

Firefighter Rehab Workgroup
December 11, 2013

Present:

Chris Bell	Jess Freire	Robert Gleason Jr., NAS
Mike Leyden	Drew Hazelton, Rescue Inc.	Dan Wolfson, MD
Jessica Racussin, MD	Chris Fellows, Rescue, Inc.	Seth Lasker, BFD
Eric Cochran	Karen Rancourt, Rescue Inc.	Ben O'Brien, PFFV
Dean Scott, Enosburg	Bill Hathaway	Brian Constable, Cambridge
Tom Barefoot, MRVAS	Erin Ingebretsen, Bennington	Jim Finger, RAS
Joe Kelly, Barre City	Mike Skaza, VFA	Bill Mapes, RAS
Mike Collins, IBM Fire		

Chris Bell welcomed the group and gave an intro. Firefighter rehab has been an ongoing issue with differing points of view. Not yet in statewide protocol. It's come up a few times over last couple of years. The hope is to utilize the workgroup to reach consensus about responsibilities/roles, etc.

EMS staff is aware that there are already agencies already providing firefighter rehab or working with fire departments to provide rehab. Chris explained that we are interested to hear how rehab works now or what should work going forward. NFPA 1584 is a suggested standard for the fire service related to rehab.

Is there a need for rehab? What is the role of EMS or fire?

Rescue Inc.

- Provides service to 15 area towns – Rescue is automatic on first alarm, except Brattleboro, which is second alarm.
- If working fire, try to grab folks after second bottle.
- Not all town chiefs are on board with it, so depends on town.
- Provide: water, food if long duration, place to rest, ensure hydration. Provide logistics, take care of injured occupants. Take set of vitals.
- No written protocols and no written agreements with departments. Long-standing tradition.
- Use 1584's guidance when determining whether vital signs are within "normal limits."
- Contact medical control before releasing a firefighter outside those ranges.
- Most chiefs onboard with rehab and transport if necessary. Only occasionally does a chief overrule.
- District 13 DMA would like to develop guidelines.
- NH does not have a FF rehab protocol.

Mad River Valley Ambulance

- Provides service to 3 departments.
- MOUs with fire departments, as well as a protocol/SOG based on 1584. In place for 5 years.
- Have done trainings and take baseline vitals annually.
- Typically 2 ambulances on scene. Depending on weather and duration, they provide a tent, folding chairs, heatable structure for cold scenes.
- RAD57s in all of ambulances for CO monitoring.

- Generally keep them in 15-20 mins to settle them to safe levels. Cardiac monitoring only provided if symptoms dictate (rarely done).
- Protocol in writing. Happy to help folks develop SOGs. Provided the office a copy of the latest SOGs (2008).
- District 6 DMA saw a copy in 2008.
- Cardiac monitoring only provided if there is a reason.
- Unaware of whether the 3 fire departments subscribe to NFPA 1582 or 1583 as far as medical/physical fitness standards.

Cambridge

- Annual vitals at CPR training.
- Guidelines similar to MRVAS.

Barre City

- Utilize an SOG. Includes vitals as well as body temp (100.6F). Also have Rad57s and establish 5 ppm as someone coming into rehab. SOG also establishes return to duty/removal from duty levels.
- SOG doesn't specifically mention NFPA standard. Establishes what happens in rehab, like hydration and no smoking.
- Not aware that DMA has seen or approved the SOG.
- ALS personnel make the "medically sound/return to duty" call. No mention of physician involvement. Based on established criteria. Vitals within limits set.
- SOG utilized with mutual aid agencies also. Can present problems if the agency isn't aware of the SOG. Can be hit or miss. Chris –
- Not aware of whether Barre City follows 1582 and 1583.

Ben O'Brien (PFFV) noted that only 1 department in Vermont follows NFPA 1582 and 1583 past the point of initial employment, and that is Air Guard Fire. Departments typically don't adopt all of the NFPA standards. Rather they use them as guidelines, picking and choosing the elements from standards they wish to use.

Suggestions

- State needs to establish guidelines and EMS needs to have input on physical condition. Once they treat a patient, it should go through medical control. Should be based on fire and not EMS though.
- Needs to be local issue, hammered out ahead, working with EMS agencies and their fire departments, to come up with an understanding. Guidance from EMS on what they may encounter might be helpful but needs to remain a local issue. A guideline from EMS will create more issues than prepared to address.
- Agree with above points. Different areas of state have different resources available to them. A guideline that is too broad or deep could quickly out-resource an area. Most fire departments provide the basic platform for firefighter rehab.

Who makes the go/no go decision? Who makes the return to work decision?

Chris said that one sticking point in past may have been having EMS make go/no go decision. He said that prior to coming to Vermont, he assumed the fire chief would want EMS making that decision.

Burlington Fire

- Red Cross also involved with rehab.
- Decision should come from fire side. As EMS providers, there is limited interaction with each firefighter. A 20-minute snapshot doesn't provide an opportunity to really recognize each individual's physical or emotional reaction to a stressful situation.

Cambridge

- It's the IC's decision. If the person is outside of the guideline vitals, IC may determine a return to duty or a longer stay in rehab.
- Fire and EMS chiefs have approved what "baselines" are normal after 20 minutes in rehab. If there is a deviation from vitals, firefighter can stay in rehab longer.
- Procedures are in writing and Brian Constable will provide them to VT EMS. DMA may have been involved but unsure.

Jess Racussin, District 7 DMA

- EMS in D7 doesn't want to be final decision makers. Don't feel comfortable.
- As medical control, difficult to make the decision without seeing the patient. Generally fire chief's decision. Fire IC generally looks to EMS for guidance, and they don't want that responsibility.
- When does a firefighter become a patient? When you take vitals? When you give them oxygen? If given more than water in District 7, firefighter must sign a refusal form. Oxygen is a prescription drug.
- An ambulance does stand by at all working fire scenes.

Chris asked what other agencies do as far as oxygen administration and whether that guides a decision to transport or complete a refusal form. Is firefighter rehab the exception to the "oxygen equals transport or refusal" rule? No adverse action, just clarification.

Cambridge

- If oxygen is applied, it means the EMS provider saw something. Not sure it's in writing about a refusal.

Mad River

- Use oxygen when we felt in the best interest of firefighter. Oxygen administration alone does not require transport or a signed refusal. They're in a hurry to get going and we try to keep it simple. Use ox as therapy; likely to help them recover quicker. Part of goal is to rehab and get them back in, so we don't draw the line so brightly.

Barre City

- If treatment path is utilized, medical control is generally contacted to share info and ask opinion. Involving medical control changes relationship between EMS and firefighter that's in rehab.

Chris Bell

- Oxygen is a prescription drug and not something you can distribute without medical oversight and protocols. Open to number of outcomes/options including guidance and local development, but oxygen administration is going to be a clarifying point. EMS providers need to be on right side of the line.
- DMAs are concerned about decision making (EMS) and also any resulting liability to DMA or ED physicians. Or does the liability lie with fire and whichever officer makes the decision?
- DMAs also concerned about the weight given the predictive value of a set of vital signs. Hard to say based on one set of vitals or annually repeated vitals to predict go/no go. Worried about putting a stamp of approval on an inherently dangerous activity.

Burlington Fire

- Symptoms over vitals. Just walking down the street in fire gear creates stress. Have to give latitude toward how individual is feeling. If firefighter is short of breath, they are treated as patient and given oxygen. Normally not giving oxygen.
- Setting benchmarks will hamper some fire operations and don't want to see that happen.

Chris Bell pointed out that shortness of breath, heat-related emergencies or chest pain are covered in protocol. Seems like agencies with guidelines have clear lines when folks have an actual complaint. The group agreed that utilizing symptoms rather than specific vital sign limits makes sense. Members of the group also agreed that having EMS make a go/no go decision is difficult. Traditionally firefighters want to drop out of rehab and reenter the fire ground. MRVA noted that their reasoning for bringing two ambulances to a working fire is so that one may be used for transport.

Chris likened what appears to be happening during firefighter rehab to occupational health rather than EMS responding to a complaint and following protocols. That's where the physician discomfort arises. Rehab is unlike anything else EMS does. A screening exam is not something taught during any EMS training. He asked whether the group was in consensus that this type of function is not an EMS role?

MRVAS

- Disagree in theory. IC is busy. EMS is there, off to the side, taking folks in, cooling them down, warming them up, etc. Heard the concerns about making the decision but a decision has to make it.
- The process has to be simple in a complicated fire ground setting.

Rescue Inc

- Does not use baseline vitals any more, except for full timers, who go through occupational program and get baseline annually.
- EMS keeps an officer at the command post. If there's a question that a person needs evaluation or treatment beyond the ability of rehab team, that information is relayed. The IC is where the buck stops. We've never run into a point where we feel a guy shouldn't go back in....if vitals are

wrong or symptoms persist they're proactive in keeping them out longer or getting them transported. It's collaborative.

Barre City

- High school athletic coaches have guidelines for go/no go. How do they do that? Maybe look at that.

Mike Skaza said the Fire Academy staff look for symptoms because that's what the standards say to be alert for. Symptoms drop them into protocol once they enter that realm.

Chris said that in talking with Chris Herrick, the HazMat team has their own criteria and their own rehab standards, go/no go etc. HazMat team members also get a set of pre-entry and exit vitals. He assumed they all have to do annual physicals also and do 1582 annual screening. This practice is not realistic for the fire service.

Tom Barefoot noted that EMS makes go/no go decisions all the time with respect to MVAs and other incidents. With dozens of firefighters cycling through rehab, the point is not to tie things up too much with procedures that don't relate to firefighters.

Chris said that while EMS providers are called upon to make routine go/no go decisions, those decisions do not involve sending an individual into a situation of 110% exertion or into a life threatening environment. An EMS provider's role is to educate patient and let the patient make the transport decision. Just by looking at a patient, no one can determine if and when an MI will occur.

MRVAS

- Fire chiefs want to make the final decision but don't have the information and depend on the expert advice from EMS.
- Firefighters now buy into rehab, recognizing that if they sit and recover, they can do a better/safer job when they return to the fire ground.

Plan moving forward?

- Tom will research the evidence behind vital sign standards and the decision-making practices of firefighter rehab.
- Is it possible to create a set of criteria that takes the decision-making off the IC, the EMS providers and the firefighter? Either meet it or don't?
- Gaining buy-in with fire departments unfamiliar with rehab and EMS may take time.
- Bill Hathaway said VSFA has been calling for this type of guidance for years. They wish EMS on the scene to take care of the firefighters. Firefighters in Vermont tend to be mostly volunteer and not necessarily in the best physical condition. Mike Skaza agreed. Rehab theory is now contained in the FF1 curriculum.
- First responder services may also be interested in becoming involved in rehab if the area's ambulance service resources are stretched too thin.

Firefighter Rehab Workgroup

December 11, 2013

Page 6

Chris asked for SOGs/guidelines/policies to be sent to the office this week. If staff feel they have enough material to begin drafting guidelines, they will do so and then call another meeting. If not, another meeting date will be set. DMA involvement will also be requested.

Meeting adjourned with thanks to the group for participating