



NEWS

Newsletter of the National Association of EMS Physicians

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The National Association of EMS Physicians is an organization of physicians and other professionals who provide leadership and foster excellence in out-of-hospital emergency medical services.

The NAEMSP newsletter is designed to inform members of interesting developments in the field of EMS. Members are encouraged to send information which may be of interest to others reading this publication.

NAEMSP News is the official bimonthly newsletter of the National Association of EMS Physicians (NAEMSP).

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May 2000 issue:
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Some Reflections on Alternative Triage Criteria

Keith Neely, MPA, PhD (cand.)

Soon it may be common place for EMS dispatchers to refer certain callers to a nurse advice service rather than dispatching an ambulance. It may also be quite common for paramedics to recommend to certain patients some alternative form of transportation to the emergency department, or even to some other care setting. The object of this practice is to more precisely match health services resources to user need.

That is the envisioned future. Whether these new practices actually find favor or remain in the good graces of EMS planners depends upon how new decision guidelines are developed, monitored and applied. At the moment, we don't yet know what constitutes a good guideline or a bad one, but there are some reasonable considerations.

It is clear to all that any such guideline must be carefully constructed and validated. This means not only do experts develop the criteria, but the criteria is also prospectively tested. This has been said before. A critical discussion must accompany guideline development. What level of under triage is a community willing to tolerate? No guideline will be perfectly sensitive. Is five percent undertriage acceptable? Is two percent? As this bar is raised, guideline specificity declines. This means fewer EMS system users are referred to alternative resources. This may cause an adverse impact on the economic expectations placed on new guidelines. This policy issue should be thoroughly discussed by all stakeholders.

An associated discussion is what constitutes true need for EMS services. We agree that a core mission of EMS is to assure that lives are not unnecessarily lost. What other community values also should be incorporated into a new triage guideline intended to determine EMS necessity? Is pain control or fracture immobilization a necessary EMS services requiring ambulance response and transportation? Should we transport by ambulance someone who falls outside the medical criteria but has no other means of getting to the hospital?

Despite the care and rigor associated with guideline development, under triage remains likely. One buffer may be EMS dispatcher and paramedic caution. Research on alternative dispatcher guidelines conducted in King County, Washington, and Portland, Oregon, indicates a high level of dispatcher caution associated with triaging callers away from EMS services. Allowing this caution to work may protect against under triage. Systematic review of the decision-making process and the outcomes of those referred to alternative services also will remain necessary.

Triage criteria reflect diverse community values. Those values are changing. The practice of matching resources to need may ascend past our tried and true practice of sending maximum resources to most callers, regardless of the cost or apparent need. This will be complex and will require skillful research, leadership and consensus building. *

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2000 and beyond!

By the time this issue hits your mailboxes, it will officially be the new millennium and we will have completed our January 2000 NAEMSP Annual Meeting. I write this column in anticipation of that event and the firm knowledge (based on recent annual meetings) that I will leave that meeting tired but extremely invigorated.

It is always a pleasure to attend one of the NAEMSP annual meetings. My wife refers to it as my annual EMS "blood transfusion." In addition to the valuable educational sessions (again, David Cone, MD, has done a phenomenal job!), it is great fun to meet with the members of the association and talk about things going on in EMS systems all over the country (and now internationally!). I always leave the meetings with great ideas (and great intentions) for the association and for our local EMS system. Specifically regarding this meeting, we are all indebted to Dr. Cone and all of our NAEMSP staff (especially Jennifer Kimzey) for the countless hours they have invested in making the meeting successful. I am also indebted to the staff, the board and the membership of the association for support of NAEMSP and of the EMS activities that we promote and support.

Now that we have hopefully survived the Y2K transition, we can look forward to the direction of the association for the coming years. EMS is in a period of potentially significant transition over the next few years. This will be a time of increased interaction (and hopefully cooperation) among national, state and local organizations as we work through this transition. As the health care system continues to evolve, we must continue to educate legislators, insurers, others in the medical community and the general lay community about the resources (current and potential) that the EMS community can offer. NAEMSP looks forward to working with all these organizations in ensuring the growth of EMS and the provision of appropriate medical oversight activities for EMS personnel and agencies.

The association will continue to support the membership in whatever ways it can. We count on the members to help define the type of support needed. In addition to quality educational programs and publications (e.g., *Prehospital Emergency Care*, *NAEMSP News* and texts), we will continue to research important topics and present position statements in a timely manner. Position statements currently in review and development include response time standards, pain management, RSI, patient restraint and closed head injury management. (Let us know if you have other suggestions.) We are currently gathering data regarding the need for and potential impact of medical director's insurance ... please complete the e-mail survey that you have recently received, or fill out the form in this newsletter, if you have not already done so.

Most importantly, we can continue to support each other. One of the most valuable aspects of the association is the ability to meet others who are trying to address the same issues and share thoughts, ideas and lessons learned; networking is a critical aspect of our success. We are all resources to others ... locally, nationally and internationally. I recently had the opportunity to speak at the 10th Annual Meeting of the Korean Society of Emergency Medicine. This meeting was co-sponsored by Medtronic/Physio-Control and I am grateful to them for the invitation to participate. It was amazing to meet emergency physicians, nurses and EMS personnel from there, share some of our lessons in EMS/EM and AED implementation, and experience their enthusiasm for the growing specialty. Other international activities were well demonstrated by the presentations at our meeting.

In addition, I have recently had the opportunity of talking with a medical director in a very rural area who was experiencing difficulty with a local agency that wanted to operate without any medical direction. And, via e-mail, I have been discussing with one of our



Jon Krohmer, MD

professional members issues of how difficult it is for her to work in a metropolitan area because of the conflicting medical control requirements and differing protocols among multiple EMS "systems" in close geographic proximity to each other. The networking is wonderful!

As I was walking around one of the educational sessions in Korea, one of my hosts came up to me and said, "You must really like what you are doing. It shows!" What a wonderful thing to say. Through our association and our daily activities, we all have the opportunity to "show" our interest, enthusiasm and knowledge and to help EMS grow.

Thanks to our membership, board and staff for their support of the association. Happy new year and best wishes to you all for the coming year! ★

NEW MEMBERSHIP DIRECTORY IN PROGRESS

Directory verification forms for the new upcoming membership directory were mailed to all current members in early December and were to be returned with any changes or additions by January 10, 2000. If you did not receive the form or did not return it by the deadline, contact Heather Barry at the NAEMSP Executive Office (913/492-5858, ext. 448) to determine if your information could still be updated in time for inclusion in the new membership directory. The membership directory will mail in March.

ARE YOU COVERED? ARE YOU COVERED? Insurance for Medical Director's Acts ARE YOU COVERED? ARE YOU COVERED?

Jay V. Krafstur

Our first column discussing medical director liability appeared in the September 1999 issue of *NAEMSP News*. Justifiably concerned with their potential liabilities, we received a host of phone calls, letters and e-mails from medical directors around the country asking whether their existing liability insurance program provided coverage for claims against them arising out of their decisions and actions in their capacity as medical directors. As we discussed in that first column, potential liability typically arises through two sources: your advice and direction to various EMS organizations; and your role as evaluator and disciplinarian of paramedics and EMTs, including the decision to temporarily suspend or permanently discharge an EMT or paramedic.

Preliminarily, there are several factors to mention that touch on this question of protection for a medical director's acts before one can address how insurance protection comes into play. As we mentioned in the first column, there have not yet been a flood of these claims asserted, although we will probably see more in time. Second, you may have other, non-insurance contracts or agreements where some person, organization or company has agreed to defend and indemnify you for claims arising out of your medical director activities. These could include, among others, your contract with the hospital whose emergency department you work in, with your medical group, with the city or county you advise, or with a specific EMS organization. Depending on the protection afforded in those arrangements, you may want to tender any medical director claims against you to those organizations. Finally, there are some jurisdictions that now immunize physicians for claims arising out of their activities as medical directors. Illinois' EMS Act states, "No EMS medical director who in good faith exercises his responsibilities under this Act shall be liable for damages in any civil action based on such activities unless an act or omission during the course of such activities constitutes willful and wanton misconduct." Although perhaps a topic for fuller treatment in a future column, medical directors in states who have qualified immunity for EMS professionals might succeed in having that immunity extended to them.

Potential Sources of Existing Medical Director Insurance Coverage

Bear in mind that although others such as insurance brokers, physician colleagues or practice managers, hospital administrators, or EMS organizations may have remarked to you concerning the scope of various insurance policies, only a careful reading of the contract itself will tell you whether it covers you for your medical director activities. Moreover, although it is true that most insurance contracts have standard, or form language, virtually all policies also have conditions, exclusions and endorsements in addition to the main insuring agreement. Accordingly, the entire policy must be reviewed before you can conclude that it covers you

for your acts or omissions as a medical director. To determine whether you have insurance for these activities, several potential insurance sources should be considered. First check your professional liability, or malpractice policy (hereafter "professional liability policy") that purports to cover you for your work in the emergency department or other primary place of practice. This policy may have been issued to you alone, or it may include you as a part of a larger medical group. During this review, do not rely on a Certificate of Insurance to answer this question. Certificates of Insurance are typically issued to someone as proof that a required policy has been issued. Certificates are not policies, and they confer no rights of insurance. Second, depending on the nature of your employment relationship with your hospital, the hospital's malpractice policy might apply. Although in our experience this is unlikely, this part of the review should not be overlooked. As an aside, we realize that you may not have in your possession some of the policies we mention here. They may be difficult or awkward to obtain. We may be able to recommend ways to address this situation on a case-by-case basis. Third, you should review the professional liability policy of the EMS organization for which you provide your medical directorship. As we will discuss further below, some of the more recent policies issued to EMS organizations are including medical director coverage.

What Actions Should Medical Directors Take?

Now that you know the common sources of potential medical director insurance coverage, what steps should you take to ensure you are covered? First, review both the non-insurance contracts we mentioned above, or other indemnity agreements you might have with the EMS organization itself. Even if your own insurance handles your claim, the insurer may have a right to seek reimbursement from that other person. Second, review all potentially applicable insurance sources we have discussed, and remember that there might be other potential insurance sources that we have not mentioned. Do not feel constrained by the short list provided here. Third, and certainly the most important, if you find you are not covered for your acts as a medical director by any of these sources, then you must seriously consider changing something to secure this protection. A few obvious changes come to mind. Depending on who insures you or your medical group, medical director coverage can be added to your professional liability policy. Although this would constitute an additional coverage for which the insurer might want additional premium, there have been relatively few of these claims so the new coverage should be inexpensive. Second, consider asking the EMS organization you direct to add you as an additional named insured on its professional liability policy. Alternatively, ask that organization to pay the additional premium for adding this coverage to your own professional liability policy. Indeed, several insurers of EMS organizations are now including this cover-

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ELECTION RESULTS

We are pleased to announce the following NAEMSP Board of Directors election results:

- Members-at-Large:** Dr. David Cone
Dr. Michael Sayre
- Appointed to the Board:** Dr. Thomas Blackwell

As program chair for NAEMSP's January 2001 Annual Meeting, Dr. Blackwell assumes the appointed position vacated by Dr. David Cone.

Your complete board includes:

- President:** Dr. Jon Krohmer
Kcems@aol.com
- President-elect:** Dr. Richard Hunt
Huntr@mailbox.hscsy.edu
- Secretary-Treasurer:** Dr. Robert Bass
Rbass@mdems.umaryland.edu
- Past President:** Dr. Robert Swor
Raswor@aol.com
- Members-at-Large:** Dr. Thomas Blackwell
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Dr. Robert Domeier
Rdomeier@aol.com
Dr. Robert O'Connor
Roconnor@christianacare.org
Dr. Michael Sayre
Michael.Sayre.uc.edu

- Professional Member-at-Large:**
Mr. Keith Neely
Neely@ohsu.edu

Thank you to all our members who took the time to vote for your NAEMSP Board of Directors.

Farewell to Board Member Dr. Brian Zachariah

NAEMSP wishes to thank Dr. Brian Zachariah for faithfully serving NAEMSP for many years on the board. Dr. Zachariah chose to not run for re-election to the board due to other time commitments.

Brian S. Zachariah, MD, Leaves NAEMSP Board of Directors

The NAEMSP Board of Directors greatly extends its appreciation to Brian Zachariah, MD, for his service to the association as a member-at-large to the board for the past two years. Due to increasing professional responsibilities (and a desire for some free time with his family), Brian elected not to run for a second term on the board. His wisdom and clear thinking has been a great asset to the association.

Brian is a former associate medical director for the Houston Fire Department. He recently served as an associate professor and director of EMS at the University of Texas Southwestern Medical Center (and Parkland Memorial Hospital) in Dallas, and as the medical director for the EMS program of the Dallas Fire Department and several surrounding departments. He is currently the medical director for XXX Hospital in Dallas and continues to work with several area fire departments.

We wish Brian great success and offer our grateful thanks.

Come see what
* awaits you in
Cloquet, MN.

Exceptional opportunities exist for four Emergency Medicine physicians at Community Memorial Hospital in Cloquet, MN. The selected physicians will join a growing, established hospital with state-of-the-art facilities. These physicians must be ACLS certified. The shifts will be 12 hours, 3 days per week. The hospital is affiliated with St. Luke's Hospital, a Regional Trauma Center, and has 400 affiliated physicians.

Cloquet is a growing community with a strong economic base, social and civic structure. It is a community of over 10,000 people and serves along with other area communities. The growth center for the Iron Range, Cloquet is just 10 miles away from Duluth, MN where you can find numerous civic, cultural and recreational activities and events. The community is active in planning its own future and generously involved with the educational development of its youth.

Compensation is competitive with excellent benefit package.

For more information, please contact:

Vicki Trauba, Recruitment Specialist • St. Luke's Hospital, 600 East Superior Street, Suite 404, Duluth, MN 55802 • Phone: 800-997-6685 • Fax: 218-727-9392 • E-mail: vtrauba@ruralcenter.org

FICEMS REPORT

Sandy Bogucki, MD, PhD, NAEMSP Liaison to FICEMS

The regular, quarterly meeting of the Federal Inter-Agency Committee on EMS (FICEMS) was held in the General Services Administration (GSA) offices in Crystal City (Arlington, Virginia) on December 2, 1999. It was chaired by Bill Troup of the U.S. Fire Administration.

Prior to the meeting, a memorandum from Kenneth O. Burris Jr., who will be assuming the duties of the chair, was received by all committee members and liaisons. The text of the memorandum includes the following:

... As the former fire chief of a municipal fire department with over 23 years of fire service experience, I have a deep appreciation of the EMS role in the fire service and the public sector. FICEMS has my support and my commitment as I carry out my duties as chief operating officer of the United States Fire Administration (USFA).

USFA has recently developed an EMS TEAM to coordinate all issues involving EMS, including FICEMS. The mission of USFA's EMS Team is to support the Federal Emergency Management Agency (FEMA)/USFA mission to serve the fire and emergency service constituents via the coordination and clear linkage of training and programmatic EMS activities. FICEMS serves as a forum to establish and facilitate effective communication and coordination among federal agencies involved in activities related to EMS. USFA's EMS Team does the same within USFA.

USFA's EMS Team will support the FICEMS chairperson in administering the operations so that it can best serve your agency through the sharing of EMS information. The USFA technical staff members involved in the facilitation of this committee have extensive background in EMS which will assist in the revitalization of FICEMS.

The following items of particular interest to the NAEMSP membership were included in the reports from the various agencies and/or discussed during the three-hour meeting.

GSA (Globerman): Mr. Globerman needs comments and information from interested parties regarding the next revision of the KKK federal ambulance specification. Content areas were finalized at a meeting on December 16. Drafts will be made available electronically to FICEMS members for review when ready. His office is also assisting the ambulance manufacturers and Ford in the process of improving the electrical interface with the Ford chassis. Input on this issue can be directed to him.

DOT/NHTSA (Henry): The state directors' implementation guide for EMT-P and EMT-I curriculum rollouts are ready for distribution. It is being sent to state EMS offices and is available on their Web site. Statewide EMS reassessment is available now. NHTSA recommends reassessment four to five years after initial assessment. Interested states can request reassessment through state highway safety offices and NHTSA regional offices. The assessment "standards" have been updated and will be provided to FICEMS members at the next meeting. NHTSA is presently establishing its peer review list for the EMS Research Agenda for the Future. Anyone wishing to participate in this effort should contact the EMS program at NHTSA.

OSHA (Pierce): OSHA Directive #CPL2-2.44D referencing 29CFR 1910.1030, Occupational Exposure to Bloodborne

Pathogens, was issued November 5, 1999. It essentially updates the 1992 directive that highlights review procedures, personal protective equipment and new technology aimed at controlling workplace exposures. It also incorporates current CDC recommendations for immunization and post-exposure prophylaxis. A summary of comments received by OSHA on the proposed directive was distributed and is available from the office (see below).

A proposed ergonomics standard to be included in 29CFR 1910 was published in the *Federal Register* on November 23, 1999. While the main thrust of the standard is aimed at reducing the toll of musculoskeletal disorders due to repetitive motion, it does include reference to lifting patients. The comment period on this proposal closes February 1, 2000. Further information and contacts can be found on the OSHA home page (www.osha.gov).

NTIS (Hounsell): A training video on ergonomics produced by OSHA is available through their service. The National Technical Information Service (NTIS) is part of the Department of Commerce.

USDA (Barrett): The list of recipients of grants and loans awarded under the Community Facility Loans and Grants for Fire and Rescue Facilities administered by the Rural Housing Service at the U.S. Department of Agriculture (USDA) was distributed. In all, roughly \$29 million was committed under this program in FY 1999. Information regarding this program can be obtained from the Rural Housing Service at 202/720-1500.

USFA (Troup): The U.S. Fire Administration (USFA) is in the process of developing a National Fire Research Agenda in cooperation with the National Institute for Standards and Technology (NIST). Input on this issue can be directed to Mr. Troup at bill.troup@fema.gov. He also reported that approximately 200,000 copies of the monograph on fire service funding have been distributed thus far, and it is currently in its third reprinting. Additionally, reports on "New Technologies in Accountability" and "New Technologies in Hazmat Response" are in press. Contact Mr. Troup for copies, which are all free of charge.

USFA/NFA (Kimball): Mr. Kimball was introduced as the new National Fire Academy (NFA) program chair for Hazardous Materials and Counter-terrorism. He updated the committee on programs currently in progress and activities planned for the next year. He can be contacted at 301/447-1533 or john.kimball@fema.gov.

Briefly, reports from the private sector included:

ASTM (Chambers): New proposed standards for both air and ground ambulances are out for comment. Anyone interested should contact Charles Glass or Pete Chambers at the American Society for Testing and Materials (ASTM).

The International Association of Fire Chiefs (IAFC), International Association of Firefighters (IAFF) and the American Ambulance Association (AAA) all reported on their participation in the HCFA Negotiated Rule Making process.

Finally, William Fabbri, MD, FACEP, provided a presentation on his work with EMS in the FBI, preparing for WMD incidents. ★

Legislative UPDATE

There have been a number of events happening on the federal level that will undoubtedly impact the world of EMS. These include not only legislative activity, but also the very important activities of the Negotiated Rule Making Process with the Health Care Financing Administration (HCFA) which have occurred throughout 1999.

Congress has finally adjourned the first session of the 106th Congress. The following are highlights of bills that will impact EMS:

1. *Cardiac Arrest Survival Act. (S. 1488)*. Directs the secretary of HHS to develop Public Access Defibrillation programs for federal facilities. It also provides liability ("Good Samaritan") protection for users of and trainers for the devices. This passed the Senate right before adjournment, but will now have to wait for the House to reconvene in the second session.
2. *Patient Protection Act. (Norwood-Dingell Bill)*. Passed in different versions by the House and Senate and now must go to conference committee. Unfortunately the conference committee membership has been a subject of much political maneuvering. Speaker Dennis Hastert has named, or is expected to name, a group that consists mostly of individuals who did NOT vote for final passage of the bill. In any event, no action will take place now until the next millennium. This bill gives patients more rights in dealing with their HMOs.
3. *Balanced Budget "Give-back" Bill*. Passed by both House and Senate. The Balanced Budget Act of 1997 decreased the amount of money available from Medicare, which was especially tough on teaching and rural hospitals. This "give-back" bill restores \$16 billion over the next five years and \$27 billion over the next 10 years to replace some of the unintended consequences of the original BBA. It is a complex bill, but it will have several parts that will impact EMS. It will restore a substantial amount to teaching hospitals for indirect medical education add-ons. It also increases and makes more equitable payments for direct medical education. (More stable teaching hospitals can better teach EMS and support EMS systems.) The "give-back" bill also supports rural hospitals by allowing them to become "critical access hospitals" (CAH). Even rural hospitals that downsized or closed in the past 10 years can revive to become such CAHs, if they provide 24-hour emergency care. Obviously this could be of great help to rural EMS. The bill also supports rural graduate medical education to a great extent, by providing exceptions to residency caps.
4. *The Wireless Communications and Public Health Safety Act*. Signed into law by the president in late October, this was designed to ensure that cellular callers get the same 911 service as those citizens calling by landline.
5. *Poison Control Centers Bill (S.632/ H.R.1221)*. The Senate passed a different bill from the House version. The House leadership is resistant to considering the bill which provides for stable federal funding of poison control centers and for related public education. Poison control centers can be a resource for toxicologic emergencies for rural EMS systems who often do not have access to full-time medical control.

Negotiated Rule Making (NRM) Process with HCFA. This is a complex consensus process which began early in 1999 and has met on and off through the year for about 14 sessions. Unfortunately, there is only one physician on this group. However, NAEMSP and ACEP are fortunate in being ably represented by Dr. Robert Bass from Maryland. I cannot possibly reiterate all of the matters considered in these sessions, but I will try to give the highlights of what will affect EMS. HCFA has said that implementation is not likely to occur before January 1, 2001, because of the legal processes that have to occur once the NRM Committee reaches consensus.

- The seven major issues addressed included:
 - A. Type of service furnished (level of care)
 - B. Type of provider (should volunteer, municipal and private providers be treated differently?)
 - C. Definition of appropriate regional differences (geographic wage adjustment)
 - D. Operational differences (ALS/BLS, ground/air, etc.)
 - E. Whether mileage should be paid separately and what the base and mileage should cover
 - F. Phase in of the fee schedule
 - G. Mechanism to control expenditures (increasing numbers of runs, volunteers who didn't used to charge starting to, changes in providers from BLS to ALS, etc.)
- Coverage was not on the table for discussion. Services not paid for today will not be paid for in the future. Transportation is the covered benefit, not care provided (i.e., there will be no reimbursement for treatment without transport). First responders were not part of the discussion at all.
- "Consensus on Service Level" Definitions:

The level of service is defined by the skill provided, assuming the skill provided is medically necessary.

 - *BLS*: BLS service is defined as the skills contained in the National Core Content and Practice Blueprint for the EMT-Basic including IV without an ALS assessment.
 - *ALS Level 1*: Where medically necessary, an ALS assessment by an ALS provider or the provision of an ALS intervention.
 - *ALS Level 2*: At least three medications [doses] or one of the following ALS procedures: [manual] defibrillation/



cardioversion, endotracheal intubation, central line, pacing, chest decompression, surgical airway, advanced invasive airway (e.g., PTL, Combitube) or intraosseous access.

- Specialty transport: "When medically necessary, a level of service provided beyond the scope of the national paramedic curriculum. This is necessary when a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (nursing, medicine, respiratory care, cardiovascular care or a paramedic with additional training). Examples of transports that necessitate specialty care level services would include critical care transports, neonatal or perinatal transports, or patients on intra-aortic balloon pumps or requiring complex ventilator care. This level of care is frequently mandated by EMTALA for inter-facility transfers. Coding for this level of service recognizes the additional costs of providing that higher level of specialty care during transport."

The roughly \$2.6 billion available for the EMS pie will be divided up amongst the providers in a complex fashion based on the nature of care provided and geographical location.

This is but a snapshot of federal lawmaking and regulatory impacting on EMS. It will be even more interesting to see what the new millennium will bring. ★



CHRISTIANA CARE HEALTH SYSTEM

Christiana Care Health System is currently seeking qualified applicants for their newly established Fellowship in Emergency Medical Services. The Fellowship is a 12 or 24 month SAEM/ Physio-control approved program, with emphasis on EMS research and education.

Christiana Care Health System is an academic residency training site in Delaware, with an established clinical research program for emergency medicine, trauma, and cardiology, and is actively involved in EMS education, base station operations, medical direction, and research for EMS within Delaware and surrounding areas.

Candidates for the 2000-2001 academic year are being recruited. Applicants should be graduates of an accredited emergency medicine residency program. Those interested should contact the Fellowship Director, Robert E. O'Connor, M.D., MPH at (302) 733-4176, or write: Christiana Care Health System, Department of Emergency Medicine, 4755 Oglethorpe-Stanton Road, Newark Delaware 19718. E-mail: roconnor@christianacare.org.

GRANTS UPDATE

Medical Direction: National Standard Curriculum

The National Association of EMS Physicians (NAEMSP) is looking for a site for their second pilot study of the National Standard Curriculum. If you are interested in hosting this pilot study of the curriculum in the spring of 2000, please contact Jennifer Kimzey at the NAEMSP Executive Office at 913/492-5858, ext. 414, or by e-mail at jkimzey@goAMP.com.

National EMS Research Agenda

NAEMSP, in cooperation with the National Highway Traffic Safety Administration and Maternal and Child Health Bureau, has contracted to produce a National EMS Research Agenda. Michael Sayre, MD, has been chosen as the principal investigator for the contract, with Lynn White, MS, and Lawrence Brown, EMT-P, serving as co-investigators. The Steering Committee for the project includes Michael Armacost, MA, NREMT-P; J. Michael Dean, MD, MBA; Scott B. Frame, MD, FACS; Baxter Larmon, PhD, MICP; Susan McLean, RN, PhD; N. Clay Mann, PhD, MS; Gregg Margolis, MS, NREMT-P; Michael O'Keefe; Daniel W. Spaite, MD, FACEP; Jon Krohmer, MD; Susan D. McHenry, MS; Timothy Davis, MD; Elinor Walker and Mary McDonald Hand, MSPH, RN.

The first Steering Committee meeting was held November 22-23, 1999, in Kansas City, Missouri. The second meeting will be held January 31-February 1, 2000, at a location yet to be determined. There will be a national review team compiled to review the draft document in the fall of 2000.

"Insurance for Medical Director's Acts" continued from page 3

age as part of their policies. Accordingly, those EMS organizations may already be contemplating their need to afford this coverage to you. Finally, several insurers are selling or preparing to sell a stand alone medical director policy. These policies might be slightly broader in scope than adding on coverage to existing policies.

Although the floodgates have not yet opened for claims against medical directors, the time to confirm your coverage for these claims is now, before the first claim comes in. If you are uncertain about the scope and inter-relationship of these policies, please consult someone who is knowledgeable in both EMS and insurance issues. ★

Jay V. Krafur is the founder and former partner in charge of Rivkin, Radler & Kremer's Emergency Services Practice Group. On January 1, 2000, Mr. Krafur started a new firm, The Krafur Law Group, which specializes in the emergency services industry. Questions may be forwarded to Mr. Krafur at The Krafur Law Group, 30 N. LaSalle St., Ste. 4300, Chicago, IL 60602, jaykrafur@krafurlaw.com, 312/899-0269.

Introduction

The medical workgroup, at the request of the committee, is forwarding the following recommendations:

1. Definitions of the levels of medical services provided by an ambulance.
2. A list of medical conditions that would assist in determining the medical necessity for transport by an ambulance, including the level of services provided.
3. Changes in the existing Medicare guidelines for air medical transports.

In developing the recommendations the workgroup met in May, June, July, September and November. Interim reports were submitted to the NRM Committee in June, August and October. A list of the medical workgroup members is attached.

Levels of Ambulance Services

Basic Life Support (BLS)

Where medically necessary, the provision of basic life support services as defined in the National EMS Education and Practice Blueprint for the EMT-Basic including the establishment of a peripheral intravenous line.

Advanced Life Support 1 (ALS 1)

Where medically necessary, an assessment by an advanced life support provider and/or the provision of one or more ALS interventions.

An advanced life support provider is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint.

An ALS intervention is defined as a procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

Advance Life Support 2 (ALS 2)

Where medically necessary, the administration of at least three different medications and/or the provision of one or more of the following ALS procedures: manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway or intraosseous line.

Specialty Care Transport

When medically necessary, in a critically injured or ill patient, a level of inter-facility service provided beyond the scope of the Paramedic as defined in the National EMS Education and Practice Blueprint. This is necessary when a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (nursing, medicine, respiratory care, cardiovascular care or a paramedic with additional training). Examples of transports that would necessitate specialty care level services would include, but not be limited to, initiating or monitoring the following:

General

- Vasoactive infusions requiring titration, including but not limited to:
 - Epinephrine, norepinephrine
 - Dopamine
 - Dobutamine
 - Neosynephrine
 - Labetalol
 - Esmolol
 - Nitroprusside
 - Amiodarone
 - Intravenous nitroglycerin
 - Diltiazem
- Infusion of blood or blood products
- Titration of chemical paralysis/sedation
- Chest tubes
- Pericardial catheters
- Insulin
- Thrombolytics

Respiratory

- Requires specific mechanical ventilatory support
 - Pressure-controlled ventilation
 - Reverse I:E ventilation
 - PEEP greater than 5.0CM water
 - Pressure support ventilation
 - High frequency ventilation
- Acute cricothyrotomy or tracheostomy

Cardiac

- Temporary pacing (transvenous, external)
- Intra-aortic balloon pump
- Pulmonary artery pressure monitoring (Swan-Ganz)
- Ventricular assist device

- Femoral arterial sheath
- Central venous pressure
- Intracranial pressure monitoring
- Extracorporeal membrane oxygenation
- Arterial lines

Obstetric

- Preterm labor with tocolytics required
- Management of eclampsia/pre-eclampsia
- Fetal monitoring required
- Condition which may result in birth of less than 2000 grams or less than 34-week gestation infant
- Infusion via epidural catheters

Neonates/Pediatrics

- Less than 2000 grams or less than 34-week gestation infant
- Cardiac disorder with hemodynamic/respiratory compromise
- Infant Respiratory Distress Syndrome
- Metabolic acidosis greater than two hours post-delivery
- Sepsis, meningitis in newborns

Medical Conditions and the Medical Necessity for Ambulance Transport

The workgroup is submitting the following list as a list of conditions to be utilized in establishing the need for transport by ambulance and the level of care that should be provided.

Air Medical Transport Guidelines

The workgroup recommends replacing the list of conditions in section 2120.4 B (Medical Appropriateness) with the following:

- Acute neurological emergencies requiring emergent-/time-sensitive interventions not available at the sending facility, e.g.:
 - Intracerebral hemorrhage
 - Status epilepticus
 - Acute stroke
 - Diffuse cerebral edema
 - Acute hydrocephalus
 - CNS infection requiring operative intervention
 - Thrombolytics
- Acute vascular emergencies requiring emergent-/time-sensitive inter-

continued on page 10

News From the Executive Office

Dede Gish-Panjada, Executive Director, and Beth Panther, Association Manager

We hope that the new millennium finds you well and not encountering any lingering Y2K problems!

By the time you receive this newsletter, NAEMSP's 2000 Annual Meeting will be a thing of the past. As of this writing, the number of registrants exceeds the number at this time last year, so we are expecting a great turnout and a very productive meeting. The March issue of *NAEMSP News* will contain complete information about the conference.

Plans are already underway for NAEMSP 2001 to be held January 18- 20, 2001, at the Sanibel Harbour Resort & Spa in Fort Myers, Florida. Program ideas and speakers are still being accepted for this conference, so please send your suggestions to Dr. Tom Blackwell, program chair, at tblackwell@carolinas.org. We always appreciate your input and want to ensure our educational programs are meeting your learning needs and give you cutting-edge updates in technology, pharmaceuticals and management breakthroughs.

As noted on page 4, Dr. David Cone was elected to serve on the NAEMSP Board of Directors, and Dr. Michael Sayre

was re-elected to the board, both as members-at-large. Because of his role as program chair, Dr. Cone has been on the board for a few years in an appointed position. We would like to welcome Dr. Blackwell as a new board member, since as program chair, he will now sit on the board in the appointed position vacated by Dr. Cone. We look forward to continuing to work with these exceptional individuals, as well as the entire NAEMSP Board of Directors. A complete list of the board is on page 4.

Please remember to continue referring your colleagues to NAEMSP for membership. We are always happy to send a membership application via mail or fax. Please visit our Web site at www.naemsp.org. We wish to strengthen our organization and the pre-hospital practice of EMS by involving more physician and professional member practitioners.

We at the NAEMSP Executive Office hope you had a happy and healthy holiday and wish you the best in the new year.

In Memory

NAEMSP is saddened to announce the death of Los Angeles County Sheriff's Reserve Commander David Rasumoff, MD, who died in his sleep of natural causes in mid-November. He was 58 years old.

Dr. Rasumoff had been a reserve deputy sheriff for almost 20 years and was a part-time faculty member in the Department of Emergency Medicine for the Los Angeles County + University of Southern California Medical Center. Referred to by many simply as "Doctor Dave," he had recently been in charge of the Sheriff's Department's EMT training program for search and rescue personnel. Both in his capacity as a reserve deputy sheriff and as an emergency medicine physician, he was one of the founders of the program which placed base station qualified physicians along with a team of airborne paramedics directly into the County's Air 5 search and rescue helicopter. Additionally, Dr. Rasumoff was one of a handful of physicians nationwide who had undergone the rigorous training to allow himself to be deployed alongside emergency services detail paramedics within the tactical perimeters of SWAT operations. This combination of law enforcement and emergency medical expertise had made him a highly sought after and nationally known consultant for local, federal and military law enforcement training institutions, where he helped develop tactics for rescuing and providing emergency medical care to downed officers who may still be caught in the middle of a firefight. He had just recently been honored by the Department of Defense for his lifetime commitment to excellence in tactical medical training, which has already and will continue to save the lives of law enforcement personnel everywhere.

David Rasumoff, MD, made his mark on the Los Angeles County Sheriff's Department and will be missed by all who had the privilege of knowing and working with him.

*Submitted by Richard J. Moak, Lieutenant
Medical Services Bureau
Los Angeles County Sheriff's Department*

The Timothy T. Fleming, MD, Professorship in Emergency Medicine

Several issues ago, we sadly announced the death of Tim Fleming, MD, former state medical director in New Mexico after a long battle with cancer. His friends and colleagues have recently established the Timothy T. Fleming, MD, Professorship in Emergency Medicine "to educate aspiring physicians, EMTs and nurses on progressive methods for both the alleviation of suffering and in life-saving, stabilizing care prior to hospitalization. Another component will be training in disaster medicine and the delivery of health care when mass casualties occur."

Further information may be obtained from (or donations made to):

Timothy T. Fleming, MD,
Professorship in Emergency Medicine
UNM Foundation
Two Woodward Center
700 Lomas Blvd., NE, Ste. 203
Albuquerque, NM 87131-3196

- ventions not available with sending facilities:
- Thoracic or abdominal aortic aneurysm with dissection or impending dissection
 - Acute occlusion of major vessels resulting in limb-threatening ischemia
 - Acute surgical emergencies requiring emergent/time-sensitive interventions not available at the sending facility.
 - Critically ill patients with compromised hemodynamic/respiratory function who require intensive care during transport and whose time of transfer between critical care units must be minimized during transport.
 - Critically ill obstetric patients who require intensive care during transport and whose time of transfer between facilities must be minimized to prevent patient/fetal morbidity:
 - Conditions resulting in probably birth weight less than 2000

- grams or gestation less than 34 weeks
- Premature labor with delivery of low birth weight infant
- Acute cardiac emergencies requiring emergent/time-sensitive intervention not available at sending facility:
 - Angioplasty
 - Stent placement
 - Cardiac surgery
 - Intraortic balloon pump **placement**
 - Thrombolytics
 - Cardiogenic shock
- Critically ill neonatal/pediatric patients with potentially compromised hemodynamic/respiratory function, a metabolic acidosis greater than two hours post-delivery, sepsis or meningitis
- Patient with electrolyte disturbances and toxic exposure requiring immediate life-saving **intervention**
 - Hemoperfusion
 - Hemodialysis

- Transplantation patients (fixed wing vs. helicopter)
- Patients requiring care in a specialty center not available at the sending facility
 - Conditions requiring treatment in a Hyperbaric Oxygen Unit
 - Burns requiring treatment in a burn treatment center
 - Potentially life or limb-threatening trauma requiring treatment at a trauma center including penetrating eye injuries
- EMTALA physician-certified inter-facility transfer (not a patient request)
- EMS regional or state-approved protocol identifies need for on-scene air transport

In addition the workgroup recommends that section 2120.4 C (Time needed for Land Transport) be deleted. The workgroup felt that the issue of clinical benefit vis-à-vis time saved was addressed in section B and that the reference to 30 to 60 minutes of transport time by ground was not appropriate as a general guideline. ★

Letter from the Medical Director

The following letter regarding medical director's liability insurance was e-mailed in November to all physician members for whom the NAEMSP Executive Office had an e-mail address in the database. We've received many responses to date; however, if you did not receive the e-mail or did not respond to it, please take a moment now to read the following letter from President Dr. Jon Krohmer, and fill out the survey form on page 11. (Also, if you did not receive the e-mail, please be sure to update us with your e-mail address.)

RE: Medical Director's Liability Insurance

Dear NAEMSP Physician Member:

The National Association of EMS Physicians (NAEMSP) has been investigating the issue of providing medical malpractice insurance for EMS medical directors as a member benefit for several years. Most of the discussions to date with insurers have been fairly unproductive. Recently, however, we have been working with a group who has been much more interested.

One of the issues that is unclear to the insurance industry is the potential risk that EMS medical directors face. (That's good for us as it indicates that there is not a lot of case law or case history out there that involves medical directors.) However, it makes it difficult for the insurer to make risk estimates, which is what they base premiums upon.

To help gather some of this information and hopefully get NAEMSP reasonable premium rates for our members, the group we are working with has asked for additional information regarding the exposure risk of EMS medical directors. To that end, there is a brief survey form on page 11 that we ask you to complete and return to the insurer. This information is confidential and will not be used for any purpose other than to gather general information about EMS medical director's experiences to date.

The survey is broken down into two areas: The first area addresses exposure experience regarding medical/clinical care related activities (e.g., the lawsuit resulted from patient care activities of the medical director or those for whom s/he serves as the medical director). The second area addresses issues of exposure experience regarding administrative/ employment practice functions that the medical director performs (e.g., being sued for withholding medical control privileges for personnel who are not clinically meeting the system standards).

This survey is very important to the assessment that we need to make to continue with this process. If you have any questions or concerns, please feel free to contact the NAEMSP Executive Office directly (phone: 913/492-5858, e-mail: naemsp-info@goAMP.com). I encourage everyone to complete and return the survey directly to Near North Insurance Brokerage via the fax number listed by February 1.

Thank you.

Sincerely yours,

Jon R. Krohmer, MD
NAEMSP President

This is a privileged & confidential document prepared solely for insurance purposes.

Statement of Understanding

In your capacity as an EMS medical director, please indicate the following:

Medical Professional Liability:

- a) Have you ever been involved in a malpractice claim, suit or incident, either directly or indirectly, in your capacity as an EMS medical director? Yes No
- b) Do you have knowledge of any incidents in the past which may give rise to a claim being filed against you in the future which has not been reported to any previous insurance carrier? Yes No
- c) If "yes," please describe each claim, suit or incident, regardless of its outcome. Include current status, amounts paid and amounts expected to be paid. Please use a separate addendum if necessary.

Employment Practices Liability:

- a) Please provide a listing of all employment practices claims that you've been involved in, in your capacity as an EMS medical director. If none, so state. Please use a separate addendum if necessary.

Year	Type	Allegations	Status	Loss/Settlement	Defense

- b) Please provide a listing of any facts or circumstances which may result in any employment practices claims being made against you in your capacity as an EMS medical director, including those involving employees, independent contractors, customers/clients or other third parties. If none, so state. Please use a separate addendum if necessary.

Specialty _____

Signature _____ Date _____ Board-certified? Yes No

Print Name _____

Address _____ City _____ State _____ County _____

Phone _____ Fax _____ E-mail _____

Based on the attached communiqué from the president of NAEMSP, do you have an interest in participating in this insurance program, at an approximate yearly premium of \$2,500? Yes No

If no, why not? _____

Please return completed form to: **Near North Insurance Brokerage, Inc.**
Attn: Linda Miliken
Fax: 312/915-4691

EMS Calendar ...

January 17-20, 2000: ACEP Winter Symposium 2000.
Location: Kauai, Hawaii. Contact: 800/798-1822.

March 5-8, 2000: 5th World Conference on Injury Prevention and Control. Location: New Delhi, India. Contact: E-mail to awconfer@del2.vsnl.net.in

March 6-10, 2000: Park City 2000: Emergencies in Medicine. Location: Park City, Utah. Contact: 800/544-9269.

March 20-22, 2000: Trauma and Critical Care 2000. Location: Las Vegas, Nevada. Contact: 713/798-4557.

March 22-26, 2000: EMS Today 2000: Conference and Exposition. Location: Orlando, Florida. Contact: 800/266-JEMS.

March 27-29, 2000: Emergency Medical Services for Children (EMSC) Conference. Location: Baltimore, Maryland. Contact: 202/884-4927.

April 17-19, 2000: IAFC Fire Rescue Med: Critical Issues in Fire Service-Based EMS. Location: Las Vegas, Nevada. Contact: 703/273-0911.

April 27-30, 2000: Disaster 2000, Florida Emergency Foundation. Location: Orlando, Florida. Contact: 800/766-6335.

The deadline for article and advertisement submissions for the March 2000 issue of [NAEMSP News](#) is January 27.

NAEMSP Welcomes New Members

Satya Agarwal	Robert Phelan
John Berg	Julien Poitros
Steven Chin	Michael Press
Bill Cross	Brian Robb
Bill Curtis	Martin Thornton
William Fisher	George Velianoff
Jay Johannigman	Scott Weingart
Brian Mahoney	Robert Yoesle
Andrew Milstein	Sister Catherine Young
Louis Mire	



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