NASEMSO Model EMS Clinical Guidelines Project

November 14, 2016
1:00 PM EST
Work Group Meeting

Meeting Record

Attending – Carol Cunningham, Rich Kamin, Harry Sibold, John Lyng, Julio Lairet, Susan McHenry, Manish Shah, Doug Kupas, Mary Hedges, Jeff Jarvis, Joe Nelson, Allen Yee

Call to Order, Roll Call – Dr. Carol Cunningham called the meeting to order at 1:06 pm.

Review September 12 Meeting Record – The September 12 meeting record was approved as submitted.

Work Group In-Person Meeting Discussion – Carol noted the budget is very limited and that efforts will be made to cover travel expenses for those who have no other means of covering the cost. Her State EMS office contractually covers her travel to the NAEMSP Meeting, so she will not ask for travel reimbursement. Dr. Jeff Jarvis said his hospital would cover the travel but he wanted information on the reduced hotel rate. The link to the hotel is included in the documents sent with today's meeting notice, but Mary will send another email with the informatmon. The workgroup will meet:

- Saturday, Jan 21, 7:00 – 9:00 PM
- Sunday, Jan 22, 8:30 AM – 5:00 PM
- Monday, Jan 23, 8:30 – 11 AM (if needed)

Carol reminded everyone to let Mary know if attending and if travel support will be needed. **Action:** RSVP to Mary and, if needed, submit expense application to Mary by Nov. 20.

Baseline Assessment of Model EMS Guidelines – Mary Hedges reviewed the responses to the two surveys. The first survey was sent to those who requested a Word copy of the document (approximately 70 over 2 years). Twenty responded to the survey. The second survey was sent to the state and territorial EMS offices; 30 responses were received. **Action:** Mary will prepare summary of the baseline assessments and share with the workgroup about one week before the baseline assessemt is due to NHTSA on December 8.

See Links to Baseline Assessment (Survey Monkey) Responses

For those who requested the Word document:
https://www.surveymonkey.com/results/SM-XJ27PH9N/

For State EMS Offices:
https://www.surveymonkey.com/results/SM-J5MY6H9N/

Review of Comments (continued from last two meetings) – The workgroup reviewed and made decisions on the following comments received.

Tachycardia "with a pulse" is redundant - "Tachycardia" – *This is from ACLS. Do not remove it.*
Add "Traumatic Arrest" – *This is addressed elsewhere (under cardiac arrest or trauma).*
"Altitude Sickness" and "Altitude Illness" seem redundant – *The workgroup did not see a need to amend the title of this chapter*
"Dead on arrival" and "Determination of Death/Withholding" seem redundant – *The workgroup did not see a need to amend the title of this chapter.* Add "Rapid Sequence Intubation" and decision trees a.la. Welles "Emergency Airway Management" – *Doug Kupas and others said we make an important statement by not including RSI.*
Add Ventilator Management – *Allen Yee said there may be a need for post-invasive airway management. It was decided to include ventilatory parameters and not discuss specific management of the ventilator.*
Comments from Ian D Berghorn, Paramedic, Windsor EMS, US Army, CT (speaking as individual)

I think there needs to be a distinction between diagnostic pathways and therapies. This document (like most EMS protocols) seems to use them interchangeably. You should have the diagnostic pathways (patient with inadequate blood glucose, patient with myocardial infarct, patient with burns) in the first section and link them to the therapeutic guidance (e.g., managing pain, managing inadequate ventilatory effort, managing bronchoconstriction, managing inadequate coronary perfusion, managing re-entrant dysrhythmias, etc) in the second. That would eliminate a lot of repetition throughout the document.

Carol pointed out that when links are included, it may not work well when harvesting out a section. Rich added that linking works well when using the document electronically, but many are still using a hard copy in a 3-ring binder. Also, electronic links do not work well in disasters. John Lyng said electronic devices are increasingly used and the more we can eliminate reduncancies, the better and more palatable it would be. Also, it makes the review and revision process much more difficult if it is in multiple places. Alhough we may not be ready to change the format, it may be helpful to decrease redundancy by increasing reference from one place to another in the document.

Comment from Scot Phelps, Paramedic x 29 yrs, Attny, Ambulance Science Fellowship Program, NY (speaking as individual)

Should LVADs and other external cardiac devices have a guideline or are they covered elsewhere in the guidelines? There is variable in the way information is presented to EMS in regards to treatment options based upon who teaches the class. Having a standardized approach may be beneficial.

Comment from John Spencer, Paramedic, CT DPH OEMS (speaking as individual)

LVAD - Care for LVAD (left ventricular assist device) patients. We have several of these patients in our service area.
Allen said there will be some guidance issued shortly in Circulation on LVAD devices. The workgroup decided to wait until the new information is published.

BLS Patient - Another item is some guidance for crews to use in determining when a patient can be considered a BLS patient. In our service area we have some of our units staffed with a paramedic and an EMT. The question, which is very gray, is when can the paramedic let the EMT attend on the

call. *Workgroup will not address Paramedic to EMT. The states have legislative authority to determine the staffing of EMS units, and there is wide variation on the minimum staffing required.*

Comments from Randy Bloom, Paramedic, Emergent Health Partners, MI (speaking as individual)

Care of patients in Hospice - I would propose developing guidelines for the care of patients in Hospice, emphasizing the pre-identification of Hospice patients in a community, establishing policies around the use of oral medications in "hospice care packages" by EMS, and establishing protocols for communication and coordination between EMS and hospice agencies.
Allen recommended something more general about end-of-life care because it varies significantly among states. Rich pointed out the guidelines currently address it slightly; there is concern that any more would be controversial because of hospice care transitioning to the realm of community paramedicine. In addition, states determine the parameters of the care provided under the umbrella of hospice, and any guideline may conflict with state legislation.

Comment from Dr. Kevin Munjal, Mount Sinai Health System (speaking as individual)

EVD patients - I'd recommend under the exposure-biologic/infectious dedicate a section specifically to handling of EVD patients.
The workgroup suggested we may want to include something generic. The focus may be best directed toward situational awareness and the need for a heightened level selected PPE dependent upon threat and the risk assessment in the region where EMS is providing care. Mary pointed out that NASEMSO is beginning a new HRSA-funded project dealing with transport of high consequence infectious disease.

Paul Roszko, MD, US Navy, VA (*speaking as individual)*

Eye Emergencies and Mobile Integrated Healthcare guidelines should be considered.
Eye trauma has already been addressed. The workgroup decided to omit any guidelines related to community paramedicine because it is still being developed.

Brian Barhorst, MD, Porstmouth Ambulance, OH (speaking as individual

Adjourned – The meeting adjourned at 2:12 PM EST.

Next Meeting – December 12