CONNECTICUT EMS ADVISORY BOARD

Wednesday, January 27, 2020 at 0900 hours

Via teleconference due to COVID-19 Pandemic

Approved February 24, 2021

Members Attendees:	G. Allard, L. Bolton, N. Brescia, W. Campion, M. Daniels, R. Guthrie, S. Johnson, K. McClaine, J. Oats, J. Paretzky, F. Potter, I. Smith, J. Quinlavin, D. Tompkins.
OEMS Staff:	R. Coler, R. Kamin, A. Pugliese, J. Demers, K. Hickcox, M. Zacchera, J. Reynolds
Regional Presidents	M. Blake, W. Fitzmaurice, M. Wilson
Committee Chairs	K. Ferrarotti (Health and Wellness), R. Kamin and K. McClaine (CEMSMAC), W. Fitzmaurice (CORP), J. Beaulieu (MIH), B. Morris (CMED), L. Brockett (Education & Training), S. Gregg (Trauma)
Guests	S. Conley, K. Coupe, P. Canning, D. Smith, Kim Aroh, M. Osbourne
Board Chair:	G. Allard

Meeting opened at 0907 hours

TOPIC	ISSUE	DISCUSSION	ACTION
Moment of Silence	In memorial	• George "Randy" Daggett, former AB Member and Director of KB Ambulance • Pat Dragon, EMT & Deputy Chief E. Brooklyn Fire, retired CSP • Don Kutz, Deputy Chief Montville Fire • Christine Kutz, EMT Montville Fire • Jim McKenna, Retired MTA Officer • Christopher Batten Jr., Troup G	
Minutes	Minutes of December 21, 2020		Motion to accept Dec. 21, 2020 minutes 1st M. Blake, 2nd W. Fitzmaurice. Motion passed unanimously.
Public comment		None	
DPH-OEMS, R. Coler	Written report submitted Jan 2021	• Review of written report. • Vaccine Training Discussion, Part One and Part Two – also in-house training - info can be found on website • 300+ volunteers • As # of vaccines increase, vaccinators will also increase • Q: Is there a need for EMS folks to be vaccinators? Depends on the number of	https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/PLIS/Approved-COVID-19-Vaccination-Training-Programs

TOPIC	ISSUE	DISCUSSION	ACTION
		vaccines – ctresponds.ct.gov; if you are needed, they will call; K. McClaine/R. Kamin advised that all EMS personnel should get training as state increases need. • Discussion and clarification regarding EMS personnel injecting EPI which is not allowed outside of the 911 system.	
	EMS-C V. Barnes	• No Report	
Chair's report	G. Allard	• Committee annual reports are due in January. • Reminder - Committee leaders should be updating committee goals • Appointments for Open Seats - Josh Beaulieu (MFD), Kate Coupe (Granby EMS), Steve Conley (ASM), Phil Onofiro (Nelson), John Pierce (Hunters) • Fire/EMS Caucus, Chair invited, meeting reviewed.	
	Breakout Session	None	
Committee Reports	CEMSMAC R. Kamin, K. McClaine	• Review of minutes. • EMS for children position has been posted.	• Link to ctresponds.ct.gov for vaccinator info

TOPIC	ISSUE	DISCUSSION	ACTION
	Minutes submitted for January 7, 2021	• CARES Contact, Jackson O'Brien. • Diversion Document in process, sent to board for comments • Scope of Practice sent to board for comments • Minimum Equipment List • Sub-committee set up for lessons learned • Discussion around ADV Board submitting a suggestion for a governor's Exec Order regarding EMS EPI pen.	CEMSMAC wants all communication to them about Proposed Scope of Practice and Statewide Diversion Guidelines before next meeting so that this can be acted on during that meeting. Please direct any questions or comments to Rich Kamin at richard.kamin@ct.gov or Kyle McClaine at kyle.mcclaine@hhchealth.org. The documents are attached below for your review. In addition to that, if you have any suggestions for additions or deletions to the current EMS Equipment List now is the time to act. Again, please notify either of the two doctors via their email. Thank you. Appendix 1 Next meeting Feb 11, 2021
	Communications B. Morris	• Discussion on legislative committee regarding CMED oversight; no defined lead agency for CMED. • Going forward with statewide establishing Everbridge for CMED.	Minutes will be sent out.
	Data J. Beaulieu	• First formal meeting held on Jan.19th. • Still opportunity for participants. • R. Coler thanks H. Fitzgerald for achieving 100% info into Image Trend.	Meetings to be held 3rd Tuesday of the month.

TOPIC	ISSUE	DISCUSSION	ACTION
			Next Meeting Feb. 16, 2021
	CORP W. Fitzmaurice	• Region 1 presented awards; Region 3 has one award left to present • 2021 CT EMS process to start • Draft of annual report sent to group for comments	
	Regionalization J. Laucella	• No report	
	Legislative, G. Allard for M. Loiz	• MHFA • PTSI, Senate Bill 142 • CMED language • Stretcher Van, Proposed Bill 409 • Non-Emergency Transport, House Bill 1154, • Study of technical for ems and police re Opioid overdoses, Proposed Bill 5078, • SB 116 Mental Health related SB 142 Worker's Comp related (PTSI) SB 364 similar to above but all encompassing not just EMS, DOC and Dispatchers SB 409 Stretcher Van	CT Legislation session will be 100% virtual for the session

TOPIC	ISSUE	DISCUSSION	ACTION
		HB 5114 NE transportation for non ambulatory nursing home patients HB 5078 Study Technology that first responders can use when responding to Opioid overdoses HB 5307 Price Gouging - an attempt to disallow this from occurring especially during a declared emergency (i.e. gloves)	
	MIH J. Beaulieu	• Working on End of year report; committee to stay the same for 2021 • Committee leadership will stay the same	Meetings held 4th Thursday of the month. Next meeting Jan. 28, 2021
	Health & Wellness K. Ferrarotti, Jan 8th minutes submitted	• Group is growing, asking for active participants. • Survey is out with responses coming in.	Meetings are 2nd Friday every other month. Next meeting Feb. 12, 2021
	Nominating	• No report	
	Ed and Training L. Brockett	• M. Osborne is Vice Chair. • Annual report is drafted. • Updated BLS PowerPoints. • Updated IFT program.	

TOPIC	ISSUE	DISCUSSION	ACTION
		• EMS Instructors will occur in a 2-year review.	
	Trauma, S. Gregg	• Heidi attended meeting, registry up and running • Email chain/conversation around process of what we should do to move forward on research goal and objectives. • Successful year, less with work in progress, not as many trauma bills. • Working on an annual report.	Meeting 2nd Wed. of every other month Next meeting March 10, 2021
	New Business	• Suggestion to send cards to families of those in memorial.	
Next Meeting	Feb, 24, 2021	Via teleconference at 0900 hours	
Adjournment	At 10:07		

Irene C. Smith RN, Secretary and Angela Pugliese, OEMS.
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Appendix 1

DRAFT

Date: January 17, 2008

From: J. Robert Galvin, Commissioner

STATE-WIDE DIVERSION GUIDELINES

Please review the attached guidelines regarding hospital diversions. These guidelines should be used as a template for regional and local coordination if hospital diversions are necessary.

This is a revision to the established guidelines, which were initially put into place, in 2002 and updated in 2008[TK1] . The Connecticut EMS Medical Advisory Committee (CEMSMAC) and the Connecticut EMS Advisory Board have both provided review and approval on the subject of hospital diversions and I am supportive of the revisions.

Non-MCI Conditions:

Diversion should be utilized by an institution only as a last resort when patient safety within the institution may be jeopardized due to census, or when the institution is not able to offer some or all of its normal services (CT, STEMI, Stroke, Trauma, etc.). Diverting an ambulance can potentially place the patient being transported at increased risk [TK2] ; therefore the risk/benefit of the decision must be carefully weighed.

Before diversion due to census is contemplated, the institution considering diversion shall ensure that the Emergency Department (ED) is not filled with admitted patients waiting to go to other areas of the hospital. EDs filled with admitted patients are impeded in their ability to treat emergent patients and are delayed in treating new arrivals [TK3]. Examples of interventions that may help is: expediting discharges, bringing additional staff into the hospital, paying overtime/bonuses for staff to pick up shifts, bringing additional beds into service, and considering the cancellation of elective admissions or procedures for that day or the next [TK4] .

EMS Regions with a specific diversion policy in place should make sure the components contained herein are included in their process. Any concerns or need for variation of the regional policies should be brought before the CEMSMAC **prior to implementation.** All regional policies should be sent to the CEMSMAC to be kept on file [TK5] [TK6] .

There are two types of Non-MCI condition diversion:

1. Emergent Operational Diversion due to an acute event in the hospital such as a fire, burst pipes, electrical shut-down, a threat/act of violence, or Hazmat contamination that directly or indirectly affects the ED operation and patient safety.

Emergent operational diversion may be required due to blocked routes of travel to the hospital secondary to an emergent situation.

In those cases where the ED may need to go on diversion acutely, only C-Med needs to be notified. C-Med will in turn notify the surrounding hospitals.

2. Emergent Diversion due to high ED census, lack of hospital beds, or inability to provide imaging or specialty care (CT, STEMI, Stroke, Trauma)

a. The hospital that wishes to divert must obtain the permission from the hospital(s) it wishes to divert to. The hospital(s) willing to accept must be a reasonable distance from the diverting hospital. It is not acceptable to expect ambulances to travel large distances out of their assigned areas unless there is an MCI declared.

b. C-Med will only accept the diversion status if it has the name(s) of the responsible parties at the diverting and accepting hospitals.

c. The C-Med center in the region where the diversion is occurring, will notify all the other area hospitals by a general toned announcement.

d. The C-Med center where the diversion is occurring will notify the neighboring C-Med center if diverting ambulances are crossing over to that region.

e. Diversion must be formally renewed every four hours with C-Med and the accepting hospitals. If the time expires and the diverting hospital has not extended diversion with the permission of the accepting hospital(s), CMED will announce that the diverting hospital has resumed normal operation.

f. As the internal or external reasons for diversion improve, it is expected that the diverting institution will cancel its diversion status as soon as possible.

g. Any hospital accepting diversion may remove itself, at any time, from the accepting list by notifying C-Med.

h. If a hospital that is contemplating diversion finds no accepting hospitals, it cannot divert.

i. If a diverting hospital has lost all those institutions that were accepting, it must cease to divert unless it can find an alternate accepting hospital.

j. In the event that severe weather conditions exist, C-Med may advise the diverting and receiving hospitals of these conditions. The final decision to implement/continue diversion will rest with the involved hospitals.

Scene providers should use the state trauma diversion criteria as well as the attached diversion criteria for guidance and contact medical control for destination decisions.

A hospital, regardless of its diversion status, must accept a patient who is so unstable that in the opinion of the ambulance crew the patient must be taken to the closest hospital. On-line medical direction must be contacted to discuss the impending arrival of the unstable patient to the diverting hospital.

[TK1]Cite both 2002 and 2008???

[TK2]Citation?

[TK3]citation

[TK4]Not sure if we shouldn't get rid of this entire paragraph

[TK5]This supports, maybe obligates, the inclusion of a diversion policy/protocol into the statewide protocols.

[TK6]Any current regional policy in place? If not then can reword this section