

Medical Control Board Meeting Minutes

Location: Zoom Meeting

Date: 5/20/2020

Time: 1600 hrs

Attendees: Chief E. Jaramillo, Dr. K. Pruett, Chief C. Ortiz, Dr. I. Medoro, Dr. Habrat, Dr. G Khalsa, Chief R. Rose, R. LaPrise, D. Chapek, J. Hackett

Agenda items

1. Hospital Systems Reports:

- A. Medoro for Pres- median volumes are down. Status quo. They call this the summer lull right now. Numbers were in the low 300's and we are back in to the 400's. We are seeing more but not a massive spike. ICU's have been put at phase 2 surge capacity for Pres (subject to change). Added 6 more non Covid ICU beds in the Peds ICU.
- B. Habrat for UNM- Opposite of Pres. Spike in patients and volumes are getting back to normal. Set up area outside the hospital to do rapid screenings on low risk patients. Dr. Pruett ICU over 100% capacity and are overflowing to Carrie Tingley beds from Med ICU, Neuro ICU, and Trauma ICU.
- C. Randy for Lovelace- Running separate Covid ER downtown with hopes it's not creating confusion for the crews. Concentrating patient downtown so they are not generating a lot of transfers from Women's and West Side. Covid volumes are back up a bit not a complete reversion back to normal. No major changes from last month. Most Covid patients are coming in from out of town.
- D. Khalsa for VA-Volumes have picked up again but not to pre-Covid levels. Moving forward with Telestroke with weekly calls for the program with a lot of teaching going on and a site visit in June. No stroke patients to VA just yet until it's a proven system. Designated Covid floors not used that much. Opened up beds to non Covid patients because the Covid volume has not been that high for us. Opening up hospital for elective procedures. Hoping to get tele-neurosurgery as well trying not to have to transfer out so many patients.

2. Old business:

- A. Nothing to report

3. New business:

- A. Alternative Response Modeling: Dr. Pruett opened up explaining the need for an alternate response model as ED's are getting busier around the nation talk about alternate response discussions are being had. Dr. Medoro has been working on an alternate response model for

alternative destinations taking lower acuity patients not only to the ED's but also to urgent care or primary care as well. Huston given as an example with their ETHAN project. She noted it's not an operational discussion but to think about from a physician's standpoint what medical complaints can be offloaded from the ED to an Urgent Care. Lay the ground work for MCB to have an idea of what we are comfortable with if questions arise for an alternate response model.

- B. Dr. Khalsa asked for clarification. Dr. Pruett explained one option provider (Paramedic) can be in the dispatch center who can ask more questions to triage them by the patients answers and explain to them they can receive a Lyft to an urgent care, or still dispatch out a unit assess them in person and do a telehealth visit. Explained the benefit of the former as you can keep ALS units available. Dr. Medoro explained he has been working on this for over 3 years and tried to base it off the ETHAN model, which is to send out a unit and do a telehealth visit and get the patient to an urgent care. With Covid we are trying to figure out a way to save time and or units. Paramedic screening is a new part to this type of model in case we are in a surge capacity situation we can keep the scene time low and keep units available. We will still need to vet out how that will work. Asked if MCB is comfortable with this type of model.
- C. Dr. Khalsa gave the suggestion instead of consortium doing the telehealth visit we can send them to a tele-urgent care so the patient won't have to drive anywhere. That suggestion was taken and he was asked for call types that he thought would be acceptable to send to urgent care. Dr. Khalsa spoke of his reservations about crews not knowing the disease process as opposed to what it looks like at that moment and them maybe not catching something that "may progress into something more serious could have bad outcomes in the future."
- D. Dr. Pruett explained some of the coding numbers and explained about how caller response to questions drive some of the codings and responses to low acuity calls. Stating that if a paramedic is in the dispatch they can have red flags to look for on pre-approved call types. Dr. Medoro also referenced the medic buddy concept and how they filter out low acuity call types for them to respond to. Only 1 call from medic buddy for a more severe patient who needed higher level of care.
- E. While speaking of safety criteria Dr. Medoro found a discrepancy in the 3A2 and 3A3 they needed to have over the joint. Dr. Pruett responded with "that's why I put the telehealth a 3A1 is a non-dangerous body area. 3A2 and 3A3 are non-recent superficiaals 3A1 is not." Dr. Medoro further explains that we are trying to drill down for inclusion criteria of low acuity incidents. He asked for Randy and Jot for their input on low acuity incident types.

Dr. Khalsa asked for a percentage of calls that don't transported right now. Dr. Pruett answered that all call types can get transported and there is nothing allowing EMS to say no you're not sick we're not taking you. "Covid has brought a lot of common sense to the table and I think it was (CMS) just agreed a couple of months ago to actually reimburse for this type of alternative destination for lower acuity stuff to relieve the burden on EMS as well as relieving the burden the ED with the thought that there was going to be a massive influx of patients. It's a move in the right direction." It was also explained about a sobering center for alcohol intoxicated patients. Chapek chimed in to answer the question as well stating we see a cancel rate of about 30% which are "patients with low acuity medical conditions up to cardiac arrest patients who are not transported from their home." He said "with these cancels we have no follow up and no follow up care. The ability to coordinate that 30% who

concerned enough to call 911 but not concerned enough to go in by ambulance, we'd love to see them get referred some place else that is appropriate for their care." Dr Khalsa said he thought it was higher like 50% of patients didn't get transported. Dr. Pruett gave call types that refuse the most. MVA's, falls, and lower acuity assault calls.

- F. Dr. Khalsa asked for how many calls this model would apply to with the criteria provided? Dr. Medoro responded with "... we ran in the system that's city and county we did 230 total calls for the day of the low end calls 121 in the city In the county valley they had 30 calls that were considered low priority calls... to save the system annually \$2M for the system we would need to run 10 or 15 of these calls a day. That would be enough, to re-coop, for the agency that shows up, for the urgent care and for any transport methodology..." and then "...depending on how well our crews respond to this it may be a very low call volume may be only 5 of these a day... we would need to clear about 15 of these a day to make it financially viable...."
- G. Dr. Khalsa asked a logistical question about waiting for a telehealth visit instead of transporting to the nearest urgent care. Dr. Medoro explained that Huston doesn't wait for the telehealth and will not transport to an urgent care if the patient needs higher level of care. Average call for telehealth in the ETHAN system is 6 min. long. AAS time on task is about 60 min. potential for 40 min decrease of time on task would allow for more unit availability. On duty ED physicians will not be required to answer telehealth calls, calls will be taken by contracted EM physicians.
- H. Dr. Pruett explained the chart a bit and asked for any feedback, or any known criteria that isn't on the chart that would keep patient out of an alternate destination, be emailed back. This talk doesn't mean that it is going into the guidelines. No agency has come to us with a plan.
- I. Chief Rose wanted to know about the logistical needs for putting a paramedic in dispatch and also wanted to know what the PRC regulations are that will allow us to refuse to transport a patient to an ED. Dr. Pruett reminded him the models presented were just suggestions and that each agency can figure out the operations if an when we decide to go with an alternate destination model. Chief Jaramillo explained that AFR has been looking at the PRC regulations and stated that AFR is working on that and will share information as it becomes available. Both BCFD and AFR are concerned about staffing of paramedics. Dr. Medoro commented that any model going forth will have to look at both the medical side and the operational side of this. He offered help in anyway to assist for the operational side. Chief Rose expressed excitement for the model but said there might be hang ups operationally. Dr. Medoro explained there might be phases to a roll out of this type.

4. Public Comment:

A: Nothing to report

5. Motion to adjourn

Action items	Owner(s)	Deadline	Status
Hospital Systems	Dr. Medoro Pres Dr. Habrat UNM Dr. Khalsa VA Randy Lovelace		
No Old Business			
Alternative Response Model	Dr. I. Medoro Dr. K. Pruet	Open	Open
No Public comment			