

**Medical Direction Committee
Marriott West - Richmond
April 9, 2009
10:30 am**

Members Present:	Members Absent:	Staff:	Others:
Charles Lane, M.D. Sabina Braithwaite, M.D. George Lindbeck, M.D. Stewart Martin, M.D. John Potter, M.D. Asher Brand, M.D. – Chair Allen Yee, M.D. Theresa Guins, M.D. Cheryl Lawson, M.D. Mark Franke, M.D.	Dave Garth, M.D. - Excused	Gary Brown Scott Winston Michael Berg Greg Neiman Amanda Davis Tim Perkins Tom Nevetral Beth Singer Paul Sharpe	Steve Graves –TheCornerGroup Mary Kathryn Allen Tracy Thomas Heidi Hooker Deborah Akers Tina Skinner Randall Gelderich, M.D. Randy Abernathy Chris Cannon-Norfolk Aeromed. Susan Smith- Carilion Aeromed./ Project Synergy

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
I. Welcome	The meeting was called to order at 10:30 am by Chairman Asher Brand, M.D.	
II. Introductions		
III. Approval of Minutes	The Committee approved the January 8, 2009 Medical Direction Committee Minutes.	Motion By: Stewart Martin, M.D. to accept the minutes as presented. Motion seconded by: Charles Lane, M.D. Motion... approved.
IV. New Business		
a. Aeromedical Utilization/Destination Guidelines	Susan Smith – Carilion (Lifeguard 10) Aeromedical and Chris Cannon-Norfolk (Nightingale) Aeromedical presented an overview on behalf of “Project Synergy”- One Piece of the HEMS Utilization Puzzle”. Project Synergy is a sub-committee of the Medevac Committee of the state EMS Advisory Board. HEMS programs serving Virginia will conduct chart reviews and examine patient outcomes to monitor for appropriate HEMS utilization and provide standardized follow-up education to ground EMS providers. This is a Quality Assurance initiative. <i>The intent is not to state that an over-</i>	

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	<p><i>utilization problem exists, but to be proactive, attempt to optimize the safety of all services in the state, and to dispel any rumors associated with recent attention related to over-utilization of air medical services.</i> Presently, HEMS is reviewing one piece of the puzzle which is the evaluation of trauma patients who are flown from the scene versus their discharge <24 hours. Safety and launch criteria are a “training” key in Virginia for the group.</p> <p>A question was raised by Sabina Braithwaite, M.D. “could EMS help to complete the loop?” Could the hospitals who participate in this process be encouraged to get involved with submission of IRBs (due to HIPAA issues) to look at the data. The collection of data is the key. This would assist with identifying whether HEMS is a better mode of patient transportation than via ground transportation.</p> <p>It was asked if anyone was aware of splitting the law enforcement and the medical components for aeromedical services in Maryland. It was stated that no one knew of any plans to do so.</p> <p>See the following web link for more information on 14 CFR Parts 91 and 135, Flight Into Known or Forecast Severe Icing Conditions:</p> <p>http://www.faa.gov/other_visit/aviation_industry/airline_operators/airline_safety/safo/all_safo/media/2008/SAFO08006.pdf</p>	
b. Point of Care Pilot Project	<p>Jack Potter, M.D. was on hand to share his proposed pilot program for the Lord Fairfax EMS Council region, <i>Point of Care Cardiac Markers and ECG in Pre-Hospital Environment</i>. This pilot program will evaluate the following criteria:</p> <ul style="list-style-type: none"> • Facilitate decision making to transport patients to the most appropriate hospital in the setting of acute coronary syndrome (ACS). • Decrease interval between the onset of symptoms and definitive care for patients that might otherwise initially go to non-PCI hospitals. <p>This pilot will be accomplished via utilization of pre-hospital wireless EKG and cardiac enzymes testing.</p> <ul style="list-style-type: none"> • Communications gateway installed in EMS vehicle for wireless Internet connection • Current default is cellular signal using a four (4) watt signal amplifier, but multiple alternate technologies are possible including radio frequency (requires data capable radios) or satellite. • Laptop computer connects gateway to data device (12 lead monitor or lab analyzer). • If cardiac marker is positive the hospital physician contacts the nearest typical destination hospital to discuss enzyme findings and arrange transport (I-Stat Analyzer Platform). <p>The placement of mobile wireless Internet in the ambulance with a 4 watt booster improves</p>	

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	<p>reception/transmission with a laptop computer being used as an analyzer for the 12 lead EKG. The Dell equivalent of “toughbook” laptops are being used along with a V pro chip for remote management which works as a Wi-Fi in and around the ambulance.</p> <ul style="list-style-type: none"> • 5 analyzers being used in the field on ALS ambulances • 6 month measurement end points are being evaluated <p>For additional pilot project information, please contact Jack Potter, M.D. at jpotter@valleyhealthlink.com or by phoning (540) 536-8000.</p>	<p>Motion by Stewart Martin, M.D. and seconded by Sabina Braithwaite, M.D. to endorse the pilot project...Motion passed.</p>
<p>c. NREMT I-99Transition to NREMT Paramedic</p>	<p>Tom Nevetral shared details of the proposed NREMT Intermediate Transition to Paramedic program as detailed in <i>The Registry</i>. The NREMT reports that “although I-99s are certified to perform many of the same interventions as paramedics, educators and supervisors have reported that I/99s lack the depth of knowledge of a Paramedic. Because the gap exists regarding knowledge and a few additional drugs that can be covered in a classroom, the NREMT believes the gap between the I/99 and Paramedic levels can be effectively bridged via a transition course without clinical or field internship. Although the gap of material between the I/99 and Paramedic levels hasn’t been identified, it appears this transition course may run over two or even three recertification cycles.”</p> <p>“The ultimate goal, however, is that I/99s must show completion of a transition course that bridges the knowledge gap, however broad the gap is. Once the I/99 completes this transition course he/she can take the NREMT Paramedic (written) examination up to six times. The NREMT does not plan to test I/99s for practical skills since the I/99 practical exam is almost identical to the Paramedic practical exam.”</p> <p>This proposal was presented to the Professional Development Committee (PDC) at their meeting the day before and the PDC had major concerns with the proposal. It has been rumored that the transition program may be as few as 72 hours (NREMT transition program is presently being developed by the National Association of State EMS Officials (NASEMSO). The PDC felt that allowing this transition program to occur would be undermining the Intermediate Bridge to Paramedic program that has currently been used since the 2000 Paramedic curriculum was instituted. The present Virginia Intermediate Bridge to Paramedic is approximately 450 hours including competency hours.</p> <p>Virginia has shared great success on NREMT testing since incorporating accreditation and the current bridge programs which lead to Intermediate and Paramedic certification. To lower the academic standards as presently suggested could be detrimental to the patients we serve.</p>	<p>The Professional Development Committee (PDC) made the following motion and asked that the Medical Direction Committee (MDC) support the motion: Motion By: Nick Klimenko that we have a proven EMT-Intermediate to Paramedic Bridge program in Virginia and PDC endorses this course as the way to transition in the future and not support the</p>

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	<p>After much discussion, the MDC decided that since the exact hour's requirement and other details for the proposed Intermediate Transition to Paramedic Program is not available, that they would table further action on this item and will revisit it at their next meeting.</p>	<p>proposed NREMT Transition. Seconded by Jeffrey Reynolds. Motion... Unanimously Approved.</p> <p>Issue tabled until next MDC meeting for further review.</p>
<p>d. Composition of Medical Direction Committee</p>	<p>Asher Brand, M.D. advised that he had been approached by stake holders who desired to have involvement on the Medical Direction Committee by members who were not physicians. After discussion the committee called for the question.</p> <p>Concerns can always be presented to the Professional Development Committee, which has representation from multiple groups, and also has Charles Lane, M.D. who serves on both committees as the MDC liaison. The Professional Development Committee has always worked closely with the Medical Direction Committee on various issues.</p>	<p>Motion by Jack Potter, M.D. to maintain the present committee structure consisting of physicians and it was seconded by Charles Lane, M.D...Motion passed.</p>
<p>e. Division of Educational Development Training Plan <i>Dateline 2014</i></p>	<p>Tom Nevetral reported that Division of Educational Development was working on a document that outlines the DED training plan for the next five years. Once this document is finalized it will be presented to the Medical Direction Committee for their comments.</p>	
<p>f. OMD/Agency Autonomy & Statewide Guidelines</p>	<p><u>Asher Brand, M.D. briefly reviewed the discussion held in a pre-meeting conference with Dr. Levine. There was concern among the physicians on the Medical Direction Committee regarding agency autonomy if Statewide Guidelines and triage plans are developed in such a way that they are inflexible.</u></p>	
<p>V. Old Business</p>		
<p>a. Virginia Scope of Practice Final Review & Forward to EMS Adv. Board for Action</p>	<p>The final draft of the Virginia Scope of Practice document (Procedures & Formulary) was presented for final review and comment prior to presenting the document to the state EMS Advisory Board for approval. There was some discussion on spelling errors and removing confusing phrases to better</p>	<p>1. "Lower airway mechanical" – removed - confusing and examples could not be identified.</p>

Deleted: Asher Brand, M.D. advised no further discussion was indicated on this issue.

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	<p>clarify the document. Once these issues were corrected the document had the consensus of committee with the EXCEPTION of the omission of allowing Intermediates to conduct rapid sequence induction (RSI):</p> <ul style="list-style-type: none"> • Intubation – pharmacological facilitation with paralytic • Intubation – pharmacological facilitation without paralytic (adult neuromuscular blockade) <p>After much discussion, the document was tabled until the next meeting for further review and discussion on the topic of Intermediates being allowed to perform RSI.</p> <p>Mark Franke, M.D. will bring back to the committee some data on RSI in Northern Virginia for further discussion for the next meeting.</p>	<p>2. "Intubation" – orotracheal – removed "as to age groups" and added "over age 12".</p> <p>3. "Intubation" – pediatric neonate – "up to 12 but not yet 12 but size appropriate" – removed.</p> <p>4. "Hemodynamic monitoring" – ECG acquiring – added "acquisition".</p> <p>5. "Hemodynamic monitoring" – interpretation " added – "ECG" interpretation. Omit "12 lead ECG obtain".</p> <p>6. "Other techniques" – pleural decompression – "?chest tube" – removed.</p> <p>Motion by Mark Franke, M.D. and seconded by Stewart Martin, M.D. to table the issue until the next meeting...Motion passed.</p>
<p>VI. AHA/VDH Stroke Systems Plan Update</p>	<p>Keltcie Delamar reported on the Stroke and STEMI projects: STROKE Systems of Care:</p> <ul style="list-style-type: none"> • The Virginia Stroke Systems (VSS) Task Force meets April 15. Project Teams for Web Development, Rehab, Acute/Subacute Care, the VSS Ambassador Panel, and Field EMS will report on their strategic plans for building stroke systems of care. The Field EMS Project Team has polled regions across the state and determined all are using stroke protocols, though not all consistent. • The health dept has launched a stroke social marketing campaign to support VSS goals to build community awareness. Radio, print, and TV ads are being actively promoted in the central Shenandoah area (available to view at www.virginiastrokesystems.org). 	

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	<ul style="list-style-type: none"> • The VA Hospital and Healthcare Association assisted VSS with resurvey of the stroke hospitals to determine changes in roles of the hospitals in treating stroke. The data will be used to support facilities in making improvements. Several new certified Primary Stroke Centers will be depicted on the updated Stroke Hospital Roles Map. There are at least 13 additional hospitals in VA currently preparing to apply for certification. • Copies of AHA's EMS Stroke Survey Report were shared. <p>STEMI Systems of Care</p> <ul style="list-style-type: none"> • The Virginia Heart Attack Coalition (VHAC) is the statewide coalition helping AHA to launch Mission: Lifeline, the national initiative to drive STEMI systems of care. A statewide summit is planned for Saturday, May 16 to bring together stakeholders to begin addressing regional team development. Registration is open at www.vcacc.org until April 30. • VHAC Project Teams are being formed, including Data & Outcomes, Field Adaptations/Toolshed, Web Development, and Regional Team Development. 6 regions have been identified in the state, loosely following the hospital association's trauma regions. • STEMI systems are being identified, including several that are Council-wide, and many other smaller natural systems. Systems have the opportunity to register online with Mission: Lifeline. 4 systems are registered in VA so far. • AHA's EMS STEMI Survey results have been released, with several disclaimers including imperfect data collection methods, though the survey still can provide broad overview information. Nationally it revealed a higher level of 12-lead equipment in the field than expected. The survey is slated for publication. (Copies were available for review.) • AHA Mission: Lifeline has finalized criteria for ideal STEMI systems of care (copies shared). Criteria may be fine-tuned based on feedback after rolling out for implementation by the field. Available online at http://www.americanheart.org/presenter.jhtml?identifier=3061630. • AHA is pursuing development of a PCI certification similar to stroke center certification, to be administered by an independent party such as The Joint Commission or The Society of Chest Pain Centers. • Mission: Lifeline is seeking funding to provide regional coordinators who will support implementation at the grassroots level. Funding goal for the Mid-Atlantic Affiliate is for \$5.7 million, with \$280K raised so far in this affiliate (\$300K nationally). 	
VII. Trauma Triage Report	Paul Sharpe advised that the Trauma Triage Plan must be approved every three years and he will share the reports with the Medical Direction Committee for their information.	
VIII. State OMD Report		
a. Statewide Guidelines &	George Lindbeck, M.D. advised that he would like to establish a sub-committee to work on	

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<p>Drug Boxes</p> <p>b. Statewide/Regional STEMI Initiatives</p> <p>c. On-line Medical Direction</p>	<p>establishing Statewide “guidelines” and drug boxes to standardize the treatment of patients across the Commonwealth. The drug box group would consist of providers, physicians, pharmacists, hospital administrators, etc. to better involve the decision makers in this process.</p> <p>The Office of EMS has been involved in this initiative. The <u>Mission: Lifeline Bridging Form</u> is being developed for use of STEMI Referral Hospitals and will focus on abbreviated STEMI emergency treatment, process times, and discharge data.</p> <p>EMS should develop “prearranged EMS destination protocols for STEMI patients.” As well as maintaining a standardized algorithm for evaluating and treating patients with symptoms suggestive of myocardial ischemia.”</p> <p>George Lindbeck, M.D. advised that “on-line medical direction” is handled differently across the Commonwealth from hospital to hospital. He is going to institute a hospital based survey to determine how hospitals provide “on-line medical direction”. Dr. Lindbeck also reminded the committee members to utilize the medical directors discussion board (http://vaems.org/meddir)</p>	
<p>IX. EMS Training Funds & Accreditation Update</p>	<p>Chad Blosser made the following report:</p> <p><u>Accreditation</u> The accreditation program is starting to see a lot more activity now that we have reached the point where sites are beginning to have to go through reaccreditation.</p> <p>The Center for EMS, Inc. in Portsmouth and Rappahannock EMS Council in Fredericksburg have applied for and received state paramedic accreditation. The UVa Prehospital program, Center for Emergency Health Services, Inc., and Central Shenandoah EMS Council are all up for reaccreditation over the next 9 months.</p> <p><u>EMSTF</u> As of March 27th, the EMSTF program reached its contracting threshold of \$3 million. The Office is no longer accepting or approving EMSTF contracts for the remainder of the fiscal year. New contracts will be available beginning sometime in late May or early June for FY10.</p> <p>Statistics for the program for FY09 are listed below:</p>	

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	<table border="1" data-bbox="438 339 1251 600"> <thead> <tr> <th></th> <th>Commit \$</th> <th>Payment \$</th> <th>Balance \$</th> </tr> </thead> <tbody> <tr> <td>Fiscal Year 2009</td> <td>\$3,060,778.50</td> <td>\$1,174,072.74</td> <td>\$1,886,705.76</td> </tr> <tr> <td>40 BLS Initial Course Funding</td> <td>\$799,752.00</td> <td>\$454,253.37</td> <td>\$345,498.63</td> </tr> <tr> <td>43 BLS CE Course Funding</td> <td>\$113,400.00</td> <td>\$44,511.27</td> <td>\$68,888.73</td> </tr> <tr> <td>44 ALS CE Course Funding</td> <td>\$304,080.00</td> <td>\$67,726.50</td> <td>\$236,353.50</td> </tr> <tr> <td>45 BLS Auxiliary Program</td> <td>\$68,000.00</td> <td>\$13,360.00</td> <td>\$54,640.00</td> </tr> <tr> <td>46 ALS Auxiliary Program</td> <td>\$852,000.00</td> <td>\$121,002.25</td> <td>\$730,997.75</td> </tr> <tr> <td>49 ALS Initial Course Funding</td> <td>\$923,546.50</td> <td>\$473,219.35</td> <td>\$450,327.15</td> </tr> <tr> <td>(Not Categorized)</td> <td>\$0.00</td> <td>\$0.00</td> <td>\$0.00</td> </tr> </tbody> </table> <p data-bbox="359 623 1297 695">A disturbing trend has started with the EMSTF program. Recently, there have been a number of reports which have come into the Office from across the state regarding the actions of a few EMT-Instructors.</p> <p data-bbox="359 721 491 743"><u>The Problem</u></p> <p data-bbox="359 769 1308 889">There are several Instructors/Coordinators who are not pleased with the contract requirement that "...Students must be affiliated with a Virginia licensed EMS agency at the time they become certified in order for the Contractor to be eligible to receive payment for said student." In an effort to ensure a full payout on their EMS Training Funds contract, said instructors are resorting to misleading and oftentimes deceitful ways to obtain the full value of the contract.</p> <p data-bbox="359 915 1251 987">The Office considers such actions and "work-arounds" to be falsification of records to the Office of EMS. As we learn about such nefarious activity, we are reporting said activity to the Manager of Regulation and Compliance and requesting a formal investigation.</p> <p data-bbox="359 1013 1329 1058">As contractors in the EMS Training Funds program, each instructor signs a contract which is a legally binding document. In that contract there is a provision in Section V.B.3 which reads in part:</p> <p data-bbox="359 1084 1329 1209"><i>"This Contract may be terminated for cause by the Purchasing Agency. For purposes of this paragraph, "for cause" includes violating the terms of this Contract, the submission of falsified records to the Purchasing Agency, or the distortion, forgery or misrepresentation of information to the Purchasing Agency, EMS Providers or students. Termination for cause may result in the Purchasing Agency refusing to entertain contracts from Contractor for a period of five (5) years. If the</i></p>		Commit \$	Payment \$	Balance \$	Fiscal Year 2009	\$3,060,778.50	\$1,174,072.74	\$1,886,705.76	40 BLS Initial Course Funding	\$799,752.00	\$454,253.37	\$345,498.63	43 BLS CE Course Funding	\$113,400.00	\$44,511.27	\$68,888.73	44 ALS CE Course Funding	\$304,080.00	\$67,726.50	\$236,353.50	45 BLS Auxiliary Program	\$68,000.00	\$13,360.00	\$54,640.00	46 ALS Auxiliary Program	\$852,000.00	\$121,002.25	\$730,997.75	49 ALS Initial Course Funding	\$923,546.50	\$473,219.35	\$450,327.15	(Not Categorized)	\$0.00	\$0.00	\$0.00	
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	<p><i>submission of falsified records or the distortion, forgery or misrepresentation of information is discovered after disbursement of funds, Contractor must return all funds disbursed. Nothing in this section shall be construed to prohibit the Purchasing Agency from taking legal action against the Contractor."</i></p> <p>The Office of EMS takes seriously its responsibility for managing all monies under its budgetary control...this includes the EMS Training Funds program. The goal of the EMSTF program is to supplement instructors for the time, effort and equipment needed in order to conduct EMS training programs across the Commonwealth. This outcomes based program has an excellent track record and has been extremely successful in assisting with the overall recruitment and retention of EMS providers across the state.</p>	
X. ALS Programs Report	<p>Tom Nevetral reported that several EMS providers have called the Office interested in the NREMT Intermediate Transition to Paramedic process and were inquiring about the process to sit for the NREMT Intermediate examination. The Office has been advising them that there is a process for Virginia Intermediate's to sit for the NREMT that was developed in 2002. They are encouraged to sit for the NREMT Intermediate examination. However, they are also being told that Virginia has not approved the NREMT Intermediate Transition to Paramedic proposal.</p> <p>On August 7th Mr. Greg Margolis, Associate Director of NREMT will be available to respond to questions from the members of the Governors Advisory Board, regional EMS councils and ALS- Coordinators prior to the August Governor's Advisory Board meeting.</p> <p>The Office will better market the process for Virginia EMT-Basics who wish to become NREMT EMTs. It was suggested by the Professional Development Committee to develop a memo similar to the one that is handed out at the NREMT Intermediate & Paramedic test sites describing the process to become eligible for NREMT Basic testing.</p>	
XI. BLS Programs Report	<p>Greg Neiman reported that the Office completed an EMT Instructor practical examination with 19 candidates completing the examination. He advised that there will be an EMT Instructor Institute in Blacksburg from June 13 - 17th. The new BLS Practical examination will be rolled out on September 1st.</p> <p>Charles Lane, M.D. reported that the Professional Development Committee addressed an issue that was occurring where EMT Instructors were advising their students to mark their Virginia EMS certification applications with an agency number so that the EMT Instructors could receive the higher value for EMSTF re-imbursement based on agency affiliation. This issue is being addressed by the</p>	

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	Office of EMS with all Instructors.	
XII. Regional EMS Council Report	None	
XIII. Public Comment	None	
XIV. For the Good of the Order	There is an ACEP Meeting scheduled for Boston, MA October 5—8, 2009 that conflicts with the scheduled October 8 th MDC meeting. How do we proceed with the date?	Meeting Dates: <ul style="list-style-type: none"> • July 9, 2009 • October 8, 2009
XV. Adjourn	Motion to adjourn at 3:35 PM.	