Medical Direction Committee
OEMS 1041 Technology Park Drive, Glen Allen
October 8, 2009
10:30 am

Members Present:	Members Absent:	Staff:	Others:
Charles Lane, M.D.		Gary Brown	Greg Rauch
Allen Yee, M.D.		Scott Winston	Heidi Hooker
George Lindbeck, M.D.		Michael Berg	Jerry Andrews
Stewart Martin, M.D.		Greg Neiman	Jeff Meyer
Scott Weir, M.D.		Tom Nevetral	Kate Passow
Asher Brand, M.D.		Chad Blosser	Daniel Kim
Theresa Guins, M.D.		Warren Short	Dave Cullen
Marilyn McLeod, M.D.			Keltcie Delamar
Mark Franke, M.D.			Wayne Woo
James Dudley, M.D.			Mary Kathryn Allen
Cheryl Lawson, M.D.			Scott Winston
			Greg Cassis
			David Cullen
			Debbie Akers

Topic/Subject	Discussion	Recommendations, Action/Follow-up; Responsible Person
I. Welcome	The meeting was called to order at 10:35 AM by Chairperson Asher Brand, M.D.	
II. Introductions	Asher Brand, M.D. requested that everyone introduce themselves.	
III. Approval of Minutes	Minutes were requested to be corrected to reflect comments by Scott Weir, M.D. and Allen Yee, M.D. ***Amendment to previous meeting (July 9, 2009)*** - Dr Weir voiced concern regarding the potential for unintended consequences accompanying the centralization of Medical Direction. These included the following • 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	**July 9, 2009 minutes will be corrected and reviewed at the January 21, 2010 meeting.**

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	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 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. o 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.	
IV. AHA/VDH Stroke Systems Plan Update	AHA/VDH Stroke Systems Plan Update ▪ Virginia Stroke Systems Task Force, appointed by health dept, working on a number of nationally developed progress markers to drive improvements in stoke systems of care: o Developing position on expansion of window of treatment for tPA to help guide hospitals treating stroke in VA o Developing a stroke coordinator's consortium to build networks between providers and serve as a forum to share best practice. Have secured 410K grant from VA Dept of Health Heart Disease and Stroke Prevention Project to fund the consortium. o Updated Stroke Hospital Roles Map now posted online at VSS website: www.virginiastrokesystems.org – depicts certified Primary Stroke Centers (PSC) and roles of other VA hospitals treating stroke based on self-reported data (not tied to quality of care). o At least 3 small VA hospitals currently preparing or pursuing PSC certification thru the use of telemedicine, a very viable mechanism to deliver stroke care. None certified yet.	**A question was raised by Scott Weir, M.D. inquiring if anyone had "extended the stroke patient window?" 3 hour window extended to 4.5 hours (Northern VA EMS) and 3 hour to 6 hours (Blue Ridge EMS).**

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	o Field EMS Project Tam still working on draft of stroke plan to bring field perspective to the national guidelines in addressing the EMS legislation passed last year.	
V. New Business		
a. Alternatives to Statewide Guidelines – Recommendations to State EMS Advisory Board: **i. OMD accountability** **ii. Promoting Uniformity** **iii. Disciplinary Pathway for OMDs & Agencies with Unsafe Medical Protocols**	Deferred agenda items under a. to number 8 below.	
b. Discussion of Statewide Triage Schemes **c. Implications of State EMS Advisory Board Rejection of Trauma Triage Plan**	The State EMS Advisory Board August 7, 2009 meeting defeated a motion to adopt the presented *Statewide Trauma Triage Plan.* Asher Brand, M.D. requested that the Medical Direction Committee review the *Statewide Trauma Triage Plan* so that comments could be made to the Chair of the Trauma Oversight & Management Committee and then forwarded to the State EMS Advisory Board at their next meeting. The recommendations are noted in the attached plan (see attached *Statewide Trauma Triage Plan)* with modifications.	**MOTION: Made by Stewart Martin, M.D. and seconded by Scott Weir, M.D. to forward the recommendations by the Medical Direction Committee on Statewide Trauma Triage Plan to the State EMS Advisory Board. Motion… approved.**
d. Absentee Voting Ballots for EMS Personnel	Tom Nevetral reported that EMS providers along with law enforcement and fire personnel could submit absentee ballots. More information was available on the OEMS web site www.vdh.virginia.gov/oems	
VI. Old Business Workforce Development	No report.	

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Committee (WDC) Standards of Excellence Tier 1 Equipment Standards Presentation		
VII. Research Requests	Mark Franke, M.D. made a presentation on Intermediates who are participating in advanced airway procedures within the department conducting Rapid Sequence Induction (RSI) for adults & children and surgical cricoidthyroidotomies. Mark Franke, M.D. summarized the training program that both Intermediates and paramedics must participate in. ALS providers take eight (8) hours of additional airway training; six (6) months of internship and physician directed continuing education (CE) twice annually. All RSI and endotracheal intubations are documented through a stringent QA survey tool and reviewed by the EMS Captain and Mark Franke, M.D. Physician confirmation of the proper placement of the airway at the receiving hospital. There is an annual review of the advanced airway skills performed. In 2009 there have been 47 intubations and 2 cases where the patient could not be intubated with one patient requiring a surgical airway. In the second difficult airway a King airway was placed with no adverse airway affect. Over one-third of the forty-seven intubations involved RSI. Since the introduction of CPAP, endotracheal intubations have been reduced by one-third. (King airway has replaced the LMA in the field). The department introduced the Bougie with the paramedics and Intermediates utilizing it about 50% of the time to utilize and retain their airway skills. Surgical airways are practiced utilizing deer airways which replicates the human airway extremely well. Present staffing consists of fifty-three (53) ALS providers (medics) with 25% being Intermediates and 75% being paramedics. There was no significant difference in the success of Intermediates versus Paramedics. There are three ALS providers on the scene with maximum attempts per medic limited to two attempts at endotracheal intubation. Discussion followed on who should be pushing the RSI medications and who should be performing the intubation. Mark Franke, M.D. questioned why he would instruct a new paramedic who had just completed his preceptor program and minimal field experience to intubate when he had an Intermediate with ten years field experience partnered with him?	**MOTION: Made by Mark Franke, M.D. to conduct a two-year pilot study to allow**

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	Scott Weir, M.D. advised that his agency transports to the same hospitals but they do not allow their Intermediates to RSI and they could be utilized as a control group, if necessary.	**Intermediates to perform RSI and surgical airways and to report back to the Medical Direction Committee with data. Data will be shared with the Medical Direction Committee at the one year mark (October 2010 meeting). Motioned seconded by Stewart Martin, M.D… 8 yeas, 3 nays…Motioned passed.**
VIII. State OMD Issues – George Lindbeck, M.D. **a. Statewide Guidelines & Formulary Workgroups**	a. George Lindbeck, M.D. advised that the Statewide Guidelines Workgroup met at the Office of EMS on September 23. The committee discussed various methods to address this issue. A reading file was distributed for review prior to the next meeting. The possibility of establishing virtual (webinars) meetings was discussed and is being pursued as a possibility to embrace all parts of the Commonwealth. Asher Brand, M.D. made the comment that the Medical Direction Committee (MDC) should move forward in a parallel and complimentary effort to the Statewide Guidelines Committee's efforts. MDC should facilitate as a resource, to EMS agencies and regional EMS councils, along with offering opinions on the guidelines and formulary (drug box) and should develop a pathway for disciplinary actions. Asher Brand, M.D. feels that the Statewide Guidelines should be deposited in a third party entity (ACEP, etc.). Allen Yee, M.D. stated that the Medical Direction Committee needs to support the Statewide Guidelines & Formulary projects to move this project along. George Lindbeck, M.D. states that he feels there are guidelines which require specific criteria (guidelines) but probably 97% do not require a specific re-write from what is presently practiced. Philosophical discussion ensued and Allen Yee, M.D. suggested: 1. Identify the process that is appropriate (resource document). 2. Limit the process that is bad. b. George Lindbeck, M.D. presented the DRAFT STEMI document and made recommended changes.	George Lindbeck, M.D. supplied an article on Trauma Triage which can be viewed at: http://www.cdc.gov/mmwr/PDF/rr/rr5801.pdf **George Lindbeck, M.D. will develop goals & objectives to be shared with the Medical Direction Committee before their January 14, 2010 meeting.** **Motion: Allen Yee, M.D. made a motion to have the Statewide Patient Care Guidelines workgroup create a document of patient care guidelines. Medical Direction Committee is in support of this document as a platform for minimum guidelines. Seconded by James Dudley, M.D. Motion…passed.**

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b. Statewide & Regional STEMI Initiatives	Statewide and Regional STEMI initiatives
	▪ Health Commissioner Remley has blessed the efforts of the Mission Lifeline-Virginia Heart Attack Coalition and made resources of the health department's epidemiology and vital statistics available.
	  o ML-VHAC Task Force currently evaluating formats and data points that the Dept of EPI will track.
	▪ Funding is being pursued by AHA Mission Lifeline with several potential sources in progress, and one gift of $50K secured in NoVa/DC most likely to be restricted for EMS training. Primary ML funding goal is to fund ML Director positions to help bring resources to the provider level
	  o With no ML Directors funded yet, we are positioning Regional Leads (volunteers) to implement parts of this so we can help move systems forward based on national criteria
	▪ The task force is evaluating the draft STEMI Position Paper to help make sure the field perspective is addressed (as a concept paper, not a state plan). There have been no objections; both AHA and ACC support the document.
	▪ Web site is under development and will serve as a resource and education portal (linked to AHA Mission Lifeline) www.virginiaheartattackcoalition.org.
	  o ML-VHAC has created a map (posted on web site) that shows based on best information available where the 24/7 PCI providers are in the state – goal is to help identify where STEMI systems are operating, either organized or under development.
	▪ AHA EMS provider course for 12-lead ECG has been released: Learn Rapid STEMI ID – we are evaluating options to make discounts available to the field. Completion of course makes the provider eligible for voluntary recognition by AHA ML.
	
	(NOTE :) The STEMI map was discussed heavily prior to adoption.
		Motion: Stewart Martin, M.D. made a motion to endorse the Statewide/Regional STEMI Initiatives document. Seconded by Marilyn McLeod. Motion…passed.
		
		See the attachment "*EMS and STEMI*" document that was approved.

c. On-line Medical Direction	c. Deferred discussion to next meeting.	
d. H1N1 Tool Kit	d. H1N1 Tool Kit for EMS Administrators has been developed for Operational Medical Directors. Statement made that hospitals have to be made aware to have vaccines available for EMS provider inoculations. Allen Yee, M.D. inquired about the reassurance that hospitals have identified the need to make available the vaccine to EMS providers. Warren Short advised that he would take the concern back to Karen Owens who is the	**Allen Yee, M.D. made a motion to adopt the recommendation from the Office of EMS to remove from the Virginia Scope of Practice procedures, the word "Vaccines" as it is confusing to agencies and providers to have it listed. The Health Commissioner can approve this task for EMS in the event of a declared emergency. Motion seconded**

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	OEMS H1N1 Coordinator.	**by Charles Lane, M.D. Motion …passed.**
IX. RSAF Grants Review	Tom Nevetral advised that RSAF would like a definitive decision from the Medical Direction Committee to better guide the RSAF committee on the grading of grants for the Autopulse. Typically graded low for RSAF grant applications.	
X. EMS Training Programs & Accreditation Update – Chad Blosser	Chad advised that the Office was out of money for the EMS Training Funds (EMSTF) for the remainder of the year.	
XI. ALS Programs Issues – Tom Nevetral	PES has completed the Atlantic EMS Council Practice Analysis and the Division of Educational Development is presently reviewing the document. It will be posted on the OEMS web page soon.	
XII. BLS Programs Issues - Greg Neiman	Greg Neiman advised that there will be an EMT Instructor Institute held on October 10-14, 2009 for 12 candidates along with an EMS Instructor Update on Saturday. EMT-Instructor pre-tests should resume October 31, 2009. The start date on a Course Approval request can be shifted if the course has not yet begun and it is less than a thirty day change. Dates requested to be moved beyond thirty days will review a new Course Approval	**The Professional Development Committee (PDC) approved a motion to adopt an option that would allow basic providers to be awarded in Area 10 (2 hours of Automated External Defibrillation) the ability to attend continuing education in the topic of OB/gynecological emergencies to be utilized to meet all or part of Area 10. Motion to accept the PDC motion as presented by Charles Lane, M.D… Motion passed.**
XIII. Regulation & Compliance- Mike Berg	• There were three commercial EMS agencies that were affected by the expiration of their Operational Medical Director but within twenty-four hours they had acquired new OMDs. No EMS agencies suffered during this process. • 12VAC5-31 Virginia Emergency Medical Services Regulations sitting in Governor's Office for 51 days and 12VAC5-66 Regulations Governing	

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	Durable Do Not Resuscitate legislation has been sitting the Governor's Office for 107 days. • In 2005 legislation in the form of Senate Bill 1150 advises that any hunting accidents must be reported to Game and Inland Fisheries. • During the 2005 General Assembly, SB 1150 (Stolle) was passed and amended § 29.1- 530.4 of the *Code of Virginia*, effective March 23, 2005 (http://leg1.state.va.us/cgibin/legp504.exe?000+cod+29.1-530.4), and states in part: *"Any law-enforcement agency or emergency medical service provider that receives a report that a person engaged in hunting as defined in § 29.1-100 has suffered serious bodily injury or death, shall immediately give notice of the incident to the Department of Game and Inland Fisheries."* In reviewing the actual bill, it requires that the Department of Game and Inland Fisheries to be contacted within five days of the incident (http://leg1.state.va.us/cgibin/legp504.exe?051+sum+SB1150S). It is a Class 4 misdemeanor for failing to report this information. http://www.vdh.virginia.gov/OEMS/Files_page/regulation/DGIFMandatedReporting.pdf • July 1 of this year the Department of Criminal Justice & requires the any victim of crime be reported as follows: **Virginia Department of Criminal Justice Services** Guidance Regarding Implementation of the Code Provision that the Department of Criminal Justice Services be Contacted in Emergencies Due to the passage of HB2612 and SB1150 (affects the *Code of Virginia* §§22.1-279.8, 23-9.2:9, 32.1-111.3, 32.1-111.11, 44-146.18, and 44-146.19) public schools, state institutions of higher education, the Board of Health, regional emergency medical services councils, the Virginia Department of Emergency Management and local emergency management officials must include the following information in their emergency response plans: *The plan shall include a provision that the Department of Criminal Justice Services and the Virginia Criminal Injuries Compensation Fund shall be contacted*	

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	immediately to deploy assistance in the event of an emergency as defined in the emergency response plan when there are victims as defined in § 19.2-11.01, as well as current contact information for both.	
XIV. Public Comment	None	
XV. For the Good of the Order	**2010 Meeting Dates:** • **January 14** • **April 8** • **July 8** • **October 7**	
XIV. Adjourn	Motion to adjourn at 4:35 PM.	