STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY

MAINE EMERGENCY MEDICAL SERVICES

152 STATE HOUSE STATION

AUGUSTA, MAINE 04333

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Medical Direction and Practices Board
Minutes
October 19, 2016

Member Present: Dr. Sholl, Dr. Zimmerman, Dr. Pieh, Dr. Couture, Dr. Saquet, Dr. Kendall, Dr. Nash, Dr. Busko, Jo Horn (Community rep for IRB)

Members Absent: Aroostook and Southern Maine have open seats.

Staff: Shaun St. Germain, Jason Oko, Don Sheets

Guests: Rick Petrie, Stephanie Cordwell, Nathan Yerxa, Pete Allen, Joanne Lebrun, Dennis Russell, Kevin Gurney, Marc Minkler, Christopher Pare´, Dr. Michael Schmitz, John Kooistra

1) Introductions – Dr. Sholl
2) July 2016 MDPB Minutes – Dr. Busko, Dr. Pieh
3) State/Community Paramedicine/Medical Director Manual/CARES/Heart Rescue Update – St. Germain
    a. Community Paramedicine
        i. St. George submitted an amendment to their project which was approved by the steering committee.
        ii. Proposed legislation has been approved by the governor which will now be put forth to the legislature.
        iii. DHHS – Work continues to establish a definition of episodic care.
        iv. Humana is working with Maine EMS on the potential metrics and protocols that could be used for United to visit some of their members.
        v. Medical director manual is up on the website
    b. CARES – We continue to work on getting the registry running.

4) IRB – VT Naloxone paper – Jo Horn was present as the community representative for the IRB review.
    a. Dr. Sholl gave an overview for the new members present at the committee about the process of an IRB review.

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b. Dr. Dan Wolfson from VT is interested in evaluating the effectiveness and safety of EMT administered naloxone and wants to partner with Maine and NH to study this.
c. Motion to accept Pieh, Second Couture Unanimous

5) PEGASUS Update – No update
6) Special Circumstances Protocols – Region 1 special circumstances protocol – Zimmerman
    a. This is a young patient with Pulmonary Hypertension. This is a transport guideline to transport to SMMC if the providers are unable to gain IV access and direct to MMC if the patients access is regained.
    b. Motion to approve as written by Pieh, Second by Nash. Unanimous
    c. There was a lot of discussion about the LVAD protocol and the work that is now going on at MMC and how we might push out more education.
7) New Devices – NONE
8) Naloxone – Discussion surrounding concerns with 4 mg dosing provided to Law Enforcement. Anecdotal cases in which multiple doses in a short time and not a single dose issue. Report of 11 cases of agitation with single doses. Outcome - reemphasize the potential for agitation as an adverse reaction to opioid reversal.
    a. Reported shortage of Naloxone that has not been substantiated and does not seem to be a larger issue. There is general concern about medication shortages after the medication shortages of 2009/2010. Don Sheets has drafted a letter, similar to the letters distributed in 2009/2010, discussing response to a potential naloxone shortage. Will share with the MDPB for review.
9) Carfentanil – No confirmed cases yet in Maine (one report that was not substantiated). Will develop reminders to providers and services regarding personal protection and management of patients with suspected novel opioid overdose.
10) Hot packs – Pieh
    a. Review of one case in which a patient suffered burns from heal b=packs. Discussed a small number of cases with similar outcomes. The MDPB will develop information recommending services check their current heat pack supplies and order hot packs that heat to less than 113 degrees, avoid placing the heat packs directly on the skin and check the skin under heat packs frequently.
11) Protecting patient access to Emergency Medications Act of 2016 – Sholl
    a. Definition of Medical Director @ https://www.congress.gov/bill/114th-congress/senate-bill/2932/text
        i. Do not know exactly what the language regarding medical direction will require but will follow as this requirement may have a significant effect on Maine EMS Services.

1) Red Section – Zimmerman –
    a. Every change made at the level of the protocols has an impact – most of those impacts are positive, but even positive impacts require significant effort when applied at the population level. All changes made MUST BE in the best interest of the patient – some of these will be applied at the side of the patient while others will be system designs.

When thinking about all of our proposed protocol changes this year (similar to other years) I would like to apply the following change matrix:

b. What is the MOTIVATION of the change?
    i. All of our changes should be patient centric. Remembering that, from our vantage, our entire means of reaching patients is through our providers, provider benefit is a secondary goal.
c. What is the PURPOSE of the suggested change?
    i. What gap does the suggested change fill?
    ii. If no gap is present, how does this change IMPROVE what we are currently doing?
d. What is the EVIDENCE behind the suggested change?
    i. How does this change compare to what we are currently doing?
    ii. How strong is the level of evidence? Recall, strong level evidence suggests low to no risk with proven benefit and SHOULD be performed (almost uniformly). Weak level evidence suggests either less certain benefit OR risks that approach the level of benefit and therefore MUST be weighed based on local values and preferences.
e. What is the IMPACT of the suggested change?
    i. Education?
    ii. QI?
    iii. Communication/Interface with the healthcare system?
    iv. Medical Direction?
    v. Financial?
f. Alter the chest pain protocol to have 3 categories of Cardiac: Suspected Cardiac, Trauma, unknown etiology
    i. Can we push pearls to a separate page and work so the app opens them as a second page? Don will work on this
g. Add language to remind AEMTs that they are not licensed or certified to interpret 12 Leads. There is an ask, to reiterate in the education that the AEMT cannot modify the paramedic response in any case other than anaphylaxis. This was intended to be removed from the protocols during the 2015 update – but was not removed in the editing process.
h. Cardiac Monitor should go to the patients' side for initial review. There is a known behavior issue with this currently.
i. Make sure that we are only administering O2 to patients with less than 94% Dr. Pieh asked for a clarification that we want less than 100% (will use language from the AHA and others - 94-99%)
j. STEMI – Clean up the protocol so inclusion criteria are only under the paramedic.
k. Discussion regarding adding language about having pads ready in the event of dysrhythmia.
l. Add a PEARL for all MIs as there is no increased incidence of hypotension in Right side involvement. There is actually higher incidence in non-IMI
m. Update the Checklist for chest pain.
n. Add aortic dissection as a cause of chest pain.
o. Discussion re: the life vest- Dr. Busko is going to draft a letter to services to act as guidance about what to do with these devices.

12) Retreat discussion – Sholl

13) Medical Director course at Samosett – All

14) Old Business

a. Operations – Infection Control
b. Education – Chris still here no meeting
c. IFT – No meeting
d. QI – No meeting
e. Dr. Zimmerman 1239

QI Committee will meet at 12:30

1) Status of Patient Sign Off Project
2) Next Project