Wisconsin Department of Health Services
Division of Public Health
Emergency Medical Services Section

Physician Advisory Committee Minutes
April 18, 2017
1:00PM - 5:00PM
Madison Marriott West
1313 John Q Hammons Dr, Middleton, WI 53562

Meeting Invitees:

x	Steve Andrews, MD (Chair)	phone	Christopher Eberlein, MD		James Newlun (Wisconsin EMS Director)
phone	Mark Schultz, DO (Vice-Chair)	x	Sean Marquis, MD	x	Suzanne Martens, MD (State EMS/Trauma Medical Director)
vacat	Chuck Cady, MD	x	Steven Zils, MD		
x	Riccardo Colella, DO		Bryan McNally (Executive Director CARES)	x	Michael Clark, MD (EMS Board)

There is usually a quorum of WI EMS Board members at this meeting and the EMS Board will routinely take concurrent action on items brought up at this meeting.

Agenda:

Time:	Topic:	Lead:	Follow-up Items:	Notes:
13:06	Introductions Public Comment			Introductions No public comments
	Approval of Meeting Minutes			Approved
	CARES Registry Presentation	Bryan McNally		Cardiac Arrest Registry to Enhance Survival https://mycares.net/

13:09 CARES Registry currently being used in Dane Co and Milwaukee Co. CARES Registry started as cardiac arrest data program in Atlanta. How to use local data to improve cardiac arrest care. Has had a subscription model for the past 2 years. Emphasis on community links in the chain of survival. National CARES report for 2016 to be published in the next few days. This allows for local data to have a national background. Incident data showed twice as many cardiac arrests did not qualify for resuscitation as those that did. About 20 states currently participating statewide. About 13 states with partial use. Evaluating best use of state coordinator. How to add communities throughout the state. 2 methods for EMS data entry: via computer entry or database extraction with certain vendors. Currently Dane and Milwaukee enter their own data manually. Data elements: demographic, EMS 10 points, hospital 5 points. Have the ability to link between hospitals due to transfers. Current national statistics demonstrated. Each agency inputting data owns their own data. Aggregate data can be compiled regionally or statewide. Pan-Asian Resuscitation Outcomes Study expansion. Development and support of Dispatcher assisted CPR, produced 1 hr training session. Example of local versus national data. Example of incidence of bystander CPR, then associated survival, showing impact. After about 3 years of data can start doing county/regional geomapping. Consideration for proposed metrics for Healthy People 2020. Data shows increased bystander CPR in communities who track this data. Have pediatric subset data. Hospital coordinator expected to log in maybe once a month and check their data input.

Discussion: CARES has tried to align with NEMSIS, not complete. Better to load from third party programs. Can extract from Image Trend programs. Many communities start with manual entry.

Can community members not participating access the data: Must be released by the local participating parties, CARES will not release it. How to get a report to compare comparable communities? There are tailored reports for this, must check the denominator for validity.

Cost: $15K state fee, regardless of size/population. Adding other communities does not add fees.

State Coordinator expectations: FTE vs PT, how to use additional time, coord must also train regional/local coordinators. Many states have had their state coord set up and run the Resuscitation Academy program. CARES has examples of where/how to place the state coordinator for best use.

	State Medical Director report	Dr. Martens		

Input on investigations regarding scope, standard of care, DEA practices, Narcan use, IM Epi training. Recorded hours continue to be about 50 per month. Discussion on how to note shared hours, such as conferences I would have attended regardless, and presentations made not necessarily as a State EMS representative, but likely chosen due to my position.

NASEMSO conversations/contributions with feedback on Narcan use, IM Epi, State-wide protocol use. Request for pediatric DNR information yielded few responses. Maine, Ohio and Nevada have some reference rules and forms.
The Maine EMS Comfort Care/Do Not Resuscitate (CC/DNR) Directive or CC/DNR Order form is downloadable from the Maine EMS website - http://www.maine.gov/ems/publications/index.html#ccdnr.
The standard DNR initiated by pt has age >18 requirement; comfort care/DNR order does not state age.
The link to Ohio's legislation for the Ohio DNR Comfort Care program is as follows: http://codes.ohio.gov/oac/3701-62. There have been multiple efforts made by the Ohio Department of Health to transition the Ohio DNR Comfort Care program to a MOLST/POLST model since 2005. Their efforts, thus far, have been unsuccessful due to objections from the right to life organizations.
There are two of Nevada Revised Statutes that contains information about DNR's for minors. All information relating to withholding life-saving treatment is covered by NRS 450B.400 thru NRS 450B.595. Here is a link: https://www.leg.state.nv.us/Nrs/NRS-450B.html#NRS450BSec400 if you want to read it all in detail.
2. A patient who is less than 18 years of age and who: (a) Has been determined by the patient's attending physician to be in a terminal condition; and (b) Has executed a Physician Order for Life-Sustaining Treatment form pursuant to NRS 449.691 to 449.697, inclusive, if the form provides that the patient is not to receive life-resuscitating treatment or has been issued a do-not-resuscitate order pursuant to NRS 450B.510.

In process of reviewing the Connecticut evidence-based guidelines for adoption in Wisconsin. Original Word document requested due to issues working from the PDF format.

	Minimum Medical List for Care Level	Dr. Martens		

Expansion of this if added to the scopes document will be too large. Question on exactly which medications are "required" at the paramedic level, such as 1 benzodiazepine and 1 narcotic and 1 vasopressor; ACLS medications.

List to be distributed to PAC for each member to research medications not obviously mandatory or optional. Bring back references.

	Any State Medical Director issues needing advice	Dr. Martens		

Scopes questions were already added to the agenda: Phenylephrine, Wound packing; Scopes questions/corrections

	Communications with State EMS office	James Newlun	Use of Dopamine- Query state database results	Request PAC member for Critical Care Work Group

Dopamine use report: 1300 incidents found (of how many calls?). This was an error, different report.

Critical Care Work Group: Will look at comparison with aeromedical requirements, educational requirements. PAC representative: Andrews, Colella

CARES Registry: Newlun to review information from presentation. Colella motion to pursue expanding CARES statewide. Zils second. Discussion: To define FTE funding, integrate Public Health or HCCs or WHA. How to allocate the time. Approved. EMS Bd motion by Clarke, second by Meier. Approved.

	Hospital Ambulance Diversion	Dr. Colella		

14:36 Emergency Department Access of Care Initiative

Milwaukee Co EMS and governance: Medical Society, ED Leadership, EMS Council. Function under rule, ordinance and EMS contract.

Project started in 2013. Looked into informed choice on destinations. Noted that when one hospital goes on diversion it was followed by many others. Pt satisfaction declined when forced to other facilities. Longer ambulance times. Citizens learned to just drive themselves in.

Improved ED Access: All ROSC to closest appropriate facility. STEMI and Stroke to closest appropriate facility. Phase III is all patients allowed to go to the facility of their choice, 4/1/16 started. 6 months of data compared. Can go on bypass for disaster situations. Call volume similar. Ambulance turn-around time same. Signif decr in ED closure time: 4773 hrs down to 13 hrs. No pt safety events reported. Limitations: no interfacility data, no info from private ambulances. ED volumes same. Ambulance arrivals same. Destination policy on MCEMS website.

Emphasis on hospital capacity, not just ED capacity issue. Requires facility-wide plan.

	Controlled Substance Destruction	Dr. Zils		

15:00 Example of transitioning agency formulary and needing to destroy excess controlled substances. DEA updated this process in 2014. Form required. Reverse distribution is expensive. Ability to render the medication as non-retrievable required. Dr. Zils found a system on Amazon and it has worked well. Dr. Zils will contribute updates to the State EMS document and bring back for approval.

Scope of Practice				
	Tourniquet- remove ** at every level			

Tourniquets are being taught at all levels. Is this to be required at all levels? Andrews motion: Hemorrhage control extremity tourniquet *EMR, remove stars at all other levels. Colella second. Approved.

	Selective Spinal Immobilization- remove **, add to EMR level			

Question of SSI being taught in curriculum – does not appear to be. SSI is in the WI S&P manual.

	Dopamine remove from Paramedic Medication list			

15:25 EMS Office report:502 uses of Dopamine per year, for 500,000 calls. Question of preferred use for sepsis and cardiogenic shock. Check literature for use, efficacy, side-effects. PAC to research.

	Phenylephrine add to Paramedic Medication list (IN/IV/IO/IM)			

Motion Andrews: Add Phenylephrine to the Paramedic medication list. Marquis second. Discussion on having 5 pressors (Epi, Norepi, Dopamine, Vasopressin, Phenyleph). Potential for Dopamine to phase out. In favor 3, abstain 1. Approved.

Discussed that new scope changes will come out in January of each year.

	Wound Packing add to scope at all levels			

Hemostatic agent is on list. Wound packing technique is not in standard curriculum. Recognition that wound packing is the correct technique. Does not require change. Put out as best practice. Motion Marquis: Have wound packing as *skill at all levels. Note that it is in the WI S&P manual. Zils second. Approved.				
Protocols				
	Stroke Interfacility TPA protocols			
16:02 Suggested update from Coverdel program. Statement of "Do not discontinue Alteplase unless directed to do so by a MD." Discussion on Paramedic scope of practice. To be further discussed at the next meeting.				
	Any protocols that State Medical Director desires PAC review			
Connecticut EBM protocols examples Safe transport of children – position paper Both previously discussed				

	State List Scope of Practice corrections?			Intubation- Medication Assisted (non-paralytic) (Requires 1-Paramedica & 1-Advanced Airway Trained Provider Patient Side) Ventilators – Variable Setting … Paramedic X(3) should be X(3)* Cardiocerebral Resuscitation (CCR) is ** at each level except CCP which is *, should be * at every level Defibrillation - Automated/Semi-Automated (AED) … FA is X and EMR is X, should be X* at FA and EMR level. Splinting- Vacuum listed aa X* at every level except TEMS and there is listed as X, should be X* at every level Assisted Patient Medications: 1. Glucagon Auto-Injector Only list at TEMS level as X**, should be X* 2. Nitroglycerin not listed under TEMS but is listed EMT-CCP, should be X* for TEMS 3. Oral Glucose is X* at EMR thru CCP, but is X at FA and TEMS, should be X* at every level Medication Administration Routes: 1. Aerosolized/Nebulized for TEMS is X**, should be X* 2. Auto-injector for TEMS is X**, should be X* for TEMS and for every level except EMR where X** should be kept 3. Intramuscular for TEMS is X**, should be X* for TEMS 4. Intraosseous (IO) not listed for TEMS, should be X* 5. Intravenouse (IV)) not listed for TEMS, should be X* 6. Subcutaneous (SQ) not listed for TEMS, should be X* 7. Sub-Lingual (SL) not listed for TEMS, should be X* Initiation/Maintenance/Fluids 1. Maintenace- Non-Medicate IV Fluids not listed for TEMS, should be X* 2. Intraosseous (IO) not listed for TEMS, should be X* 3. Peripheral not listed for TEMS, should be X* 4. Saline Lock not listed for TEMS, should be X* Medications Approved Per Protocol 1. All TEMS listed should by X*
16:33 To be reviewed by the State EMS Office in detail				
If time allows	Topics for next meeting			Clark: HazMat considerations: topical calcium gluconate, 2-PAM not in the autoinjector, full cyanide kit, pardoxime Controlled substance destruction Benchmarks for EMS Freestanding EDs

If time allows				
	Adjourn @ 16:38			

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