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 – November 16, 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, Kate Zimmerman, Tim Pieh, Beth Collamore, Bethany Nash, Mike Bohanske, Kelly Meehan-Coussee, Rachel Williams, Dave Saquet, Seth Ritter, Emily Wells*
Members Absent:	*Benji Lowry, Pete Tilney*
MEMS Staff:	*Chris Azevedo, Marc Minkler, Darren Davis, Ashley Moody, Jason Oko, Jason Cooney,*
Stakeholders:	*Chip Getchell, Dwight Corning, Eric Wellman, Frank McClellan, Jay Bradshaw, Joanne Lebrun, Josh McNally, Kristina Donnellan, Rick Petrie, Rob McGraw, Sally Taylor, Steve Almquist, Dr. Norm Dinerman, Dr. Kevin Kendall, Stephen Smith*

1) Introductions
    a. Dr. Sholl calls the meeting to order at 0934 and conducts introductions.

2) October 2022 MDPB Minutes
    a. Approval of the October 2022 minutes is tabled until the December minutes.

3) State Update – 0940-0955
    a. Director Sam Hurley is unavailable to give an update from the office.
    b. Dr. Sholl discusses the EMS Board's strategic planning process.
        i. Dr. Sholl reminds the group about making time during the December MDPB meeting to discuss medical director items, as well as the prospects for changes in EMS regional layout to affect the MDPB.
        ii. Also, there will be some time to circle back and talk with Dr. Becknell regarding medical direction in the future and what care in Maine EMS should look like.

4) Special Circumstances Protocol Review – NONE
    a. None

5) Alternate Devices – NONE
    a. None

6) Pilot Program Reviews
    a. Portland Fire Department/MEDCU MMO Report to the MDPB
        i. The Department representative was not present yet to give report. Sean Donoghue gave report later on in the meeting, but this is being noted here. Dr. Sholl shared his screen as Chief Donoghue gave report.
        ii. Dr. Sholl shares his screen as Sean Donaghue gives the pilot report out.

b. Jackman Pilot
    i. Dr. Sholl discusses the agreement with Dr. Busko to reduce the frequency of report outs to bi-monthly, beginning in January. No discussion from the group.

7) IRB Review – VT State EMS IRB – Evaluation of 30-Day Survival from OHCA for Tibia vs. Humeral Head IO Placement
    a. Dr. Zimmerman discusses. This is coming from colleagues in Vermont, who are looking at OHCA. Dr. Dan Wolfson is the Vermont state Medical Director. They'd like to compare and contrast outcomes for IO placements in the field and sites where they were placed. The data to be studied would be that in Maine, New Hampshire, and Vermont, and looking at survival outcomes. This is a retrospective study of OHCA data. For their project, they'd need to obtain data from Maine, possibly using CARES and MEFIRS.
    b. Dr. Sholl explains the study further.
        i. This will look at data repositories for:
            1. EMS run reports identifying cardiac arrests, presence of IO placement, and site.
            2. DHHS state death reporting databases
        ii. This will require fairly identifiable information to be able to compare and contrast data between the two databases.
    c. Motion made by Dr. Bohanske and seconded by Dr. Collamore to approve the IRB proposal. Discussion.
        i. Brief discussion by Drs. Nash, Ritter, Sholl, and Bohanske. Dr. Sholl notes that this will be the third project that MDPB has taken on as part of the Northern New England group.
        ii. Ashley Moody asks if they are asking Maine EMS to provide outcome data, or if they have another mechanism to obtain that? Dr. Sholl answers that they do have another mechanism for obtaining data. DHHS has a mortality database. Dr. Sholl discusses.
        iii. Darren Davis notes that the Attorney General's office requires Maine EMS to track data requests and asks that Dr. Sholl forward these data requests to Maine EMS.
    d. The motion is carried.
    e. Dr. Sholl and Jason Oko give a heads-up brief on several coming IRB requests. There will be 3 IRB reviews coming next month from Maine Health. Also, there will be a review if the agreement for use of Hospital Hub data.

8) UPDATE – Medication Shortages
    a. Dr. Nash
        i. The charcoal issue is slowly resolving. Nothing new to report this month.
    b. Dr. Zimmerman asks about possible issues with ketamine and concentration issues. Dr. Nash reports that with regard to the dose concentrations used by EMS, the concentration used is in supply and is available.

9) Emerging Infectious Diseases
    a. Dr. Sholl discusses the Ebola outbreak in Uganda that the World Health Organization is tracking.
        i. This has engendered attention from federal and state level CDCs across the country, as well as the World Health Organization.
        ii. This is a different strain than the previous outbreaks in 2014 – 15, and earlier this year. This is a Sudanese strain, for which there are limited protective measures and also has a relatively high mortality rate in its early stages.
        iii. Dr. Sholl discusses focus of concern nationwide. While Colorado recently had a visiting resident of Uganda develop a fever. it did not turn out to be Ebola. However, it certainly got them thinking about their systems of care and response measures if it had turned out otherwise.

b. Dr. Sholl discuses seasonal influenza, vaccinations, and protective postures.
c. Dr. Williams discusses the current RSV outbreak in the state.
    i. This is present and still widely emerging. Dr. Williams discusses measures being made to accommodate increased RSV patient volume, and high-flow O2 measures. This includes boarding patients in the emergency department.
    ii. At this point, we are not at the back end of the outbreak. It may peak during winter.
    iii. Dr. Ritter asks if anyone is using the BioFire Respiratory Virous panel. Dr. Williams responds that they are not. Discussion.
    iv. Dr. Pieh asks for a bronchiolitis update
        1. Dr. Williams notes she has just given a lecture on this last week at Samoset.
        2. Dr. Sholl asks Dr. Pieh if he'd might work on a clinical update with Dr. Williams that can be distributed later. Dr. Pieh agrees
    v. With regard to the clinical update, Dr. Williams reminds all that RSV and bronchiolitis are diseases of children less than two years old. However, viral pneumonia, asthma, and wheezing in older children in older kids is due to a different process. Our protocol does say "may repeat the nebulizer times three." Dr. Williams recommends, that in cases of older children with more of an asthma pathway, that providers should have a lower threshold for giving multiple nebulizers and should not wait to do so, versus giving a single nebulizer treatment and waiting.

10) 2023 Protocol review process
    a. Timeline review – Sholl/Zimmerman/Collamore
        i. Dr. Sholl discusses timeline progression, shares his screen with the timeline, with the group.
        ii. Dr. Zimmerman reminds the section authors to please make sure they forward their completed change documents.
    b. Update Protocol Review Webinar Discussion Time Change
        i. This has been re-scheduled for 8 December 2022, due to Samoset.
    c. Blue Section
        i. Dr. Bohanske leads the discussion, which picks up with bougie use discussion.
            1. Dr. Bohanske reviews some study data that is not reflective of a need to prescribe use of a bougie with every intubation attempt. The recommendation is made to remove the current bougie prescription verbiage from the protocol and relegate bougie use to an educational item. Discussion by the group.
            2. Dr. Pieh discusses that he does use a bougie every time and elaborates on his specific reasoning. However, there does not appear to be evidence to support maintaining the current verbiage. Dr. Pieh asks Dr. Dinerman to discuss past data from LifeFlight of Maine.
            3. Dr. Dinerman discusses that LifeFlight has used the bougie with success. The language issue of mandating use can be problematic. However, for LifeFlight, the expectation has been to use a bougie with every attempt and this has been successful, for that organization.
            4. Eric Wellman adds from chat: The key part of this discussion may also be the frequency of attempting intubation and how often clinicians practice airway management when they do not have opportunity to intubate patients.
            5. Dr. Saquet discusses the issue of frequency of intubation and practice and familiarity with bougie technique.
            6. Dr. Sholl discusses data regarding number of intubations per number of providers. There has been a definite drop-off in that number.
            7. Discussion by the group.
            8. Marc Minkler adds from chat: I suspect the drop in intubations is related to no transport of cardiac arrest patients

9. Dr. Sholl recommends amending the current verbiage into a recommendation that still encourages the use of bougies, rather than removing the verbiage totally.
10. Motion made by Dr. Saquet and seconded by Dr. Meehan-Coussee to amend the current prescriptive language to state "use of bougies on all intubations with ETT size 6 or greater is strongly encouraged."
    a. Discussion by the group.
    b. Dr. Bohanske asks if the language should also be pasted into the pre-intubation checklist. Dr. Sholl concurs this should be done.
    c. Dr. Pieh suggests including some language acknowledging provider comfort level and previous practice in selection or non-selection of bougie use. Dr. Meehan-Coussee suggests that Dr. Pieh's point may better be utilized in the education. Dr. Pieh agrees.
11. Motion, as phrased by Dr. Sholl, is carried.

ii. Blue 4 Confirmation and monitoring of airways.
    1. Change "intubate patient" to "place advanced airway."

iii. Blue 7 Resp distress with bronchospasm
    1. Dr. Bohanske proposes the addition of the statement to the EMT/AEMT section of the protocol
        a. "CPAP should be initiated at the lowest possible setting for your equipment and titrated slowly (every 5 minutes). Do not exceed 10 cmH2O.
    2. Discussion of the suggestion by the group.
    3. Motion made by Dr. Bohanske and seconded by Dr. Collamore to add the amended statement, "CPAP should be initiated at 5 cmH20 and titrated slowly (every 5 minutes) as needed. Do not exceed 10 cmH20." Discussion.
    4. Motion carried.

iv. Blue 15 Tracheostomy Care
    1. Dr. Bohanske discusses a change suggestion that was submitted by a provider regarding the use of saline in nebulizers. The provider had been taught that you could only use sterile, preservative-free saline bullets, due to possibility of negative effects of preservatives used in vials or saline bags.
    2. Dr. Bohanske discusses his efforts in researching the issue and shares his findings.
    3. With regard to the protocol change request, Dr. Bohanske proposes educating that use of saline flushes is appropriate for use in nebulizers. The group agrees.

v. Dr. Saquet introduces the possibility of allowing the use of IGel BIADs at the EMT level for services that have service-level medical directors, if so trained and equipped.
    1. Dr. Sholl suggests that Dr. Saquet write up the proposal for review by the group in December. Dr. Saquet agrees.

vi. Dr. Pieh discusses a verbal change request for RSI and why this should not be addressed in an official capacity at this time.
    1. Dr. Sholl acknowledges prior discussion of the topic between Drs. Pieh and Bohanske. A previous review group had looked at this in the context of the Jackman Pilot and didn't feel comfortable authorizing RSI in the context of the Jackman Pilot protocols. Making RSI was not considered in the context of making this a protocol for the state.
    2. Dr. Sholl suggests it may be time to bring this topic up for initial work by a small group and then, perhaps have the group bring this up to MDPB for review. Dr. Sholl suggests continuing the discussion offline.

d. Green section – Termination of Resuscitation due to Trauma
    i. Dr. Meehan-Coussee shares her screen and discusses suggestions for guidance regarding cardiac arrests in trauma situations as outlined in a Word document.
        1. Inclusion and exclusion criteria have not changed.
        2. Changes
            a. Add asterisk under EMT guidance which refers to new PEARL
                i. "Consider calling for ALS early in traumas where the patient is high-risk for traumatic cardiac arrest (i.e., prolonged entrapment, etc.) to either meet on scene or rendezvous en route as treatment of hypotension and tension pneumothorax can be life-saving procedures, both of which may cause cardiac arrest in a trauma patient.
            b. Re-ordered EMT guidance
                i. Dr. Meehan-Coussee discusses changes to each item.
                ii. Discussion of specific change items by the group.
                iii. Dr. Zimmerman comments that a number of discussed changes are not reflected on the change sheet that is on screen and would like to ensure that those be accounted for, as well, in print.
    ii. Motion made by Dr. Bohanske and seconded by Dr. Meehan-Coussee to accept the proposed changes as written on the Word document displayed on screen.
        1. Discussion.
            a. Dr. Zimmerman asks if the protocol prescribes transport in an ambulance for 15 minutes using manual CPR? Dr. Bohanske answers that it likely does, due to this being a potentially salvageable patient, reversible, the absence of resources in the field, and the time interval.
                i. Dr. Zimmerman discusses the issue of educating around performance of CPR in an otherwise unsafe environment and the likely possibility that providers in that case are doing ineffective CPR for 15 minutes. Discussion by the group.
            b. Dr. Ritter discusses the trade-off in safety and efficacy in the possible absence of ED capability of interventions needed.
            c. Discussion by Drs. Sholl and Zimmerman regarding crew safety and efficacy of treatment, in addition to the possible provider education curve.
            d. Sally Taylor notes the requirement for service safety plans and asks if protocols discussing performance of manual CPR in a moving ambulance will necessitate addendum to that safety plan? Dr. Meehan-Coussee discusses.
            e. Dr. Bohanske advocates for transport of salvageable trauma arrest patients if transport to and arrival at ED can be timely.
            f. Dr. Sholl asks the group how to navigate possible provider confusion over performance of manual CPR per proposed protocol changes, given historic emphasis on crew safety and efficacy of CPR. Discussion by the group.
            g. Dr. Saquet suggests it might be better to consider the motion after some offline work to make the changes read better in print.
        2. Motion rescinded by Drs. Bohanske and Meehan-Coussee.
        3. Dr. Sholl proposes the protocol be worked on off-line and brought back to the group with changes at the December meeting.

e. Group takes a 5-minute break.
f. Red Section
    i. Dr. Saquet shares his screen and leads the discussion.
        1. Red 2 Chest Pain Cardiac origin – editorial change only
            a. Change nitroglycerin dosing verbiage to clarify avoid confusion
                i. Item AEMT #9 to read: "0.4 mg Tablet or Spay SL every 5 minutes x 3 doses."
            b. Discussion by the group. Group approval for the change suggestion.
        2. Red 2 STEMI Criteria
            a. Dr. Saquet queries the group regarding a role for allowance of an EMT/AEMT who has acquired a 12-Lead ECG that says "acute MI suspected" to contact OLMC, notify them they've acquired such an ECG and transmit.
            b. This would not be a "Code STEMI" by the EMT/AEMT, but more just transmission of the 12-Lead for the call by the physician
            c. Discussion.
                i. This may be a solution in search of a problem.
                ii. Dr. Sholl asks if the suggestion is to have OLMC activate the cath lab based solely upon the machine's interpretation of STEMI? Dr. Saquet answers that it is not.
                iii. Discussion of transmission capability of services in the Region.
                iv. Suggestion that this may be more of an education item.
        3. Red 5 Fibrinolytic Check list
            a. Question regarding putting the time parameters (>12 hours) anywhere else in the protocols (i.e., in STEMI Criteria)?
                i. Discussion by t
    ii. Work on the Red section is tabled at this point, due to time.

11) Update – Ketamine in Delirium with Agitated Behavior and QI
    a. Dr. Sholl addresses.
        i. Dr. Sholl is appreciative of the group's commitment to be actively involved in QI efforts towards looking at these events.
        ii. Some of the sentinel events across the nation have culminated in legal action. This has caused much dialogue within the group. The efforts we've expended in awareness and provider support in these cases has been valuable. Dr. Sholl has had discussions with Drs. Nash and Ritter regarding operationalization. Need to reach out to all in discussion and to loop in Jason Oko to find out if there's a way to automate some of this in MEFIRS.
        iii. Discussion
            1. Jason Oko asks if there are any Regional Medical Directors who are NOT getting a weekly ketamine report? Dr. Saquet is not receiving a weekly report but is tracking it at his level.

12) Update - Pre-Hospital Physician
    a. Dr. Sholl and Pieh discuss with the group.
    b. Dr. Pieh
        i. We are working to define what attributes of a physician we want to verify in order to function as part of the EMS system. We've been working with how to embrace that once those attributes have been identified, what type of regulation should be developed around them and how is physician care is to be documented.
    c. Dr. Meehan-Coussee
        i. Thanks all who have been involved in work on this.

13) Update - PIFT
    a. Dr. Tilney was unavailable to report.

14) Update – MDPB ALS Position
    a. Dr. Sholl updates the group on the status of the process of filling the current vacancy.
        i. Application period closed 1 Nov 2022. We have 11 applicants.
        ii. Dr. Sholl will be working with the interview panel to develop a good interview process. A more realistic timeline for beginning is after the Thanksgiving holiday.
        iii. Thanks to Drs. Bohanske, Ritter, and Saquet, who offered to be alternates for the panel.
15) At this time, the report out for the Portland FD pilot project is given, as the project managers are now present. See item #6. a above.

Old Business

1) **Ops** – Director Hurley/Ops Team Members
    a. Sally Taylor
        i. There was no Ops meeting

2) **Education** – A Koplovsky/C Azevedo
    a. The final meeting of the Maine EMS Exam committee was yesterday. The Exam and Education committees are being consolidated into the Maine EMS Education and Examinations committee, effective December 2023. Carry-over items for the Exam committee have been identified and will be crossed over to Education. The chairs of those committees have met to discuss the consolidation. Maine EMS is assisting with the consolidation.
    b. Work continues on updating the training center standards document.

3) **QI** – C Getchell/J Oko
    a. Chip
        i. No meeting last month due to supplemental Board meeting.
        ii. Safety newsletter is being worked on and will be the focus for today's meeting.

4) **Community Paramedicine** – B. Lowry/J Oko
    a. Jason Oko
        i. Continues to meet. There have been two meetings in October to work on SOP document. It was agreed to have an additional off-cycle meeting to continue work. Goal is to take SOP document and let Maine Care decide how it can re-imburse. The results will be brought back to the committee to protocolize SOP.
        ii. If there are any Medical Directors needing assistance in reporting for being service medical directors, please reach out to Jason Cooney or Melissa Adams.

5) **EMSC** – M Minkler, R Williams
    a. Dr. Williams – nothing to report at this time.

6) TAC – K Zimmerman, A Moody
    a. Ashley Moody
        i. TAC did not meet.

7) **MSA** – K Zimmerman, A Moody
    a. Ashley Moody
        i. They are working on provider education and care flow paths.
8) **Cardiovascular Council**, A Moody
    a. Ashley Moody
        i. Working on CARES data for the end of the week.

9) **Maine Heart Rescue** – M Sholl, C Azevedo
    a. Sally Taylor gives the brief on the RA presented at Samoset this past weekend.
        i. There were 30 students in attendance, and it was very successful. We have gained some traction and we wish to maintain it moving forward.

10) Adjournment
    a. Motion to adjourn by Dr. Saquet.
    b. Meeting adjourned at 1253 hrs.

The QI Committee meeting will begin at 1330