

MDPB Minutes, October 20, 2004

Members In Attendance: David Ettinger, Beth Collamore, Dave McKelway, Alfred Riel, Kevin Kendall, Steve Diaz

MEMS Staff In Attendance: Jay Bradshaw, Dawn Kinney

Guests: Norm Dinerman, Larry Hopperstead, Rick Petrie, David Ciraulo, Julie Ontengco, Lori Metayer, Scott French, Joe Lahood, Paul Marcolini, Joanne LeBrun, Jim McKenney, Steve Leach, Kevin Marston, Jeff Regis, David White, Dan Palladino, Bill Dunwoody, Rhonda Chase, Dan Batsie, Alan Azzara, Scott Latulippe, Adrian Boyle, Rob Tarbox, Marcus Day

- I. Acceptance of September minutes— first by McKelway, second by Collamore, unanimous approval
- II. Bradshaw: Budget and Legislature no update. EMS study has been broken into work categories and work groups are forming—contact Jay if interested. BRW—this state study is the most downloaded document on the Maine EMS website.
- III. Protocols: We are OK with Fentanyl as a standing order because our state protocols are just that—protocols and not guidelines. Diaz discussed with Dan Lambert. Jay has prices for adopted meds—Cheap! CAC group OK with our not using amiodarone, so lidocaine stands. Next CAC meeting is December 15 at 6:30 pm at Dean 4, Thayer Hospital, MaineGeneral Medical Center. Much discussion re: Fentanyl--Diaz has been responding to a lot of these concerns, has generated a document, and is speaking at ENA next month.
- IV. RSI: Opened this with a few caveats—(1) this is not for everyone, but will be a program that sets a high bar and will have an ongoing certification component, QI component and is an extra “piece” to a paramedic’s training; (2) is one component of an airway algorithm as we have adopted in Maine; (3) is looking at a unique niche in those with head trauma—not a carte blanche reflex in those with respiratory failure. Much discussion around this including not great studies re: the lives saved measure against the potential (real) increased morbidity. Diaz has asked Burton to get an article and raw data from the current ACEP scientific assembly (article 379)—they claim success with a success rate of 87% for intubation, and need the raw data to make sense of some assertions—90.4% of their patients were in arrest in phase 2 and had a definitive airway. Received this with the extrapolation that these would have all died without, but I am not sure with the abstract whether these airways were obtained with RSI (in this subgroup)—also, this subgroup mortality rate is not clearly divided out in the abstract (where did they count these patients and were all these alive at the study endpoint). They claim an increase in survival with RSI from 67% to 78%-- the raw numbers would help make sense of this immensely (what happened to those in arrest—did they die despite an airway?). I suspect some data dredging has occurred and perhaps mixing of historical cohort with their subgroup analysis. Will await JB's

numbers. Dr. Hopperstead is also looking at numbers from CMMC to help make sense of this—RSI with Lifeflight seems to have increase survival (early interpretation of his numbers)—specifically 31 lives saved through this procedure. Studies with prehospital RSI do show morbidity, and difficult to tell if the patient selection with “inflicted” morbidity is better than what their outcome would have been—that is, would these patients have died without RSI. That is the question. Subgroup volunteers to help define the team composition, ongoing certification requirements, the regulatory arm, adding to the airway algorithm, and defining the protocol so that transport is not delayed. Dr. Ciraulo has done this similar type project in Tennessee and has much helpful insight. The subgroup composition is as follows—Steve Leach, Peter Goth, David Ciraulo, Dan Palladino, Dan Batsie, Rick Petrie, Kevin Kendall, Jay Bradshaw, David White, Elliot Smith, Dave McKelway, Al Riel, Paul Marcolini, Steve Diaz. Will see if we can meet November 3rd, 3-5 pm and again November 17, 8:30-9:30 am.

- V. PIFT: Meeting this afternoon, goal to have written proposal for meds, devices, stability definition, and QI.
- VI. Medical Control Competency: OLMC exam in the works, Diaz needs help with questions and scenarios. As well, attempting to get Chapter Grant from ACEP. Send suggestions for question/scenarios to Diaz via e-mail. Follow-through for this project may lie with MHA, and how do we enforce this—need to think about link to licensing, incentives and disincentives.
- VII. Patient Sign-offs/hypoglycemic patients: Proposed document as follows after much discussion (we are also waiting for a cover letter that accompanied the initiation of this in the tricounty region). Also discussion around other potential “treat and release” type situations. At this point, this issue is common and germane, and perhaps is best to keep this as our one template since issue of capacity is most prevalent here —

Guideline for Diabetic Patient Signoff

It is in the best interest of a patient treated for hypoglycemia to continue to the hospital in the company of EMS personnel. If a competent diabetic patient refuses to be transported to the hospital and is then “signed off” by a provider, then all of the following conditions must be met and documented (Basic EMT’s are encouraged to contact OLMC while awaiting ALS arrival or if OLMC is the Basic EMT’s closest ALS):

- The provider (EMT-I, CC, or EMT-P) feels that it is appropriate not to transport this patient
- OLMC must be consulted in the decision process
- The patient is an insulin-dependent diabetic (IDDM, insulin-dependent diabetes mellitus), and NOT on oral hypoglycemics.*
- This is NOT the first hypoglycemic crisis for this patient
- The patient is afebrile

- The patient responds to a normal blood sugar level (> 95 mg/dl) after 1 amp of D₅₀.
- The patient will be left in the care of a responsible adult.
- The patient agrees to food intake and is able to recheck their own blood sugar.

* Oral blood-glucose lowering drugs include: Diabeta (Glyburide), Diabinese (Chlorpropamide), Glucotrol (Glipizide), Glynase (Glyburide), Micronase, Orinase (Tolbutamide), Tolinase (Tolazamide)

- VIII. Passing care to a lower license level: much discussion surrounding having Basic EMTs teching calls without ALS in the ambulance after ALS assessment, and many permutations on this. This is done in Region 1 and has many regulatory components to it. Not an appropriate item for MDPB to weigh in on, but perhaps regions could all share and learn from Region 1 if they desire to follow suit.
- IX. Disaster protocols: Diaz presented ideas to generate disaster protocols for hazmat paramedics, physician assistants working out of hospital in disasters, and bomb squad suit removal. Support from the group, will look to John Bastin for help.
- X. Next Meeting: November 17, 2004