Wisconsin Department of Health Services
Wisconsin Division of Public Health
Emergency Medical Services Section
Physician Advisory Committee
Tuesday, October 4th, 2016

12:00PM - 5:00PM

Madison Marriott West

1313 John Q Hammons Drive; Middleton, WI 53562

Minutes

Meeting Invitees:

x	Steve Andrews, MD (Chair)	x	Riccardo Colella, DO – remote after 15:00	x	Steven Zils, MD
x	Mark Schultz, DO (Vice-Chair)	x	Christopher Eberlein, MD - phone	x	Suzanne Martens, MD (State EMS Medical Director)
	Chuck Cady, MD	x	Sean Marquis, MD		
x	James Newlun (Wisconsin EMS Director)				

Board: Mike Clark, Greg West

Guest: Bill Berkhahn, Paramedic

See second attendance sheet for combined session after 15:00

Agenda:

Insert Date and Location				
Time:	**Topic:**	**Lead:**	**Follow-up Items:**	**Notes:**
12:00 PM	Introductions & Comments/Questions from Public			No Public Comments
12:10 PM	Approval of Meeting Minutes			**Motion by Steven Zils, second by Mark Schultz to approve the minutes from the June meeting. Motion Carried.**
12:15 PM	Next Meetings for 2016			Question combined meeting with EMS Board? December 6th
	EMS Board discussing changing format to more continuous action during subcommittee meetings to use all of the time better, less repetitious. Decision pending.			
12:20 PM	State Medical Director report	Dr. Martens	Status of training for Single Paramedic Medically Assisted Airway with trained assistant	Completed Manually drawn Epi training packet Status of Single Paramedic Medically assisted airway with trained assistant Issues on EMR Epi support documents. Hope to come out next week. MAA pending. Excellent training resources from New Hampshire EMS Office to be referenced if this goes forward.

	Discussion on how to use MAA with assistant for jump medics responding – this will only work with the same medical director, or group of medical directors; consistent maintenance of training is the problem.
	Required QA points: How well will this translate from 3rd party vendors?
	
	State Medical Director activities summary given at PSOW. Slides available on the PSOW website. Promotion of Just Culture; meetings/representation; EMS Section resource; investigations; protocol reviews. EMR manually-drawn Epi project.
	Tracking hours, detailing job description. Averaging 40-50 hours/month recorded, hours missing.
	Future projects: Protocol edits and updates, ongoing; MAA and Advanced Airway Assistant proposal; follow new advanced skills for safety and impact; Critical Care Interfacility data; resource/reference library; best practice examples, list of practices to avoid; facilitating the name change process (examples of National Registry and Nursing Board); visit agencies
	
	NASEMSO fall meeting points
	• Ohio Carfentanil notice release
	  ○ Local Naloxone shortage; not reported by FDA **OH statute that Naloxone must prioritize EMS in supply chain**
	  ○ Other states are tracking delays in treatment due to Naloxone use during codes or FBAO (code at restaurant was steak impaction, not fixed by LEO or FF naloxone, started mechanical CPR, not until ALS got there to manage the airway did they find the steak in the airway)
	• Military Trauma Care
	  ○ Many states require a commercial tourniquet on every licensed ambulance
	• Promotion of utilization of the CARES program for cardiac arrest data
	  ○ Some states use Image Trend to directly transfer data into CARES
	  ○ Currently identifies about 1/3 of cardiac arrests in US
	  ○ Considerations of cost, software bridges, required State CARES Registrar
	• ASPR: Enhancing the ability of EMS to transfer pts with suspected or confirmed high level infectious diseases; only 10 states have a destination facility
	• Compass project: how to do something this the NEMSIS 3 data to define performance measures
	  ○ Example: 10 cardiac arrest goals/benchmarks
	• Model EMS Clinical Guidelines
	  ○ Focused on pt care, not on skills/scope levels as they are different in each state
	  ○ Benchmarks built in
	  ○ Ohio EMS did use this as the basis for their basic protocols; also had excellent pediatric input
	  ○ CT and the New England states doing same; great examples			

	• MN investigating manually-drawn Epi by EMTs with "volume limited syringe" = 0.5ml syringe or adjunct on syringe plunger; neither currently exist
	  ○ WI EMR project discussed; will be watched for outcomes and safety
	• Fatigue in EMS project, partner with DOT but in Behavioral Science section, different viewpoint; continue until June 2018
	  ○ Finding a huge volume of references
	  ○ Looking at vehicle crashes, med errors, skills errors
	• Unplanned extubation – Art Kanowitz (CO)
	  ○ Based on ICU data with morbidity and cost impacts; mostly unknown in EMS and difficult to track; need increased awareness			

12:50 PM	Communications with State EMS office	James Newlun	EMS Office report	See later in meeting
1:50 PM	Communication with other Committees or related agencies: HCC Regional Medical Directors Online Medical Control and Resource hospital standards?			Not discussed
2:10 PM	HCC Regional Medical Advisor outreach to Local Medical Directors		Any reports on outreach to EMS Medical Directors in HCC regions?	Eberlein: had been discussed but nothing set yet. Trying to have some protocol review sharing and support.
Protocols				
2:30 PM	Traumatic Arrest			Some bullet points clarified Points 9-10 with times: If witnessed CA and 15 min transport time….

				Questions of pulse rate **Approved with edits**. Andrews has updated version.
	Leg Lift Valsalva Maneuver			**Approved**
	Cardiogenic Shock			SBP <100 to define cardiogenic shock How to enact this protocol as cardiogenic shock Put under Shock protocol. More to be revised.
	Toxic Exposure & Overdose			Increase Narcan dose up to 10 mg Reworked emphasis on OPA/BVM then Narcan, then advanced airway if not responding to Narcan. But not adv airway and then Narcan. More to be revised.
	Allergy & Anaphylaxis			Epi updates, more edits See Dr. Andrews versions – Pediatric version **approved**, Adult needs additional review
Break				
Scope of Practice				EMS Board members present for discussion
3:15 PM	**EMR scope of practice** Removal of "Spinal Immobilization **" at EMR level Add 12 Lead EKG	Dr. Cady Bill Berkhahn Paramedic		Training Officer Bonduel Area EMS First Responders
	Spinal Immobilization deferred to next meeting, Dr. Cady not present. Bill Berkham: Requested this skill over 2 years ago in the Shawano area. Approved as a pilot; consideration of location and distance between local PCI facilities. Approved in-house training. Have been doing this with good examples of scene times. On-going QA, all cases reviewed.			

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<tr><td></td><td colspan="4">Typically 12-lead done in less than 5 mins. No cases of leads requiring to be changed or repositioned. Do training every 6 months. Emphasize treating life-threats before EKG as needed.
Have 21 cases in 2.5 years; 1 STEMI.
Using LifePack 15 (funded by community donations within 4 months); chose this over LIfePack 12 with upgrade, can also use CO for FF rehab. Same as responding Shawano ambulance, keep it on the pt until at ED. EMR LifePack can transmit; ambulance does not.
Staff (11) is mixed EMR, EMT and some paramedics. Found that EMTs also need to be trained in this. They do not allow new staff to practice until all advanced skills learned.

Discussion on difference, or lack there-of, EMR** and EMT. Per Scopes document: FBAO with Laryngoscope, and Patient-assisted medication with NTG

Question of non-transporting EMT staffing requirement with 2 providers. Need to define language and intent in rule. Meant to promote response, not hinder.

Motion by Steve Andrews, second by Mark Schultz to continue this pilot project. <u>Motion Carried.</u>
Discussion on how much longer this will be considered a pilot, and the expectations of pilots in general.
Berkhan asked to provide his training slides for reference.</td></tr>
<tr><td></td><td><u>Tactical EMS Scope of Practice</u>

Needle Decompression at all levels</td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="4">Zils: Definition of “practice of medicine” in WI. LEOs not legally allowed to do this. Counter-argument that it is very unlikely to be sued for this.
Research with vented versus non-vented chest seals (pig studies); so less of a push for needle decomp.
Another reason for TEMS scope.
No motion needed, as no change suggested</td></tr>
<tr><td></td><td>Chest Seals (vented preferred) at all levels

Furosemide (Lasix) for Mobile Integrated Health?</td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="4">Zils: Change scope to reflect the preference of vented chest seals. Not actually listed in scopes document. Occlusive dressing in training. No motion.
Motion by Steven Zils, second by Steve Andrews to recommend to ask the Office to communicate the best practice of using vented chest seals. <u>Motion Carried.</u></td></tr>
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<tr><td></td><td colspan="4">Furosemide for CP/MIH:
Last discussion on removing it from P but still in IFT. Currently no scope for CP/MIH, so difficult to address the place/applicability of Lasix. The previous discussion did not consider CP/MIH at all.</td></tr>
<tr><td></td><td>Communications with State EMS office</td><td>James Newlun</td><td>EMS Office report

Status of ongoing Operational Plan/Medical Protocol approval by state office

Listing Service Director and Medical Director on State Website- status?

DEA license for Ambulance services?

Previous Scope Recommendations not implemented yet?
1.Remove Furosemide (Lasix) at Intermediate and Paramedic level for field use. Still allow for interfacility.
2. Paramedic to maintain (but not initiate) blood products as **
3.Paramedic Ntiroglycerin drip remove “(w/pump)”
4.Patients Own Physician Prescribed Emergency Medication with on line Medical Control approval</td><td>Recommendations for legislative drafting?

Are these being implemented? When will they be published? If so, what timeline?

Also from October 2015 PAC meeting:

Endotracheal Intubation requires continuous ETCO2 waveform capnography (for any new increase in service, for all services by 2021). INTERMEDIATE TECHNICIAN, INTERMEDIATE, PARAMEDIC SCOPE OF PRACTICE</td></tr>
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<tr><td></td><td></td><td></td><td>5.Patient Physical Restraint Application as ** for EMR
6. Acetaminophen added to Paramedic scope and formulary
7. TEMS scope of practice</td><td></td></tr>
<tr><td></td><td colspan="4">More documents for EMR Epi. Sandy processing.
More info from Legislative Study. Will discuss at Board meeting.
Process of advancing changes through PAC and the Board, in whichever order appropriate, so all know the same information.
Memo coming out: Special Events Planning, based on rule.
NCCP use, Helen doing investigation on this and its application in practice.
Still looking for outstanding protocols and op plans. Office staff have a spreadsheet on this processing. Regional coordinators will have more ownership, more attention to completion. Recognize that up-front acknowledgement of receipt important, confirmation email.
James will bring spreadsheets to meetings.
Website updates being done; if errors found make sure to report them.
2 new Coordinator positions being hired. Had 48 applicants for these positions.

Outstanding items:
Listing Service Director and Medical Director on the website: not pursued yet, still on list; noted that high rate of turnover of Service Directors and need to dedicate Section staff time elsewhere may preclude this. Consider automatically posting list on website every few months for agencies to check and make corrections.
DEA legislation status: Federal versus State. State legislation needed to acknowledge EMS agencies as mid-level providers.
List of scope recommendations to be implemented; including ETCO2 requirement for intubation; required for new adv skill; grandfathered if currently intubating until 2021.</td></tr>
<tr><td>4:55 PM</td><td>Topics for next meetings</td><td></td><td></td><td>critical care protocols
TEMS protocols
Removal of “Spinal Immobilization **” at EMR level
Rework Shock protocol together; Hypovolemic and non-Hypovolemic
Finish Tox/OD
Address similar changes to AMS
Address inserting ETCO2 to these</td></tr>
<tr><td>5:00 PM</td><td>Adjourn</td><td></td><td></td><td>Adjourn 16:59</td></tr>
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Statutory duties

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

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