Meeting Minutes

Subject:	Medical Services Committee
Date:	September 9, 2016 – final
Voting Members:	Dr. Burstein (chair), P. Brennan, Dr. Cohen, Dr. Conway, Dr. Dyer, S. Gaughan, Dr. Geller, Dr. Gutierrez, Dr. Old, Dr. Restuccia, Dr. Tennyson, Dr. Tollefsen, Dr. Walker and Dr. Walter.
Absent Members:	L. Moriarty

1.0 Agenda

2.0 Call to Order

Dr. Jon Burstein called to order the September meeting of the Emergency Medical Care Advisory Board's Medical Committee at 10:01am on September 9, 2016 in the Training Room at the Massachusetts Emergency Management Agency (MEMA)-Framingham.

3.0 Motions

The following table lists the motions made during the meeting.

Motion	Result
Motion by Dr. Geller to accept the June minutes Seconded by Dr. Dyer.	Approved- unanimous vote

Motion	Result
Motion: by Dr. Geller to approve MSC appointment of Dr. Gutierrez. Seconded Dr. Dyer.	Approved – unanimous vote.

Motion	Result
Motion: by Dr. Dyer to add a proper eye shield to the ambulance equipment list. Seconded Dr. Restuccia.	**Approved** – unanimous vote.

Motion	Result
Motion: by Dr. Walter to 1. increase the maximum dose (of Naloxone) to 4mg for Intranasal administration, 2. Add multistep IM dosing. Seconded by Dr. Geller.	**Approved** – unanimous vote.

Motion	Result
Motion: by Dr. Tollefsen to add a bullet at the top of Protocol 2.14-Ensure Adequate Ventilation. Seconded by Dr. Geller.	**Approved** – unanimous vote.

Motion	Result
Motion: by Dr. Tennyson to increase for the Advanced EMT to read (Naloxone) 0.4mg to 4mg IM. Seconded by Dr. Walker.	**Approved** – unanimous vote.

Motion	Result
Motion: by Dr. Dyer to add a section to the EMT Standing order in 2.6p Bronchospasm protocol) for patients 5 years of age older to receive Epinephrine IM as per the Statewide treatment Protocols. Seconded by Dr. Restuccia.	**Approved** – unanimous vote.

Motion	Result
Motion: by Dr. Tollefsen to add the Epinephrine dosing to the EMT Standing order for patients 6 months of age older using the dosing listed in Protocol 2.2P Allergic Reaction/ Anaphylaxis Pediatric. Seconded by Dr. Geller.	**Approved** – unanimous vote.

4.0Action Items

The following table lists the action items identified during the meeting

Item	Responsibility

1. Acceptance of Minutes: June 10, 2016 meeting
2. New member Dr. Camilo Gutierrez for EMSC-introduced as new MSC board member. Pediatric ED physician at Boston Medical Center. Liaison to EMS and Trauma Services. Emergency Medical Services for Children (EMSC) member.
   Motion: by Dr. Geller to approve MSC appointment of Dr. Gutierrez. Seconded Dr. Dyer. Approved-unanimous vote
3. Task Force reports
   a. ELVO CVA (informational)-Anita Christie-DPH Coverdell Stroke Program
   Goal is to improve Stroke Care. An advisory group and infrastructure are needed to determine the Point of Entry Plan for a Stroke patient. Data is being collected under a CDC grant from hospitals and skilled nursing facilities at present. MATRIS data is being assimilated. 5 hospitals-Boston Medical Center, Mercy, Mt. Auburn, North Shore-Salem and UMass-

participate. Currently working to expand members to the Coverdell Advisory group to advise on next steps. Recommendation to consider interventional capabilities of institutions. Will consider expanding data points in MATRIS-available now for services that wish to turn on fields. EMS can contact Regional Offices to participate. Services can begin to collect information using additional stroke scales.

4. Old Business
   a. (System CQI report)
   b. (MATRIS)

5. New Business

OEMS Director position-M. Sinacola.
Position posted 1st round interviews to be completed by 9/23/16. 2nd interviews to be completed by the December holidays.

Dr. Dyer-eye shield-requests a change to the ambulance required equipment.
Motion: by Dr. Dyer to add a proper eye shield to the ambulance equipment list. Seconded Dr. Restuccia. Approved-unanimous vote.

Naloxone dosing (Dr. Walley et al)-PowerPoint Presentation-opioid overdose deaths continue to rise.
The maximum number of doses of naloxone used by EMS is increasing. 4 available formulations.
1) Nasal Atomizer 2mg/2ml (can equip with needles with sheaths for intramuscular (IM) dosing)
2) newer item-Nasal Spray 4 mg/0.1 ml. –Single step dosing.
3) Auto-injector 0.4 mh/1ml and IM and
4) IM injection 0.4 mg/1ml.
Recommend changing Protocol 2.14 Poisoning/Substance Abuse/ overdose Toxicology Protocol Adult & Pediatric dosing to 2mg to 4mg nasal atomizer.
Motion: by Dr. Walter to 1. increase the maximum dose to 4mg for Intranasal administration, 2. Add multistep IM dosing. Seconded by Dr. Geller. Approved-unanimous vote.
Regarding ventilation a bullet should be added as a reminder to ensure adequate ventilation.
Motion: by Dr. Tollefsen to add a bullet at the top of Protocol 2.14-Ensure Adequate Ventilation.
Seconded by Dr. Geller. Approved-unanimous vote.
Motion: by Dr. Tennyson to increase for the Advanced EMT to read 0.4mg to 4mg IM.
Seconded by Dr. Walker. Approved-unanimous vote.

Diltiazem weight-based dosing-Dr. Burstein
As written Diltiazem is a weight based medication. Is there a reason to limit the dose for larger patients? No adverse effects noted. No change.

Neonate Critical Care IFT-Critical Care Transport(CCT) is not readily available. The current protocol calls for CCT for a neonate 30 days of age or younger. The intent was to have CCT for a critical neonate going to a higher level of care. To gather information-the number of neonates transported, the reason for CCT and discuss at the October meeting. Note: concern raised transporting neonate in a hospital isolette.

IM epinephrine for bronchospasm (Dr. Dyer)
For a pediatric patient is in extreme distress, in danger of imminent death Epinephrine should be available for Protocol 2.6 Bronchospasm/Respiratory Distress-Pediatric.

Language to read:
Severe Distress: May administer IM in appropriate dosing per Statewide treatment Protocols under all the following conditions
-age greater than or equal to 5 years
-known history of asthma or reactive airway disease or bronchospasm or bronchodilators prescribed
and
–patient in respiratory arrest or approaching respiratory arrest(requiring BVM)-include diminished or absent breath sounds
and-oxygen saturation less than 91% despite supplemental oxygen or unmeasurable

Motion: by Dr. Dyer to add a section to the EMT Standing order for patients 5 years of age older or with the language presented to MSC Voting Members. Seconded by Dr. Restuccia. Approved-unanimous vote.
Age range discussed-
Motion: by Dr. Tollefsen to add a section to the EMT Standing order for patients 6 months of age older or with the dosing language from Protocol 2.2P Allergic Reaction/ Anaphylaxis Pediatric. Seconded by Dr. Geller. Approved-unanimous vote.

Language to read: Severe Distress: May administer IM in appropriate dosing per Statewide treatment Protocols(=Epinephrine 0.15 mg for a pediatric patient with body weight less than 25 kg, if body weight is over 25kg use adult dose Epinephrine auto injector 0.3 mg. A second injection in 5 minutes may be necessary.) under all the following conditions
-age greater than or equal to 6 months
-known history of asthma or reactive airway disease or bronchospasm or bronchodilators prescribed
and–patient in respiratory arrest or approaching respiratory arrest(requiring BVM)-include
diminished or absent breath sounds
and-oxygen saturation less than 91% despite supplemental oxygen or unmeasurable

Update on Public Health Council Regulations-M. Sinacola. EMTs no longer have to carry a physical card. Approved by PHC, Secretary of State to promulgate.

Meeting adjourned at 12 noon
Next Meeting: October 14, 2016