OFFICE OF THE MEDICAL DIRECTOR
EMERGENCY PHYSICIANS ADVISORY BOARD

07/26/2018 EPAB Board Meeting Minutes

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
Michael Farris	CareFlite	Chad Carr	MAEMSA	Austin Cox	OMD
Casey Davis	FRAB / BFD	Kristofer Schleicher	MAEMSA	Rick Freeman	OMD
Jason Cearley	FWFD	Desiree Partain	MedStar	Kier Brister	OMD
Robert Barton	FWFD	Desiree Partain	MedStar	Laura Long	OMD
Catherine Colquitt	TCPH	Joan Jordan	MedStar	Veer Vithalani	OMD
Orianna Nibarger	THFW	Richard Brooks	MedStar	Bret Paterson	OMD
Robert Genzel	THR	Amanda Robbins	THFW	Michael Newberry	OMD
Gan Su	MCFW	Daniel Ebbett	MedStar	Lourdes M Rodrigues -Lugo	FWOEM
Scott Keenum	FWPD	Steve Dean	FWPD		

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I. Opening - Gary Floyd
   A. Called the meeting to order at 12:35
   B. Roll Call of Voting Members
      1. Proxy votes:
         1. Anant Patel - Robert Genzel
         2. Rajesh Gandhi - Moore or Johnson (neither present)
         3. Alana Snyder - Gan Su
      2. Not present for roll call but arrived during the meeting
         1. William Witham
         2. Dan Goggin
   C. Minutes reviewed and stand approved with no corrections - No opposition

II. Public Heath - Catherine Colquitt
   A. There has been an uptick in Murine Typhus from fleas on rats and feral cats
      1. Non-descript illness with rash
   B. West Nile cases
      1. Remind everyone about mosquito control measures

III. Emergency Management Department -Lourdes M Rodrigues -Lugo
   A. Working with the hospitals for the emergency simulation exercises and programs
   B. Visiting long term care facilities to help them with CNS regulations and disaster planning / headcount
      1. . Richard Brooks from MedStar has created a tool to assist MedStar and OEM sharing data from these facilities.
      2. Question: Is the information posted somewhere in the building for Fire Departments? No, It is only internal and shared with OEM. It contains personal information such as cell phone numbers.
      3. Question: If fire gets called to a building shouldn't they know? What about the headcount? Richard Brooks will look into it.

IV. FRAB - Casey Davis -
   A. Have not met since April, next meeting in August
   B. EPCR project is still moving forward
      1. Burleson is still up and operational
      2. Haltom City is testing the system
      3. Saginaw is operational and using it for 100% of the EMS calls
      4. Fort Worth Fire is looking into a pilot with Image Trend directly
   C. Lift assist pilot project report
      1. Staff was trained in early June with the program starting June 7th.
         1. Focused training -
            i. Adjust thinking about these calls from a utility call to a patient call
            ii. Worked with MedStar and OMD to create a patient care chart in the image trend program that would help answer specific questions on whether or not the patient needed to be transported or if they were a true AMA.
            iii. Training on decisional capacity and judging that during their assessment of the patient.
            iv. Preventative type things like looking for loose rugs, nonslip shoes or socks, using a walker, and different things they might be able to fix quickly in the short term
      2. When the program went live fire sat down with the police department, who runs the dispatch center, and explained to them what was being done, which in turn had them looking internally

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to update which calls would go to the EMD. Upon starting the program the EMD calls went up and the lift assist calls went down. This change means that the calls that get EMD'd and get an ambulance much quicker, so the patient will get the care that they need much quicker.

3. It's still early in the program, but so far there have been 51 of this type of call, with about half being a true lift assist and half being transported or AMA'd
4. Reviewed an interesting case that this allowed them to find. Septic patient, didn't realize how sick they were, and called for a lift assist. The crew checking the vital signs found they needed to be transported. Getting the patient the help they needed much quicker than if the call had been treated as a utility call.
5. It is taking about 10 minutes for the crews to go through these new steps, but it is not really showing to increase their task times.

V. MAEMSA / MedStar - Kristofer Schleicher & Joan Jordan

A. The MAEMSA board has not met since the last EPAB meeting
B. Work continues on finalizing the contracts for the purchase of property for the two deployment centers, North and South. Those will hopefully go before the MAEMSA board in the August meeting.
C. New ambulances are on their way with four arriving any day now
D. In the midst of the budgeting process which Joan will say more about.
   1. The budgeting is ongoing
   2. The annual work shop for the MAEMSA board and the EPAB board will be on the 15th at 8:00 am at the Fort Worth Club
   3. It will then get approved by the MAEMSA board at the August meeting on the 22nd.
E. Question: The building of the centers, North and South, does that money come from reserve funds?
   1. Actually it's through a finance the property in the south, we are not sure. It's not very expensive, the property we are looking at, it's not expensive will be financed out of cash. The rest will be financed.
   2. The board approved a loan package of twenty million dollars to use for the deployment centers and the entire new fleet that we are getting in the next five years. We will use some of that for that purpose, we have not decided exactly when or how.
F. Question: Does that go before the member cities?
   1. No, it just goes before the board

VI. Executive Committee Report - Gary Floyd

1. Met with members of the MAEMSA board occurred on Friday the 15th, at which time your executive committee proposed a compromise to the plan to terminate contract or allow the contract to expire September 30th of our Medical Director. We proposed to reinstate that for twelve months to set up appropriate plans to the issues that have come forward since that action was taken. In the three meetings we have heard several different issues and we proposed a plan to do that. That plan was rejected on the 16th. So now the executive committee is trying to meet to decide what next, where do we go. Dr. Floyd was sent an email from MedStar on behalf of Chairman Byrd asking about the transition and transition plan so we are going to have a closed meeting to discuss the duties and reassignment of duties as soon as we get through the business of this to close meeting to discuss duties, what do we do in the interim period, before we take any steps that way.

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VII. Financial Report - John Geesbreght

1. Review of the provided report showing expenses are under budget and the trend shows that we will be under budget for the year again this year, as we usually are.

VIII. Medical Directors Report - Neal Richmond

1. Budget
    1. August 15th there will be a meeting to discuss the budget. We don't know how those discussions will go but we can go over our proposed budget. If this board approves, we can offer that up, since the ordinance says this board will prepare a budget for review.
    2. We will have an August meeting on a Thursday after that meeting we will have an EPAB meeting to discuss the budget since it will not wait until the September meeting.
    3. Review of the handout and the breakdown of the 3.2% increase, the majority of which is for standard cost of living increase for the staff. The executive committee has reviewed the details and has found this to be in line with the current year's budget. Vote to approve moving forward with this budget to the MAEMSA meeting in August and to allow the executive committee to discuss further revision if needed as result of those meetings. Stands approved - unanimously. Details are in your packet if you would like take them home for review.
    4. Capital proposals - video laryngoscopy, updated sim equipment, and mechanical CPR devices
2. Office staff lost another individual, we are now down three individuals in OMD.
3. Time taken to credential individuals in the system is still trending down.
    1. Question: We keep training and training and training new medics for the system, but it is reported that our separation rates are quite low, so our system hasn't put that many more trucks out in the field. Do we have any idea how many of our medics are one to two shift part timers? Compared to full timers? Can you get that number for us?
        a. Dr. Richmond - In the last MAEMSA meeting separation rates were discussed as dropping from 25% to 15% so it would be a good thing to discuss with the board on how those numbers are calculated. Joan? Do you have those numbers?
        b. Joan Jordan - Not of the top of my head, I don't.
        c. Dr. Richmond - It is not something that I can explain but would be a good discussion for the MAEMSA meeting.
    2. Question: Is that 25% per year? A 25% per year reduction in separation?
        a. Joan - Yes, it was 25 % for a number of year, it tends to vary with whether or not fire is hiring. But we have cut it a lot in the last two years and 15% is what we have in the last twelve months.
    3. Question: So what happened? If fire is still hiring? Why the significant drop?
        a. Joan - We still have other reasons, paramedics want to be nurses and doctors. The want to work in hospitals, it is a hard business and they don't stay forever. We are keeping them as long as we can with our retention programs and our paramedic classes.
    4. Question: Do you know what your five year turnover is? New hire to five years?
        a. Joan - No, I'm sorry, I don't
    5. Question: What about seniority rates?
        a. Joan - I don't have my computer and sorry, but I'm not good off the top of my head
    6. Question: It seems like with the number of classes, it seems those classes should be decreasing in number
        a. Joan - They are decreasing in number

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4. FRO training update
    1. Actively working with 12 of the 14 FRO's to train on the quarterly CE's
    2. CE is not cookie cutter based, it is QA/QI based fro our service so it needs to be tweaked a bit from the one presented to MedStar to fit the FRO's better.
    3. Usually delivered in four hour blocks, lecture based with skills, in house at their facilities.
5. QA Report - Veer Vithalani
    1. Usual KPI's are in your packet.
    2. Tracking system trends by priority level
    3. The fact that we can get these numbers is amazing, and they look like big numbers, but that is because we look for them. On the national level, there is a database that keeps track of these things and shows our improvements,
    4. Case review times reviewed chart will be added to our reports, the high level cases are the only ones where people may be pulled from the street for remediation and / or additional training. This may take up to four days, but to be clear, it does not keep them from working for four days. That includes the training time.
    5. Cardiac arrest metrics show our time on chest metrics are good. We have been struggling with rate since last November. The data shows we are continually too fast, the depth has not been deep enough. The target of 2 to 2/12 inches on every single compression is small. A lot of this speaks to the feedback devices we are using and trying to figure out what the issue is. November is when we switched to the new monitor system. We had anticipated a little bit drop but, for whatever reason, it has stayed pretty low consistently.
        a. Neal - Richmond -The chest compression fraction, rate, and pausing frequency are clearly correlated with outcome, so this is not an insignificant problem. There have been some concerns voiced this year about how the RFP process was vetted, and I don't want to get into that here, but I think it's something we want to talk about in authority board about in the near future. But we did express a number of concerns about jumping in without having this device fully vetted and functional for the way we think they should be used. A lot of this has to do with feedback and the way the alarm systems work. I think we are going to present all this in much more fine detail but the message here is that what we were concerned about is coming. These are very challenging things, and rate is something that is critically important 110 to 120 and it's not because our people aren't doing anything in the field, but the feedback is very device dependent. You don't need the device to keep you on the chest 90% of the time that is something we can teach as a core value. Things that are device specific again are playing out as we were very concerned.
        b. Question: Is this a problem getting data from the device:
            i. No, the main issue we have identified is the way the feedback is given.
        c. Everyone was used to Phillips where the prompts were vocal (compress faster/slower etc) and this system is very different using metronomes. Part of it may still be getting used to the device and part of it is the fact that one thing we discovered is that they don't actually tell you "slow down" until you hit 150+ on your rate which is 30 above the upper limit that we are measuring. There is a graphic and the metronome but no verbal feedback. We are working with Zoll to try to get the margins set differently. We have made some process in terms of software now we are working on the alarms so hopefully we will eventually get there, it's just slower than we would prefer. What looks like subtle nuances in devices can have large impacts. There are clearly some substantial differences in areas that happen when they happen

d. Question: What is the difficulty in getting a 120 - 130 pulse monitor with an oral cue on each truck?
    i. The monitor has a metronome so each truck does have a feedback device. We are working with Zoll to take care of the issues with the metronome triggering when not needed or not being heard.

6. Laryngoscopy metrics show that we are at around 67%. Historically we were up in the 80s, so in that time we have not one but two separate CE sessions where we talked about general airway management and the actual mechanics of laryngoscopy. Video shows to help with peoples skills, so we should get our medics the tools they need.

6. In future meetings we would like to be looking at resuscitation centers. Does it make sense to take certain patients to centers that are running and staffed for cardiac cath 24 x 7? We should discuss it in the fall sometime with our partners.
7. Next up we have ongoing technology issues we aren't getting the assistance we need with. - Neal Richmond
    1. A few years ago we asked for a software system that could help with some of the quality issues by pulling information directly off the patient care report, trauma patient report, Cad system and a couple other areas. We have not been able to get this off the ground. Some of it has to do with the system switching CADs and EPCRs. The company, First Pass, is just struggling.
    2. Next is the OLPG line. We have been asking for a really robust, protected line for protocol guidance for several years now. We pulled in most of the medical control to be in house, so our staff and doctors handle the questions instead of the ER because we are more connected to the protocols. What we are using now isn't really compliant.
    3. The last thing is that we turned over an issue to MAEMSA that we are often the second or tertiary call for the 911 system. While we spend all this time and effort training on airways and making sure that our CPR rates are great, it becomes a little bit futile, if by the time the call gets dispatched it's gone through five to ten minutes of phone calls. I say five to ten minutes, but none of us have an idea of how long it takes in the community. Once the call hits MedStar we know exactly how long it takes to get people responding, but we don't know how long it took to go through two other PSAPS. Last we heard Dr. Byrd picked this up when he came in, close to a year ago. All we have heard since then at the MAEMSA is that it was not discussed at the 911board. MAEMSA seems to be wanting to handle this. I think this is a pretty critical shift for the community. We have been talking about this for at least three years and trying to move forward. There are at least ten to twenty systems our size in the country that have fully integrated 911. It is a politically charged issue but the delay caused by everybody wanting control of their own 911 system could be costing the patients in the truly critical calls. EPAB should be getting involved with this as it is a community health public health issue as far as I am concerned.
8. Other challenges - Neal Richmond
    1. We have been talking about this for at least a year or so with legal counsel that our protocol for refusals are very clear in that you can only do a refusal or take a full refusal after taking a full decisional capacity assessment so that a patient can make an informed decision about their care. We have posed to legal counsel this issue that we were guided to when patients do not have capacity in final analysis that we can't force them into a truck. We have to respect that. In the system there is also a disposition against medical advice, it has been suggested that this is putting all of us, this is putting EPAB, putting the Medical directors, putting the Authority and the city as risk. I am very concerned that we call these non-transports "against medical advice"

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because these patients don't have capacity to refuse. So what we are requesting is a separate radio disposition. This has been done in other large cities. We accomplished this in New York City, there is a separate disposition code. I don't see this as a big challenge but we do seem to be reaching an impasse, so I want to just pose this to the board as it is something I think we also want to get a grip on this year.

IX. Closed session

X. Return from Closed Session

1. Re-opened from closed session - Gary Floyd - 2:30
2. Meeting adjourned - Gary Floyd - 2:32

Minutes submitted by: Laura Long