drs. Norcross and Phillips were named to this subcommittee.* It was suggested that the discussions about ventilators be divided into interhospital and emergent site issues. Persons with strong feelings about the use of ventilators should contact Dr. Phillips or Dr. Norcross.

MAST TROUSERS

The next issue to be discussed was whether MAST trousers should remain as required ambulance equipment. Mr. Fanning stated that there are a number of ambulance services whose medical control physicians will not allow them to use MAST trousers, but they are currently required ambulance equipment. Changing this requirement would require a regulatory change. Mr. Fanning wanted the opinion of this committee to take to the Equipment and Standards Committee. Dr. Baker made a motion to no longer require MAST trousers as ambulance equipment. Dr. Gerard seconded the motion. Mr. Smith asked for clarification that, although

this Committee recommends the trousers not be required, this change must go through the legislature as a regulatory change. A vote was taken and the motion passed.

TESTING OF INSERVICE RECERTIFIED EMTS

Dr. Gerard reported that he has not been able to make any progress on developing a test to compare the results of in-service testing vs. recertification courses. Dr. DesChamps said that he had discussed developing a testing mechanism, but Mr. Fanning had mentioned the possibility of using the state exam for this purpose. Mr. Fanning said that, however, there could be problems with using the state exam. His staff reported to him that it would be difficult to maintain the security of the exam and that there would be staff time or expense in scoring the exam.

Dr. Sorrell said that there should be random testing of several different services and that when the EMTs are tested, they should be reassured that their scores would not affect their certifications. Dr. DesChamps said that the test results should be available to the local medical control physicians. Dr. Gerard said he would work with the Division of EMS staff to develop this testing.

REVISED STATE PROTOCOLS

Dr. Gerard said that he has obtained protocols from all the counties and from out-of-state and is in the process of examining them. He will put them in algorithm form and combine them as a reference material. He anticipates completion by the next meeting.

NHTSA ASSESSMENT

Mr. Fanning explained that Div. Of EMS staff has met with the coordinators of the assessment team from Washington. The visit is scheduled for the last week of April. It will be an assessment of the whole system, not of the staff or committees. The assessment is provided by grant funding. The team will consist of 2 state EMS directors, 1 emergency physician, 1 trauma surgeon, and 1 state training coordinator. The team will spend three days on the assessment based on interviews and documents put together by staff. Forty-eight of the 50 states have already had assessments. Our assessment will be used to gain support for further development of our EMS system.

QUALITY IMPROVEMENT REPORTS

The Committee had been mailed a copy of state data from the ambulance run reports. Mr. Fanning asked for comments on the reports, but none were received.

LONG RANGE PLANNING

The Committee had also been mailed a copy of some issues that had been raised in an ad hoc committee review of long range planning. Dr. DesChamps asked if anyone had anything to add to this list. Dr. Sorrell said that he would like to examine the issue of running lights and sirens to all calls. Charleston County does not run them on each call, but Richland County does. Dr. Weinstein said that he had read a study that said doing so only reduces the call time by 42 seconds.

Dr. Baker said she would like to examine dispatch protocols and 911. Discussion revolved around the fact that very little medical training is required in 911 dispatch training and when sheriffs' departments are involved, there is very little interest in that medical training. Mr. Warren said that he believes that it is crucial that the Medical Control Committee take a stand on this issue and establish screening protocols. Dr. Weinstein said that an ACEP committee would be spearheading such a study.

Dr. Phillips said he would like to examine communications problems; that the 155.340 system is inadequate. There was much discussion about the trend toward 800 MHz and the fact that counties are required to develop their own communications plans working with all public service agencies in the counties. But the fact that all agencies must agree on one plan has slowed down the completion of communication plans in many counties. Mr. Futrell said that if a county has a communications plan in effect, 800 MHz radios may be funded through grant-in-aid. *Mr. Fanning promised the Committee a report by mail of counties which have approved plans for 800 MHz.*

Dr. DesChamps stated that the issues to address and the order in which to address them would be discussed at the next meeting.

Mr. Futrell commented that he appreciated the Committee's actions on MAST trousers and 12-lead EKG as guidelines for regulatory changes. He said that, more than likely, under today's regulations if the Committee wants to turn a local option issues to local medical control physicians there is going to have to be either an approval process or minimum standard process compared to what is going on in current curriculum. Certification may have to be extended to 12-leads.

The Committee determined that the next Committee meeting date, based on the need to hear trauma center designation recommendations and timed with the Advisory Council meetings, should be the afternoon of Wednesday, February 7, 1996.

With no further discussion, the meeting was adjourned.