

10/21/11

To: DMAT PA-1 Medical Staff, Physician Members

From: Keith Conover, Team Medical Director

Subject: DMAT PA-1 Medical Staff assessment and capacities

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It is said that it is better to self-regulate than let the government regulate you. Well, we don't have a lot of choice about how the government regulates *us*, but there is one relative lack of regulation within NDMS that we might want to address ourselves. At least that way when NDMS finally regulates it, it won't come as such a shock.

I'm talking about clinical credentialing of our medical staff. Yes, currently NDMS has some credentialing, but it's only to make sure that you have the minimum credentials for your job.

Traditionally, to the NDMS, a doctor was a doctor, and a mid-level was a mid-level. It didn't matter if you're a primary care physician, an emergency physician, or a pediatric hematologist.

This ends up with occasional mismatch between our capacities as providers (=docs + midlevels) and the demands of a DMAT. DMATs do many different things – provide an ED-in-a-tent, expand an ED when demand peaks, provide primary care for those in an area without it, provide backfill to hospitals whose medical staff has been decimated, provide care at shelters, now even provide critical care transport and likely other teams for special needs. While all DMAT docs and mid-levels try to keep up with appropriate skills, it's not always easy, and there's little guidance as to what is needed and how to get the training. Yes, yes, we all need to know how to set up tents, site a BOO, and care for generators and other DMAT equipment, but I'm talking about *medical* skills.

We've done some internal team training and credentialing with skills such as airway management, ventilator management, use of monitor/defibrillators, and wound closures. But there's much more than this that we providers are expected to do.

NDMS is working on credentialing right now. (With the new Critical Care, Primary Care, and Acute Care teams and the like, we're already started that way.) But if we can start working on the same issue within DMAT PA-1, we'll be in better shape when NDMS starts system-wide credentialing.

To further this idea along, starting with the next meeting (November 17) we will be having DMAT PA-1 Medical Staff meetings from 6 PM to 6:30 PM right before each regularly-scheduled team meeting, in or near the meeting room for the regular DMAT meeting.

I'll email a summary of each meeting to all on the medical staff. If there is demand, maybe we can get the meeting teleconferencing set up early so that those of you unable to physically attend may participate. Let me know.

A tentative agenda for the group includes the following issues.

1. Should Medical Staff meetings be limited to physicians, or should they include mid-levels?
2. What should be the core capabilities of a DMAT doc or mid-level?
3. What are the best ways for DMAT providers to document their capacity to perform these skills?
4. What are the best ways for DMAT providers to bring themselves up to snuff in the appropriate skills, and to assure that these skills are retained?
5. For DMAT-useful skills beyond the core, how do we similarly document and train for these?

My initial thought is that we might try to develop a self-assessment tool.

We could, for instance, look at the skill lists used by hospitals in credentialing emergency physicians and mid-levels working in the ED, as that would likely correspond well with much of what DMATs do. But such hospital-based credentialing may not include skills needed in primary care, which is much more of an office-based specialty, and a fair bit of what we do. Perhaps one of you knows of some good primary care credentialing tool that we might plagiarize.

I have gone through some of my old emergency medicine credentialing documents and below you will find a *very rough* list of possible skills we can discuss.

We aren't going to expect all DMAT providers to have all the skills of a board-certified emergency physician. However, we may come up with a certain core of emergency medicine skills, plus some primary care skills, slanted to the DMAT environment. We could then work on helping all our provider colleagues to achieve and sustain this level of skill.

There are just some thoughts to get us started. Please bring other ideas to the meeting to discuss. Keep in mind the end-goals: to improve the quality of service we provide, and to make the DMAT experience more satisfying for all of us.

Thank you very much.

Topic	Basic Core?	Extended Core?	Specialist?
Abscess incision and drainage			
Analgesia (including IV medications)			
Anoscopy			
Arterial cannulation for monitoring			
Arterial puncture for blood gas			
Arthrocentesis			
Bartholin cyst incision and drainage			
Bladder Catheterization			
Burns: management (general)			
Burns: escharotomy			
Cardiac defibrillation			
Cardiac pacing (external = transthoracic)			
Cardiac pacing (transvenous)			
Cardiac Resuscitation (including defibrillation and synchronized cardioversion, ACLS drugs)			
Closed reduction of hernia			
Contrast injection for imaging			
CPAP and BiPAP management			
Cricothyrotomy			
Culdocentesis			
Cystourethrogram			
Delivery of newborn			
Dislocations: closed reduction			
Electrocardiogram interpretation			
Electrolyte and metabolic management			
Endotracheal intubation (oral, nasal)			
Eye examination: Slit lamp (including foreign body removal)			

Eye examination: Wood's light			
Fecal occult blood testing			
Foreign body removal: cutaneous, nasal/otic, and corneal/conjunctival			
Fracture splinting with plaster and fiberglass material			
Fractures: closed reduction			
Laboratory study interpretation (iStat common studies)			
Local anaesthesia			
Lumbar puncture			
Nail removal			
Nasal cautery and packing			
Nasogastric intubation			
Nerve blocks: digital, facial, dental, other regional blocks			
Neuromuscular blockade			
Ocular tonometry			
Oxygen therapy			
Pediatric resuscitation			
Percutaneous transtracheal jet ventilation			
Pericardiocentesis			
Pericardiocentesis			
Prehospital Airways (Combitube, King LT)			
Procedural sedation			
Proctoscopy and sigmoidoscopy			
Psychiatric evaluation and therapy			
Radiographic study interpretation			
Removal of Cerumen (curette, irrigation, suction)			
Respirator management			
Sexual Assault examination collection of specimens			
Sexually transmitted diseases evaluation and treatment			
Spinal immobilization and clearing			

