OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: State EMS Board			Attending: Separate list compiled by DHS EMS Section.
Date: 6/5/2018	Time Started: 09:00	Time Ended: 16:39	
Location: 1 West Wilson, Madison, WI (DHS Offices)			Presiding Officer: Biggart, Jerry (EMS Board Chair)

Minutes

1. Welcome and committee member check-in.
2. Introductions of EMS Board, EMS Office staff, and attendees.
    a. Short building layout orientation.
    b. Mark Lockhart, EMS Section Chief, introduction.
3. Public comments:
    a. "Be somebody" recruitment announced. Flyer provided.
4. Weiss resigned from the Board. Minutes from April 17 and 18, 2018 meetings were updated by Chair Biggart. Kimlicka noted the minutes stated they would be approved on June 6, 2018. The date should be June 5, 2018. Motion made by Biggart to approve. Motion passed.
5. Standing EMS Committee – System Quality & Data
    a. Summary of previous meeting minutes. Motion by Rukavina to approve. Motion passed.
    b. Discussed data collection and reporting options with ImageTrend and Biosphere given existing challenges in collecting, compiling, retrieving, and reporting both stand-alone agency and statewide EMS data.
    c. Office is looking at having a backup for the data manager within the Office.
    d. Statement of work from the committee produced to include five items (see System Quality and Data minutes from the April 2018 meeting) and forwarded to the Office. Committee would like to see three reports in time to review for the August meeting. Meier will generate reports with data points and forward to the Office as a potential template.
    e. Remainder of agenda cannot be addressed given lack of available reports.
    f. CARES data (2016 and 2017) from Milwaukee and Dane counties was reviewed. Will add as a standing item for the committee. (Challenge has been funding for a coordinator position through the state.)
6. Break from 9:53 to 10:02
7. Standing EMS Committee – Education & Training
    a. Update from the WTCS.
        i. EMS Training Officer program. Joint project between WTCS and DHS. Weir is currently creating the content (course competencies/above-the-line). Interactive/web-based. Agency medical director will need to be involved. Generate equivalent of Instructor I certification. Presentation at the Governors' conference in August. Being proposed to provide an option; not a mandate. Two to three-year project. Have partnered with several organizations to provide free, flexible training options. Looking to provide a method for agencies to enter flexible content refresher information into e-licensing directly for streamlining the tracking of providers and their continuing/flexible education. Will be NCCP-compliant.
        ii. NAEMSE in September and CoAEMSP (accreditation conference) in Louisville next week. Actively going to site visits. Well-received by site reviewers. Intention was to fill-the-gaps, not be "big brother;" provide state perspective.
        iii. EMS Instructor II certification course. Certification course is 100% online. Webinar is provided once a month (will be moved to online through WiTrain). 34 instructors have completed the course since October. 37 are currently enrolled. Since July 2013, 208 instructors

have taken the course.

iv. Deadline for MIH survey was May 30. 274 responses (18% return). 40 were incomplete when submitted. Data is being compiled by the Medical College of Wisconsin. More information should be available by the next Board meeting.

v. State-called meeting coming up at FVTC (February 2019). Going back to a more "organic" meeting with less extemporaneous information not pertinent to in-state needs. Wants to try to resurrect the best practices segment. Eye on accreditation coming to the other levels (below Paramedic).

vi. General projects:

1. Curriculum and S&P revisions. All need to be redone. No major changes anticipated. Will complete Standards &Procedures manual concurrently. Need to generate MIH curriculum.
2. EMS instructor application process upgrade. More user-friendly and adaptable.
3. Updating EMS training center operational plan process. (Possibly roll-out at February 2019 FVTC meeting.) All preceptors will need to be identified. Online trainings and certificates for preceptors.

vii. NREMT EMT psychomotor testing through MOU with DHS. Will bring on new EMT examiners (two to three people). Looking at adding up to 10 examiners at the ALS levels.

b. EMR to EMT bridge pilot. Possibly more of a "sequential" training rather than a transition. Pilot was not successful. Currently, anyone going from EMR to EMT must take the full EMT. Question as to whether CPL or a PLA would be appropriate or allowable.

c. DHS role in CoAEMSP accreditation visits. No hidden agenda. There to support the training centers and our students. Opportunity for training centers to pre-plan visits in cooperation with the Office and WTCS.

d. NCCP model. NREMT accepts all localized education and the DHS approves what agencies provide through their flexible refreshers. Thus, the "Wisconsin" model is acceptable by the NREMT. All three options to renew through NREMT are acceptable. Thus, DHS will not be producing any specific materials for continuing education.

e. First Aid column removed from the Scope of Practice. Questions regarding first aid are still present, especially for non-EMS groups and providers who are functioning as good Samaritans. Moved to the Systems Committee.

8. Break from 11:16 to 11:19

9. EMS for Children

a. Introductions.

b. EMS survey data. Hospital-based survey is open regarding interfacility transport agreements and guidelines.

c. Education and outreach. May 9 training was held. Online respiratory distress training module is being created. (End of December is the target date for completion.)

d. EMSC newsletter launched during EMS week. 2018 pediatric champion announced (Chief Path, Stoddard Fire). Newsletter available on their website.

e. Patient at-risk program. Per the national EMSC meeting (April/May 2018), work for online registry for patient with special needs is ongoing.

f. Working with 14 different EDs in Wisconsin to work on improving pediatric readiness. Site visits have been occurring.

g. Have not updated data over past few meetings given vacancy in epidemiologist position.

h. Community EMS concepts specific to the pediatric population. Question as to what type of prevention programs would be appropriate to build with regard to community EMS and pediatric care. Are there pediatric "frequent users" of EMS services? Biggart would like to see a list of common pediatric issues and problems that could be addressed through prevention and community EMS.

i. PALS scenarios provided by the AHA are not tailored to EMS. Would be nice to have some. Other organizations besides the AHA provide pediatric advanced life support information.

j. Discussion regarding BLS supraglottic devices as utilized in the pediatric population.

k. Next meeting for EMSC with EMS Board is in October. Will be sending out a survey to EMSC to see if there could be a meeting of the EMSC group before that date.
l. Need to address the approval of minutes and distribute previous meetings minutes.
m. Motion to approve meeting minutes from December, February, and April by Ridings. Motion passed.

10. Break from 11:54 to 13:06.
11. Board Chair is talking with Mark "as we go" to bring him up to speed.
12. State Medical Director report.
    a. Report on State Medical Director hours (approximately 55.7 per month that was recorded; more hours are not recorded).
    b. Presented WARDS data examples at the NAEMSP-WI meeting (Haldon v. Geodon, annual EMS calls, licensed providers, trauma center map, calls by provider for a single service, average scene time for a single service, refusals by provider for a single service, time to first EKG by provider for a single service, Ohio Narcan use, and North Carolina falls data).
    c. NASEMSO meeting in Rhode Island
        i. EMS 2050 comments received.
        ii. Model Guidelines comments received.
        iii. Many states do not require medical directors at the EMT level.
        iv. Lights and siren usage study and Wisconsin is at the top of the list for running with lights and siren.
        v. Cautionary tales regarding legislation: Fentanyl ban except hospice (EMS was never considered as an exception). Rules for stroke centers (over-legislated and new thrombectomy centers did not fit).
        vi. Successful legislation: Nursing Board in Maryland helped define what a transporting Nurse's qualifications should be.
        vii. Project to develop an ethics statement for EMS medical directors.
        viii. Chicago Fire changed cardiac arrest protocols based upon CARES data.
        ix. ImageTrend presentation regarding "CrewCare" app. (Self-diagnostic tools to measure stressors.)
        x. Outcomes data from hospitals can still be an issue.
        xi. Imposter DEA agent (from Detroit) asking about medication distribution.
        xii. Status of recognizing EMS agencies given changes from Emergency Medications Act is still in flux.
        xiii. In-house training: Do not use "real but expired" medications. Using food coloring in water works well.
        xiv. Uber has been asking about setting up an ambulance service. Direct them to the state law/regulations.
    d. Las Vegas shooting information (deferred to the end of the agenda, if there is time).
13. PAC Meeting
    a. Roll call.
    b. No public comment.
    c. Discuss future direction of PAC. Proposal to change how PAC operates: Address issues that come from the Office, State Medical Director, or the EMS Board. Would like to address other issues through NAEMSP-Wisconsin. (Thus, narrow the scope of PAC while expanding the role of NAEMSP-Wisconsin and run them concurrently or closely-associated thereto.) Group preferred keeping the PAC and NAEMSP-Wisconsin meetings on Tuesday.
    d. Annual activity report of State EMS Medical Director. Hours and topics/categories were summarized. (25% to 33% of actual hours are approximated to not be reported.) More time spent on travel and less on emails than originally anticipated. Top four activities involved investigations, EMS Section questions, data mining, and PAC work. Wants to improve communications with agency medical directors.
    e. CPAP and DNR. Question as to whether CPAP could be applied to a person with a valid DNR. Agreement that CPAP is appropriate as a "comfort care measure" for a person with a valid DNR. Motion Clark that CPAP is an indicated treatment for a patient with a DNR. Motion

passed (unanimous).

f. Break from 14:09 to 14:22.

g. Antimicrobials at the paramedic level. Previous discussions involved maintaining versus starting or implementing; was acceptable for paramedics to maintain antimicrobials (not start or implement, though). The thought was to handle antimicrobials similar to blood products. Proposal to update scope to denote antimicrobials with the blood product language. Approximately 40 paramedic services were "grandfathered" when critical care was initiated (thus, being allowed to maintain antimicrobials). Motion Clark to update the scope of practice to read "blood, blood product, and antimicrobial monitoring" to be included at the paramedic level. Per discussion, the items will be separated and Clark agreed with the amendment to his motion to denote "antimicrobial monitoring" as a separate line item to be included within the scope of practice for the paramedic level. Motion passed. Group believes this should be a high priority item for the office. Question regarding initiation to be deferred to another meeting.
    i. Board and PAC would like to review information from the Office regarding proposed updates to scope and operational plans with an eye on flexible staffing. Request of the Office to forward the draft documents to PAC for consideration and input. All comments from PAC are to be returned to Zils. Time is of the essence to address this concern.

h. Prior EMR scope changes and curriculum. Given the removal of double star from Narcan, wound packing, and tourniquets, are they included in the current curriculum? Additionally, the current document available on the website is not updated since the December PAC meeting. The updated document is with the forms center. Curricula at the various levels will be updated (the information is not there now). Many training centers teach the advanced skills, but not all.

i. Trauma unclassified hospital transport destination position statement. Was approved by PAC and presented at the STAC meeting in December. Unclear as to whether there is an outstanding issue. STAC discussed the statement at their March meeting. Questions from STAC were forwarded to Biggart on June 4. Pullen will be forwarding to the Board and PAC. STAC would like to see PAC stick to the triage and transport guidelines and RTACs should designate based upon local factors. Document with feedback provided by STAC was reviewed. PAC was comfortable with "preamble" changes, but not the rest. There will be discussion tomorrow at the joint STAC meeting. Would be helpful to know how many patients are transferred from an unclassified facility to a trauma center (or if the patients died at the unclassified facility).

j. STEMI/stroke destination position statement. Draft stroke document was discussed and some changes were proposed and incorporated. Desire to have this document come out from the Office as part of the destination guidelines. Motion Andrews to approve the stroke document as amended. Motion passed. Draft STEMI document was discussed and some changes were proposed and incorporated. Motion Andrews to approve the STEMI document as amended. Motion passed.

k. State medical director questions.
    i. Ventilator use in the field… Should CCPs be able to change ventilator settings if available on a 911 call (versus intercept)? Issues arise when helicopter field responses are involved given CCP staffing on a helicopter. Per Office, CCP is interfacility only, not 911. More discussion will be warranted and will be a future agenda item.
    ii. Is BiPAP paramedic or CCP? Was originally in CCP only. More discussion will be warranted and will be a future agenda item.
    iii. Staffing on an intercept… Can a paramedic on an intercept replace the "extra" EMT? Do they have to be on the same service in order to form a legal crew? More discussion will be warranted and will be a future agenda item.

l. Remaining agenda items already addressed in previous items.

m. Future new business.
    i. Please try to provide evidence and data behind recommendations.

14. Meeting recessed at 16:39.

Prepared by: West, Gregory on 6/5/2018.

Approved by EMS Board 8/1/2018