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

*Members Absent*:

*MEMS Staff*: *Marc Minkler, Jason Oko, Darren Davis, Anna Massefski, Robert Glaspy, Soliana Goldrich, Megan Salois*

*Stakeholders:* *Norm Dinerman, Chip Getchell, Frank McClellan, Michael Reeney, Rob Sharkey, Joanne Lebrun, Myles Block, Anita Chadbourne, Dann Clark, Stephanie Cordwell, Phill MacCallum, Sally Taylor, Jeremy Ogden, Stephen Smith, Fred Porter, Mike Senecal, Chris Pare, Dwight Corning*

1) Introductions
    a. Dr. Sholl makes introductions and takes roll call

2) January 2023 MDPB Minutes
    a. Motion to accept the January 2023 meeting minutes made by Dr. Collamore and seconded by Dr. Lowry. Motion is carried.
3) State Update
    a. Director Hurley is unable to make the meeting and so, there was no state update from the EMS office.
    b. Dr. Sholl discusses the selection process for ALS Representative position
        i. The interview panel has interviewed 11 candidates in round one, using a standardized question template.
        ii. There will be a second round of interviews in March. The selected candidate will need to be approved by MDPB and then confirmed by the EMS Board. The position is not likely to be filled until April.

4) Special Circumstances Protocol Review – NONE

5) Alternate Devices – NONE

6) Pilot Program Reviews – NO REVIEW THIS MONTH

7) UPDATE – Medication Shortages
    a. Dr. Nash advises that the only outstanding shortage is the current midazolam concentration. Nothing further to report.
    b. Dr. Bohanske advises that ketamine has been short for hospital use. That may or may not be affecting the EMS Pyxis, however, the topic is brought up for awareness.
        i. Dr. Nash advises that various concentrations of ketamine are in shortage, which may or may not affect EMS.
    c. Dr. Ritter advises that concentrations of D50 have become short, so in some places it is being replaced with D10.
8) Emerging Infectious Diseases – 1015 – 1030 – Sholl
    a. Dr. Sholl discusses.
        i. There have been increasing numbers of COVID cases within the state. It is important to maintain protective postures. Discusses.
        ii. The environment has turned corners with responses to both monkey pox and Ebola outbreaks.
9) 2023 Protocol review process – 1030 - 1220 – All
    a. Timeline review
        i. Dr. Sholl shares his screen and reviews the timeline progress.
        ii. The Pink and Ecchymotic sections remain to be reviewed.
        iii. Drs. Collamore, Sholl, and Zimmerman are monitoring deliverables and the timeline and whether or not there will be a need for additional meetings.
    b. Protocol Review Webinar - March 9, 12-1pm
        i. Dr. Sholl discusses the last webinar and encourages attendance at next month's webinar.
    c. Discussion – Protocol Review Process
        i. Dr. Sholl discusses aspects of the protocol review process
            1. Shares his screen and discusses ideas that were brought forth in the debrief from the 2021 Protocol update cycle. There have been ebbs and flows with the current process and Dr. Sholl would like to address selected items.
                a. The group works best when all are prepared to discuss the topic.
                    i. When all have been given time and material it sets the stage for good discussion.
                    ii. There have been ebbs and flows in this area this cycle.
                b. The more the focus has been on the process agreed upon – motivation, purpose, impact, the better the more facilitated the conversations more robust the decisions are. There is also better ability to defend those decisions as much as possible downstream with our constituents.
                c. Advises that as the end of the protocol review period approaches, the group may need to be more facilitated in order to maintain timeline and deliverables.
                d. Dr. Sholl reviews and discusses the importance of the change documents, and the feedback from providers, voicing the value of them.
                    i. Dr. Zimmerman discusses her efforts to keep up on the change documents and ensure completeness and accuracy. Asks that section authors please advise of any challenges with completing change documents, or if there are any questions regarding material that should be included.
                    ii. Dr. Ritter suggests assigning roles, e.g., one author is the presenter and the second is responsible for the change document.

2. Dr. Sholl discusses process.
    a. Dr. Sholl discusses how a change in use of backboards had a large impact on spinal management back in 2015. Discussion of the importance of consideration of current and future impacts of changes.
    b. Dr. Sholl discusses consideration of motivation for protocol changes. Emphasizes that changes should be patient-centric.
    c. Discussion of consideration of the purpose of suggested change.
        i. What is the issue to address, and is there really an issue that needs addressing? If so, can the solution being considered really mitigate the issue or affect it? Has a need been demonstrated? If need exists, should EMS the who fills the gap? If no gap present, does suggested change improve current practices and/or outcomes? Also, use of incidence data may play a role in defining purpose and should be used.
    d. Discussion of consideration of evidence behind suggested changes.
        i. Consideration of strength of evidence for and/or against the change.
        ii. Consideration of risk and risk tolerance along with evidence consideration. Consideration of use of "grade process."
    e. Discussion of consideration of impact of suggested change.
        i. Discussion of list items to be considered: positive/negative, education required, QI required, medical direction (state, regional, service), financial, interface with other parts of the healthcare system.
    f. Dr. Sholl asks the group to reflect on experience in decision-making processes and what has helped.

d. Discussion – MDPB Deliverables
    i. Dr. Zimmerman shares her screen and discusses chart of deliverables, and timeline, with the group.
    ii. Dr. Sholl asks section authors to ensure they have submitted the most current versions of their materials, specifically review of LucidChart edits and completion of finalized change documents.
e. Red Section – Ritter/Saquet/All
    i. Marc Minkler shares his screen and presents data regarding frequency of incidence of cardiac arrest situations in which there may have been opportunities for AEMTs to have administered epinephrine and in which it may have been helpful to do so.
        1. 1818 PCRs considered "worked" cardiac arrests.
        2. 138 out of 1818 (7.5%) "worked" arrests with AEMT as highest level of licensure
        3. Of 138 AEMT "worked" arrests:
            a. 14 were AEMT level but with an EMT level service and epinephrine would not have been an option.
            b. 103 resuscitations would not likely have benefitted from AEMT use of epinephrine
            c. 21 may have benefitted from AEMT administered epinephrine.
        4. Discussion of statistics by services, permit level and by county.
        5. Discussion of other eastern and midwestern states allowing epinephrine use by AEMTs for cardiac arrest.
    ii. Discussion – AEMT and Epinephrine
        1. Dr. Bohanske

a. Discusses incidents wherein no ALS interventions were performed prior to arrival of a paramedic. Perhaps reason was that AEMT was working on CPR and other interventions prioritized over IV initiation?

2. Dr. Sholl shares his screen and discusses survival rates for cardiac arrest or patients with ROSC.
3. Dr. Ritter asks would it make sense to have a time stamp denoting arrival of various levels of service in the patient care reporting? Would that improve the ability to query better data regarding patient care at different levels?
4. Emily Wells discusses agreement with postulation that AEMT would likely be focusing on other necessary interventions in the absence of ability to administer medications prior to paramedic arrival. Also discusses potential positive impacts to ability to assist paramedic with care as well as size of lift to effect this proposed change.
5. Discussion by the group.

iii. Dr. Ritter shares his screen and discusses proposed changes with the group.

1. Epinephrine for AEMTs
    a. Review of study regarding early administration of epinephrine versus acquisition of ROSC.
    b. How should this be done?
        i. Consider "if so trained"
        ii. Must continue paramedic response
        iii. Encourage QI
        iv. Reinforce hierarchy of interventions in cardiac arrest
    c. Dr. Sholl discusses need for emphasizing priorities patient care.
    d. Dr. Sholl discusses utilization of service level medical directors in service level credentialling.
        i. Dr. Collamore expresses concern with losing ground on the importance of high-performance CPR and defibrillation over administration of epinephrine.
    e. Dr. Zimmerman asks if this protocol change includes administration of epinephrine by AEMTs to pediatric patients as well.
        i. Dr. Williams replies that she has a change proposal coming regarding moving pediatric resuscitation protocols to be separate and recommending this also apply to pediatric patients.
        ii. Discussion by the group.
        iii. Dr. Nash points out that medication calculation is not a skill required for AEMTs. Expresses concern with expanding to pediatrics. Marc Minkler agrees, but also points out exclusion of a significant patient population which also needs the same medicine and care. Discussion by the group.
    f. Motion made by Dr. Pieh to approve cardiac epinephrine for adult patients in cardiac arrest, at the AEMT level, "if so trained," and seconded by Dr. Meehan-Coussee. Discussion.
        i. Dr. Bohanske discusses challenges to credentialling by service level medical directors, for AEMTs, regarding this protocol and recommends building need for medical director oversight and importance of medical director involvement in the education for this protocol and in QI for cardiac arrest, into the education around this change.
        ii. Dr. Sholl agrees and points out that this change may highlight the need for consideration of credentialling in the future. Discusses.

iii. Dr. Saquet discusses the role of the medical director. It has been a challenge just implementing the requirement for services to have a medical director. It may be prudent to consider the lift that credentialling by service level medical directors would have at this time.
iv. Discussion of credentialling and medical direction by the group.
v. Suggestion is made to amend motion language to that written by Dr. Ritter in his presentation. Drs. Pieh and Meehan-Coussee amend the motion to accept the proposal to adopt the use of epinephrine in a cardiac arrest for use at the AEMT level, for adults only, as outlined in the language presented by Dr. Ritter in his presentation (shown as follows):
    - Ensure high performance CPR
    - Defibrillate, if indicated
    - Establish IV/IO…Epinephrine 1 mg IV/IO push, if so trained and equipped
    - Manage the airway per Blue 3
    - Must continue paramedic response
vi. No further discussion. Motion is carried.

2. Refractory VF treatment change
    a. Dr. Ritter discusses the 2021 change to this protocol and the study that was the impetus for discussion of that protocol change. There has since been a newer study by the same authors of the original study, which Dr. Ritter discusses.
        i. The proposed change is to consider the following in case of refractory VF (after 3 unsuccessful shocks and administration of epinephrine and amiodarone):
            - Consider dual sequential external defibrillation (DSED) after 3rd defibrillation, if a second defibrillator is available
            - Use vector change after 3rd defibrillation, if a second defibrillation is NOT available. Consider DSED for subsequent defibrillations if a second defibrillator becomes available
            - With any defibrillation attempt, ensure adequate pad contact
        ii. Discussion by the group.
        iii. Dr. Sholl makes the motion that the protocol be reorganized to prioritize DSED in advance of vector change in the circumstance that there are two defibrillators on the scene, leaving the proposed language about pad contact and moving it up to the top of the protocol, and maintaining the caveat regarding manufacturer's warranties and checking them. Motion seconded by Dr. Pieh. No discussion. Motion is carried.
3. Pacer pad placement
    a. Proposal to consider using anterior-posterior pad placement initially when pacing. Dr. Ritter discusses the study supporting this change.
    b. Dr. Ritter proposes adding "consider initial ateroposterior pacing pad placement over anteriorlateral placement" in the pacing protocol.

c. Discussion regarding placing this in a PEARL or elsewhere. It is agreed by the group to place this statement into a PEARL, without making a motion.

4. Dr. Ritter discusses a proposal to prioritize patient stabilization in cases of ROSC, prior to patient transport.
    a. This fits the acronym, "SAVE A LIFE"
        i. Stabilize – stay on scene vs rapid departure
        ii. Airway – if still unresponsive, establish a definitive airway (SGA, ETT)
        iii. Vitals – change frequency to every 3 mins
        iv. EtCO2 – monitor airway and re-arrest
        v. Alert – Alert and activate hospital
        vi. Levophed – focus on CPP, goal is MAP > 80 mmHg, LUCAS device in place
        vii. IV – if only an IO has been placed
        viii. Follow up Vital Signs – Ensure stability before departure
        ix. EKG – may affect destination, delayed EKG increases accuracy
    b. Discussion
        i. Dr. Sholl recommends replacing the proprietary "Lucas" verbiage with "mechanical CPR device" or similar.
    c. Dr. Zimmerman asks if this is to be added as another page/checklist.
        i. Discussion.
    d. Dr. Sholl discusses prioritizing vital signs and management of hypotension over initial 12-lead, in the current protocol (Red 16), and notes commonality of ischemic or injury patterns present on 12-leads immediately after arrest due to ischemia or defibrillation and adding a checklist at the end of the protocol.
    e. Dr. Sholl suggests the group allowing himself and Dr. Zimmerman to edit the current protocol and add a checklist at the end. The group agrees.
5. Dr. Ritter discusses other changes that were proposed.
    a. Lidocaine as alternative for amiodarone in VF/VT
        i. Approved by AHA, but, in the prehospital arena, it can't be proven that lidocaine is any more effective than amiodarone.
        ii. At best, lidocaine is duplication of medication already in use.
        iii. Not recommending
    b. Prehospital lytics for STEMI
        i. Not enough QA/QI credentialling, numerous STEMI mimics that would result in poor outcomes if lytics were given in those cases
        ii. Not recommending
    c. Load distributing band devices for mCPR
        i. Outside of manufacturer's data, these devices have been shown to cause injuries (aortic, unusual rib fractures, pneumo/hemo thoraces).
        ii. Doesn't meet AHA guidance standard for rate
        iii. Find that there is little evidence to suggest disregarding the AHA standard or the need for these devices to meet it.
        iv. Not recommending
    d. Call for New England Donor Services
        i. This is mentioned in the Grey and Red sections.
        ii. Suggested changes
            - Grey 9 – Change "consider contacting," to "contact"

- Red 15 – Change “notification” to “notify”

iii. Discussion of this change by the group.
iv. Dr. Sholl proposes Grey section authors if this change could be put up for discussion for the Grey section and proposes that this change should be included in the education for the Red section. Dr. Ritter agrees that putting a tab in MEFIRS for this would be a good idea.

10) Update - Pre-Hospital Physician
    a. Dr. Sholl discusses progress on this project.
        i. Ongoing conversation.
11) Update – PIFT
    a. Dr. Sholl gives a summary of progress.
    b. Dr. Tilney has been working hard on this. Upcoming MDPB meeting will include dedication to discussion of some of the PIFT work Dr. Tilney is doing. Reminder, documents from this work will come before MDPB for approval.
12) Protocol Catch Up
    a. Dr. Zimmerman has been doing a great job with tracking the loose ends for the protocol update process.
        i. Traumatic Arrest Protocol

**Old Business –** 1245 - 1300

1) **Ops** – Director Hurley/Ops Team Members
    a. No report
2) **Education** – A Koplovsky/C Azevedo
    a. Sally Taylor give report.
        i. Training center standards have been completed. They will be presented for the April meeting for approval.
        ii. Discussing PSEs and continuation of these for candidates needing re-testing and or re-entry candidates
        iii. Anna Massefski spoke briefly about the Explorer program and will give a presentation at the March meeting.
3) **QI** – C Getchell/J Oko
    a. Chip Getchell give report
        i. The QI committee will meet at 1330 today.
        ii. They are hoping to finish the winter newsletter.
4) **Community Paramedicine** – B. Lowry/J Oko
    a. Soliana Goldrich gives report
        i. Awaiting MDPB to review the scope of practice
        ii. Also working on a formulary
5) **EMSC** – M Minkler, R Williams
    a. Still doing pediatric education survey. Response rate at 49% currently.
    b. Still awaiting results from application to HRSA to continue EMS-C grant.
    c. Soliana Goldrich discusses the RFA was released healthcare disparities for paramedicine.
**6)** **TAC –** K Zimmerman, A Moody
    a. Met last month
    b. Continues work on the trauma plan and its rural aspects.
    c. Working with Jason Oko on developing an annual trauma report.
    d. Working with hospitals regarding a statewide trauma registry
7) **MSA** – K Zimmerman, A Moody

    a. Met last month and continues to work on filling their positions.
    b. Working on FAST-ED education for physicians.
8) **Cardiovascular Council**, A Moody
    a. No report
9) **Maine Heart Rescue** – M Sholl, C Azevedo
    a. No report

Motion to adjourn by Dr. Collamore and seconded by Dr. Saquet.

Meeting adjourned at 1309 hrs.