



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
 July 21, 2010
 Minutes

Medical Directors Present – Diaz, Sholl, Cormier, Goth, Busko, Kendall, Pieh

Medical Directors Absent – Randolph

Staff Present – Kerry Pomelow, Dawn Kenny, Jon Powers, Drexell White, Alan Leo

Guests – Joanne Lebrun, Scott Cook, S Evans, Don Sheets, Eric Wellman, Bob Petersen, Brign Mullis, Mike Senecal, Emily Carter, Heather Cady, Julie Ontangco, Chris Pare, Jeff Regis, Donnie Carroll, Myle Block, Eric Michaud, Dan Batsie

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| June 2010 Minutes | Reviewed June minutes | Motion to Accept – Kendall Seconded - Cormier Accepted All |
| ME EMS Update | Drex – Nothing to review | |
| New Devices | None Presented to the MDPB | |
| Protocol Review | Green Section – Peter Goth Red Section – Marlene Cormier | See protocol review notes – To be released in August. |
| Special Circumstances Protocols | General Concepts - History of the program – patients with rare disease occasionally ask that EMS participate in their specialized care. Have created a Special Circumstance Protocol for these events. First draft was approved 7 years ago. Discussions were reinitiated recently. Must be approved by both the pt’s physician and the regional or service medical director. The patient or family work with local EMS to create their protocol (vetted by primary care or attending physician and service | Motion – Goth - To accept Jonnathan’s revised Template for Special Circumstances Protocol for |

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| | <p>medical director). This protocol is held locally and at the state (must be approved by MDPB as protocols are statute and ultimately must be approved at the MDPB level)</p> <p>Central Venous Access – J Busko – In 2008, eliminated EMS ability to access central venous devices except in OHCA. Motivated out of the risk for line infection. There are, however, patients with central access devices that require venous access BUT are not ill enough to require IO device. Purpose of this protocol is to create relationships between the EMS Service and their local hospital to create individual protocols allowing access of these devices. The patient, the PCP, and the hospital infection control hospital all involved in this protocol (discussion re: Regional or Service Medical Director). Using the device as trained, all capable of using the device would require training.</p> <p>See Attached proposal</p> <p>JB – Has received questions from PIFT agencies about patients who have encountered pt’s with accessed central venous devices but are not able to use these. J Busko added a section on “Just in Time” training for PIFT providers to learn how to use the device AND a physician order to access the device.</p> <p>S Diaz – Would divide the pre-hospital section from the PIFT section. Also would advise to NOT bypass the MDPB as only the MDPB is able to set protocol in the state</p> <p>J BUSko – To edit the request based on S Diaz’s comments (separate the PIFT and the Standard EMS components) and maintain the MDPB as the authority and approval process</p> <p>PIFT Discussion – J Busko and Dan Batsie – PIFT Training already includes accessing central venous devices. Need to re-approve this as it was made invalid by the 2008 changes.</p> <p>S Diaz – should take this (and the idea of “Just in Time Training” to verify sterile procedure) to Education and Ops</p> | <p>Accessing central lines. DIAZ</p> <p>Seconded – Busko</p> <p>Accepted – All</p> |
| <p>Protocol Review Process</p> | <p>Following Sections Remain –</p> <p>Blue - Tim June</p> <p>Red – Marlene July</p> <p>Green – Peter July</p> <p>Yellow - Kevin June</p> <p>New Proposal – once this process finished, Matt/Jay/Steve will compile changes for internal and external review over August. The MDPB will take August off – then reconvene in Sept with a goal of fine tuning one section each month with internal and external comments.</p> | |
| <p>Drug Shortages</p> | <p>Dextrose – doses of 50% have been in short supply for weeks to months</p> | |

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| | <p>Epi – Pre-Loaded 1:10,000 – came to our attention last week.</p> <p>Maine EMS does not mandate how medications are supplied to EMS providers but can make suggestions regarding safety and safe practices. Steve Diaz is drafting a letter informing providers and physicians of these shortages (and asking services to discuss this with their affiliate pharmacies) and suggesting the importance of prefilled devices if at all possible. If not, then the letter will describe other options.</p> <p>Website for reviewing drug shortages = http://www.fda.gov/Drugs/DrugSafety/DrugShortages/ucm050792.htm</p> <p>Message to pharmacies – Maine EMS can not tell pharmacies how to supply the medications – but can make suggestions regarding patient safety. A service should continue current practices if at all possible. If using pre-filled devices, continue using these rather than changing packages.</p> <p>New from 7-10 –</p> <p>Southern and Central Maine have begun to feel the shortage of Epi</p> <p>S Diaz – mentions that “Just in Time” training for epi – Has been shown ineffective and recommends early communication with hospital pharmacies</p> | |
| <p>Portland Fire Department Pilot Project</p> | <p>Sholl – Introduces the concept J Kooistra – Describes the project. PFD/MEDCU licensed at the paramedic level. Requesting identification of code types (including public assist) that would be identified by dispatch and allow for a tiered response – with medic, I or Basic as the individual assessor. Individual engines to be deployed INSTEAD of and ambulance with a medic in these situations</p> <p>Sholl - Necessary for Acceptance –</p> <ol style="list-style-type: none"> 1) Educational model – ie – protocols for patient assessment in each of these 2) Quality Assurance Program <p>J Busko – not comfortable including 26 A-1 IF non-transport is the objective –once the diagnosis or decision is set in place, it is difficult to change that direction.</p> <p>S Diaz – Suggests – continue working forward with a, b, c, d – need more information regarding the e. group – suggests collecting more data and bringing this back to the MDPB</p> | <p>Motion – Allow continued development for the Pilot Project INCLUDING only – criteria A, B, C, and D. Bring the MDPB data on the outcomes of the category E. patients for review and consideration at a later date. – Sholl</p> <p>Seconded - Pieh</p> <p>Approved – All</p> |
| <p>Old Business</p> | | |

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| Airway Subcommittee | All reports held secondary to protocol review process |
| HART Update | |
| MEMS Education | |
| MEMS Operations | |
| PIFT Teaching to Hospitals | |
| MEMS QI | |
| Neonatal Transport | |

Next Meetings – Sept 15, 2010 – 9:30 – 12:30
Maine EMS QI – 13:00 – 15:00