MEDICAL OVERSIGHT COMMITTEE MEETING			
MINUTES	**DATE** December 13, 2016	**TIME** 9:32 a.m. – 11: a.m.	**LOCATION** ODPS – Division of EMS, Room 1101 1970 W. Broad St., Columbus, Ohio 43218
ATTENDEES	Committee Members: Geoff Dutton – Chair, Dr. Thomas Charlton, Deanna Dahl-Grove, James Davis, Martin Fuller, Mark Marchetta, Brent Parquette, Dr. Daniel Schwerin, Tami Wires, Allen Young. ODPS-Division of Emergency Medical Services (EMS) Staff: Dr. Carol Cunningham, Executive Director House, John Molnar, Susan Edwards. ODPS Staff: Ron Wehner. Visitors and Guests: Dr. Paul Zeeb, Phil Koster, Kent Appelhans, Matthew Wells, Tom Edminson, Joel Dickens, Deanna Harris, Barry Seth.		
ABSENT	Dr. Eric Cortez, Eric Wiedlebacher.		
AGENDA TOPICS			
TOPIC	**Announcements and Introductions**		
	Reminder that the Division of EMS needs the new committee member applications and a copy of their resumes by December 15, 2016.		
ACTION ITEMS		**PERSON RESPONSIBLE**	**DEADLINE**
Approval of Minutes (October 2016)			
	Meeting minutes from the October 2016 meeting were presented for approval. Corrections to attendees – Dr. Cortez should be added to attendees, and Dr. Dahl-Grove and Mr. Davis should be removed from the list of attendees. Motion made by Dr. Schwerin, seconded by Dr. Charlton. All in favor. None opposed. Minutes approved.		
ACTION ITEMS		**PERSON RESPONSIBLE**	**DEADLINE**
None			
OLD BUSINESS			
TOPIC	**Community Paramedicine**		
	The topic of Dr. Zeeb's proposed regional community paramedic program's protocols was presented at the last Board meeting. Following a discussion, the Board and legal counsel did not feel that the Board can approve protocols or procedures, and that their legislative authority is limited to scope of practice which has been answered. Dr. Zeeb agreed to report back after the program has been operating for 6 months or so. Dr. Cunningham reported that the advisory on community paramedicine and mobile integrated healthcare that had been anticipated to move ahead at the National EMS Advisory Council (NEMSAC) meeting was tabled until the April meeting. Once this advisory is finalized, there should be a better idea of where community paramedicine is heading nationally. Funding was provided for the revision of NHTSA's EMS Agenda for the Future and the National EMS Scope of Practice Model documents. It is hoped that the scope of community paramedicine will be part of that revised document. Discussion ensued regarding the compendium on mobile integrated healthcare that was included with Board packet for the EMFTS Board to review.		

	Director House encouraged people to continue to bring scope of practice issues and questions before this committee and the Board. He also brought up proposed language that would modify and add a definition of non-EMS organizations which is currently lacking in the Ohio statute and that requires among other things, a medical director that meets the qualifications to serve as a medical director of an EMS agency. For organizations that are non-EMS and do strictly community paramedicine, the proposed language would permit a medical director with a non-EMS background. A discussion ensued regarding post-op wound care and soft tissue management as it pertains to scope of practice and education and training components as well as training in general for community paramedicine. Deanna Harris, the EMFTS Board Chair, stated that the goal of the language within the mobile integrated healthcare legislation was intended to be enabling. It was purposely left vague as to training for specific duties and medical direction. It is important to know what the needs are based upon the services that each department wishes to provide. Director House observed that the law does not give the EMFTS Board any authority over anything other than scope of practice and requiring medical directors. Training is currently in the hands of the medical director but may not exceed the Ohio EMS scope of practice. Mr. Marchetta questioned the difference between community paramedicine and home healthcare and how to delineate the two. Dr. Cunningham pointed out that every community paramedicine program would be different because every community has different needs. The NEMSAC advisory on community paramedicine and mobile integrated healthcare is extensive. If it moves ahead at the next NEMSAC meeting in April, there will provide a better idea about the direction community paramedicine and mobile integrated health care will take on a national level, and it will clarify the scope of practice. Mr. Davis applauded Dr. Zeeb and the presented protocol. He suggested it be held up as a model, and that we should thank Dr. Zeeb for his work. The legal liability of crossing jurisdictions was briefly discussed as cited within the Attorney General's opinion as well as the need of mutual aid agreements and a guidance for billing for services in another jurisdiction. A timeframe was discussed for when Dr. Zeeb would able to provide feedback to the Board. Dr. Zeeb responded that it would be at least 4 to 6 months anticipating August as a probable time frame. Dr. Cunningham suggested the board retreat in February 2018.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Dr. Zeeb to bring feedback on program to the 2018 board retreat.		

NEW BUSINESS	
TOPIC	**CHANGE TO SCOPE OF PRACTICE – TRANSPORT REQUIREMENTS**
	Geoffrey Dutton introduced Mr. Phil Koster, Vice President of Medcare Ambulance, whose letter was included with the committee meeting information to discuss further the committee recommendation and the Board's decision on transporting patients with capped IVs by EMTs. Mr. Koster explained that this decision puts a greater strain on ALS

	resources which may be limited. He noted the Board's decision to require a medic for the transport of a patient with an IV lock as a sole determinant for going to a higher level of care or to be admitted. He felt it seemed counter-intuitive that EMTs may transport in one case but not in the other. If there are concerns that the IV may come out and there is a bleeding control concern, that issue may easily be remedied by training. The additional issue is that of transporting from a lower level of care to a higher level of care indicates that the patient has a higher acuity. He felt that the patient's acuity should drive the determinant of paramedic attendance not solely on the PIC line procedure. Mr. Koster referred to many cases including psychiatric patients who are being transported from point A to point B. With the emergence of free-standing emergency rooms, he is seeing more patient transfers. As far as a patient needing to be admitted for observation or otherwise for very low acuity, such as in a case of cellulitis, this is now taxing the system and the tax payers because Medicare and Medicaid are being billed at the higher rate. Mr. Koster said he did some research prior to the meeting which he included in the letter. Nationally, he felt that this is becoming a standard practice. He is waiting to hear back from states that have yet to respond, but he felt that the status indicates that Ohio is out of the norm in regard to the issue of transporting a patient with a heplock. Dr. Cunningham asked for more information on the source of this information. Mr. Koster reported that information came from head of each state agency handling EMS which varied by state. Dr. Cunningham gave overview of the many phone calls and emails she received because she wrote the memo regarding the Board's decision, and comments she received both supported the position and opposed the position. During the original discussion, it was a question of if the patient needed treatment during transport, i.e. if they were sick enough to be going to a hospital or higher level of acuity, then someone in the back of the squad should be able to handle complications. That is outside the scope of practice for an EMT basic. The rule was written for the whole state not just select municipalities. One Ohio county has no hospital and multiple agencies that have over a 45-minute drive to get to a hospital. Forty-five minutes or more is a long time if a patient deteriorates and you don't have the ability to treat them. The other issue was that, although a lot of transfers come from emergency departments, a lot of them are interfacility transfers (inpatients). It is a rarity that non-emergency department medical staff physicians have any idea about the scope of practice for an EMT or any other EMS level. The doctor on call gives a verbal order to transport and they don't care how the transport happens. They just want the patient out of the hospital not realizing their EMTALA obligation and that they are responsible for that patient until that patient arrives at the receiving facility. The other issue is the need for education which the Board embraces. As the scope of practice is expanded, the intention is to also expand education. We have less control over hospitals because Ohio is the only state in the nation that has no state accreditation for hospitals. Some of the states that allow interfacility transport of patients with PIC lines have more control over what the non-emergency physicians are doing because they have more control over the hospitals. Also, states that have allowed EMTs to transport have some form of education at varying levels based on how far they have to transport. Dr. Cunningham and the Division of EMS received tons of phone calls about this which is why an information sheet was subsequently posted on the website. Executive Director House added that the decision was up to the Board and that the Board carefully discussed at the last Board meeting. The Board decided to reevaluate

this topic and move further as time goes on. The consensus of the Board was that they wanted to do what was right for the patient.

Dr. Cunningham stated that she had a conversation with from Ohio Health's legal counsel. After listening to the reasoning behind the Board's decision, he said he fully supported it and felt that this was the best way to protect the patient considering that the state has no control over transferring physicians who either don't know or don't care about EMTALA regulations.

Mr. Davis affirmed that this decision is a Board decision, but noted that there is an action item from a constituent in front of the Medical Oversight Committee, and that the Committee needed to make a motion, and under discussion of that motion have this discussion, and make a recommendation to the Board. Then based upon the Committee's recommendation, the Board will consider making a decision at their meeting tomorrow. This decision was debated last month, and it was not done with the intent to cause harm to the transport industry. According to Mr. Koster's letter, there was an unintended consequence. The question for the Committee is if the result has caused an unintended consequence that is impacting patient care or is there something else that the Committee should examine. Mr. Davis made a motion that the Medical Oversight Committee make a recommendation to amend the scope of practice to include capped IVs. He stated that if someone seconded his motion, it could be discussed. He felt that the decision for transport should be made on the condition of the patient and not the destination.

Dr. Schwerin seconded the motion.

Mr. Dutton observed that the motion would need to be more than that because the Board's decision regarding the expansion of the EMT scope of practice had already happened. The question is whether consideration of the destination should be part of that determination.

Mr. Davis disagreed.

Ms. Wires pointed out that the decision from last month increased the scope of practice. She stated that the problem is that, prior to the Board's decision, transport of patients with heplocks by EMTs were taking place even though it was outside of the scope of practice.

Dr. Cunningham thought it would be a good idea to gather more information from the other states regarding scope and training provided for transport.

Mr. Dutton asked that the motion be repeated. The motion was restated as follows: To amend the scope of practice for an EMT Basic to be allowed to transport a patient with a capped IV access without discrimination to destination.

Dr. Schwerin discussed the benefit of allowing EMTs to transport low-risk patients and the impact of free-standing emergency departments. He also said that NHTSA, in their paperwork, already says it is within the scope of an EMT to transport. Dr. Cunningham reported that transport of patients by EMTs with IVs in place is not included in the current edition of NHTSA's National EMS Scope of Practice Model.

	Further discussion ensued regarding transport issues, problems associated with transport, and unintended consequences of the policy. Executive Director House asked if there were other parameters that could be set that would help drive patient condition as the determinant. Continued discussion of patient care and the effect of the unintended consequence of delay of care. Discussion of understanding by physicians regarding the scopes of practice of EMTs and AEMTs. A suggestion was made to amend the motion to hold the discussion of this topic for Board Retreat to allow for research and more time for discussion. Mr. Davis declined to amend motion and stated the committee had a responsibility to present the motion to the Board at the next meeting. The motion on the table to remove the destination element due to unforeseen circumstances that may include delay in patients being transported, increased cost to customers, increase in difficulty staffing and maintaining status of vehicles for private transporting companies, and an unnecessary utilization increase in use of 911 response to local communities. Mr. Davis stated that he felt that the decision was not based on anything other than speculation. Suggestion was made to vote on the motion and take to Board for a decision. Ms. Wires abstained. All in favor, none opposed.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Take language to Board for rules changes.	Chairman Dutton	December 14

Motion to adjourn was made at 11:30 a.m. by Mr. Marchetta, seconded by Ms. Wires. 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, February 14, 2017 – Cancelled
- Tuesday, April 18, 2017
- Tuesday, June 20, 2017
- Tuesday, August 15, 2017
- Tuesday, October 17, 2017
- Tuesday, December 12, 2017

MINUTES APPROVED

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Geoff Dutton, Acting Chair Date