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 Directors and Practice Board
December 21, 2016
Minutes

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

Members Absent – Dr. Jalbuena, Dr. Kendall, Regions 1 and 5 Currently Vacant

Staff – Director St. Germain, Don Sheets

1) November 2017 Minutes – Motion to approve Dr. Nash, Dr. Zimmerman - Unanimous
2) State/Community Paramedicine/Medical Director Manual/CARES/Heart Rescue Update – St Germain
    a. Staffing issues have been impacting the office. Jon Powers has left the office and we are seeking approval to fill the position. We have been told that the open EMD position is not going to be filled and is going to be cut from the state headcount.
    b. Community paramedicine(CP) - there is work being done to move CP from pilot status to a program administered by our Board such as all other EMS is currently covered
    c. Medical Director Education will be forthcoming as work continues.
    d. CARES data is being entered and we will be looking to contract with an individual to do some of the data entry temporarily as staff is stretched thin currently.
    e. Discussion – New England Council Meeting
        i. Dr. Sholl, Dr. Zimmerman, and Shaun attended the meeting with good discussions being had amongst the state EMS offices
        ii. REPLICA is an interstate compact similar to nursing and other allied health professions. This would allow providers to work across state lines without licensing. Maine EMS is watching how this is working through other states and is evaluating what steps would need to be taken to join the compact.
3) PEGASUS Update – Manuscripts are being sent for publication and review, data analysis will begin shortly.
4) Special Circumstances Protocols

a. This is very similar to a recent protocol that was brought to this committee, a Patient on Remodulin,
    i. **Dr. Pieh motioned to approve, Dr. Couture seconded, Unanimous**
b. Dr. Couture wanted to make folks aware that in the next 6 months there will be patients with implanted pumps and Remodulin amongst our patient population.

5) New Devices – NONE
    a. NOTE – after discussion last month – a letter went out to services re: Mucosal Atomizer devices.

1) Protocol Review – Finish Red Section, Next Pink Section, Begin Yellow 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?
        v. Financial?
2) Red Review
3) Termination of resuscitation(TOR)
    a. There is interest at the New England level to create a uniform or similar TOR protocols. Dr. Zimmerman will be working with the other Medical Directors to find ways to be more similar and to review the latest science.
    b. Dr. Zimmerman is going to send out the current language to the MDPB for feedback that she can take to the New England group
4) Cardiac Arrest algorithm

a. Airway management discussion. Clarified language that still leaves the decision in the hands of the on-scene provider to make a judgment call about how to manage the patient.

5) Double Sequential Defibrillation(DSD) is going to be changed to a Refractory VF/VT protocol – Dr. Zimmerman will send out the draft.
6) Proposal to add IN midazolam as premedication for cardioversion Dr. Zimmerman and Dr. Nash will look at the dosing necessary for this.
7) Narrow Complex tachycardia is going to be reformatted
8) Clean up to remove Pearl and add midazolam in Bradycardia for pacing
9) Add pearl in syncope for other causes
10) Follow-up on policy review for EMMC Cath-Lab
    a. Major change is a request to change the drive time from 45 minutes to 60 minutes. This would be calculated based upon non-emergent drive time. This is based upon system improvements in their system so they want to capture more patients to provide therapy.
    b. The group also wants to get the heart committee back together
    c. Dr. Busko motioned to accept the change Dr. Sholl seconded – unanimous

Pink

11) ALTE will be renamed BRUE - Brief Resolved Unexplained Event
    a. Language update
12) There will be a removal of time ranges in dosing across the board for medication admin.
13) Addition of pediatric Ketamine for Pain to be the same language as the adult pain management protocol
14) Clean up language peds seizures1 to just have call ALS
15) Removal of IV specific gauge in peds
16) Seizure and pain management will be moved to adult sections
17) Remove airway language on Pink 9 and just reference airway management protocol
18) Pink 11 5b added to include magnesium
19) Remove peds language from blue 6 number 10
20) Pink 11 Add adult Pearl from blue 7
21) Add bicarb and magnesium dosing recommendations to the peds cardiac arrest meds.
    a. Dr. Nash is going to look at the concentration of bicarb for peds.
22) Education about 3way stopcock to be added.
23) Kings are now available down to 3.5 kg fixing the previous issues with needing kings and LMA's

Yellow

24) Dr. Zimmerman is going to discuss bicarb dosing for peds and adults in toxins and arrest with Poison Control
25) Add reference to naloxone administration toreview the patient signoff protocol
26) Clarify language around auto injectors for organophosphates
27) Change yellow 10 to heat stroke

28) Clarification between Heat exhaustion and Stroke language “CNS dysfunction”
29) Clarify dose of tetracain
30) Add a CO protocol and don’t touch CN
31) Add clarification for drowning submersion to “unless if there is a known mechanism don’t manage spine” and refer back to spinal protocol
    a. Also add CPAP or other means of positive pressure vent
6) Discussion re: April/May Meetings
7) Old Business
    a. Operations - No
    b. Education - No
    c. IFT - No
    d. QI – Will be discussing spine management project.

PHONE: (207) 626-3860 TTY: (207) 287-3659 FAX: (207) 287-6251