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
18 Jan 2023
Conference Phone Number: 1-646-876-9923 **Meeting Number:** 81559853848
Zoom Address: https://mainestate.zoom.us/j/81559853848

Please Note: This meeting will be shared with the LifeFlight of Maine CPC, which will begin at 1115. Please note, these meetings will be virtual. MDPB Agenda – Meeting begins at 0900

Meeting Minutes

Members present:	*Matt Sholl, Beth Collamore, Tim Pieh, Kelly Meehan-Coussee, Seth Ritter, Mike Bohanske, Kate Zimmerman, Benjy Lowry, Bethany Nash, Rachel Williams, Dave Saquet, Pete Tilney*
Members Absent:	
MEMS Staff:	*Chris Azevedo, Jason Cooney, Sam Hurley, Marc Minkler, Emily Wells, Jason Oko, Robert Glaspy, Melissa Adams, Ashley Moody, Darren Davis, Megan Salois*
Stakeholders:	*Mike, Choate, Dwight Corning, Chip Getchell, Myles Block, Cecily Swinburne, Dr. Kevin Kendall, Rick Petrie, Sally Taylor, Shawn Cordwell, Joanne Lebrun, Chris Pare, Dr. Jonnathan Busko, Steve Almquist, Rebecca Taylor, Daniel Soucier, Jessica Benson-Yang, Frank McClellan, McGraw, Marcella Sorg, Gordon Smith, Fred Porter, Alexander Rezk, Joanna Benoit, Michael Reeney, Tom Gutow, Amy McKinley*

1) Introductions – 0900-0905 –Sholl
    a. Dr. Sholl makes introductions and takes roll call.
2) Approval of October 2022 and Dec 2022 MDPB Minutes
    a. October 2022 minutes
        i. Motion to approve the October 2022 meeting minutes is made by Dr. Collamore and seconded by Dr. Meehan-Coussee. No discussion Motion carried
    b. December 2022
        i. Motion to approve the December 2022 meeting minutes is made by Dr. Collamore and seconded by Dr. Saquet. No discussion. Motion is carried.
3) State Update – 0910-0925 - Director Hurley
    a. Director Sam Hurley gives the update Maine EMS Office.
        i. Director Hurley thanks the group for its work.
        ii. Director Hurley discusses pertinent upcoming bills submitted to the legislature
            1. LD 47 clarifies verbiage in the Maine EMS Act, regarding ability of Maine EMS to revoke an EMS license. The EMS Board actually does have the authority to revoke an EMS license and an additional clause referring such cases to District Court is being removed.
            2. Other bills related to the Blue-Ribbon Commission are in the works.
            3. Bills clarifying the differences between home health care and community paramedicine are being developed for submission

iii. Moving forward with work in community paramedicine. Dr. Lowry has been working with the committee to complete the scope of practice document, which is ready for MDPB review.
iv. Working on an RFP for medical director for the Substance Use Disorder program.
v. We have published the position announcement for Maine EMS Deputy Director and have also posted an additional Substance Use Disorder position.
vi. We will be reaching out to establish an ambassador program for the Substance Use Disorder program. Discusses position details. There will be a stipend associated with the position. We are currently working on the number of positions we will have.
vii. Discussion with the group, of an item regarding protocols that was voiced at a recent EMS meeting in Washington County. Concerns were expressed regarding the need to explain the "why" regarding protocol changes. Director Hurley emphasizes importance of having clear and accurate change sheets for protocol revisions and changes. These are published with the protocol changes, for the instructors and services to review for their education and planning. Change sheets are especially prominent in explaining operational importance and in being able to operationalize the protocols. This same concern has been voiced at meetings in other counties, as well.
    1. Dr. Pieh agrees with input regarding change sheets. It's not always known which of the changes are likely to be the greatest pressure on service chiefs. Would like to get some input from staff to assist with feeling this out.
    2. Dr. Ritter asks if there were any other specific themes that could be brought back to the group regarding specific items or sections in the protocol change process?
        a. Director Hurley discusses that the magnitude of changes in 2021 were noted to have been dramatic, especially with the EMT scope of practice. For many service leaders that had more of an impact than past years.
        b. Director Hurley recommends that if equipment or medications or procedures are being added that require a notable degree of support, it should just be part of the revision process to consider that and ask those questions to the services first.
        c. Also, we should be conscientious of the training burden those changes will result in. For any skill or item, we want to introduce to a specific license level, is the value added by the effort to provide the training to everyone greater than the value of simply taking the population who desires the skill/procedure and advancing them to the next higher level of licensure? Is the appropriate direction to push skills/procedures "down" or to push the providers "up" to the next level of licensure, in the best interest of the system?
    3. Dr. Zimmerman – Appreciates feedback. Re-iterates need for section authors to send most current versions of changes/presentations, due to confusion created by multiple versions in the file.
        a. Also important for service leaders to be more engaged with MDPB as well. MDPB and protocol forums are open meetings. Expresses concerns with releasing unapproved changes to the public.
        b. Director Hurley agrees and discusses possible options for making change information more accessible and getting service leaders more engaged with the changes that are being proposed.
        c. Dr. Saquet relates difficulties and expressed frustrations with CPAP training for EMTs in Washington County.
    4. Dr. Meehan-Coussee
        a. Regarding availability for access to ongoing work, this is another argument in favor of having ongoing conversations with your medical directors. Discusses.
    5. Dr. Sholl summarizes points in the discussion and re-iterates the need for accurate and up to date change sheets.
viii. Emily Wells asks Director Hurley regarding fixes for protocol app.
    1. Director Hurley addresses and notes that Maine EMS will contact the app developer and give updates or feedback on the items.

4) Special Circumstances Protocol Review – NONE

5) New Devices – NONE

6) Pilot Program Reviews 0925 - 0945– Sholl – Pilot Program Members
    a. Jackman Pilot Project Report to the MDPB
        i. Dr. Jonnathan Busko gives the project update.
7) Data Request Review – Overdose Patient Journey Task Force – 0945 – 0955
    a. Darren Davis discusses some Maine overdose statistics and introduces guests to the group
        i. Joanna Benoit – Project Director for the Opioid Data to Action Project of DHHS and OBH
        ii. Dr. Marcella Sorg- UMaine, representing the Margaret Chase Smith Policy Center
        iii. Gordon Smith – Director of Opioid Response for the state of Maine
    b. Joanna Benoit discusses the data request.
        i. This is a federally funded grant focusing on high impact data initiatives that can lead to informed action planning. Our ask is to have access to patient records of those who do interact with EMS for an overdose event. We want to look at what else they are seeing EMS for and, what trends are we seeing among those patients so that we may be able to identify areas of intervention or ways to divert patients away from risk of opioid overdose events
    c. Dr. Sorg – Discusses and elaborates further on Ms. Benoit's points. Discusses specific trends being examined in the opioid overdose event patient population, and other determinants of health.
    d. Rebecca Taylor – Director of research and evaluation at OBH.
        i. This group has been working over the past three years. EMS data is one of the richest data bases available around fatal and non-fatal overdoses in Maine. Discusses goal of data examination to determine intervention and avoidance points for the specific patient population.
    e. Gordon Smith discusses his role in the project.
    f. Discussion of the data request by Dr. Sholl and the group.
    g. Dr. Sholl asks the guests to discuss the process for safeguarding personal identified information. This process is discussed by Dr. Sorg.
    h. Rick Petrie relates that it often isn't clear exactly what the role of EMS is in assisting in the opioid crisis, aside from acute treatment of overdoses. They see naloxone leave behind as only a stop-gap measure, but not doing anything to impact other aspects of the crisis. What do you see as the EMS role in assisting with this issue?
        i. Gordon Smith responds.
            1. Role is increasingly critical to entire opioid response, because there are now increasing numbers of patients for which EMS may be the only interface with a given individual. This is why naloxone leave behind is so critical.
            2. Mr. Smith acknowledges the emotional toll of continual response to the same patients and even losing the patient on one of those calls may be one reason for people leaving the field. So, it's important that EMS know that they are, in fact, part of the bigger picture.
            3. Discusses the need to be able to relate to EMS that their role is important and how it is part of the bigger picture of addressing the opioid crisis.
            4. Discussion by the project group with Rick Petrie.
    i. Motion to support the data request made by Dr. Zimmerman and seconded by Dr. Pieh. No discussion. Motion is carried.
    j. Dr. Sholl asks the guests if it would be possible to hear some follow up from their study. Joanna Benoit, from the group, who agrees that this would be great.
8) UPDATE – Medication Shortages – Nash/All –0955 – 1010
    a. Dr. Nash advises that they are still working on midazolam concentrations in some areas and discusses ketamine and fentanyl issues.
    b. Dr. Sholl reminds all that the bulletins regarding midazolam and Bronchiolitis have been released.
9) Emerging Infectious Diseases – 1010-1020 – Sholl
    a. Dr. Sholl discusses tracking of four separate infectious disease outbreaks
        i. RSV
        ii. Ebola
        iii. Influenza
        iv. COVID
    b. Dr. Williams
        i. RSV outbreak appears to be stabilizing and actually coming down.
        ii. COVID appears to be coming back up.
    c. Dr. Sholl
        i. Flu numbers last month were up but appear to be peaking now.

ii. Ebola in affected areas of the world, is going down.

10) 2023 Protocol review process – 1020 – 1100 – All
    a. Timeline review – Sholl/Zimmerman/Collamore
        i. Dr. Sholl discusses timeline progress.
            1. We are a bit behind schedule. Perhaps we can discuss an additional meeting at our February meeting.
            2. Goal is to wrap up revision process in April, with education development beginning in May – July with parallel MEMSEd process for September.
    b. Jan 12th Protocol Webinar Discussion – Review
        i. Dr. Sholl and Dr. Collamore discuss protocol forum last week.
        ii. Chris Azevedo discusses forum survey results and feedback, as well as attendance numbers.
            1. Dr. Meehan-Coussee asks if there is a way to follow up with questions or issues brought up in the surveys?
                a. Chris Azevedo – we could make the surveys identifiable, or we can make it clear to participants that if they want specific feedback, whom they can contact.
                b. Dr. Meehan-Coussee highlights the role of the ALS/BLS positions on the MDPB in provider interaction and feedback.
                c. Dr. Saquet encourages providers to reach out to himself, as well.
        iii. Next Protocol Review Webinar Discussion March 9th noon – 1pm
    c. Red Section – Saquet and Ritter
        i. Dr. Saquet presents a proposed change to add epinephrine to the Maine EMS scope of practice, for administration during cardiac arrest scenarios per protocol Red #8. Discussion by the group.
            1. Dr. Ritter discusses the potential benefits and clinical efficacy of early epinephrine and balancing that against the lift required to do so.
            2. Dr. Saquet adds that this specific change was one that was suggested by EMS clinicians in his region.
            3. Dr. Meehan-Coussee agrees this would be a beneficial change.
            4. Dr. Sholl cautions regarding the possibility that this addition may result in an impression among clinicians that paramedic level response is no longer needed on a cardiac arrest because AEMTs would be able to administer epinephrine.
            5. Dr. Sholl discusses that, like the 2021 protocol updates, this change is actually only an alignment of Maine EMS AEMT scope of practice with that of the National EMS Scope of Practice Model at the AEMT level. However, he raises the following points:
                a. Considering the lift from the 2021 changes, is this the right time to add this change?
                b. We should also be mindful of our process, i.e.,
                    i. Is the incidence of occurrence high enough to warrant the change?
                    ii. Do we have evidence to show that this change is beneficial?
                    iii. Consideration of impact of making the change
            6. Dr. Ritter asks if Maine EMS will pull data to look at frequency of occurrence?
                a. Jason Oko responds that this is something that Maine EMS can do.
                b. Dr. Ritter adds that having this sort of data would go a long way towards providing evidence to support the decision to effect the change.
                c. Dr. Saquet adds that the services that this would affect would be services that are only AEMT, with no paramedic en route. Also, this would assist Paramedic services with AEMTs and allow them to assist in those cases as well.
            7. Chris Azevedo
                a. Discusses consideration of the potential of blurring of AEMT and paramedics in the future after this step is taken, and if the reason it was done was simply to satisfy a perceived need for which there has been no evidence to collect, or simply to align the AEMT scopes of practice between the National Model and Maine EMS.
                    i. Where does this lead –
                        - do we open ACLS and other paramedic level to AEMTs for the same reason, Interpretation of 12-Leads, etc.?
                    ii. Is the solution/is the solution not, to upgrade the training of the providers in those services vs making a statewide change?

b. Dr. Ritter provides some additional perspective
    i. It would be ideal if all services were certified at a paramedic level and were first on the scene. At the same time, by doing that, it would by diluting case experiences per paramedic.
    ii. There are also issues of funding courses, attendance, and then salaries.
    iii. While the point on blurring scope of practice lines is valid and fair, if we put the patient at the center of it, we're probably thinking about changing this for the right reason.
c. Dr. Pieh discusses that the scope of practice is national and feels that this would be an appropriate change, but asks how is the operational or training lift measured?
    i. Dr. Bohanske – we honor it by considering it
        - Educational lift is small – this is in scope of practice and in initial licensure training
        - Operational lift would be that ACLS medications are only available to services running at the AEMT level.
    ii. Dr. Sholl discusses.
        - Agrees that it is currently in scope of practice, but there are a large cohort of currently licensed AEMTs for whom we'd have to provide that initial level training.
        - It isn't commonplace for AEMTs to be mandated to take ACLS.
    iii. Chris Azevedo
        - ACLS is not required for the AEMT level.
        - The question, however, is that, OK, cardiac epinephrine is added to the AEMT practice. But then, come next protocol update cycle, does the scope of practice become the rest of ACLS?
        - If the group decides to do this, there should first be a robust discussion of the context in which this change is to be effected, parameters for administration, whys and wherefores. It's a good guess that that is going to be the next topic of discussion by services and providers on the floor
    iv. Dr. Saquet
        - Relates that while hospitals use epinephrine auto-injectors because the 5-Rs aren't often not considered in the head of a situation like anaphylaxis. Yet, we allow EMTs, AEMTs and paramedics to do ready, check, inject, which is more than what most people in hospitals are allowed to do. So, from a 5-R perspective we've already trained them on this. There is already epinephrine in the trucks, and we can give them a different concentration. I don't think this would be that much of a lift from this particular perspective.
d. Dr. Ritter
    i. Recommends centering this on the patient and what the national guidelines are.
    ii. Puts forward the possibility of considering for next cycle, if we made this change this cycle, having services perhaps, put their AEMTs through ACLS or whatever standard is that you wanted. But national guidelines are never going to approximate AEMTs to what paramedics can or should do.

ii. It is decided by the group to delay decision until the February meeting, so that some data may be compiled and reviewed for a decision on this change, at that time.

d. Dr. Sholl reviews Catalogue of Items for Later Date
    i. LZ Discussion/Updates
    ii. Trauma Arrest Protocol

11) Update – MDPB ALS Position
    a. Interview panel
        i. Dr. Sholl updates the group on the status of the process.
            1. Eleven total candidates. Half have been interviewed. Anticipating a two-round interview process.
            2. Estimate having a candidate name for the group by the March Meeting.

12) Ongoing Items for Future Meeting Discussion
    a. Update – Ketamine in Delirium with Agitated Behavior and QI
    b. Update - Pre-Hospital Physician - TP
    c. Update - PIFT –PT
    d. Update - Regional Medical Director Job Description update -MB

Old Business – 1105-1115

1) **Ops** – Director Hurley/Ops Team Members
    a. No operations brief was given.
2) **Education** – A Koplovsky/C Azevedo
    a. New Co-chair name to be submitted to the Board Chair
    b. Training Center Standards are nearing completion of review.
3) **QI** – C Getchell
    a. Committee meets at 1330 this afternoon. Work continues on Safety Newsletter.
4) **Community Paramedicine** – B. Lowry
    a. Scope of practice and protocols are ready to submit.
    b. Work beginning on the formulary and annual goals.
5) **EMSC** – M Minkler
    a. Currently conducting a survey of all EMS services in Maine regarding pediatric focused education and training at the service level. Survey is open through March. The information gained from the survey drives education efforts.
6) **TAC –**A Moody
    a. Next Tuesday is TAC and MSA's quarterly meetings.
    b. Currently making progress on the AED Registry roll-out
7) **MSA** – K Zimmerman, A Moody
    a. No further report.
8) **Cardiovascular Council**, A Moody
    a. Working on outcomes data for CARES. Will be reaching out for assistance from hospitals.
9) EMD – Melissa Adams
    a. Continuing to get questions regarding the U-21 codes regarding pandemic response.
        i. These are still in effect.
        ii. Step 1 is surveillance at the dispatch level and identifying persons who have indicators of infectious disease and giving the pre-alert.
        iii. We've also had questions in Licensing regarding whether or not the pandemic protocols are still active, which they are.
10) **Maine Heart Rescue** – M Sholl, C Azevedo
    a. No report.

Regular meeting adjourned at 1115 hours.

The LFOM CPC Meeting will begin at 1115. The QI Committee meeting will begin at 1330

Meeting transitions to LFOM CPC at 1116hrs.