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 20, 2012
9:30 am
Minutes

<table>
<tr><td colspan="3"><u>Medical Directors Present</u> – Kendall, Cormier, Randolph, Sholl, Pieh, Goth, Chagrasulis
<u>Medical Directors Absent</u> – Busko
<u>MEMS Staff Present</u> – Kinney, Leo, Bradshaw, Powers
<u>Guests</u> – Rick Petrie, Kevin Gurney, Shawn Evans, Tom Judge, Mike Choate, Ben Murphy, Kerry Sousa Pomelow, Kevin Duross, John Brady, Chris Paré, John Kooistra, Terry Walsh, Marc Minkler, Don Sheets, Butch Russell, Michael Schmitz, Nathan Yerxa, Norm Dinerman, Joanne LeBrun, Dan Batsie</td></tr>
<tr><td>May 2012 Minutes</td><td></td><td>Motion to Approve: Pieh
Seconded: Goth
Approved: All</td></tr>
<tr><td>ME EMS Upd</td><td colspan="2"><u>Bradshaw</u> – MEMS Board reviewed the draft rules changes suggestions – the decisions will be complied and submitte to the AG's office. Public hearings expected in the early fall – with draft version published before
No budget changes to date. Working on Zero Based Budget reports that will be used for FY 2014-2015</td></tr>
<tr><td>New Devices</td><td colspan="2">None Submitted</td></tr>
<tr><td>Special Circumstanc Protocol</td><td colspan="2">None Submitted</td></tr>
<tr><td>Agitated Patient Pilot Project</td><td colspan="2">W Randolph - Mid Coast – few cases in comparison to earlier in 2011. Still seeing the patients but the behavior is not as severe as before and seeing fewer numbers of these patients in whole.
R Petrie – No cases he is aware of in the Bangor area.</td></tr>
<tr><td>Life Flight of Maine – Non-Prescribed Intervention Policy</td><td colspan="2">1) <u>Review the policy and the impetus for the policy</u> – T Judge – 1,600 pts/year. Generally require significant needs from the providers. Discussed the QI process for LFOM. Occasionally encounter events or patient needs outside of the protocols – review these events. 83% of patients are IFT's. Most of the events described are in the IFT patient population and often there is a physician present who asks for assistance with a procedure or therapy (gives the example of pericardialcentesis and discusses central lines). And wants to have a clear discussion for the crews to involve medical direction. Notes that discussion with the medical director's is not always possible… How often does this happen – answer < 1. And how often is the crew NOT able to contact OLMC -
2) <u>Question #1 – Is this policy operationally necessary?</u> – M Cormier – Yes, T Pieh – Yes, but I struggle with not contacting OLMC, P Goth - Need to account for the nuances that occur on the scene – this is not unique to LFOM, J Busko (written comments) - "I would say "yes," a policy like this should exist (see commentary after my answers). There are situations that are infrequently encountered by LOM for which a protocol does not exist and cannot exist.", W Randolph – Having an "Unusual Circumstance Protocol" is reasonable, R Chagrasulis – Mixed feelings – concerns about how this relates to the rest of the EMS world, but if we are going in this direction, do we go here for everyone?
3) <u>Question #2 – Is the policy medically safe for patients?</u> – K Kendall – Yes, presents heroics but gives range</td></tr>
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	for the providers caring for the patient noting that they must contact OLMC afterward, M Cormier - , R Chagrasulis – I don't think this is safe applied to the whole of EMS - but yes in the context of LFOM, W Randolph – Comments on Just Culture – can we apply this to EMS?, J Busko – "A qualified "yes.". There are patients who will require potential death-staving interventions that are not adequately addressed by the protocols" 4) <u>How is the QI process structured?</u> – Norm or Kevin contacted – triggers the ERT (Event Review Team) – separate from the other QI processes… Norm and Kevin review these charts as well to look for these cases. Also review all airway, peds, chest, blood and Art Line cases… Does not believe that these events can be missed but believes that the events cannot be missed… Make up of the ERT – Lead by physician (was Kelly Klein), pilot, and one of the flight crew – then multidisciplinary, medics, nurses, mechanics, etc. who have gone through the event, then monitor this provider's charts. 5) <u>Is there role for the MDPB or another outside stakeholder with knowledge of the EMS system in Maine to be involved in that QI process?</u> – Norm – It depends on what level the MDPB wants to be involved – MDPB is involved in the CPC, Kevin's monthly meetings on QI does have outside person's on it, What about the ERT? T Pieh – don't think that the MDPB should be involved in day-to-day reviews BUT interested in summary of events that occur at the level of the MDPB – able to review generically – T Judge – review this as a part of the annual review. MOTION – The MDPB approves the policy with the understanding that all events reviewed within the policy are presented in the LFOM annual report. T Pieh Seconded – P Goth Discussion – Approved - ALL	
Community Paramedicine Update	The Board of EMS approved the guidelines for CP projects. After August 30, 2012, Maine EMS will be able to approve applications. Approval process will include the CP Steering Committee. MEMS working on contract for new CP coordinator.	
Medication Shortage Update	Update from the Regions – New Shortages Region 5 – nothing to report Region 3/4/6 – no new changes have gotten close to having critical shortages but have been resupplied within time. Region 1 – Some hospitals short of epi and bicarb – but no substitutions for EMS. Have heard about concerns but nothing new. Region 2 – Nothing new Review alternatives to benzodiazepines for seizures	
Discussion: Patients with decision making capacity refusing transport	Follow Up re: Systems adopting processes to integrate with Law Enforcement re: these patients.	
Revisit – Protocol Revi Process Discussion	Recap – Concept of New England Regional Protocols	
MEDCU Pilot Project Follow Up	Last reviewed in July with the intention of a six-month follow up. Need to review the status to date, in particular the MDPB would like to review the following: 1) Numbers of patients encountered, "type" of patients (based on dispatch determinant code), 2) Number of ED visits to local hospitals within a 72 hour period, 3) Number of hospital admissions within same period of time, and 4) Leadership's overall impression on the merits of the program and discussion re: continuation vs ceasing the program based on the impact vs. the outcomes and benefits	

	Total patients in > 18 months = 324 (estimated 1.8% of the patient encounters) 50 were obvious deaths 274 were falls without obvious injury – of these – 45 were transferred, 229 were not transferred (18.2% transferred, 81.8% not transported). Of the 229 – 18 called 911 again, 13 presented on own to hospitals locally (31 total reentered the medic care system – or 13.5% of the 229 Of these, approximately 8 were admitted to the hospital (all within the first review period) = 8/229 = 3.5 % Thoughts from the service 1) Large amount of effort to do this. 2) Will only work if the EMD protocols are followed strictly 3) Going to fewer public assists given that the service is using EMD thoroughly 4) Would like to make it permanent – understanding the workload on the service. (Of note, did no enact the CO policy, Also received push back from dispatchers regarding poison calls therefore have yet to enact that policy – would have been 31 calls for 2011). T Walsh does not know whe this can be expanded – discusses elements that will be addressed in the rules. Notes the importance of culture change via this program Discussion – this is been accomplished as a pilot project for now – if continued, could continue as a pilot to amend practice (which is a board decision). Others wishing to do this project would have to meet the similar performance requirements of MEDCU. MOTION – T Pieh – To continue the pilot project as described with alterations at present. SECONDED – M Cormier Discussion – What are the reporting needs? Pilot currently describes 6-month reports back to the MDPB Approved – All	
Old Business		
MEMS Education	Continue working on transition courses and continuing CEH modifications and CVO modifications – but nothing new to report	
MEMS Operations	Reviewed the EMS Supplement at last meeting and strategizing for the future. Permission to post the .pdf of the supplem on the website. Contract committee met and contracts renewed and sent to regional offices.	
MEMS QI	Reviewing the QI project today.	
IFT Subcommitte	Work-plan discussed at today's meeting	

Next Meetings – July 18, 2012

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