

EMS Leadership Call

November 4, 2021

Came into the meeting late, already in session at 11:04 a.m.

Medical Advisor Update – Dr. Wolfson

There will be a case review on November 22nd from 7 – 8 p.m. on Zoom. The topic is epinephrine use by AEMTs for out-of-hospital cardiac arrest. Should those patients actually be given cardiac epi by AEMTs? What does the evidence show? Jared Bomba, MD, and Jamie Benson, AEMT and medical student, have done great research and have been published. Dan will lead the discussion and is hoping to add a pharmacist to the discussion panel.

Training – Bambi

Pedi-to-Go session is on 10/26 7 p.m. Bambi will send the link to anyone who would like to have it. Case review and discussion on Cultural Competency will be presented.

About to offer a licensed skills lab course. This is an entry-level program into EMS education open to anyone interested in helping EMS practitioners develop strong motor skills. The students will learn assessment and instruction techniques and be provided tips about how adults learn. The first part of the course is online and self-paced; second part is a one-day lab. All but 2 districts (District 5 and District 11 remain) have host agencies for these courses. Courses will begin toward the end of December/early January and end at the end of January/beginning of Feb. There is an application in LIGHTS.

To date, over 100 providers have been trained at the new VEFR level. By the end of the year, that number will be closer to 160 newly trained providers in the field. Services are using it as a recruitment tool. Great opportunity to increase member base. Working with police and fire departments to share information.

VEFR folks will not be issued licenses until our new rules go into place. The rules have passed ICAR and are headed to LCAR in the next few weeks.

Adam – where do we stand with it being a part of the licensed crew? Will - that language is included in the proposed EMS rule changes. Public comments should be sent to Brendon Atwood by the end of the day today. Ray – that information is on the home page also.

Mark (District 7) – Thanked Will for coming to the meeting last night. Very helpful. Mark asked if there are any updates on next VTEMS conference? Will – currently in negotiations with a site. Tentatively looking at the end of April or early May. Planning in person. However, COVID-19 is driving the ship. Part of the contract includes language that would allow us to back out if case counts were high and the timing was wrong.

Will – EMS Rule

Public comment closes today. Can also email comments to Will or Ray and we can forward them on. Last week was the public hearing and one person spoke. We do look forward to hearing from you folks about the language we propose. We look at all comments and evaluate each of them. There have been several times that we've updated the language in the rule based on comment. You folks have a voice

and we're listening. Example: We all thought the language around the new lab instructor was clear, but we received several comments along the same line. They felt it would be a barrier to license these lab instructors. But when we went back through the language, we realized we didn't communicate it clearly. So we've edited the language. Policy takes all the comments that come in and they group like comments. So when we publish our responses (probably next week), we went through 7 principle themes and drafted responses. Hope the LCAR merging will happen in the next few weeks. We're still on track for an early August 2022 implementation date. The EMS Advisory committee and the EMS Education Council have been an important part of the process.

Will – heard from many services about concerns with changing policies within law enforcement regarding the use of force policy issued in early October. Doesn't say explicitly in the policy but I've heard concerns about law enforcement not responding to some situations EMS responds to. Leaves EMS lacking security and assistance. Not speaking for VSP or law enforcement...just conveying information. Had a great conversation in D7 last night. One change is when a call is made to 911 threatening another or a suicide, and that person is alone ... no family or friends present ... law enforcement may not be sent. VSP reps have been clear that if the person poses no risk to anyone other than themselves, LE (law enforcement) won't be responding. But EMS will....

LE is trying to limit some of the use of deadly force by not responding to attempted suicides. EMS will still end up on scene. Several protocols should be reviewed with your crews so they can better navigate these challenging calls.

First off, slow down. Don't be rolling in with the assumption that everything is fine. We have to assume there's a security concern, just as the time for assessment taken at a hazmat scene.

Yes, we have a duty to respond. But that duty is not limitless. One of the bumpers/guardrails we hit is when we have concerns about scene security. You will respond, but you have a right to navigate that scene from a safe distance. Don't rush in. It would be unreasonable to assume that EMS providers would proceed unsafely into a scene.

Scene safety is engrained in education and nothing in protocol says you have to assume an unreasonable amount of risk. Here are some of the protocols to reference as you talk to your crews. This is a big change. We're only talking about a subset of calls...a suicide in public is different. This is a small subset of calls.

2.5 Behavioral – we need to rethink how we approach these emergencies in our communities. We need to rely upon our partner agencies to assist when they can, perhaps bring to the scene a mental health individual who can better deliver care to an individual. In the past, you might have engaged and transported a patient to the ER. But that's not the right place for these folks. We've seen some areas in the state embed mental health practitioners into their EMS/police agencies. LE might take them to the scene but LE isn't the primary agency engaging the individual.

EMS practitioners and LE/mental health partners and elected officials all need to understand how our response to this type of crisis looks different than other calls. Maybe we need to engage the individual on the phone before we put ourselves in direct contact with the person.

Please begin to have those conversations across those agencies. Now is the time to engage your partners in a discussion about the new policy and what their stance is going to be.

8.14 Police Custody and 8.15 Patient Refusal – Consider a situation where suicide is threatened and the person is home alone, and you're alone, parked down the road, and staging for law enforcement's arrival. But the LE supervisor says nope, they're not coming and they have no resources to deescalate the call. The next step would be to reach out to your mental health team. Hopefully you've done some pre-planning. We all know there's a shortage of mental health counselors. That's a work in progress. Certainly a tough situation at 0200. Let's say there's no one from the mental health field that can come. The next step is you reach out to medical direction and share the situation. Share your concerns for security and safety. Explain that there are no LE or mental health asset options. Ultimately, we may have to decide we have no more options and it's not safe to enter the scene. Ultimately, you'd drive away and document precisely what happened. All of this exists in protocol today. This is an example of a call that we may not find resolution for. We may not be able to assist this person. Our duty to act does have a limit. That's a bumper/guardrail to protect EMS practitioners.

If in a rural area of the state with no cellular contact, how can I contact help? First, you may have to relocate to a point where you have cell service. You may have to drive 5-10 miles away to get cell service. Or drive back to your station to gain communication access. 8.15 covers all of this.

In some ways, LE has forced our hand at rethinking how we respond to these situations. This very well might be to have more robust conversations across our communities about mental health support. The sooner we can have these conversations with all our partners and pre-plan our responses to these incidents, the better we set our crews up for the best-possible outcome. It'll be very different than what's felt right to us in the past. It feels like a moral/ethical dilemma. We'll have to tackle those feelings as we go. But we do not demand EMS practitioners put themselves in danger. No one wants anyone harmed. There are folks in our communities that we may not be able to reach.

Please begin these conversations now. I'm happy to come to any meeting, district, team, whatever. Happy to facilitate, provide perspectives, etc. as needed.

Dr. Wolfson will discuss this issue on 11/12 with DMAs.

Adam – sounds nice on paper, unfortunate VT EMS is letting VSP force our hand on this... If VSP can say no, why can't EMS say no. In our area, hard to even get a mental health provider at 4 p.m., let alone 4 a.m. If LE isn't going, then a mental health team needs to be made available on a mandatory basis. Nice LE is getting out of the job of being mental health providers and punting to us but needs to get punted to the mental health practitioners, not EMS.

Will – can EMS triage these calls? Great question and one that needs to be explored further.

VSP is forcing us into this situation? While it's true we had no warning about the policy changes, conversations with Commissioner Shirling's office are ongoing.

Mental health teams are needed? We agree. We've seen that successfully happen in other parts of the state. Putting this issue on the table of elected officials is important. We need to engage them.

Adam – why is the onus on us? Will – we're not the only ones the onus is on, but it immediately impacts us today. Concerns us all. VSP isn't knocking on every town manager's door, so the onus is on us to share the changes. We need to share our concerns.

LE staging....stage for them even if you know they're not coming. Reach out to a LE supervisor to discuss the call. But have that conversation NOW. Don't wait for the emergency to happen. Perhaps pre-planning can happen. Lay the groundwork.

Doug Brent – The legislature thrust this onto the LE community. LE reacted to a legislative requirement. It's not just a policing whim. Secondly, I don't think it was rolled out well. We don't want to hurry into these situations, but at this moment, we have to rush into this policy decision and pick up the pieces. Don't feel we can change the policy...just adapt to it. Third, this is like the dog on the ice. If we don't do something, someone will. There are sidewalk saviors that will also want to insert themselves into the situation. I'll continue to communicate with Will on this. Lots of partners to engage.

Will – we do not have a perfect solution for these situations right now. Just a stopgap measure. I urge you all to contact your elected officials and share concerns about this legislation.

Wendi – With any other call, dispatchers get additional information. Does the dispatch center have a questionnaire they go through to establish harm/risk level? Or can dispatch put them in touch with a mental health worker prior to dispatching EMS? Talk them down a bit til they're willing to go with EMS?

In referring to protocols and contacting medical direction, what are we expecting from medical direction. I can envision the doc saying, hey, just bring the patient in. What do we expect them to say?

Lastly, Wendi shared a personal experience with an EMS call. Information on a call wasn't clear. The individual was acting in a threatening manner after an overdose. The EMS crew was able to back out, but the individual remained threatening. LE wasn't coming. Lots of time we just want LE to protect us in the back of the rig or in the living room.

Will – great points. Capabilities of dispatch centers vary across the state, but that's another set of partners we need to have conversations with. Is there an opportunity for the call taker or the person themselves to gain info? Probably. But that won't happen til we learn their capabilities and figure out how we can utilize them.

You mentioned contacting medical direction. 8.14 tells you to report that to medical direction when you can't bring the patient in. Our protocols give you an out; you call and report you are unable to bring that person out. That's a case where we may not have a resolution to the call. DW will have those conversations with DMAs in November.

DW – Agree with Will, and yes, we'll talk with the DMAs on 11/12. And there are a couple on this call today as well. We've run into this before with patients we can't transport, so there is protection for you in protocol. Dispatch in VT is varied, but the initial 911 calls go through the statewide E-911 PSAPs and they follow a standard protocol for asking questions, and that includes assessing for scene safety and weapons. They also dispatch for PD, so we assume they're asking these questions to allow LE to make decisions. We'll have a conversation with them to help assure they're covering what we need to know as well.

Doug Brent – Just bought 12th edition of the AAOS. There's 8 pages of mental health and a half a page about suicide in a 1600-page book. In the police academy, 8 hours of mental health training are provided. So none of us have the mental health training necessary—not EMS and not LE. I get the suicide by cop thing, but it's important to remember the times the LE have talked folks out of suicide.

Are we throwing the baby out of the bath water? Are we forgetting all the times LE has intervened and saved lives? LE isn't to blame for suicide by cop situations.

Will – great points.

Appreciate everyone's time.

Adjourn at 12:10 p.m.

Will be hosting this meeting again tonight.