

Interfacility Transfer Workgroup  
December 5, 2013

Present:

Chris Bell	Mike Leyden	Jessica Freire
Dan Wolfson	Mark Considine	Drew Hazelton
Karen Rancourt	Patti Wolff	IFT Workgroup
Kyle Madigan	Adam Heuslein	Jay Wood
Jim Finger	Mike Tarbell	Mark Podgwaite
Moe Paquette	George Brothers	Erin Ingebretsen
John Starke	Brian Richardson	

Chris thanked participants for attending the first of several meetings on the topic of interfacility transfers.

Dr. Wolfson reviewed the IFT protocol.

Should the following be included in IFT and at what level of crew/patient condition?

- PO med assistance? Administration? What if the patient cannot open the vial?
- PCA pump? Currently an AEMT skill. But if EMTs can administer intranasal naloxone, does that change the view on a PCA pump?
- What about dynamic cardiac monitoring? DCM and ongoing interpretation is a paramedic-level skill but more education will be required.
- With naloxone on board, can a BLS crew transport a premedicated patient?

Suggestions/Comments:

- Look to the DMAs for guidance.
- Patient-focused care means the patient's comfort and health is important. Might be important to clarify in the protocols.
- PCA pump will be added to the category for AEMT scope.
- When a pump is placed before transport, the hospital staff is reluctant to give EMS a key. Should that pump be replaced by one the crew carries? Is there a distinction between a patient who had one placed in the hospital recently vs. a patient who always has one.

Mark Considine – at the aemt level, will the list be modified to include their new skills and scope? ML we listed a few yes and no categories, but as of 1/1 the providers will be able to function at their scope of practice. MC – so the second category will need to be modified to represent that's included in AEMT scope.

MC – pca pumps. What if the hospital places the pump and want it to continue. The hospital is reluctant to give the key to the pump. ML so patient receives a new pca pump. Still on pca when the patient transfers. Patti – hospitals reluctant to give a key when narcotics are signed out to someone specific. Conversely we come up with a drip that will suffice. Jess – our agency had a key and we used a documentation process with the facility. DW – facility-based issue.

JF – patient controlled as much as possible. ML – okay, but it still needs to be facility-weighted also.

MC – pre-existing pic line? Clear now that if there's a central line it needs to be a ccp. But if there's no additive running and it's been in place for 9 months, who's able to transport that? ML the way it is written now, it would be in the third level. But we could consider it. Thoughts on pic lines now?

ML scope creep means education. Just keep that in mind.

Paramedic: We don't have the best picture of the existing ccp enhancements, but we know we're going in a different direction. The vt ccp program as we've come to understand it was developed as an in-state program to match up against the capabilities of other systems. Captured in the most recent set of rules and outlined a set scope 6.2.6.5.5 Pumps, IV Hep Nitro, nutrition, etc. Our vision going forward with rule making is to not list a scope of practice in the rules. Time line for rules is probably late 2014/early 2015. We're not stalling...it's based on VDH priorities. Currently ccp has a varying degree of dma buy-in. Some might say it meets their needs...others might have no information on it at all. Systemically we probably need to poll them.

Now we have ccp juxtaposed to the NSOP model. This has teased up some changes to scope that will right up to and over in some cases the existing ccp model.

Paramedics have a set of skills and abilities and some knowledge that cover some topics: infusion pumps, continuation of blood products, central line monitoring, blood chemistry analysis, chest tube maintenance and monitoring, initiation and maintenance of thrombolytics, access of indwelling catheters. The scope references physician approved medications. Which physician what context and what circumstances? This is all Paramedic (transitioned) scope. So if we look at the IFT piece, do these key pieces get broken into an IFT protocol and if they do, how do we capture them and make them available?

Meds is a separate discussion, and what are the implications. The rest of the discussion is what about CCP and scope enhancements?

DW – between paramedic and ccp, we're still missing certain medications and certain knowledge base that isn't included in the new paramedic scope, particularly with an IFT paramedic. Feel it requires a higher level of training.

ML – ATVs are referenced in our protocols solely for cardiac arrests, as opposed to a patient on a vent going interfacility. We have more research to do as to what the scope intended. That will lead us into the full-feature ventilators and where we think they belong. It also may be worth considering some of the national level discussions, as well as neighboring state discussions. CCP terminology even is subject to debate. Some state uses PIFT with a IFT credential, while others may have CCP. Landscape is open for future discussion and design. Folks have asked thusfar for

Ventilators – full featured, multiple med infusions, isolated skills like central line insertion, RSI/advanced airway, arterial lines – placement and monitoring (potentially both), what else???

MC – can't just shut off IFT transfers on 1/1 automatically. Is there a priority order of what objectives get done first? Can't just come to a grinding halt. It represents a change in education as well as operationally. ML – that's why we're meeting, trying to gauge the reactions and where we might be able to plot a clear pathway. JF – glycoproteins (doing them since 2007). Conti – diff between p/p, p/nurse, nurse/ccp transports? ML – good question. There are lots of enhanced configurations, so we're talking about a nurse/medic or p/p combo. Good question.

MConti paracardial centesis, surgical cricy, chest tubes.

ML – we also need to look at the delineation between a p and a nurse. Complimentary vs interchangeable. Believe that will continue to be a less common model. Nurses get in the back of rigs now, but that may not be a crew enhancement.

Kyle – QA/QI responsibilities. Also, we went through this in NH It's the amount of training and new equipment (the cost to become a CCP service) weighs heavy on some services. That's why the PIFT vs CCT. How often is the turnover in your department, etc. to keep this core of people trained up.

Patti – Lots of hosps don't know who t call and the er secretary just calls whomever. Algorithm helps.

We borrowed a version, flipbook based on level, and we're in draft now. We borrowed from NH who borrowed from Utah.

Moe Paquette – mt as. Don't expect a medic to be placing chest tubes or doing paracardial centesis. Expect them to handle whatever meds are running. Been a medic for 17 yrs Expand the scope to cover meds, but not to the insertion of central lines. How to I save my little ER and keep my one nurse here in the middle of the night to transfer a patient. ML thoughts on ventilators? MP – I have the opportunity to call in a resp therapist to go with patient. Majority of patients go to Dartmouth – 25 inutes by ground. No real opinion. If they had a vent and the settings were set ands omething happened, could shut off the vent and bag the patient. JF – may have to look at modules for specific areas. Some areas won't be doing it while some may.

Moe – volume. 10 ifts a day with vented patients, chest tubes and multiple meds. Vs paramedic who does one ventilator run a day. Comfort comes with doing skills frequently. ML – brush up against educatin and verification of competency. Many things we're batting around now are enhancements for the existing VT CCPs. Philosophically VDH isn't interested in designing curricula and implementing certifications. That's why we use NREMT. So doing comprehensive holistic education or modular education enters an arena we may need to consider.

So clinically, what else? MCondi – with full-featured vent, vent management and understanding physiology or just making the run. Abg (arterial blood gas interpretation),

Considine – From a formulary standpoint would it e based on classes of meds vs. limiting it to a particular med? Could be 5 diff beta blockers. Medic needs an understanding of beta blockers, but not necessarily a specific one. ML NH focuses on classes of drugs. NSOP indicates physician approed medications. Expect that's how we're leaning. Medics should know about classes of drugs. I like the idea of learning about classes of drugs but it speaks to education.

Moe – diff between med being started in hospital and monitored/maintained in transfer vs a med started during transport. DW – agree. Diff from a physician starting a nycardapine drip that needs titrating. More than just being familiar with standard drips. Moe – agree. That's more ccp. DW – it's a balance. We want to do what's right for the patient and get them on the way to a tertiary care facility. And make sure they have the right crew during the trip.

DW – do you have enough resources and support to get the crews together you need or would it be helpful to have a transfer call center? Moe – interesting concept to have a central referral center. Patti – interesting. We transfer sometimes to Plattsburgh, as well as dhart. That would link the closest and

most appropriate crew. Dartmouth already has that type of system in place, and fahc has considered it. Albany, Bay state in springfield. DW brings us to the idea of regional system of transfer.

Conti – Need to differentiate between meds from facility and meds we start. ML – all meds in scope are available to a provider. If we approach this from a class perspective, would we live with an exclusion list? Class X except these specific one(s)? Again, it's open to discussion. Moe – a list of exclusionary meds will be shorter than inclusive list. Conti – advanced advanced level? In southern vt they can call dhart who has advanced medications and procedures. Moe - Where will we stick PIFT and CCTP. National curriculum for CC-P. New para curriculum involves some of that. Delineation between paramedic and ccp is an easy one to make up to the local flavor and what they're going to be allowed to do.

Conti – we do nurse/paramedic configuration. Safest for the patient in a 3-hour transport. Failsafe program. Pulling the nurse out of the mix puts more responsibility of medic. Training for nurses and paramedics are the same. They can do the same things. A medic in the back of a truck for an ift is functioning at a different level.

Moe – small community hospital where we see lesser amount of critical patients. My nurses wouldn't be able to place a central line. She has a role but it wouldn't be a critical intervention. Patti – agree. Local small hospital who puts a nurse in the back of a rig doesn't make a cct crew. Vs. Dartmouth and FAHC. Moe – but if a non ccp medic is on a rig and I send a patient on an antibiotic, we need a nurse on the rig.

Kyle - dhart and fahc really have critical care crews and a system. But the focus needs to be on the medic services and how we're going to help rural hospitals transfer patients. Patient on heparin and nitro drip, etc. Perhaps some of that will be more clarified with the national scope. Lots of patients that need pift level transports, and finding that level is a challenge. If no one else can, dhart will do it. How can we grow more.

Brattleboro – echo the sentiment. PIFT model would be a lower cost to the services meets the needs to most of the patients, and not a lot of scope creep. Most cost effective. And not get as caught up on CC, which seems like a different beast.

DW – how has pift been working in NH? Kyle we struggle with not having enough pift providers. Need to build up the numbers at all services. PIFT complex ventilator settings has caused a lot of confusion. Is that bipap? Excessive peep? Pressure support or control? If we clarify that better, we can avoid the NH pitfalls. Part of the issue is having enough providers at the pift level. There's a limited number of crew cct services in the region. JFinger – That's across the board.

DW – so for agency leaders how do we look at the issues of QI, credentialing, a PIFT-level program, a CCP curriculum as a standardized credentialing program. If not that, then what?

Patti – FPC, CACP, CCEMTP. FPC – self study and test. There are lots of options. And don't have to be cost prohibitive. Jess – NH pushed the education out to the hospitals and services and they're having inconsistency issues. That's what we would like to avoid. The pift in bratt should have the same as the pift in Grand Isle. ML – and set a similar expectation set whether coming out of Grace Cottage or Copley. What's in this set of scope enhancements and then how do we address equipment and training, credentialing? Is "I went to school" enough or do they need a certification?

MC – reimbursement addresses SCT in rule. And to any service administrator, that’s important. This allows an agency the maximum billing profile. And VDH will have to work with CMS to make sure that things align.

ML – education/training? Thoughts? JF – diff levels in diff areas. VTized. Generally the same but then allow the hospital to credential a provider for a particular piece of equipment. Nationally certified provider still needs credentialing on local equipment. ML – when we’ve looked at educ options, we have a recognition that in some ways these programs may be overkill. The provider may come back overeducated. Aortic balloon pumps aren’t frequent in NE, but there may be training and questions on the exam. JF – that’s what I was trying to say. Can we do it more cost effectively and produce the numbers we need. Moe – either ccp or not. Not sure I care for the ift certification. What do other states use for qa/qi? Is there a way to look at these electronically? ML – those are options...looking at the calls to look at the enhancements. But first we need to train them.

DW – NH has the PIFT program. A homegrown lesser CCP. Jess – for the majority of states, the ideal ground is a homegrown program and each state is different. There’s no “PIFT” program out there. They’re watered down versions of the CCP programs out there. Kyle - NH borrowed and modified Maine’s program.

DW – how many agencies doing SCTs on a regular basis are open to sending their people to a national course? If you want to be billing for SCT, then your people should go through a CCP course. Can we avoid the homegrown PIFT vs. an official CCP level? Would that work for various agencies around the state? Brattleboro said no, they like the PIFT model? Jon – national scope covers cost of PIFT with a few exceptions. Not sure that if do just a bit more than the existing P, it’ll be affordable. But if you want to be CCP, that’s a whole other animal. Moe – slightly expand the paramedic scope vs a true CCP. We can use the tertiary care facility’s transfer crew, so we’re lucky. More the PIFT scope, not the CP scope. Drew – if the need is to send them off to CCP training, we’d do that. Our turnaround rate from DHART is pretty high. MC – most common medication is heparin. That’s SCT and not within Paramedic scope. And we’re most likely headed to Dartmouth. Drew – also moving this into a paramedic level transfer, that won’t allow billing at the SCT rate. DW - ? antibiotics, electrolytes, infusion pumps,

JF – only way in WY we could bill for SCT we had to have a critical care nurse. Medicare/Medicare is looking at the new scope and we believe changes are coming. MC – good idea to prepare for the future. First program was the umbc program in Rutland in 2005. Then vt program began because it was cost prohibitive. Also for official board certification, what would happen if the ccps in vt took the refresher modules? Would they be allowed and able to challenge the exam? ML – Definitely worth looking at. UMBC course vs 6 modules vs challenge...lots of options.

ML other thoughts/suggestions? MC – ventilator module is important to us. Increased use of cpap at home, patient subsequently goes onto bipap, which requires a full ventilator. Do you downgrade a patient to cpap with fixed peep? And lots of facilities don’t have a respiratory technician that can go. EDs are aggressive with airway management. RSI, post intubation, meds, etc.

Drew – CCP on 1/1??? What happens then? What happens with scope as current CCP on 1/1?? ML – that rule doesn’t expire but there’s more transitory clause in the rule that needs interpretation. We’re trying to get ahead of things fast enough so we don’t have to field 15 individual requests. We’ll publish more broad, definitive guidance as a priority.

JF – next meeting date? January? We'll publish one. We can pole for availability. Appreciate your time  
Probably mid January.