Wisconsin Department of Health Services
Wisconsin Division of Public Health
Emergency Medical Services Section
Physician Advisory Committee
Minutes

Date: February 3,2016
Recorder: Dr. Suzanne Martens

Meeting Attendees:

	Andrews, Cady, Zils, Schultz, Eberlein, Marquis, Happel, Newlun, Martens				
	Colella on-line 15:29 – 16:25		Lemke on-line		

Agenda:

Time:
February 3, 2016 from 2:00 PM – 5:16 PM Wisconsin Dells, Wisconsin

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	Item	Discussion	Disposition
1.	Introductions	Andrews, Cady, Zils, Schultz, Eberlein, Marquis Happel, Newlun, Lemke on-line Colella on-line 15:29 – 16:25	
		Andrews announced the addition of Dr. Tamas as Pediatric representative to start this week.	
2.	Approval of Minutes	Motion Marquis, Eberlien second. Approved	Approved
3.	Meeting Schedule	Next Meetings 2016 April 12th (Change from preliminary April 5th) June 7th August ? EMS Board working meeting on August 2nd. October 4th (Change from preliminary October 11th) December 6th Marriot more expensive. Sheraton coming back into price range, being confirmed WI Dells in June, then forward. Question of August meeting = pending	Information
4.	State Medical Director Report	Hours: email to PAC; add descriptives; protocols reviewed Protocol inquiries/updates, op plan updates; no new case investigations in Jan NASEMSO medical directors meeting at NAEMSP conference DEA bill; Narcan use and shortages; discussions of issues	Information
5.	Communications with State EMS Office	EMR skills questions: restraints, mechanical CPR device, nebulizer Nebulizer [exists **] Mechanical device should be ** [is actually on p3] Physical restraint application: is this in curriculum? EMR expected to assist an EMT. Noted to not be in current curriculum	Clarification

		<u>Epi: EpiPen vs manually drawn for EMR</u> The EpiPen has become prohibitively expensive. Discussion on safety, well known medication error of giving IM Epi through an IV. EMR would not be in this situation, do not start IVs. Noted availability of 0.5ml syringe = safety Motion: Approve manually drawn Epi at EMR level with ** Motion Zils, Cady second Discussion: with additional guidance to include 0.5ml syringes (strongly recommended) added as subnote in the Combined Scopes document Recommended safety precaution, label as "IM ONLY" Recommended 1ml vial/ampoules primarily (unless med shortages) These points are for best practices to guide training. Approved unanimously IM route added to EMR level as ** (not a separate motion)	Approve manually drawn Epi at EMR level with ** See also safety recommendations
		<u>Questions of paramedic agencies utilizing blood products.</u> Was a grandfathered scope? Now part of CCP. Consideration of IFT needs. Examples: trauma with transfusion, hemorrhagic stroke. **Place on agenda for next meeting.	Agenda item for next meeting
		<u>High-dose NTG for CHF:</u> Cady asked about using Dial-a-Flow tubing to deliver high-dose NTG. IV NTG requires a pump. Recognized that Dial-a-Flow tubing not a substitute for a pump. SL NTG difficult to use with CPAP. High-dose would interrupt repeatedly. Spray expensive. Tabs do not dissolve adequately. NTG paste not effective or controllable. Cady to bring back data/articles on titratable tubing vs pump. Discussion on the use/need for pumps and acceptable range and errors with infusions without pumps. Schultz: question of safety of IV infusions overall; does not think all paramedic agencies should be required to use pumps, cost prohibitive. **Further discussion at next meeting.	Cady to bring back data/articles on titratable tubing vs pump. Further discussion for next meeting.

		Single medic MAA: Did not pass at last Board meeting; did not achieve a majority vote. Looking at information on training (Martens) and WARDS data (Happel) if this were to move forward. **Distribute NH state training program to PAC for discussion at next meeting.	Martens to distribute NH State training program example. Happel defining WARDS data availability.
		Protocol and Ops Plans processing Back-log recognized. Office is moving forward on this. Office has a matrix to identify date of receipt, primary person responsible, progress. Current process should be an email response in 1-2 days, acknowledge receipt. Upgrade request: at least 1 month. Downgrade request: more quickly. Request protocol changes identified, listed or with track-changes on. New application tied to E-licensing with updates to Op Plan, also to allow focus on changes. Explanation on processes of all of these. Cady: Question on authority on protocol with the medical director vs the Office. Op Plans should go to the Office. Question previously went to corp counsel; told it was required in rule; that rule was not identified. Office thought it would be moving to spot-checks or audits. OLC advised they must all be reviewed. Discussion on State-wide standard protocols. PAC requests Newlun to seek opinion from OLC to move to a reasonable %audit instead of 100% review. PAC does not believe the Office should be required to audit all of these protocols. The agency medical director should be more responsible. The Office staff have many more things to do that would be a better use of their time. Happel/Newlun: Moving to put Op Plan on E-licensing. Accessible, updateable.	PAC requests Newlun to seek opinion from OLC to move to a reasonable %audit instead of 100% review. PAC does not believe the Office should be required to audit all of these protocols. The agency medical director should be more responsible. The Office staff have many more things to do that would be a better use of their time.
6.	Sample Protocols versus Opt Out Protocols (Statewide protocols that any medical	Cady: Standard protocols would need to support the least common denominator, which stifle advancement. Standard guidelines were made to me modified. Possible PDF forum with med/dose options that would need to be defined or chosen.	Newlun/Happel inquiring of possibility of mandating protocols for all levels, focus on

	director can opt out of with their own protocols)	Would be more work for PAC to write opt-out protocols vs current guidelines; would need to be more specific. Good concept for future and updates; unrealistic to change all of them at once. Also used to have much longer PAC meetings. Can approved protocols be posted or made available as examples. Discussion that there is a means to link protocols to WARDS, to show if procedures done were c/w protocol, generate a correlation score. Discussion on focus for EMR/EMT; recognized that advanced skills would also make these variable. Newlun/Happel inquiring of possibility of mandating protocols for all levels, focus on EMR/EMT.	EMR/EMT.
7.	Scopes of Practice	Tranexamic Acid (TXA) added as **? This is available at the Paramedic level. Is this applicable at other levels? Should this be promoted at the Intermediate or AEMT? No. Ask Dr .Tamas about peds dosing or need for lower age limit.	Ask Dr .Tamas about peds dosing or need for lower age limit.
8.	CPR updates from ROC data	Discussion moved up as Dr. Colella has time limitations. ROC trial 30:2 vs interposed ventilations for Cardiac Arrest N Engl J Med 2015; 373:2203-2214 December 3, 2015 http://www.nejm.org/doi/full/10.1056/NEJMoa1509139 Colella comments before going to mobile access: Equivalent outcomes based on intention-to-treat; when based on actual treatment, there was. Interposed vents = more vents delivered Not equivalent to CCR No changes indicated based on this data. All equivalent.	No changes indicated based on this data. All equivalent.
9.	Scopes of Practice	Furosemide (Lasix) removal Motion: Cady: remove Lasix from list at I/P levels. Second: Zils/Colella Discussion: Can still use for IFT, as additional medication. Remove from paramedic list for field use. How to distribute this information? Memo. Approved unanimously.	PAC recommends removal of Lasix from I/P standard medication list. May use for P Interfacility transport.

		Manual drawn epinephrine for EMR ** Previously discussed	
		Separate Tactical EMS Scope of Practice? • Needle Decompression • Junctional Tourniquet Previously discussed, the EMS Office can only oversee or regulate EMS providers. Currently used OTC meds, being provided as self-administered. More challenging to build a scope. Define only for TEMS? even at EMTs? Could be restricted by the interpretation of "practicing medicine" for invasive procedures and other medications. The goal is to allow trained TEMS providers to be able to practice. Recognized that law enforcement officers with no EMS training are allowed to perform these skills. Discussed needle decompression and determined this would be within a TEMS scope to be better defined. Motion: Cady: Create a TEMS scope of practice. Second: Eberlein Discussion: RTF different from TEMS. Approved unanimously Motion: Cady: TEMS scope will be limited to a TEMS response. Second: Zils Discussion done: Due to environment, purpose and training this focuses on high risk pts, not the general population. Approved unanimously	PAC recommends the development of a TEMS scope of practice. PAC recommends that the TEMS scope will be limited to a TEMS response.
10.	Topics for next meeting	Andrews has the list Acetaminophen Meeting logistics, time, overlap	
11.	Adjournment	Adjourned 17:16	

Upcoming Meetings:

Meeting	Date	Time	Facilitator/Host
Physician Advisory Committee	April 12, 2016	12:00 PM -5:00 PM	
Physician Advisory Committee	June 7, 2016	12:00 PM-5:00 PM	