

**Medical Direction and Practice Board**  
**17-September-2008**  
**Minutes**

**In Attendance Members:** Tony Bock, Steve Diaz, Jonnathan Busko, Kevin Kendall, David Ettinger, Tim Pieh, Matt Sholl, Peter Goth

**In Attendance Staff:** Jay Bradshaw, Alan Leo

**In Attendance Guests:** Joanne LeBrun, Doris Laslie, Rick Petrie (Ops Rep), Dan Batsie, Ginny Brockway, Tim Beals (MEMS Board Rep), Chris Moretto, Robin Overlock, Warren Waltz, Jason Fairbrother, John Brady, Dave Riss, Norm Dinerman

<b>Topic</b>	<b>Discussion</b>	<b>Action(s)</b>
1) Introductions and Announcements	Today's Schedule, Samoset EMS course in November	None
2) Minutes July 2008	No discussion	Motion by Busko to accept; second by Sholl; unanimous approval
3) Legislation/Budget	Bradshaw presented that the first regular legislative session starts in January. MEMS is planning to request some bills which would fall under "housekeeping" such as the following : (a) EMD licensures; (b) technical changes on Investigation per AG recommendations; (c) requesting 2 new positions in MEMS – a planning and research position which would function essentially as an assistant director and another secretarial position—of note, these staffing changes would get us back to 1980 levels of staffing; (d) request that EMD training move from PUCs to MEMS as this will provide better coordination. Additionally, the Board of MEMS will be looking at EMS rules and this will begin in a couple of weeks – this is an open process which takes 6-9 months to complete typically. Budget update would be the new positions requested	No action
4) Annual Goals	MDPB 2008-2009 Annual goals (from last month's discussion, Diaz organized and presented for ratification): 1) Diversion 2) Disaster Protocols/Companion Book 3) Specialty Programming/Companion Book 4) Wilderness Medicine/Companion Book 5) Continue OLMC and Medical Direction Work 6) Future Evolution of Protocol Book 7) Update on Status and MDPB role in EMD 8) Continue HART participation	Motion by Busko with Second by Sholl to accept this slate as our annual goals, and was unanimously supported. This will be presented to the MEMS board.
5) Destination Follow-up	Diaz and Petrie have been working on this and Diaz read aloud the following: "Transport Medicine Option Selection—	Recommendation to have the regions reach out to PIFT services and to either request

Guide For Referring Clinicians—  
Transferring patients from one hospital facility to another can be a difficult endeavor depending on the patient's severity of illness. To assist with this process but not a solution for all such transfers is the Paramedic Interfacility Protocol (PIFT).

PIFT allows a patient to be cared for by a specially trained paramedic with the following caveats: the patient must be able to be attended to by a sole paramedic provider based on patient stability and attention to devices. An intubated patient or a patient with unstable vital signs would not be an appropriate patient for a PIFT transfer. Examples where PIFT would not be necessary could include the following (not an exhaustive list):

- a) Patient centric device such as a PCA
- b) Patient on IV normal saline

Examples where a PIFT run would not be appropriate:

- a) Intubated patient
- b) Patient on multiple pressors

When crew configuration beyond a PIFT is required, some additional crew member options are the following:

- a) RN with appropriate skill and training
- b) Respiratory therapist
- c) Physician

Other transport options for a patient with severe illness include the following:

- a) air medical transport (weather permitting), such as Fresh Air or Lifeflight of Maine
- b) Specialty transports such as neonates available from EMMC and MMC

We always strongly encourage that the sending and receiving physicians have a conversation around appropriate transport options and that the transporting EMS crew are part of that discussion prior to patient departure.”

Discussion and how to further craft this then followed. Dinerman suggested the concept of promoting within the state that each hospital should have an identified group of folks (potentially ED docs?) to be the final authority or to opine on interfacility transports. Is this suggestion cumbersome and politically charged? Perhaps this could be a suggestion on how to help hospitals accomplish interfacility transfers in a better way?

sample of reviews and forms and/or concerns with the PIFT QI process.

	<p>Again, the group of experts could be ED docs or other vested physicians within a particular healthcare system. The idea is that it would be helpful to have a physician who knows EMS in the loop.</p> <p>Group discussion ensued and some of the following points were offered: PIFT works well when the service medical director is vested in the service and understands PIFT. EMMC is gearing up to be like CMMC and MMC REMIS with a one-call system. Education to all physicians and providers of PIFT of rules, laws and best practice is needed. Could we force an a priori assessment on sending hospitals on all PIFTs to fall to the ED doc of the day and time?</p> <p>It should be noted that today's EDs in Maine are not fully staffed by vested and system knowledgeable ED physicians as in the past – many job openings and locum tenens use in many of our EDs.</p> <p>Question of PIFT volume change—should we look at this? What would this tell us? Can we look at PIFT data and untoward events? Do we need to refine the QI process around PIFT? Do we need again to look at a confidential questionnaire process for EMS?</p> <p>Of note, the retrospective QI process for PIFT is also a system requirement as well as this discussion of real time intervention if needed for when a PIFT is or is not appropriate and how to help hospitals have the right crew configuration for transfers.</p>	
6) NAEMSP October 11 course in Maine	Postponed, only 6 people responded; looking to see if we can partner with Winter Sugarloaf conference with Maine ACEP	No action
7) CPAP	Batsie presented final data and conclusions from this pilot project which ended July 1, 2008. We have 110 incomplete data sets out of 241 patients (hospital data not available). Average age in our cohort is 77 years and 49% male and 51% female. 63% of the cases were deemed to be CHF. No untoward events noted. This is a good EMS option and anecdotally, very well accepted and found to be helpful.	The MDPB thanked Batsie for all his work on this and further data mining here is not needed – CPAP now in protocol and our experience reflects contemporary national experience. A letter to all participants from MEMS will be issued thanking them for their participation.
8) Specialty Program Update	In Education committee	No action
9) Disaster program Update	Committee has divided the work and Diaz, Busko and Sholl are on point for the	No action

	sections—they are reconvening in October	
10) Wilderness Medicine Program Update	Woodard is convening this group on October 2, 2008, 1-4 pm at MEMS	No action
11) MEMS QI	Continue to work on psychiatric transfer concerns and LeBrun continuing her policy work so that EMS agencies can all share their experiences and procedures; 12-lead QI still being highly suggested and will need rules change to help us enforce this as a mandatory requirement; Airway QI continuing and we struggle with publishing any data since compliance is such a large issue; protocol QI discussed here last meeting and we are going to look at Fentanyl and Ondansetron use today in MEMS QI to see if anything can be done in this arena without taking another major project at this time	No action
12) MEMS Education Committee	Major work focusing on training standards document per Batsie	No action
13) MEMS Operations Committee	Petrie reported the following work on the following list of items occurring at this committee: (a) AVOC and looking to develop a refresher and new instructor course; (b) IPE and retest issues; (c) Legislative update as heard here; (d) CEH process and working on roster issues; (e) CPR and AED certification required for EMD providers (Healthcare provider certification); (f) AED state contract has a glitch and has been rescinded—in place until September 24, 2008 then back out for bid; (g) committee reports; (h) funding for EMS system – question of dedicated funding and this would have to be taken on by the regions and currently working out the issue of also the contract cost per region (much difficulty here); and (i) EMS memorial fundraising with goal of \$300,000.00 dollars.	
14) National Scope of Practice	Question arose whether MEMS is looking at this and the answer is yes. Goes to NHTSA next week and NHTSA has a year to make a decision around this—Jay reported that it appears Maine is relatively closely aligned with 3 of the 4 proposed levels (the 4 <sup>th</sup> being is the proposed Advanced EMT , which appears close to our current Intermediate EMT)	
15) October Round Table	Busko will present “Shotgun Approaches of Respiratory Distress”	No action
16) Therapeutic Hypothermia Discussion	Presentation by Kendall reviewing current literature and anecdotes with LOM experience which included on scene call – LOM did come to the MDPB in order to secure the protocol for interfacility use of this protocol and at this point they have	This is not ready for presentation to MDPB and at this point this is not a protocol for the prehospital arena based on patient selection and use of appropriate resources for code

	<p>not come to the MDPB with this formal request. Presentation ended with request if LOM can respond to scene calls to begin therapeutic hypothermia – given the fact that a paralytic is necessary in order to initiate this protocol, the only current service in Maine who may be able to provide this in the Prehospital arena is LOM. Bigger issue of the patient selection of witnessed v fib or pulseless v tach patient, and concern of LOM responding to code 99s.</p>	<p>99. LOM to consider bringing a more formal request with all the necessary safeguard of patient selection and resource utilization next month.</p>
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**10) Next Meeting: October 15, 2008**

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