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

PAUL R. LEPAGE
GOVERNOR

JOHN MORRIS
COMMISSIONER

JAY BRADSHAW
DIRECTOR

Medical Direction and Practice Board
May 16, 2012
9:30 am
Minutes

<table>
<tr><td colspan="3">Medical Directors Present –Busko, Sholl, Pieh, Goth, Chagrasulis
Medical Directors Absent – Randolph, Klein, Cormier
MEMS Staff Present – A Leo, D Kinney, J Bradshaw, J Powers

Guests – John Brady, John Kooistra, Tim Nangle, Heather Cady, Joanne Lebrun, Butch Russell, Don Sheets, Nathan Yerxa, Dan Batsie, Rick Petrie, Brian Chamberlin, Michael Schmitz, Alex Lyman, Kerry Pomelow, Kimberly Lane, Cassandra Purrington, Scott McDermid, Chris Paré, Marc Minkler</td></tr>
<tr><td>April 2012 Minutes</td><td>Presented</td><td>Motion to Accept: Pieh
Seconded: Goth
Approved By: All</td></tr>
<tr><td>ME EMS Update</td><td colspan="2">MEMS looking to fill 3 positions – Training Coordinator (reposted today and accepting positions til June 13), Trauma Coordinator and Community Paramedicine Coordinator.

Budget group met and are flat funding the department

Legislature remain in session – impacts the effective date of the community Paramedicine bill (that will go into effect 90 days after the legislature adjourns – some time in August)

Rules draft have been circulated and looking for comments – to be sent to Maine EMS by Friday (May 18th) and these will be presented to the Board at the June meeting.

BC – Question regarding rewording of the regions – JB – discusses historic interest in changing this language to allow the board to define the regional boundaries
DR asks about the Community Paramedicine RFP and the number of applicants – JB, MEMS Received one.</td></tr>
<tr><td>New Devices</td><td colspan="2">None Submitted</td></tr>
<tr><td>Special Circumstanc Protocol</td><td colspan="2">None Submitted</td></tr>
<tr><td>Agitated Patient Pilot Project</td><td colspan="2">Update - JB – 2 out of three trainings have been completed. Mid Coast has seen no EMS cases – in part thought due to decreased use of Bath Salts but also due to law enforcement being more aggressive in managing these patients exclusively.

Question has come up – What if Versed is no longer available?</td></tr>
<tr><td>Upcoming MDPB Agenda</td><td colspan="2">1) Life Flight of Maine – review of the “Just Culture” protocol/policy – recent discussion at the Maine EMS Board level regarding this protocol/policy. MEMS Board has asked for MDPB review. Will forward information to members before the next meeting</td></tr>
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Items	2) MEDCU Pilot Project – Last reviewed in July with the intention of a six-month follow up. Need to review the status to date, in particular the MDPB would like to review the following: Numbers of patients encountered, “type” of patients (based on dispatch determinant code), number of ED visits to local hospitals within a 72 hour period, number of hospital admissions within same period of time, and leadership’s overall impression on the merits of the program and discussion re: continuation vs. ceasing the program based on the impact vs. the outcomes and benefits 3) EMS Awards next week Wednesday Hall of Flags at 11:00	
Community Paramedicin	RFP for coordinator has been out Informational Meetings are being held (Kevin McGinis remains involved – he and Jay are meeting with health care contingencies and stakeholders). PG – what is the nature of these discussions? JB explained. Board would not be able to approve pilot projects until legislature is closed and the bill goes live CP Training ongoing at NMCC	
Drug Shortages	Update from the Regions – 1) Region 1 – MM – notified that York hospital ran out of Sodium Bicarb – also out of Epi 1:10,000. Have heard this epi shortage is the case with other hospitals in the region. Goodall and Mercy continue to have shortages in Benzo’s. 2) Region 2 – JL - No new updates – no alternative protocols and no new indication of critical shortages. 3) Region 3 – TP – No new word. Good communication between the regional office and the hospital pharmacies. RP sends regular emails to the pharmacists and has been getting good feedback. 4) Region 4 – RP – one sub-region has activated the Zofran ODT protocol. EMMC has maintained stock of benzo’s. JB – no new comments. 5) Region 5 – PG – no updates. 6) Region 6 – RP – no updates. New Shortages (esp in Region 1 hospitals) – epi 1:10,000 Pieh drafted a letter urging regular communication for MDPB review and use regionally if necessary. Regional and sub-regional discussions re: medication sharing continues. Follow up discussion re: Alternates to Benzo’s in the face of Sz – Pieh: MGH is out of phosphenytoin – due to national recall. Randolph: Not Present Sholl: Discussed with Neurology Sholl – email conversation with OR – Hi Matt, We were unable to order any more benzos of any variety. We considered alternative meds, but couldn’t get any of them. Our largest providers still had a supply available and we looked into trading - but the DEA squashed that. The funny thing is that our big EMS agencies did get in a new supply that was a completely new concentration - and that caused a bunch of consternation. Finally, some agencies actually decided to go ahead and carry the expired drugs (mine own included). We now have everything up to date because we have gone to a pharmacy compounder for our midazolam. From a State perspective, we have done nothing yet but we are discussing providing "blanket waivers" for agencies to carry expired drugs - provided that they document their decision making process. It does nothing to protect them from liability but it does provide some regulatory relief. Ritu	**Review alternates to benzo’s for sz.** **Alternate benzo’s and dosages for agitated patient protocol.**

Discussion: Patients with decision making capacity refusing transport	Feedback from the AAG who has reviewed the language as well as Grey 14. Approves of the language but urged that we consider adding this as clarification to Grey 14. Listed from the December 2011 Minutes: <u>Value of Communication with PCP/Family or POA/Nursing Home Staff/Medical Control</u> A statement to the effect of: "EMS providers should communicate the discovery of decision making capacity and the patient's right to refuse transfer with invested parties. OLMC or the physician ordering transport must be contacted by EMS in this decision making process. It is suggested that the consulted physician discuss directly with the patient." <u>Documentation of DMC and discussion</u> "In all cases of patients who refuse transport, it is essential to document the elements listed above, to include: 1) Calm, competent, sober, and alert (from the C-Spine protocol) – absence of an acute medical/surgical or traumatic process that impairs the patient's capacity 2) Greater than 18 years, emancipated, or contact with guardian 3) What services were offered to the patient? 4) Their statement for refusal 5) Statement of risks and patient understanding of risk 6) Patient is aware they may change their mind at any time" Follow Up – 1) Discussion with Law Enforcement regarding their process of determining decision making capacity 2) Process mapping the outcomes in these patients – i.e.: should the EMS provider and OLMC determine a patient needs to be transferred but there is no support from law enforcement, what are the options for EMS? How to reconcile discrepancies between EMS and LEO for patients that refuse care but EMS believes (with OLMC) that the patient does not have decision making capacity but patient continues to refuse and police do not believe the patient should be restrained. Tim has come up with a stepwise process 1) Patient determined to not have decision making capacity by EMS 2) OLMC contacted 3) Patient discusses with OLMC 4) Patient still refuses 5) Law Enforcement is contacted 6) Law Enforcement evaluates and works through their process of determining whether the patient should be taken into protective custody (Tim has discussed with Augusta PD who noted most of their decision is based on mental health law and discussion with third party) 7) Should discrepancy exist between Law Enforcement and EMS – the police officer or police supervisor discusses with OLMC 8) Decision made between OLMC/Law Enforcement Caveats – 1) Maine General has robust security that allows police to turn the patient over to security and return to duty. 2) Have agreed locally to ensure excellent QI of these cases and education regarding the importance of excellent documentation. Discussion –	
Revisit – Protocol Review Process Discussion	Recap – Historic interest from the MDPB in altering the cycle length for protocol changes. Follow Up –regarding regional level discussions and polling constituents 1) Region 1 – MM comments heard were positive from region 1. One concern was expens of mandatory classes, although these services were enthusiastic about using MEMSEd do this on duty or on personal time. Some concerns about the lack of printed protocol books. 2) Region 2 – JL – discussed with providers during a chief's meeting as well as other venu	**MOTION: Chagrasulis: To alter cycle length of protocol changes to a 24 month**

Sent out a survey and had limited responses (9). Overall, responders appreciated the process of the review this last time. Suggestions for improvement were included (? Livir document, evidence based, thoughts that the basic and advanced online education sho be separate on MEMSEd.org). Regarding cycle length – responders were interested in moving to a more frequent cycle length.

3) Region 3 – TP/RP – performed a survey across the three regions. Received 104 replies Overall – support for a 2-year cycle.
4) Region 4 – see region 3.
5) Region 5 – PG – Fine with cycle length changes and were pleased with the roll out –esp face to face dialogue about the protocols.
6) Region 6 – see region 3.

Discussion on Motion –
PG – Why 24 months? Can we do this more frequently? BC – believes more frequently is unrealistic. JB – a 2-year cycle is also what we agreed upon earlier and polled our providers about.
JBrad – Interested in setting a schedule for review and an understanding of what our time frame and cycle is for the providers and services.
JL – Key to this is keeping to a time line

Note – will need to begin our protocol review process next month…

<u>New Topic – New England Regional EMS Guidelines</u>
Background – National/Regional – proposed components – guideline, education, QI markers – concept at the state level – these guidelines are an entry point will be matched to the NEMSIS a NASEMSO suggested guideline lists
Benefits:

1) Standardization across a large area
2) Work sharing – benefits to the MDPB, education
3) QI – standardization of language increases ability to review the system
4) Operational – formatting changes, flow of document

Downsides:

1) Decreased autonomy regarding protocols

Discussion –
JB – Questions if there need to be a rules change. JB – notes that as long as the MDPB signs o on this, there would need to be no rules changes.
HC – notes that the air medical programs are looking to do the same in New England (plus New York).
BC – scope of practice discussion.
PG – recalls historical process and the state experience with ASTM

<u>Medical Director Input</u>
BC – the protocols should be evidence based and working together – the more that process ma occur. This appears to be a "no-brainer". Will need to create dialogue internally and externally a the MDPB role will not change as we will still approve.
JB – Good thought – as long as we have core protocols and have flexibility to add on unique pieces as a state… Will likely take a technological investment of resources we already have to make this work.
PG – Cautionary comments – the "sweet spot" may be regional and new England based rather than nationally. Reflects on the process of moving toward state protocols – and the value of bei involved at a larger level.
TP – Exciting idea. Reflects on the potential process -
MS (for MC) – Interested in the idea and using data to drive decisions. Only concern is how to structure this and develop this in the future and get feedback from providers and other stake-holders… Need to make sure the providers do not feel as if the process I moving a step further from them..

<u>Regional Director Input</u>
RP – looking at best practices is good. I think this is a good idea. Only concern is, would this slo the process.

cycle for protocol review, feedback, development, and education.
Seconded: Pieh
Approved: ALL

	JL – We do have very large borders and this could be very helpful. Also with technological fixes we can address some of the issues of input. Helpful from a disaster standpoint. Asks – would it helpful to choose certain elements vs. looking at a wholesale change… Personal perspective is that Maine is very blessed by active medical direction and that we could be helpful in the regiona process. Shared educational resources could be very useful MM – thinks an evidence base is helpful. Would be inclined to look at this from a business mode is this feasible? How different are we from other states and can we identify a core set of protoco across the states. Education Committee DB – Like pooling resources – makes sense. As long as there is local reps for a “uber” committe	

Old Business	
MEMS Education	No meeting in May but working on transition modules and CEHs to align with national education standards.
MEMS Operations	Supplement coming out this Friday in daily papers across the state.
MEMS QI	
IFT Subcommitte	

Next Meetings – June 20, 2012

IFT – 8:30 – 9:30
MDPB – 9:30 – 12:30
QI – 1:00 – 3:00