

Medical Direction and Practice Board
15-July-2009
Minutes

In Attendance Members: Tim Pieh, Matt Sholl, Peter Goth, Jonnathan Busko, Steve Diaz

Excused Members: Kevin Kendall, Colin Coor

In Attendance Staff: Jay Bradshaw, Jan Brinkman, Jon Powers, Alan Leo

In Attendance Guests: Joseph LaHood, Joanne LeBrun, Norm Dinerman, Ginny Brockway, Sam Clark, Kelsi Bean, Brittany Whittlesy, John Brady, Rick Petrie (Ops. Rep.), Butch Russell, Jeff Regis

Topic	Discussion	Action(s)
1) Minutes June 2009	None	Motion by Sholl with second by Busko to accept, unanimous approval
2) MDPB Member Disclosures	Pieh – Augusta Fire Dept Medical Director, EMT-I for Belgrade Fire and Rescue, ED doc at MaineGeneral; Goth – ED doc at TAMC, CCTI director, works with Lifelight of Maine QA and training; member of Lifelight Foundation Board; Busko – ED doc at EMMC, owner / instructor CDS Outdoor School, LearnMoreSaveLives.com, Emergency Medical Resource Consulting International Inc, medical director Hermon Mountain Ski Patrol and Bangor Police Department Special Response Team; Sholl—Maine Medical Center ED doc, Medical Director for Portland Fire Dept, Chair of Region 1 Education Committee; Diaz – ED doc and Vice President for MaineGeneral, AHA regional faculty and national stroke planning member, medical director of Delta Ambulance	None
3) MEMS Update	Bradshaw updated us – we are in our new fiscal year, and legislature looking for \$100 million dollar in cuts. With a reference to Tim Sample – “The depression would not have been so bad if it did not follow hard times.” Some cost savings measures the MEMS office instituted are now part of a global system measure of cost savings that no longer credits them with these savings. H1N1 and seasonal flu with mass vaccination is a consideration for this upcoming fall, with lead as Maine CDC. MDOC course October 2009 – encouragement to attend. Mental Health Transfers have been suggested to go directly from a home to mental health facility without the primary destination as an ED, and our reply has been the following: “The issue of transporting mental health patients directly from the field to a mental health facility has been raised a few times	Convene a group to answer this specific mental health question can be sought and at this point, the point person is LeBrun.

	<p>recently, and while there are potential benefits of such an option, this is not currently permitted. Patients who are transported by EMS should be taken to the nearest appropriate emergency department where they can receive a medical evaluation before transfer to another hospital.” LeBrun has suggested meeting with stakeholders and Busko has commented that EMS should not be the barrier to move to this model. Diaz reminded group that ED physicians and psychiatrists have been working on a statewide program and process, and thus far, psychiatrists have not been willing in these sessions to forgo a medical screening exam.</p>	
4) BAN	<p>Breath Actuated Nebulizers are becoming more common in both routine care and ED care. Pieh is requesting articles on this topic and Diaz will look into this. Busko states used at EMMC for moderately ill patients and that regular mist nebs for mildly ill patients and continuous nebs with or without Bipap for ill patients. Busko also commented on the use of Nebulized Fentanyl, but at this point, the scope of this discussion is related to medications for nebulization currently in protocol</p>	<p>Request to take this to Operations and Education for consideration and follow-up on this September 2009.</p>
5) Ventilator Update	<p>Pending further discussion as we get our work back from the PIFT survey, airway discussion and critical care discussion. No change as from previous (last meeting), and that a patient who is being ventilated by a vent or person is considered to be in the position as being “beyond PIFT” and should be transported by PIFT paramedic with appropriate second staff person of RN or RT or other appropriate provider that is usually hospital-based save the Lifeflight model.</p>	<p>Further discussion pending other outstanding work.</p>
6) PIFT Update	<p>LeBrun let us know update in process, will be ready for September 2009 MDPB meeting</p>	<p>For September 2009 meeting</p>
7) Airway Update	<p>Shall distributed handout outlining 7 items we should address in our attempt to learn our gap on airway management once some is finished with initial training. In the national EMS scope of practice document, intubation would be only at the paramedic level and not the advanced paramedic level (our EMT-I). Will convene a subgroup to work on this on September 16, 2009 at 8:30 am here at Maine EMS just prior to the MDPB meeting. Pieh had concerns on the emotional response as many providers do link their EMS identity with the ability to</p>	<p>This subgroup will convene at 8:30 am on September 16, 2009 and we will attempt to avoid scope creep. Education of airway as a primary change will need discussion and encourage education committee to bring this to us. Second, medication facilitated intubation difficult to simply plug into our current system, will need this as a separate project that will be held to a high level of training, QI and</p>

	<p>intubate. Busko wonders how we first influence primary education, and although this is a germane issue, it is beyond the scope of what came to us to answer— thus at this point, will keep this focus and this issue will come to us as the education committee digests and recommends to us any changes based upon the national scope of practice and other national EMS initiatives. Busko also wondered about looking at and incorporating medication facilitated intubation, and again, this is germane but beyond the scope of this group. We discussed the benefits and drivers in having us become more aligned nationally with standardization endeavors, including cross state certification, helping other states in emergencies, being able to be compliant with future QI initiatives, and being part of a larger resource conscious medical system.</p>	<p>thus will require some outstanding resources.</p>
8) Critical Care Update	<p>Goth asked for clarification between critical care transport and specialty care transport – specialty care is the definition by CMS on a transport which is anything above the usual paramedic level. Critical care is more out of the UMBC mantra of life-threatening injury requiring specialized training. This does get confusing, and online resource* (at bottom of page) has definitions that can be helpful. If we license a service at the critical care level, who will hold that? – MHA, MEMS? And finally, consideration of moving tools for advanced airway to a CCT level? There is discussion around this at other system levels. Petrie articulated that major issue is that EMS never was ready to tackle the issue of transfers.</p>	<p>Transfer Meeting: 11:30 am to 12:30 pm on Wednesday, September 16, 2009</p>
9) Education Update	<p>Brinkman updated us on training center process moving along with six letters of interest and looking for more; IC curriculum includes separating the instructors from the coordinator levels; involved in Advanced EMT (EMT-I in Maine) discussions; discussing continuing education issues; looking at refresher courses and volume based vs competency-based. Question of how we use the national registry, and we use the registry for initial certification for first responder, basic and paramedic level.</p>	<p>None</p>
10) Operations Update	<p>Bradshaw updated us on possible changes in manner which practical exams conducted and do we incorporate into</p>	<p>None</p>

	responsibility of training centers; possible highway safety projects being discussed; and other items were discussed	
11) OLMC Update	Busko updated us that he has noted that the Maine ACEP site has the OLMC items as downloadable items, and not interactive. Busko has his own site which he will develop into being interactive for this. Also, discussion of how we make this hard-wired for delivering OLMC – that is to say, how can we mandate that providers giving OLMC are successful in completing this educational component. This will need discussions with MHA, Maine ACEP and other stakeholders. LeBrun offered caution her only as regions are approaching EDs and hospitals to connect with them differently this year.	LeBrun requested some CDs of the OLMC program – MEMS office will send out.
12) Roundtable	CPR – a one hour discussion focused around the following 3 papers: <i>A Three Phase Temporal Model for Cardiopulmonary Resuscitation following Cardiac Arrest</i> , Weisfelt, M, Transactions of the Clinical and Climatological Association, Vol 155, 2004, pp 115-122. <i>Minimally Interrupted Cardiac Resuscitation by Emergency Medical Services for Out-Of-Hospital Cardiac Arrest</i> , Bobrow, B <i>et al</i> , JAMA, March 12, 2008, Vol 299, No 10 pp 1158-1165. <i>Defibrillation or Cardiopulmonary Resuscitation First for Patients with Out-Of-Hospital Cardiac Arrests Found by Paramedics to be in Ventricular Fibrillation? A Randomised Controlled Trial</i> , Baker, PW <i>et al</i> , Resuscitation, 2008, 79, pp 424-431.	Good Discussion
13) Next Meeting: September 16, 2009		
* http://www.nhtsa.dot.gov/people/injury/ems/Interfacility/pages/MajorTopic1.htm		