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 – September 21, 2022
Conference Phone Number: 1-646-876-9923 **Meeting Number:** 81559853848
Zoom Address: https://mainestate.zoom.us/j/81559853848

Members present:	*Matt Sholl, Kelly Meehan-Coussee, Beth Collamore, Dave Saquet, Michael Bohanske, Tim Pieh, Kate Zimmerman, Emily Wells, Bethany Nash, Benji Lowry, Seth Ritter, Rachel Williams*
Members Absent:	*Pete Tilney*
MEMS Staff:	*Chris Azevedo, Jason Oko, Darren Davis, Sam Hurley, Ashley Moody, Marc Minkler*
Stakeholders:	*Eric Wellman, Joanne Lebrun, Don Sheets, Jessica Page, Chip Getchell, Dr. Norm Dinerman, Sally Taylor, Dr. Kevin Kendall, Chris Pare, Stephanie Cordwell, Dr. John Becknell, Dr. Jonnathan Busko, Rick Petrie, Dawn McAllister, Dwight Corning, Steven Smith*

1) Introductions
    a. Dr. Sholl introduces the group members and does roll call.
2) Approval of August 2022 MDPB Minutes
    a. Motion to approve the August minutes made by Dr. Collamore and seconded by Dr. Meehan-Coussee.
    b. Discussion. Dr. Sholl suggests clarification regarding approval of forced air rewarming devices.
    c. Motion to accept, with changes suggested by Dr. Sholl, is carried.
3) State Update – 0940-0955 – Director Hurley
    a. Director Sam Hurley
        i. We are actively working on multiple grant positions. Director Hurley discusses the various positions and current status.
            1. Substance Use Disorder Program Manager – Megan Salois has been hired to fill the position and will be starting at the end of October.
                a. Two Comprehensive Health Planner positions have been re-posted.
            2. Emily Burgess has now started as our new Office Associate II, replacing Jessica Ricciardelli.
            3. The Deputy Director position should be approved by HR this week.
            4. We will be conducting interviews for the Explorer position in the next few weeks. Director Hurley discusses the position.
            5. Maine EMS has received a planning grant from AmeriCorps. Director Hurley discusses the grant. This position will be working with the services to provide education on using MEFIRS/ImageTrend as tools to do QA/QI. This will assist services in being able to comply with the requirement. This is possibly for 4-5 positions in the field.
        ii. Discusses strategic planning work at the last EMS Board meeting.

1. Accepted transition from six regions to four. Rules must be subsequently written to accomplish this. The process will involve hearings and public comment. We will also be engaging members of the MDPB.
2. The Board also adopted a statement of unified vision for 2035.
3. The Board also approved an "ideal organizational structure" for Maine EMS. This structure retains an EMS Board that is reduced to nine members, overseeing the EMS system as a whole. There will also be a separate, but connected, nine-member Board of Licensing that will oversee personnel and service licensing matters. Director Hurley discusses the Board of Licensing functions.

iii. Dr. Zimmerman asks Director Hurley if he anticipates having an assistant or associate medical director at the Regional levels? This may be something worth discussing offline.

1. Dr. Sholl discusses that the decision regarding regions will definitely affect MDPB composition. Recommends spending some time in the future for planning out direction for MDPB to proceed.
2. Dr. Bohanske suggests a timeline and an outline showing structure changes and how MDPB roles will change.
3. Director Hurley
    a. We are committed to that process. The ideal would be for the change to happen 1 Jul 2023, in order to align with the fiscal year. We understand that rulemaking takes time. We are working with the Rules Committee and the Board Chair. We hope to have draft language ready in case we need to add seats to MDPB. We understand this will affect a multitude of entities within the Maine EMS system.
4. Dr. Pieh asks, with the change from six to four regions, are the philosophical concept of the regions going to change, as far as what they are going to deliver? Will the way that the regions service individual EMS clinicians and services going to change?
    a. Director Hurley
        i. With the strategic planning process, that is potentially up for discussion. But it is seen that they will continue to represent the interests of the Regions and services and provide support for them regardless of any structure changes. But the current structure is contractual, so the deliverables for the regional contractors are defined by the Board and are subject to change every year. The Regional contractors sub-contract out for Regional medical direction- so that is where differences in what is happening in each region. So, there may be a move to standardize some of those things. Discusses bringing the regions under the state and contracting the medical directors directly under the state, versus under each regional contractor.
5. Dr. Pieh asks, if only the geographic region changes were decided and the support for them was not, what was the deciding factor in approval of that decision?
    a. Director Hurley discusses that the suggestion to change the regions came from two prior state system assessment reports. Also, the current vacancies on the Board were a factor because they would facilitate the change, and a decision was needed. If a structural change in the regions wasn't made at this time, the ability and conditions that would be favorable to do so in the future would be significantly delayed.

6. Dr. Ritter asks, why work towards this change when we're still in the middle of the planning process- it seems, in some ways premature? The Board approved the rulemaking process, but does that mean they've already approved going to a four-region model, or does it mean that they are making rules and there will be an approval vote down the line?
    a. Director Hurley
        i. There will be an approval vote down the line. The Board directed the Committee to move to a specific four-region model that was presented to them. Discusses. That will go through public comment and then have to be approved by the Board.
        ii. The evidence regarding the need for a transition has been abundantly clear through multiple reports and has been detailed multiple times. The motivation for moving on the change wasn't the strategic planning consultant agreeing with the previous opinion, but that the items referenced in those previous reports are continually re-appearing in the conversations being had with stakeholders currently.

iv. Dr. Saquet- Asks if there is anything being done legislatively, to address provider pay? Discusses difficulties he's experiencing in trying to recruit providers and encourage retention.
    1. Director Hurley – the Blue-Ribbon Commission has identified that funding is definitely a primary item that needs to be addressed. The Maine EMS Board and Office has zero capacity to affect clinician pay or service reimbursement. However, they do - and are - lobbying the legislature to increase income, reimbursement and wages throughout the system and the state. It should be noted that the state legislature does not have the ability to change federal reimbursement rates. Director Hurley discusses various reimbursement methods and subsidies, hidden costs, and methods of effectively accounting and projecting cost.
    2. Director Hurley discusses with the group, various factors which contribute to provider retention and pay, and service reimbursement issues.

v. Dr. Sholl offers that the last Board meeting was more productive, in terms of decisions for significant movement, than they have been in years. Re-iterates need for developing a plan for action around the projected movement in regions. Queries the group for interest in options for discussions to come.

b. Service Level Medical Director Announcement – Discussion – Sholl/All
    i. Dr. Sholl discusses the recently released email notice reminder to services, of the requirement to have service level medical directors for services licenses/permitted at AEMT and paramedic levels.
        1. Dr. Zimmerman discusses the notice content with the group and gives a heads up that many in the group may be getting requests from services to be their medical directors. We know that the Regional Medical Directors cannot function effectively as medical directors for all EMS services. Services may also be seeking assistance with finding physicians who are interested in becoming service medical directors.
        2. Dr. Pieh discusses need for some sort of fair reimbursement for service medical directors to be able to be effective in providing medical direction. Discusses efforts that he and Dr. Meehan-Coussee have been making regarding setting a number figure for contract purposes, that might allow services to buy enough time for medical directors to actually be participatory in QA and other functions with the service.

4) Discussion: Strategic Planning – 0955 – 1015 – Dr John Becknell/All
    a. Dr. Sholl introduces Dr. John Becknell
    b. Dr. Becknell addresses some of the concerns brought forward by some of the members, as well as addressing the group regarding why those issues are occurring and paths to address them.
        i. Dr. Becknell discusses issues reimbursement and staffing issues and changing culture, that has its roots in the past history of EMS being delivered from locally developed, organic entities providing EMS without the full cost of providing EMS being understood.
        ii. A reckoning is happening. In Maine, this has been a local function that has never really considered the full and true costs of providing this service and how to pay for it.
        iii. As we go forward, the real work to be done is all stakeholders needing to understand that today, these services are provided in Maine in an ad hoc manner, through local people with interest and initiative. There is no requirement for these services to be provided, so there is no responsibility for the cost.
        iv. Those issues alone, continue to surface. So, the question we have to ask is, do we still want those services, and at what quality and cost, and who will pay for the services?
        v. We must get serious about the clinician experience, which they are telling us is, horrible. We must find a match between the rewards and the delivery of this care. Right now, the conflict between the two is causing workforce staffing issues. Dr. Becknell explains and discusses this topic.
        vi. Dr. Becknell discusses "where we are," and the vision statement that was approved by the EMS Board.
            1. Strategic planning at this point is about building plans to support that vision.
            2. The MDPBs relation to strategic planning regards the areas of medical direction, clinical care, systems of care. Discusses.
            3. Dr. Becknell asks the group, when you think of addressing medical direction and practices, what are the things you think of, at a 30,000-foot view, and asks Dr. Sholl if they should go into this now or at a later time?
    c. Dr. Sholl discusses group consideration of the future of medical direction along side discussion of regional changes, in discussion over the next several weeks. Dr. Becknell adds a request that the group consider what changes need to be made in clinical medical care.
    d. Dr. Pieh discusses his perspective on considering these changes.
        i. It's hard to have high-level conversations or hear big changes discussed without having something specific on paper or on screen to refer to, during the conversation. It would be helpful to have something like this during the coming conversations.
        ii. Dr. Pieh asks that we open every position, define what it means to be there, and then, there's a process of application for those interested. It is critically important that this be open and be objectively defined regarding needs of medical direction – both regionally and on MDPB. There should subsequently be a process in which those in each position are cyclically assessed.
    e. Dr. Meehan-Cousee echoes Dr. Pieh's concerns and also recommends setting aside time for planning of specific goals and objectives, and discussion in the future.
    f. Dr. Saquet
        i. Discusses volunteerism and issues affecting its decline and its future, and the need to address their effects on both emergency and non-emergency transports.
5) Special Circumstances Protocol Review – NONE
6) Alternate Devices – NONE
7) Pilot Program Reviews 1015 – 1030 – Sholl – Pilot Program Members
    a. Jackman Pilot Project Report to the MDPB
    b. Dr. Busko gives the report
        i. CPC reviewed all cases. No concerns for July.
        ii. August-5 cases, 5 ED visits prevented, 7- reportable procedures

            iii. Discusses Reportable procedures.
    c. Discussion and questions by the group.

8) UPDATE – Medication Shortages – Nash/All – 1030 – 1045
    a. Dr. Nash
        i. Activated charcoal is almost not available at all. Where available, is only enough for one dose.
        ii. Discussion of the situation by Dr. Sholl. And the group. In similar situations, one option is to look for an alternative medication. In this case, there really is no alternative medication that would be useful.
            1. Dr. Ritter discusses utility of activated charcoal in EMS. Perhaps this might be an intervention to retire. Discussion.
            2. Dr. Sholl queries the group if this issue may be would be worth putting out a clinical bulletin asking services to retain old stock and consult with Poison Control while on scene, regarding use of expired stock versus holding intervention. Discussion.
            3. Dr. Sholl will discuss the shortage with Poison Control and asks for volunteers to work on a bulletin. Drs. Nash and Ritter volunteer.

9) COVID-19 – 1045 – 1100 – Sholl
    a. Reminder re: Meeting October 3 – 0800 – 0900
        i. Dr. Sholl discusses a reminder that the group had agreed one more time, on 3 October, to discuss COVID. Dr. Pieh has a request of the group to have a discussion regarding the posture that hospitals are taking, moving forward. Drs. Sholl and Pieh will develop an agenda for the meeting. Dr. Sholl will share with the group. Discusses tentative topics.

10) 2023 Protocol review process – 1100 - 1215 – All
    a. Timeline review
        i. Dr. Sholl shares his screen and reviews the timeline progress, so far.
        ii. Green section hopefully finishes today. It's possible that the blue, and possibly red sections may be covered by October.
    b. Reminder: Change Documents
        i. Dr. Sholl asks that section authors send in final change documents and any latent education materials, as he hasn't received the final change documents from all the protocol sections that have been completed so far. Dr. Sholl would like to be able to share the finished change documents with the larger community, as a whole.
        ii. Dr. Zimmerman has reviewed previous protocol section work and has sent any specific questions regarding the clarifications to the changes, to the section authors. It is anticipated that as soon as she has received answers and documented any needed clarification, that she will be able to post them on the website.
        iii. Dr. Collamore adds that, if section authors want to send her their completed change documents, that she can create slides using the affected protocol page, that the section authors can use during their presentations to the MDPB.
    c. EMS Stakeholder Protocol Forum – Sholl/Zimmerman/Collamore/Meehan-Coussee
        i. The last forum was held on 8 Sep 2022. Chris Azevedo discusses attendance statistic and survey regarding attendee satisfaction.
        ii. Dr. Sholl discusses questions presented at last forum.
        iii. Potential for future Droperidol use.
        iv. Medication concentrations
        v. Dr. Collamore discusses questions regarding past medication suggestions that had not been adopted, as well as medical devices.
        vi. Next Protocol Review Webinar Discussion November 10, noon – 1pm
    d. Green Section – Meehan-Cousee/Bohanske/Ritter/All
        i. Dr. Meehan-Coussee leads discussion of the Green section
            1. Minimum LZ- still waiting to hear from Dr. Tilney

2. Trauma triage
    - a. Would like to include a reference for significant burns and lightning strike or electrical trauma.
        - i. Discusses placement options for both
        - ii. Addition into mechanism of injury criteria for the "yellow" box, or addition as a PEARL.
        - iii. Dr. Sholl discusses that the exact way to insert the change can be figured out after some play with the graphics program, to see which works better.
    - b. Last item in this group is request for asterisk next to systolic blood pressures, referring to the note, "obtain manual blood pressure whenever possible, and consider monitoring pulse pressure as an early sign of hypotension."
    - c. The motion to approve the above changes to the Green section is made by Dr. Saquet and seconded by Dr. Collamore. No discussion. Motion carries.
    - d. Dr. Meehan-Cousee relates that these approved changes would replace Trauma Triage 1 & 2.
3. Trauma triage #3
    - a. Change to Item #1.b, to read "If patient requires RTC, but is unstable or needs immediate life-saving interventions OR if RTC is >45 mins, transport to closest ED."
4. PEARLS
    - a. In consideration of Trauma Triage #3, it may be good to add some clarification for the PEARLS. Dr. Meehan-Coussee's slide presents the following changes:
        - i. EMS Clinician triage to appropriate level Trauma center is beneficial to patient outcomes
        - ii. Pt with any suspicion for specialty surg needs including neuro should be transferred to Level 1 or 2 whenever possible
        - iii. If additional transfer time to L1 or 2 center is felt to be deleterious to patient, transfer to highest level trauma center available or the nearest ED
        - iv. Refer to OLMC for questions.
    - b. Dr. Meehan-Coussee asks regarding whether to delay approval for this until we have decisions from TAC? Dr. Sholl discusses.
    - c. Motion is made to approve PEARLS by Dr. Bohanske and seconded by Dr. Ritter. No discussion. Motion carries.
5. Head Trauma #1
    - a. Dr. Meehan-Coussee reviews past discussion of changes to this section. There had been discussion of formatting, and a long discussion about the PEARL.
    - b. Slide shows the following changes:
        - i. In the introduction, item #3. Replace current verbiage with, "If available, use continuous quantitative end-tidal CO2 monitoring for ALL severe TBI patients."
        - ii. Edit the green "E" strip, representing the EMT scope of practice, to start at the point on the page where the EMT protocol actually begins.
6. Head Trauma #2
    - a. Movement of item #10 to highlight the transition from EMT level of care to AEMT level of care on the protocol slide.

b. EMT PEARL – remove “advanced airway management” and replace “if available” with “if so trained and equipped.”
c. AEMT/Paramedic
    i. Remove #10 – already under EMT
d. 11. Change “if advance airway” to adjust ventilatory rates to meet goal ETCO2 levels between 35-45 mmHg (target = 40 mmHg)
e. Marc Minkler asks for clarification regarding whether or not the protocol is supposed to imply that ETCO2 is now available for the EMT level. Dr. Sholl replies that it is not.

7. Head Trauma #3
    a. #15. Please Note: IV/IO Ondansetron is preferred rout for patients with moderate to severe head injuries. (Makes current item #15 statement clearer). Removing the rest of the sentence.
8. Head Trauma #4
    a. Airway algorithm: BOTTOM LEFT BOX. Add – “if available,” to Variable rate timer and pressure control bag.
9. Hemorrhage
    a. EMT #3. – If life threat, bleeding is due to epistaxis, pinch patient nose continuously for 10-15 mins (or apply nasal clamp if available), have patient lean forward to prevent aspiration or vomiting from swallowing large amounts of blood, and blood and see facial/dental trauma if appropriate
    b. Add “* if hemorrhage is due to epistaxis, see facial/dental”
        i. Dr. Sholl suggests moving this change to epistaxis section.
10. Hemorrhagic Shock #1
    a. EMT #4. – “If due to unstable fracture…” change verbiage from, ”may consider,” to “apply” with regard to pelvic binders.
    b. AEMT/P
    c. Item #8 d. – Change this item to a PEARL and add in the following at end of statement: “…while still aiming for age-appropriate BP in hemorrhagic shock and head injuries.”
11. Hemorrhagic Shock #2
    a. Paramedic Item #11c.i., change “gram” abbreviation to “1G” versus writing “1gr”
    b. Sam Hurley asks if those units shouldn’t be written out for clarity. Discussion.
    c. After discussion, it is decided, instead to add “Gram” and “Milligram”
12. Burn #1
    a. EMT 7* (ADD PEARL)
        i. *Severe burns include >10% BSA (counting only partial and full thickness burns), airway involvement, genital burns, burns to the hands or face, etc. Severe burns should be transported following the trauma triage guidelines. Please see trauma triage Green “X.” Discussion of this item by the group.
13. Universal Pain Management #2
    a. Dr. Meehan-Coussee brings attention to the fact that there will be no recommendations regarding changing the formulations of Tylenol.
    b. Paramedic 10.
        i. “If contraindications to oral pain med, consider acetaminophen IV 10-15 mg/kg IV up to 1,000 mg undiluted once over 15 minutes. (Keep a. NOTE…)”
        ii. Discussion on this change by Dr. Meehan-Coussee and the group.

iii. Motion is made by Dr. Meehan-Coussee to change acetaminophen dosing for IV from 12.5 mg/kg to 10 – 15 mg/kg, to keep the dosing aligned with the recommendation for oral dosing. The motion is seconded by Dr. Ritter. Discussion. Dr. Zimmerman adds "with a max dose of 1 gram." Motion is carried.

c. Paramedic 11.
   i. A. Add the word, "Either" to the phrase, "… fentanyl, OR ketamine, c. OR 50% nitrous oxide/oxygen Mixture."
d. Paramedic 11.a.ii
   i. Fentanyl may be ineffective in patients with an underlying opioid use disorder, on opioids chronically (i.e., Methadone) or on opioid antagonists (i.e., Suboxone)
e. PEARLS 3
   i. If using Tylenol in a glass container, you must use vented IV tubing.

ii. Review of the Green section was stopped at this point.

e. Blue Section – Bohanske/Pieh/All
   i. Tabled until October meeting
f. Discussion re: Upcoming Protocol Review Schedule

11) Update – Ketamine in Delirium with Agitated Behavior and QI – 1215-1225
   a. Dr. Sholl discusses recent letter and investigation report from Colorado Health, regarding a case involving ketamine related patient death, and which gives recommendations post case review. The issues discussed in the letter are gaining national attention.
   b. Dr. Sholl asks for volunteers to work with him to examine the materials and bring some recommendations back to the group. Drs. Saquet and Collamore volunteer. Discussion.

12) Update - Pre-Hospital Physician – 1225-1230
   a. Dr. Pieh – work continues on items to be brought back to the group.

13) Update - PIFT – 1230 – 1235
   a. Dr. Sholl
      i. There is a conversation going on in a Board sub-committee regarding inter-facility transport. IFT has been a large topic of conversation at the Board level and in strategic planning. IFT was organically developed around 911 system. These are something that the 911 system has just been doing. Interfacility transports are a big part of the system and of system strategic planning.
      ii. Dr. Saquet notes that during the meeting, there was a question regarding the authority to govern PIFT scope of practice and who does what. There was a back-and-forth discussion with the Education Committee, and the question got put to the Board.
      iii. Dr. Sholl discusses.
         1. EMS Board defines scopes of practice for all EMS clinicians. There is a scope of practice piece to this.
         2. There is a part of EMTALA, suggesting physicians provide orders between transferring and receiving hospitals. But physicians are not always providing orders. There has been some dialogue around whether or not Maine EMS could offer some foundational back up guidelines/protocols to address care in these situations.
         3. Dr. Tilney is working on the PIFT part of this, i.e., scope of practice, formulary, is there a rationale to develop supportive protocols for this, in case the sending physician does not provide specific orders or protocols.

14) Update – MDPB ALS Position – 1235 – 1250
   a. Dr. Sholl

i. Claire Dufort has resigned from her MDPB position, due to workload requirements at her primary job, after being promoted to Lieutenant.
ii. We will need to recruit for that position. Perhaps, we can re-post that position announcement and MDPB members could assist in recruiting.
iii. Dr. Sholl solicits interest amongst the group, for an interview panel.
iv. Hope to get position filled in the next few months.
v. Dr. Nash, Zimmerman, Meehan-Coussee, Bohanske, Ritter, Saquet, offer to assist.

Old Business – 1250 - 1300

1) **Ops** – Director Hurley/Ops Team Members
    a. Sally Taylor nothing to report
2) **Education** – C Azevedo
    a. The Education committee met. Work continues on Training Center Standards revisions.
    b. Discussion on EMT portfolios.
    c. Discussion on NCCP transition.
3) **QI** – C Getchell
    a. Meeting at 1330 today
    b. Primary objective is to approve the summer newsletter.
    c. Fall newsletter will be a safety newsletter.
4) **Community Paramedicine** – B. Lowry
    a. Continue to work on scope of practice.
    b. Voted on personnel to fill three open committee positions.
5) **EMSC** – M Minkler, R Williams
    a. Dr. Williams
        i. Marc Minkler continues to do work around PEDS/OB care and transportation.
        ii. There is an EMS-C committee meeting on 4 October.
6) **TAC –** A Moody
    a. Quarterly meeting is 25 October
    b. Continuing small committee study group
    c. CARES – begun follow-up with services regarding correct documentation in MEFIRS
7) **MSA** – K Zimmerman, A Moody
    a. At your respective, hospitals, if you have a Neurologist who might be interested in joining, have them reach out to Dr. Zimmerman, or see the website.
8) **Cardiovascular Council**, A Moody
    a. Working with the CDC and Rural Health to formulate a plan for the Cardiovascular Council to move forward. Both organizations already have committees. We are working to see if it makes sense to add some of the EMS representatives to add to a committee that's already established, we aren't reinventing the wheel.
    b. Working on Heart Safe Communities guidelines, so we can work on getting that out to municipalities.
    c. Dr. Sholl adds that they've had some data sharing meetings with Maine Hospital Association and Health InfoNet. We are excited about that process. They are working on MOUs to allow Health InfoNet to share information with us, so that we can draw that data into our CARES experience.
9) **Maine Heart Rescue** – M Sholl, C Azevedo
    a. The Maryland Resuscitation Academy will be presenting their 2-day Academy at the Samoset EMS Conference. Sally Taylor and Chris Azevedo are working on the details of spaces and equipment.
    b. Dr. Sholl discusses the Resuscitation and recommends attendance.

Motion to adjourn by is made Dr. Bohanske and seconded by Dr. Saquet.

Meeting adjourned at 1250 hrs.

The QI Committee meeting will begin at 1330