01/18/2018 EPAB Board Meeting Minutes

Attendees:

Voting Member	Represents	Jan 18	Mar 22	May 24	July 26	Sept 27	Dec 06
Chris Bolton	Baylor All Saints	☑	☐	☐	☐	☐	☐
Daniel Guzman	Cook Children's	☐	☐	☐	☐	☐	☐
Anant Patel	JPS	☐	☐	☐	☐	☐	☐
Rajesh Gandhi	JPS (Trauma)	☐	☐	☐	☐	☐	☐
Holly Baselle	MedCtrAlliance	☐	☐	☐	☐	☐	☐
Alana Snyder	MCFW	☐	☐	☐	☐	☐	☐
Steven Martin	TCMS	☐	☐	☐	☐	☐	☐
Gary Floyd	TCMS	☑	☐	☐	☐	☐	☐
Dan Goggin	TCMS	☑	☐	☐	☐	☐	☐
Angela Self	TCMS	☐	☐	☐	☐	☐	☐
Brett Cochrum	TCMS	☐	☐	☐	☐	☐	☐
John Geesbreght	THR - FW	☑	☐	☐	☐	☐	☐
Brad Commons	THR – Alliance	☐	☐	☐	☐	☐	☐
William Witham	THR (Trauma)	☑	☐	☐	☐	☐	☐
Shawn Sanderson	THR - Huguely	☐	☐	☐	☐	☐	☐
Michelle Beeson	THR - SW	☑	☐	☐	☐	☐	☐

Attendee	Representing	Attendee	Representing	Attendee	Representing
Douglas Hooten	MAEMSA	Ken Simpson	MAEMSA	Kristin Wilson	THFW
Amanda Robbins	FWESC	Kate Colquitt	TCPH	Michael Farris	CareFlite
Matt Zavadsky	MedStar	Kristofer Schleicher	MedStar	Page Carter	CareFlite
Joan Jordan	MedStar	Richard Brooks	MedStar	Desiree Partain	MedStar
Dwayne Howerton	OMD	William Gleason	OMD	Veer Vithalani	OMD
Casey Davis	BFD	Perry Bynum	HCFD	James White	HCFD
David Davies	OMD	Jason Cearley	FWFD	Neal Richmond	OMD
Laura Long	OMD	Brian Miller	OMD		

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1. Opening - Dr. Floyd
    a. Meeting called to order at 12:45
        i. Proxy votes to Dr. Bolton from Dr. Patel and Dr. Martin
        ii. Proxy votes to Dr. Geesbreght from Dr. Commons
        iii. Proxy votes to Dr. Floyd from Dr. Guzman
2. Review of Minutes - On hold so we can start and give additional members time to arrive
3. Community Reports
    a. Public Health - Catherine Colquitt
        i. Flu season -
            1. Vaccine will help to mitigate flu if contracted.
            2. CDC has information on their website
            3. Asking that it be treated immediately and not to stop treatment if testing says it isn't the flu
    b. EOC -No Representative available
    c. FRAB- Chief Davis (Burleson FD)
        i. Trial of tablets in Burleson is going well.
        ii. Saginaw should start trial soon
        iii. Fort Worth has extended their trail another 6 months to give their IT time to work through a few issues
    d. MAEMSA / MedStar - Doug Hooten
        i. Finished the financial audit with no issues. Will be discussed further in the next MAEMSA meeting
        ii. New Center up north in the next five years
        iii. New ambulances will start arriving in March
        iv. Changes in Temperature and Flu season have been keeping us busy
4. Executive Board Report – Dr. Floyd
    a. The executive board met, but did not vote on any issues
5. Financial Report – Dr. Floyd
    a. Review of the provided report
6. Medical Directors Report
    a. Quality Assurance Review - William "Buck" Gleason
        i. Sentinel Events Reviewed
        ii. Disposition Reviewed
        iii. System Improvement Trends
            1. STEMI Recognition and ACS Protocol
            2. Cardiac arrest management
            3. Spinal Motion Restriction protocol
            4. AMA/RAS Protocol
            5. Advanced airway management
        iv. Monitor fatigue is being work through. New monitors alarm so often that they are not as effective.

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v. The new software doesn't allow for the quick report card to be sent back to the crew. We are working on a way to send the crew feedback fasters.

b. Training and Education - David Davies
   i. 3 milestones based on certification and credentialing of provider
   ii. Completed weekly by candidates and FTO
   iii. Reviewed and verified by OMD at two-week meeting
   iv. 5 Major Competency Categories
   v. 21 (Tentative) Sub-competency Categories
   vi. Produces an overall picture of functioning at credentialing level
c. MIH Updates - Dr. Richmond
   i. Compliance (Is graduation after 30-90 days a function of compliance with the program?)
   ii. Program management and follow-up
   iii. Were MIH visits kept?
   iv. Were PCP visits kept?
   v. Were PCPs available for consultation?
   vi. Was there compliance with medications?
   vii. Patient self-report
   viii. Medication inventory (pill count, RX refill)
   ix. Is there compliance with dietary recommendations?
   x. Patient self-report
   xi. Food inventory
   xii. Are there other contributing compliance factors?
   xiii. Quality of Care: clinical program effectiveness and safety (Is graduation after 30-90 days a function of quality of care?)
   xiv. Were symptoms/signs appropriately evaluated?
   xv. Vitals, SpO2 and EtCO2, weight, SOB/DOE, edema, exercise capacity, orthopnea/pnd
   xvi. Were iStat measurements appropriately performed and abnormal values addressed?
   xvii. Were EKGs performed for abnormal sx/signs, and were abnormal findings addressed?
   xviii. Were patients treated as per protocol?
   xix. Diuresis
   xx. Potassium supplementation
   xxi. Other
   xxii. Was there appropriate follow-up?
   xxiii. We need to look into what we are going to do as a system for these individuals.

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d. Lift assist - Dr. Vithalani
    i. Patient assessment

History

ii. Attempt to speak with the patient and/or whomever called 911, as well as any family, friends, bystanders, patient surrogates, or guardians and/or medical personnel on scene
iii. Obtain a history of present illness, including circumstances leading to the need for the lift-assist
iv. Evaluate past medical history, including risk factors and the use of medications that may pertain to the current request for assistance.

Physical

v. Obtain vital signs and perform a physical exam
vi. Decisional Capacity
vii. Develop a differential diagnosis specific to the patient presentation
viii. If there is a high index of suspicion for illness or injury, and if the patient refuses medical treatment and/or transport, explain the risks and consequences of refusing treatment and/or transport at the patient's level of understanding, based upon the differential diagnosis
ix. Protocol Pearls
x. Patients, patients guardians, or patients health care surrogates must demonstrate decisional capacity in order to make an informed refusal of consent for treatment and/or transport
xi. A patient's decisional capacity may be impaired as a result of, but not limited to, the following:
xii. Use and/or abuse of alcohol, illegal or prescription drugs, or toxic substances
xiii. Head trauma, dementia, encephalopathy, and/or mental retardation
xiv. Acute or chronic psychiatric illness
xv. Medical illness including, but not limited to, the following: hypoxia, hypotension, hyperglycemia, hypoglycemia, dehydration, and sepsis
xvi. If patient lacks decisional capacity, and refuses treatment or transport:
xvii. Ensure provider safety first and foremost
xviii. Contact Field Supervisor and/or OMD/OLPG as necessary
xix. Next steps include coming together as a system to defining what we are all going to do on most of these calls, then looking at these charts to see what happens to these patients.
xx. Dr. Floyd - While it does create additional work for the system, this is one of the aspects of what we are here for. Nationally the mobile healthcare cases are being scrutinized, and we may need to start looking at how to get these individuals educated about their illness.
xxi. M. Zavadsky - As discussed in system performance committee, when does a person become a patient? When does a lift assist need an assessment?
    1. Is it every time?
    2. A specific number of time?

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xxii. Dr. Witham –
   1. Are we proposing that every lift assist get vitals and a little H&P? Yes, that is in the protocol.
   2. Will that put them in the system to make this easier to track? Yes

xxiii. Chief Davis (Burleson FD) - 80% of their calls are EMS, and are trying to educate and update their system accordingly

xxiv. Chief Cearley – (Fort Worth FD) is working on updating their systems and training for the additional work being added to the FROs

7. Minutes reviewed and approved

8. Adjournment:
   Meeting was adjourned at 14:00 by Dr. Floyd. The next general meeting will be at 12:30 on 03/22/2018.

Minutes submitted by: Laura Long