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

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Medical Direction and Practices Board
Agenda
June 15, 2016

Members Present – Dr. Sholl, Dr. Pieh, Dr. Couture, Dr. Busko, Dr. Jalbuena, Dr. Zimmerman, Dr. Kendall
Members Absent – Region 5 Currently Vacant
Staff – Shaun St. Germain, Don Sheets
Stakeholders – Joanne Lebrun, Dan Batsie, Chris Pare, Marc Minkler, Nate Yerxa, Dennis Russell, Chip Getchel, Kevin Gurney, Mike Senecal, Heather Cady, Brian Chamberlin, Pete Alan, Nate Contreras, Tony Attardo, Rick Petrie, David Saquet, Emily Mills, Stephen Smith, Joseph, Stephanie Cordwell

1) Introductions – Sholl
2) 2016 MDPB Minutes –Motion to approve as distributed Dr. Couture, Dr. Zimmerman Unanimous
3) State/Community Paramedicine/Medical Director Manual/CARES/Heart Rescue Update – St. Germain
    a. Medical Director Manual is complete and in-person/on line training is being developed currently.
4) PEGASUS Update – Sholl
    a. No new update
5) Special Circumstances Protocols – NONE
6) New Devices – NONE
7) Pilot Program Consideration – Video Laryngoscopy – Sholl/Contreras/Martel
    a. Dr. Sholl gave a synopsis of the program.
    b. Education Program – Will be on MEMSEd
    c. Dr. Pieh asked if this was strictly a Video Laryngoscope (VL) or Direct Laryngoscope (DL) with video assistance? – This is a DL blade so it does not deviate from current practice or the skill set currently trained with by Paramedics.
        i. Does this device record the video? – No it does not
    d. Motion to approve the program as proposed: Dr. Pieh, Dr. Zimmerman – Unanimous
8) Physician EMS Responders – Dr. Sholl has been working with Katie Johnson from the AGs office to offer protection from liability for Physicians involved in EMS response. This would be something that would likely need to be put into statute but this is part of the discussion.
9) Recruitment Update/Discussion – Interviews will begin today.
10) Protocol Review Gold/Blue Section – every change made at the level of the protocols has an impact – most of those impacts are positive, but even positive impacts require significant effort when applied at the population level. All changes made MUST BE in the best interest of the patient – some of these will be applied at the side of the patient while others will be system designs. When thinking

about all of our proposed protocol changes this year (similar to other years) I would like to apply the following change matrix:

a. What is the MOTIVATION of the change?
    i. All of our changes should be patient centric. Remembering that, from our vantage, our entire means of reaching patients is through our providers, provider benefit is a secondary goal.
b. What is the PURPOSE of the suggested change?
    i. What gap does the suggested change fill?
    ii. If no gap is present, how does this change IMPROVE what we are currently doing?
c. What is the EVIDENCE behind the suggested change?
    i. How does this change compare to what we are currently doing?
    ii. How strong is the level of evidence? Recall, strong level evidence suggests low to no risk with proven benefit and SHOULD be performed (almost uniformly). Weak level evidence suggests either less certain benefit OR risks that approach the level of benefit and therefore MUST be weighed based on local values and preferences.
d. What is the IMPACT of the suggested change?
    i. Education?
    ii. QI?
    iii. Communication/Interface with the healthcare system?
    iv. Medical Direction?
    v. Financial?
e. Items Left from Gold Section –
    i. Epi Subcommittee – (TP/JMB/BN/AC) were all going to discuss the following options: **The Group was not yet ready to discuss this**
        1. Removing 1:1000 all together in favor of mg based dosing
        2. Maintaining 1:1000 – but finding some operational or educational means to minimize medical errors
        3. Build a pearl as well as white paper and possibly in-protocol app-based training surrounding use of epi
    ii. IN Midazolam Consideration (TP) this may come up more naturally in the Rink review, but will leave this here in order to keep it on our agenda :
        1. **Dr. Pieh wants to wait for the PINK section**
        2. What concentrations are being provided throughout the state and how variable is the provision of different concentrations?
        3. What data shows bioavailability of IN Midazolam vs IM or IV?
        4. What is the IN dose equivalent to 10 mg of midazolam IM and what is the time to peak concentration
        5. Dry non-bloody and non-congested nasal canal – are we clear that you cannot deliver through that route.
        6. How much of the volume are we losing through the atomizer or through a needle?
    iii. Pain Management Protocol – **JMB this will wait in order to focus on blue**
        1. f/u on discussion of creating a general pain management protocol for trauma, abdominal, chest – etc. with the ability to contact OLMC in alternate circumstances (including back pain)
    iv. Need to come back to the Stroke Protocol (TP) **This will wait to focus on blue**
        1. Status of the NH, VT, ME dialogue
        2. Stroke Checklist

3. Reinforce Last Known Well
4. Revising/revisiting the ABSOLUTE contraindications
5. Discovering a mechanism to train and discuss the current and newly developed anticoagulant agents. (White Paper)

11) Blue Section –
    a. Apneic Oxygenation – The history of this is for a patient who is going to be intubated via medication facilitation.
        i. Dr. Pieh has concerns about the operational impact with needing multiple sources of O2 and that this may draw us away from the work that has been done with the existing airway protocol.
        ii. Dr. Sholl followed this with a synopsis of who we manage airways on in Maine.
        iii. Group consensus was to introduce a PEARL to include language that describes the use of this technique when oxygenation goals are not being met.
    b. Encouragement to use a vent for face mask ventilation as opposed to a BVM
        i. Dr. Pieh asked how this impacts CPR where the AHA opened up the idea of 10-1 as well as 30-2
        ii. Motion to approve Dr. Couture, Dr. Jalbuena to add a PEARL encouraging the use of a vent for face mask ventilation Dr. Pieh opposed all others in favor.
    c. Use of Ketamine for anxiolysis in the CPAP patient
        i. There were some concerns about the system hospitals being ready to accept these patients.
        ii. There was a large discussion about the cost this has on the system. Education of providers and hospitals, adding the new medication, etc.
        iii. Dr. Pieh proposed a protocol to contact OLMC for the use of Midazolam in these patients, Dr. Kendall seconds – 2.5 mg IV or 5 mg IM. 4 for 3 against motion caries
        iv. Dr. Pieh wants a follow up conversation the impact of ops and education
        v. There will be continued discussion about the use of Ketamine at the July meeting. Dr. Busko will provide an updated tracking sheet for that meeting.

12) Old Business
    a. Operations - None
    b. Education – Dan Batsie has accepted a position leading Vermont's EMS office and will be leaving likely in August. Chris Pare will be serving as the interim chair as we work out some other details.
    c. IFT – Management of intubated patients with Vents
    d. QI – Meeting after to discuss the education.
13) Motion to adjourn Dr. Couture 1132