

**Medical Direction and Practice Board**

**19-Jul-06**

**Minutes**

**In Attendance**

**Members:** Steve Diaz, David McKelway, Matt Sholl, David Ettinger, Paul Liebow

**Staff:** Jay Bradshaw, David Kingdon

**Guests:** Paul Marcolini, Jeff Regis, Dan Palladino, Warren Waltz, Robin Overlock, Lori Metayer, Joanne LeBrun, Rhonda Chase

<b><u>Topic</u></b>	<b><u>Discussion</u></b>	<b><u>Action(s)</u></b>
1) Pan Flu	This is one of our annual objectives. Kingdon presented a draft he is working on on EMS and Pan Flu. This is an effort with coordination with OPHEL, Maine CDC, MEMA, et al. Issue of protection for families of EMS personnel as well. Lebrun had attended a public safety meeting the day before and they advocate for family protection, for some responses to have EMS personnel trained to vaccination administration level, because of potential reduction in work force could MDPB look at protocols for provider initiated patient sign-offs and/or EMD sign offs if necessary. McKelway voiced that we need to be sure that EMD is part of this process and what is the current EMD process? EMD is currently in the Rules process and also noted that teletype may be useful in this realm. We discussed many aspects of what new protocols may do and/or mean, but what is the threshold for implementation? If the system (which includes public health, hospitals, etc.) is operating at 80% capacity, is that business as usual? At what point do we need to "off load" and how do we do that? do we have graduated responses, and how do we know when to implement which level of graduated response? Current stockpiles of PPE will diminish	Lots of issues: First step to reach out to Maine CDC, and see how they are templating their response and how do we fit. Attend Sept 20, 2006 conference. Diaz and Bradshaw can let Maine CDC know providers and administrators have concerns, but also that they have encouraged those with concerns to come forward to the Maine CDC. Will need to eventually reach out to RRC's and MHA and others.

	<p>quickly. Need to discuss this with Maine CDC, MHA, RRC's and probably others. LeBrun shared that one hospital in her region is looking at investing \$150,000.00 for PPE. How can Maine CDC help us with their 211 hotline, if it is going to be used in this venue? Can we extend use of PPE, specifically reuse N95 masks? What happens to those who transplant to maine in this crisis? What happens to OLMC and should we again have the discussion of regionalized OLMC? How do we morph standing orders, do we have traditional and then extended? discussion of MDPB members attending Sept 20, 2006 conference which does conflict with this meeting- - and we need to see if the conference has specific sessions which might meet our goals. LeBrun shared her questions and concerns with Maine CDC and Diaz and Bradshaw responded that they can present MEMS side of things but not in a position to critique Maine CDC-- if providers have specific issues, either individually or as groups they can share this with the Maine CDC.</p>	
2) Minutes from June 2006	First by McKelway, second by Ettinger All in favor	Minutes Accepted
3) Legislative, Budget, EMStar	Bradshaw updated that no changes in legislature or budet and that EMStar work continues	No Action

4) OLMC

Presentation by Sholl for Busko;  
After the presentation, the following comments were offered--  
1) LeBrun asked if there was a way we could add audio to the presentation and commented that the information in the notes section of the presentation could be included by adding audio. I mentioned to her that I had similar thoughts. The comments you've added in the notes section of the powerpoint presentation could be the dialogue for an audio section. Diaz mentioned when we get toward the end of the process, we should sit down with some IT folks and figure out the logistics and technology part.  
2) Regarding our questions about how to include the protocols, Marcolini suggested that the final version have a hyperlink to the ME State protocols. We thought about this more and the idea of a formatted version of the protocols with menus that easily move someone through the protocols was brought up. This could be packaged with the presentation on a website and could act after the fact as a web-based reference for OLMC officers to use "on the fly".  
3) Another suggestion was to add an audio file that acted as an example of communications between OLMC and a pre-hospital provider.  
4) Sholl mentioned our questions about the ME specific data. Bradshaw is going to send us an informational presentation he put together that should include all of our questions. People were also interested in having us add information about the resources specific to each region as well as adding a bit on the differences between a service licensed at the paramedic level vs. a service with a paramedic permit. People were also interested in having a bit more information on provider's level of

Sholl and Busko will follow-up on the comments offered, and we will look for further clarification this fall.

practice - in specific, levels of care that are a bit less familiar such as the critical care technician and, when up and running, the PIFT level of training. Other good ideas were to introduce the concept of the ME QI program and the ME EMS Database as a resource for OLMC providers and to introduce regional projects specific to EMS such as the CPAP project.

5) There was a discussion about permissible orders. The general thought was that we may want to temper this slide to ensure we make known the MDPB's stance that permissible orders should be dissuaded. The fear is that we may see OLMC providers moving way beyond the protocols and offering paramedics potentially dangerous options in the field - such as medication assisted intubation. Apparently Maine is different than many states and OLMC is not covered by malpractice insurance BUT the OLMC officer is protected as long as s/he stays within the established EMS protocols. A caveat came up that if a OLMC officer DOES decide to move beyond the protocols, the paramedic must agree to the option and this option is a one time order (ie it does not become a standard practice). Bradshaw is going to get the statute for us that notes OLMC is not protected when acting outside the protocols. Lebrun asked if we thought it helpful to add in a list of things that were not in the protocols (such as medication facilitated intubation). 6) The next discussion point surrounded the EMTALA Slides. Sholl's comments to the group were that we may want to further define what EMTALA is and what it means to Emergency Medicine practitioners. Another suggestion was to further define the

implications on EMS and OLMC - ie: in sign off's and the ideas of informed consent and capacity. Perhaps this would be a good place to bring these concepts up and concretely define what we see as the steps to a patient sign off in the presentation? Diaz mentioned we should use the verbatim verbiage from EMTALA that "any patient has a right to an appropriate medical screening exam to rule out emergency medical condition" instead of what is in the presentation currently. Implicit in this is that the exam is performed by a physician or mid-level provider. This gets us to the issues of no transport and perhaps we should be a bit more directed here regarding the rules surrounding patient no transport. 7) The next major point we discussed was the "Statement from the MDPB" section. The overall thought was that these are tremendously difficult situations to deal with and no one answer exists for these dilemmas. The overall suggestion was to use this section to further flush out the practice of patient sign-offs (including the concept of capacity and informed consent). It was further suggested that the situation posed in the slides (ie: minor involved in accident with no apparent injuries AND the intoxicated patient refusing care with obvious injuries) were perhaps two of the most medico-legally difficult situations and that even a discussion about informed consent and capacity may not capture the true difficulty of these cases. Diaz suggested we poll the MDPB members about their approaches to these situations and attempt to add some personal experience to this section - such as the practice of talking directly to the patient on line in an effort to persuade them to come to the hospital. Finally, the concept of

transporting against will come up as a topic that should be addressed. 8) Add a bit about definitions and the Brown Section. 9) QI system nutshell. 10) Projects, eg CPAP and IO. 11) Expectation of when run reports left in the ED. 12) Lastly - discussion of the idea of the test and it was suggested that the test be case based and the topics be based on the most common EMS complaints in Maine. Beta test this perhaps through the MMC EM residents

5) CAC	Renamed HART and has partnered with MQF; adopted MEMS QI recommendations on form and flow of paperwork	Will continue to report out here
6) PIFT	In Beta testing	No new actions, beta testing to continue
7) MEMS QI	Meeting this afternoon; Airway begins Sept 1, 2006; 12 lead in 2007 after roll out of standardized training for Maine	Will continue to report out here

8) Annual Goals	Reviewed the list, looking for medical directors to volunteer for sections. LeBrun voiced that the process never finished completion in review but Diaz thought that we had discussed that our process which had been outlined would perhaps take 18 months.	MDPB members to give Diaz their preference.
9) NAAK	All our disaster work including NAAK currently in the hands of OPHEP, and they have a change. Will add this to annual goals and see if we can progress here	Looking for direction from OPHEP when appropriate
10) Next Meeting	September Pan Flu conference	Date pending asking MDPB members about Sept conference