

OFFICE OF PREHOSPITAL CARE NEWSLETTER

EMS Research and HIPAA

By Aaron Farney

Summertime is here and EMS research at the University of Rochester is in full swing. The Trauma Triage Study, run by Dr. Jeremy Cushman and Dr. Manish Shah, is aggressively pushing toward its desired 2,000 patients. Thanks to the overwhelming support of EMS providers, it is quickly approaching the 700 mark. We continue to do better than the other hospitals participating in this study! Additionally, the Geriatric Study, run by Dr. Manish Shah, commenced June 1. Over 50 patients have been enrolled by participating EMS providers.

Chances are you, as an EMS provider, have been asked to participate in a research study during one or more of your visits to the ED. If not, you probably will soon. You may wonder if you are violating HIPAA by participating—the answer is no.

Research involving human subjects and conducted at an institution such as the University of Rochester is strictly governed by an IRB, or Institutional Review Board. A researcher

must create a written set of protocols detailing their proposed study and how it will be conducted. The IRB closely reviews submitted research proposals to ensure they are worthy of being conducted, abide by all ethical standards, and are compliant with all laws, including HIPAA. Research studies cannot move forward until they receive IRB approval.

Some studies approved by an IRB require informed consent from the subject to obtain protected health information, or PHI. The Geriatric Study is an example of this. Participating EMS providers give consent prior to starting the study, and the patients provide consent in the ED. Some studies are granted a *waiver of consent*. The Trauma Triage Study is an example of this. In such studies, the IRB has determined it is not necessary to obtain subject consent and authorization. Waivers are typically limited to studies where consent is impractical, such as when there is no direct interac-

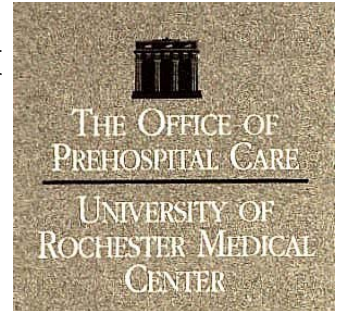
tion with the subject, and in which the information being collected poses minimal risk to the subject and their privacy. To prove minimal risk, the researcher must provide a plan to protect subject identifiers from improper use and disclosure, destroy the identifiers as soon as possible, and assure that collected PHI will not be disclosed in violation of HIPAA.

An IRB-approved research study is only as solid as those running it. Thus, the IRB requires anyone who will be conducting the study to undergo specialized training in ethics, regulation, and HIPAA. Rest assured that participation in any research study being performed at the University of Rochester and involving EMS has been IRB-approved and is in full compliance with HIPAA.

Anyone with further questions or concerns is encouraged to contact Dr. Shah or Dr. Cushman. Thank you for your interest and participation in advancing EMS care!

VOLUME 11

JULY 2007



INSIDE THIS ISSUE:

ALTE?	2
PCRs	3
Web-casting	3
OPC Contact Information	4
Specific Hospital Issues—Ct Info	4
Upcoming Events	4

Currently there are 608 people enrolled in the Trauma Study. Of those 608, 106 were enrolled based on the forms that were initiated by EMS providers. Way to go!



ALTE?

By Jeremy Cushman, MD

We've added a new acronym to your EMS vocabulary: ALTE (Apparent Life Threatening Event). So what is it? It's a symptom, really, not a diagnosis at all. Its not SIDS or near SIDS, nor is it an overreacting mother or father. It's an episode in an infant or child less than 2 years old which is frightening to the observer and is characterized by one or more of the following:

- Apnea (central or obstructive)
- Skin color change: cyanosis (blue), erythema, (red), pallor (white), plethora (fluid)
- Marked change in muscle tone ("floppy")
- Choking or gagging not associated with feeding or a witnessed foreign body aspiration
- Seizure-like activity

ALTE occurs most frequently in infants less than one year of age, although cases have been reported in children less than two, thus the criteria you see above (which also just happens to be in your new MLREMS protocols!).

So if it's a symptom, what is it a symptom of? Well, the list is really long and includes everything from GI (volvulus, intussusception, gastroesophageal reflux, etc), Neurologic (seizure, infection, malignancy, malformations, CNS bleeding, etc), Respiratory (infection, partial airway obstruction, central apnea, etc), Cardiac (arrhythmia, congenital heart disease, cardiomyopathy, etc), Metabolic Abnormalities (endocrine disorders, in-born errors of metabolism, sepsis, etc), child abuse, and our favorite – idiopathic (meaning we just don't know). As you can see, some of those things aren't too big a deal (reflux) some are (congenital heart disease). How do we know which one is which? We don't. Not in the field at least. It's just as hard in the ED – nearly every patient

that presents with an ALTE will be admitted to the hospital for lots of tests and observation because the potential for bad things is high, and there is nothing on physical exam or an EKG that will allow a pediatrician to accurately exclude some of the "bad things".

We've all taken the call: "Respond for the infant not breathing." Right? We get there and the child is happily playing in mom's arms. We cancel ALS, mom doesn't want the 8 month old to go to the hospital. Sure the child went floppy in her arms and started to turn blue, but shortly after she called 9-1-1 the child suddenly perked back up. Besides, the kid sure does look great now. We have them sign our PCR, she'll follow up with the pediatrician, and we go back in service. Sound familiar?

Hmm, lets take a look at the evidence. A study evaluated a region similar to ours and found about 7% of pediatric calls could be classified as an ALTE. We don't (yet) know how many potential ALTE calls we run in this region but its safe to assume the percentage is similar. 83% of the time, the EMS provider got on scene and found the child to be in no acute distress and had a normal exam (sound familiar?). However, 48% of patients that had a normal exam on scene, had significant illnesses upon ED and hospital admission. Uh oh.

So what does that tell us? It tells us that no matter how good we think we are in determining who is sick and who's not – we aren't. Basic, paramedic or doc, it doesn't make a difference. Therein lies the purpose of the new protocol: if an ALTE occurs (which remember, is by history, not by how the child looks when

you get there) you should make every attempt to get the child to the ED for an evaluation. You are doing what is in the best interest of the child.

That means the only person that can refuse transport is a parent or legal guardian (not the babysitter) and if they are refusing transport, you must call Pediatric Medical Control. Not because we don't think you can convince them, but to help you use every resource at your disposal to get the patient to the hospital for the evaluation they should have.

What do we do on the way to the hospital? Honestly, not much. Supportive care, ALS evaluation and transport. These patients should have an ALS evaluation, no matter how good the child looks, so please don't cancel them once you get on scene. Sure, they can slow down, but they should still be part of the management and decision team to help ensure the infant is evaluated in the ED. Monitor if you can, IV only if you really need to give them something, don't make it a routine part of your work up since the poor kid is sure to get poked in the ED to draw blood cultures and other tests.

ALTE is an important addition to our vocabulary, and recognizing and taking it seriously is imperative to the young infants who look to us for care. I hope you now understand why.

PCRs

By Sheri Stollo, BSN, EMT-P

Most anyone in EMS will tell you about the cool things we get to do, but no one will tell you how fun it is to fill out the PCR for the call. While most people understand that the PCR is an important document, sometimes we forget just how important it is.

The doctors and nurses in the ED do indeed read the information that is on your PCR. They may not read it the instant you drop it off, but they do read it. The information that the PCR contains tells them how the patient initially presented—the symptoms, the interventions, and the response to those interventions.

The inpatient doctors read the PCRs also. The PCR information can make the difference as to whether the patient gets certain testing and procedures done, such as getting an angiogram or pacemaker. More importantly, the list of allergies and medications on the PCR helps to ensure that the patient does not get medications that he/she is allergic to and is placed on all the medications he/she normally takes.

A new federal initiative has the hospitals "reconcile" each patient's

medications. What this means is that for each patient that goes to a hospital, the hospital staff will use all sources to determine the true medication list (including doses!). A key source is the PCR. Then, before discharge, the hospital will go over the medications and make sure that the patient gets all the medicines.

Despite the critical importance of the PCR, we do not always complete our job by finishing and leaving a PCR behind as documentation of what we did. We as a group want to be seen as the professionals we are, yet by not completing the documentation, we potentially hurt our patients. Sure we tell the nurse in triage and the physicians if we see them, but things are often forgotten or not thought of at that point. By completing the job and leaving the documentation we help the hospital staff in their efforts to take good care of each patient.

Recently we have been receiving comments from the area hospitals that agencies are getting into the habit of NOT leaving PCRs when they drop off their patients. Leaving a PCR is required by the

State and the Region because it is so important to providing quality care to our patients. So, not only it is unprofessional to drop off a patient without the proper documentation, it is against the rules (not to mention it is also a huge legal risk).

As agencies begin using electronic PCR documenting, the hospitals have allowed a 2 hour window to complete and submit PCRs. It is the responsibility of each agency and provider to make sure that the hospitals get the PCR within the 2 hour window. For most agencies, the computer system is automatically faxing the PCRs, so we do not have to worry about it. Make sure you know what your agency is doing.

It is very important to remember, agencies that do not have electronic PCRs are still required to leave a PCR at the time they drop off their patient.

Please help the patients by providing the Emergency Department staff with the information they need to take the best care of our patients.

WEBCASTING

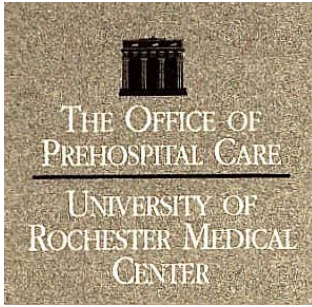
By Sheri Stollo, BSN, EMT-P

In January when our new Governor took office, he signed Executive Order #3. EO#3 supports the idea of open government by mandating that all public meetings involving state bodies be web-cast. It was also made clear that the EMS Program Agencies absorb the cost of this mandate without benefit of additional funding.

What does this mean for our re-

gion? It means that NYS is requiring us to web-cast both the REMAC and MLREMS Council meetings, but will not be increasing our budget to help defray the cost. In order to comply with EO#3, funding must be cut from other areas of the budget. At this time, the Monroe-Livingston Region will be in compliance with EO#3 as of the August MLREMS/REMAC meetings.

In order to keep costs down, both the Council and the REMAC have decided to meet only once every other month, instead of continuing with once a month meetings. In addition both REMAC and MLREMS will be meeting on the same day, one after the other. Meetings will now be held the 3rd Monday of the month. The Council will meet first at 4:00pm and the REMAC will meet at 5:30.



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If your agency needs PCR's contact OPC @ 463-2900

Reminder—if your agency has switched to an ePCR system,
the PCRnet PCR's should no longer be used.
Cheat sheets will be available for agencies to use instead.

Specific Hospital Issues—Contact Information

OPC receives numerous phone calls for specific hospital issues. We encourage agencies to contact the hospital directly. Below is the contact information, which is also listed on the MLREMS website.

Highland Hospital—Dr. Hilmi or Dr. Cunningham

John_Hilmi@urmc.rochester.edu
Michael_Cunningham@urmc.rochester.edu

Lakeside Hospital—Dr. Kasaraneni

395-6095 ext 4205 OR
Manmadharao.kasaraneni@lakesidehealth.com

Rochester General Hospital—Dr. Elsen

922-3846 OR
Stephanie.elsen@viahealth.org

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Unity Hospital—Dr. Biernbaum

723-7035 OR
rbiernbaum@unityhealth.org

Upcoming Events

- MLREMS Meeting— August 20th, 4:00 pm
- REMAC Meeting— August 20th, 5:30 pm
- ALS Meeting—August 20th, 6:30 pm (or directly after REMAC)
- CME Training—posted on the website: www.mlrems.org