STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY

MAINE EMERGENCY MEDICAL SERVICES

152 STATE HOUSE STATION

AUGUSTA, MAINE 04333

PAUL R. LEPAGE
GOVERNOR

JOHN E. MORRIS
COMMISSIONER

SHAUN A. ST. GERMAIN
DIRECTOR

Medical Direction and Practices Board
Minutes
November 16, 2016

Members Present – Dr. Sholl, Dr. Zimmerman, Dr. Busko, Dr. Sequet, Dr. Nash, Dr. Pieh, Dr. Couture, Dr. Jalbuena

Members Absent – Atlantic Partners EMS is working to fill the Region 1 position, Aroostook EMS is working to fill the Region 5 position, Dr. Kendall

Staff – Shaun St. Germain, Don Sheets, Jon Powers, Katie Johnson

Guest – Dr. Dinerman, Ben Zetterman, Dr. Bohanske, Dennis Russell, Nathan Yerxa, Pete Allen, Joanne Lebrun, Gabriel Palomino, George Ferland, Wesley Tabb, Kevin Gurney, Dustin Nadeau, Chip Getchell, Dr. Ritter

1) Introductions – Sholl
2) October 2016 MDPB Minutes – Sholl – Tim, Kate – Unanimous
3) State/Community Paramedicine/Medical Director Manual/CARES/Heart Rescue Update – St. Germain
    a. NEMHS is pulling out of CP
    b. The medical director guidebook is up and corrected as the original PDF was missing a number of pages.
    c. Don gave and update about CARES and the entry work that is being completed.
    d. Protecting Patient Access to EMS Medications – We need to start messaging around the state to prepare services for the cost of a DEA license and involvement of a Medical Director.
4) PEGASUS Update – Sholl
    a. It has been one year since the final implementation of the PEGASUS guidelines and the project is looking to begin the data review.
5) Special Circumstances Protocols – None
    a. Discussions with Cardiology and Pulmonology
6) New Devices – NONE
7) Border Patrol and Naloxone

a. Don was approached by the US Border Patrol HQ about a naloxone program they have been working on and would like to implement nationally.
b. Gabriel Palomino from the US Border Patrol explained the rational for this program. The agency wants to be respectful of State authority and to be collaboratively with us for awareness and to ensure that we are comfortable with the program. They are trying to make this standardized across the nation and are very appreciative of our willingness to work with them to do this.
c. The MDPB were in favor of supporting this program and had no concerns with the agents following this even though some may be licensed EMS providers.

8) Naloxone/Heat Packs – Notices sent re: Novel opioids and Heat Packs – Thanks to Beth, Kate, Tim, Don and Shaun
    a. Discussion re: letter for use only in potential naloxone shortage.
        i. This letter is intended to remind providers that in the absence of naloxone we have the tools available to manage these patients and that we need to focus on airway support.
    b. Heat pack letter went out to services.
9) Discussion – Maine Freedom of Access Act and the MDPB's activities
    a. Katie Johnson from the AGs office came and presented information about the impact of FOAA on the operations of the MDPB.
    b. History – Due to some recent activities and concerns that were raised the AGs office took a look at how we were operating.
    c. Impact – MDPB cannot have offline discussions that will result a decision being made or deliberation prior to a meeting that could sway an end decision.
10) Red Section - 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:
    a. 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.
    b. 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?
    c. 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.
    d. What is the IMPACT of the suggested change?
        i. Education?

ii. QI?
iii. Communication/Interface with the healthcare system?
iv. Medical Direction?

e. Cardiac arrest AEMT
   i. There was a discussion about adding a suggestion to use of BIAD but this conflicted with the desire to keep a reference to manage airway as appropriate and direct providers back to the airway management protocol.
   ii. There will be guidance about volume and rate control specific to airway management and cardiac arrest.
f. Cardiac arrest Paramedic
   i. There will not be an addition of lidocaine
   ii. Double sequential defib – Motion is to insert consider dual defib, if no second defib consider changing vector Tracy, Tim – amended to include contacting OLMC for this decision pathway. 9-1 motion passes
   iii. Bicarb for specific suspected metabolic acidosis and changing language to if you administer contact OLMC remove OLMC orders for admin.
   iv. Add phone for use of amiodarone post ROSC
g. Checklist will have contact Medical Consult for complex cases added.
   i. Addition of a cardiac arrest checklist. This is not intended to be linear but serve as a reminder of areas to cover and ensure that they have been covered.
h. Termination of resuscitation – 20 minutes?
   i. Asystole – terminate?
   ii. Slow PEA – consider termination?
   iii. Fast PEA - 45 Minutes?
   iv. Refractory VF – 60 minutes? We will need to define refractory VF/VT
   v. More consideration needs to be given to this and Dr. Sholl and Dr. Zimmerman will bring a draft back next meeting.
i. Post Rosc –
   i. No change yet
j. PEARL about wide complex irregular rhythm will be added.

11) Old Business
   a. Operations – infection control programs are being discussed, the EMS awards and insert are also being discussed.
   b. Education –
   c. IFT - Did Not Meet
   d. QI - Did Not Meet

Motion to adjourn TIM 1258

QI Committee will meet at 13:00