

MEDICAL CONTROL COMMITTEE

March 2, 2000

MINUTES

Members Present:	Others Present:
Ed DesChamps, MD, Chairman	Mark Meijer, MD
Doug Norcross, MD	Richard Boyer, MD
John Sorrell, MD	Andre Creese, MD
Cliff Staggs, MD	W. J. Hollins, MD
Steve Shelton, MD	N. Lefever, MD
Carol Burger, MD	John Ringwood, MD
Richard Rogers, MD	Otis Speight, MD
	Anthony Bostick, MD
	Joe Fanning
	Alonzo Smith
	Phyllis Beasley
	Rene McDonald
	Dave McDonald
	Joe O'Connor

MINUTES FROM 11/18/99

Dr. DesChamps called the meeting to order and asked if there were any corrections, additions or changes to the minutes from 11/18/99. There were none. **By Committee consensus, the minutes stand as written.**

INTRODUCTION OF NEW COMMITTEE MEMBER

Dr. DesChamps introduced the newest member of the Medical Control Committee, Dr. Cliff Staggs. Dr. Cliff Staggs represents the EMS Committee of the South Carolina College of

Emergency Physicians. He replaces Dr. Steve Shelton, who became the Midlands EMS Region Medical Director and assumed that role on the Committee. Dr. Shelton replaces Dr. Bill Gerard who resigned as Midlands Regional Medical Director.

UPDATE ON CRITICAL CARE PARAMEDIC PILOT PROJECT

Renee McDonald and Dave McDonald presented a written report to the Committee on the first six months of data of the Critical Care Paramedic pilot project. Ms. McDonald explained that two CCP courses have been completed with about 35 EMT-P's trained and that they are tentatively planning another training course for August or September. She reported that they have had no serious incidents related to the critical care transports, about 737 transports total since July. There was one cardiac arrest during transport and Dr. Baker, who is the medical control physician in charge of this pilot project, was the physician who accepted this patient. Transport ventilators are being used frequently. (A question related to Retavase was addressed at an earlier Medical Control Committee meeting.)

Dr. Baker commended the staff and paramedics of Mobile Care Ambulance Service. She said that the program had a slow start, but the numbers of critical care transports have begun to increase rapidly.

Dr. Shelton asked about the original project's proposal to conduct a statistical evaluation of transports which fell out based on Apache scores. Ms. McDonald said they are still working on that. Dr. Baker is conducting 100% case review.

Dr. Norcross asked about the level of critical illness of the patients that they have been transporting, i.e. have they mostly been cardiac failure or have any multi-system organ failures, renal failure type patients been transported? Ms. McDonald said that they have transported some very ill patients, including renal failure, but have not had any get any sicker during the transport.

Dr. Norcross asked if there had been any problems reaching medical control if necessary. Ms. McDonald responded that there have not been many times when they needed to contact medical control, but when they have, they have not had any trouble reaching any of the sending physicians and that Dr. Burger was always there as backup.

Dr. DesChamps said that another data report would be due in 6 months.

DRUG LIST ADDITIONS

Tirofiban/Aggrastat and Eptifibatide/Integrilin

Both are cardiac drugs and are requested by Beaufort County EMS as additions to the interfacility drug list.

Before addressing the adoption of these drugs, Dr. Sorrell asked what the future of the interfacility drug form is. The form has been approved by the EMS Advisory Council but must go before the DHEC Board.

Dr. Hollins asked if Reopro could be added also, since it is used as commonly as Tirofiban and Eptifibatide, depending on the preference of the physician. **Dr. Burger agreed and the consensus of the Committee was to add Reopro. Dr. DesChamps said that he and Alonzo could work up the information for the interfacility drug list.**

Dr. Shelton questioned the dosages listed. The Committee agreed that the dosages appeared to be correct.

Dr. Burger asked if a bleeding problem were to occur, could the medicine be discontinued. Dr. DesChamps said that yes, an interfacility drug can be discontinued.

Dr. Burger made a motion that Eptifibatide/Integrilin, Tirofiban/Aggrastat and Reopro be approved as interfacility drugs unless the proposed interfacility drug form is approved previous to the implementation of the drugs. Dr. Staggs seconded the motion. The motion was approved.

Amiodarone/Cordarone

The next drug presented by Dr. Sorrell was Amiodarone/Cordarone, requested for inclusion on the prehospital drug list by Beaufort County EMS and Jasper Co. EMS.

Dr. Staggs asked Dr. Hollins (a cardiologist attending the meeting) if the dosage listed on the request, 150-500 mg IV over 10 minutes, 0.5-1 mg/min continuous, was appropriate. He said that he had seen papers which recommended 300 mg as the upper dose. The dosages on the requests by Beaufort County and Jasper County were different. Dr. Burger said this drug should not be used at all without online medical control. Dr. Shelton agreed.

Dr. Burger also said that its use had not been agreed on by the Heart Association. Dr. Hollins said that it is a “bizarre” drug, that you can’t give too much.

Dr. DesChamps asked where in the protocol this drug should be placed. Should it be placed behind Lidocaine? Dr. Burger said the local EMS should decide where in the local protocol it should be used. Dr. Hollins said he uses it behind Lidocaine; it is most effective like that.

Dr. Ringwood expressed concern over approving this drug for use with pediatrics. He said that it appears to be all right, but had concerns about adverse reactions during a 30 minute administration time (*this may not be right, tape muffled*). Dr. Ringwood recommended NOT approving this drug for use in pediatric cases at this time.

Dr. Sorrell made a motion to adopt Amiodarone/Cordarone as a Local Option drug with a dose up to 300 mg. The local medical control physician can decide whether to use the drug in his standing order or only with direct on-line medical control. It will not be approved for pediatric use at this time. The motion was seconded. There was then discussion about when to use the Cordarone. It was agreed that the drug be recommended as a “*second line*” drug after shocking and Lidocaine. **The motion was approved.**

Nitroglycerine Drip

Per Dr. Sorrell, Berkeley County EMS submitted a request to add Nitroglycerine Drip on the prehospital drug list.

Several committee members expressed concern over the need to add this to the list. Drs. Burger and Shelton said there might be problems carrying enough pumps on the trucks. There were also concerns about adding this when sublingual applications were available. Dr Sorrell said that there was a limitation of three dosages sublingually, according to protocol. Dr. Burger said that perhaps the protocol should be changed; then Dr. Shelton said that more doses could be given if directed by on-line medical control.

Dr. Norcross made a motion to reject the addition of nitroglycerin drip to the prehospital drug list. Dr. Rogers seconded the motion. The motion passed.

Dr. Hollins suggested adding to the drug list a contraindication for the use of nitroglycerin when Viagra has been used by a patient within the last 24 hours. The Committee agreed that this contraindication should be added.

PROTOCOLS

The current version of the state-approved protocols had been sent out earlier to several members of the Medical Control Committee.

Dr. DesChamps said that the only comments he had seen were minor, “cleaning up” changes; no major shifts in medications or strategies or no new protocols. He proposed that review of the protocols be delayed until a later meeting to give him a chance to incorporate the “clean ups.”

Dr. Shelton commented that he found the flow chart format of the protocols difficult to manipulate, especially if you don’t have the software necessary to make changes. He asked if the Committee should consider going to a text format for the protocols, since everyone has word processing software. He said the text version could be available in addition to the flow chart format.

Dr. DesChamps said that he and staff would develop text versions of the protocols.

Dr. Shelton then questioned the use of Bretylium in the protocols; it is not easily available. The

Committee agreed to change the wording to “*consider*” Bretylium.

LMA UPDATE

Dr. Norcross said there is no report. Dr. Rogers said that at a recent conference he attended, an anesthesiologist, Dr. Rosenblatt, spoke highly of the use of LMA’s for difficult airways. Dr. DesChamps said that several services were very interested in incorporating the use of LMA’s. *Dr. Rogers said he would send a copy of the LMA report and staff can mail it to all Committee members.*

TRAUMA SYSTEM COMMITTEE

Lexington Medical Center Level III Trauma Center Redesignation

Dr. Norcross explained that Lexington Medical Center was reviewed for Level III trauma center redesignation by Dr. Mark Reynolds, Dr. Baird Oldfield, and Debbie Couillard. He said that the hospital got a glowing report for its QI process. He said that the Trauma System Committee recommended that Lexington Medical Center be redesignated as a Level III trauma center.

Dr. Norcross then made a motion to redesignate Lexington Medical Center 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. Dr. Shelton abstained from voting.

New Criteria

Dr. Norcross said that a subcommittee of the Trauma System Committee is reviewing the new ACS criteria for adaptation and adoption in South Carolina. He said that if the criteria were adopted as presented by ACS, then most of the hospitals in South Carolina, as well as across the country, would be not be eligible for designation. He said the biggest change that is being considered is that for hospitals receiving a minimum number of patients with ISS >10, the trauma director can be an emergency physician.

Trauma Center Bypass

Dr. Norcross announced that the Trauma Committee had sought an opinion from DHEC Legal Office regarding DHEC EMS’ authority to require bypass of a non-designated hospital. The Legal Office had returned its opinion which verified that DHEC EMS does have the authority to require EMS providers to bypass non-designated hospitals with seriously injured patients. At this time, the Committee and EMS staff have chosen not to implement this authority.

The Redesignation Process

Dr. Norcross explained that now that the redesignations of the Level III trauma centers under the QI redesignation process was complete. He said that we had delayed the redesignations of Level I and II hospitals until the completion of the Level III's to see how well that redesignation system worked. With Level I and II trauma centers, out of state review teams are brought in at the expense of the hospitals and we didn't want the hospitals to incur this expense until we knew this process worked. He said that it was the opinion of the reviewers, staff and the Trauma Committee that using the QI redesignation process with a set of prescribed filters has not worked well. The process is cumbersome and does not accomplish what we want. He said we do not want to bring in out of state teams for this process. He said the Trauma Committee agreed that they do not want to use this process for Levels I and II, and not again for Level III's.

Dr. Norcross made a motion to delay the redesignations of all Level I and II trauma centers with a formal, full review until after the new criteria are passed; and for the redesignations to begin the first calendar year after the adoption of the criteria. The motion was seconded. The motion was approved.

Dr. Burger asked how often the redesignations would be conducted. Dr. Norcross said redesignations would be conducted every 5 years.

Dr. Norcross made another motion to change the Level III trauma center redesignations to a full, regular review every 5 years and for those hospitals which have undergone a QI redesignation, the first new full review will be conducted three years from the last redesignation. Dr. Ringwood suggested that hospitals submit a letter to DHEC EMS midway through the time period until the next redesignation and this letter should be an expression of the hospital's continuing commitment to provide the expected level of care of trauma patients as expressed in the criteria. Dr. Shelton agreed. Dr. Norcross said that there is a requirement that hospitals notify DHEC EMS of any significant changes in their trauma program. **The motion was seconded. The motion passed.**

Dr. Norcross said that the Trauma System Committee would address the process to correct problems that are discovered at designated trauma centers and develop a formal complaint process.

Dr. Norcross also announced that a QI subcommittee is reviewing whether or not there should be specific audit filters required of hospitals. The subcommittee is also charged with developing audit filters for the state level to monitor progress of the state's trauma system.

Dr. Norcross said that plans are in the works for four regional trauma meetings to discuss a variety of issues of concern about the state's trauma system. The first one will be held in Palmetto Richland Hospital's catchment area.

PROPOSED PHARMACY REGULATIONS

Dr. DesChamps said that an issue regarding new pharmacy regulations has recently come to the attention of EMS providers. He asked Don Lundy, president of the EMS Association to explain the issues surrounding these new regulations to the Medical Control Committee.

Mr. Lundy explained that, in 1994, an act was passed controlling pharmacies in the state. Regulations were passed several years after that which requires pharmacy permits and consulting pharmacists for EMS providers, as well as other agencies which store any prescriptive agent, including oxygen. The permits would be required for each substation of an EMS provider and, including the hiring of a consulting pharmacist, would be a great expense to EMS providers. Right now, the regulations have not gone into effect, they are in the “*education*” phase.

The question was asked about whether EMS was not exempt for the consulting pharmacist because they operate under the license of their medical control physician. Mr. Lundy said that the EMS Association believes that EMS should be exempt since they operate under physicians’ licenses, but the Pharmacy Board disagrees.

Dr. Mark Meijer encouraged the Medical Control Committee to get the Medical Association involved in this issue, not just emergency physicians.

The Medical Control Committee agreed that they should present a resolution to the Board meeting of South Carolina College of Emergency Physicians at its meeting on March 3. They agreed that the resolution should read:

“After consideration of the potentially critical negative impact on South Carolina’s EMS system, including county-supported services, volunteer rescue squads, first responder agencies and fire services, the Medical Control Committee requests that South Carolina College of Emergency Physicians and the South Carolina Medical Society join the Medical Control Committee in opposing the pharmacy regulations as they pertain to these physician-affiliated agencies. These agencies already operate under a physician’s license and therefore should be exempt from these regulations. All medications dispensed by these agencies are already under physician orders.”

A motion was made to accept the above statement. The motion was seconded. The motion passed.

YEAR IN REVIEW

Dr. DesChamps briefly reviewed the document which was distributed, called “*Year in Review.*”

This document is a summary of the actions passed and issues addressed during the last calendar year by the Committees working with EMS. It was developed as an information tool for the recertification of medical control physicians. (See attached.)

A suggestion was made that the drugs which were approved for use with RSI should be added on the ambulance run report.

There was some discussion about what elements of the new paramedic curriculum would be adopted. Mr. Smith said that there were major concerns about the increased number of hours and the expense involved in implementing such an extended curriculum, but that SC wants to stay as close to national standards as possible. SC wants its students to be able to have reciprocity with other states and to do as well on national tests as possible.

Re: trauma system--Dr. DesChamps announced that USC is working with DHEC EMS to develop a proposal on strengthening the state’s trauma system. They will contact us when they have developed their proposal.

RECERTIFICATION OF MEDICAL CONTROL PHYSICIANS

Ms. Beasley said that in addition to the original list of ways for medical control physicians to recertify there are several others which might be considered, including:

- Service as a trauma center site reviewer;
- Service on a subcommittee of EMS Advisory Council, Medical Control Committee, EMS-C Committee, Training Committee or any other subcommittee.

Dr. Sorrell asked what means were already approved. Ms. Beasley listed some of the approved methods of recertification:

- attendance at the annual medical control workshop or viewing a tape of it
- attending a Committee meeting
- reading two sets of minutes and commenting
- reviewing the protocols and commenting.

Dr. Meijer said that the Medical Control Committee should be as flexible as possible and offer as many means of recertification as possible.

Dr. Sorrell said that the document “*Year in Review*” would be a good update and means of recertification. A questionnaire for return could be developed to go with it. Dr. Shelton agreed. Dr. DesChamps said that document could be put on the web, too. Dr. Sorrell said that the document should be mailed to all medical control physicians.

The question was asked about whether attendance at the Medical Control Physicians' Workshop should be required periodically. Dr. DesChamps said that it had been discussed, but not decided.

Dr. Staggs said that the workshop provided valuable information that makes a medical control physician review his or her current activities.

Dr. Meijer suggested developing a list of 20 recertification options and requiring 5 each year, but not to repeat the same 5 each year.

Dr. Bostick supported requiring attendance at the Medical Control Physician Workshop.

CHEM-STRIP ANALYSIS FOR EMT-B'S

Dr. Speight asked the Committee if it is allowed for EMT-B's to use Accucheck on their patients. This is a procedure that patients can perform at home, but it is not an approved skill for EMT-B's.

Dr. Sorrell made a motion that the use of Accuchecks, or chem-strip analysis, for glucose monitoring, be allowed at the EMT-B level, local option, with appropriate quality improvement and under protocol. Dr. Norcross seconded the motion. The motion passed.

ROUTE OF ADMINISTRATION: INTRANASAL

Joe O'Connor passed out a newly developed means of a route of administration of drugs: an intranasal device, also called an mucosal atomizer device. He said that dosage by this means has been shown to be equivalent to IV. In EMS, it could be useful for dosing Valium and Narcan. He asked what the procedure was to have this means of administration approved. Dr. Shelton said that he should get the literature to DHEC EMS staff to mail to Committee members to review.

Dr. Sorrell asked that a subcommittee be formed to review the Inservice Training Program. He said that the subcommittee should have representatives from Medical Control Committee and Training Committee. Dr. DesChamps said that he agreed; that recently he had reviewed cases of programs which had flagrant violations of the program. **The Committee agreed by consensus that IST program should be reviewed and the subcommittee will be composed of Drs. Burger and Sorrell from Medical Control Committee and two members from the Training Committee and two staff people.**

AGENDA ITEMS NOT ADDRESSED AT THIS MEETING:

- Update of state-approved protocols
- LMA Update - Dr. Norcross

AGENDA /OTHER CONTINUING ITEMS NOT RESOLVED/CONCLUDED AT THIS MEETING:

(see above)

- Other methods of recertification for medical control physicians - staff
- EMT-B transport of patients on transport ventilators (continued from 11/18/99) - Dr. Shelton
- Results of dispatchers survey from NENA (continued from 5/99)
- Cricothyrotomies as a state approved skill (from 11/18/99)
- Changing MCC meeting schedule

STAFF/OTHER REPORTS DUE AT NEXT MEETING:

- Legal opinion of authority of local medical control physician during disasters - staff

STAFF ACTIONS NEEDED:

- Submit interfacility drug form to DHEC Board (from 11/18/99)

MEDICAL CONTROL COMMITTEE

May 25, 2000

MINUTES

<u>Members Present:</u>	<u>Others Present:</u>
Dr. Ed DesChamps, Chairman	Dr. David Gatti
Dr. Doug Norcross	Susan Breen
Dr. Bob Malanuk	Dr. John Ringwood
Dr. Cliff Staggs	Greg Shore
Dr. John Sorrell	Joe Fanning
Dr. Carol Burger	Phyllis Beasley
	Doug Maness

DEMONSTRATION OF LMA FASTRACK

Mr. Clayton Hodges, sales representative, demonstrated the use of the LMA Fastrack. This demonstration was conducted as part of the Committee's ongoing process to determine if cricothyrotomies should be adopted as a prehospital skill, or if the LMA could be used prior to or instead of cricothyrotomies.

Dr. DesChamps asked Mr. Hodges what kind of training would be necessary for EMTs to have in order to be able to use the LMA. Mr. Hodges explained that he trains with the use of a manikin and it takes about four hours. Mr. Hodges said that he would provide a "train the trainers" session with his own videos and training modules.

Dr. Sorrell asked about pediatric sizes. Mr. Hodges said that you can use a "size 3" on a 10 year old. He said that for smaller pediatrics you have to go to the reusable type of LMA. There was a question about pricing. Mr. Hodges said that the price on the disposable Fastrack was \$36 and replacement ET tubes were \$67.

The Committee asked Mr. Hodges for information on other field EMS services that are using the LMA.

Dr. DesChamps suggested that Charleston County EMS would be interested in conducting a pilot project using the LMA and Dr. Burger said that Greenville County EMS may want to try, too.

Dr. DesChamps asked that the Airway Subcommittee be reconvened to discuss the use of the LMA.

There was then discussion about whether the LMA needed to be tried as a pilot project, or whether the Committee had done enough research on its appropriateness. The consensus of the

Committee was that it would not be necessary to have a pilot project on LMA's. Mr. Smith said that its use is similar or easier to use than combi-tube and PTL.

Dr. Norcross made a motion to approve the LMA as an airway adjunct for all levels of EMT's following development of a training module by the Training Committee and that data should be kept on its use for the first six months following implementation. Dr. Burger seconded the motion. The motion passed.

The Committee agreed that its use should be noted in comments in the ambulance run reports. Dr. DesChamps said that when the memo is sent out explaining that its use has been approved, then the memo should also explain that its use should be noted on the ambulance run report.

Dr. Norcross suggested having Dr. Pinosky (anesthesiologist from MUSC) to assist in training.

The Committee also suggested that staff ask the Training Committee about combining hours of training of all the different airway methods. They noted that there may be too many special training sessions that overlap with each other and with BTLS, etc.

MINUTES FROM 3/2/00

Dr. Norcross made a motion to approve the minutes from March 2, 2000, as written. Dr. Miller seconded the motion. The motion passed.

ACTIONS FROM THE TRAUMA SYSTEM COMMITTEE

The Trauma System Committee had met immediately prior to this meeting of the Medical Control Committee. Dr. Norcross presented the information and motions from that meeting.

Level III Redesignation of Grandstrand Regional Medical Center:

Dr. Norcross explained that the Trauma Committee and the site review team which reviewed Grandstrand had several major concerns, including the lack of a structured trauma program and a lack of documentation with QI.

**Dr. Norcross made a motion to approve the decision of the Trauma System Committee on the Level III redesignation of Grandstrand Regional Medical Center which was:
To redesignate the hospital as a Level III trauma center under Redesignation Option #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/improvement. 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 category 1 or 3") with specific recommendations for corrections:**

Prior to the next review, the hospital should:

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1. **Appoint a formal trauma director to coordinate the policies and activities of the trauma team;**
 2. **Improve documentation of Glasgow Coma Scale and Revised Trauma Score; Improve documentation of the QI filters, including written documentation of "loop closure";**
 3. **Develop written trauma guidelines (i.e. for trauma team member roles, trauma alerts, trauma care protocols)**
 4. **When the second team reviews the hospital, they will only review QI activities related to redesignation audit filters #2, #3, #7, #11 and #12.**

Dr. Sorrell seconded the motion. The motion passed.

Dr. Miller agreed to be site team leader for the next review team. (The team will be comprised of Dr. Miller as leader, an emergency physician and a critical care nurse.)

New Trauma Center Designation Criteria:

A subcommittee of the Trauma System Committee had been charged with reviewing the new 1999 edition of the American College of Surgeon trauma center criteria for approval in our state. The subcommittee had recommended many changes, some fairly significant and the Trauma System Committee had reviewed those changes and added a few more clarifications/changes. Dr. Norcross reviewed the changes as approved by the Trauma System Committee in detail. The changes included some "reductions" in requirements, including (the following are the most significant changes; see the criteria document for all changes):

1. Addition of a note explaining that care for the pediatric trauma patient should be addressed through the guidelines for the "Pediatric Centers for Excellence".
2. Re: Institutional Organization, Trauma Program Medical Director, the subcommittee had added a footnote that the trauma program medical director at a Level III hospital may be an emergency physician, who meets the qualifications listed under the section "Clinical Qualifications." If a Level III trauma center admits less than 20 trauma patients a year with an ISS greater than 10, then the trauma program director may be an emergency physician. However, a general surgeon must be a member of the trauma multidisciplinary committee.
3. Re: Clinical Qualifications for general/trauma surgeon and emergency medicine: the Committee changed the 16 hours CME requirement to 8 hours (inside institution allowed). The Committee also changed Footnote 5 to read: "The Emergency Department physician(s) must be board certified or board eligible in an ABMS specialty. At Level III trauma centers, the physician also must be board certified or eligible in an ABMS specialty or must be a career-oriented emergency physician whose practice is primarily in emergency medicine." The Committee also decided to require ATLS certification for general surgeons who are not board certified or eligible or have not completed a surgical residency (added to footnote).
4. Re: Facilities/Resources/Capabilities, Volume Performance: The Committee changed the Volume Performance numbers from 1,200/year at Level I to 800/year for Level I

trauma centers. The requirement for numbers of patients with ISS>15 from 240 total/35 patients per surgeon to 150 total/30 per surgeon.

5. A section related to Disaster/Mass Casualty Preparedness was added.
6. The ACS long list of prevention activities was pared down by the Committee to "Injury prevention activities/education."

Dr. Miller said that these changes were in line with a nationwide "grumbling" about the stringent ACS criteria. He said that this document is a commendable revision.

Dr. Norcross made a motion to accept the proposed trauma center criteria guidelines. Dr. Malanuk seconded the motion. The motion passed.

Required Audit Filters:

Dr. Norcross explained that the Trauma System Committee has decided to do away with the required redesignation audit filters. During the last redesignation reviews of Level III trauma centers it was discovered that the system for redesignation using these filters does not work well since Level III trauma centers often see different types of patients and it is difficult to judge a hospital's quality improvement program based on these filters. However, the QI Subcommittee felt that there should be some minimal required audit filters in place.

Dr. Norcross reported that the Trauma System Committee passed the following recommended required audit filters:

1. All trauma deaths should be reviewed and documentation from these reviews should be made available to the trauma multidisciplinary committee (if reviewed by M&M or some other hospital committee)
2. Review any trauma patient with an unplanned re-admission to ICU or an unplanned admission to the ICU from a medical/surgical unit.
3. Monitor all trauma patients transferred out from the Emergency Department.
4. In addition to the required audit filters, at the time of review, the hospital must demonstrate an appropriate trauma QI process consistent with Chapter 16, "Performance Improvement" of the 1999 edition of the American College of Surgeons' 'Resources for Optimal Care of the Injured Patient' ("The Gold Book")

Dr. Norcross also said that the newly approved trauma center criteria has several required filters incorporated in it including: audit of all trauma deaths; morbidity and mortality review; nursing audit; review of prehospital trauma care; review of times and reasons for trauma-related diversion; and review of times and reasons for transfer of injured patients.

Dr. Miller said that on the ACS website, there is an excellent guide for conducting trauma PI programs. *Staff agreed to print out this information and mail it to all trauma centers.*

Dr. Norcross made a motion to approve the filters as recommended by the Trauma System Committee. Dr. Burger seconded the motion. The motion passed.

Handling Complaints about Trauma Centers:

Dr. Norcross explained that the issue of how DHEC should handle complaints about trauma centers was brought to the Trauma Committee. He said that a subcommittee has been appointed to develop policies and procedures for handling complaints.

Trauma Center Level Downgrade:

Dr. Norcross reported that the issue had been discussed about how to handle a trauma center's request to downgrade their level of classification. He said that the Committee agreed that the hospital should send a letter to DHEC with their request and a decision would be made by the Committee at that time.

Trauma System:

Dr. Norcross reported that because of the financial and other problems being experienced by the state's trauma centers, Jim Walker of the SC Hospital Association has agreed to organize an effort to bring legislative support for the system. He will be working with the Level I and II trauma centers.

RECERTIFICATION OF MEDICAL CONTROL PHYSICIANS

Ms. Beasley said that at the last Medical Control Committee meeting, two further means of recertification for medical control physicians had been mentioned and discussed, but no vote had been taken on whether to accept those means of recertification. They were: service as a trauma center site reviewer; and service on a subcommittee of EMS Advisory Council, Medical Control Committee, EMS-C Committee, Training Committee or any other DHEC-EMS subcommittee.

Dr. Sorrell made a motion to approve the two extra means of medical control physician recertification. The motion was seconded. The motion was approved.

RECERTIFICATION OF MEDICAL CONTROL PHYSICIANS OF SPECIAL PURPOSE AMBULANCE PROVIDERS

There had been a complaint that medical control physicians of special purpose ambulance providers should not have to recertify. Dr. DesChamps said that he felt that it is important that these physicians interface with the rest of EMS. Dr. Sorrell said that it is also important that these physicians be familiar with the requirements of EMS providers. He said that the recertification requirements are minimal.

There was no motion made to allow the medical control physicians of special purpose ambulance providers to be exempt from the requirement to recertify.

LMA'S

Dr. Norcross added to the earlier presentation about LMA's that the Committee should make sure, with Dr. Ringwood's approval, that LMA's are approved for pediatric use.

LOCAL MEDICAL DIRECTORS' AUTHORITY DURING DISASTER SITUATIONS

Dr. DesChamps' reported that the DHEC Legal Department had given EMS an opinion on the request for information about following protocol and drug lists during disaster situations. There had been a request to allow local medical control physicians to run the medical aspects of EMS within appropriate boundaries. He reported that the Legal Department determined that as long as no law or regulation is broken, and that the actions are only a temporary change of policy (drug lists and protocols are considered policy) it would be allowable. The Legal Department suggested that guidance be developed clarifying what is policy vs. regulations/law and what type changes would be allowable. Dr. Norcross pointed out that these issues deal only with declared disasters. *Dr. Burger suggested just issuing a blanket statement saying to use judgement and keep the patient's best interests in mind.*

PEDIATRIC PROTOCOL REVISIONS

Dr. Ringwood reviewed the EMS-C Committee changes as presented in a summary sheet provided to the Committee (see attached).

On the pediatric multiple trauma protocol, Dr. Norcross also suggested that the Trendelenburg prn was irrelevant and could be taken out. He said that there is clinical evidence that it has no benefit. Dr. Ringwood said he has no problem with taking it out.

Dr. Ringwood mentioned that under the Pediatric Tachycardia the Committee is going to discuss the administration of Adenosine by IO at a later date.

Dr. DesChamps made a motion to adopt the 2000 Pediatric Protocols from EMSC as guidelines. Dr. Norcross seconded the motion. The motion passed.

Mr. Smith asked about the change of Adenosine dosage under Pediatric Tachycardia. Dr. Ringwood said that the dosage listed under recommended changes is the correct pediatric dose. Dr. DesChamps asked if the Committee reviewed the protocols along with the EMS prehospital drug list. Ms. Breen said that Mr. Maness did and found that Ibuprofen was not on the prehospital list, so the protocol for pediatric pain was recommended for deletion.

PREHOSPITAL DRUG LIST AND INTERFACILITY DRUG FORM UPDATE

Dr. DesChamps mentioned that he and Mr. Smith were in the process of updating the current prehospital drug formulary. Amiodarone was taken to the DHEC Board and it was approved. They did not take the interfacility drug form or the proposed additions to the interfacility drug

list until Dr. Waddell, Deputy Director of Health Services, can adapt the interfacility drug form for her approval.

Dr. Norcross asked what other states are doing. He suggested that this research be done so that information could be taken to the Board.

Greg Shore stated that he has run into a problem with interfacility transport (with drugs not on the interfacility list) that a nurse with the Greenville Hospital System circulated information to nurses saying that they cannot ride in an ambulance to transport an interfacility patient unless there is a protocol. There is a problem with interfacility transports now for drugs that are not under the interfacility list, including Aggrastat. There is also a problem with Medicare reimbursement if the nurse who travels in the ambulance is not with the hospital service that is transporting.

Dr. Shealy said that these days there are not usually extra nurses available to ride in ambulances. He said that leaves two options: to not transport the patient or to transport without the benefit of the drugs that are being used. He said that it is best for the patient to be transported and the liability should lie with the physician who felt that the patient was stable enough to transport on the drug.

Dr. DesChamps said that Aggrastat and Reopro were passed at the beach meeting and that they had hoped that the drugs and/or list could have been taken to the last DHEC Board meeting. He said that if staff and Dr. Waddell cannot reach an agreement about the interfacility form, staff may have to go ahead and take the interfacility drugs.

BOARD OF PHARMACY REGULATIONS

Dr. DesChamps gave an update on the Board of Pharmacy regulations which were going to affect EMS providers. He said that the EMS Association and Wilbur Harling of DHEC's Drug Control Bureau, have been working with the Board of Pharmacy to reach a compromise on the regulations. Most of the issues have been resolved. EMS providers will still have to have a "Non-dispensing pharmacy permit" if they have anything other than oxygen, but there will be no charge for these permits. The EMS providers will not have to have a consulting pharmacist; the service's medical control physician will serve that role. These changes are still in the legislature. It is the service's responsibility to get the pharmacy permit.

NUBAIN ABUSE

Dr. DesChamps reported that recently there have been a couple of cases of Nubain abuse, even though Nubain is not a scheduled drug. He said that he and Mr. Smith have talked about developing a policy making Nubain a "controlled substance" and ask that it be inventoried and stored like Morphine and Valium.

The Committee did not come to any agreement on this issue.

MAGNESIUM SULFATE

Dr. Sorrell said that at the beach meeting in March, the Medical Control Committee talked about adding Magnesium Sulfate to the prehospital drug list as a second line drug after Lidocaine for V-tach since bretylium is no longer available.

Dr. Sorrell made a motion to add Magnesium Sulfate to the prehospital drug list. Mr. Smith asked if he wanted it added right away, since we had already taken drugs to the Board. However, Mr. Smith said that if the Committee said it needed to be done right away, staff would take it. Dr. Sorrell said that since Bretylium was no longer available, the use of Magnesium Sulfate becomes more urgent. Dr. Shealy suggested expanding the list of indications for its use. Dr. Ringwood wanted to check the pediatric dose.

Dr. DesChamps suggested taking Magnesium Sulfate to the Board at the same time as the interfacility drug form. Mr. Smith reviewed that the indications for the drug should be as used in the AHA algorithm and for eclampsia. Dr. DesChamps said they will review the drug for use in other indications.

Dr. Malanuk seconded the motion. Dr. Sorrell said that the dosage should be up to 4 grams on protocol and up to 15 grams with on-line medical control. Dr. Ringwood said he would check the pediatric dose. *Dr. DesChamps said he would "clean up" the drug form and mail it out.* **The motion passed.**

EFFECTS OF TEMPERATURES ON DRUG STORAGE IN AMBULANCES

Dr. DesChamps brought the Committee's attention to an article which was handed out called "The Effect of Temperature Changes on Drugs Used in Ambulances" from the EMS Insider magazine. He said this is further information to add to a discussion from many months ago about the same issue.

CRITICAL CARE PILOT PROJECT

Mr. Smith told the Committee that he has been approached by another service wishing to participate in the Critical Care Paramedic pilot project. He asked the Committee if their intent had been to limit participation in this project to the original two applicants. Mr. Shore said that his service might want to participate also, since he is having problems with getting nurses for his interfacility transports.

There was much discussion about whether to allow Mr. Shore's service to participate in the project. Dr. DesChamps suggested that by the time the next six months' worth of data has been received from Mobile Care Ambulance, the Committee might want to consider take CCP off pilot project status. The Committee then discussed allowing Mr. Shore to submit an application to join the project. Mr. Shore said that he will soon have more people trained in the Critical Care Paramedic course and will submit a formal request to participate in the pilot project.

SCHEDULING OF TRAUMA CENTER REDESIGNATIONS

A schedule showing the proposed dates and types of the next trauma center redesignations had been passed out to Committee members. Dr. Malanuk expressed concerns about the timing of the next redesignations. He said that several hospitals are being penalized for being among the first group to be redesignated. A suggestion was made to just throw hospitals' names "in the hat" to decide who gets reviewed in what order. No decision or action was taken on this suggestion.

With no further discussion, the meeting was adjourned.

AGENDA ITEMS NOT ADDRESSED AT THIS MEETING:

None

AGENDA/OTHER CONTINUING ITEMS NOT RESOLVED/CONCLUDED AT THIS MEETING:

- ✓ Need to address cricothyrotomies as a state skill; Training Committee to develop a training module for LMA's
- ✓ Revision of adult state-approved protocols
- ✓ EMT-B transport of patients on transport ventilators (continued from 11/18/99 - Dr. Shelton)
- ✓ Results of dispatchers survey from NENA (continued from 5/99-staff)
- ✓ Changing MCC meeting schedule (continued from 3/2/00 - staff)
- ✓ Need agreement on whether or not to adopt a policy to treat Nubain as a scheduled drug

STAFF/OTHER REPORTS DUE AT NEXT MEETING:

- ✓ List of other states who allow EMS use of LMA's (from Mr. Hodges-salesperson)
- ✓ Need information on pediatric use of LMA's from Dr. Ringwood

STAFF ACTIONS NEEDED:

- ✓ Ask Training Committee to develop a training module for LMA's (following Advisory Council approval) and ask the Training Committee about combining hours of training of all the different airway methods
- ✓ Once LMA use is activated, a memo should be sent to the field requiring EMS providers to note instances of LMA use on the comments section of the ARR
- ✓ Once EMS Advisory Council approval is received for new trauma center designation criteria, mail out copies of the criteria to all hospitals
- ✓ Mail out information on the new required audit filters to hospitals, along with a copy of the information on PI from the ACS website
- ✓ Send memo to all medical control physicians and EMS directors about the two new methods for recertification
- ✓ Following EMS Advisory Council and DHEC Board approval, send out to EMS providers a sheet on Magnesium Sulfate
- ✓ Issue memo to the field related to following of protocols and drug lists during disasters

MEDICAL CONTROL COMMITTEE

September 13, 2000

MINUTES

Members Present:	Others Present:
Dr. Ed DesChamps, Chairman	Lewis Moore, EMT-P
Dr. Carol Burger	Dave McDonald
Dr. Doug Norcross	Renee McDonald
Dr. John Sorrell	Dr. Tommy Gibbons
Dr. Richard Rogers	Dr. John Ringwood
Dr. Robert Malanuk	Joe Fanning
Dr. Ron Fuerst	Phyllis Beasley
	Douglas Maness
	Al Futrell
	Dr. Scott Carroll

REVIEW/APPROVAL OF MINUTES FROM 5/25/00

Dr. DesChamps asked the Committee if there were any changes or additions to the minutes from the meeting in May. There were none suggested. Dr. Sorrell made a motion to approve the minutes from May 25, 2000. Dr. Baker seconded the motion. The motion passed.

REPORT ON ASA USE IN CHEST PAIN: Dr. Tommy Gibbons, SCCEP

Dr. Tommy Gibbons, president of the SC College of Emergency Physicians addressed the Committee with some information he had received at the Carolina Medical Review Committee (Medicare). He said that that Committee had been looking at the early use of aspirin nationwide for cardiac emergencies. He said that the study found that aspirin was not being used enough throughout the nation and that when it was used there is a disparity in its use between white people and African Americans. South Carolina is one of the states showing low use of aspirin. Dr. Gibbons said the report from the Committee showed that 88% of cardiac patients in South Carolina hospitals were given aspirin within 24 hours of the arrival of the cardiac patient. In the case of African Americans, it was 77%.

Dr. DesChamps said that Victor ran numbers from the ambulance run report for “*signal 80’s*” (chest pain) to indicate how many times aspirin was used. The report had three months’ of data, with 7,591 patients with coronary problems marked. In this patient population there were 264 patients who were administered aspirin 282 times by seven EMS providers.

Dr. Gibbons felt that the early use of aspirin in cardiac patients could be increased if EMS providers were encouraged to review their protocols and include this treatment in their protocols

and that the teaching programs could emphasize this treatment. Dr. DesChamps said that aspirin is included in the state approved adult protocols.

The Medical Control Committee requested that staff disseminate a memo about the use of aspirin and ask EMS providers to review their protocols, CQI the use of aspirin and report information to DHEC. Mr. Fanning suggested putting a request in the memo for service to make sure they record their “Signal 80” information correctly.

AIRWAY SUBCOMMITTEE REPORT (LMA’s and Cricothyrotomies)

Dr. Norcross explained that the Airway Subcommittee had met that morning to try and develop recommendations regarding cricothyrotomies as a state skill, since they have been in pilot project status for ten years. He stated that RSI had already been approved as a statewide skill and LMA’s had been discussed as a “rescue” airway for failed RSI.

The Airway Subcommittee had already approved LMA’s and asked Training Committee to develop a training module. **The Subcommittee is asking that any service performing RSI’s be required to use LMA’s. The Subcommittee wants to make cricothyrotomies an optional skill statewide.** Dr. Norcross said that the data from Spartanburg EMS said it is rare to have a need for cricothyrotomies, no more than 1 or 2 a year. He said there is some disagreement among committee members about cricothyrotomies. The consensus of the committee is that LMA’s would not be required for services performing crics.

Dr. Norcross made the motion that the use of LMA’s be required in any service which performs RSI and, for services already using RSI, that the use of LMA’s begin within 6 months of the LMA training module being developed. Dr. Malanuk seconded the motion.

Discussion: Dr. Burger said that the cost of LMA’s is about \$36 each and each truck would require 3 sizes, but this is not a prohibitive cost. Dr. Sorrell clarified that although services using RSI would be required to use LMA’s, the Committee last time approved the use of LMA’s for any service wishing to use them.

There was no further discussion. **The motion passed.**

Dr. Norcross said that he did not want to make the motion about cricothyrotomies, because he disagrees with allowing them. **Dr. Burger made the motion to open up cricothyrotomies, or surgical airways, to the state level as an optional skill and the EMS Section and Training Committee will develop a training module and a data collection and CQI packet with 100% audit of all cricothyrotomies. Dr. Rogers seconded the motion.**

Discussion: Dr. Norcross expressed concern for overuse of crics. Dr. Burger said that the subcommittee had discussed that, but she said that the only time that crics should be used is when no airway is possible. If no airway is possible, then RSI and LMA use would not be possible. Mr. Moore said that Spartanburg’s protocols are that if the patient needs a mechanical airway and they are unable to be bagged and therefore, unable to maintain an airway, only then

can cricothyrotomy be done. Dr. Norcross said that “unable to ventilate” is too close to “unable to tube”. Dr. Fuerst suggested that RSI, LMA’s and crics should be “packaged” together. Dr. Sorrell said that they shouldn’t be “packaged” together, but that if a service is going to do crics, then the EMT’s should have had training in LMA’s and RSI.

Dr. DesChamps asked Mr. Moore what Spartanburg’s step protocols for cricothyrotomies are. Mr. Moore said that, obviously, Spartanburg is not doing LMA’s or RSI. He said that once they get to the point where a patient needs a mechanical airway; after a bag valve has been attempted and after an intubation has been attempted and failed; and an airway is unable to be maintained, then the surgical cric can be used. In other words, if the patient is unable to be ventilated in any means, then the cric can be used. Dr. Burger said the use of crics should be monitored closely.

Dr. DesChamps asked Mr. Fanning to help make additions to the ambulance run report for LMA, cricothyrotomies, RSI, ET tubes and numbers of attempts. Mr. Fanning cautioned that he would try, if they had not already been printed.

Dr. Norcross said that the training and CQI for cricothyrotomies should be modeled after Spartanburg County EMS’ program.

Dr. Burger then asked to **amend her motion to read “To open up cricothyrotomies, or surgical airways, to the state level as an optional skill and the EMS Section and Training Committee will develop a training module and a data collection and CQI packet with 100% state audit of all cricothyrotomies and all services who wish to perform cricothyrotomies must already have functioning RSI and LMA skills and training.” The motion was seconded.**

Dr. Sorrell asked, if a service wants to perform cricothyrotomies, will they have to request this skill from DHEC? Dr. Burger responded, “yes” and they will have to send in their data on cricothyrotomies for review.

Dr. Carroll said that his major concern is that there will be trained, but under qualified personnel who are overanxious to perform crics.

Dr. Burger explained that there will be restrictions on who can perform cricothyrotomies: the paramedic must have been an EMT-P for 2 or 3 years and would have to be a member of that service for a certain number of years. Dr. DesChamps added that performing cricothyrotomies would be up to the local medical control.

Dr. Des Champs also clarified that the restrictions on who could perform cricothyrotomies would be in the training packet. Mr. Moore disagreed with this saying that the required experience level should be determined by the medical control physician; that it would not be right to allow only certain patients to be saved by a cric just because the paramedic on their truck was allowed to do crics, but another patient’s paramedics could not.

The Committee agreed to leave the details for the training and experience level for performing cricothyrotomies to the Training Committee and the Advisory Council.

The motion was put to a vote: five members were in favor; two were opposed. The motion passed.

Dr. Sorrell said that between the training for RSI and other airway training modules, there is a lot of overlapping airway training modules.

Dr. DesChamps suggested developing an airway training checklist. For example, if you have had ACLS, then you have already had training in certain designated skills. Dr. Sorrell said that the Training Committee should look at a way of streamlining airway training.

Staff will ask the Training Committee to review airway training for overlaps and look at ways to “streamline” this training.

Dr. Norcross said that the Airway Subcommittee also looked at the gaps in ambulance equipment regulations; i.e. the lack of a requirement for McGill forceps. Mr. Futrell explained that the DHEC Legal Department said that putting things in policy is “not worth anything legally.”

Mr. Fanning suggested that, until new regulations could be passed, a memo should be sent out suggesting the addition of the recommended equipment (McGill forceps, stylets for adult ET tubes, extra batteries and bulbs for advanced airway equipment). Mr. Fanning said that if the EMS legislation is changed in 2000, then after July 2001, we can request changes.

CRITICAL CARE PARAMEDIC PROJECT

Renee and Dave McDonald of Mobile Care Ambulance Service presented the second of the data reports from their Critical care Paramedic Pilot project. They reported that there had been 72 calls in six months’ calling for “expanded skills.” They passed out a formal report the Medical Control Committee members.

They also reported that they still have not had any difficulties in contacting medical control physicians when needed.

They said they have run a total of 1,900 calls and a total of 187 fell out for care in the CCP project. Their average transport time is 45 minutes. They reported that there has been some increase in the numbers, but they are still having difficulty in getting the word out to physicians about the program.

Dr. Des Champs asked the Committee what they felt the next step in this pilot project should be. Dave McDonald said he felt that the CCP should be treated as any other class. Dr. Fuerst questioned the training of the CCP’s to perform the skills they are allowed. He asked that if the CCP’s are acting like ICU nurses, shouldn’t these people have AA degrees?

Dr. Burger said there needs to be stringent guidelines to implement CCP programs. She said that just because two people take the CCP course, it does not make them a CCP “team.” Renee McDonald said that just because a nurse travels in an ambulance, does not mean that the patient is getting a nurse experienced in critical care. She said that the CCP program should be treated similar to doing RSI: a service interested in offering it should have to apply to the state and strict guidelines for initiating this type transport should be developed. Dr. Burger said she has concerns that services may have two paramedics who took the CCP course and will then try to pass themselves off as offering CCP transports. Dr. Sorrell said that, at this time, there does not need to be another level of certification by the state, but he is all in favor of increased education.

The Committee questioned whether the CCP pilot project should be taken off pilot project status. There have been no other requests to join the pilot project. The Committee agreed that guidelines for a CCP service should be developed; i.e. number of CCP-trained personnel per service, equipment, training guidelines, CQI guidelines so that when it was time to open up this project at a state level, there will be specific requirements. The pilot project application can be used as a base to develop these guidelines, and these guidelines would be used if any other service wants to join the pilot project.

There was then discussion about regulations and allowing nurses to travel in an ambulance and calling the ambulance run a critical care transport. There were reports of an EMS provider in the upstate hiring an off-duty nurse to ride in an ambulance so that the service could transport critical patients. Mr. Futrell and Mr. Fanning explained that this is against regulations, that if a nurse rides in an ambulance in order to transport a patient which needs additional critical care, then that nurse must come from the sending or receiving hospital and must be employed by them at the time. Dr. Burger said that this is going on in the upstate right now; she said she would give the information to Mr. Fanning.

Dr. Baker made a motion to change the Critical Care Paramedic pilot project data reports due from Mobile Care Ambulance to annual reports, rather than every 6 months. Dr. Rogers seconded the motion. The motion passed.

FURTHER CHANGES TO THE TRAUMA CENTER CRITERIA

Dr. Norcross said that after the last Medical Control Committee meeting and the review and approval of the new trauma center criteria, he had noted a few discrepancies that needed changing. He explained these to the Committee:

- **Under “Trauma Program Medical Director” in the INSTITUTIONAL ORGANIZATION section, at Level III, the requirement should be changed from “D” to “E”;**
- **On Page 4, in the FACILITIES/RESOURCES/CAPABILITIES section, Radiological Services, Computed Tomography, a footnote should be added to the requirement of an in-house CT Technician at Levels I and II, to “allow for a process to be in place to ensure immediately availability.”;**

- Also on Page 4, in the FACILITIES/RESOURCES/CAPABILITIES section, Operating Room, Age-specific equipment, the “E” requirement for X-ray capability, including c-arm image intensifier at Level III, should be changed to “D”;
- On Page 7 in Footnote 11, “Level I and II” should be added to describe the general surgeon(s);
- On Page 8 in Footnote 14, “Level I and II” should be added to describe the emergency physicians.

In Footnote 14, the Committee then discussed the ATLS requirements for emergency physicians. The Committee agreed that the footnote should be changed to clarify that current ATLS verification is required only for emergency physicians who are not board certified or board eligible in emergency medicine or general surgery.

Dr. Norcross made a motion to add the above suggested changes to the SC criteria. Dr. Burger seconded the motion.

There was then further discussion about the ATLS requirement at Level III trauma centers. The Committee generally felt that this should stand. There was further discussion about the difficulty of getting into an ATLS class. So the Committee agreed to modify Footnote 14 to read “current ATLS verification is ‘strongly encouraged’ instead of required.

The motion was amended to change the emergency physician ATLS requirement to “strongly encouraged to be ATLS verified.” The motion, including this and the earlier changes, was passed.

Dr. Norcross then explained the handout from the SC Health Alliance. Jim Walker of the SC Health Alliance and member of the Trauma System Committee, and Jay Hamm, Trauma Nurse Coordinator at Palmetto Richland, have up together a two-page “white paper” regarding the need for changes in the trauma system and the need for support for the trauma system. This paper was approved by the SCHA board for further development and for presentation to the SC Legislature. It is hoped that this will bring about some financial support from the legislature for the system.

DISCUSSION OF ON-LINE MEDICAL CONTROL PHYSICIAN TRAINING

Dr. DesChamps said that although we are now requiring initial and recertification training for offline medical control physicians, there is no training required of online physicians in the emergency rooms.

Dr. Gibbons said that SCCEP has begun discussion on providing boards in the emergency departments for important numbers and other information. He also said that they have looked into developing a 10-minute training video for emergency physicians. He said two of the problems with this are the cost, about \$10,000 to produce a video and trying to get the physicians to watch it. He said they might be able to award CME’s to watch the video.

Dr. DesChamps suggested having DHEC's media department develop the video. They can do that as a service, at no charge. He said that they have been working with George Rice to produce monthly satellite training programs for EMTs.

Dr. DesChamps said he has also encouraged EMS providers to put copies of their protocols in the ED to which they transport.

INTERFACILITY DRUG LIST

Dr. DesChamps announced that the interfacility drug form got approved and a copy is enclosed in the meeting packet. Now EMT-P's can transport any patient receiving any drug as long as the form is signed and they received a briefing.

ADULT PROTOCOLS

Dr. DesChamps said that the Committee is still in the process of revising the adult protocols. This time they will be produced in both flow chart and text form.

Dr. DesChamps said that there are questions about DNR orders. Medics ask him about what constitutes DNR: what should they do and not do? How far can you go before you violate the DNR order? The comment was made that the EMT can do any first aid and anything short of DNR. The suggestion was made that if they are in doubt, call medical control. It was agreed that DNR would mean no tubes and no blood products. Mr. Futrell said that the DNR order said you can give palliative measures which would mean that oxygen was okay.

Dr. DesChamps said that some educational information with examples should be developed. He said that this issue should be sent to the Training Committee to develop some information/training module on this. He also asked Ms. Beasley to include this topic at the next Medical Control Physician's workshop.

Dr. DesChamps said that there are new ACLS guidelines; some have changed significantly. He said that one change is that they are using Vasopressin for VFib and VTach. He said that the Committee should be looking at those soon.

OFF CAMPUS FACILITIES

Ms. Beasley said that an internal memo has been sent out, mostly about the licensing issues surrounding the freestanding emergency departments, but also saying that transport protocols should be developed in advance. Ms. Beasley said that EMS providers have brought up transport to these facilities on several occasions.

Dr. Sorrell asked who makes the decision to transport patients to these facilities, is it DHEC or whom. Mr. Futrell said it is generally a local decision.

Dr. Gibbons said the whole thing becomes an EMTALA issue. The off campus facility must provide consistent care. If you start picking and choosing who goes to these facilities and there has not been a medical screening exam, then a medical screening exam is no longer being provided consistently and this could be a problem.

Dr. Sorrell said that in Charleston, they set guidelines that in order to have emergency transports these facilities must provide the same level of care and resuscitation and must be open 24 hours a day. The 24/hour qualification eliminated some facilities.

There was much further discussion about how to determine transports to these facilities. There was no resolution to determine if the Medical Control Committee needed any action. *It was determined that this issue should be brought up at another meeting.*

REPORT ON MEDICAL CONTROL PHYSICIAN RECERTIFICATIONS

Dr. DesChamps gave a report on the recertifications of medical control physicians to date:

- 90 active medical control physicians currently
- 54 or 60% have recertified to date
- 11 recertified by means of the medical control physician workshop video
- 29 recertified by the medical control physician's workshop
- 8 recertified by reviewing and commenting on minutes
- 6 recertified by other means (usually service on or attendance at a committee meeting)

REPORT ON THE EMS RETREAT

Dr. DesChamps reported that the EMS Section held its annual retreat with several representatives from outside the division. One of the issues that was discussed was to develop a radio, wireless disaster plan for neighboring organizations. He asked if anyone had interest in serving on that subcommittee. No one volunteered.

He also asked Mr. Fanning to address the dispatch issue. Mr. Fanning said that he is sending his own survey to EMS people in each county to gather information about dispatch throughout the state. He said that we should form a committee after the survey comes back to look at how to get more training on medical dispatch completed throughout the state. He said that NENA had never completed the survey they had promised.

Dr. Gibbons said that unless there is some state money to help, it would be difficult to require medical dispatch training.

DISCUSSION REGARDING NUBAIN AS A CONTROLLED SUBSTANCE

Dr. DesChamps explained that there have been some instances of Nubain abuse. He said that there had been discussion of sending a policy around asking EMS providers to treat, store and inventory Nubain as if it were a controlled substance.

There was some discussion about the requirements of controlled substances, then Mr. Futrell asked the Committee if they had heard about the pharmacy regulations changes. Mr. Fanning said that the pharmacy changes and guidelines should take care of the Nubain problem. *Mr. Futrell also asked Dr. DesChamps to include pharmacy regulation changes in the Medical Control Physician Workshop.*

There was no resolution or agreement to take any action on this issue.

MEETING DATES OF MEDICAL CONTROL COMMITTEE

Dr. DesChamps said that consideration had been given to setting regular MCC meetings the Wednesday before each EMS Advisory Council meeting. Dr. Rogers said that most emergency departments have regularly scheduled meetings and he said this makes it easier to schedule. Mr. Fanning said that it used to be that MCC meetings were scheduled based on agenda, but now the agendas are always full.

Dr. DesChamps asked Ms. Beasley to poll the Committee members about whether to set regular MCC meetings prior to the EMS Advisory Council.

With no further discussion, the meeting was adjourned.

AGENDA ITEMS NOT ADDRESSED AT THIS MEETING:

- * Changes to Adult Protocols
 - o Additions of other protocols
 - o Clarifications of DNR orders
 - o New ACLS Guidelines/drugs
- * Announcement of a Private Helicopter Service in the Upstate
- * EMT-B transport of patients on transport ventilators (Dr. Shelton)

AGENDA/OTHER CONTINUING ITEMS NOT RESOLVED/CONCLUDED AT THIS MEETING:

- o Revision of state approved adult protocols
- o EMT-B transport of patients on transport ventilators
- o EMS transports to “off campus” medical facilities

STAFF/OTHER REPORTS DUE AT NEXT MEETING:

- o Results of Mr. Fanning’s dispatch survey
- o Results of poll of MCC members re: meeting prior to each Advisory Council

STAFF OR COMMITTEE ACTIONS NEEDED:

- Send out memo to remind EMS providers to consider use of aspirin in cardiac cases and to be sure and record “signal 80” information correctly
- Add to the ambulance run report, sections to note the use of LMA’s, RSI, cricothyrotomies and numbers of attempts
- Training Committee to review airway training for overlaps and look at ways to “streamline” this training; i.e. develop an airway training checklist
- Send out memo to recommend that EMS providers stock their ambulances with McGill forceps, stylets for adult ET tubes, extra batteries and bulbs for advanced airway equipment.
- Develop guidelines for Critical Care Paramedic services (i.e. numbers who should be trained, years of experience, CQI, etc.) (or should this wait until the pilot project is approved statewide?)