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 Meeting
May 21, 2014
Minutes

MDPB members present: Dr. Sholl, Dr. Goth, Dr. Busko, Dr. Pieh, Dr. Zimmerman, Dr. Kendall, Dr. Randolph
MDPB members absent: Dr. Chagrasulis
Guests: Dan Batsie, Rick Petrie, Brian Chamberlin, Nathan Yerxa, Shawn Evans, Dennis Russell, Joanne LeBrun, Lisa MacVane, John Brady, Kevin Gurney, Mike Choate, Pete Tilney, Norm Dinerman

1) MDPB will begin at 9:30
    a. Review of April Minutes Motion to approve by Dr. Pieh, second by Dr. Randolph Unanimous approval

    b. State Update – Jay reported that the EMS awards ceremony will be tomorrow at the State House Hall of Flags. Weather permitting there will be a wreath laying afterword

    c. Community Paramedicine Update – 11 of 12 service participating 350 patient care reports have been documented. USM Muskie school will be taking over the evaluation piece of the projects

    d. New Devices
        i. Review of timeline for PEEP valves – Dr. Pieh has reported that this will be sent out after this meeting and can be discussed at the next meeting
            1. Dr. Sholl reminds the group of the process of regional review then lead time for the MDPB to review documents before the discussion
        ii. Dr. Zimmerman has asked that the MDPB review a new ETCO2 device which will be presented at the next meeting

    e. Special Circumstances Protocols – NONE

    f. PEGASUS and Model Guidelines Update
        i. States and stakeholders had the opportunity to comment on the draft protocols that went out. Second draft will be updated and sent out in the

next month or two. The group met recently to go over comments and comments were incorporated into the document.

ii. There is also discussion ongoing about when protocols will be available to the New England states for utilization and it may not be until the second quarter of 2015.

iii. Metrics are being worked on for determining the outcomes of patients and how EMS can implement them.

iv. Education is currently being built and a website is being set up to host this education. There will also be Apps, Twitter, Facebook and other social media products for end users.

v. Two of the protocols are going to be used in an actual study but a total of 8 protocols have been developed.

vi. Dr. Sholl would like to see what we can do at a high level about the utility of protocols across New England around the momentum of this project. Currently many of the study populations have been highly controlled studies in large urban settings in the best of circumstances. As we roll out these new protocols it could be interesting to see how this changes when large non-urban systems utilize these protocols.

vii. Permissive hypotension was a topic of discussion and the PEGASUS group chose not to engage in this due to lacking literature in the pediatric population as well as stakeholder feedback from pediatric trauma surgeons.

viii. Rick reported that Dr. Manish Shaw will be here in November for the MCOT conference and has made himself available for discussions.

g. Discussion with LifeFlight of Maine - Drs. Dinerman and Tilney

i. Discussion re: protocols, QI, etc.

1. Pete Tilney discussed LFOMs desire to focus the annual MDPB presentation on the clinical performance of LOM.
2. The case review process has been updated to better guide quality practice within LFOM.Every chart is reviewed by Doctors Dinerman or Tilney. In addition, all charts are reviewed by one or more crew members. As a third layer of routine review, all vented patients receive additional scrutiny by a designated LOM provider at each base with special focus on vent management.
3. Weekly Monday morning telephone conferences discuss what issues exist and if they are operational, system, or provider and how to best correct these issues.
4. Monthly there is a QAPI workgroup harvests teaching points from the month's case reviews. This leads to quarterly education meetings of case review rounds. This also offers the opportunity to look at trends of call types and helps to determine the necessity of protocol change and development.
5. This has also helped to create new metrics for what cases get reviewed. The intention is to help look at system utilization to aid in education of services for appropriateness of transport modes. Both to call earlier or call more appropriate service.
6. One major topic of review has been their review of their own triage system for which hospital they transport patients to.

7. What has been identified is with a new review system is that they were missing charts that had great benefit to the system for educational points both positive and negative and being less specific about the criteria they are casting a wider net over the process and capturing more patients.
8. Protocol Development is being redone and is currently in the revision process.. Items for change, this includes additions and subtractions of medications within the following groups or treatment modalities
    a. Anti-hypertensive management
    b. TXA – Discussion was had about what value this medication had in scene response where data does not demonstrate any benefit of speed as long as the medication was administered within 3 hours. With LFOM short transport times is there truly a benefit with the cost of stocking the medication. There are however, transports which require considerable time. Dr. Sholl and Dr. Busko reflected that the data did make some indication that speed may play a factor but the study was not designed to drill down much beyond the 2-3 hour window.
        i. Dr. Busko asked if there would be other indications for this medication other than trauma. He referenced the use for years in OB patients with uncontrolled hemorrhage.
    c. Prothrombin complex concentrate
    d. Mannitol vs Hypertonic Saline
    e. Airway changes on the use of the Storz CMAC
        i. Passive oxygenation
        ii. Increased use of Ketamine
        iii. Pulmonary Embolus
    f. Cardiac (STEMI patient management) has still been an issue for LFOM as the three centers they work with have different guidelines
    g. New guidelines surrounding skill maintenance and training. There is improved documentation of process and individual provider training.
        i. This started a conversation about process and if individual providers have different sets of allowable skills. LFOM is making every attempt to move to a single set of skills to eliminate the difficulty caused by patients not receiving the same care.
    h. Non-prescribed intervention – this has been an ongoing issue for LFOM as they routinely get asked to perform or assist in procedures outside of their prescribed protocols (as “Off-protocol or Non-protocol” interventions. LFOM has worked diligently to set a scope and stick to it. This has included increasing training in some areas and placing hard stops on some procedures (such as peri-mortem C-sections or field amputations). This effort was to reduce the gray

area that provider are often stuck in. Protocols evolve to reflect contemporary practice, with due regard for the need to maintain individual experience rates to sustain any given skill set which is required.

9. LFOM Advanced airway
    a. 2006-2013 679 cases of advanced airway maneuvers.
    b. Implementation of the CMAC to improve the safety of patients in RSI procedures
    c. Extensive review of the various outcomes of patients looking also at the comorbidities of patients about some elements making it more difficult. With increased training and direction about the best practices of increasing success has increased the success of the providers at managing the patient's airway. Expectation is now that the CMAC be used on all intubation attempts. The addition of the CMAC has increased success to 95% first attempt success. This is a one year look and they are excited to see if this continues over time as they continue to work on the process of airway management to include all tools in association recognizing that no single device will be the magic tool but using tools together can increase success.
    d. Passive oxygenation appears to have decreased the number of hypoxic events that LFOM has experienced.
    e. LFOM has additionally started setting targets on many procedures and times and looking at this with other agencies across the nation to compare and learn from each other to determine best practice.
    f. The creation of a stat launch process for the Transfer Centers and MedComm, enables immediate activation and launch of the flight team for selected patients. This is in parallel with the identification of an accepting physician and hospital destination.

h. Review and Approve Law Enforcement/Fire fighter Narcan Education
    i. Jay distributed a PowerPoint for review by the MDPB as an option for approval by the MDPB.
    ii. Dr. Zimmerman expressed concern about the dosing scheme in the presentation and the possibility of violent outcomes with the full 2mg dosing recommended. Dr. Goth echoed this concern that these patients.
        1. Jay discussed that the issue here is these are untrained people providing this medication and while there is concern it may be difficult to educate individuals about incremental dosing.
        2. Dr. Busko recommended half in one nostril wait 5 minutes then give the second half in the other nostril if the patient did not improve. Dr. Sholl echoed this as simple but safer than giving the whole dose but not perfect.
            **a. Motion by Dr. Randolph Dr. Busko to incremental doses 6 for 1 against**

3. Much discussion about what the correct increments were. Dr. Sholl reminded folks that the way the law reads is that this may be patient's Narcan rather then something the fire department or police officer bring. This may mean that the frequency is going to be low.
4. Dr. Busko recommends that as the pediatric dosing already requires quarter dosing so this would be consistent across all patients.
5. John Brady brought up the point that this training does not include training on identifying death and patients may not get CPR when they should.
    a. **Dr. Pieh made a motion of half the dose wait one minute then the second half if there has not been a response. Dr. Zimmerman seconds. Dr. Goth's discussion is that he is concerned about titration. Dr. Sholl made a comment that these patients won't be titrated but will be woken up as these police and fire individuals will not have the training to make the determination of what is appropriate. Vote 6-1 pass**

iii. The next item of discussion is what we do with cross trained fire fighter or police officer.
1. There was discussion about the MDPB about allowing fire fighters and police to perform this if so trained and approved by their service.
2. John Brady expressed concern about his service and that they are licensed as a service and would have a lot of confusion about who can do what and when.
3. Don Sheets echoed that this from a training standpoint may cause issues as we have told individuals hoping off a fire truck can't perform skills without appropriate equipment and following protocol. This may be an issue as it goes against this message.
4. Dr. Sholl offered that for now we state that individuals act within the role they are responding in and utilize this protocol as approved by the service and state. There was a lot of discussion amongst the MDPB about variance in training and practice.
    a. **Dr. Pieh motioned that any licensed provider act within the scope of MEMS protocol if you are licensed and responding for a MEMS licensed service. Second by Dr. Busko Unanimous approval**
5. The discussion was that current practice is providing better care than the mechanism of the unlicensed training.
6. Dr. Zimmerman asked what risk a physician incurs if they provide a prescription to a police department. The answer was they are providing a prescription to an unlicensed
7. Chris Pare shared that it would be helpful to have a letter sent out from the MDPB or MEMS about rational for keeping providers to the MEMS protocols.

i. Preparing for upcoming protocol review

i. Consensus agreement on MDPB responsibilities and process to prepare for review
    1. Dr. Sholl reminds the group that medical directors need to be prepared for these discussions and he asks that people ask questions ahead of time so discussion can be purposeful. Provide evidence to support your rational for change. Dr. Pieh asks for one to two weeks ahead that the literature be put out for all to review and digest.
ii. Review of first conference call and discussion of upcoming schedule – The first conference call has happened already and feedback was positive from those involved. Roughly 40 participants were involved in the call.
    1. Joanne commented that having the protocol available for the discussion as it would be an added visual.

j. St George Community Paramedicine interest in B12 program –
    i. Follow up with Dr. Randolph and discussion on process for inclusion in the CP program. It was determined that this is best served through the CP steering committee reviewing this as part of the CP project.

k. Old Business
    i. Education – No new news
    ii. Operations – Rick reported that they EMS awards will include the first wreath laying if the weather cooperates. The 4th EMS week insert went out Friday in the paper.

**2) Adjourned 1243**