STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
152 STATE HOUSE STATION
AUGUSTA, MAINE 04333

JANET T. MILLS
GOVERNOR

MIKE SAUSCHUCK
COMMISSIONER

JAY BRADSHAW
DIRECTOR

Medical Direction and Practices Board
October 16, 2019
Conference Phone Number: 1-720-707-2699
Meeting Number: 345 024 1513

This meeting is combined with the LifeFlight of Maine Clinical Practice Committee. Meeting begins at 0900 to accommodate, versus normal 0930 time.

MDPB Minutes – Meeting begins at 0900

PRESENT:

Members: Tim Pieh, Kate Zimmerman, Matt Sholl, Seth Ritter, Beth Collamore, Pete Tilney, Mike Bohanske, Bethany Nash, Matt Opacic
Staff: Jay Bradshaw, Chris Azevedo, Marc Minkler, Jason Oko
Others: Rick Petrie, Chip Getchell, Ben Zetterman, Dr. Norm Dinerman, Nick Hansen, Joanne Lebrun, Mike Choate, Chuck Hogan, Kelly Klein, Steve Smith, Brock Robinson, Julie Ontengco, Peter Goth

Minutes: CMA

1) Introductions/Roll Call

2) Sept 2019 MDPB Minutes
    a. Tabled for November meeting
3) State Update
    a. Medical Director's Resources
    b. CARES
        i. Ongoing work with EMORY to harvest info from MEFIRS system. Jason has spoken with some services regarding entering their own data
    c. Heart Rescue/RA- updates for next May's conference given
    d. EMC-C: report by Marc Minkler regarding Samoset events and upcoming projects
    e. Staffing and new MDPB positions- Jay Bradshaw

i. Sam Hurley, the new EMS Director starts Monday. Jay staying to assist with transition
ii. Announcement forthcoming regarding licensing agent
iii. Closing applications for data position on Friday
iv. Legislation- same as last month (see minutes)
    1. Also, bill allowing paramedics to work in hospitals- Dr. Ritter and Mr. Bradshaw described.
    2. Bill requiring telephone instructions for CPR, which dispatchers have been doing in some places already
    3. Bill dealing with e-cigarettes, healthcare coverage
    4. Bill to sponsor blue ribbon review of Maine EMS system structure

4) Special Circumstances protocols- none
5) New Devices- none
6) Medication Shortage issues
    a. Sodium Bicarb- ongoing discussion on supplying it in vials
    b. D50
    c. Epi
    d. Dr. Nash has worked on education which has been posted on the web
    e. Dr. Nash discussed use of available packaging of meds in shortage
    f. Clinical Update was put together regarding Medication Shortage Procedures and training for it (slide show posted on web page)
7) Protocol Update Process
    a. Five are completed. One more in Bangor tomorrow. Discussion of how these are going ensued.
    b. MEMSEd- Chris Azevedo
        i. 2 issues- MOODLE and Storyline
        ii. Exam creation for end of the program
            1. It was asked at one of protocol updates if this exam could be made available publicly. Yes, it can be.
            2. Section authors could submit questions from their sections.
            3. Narration- MAINE EMS is looking for section authors to assist with narration of sections
        iii. FAQ section in development. Will bring to next MDPB meeting.
        iv. Rick Petrie asked if services would be able to upload the protocol review course SCORM packet to their own LMS, where services have them. Yes, they can.
    c. Dr. Sholl would like to spend some time in debrief of this process with MDPB, possibly in December. Asked for ideas for improvement regarding this process
    d. Consider next process timeline, with consideration for building the education part.
8) Approved equipment
    a. Jason Oko has been working to create agreement between Rules and MDPB regarding approved equipment
    b. two issues last month

i. VL-already done
ii. mCPR devices
    1. Dr. Bohanske- how do we provide guidance on devices which are safe and which are not?
    2. Need device to meet AHA metrics, but they change
        a. So, phrase it to cover changes "meets current AHA requirements"
    3. Discussion on language regarding quantifying "well-studied, significant exposure" piece.
    4. JAMA cardiology article on an older trial (Bohanske discusses): heat map calculations regarding relationship between compression rate and depth
        a. 107 bpm and 4-5 cm depth best outcomes in cited study
        b. Aligns with AHA recommendations
    5. We should have our mCPR devices performance specs align with the evidence presented
    6. Recommended language for mCPR approval: "mechanical chest compression device meets current AHA recommendations for both rate and depth"
    7. Motion to accept language by Dr. Bohanske; seconded by Dr. Pieh; motion approved

c. Approval of restraint language
    i. Discussion of verbiage for elements for restraint approval
        1. Currently- "commercially available soft restraints"
        2. Dr. Collamore- hospitals in her region are going to "releasable" device, to facilitate quick removal from restraint if needed for patient care. Do we need to adopt this likewise?
        3. Dr. Pieh- do we need to spec out 2-point, 4-point, etc.?
        4. Marc Minkler- do we need to consider disposability with regard to soft restraints, in cases of contamination?
    ii. Soft, mechanical, disposable or easily decontaminated, capable of being released with a key or alternate device,
d. Motion by Dr. Sholl: approved devices must be mechanical, soft, disposable or easily decontaminated, and capable of being released without a key or alternate device, allows for continual evaluation of distal perfusion (SpO2, etc., distal to placement; second by Dr. Pieh; approved
e. Kelly Klein- allows for continual evaluation of distal perfusion (SpO2, etc.)
f. Question regarding a need to specify whether this should be 4-pt, 6-pt, etc.
    i. Dr. Sholl- no, with the object being to leave that decision up to the provider in order that the degree of restraint be appropriate for the particular situation. He and Dr. Collamore can work on language for the FAQ
    ii. Dr. Collamore- suggests a hyperlinked video on restraint (MOAB, etc.). Dr. Pieh continued with linking with local hospitals in training. Dr. Sholl-

suggests working offline on training resources for education regarding restraints. John Kooistra suggests an instructor who has a class on restraints

g. NOTE: Add request for requirement for provider training on restraints to FAQ section of protocol update.

9) ET3 - Dr. Sholl
   a. Dr. Busko, Dr. Sholl and Mr. Bradshaw have been discussing process and resources for services that have applied to be ET3. Product we need to work on is the pathways to define a patient who can be cared for in an alternate environment than a hospital ER.
   b. 2 pathways
      i. Create new resources
      ii. Find ways to utilize existing resources
   c. Cautious regarding nurse triage systems
      i. Suggest resourcing a physician, PA or NP working in an urgent care/ER setting

10) TOR enroute to hospital discussion- Dr. Tim Pieh
   a. Situation: patient dies while enroute to ER and want to drop patient at local ER, so they can clear for another call
   b. Have been reaching out to resources to find out where barriers are originating from. Reaching out to hospital medical directors and system medical directors
   c. Perceptions in hospital differ from what the rules actually say
   d. Efforts should be centered around re-education and information regarding what the rules actually say

11) PIFT- Drs. Sholl and Tilney
   a. In past processes, there have been a small core group working on this, who brings back suggestions to MDPB for approval
   b. Should retain this mode of operation
   c. There has been continued interest in overhaul of PIFT and having MDPB participate in this process
   d. Dr. Tilney-
      i. Looked at what IFT looks like in the state right now? We don't know
      ii. Some perception is that IFT = SCT
      iii. When they looked at runs, they were surprised about lack of supervision on many calls.
      iv. Started to identify what issues are; then split them up; decide who is providing oversight for PIFT calls;
      v. Ideas for soliciting medical directors specifically for oversight of PIFT level calls, and qualifying it with requirements for having PIFT
      vi. Have to acknowledge that hospitals have a significant stake in care of patients for which they've begun care and then are transferring somewhere else.
      vii. Must define difference between PIFT and SCT and help entities better utilize each appropriately.

viii. Organizations doing these Must have certain pieces in place to support each
ix. Rick Petrie
    1. Asks that MDPB consider making recommendation that MEMS get out of the PIFT business. Not enough resources to stay fluid and keep updated. Writing single program to fit all needs is impossible. Set a deadline after which PIFT will no longer exist. If you want to continue doing such transports, you must contract with a medical director who will be responsible for overseeing training and transports.
    2. Mr. Bradshaw comments not to be too hasty, as PIFT is incorporated into Rules now. There are many considerations to make.
    3. Discussion ends at this point.

12) O2 Administration and Airway Data (MEFIRS)- Jason Oko
    a. PPT with pie charts
    b. CPAP is most common airway intervention

13) Old Business
    a. Operations- nothing
    b. Education- nothing
    c. QI- meeting today. Newsletter 2nd quarter is forthcoming
    d. Community Paramedicine- meeting next month
    e. Maine Heart Rescue
        i. Discussions ongoing.
        ii. 28-29 May NNE RA date

14) Motion to adjourn- Dr. Tim Pieh motioned; Dr. Beth Collamore seconded. Approved.