



STATE OF MAINE
 DEPARTMENT OF PUBLIC SAFETY
 MAINE EMERGENCY MEDICAL SERVICES
 152 STATE HOUSE STATION
 AUGUSTA, MAINE
 04333



JOHN ELIAS BALDACCI
 GOVERNOR

ANNE H. JORDAN
 COMMISSIONER

JAY BRADSHAW
 DIRECTOR

Maine EMS
 December 15, 2010
 09:30 – 12:30
 Agenda

Medical Directors Present – R Chagrasulis, M Cormier, P Goth, M Sholl, J Busko, T Pieh, S Diaz
Medical Directors Absent – W Randolph
MEMS Staff Present – K Pomelow, D Kenney, J Powers, J Bradshaw

Guests – Shawn Evans, Joanne LeBrun, John Brady, Don Sheets, Butch Russell, Ginny Brockway, Rick Petrie, Michael Schmitz, Dan Batsie, Myles Block, Eric Mailman, Lane Gould, Dan Brunelle, Chris Pare, Shaun St. Germaine, Charles Napolitano, Julie Ontengco, Kyle Baker

November 2010 Minutes	Reviewed by all	Motion to Accept – Chagrasulis Second – Cormier Approved - All
ME EMS Update	Bradshaw/MEMS Staff – (1) New Commissioner for Public Safety is John Morris; (2) MEMS is working on draft legislation that make a number of technical edits, will reference the assistant state EMS medical director, will permit access to MEMSRR for the Medical Examiner’s office, and enable MEMSRR data to be used for approved research projects and linkage with Maine CDC.	
New Devices	None new, clarification of process and question on allowance of using airway devices. Previous direction on airway devices was OK to use if FDA approved, and slight rub with the FDA approval usually not directed to EMS use.	
Protocol Review Process	<u>Comments to date</u> – <u>Sholl</u> – updated us on the process, and the following reviewed today: 1) Intermediate medications: review of request to have Narcan be a medication to be used without having to call medical control. J Powers gave a handout showing a year’s worth of data on medications administered by EMT-Intermediates detailed by EMS Region. There are 840 intermediates in Maine, (please refer to the handout). Narcan was given 13 times by Intermediates in one year. We decided to leave Narcan as is, and emphasize focus on airway management. Request to have dextrose without OLMC for hypoglycemia. <i>Motion by Busko to remove OLMC for 25 grams of dextrose administration</i>	

in adult patients suffering from hypoglycemia. Second by Goth. Discussion ensued of trying to keep the Intermediate protocols uniform, and not have different OLMC interventions dependent on the drug. Vote defeated with 2 in support (Busko and Goth) and all others against.

- 2) Cardiac Monitoring at the Advanced EMT level (A-EMT): No monitoring for rhythms in the A-EMT unlike our current EMT-I. To ID rhythms, 48 hours of course work. Six rhythms are identified by EMT-I (NSR, Sinus Brady, Sinus Tachy, VT, VF and Asystole). Positive value added was voiced by many MDPB members. To add rhythm recognition to the EMT-A moves it from about 150 hour course to a 175 hour course. (current EMT-I course is 150 hours). We asked J Powers to bring us data to our next meeting – Number of IFT’s, IFT’s with EMT-I only, and IFT’s with EMT-I only when cardiac monitoring used.
- 3) Hypothermia protocol: Handout circulated by Busko – conversations ensued on the populations we are addressing, as consulting with WMA and Alaska for its protocols brings in a lot of wilderness medicine for protocols that we generally look at as being “urban” based. Busko to talk off line with Sholl to further edit.
- 4) IO and lidocaine discussion: Handout given to support the argument for using lidocaine (from EZ IO), review of current protocol indications for IO use (purple 2). Recommendation is 2% lidocaine without preservative. In 2009, Maine had 265 adult IO’s placed, and after taking out cardiac arrest, 121 patients left. For KV, 5/52 patients during this year would have qualified for lidocaine use, for state of Maine, 10% would have benefited from lidocaine use (less than 12 patients). Other discussion on whether IO should be used in patients that can perceive pain, and if so, then lidocaine should be used. **Motion by Diaz to accept page 7 as a protocol with friendly amendment of including for those who do experience pain into the inclusion criteria. Second by Cormier.** Discussion of exact inclusion criteria into use of lidocaine. Vote: Unanimous support
- 5) Lights and Sirens: Not for the protocols, but a letter to go out to clarify patient transport and use of lights and sirens. Statement from MDPB on when lights and sirens might make sense, and explicit statement of when only to use lights and sirens. Covered in Title 29-A. Code 3 is approved in cases for risk to life and limb. Suggestion that if we are going to look at this, to also look at other ambulance operational issues e. CAAS does not specifically address this issue in their accreditation requirements; however, CAMTS does, ACEP has white paper on this. Busko sent a draft letter around to MDPB members a few months ago. We will re-circulate the letter and bring position statements from other organizations to further discuss at our next MDPB. Busko, Bradshaw and Sholl will meet to pull together presentation before next meeting.
- 6) Comments received by Sholl and Bradshaw – will be updated monthly and edits highlighted.

Proposed Schedule for Protocol Review:

- 1) Purple, Brown, Grey – January
- 2) Blue and Red – February
- 3) Gold and Green – March
- 4) Yellow and Pink – April

Medication Shortage	Draft circulated by Bradshaw. This is to address the issue of protocol specific medication not being available.	Consensus of acceptance
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Policy		
CPAP and PIFT Question	Not yet ready for MDPB discussion, will be offline with Sholl, Bradshaw and Diaz and will be brought back next month.	
Interfacility Transport Committee	Meeting this am, focused on best for patient care and safety, and critically ill patients are transported via a system of varying degrees of individual hospital knowledge. PIFT is continually being refined and highlighted. Overall, what is our vision for IFT for the state, and this umbrella goal includes PIFT and critical care transport. Who else needs to be at this subcommittee? One group of folks that might help us a lot is the MHA. Question if it would be helpful to have DHHS participate – if so, we need specific question that we are asking them, because span of their group is large, and the question will have to be directed to the right person.. Maine ACEP, ENA, the nursing board and others may also have a stake in this.	
Maine EMS Regional Meetings	January 24 in Region 6 (Midcoast) – have met with Regions 1, 3, and 4 thus far. We are also willing to visit the other regions if they have interest (2 and 5). We visit protocols, PIFT and medical direction during the discussions on our visits.	
Special Circumstances Protocols	Bradshaw and Sholl updated this and form on website. Part of the feedback from someone is that the last form was not user friendly to the lay public.	On website with cover letter.
Old Business		
MEMS Education	Path of reviewing protocols. Monthly updates on what we are considering will be forthcoming, but finalization of this not available to the very end.	
MEMS Operations	<p>Question of Ops looking at the protocols and give a master list of items that may be needed on an ongoing fashion – pluses and minuses discussed. January 2011 meeting to work with all Maine newspapers to look at Maine EMS week in May to help highlight EMS. Case came up with physician who is retired military who has moved to Maine and wishes to run EMS service and go on calls. Thought it would be good to prepare information packet for items for such physicians to think about. Progress reports due end of this month. AVOC train the trainer program planned for Spring 2011.</p> <p>Transporting Children Safely in Ambulance program was updated and taught around the state. There will be another round of data grants next month. Goal of these grants will be to support improvements in collecting run report data. Services requesting grant funds must be in full compliance with MEMSRR reporting requirements. Maine HAN coordinator coming back to Ops in January 2011 to continue development of the notification system.</p>	
MEMS QI	No meeting today, recent discussions encompass a state based QI resource manual. Rick Petrie has created a regional resource around QI, and he has been working with NY state using their document. Since then, Sholl has taken this and is looking to morph as a state resource. QI at the state level is difficult to link to the service or individual level, so will continue to look at this new concept at our next QI meeting.	

HART Update	Reconvening in 2011 to look at how we go forward.
Other	Central Venous Device (Busko): if already accessed, OK to use – from Operations, this is covered in training programs. This was clarified since last meeting.

Next meetings – January 19, 2011

MDPB Executive Session 8:30 – 9:00,

IFT Subcommittee 9:00 – 10:00

MDPB 10:00 – 12:30,

MEMS QI 1-3