

**MEMS CAC**  
**21-Jun-06**  
**Minutes**

**In Attendance (sign in list never made it to chair and this is from memory, please let me know if you attended-- Diaz):** Chris McCarthy, Tish Tanski, Dennis Shubert, Bud Kellett, Larry Hopperstead, David White, Dan Batsie, David Kindgon, Rick Petrie, Paul Liebow, George Petropoulos, Steve Diaz

<u>Topic</u>	<u>Discussion</u>	<u>Action(s)</u>
1) Introductions	Diaz introduced the role of the CAC and McCarthy reviewed the role of MQF and its committee on AMI. We share many common goals on trying to standardize and deliver best practice in EMS in both the prehospital and intrahospital arena. Target areas of work include prehospital ASA administration and 12 lead EKG use. Intrahospital work on timely and effective patient transfer. Around all these projects we need to link QI.	No action.
2) Goals of combining MQF and CAC in this realm	Maine EMS and Maine Quality Forum have common goals as noted above. The goal of combining would be better resource management and avoidance of duplication of efforts	No formal actions, and would suggest tacit acceptance of working together. Later in the meeting this was formalize by a query from Shubert with a consensus agreement then ensuing.

3) 12 lead QI

McCarthy mentioned that they are looking at a grant from HRSA to look at national models for comprehensive care. We discussed the 12 Lead EKG QI form which at the last CAC was amended to have a physician action line. MEMS QI committee discussed this addition and since this takes the form from the paramedic to the hospital purview, the chance of decreased compliance is enhanced. Recommendation from MEMS QI not to include the line and keep the form in the EMS realm. Perhaps link the data requested to hospital QI which is currently in place on a form used both by MMC and EMMS and may be adopted by CMMC. Kingdon asked who "owned the form" and this falls to Diaz as chair of MEMS QI-- Kingdon suggested that you could keep the form if a project manager followed up on collection-- this is not possible with resources at hand. Hopperstead asked if we could include symptom complex on the form, and it was noted that this form is hand in hand with a copy of the EMS run report and a copy of the 12 lead EKG. Liebow asked if we can force hospitals to comply with QI and Shubert responded that this is a last resort. Agreement to add the hospital name and hospital medical record number to 12 lead EKG QI form to make it easier to link data. Petropoulos asked who is doing QA, and in larger health systems they have data coordinators. Kellett asked if the EKG stays at the hospital and the answer is yes. A flow of the QI form was outlined by Diaz which came from the MEMS QI committee and that is attached to these minutes

12 Lead EKG form amended to take away physician action line and add hospital name and hospital medical record number; flow process for form outlined.

4) 12 lead training	<p>Handout circulated by Batsie. This would then go to lesson plan, curriculum and total program for teaching. For refreshers, queried by McCarthy about web-based products and these are appropriate for refreshers. Noted by Dinerman to include a portion of the teaching around the variance that may occur with the computer over-read and the human read and how to rectify this. Query to the MEMS staff how many machines needed-- Diaz listed the data from Bradshaw from the last CAC meeting that the total number of paramedic services not using 12 lead machines is low (perhaps 4/20), but exact number not known. Kellett recommended for 12 lead machine acquisition that services partner with hospitals to see if procurement via grants from companies might then be possible. "In A Heartbeat" program presented by Tanski and flyer distributed. Membership from EMS still needed on some committees including data and metrics.</p>	<p>Batsie et al (Ettinger, Kendall, Diaz and any other interested parties) to work on developing the 12 lead training program. Looking to MEMS staff to see if number of 12 lead machines needed can be ascertained. Need to then figure a budget if we are going to approach hospitals to try to get a grant to help get 12 leads for all the licensed paramedic services.</p>
5) EMD	<p>Kingdon reviewed how this is medical call taking and dispatch. Goal is to create a standard for Maine and many different programs are in place in the US. Discussion of perhaps a simple goal for ASA administration to any adult who calls in with atraumatic chest pain. Kingdon is looking at all major EMD programs but again, is looking to see if there is a good standard that we can proscript for Maine</p>	<p>Kingdon will keep us updated.</p>
6) Next Meeting	<p>Summer reprieve</p>	<p>Sep-06</p>