

MEDICAL CONTROL COMMITTEE

Minutes

February 7, 1996

<u>Members Present:</u>	<u>Others Present:</u>
Ed DesChamps, M.D., Chairman	Richard Miller, M.D.
Richard Rogers, M.D.	Joe Fanning
Doug Norcross, M.D.	Phyllis Beasley
Dan Phillips, M.D.	Rod Bowman
Bill Gerard, M.D.	Alonzo Smith
Carol Baker, M.D.	Jim Catoe
John Sorrell, M.D.	Don Whiteley
Richard Bell, M.D.	Terry Horton
	Susan Collins
	Jim Sullivan
	James Lee, M.D.
	Eric Weinstein, M.D.
	Deborah Woolard, M.D.
	Doug Warren
	Cindy Lee, R.N.
	Hart Smith, R.N.
	Marie Segars, R.N.
	Scott Robinson
	Daniel Brenyo, Jr.

A motion to accept the minutes from the meeting of December 13, 1995 was made by Dr. Norcross and seconded by Dr. Gerard. The motion passed.

TRAUMA CENTER DESIGNATIONS

The Designation Review Committee had motions related to the Level III trauma center designation applications of Carolinas Hospital System and McLeod Regional Medical Center in Florence. Dr. Sorrell was asked to present the recommendations of the Designation Review

Committee which met immediately prior to the Medical Control Committee. Dr. DesChamps dismissed the representatives from McLeod Regional Medical Center, then opened the discussion with the committee's recommendation regarding the application of Carolinas Hospital System. He stated the committee recommends designation option #3, "That designation should be withheld until the hospital can correct the deficiencies in the essential areas noted. The hospital has deficits in some important essential areas. These areas are not likely to be easy to correct and will probably require up to six months to correct."

Dr. Miller, leader of the site team which reviewed Carolinas Hospital System, read the site team's report to the Committee. He cited significant problems including a lack of numbers of appropriate trauma records for review, insufficient general surgery commitment to the care of trauma patients and insufficient evidence of a quality improvement process.

Dr. DesChamps asked if any Medical Control Committee members had questions for the hospital staff who were attending the meeting. He asked that discussion by the Medical Control Committee be held until after both hospitals' cases were presented.

Dr. Phillips asked how long the trauma registry had been kept. Dr. Weinstein responded that records had been kept from August to mid-November (the time of the site visit). He stated that until recently trauma patients were not routinely transported to Carolinas, but current staff has promoted a change in this policy. He stated that Dr. Cauthen, head of their emergency department and medical control for Florence Co. has now directed most trauma patients to Carolinas.

There was also discussion about emergency department coverage and location of the emergency departments of Carolina's two "towers." Reassurance was provided by Dr. Weinstein that trauma patients aren't transferred between emergency departments at the hospital. He also offered explanation of why specialists were frequently seeing trauma patients rather than the general surgeons, i.e. managed care policies, tiered response.

Dr. Sorrell explained that in the designation process the committee has to base its decisions on the information it has from the site team's findings and not on progress or information which has occurred after the visit.

Dr. DesChamps then dismissed the Carolinas representatives from the room and readmitted the representatives from McLeod Regional Medical Center. Dr. Sorrell then presented the designation recommendation of the Designation Review Committee for McLeod. He stated that the subcommittee recommended Option #3 "That designation should be withheld until the hospital can correct the deficiencies in the essential areas noted. The hospital has deficits in some important essential areas. These areas are not likely to be easy to correct and will probably require up to six months to correct." He asked Dr. Miller to present the findings of the site review team.

Dr. Miller stated that at the site review on December 18, 1995, the team found that the hospital was committed to caring for the trauma patient and that the emergency department had an excellent understanding of the emergency department portion of trauma management and the ancillary care facilities are more than adequate to manage trauma. However, the team found that the general surgery commitment to the care of trauma patients was insufficient. Weaknesses were that none of the surgeons were pursuing continuing education or ATLS certification and that chart review showed a large percentage of trauma patients being admitted to subspecialties. Nursing records also needed improvement.

Dr. DesChamps asked the Committee if they had any questions to address to McLeod representative, Marie Segars, vice-president of patient services. Dr. Norcross asked what extent of patient evaluation McLeod expects of the community hospitals who transfer in trauma patients. Ms. Segars responded that they expect the community hospitals to evaluate the patients to the extent of their capabilities; that they suspect that the community hospitals are run differently during the day than they are at night i.e. lack of general surgeon assessment. She stated that McLeod has asked the community hospitals to provide consistent level of care and provide for backup physician response at all hours. Dr. Norcross asked who the transfers were being called in to at McLeod. Ms. Segars said that about 60% of the transfers are called in to someone on medical staff whom the community hospital physician knows. The other 40% are called into the emergency department.

Dr. Sorrell then requested that the Committee go into the executive session to discuss the hospitals. Before dismissal of the hospital staffs, Dr. Phillips asked what the role of the McLeod surgeons had been in pursuing designation. Ms. Segars stated that the surgeons had not been the driving force initially, but their attitudes are changing. McLeod is looking to hire two in-house trauma surgeons, with the support of the community general surgeons.

Dr. DesChamps then dismissed everyone but Medical Control Committee members, DHEC staff and Dr. Lee, who served on the Designation Review Committee. Dr. DesChamps clarified to the Committee that, as the former Pee Dee Medical Control physician, he was abstaining from voting. Dr. Gerard also abstained from discussion involving the hospitals and from voting.

Dr. Sorrell reiterated that the Designation Review Committee recommended Option #3 for Carolinas Hospital System and asked Ms. Beasley if there were any additional comments. She stated that discoveries from the chart review indicated many admissions by the emergency physician. Further review of their "Trauma Team Roles and Responsibilities" document revealed the statement "the emergency department physician assumes the role of the trauma team leader until arrival of the general surgeon or until the patient is admitted to CHS or transferred to a Level I or II facility." Ms. Beasley suggested that the policy should be amended to take out the phrase "or until the patient is admitted to CHS."

Dr. Norcross asked for clarification on the types of patients being admitted to specialties, rather

than general surgery. Dr. Miller explained the types of trauma records which he took into account and that the ones considered in the evaluation should have been admitted to general surgery.

There was then discussions about the fact that it appeared that at both hospitals the administrations are the driving forces behind the designations. Dr. Norcross stated that there seems to be a lack of understanding about the need to get trauma patients transferred from the community hospitals to definitive care facilities in a prompt manner. He stated that he has seen that the hospitals are asking for too many tests before transfers are accepted.

Dr. Miller stated that both hospitals are committed to being trauma centers and he believes that if they follow the Committee's recommendations they can achieve designation.

In regard to Carolinas Hospital System's application for designation as a Level III trauma center, Dr. Sorrell made a motion that the Committee approve Option #3 (see attached). The motion also included the recommendation by staff that their written trauma policy be changed to exclude admission of trauma patients by emergency physicians.

There were some comments from the Committee, including support for the motion by Dr. Lee, a member of the Designation Review Subcommittee. Dr. Lee stated that it appeared from the discussion that there were serious difficulties in surgical response and that the hospital should be able to take the recommendations back to its staff to achieve the needed improvements.

The motion was seconded. Dr. Sorrell asked if there was any further discussion. Dr. Baker asked for clarification if this motion was only for Carolinas Hospital System; it was. The motion passed. Dr. Bell opposed. Dr. Gerard and Dr. DesChamps abstained.

Dr. Sorrell then asked the Committee to address the recommendation for McLeod Regional Medical Center. Dr. Bell expressed concern over the reported lack of surgical involvement in the treatment of trauma patients and surgical leadership. He reiterated that this is a serious deficiency and the hospital has to make a lot of changes. Dr. Bell stated that he felt that the changes could not be implemented in six months.

Dr. Sorrell stated that the Designation Review Subcommittee also recommended option #3 "That designation should be withheld until the hospital can correct the deficiencies in the essential areas noted. The hospital has deficits in some important essential areas. These areas are not likely to be easy to correct and will probably require up to six months to correct" with an additional comment by staff. Ms. Beasley explained that comments by the hospital staff during the Designation Review Subcommittee indicated that they do not understand fully how the registry and the QA process should be used; e.g. they indicated that they would not be entering trauma patients in the registry until after the patient had been discharged and addressed in the QA process. Mr. Fanning clarified that he felt that the hospital decided to handle the QA in this manner after the site team's review had found problems in QA. Dr. Miller stated that he was not

clear on the hospital's comment. Dr. Bell said that he felt that it was not in the purview of the Committee to criticize how they do their QI, as long as it gets done. He stated that they do not necessarily have to use the registry for QI. Dr. Sorrell stated that since this issue and the hospital's comments about the QI process were unclear, that a recommendation related to this should not be included in the motion.

Dr. Sorrell made a motion to accept the Designation Option #3 for McLeod Regional Medical Center with the weaknesses noticed on the site team's report and mention the registry concerns.

Dr. Malanuk asked to amend this motion and the previous motion by saying that the deficiencies will require (at) 6 months rather than up to 6 months to correct. He stated that if we provide the hospitals with a set date for revisit it would simplify the process and the hospitals would not be in a race to be revisited. Dr. Baker asked if there should be any mention in the motion about concerns regarding accepting transfers. Dr. Bell stated that the time to work out appropriateness of transfer is not 2 a.m. in the morning with a patient lying there, but to send the patient and then work out the problems later. Dr. Bell said that it is apparent that McLeod does not understand this. Dr. Norcross said that the team should be made aware of this problem so that they can monitor the transfer charts.

There was lengthy discussion about the severity of the surgical response and leadership problems at McLeod and the reasons for the decision of the administration at McLeod to finally submit an application for trauma center designation.

Dr. Sorrell asked for further discussion on the motion for Designation Option #3, including amendments to reflect a second site review at 6 months, no sooner, and emphasis on timely acceptance of transfer patients. The motion passed. Dr. Bell opposed. Drs. DesChamps and Gerard abstained.

The hospitals were brought back in the room for the results of the motions. There were some questions about the timing of the revisits. The Committee stated that the revisits will be conducted at 6 months, about the middle of August 1996. Designation Review Subcommittee and Medical Control Committee meetings will be held as soon as feasible following the site reviews.

TRANSPORT VENTILATORS

Dr. Norcross presented the report of the subcommittee on transport ventilators. The subcommittee of Drs. Norcross and Phillips had met with a representative from a medical equipment sales company, Paul Lucas from Lowcountry Regional EMS and Alonzo Smith and Phyllis Beasley from the Division of EMS to discuss the use of transport ventilators by prehospital personnel.

Dr. Norcross stated that the issue of the use of transport ventilators came up when the Invasive/Implanted Device Manual was drafted by the Medical Control Committee, but the discussion was tabled until their use could be investigated. He said that according to EMS personnel and the sales representative, transport ventilators were in common use across the state ("hundreds"). He reiterated the concerns of prehospital personnel that the use of transport ventilators is essential, especially for long transports. The sales representative brought a sample ventilator to illustrate that it is a simple device and its use is often initiated by EMTs. Dr. Norcross stated that the prehospital transport ventilator does not fall in the realm of the device manual. The subcommittee drafted a motion for the approval of the use of these ventilators. Dr. Norcross also mentioned that these ventilators are FDA approved and that these are not intended for long term use. The subcommittee's motion was:

"FDA approved portable ventilators designed for short term transport should be approved for use by EMS in South Carolina with the following provisions:

1. Use is limited to paramedics and intermediates. This device may also be used by basic Emergency Medical Technicians who have completed a course of study providing the additional expertise and skills contained in the 1994 Basic EMT National Standard Curriculum as approved by the Department of Health and Environmental Control, Division of Emergency Medical Services.
2. The current South Carolina EMT curriculum at all levels should be modified to include training in the use of these devices and the basic physiology required to use these devices safely.
3. All services using these devices must do so under standing orders and protocols signed by the medical control physician and which include the means by which the ventilator settings will be determined. To operate outside of these protocols would require direct orders from an on-line medical control physician.
4. Services currently employing these devices must be able to demonstrate in-service training on the use of these devices, and understanding of the basic physiology required to use them safely and the standing orders and protocols governing their use within ninety (90) days of notification of this action by the Division of EMS.
5. Emergency Medical Services must incorporate into their in-service training programs of their quarterly training programs the use of these devices and the basic physiology required to use them safely. Services using these devices must also include the standing orders and protocols governing their use and the operation of the specific device being used.

6. This motion does not apply to ventilators designed for long term home or health care facility use.

Dr. Weinstein asked if there were any template set up for a training program for transport ventilators or if there were any standards for training. Mr. Smith said that he has been in contact with a sales representative who will send a suggested training outline that can be used. Dr. Norcross clarified that, although the training programs will not be regulated by DHEC, the medical control physician of each service will be responsible for incorporating and monitoring the service's training program. Dr. DesChamps asked how much time would be added to the curricula by including information on transport ventilators. Dr. Norcross said that he did not anticipate more than an hour, because the information will only be concerned with some physiology and setting tidal volumes and rates on this simple equipment.

Dr. DesChamps asked if the subcommittee considered the use of pulse oximeters with the transport ventilators. Dr. Norcross responded that since they are not required with bag valve masks, the subcommittee did not consider requiring their use with transport ventilators. The training officer from Laurens County EMS commented that they use transport ventilators and are considering taking pulse oximeters off their ambulances because in 50% of the times in which the pulse oximeter was used, patient treatment was incorrect because the crew was responding to the machine and not the patient. He also stated that the thumper has been used as a ventilation device in the past in cardiac patients.

Dr. Sorrell expressed concern that with bag masks, the EMT can feel the ventilations and is watching the patient, but with transport ventilators, ventilations are not monitored individually and a lung could be "blown" more easily. Dr. Norcross reiterated that is why the motion stresses requiring training and attempts to put use of the transport ventilator under the control of each service's medical control physician. Dr. Norcross stated that the individual medical control physician could require use of the pulse oximetry, but that since it is not required for bag valve masks, the subcommittee did not feel that they could require it with transport ventilators. The Committee agreed that the motion, point number 4, should be changed to require training on methods to include rate and tidal volume.

Dr. Bell asked about actual number of times transport ventilators have been used. Staff stated that information is not currently available from the ambulance run report data. It was agreed that a place should be added on the ambulance run report form to indicate the use of transport ventilators.

Dr. Norcross clarified that a physician or nurse must be used on transports with the hospital transport ventilators and that the proposed motion is restricted to short term use of the simple prehospital transport ventilators.

Dr. DesChamps asked for a second on the motion with the additions of training requirements to

include rate and tidal volume and the addition of place on the ambulance run report to record the use of transport ventilators. Dr. Sorrell seconded the motion. The motion passed.

Dr. Norcross stated that hospital ventilators should be added to the device manual.

CLARIFICATION ON PEDIATRIC ALBUTEROL DOSAGE

The next item on the agenda was a consideration of comments on the last approval of the pediatric dosage of Albuterol. Mr. Smith explained that when a memo was sent to the EMS Advisory Council members for a mail vote on this, comments were received from Upstate EMS Council regarding dosage. After much discussion, it was agreed that the correct dosage was "All patients regardless of age: may receive a dosage of up to a maximum of 1cc (5mg) of aerosolized Albuterol with no on-line medical control. Repeat treatments of aerosolized Albuterol may be given only with on-line medical control."

Mr. Smith indicated that he discussed the issue of new dosage amounts with DHEC legal counsel (Cheryl Bullard) and she concurred that at this point, it is permissible for the Medical Control Committee to rule on this issue. A motion was made by Dr. Baker to accept this corrected dosage amount. The motion was seconded by Dr. Rogers. The motion passed.

BLOOD TUBES

Dr. DesChamps explained that frequently hospitals will not accept or use blood samples which are being taken by EMTs in the field. However, blood tubes are currently required ambulance equipment. He asked the Committee if it would consider making that an optional procedure. Dr. Phillips agreed and made a motion that blood sampling and the use of blood tubes become a local option. Dr. Baker seconded the motion. The motion passed.

INFORMATION ON EVALUATION OF IN-SERVICE TRAINING

Mr. Fanning explained that recently he and Dr. DesChamps met to further discuss the issues surrounding the need to examine the effectiveness of current in-service training recertification. He said that, at one point, it had been suggested that Dr. Gerard develop a test to verify the effectiveness of in-service training, but it was decided that there would be a less time-consuming and difficult means to determine this information. Mr. Fanning said that staff would like to use the present paramedic test which is given to those recertifying by course testing. He said that this test would be given to a sampling of the paramedics who had recertified by in-service training. The issue also arose about the cost of grading, since the tests are weighted.

There was much discussion about options available for grading. Other problems associated with testing in-service recertifications include overcoming statistical problems, comparing urban and rural and small and large services, convincing paramedics to take the test. Dr. DesChamps also

mentioned that the Committee also would need to look at the number of times paramedics had recertified through in-service; the state is in the third cycle of in-service recertifications.

STATE APPROVED PROTOCOLS

Dr. Gerard reported that he is still working on suggested state-approved protocols. He expected to have something for the Committee by the next meeting.

CHANGES IN LEVEL III TRAUMA CENTER APPLICATION

Ms. Beasley reported that she had developed some suggested changes in the Level III application which would streamline the process for the hospitals, or at least delete required information that is not used by the teams and require other types of information which is needed.

An important change she suggested was to delete the requirement of three months of call schedules for the subspecialties and any other optional medical specialty, but still require the schedules if 2 or less physicians are covering the specialty. Lists of the physicians would be required instead. Call schedules for general surgeons would still be required.

Another change would be to require documents related to quality assurance activities; no documentation had previously been required in advance. A copy of the quality assurance policy and process would be required, as well as a copy of the minutes of at least one month's trauma multidisciplinary committee meeting. Other changes would be a requirement for a listing of continuing medical education programs which had been presented and a list of community injury prevention and public education programs.

She also suggested that the requirement of submitting the credentialing process for surgeons admitting to the ICU be dropped because the credentialing requirements are not specified by ACS and hospitals have showed much concern about what credentialing to require. Dr. Bell stated that the hospitals should simply design a process and credentialing requirements which are hospital-driven. It makes hospital take time to consider whether physicians who are admitting to the ICU and have ICU privileges are qualified to do so. Ms. Beasley agreed to add that requirement for information back into the application.

NEXT MEETING

The next meeting would be the drug meeting. Dr. Baker had asked if nitrous for children, amyl nitrate for cyanide poisoning and cetacain and xylocaine 2% jelly for nasal intubations had to be considered as items on the drug list, or could be addressed separately. Staff said that those requests must be submitted as additions to the drug list.

Because of Self Memorial's upcoming site review on March 21, the Committee decided not to

meet at the EMS Symposium on March 16, but to determine a meeting date after Self's review and well prior to the NHTSA assessment on April 29, or just prior to the EMS Advisory Council meeting on May 9. Staff agreed to poll the Committee for meeting dates.

OTHER COMMENTS RELATED TO TRAUMA DESIGNATIONS

In response to the difficulties encountered during the recent site reviews at the Florence hospitals, Dr. Bell offered several suggestions to avoid further awkward situations for the site teams and to streamline the designation process. Those suggestions included:

1. Develop a specific, standardized process for the review.
2. No recommendations for designation should be offered at the site visit.
3. The site team should report only what they found, not make suggestions or comments.
4. Staff should write the Pennsylvania Trauma System Foundation for a copy of their policy on site reviews.
5. Staff should develop a formal program of consultation for institutions.

With no further discussion, the meeting was adjourned.

MEDICAL CONTROL COMMITTEE

MINUTES (Revised following 7/96 meeting)

April 17, 1996

<u>Members present:</u>	<u>Others present:</u>
Dr. Ed DesChamps, Chairman	Dr. Steve Shelton
Dr. Bill Gerard	Ed Allen
Dr. Dan Phillips	Connie Godowns, RN
Dr. Bob Malanuk	Jay Hamm, RN
Dr. John Sorrell	Tony Woodberry
Dr. Richard Rogers	Richard Harrison
	Joe Fanning
	Al Futrell
	Phyllis Beasley
	Alonzo Smith

Dr. DesChamps began the meeting by asking if there were any changes needed to the minutes of the February 7, 1996 meeting. Dr. Malanuk made a motion to approve the minutes as written. The motion was seconded and approved.

TRAUMA CENTER APPLICATION OF SELF MEMORIAL HOSPITAL

The first item on the agenda was consideration of the recommendation of the Designation Review Committee regarding the Level III trauma center designation application of Self Memorial Hospital. Dr. Sorrell, Chairman of the Designation Review Subcommittee, said that the subcommittee recommended Designation Option #3 "That designation should be withheld until the hospital can correct the deficiencies in the essential areas noted. The hospital has deficits in some important essential areas. These areas are not likely to be easy to correct and will probably require up to six months to correct." Dr. Sorrell explained that the subcommittee decided on this option based on two problems: 1) that although the hospital's trauma QI program had been developed and organized; it did not yet have sufficient data to assess its effectiveness. At the time of the site visit, there were no minutes available to determine if the process was functioning properly. 2) That senior level emergency residents, working part-time in the emergency department were handling single coverage shifts.

Dr. Malanuk made a motion to adopt the subcommittee's recommendation with noted deficiencies. The motion was seconded by Dr. Rogers.

Dr. Gerard stated that the problems seemed minor and would be corrected within 90 days. He asked the difference between Option #2 (to designate and re-check in 90 days) and Option #3. Dr. DesChamps explained that in the past the Committee has not allowed "liberalization of elements" of the criteria and that, although the Committee could see that the hospital could clearly be designated in the near future, they were afraid that there would be problems in maintaining a firm line down the road with designations.

Some discussion followed about the hospital being penalized for using emergency physicians, rather than full-time physicians of other specialties and the requirement for career-oriented emergency physicians. There was also discussion about the requirement for currently designated hospitals to notify DHEC of any changes in their trauma personnel.

The Committee then took a vote. Two members abstained: Dr. Phillips and Dr. Gerard. The motion passed.

PROPOSED STATE PROTOCOLS

Dr. Gerard passed out copies of the proposed state protocols which he has developed and are in algorithm form. He based these protocols on other states' protocols and protocols within the state. He explained that the pediatric protocols were not included yet, because the EMSC Committee was still in the process of working on seizures, child abuse and drowning.

Dr. Gerard asked the Medical Control Committee to review the protocols for comments, additions, and corrections. He asked that their responses and comments be forwarded to Alonzo Smith of Division of EMS staff, so that they could then be forwarded together to Dr. Gerard. He commented that these protocols were reviewed carefully and based on the capabilities in South Carolina.

The Medical Control Committee agreed that the protocols appeared very complete and would be very useful as individual services develop and update their own protocols. They commended Dr. Gerard for an excellent job.

DRUG LIST ADDITION REQUESTS

NITRONOX:

Submitted by Greenville County EMS/Dr. Carol Baker

Request for an increase in the age range for use; to extend age for use down to age 6 and older, if the patient is able to cooperate by holding the mask.

Dr. Phillips made a motion to accept the change to read "pediatric dosage: any age old enough

to hold the mask to administer." The motion was seconded.

Dr. Sorrell questioned the Committee about whether the paramedic could hold the mask if the child doesn't want to. The Committee responded "no", the medication must be self-administered.

The motion passed.

DIAZEPAM (VALIUM):

Submitted by Charleston Co. EMS/Dr. John Sorrell

Request for a change in use of the drug

Charleston County EMS submitted this drug for use in sedation and muscle relaxation in the patient who is difficult to intubate. Dr. Sorrell said that the request for usage would also be for the combative patient. There were questions about the FDA's approved usages for valium. Dr. Sorrell stated that the PDR cites that it can be used as a sedative and muscle relaxation. Dr. Gerard asked if it could be used just for the combative patient. Dr. Sorrell said that his request was to assist with intubation, but that it could also be used for the combative patient. Mr. Smith said it is currently approved for major motor seizures, status epilepticus, premedication prior to cardioversion, transcutaneous pacing, skeletal muscle relaxant and acute anxiety states.

Dr. Sorrell made a motion to allow diazepam (Valium) as a premedication prior to intubating the combative patient. Dr. Rogers seconded the motion. The motion passed.

FLUMAZENIL (ROMAZICON, formerly MAZICON):

Submitted by Medical Transport System of Florence/Dr. Richard Rogers

Request for an addition to the drug list

Dr. Rogers asked that this drug be considered for addition to the state drug list and the interfacility drug list. The drug would be used in instances of Benzodiazepine overdose and the reversal of conscious sedation. The Committee recommended approval of this drug since prior to this they approved the use of Diazepam as a premedication for combative patients and difficult intubations.

Dr. Sorrell made a motion to approve the use of Flumazenil for the reversal of acute side effects of Benzodiazepine, limited to iatrogenic causes, with on-line medical control. Dr. Rogers seconded the motion. Dr. DesChamps asked that the definition of iatrogenic be included in parenthesis next to the word. The Committee agreed on that addition to the motion.

Dr. Sorrell asked about the dosages. The Committee agreed that this drug is approved only for adult dosages as cited in the request.

The motion passed.

PROMETHAZINE HCl (PHENERGAN):

Submitted by Medical Transport System of Florence/Dr. Richard Rogers

Request for an addition to the drug list

The drug is requested for use in the relief of nausea in long transports. Dr. Phillips commented that he did not approve of the use of this drug for use in acute cases, but only for long, interfacility transports.

Dr. Rogers made a motion that promethazine HCl (Phenergan) be added to the interfacility drug list for usage to be available as an anti-emetic (vomiting).

Mr. Futrell suggested that a condition be put on the motion that the drug be supplied by the sending hospital for use by EMS, but not kept on ambulances. The Committee agreed that this was the idea as approval for interfacility use.

The Committee then discussed the need for specifying age range. They amended the motion to add that it can be used for persons ages 12 and older with on-line medical control. The motion was seconded. The motion passed.

DILTIAZEM (CARDIAZEM)

Submitted by Edgefield County EMS/Dr. Bill Gerard

Request for an addition to the drug list

Dr. Gerard explained that this drug is requested for inclusion on the list for use in the transport of refractory tachycardia patients not responding to digitalis. It is the only SVT drug with an acceptable therapeutic ratio for short term use. It would be supplied in 5 cc vials, 25 mg for IV bolus or drip infusion. The question was raised about whether there is already a drug on the list which would provide the same benefits. Dr. Phillips stated adenosine is on the list, but cardiazem is the drug of choice. He also stated that if the Committee is supplying a better drug for their use, should the Committee not drop the other drug. Dr. Gerard stated that a problem he has with this drug is that it is only good for one month at room temperature and has to be refrigerated. It must be destroyed after one month of storage at room temperature. Dr. DesChamps explained that drug adulteration is a problem that is being addressed nationwide and is on the agenda for the Medical Control Committee for this meeting.

Dr. Sorrell said that this drug is appropriate mainly for the rare patient who has atrial fibrillation with a fast ventricular rate and is stable and doesn't need to be cardioverted. He said he did not see a great need for the medication.

Dr. Phillips said he would like to see numbers from the service verifying the need for cardiazem. He also said that the service should also document their means of storage and exchange with the hospital. The discussion was tabled until that data was available.

Dr. DesChamps said a letter would be sent to the service asking for that information.

Dr. Phillips said the same information should be gathered about existing drugs. Mr. Futrell said that staff member Clarke Greene could run a printout of all the prehospital drugs that are being used. It was recommended that the Committee study this information and research the need to reduce the number of drugs on the list. Mr. Smith said that a "core list" of prehospital drugs should be developed and a separate list of additional/supplemental drugs, or "physician-option" drugs. He also said that the drugs should be defined separately for EMT testing purposes.

ASPIRIN (ACETYLSALICYLIC ACID) - CHILDREN'S CHEWABLE ASPIRIN

Submitted by Beaufort County Emergency Medical Service/Dr. Sam Kini/Dr. John Sorrell

Request for an addition to the drug list

Mr. Smith said that many services have requested the drug for use in conjunction with 12-lead EKG, which was recently passed as an optional field procedure.

In the drug request, the indication is for myocardial infarction. Dr. Phillips said that indications should be "chest pains suspicious of cardiac origin." He also stated that the use of the aspirin should not be limited to use with 12-lead EKG.

Dr. Phillips made a motion to approve aspirin as an addition to the drug list in instances of chest pains suspicious of cardiac origin, with the adult dosage being 2 to 4 children's aspirin or 162-324 mg. The motion was seconded. The motion passed.

CETACAINE TOPICAL ANESTHETIC SPRAY/ XYLOCAINE 2% JELLY

Submitted by Greenville County EMS/Dr. Carol Baker

Request for an addition to the drug list

The Committee said that they had discussed lidocaine jelly in the past and had approved its use as a lubricant; it was not considered a drug.

The Medical Control Committee was unclear about the proposed purpose for the Cetacaine topical spray and the amount of and frequency of usage. Discussion on this was tabled until clarification could be made.

The Committee said that Xylocaine 2% jelly should be approved and should be listed for use in the appropriate document. Dr. Phillips made a motion that the Committee approve Xylocaine 2% jelly for assistance in passing naso-gastric tubes and naso-tracheal intubations as a lubricant anesthetic, and ask for more information on the intended use of Cetacaine, how it is intended for use and how often it will be used. The motion was seconded. The motion passed.

Mr. Smith asked for clarification about where the lidocaine jelly approval would be listed. The Committee said that it should be included in special information under lidocaine.

LILLY CYANIDE ANTIDOTE KIT

Submitted by Greenville County EMS/Dr. Carol Baker

Request for an addition to the drug list

There was much discussion about the need for this kit to be carried on ambulances. There was also discussion on which agencies actually keep the kits and how frequently the kits might be used. Dr. Phillips stated that most hospitals keep one or two kits. He said that it is not a benign treatment. The Committee stated that this request is for using the kit for the highly symptomatic patient with known cyanide exposure. There was discussion about where the drug should be located, whether it would be best placed in hospitals, ambulances or industries, especially since it would be a rare need. The Committee decided to defer the discussion for further information from Dr. Baker at a later meeting.

DRUG ADULTERATION

Dr. DesChamps passed out two handouts: New Jersey EMS' policies and study on drug adulteration and a study on drug adulteration by the State EMS Association. He said that this is an up and coming subject. Of particular concern here are the problems created by temperature fluctuations in ambulances. He asked the Committee to review the documents for the next meeting to determine if there is a problem in S.C. and how the Committee should address the problem.

Dr. Phillips said that the Committee should first make the EMS services aware of potential problems in a letter and develop guidelines for preventing drug adulterations before requiring methods for drug storage. Dr. Sorrell said that in extreme temperatures equipment such as pulse oximeters may not work accurately.

The Committee will revisit this topic next meeting.

INFORMATION ON THE UPCOMING NHTSA ASSESSMENT

Ms. Beasley reported that the assessment will be held at the Embassy Suites Hotel in Columbia. The team arrives on Monday, April 29 and begins the assessment on Tuesday. The report is presented on Thursday, May 2. The Medical Control Committee is invited to the working social on the evening of Tuesday, April 30.

There is a staff copy of the briefing book and it is available for the Medical Control Committee to review. Maps with geographic and EMS information have been prepared. The interviews take place all day Tuesday and half of the day on Wednesday. The report will address ten topic areas.

REDUCTION OF MEMBERSHIP OF TRAUMA SYSTEM COMMITTEE

Ms. Beasley asked the Committee to consider reducing the membership of the current Trauma System Committee (a subcommittee of Medical Control). The current membership, based on requirements of the former DHHS DTEMS federal grant is 39. Ms. Beasley suggested that there be one, smaller Trauma Committee to address all issues specifically related to the development of the trauma system and the designation of hospitals. She suggested that a balance of representatives be determined based on what the current committee membership categories are. She said she would mail a copy of the current membership with the minutes.

Mr. Futrell asked how this committee would fit in the structure of the other committees. It was agreed that the Trauma Committee would remain a subcommittee of the Medical Control Committee. Dr. Sorrell suggested that Ms. Beasley develop a proposal for the committee structure prior to the next meeting.

Ms. Beasley also passed out, for informational purposes, a detailed listing of the actual designation application process steps. This document was drafted to mail out to trauma center applicants to clarify the designation process. She asked for input and suggestions for changes from the Medical Control Committee.

PROPOSED MEDICAL CONTROL PHYSICIANS REFRESHER WORKSHOP

Dr. DesChamps said that the question of whether to have refresher medical control physicians workshops has risen periodically. This type workshop would be designed for physicians who have taken the initial half day course many years earlier and have continued to serve as medical control physicians for many years, but have not attended a more recent workshop. Dr. DesChamps suggested that a brief workshop could be developed to update those physicians on the many changes in the EMS system and this workshop could be required every 2 or 3 years. He asked for feedback from the Committee. Mr. Fanning suggested that the Committee design the workshop and staff would implement it.

Dr. Gerard suggested that each regional medical director should put on their own workshop for the physicians in their own regions. Mr. Fanning said that this had been tried in the past and there was little participation. He suggested that Dr. Gerard could pilot this idea in his region. Dr. Gerard said that he felt that in his region there is a need for physicians who give orders over the phone to attend such a workshop and that they probably would not be likely to go to the EMS Symposium at the beach.

Dr. Sorrell agreed that there are a lot of physicians who communicate with EMS but have no knowledge of the functioning of the EMS system. Dr. Phillips said that he felt that it is not unreasonable to require any physician who works with EMS to take the workshop. Dr. Gerard said he would like for orders to be given out over the radio only by physicians who have had the training.

Dr. Gerard reiterated that he felt that it would be easier to get attendance to a local workshop and that there should be some kind of credentialing for physicians giving orders over the radio. Mr. Fanning asked if Dr. Gerard could put together a local workshop in his region prior to November. Discussion also arose about centralized medical control. Mr. Fanning stated that S.C. had no legislative authority to regulate medical control.

LONG RANGE PLANNING

Deferred until after the NHTSA assessment.

OTHER BUSINESS

Mr. Smith asked for clarification on whether it's okay for EMS services to use INTs. It is his understanding that some EMS services have been purchasing the INTs, but their use is not in the curriculum. Dr. Sorrell said that this issue was discussed several years ago and decided that it was okay for services to use INTs and flush them with saline. Dr. Phillips said there was no difference between using an INT and starting an IV. Dr. DesChamps said that the INTs were approved for hepllock, not saline, but he believed it could be determined on a local level.

Dr. Dick Shelton introduced himself as an emergency physician at Richland Memorial Hospital and medical director for Rural Metro. He explained that the EMS Committee of ACEP is working on providing information to dispatchers. NAEMSP has a policy paper on the use of lights and sirens which ACEP has adopted. He explained that dispatchers should be aware that the use of lights and sirens increases the chances of accidents. He asked the Medical Control Committee to look over the paper for their recommendations for changes. There was then some discussion about the need for medical training for dispatchers.

The date of the next meeting will be confirmed by a poll at a later date, based on a proposed agenda. With no further comments, the meeting was adjourned.

**MINUTES OF THE
EMS MEDICAL CONTROL COMMITTEE**

**JULY 10, 1996
10:00 A.M.**

**SECOND FLOOR CONFERENCE ROOM
HERITAGE BUILDING**

<u>Members Present:</u>	<u>Others Present:</u>
Ed DesChamps, MD, Chairman	Al Futrell
Richard Rogers, MD	Joe Fanning
Carol Baker, MD	Alonzo Smith
Bill Gerard, MD	Phyllis Beasley
Dan Phillips, MD	Freddie Andrews
Doug Norcross, MD	Thomy Windham
Bob Malanuk, MD	John Ringwood, MD
	Richard Miller, MD
	Deborah Woolard, MD
	Susan Collins

The Medical Control Committee meeting was called to order by Dr. DesChamps.

Dr. DesChamps asked that the minutes of the last meeting be reviewed for approval. Ms. Beasley said there was one change; Dr. Roger's name was omitted as having attended the meeting. Dr. Phillips made a motion to approve the minutes. Dr. Rogers seconded the motion. The motion passed.

REVIEW OF THE DESIGNATION DECISION FOR SELF MEMORIAL HOSPITAL

Following the Medical Control Committee's April 17 meeting, a letter had been submitted by Dr. Norcross asking the Committee to review its decision of Designation Option 3 (not to designate at this time) for Self Memorial Hospital. Dr. Norcross, team leader for the site review at Self had not been present at the Committee meeting in which the decision had been made. Dr. Norcross reiterated that his concerns with Self had been that the QI process was in place, but not up and running, and the use of residents for coverage in the emergency department. Dr. Norcross pointed out that he had been impressed with the trauma operations at Self and that the team had to look hard to find anything to cite them on. He felt that the use of the fourth year

residents was not a significant issue, since they were to come on contract as full-time attending physicians in July. He stated that, as the site team leader for that review, he felt that the Committee should have chosen Designation Option #2 (designate, but make corrections within 3 months).

Dr. Malanuk commented that his concern with the use of the residents was that there were no protocols as to what kind of physicians would be allowed to staff the emergency department.

There was then discussion regarding the QI program at Self. Several members agreed that the QI program is in place but was not implemented and that this was an important element for designation. Dr. Norcross asked that the minutes of the last meeting be corrected to reflect that rather than saying the QI process had not yet been implement; the correct statement should be that the QI process had been developed, but at the time of the site visit there was not sufficient data to evaluate its effectiveness.

Dr. Norcross made a motion to reconsider the application of Self and grant Designation Option #2 (designation of Self Memorial Hospital as a Level III trauma center but with the understanding that the hospital will correct the problems noted and report them to the Committee within 90 days) until the QI program has had an opportunity to evaluate charts and illustrate the effectiveness of the program. Dr. Bell seconded the motion. The motion passed. A motion was also made and seconded that the minutes be clarified to reflect what was pointed out in the meeting but was not given in Dr. Norcross's report. The motion passed.

TRAUMA DESIGNATION STANDARDIZATION

The next topic for discussion was the presentation of draft documents designed to standardize the trauma center designation process. Dr. Bell had requested that the process be evaluated and changed based on many issues that had arisen during the past about the review process and the decision outcomes. The new process would become effective during the January 1997 application cycle, and for the 1996 site reviews which had not yet been conducted. Dr. Bell, Dr. DesChamps and Phyllis Beasley met in June and developed a proposal for the standardization of the process. The documents presented at this meeting were developed based on examples from Oregon, Florida and the Pennsylvania Trauma Foundation, adapted to meet S.C.'s needs. Dr. Bell turned over the presentation of the proposed documents to Ms. Beasley.

Ms. Beasley said that part of the standardization would be the requirement of a training workshop for all volunteers who wish to serve as team members. The workshop is proposed for September. Ms. Beasley passed out policy packets for trauma center designation site team members and went over the packet in detail with the committee.

- **Regarding the new recommendation that Division of EMS encourages the applicant hospital to arrange a consultation, at the hospital's**

expense, of a knowledgeable physician to review the hospital's trauma program prior to the site review. The physician which provides this service will not be a member of the hospital site review team and this service will be coordinated through the DHEC/Division of EMS.

- Discussion: Comments from the committee is that this section deserves a lot of interest. Some problems noted earlier with designations could possibly have been eliminated if this had been done. Is there protection for the person doing the consultation if he doesn't acknowledge something that the surveyor picks up on, or if there is disagreement between the two? Whoever does consultations will have to know what the process is. *Dr. Bell recommended that staff draft a legal document to protect the consulting physician.*
- **Regarding recommendations for data collection:** DHEC/Division of EMS will note to the trauma center applicants that the trauma registry software should be installed prior to the designation process. Applicant hospitals must have at least 100 patients entered in the registry.
- Discussion: Ms. Beasley said the Division of EMS is asking that the software be installed for 6 months (at least 100 patients). The committee clarified that the hospital must have at least 100 patients that meet the minimum criteria for inclusion in the registry; if they get those 100 patients sooner than within 6 months, then the site review can be conducted.
- A patient summary sheet was developed for use with each record during the site review process and will be used during the chart review process.
- **Regarding the site review and scheduling:** Changes include that all team members must have attended a site review team workshop sponsored by the Division of EMS in order to serve as a member of the level III designation review team.
- Discussion: What is a surgeon with in-depth trauma surgery experience? Someone who has attended the workshop and has experience dealing with trauma patients. Is a board certified emergency physician a physician certified in emergency medicine or a board certified physician who does emergency medicine? Physician has to be a board certified emergency physician.
- Regarding the site review: Clarifications include that as level III trauma center site reviewers are volunteer and only reimbursed for travel expenses and volunteers are limited within the state, the Division of EMS

cannot guarantee the availability of reviewers who are completely distanced from the hospital. At the conclusion of the site review the review team will thank the hospital for their hospitality and will use that final opportunity to clarify any remaining questions. None of the team's findings will be revealed at that time nor will the recommendations for designation be made by the team. Recommendations for designation or decisions not to designate are the sole responsibility of the Trauma Committee and the Medical Control Committee.

- Discussion: The philosophy is that the site surveyors are "fact finders." They will pass no judgment at the time of the survey as to whether the hospital is in compliance or not. The exit interview is designed to only clarify questions that may have come up, not to discuss the findings. The doctors agreed that a copy of the report will be given to the hospital prior to the meeting.
- **Regarding changes in the method of the site review:** The findings of the site review team are recorded on forms provided for medical review and designation criteria. The completed forms are collected at the end of the site review by the staff member. The findings of the team are summarized by staff and provided to members of the trauma committee and applicant hospital. The Trauma Committee makes an initial recommendation for designation which is then submitted to the Medical Control Committee immediately following the Trauma Committee meeting. The Medical Control Committee is also provided a copy of the summarized finding of the team.
- **Regarding an appeals process:** Ms. Beasley said there had been a few complaints regarding the lack of a formal appeals procedure, so there is now a written one in place.
- Discussion: Question asked if this gives the EMS Advisory Council the right to override the Medical Control Committee. The answer is yes since this is a sub-committee. Question asked of who on the EMS Advisory Council has the expertise of trauma systems to decide whether an override is appropriate or not. Mr. Fanning stated probably no one, but the Board is the same way. Suggested that someone with expertise is in attendance at the EMS Advisory Council meeting. *Ms. Beasley suggested adding to this section that the members of the site review team and the Medical Control Committee members will be notified of any appeals.*
- **Discussion regarding the timetable:** Point of clarification: Looks as if the Division of EMS is requesting that hospitals set up the registry around the 1st of March, then hospital is asked for review dates. This looks as if

hospital is not given six months to collect 100 patients. *Ms. Beasley will include in initial letter to non-designated hospitals saying if they intend to apply for designation, registry needs to be set up immediately.*

- **Regarding the outline of responsibilities for EMS and site team members:**
- The in-state review team for level III trauma center designation will be composed of three members: a surgeon with expertise in trauma, a physician board certified in emergency medicine, a critical care nurse with expertise in quality assurance.
- Suggestion: to change critical care nurse to a nurse with experience in trauma/critical care/quality assurance.

Changes requested for the designation criteria form and medical record review form will be forwarded to Ms. Beasley and addressed at the next Medical Control Committee meeting.

The Medical Control Committee agreed by consensus that there will be a mini workshop for the site review teams in September. Ms. Beasley asked that the Committee help solicit members for the site review teams.

CHANGES IN TRAUMA SYSTEM COMMITTEE

Dr. DesChamps and EMS staff have recommended that the 37-member Trauma Systems Committee be reduced to a working size committee. The Committee had been large initially to meet requirements of the trauma grant. The Committee had several smaller, working subcommittees. However, with the disappearance of grant funds, it is now proposed that one smaller trauma subcommittee of the Medical Control Committee be developed to address all trauma related issues. The proposal for this committee includes representation from all levels of trauma centers and other key representation. A recommendation was made to include a pediatric specialist. A suggestion was made to change the name of the Trauma Systems Committee to the Trauma Systems Subcommittee.

A final suggestion was to accept the list as is, not based on the individuals but the positions they fill, to change the two level III trauma registrars to one, an EMS regional director and add board certified pediatric specialist. Dr. Norcross and Dr. DesChamps will work on a recommended list to fill the positions on the sub-committee.

TRAUMA CENTER REDESIGNATIONS

Scheduling of redesignations was discussed. Ms. Beasley said this is an issue because redesignations were approved for every 2 years with the 6th year being the full designation. Ms. Beasley said there is a shortage of staff and the process is behind. Should the process be longer? **A motion was made that the new Trauma Systems Subcommittee develop a packet for the**

redesignation process with the assumption that no redesignations will be done prior to January 1997 calendar year. The motion was seconded. The motion passed.

STATE PROTOCOLS

Dr. Ringwood and Dr. Woolard addressed pediatric protocols developed by EMS-C committee. Dr. Ringwood stated that as soon as the committee puts the protocols into a final form, they would be presented to the Medical Control Committee. Dr. Gerard had no major changes to the protocols he's working on.

D50W FOR INTERMEDIATES PILOT PROJECT

Dr. Rogers presented the pilot project to allow EMT-I's to use D50W. Dr. Rogers said in the area of Lee County (Bishopville Rescue Squad and Lynchburg Rescue Squad) it is felt that they could increase the level of patient care for hypoglycemia, even though the units are BLS providers. The biggest concern Dr. DesChamps has is that intermediate EMTs have all of the skills for starting I.V.s but no drug agents have been moved down to this level, other than self administered drugs. **Dr. Phillips made a motion to approve the pilot project. The motion was seconded by Dr. Rogers. The motion passed. Dr. DesChamps abstained.**

DRUGS

The Committee began discussion of the drugs which were tabled from the April meeting.. Lidocaine jel was approved at the last meeting. Cetacaine topical anesthetic spray was placed on hold because of uncertainty for use of Cetacaine and Lidocaine. Mr. Smith said that a footnote was added to Lidocaine to inform that Lidocaine jel could be used in lieu of Cetacaine. Dr. Baker asked that Cetacaine be withdrawn.

The Lilly Cyanide kit was discussed. Dr. Baker said that maybe this could be a pilot project with services who have HAZ-MAT capabilities. Mr. Smith will give Dr. Baker the necessary paperwork to start the pilot project for the Cyanide kit.

Dr. Gerard presented Diltiazem which was resubmitted by Edgefield County EMS. Questions from previous discussions were: how was it to be stored since it was only good for 30 days, but now dual vials are available; how frequently would it be used and how expensive is it? Dr. DesChamps said that maybe the committee should think about developing a sub-committee to look at drugs in general. **Dr. Phillips made a motion to replace Verapamil with Diltizem for atrial defibrillation. The motion was seconded by Dr. Baker.** Time frame for removing Verapamil to allow all of the services to change the protocols, educate the paramedics, and include it on the ARRs. Dr. Baker asked the committee to consider the expense of the drug. **The motion was withdrawn. Dr. Phillips made a new motion to approve Diltiazem (but not replace Verapamil). The motion was seconded by Dr. Baker. The motion passed. Dr. Gerard made a motion was made to add Ativan (injectable, same indications as Valium, in the appropriate dosages) to the drug list. The motion was seconded. The**

motion passed.

The Medical Control Committee discussed the idea of two drug lists, one of which would include required drugs and one which would include drugs which would be local physician option. The purpose would be to have a list of drugs absolutely essential for resuscitative procedures. There would then be a state-approved list from which local physicians may pick the drugs to use at their local service. Dr. DesChamps said the paramedic would have to learn the core drugs and whatever drugs local physician requires them to have. Mr. Smith's concern is that the paramedics aren't really learning the interfacility drugs and feeling inundated with the prehospital drugs.

Another suggestion in lieu of the core list was to get rid of the drugs that are not used a certain number of times a year statewide.

Dr. Ringwood asked if there is a committee that focuses on the drug list specifically and expressed a concern on the amount of time the Committee spends on this particular agenda item.

Dr. Norcross made a motion to not develop a separate local physician option and core list, but instead appoint a sub-committee to look at the present drug list and delete those drugs not necessarily used, and to assure that members from the EMS-C Committee serve on this sub-committee for pediatric input. Dr. Rogers seconded the motion. The motion passed.

Dr. DesChamps appointed the annual drug re-review committee: Dr. Baker, Dr. Sorrell, Dr. Woolard, Dr. Ringwood and Alonzo Smith.

Liberalized aspirin to EMT-B was discussed. A question was raised whether or not to allow EMT-B to utilize aspirin in chest pain suspicious of myocardial origin. The Committee decided not to address this question until a formal request is sent in.

DRUG ADULTERATION

No new studies or other informational items were noted.

NHTSA ASSESSMENT

Mr. Fanning addressed some of the highlights of the NHTSA Assessment of EMS. NHTSA made recommendations which included that EMS have some kind of uniform system for testing for certification and an improvement for system of data collection (rather than key one service's run reports for one month keying should be more random).

Mr. Fanning said that EMS has applied for grants for training First Responders, improving data systems and prevention.

Ms. Beasley passed out a copy of the after-action plan for the assessment sections regarding facilities, medical control, and the trauma system. She said that many of the actions related to

the recommendations are already underway or completed.

ADDITION OF MCP REFRESHER COURSE

In the course of the discussion of the NHTSA Assessment recommendations, Dr. DesChamps said that he and Mr. Fanning are looking into upgrading the workshop at the symposium with some input from ACEP.

FIRST RESPONDERS

Mr. Fanning stated that a committee is being developed to start the regulations for implementation of the First Responder legislation that has been passed.

With no further discussion, the meeting was adjourned. The next Medical Control Committee meeting will be scheduled for September, prior to the September 12 EMS Advisory Council meeting.

MEDICAL CONTROL COMMITTEE

Wednesday, September 11, 1996

MINUTES

<u>Members Present:</u>	<u>Others present:</u>
Ed DesChamps, MD, Chairman	Joe Fanning
Richard L. Rogers, MD	Phyllis Beasley
John F. Sorrell, MD	Deborah Woolard, MD
Richard M. Bell, MD	Freddie Andrews
Doug Norcross, MD	Judy Jones, RN
William C. Gerard, MD	Doug Warren
	Eric Weinstein, MD
	Hart Smith, RN
	Diane Howell, RN
	Lynn Nadeau, RN
	Cindy Lee, RN
	Wilma Powell, RN
	Andrew Donato, MD
	Lorri Gibbons, RN

Dr. DesChamps began the meeting by asking for a review of the minutes of July 10 for approval. **A motion was made to approve the minutes. The motion was seconded. The minutes were approved.** (Later it was noted that a change should be made on Page 6--in the motion to approve Diltiazem, change "defibrillation" to "fibrillation.")

PHYSICIAN LICENSURE FOR NARCOTIC DRUGS

Dr. DesChamps introduced a representative of DHEC's Bureau of Drug Control, Barbara Boyd. Ms. Boyd was in attendance to answer questions related to the licensure requirements for medical control physicians who allow their services to use narcotic drugs. Among the points Ms. Boyd made were:

- All county EMS drug registrations need to be in the name of the medical control physician and that physician delegates authority to dispense the drugs.
- If there are separate services under the supervision of the medical control physician, but they are all county-related (same county), then the physician only needs one license
- The medical control physician must have separate licenses for each different private service he supervises.

- If a medical control physician leaves a service, he should notify the Bureau of Drug Control and his registration is null. However, he may issue a power of attorney so that someone else in the service can issue the drugs. (The Bureau of Drug Control should also be notified of address changes.)
- The medical control physician is responsible for accounting for all the controlled drugs used by the service. He must keep close records documenting including the “in’s and out’s” of the drugs, the quantities distributed and used and the dates when used.
- If a service’s controlled substances have exceeded their expiration dates, the physician should contact the Bureau of Drug Control to have the inspector for that area destroy those drugs.

Dr. Sorrell asked what the procedure would be for destruction of a 10mg vial of morphine if only 2 mg. were used; would the physician have to keep that partially used vial? Ms. Boyd said that the physician could destroy that small an amount but it should be destroyed in the presence of two other persons and document the event with witnesses and keep that record on file.

Dr. Sorrell also commented that he used to keep all the federal forms, in particular, with him at his home as a matter of protecting the information. However, he was told that the forms should be kept at the service. He felt that he had less control over the forms and drugs this way. Ms. Boyd confirmed that was correct, especially as the federal forms were concerned. She added that in some instances, such as a long distance between the service and the location of the medical control physician (i.e. service in Walterboro, physician in Edisto Island), an exception to keep the forms with the physician could be made.

There were no further questions.

TRAUMA ISSUES

Dr. Norcross, Chairman, presented the report of the Trauma System Committee. He announced that the Trauma System Committee was recently revised to decrease its number to a more “workable” size, with representation from all appropriate areas.

The Committee revised the designation options to accommodate instances of designations after a second review (which had formerly kept a hospital from being designated). Statements were added to allow hospitals to fall into Options 1, 2 or 4, but after a re-review the hospital could not be put in Option 3 again. Under Option 3, the statement was added “At the time of re-review, the hospital may be categorized according to Options 1, 2, or 4.” (See attached.) Under Option 4, the phrase “and the hospital must submit a new application at the next application cycle in order to be reconsidered” was added. (See attached.)

Dr. Sorrell made a motion to accept the changes to the designation options. Dr. Gerard seconded the motion.

Dr. Weinstein asked what would happen if, under Designation Option 2, a hospital did not correct the problems noted within the 90 day deadline. Dr. Norcross responded that the intent of that option is that the hospital must correct the problems in order to remain as a designated trauma center, but the issue may need to be addressed further.

The motion was approved.

Dr. Norcross then presented the Trauma System Committee's recommendations for designations of Carolinas Hospital System and McLeod Regional Medical Center.

The Trauma System Committee recommended that Carolinas Hospital System be given Designation Option 1: "To designate the hospital as a Level III trauma center. The hospital has everything required and is designated with no questions or problems." Dr. Sorrell made a motion to accept the recommendation. The motion was seconded by Dr. Bell. The motion passed, with Dr. DesChamps abstaining.

Dr. Norcross then presented the recommendation for designation of McLeod Regional Medical Center. The Committee's recommendations were based on the results of the site team's report and discussion in committee regarding transfer issues. The Trauma System Committee determined that McLeod Regional Medical Center should be designated as a trauma center, but with certain issues that must be resolved within 90 days. The Committee felt that there were still questions regarding delays in transfers from outlying hospitals and that quality improvement was not addressing key issues. The issues of inadequate nursing documentation were documented in the site team's report.

Dr. Sorrell made a motion to accept the recommendation that "McLeod Regional Medical Center be designated as a Level III 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/improvements. The problems are: 1) the hospital should continue to work on improving nursing documentation; 2) the hospital should continue to work on improving surgical expeditious involvement in trauma care and increasing surgical trauma CME activities; 3) the hospital should ensure that the surgeons are more involved in the QI process. Dr. Bell seconded the motion. The motion passed. Dr. DesChamps abstained.

Dr. Norcross then reported that there are two hospitals which have submitted their trauma center applications: Kershaw County Medical Center and Piedmont Medical Center. These hospitals will be reviewed before the end of December, following the training of site reviewers at the newly required site reviewers' workshop. The first site reviewers' workshop is scheduled for Wednesday, October 16 from 10 a.m. to 2 p.m. Ms. Beasley said that enough nurses have signed up, but she could use the Committee's help in recruiting more emergency physicians and surgeons.

Dr. Norcross then discussed the Trauma System Committee's recommendation to require EMS services to develop written trauma transport protocols. In light of the state's efforts to formulate regional trauma plans and ensure appropriate transport of trauma patients, the Committee agreed

that this was an appropriate recommendation. **Dr. Bell made a motion to accept the recommendation “to mandate that all EMS services have written trauma transport protocols and that they be included with all other protocols for submission to the state office, with copies sent to the EMS regional offices for inclusion in the regional plans.” The motion was seconded. The motion passed.**

PROTOCOLS

Dr. Gerard was unable to present the Committee with the updated adult protocols. He explained that a resident who had been working with him on changing the protocols has left and the protocols were in MacIntosh format. He is having difficulty transferring the files to IBM format.

Dr. Woolard presented her copies of the pediatric protocols. These had already been reviewed and approved by the EMSC Committee. Dr. Woolard reviewed several minor corrections/changes which still needed to be made in the protocols. Those changes were simply the additions of “yes” or “no” answers by the arrows following “duration >15-20 min?” on Pediatric Seizures and “yes” or “no” answers by the arrows following “Serious injury? Burns?” on Pediatric Shock/Hypotension.

Mr. Warren asked if the pediatric drug dosages have been aligned with the state drug list? Dr. Woolard said no, but said that the EMSC recommends that a review be conducted. She said that the Committee elected to go ahead and include the drugs on the protocols. She said that the Committee wants to include Motrin as a potential oral analgesic/antipyretic for children in long transports. She said she knew that neither Motrin nor Tylenol were on the state drug list for children. She said that Toradol was an IV non-narcotic drug which the Committee recommends should be considered for inclusion on the drug list.

The Medical Control Committee asked that Dr. Woolard present a list of the changes which would be needed in the state drug list to make the pediatric protocols complete. The Committee agreed that the protocols should not be distributed until the drug requirements had been evaluated and until the adult protocols could be completed.

PEDIATRIC EQUIPMENT LIST

Dr. Woolard then presented the EMSC Committee’s recommended pediatric equipment list for ambulances. The list has already been to the Equipment and Standards Committee. **According to Dr. Woolard, the EMSC Committee feels strongly that pediatric bag valve/mask, pediatric masks (4 sizes), endotracheal tubes (2.5 - 6.0mm), pediatric non-rebreather mask, intubation stylet (6 fr.), laryngoscope blades (0,1,2 straight), suction catheters (6, 8, and 10 fr), and rigid suction tip (eg Yankaur) should be required equipment.** They are currently listed as suggested equipment. These pieces of equipment should be included on both BLS and ALS lists. **Laryngoscope blade (2 curved) should be added as optional on ALS and BLS. Dr. Woolard said the Committee also recommends adding a thermometer and end-tidal CO2 detector on the suggested list.**

The Medical Control Committee determined that PASG (pediatric) should be moved to

optional. The Committee also said that intraosseous needles (14-18 ga.) should be required.

There was discussion that even though a services BLS personnel are not intubating, the equipment should still be required because the equipment should always be available in case a physician or advanced personnel were available to perform an intubation. However, it was decided that the intubation equipment should only be required for a BLS service, if their BLS personnel are allowed to intubate.

Dr. Bell made a motion to send this amended pediatric equipment list to the Equipment and Standards Committee with a strong endorsement of support from the Medical Control Committee. The motion was seconded. The motion passed.

EMERGENCY MEDICAL DISPATCH

Dr. Weinstein presented a paper he wrote emphasizing the lack of medical training for dispatchers and the lack of physician involvement in training and quality improvement for dispatchers. He emphasized the importance of proper dispatching, i.e. the right ambulance to the scene promptly and the need for good first responder information over the phone.

Mr. Warren explained that he had just received a copy of the 40-hour dispatcher curriculum from the Criminal Justice Academy and the recommendations submitted by him and Alonzo Smith had been changed substantially. He has not had a chance to completely review and analyze the curriculum and would like to do so before presenting a summary to the Committee at its next meeting. Dr. Weinstein asked DHEC certification for dispatchers was required. The answer is "no."

There was much discussion about what authority DHEC has to required medical training or certification. Many of the requirements and the role of EMTs are set by local authority.

Dr. Bell asked Dr. Weinstein to define the problem. He said that, generically, people need to know what they are doing. He suggested that specific problems should be defined; are bad decisions for dispatch being made? This information is necessary if we are going to convince other agencies to make changes. Dr. Sorrell suggested that decisions on whether to send BLS or ALS are less important than learning the skill to get the right information from the call and to learn to use pre-arrival instructions. Dr. Sorrell and Mr. Warren emphasized the need to gather appropriate information to avoid problems with running lights and sirens unnecessarily and dangerously.

Mr. Warren said that he is convinced that if we emphasize it strongly enough, changes can be made in the curriculum to increase the amount of medical training. Mr. Fanning said that numerous pleas have been made and promises given and the training was still not emphasized. He was less certain of DHEC's ability to effect a change.

Dr. Bell asked Doug Warren to review the dispatch curriculum and bring a summary back to the Committee as a point of information. Then the Committee can develop a recommendation to

present to the appropriate persons at the Academy.

PILOT PROJECT: TRANSPORT OF PATIENTS ON INTEGRILIN

Lorri Gibbons, RN, coordinator of the project explained to the Committee that Lexington Medical Center is participating in a study of the use of the drug Integrelin for unstable angina in patients being transported from Lexington to Providence Hospital for definitive care. They are asking permission to transport patients using this non-FDA approved IV drug.

The Committee explained that Lexington Co. EMS would not need permission to transport the drug if the hospital sends a nurse with the patients that are transferred. This would save much time in dealing with the bureaucratic process and having to receive approval for a non-FDA approved drug through the DHEC Board. Ms. Gibbons agreed this would be the best way to handle this.

LIGHTS AND SIRENS

Dr. Weinstein passed out a paper regarding the use of lights and sirens from the National Association of EMS Directors and the National Association of Emergency Medical Service Physicians. He asked that it be put on the agenda for the next meeting.

TRAUMA REDESIGNATION INFO

Dr. Bell asked about the paper passed out with dates on proposed hospital redesignations. Dr. Norcross explained that this was considered at the earlier Trauma System Committee and the numbers (dates) were not relevant; they had been considered at one time. He explained that the issue of redesignations needs to be reconsidered because of the changes in trauma funding and staffing. He said that this issue and options will be considered by a subcommittee of the Trauma System Committee.

Dr. Bell reported that he felt that the new chart review process practiced at Florence went well and will only need minor changes.

Mr. Fanning apologized for not having ambulance run report data available for the Committee as promised. He explained some staffing and data difficulties which prevented the production of the reports. *He said that data would be available for the next meeting.*

Dr. Bell asked if Ms. Beasley had received clarification from Pennsylvania about the designation decision making process. She said she had not written yet, but it was “on her list.”

Ms. Beasley added for clarification a point from the discussion of the last meeting that Verapamil is not on the state drug list, but it would not affect the motion to approve Diltiazem. Dr. DesChamps pointed out also that the motion for Diltiazem should be changed to read “for atrial fibrillation” not “defibrillation.” Ms. Beasley agreed to make that change.

With no further discussion, the meeting was adjourned.