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

JANET T. MILLS
GOVERNOR

MIKE SAUSCHUCK
COMMISSIONER

J. SAM HURLEY
DIRECTOR

Medical Direction and Practices Board – March 15, 2023
Conference Phone Number: 1-646-876-9923 **Meeting Number:** 81559853848
Zoom Address: https://mainestate.zoom.us/j/81559853848

Meeting Minutes

Members present: *Matt Sholl, Beth Collamore, Kelly Meehan-Coussee, Michael Bohanske, Kate Zimmerman, Rachel Williams, Benji Lowry, Pete Tilney, Seth Ritter, Dave Saquet, Bethany Nash, Tim Pieh, Emily Wells*

Members Absent:

MEMS Staff: *Chris Azevedo, Marc Minkler, Jason Cooney, Soliana Goldrich, Jason Oko, Darren Davis, Anna Massefski, Ashley Moody, Megan Salois, Jason Oko, Sam Hurley, Robert Glaspy*

Stakeholders: *Don Sheets, Polly Wood, Jay Bradshaw, Steve Almquist, Chip Getchell, Frank McClellan, Scott Smith, Myles Block, Norm Dinerman, Sally Taylor, Kevin Curry, Chris Pare, Kevin Kendall, Dwight Corning, Brian Langerman, Rob Sharkey, Rick Petrie, Jonnathan Busko, Chris Mitchell, Rebecca Royer, Colin Ayer, Phil MacCallum, Steve Diaz*

1) Introductions
    a. Meeting begins at 0934. Dr. Sholl makes introductions and takes roll.

2) February 2023 MDPB Minutes
    a. Dr. Zimmerman notes one correction to be made to a date on page 3. Motion to approve the February 2023 meeting minutes made by Dr. Nash and seconded by Dr. Collamore. No discussion. Motion is carried.

3) State Update
    a. Director Sam Hurley gives the update from the state office.
        i. Maine EMS is conducting the final interviews for the Deputy Director position. There are now four candidates to interview. It is estimated that the process will be completed by the end of this month.
        ii. We are working to bring onboard a new office associate to replace Emily Burgess, who has transferred to the Fire Marshall's Office.
        iii. A second Substance Use Disorder Response Coordinator position will be re-posted. We did have a candidate who interviewed, but the salary was not within their acceptable range. We encourage all to recommend application for the position to those you know who might be interested in a position such as this.
        iv. The office is currently working on an RFP for medical direction support related to Medications for Opioid Use Disorder (MOUD) programs and some of our substance use disorder programming. This should be coming out within the next month.

v. Working on an ambassador program, which will be six EMS clinicians throughout the state who would be local ambassadors for local substance abuse disorder programs.
vi. Our partners at Highway Safety may be able to increase funding support for us, which would be put into a project to provide mobile internet capability for ambulances. Discussion of this project, by Director Hurley.
vii. Continuing work with EMS-C on the national and statewide pediatric education survey for EMS services.
viii. Dr. Ritter asks regarding no longer allowing video appointments for OUD, as COVID accommodations are phased out. Also, Dr. Ritter asks if there are updates to the COVID playbook.
    1. Director Hurley, relates that the protective measures posture has not changed, including masking. Also, there is a need for some updates, but they have not yet been done.
ix. Director Hurley discusses multiple bills that are being heard by the legislature and its standing committees:
    1. There is a bill to support funding of the Length of Service Award Program (LOSAP) for EMS.
    2. There is one bill to remove EMS Board authority make rules to issue vaccine rules for COVID and influenza.
    3. Other bills that may affect EMS, but the Office will not provide testimony on. These include worker's compensation. Another involves tort claims that may remove protections for EMS unless they work for a municipal entity.
    4. Additional bills relate to the Blue-Ribbon Commission – allowance for non-municipal entities to participate in State retirement, medical and disability plans.
    5. LD—883 adds an exemption to home health licensure to CP agencies and personnel.
    6. LD-981 requires all EMS personnel to be trained to dispense naloxone. This will likely be handled via the protocols, however, and a requirement for all services to be trained to dispense naloxone.
    7. LD-1119, is a bill clarifying criminal statute regarding assault on EMS personnel, and makes it a felony.
    8. LD-1142 eliminates registration fees for volunteer firefighters and EMS clinicians.
    9. More information about the bills the EMS office is monitoring is contained in the staff update to the EMS Board.
x. Dr. Sholl discusses the EMS Board's ask that the Rules committee discuss the geography of the regions and what that might look like with the proposed changes.
    1. The group had decided that the way to address this was to ask the Regional Medical Directors to consider what the job looks like now, what it might look like in the future, and how the changes in geography might affect that.
    2. Dr. Bohanske discusses. The Regional Medical Directors drafted a document discussing what their vision for the future would look like, in regard to strategic planning, would look like. The group hopes this is helpful to the strategic planning effort.

4) Special Circumstances Protocol Review – NONE

5) Alternate Devices – NONE

6) Pilot Program Reviews – 0955 – 1005
    a. Jackman Pilot Project

i. Dr. Sholl shares his screen with the group and Dr. Jonnathan Busko gives his CAIP report.

7) UPDATE – Medication Shortages – Nash/All – 1005 – 1015
    a. Dr. Nash relates that the midazolam issue is beginning to resolve, and her hospital is beginning to be able to revert to their standard concentrations.
    b. Ketamine is still on back order, with a release date of approximately May.
    c. D50 is still on back order. Monitoring the situation.
    d. Dr. Zimmerman asks regarding a possible issue with albuterol. Dr. Nash suspects any issue is likely limited to inhalers
8) Emerging Infectious Diseases – 1015 – 1020 – Sholl
    a. Dr. Tilney relates that there have been multiple cases of syphilis (one was an infant born with it congenitally) and other STDs as well as resurgent cases of hepatitis (GI related).
    b. Director Hurley discusses the paradigm of how we may be able to advise patients of the pilot projects (Jackman and Portland) about the potential for syphilis and the importance of getting tested.
    c. No further updates.
9) 2023 Protocol review process – 1020 – 1200 – All
    a. Timeline review – Sholl/Zimmerman/Collamore
        i. Dr. Sholl shares his screen with the group and discusses progression on the timeline for protocol work.
        ii. Beginning June/July timeframe, review of deliverables is expected to begin. Dr. Sholl advises the group to begin thinking about white papers at this time and asks for preliminary thoughts on them.
        iii. Dr. Zimmerman also asks the group to think about QI and quality metrics for your protocol section, as well.
        iv. Director Hurley asks that should there be any changes that require additional data elements, the section authors should be working with the data team to figure out how those elements should be documented in MEFIRS patient care reporting.
    b. Discussion – Protocol Review Webinar – March 9, 12-1pm
        i. Discussion of the webinar by Drs. Sholl and Collamore
            1. Red protocol changes discussed. Most discussion focused around new England Donor services. Mr. Reeney, from New England Donor Services was present and was able to clarify items regarding the protocol changes.
            2. Dr. Pieh discusses his perspective on the forum.
            3. Next forum is in May. Hopefully will be able to report on Pink section. Will decide whether or not we will need additional webinars at that time.
    c. Follow Up – MDPB Deliverables
        i. Discussed by Dr. Sholl under timeline review.
    d. Pink Section – Williams/Lowry/All
        i. Dr. Williams shares her screen and discusses proposed Pink section changes with the group.
        ii. Pink 2 – Croup
            1. Change max dose of dexamethasone to 16 mgs for croup
                a. Aligns with American Academy of Pediatrics.
                b. Dr. Sholl proposes show of hands regarding group approval versus roll call vote.
                c. Dr. Bohanske asks how this will align with Blue Bronchospasm protocol. Dr. Williams would like to change the dose in the protocol for pediatric and adult bronchospasm (Blue), as well.
                d. Ashley Moody asks regarding the concentration necessary, as that would require a drug box change. Dr. Nash advises there would only be a need to increase the par level, which would not be costly.

e. Dr. Pieh discusses data regarding differences in dosing. Is there additional evidence or data supporting increasing the dose? Discussion.
f. The group agrees with the change.

2. Blue 8 Asthma – Dr. Williams discusses pediatric oriented changes for this sections.
    a. Change max dose of dexamethasone to 16 mg for asthma for both pediatric AND adult patients.
    b. Change magnesium sulfate administration to "over 20 minutes" for both Pediatric and adult patients due to possibility of rapid infusion causing hypotension and bradycardia.
        i. Dr. Ritter discusses and expresses that there isn't enough evidence, necessarily to cause concern enough to need to increase infusion time.
        ii. Dr. Nash discusses administration via IV pump versus IV push.
    c. Marc Minkler comments that the current language reads as a "push" dose and does not stipulate that this is dosing via IV pump. So, pushing this over pushing this over the proposed increase to 20 minutes would be very challenging. Recommends that if this is to be infused over time and not a push dose, it should be required that this should be done via IV pump by a paramedic.
    d. Discussion by the group.
        i. Dr. Sholl recommends that whatever changes are agreed upon to be made here for pediatrics should be mirrored for adults as well.
        ii. Dr. Williams agrees with suggestion to add that this should be via IV pump.
        iii. Dr. Nash agrees with infusion rate over 15-20 minutes. Notes that pumps can accommodate any timeframe. The potential issue is the volume being infused over that timeframe. Suggest verbiage directing to "dilute and infuse over 20 minutes," however Dr. Nash is unsure of whether or not to be specific in the protocols, due to need to change concentrations in cases of shortages.
        iv. Dr. Ritter agrees that this should be infused over 15 minutes.
    e. Dr. Sholl polls the group regarding increasing the infusion duration, requiring pumps, and making accommodating verbiage changes.
        i. The group agrees.
    f. Dr. Pieh queries the group regarding what size of IV fluid bag should be used for dilution. Dr. Nash expresses hesitancy to be prescriptive, due to the need to maintain options in cases of shortages of fluids, etc. Discussion. Dr. Nash agrees to make some recommendations regarding fluid volumes for dilution and pump administration.
    g. The group agrees that for Torsades and eclampsia, the current protocol language should be retained, and **not changed** to mirror the changes being made for the adult and pediatric asthma protocol, here.
3. Blue 6 – Post intubation/BIAD pain control
    a. For anxiolysis post intubation, add phrase "may repeat" for pediatric midazolam dosing for both 6 months and for 6 months to 12-year age groups
    b. The group agrees.

4. Gold 6 – Hypoglycemic emergencies
    a. In the weigh-based dosing chart for this protocol, the dosing only goes down to 10 kg. Dr. Williams recommends adding two new rows to the current chart, with appropriate dosing to effectively treat younger infants with hypoglycemia.
        i. 3 lbs/6.6kg – 15mL volume
        ii. 5lbs/11kg – 25 mL volume
    b. The group agrees with the proposed change.
5. Gold 9 – Seizures
    a. Change item #10 for Paramedic
        i. It was identified by pediatric/OB providers and instructors for the Basic Life Support for Obstetrics (BLS-O) course that the current protocol dosing for eclampsia does not align with that used by those practitioners in the hospital/ER setting. Dr. Williams discusses.
            - For peds/OB practitioners, treatment algorithm usually consists of two rounds of magnesium sulfate, followed by use of a benzodiazepine as third round agent.
        ii. Dr. Williams summarizes the proposed changes as follows:
            - Align the orders of medication intervention
            - Clarify that if the patient is pregnant and is having a seizure, to give the magnesium sulfate first and clarify the dosing.
        iii. Discussion by the group.
        iv. For patients visibly pregnant or less than 6 weeks post-partum who are seizing or postictal
            - Magnesium sulfate 4 g IV/IO over 20 minutes. If IV/IO not available, magnesium sulfate 8 g IM (4G in each buttock).
                a. Once IV established, administer magnesium sulfate 1g/hr continuous infusion
            - For recurrent seizure, administer additional magnesium sulfate 2 g IV/IO bolus over 3-5 mins
            - For refractory seizure, administer one of the following:
                a. Midazolam 10 mg IM; or
                b. Midazolam 5 mg IV/IO
            - Question posed to the group: do we move this item above #9? Or add “if pregnant, move to #10?
        v. Discussion by the group.
        vi. Group agrees to insert a line in #9, “If patient is visibly pregnant or 6 weeks post-partum, proceed to #10.”
        vii. Dr. Sholl suggests changing the current 10-minute infusion time to 15 minutes, to ensure parity with other protocols.

viii. Dr. Sholl discusses concerns with total duration of time it takes in this protocol, to get to benzodiazepine use, as the longer a patient remains in seizures, the greater the potential risk the seizure will be refractors. Proposes the group allow offline editing which will:
- Prioritize magnesium sulfate in females who are visibly pregnant or recently post -partum
- Administration of magnesium sulfate will be over 15 minutes
- Develop language to address time to second agent

ix. The group agrees.

6. Gold 16 Medical Shock
    a. Edit verbiage at bottom of chart to correct typographical error.
7. Pink 4 childbirth
    a. Add administration of oxytocin to item #6
        i. "After delivery of fetus and placenta, administer oxytocin 10 Units IM to the mother. Note: in cases of multiple fetuses, do not give until all placentas are delivered."
    b. Dr. Williams discusses evidence to support the addition.
        i. Giving oxytocin to preempt post-partum hemorrhage is safe.
            - Discusses multiple studies regarding safety and efficacy.
        ii. Addition of this is also consistent with protocols in other states
        iii. Dr. Nash adds that the medication is not expensive, with regard to impact.
    c. Discussion of impact of the change.
        i. Query of number of deliveries in the state.
        ii. Marc Minkler discusses feedback from OB practitioners regarding possibility of adding this medication to protocols for prehospital providers.
        iii. Dr. Lowry agrees that this is very well supported in the literature.
        iv. Chip Getchell asks, from chat, regarding the possibility of an unknown second fetus. Dr. Lowry discusses that it is likely the patient will already know this, but this should also be prudently researched.
        v. Marc Minkler asks if the intention with this protocol is to be a paramedic level intervention only? Drs. Sholl and Nash reply that this is intended to be a paramedic-only intervention.
        vi. Dr. Lowry adds, regarding possibility of a second fetus, that literature recommends against giving oxytocin in the presence of a second fetus due to possibility of uterine rupture and death of the second fetus. Asks if we are comfortable with the risk, or the likelihood that patients will be aware of the presence of a second fetus. Dr. Sholl suggests addressing that concern with verbiage in the protocol.
    d. Motion made by Dr. Nash and seconded by Dr. Bohanske to add oxytocin to the formulary, and to add this protocol for administration

of oxytocin for IM administration at the paramedic level only, post-partum for prehospital delivery. Discussion

i. Dr. Zimmerman asks if the intent is to use the verbiage regarding multiple pregnancies that is on the slide. Dr. Williams replies that specific verbiage is up to the group.
ii. Mark Minkler recommends changing the verbiage given on the slide to state "multiple fetuses," versus "multiple pregnancies," as it is a more correct term.
iii. Dr. Sholl states protocol verbiage to read as follows:
- "After delivery of fetus and placenta, administer oxytocin 10 Units IM to the mother. Note: In known multiple fetuses, do not give until all placentas are delivered."

e. Motion carries.

8. Pink 4 Childbirth
   a. Item #7
      i. Add "for premature infants, wrap the torso and extremities of the baby in food grade or medical grade plastic wrap.
      ii. Fully updated text:
         - 8. During transport, the baby should be placed in an appropriate child passenger restraint system with the head supported.
         - 9. Maintain warmth during transport. Hypothermia in the newborn may cause decreased LOC, hypoglycemia, bradycardia, and hypotension. Wrap the baby in warm blankets or aluminum foil blankets (i.e., "space blankets") and a warming hat to minimize heat loss. Consider using a Maine EMS approved infant warming pad during transport. For premature infants, wrap the torso and extremities of the baby in food grade or medical-grade plastic wrap.
      iii. Dr. Sholl motions to adopt Dr. Williams's language with additional material for maintaining warmth, and to keep the airway statement. Motion seconded by Dr. Zimmerman.
      iv. Motion carries.
9. Pink 5 Prolapsed Umbilical Cord
   a. Recommendation to remove verbiage "assess for pulsations in the cord," as it likely doesn't change management.
   b. Discussion by the group.
   c. Agreement by the group.
10. Pink 5 Breech Birth
   a. Change title (line "c.") to "Breech birth - presentation of buttocks or extremity first.
   b. The group agrees to the change.
11. Pink 5 Breech Birth
   a. Change c.ii. to
      i. "If the head fails to deliver within 30 seconds of the legs, place two fingers into the vagina to locate the infant's mouth. Press the vaginal wall away from the infant's mouth to maintain the fetal airway."
      ii. The group agrees

12. Pink 7 Neonatal resuscitation
    a. Dr. Williams advises that the National Academy of Pediatrics has revised the Neonatal Resuscitation Program curriculum. The resuscitation treatment algorithm has been updated to reflect a change in initial epinephrine dosing to an IV or IO dose of 0.02 mg/kg (equal to 0.2 mL/kg).
    b. The recommendation is to change the current protocol initial epinephrine dosing from 0.01 mg/kg to 0.02 mg/kg, in alignment with the NRP recommendation.
    c. Dr. Nash advises the lift for this might be limited to highlight emphasis on the dosing change, for the education. Marc Minkler agrees and recommends clarifying the definition of "neonatal" and the intent of the dosing for that population.
        i. Dr. Sholl asks if the protocol should define "neonatal" for this instance.
        ii. Dr. Zimmerman advises that the purple section defines "neonatal" as an infant less than or equal to 28 days of age.
    d. The group approves the change and agrees that the definition for "neonatal" should be defined as less than or equal to 28 days, and that this definition should also be ported over to Pink 2.
13. Red 12 Pediatric Cardiac Arrest
    a. Recommendations to do the following
        i. Revise the verbiage to incorporate the pediatric medication dosages directly into the protocol, versus keeping them only in the chart, which must be looked at separately. This change suggestion came from a field clinician as a way of mitigating delays in medication administration due to having to look in separate places for the treatment algorithms and then for the medication dosing. Subsequent recommendation that the pediatric arrest medication chart then be deleted entirely.
        ii. Add new pediatric post-resuscitation protocol
        iii. Consider whether or not pediatric cardiac arrest should stay in the Red section, or be moved to the Pink section
        iv. Incorporate the remaining pediatric cardiac medications and dosages into their respective protocols (as with pediatric cardiac arrest), and delete the Pediatric Cardiac Medications & Dosages chart altogether.
        v. Discussion by the group
    b. After polling the group, the decision is to both incorporate the pediatric medication dosing into the protocol and also to leave the chart in the Red section.
14. Pink Cardiac Arrest #1
    a. Proposal to put the pediatric arrest protocol in the Pink section and remove it from Red.
    b. Dr. Williams shows a slide of the proposed verbiage in the protocol at EMT, AEMT and Paramedic levels. Advises much of the verbiage is taken from the adult cardiac arrest protocol.
        i. Dr. Lowry advises that nothing for pediatric arrest is outlined in the manner shown in the slide, only reference to the pediatric chart in the adult cardiac arrest protocol.

ii. Dr. Sholl discusses that there has been come controversy around compression : ventilation ratios prior to and post-intubation. Dr. Bohanske relates prior discussion points on the subject.
- Discussion of specific verbiage.

iii. Dr. Sholl points out that, while cardiac epinephrine at the AEMT level has been approved for adults, it has not yet been approved for pediatrics.
- Dr. Williams discusses epinephrine administration for pediatrics and inclusion for the same at the AEMT level.

c. Discussion is paused at this point.

10) Discussion – Community Paramedicine Committee Scope of Practice Document
   a. Dr. Sholl introduces the Community Paramedicine Scope of Practice document.
      i. Dr. Sholl shares his screen while Dr. Lowry and Soliana Goldrich discuss the document with the group.
      ii. Discussion by the group.
      iii. Dr. Pieh makes the motion to accept the document as written. Motion is seconded by Dr. Meehan-Coussee.
      iv. Motion is carried.
11) Update – PIFT
   a. Dr. Tilney shares his screen and discusses proposed change documents for updating of the PIFT program.
      i. Areas for update
         1. Oversight
         2. Design
         3. Coordination
         4. Documents
         5. Guidelines
      ii. MDPB input vs Maine EMS vs State input
         1. Dr. Tilney discusses the overarching issue of "who owns PIFT?" Who is the regulating entity?
         2. Dr. Norm Dinerman defines- "IFT is a physician provider prescribed event"
            a. EMTALA states that the sending providers are ultimately responsible for care rendered until patients cross threshold of receiving facility.
               i. With this in mind, does this change who the regulating body is?
            b. Director Hurley relates that AG office states that sending physician does not have the authority to alter the transporting crew's scope of practice. Scope is defined by the Board and cannot be amended by sending physician orders. While it may not be best practice for the MDPB to protocolize IFTs, but they can provide guidance. The question comes down to whether or not the prescribed treatment falls into the paramedic scope of practice. If it does not, it can't be done by the paramedic.
      iii. Dr. Tilney discusses a compromise between EMS and sending physicians.
      iv. Dr. Tilney discusses the items sent to the group prior to today's meeting.
         1. 2023 IFT Transfer Algorithm for PIFT
         2. 2023 Letter to CEOs and ED Directors
         3. 2023 Letter to EMS Service Chiefs
         4. 2023 Letter to Medical Directors

5. 2023 PIFT Guidelines

b. Dr. Tilney opens the floor to feedback from the group.
   i. Discussion by the group.
   ii. Dr. Tilney discusses recommendations for updates contained in the documents that were distributed and asks for feedback from all meeting participants.

12) Update – MDPB ALS Position – 1240 – 1245 – Interview Panel
   a. Dr. Sholl discusses the Interview Panel and the work done during the candidate selection process.
   b. Dr. Sholl puts forward Colin Ayers's name to the group as the panel's selection for the position. Discussion.
   c. Colin Ayer introduces himself to the group.
   d. Motion to accept Colin Ayer made by Dr. Collamore and seconded by Dr. Williams. No discussion. Motion is carried. Mr. Ayers's name will be forwarded to the EMS Board for confirmation.

13) Discussion: Work Group to discuss Delta Vent Transport Pilot Program – 1245 – 1250
   a. Dr. Sholl discusses an ask for the group to review a ventilator transport pilot program for Delta Ambulance.
      i. A work group is needed to perform the review process. Dr. Sholl solicits volunteers.
         1. Drs. Meehan-Coussee and Tilney volunteer to work with Dr. Sholl on review of the pilot program.
14) Dr. Sholl conducts a straw poll for attendance at the April meeting.
15) Dr. Sholl solicits interest in a retreat planning committee. Please contact Drs. Sholl or Zimmerman.
16) Protocol To Do List
   a. Traumatic Arrest Protocol
   b. Others

Old Business – 1250 - 1300

1) **Ops** – Director Hurley/Ops Team Members
   a. Nothing to report.
2) **Education** – A Koplovsky/C Azevedo
   a. Sally Taylor – Training Center Standards are finalized. PSE work and Explorer program.
3) **QI** – C Getchell/J Oko
   a. Meeting at 1330. Last remaining position to be filled. Work continues on pediatric newsletter.
4) **Community Paramedicine** – B. Lowry/J Oko
   a. Work on data from MEFIRS and on the formulary
5) **EMSC** – M Minkler, R Williams
   a. Work continues on pediatric education survey
   b. Awaiting word from HRSA on funding for the program.
   c. NHTSA beginning crash testing standards work for pediatric transport devices.
6) **TAC –** K Zimmerman, A Moody
   a. TAC and MSA meetings are both in April. Soliciting for new membership.
   b. Work continues on trauma plan.
   c. Work continues on CARES.
7) **MSA** – K Zimmerman, A Moody
8) **Cardiovascular Council**, A Moody
9) **Maine Heart Rescue** – M Sholl, C Azevedo

Motion to adjourn is made by Dr. Collamore and seconded by Dr. Williams. Meeting is adjourned at 1317 hrs.