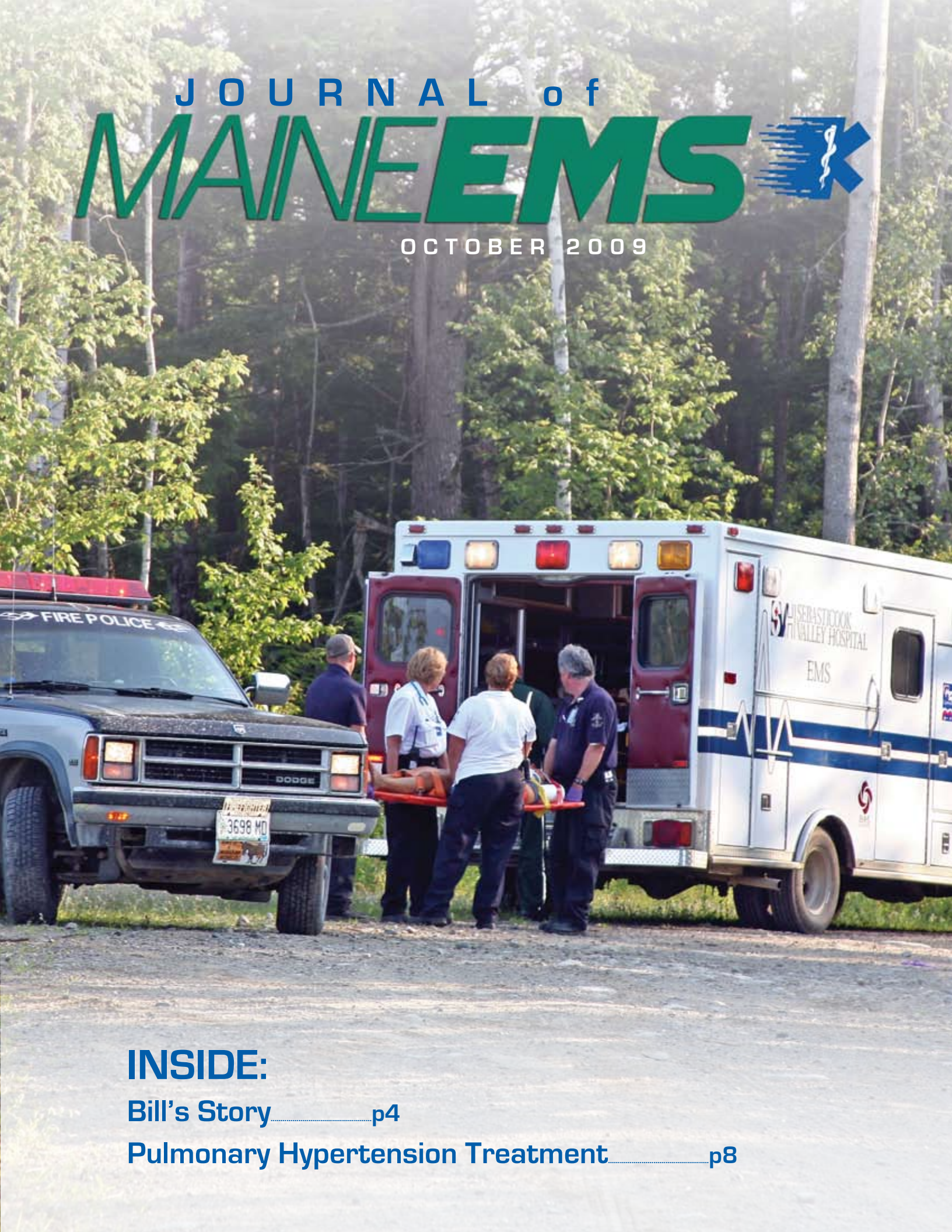
JOURNAL of MAINE EMS

OCTOBER 2009



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BY JAY BRADSHAW, EMT-P
DIRECTOR MAINE EMS

Goodbyes, new rules and MEMSRR

I make few apologies for the fact that these columns often start with a casual reference to the weather or the local geography. Especially this time of year, I can think of no place better to be than in Maine. After a record breaking cold and wet early summer, the past couple of months have been near picture perfect. We took a motorcycle ride over Labor Day weekend and my wife got to see her first Demolition Derby. Clearly she has lived a sheltered life.

Fall is a season of change, and this fall that included our saying goodbye to Jan Brinkman, RN, EMT-P, who has been the MEMS Training & Education Coordinator for the past 2 years. Jan came to us from a nursing position in her home town of Farmington, and left us to return to a clinical setting.

In her time here, Jan impressed us all with her attention to details, her positive attitude, and her always present sense of humor. She was also a pretty good cook and her timing for bringing in some homemade treat was always perfect. We'll miss her.

We are in the process of seeking a qualified replacement, and hope to introduce you to that person in the next issue.

Meanwhile, there are lots of things happening on the educational front.

Medivax

It's hard to get through a day without hearing something about a flu virus; either the seasonal flu or the H1N1 virus. Maine EMS has been working closely with Maine CDC, Maine Emergency Management, and the regional EMS offices to get ALS providers trained in administering these vaccines when they become available.

EMT-I, EMT-C, and EMT-P providers who have taken the MEMS Medivax training program may administer the vaccines when done as part of a physician prescribed event.

Getting the message out regarding the flu vaccines is both a huge challenge and great opportunity for EMS. Because the information is constantly being updated, we recommend frequently visiting the Maine CDC web site: www.maineflu.gov and the US CDC web site: www.cdc.gov From both of these

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Contributing Editors

Copy Editor
Nancy McGinnis
PO Box 336
Hallowell, ME 04347

Maine EMS
Jay Bradshaw, EMT-P
152 State House Station
Augusta, ME 04333-0152

Maine Ambulance Association
Tim Beals, MBA, EMT-P
PO Box 202
Waterville, ME 04903-0202

Maine ACEP
John R. Saucier, MD
Maine Medical Center ED
22 Bramhall Street
Portland, ME 04102

Maine ACS/MCOT
Robert Winchell, MD, FACS
887 Congress Street
Suite 210
Portland, ME 04102

Maine ENA
Tammy Lachance, RN, BSN, CEN
Central Maine Medical Center
300 Main Street
Lewiston, ME 04240

Cover photo by Michele Barker.

sites you can sign up for automatic notification of changes and important messages.

The target population for H1N1 is somewhat different than the seasonal flu and initially there will be limited doses of the H1N1 vaccine available. However, health care providers, including EMS, are included in the first tier of those who will be able to receive the H1N1 vaccine. Maine CDC estimates that over the next few months there will be adequate vaccine available for all who are interested, but that supply will take some time to arrive in state.

Rules changes

October 1, 2009, was the effective date for many new and updated EMS Rules. The section on equipment requirements will become effective on January 1, 2010. Elsewhere in this issue is an article with the highlights of the changes. The Rules are available for downloading at our web site www.maine.gov/dps/ems

MEMSRR

The Maine EMS Run Reporting System has now been 100% electronic for the past 6 months – and since that time there have been almost 190,000 runs entered and/or uploaded.

With time and as users understand how to utilize this new platform, the comfort level with the system increases. Service chiefs are finding a significant reduction in billing errors and in the turnaround for reimbursement. For the first time, many are using the system to provide up-to-the-minute activity reports to their crew, municipal leaders, and to the public.

The more people know about EMS, the more they are likely to understand the multitude of services we provide to communities and why their support is so important.

That's the good news. The "rest of the story" is that the quality of the data is an area that can only improve by each of us understanding why this is important, and by each of us taking the time to accurately complete the run reports.

EMS run reports are a lot more than a means to get paid quickly or impress the public with our response time and variety of calls. It is an essential part of providing good patient care. The information we provide is used by staff in emergency departments, medical records, trauma and cardiovascular teams to name just a few.

I know this sounds easy to say sitting at a computer typing on an overcast day – and that things are different at 0-dark-30 when the rig is a mess and another call is waiting.

But we also know that people who work in EMS really want to provide good patient care. We want to be sure we get complete vital signs, do a good assessment, get a good medical history, and provide the right care at the right time, including the right information in the run reporting system.

Thanks for being a part of our EMS system. See you in a few months.

Remembering Each Sacrifice, Honoring Each Contribution

More than $30,000 has already been raised for the Maine EMS Memorial planned to be constructed next to the fire and law enforcement memorials next to the capitol on State Street in Augusta, but more donations are needed to meet the $300,000 goal.

For more information on how to donate, visit www.kvems.org.

Wm. Thomas Hyde Award Presented

Kelly Roderick, KVEMSC

Congratulations to Jeremy Damren, EMT-P of Belgrade, who is this year's recipient of the Wm. Thomas Hyde Award in the Kennebec Valley Region. Jeremy works as State Exercise Coordinator for Maine Emergency Management in Augusta, along with his duties as paramedic with Delta Ambulance and Belgrade Rescue, and patrolman for Newport Police Department. As an EMS Instructor Coordinator, Jeremy has taught various levels of the licensure training program and many specialty programs throughout the state.

He was nominated for his strong commitment to the advancement of EMS education, policy and development within his region and the state. Jeremy is always looking for opportunities to help out in committees, teaching, and community events. His peers can count on him and so can his family.

Jeremy comes from a long family history of community service and dedication to public safety, yet always has time to visit relatives, help them with chores or drive them to appointments when needed. Family is important to the Damrens and something Jeremy always puts first.

All these traits are ones that represent the late Wm. Thomas Hyde who loved public safety, love to teach and love his family. He would be proud to know that Jeremy was this year's award winner in his name. Congratulations Jeremy, WELL DONE!

Bill's Story

Jeremy Damren , EMT-P and Kerry Pomelow, EMT-P

For the most part, in time, we all become complacent in our EMS careers. Often, we thrive on the interesting calls which trigger our sympathetic nervous system, confirming our adrenaline junkie status. But too often our calls are routine or lacking excitement or a challenge. This was not the case for members of the Belgrade Fire and Rescue Department on May 24, 2009.

Belgrade Fire and Rescue has always been a close knit department. You could call us a family like most rural fire and rescue departments. The majority of members have been on for years or even decades, including the department's Deputy Chief, Bill Pulsifer.

Bill not only serves as the department's deputy chief, but fills in as father, grandfather, friend, teacher, mechanical engineer, or someone who would not mind straightening you out if you were out of line. He has been with the department since 1947 and claims to be only 74 years old. In spite of his years in most cases, he can run circles around us young firefighters. Everyone has a Bill on their department. Everyone knows the value of having a Bill, not only the knowledge, skills, experience, dedication; but also the ability to be a commendable role model.

The call came in for a boat on fire in the middle of the 17th largest lake in Maine, Great Pond. This was not an abnormal call. With our population tripling in the summer months, like most summer lake communities, one can expect more boats to occupy the lakes. However, what was to come would be anything but routine.

Bill lives closest to the Belgrade Lakes Fire Station, where our department's boat is stored. After hearing the call, Bill managed to roll the boat out of the station and hitch it onto his truck to drive 1 mile to the Great Pond boat landing. Upon arrival, he launched the boat into the lake as other firefighters arrived and headed out to the fire.

Bill stayed back on shore. He was in the company of my brother Scott Damren EMT-I/FF, and fellow department members Conrad Shaw EMT-B/FF, Megan Breau EMT-I/FF, Kate Pow EMT-B/FF, and Scott Routhier EMT-I/FF. They were gathered on shore talking when Bill leaned on Scott and stated, "I think I'll just lie down right here." Bill became unresponsive before he lowered himself to the ground and ended up dead weight falling onto Scott, who was able to assist him to the ground.

At first everyone was shocked and wanted to believe that Bill was just joking around with them. A few seconds later, after Bill's lips began turning blue and he was not responding to anyone's commands, the crew knew that he was not joking.

The next six minutes will probably be the longest six minutes of that crew's life. After determining that Bill had stopped breathing and had no pulse, they began to perform their 30 compressions to 2 breaths CPR. Fortunately, our rescue truck was nearby. Some one retrieved the Lifepack 12 and hooked him up to it. The monitor indicated to shock Bill, which the crew did. After defibrillating him, they continued to maintain oxygen and compressions. Approximately 1 minute after the shock was administered, Bill opened his eyes.

"Did you boys find that boat on fire yet?" Those words were the best that crew could ever hear. They all admitted that they had never had a cardiac arrest victim awaken, especially with those words. After a coming down from their sympathetic reaction, tears were shared.

Our resident State Police Officer, Trooper Diane Perkins-Vance, offered to go and get his wife, Marie, and bring her to the scene. Not knowing if Bill would go back into cardiac arrest, the crew knew this would be a good idea. Upon her arrival, the first thing Marie did was walk over to Bill's side, grab his pager from his side, and state, "That will be the end of this!"

Bill was transported to the hospital, only complaining about ribs in his chest hurting a little. Later, tests were done and it was determined that he would need a triple bypass as three of the arteries in his heart were 90% blocked.

Bill has gone for his surgery and has made a full recovery. He has gotten his pager back and recently stacked two loads of wood with his grandson. He has volunteered to open up my future emergency medical technician courses describing the importance of CPR and proper basic life support skills.

Although Bill has said that dying was very peaceful and he is not afraid to do so, he agrees that he was not ready and is ever so thankful for the actions of the crew members. As for Marie, well, she knows that if Bill had not been with his EMS family, this could have been a story of remembrance and not a story of recognition. She is just waiting for a longer ride in a State Police cruiser.

A job well done to the Belgrade Rescue EMTs and Intermediates.

Maine EMS
Rules Change Highlights

Alan Leo, EMT-B

The 2009 revision of the Maine Emergency Medical Services system Rules was adopted by the Maine EMS Board at its June 3, 2009, and July 1, 2009 meetings. Adoption of the rules followed a process lasting almost a year that included review by a rules committee appointed by the MEMS Board, as well as public hearings allowing input from local, regional, and state EMS providers, and administrators and members of the public. Written comment was also accepted. All of the comments and concerns were taken into consideration during this process and the final product follows.

A few of the revisions are major changes or additions while most are not. This article will give you all a first hand look at those changes. Please note that Chapters 1 through 16 became effective on October 1, 2009. Chapter 17 will become effective on January 1, 2010 to allow those who need to purchase any new equipment the time to do so.

Chapter 1, Missions And Goals Of The Maine EMS System. This chapter has clarification changes only.

Chapter 2, Definitions, defines the terms that are used throughout the Maine EMS Rules.

Chapter 3, Ground Ambulance Service And Non-Transporting Service Licenses contains the requirements for obtaining and maintaining a ground ambulance service or non-transporting service license. *Section 2.5-Base Location* simplifies the process for a service with multiple base locations to license. *Section 9-Patient Care Reporting*, this is one of the most significant changes as it removes the "paper" report reference due from all services reporting electronically, and shortens the time frame for reporting from monthly to 3 business days. The change was made in order to compile statistics in a timely fashion. The remaining changes remove references to the regions concerning regulatory issues and decisions that are the responsibility of Maine EMS.

Chapter 3-A, Emergency Medical Dispatch Center Licensure. The changes in this chapter bring the licensing requirements for Dispatch Centers in line with Maine statute.

Chapter 4, Air Ambulance Services Licenses. *Section 2.5-Base Location*, simplifies the process for a service with multiple locations to license. *Section 9-Patient Care Reporting*, the wording was changed to be consistent through out the Rules. The remaining changes were made to conform to national standards and federal regulations for Scene Response Air Ambulances.

Chapters 5, Personnel Licenses. Removed out dated language, testing and CEH requirements that became obsolete, and regional medical director approval of a license application. Another significant change here is the 3 year period to renew ***after*** expiration now becomes a 2 year period.

Chapter 5-A, Emergency Medical Dispatcher Licenses. The changes and additions were made in order to comply with Maine statute. EMD Services and Providers have until January 1, 2010 to become certified by the provider of the MEMS Board-approved statewide EMD protocol.

Chapter 6, Advanced Life Support Drugs And Medications. The only changes are references to other chapters in the rules.

Chapter 7, State Licensing Examinations. The changes made in this chapter provide a clearer description of the testing standards for MEMS Licensure.

Chapter 8, Training Courses and Continuing Education Programs Used For Licensure. *Section 1.G* establishes a Training Center as the approved entity allowed by the MEMS Board to provide EMS education for provider licensure. *Section 2.2* changes make a broader range of educational opportunities available for provider relicensing. *Section 2.4* allows the Training Center to conduct CEH programs for provider relicensing.

Chapter 9, Instructor Coordinator Licenses. Clarifies that I/C's hold a *license* instead of a *certification* which conforms to Maine statute, and reference to such is made throughout this chapter. The addition of *Section 3.D and E* concerning criminal convictions and actions taken against any license held by the applicant was made to be consistent with licensing procedures through the Rules.

Chapter 9-A, Emergency Medical Dispatch Training, Instructors and Continuing Education. Changes and additions in this chapter were made to conform to Maine statute, and to describe the role of MEMS and the Board involving the education requirements for EMD providers and instructors.

Chapter 10, Reciprocity. The only change in this chapter replaces *province* with *territory*.

Chapters 11, 12, and 13. Only grammatical changes or no changes.

Chapter 14, Sexual Misconduct. *Section 1.4.C.* This change better defines the charge.

continued on next page

THE RESIDENTS CORNER

Meghan Lindstrom, MD
CHIEF RESIDENT, MAINE MEDICAL CENTER

Thoughts on Physician/EMS Interactions

At the Maine Medical Emergency Residency, we recently had the privilege to welcome our new intern class of eight bright-eyed and bushy-tailed Emergency Residents. While the start of residency is often fraught with uncertainty and the stress of "learning the ropes", one of the best aspects of the first two months of our intern year involves working with local EMS programs through ride-alongs. An excellent extension and development of this concept has been the Medical Direction Program, where a group of 1st, 2nd, and 3rd year EM residents provide medical direction to various Portland-area EMS services.

One positive development of both the ride-alongs and now our medical directing is the improvement in physician/EMS interactions from both sides. At the core of this improvement, I believe, is the simple fact that we now better know more of the EMS providers that wheel through our doors, and have relationships that exist beyond the brief interaction that occurs in the critical care room. I believe that without this connection, the Physician/EMS interactions that happen every day are less effective.

John Saucier wrote an article in the last JOMEMS about an intern getting a hard time from a cardiologist regarding an admission, basically due to the fact that the intern was "new." Unfortunately, this is the way of medicine. I am now a 3rd year resident, and despite having relatively little more experience than the 2nd or even 1st years, I can get things done when interacting with my colleagues on other services in the hospital simply because I know them, and they know me.

Despite an overly hierarchical structure in the hospital, there is some human nature involved. Why should I trust this person who I really don't know at all? Unfortunately, despite the fact that emergency physicians interact with EMS providers every day, at times it feels that the same lack of understanding undercuts physician/EMS interactions.

Why is this? There are surely a number of reasons, including the rapid pace of many of the EMS to physician patient handoffs. Additionally, the space that EMS providers are given to complete charts is often completely separate from the main area of the ED. Unfortunately, these and other aspects of the emergency department do not promote the physician/EMS relationship.

On the bright side, as our ride-alongs and medical directorships have shown, it is relatively easy to improve this relationship. It is fantastic to be in a trauma room, and see one of the paramedics from the town I work with (Scarborough) roll in the door. There is a great level of trust and camaraderie right from the moment I start hearing their report.

The message is that we all (both EMS providers and emergency physicians) can easily try to make a point to interact with each other beyond the quick patient hand-off that we do. Whether it's us physicians peeking into the EMS documentation area to say hi, EMS providers touching base after an interesting case, or either side giving feedback on what went well or not so well.

Little steps like this may make our jobs more rewarding, facilitate patient care, and improve the communication that is so critical to both EMS and emergency physicians. We're looking forward to even more.

Rules Change Highlights

continued from previous page

Chapter 15, Maine EMS Regions and Regional Councils. *Section 3.2.C Service Affiliation with Regions.* This change clarifies the language of the existing rule with regards to when and how changes may be made to service affiliations within regional designations. Section 4.2, this change removes the approval of the regional Medical Director in regards to a provider's ability to practice in that region. Both of these changes are consistent with other changes through the Rules

Chapter 16, Death benefits for Emergency Medical Services Persons Who Die in the Line of Duty. This chapter has grammatical changes only.

Chapter 17, Equipment Lists For Maine EMS Services and Regional EMS Radio Frequencies. The changes reflect the equipment needed to conform to the MEMS Protocols. Some of the major changes are the addition of following equipment:

Non-Transporting Services: 1-AED

Ground Ambulances Services: 1-AED, 1-Pulse Oximeter,1-Tourniquet (commercially prepared for hemorrhage control), **with 1-Glucometer being optional**.

Advanced Life Support: 12 Lead capabilities, colorimetric or continuous wave form capnography, 1- glucometer, periglottic or transglottic airway devices.

I am sure that there will still be many questions that will arise after the implementation of these Rules. Please contact Maine EMS if you have any questions.

Annual Meeting for Maine Ambulance Association

Kelly Roderick, MMA

Maine Ambulance Association will be holding its annual meeting and informational session on Wednesday, November 11, 2009 at the Mid Coast Conference located at the Samoset Resort in Rockland.

The meeting will begin with a social time at 5 pm followed by dinner and business meeting with elections at 6 pm. A presentation related to Medicare Compliance will immediately follow. Learn what your service, large or small, needs to have in order to be compliant and what items would be looked at should you be audited.

Everyone is invited and information on joining the Maine Ambulance Association will be on hand as will current board members to answer any questions you might have. Watch for registration information to be distributed soon, or you can call the MAA at 872-0427.

Maine ACEP

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Scott E. Kemmerer, MD, FACEP | President Maine ACEP

President's Message

The last two years have been quite busy for Maine ACEP. Under the superb leadership and hard work of Dr. Michael Gibbs, our organization was able to accomplish several goals. First, in an effort to reduce medication diversion in the state, Dr. Gibbs put together an educational program that was given 3 times across the state to educate providers on the issue. Since then Maine ACEP has been awarded a grant to continue that education process. Second, Anna Bragdon (Maine ACEP's Executive Director) and Dr. Gibbs fought for legislation to upgrade the motorcycle helmet law to cover teens up to the age of 18. This was a major battle. Dr. Gibbs' testimony to the state transportation committee tipped the scales and the bill passed this past spring. Lastly, Dr. Gibbs was able to gain support for raising our dues to put our organization back in the black financially.

I became president this past March and have decided to focus on issues around the report card scores given to our state by national ACEP. Every few years ACEP grades all 50 states on issues such as access to emergency care, quality and patient safety, medical liability environment, public health and injury prevention, and disaster preparedness. Overall we did fairly well, but in two categories, medical liability and disaster preparedness, we received scores of D+ and D-. My goal over the next two years is to find ways to help our state improve some identified obstacles so that the next report card reflects more favorably on our state. Disaster preparedness is a key issue as we face a potential H1N1 pandemic this fall and winter.

Two other issues that we will be tackling are physician recruitment and an updated medical control course which we will be placing on our web site for providers across the state to earn CME and become certified as medical control providers. There is a lot of information on our web site and it has a lot of links to legislators, national ACEP programs, the Maine Medical Association, and many others. Please visit us at www.maineacep.org.

Pulmonary Hypertension Treatment

Gov. Baldacci has issued a proclamation designating November, 2009, as Pulmonary Hypertension Awareness Month. The proclamation states in part, "WHEREAS, the health of our people is the foundation for a caring and productive society, and our future rests with our ability to find cures for, and adequately treat individuals who are afflicted with a variety of illnesses including pulmonary hypertension; …".

As members of the EMS community, do we know how to provide adequate treatment for individuals with pulmonary hypertension (PH)?

As EMS personnel, we often respond to emergency situations that do not fit the typical textbook situations that we have studied in class. There are many situations that involve rare, life-threatening diseases that have their unique characteristics. Such is the case of pulmonary hypertension. When my wife was first diagnosed in the mid-70's, the literature listed a life expectancy in terms of months. She has defied the odds! Since that time, I have had the opportunity to meet many individuals coping with the disease. I have also heard several horror stories regarding the care that these individuals received both pre-hospital and even in emergency rooms. PH, also sometimes referred to as Pulmonary Arterial Hypertension and Primary Pulmonary Hypertension, is a rare disease that requires specialized treatment. On my wife's medication pump there is a label that reads "DO NOT SHUT OFF OR DISCONNECT – DEATH MAY RESULT."

As PH and the related medical conditions vary greatly, the following scenario may or may not be typical. However, the recommended treatment for PH was compiled and scientifically reviewed by the Pulmonary Hypertension Association and by Maine EMS.

The scenario is that you have responded to a 911 call to a residence with a complaint of an unresponsive victim, having difficulty breathing. As you enter the residence, you find the victim sitting in a chair, gasping for breath. Their face has an obviously red flush. A nasal cannula is being used delivering oxygen at 3 lpm from a home oxygen concentrator. Next to the victim is an insulated pouch containing what appears to be a medication pump sandwiched between two ice packs. Leading from the pump is a single tube which ends beneath an occlusive bandage on the patient's upper left chest. A connection on the tubing appears to have split and a clear liquid or blood is leaking from the area and has saturated the victim's shirt. Respirations are 24, pulse 90 and BP is 100/60. The patient's O2 saturation is 86%. The patient feels warm to the touch and has a temperature of 100.8° F. The caregiver with the victim begins to explain that the victim has pulmonary hypertension.

What is PH and how do you treat the condition?

PH is a rare disorder of the blood vessels in the lungs. The pulmonary arteries become narrowed and the pressure in the arteries rises above normal levels. This causes strain on the heart and may become life threatening. PH may be secondary to other disease states, such as emphysema, bronchitis, scleroderma or pulmonary thromboembolism. It may be familial (there appear to be hereditary links), may be related to use of diet drugs (fenfluramine and dexfenfluramine), or may be primary or idiopathic pulmonary hypertension. Idiopathic pulmonary hypertension is extremely rare, occurring in 2 persons per million per year.

As with any population, PH patients vary greatly in age and with presentation. The disease affects both males and females. It can affect newborns, children, young adults, as well as the elderly. Some patients may not look sick at all, while others may be in wheelchairs. Others may require oxygen or have medication continuously delivered by a pump. PH patients may need emergency assistance because of an accident, an interruption of medication delivery for those on IV therapy, or because of other complications associated with their pulmonary hypertension.

PH patients may be on one or more of the following medications to treat PH: treprostinil (Remodulin®) subcutaneous or intravenous, epoprostenol (Flolan®) IV, illoprost (Ventavis®), treprostinil (Tyvaso®) inhaled, bosentan (Tracleer®) oral, sildenafil (Revatio® or Viagra®) oral, and/or letairis (Ambrisentan®) oral. No PH medication should ever be stopped or dosage changed during a hospitalization without first consulting the attending physician who is treating that specific patient's PH.

Medication emergencies may occur with Flolan® or Remodulin®. Flolan® is a PAH drug given by continuous intravenous infusion through a permanent dedicated catheter (central line) placed in one of the large veins going to the heart. It is given this way because epoprostenol only lasts in the bloodstream for 3-5 minutes. A pump is used to deliver the drug.

Remodulin® may be delivered either subcutaneously or via a surgically placed central line, much like Flolan® and is also delivered by a pump. The half-life of Remodulin® is about 4.5 hours, although symptoms due to drug interruption can occur in less than one hour.

If a pulmonary hypertension patient is on Flolan® or Remodulin® via intravenous delivery, and the catheter comes out or is damaged, or the pump stops working, it is a true medical emergency.

Since these medications are beyond the scope of EMS, there is a process for responding to patients in your area who have this and other rare diseases. In such cases, your service can have protocols established by having the service medical director coordinate such protocols with the Maine EMS Medical Direction and Practice Board.

A patient on Flolan® or Remodulin® cannot tolerate an interruption in the delivery of this medication. An alternative IV (peripheral IV) may be need-

ed when troubleshooting medication delivery and the medication may need to be temporarily delivered via this peripheral route. On Line Medical Control (OLMC) should be consulted as other medications can also be administered at home via central lines and conceivably an overdose may be occurring causing a patient to have dire physiology.

With clear medical direction from OLMC, the diversion of the medication while maintaining the active pump action (in other words, keeping the pump "ON") may occur.

Nuances are also here which include not priming this line (a bolus of this medication could be fatal). Managing medication changes and trying to reset or program on an unfamiliar pump has high potential for medical mishap, so that should not be attempted. Also, if the central line is intact and working, it should not be manipulated by anyone or used for drawing blood. If additional intravenous medications are needed, a peripheral IV line should be established and used. If you do switch the patient's infusion from central to peripheral after consulting with OLMC, be sure to clamp off the central line. As usual, the best practice is to bring all the patient's medications with you to the nearest appropriate ED.

Questions or concerns are best handled by the patient's PH specialist or care center.

A patient receiving medication via a pump is either receiving Flolan® or Remodulin®. The use of ice packs implicates Flolan® as the medication for a patient with PH who has medication being infused via a central line.

In conclusion, fatal or near fatal pre-emergency errors occur when pumps are turned off, disconnected, or the central line is used for other purposes. These situations need to be avoided. Additional information on the disease and treatments may be found on the Pulmonary Hypertension Association's website: www.PHAssociation.org.

References:

Pulmonary Hypertension Awareness Month Proclamation, John E. Baldacci, Governor, State of Maine, July 9, 2009.

Emergency 101 Information for Emergency Medical Providers, Pulmonary Hypertension Association.

Pulmonary Hypertension, A Patient's Survival Guide, 3rd edition, Gail Boyer Hayes, Pulmonary Hypertension Association, 2004.

Pulmonary Hypertension Association website: www.PHAssociation.org

CEH Corner

Once you have finished reading and understanding this issue's article on Pulmonary Hypertension, complete the questions below and forward your answers by mail or electronically to MEMS Journal/CEH Corner, Maine EMS, 45 Commerce Drive, Suite 1, 152 State House Station, Augusta, ME 04333-0152 or maine.ems@maine.gov. Your completed questions must be received no later than November 30, 2009 to receive your 0.5 hour in Cat 2 BLS Topics 0.5 hour in Cat 4 ALS Topics

Name_____ EMS or EMD License Number_____

1. What is Pumonary Hypertension (PH)? _____

_____

2. What other diagnostic terms may be used to describe PH? _____

_____

3. List 5 characteristics of PH: _____

_____

4. What should you do if you know there is a patient with PH or another rare disease in your service's area? _____

_____

5. If you are called to the home of a PH patient, what are 3 important steps to take? _____

_____

BY KEVIN MCGINNIS, MPS, EMT-P

Got Radio?

Narrowbanding: This Means You!

A finger on the pulse (and other VS) of the EMS system by looking at issues at the state and national levels through the eyes of a former Maine EMS director who gets around more than he sometimes would like to.

In writing this article I am plagiarizing myself from the "Guide to Emergency Medical Services Information Communications Technology (ICT) Systems For EMS Officials" which may be downloaded at http://www.nasemso.org/Projects/CommunicationsTechnology/index.asp (warning it is 76 MB because it is full of embedded files ("click-on and see") full of good information. There is a section and materials on narrowbanding.

One of the hats I wear is communications technology advisor to four national EMS associations (the National Association of State EMS Officials, the National Association of EMS Physicians, the National Association of EMTs, and the National Association of EMS Educators). They share me because communications does not beep loudly on their radar screens amidst all else that is going on. Yet, they all realize that effective communications are crucial to our everyday work and expanded broadband communications are key to improving field care in the future. So, I contribute to keeping their leadership and members apprised of critical contemporary issues.

Such an issue is the Federal Communications Commission (FCC) enforced "narrowbanding of frequencies below 512 MHz" (megahertz – a unit of bandwidth in the overall range of bandwidth; like very high frequency (VHF) such as the traditional EMS frequencies used in Maine of 155.340, 155.325, 155.355, 155.385 and 155.400 MHz and ultra high frequencies (UHF) in the 450-470 MHz range once used in Maine for EKG telemetry sent to hospitals).

Basically, **every EMS provider (prehospital and hospital emergency department) is potentially affected by narrowbanding and must comply with its provisions by January 1, 2013**. Because the narrowbanding rules may require the replacement of portable and mobile radios, as well as hospital and other radio consoles and other infrastructure, the need to plan and budget for these changes in the budgetary cycles of most EMS agencies and the municipalities that support us means starting now. **If you have an EMS frequency radio, this means you!**

Despite the fact that the FCC has provided many years of advance warning on this, a surprisingly large number of people across the country in public safety systems are just taking notice. So, be concerned if you haven't started to think about this, but know that you are not alone in the boat.

What is narrowbanding? Today, your license for an EMS frequency (say 155.340) would include a bandwidth 25 KHz (kilohertz) wide around the center frequency 155.340 (we'll call this "wideband" or WB). After 2013, your equipment can emit frequency 155.340 with only a 12.5 KHz width (we'll call this "narrowband" or NB) . Eventually, the FCC intends to make these 6.25 KHz wide. The purpose is to relieve congestion by creating new, narrower frequencies (though it is a myth that you get two frequencies to use for each one "narrowed". Nor are you automatically entitled to the frequencies created around yours…an issue which may cause interference down the road).

How big is this problem for you? Depends.

Most radios and equipment purchased after 1997 should be narrowband capable and may require no more than reprogramming. Older equipment will need to be replaced. One of the first steps in your narrowbanding process will be to decipher whether your equipment is narrowband capable or not. In all likelihood, you are not the one to do this. It is not straightforward for most of us. For instance, different models of one of Motorola's most popular handheld units may or may not be narrowband capable and there are a gazzilion of them out there in Maine.

My point in emphasizing this is that, unless you are a radio communications engineer or technician, **you need help**. To successfully go through the narrowbanding process, **you must have either a staff communications support tech or a radio service vendor with a clue** (about narrowbanding).

So, once you have confirmed that your radio tech is up-to-speed on narrowbanding, here are the general steps you need to follow. The following was adapted from a very smart radio guy named Nick Ruark (http://www.qualitymobile.com/Part90NBNav.htm) :

(1) Verify that your agency or facility has a current and valid FCC Part 90 radio station license. Your service tech should be able to help you with this and, if necessary to contact your FCC certified frequency coordinator (the list of all of them, and they vary by type of public safety agency, is at http://www.fcc.gov/pshs/public-safety-spectrum/coord.html; the **International Municipal Signal Association-IMSA, is the frequency coordinator for EMS**; go to fireems@imsasafety.org). These folks can help track this down and coordinate revising your license to add the narrowband (NB) emitter designation and remove the wideband (WB) emitter designation. I have seen folks suggest doing this in two relicensing steps to add the NB so that you can operate in mixed WB/NB mode as you change and cutover equipment, and then (before January, 2013) to remove the WB and operate solely on NB. Others discourage mixed WB/NB operation because of potential interference. How

Effective communications are crucial to our everyday work and expanded broadband communications are key to improving field care in the future.

you handle this will depend on the complexity of your system and your inventory of equipment. Your service tech should have the final say in this conversion and relicensing process. There is a frequency coordination fee each time you change your license.

(2) Conduct a full inventory of all radios in your system including all portable, mobile, dispatcher-used, wireless data, and on or off-site base or repeater radios (include makes and models and, if possible, serial numbers).

(3) With your service tech, determine which equipment can be re-programmed and which must be replaced.

(4) Establish the necessary budget figures to cover the services and equipment required for NB transition, including all licensing fees. Make sure that the budget cycle supports complete transition and relicensing before January 1, 2013.

(5) Develop a WB to NB system conversion/cutover plan that addresses:

a. The elimination of WB-only equipment and installation of NB-capable off-site base or repeater stations and all other needed radio equipment; and

b. The actual reprogramming of all radios in a system as close to simultaneously as possible.

c. Coordinating with agencies/hospital facilities that routinely communicate with you on these frequencies.

(6) Schedule and coordinate the actual system conversion/cutover. Make certain that all radio users have been advised in advance and are aware of the process. Again, all hospitals and local EMS agencies should coordinate this process to the extent possible. Mixed WB/NB operations in any given locale can cause interference.

(7) Modify your FCC radio station license to remove any WB emission designators, replacing them with the correct NB emission designators. Make any other changes or updates to a license that may be required (see 1 above).

Again, given the long and difficult budgeting processes that most of us have this process needs to have started yesterday --- **wait no longer!**

The following are some additional resources that may be of help to you as you address the FCC narrowbanding mandate:

International Association of Fire Chiefs (IAFC)
FCC Narrowbanding Mandate: A Public Safety Guide For Compliance
www.iafc.org/associations/4685/files/comm_Narrowbanding.pdf

FCC
Tech Topic 16: Narrow Banding Public Safety Communication Channels
www.fcc.gov/pshs/techtopics/techtopics16.html
FCC "refarming" history (with jpegs)
wireless.fcc.gov/services/index.htm?job=operations&id=private_land_radio
FCC's "narrowbanding" mandate
hraunfoss.fcc.gov/edocs_public/attachmatch/FCC-04-292A1.pdf (2004 Order)
hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-271692A1.pdf (2007 Order)
hraunfoss.fcc.gov/edocs_public/attachmatch/FCC-08-127A1.pdf
(2008 6.25 KHz Migration Clarification)

APCO
www.apcointl.org/frequency/documents/NBFLIER.pdf

Yahoo Forum – this is an on-going forum on NB
groups.yahoo.com/group/LMR_Narrowbanding

National Institute of Justice (NIJ)
Understanding Narrowbanding
www.ojp.usdoj.gov/nij/topics/technology/communication/fcc-narrowbanding.htm

Report of Final Actions

Taken by the Maine EMS Investigations Committee

This notice is written in accordance with direction of the Maine EMS Board that the names, violations, and final disciplinary actions involving licensees who were subject to a fine, suspension, reprimand, requested voluntary surrender, and or revocation of their EMS licenses and or I/C certification be published in the Maine EMS Journal as a public notice.

The information listed in this section reflects the final action(s) taken by the Maine EMS Board. This information does not include pending actions or cases under appeal. This information does not contain, nor does it reflect, all of the factors involved in determining the final action, such as the severity of the misconduct/violation, the licensee's criminal and disciplinary history, or other mitigating factors. This publication is not intended as a guide to the level of disciplinary actions for a particular violation or misconduct, but rather as a publication that will increase awareness, reduce repetitive investigations, identify potential problem areas, and assist in determining areas for improvements in the quality and delivery of EMS statewide.

2009

Name: Isle au Haut (MEMS # 908)
Violation: Service license expired and that the Service continued to respond and provide emergency medical treatment on two calls, Maine EMS Rules Chapter 11 § (1)(3) and 32 M.R.S.A. §82 (1).
Action: Isle au Haut entered into a Consent Agreement which imposed a reprimand.
Date: June 3, 2009, 2009

Name Mike Barter (MEMS I/C 305)
Violation: Providing Instruction as a lead Instructor/Coordinator without a current certification. Maine EMS Rules Chapter 9 (5)(O).
Action: Enter into a Consent Agreement which imposes a reprimand and a suspended fine of $100.00.
Date: September 18, 2009

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Roger Audette, Augusta Fire Department

Don Rowell, CMP Communication Center

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Easy as ABC

It was a deep laceration through the muscle fascia of the inner upper arm. The pediatric surgeon injected lidocaine into the intact skin bordering the wound. Something was missing however. There was only quiet discussion about wound closure technique. Absent was the screaming from the 10-year-old patient receiving the local anesthetic. There was no continuous cajoling from the nurse to hold still. The boy was staring at a far away place, eyes rhythmically scanning back and forth, mouth opening and closing gently. The magic of ketamine and midazolam making the stress of the procedure disappear.

As the EM resident and I titrated the ketamine to pulse rise and patient movement, I reflected on how different this scene was 30 years ago. We had limited options then on how to handle the patient's pain and anxiety in a similar situation. There was Brutaine, just hold the child down, get the lidocaine in and do the job. There was DPS given IM, a mixture of Demerol, Phenergan and Sparine (an analog of thorazine), but it was unpredictable and was later shown to be associated with significant respiratory depression. There was the OR for general anesthesia. And that was it for quite a while.

Agents such as ketamine, propofol, etomidate and midazolam have been around for 20 years in the anesthesia world but were rare in the emergency setting until the last 10 years. Ketamine for procedural sedation was used in third world countries in the missions staffed through Loma Linda University. A clinical trial by Havel et al showed Propofol to be safe for this usage in the emergency setting in 1999. (AEM, 1999 6: 989-97) An accompanying editorial by Steven Green MD, coincidentally from the ED at Loma Linda, proclaimed the agent as "not ready for prime time." (AEM, Oct. 1999, v6,n 10 pp 975-978) At least according to that highly credible medical news source Fox News Online, July 29, 2009, Propofol and Michael Jackson's doctor have now definitely hit the headlines.

So what has changed in the last 20 years? Well, thanks to the research of pioneers in procedural sedation in emergency departments across the country these agents have been shown to be safe in the hands of trained emergency docs. There were political battles as well as research hurdles to overcome in showing that this was true. With the door opened to their use, emergency physicians have learned the benefits and pitfalls of a number of agents. One of Dr. Green's caveats of lack of experience compared to anesthesiologists no longer exists. On a recent evening shift there were 4 shoulder dislocations requiring some combination of sedative and analgesic agent in order to accomplish the reduction. All were successful in the ED and all were discharged without OR time.

From obtaining CT scans on uncooperative children to cardioversions to abscess drainage, joint reductions, fracture realignment, complicated sutures, even fecal disempactions, the list of uses for these agents continues to grow. The warnings of hypotension and respiratory depression are not to be taken lightly. Each procedure requires a nurse to monitor vital signs, oxymetry, capnometry; and to obtain and chart medications; a physician to assess the level of sedation and react to respiratory depression, hypotension and other adverse events; and the team who will be doing the procedure. In a busy ED, gathering the space and personnel resources is difficult and significant waits are expected. While the procedure is ongoing there is a time out for all involved so there must be adequate staff and space to handle whatever urgent case comes in during this period. In a single coverage ED, good luck getting this accomplished. You are back to the old days, the OR or transfer.

While fentanyl and midazolam have found their way successfully into the EMS world, it is less likely for etomidate or propofol to venture past the ED doors for the foreseeable future. The narrow therapeutic to toxic window, the lack of reversibility of the agents and the more chaotic arena of the prehospital world are significant barriers to their use. In other words, attending to the ABC's while using these agents actually ain't easy.

A Hot Time at the 12th Beach to Beacon

It was a beautiful, warm, sunny August morning for the start of the Beach to Beacon 10 K race this year. Unfortunately that's not what you want for a 6+ mile race with 5,800 runners of varying fitness. As a result, we treated the largest number of patients in the history of the event. 102 patients (2%) were seen and treated at the medical tent, primarily for heat related illness. There were only two transports to the hospital both of which were later released in good condition from the ED. Patients with exertional heatstroke and core rectal temps topping 107° F were readily treated with immersion in ice water tubs (16 of them). Disorientation and sometimes combativeness were common, but after 10-15 minutes of cooling most patients recovered and were taken out of the ice baths and allowed to rest for an additional 20 minutes before rejoining family and friends. There were over 100 medical volunteers who functioned extremely well in a very chaotic environment. Thanks to the superb direction of Chris Troyanos ATC (medical coordinator) , Michael Baumann MD (MMC ED) and Mylan Cohen MD (Cardiology) this was a rewarding experience for patients and providers alike. If you have an interest in volunteering for next year's race let me know and I will add you to the mailing list.

MEMSRR Update & Tips

Documenting a Transfer of Patient Care

Jon Powers, NREMT-P; Data and Preparedness Coordinator

Over the past couple of months I have received a number of questions on whether or not a service should be using the "Transfer of Patient Care" section of the run report.

A patient transfer is defined as conveyance of the responsibility for the care of a patient from one entity to another. It may involve the discharge from one entity and the admission to another along with the patient's medical records or copies. By this definition there are a couple of different scenarios where this takes place in the field.

The first is pretty common in Maine EMS; the transfer of care from a "Non Transporting" service to their "Transporting" service. In this case First Responders have arrived at a patient and assumed patient care and treatment. After some period of time, the transporting service arrives and will assume patient care from the non-transporting service.

As an Example: Belgrade Rescue responds for a medical emergency and Delta Ambulance arrives 20 minutes after to transport the patient to the hospital. Belgrade rescue transfers care to Delta on scene. When Belgrade Rescue enters their run sheet it would look similar to the following;

Response Request

- (●) 911 Response (Scene)
- ( ) Flagdown/Walk-in
- ( ) Intercept
- ( ) Interfacility Transfer (Scheduled)
- ( ) Interfacility Transfer (Unscheduled)
- ( ) Medical Transport
- ( ) Mutual Aid
- ( ) PIFT (Paramedic Interfacility Transfer)
- ( ) Standby

Primary Role of Unit

- ( ) ALS Ground Transport
- ( ) BLS Ground Transport
- ( ) Critical Care Ground Transport
- ( ) Fixed Wing Transport
- (●) Non-Transport
- ( ) Rescue
- ( ) Rotor Craft Transport
- ( ) Supervisor
- ( ) Transport

Response Disposition

- ( ) Treated, Transported by EMS (BLS)
- ( ) Treated, Transported by EMS (ALS)
- ( ) Cancelled
- ( ) Standby Only - No Patient Contacts
- (●) Treated, Transferred Care
- ( ) No Treatment Required
- ( ) Patient Refused Care
- ( ) Treated and Released
- ( ) No Patient Found
- ( ) Treated, Transported by Law Enforcement
- ( ) Treated, Transported by Private Vehicle
- ( ) Dead at Scene

Transfer of Patient Care

Time ALS/Alternate Care Called: 09/01/09 (mm/dd/yyyy) 1500 (HHmm)
Time Patient Care Transferred: 09/01/09 (mm/dd/yyyy) 1525 (HHmm)
Agency Transferred To: Delta Amb Corp/Waterville (0215)
Agency Received From:

There is no need to fill in the "Agency Received From" because Belgrade Rescue did not receive this patient from another service.

The transporting service, in this case Delta Ambulance, would select the following options;

Response Request

- (●) 911 Response (Scene)
- ( ) Flagdown/Walk-in
- ( ) Intercept
- ( ) Interfacility Transfer (Scheduled)
- ( ) Interfacility Transfer (Unscheduled)
- ( ) Medical Transport
- ( ) Mutual Aid
- ( ) PIFT (Paramedic Interfacility Transfer)
- ( ) Standby

Primary Role of Unit

- (●) ALS Ground Transport
- ( ) BLS Ground Transport
- ( ) Critical Care Ground Transport
- ( ) Fixed Wing Transport
- ( ) Non-Transport
- ( ) Rescue
- ( ) Rotor Craft Transport
- ( ) Supervisor
- ( ) Transport

Response Disposition

- ( ) Treated, Transported by EMS (BLS)
- (●) Treated, Transported by EMS (ALS)
- ( ) Cancelled
- ( ) Standby Only - No Patient Contacts
- ( ) Treated, Transferred Care
- ( ) No Treatment Required
- ( ) Patient Refused Care
- ( ) Treated and Released
- ( ) No Patient Found
- ( ) Treated, Transported by Law Enforcement
- ( ) Treated, Transported by Private Vehicle
- ( ) Dead at Scene

Transfer of Patient Care

Time ALS/Alternate Care Called: 09/01/09 (mm/dd/yyyy) 1500 (HHmm)
Time Patient Care Transferred: 09/01/09 (mm/dd/yyyy) 1525 (HHmm)
Agency Transferred To:
Agency Received From: Belgrade Rescue (0857)

This type of transfer of care also occurs frequently on a scene call for Life Flight and for many of the island services where there is a physical transfer from one service to another.

The second scenario is also pretty common but causes a lot of confusion when it comes to documentation. Many services that are licensed or may be staffed at the BLS level may need to call another service to provide a paramedic to treat their patient while en route to the hospital. In these cases the paramedic gets on board with the transporting crew and may continue to the hospital.

Some may question if this is really a transfer of care because "the patient never leaves my truck." However because it is a transfer of responsibility, it is also a transfer of care. When a paramedic (or other professional licensed at a higher level of care) from another service arrives and initiates treatment, they (both the backup service and the paramedic) have accepted the responsibility for patient care. Therefore, a transfer of care needs to be documented in a similar manner as the example provided in the first scenario.

For the transporting service, it is important to understand that any care performed by the paramedic will be documented on their run sheet and there is no need to duplicate this or to put ALS level procedures under someone else's name that may not have these procedures or medications in their scope of practice. Doing that may cause QA/QI review problems.

By documenting this transfer of care, it provides our run reporting system with the information necessary to begin making the connection between services and identify these two different run sheets as one patient care report. At the hospital level, staff are able to search for the patient and complete the linking of these two run sheets and view the complete pre hospital care report.

If you have any questions on this topic or about any part of the MEMSRR please contact me either by phone at 626-3861 or by e-mail at jon.n.powers@maine.gov

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MAINE EMS TEAM LEADERS

Ever wondered who to call when you have a question, complaint, concern or compliment about your EMS system? Listed below are the members of the Maine EMS Board, Maine EMS Staff, and the Regional Coordinators and Medical Directors. Each and every EMS team member in Maine is encouraged to get involved with how your system is run. So get involved—give us a call!

Maine EMS Board Members

Southern Maine EMS Rep	VACANT		
Kennebec Valley EMS Rep	Tim Beals, EMT-P	PO Box 747, Waterville, ME 04903	TEL: 872-4000
Aroostook EMS Rep	Percy Thibeau, EMT-P	229 US Rt. 1, Frenchville, ME 04745	TEL: 543-6697
Tri-County EMS Rep	Lori Metayer, RN, EMT-P	3 Woodland Avenue, Lisbon Falls, ME 04252	TEL: 353-4546
Northeastern EMS Rep	Paul Knowlton, EMT-P	274 Pearl Street, Bangor, ME 04401	TEL: 941-5100
Mid-Coast EMS Rep	Steven E. Leach, EMT-P	PO Box 894, Union, ME 04862	TEL: 785-2260
Physician Rep	Peter DiPietrantonio, DO	4 Picnic Hill Road, Freeport, ME 04032	TEL: 373-2220
Nurse Rep	Geneva Sides, RN	PO Box 287, St. Albans, ME 04971	TEL: 487-5141 x269
First Responder Service	Richard Doughty, EMT-P	4153 Union Street, Levant, ME 04456	TEL: 941-5900
Emergency Medical Dispatch	James E. Ryan, Jr.	62 Main Trail, Hampden, ME 04444	TEL: 570-3773
For Profit Service	Joseph Conley, EMT-P	11 Deer Hill Avenue, Standish, ME 04084	TEL: 252-3947
Not For Profit Service	Bob Hand, EMT-P	100 Hill Street, So. Paris, ME 04281	TEL: 890-6350
State Medical Control Director	Steven E. Diaz, MD	Maine EMS, 152 State House Station, Augusta, ME 04333	
Hospital Rep	Judy Gerrish, RN	891 West Main Street, Suite 400, Dover-Foxcroft, ME 04426	TEL: 564-4207
Municipal EMS Service Rep	Wayne Werts, EMT-P, Chief	Auburn Fire Department, 550 Minot Avenue, Auburn, ME 04210	TEL: 783-6931
Fire Chief Rep	Roy Woods, Chief	Caribou Fire Department	TEL: 493-4204
Public Rep	VACANT		
Public Rep	Ken Albert, Esq., RN	12 South Ridge Lane, Lewiston, ME	TEL: 777-5200

Maine EMS State Office Staff

152 State House Station,
Augusta, ME 04333-0152
TEL: 626-3860 | FAX: 287-6251
maine.ems@maine.gov
www.maine.gov/dps/ems

Jay Bradshaw, EMT-P, Director
jay.bradshaw@maine.gov

Drexell R. White, EMT-P, EMD Coordinator
drexell.r.white@maine.gov

Dawn Kinney, EMT-P, Licensing Agent
dawn.l.kinney@maine.gov

Alan Leo, EMT, Licensing Agent
alan.p.leo@maine.gov

Jon Powers, NREMT-P
Data and Preparedness Coordinator
jon.n.powers@maine.gov

Karen Cutler
Administrative Assistant
karen.m.cutler@maine.gov

Regional Coordinators and Medical Directors

REGION 1 — Donnell Carroll, Southern Maine EMS Council — Dr. Marlene Cormier, Medical Director
496 Ocean Street, South Portland, ME 04106
TEL: 741-2790 | FAX: 741-2158 | smems@smems.org

REGION 2 — Joanne LeBrun, Tri-County EMS Council — Dr. Kevin Kendall, Medical Director
300 Main Street, Lewiston, ME 04240
TEL: 795-2880 | FAX: 753-7280 | lebrunj@cmhc.org

REGION 3 — Rick Petrie, EMT-P, KVEMS Council — Dr. Tim Pieh, Medical Director
71 Halifax Street, Winslow, ME 04901
TEL: 877-0936 | FAX: 872-2753 | office@kvems.org

REGION 4 — Rick Petrie, EMT-P, Northeastern Maine EMS — Dr. Jonnathan Busko, Medical Director
EMCC, 354 Hogan Road, Bangor, ME 04401
TEL: 974-4880 | FAX: 974-4879 | neems@emcc.org

REGION 5 — Steve Corbin, Aroostook Maine EMS — Dr. Peter Goth, Medical Director
111 High Street, Caribou, ME 04736
TEL: 492-1624 | FAX: 492-0342 | aems@mfx.net

REGION 6 — Bill Zito, Mid-Coast EMS — Dr. Colin Coor, Medical Director
Thompson Community Center
51 South Union Rd, PO Box 610, Union, ME 04862
TEL: 785-5000 | FAX: 785-5002 | office@midcoastems.org