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

JANET T. MILLS
GOVERNOR

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COMMISSIONER

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DIRECTOR

Medical Direction and Practices Board – August 17, 2022
Conference Phone Number: 1-646-876-9923 **Meeting Number:** 81559853848
Zoom Address: https://mainestate.zoom.us/j/81559853848

Meeting Minutes

Members present:	*Matt Sholl, Kelly Meehan-Coussee, Mike Bohanske, Beth Collamore, Tim Pieh, Kate Zimmerman, Seth Ritter, Benjy Lowry, Pete Tilney, Rachel Williams, Dave Saquet, Bethany Nash*
Members Absent:	*Claire DuFort, Emily Wells*
MEMS Staff:	*Chris Azevedo, Jason Cooney, Sam Hurley, Darren Davis,*
Stakeholders:	*Jessica Page, Phil MacCallum, Chip Getchell, Chris Pare, Sally Taylor, Shawn Cordwell, Dwight Corning, Cecily Swinburne, Rob Sharkey, Rick Petrie, Michael Reeney, Steve Almquist, Dr. Kevin Kendall, Dr. Norm Dinerman*

1) Introductions and Roll Call
    a. Dr. Sholl does introductions and roll call.
2) Approval of the July 2022 MDPB Minutes
    a. Motion to approve the July meeting minutes made by Dr. Collamore and seconded by Dr. Lowry. Dr. Collamore has suggested a few grammatical corrections. Discussion regarding difficulty opening the file. Drs. Bohanske, Ritter, and Meehan-Coussee abstain from the vote. Motion carries.
3) State Update (deferred until after Alternate Devices agenda item)
    a. Director Hurley
        i. State Strategic Planning Process
            1. Working on staffing concerns for the office related to re-hiring for the Community Paramedicine Coordinator position as well as bringing on the Substance Use Disorder Program Manager.
                a. We do have interviews next week for the Substance Use Disorder Program Manager, and likely another the following week.
                b. The Community Paramedicine Coordinator position application period closes on Sunday.
            2. Preparing for the first Blue Ribbon Commission meeting on 1 Sep 2022. Working to bring some alignment to EMS voices so we all speak with one voice.
            3. There will be a conference in Portland 4 and 5 October 2022, that will be a traffic conference. We have gotten commitment from the sponsors that there will be a section dedicated to EMS highway safety. This announcement will be posted also on the Maine EMS social media pages.
4) Special Circumstances Protocol Review – NONE
5) Alternate Devices – Forced Hot Air Rewarming Devices
    a. Dr. Sholl discusses proposed approval of Forced Hot Air Rewarming Devices.

i. This device was suggested in May for consideration as a new or approved device and/or a change in the protocols. This is coming to MDPB as an approved device, because it's the most expedient mechanism to on-board this type of device
ii. The Yellow section authors have been considering this device for inclusion in Yellow section protocol changes for treatment of hypothermia.
iii. Use of this device is one of the staples of hospital treatment for hypothermic patients once they reach the ER.
iv. Discussion by the group.
1. Dr. Meehan-Coussee
a. These devices may be expensive, so some services may not opt to carry them. We are looking at these as optional devices and not mandatory.
b. Proposal: To add forced air rewarming devices as an approved category to the Maine EMS approved equipment list and to allow their use as equivalent to packing the thorax with heat packs as specified in "Yellow 11 and Yellow 12: Hypothermia" in the Maine EMS 2021 Protocols. Proposal paper on the device was submitted to MDPB for discussion and approval.
2. Dr. Ritter has been trying to research information on the charcoal vest device and is having difficulty finding resources. From what Dr. Ritter has found available, he is not sure that that type of device would be most suitable for EMS use.
3. Dr. Sholl adds that some EMS services in Maine are actively engaged in search and rescue and may be using this already in that context.
4. Dr. Pieh would like to have an option not requiring power as well but does not know much about the charcoal vests. At the same time, he expresses he'd like to have an alternative to simply using hot packs and asks that the group do some additional research on the charcoal vest.
5. Dr. Ritter puts some literature notes in the chat and expresses concern with the possibility of carbon monoxide emissions inside an ambulance, with the use of the charcoal type forced air rewarming devices.
6. Dr. Sholl notes that upon approval, this will be effective immediately. However, this will also require a retroactive statement placed in the protocols as an "if available" device.

b. Motion by Dr. Pieh and seconded by Dr. Zimmerman to proceed with approval of electric forced air re-warmers, if available, which are:
i. Electric (are not battery-powered), AND
ii. hospital grade
c. The above motion is carried.

6) Pilot Program Reviews 0955 - 1010– Sholl – Pilot Program Members
a. Jackman Pilot Project Report to the MDPB
i. Dr. Busko will not be able to attend. Rick Petrie will make the presentation, in his place.
ii. Dr. Sholl shares his screen with the presentation, as Rick Petrie gives the monthly report for the Critical Access Integrated Paramedic Program, in Jackman, Maine.
1. The CPC has reviewed all cases for the prior month and has no concerns.
2. All 12 cases in July were treated in the clinic and not in the field, and resulted in no referrals to the ED.
3. Reportable Procedures (14). All were without negative side-effects.
a. Sutures
b. Ear tele-exam
c. Eyelid eversion
d. Fluorescein application
e. Volar splint

f. Skin adhesive
g. LA local infiltration
h. Digital block

iii. Discussion.
1. Dr. Sholl asks about the current make-up of the CPC. Rick Petrie discusses the personnel make-up of the CPC. MDPB representative is the one open position.
2. Dr. Collamore asks if the digital block reported was done in support of sutures. Rick Petrie replies that it was not. The procedure was done by a paramedic as a component of treatment of an avulsed toenail.

iv. Under the topic of Additional Discussions, Rick Petrie discusses the project's plan to come to MDPB in September with several requests for additional items as noted in the slide.
1. Additional medication classes
2. Low complexity labs
3. Procedures

v. Dr. Sholl discusses that it has been rare, in the past, that pilot projects have requested additions to their pilot project processes, i.e., scope of practice, protocols, etc. Dr. Sholl asks Rick Petrie to pass on that MDPB is currently developing processes to account for the project's interest in evolving the CP program within the 3-year period of time. Recognizing that this program has already required significant investment and input from MDPB, the group would request a similar construct to support the program's request for the included additional items as well as protocols for the additional processes desired.

vi. Dr. Ritter discusses his perspective that early work on the project was in building a set of protocols to be used outside the clinic and what happened in the clinic was to be under delegated practice and appears to have gone in a different direction. Asks for elaboration from Rick Petrie.
1. Rick Petrie explains that when paramedics are working in the clinic, they are working under delegated practice. Nights and weekends, they are working as community access paramedics under the scope of practice approved by the Maine EMS Board. During the last legislative session, the idea of delegated practice was referred to the medical board. We don't know the status of that discussion at this time.
2. Dr. Sholl adds that the outcome of the legislative discussions was a requirement for a conversation between Maine EMS and the Boards of Licensure of both Medicine and Osteopathic Medicine. MDPB has reached out to them and are still waiting for that conversation to occur. But we're dedicated to getting that conversation going. There is discrepancy on the program and whether the protocols are prescriptive, and therefore, exclusive. Or, if there is room for delegated practice. That's the issue we need to bring to the Board. This will be coming to the September Board meeting for their discussion.

7) UPDATE – Medication Shortages – Nash/All – 1010 – 1020
a. Ativan. Starting to see shortage in certain concentrations of Midazolam as well. We may have to make adjustments in the future regarding concentrations that are available.

8) COVID-19 – 1020 – 1030 – Sholl
a. Discussion re: Monday Meeting Schedule
i. Dr. Sholl relates the discussion at the last COVID meeting, that we seem to be in a status quo with COVID. There is a desire to discontinue the monthly meetings for now, while maintaining this topic as part of the regular monthly MDPB meetings. There is always the option to continue with the monthly COVID meetings if necessary.

ii. Discussion amongst the group.
iii. Decision is made to have one more meeting on 3 October to wrap up some concepts, and ideas and to debrief. The September meeting would be on Labor Day and would be skipped. Motion made by Dr. Collamore and seconded by Dr. Pieh to not have the September COVID meeting and have one more monthly COVID meeting in October and to tie up current discussion and then reassess the environment and need to continue meetings afterward. Discussion. Motion is carried.

b. Notification: Monkeypox Bulletin
   i. Dr. Sholl discusses the clinical bulletin that was put out as a result of cases in Maine.

9) 2023 Protocol review process – 1030 - 1245 – All
   a. Timeline review – Sholl/Zimmerman/Collamore
      i. Dr. Sholl shares his screen and reviews the timeline.
         1. The group had discussed trying to maintain April-July for development of protocol associated materials. So, April would wrap up our review of the protocols. Despite the changes in education processes, we should still be able to compete review work on time, but we should also consider the possibility of making additional meetings to ensure we have finished the process on time.
         2. Dr. Sholl discusses protocol evolution and finding the right balance between protocol evolution and over-burdening providers and the system. This is especially poignant during the pandemic.
            a. Dr. Collamore agrees and discusses.
   b. Discussion: Change Documents
      i. Dr. Zimmerman discusses keeping up in LucidChart during the update process. Emphasizes the need to keep the change documents updated. As this is the record for change suggestion and justification, it is also important for section authors to indicate whether or not suggestions were accepted or not on the change forms.
      ii. Dr. Zimmerman's perspective is supported by Drs. Collamore and Sholl, and the Education Coordinator. Discussion by Dr. Collamore and others.
   c. Next Protocol Review Webinar Discussion
      i. The next forum is being held on September 8, noon – 1pm.
      ii. Dr. Sholl discusses conduct of the forums thus far and asks representatives from Green Section and Blue Section to attend, if possible.
   d. Yellow Section – wrap up, Norepinephrine language
      i. Poisoning/Overdose #2 protocol
      ii. Regarding the protocol for initiation of pressors, Dr. Sholl reads and discusses norepinephrine dosing, under the, which was tabled at an earlier discussion and not yet revisited.
         1. The intent was to be thoughtful about starting dose, titrating in a potentially more aggressive fashion, but also being mindful that, while there is a typical starting does in certain clinical circumstances, there are times where it might be reasonable to start a little bit higher than normal.
         2. Proposed language
            a. "The usual starting dose of norepinephrine is 0.03 mcg/kg/min. Clinical circumstances may dictate slightly higher starting does of 0.06 – 0.09 mcg/kg/min. Titrate by 0.03 mcg/kg/min every 3 minutes to meet desired clinical effect, which may include appropriate systolic blood pressure."
            b. We may offer a range or appropriate systolic blood pressures.
         3. Dr. Nash was part of this conversation regarding the language. However, the group did want to bring this back to the MDPB for discussion.
         4. Dr. Sholl advises that, due to pressors appearing in multiple protocols sections, there will be a need to revisit those places where that occurs and harmonize the language across the entire protocol document.

5. Dr. Sholl opens the topic for group discussion.
    a. Dr. Saquet asks, what were the clinical contexts specified?
6. Dr. Meehan-Cousee
    a. When we discussed how profoundly hypotensive TCA overdose patients can be, we might want to start at a slightly higher dose. The discussion was, do we need to change the starting dose, or simply put in a caveat to allow providers to clinically decide how much norepinephrine to give. We recognize that making that decision takes a fair amount of education.
7. Dr. Bohanske
    a. Do we want to leave that starting range in, or make it wider or more vague? Dr. Sholl states that setting a range was deliberate. Dr. Lowry suggests changing language to say, "require slightly higher ranges," instead of "dictate…"
8. Motion to approve the aforementioned language is made by Dr. Bohanske and seconded by Dr. Zimmerman. Motion is carried.

iii. Dr. Zimmerman revisits two unresolved pediatric midazolam and ketamine dosing questions, from the Orange section and reviews the language suggestions.
1. The proposal is for:
    a. midazolam 0.1 mg/kg intramuscular, with a max single dose of 10 mg.
    b. ketamine at same dosing as adults, 4 mg/kg for pediatric patients greater than 3 months old.
2. Dr. Sholl asks if there was a higher age range on ketamine that was discussed. Discussion by the group.
3. Dr. Saquet asks if it would be better to use a weight range. Dr. Sholl suggests it might be better to use an age range to avoid delirium with aggressive behavior.
4. Dr. Bohanske adds that the language proposed at the time of original discussion was, "for age greater than 10 years or less than 10 years old, that providers must contact OLMC." So, not ruling out use of ketamine for an 8- or 9-year-old but requiring OLMC consult.
5. Dr. Sholl asks that it would be helpful to have all of that information captured in the final change document, also, that the group had voted an approval pending Dr. Williams's agreement.
6. Dr. Williams voices her agreement on the proposed language.

iv. Dr. Collamore asks about closing the loop on a proposed change the Yellow section, Poisoning/Overdose #2 regarding repeat of sodium bicarbonate. Dr. Sholl asks to address that question offline.

e. Green Section – Meehan-Cousee/Bohanske/Ritter
i. Drs. Meehan-Coussee, Bohanske and Ritter lead the group in discussion of Green section change proposals.
ii. Minimum Landing zone #1
1. Dr. Ritter discusses the change proposal to appoint personnel to guard main and tail rotors, so no one walks into it.
2. Dr. Sholl asks Dr. Tilney's perspective on the above change. Dr. Tilney supports the change. Discussion by the group.
    a. Perhaps the latest guidance given by the latest ground safety course?
    b. "Aircraft Arrival: appoint personnel to guard main and tail rotors in accordance with guidance from most current ground safety course."
    c. Dr. Tilney agrees to take this offline to consider best alignment with current guidance.
3. Dr. Tilney discusses a question regarding LZ #2, regarding whether or not landing zones should be downwind of an incident if the incident is a HAZMAT

incident. Dr. Tilney has queried some subject matter experts but has not yet received an answer to that particular question.

4. Dr. Zimmerman asks the question of moving minimum LZ areas #1 and #2 out of green and into operations?
    a. Dr. Bohanske- historically, it's always been in green, but it's really operational. So, perhaps, it should be in Grey, Operations.
    b. Dr. Tilney agrees
    c. Dr. Zimmerman makes the motions to move "Minimum Landing Zone #1 and #2" to the Grey section. Motion is seconded by Dr. Collamore.
    d. No discussion. Motion carries.
5. The question of downwind landing zones in LZ #2 will be revisited at a later date.
6. Dr. Sholl discusses proposed change to Trauma Triage #1.
    a. Discusses changes in National Guidelines for Field Triage and shares his screen.
        i. The guidelines put forth were based closely upon the CDC 2011 first iteration of their trauma triage guidelines. This included assessment for physiologic compromise, assessment for anatomic injury, assessment for mechanism of injury, and an assessment for special patient circumstances. For patients with any of these indicators, we had recommended transport to nearest regional trauma center, if transport time is less than 45 minutes. Otherwise, transport to closest ED participating in the trauma system. If no indicators present, consider transporting to participating trauma system hospital.
        ii. The CDC has updated their triage guidelines and have moved away from those assessments we currently have in the protocol and moved towards two decision points:
            - Injury patterns
            - Mental status and vital sign changes
        iii. Dr. Sholl discusses the CDC updates in depth with the group.
    b. Wanted to find a way to embrace both changes in the trauma centers in Maine and also CDC changes and to include some of the language.
        i. For patients meeting CDC RED criteria (High Risk for Serious Injury
            - Transport to regional trauma center
            - If transport time is >45 minutes, transport to highest level trauma center available OR the closest ED which is a trauma system participating hospital
        ii. For patients meeting CDC Yellow criteria (Moderate Risk for serious injury)
            - Consider transport to a regional trauma center if transport time is <45 minutes
            - If transport time is >45 minutes, transport to highest level available or closest ED which is a trauma system participating hospital
            - If there are any questions, please contact OLMC
    c. Dr. Sholl discusses proposals for PEARLS changes.
        i. EMS Clinician triage to the appropriate level trauma enter is beneficial to patient outcomes.

ii. Patients with any suspicion for special surgical needs (including Neurosurgical injury) should be transferred to a Level 1 or level 2 Trauma center.
    - Dr. Zimmerman recommends simply specifying "Level 1 or Level 2" due to uncertainty regarding updates to the Trauma Plan.
iii. If additional transfer time to a level 1 or Level 2 trauma center is felt to be deleterious to the patient, transfer to the higher-level trauma center available or the closest emergency department. For questions, refer to OLMC.

d. Group discussion regarding nuances of making distinctions between trauma centers, trauma hospitals and specifying certain hospitals for transport of trauma patients.
e. Dr. Meehan-Coussee asks to return to the trauma triage algorithm and discusses Dr. Sholl's change proposals for trauma triage.
    i. We wanted to make sure there was discussion included in the protocol for severe burns, prolonged entrapment, and also to put in an asterisk regarding vital signs saying that attempting to maintain a manual blood pressure whenever possible is appropriate for trauma patients.
    ii. Discussion between Dr. Sholl and Dr. Meehan-Coussee
    iii. Dr. Sholl – These changes to trauma triage are a last-minute addition and I'll be happy to send these suggestions out to section authors for consideration and to bring back to the group at a later date.
    iv. More discussion amongst the group.

7. Dr. Ritter
    a. Spine assessment #1
        i. Consider changing format of spine assessment flow chart:
            - Change shape of flow chart (shows example)
            - This would eliminate past confusion caused by the layout of the current chart
        ii. Discussion by the group regarding changing the flow chart
            - Dr. Pieh questions the need to change the flowchart format
            - Dr. Bohanske relates that the motivation for change is to turn some ambiguous items into bullet questions, checklist style, much like we do with a stroke.
            - Dr. Ritter- this is one of those times when I feel format has an effect on content.
8. Dr. Saquet asks if axial loading injuries needs to be addressed. This is done in Canada.
    a. Dr. Zimmerman- we've been looking at data, unfortunately only one hospital has participated with their data. Not sure we missed any fractures in the year after we removed backboards. However, it would be helpful if we could look at data from those.
    b. Dr. Sholl- actually, we do look at axial loading in pediatrics. This is from the Pegasus project.
    c. Dr. Saquet- you think this should be peds specific? Dr. Sholl replies that pediatrics is the only place we've found this mentioned.
    d. Dr. Sholl – thanks Dr. Zimmerman for offering to amend the graphic.

e. Dr. Meehan-Cousee – only re-wording we were looking for is in the initial box (referencing current diagram)

9. Dr. Meehan-Cousee continues discussion on spine management.
    a. Spine Management #1
        i. Change verbiage to "Is patient seated and meeting all 3 criteria in the yellow box on the left side of this page to be able to self-extricate?" (remove *)
    b. Dr. Ritter
        i. Spine Management #2
            - Preferred Position: underline "the preferred position for all patients with spine management is flat and supine
            - Penetrating injury final sentence: "Emphasis should be on airway and breathing management, treatment of shock, and rapid transport following the Maine EMS Trauma Triage Guideline, Green 3."
        ii. Chest Trauma
            - Under paramedic intervention, we are trying to clarify that the intervention for decompressing a chest should only be for suspected TENSION pneumothorax, as opposed to any suspected pneumothorax.
            - Points to PEARLS – DO NOT REMOVE PREVIOUS CATHETERS. This came about from prior case.
        iii. Dr. Sholl advises no vote is needed to approve these changes.
    c. Dr. Ritter continues with Head Trauma #1
        i. EMT 3 - Adding in a mandate for continuous ETCO2 for all TBI patients.
            - Dr. Sholl advises that this is not possible at the EMT level, because ETCO2 is not an EMT skill. But the protocol does address it later on in the section.
            - Dr. Bohanske discusses that at the top of the protocol, it advises that continuous ETCO2 monitoring should be used for all severe TBI patients. Also, an advanced airway is not necessary for ETCO2 monitoring.
            - Verbiage regarding ETCO2 changed to reflect, "if available."
    d. Head Trauma #2
        i. AEMT/Paramedic
            - Remove #10- already under EMT
            - Item #11 – Change "if advanced airway" to "adjust ventilatory rates to meat goal ETCO2 levels 35-45. Target 40mmHg
10. Coverage of the Green section change proposals stopped at Head Trauma #2

f. Discussion re: Upcoming Protocol Review Schedule
    i. Dr. Sholl
        1. Perhaps by next month, we'll have a better idea of steps we need to take.
        2. Next section is the Blue section. It doesn't sound as if Blue section authors have met yet.

3. Asks if section authors could be ready to possibly go for September. May not get to Blue next month.

g. Prehospital Physician's piece
   i. Drs. Sholl and Pieh still working on this.

h. PIFT
   i. This has been occurring within the context of the IFT committee.
   ii. IFT did send some questions to Maine EMS Board and AAG office to answer.

Old Business – 1245 - 1300

1) **Ops** – Director Hurley/Ops Team Members
   a. Sally Taylor
   b. Ops has not met.
2) **Education** – A Koplovsky/C Azevedo
   a. Education committee did not meet this month.
3) **QI** – Chip Getchell
   a. Nearing completion on stroke newsletter.
   b. Have identified topic for fall newsletter- safety
4) **Community Paramedicine** – B. Lowry/J Oko
   a. Did not meet.
   b. David Davies has left Maine EMS. Will be looking for a replacement.
5) **EMSC** – M Minkler, R Williams
   a. Nothing to report.
6) **TAC –** K Zimmerman, A Moody
   a. Still working on revising trauma plan
7) **MSA** – K Zimmerman, A Moody
   a. Recruiting members. There is an opening for a neurologist.
8) **Cardiovascular Council**, A Moody
   a. Nothing to report.
9) **Maine Heart Rescue** – M Sholl, C Azevedo
   a. Chris Azevedo and Sally Taylor went to Maryland to teach at the MD Resuscitation Academy.
   b. The Maryland Resuscitation Academy will be presenting their course at the Samoset Conference 9-10 November.
10) **Next meeting**
   a. The next meeting will be on 21 September 2022.

Motion to adjourn made by Dr. Saquet and seconded by Dr. Meehan-Coussee. Meeting adjourned at 1257 hrs.

The QI Committee meeting will begin at 1330