EMSAC MINUTES – JUNE 14, 2018
Quorum: not initially (4). The minutes indicate when a quorum was achieved. This meeting was recorded electronically. The recording is available upon request from DMPSJ.

1. **Call to Order** - 12:07pm with no quorum

2. **Roll call (this includes everyone who was in attendance at any point during the meeting)**
   - voting members: Cynthiana Lightfoot (chair), Henry Lyles (initially phone), Kenneth Lyons (phone), David Milzman (phone), Jack Sava, Joelle Simpson, Caleb Ward
   - non-voting members: J. Sam Hurley representing DC Health, Robert P. Holman representing FEMS
   - administrative support: Helen McClure of DMPSJ

The group agreed to proceed through the agenda out of order in order to accommodate Dr. Holman, who had to leave early.

3. **Updates DCFEMS-RN triage/FTO status –**Dr. Holman
   - Paramedic grand rounds, next one in July, mostly doing airway management at GW. They trained the trainers, they have new materials. They are using cadavers for skills training. This is the first time it has been mandated for medics. They will probably set up ongoing skills training for new recruits with cadavers. They have trained on airway management, needle thoracotomy, "quick trach", and taser dart removal.
   - The field training and evaluation program will have round 3 in October. They are finishing round 2 right now. It is for ALS providers. There is better feedback and better evaluation forms. A vendor came in for a special evaluation. It is now an 11-week process, where they have to pass the field evaluation and a medical director interview. They do the medical director interview halfway through, if they don't pass it, they get evaluative feedback for 5 weeks to improve so they can pass it when they are interviewed a second time towards the end of the program. There is currently a 93.75% pass rate. This is for paramedic recruit classes. They have 2 classes per year. Field training officers are also reviewing practices.
   - The Nurse Triage Line (NTL) launched April 19. It has had a low volume of calls. Dr. Holman has met with roll call for all the call takers. There aren't as many calls gong to the NTL as expected, partially due to the new dispatch system, which was rolled out on the same day as NTL. They are having the call takers sit with the nurses to learn more. On June 19 they will be reassigning some codes, which should hopefully increase how many calls go to the NTL. Call takers can either send a call to dispatch or to the NTL.

- **Request:** The Chair asked for a written document of the questions the call takers ask. Dr. Holman is still improving the document, he will send it at the end of the month after it is finalized.
- Seattle also uses Criteria Based Dispatch. In the old dispatch system, the questions were very strictly laid out, with Criteria Based Dispatch, there are fewer ALS dispatches.
- The Chair asked about the skill set of call takers. Dr. Holman said they were not paramedics, nurses, or EMTs, but they were trained on how to use the system, and through experience. ALS-appropriate dispatch is working, determining what should go to NTL is still a challenge.
- The Chair asked about the background of the nurses staffing the NTL. Dr. Holman said they are RNs with an emergency background, one is a paramedic.
- There are currently no pediatric calls going to the NTL right now. It will take more training.
- They have been meeting weekly with OUC to work it out. For the patients for whom it's working, it's really working.
- Fee-for-service Medicaid and MCOs both use Lyft. For patients who need wheelchair access, they use vendors, including Yellow Cab.
- There have been about 120 NTL calls as of about 2 weeks ago, Dr. Holman did not know today's number. After June 20, he would like to see 30-50 calls per day.
- There has been no change to public communication. They wanted to send out SMS messages on government-issued emergency cell phones, but DHCF wouldn't give them the phone numbers. They are trying another tack. They have PSAs, handouts, but the best method to get the word out would be on people's phones, and eventually word of mouth.
- Dr. Simpson asked if the pilot was based on time or number of calls. Dr. Holman said that the pilot was supposed to be 6 months, but it may need to be extended because the numbers have been so low, so that they get enough numbers to have statistical power.
- The NTL is active 7:00 am to 11:00 pm.
- The NTL has enough funding. If they can solve the referral-to-NTL problem, they may be able to extend the hours, but the problem then is that clinics are closed, so maybe they won't do that.
- The study is being done by The Lab@DC.
- Richmond tried something similar, but they didn't have a way to say no. In DC, we can say no—a caller can scream and yell, but if the call taker determines they

should get a nurse and a clinic, the caller has the option of hanging up, but they don't have the power to demand an ambulance. Louisville tried something similar, but they didn't have clinics on board. DC is the first to solve the transportation problem.

- If you have Amera Health as your insurance, since April 19, they will transport you to a clinic—you self-triage. This is unrelated to the NTL.
- Dr. Simpson requested that if they decide to start doing pediatrics with the NTL they let her know. Dr. Holman explained that they have been declining pediatrics from the NTL because it's harder to triage. Dr. Simpson said clinics would have to be the driver of this.

At this point, a quorum was achieved (6)

- Dr. Simpson is proposing a survey for parents about whether a non-emergency clinic open late would be something they would use for their children.
- Dr. Holman said that about half of the calls that go to the NTL are sent back to be dispatched. They are reviewing these calls and giving feedback. They are also looking at ALS calls that are downgraded to AMR in the field to see which ones could possibly have been NTL-eligible.

- For Field Training Officers (FTOs), they are looking to have about 40, there are about 20 coming on in the fall.
  - The Chair asked whether they have the skill set to do EMT evaluations. Dr. Holman said they don't have the time. They are used for remediation and the 11-week tour. He agrees that they should do a broader EMT evaluation/ improvement, but probably not with this group. They did a couple of company-based trainings last year, now they're doing battalion-based EMT education, including EMS supervisors.
  - The Chair asked about fire officers in fire stations evaluating EMTs. What skills do they get in order to effectively evaluate EMTs? Dr. Holman said that these are performance evaluations, which are very different from field evaluations. They are classic performance evaluations, like you would use to evaluate any employee, not skills, not a test.
  - **Request:** The Chair asked for a copy of the performance evaluation.
  - **Request:** Dr. Milzman wanted to know, since FEMS is doing significantly less transport, what sort of extra training, etc. are they doing to help people adhere to protocol, etc. Dr. Holman will submit that information.

4. Interfacility Transport Guidelines—Dr. Holman

- People who are in labor are being sent from facilities without obstetrics units to those with them. FEMS doesn't do interfacility transports, but has been asked to do a number of them for these cases lately. So, they have been asking for a provider (nurse practitioner or doctor) to ride along in the vehicle. UMC is not able to provide this, so people end up delivering in the ER.
    - Dr. Milzman stated that the Assistant Medical Director and the ELO have not been good, they have asked too many questions. He thinks that if the hospital is sure the delivery isn't imminent, transport should be fine without a provider along. Medstar with a helicopter is their first call, a ground unit is their second call. Dr. Holman said that FEMS ends up being their third call, because the interfacility contractors aren't doing what they should be doing.
    - Dr. Simpson said that as a pediatric ER doctor, she sees teenagers who are in labor. She's not able to answer all the questions, because she doesn't have the skill set. Dr. Holman said that sounds like in those cases, imminence can't be assessed. Dr. Simpson said that the adult ER attending doctor, who might be able to assess imminence, due to more practice in the area, can't come look at teens in labor, because the doctor isn't allowed to leave the adult ER. But they have come up with something that helps them decide if the teen can be transported. She will send this to Dr. Holman and Dr. Sullivan.
    - Mr. Lyles said that UMC has asked Lifestar to have a truck dedicated for interfacility transport. It's now up to the DC government to find the money.

At this point, the quorum was lost (5).

5. Committee Updates

Pediatrics—Joelle Simpson

- There are no significant updates. There is an EMS conference on August 4. They are talking about protocol reviews. Mr. Lyons would like to for DC and Maryland to have the same pediatric protocol. Dr. Simpson said she hadn't seen the DC protocols in a while. The Chair suggested reinstating the protocol subcommittee that EMSAC used to have. Mr. Hurley said that DC Health is considering creating a protocol review committee. Currently, DC Health compares protocols to national standards to make sure they're compliant, but they don't compare them to each other. Dr. Simpson said she doesn't know how DC protocols are created. Mr. Hurley said that each medical director writes protocols and sends them to DC Health for review, but he thinks a committee of medical directors might make more sense and be more efficient. Dr. Simpson said there are

protocols that need updating. Mr. Hurley said that there are no regulations specifying that protocols have to be updated when national guidelines are updated. Once protocols are approved, they remain approved until they are changed, and have to be sent in for reapproval.

At this point, a quorum was achieved (6)

- Dr. Simpson can submit protocols to Dr. Holman, who can submit them to DC Health.

6. **Trauma**—Jack Sava
   - They met with Sam and looked at the first report from the trauma registry. They haven't given it to anyone yet, but they're impressed with the breadth of it and they talked about data validation and checking steps to make sure it's clean and legitimate. Very positive. Next step is turning the trauma subcommittee meeting into a performance improvement review of FEMS.

7. **Review of April/May Meeting Notes**
   - Jack Sava moved to accept the meeting notes. Joelle Simpson seconded the motion. The motion was carried unanimously.

8. **Stress & Mental Health**
   - The Chair asked Mr. Lyons if there has been any additional stress or fatigue with the change to a 24-hour schedule. Mr. Lyons said he is getting anecdotal evidence of fatigue, but he would like to see accident reports from the time since the change, and reports on sick leave usage. Mr. Lyles mentioned an article he had read about one jurisdiction in another state where the workforce went from a 24-hour shift to a 12-hour shift, and half of the workforce quit. Even though the medical director thought a 12-hour shift was better, he was forced to return to a 24-hour shift to keep enough personnel. Mr. Lyons said that the data he has read is not in favor of working a 24-hour shift. Dr. Sava said there is no optimal schedule, because one favors the worker's health, and one favors the family's health. Mr. Lyons asked who is advocating for the patient, and said we have to look at that. He thinks members will get used to any schedule. Dr. Sava said that if everyone quits, that's also not good for the patient. Mr. Lyons said we should look at the national picture and cities with a similar run volume to DC. Louisville is looking at going to seasonal employees for busy season (using people who were going to retire). Dr. Simpson asked what the expected outcome is of having this topic on the agenda. The Chair said that eventually we will create recommendations for the group.

Dr. Simpson asked whether there had been a survey of FEMS employees about fatigue/ stress and whether they liked the 24-hour shift. Mr. Lyons said there had been one, it was voluntary, and he doesn't know the results of it. The Chair will reach out to Dr. Holman to find out what was asked and what the results are. She asked if this would be helpful. Dr. Simpson said it could be helpful if we had data. Dr. Sava said that he had learned a lot in the discussion, but wondered whether we could master it and have guidelines. Mr. Hurley said that he learned that national recommendations about length of shifts were not based on a lot of evidence. Dr. Sava said it is common in the field to not have evidence, but someone needs to actually make a decision. The Chair said she will resend the 5 national recommendations for the committee to look over. Dr. Simpson asked whether we should be coming up with recommendations or asking Dr. Holman to write a proposal that the committee would review.

- Jack Sava moved to produce a recommendation that the impact of shift duration be considered, that fatigue management plans be incorporated into training, to suggest a survey incorporating the impact of shifts on people and what they want as far as shifts, and a reasoned decision should be made that incorporates all of these things, thus taking into account the needs of providers. Joelle Simpson seconded the motion. The motion passed unanimously. The committee agreed that these minutes serve as the official recommendation, and another written version will not be produced for submission to Dr. Holman.

9. New Business

- None.

10. Public Comment

- None.

11. Adjournment

- Joelle Simpson moved to adjourn the meeting. Henry Lyles seconded the motion. The motion passed unanimously. The meeting was adjourned at 1:35 pm.

Note: the following agenda items were not discussed during the meeting:

- *Update from City Council*
- *Sub-control Updates*
- *Medical-Dr. Milzman*

REMINDERS re. DELIVERABLES:

*** Dr. Holman to provide the questions that the call takers ask. Due: end of June**

Emergency Medical Services Advisory Committee (EMSAC)
Meeting Date: June 14, 2018 @ 12pm in the Reeves Center
Quorum: not initially (4); eventually (6)

*** Dr. Holman to provide a copy of the performance evaluation.**

*** Dr. Holman to explain what extra things FEMS is doing now that they aren't spending as much time on transport.**

*** Dr. Simpson to send to Dr. Holman and Dr. Sullivan the document her ER uses to decide on whether a teen in labor can be transported.**

*** Ms. Lightfoot to request a copy of the survey questions and results from the survey about stress/fatigue and what members think of a 24-hour shift that was done at FEMS.**

*** Ms. Lightfoot to resend the national recommendations about shift length.**

Respectfully submitted by Helen McClure, DMPSJ.