PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL

Your Voice In EMS

RECOMMENDATION FOR CONSIDERATION

Board Meeting Date: December 8, 2021

Subject: Expanded Use of RSI by Ground ALS Agencies – Phase 1 Recommendations

VTR#: 1221-01 Committee/Task Force: RSI Task Force

☒Recommended Goal ☒Recommended Policy Change ☐Other:

Recommendation:

The Department should accept the Phase 1 recommendations of the task force, which proposes foundational program requirements and a statewide pilot program (Phase 2) for the OPTIONAL expanded use of rapid sequential intubation by ground ALS agencies.

Rationale [Background]:

This VTR form will provide an overview of the year-long process to provide initial recommendations to the Department. Background information and the recommendations in their entirety can be found in the companion document.

Rapid sequence intubation, commonly referred to as "RSI," is an advanced airway control adjunct that involves the use of both a sedative agent and neuromuscular blocker. This procedure, considered to be high-risk but low frequency, is reserved for a subset of medical and trauma patients for which installation of an advanced airway is otherwise not possible. Impediments to the need for elective intubation or in the emergent setting may be, but are not limited to patient agitation, intact gag reflex or trismus.

The use of RSI in the prehospital setting has been a subject of long-standing controversy, both nationally and in Pennsylvania's EMS system. Although there is general agreement on the need for the procedure in certain situations, there is considerable debate as to who should perform the procedure. In Pennsylvania, RSI in the prehospital setting has historically been in the purview of the Prehospital Registered Nurse (PHRN) while providing EMS for a licensed air ambulance or ground critical care transport ambulance.

Mitigating the risk involved with expanding RSI to include ground ALS agencies lies in providing a framework that establishes standards in education, competency evaluation, physician oversight and continuous quality improvement activities. Theoretically, a ground ALS agency that is willing to subject itself to an established standard of care for RSI should expect to achieve the same outcomes and pose no greater danger to patient safety then when performed by critical care transport agencies.

The report details the need for strong medical direction and QA/QI in implementing a prehospital RSI program in PA. This strategy should include a pilot program to closely monitor and further develop as necessary the entire process of education, training, clinical practice, monitoring, and ongoing review, as enumerated herein. The Phase 2 component would develop the specific logistical details related to implementation.

As a system we should focus on strategies to achieve an inclusive, progressive, evidence-based practice environment. Excluding a procedure, medication or other treatment modality should be based on data, a lack of credible science, or an agency/provider's inability to demonstrate the established standard of care.

Medical Review [Concerns]:

This recommendation was reviewed by both the Statewide Critical Care Task Force and Medical Advisory Committee. The commentary from both groups can be found in the body of the recommendation document. Both the critical care task force and MAC voted to support the Phase 1 recommendations.

Fiscal Concerns:

In addition to clinical and operational factors, it is incumbent on the EMS agency to consider the financial ramifications of an RSI program. Operational costs include training, acquisition and proper storage of medications and medical director oversight time.

While the training costs alone are likely to be highly variable, they are estimated to be $200-$500 per provider for initial training and competency verification and some portion of those costs for annual, or more frequent, continuing education and re-evaluation by the medical director.

Potential capital costs include acquisition of training equipment such as an airway training manikin ($2,500) and/or a high-fidelity training simulator (starting at $25,000) if an existing community resource cannot be identified and/or utilized. Agencies that do not currently utilize video laryngoscopy would have an additional expense ($2,000-$3,000 ea.).

It's important for ALS agencies to keep in mind that RSI is not reimbursed at a higher rate by most insurances. Medicare, for example, will provide the same ALS2 reimbursement for RSI or a conventional endotracheal intubation, yet the costs to provide this treatment modality are much higher.

Setting aside the agency's desire to provide RSI, the financial realities of the current reimbursement environment may make it financially untenable. It is essential that an agency perform a well-rounded impact analysis, including financial considerations, before embarking on this or any other new project.

Educational Concerns:

The Phase 1 document contains comprehensive recommendations for both didactic instruction and psychomotor skill verification. The structure of these recommendations is consistent with that of the previous critical care transport expanded ALS scope of practice [critical care paramedic] project.

Plan of Implementation:

Upon acceptance of the Phase 1 recommendations by the Department, the RSI Task Force will begin development of the statewide pilot project, the details of which will be outlined the Phase 2 document. This includes protocol development, data collection tools and processes, and defining primary/secondary outcomes.

The PEHSC Committee/Task Force offers consultation to the Department in regard to the content of this Vote to Recommend (VTR) and its attached documents. The PEHSC Committee/Task Force specifically offers staff or member support to participate in Department deliberations regarding this recommendation in an effort to convey committee/task force discussions.

Board Meeting Comments/Concerns:
Approved 12/8/2021

Signed:__ _____
Date____12/8/2021_____
President

For PEHSC Use Only – PA Department of Health Response

Accept:____ Table:____ Modify:____ Reject:____

Comments:

Date of Department Response:_____