

Medical Direction and Practice Board		
September 16, 2009 - Minutes		
In Attendance: Jonnathan Busko, Matt Sholl, Tim Pieh, Peter Goth, Marlene Courmier, Colin Coor		
Excused Members: Kevin Kendall, Steve Diaz		
In Attendance Staff: Jay Bradshaw, Alan Leo, Jan Brinkman,		
In Attendance Guests: Eric Wellman, Scott Cook, Paul Liebow, Joanne Lebrun, Kristen Darling, Kelsi Bean, Mike Senecel, Jeremy O'Neil, Warren Waltz, John Brady, Brian Chamberlain, Lori Metayer, Brad Gilbert, Butch Russell, Joe Lahood, Dan Pugsley, Rick Petrie, Dan Batsie, Jeff Regis		
<u>Topic</u>	<u>Discussion</u>	<u>Action/Party Responsible</u>
1) MDPB July Minutes	Motion by C Coor	Motion by T Pieh Seconded by J Busko Accepted by all
2) ME EMS Legislative Update	1) Legislature coming back this week – appropriations looking for additional areas to cut – target is changing (\$65,000 - \$125,000). Focusing in DHHS and Education as this is where 80% of state funding goes. No active bills other than financial ones... 2) Maine EMS – NASEMSO meeting next week – M Sholl and J Bradshaw will be going. Jan Brinkman is leaving after accepting a clinical position at FMH. Have begun process of getting a waiver on the hiring freeze.	
3) H1N1 Update	M Sholl introduces the concept –discusses the states approach – Surveillance Risk Communication Mitigation Response Tiered response to the vaccination campaign – EMS part of the first tier. Federal CDC has offered some clarification on who is included in “EMS” - need to get state clarification.	
4) Medivax Immunization Program	J Bradshaw – protocol approval through the MDPB to offer vaccination. Introduced the 2009 MEdiVax campaign. Under the current requirements – sponsoring agency does not charge for the vaccination. EO signed by the governor offers broader protection AS LONG as the provider has been approved by MEMA and offers liability and worker’s	Motion from P Goth to remove section 4 Seconded by T Peih All Approved

	<p>compensation to the provider. To become approved by the MEMA director all providers go through the training and take extra steps – including having the training roster sent to MEMA (via Maine EMS). MEMA’s website has listed approved providers. (MD/DO/RN/etc need to gain MEMA approval through Maine Responds). Given that the EO offers protection, can discuss modifying the protocol to delete section 4, which discusses that the service can not charge for the administration.]</p> <p>Bradshaw discussed that we do not need this stipulation given the Governor’s EO.</p> <p>M Courmier – how long does it take to turn around the roster to MEMA?</p> <p>J Bradshaw – as soon as the roster is delivered it is sent to MEMA. Without MEMA approval, there is no statutory protection... IF we get the roster, it is our top priority. Presently, our turn around is a few hours BUT this can not be guaranteed if the system is overwhelmed with rosters.</p> <p>R Petrie – where is the list. J Bradshaw sent the link yesterday</p> <p>R Petrie – we’ve held 4 – 5 trainings between the 2 regions. Questions that come up – how do we get the vaccine? Link with a local provider and use their MIP</p> <p>J Busko – when ME CDC held its H1N1 summit – if everyone who held a license to vaccinate were active – it would still require everyone to vaccinate 900 people. Without EMS activity, this number increases.</p> <p>R Petrie – even folks who teach the class need to sign the roster...</p> <p>J Bradshaw – asks for past classes to add to the roster</p>	
<p>5) ME EMS Continuity of Operations – Discussion</p>	<p>J Bradshaw – presently, protocols are drafted, vetted and approved by the MDPB. Working on protocols with the state to alter that process in the case that we cannot bring the group together – either Medical Director/Assistant/or a defined and delegated group.</p> <p>J Busko – under what situations would we need this? Can we add a stipulation that it is under circumstances in which other members of the MDPB can not be contacted.</p> <p>J Bradshaw – this would only be under the active EO and expire at the end of the EO</p> <p>T Pieh – what is our quorum? <i>Four</i></p>	<p>Motion – M Shall Seconded – T Pieh Approved by all</p>

	<p>Motion – Allow for medical director, assistant medical director or designee be allowed to make decisions WITHOUT consultation of the MDPB in the situation where a quorum of the MDPB cannot be contacted, under an Executive Order only, for the provision of continuity of operations. This is intended to be active only during the time period of the EO (30 days unless renewed).</p> <p>M Sholl – are there other circumstances we should think of?</p> <p>J Busko – We have talked in the past about having regional medical directors designating an alternate that can step in on a temporary basis. Vet these persons up front so they can then step up in the case of emergency. Could we do this for the Education and Ops group?</p> <p>C Coor – mentions he had thought about his as well</p> <p>P Goth – if this was formalized, it may offer the predecessor protection.</p> <p>J Bradshaw – statute requires the board approve the medical director and only after the board approval does the individual gain protections</p> <p>J Busko – what, if any, protection are we offered in the case of response to emergencies. Should we all register through Maine Responds? Can we check with the AG, if other providers are requested through the EMA’s be offered protection under the state’s mutual aid agreement?</p> <p>M Sholl – Maine Responds is the state’s mechanism to pre-verify providers and organize providers and therefore we should all register.</p> <p>J Lubrun – if alternate care sites are opened, how will that be managed in terms of protection for providers in regards to reimbursement and liability?</p> <p>J Busko – people going to a established and designated alternate care site is NOT an EMTALA violation. Who determines alternate sites? Regionally and the regional medical directors.</p>	<p>*J Bradshaw – will look at the statute and discuss with AG’s office</p> <p>J Bradshaw – look into question – is MDPB action necessary to approve alternate care sites either by designation or approval to transfer to these sites.</p>
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6) Physician Orders for Life Sustaining Treatment	Tabled for small group discussions	
7) ME EMS Round Table	<p>M Sholl – asks the group is there interest in continuing – YES Asks then what topics for the future?</p> <p>J Busko – mentions this may be a good time to start looking critically at the protocols and review the updates.</p> <p>J Brady – We need to think about where we are going before we can discuss the protocols. We need to know the scope for our providers before we discuss the protocols</p> <p>J Brinkman – Suggests revisiting the levels of providers and the</p>	<p>J Busko and M Sholl will discuss the gap analysis and changes as the next Round Table</p> <p>Will organize following discussions on topics pertinent to the upcoming protocols</p>
8) Medical Control Program Update	M Sholl - ME ACEP – discussed the Medical Control Program – are sending out messaging to ME ACEP members strongly encouraging all members to comply with the program and are setting goals to have 100% of members compliant by spring 2010. Also have endorsed the medical direction program (Oct 17 th).	
9) Airway Subcommittee Update	<p>M Sholl – reviews minutes from the earlier meeting and following conclusions:</p> <ol style="list-style-type: none"> 1) We are going to readdress airway management in the state as laid out in Tim’s white paper.... 2) We are going to redirect the concept of airway management through the 2011 protocols by focusing more on the patient’s needs and introducing a goals based therapy of oxygenation, ventilation and protection.... 3) This will require a significant investment in education of our providers. We will look at traditional (didactic and skills based) as well as non traditional mechanisms to reach the 4) Move toward relationships with medical direction and creating systems in care 	
10) PIFT Survey	J Lebrun – sent the executive summary to Steve	

<p>Update</p>	<p>and Jay last week. Summary of the survey – Three salient recommendations:</p> <ol style="list-style-type: none"> 1) More education of the PIFT providers – refresher training, more explanation of the purpose of PIFT 2) More involvement of the service medical director – esp. review of calls and cases 3) Education of the providers in the transporting facilities to reduce the amount of change that occurs in patient orders (changes made to become compliant with the PIFT transport). <p>M Sholl – allow MDPB to review the Executive Summary and re visit the recommendations in Oct 21 to begin discussions on accepting these and process of implementing these recommendations</p> <p>J Lahood – mentions experience as a hospital employee working in transport center and notes experience in adding support when questions arise regarding the level of transport</p> <p>P Goth mentions – can we put together a decision support tool to help transferring physicians make decisions regarding interfacility transfer</p> <p>R Petrie – mentions that one of their hospitals has compiled this and will distribute it. But mentions that these tools cannot replace local education and the PIFT service has an OBLIGATION to educate its partner hospital</p>	<p>M Sholl – MDPB review the Executive Summary over the next month and return in Oct to discuss J Lebrun’s recommendation. T Pieh mentions interest in learning the history of PIFT as a new member of the MDPB and will return in Oct with a short presentation</p>
<p>11) Critical Care Transport Update</p>	<p>P Goth – Discussed some of the questions and concerns he has received and looking to put together an FAQ or case-library. Discusses critical care training and certifications that exist nationally. Mentions this as a comment and looking to discuss with the subcommittee in the future.</p> <p>Finally, where should this land – we started by stating that “this is not and EMS function” but if we do not do this, who should?</p> <p>J Busko – also mentions a nursing certification in critical care transport and suggests this should be added.</p>	

<p>12) Breath Actuated Nebulizers</p>	<p>Review of Papers S Diaz sent in July:</p> <ol style="list-style-type: none"> 1) <i>Cost Effectiveness Analysis of Breath Actuated Inhalers</i> – Upside, 23% less medication used with similar clinical outcomes, Downside – outpatient population (different than those encountered by EMS) AND inhaler , not BAN 2) <i>Comparison of the Effectiveness of inhaler devices in asthma and COPD: a systematic review of the literature</i> – also focuses the discussion on Inhalers rather than nebulizer BUT found that BAI’s were easier to use 3) <i>Cost effectiveness of asthma treatment with a breath-actuated inhaler: how has the story changed?</i> – again, inhaler vs. neb BUT “clinical effects of BAI’s on certain patients can still be translated into greater cost effectiveness” 4) <i>Device Selection and Outcomes of Aerosol Therapy: Evidence-Based Guidelines</i> <p>P Goth – concern – the patients we would use these in may not be able to activate the BAN (poor TV due to underlying disease). M Sholl – we can use these WITH the regular nebs for patients who are ill but can still activate the neb</p> <p>T Pieh – do we need to spend the energy in adding this if we see no major benefit from these devices. Do we need to take up the resources from Ops and Education?</p> <p>R Petrie – this will take a fair amount of time and is this a priority? Where does this fit?</p> <p>J Busko – mentions that adding the BAN allows for inhaled fentanyl.</p> <p>P Goth – this is not a priority due to the fact that there is a downside and we need a system behind the use of these C Coor – would not mind tabling this discussion until next month J Busko – this in not an inconsequential discussion and there is no ground swell. Since there is interest, perhaps we begin looking at this forward to the 2011 T Pieh – would like to hold – if we can argue that</p>	<p>Motion – M Sholl Second – T Pieh Motion Approved by - all</p>
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	<p>this is beneficial then we move forward M Courmier – I need more information</p> <p>J Bradshaw - approval for devices depends on the device and since this is a device in the protocols already, it does not need board approval</p> <p>E Wellman - Should we look at our procedure for new devices – the device, literature, and impact from an education and operations standpoint be presented to the board</p> <p>T Pieh –supports this idea</p> <p>M Sholl – asks for thoughts from the room and members of Education and Ops support the above concept</p> <p>Motion – Table the discussion of BANs for the preset. Consider the addition of breath-actuated devices in the 2011 protocols.</p>	
<p>13) HART Update</p>	<p>No major changes after the recent HART committee. Did discuss the following items in depth:</p> <ol style="list-style-type: none"> 1) Addition of decision making support for EMS providers – S Diaz queried the NASEMSO list serve – discussed results 2) EMS 12 Lead QI – strong interest in excellent Quality Management mechanisms surrounding QI 3) Still discussing data points <p>NASEMSO query results – many different practices with range from computer interpretation – EMS interpretation – transmission (cell phone picture \$0.25 vs. machine sending)</p> <p>J Busko – Why is HART looking at this? Also mentions that the FDA suggests (as of the 90's) that all medical information be transmitted through FDA approved devices and that cell phones (and even faxes) are not approved by the FDA for the purposed of medical transmission.</p> <p>M Sholl – discusses the motivation behind this – experience with local partnerships is excellent and had lead to great results in reaching goals to therapy. Interest in offering services with less</p>	<p>M Sholl to discuss this at NASEMSO meeting</p>

	strong relationships decision support.	
14) MEMS QI	Airway data 12 Lead data	
15) ME EMS Education Update	<p>J Brinkman – finished gap analysis on national standards curriculum changes and that to be presented to the MDPB in Oct and the Board after.</p> <p>T Pieh – asks where we are with the change in needle thoracostomy?</p> <p>J Bradshaw – mentions has been sent to Ops then Education</p>	<p>J Brinkman – will send the board the gap analysis</p> <p>MDPB Membership – review the gap analysis AND the NITSA background information. All members need to review and arrive in Oct ready to discuss</p> <p>J Bradshaw to send the groups links.</p> <p>J Bradshaw to follow up with Education Committee</p>
16) ME EMS Operations Update	<p>R Petrie – Spent the bulk of recent discussions on H1N1 – attempting to prepare</p> <p>J Bradshaw – mentions efforts to work on safe transport of pediatrics through regional offices.</p>	
17) Specialty Program Approval	J Busko - Board has approved the process. This impacts ME EMS and MDPB as those requests will need to be vetted here first	
18) Final Business	R Petrie mentions Ryan White legislation and advocating for this through Advocates for EMS also different manufactures of hemostatic agents are looking at unrolling other products. If MDPB members hear about these be sensitive to the approval process for these and reroute questions to ME EMS and MDPB for approval.	
<p>17) Next Meeting – Oct 21st 9:30 am. Airway Subcommittee at 8:30 – 9:30 am. ME EMS QI – 1:00 pm</p>		