

**Medical Direction Committee
 Comfort Suites Virginia Center Commons
 July 9, 2009
 10:30 am**

Members Present:	Members Absent:	Staff:	Others:
Charles Lane, M.D. Sabina Braithwaite, M.D. George Lindbeck, M.D. Scott Weir, M.D. Stewart Martin, M.D. Jack Potter, M.D. Asher Brand, M.D. – Chair Dave Garth, M.D. Allen Yee, M.D. Theresa Guins, M.D.		Gary Brown Scott Winston Michael Berg Beth Singer Greg Neiman Amanda Davis Tim Perkins Paul Sharpe Tom Nevetral Beth Singer Chad Blosser Warren Short	Randall Gelderich, M.D. Randy Abernathy Jo Richmond Larry Oliver Jeff Meyer Mary Kathryn Allen Holly Frost Dave Cullen Dana Love Dan Fermil Jimmy Gray

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
I. Welcome	The meeting was called to order at 10:45 AM by Chairman Asher Brand, M.D.	
II. Introductions		
III. Approval of Minutes	<p>The Committee approved the April 9, 2009 Medical Direction Committee Minutes.</p> <p>The Chair approved a request to alter the order of the Agenda.</p> <p><u>(Correction to the minutes)</u> - Dr Weir voiced concern regarding the potential for unintended consequences accompanying the centralization of Medical Direction. These included the following</p> <ul style="list-style-type: none"> • Diminished perception of responsibility at the level closest to the delivery of patient care – EMS service represents the provision of prehospital patient care. A patient relationship exists between the EMS agency, the EMS providers and the Agency medical director. Patient-caregiver responsibilities and obligations accompany that relationship. EMS providers, EMS Agencies and EMS medical directors who do not view the patient care protocols as consistent with their interpretation of the available EMS-related literature may perceive protocols authored remotely from the point of care as a partial transfer of patient 	<p>Motion By: Stewart Martin, M.D. to accept the minutes as presented.</p> <p>Motion seconded by: Jack Potter, M.D. Motion... approved.</p> <p>See correction to the minutes</p>

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	<p>care responsibility to that remote entity. This has the potential to diminish the conscious and/or subconscious commitment to the relationship, responsibilities and obligations – at least in terms of time, effort, and sweat equity.</p> <ul style="list-style-type: none"> ○ Corollary – A diminished capacity to positively impact the provision of prehospital patient care and an excessively diminished sphere of influence may serve as significant disincentive adversely impacting both recruitment and retention. • Diminished opportunities to promote discussion and collaboration between EMS agencies and Hospitals/Health Systems – soliciting input from Hospitals/Health Systems during review and revision of protocols promotes communication across the continuum of care and integrates domains of care delivery. These opportunities may be adversely impacted. • Most all share the common objective of evidence-based prehospital patient care protocols where high quality evidence exists. The methods used should not adversely impact other parallel and related objectives. These potential adverse or unintended consequences can certainly be prevented or at least mitigated, as long as we are aware of their existence and committed to addressing them. 	
<p>IV. AHA/VDH Stroke Systems Plan Update</p>	<p>Paul Sharpe delivered the update for the stroke systems plan in the absence of Keltcie Delamar as follows: <u>Stroke</u></p> <ul style="list-style-type: none"> • Virginia Stroke Systems Task Force (VSSTF) is interested in supporting the transition to NEMSIS in any way they can – Paul Sharpe will provide a demonstration at the task force meeting on July 15. • The VSSTF Field EMS Project Team is working by request of the task force on drafting an initial EMS state stroke plan, to be reviewed by the full task force and then submitted to MDC for their input. • The Stroke Hospital Roles Map has been updated to reflect results of the Fall 2008 hospital survey. Level 2 is no longer synonymous with Primary Stroke Center (PSC) certification but the PSC’s are clearly marked on the list in red. This strategic planning tool will be posted and downloadable from the VSS web site: www.virginiastrokesystems.org within the next few weeks. • AHA is in the process of developing a funding proposal to help hospitals achieve Primary Stroke Center status through use of the “Get With The Guidelines – Stroke” quality improvement tool. A number of the targeted hospitals are in areas of the state where the Stroke Hospital Roles Map shows gaps; their participation will depend on willingness to commit to sustainability of gains realized through the project. Development of an alliance of hospital stroke coordinators this fiscal year will help support this project, and systems improvements in all hospitals across the state through a mentoring approach. 	

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	<p><u>STEMI</u></p> <ul style="list-style-type: none"> • The Mission Lifeline Virginia Heart Attack Coalition (ML-VHAC) Summit in May was highly instrumental in engaging stakeholders across the state. The group has: <ul style="list-style-type: none"> • Established 6 regions encompassing the entire state, and achieved initial formation of regional teams in each • Identified and prepared team leads/co-leads (Champions) for each of the 6 regions • Gained the public support of the Commissioner of Health, Dr. Karen Remley, and her commitment to support the project, including use of state resources in epidemiology and vital records. • Begun identification of additional existing STEMI systems throughout the state who can register at the national level for Mission: Lifeline <ul style="list-style-type: none"> **EMS systems driving regional efforts that involve the providers in their service areas (PCI and non PCI) can register, demonstrating the leadership EMS is taking to help drive improvements. Register (free) at http://www.americanheart.org/presenter.jhtml?identifier=3050213 • Developed an initial web portal for VHAC to help direct local implementation, with numerous linkages available resources: www.virginiaheartattackcoalition.org. It will be fleshed out over time as additional resources are identified. • AHA continues to work on securing a national agreement, likely with The Joint Commission or the Society of Chest Pain Centers, to collaborate on development of a hospital certification program for hospitals, to help establish defined common standards for quality of care at PCI centers. 	
<p>Trauma Triage Plan</p>	<p>Paul Sharpe gave an update on the <i>State Trauma Triage Plan</i>. Paul advised that the plan is required to be reviewed triennially by the Office of EMS. After Paul's presentation, Asher Brand, M.D. Chair had some concerns:</p> <ol style="list-style-type: none"> 1. <i>Localities do not have the flexibility to adjust the Plan to accommodate issues within their jurisdictions.</i> The plan states "Emergency Medical Services (EMS) Agencies are required by EMS Regulation 12 VAC 5-31-390 to follow triage plans" yet there is no flexibility allowed to address regional/local trauma issues. <p>Mr. Sharpe advised that requests for regional/local changes can be submitted with the council contracts and justified changes could be instituted.</p>	<p>Motion made by Jack Potter, M.D. and seconded by David Garth, M.D. to have Asher Brand, M.D., Chair, write a letter to the State EMS Advisory Board, in collaboration with other Medical Direction</p>

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	<p>2. <i>Process for revision of the Plan was questioned since input from the Medical Direction Committee was not requested.</i></p> <p>Mr. Sharpe advised that the Health Commissioner approved the process. Mr. Sharpe stated that the Office of EMS will consider a change in the way that the process is currently conducted.</p> <p>The Medical Direction Committee felt that the Professional Development Committee as well as the Medical Direction Committee should have input on the plan in the future.</p>	<p>Committee members, outlining the committee's concerns with the State Trauma Triage Plan as presented. Motion...passed.</p>
V. New Business		
<p>a. WDC Standards of Excellence Tier I Equipment Standards (Accreditation) Presentation</p>	<p>Dana Love made a presentation on behalf of the WDC Standards of Excellence Tier I Equipment Standards (Accreditation) Committee outlining that their committee was working towards establishing criteria for voluntary accreditation for equipment that should be carried on ambulances. The purpose in addressing the Medical Direction Committee was "to conduct a review and seek advice and counsel from the Medical Direction Committee regarding the committee's interpretation of the formularies and other best practices as they relate to equipment needed on ambulances to provide the current standard of care, as it may be defined by different bodies."</p> <p>Medical Direction Committee advised on several items where it was determined that the WDC Standards of Excellence Committee needed to re-think the need. Examples noted, but not limited to:</p> <ul style="list-style-type: none"> • CPR Assist Device • Wheeled assist ambulance cot 	<p>Scott Weir, M.D. agreed to work with the Standards Committee on issues requiring medical decisions.</p>
<p>b. Virginia Protocols (Best Practices) Discussion</p>	<p>Item deferred to discuss with Virginia Scope of Practice</p>	
<p>c. Board of Pharmacy Regulations</p>	<p>Asher Brand, M. D. inquired about the Board of Pharmacy requirements for "iced saline" in the treatment of hypothermia? It was noted that if the item were not part of the drug box then a Controlled Substance Registration (CSR) permit was required.</p>	
<p>d. MDC Component of State EMS Plan</p>	<p>The Office is in the process of updating the State EMS Plan and is requesting feedback from the Medical Direction Committee to review the mission, vision and to submit 3-4 core objectives for the plan. The following document was submitted to the Office by the Medical Direction Committee.</p> <p style="text-align: center;">MEDICAL DIRECTION COMMITTEE State EMS Plan Update July 9, 2009</p>	

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	<p>MISSION: The Medical Direction Committee will review and recommend guidelines and/or standards to assist EMS agencies, providers and physicians with medical procedures. It shall provide guidance to the EMS system with medical oversight, specifically in the areas of protocols, on-line medical direction, system audits, quality improvement and the improvement of patient care.</p> <p>VISION: To maximize the EMS provider and stakeholder value through world class practices To lead by example through a commitment that empowers the committee at every level to strive for the highest levels of quality, patient care and stakeholder value.</p> <p>CORE OBJECTIVES:</p> <p><i>Expand availability of Quality EMS Training.</i> - Align <u>all</u> Initial EMS educational programs to that of other allied health professions to promote the professionalization of EMS by assuring competent entry-level providers by having all EMS programs accredited and accreditation at the EMT level as an option.</p> <p><i>Enhanced Competency Based Training Programs.</i> -Continue to explore substituting the practical examination with successful completion of a recognized competency-based training program conducted by an accredited site and the use of computer technology for written examinations.</p> <p><i>Promote Quality and Evaluation.</i>- Update the Quality Improvement and certification processes, using subject matter experts, the <i>Virginia Scope of Practice, EMS Education Standards</i> and <i>AEMS Council Practice Analysis</i> to promote valid, psychometrically sound, and legally defensible certification process.</p> <p><i>Develop Partnerships with Stakeholders.</i> - Promote collaborative activities between local government, EMS agencies, hospitals and community colleges to support more community based EMS programs which lead to increased recruitment and retention of certified EMS Providers.</p> <p><i>Develop and Coordinate Patient Care Guidelines & Formulary</i> – Provide expert opinion to regional Medical Directors, agency Medical Directors and agency personnel as a resource as they develop their Patient Care Guidelines/Protocols.</p>	
VI. Old Business		
a. Virginia Scope of Practice – Procedures & Formulary	The <i>Virginia Scope of Practice – Procedures & Formulary</i> DRAFT dated April 9, 2009 was presented for final comment prior to being submitted to the State EMS Advisory Board for final review.	Motion by Sabina Braithwaite, M. D. to accept the Virginia Scope of

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	<p>A discussion involved Intermediate's in Northern Virginia who were allowed to perform RSI. The proposed Scope of Practice allows RSI at the paramedic level only. The statement was made that there is no known Intermediates in the country performing RSI except in Northern Virginia. "Maybe that should be telling us something."</p> <p>It was also stated that the Medical Direction Committee previously approved CT/Intermediates to utilize RSI under specific training and medical control. It was further stated that medicine changes and procedures need to be withdrawn and added as the medical science indicates.</p>	<p>Practice as presented. There was no second...motion dies for a lack of a second.</p> <p>Stewart Martin, M.D. made a motion to accept the <i>Virginia Scope of Practice Procedures & Formulary</i> document as a "practice maximum and educational minimum" along with the stipulations that the document be reviewed annually by the Medical Direction Committee with recommendations for modifications to be submitted to the State EMS Advisory Board and then submitted for approval by the VDH Board of Health. The provider must have appropriate education for any skill or medication that is permitted by the Agency OMD. Motion seconded by Jack Potter, M.D. Motion approved... with one dissent.</p>
<p>b. NREMT I-99 Transition to NREMT Paramedic</p>	<p>The National Association of State EMS Officials has released <i>the 2009 National EMS Education Standards Gap Analysis Template</i> that can be used by States to identify skills, content, and new course considerations not included in the previous National Standard Curricula.</p> <p>Virginia has a proven program for transitioning Intermediates to Paramedics that has been in effect for years (Intermediate Bridge to Paramedic Program).</p> <p>Larry Oliver, Chair of the Professional Development Committee (PDC) addressed the committee</p>	

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	emphasizing the concerns that PDC had with any consideration of the proposed NREMT Intermediate to Paramedic Transition Program.	
VII. Trauma Triage Report	Report delivered above as part of IV.	
VIII. State OMD Report		
a. Statewide Guidelines & Drug Boxes	George Lindbeck, M.D. advised that he was progressing on establishing two committees of stakeholders to address statewide treatment guidelines and a formulary.	
b. Statewide/Regional STEMI Initiatives	George Lindbeck, M.D. requested feedback on his Statewide/Regional STEMI Initiatives document that was sent out to committee members. A concern was expressed about the push for utilization of 12 lead devices on all ALS units and the cost incurred. No time line was suggested to accomplish this initiative and it could be accomplished as funding permitted.	
c. On-line Medical Direction	Work is occurring on determining how on-line medical direction occurs across the Commonwealth in hope of standardizing the process.	
IX. EMS Training Funds & Accreditation Update	<i>Emergency Medical Services Training Funds Summary & Accredited Training Site Directory</i> are attached.	
X. ALS Programs Report	Tom Nevetral reported that an ALS-Coordinator Meeting will be held Friday July 10, 2009 at Jefferson College of Health Sciences in Roanoke. There will also be an ALS-Coordinator Seminar (Administrative Program) on Saturday July 11 at Jefferson College of Health Sciences in Roanoke where 37 candidates have registered to attend.	
XI. BLS Programs Report	Greg Neiman reported that EMT Basic Pilot Practical exams have been progressing well towards the September 1, 2009 implementation deadline.	
XII. Regional EMS Council Report	None	
XIII. Public Comment	None	
XIV. For the Good of the Order	None	

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XV. Adjourn	Motion to adjourn at 4:15 PM.	

DRAFT