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
June 15, 2011
9:30 am – 12:30 pm
Minutes

Medical Directors Present – Marlene Cormier; Rebecca Chagrasulis; Tim Pieh; Jonnathan Busko; Whitney Randolph; Matt Sholl; Steve Diaz

MEMS Staff – Jay Bradshaw; Dawn Kinney; Kerry Pomelow; Drexell White

Regional Coordinators – Joanne LeBrun, Rick Petrie

Guests – Jeff Regis; Brian Chamberlin; Rick Petrie; Myles Block; Nathan Yerxa; John Brady; Butch Russell; John Kooistra; Chris Paré; Tim Nangle; Sandy Benton; Heather Cady; Mike Senecal; David Robie; Jessica Blomerth; Peter Daigle; Don Sheets; Ginny Brockway; Mike Choate; Joanne LeBrun; Shawn Evans; Eric Wellman; Julie Ontengco

May 2011 Minutes	Reviewed by MDPB members in attendance	MOTION: Cormier to accept, second by Chagrasulis, unanimous approval
ME EMS Update	Bill LD 1489 passed to allow us to share health information gathered through EMS for research and improvement activities, and likely to go in effect mid September 2011; other changes also attached to this bill and previously discussed; Legislature to vote on budget today (on their docket), EMS held flat which is good news; the bond bills are dead we believe; do have a vendor for updated protocol books.	Informational
New Devices	No new devices submitted for proposal; special notice that we have a centralized process for device approval, and we use the MDPB – there are a number of retailers and device manufacturers approaching services and individual providers and stating that the service or individual can use a device, but they may not always have the most up-to-date information. Caution needed before buying new devices to be sure that they are approved. The vetting of devices and subsequent approval is done by the MDPB.	Motion to clarify that ITV devices not approved by the MDPB by Dr. Sholl, second by Dr. Busko, unanimous approval.

	Discussion around ITV, and a motion made to clarify this	
Special Circumstances Protocol	How does another service in a facilitated way adopt a similar protocol to the suspension protocol approved last month. Example: We have about a dozen Congenital Adrenal Hyperplasia protocols in place. We have used the mechanism that those who add a CAH protocol have it vetted by Dr. Sholl and he reports out to the MDPB. Would recommend that the regional medical director and state medical director could approve similar protocols at other services. Operations wondered if it could be part of our standard protocols, and Dr. Busko advocated for Companion book completion that began years ago.	Consensus to continue the suspension protocol adoption as we do with CAH protocols, and to reconvene and complete the Companion Book.
Discussion on Protocol Process	(1)Who leads what section for next cycle, and can we assign that now (sections are Purple/Brown/Grey/Black; Blue; Green; Red; Yellow; Pink; and Gold). MDPB member assignments made. (2)What is the proper cycle length for updates? Three years may be too slow. Chagrasulis thinks everyone should check their sections annually for significant updates, but true annual updates too much. Busko thinks a two year cycle would be a reasonable goal, but we should be sure our EMS and physician and other colleagues know who is responsible for each section, so feedback can be ongoing. Randolph reminded us to weigh the educational impact of changes and how we sequence that – but that ongoing major information updates as they occur would be important. Overall reissuing of the total book should probably every 2-3 years. Sholl discussed a bit about how this process might work, and echoed by Diaz, and be sure to have Education and Ops in the loop so the process works on all fronts. Also, do not forget OLMC as they will need to be updated. Pieh thinks two years is the right cycle length. Cormier thinks two years is the right update length. Kerry thinks a two year cycle length might make educational updates more tenable, and Chamberlin thinks if education can look at our current update and give feedback to us based upon how they educate this current update, they could let us know what might be a good cycle length as well. Petrie thinks it is reasonable to speed up the cycle length. LeBrun commented that we should see how we do this roll out and think more critically of improving our roll out process. Also, how do we handle urgent updates – is there an improved way to do this. Dinerman commented that some of the issues we may want to look at are distance learning opportunities and iPad or iPod leveraging of information and protocol book	(A) MDPB Member Assignment to the Protocol Sections: Purple/Brown/ Grey/Black – Sholl; Blue – Pieh; Green – Busko; Red – Cormier; Yellow – Goth with Sholl to partner with him on this; Pink – Chagrasulis; Gold - Randolph (B) Process from this point on for protocol change ideas…. 1. State and region to advertise the leaders of specific sections 2. Notify services/providers to contact these people with interests in the future 3.a. Why the change – evidence behind the change and how often are we doing this? 3.b. What is the pro/con of the change 3.c. What are the

	access. Lots of discussion on leveraging technology and supporting those who have challenges perhaps with contemporary IT platforms. Proposed process by Sholl to ask state and regions to advertise leaders of the sections as assigned today, and during this advertising process, mention the process for change – and if ideas for change proposed, contact the leader, and we need to know the evidence, the impact to our protocol, the impact to our education endeavors, and the impact to overall operations. Leaders compile these changes and bring major earth-shaking articles to the MDPB for considerations – really by critical in our reading. And, Education will give us feedback on our educational roll out process. Also, we will look to plant seeds to OLMC on our potential changes. (3) Committed to our historical format for current update, but do we need to look at the format for the future. Sholl presented North Carolina, which he likes, and he reviewed their format. He also presented New Hampshire and Pennsylvania. And where does the book live – printed, Blackberry, Toughbook, iPad, iPod, etc. Busko brings the idea of a full book of protocols and then a tightly edited, bulleted book that could be on any device – that the small and bulleted book is most useful. Randolph used his book only as a reference document. Chagrasulis likes the current format but understands a transition is in place – the small book is helpful. Dinerman clarified that the idea of the Bible that is the full reference book has an edited version such as the ten commandments or pilot check list which is a minute by minute user friendly format. Choate had an idea of a Basic EMT book and then an ALS book (is the basic book plus ALS protocols)? Out of all the prehospital providers, majority are Basics. This operationally could be a bit of a challenge. Chamberlin posited querying those they update on the current protocols, and asking them how they would like the info. Also, could we also inform people of available applications to help as reference materials.	impacts of the change from an educational and operational standpoint 4. Those leaders to bring evidence based meritorious information to the group when it arises 5. Hear from Education Committee as the roll out process for the 2011 protocols occurs. (C) Sholl and a group will look at the Companion book as well and specialty protocols and try to finish and bring to the MDPB.
IRB Discussion	Why does Maine EMS have to be an IRB? Prehospital care is overseen by Maine EMS and it empowers the MDPB to set protocol, and thus, the MDPB needs to protect patients when a research project may What have we historically been doing? We have been following the rules, but on an ad hoc basis. DO we need to augment our processes? Yes, everyone should be trained per the web-based program, adoption of a handbook which has been	

	What resources exist for us to do this job proficiently? Community member: Sholl has a Ph. D. colleague who might make a good community member – Busko teed up whether this Ph. D. candidate would qualify as a community member given her link to the research community – discussion of appropriate community member, and Diaz volunteered one of his non-medical staff as this member pending further elucidation.	
MEDCU Pilot Project	MEDCU came to us to have a pilot project to have a tiered response based upon the 911 call – we approved a majority of this but did not approve those that were intoxicated to have a tiered response – but falls with no injury, CO exposure, obviously dead and poison control calls and they are here to update us on progress. Daigle, Kooistra, Brady, Nangle, and White are here to present. Since September 2010, 5400 total calls, and 134 calls met criteria for study inclusion, and those were patients who were dead (17 calls) and public assist (117 calls) without injury – CO response is less than 40 calls per year. Thus, did not look at CO calls. Also, only a handful of poison center referrals, and some other operational issues were going on, so did not look at this group either. Fifteen percent of the time (20 patients), an ambulance was requested from the 134, but none of these were for patients who were obviously dead. Of that fifteen percent (the 20 patients), many times this was a second call request, where the ambulance request is on the second dispatch to the same patient (and usually within the hour of the second call). The educational roll out was done twice, in order to improve documentation and compliance. Crews called for ambulances to scenes in large part because the patient required some sort of help that was not available from EMS and that the help is not emergent, but the patient most likely will keep calling since they need resources not readily available. 72-hour follow-up from those going to Mercy or Maine Medical Center shows no one showing up as far as we can tell from those in the study inclusion except for the 20 patients who had transport. Long-term goal is to reduce overall resources, but this is a lot of up front resources to implement.	Request to have written report for MDPB and then to MEMS board. Components to include pilot proposal, operations, lessons learned, education, pilot decisions on inclusion, data, and data follow-up. With appendix of materials used.
Community Paramedicine	Task force August 8, 2011 and Steering Committee July 11, 2011 – both at MEMS	Informational
Old Business		
MEMS Education	Lots of time on protocol education roll out with hybrid of web-based and classroom teaching model, and looking for MDPB to help teach; also looking to see how materials may be sorted to class teaching, web teaching or companion book. Each of the regional medical directors to	Informational and directive in medical directors participating in protocol roll out.

	attend a regional education meeting/forum and Sholl to bridge by attending all. Have adopted Appendix G, TCAP document – and also doing some amendments, and United Ambulance has submitted to be a training center.	
MEMS Operations	[Rick, I missed this – was teasing you too much – can you fill in and send to Matt – thanks!!] Reviewed changes in licensing program in MEMSRR	Informational
MEMS QI	Did not meet last month, in the April meeting teed up working on draft state QI manual, and we are changing the voice of the document per feedback we received. We meet today to discuss this process and need to fill in appendices.	Informational
IFT subcommittee	Algorithm reviewed and continued amendments, and need to loop back to QI	Informational
Maine ACEP Rep	Need a Maine ACEP rep to the MDPB with Diaz stepping down after today – this request is being circulated	Plea

Next meetings – July 20, 2011 (We will not be meeting in August 2011)

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