NEMSIS Internal Advisory Board

Meeting Minutes
April 1, 2021

NEMSIS Internal Advisory Board
Minutes April 1, 2021
9:30-11:30 am MST

I. **Welcome**
II. **Review Topics:**

a. Reviewed previous meeting minutes.

b. Overview of this meetings topics.

c. Anything else to discuss?

III. **Review Case Definitions** *(Clay Mann)*

a. Are we taking the right approach?
    i. Example- Article, how to define death, using 18 elements in NEMSIS
        i. https://www.tandfonline.com/doi/abs/10.1080/10903127.2020.1794435?journalCode=ipec20
    ii. Example- Article Cardiac Arrest
        i. https://onlinelibrary.wiley.com/doi/full/10.1002/emp2.12106
    iii. Case Definitions- attempt to provide a standard
b. Are there other conditions that we should consider?
    i. Long term solution- interoperability, to know end diagnosis and treatment connection
        i. This is an interim solution
        ii. Need more hospital data to identify (pregnancy, Sepsis, suicidal ideation, epilepticus, hypoglycemia, etc.)
    ii. Red lights and sirens utilization
        i. Conflicting research, billing capacity complicates things
        ii. Definition in terms of Medicare reimbursement
            1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c10.pdf
            2. https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=54574
            3. AAA Documentation Guide re: Lights and siren, discourages emergency/ non-emergency as causes confusion to payor.
            4. Emergency Response Definition for Medicare- An immediate response in which the ambulance provider/ supplier begins as quickly as possible to respond to the call
    iii. Rationale for medication administration
        i. Ketamine for sedation vs. to facilitate intubation
    iv. Stroke example: Will data analyzed from the research dataset match related results shown in dashboards or other reports? harmonize with vendors? What impact does defining a case have on the field?
    v. Case definition of ILI

i. Providers had difficulty, kept revising as had more data, it's complicated
ii. Infectious Disease National Custom Elements
    1. https://nemsis.org/wp-content/uploads/2021/02/Infectious-Disease-National-Custom-Elements-4_02.01.2021.pdf
    2. https://nemsis.org/wp-content/uploads/2021/01/Immunization-and-Vaccination-National-Custom-Data-Elements-v8-1.pdf
    3. Developed Recent Travel options in eHistory
    4. National level was requesting PPE, COVID exposure, and Vaccination requests
    5. Desire for NEMSIS to provide information for national requests
       Historically changes were made slowly, but field level often needs a quick response
    6. States are slow to approve changes, travel questions became irrelevant quickly, need a faster process to add/ remove
    7. Balance between being responsive and still having a process
    8. Perhaps a data quick response team to vet and expedite ideas
    9. Problem how rolled out (ex: as defined by local medical director) each state may have different directives, leads to inaccurate data
    10. Going forward need to become more agile
        a. How to do this? Through vendors? State Data Managers?
        b. When to add an element?
        c. When to modify an element?
        d. How do we quickly get from a national recommendation to the field personnel
        e. Perhaps the Internal Advisory Board could make these decisions
    11. Expedited process needed, fast track a National Element
    12. State data managers get push back for changes, but are eventually received well
    13. Reflect on lessons learned in COVID
    14. ET3 example is better received due to reimbursement
    15. Also need to change the national acceptance quickly
    16. Data Managers Council would not respond as quickly, perhaps the Internal Advisory Board could respond more quickly
    17. Communication and messaging is important to sell the idea
    18. Need to get definitions out to vendors and standardize quickly

IV. Focusing Defined Lists *(Julianne Ehlers)*

a. Specific codes (Opioid Overdose)
    i. How to fine tune codes to be more usable in the field
    ii. Guidance and recommendation is changing all the time
    iii. Example of 10 types of a fall, need to condense for field use?
    iv. Idea for decision trees
        i. Ex. Ketamine- then choose why you gave it
    v. State level more specific, rollup for a national element
    vi. Enough options but not too many, logic and smaller lists, less 'other' options
    vii. Cut down impression list to simplify, but sometimes creates problems
        i. Ex. Chest pain and angina
    viii. Progressive logic lists
        i. Problems created when following a path and then the situation changes
        ii. Leads to some unintended consequences
b. *Tabled:* Emerging issues (Electric Scooters)

c. *Tabled:* No current code (Excited Delirium)

V. Process to identify the need for a NEMSIS revision *(Clay Mann)*

a. Examples of currently requested additions
   i. Foreign travel and recent exposure to infectious disease
   ii. Documenting PPE needs and provider exposures
   iii. Documenting violence against providers *(address this next mtg, too)*
      i. Can we streamline the process through an app?
      ii. Violence against providers
      iii. Provider injured or assaulted
      iv. Line of Duty Death
      v. Patient Safety Organizations - reporting errors and near misses
      vi. Recommended to collect in ePCR rather than an app or different location
         i. Unions would have some concerns and say in this
         ii. Legal department has some concerns about privacy of provider
         iii. Multiple providers prove difficult to document accurately
         iv. Be careful becoming a provider, moving closer to EHR

VI. Documenting EMS care in NEMSIS *(Eric Chaney)*

a. Looking ahead- what should the focus be?
   i. Air-medical
   ii. Community Paramedicine
      i. Three different types of MIH/CP:
         i. Telemedicine
         ii. Supervisory Care
         iii. Field Clinical Care (staged care at community events)
   iii. Interfacility Transport
   iv. Critical Care Transport
   v. Pandemic Planning
b. Should there be a team to look ahead and plan?
c. Community Paramedicine- difficult to track COVID related changes

VII. v3.5.0 Interoperability Strategy *(Clay Mann)*

a. Renewing the HL7 Implementation Guide for V3.4.0 [ePCR to the ED] (V3 CDA)
b. Building an HL7 Implementation Guide for V3.5.0 [ePCR to the ED] (V3 CDA)
c. Building a FHIR profile for V3.5.0 [ePCR to the ED]
d. Building a FHIR profile for V3.5.0 [EHR data back to ePCR]
   i. Vendors would like a standard template
   ii. Primary Care Standard should also be considered
   iii. Desire to move information back into the ePCR
   iv. Building a volume 4 for a U.S. outlet
   v. Does the hospital need to be willing to connect?
      i. Connect-A-Thon ensures a connection
      ii. How are they motivated?
      iii. It depends on the hospital health record (EHR) they use

VIII. Action Items

IX. Next Meeting

X. Adjourn

Attendance: Clay Mann, Eric Chaney, Julianne Ehlers, Lauri Bradt, Ryan Stark, Tom Ludin, Remle Crowe, Chris Handley, Sundown Stauffer, Jay Ostby, Dave Millstein, Brooke Burton, Jennifer Correa, Daniel Palmer, BJ Jungmann, Greg Mears

Absent: Nathan Jung (vacation), Jay Martin

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