MEDICAL OVERSIGHT COMMITTEE MEETING

MINUTES	DATE	TIME	LOCATION
	October 18, 2016	9:37 a.m. – 11:39 a.m.	ODPS – Division of EMS, Room 1101 1970 W. Broad St., Columbus, Ohio 43218

ATTENDEES	Committee Members: Geoff Dutton – Chair, Dr. Thomas Charlton, Dr. Eric Cortez, Martin Fuller, Mark Marchetta, Brent Parquette, Dr. Daniel Schwerin, Eric Wiedlebacher, Tami Wires, Allen Young. ODPS-Division of Emergency Medical Services (EMS) Staff: John Molnar, Dr. Carol Cunningham, Executive Director House, Susan Edwards, Dave Fiffick. ODPS Staff: Visitors and Guests: Dr. Paul Zeeb, Dave Viola, Ray Poynter, Brian Williams, Paul Westlake, Christopher Menapace, Jeff Sharps, Preston Moore, Rob Martin, Gene Wind.
ABSENT	Committee Members: William Longworth, Deanna Dahl-Grove, James Davis.

AGENDA TOPICS

TOPIC	**Announcements and Introductions**
	Committee members must complete a new application and submit it to Susan Edwards with a copy of their resume by December 15, 2016. This is required to be done annually. Forms are available if you need them. Introductions of members, guests and visitors.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
None		

Approval of Minutes (June 2016)

Meeting minutes from the June 2016 meeting were presented for approval. Motion made by Dr. Charlton, seconded by Mr. Wiedlebacher. All in favor. None opposed. Minutes approved.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
None		

NEW BUSINESS

TOPIC	Removal of William Longworth
	Ch. Dutton discussed the removal of William Longworth from the committee. He has not attended for over a year and has not responded to meeting notices, emails or telephone calls. For Board and Committee members, attendance at two-thirds of the meetings annually is required. If committee supports it, recommendation will be made to the Board for his removal. Motion by Mr. Marchetta, seconded by Dr. Schwerin. All in favor, none opposed. Motion passes.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Ch. Dutton will recommend to the Board that Mr. Longworth be removed from the committee.	G. Dutton	10/19/16

TOPIC	CHANGE TO SCOPE OF PRACTICE – TRANSPORT REQUIREMENTS
DISCUSSION	Ch. Dutton suggested moving discussion of PIC lines to front of agenda due to audience interest. Dr. Cunningham presented background regarding questions forwarded to her through ASKEMS regarding scope of practice and transport of patients with central lines, heplocks, non-infusing IV lines and the scope of practice. The current Ohio EMS scope of practice language does not authorize the transport of a patient with established venous access by an EMR or EMT. Patients with peripheral venous access require an AEMT and patients with central venous access require a paramedic. Central lines have evolved since these rules were written and things like PIC lines did not exist. The other caveat is that the Board was operating solely under ORC 4765 and OAC 4765 when these rules were promulgated. Since then, the EMS and the Ohio Medical Transportation Boards have merged. There are still some variances between 4765 and 4766 and what rules apply. After 9/11, discussion of EMS's role in patient evacuation was considered. Now many treatment modalities are done on an outpatient basis that previously would not have been. The Board developed a position paper regarding transport of patients with pre-existing devices (not for interfacility transport) for emergent 9-1-1 transport or patient evacuation from healthcare facilities due to disaster. For EMS to transport someone with a heplock, there needs to be an AEMT or paramedic on board. However if using an ambulette, anyone may be transported because the provision of medical care is not anticipated and ambulettes do not fall under the scope of practice. Ambulettes are typically for someone who needs a ride to a destination for non-emergent care. This creates a conflict when a patient with this transportation need is unable to sit, ambulate, or use a wheelchair. Due to the need for a stretcher, this group of patients will require an ambulance for a routine transport. If they happen to have established IV access, then an AEMT or Paramedic is required for their transport to a site of non-emergent care. Dr. Charlton brought up the fact that, in the Cincinnati area, it is very difficult to get medical transportation period let alone specialty teams. He felt that a paramedic is required if something is infusing into the IV. However, if someone has had a PIC line for 3 weeks and is just going to dialysis, he didn't see why a basic EMT shouldn't be able to transport. If someone has had an indwelling device for some time and nothing is running through it, an EMT should be able to transport. Dr. Cunningham stated that if that patient could walk, they could go by ambulette and it would not be an issue. This committee cannot change rule or law but can make recommendations to the Board. If the recommendation is accepted by the Board, recommended change would go to the Rules Committee which would draft the rule to meet the target goals, the rule(s) would then go back to the Board for consideration, and then to the public for comment. The question was raised whether this was a scope issue or a law issue. Dr. Cunningham stated that the scope of practice does not permit the transport of patients with any form of intravenous access below the AEMT level and that she would check to see if this issue is governed by the ORC or OAC. Dr. Schwerin discussed the difference between providers who are providing an emergency service versus those providing a transport service even at the interfacility level.

Dr. Cunningham stated that the Critical Care Committee wants the current scope to be maintained for interfacility transports. The best chance of success in addressing this issue is if this committee addresses the scope as it relates to routine transports for routinely scheduled appointments and discussed the reasoning behind that position.

Discussion continued regarding various types of transport situations. If there is nothing infusing through the IV, the Medical Oversight Committee recommends that an EMT may transport in a routine setting. This would include patient transport from hospitals to extended care facilities (ECFs), patients with PIC lines discharged from the hospital who are going home or to rehabilitation centers/ECFs, rehabilitation centers to hospitals for appointments, and patients returning home or to rehabilitation centers/ECFs.

Discussion regarding wording ensued. The description entertained to be used was the scenario of no anticipated medical treatment for routine transport but unable to sit in a wheelchair instead of "routine". Transports involving emergency department to emergency department, emergency Department to inpatient, inpatient to inpatient, emergency department to inpatient, or inpatient to long-term acute care facilities (LTAC) if device/IV is in place would require medical personnel with the psychomotor skills, training, and scope of practice to use the IV, e.g. paramedic or nurse. If no infusion is running and transport is from the inpatient to subacute setting (for example rehabilitation center, nursing home, transitional care, residential), or if no infusion is running and it is a scheduled event (for example, doctor's appointment, dialysis, rehabilitation center, radiology appointment, diagnostic testing, outpatient procedure), then the patient may be transported by an EMT, and a nurse or paramedic would not be required. This is a separate scenario and discussion from a patient who activates the emergency response system (9-1-1). It was agreed to take these concepts to the Board so they can move forward with writing the rules and then to the review process, including review by this committee to make sure the intent is included in the rules. Motion to take this language to the Board. Marc Marchetta moved, Dr. Charlton seconded. None opposed, all in favor (Dr. Schwerin abstained).

A Committee member inquired about the education required on infused medications and whether it should be focused on a class or category of medications or on a specific drug. The Committee was informed that the EMFTS Board does not delineate the mode of training required, but advises that the training provided should be on a specific drug. There are some medications, some of which the EMFTS Board has cited, that truly require a nurse to administer and, if infusing, to accompany the patient during transport rather than managed by a paramedic. If a mobile intensive care unit (MoICU) is unavailable, the addition of a registered nurse to an ALS unit will make the staffing of the transport unit equivalent to that of a MoICU. Although the staffing is equivalent, an ALS unit with a nurse in an ambulance is not legally a MoICU as OAC4766 and OAR 4766 include required vehicle specifications for MoICUs that are not met by ambulances.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Take language to Board for rules changes.	Chairman Dutton	October 19

TOPIC	COMMUNITY PARAMEDICINE
	Mr. Dutton introduced Dr. Zeeb to speak about his EMS system's proposed community paramedicine plan. Dr. Zeeb stated that there are two components: the community assistance aspect and dealing with repeat runs. He stated that they are often invited into patient homes for various services beyond emergency medical services. Many patients will call 911 because they know someone will show up. They are also seeing increases in drug abuse and behavioral health. They have developed programs were they can assist their communities, and the reception has been good. The other component is how they might be able to partner with healthcare institutions and help them meet their needs. They work with Mt. Carmel East which has one of the busiest emergency departments and services zip codes with the highest CHF recidivism rates. There is tremendous interest in population health, and they have been looking in to ways to partner with Mt. Carmel East in community paramedicine. They have come to terms and built protocols and a draft contract. Their interest is to do a pilot with Mt. Carmel Health and to offer similar services to the other health systems in town. The draft contract was submitted to the Ohio Attorney General's office for his opinion in July. That opinion was very favorable and included wording that EMS providers had immunity even though the paramedics were not functioning in an emergency circumstance. One issue raised by the Attorney General was the potential that there might be an issue with the scope of practice as defined by the State. Dr. Zeeb stated that when he looks at community paramedicine and the scope of practice, he sees community paramedicine as mostly a cognitive service. They expect paramedics to evaluate patients and to make treatment decisions in concert with the patient's physicians and with him as the medical director. When he looks at the scope of practice, he only sees one thing listed in scope that he would consider as cognitive. Everything else is procedural. There are indications that there are cognitive processes that occur in order to make these treatment decisions; however, to him, the only real cognitive function within the scope of practice is the interpretation of the 12-lead echocardiogram. Dr. Zeeb stated that he has looked at the scope many times found that there is nothing that he can find that prohibits an EMS provider from performing a physical exam, obtaining a history, and making clinical decisions. He believes that paramedicine, in its current state, is primarily making decisions and recommendations based upon a patient assessment. His project team has reached a position where they have a draft contract upon which all parties involved have agreed; however, the Attorney General has brought up issues regarding scope. In Dr. Zeeb's opinion, the scope of community paramedicine is very broad. A lot of people are talking about community paramedicine and are interested in different components of community paramedicine. He works for a professional group that provides emergency services. They employ over 30 mid-level practitioners, half of whom are physician assistants. To work with a physician assistant, he must have to have a Physician Assistant Utilization plan on file with the State Medical Board. From his perspective, if we are talking about community paramedics, it is an opportunity to mirror this model, at least as a first step, until the Board is able to deal with the scope of practice issue. Dr. Zeeb submitted a community paramedic utilization plan to Executive Director House and attached their protocol. The protocol document includes information on their proposed community paramedicine training requirements, performance improvement measures, the disease entities they want to follow with their patients, and the forms they want to use with them. They currently have 3 providers training to be community paramedics to their standards and have a 4th in training. Dr.

Zeeb hopes that the Committee would look at the utilization plan and give the opinion to the Board that this is within scope. If the Board would approve it as being within scope, Dr. Zeeb's project team would be in a position where they could sign a contract and begin providing additional services.

Ch. Dutton noted that Dr. Zeeb's 75-page community paramedicine utilization plan was not forwarded to the Committee members by the time of the meeting, but he advised the Committee that he would forward the link to all of the members to review. He asked Dr. Zeeb to provide additional discussion with regard to the scope of practice and the implications on providing cognitive services.

Dr. Zeeb stated that it was his opinion that community paramedicine is a new landscape paramedics. One may not want the guy who is best at intubating and resuscitating patients. For community paramedicine, one may prefer the guy who will sit there and talk to the patients or the guy who, after the cardiac arrest, spends some time consoling the family rather than packaging up and abruptly departing the scene. He believes that guys with good clinical skills who have good gestalt when they walk in the room have the potential to provide service that is much broader then what our initial capacity and capabilities. He reported that he has been struggling with how the Board defines scope of practice in relation to community paramedicine since there is no defining curriculum and no defining quality metrics yet. If one does not have a training program and are still looking for the metrics to measure, how is the Board going to identify scope of practice? What is the knowledge base that is expected?

Dr. Schwerin inquired if one actually had to redefine the current scope of practice because this sort of practice does include previous training of the paramedic which would entail assessment skills like the psycho motor and all that so do you actually need to redefine the scope for this?

Dr. Zeeb reported that he is trying to force the issue a little bit because they have EMS providers waiting who are ready to provide community paramedicine, and he is asking the Board to approve a specific set of procedures and protocols until the Board makes a statement regarding what community paramedicine is and what is going to be allowed.

Dr. Cunningham stated that the Committee needs to take a look at this document, which is about 75 pages. The Board is going to be looking for guidance from this Committee based on our review of that document. Dr. Zeeb's proposed community paramedicine utilization plan will be distributed to the Committee members with the goal of discussing it in December. There may even be a need to schedule time during the Board retreat in February. Dr. Zeeb stated that it is his hope that, if this plan is permitted or approved, it would be available for others in central Ohio as they are interested in collaborating and developing it together. If the Board determines that it is not a scope issue, then that is all that they need to know. They cannot sign a contract until the issue of scope of practice has been addressed.

Dr. Cunningham reported that the next Medical Oversight Committee meeting is in December. She advised that , if the Committee is going to make a recommendation to the Board, the plan will need to be included in the next Board meeting packet or the discussion of this topic will need to wait until February.

Ch. Dutton noted that it is not the Committee's role to view and approve specific plans or programs as a committee or board. Instead, the Committee should be reviewing the plan specifically to determine if the plan falls within the scope of practice.

Dr. Cunningham reiterated Chairman Dutton's statement highlighting the fact that the question that needs to be answered is simple. She asked the Committee membership if everyone thought that they would be able to read the plan before the next meeting. For those who review it, each member should be able state their assessment of it in one of two statements: "Yes, it is within scope" or "No, it isn't within scope". With regarding to mobile integrated healthcare, Dr. Cunningham made the Committee aware of several initiatives that she plans to share with the Board during their October meeting. Several advisories will be going to the Federal Interagency Committee on EMS and potentially presented to Congress. As a member of the National EMS Advisory Council (NEMSAC), she co-authored one of the advisories on community paramedicine and mobile integrated health care and will be presenting it December 1st and 2nd at the NEMSAC meetings. The draft advisories will be posted in the Federal Register and available for public comments. NEMSAC will need public comments, and they will need to be submitted soon. She is informed the MOC and the Board of this as the public comment period will close prior to the next MOC meeting. In addition, other advisories will be asking NHTSA, FICEMS, and Congress to take a look at creating national standards, education curricula, and data collection for mobile integrated health care.

There was a discussion regarding crossing jurisdictional boundaries and mutual aid agreements in providing services in a non-emergency setting and the differences between community paramedicine and mutual aid agreements. There are possible issues regarding using tax dollars from one jurisdiction to another jurisdiction. Per Executive Director House, through the intrastate mutual aid compact, all public assets can be shared (no written mutual aid agreement necessary) as long as assets are requested by the jurisdiction needing the asset (no self-deployment). The first four hours of mutual aid is gratis. Response exceeding four hours may involve reimbursement of costs incurred. These agreements cover immunity, workers compensation, reimbursement, command and control and licensure. The Attorney General's opinion states otherwise with regard to community paramedicine. IMAC language was not included in Attorney General's opinion. With respect to the scope issue and the way the law was written, it really leaves the Board out legislative authority except with respect to the need to have a medical director and to comply with the EMS scope of practice. If beneficial patient care parameters are identified that are outside of the scope, we will work with the Board to get them into the scope. Training and curriculum for community paramedicine is a challenge. Community paramedicine requires different types of skills and a different type of training. The Board and the Division of EMS need to make sure that community paramedics are getting the proper training to do what is added to the scope of practice. Executive Director House stated that the first step is an evaluation to determine whether what a community paramedicine program is proposing, to determine if there are beneficial skills that lie outside the scope, and to work with the Board to add those parameters to the scope. Although he was unable to speak for the Board, he has found that the Board has been very supportive of the community paramedicine over the last couple of years and the Board and the Division of EMS ill work with the Committee to get this done.

Ch. Dutton reported that he will send out the links to the proposal and the AG opinion to the membership of the OC and to the EMFTS Board.

	Exec. Director House noted that although the Ohio EMS scope of practice matrix is on the website, he strongly advised everyone to review the rules in addition to the matrix. Ch. Dutton made the Committee aware of the recently released draft AHA standards for 9-1-1 dispatcher-assisted CPR. There is a public comment period until November 16th. Individually if you want to comment or as a committee… Dr. Cunningham stated that she felt that individual comments are more appropriate rather than a unified MOC statement. In addition, the MOC functions under the authority of the EMFTS Board.

Motion to adjourn was made at 11:39 a.m. by Mr. Davis, seconded by Dr. Schwerin. All in favor, none opposed. Motion carried. Next meetings: (Bi-monthly, TUESDAY before the third WEDNESDAY of the month at 9:30am except for December which is the Tuesday before the second Wednesday)

- Tuesday, December 13, 2016.

MINUTES APPROVED

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Geoff Dutton, Acting Chair Date