MEDICAL CONTROL BOARD
EASTERN AND WESTERN DIVISIONS
EMERGENCY PHYSICIANS FOUNDATION

The regularly scheduled meeting of the Medical Control Board was held, pursuant to Oklahoma Statute, Title 25 & 307.1 on Wednesday, March 13th, 2019 10:00 am at the following locations:

EMSA Eastern Division Headquarters in the Conference Room
1417 N. Lansing Avenue, Tulsa, OK

EMSA Western Division Headquarters in the Conference Room
1111 Classen Drive, Oklahoma City, OK

NOTICE AND AGENDA for the regularly scheduled meeting of the Medical Control Board of the Emergency Physicians Foundation, Eastern and Western Divisions, was posted in the Office of the Deputy City Clerk of Tulsa, Tuesday, March 12th, 2019 and in the Office of the City Clerk of the City of Oklahoma City on Tuesday, March 12th, 2019 more than 24 hours prior to the time set for the regularly scheduled meeting of the Medical Control Board.

1. **Roll Call** disclosed a quorum at10:00 am and the meeting was called to order by Dr. Chad Borin.

MEMBERS PRESENT:	MEMBERS ABSENT
Dr. Russell Anderson	Dr. Barrett Bradt
Dr. Roxie Albrecht	
Dr. Chad Borin	
Dr. Jeffrey Dixon	
Dr. David Gearhart	
Dr. Karyn Koller	
Dr. Keri Smith	
Dr. David Smith	
Dr. Mike Smith	
Dr. John Nalagan	

OTHERS PRESENT:

Dr. Jeffrey Goodloe, OMD	Dr. Anna Wanahita, RBI
Dr. Curtis Knoles, OMD	Bryan Jones, EMSA
Matt Cox, OMD	Bryon Schultz, AMR
Jennifer Jones, OMD	Tina Wells, AMR
David Howerton, OMD	Chris Jenkins, AMR
Duffy McAnallen, OMD	Kathy Suewell, Integris SWMC
Frank Gresh, EMSA	Dr. Dan Middlerock, EMERUS
Jim Winham, EMSA	Shannon Crinion, EMERUS
Jeremy Coombs, AMR	Samantha Mitchell, EMERUS
Kim Richards, AMR	Tyler Wedman, AMR
Taylor Nichols, AMR	

2. Farewell to MCB Board Member Dr. Brandon Boke

Dr. Goodloe thanked Dr. Brandon Boke for his years of service on the Medical Control Board and wished him good luck in his new adventure.

3. Review and Approval of January 2019 MCB Meeting Minutes

MOTION: Dr. David Smith

SECOND: Dr. Chad Borin

Aye:
Dr. Russell Anderson
Dr. Roxie Albrecht
Dr. Chad Borin
Dr. Jeffrey Dixon
Dr. David Gearhart
Dr. Karyn Koller
Dr. Keri Smith
Dr. David Smith
Dr. Mike Smith
Dr. John Nalagan

ABSENT
Dr. Barrett Bradt

4. EMSA President Report

Mr. Winham gave compliance, late call graph, exclusion summary, and destination hospital reports for December 2018 and January 2019.

Mr. Winham stated dispatch is working with the Marvlis software platform on incoming calls and where those are generated.

Mr. Winham updated the progress on the BLS transport program and that it is going well. Mr. Winham explained that EMSA is the last large high performance system to go to a BLS tier transport program.

Mr. Winham explained his frustration with patient care reports and the Cloverleaf system. EMSA is looking at ESO for a solution to the Health Data Exchange. EMSA will be scheduling a meeting with ESO and this is issue is in Mr. Winham's "top 3 things" on his to-do list.

Mr. Winham stated that the delivery of PCR's to the emergency departments is an ongoing issue.

5. Medical Director Report

Dr. Goodloe expressed timeliness of EMS documentation to emergency physicians to make informed decisions on Emergency Department care is very important.

Dr. Goodloe stated this present situation is nothing short of a disaster, however, compliments to those paramedics that are completing these PCRs in a timely manner. Some hospitals are admittedly turning a deaf ear to this issue, however, the logistics of PCR delivery is simply not working at most facilities. For example: Hillcrest Medical Center Health Information Management has mandated EMSA PCR must be received by Health Information Management and not to the Emergency Department. At present, both Hillcrest Administration and HIM are failing to deliver these PCRs to the ED in a timely manner, representing a preventable threat to patient safety and physician liability. Hillcrest is sadly not alone in this dynamic.

Dr. Goodloe asked "Anyone on the board (MCB) getting reports?" Dr. Nalagan stated that he has not seen a PCR in months. Dr. Borin stated that he was delivered a patient at 9am and did not receive a report until 3pm that afternoon.

Dr. Goodloe stated the CEO at each receiving hospital may need to be included to get this issue resolved as the hospitals are not going to get off the hook on this issue.

Dr. Goodloe asked Frank Gresh to run a report on the fractiles of timely delivery of PCRs from paramedic transmission to receiving hospital.

Mr. Gresh provided this information from
January 1 2019 – March 5 2019:

	East	West	System	Metric
People/Process	9.36%	8.21%	8.75%	Submitted before available
	59.21%	42.09%	50.19%	Submitted before or within 15 minutes of available
	67.71%	54.59%	60.80%	Submitted before or within 30 minutes of available
	3:05:36	6:01:16	4:34:35	90th Percentile Saved to Server
	1:02:58	2:02:58	1:30:45	75th Percentile Saved to Server
	1:19:50	2:50:00	2:06:57	Average Saved to Server
System/Technology	79.20%	79.01%	79.08%	Queued for Fax within 2 Minutes
	86.86%	87.55%	87.20%	Queued for Fax within 5 Minutes
	0:19:51	0:18:30	0:19:32	90th Percentile Saved to Queued
	0:01:41	0:01:43	0:01:42	75th Percentile Saved to Queued

Dr. Goodloe emphasized that some medics are clearly working hard to file PCRs timely as required, however, some are not following the MCB policy.

Dr. Goodloe linked some percentage of failure in timely documentation transmission to very worrisome staffing patterns, at least in metro OKC overnights. The Unit Hour Utilization (UHU) is a common metric in EMS systems to gauge actual work per ambulance over a shift. National "norms" are typically 0.35-0.45 (meaning that 35-45% of the shift hours are actively involved in a call – responding, on-scene care, transporting, transfer of care at ED/destination, documentation of care and readying the ambulance for the next response). Dr. Goodloe has written textbook chapters including UHU content and is facile with the concept, numbers, and norms.

Metro OKC UHU for AMR has frequently seen ambulances at 0.70+, 0.80+, and incredibly at times 0.90+. This is unsustainable, a significant risk to accurate clinical care and a significant stressor to wellness – physical and mental – of EMTs and Paramedics. The data for this concern stems from multiple metro OKC Field Operations Supervisors reports. Dr. Goodloe became increasingly concerned at a sustained pattern of excessive UHUs and queried EMSA leadership, specifically Mr. Winham and Mr. Gresh to ask for more formal data analysis. Immediately thereafter all UHU data disappeared from AMR Field Operations Supervisor reports, in itself an integrity of transparency concern. As it turned out, the night immediately prior to this MCB meeting, the Field Operations Supervisor did include UHU data in his report and Dr. Goodloe shared those data numbers with the MCB, including again multiple units 0.60+, 0.70+, and).80+.

Dr. Nalagan stated staffing patterns need to change and this staffing pattern currently is unsustainable and not safe for the community. Dr. Nalagan asked "Should the MCB draft a letter and send to AMR leadership?"

Dr. David Smith stated there has been arise in patients not being transported to the proper destination over the past 3 weeks. Physicians at Integris Baptist are very concerned. Dr. David Smith asked "Could this be due to medics transporting to the closest facility so they can get out for the next call?"

Dr. Goodloe stated that AMR should be open and transparent regarding UHUs. UHU data is NOT a proprietary business item. The staffing of ambulances, and the related readiness/capability for timely response as well as how rested and capable EMTs and Paramedics are to deliver accurate care is absolutely the domain of the MCB, representing the medical community at large in metro OKC and Tulsa, as well as the citizens that fund the EMS system through utility fees and taxes and the patients that fund the EMS system through their insurance and payments.

Mr. Winham stated the long standing contract is based on 90% compliance, therefore if they are able to have one truck in service and make 90% compliance there is nothing he can do.

Dr. Goodloe stated the public utility model when functioning like designed, mirrors the federal government system of checks and balances among its three branches. All components in the public utility model should care for the providers and the patients.

Dr. Borin requested a letter of summation of the MCB concerns be drafted and sent to Mr. Winham so that these issues can be formally addressed with AMR leadership.

Dr. David Smith asked "Can we get UHU date to follow?" Dr. Goodloe said, "Interesting you ask, when EMSA asked they were told by AMR that "we can't get it."

6. Review and Approval of Protocol 17A: MCB Destination Determination

Dr. Goodloe recommends to the MCB that 17A: Adult Stroke Destination protocol be changed to reflect that patients with acute neuro symptoms consistent with stroke in duration of less than 23 hours from last known well be transported to a level 1 stroke center (this is a hospital-based emergency department in a hospital with neuro-endovascular capability. Some hospitals with endovascular capabilities do not have it for 24/7 but do have it at times. Data shows 98% of stroke patients in metro Tulsa and 76% of stroke patients in metro OKC (symptoms less than 3 hours per 2018 calendar year analysis) already go to a comprehensive stroke center. Dr. Goodloe recommended to remove 24/7 from the protocol and just say Level 1 with endovascular call, factoring that when endovascular capability is present, then transports to that facility would be appropriate. Level I Stroke Hospitals can be either certified as Comprehensive Stroke Centers (CSC) or Primary Stroke Centers (PSC)+Mechanical Thrombectomy. Level 2 Stroke Centers are PSC with IV tPA capabilities.

Dr. David Smith asked, "Why can't patients go to any facility that can do CT perfusion imaging if not eligible for IV tPA and what is the benefit of not going to any facility that can do CT perfusion?"

Dr. Goodloe stated that some physicians are going to be unhappy with any stroke destination decision made by the MCB (depending on the facility in which they practice and their opinions of the available therapies).

Dr. Albrecht stated that OUMC only has one CT scanner so if we start getting all these CT perfusion patients for stroke alongside the usual trauma patients there could be an issue with timely CT imaging. A second CT scanner is planned but approx. a year away.

Dr. Nalagan stated his stroke center says they can do it, they can take large volumes, but OUMC with one CT scanner as it already is is a problem.

Discussion for Priority 3 Unassigned patients (those with acute neuro symptoms consistent with stroke, but in duration greater than 23 hours from last known well AND

without pre-established hospital affiliation) can go to the closest Level II or Level III Stroke Center to offload some volume at Level I Stroke Centers. The consensus was to leave that aspect unchanged, and continue to include nearest Level I Stroke Center as destination option.

Motion was approved with modifications to remove "24/7" from endovascular call criterion for Level I Stroke Center and to add "or Primary Stroke Center with Mechanical Thrombectomy" to the second criterion for Level I Stroke Center. Effective date will be 8/1/2019.

MOTION: Dr. John Nalagan SECOND: Dr. Russell Anderson

Aye:	Nay:	ABSENT
Dr. Russell Anderson	Dr. David Gearhart	Dr. Barrett Bradt
Dr. Roxie Albrecht	Dr. Keri Smith	
Dr. Chad Borin		
Dr. Jeffrey Dixon		
Dr. Karyn Koller		
Dr. David Smith		
Dr. Mike Smith		
Dr. John Nalagan		

7. Review and Approval of Protocol 17B: MCB Table Categorization of Hospitals

Dr. Goodloe referenced the addition of the four Integris Community Hospitals in metro OKC. These facilities are micro-hospitals with limited post admitting capability (eg. 8-bed inpt unit without specialty services). The currently used criteria for free-standing EDs are recommended with the addition of some examples for patients likely to require short duration admissions. The focus continues to be on eliminating preventable secondary transports from these destinations.

MOTION: Dr. John Nalagan SECOND: Dr. Roxie Albrecht

Aye:	ABSENT
Dr. Russell Anderson	Dr. Barrett Bradt
Dr. Roxie Albrecht	
Dr. Chad Borin	
Dr. Jeffrey Dixon	
Dr. David Gearhart	
Dr. Karyn Koller	
Dr. Keri Smith	
Dr. David Smith	
Dr. Mike Smith	
Dr. John Nalagan	

8. **Review and Approval of D10 being the first-line form of parenteral dextrose in Protocols: •3A: Respiratory Arrest • 4I: Specific Causes of Cardiac Arrest • 6B: Altered Mental Status • 6D: Seizure • 6E: Syncope • 6F: Dystonic Reaction • 7A: Behavioral Disorder • 9E: Dialysis Related Issues • 13D: Complications of Pregnancy • 16H: Dextrose (D50, D25 and D10)**

   Review and Approval of new sizes of nasogastric/orogastric tubes for usage with i-gel airways in Protocol 9L: Nasogastric/Orogastric Tube.

   MOTION: Dr. Roxie Albrecht — SECOND: Dr. Russell Anderson

   Aye:
   Dr. Russell Anderson
   Dr. Roxie Albrecht
   Dr. Chad Borin
   Dr. Jeffrey Dixon
   Dr. David Gearhart
   Dr. Karyn Koller
   Dr. Keri Smith
   Dr. David Smith
   Dr. Mike Smith
   Dr. John Nalagan

   ABSENT
   Dr. Barrett Bradt

9. **Review and Approval of Ambulance and EMR Inspection Form**

   David Howerton clarified the amending items are: removal of the Broselow tape (due to the Handtevy app that is available to all agencies); added specific sizes to water jel dressings: small, medium, and face; and decreased the macro drip sets.

   MOTION: Dr. David Smith — SECOND: Dr. Roxie Albrecht

   Aye:
   Dr. Russell Anderson
   Dr. Roxie Albrecht
   Dr. Chad Borin
   Dr. Jeffrey Dixon
   Dr. David Gearhart
   Dr. Karyn Koller
   Dr. Keri Smith
   Dr. David Smith
   Dr. Mike Smith
   Dr. John Nalagan

   ABSENT
   Dr. Barrett Bradt

10. Review and Approval of MPDS Card 28 - Stroke Determinant

The recommended changes for prioritization of call and send/no-send use of FD are included for all 211 MPDS determinants of Stroke. In sum, symptoms less than 23 hrs are Priority 1 with FD send. Symptoms over 23 hrs or unknown are Priority 2 without FD send unless other symptoms (dyspnea, chest pain) predominate.

MOTION: Dr. Roxie Albrecht SECOND: Dr. David Smith

Aye:	ABSENT
Dr. Russell Anderson	Dr. Barrett Bradt
Dr. Roxie Albrecht	
Dr. Chad Borin	
Dr. Jeffrey Dixon	
Dr. David Gearhart	
Dr. Karyn Koller	
Dr. Keri Smith	
Dr. David Smith	
Dr. Mike Smith	
Dr. John Nalagan	

11. Review and Approval of December 2018 and January 2019 MCB Financial Statements

MOTION: Dr. Roxie Albrecht SECOND: Dr. David Smith

Aye:	ABSENT
Dr. Russell Anderson	Dr. Barrett Bradt
Dr. Roxie Albrecht	
Dr. Chad Borin	
Dr. Jeffrey Dixon	
Dr. David Gearhart	
Dr. Karyn Koller	
Dr. Keri Smith	
Dr. David Smith	
Dr. Mike Smith	
Dr. John Nalagan	

12. Information Items

Dr. Knoles shared that i-gel training will start soon and that OMD personnel will be contacting MCB physicians regarding visits to EDs to review the i-gel airway with ED nursing and physician staff.

13. New Business

14. Next Meeting – May 8th, 2019

15. Adjournment

Upon Motion by Dr. Russell Anderson and seconded by Dr. Jeff Dixon, the Medical Control Board voted to adjourn the meeting at 12:12pm.

Approved By:
David Smith, MD
MCB Secretary

Date Approved: