Wisconsin Department of Health Services
Wisconsin Division of Public Health
Emergency Medical Services Section
Physician Advisory Committee
Minutes
Tuesday, April 12th, 2016
12:00PM - 5:00PM
Sheraton Madison Hotel
Madison, Wisconsin

Meeting Invitees:

	Steve Andrews, MD (Chair)		Riccardo Colella, DO		Steven Zils, MD
	Mark Schultz, DO (Vice-Chair)		Christopher Eberlein, MD		Suzanne Martens, MD (State EMS Medical Director)
	Chuck Cady, MD		Sean Marquis, MD		

Agenda:

Insert Date and Location				
Time:	Topic:	Lead:	Follow-up Items:	Notes:
12:00 PM	Introductions			Andrews, Eberlein, Marquis, Zils, Schultz, Cady Martens, Newlun Audience Absent:Colella
12:10 PM	Approval of Meeting Minutes			
12:15 PM	Next Meetings for 2016			June 7th August ? EMS Board working meeting on August 2nd. October 4th (Change from preliminary October 11th) December 6th
12:20 PM	State Medical Director report	Dr. Martens		

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NASEMSO Spring mtg in DC:
Much confusion on CP/MIHC; no definition, differing programs, no recognition; MN is trying to change their legislation as still not getting paid; huge concern that EMS agencies are looking to CP when they cannot cover their 911 calls because they are told this is how to make some money; caution not to let curriculum drive scope, establish needed scope first. There is a document coming out from the NAEMT referred to as EMS 3.0 which encompasses performance points and CP/MIHC, much debate on use and application and support.
Everyone else loves REPLICA; 7 States are moving to adopt, need 10; moving to report to the NPDB and a program to absorb the background check fees
Database cross-talk problems: NTDB, NHTSA and NEMSIS do not all play well together
Many States struggling with cost and balanced billing of HEMS; pts getting $60K bills and bills for launching even when no pt contact
Ambulance standards: 3 main divisions and no one knows which is best; standards organization trying to get State Directors to choose, Directors pushed back and said figure out what is optimal and acceptable alternatives
Support for Compass and EBGs, but not as far along as people believe
Fatigue Risk Management is a big topic, but not much in way of answers; Danial Patterson PhD, NRP (Carolinas, back to Pit) has a website for research: www.EMSfatigue.org
Possible Medicaid reimbursement increase project, has been successfully done in other States, involves donating to an ambulance assessment and then sharing payment funds equally
We educated the CDC rep on WI EK

Protocols and Systems Review Notes:
Blood products – discussed later in meeting
Insulin question from legislative rep: question posed as to why insulin not used by EMS for hyperglycemia, versus treatments in place for hypoglycemia. Martens provided response from medical aspect and Newlun added comments. Caution that this is the new legislative avenue, to look for other special needs topics for legislation.
Paramedic renewal problem, attestation vs listing hours
Make sure your EMT and Paramedic students who are also employees stick to performing their currently licensed scopes
☑ Where is this rule? What defines the roles of a student completely separate from being on staff
☑ Ask Tim Weir or Greg West
- West replied that CoEMSP does not allow students to be an employee at the same time. Need to find this rule.

HCC:
A Carryover Request summary was distributed Feb. 19. Carryover requests have been approved by ASPR. Tourniquet initiative approved for $214,800. Primary Healthcare Association's Crisis Prevention Institute Training for Community Health Centers was approved for $55,000. Each HCC will receive an extra $10,000 for the support of hospital or other Coalition needs ($70,000 total).
Approved for the purchase of 10,000 tourniquets. Dan Williams is creating a presentation for education on tourniquet use for Police Departments to use in training their officers on the device.
Each region will receive $10,000 in Ebola funding from a separate grant.
Suggestions for grants/funds:
- CARES network
- Lisa is the grants specialist in the EMS Office

Where are we on the PAC document library?

Noted that Dr. Cady is not listed on the State website, nor is Dr. Clark.

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12:35 PM	Communications with State EMS office	James Newlun	Operational Plan/Medical Protocol approval by state office Mandated State Medical Protocols	PAC requested reasonable audit percentage vs 100% review and requested Office of Legal Counsel opinion? If the state office is able to require services to use only state developed protocols- requested Office of Legal Counsel opinion to see if this is even within state office abilities currently?
Insulin discussed previously. Discussed that it was a positive that the legislative liaison reached out to the EMS Office. BLS ambulance service with a Paramedic staff member, can that member work as a Paramedic that day? Working to scope of provider, instead of the agency. This is another example of potential legislation changing EMS practice. Recommended to investigate cross-credientialing, mutual aid, coverage agreements. Still does not solve the problem of getting ALS meds/equipment. PAC to make a recommendation = cross-credentialling is the primary recommendation. Protocol review can become a bottleneck for activity in the Office. Newlun d/w Jenny on a basis/examples for protocols. Other option, medical director attests or uses a letter to state the protocol package is in compliance. Jenny looking at requirements on protocol review. Also if have a set of example protocols, can make standard changes more easily. Audits within new Op Plan programs, looking at 5-10% baseline; recognize that 100% is not feasible. It has been identified that protocol processing takes an excessive amount of time. PAC supports the EMS Office do random audits or focused reviews of protocols/operational plans, instead of looking at every protocol and every page of operational plan. PAC recommends provision of example protocols and requiring changes to be highlighted or marked with track changes to facilitate the approval process. . Andrews will submit recommended action items for the EMS Office considerations. Question of EMR flexible refresher will be available for the new renewal cycle. It has not been denied, hope to move forward.				
	Requests from other Committees or related agencies: Regional Medical Directors Online Medical Control and Resource hospital standards?			Possibly a cadre of regional EMS medical directors or a regional medical director (NHTSA recommendation H3)

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Regional Medical Directors: NHTSA recommendation, general statement. Resource versus Authority; default medical direction up to the State level as needed. HCCs have Regional Medical Advisors (RMA) which are funded. State Office personnel are being assigned HCC and RTAC areas also, attend meetings, answer questions. Consider making the RMA an EMS resource or contact point. Give the RMA involvement in tasks or projects. ☑ Ask RMA to find/call and engage all local EMS medical directors, give them a question to discuss. Use as framework. Do not expect RMA to necessarily become a Regional EMS medical director. On-line medical control standards/training: This is difficult. Recognized differences. The more an agency medical director is involved, the less OLMC is required. This would be preferred. No particular answers on these points.				
	State Approval for DEA license ambulance services as Mid-level Providers			http://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf
WI has done well within DEA regulations. Other states have had more problems. Hence the DEA bill movement. Andrews also emphasizes separating DEA license from the physician to the agency. 17 other States recognize EMS agencies as mid-level providers, and be able to hold their own DEA license. Would require a change in Statute. Will discuss further at next meeting.				
	Medical Director Names listed with EMS Services on State Web Site?			Also, Service Director Names listed? Email? Other contact mechanism?
If listed would enhance visibility and accountability. Question on upkeep and accuracy. ☑ Motion: List Service Director and Medical Director of the agency, but also require resources to maintain accurately by the State EMS Office and post on EMS website with current agency listing by county. Cady/Eberline. Discussion: Contact info would be service phone#. Approved x5 [Eberlein out of the room]				
15:00 Break to move to main room.				
Scope of Practice				
3:00 PM	Blood products for Paramedic as **			

15:00 Restart Blood products currently listed in CC scope only. Discussion on pros/cons. Difference between maintenance and initiation. ☑ Motion (Eberlein): Allow maintenance of blood products by Paramedics as **. Second: Cady/Marquis. Approved x6				
	Patient's Own Physician Prescribed Medication not on formulary- add to scope? What level?			
Example protocol written by Andrews. Recognize rarely used medications in time-sensitive and life-threatening situations. Schultz recommends this would be a good use of on-line medical control to confirm indications and dose. Discussion on need for education of medical control on these situations. EMS to provide route, and assist in administration. ☑ Motion: (Cady) In an emergency situation, allow providers to administer a pts own med based on prescription within the providers' skill scope in conjunction with on-line medical control. Second Schultz. Approved x6 Andrews to edit the protocol somewhat for phrasing.				
	Nitroglycerin infusion without pump at Paramedic level			Other alternatives to infusion pump?
NTG as only med that requires a pump. Cady proposes that NTG gtt for severe HTN and CHF is the EMS med of choice, but buying pumps for all rigs is cost-prohibitive. This medication is titratable and with measureable outcomes. Does the pump actually matter? Proposes the use of titrateable infusion tubing chambers en lieu of the pump. ☑ Motion (Cady) Eliminate the requirement of the pump for NTG infusion. Second Eberlein. Discussion: Titrateable tubing accuracy? Manufacturers state 5-10% error range. Cady considers testing the delivery dosing. In favor: 4, opposed 2 = Pass				
	Acetaminophen added to Paramedic Scope and formulary			**?
Not discussed				
	Taser barb removal			Does it need to be added to scope?
Some States have protocols for or prohibiting taser barb removal. PAC feels this does not need to addressed in scope.				

	<u>EMR scope of practice</u> Patient Physical Restraint Application for EMR as ** Glucagon Manually drawn for EMR as ** Capnography for EMR as ** non interpretive End Tidal CO2 Monitoring for EMR as ** 12, 15 or 18 lead EKG for EMR as ** non interpretive Cardiac Monitor for EMR as ** non interpretive Selective Spinal Immobilization for EMR as ** Splinting- Pelvic Wrap/PASG for EMR as **			

EMT scope items for consideration to be added at EMR level if they will be an alternate crew member.

☑ Motion (Eberliein) Physical restraint application. Second Cady. Discussion: Legislation will now require EMR to perform additional support roles. Restraint application is more than a 1 person task. Some other can be handled by the EMT alone. Approved x6

Motion (Cady) Remove others. Zils second. Discussion: Examples of pro/con of adding/removing spinal immobilization. Additional EMR points will be added in the future agenda. Approved x6.

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	<u>Tactical EMS Scope of Practice</u> Needle Decompression Junctional Tourniquet Minimum number of providers? At what service level? Non prescription (Over the counter) medications Skin closure (sutures, staples)			
Proposed list of skills outside of usual scope of practice. EMT/AEMT use of needle decompression. Circumstances of TEMS. Zils requests that supporting research should be brought and provided to these discussions. Question on TEMS education and training requirements. Difference between treating TEMS officers vs shooter or civilians; TEMS EMT/Medic dedicated to TEMS team. Recognized that OTC meds and skin closure are not taught in TEMS training. These are often requested in TEMS op plan. TCCC/TECC curriculum presumed accepted as standard; website noted to have 2 or 4 day courses. Do all of these extra skills require **? ☑ PAC would like to review the TECC/TCCC curriculum and list the scope.				
	Tranexamic Acid (TXA) added for Paramedic as **? Age range qualifier?			
TXA does not require **. Question pediatric application. UW Hospital does not use TXA. CHW has used it on a case-by-case basis, and only 12yo and above, 20mg/kg dose. Is TXA useful/neutral/harmful at single dose if not continued at the receiving facility.				
	Topics for next meetings			critical care protocols, TEMS protocols
TEMS scope Removal of Spinal Immob ** at EMR level Minimum medication list for stocking an ambulance				
5:00 PM	Adjourn			

Statutory duties

- Advise the Department on selection criteria and performance of the State Medical Director
- Advise the Medical Director on appropriate medical issues

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Board-assigned duties

- Assist with development of qualifications for medical directors at the local level
- Serve as an advisory committee for all related agencies (Wisconsin Technical College System Board, Department of Transportation, etc.)
- Assist with development of medical protocols for use in Wisconsin
- Recommend Scope of Practice for each EMT level
- Other duties as assigned by the EMS Board