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

WIL O'NEAL
DIRECTOR

Medical Direction and Practices Board – August 21, 2024
Conference Phone Number: 1-646-876-9923 **Meeting Number:** 81559853848
Zoom Address: https://mainestate.zoom.us/j/81559853848

Members present:	*Dr. Matthew Sholl, Dr. Beth Collamore, Dr. Kelly Meehan-Coussee, Dr. Dave Saquet, Dr. Seth Ritter, Dr. Tim Pieh, Dr. Kate Zimmerman, Dr. Pete Tilney, Bethany Nash, PharmD, Dr. Benjy Lowry, Colin Ayer, Dr. Rachel Williams*
Members Absent:	*Emily Bryant, PharmD*
MEMS Staff:	*Marc Minkler, Jason Oko, Wil O'Neal, Darren Davis, Anthony Roberts, Jason Cooney, Rob Glasby, Melissa Adams*
Stakeholders:	*Rob McGraw, Rob Sharkey, Rick Petrie, Michael Reeney, Chip Getchell, Joanne Lebrun, Dr. Norm Dinerman, Eric Wellman, John Moulton, David Ireland, Chris Pare, Mike Senecal, Brian Langerman, Shawn Cordwell, Margie O'Brien, Bill (no last name provided)*

"The mission of Maine EMS is to promote and provide for a comprehensive and effective Emergency Medical Services system to ensure optimum patient care with standards for all clinicians. All members of this board should strive to promote the core values of excellence, support, collaboration, and integrity. In serving on this board, we commit to serve the respective clinicians, communities, and residents of the jurisdictions that we represent."

1) Meeting begins at 0931 with a quorum.
2) Introductions
    a. Sholl makes introductions and roll call.

3) June MDPB minutes
    a. Sholl reads email from Dr. Busko (unable to attend as working clinically), states there is an error and he asked if Pieh was comfortable asking for the minutes to be amended. Sholl states we [Sholl & Minkler] reviewed the recording of this and the recording does say "you and I are not going to agree on the standard of care". So the way that it reads right now, and with the exception of swapping "you and I" for "we", is the exact language that was used in the context of the MDPB meeting last month. Pieh and I talked and discussed. Given that this is a recording, that it is verbatim. Unfortunately, we can't amend that but I wanted just to respect the request and make sure everyone was aware of it. Pieh has nothing further to add and states he appreciates reviewing the request.
    b. Collamore makes two minor editing corrections with no substantive changes.
    c. Motion to approve June 14, 2024 minutes made by Meehan-Coussee and seconded by Collamore with two minor editing corrections. No discussion. Lowry and Ayer abstain due to absence last month. Passes unanimously.

4) State Update

a. Office Updates
    i. O'Neal gives the state update for the group. Proposed chapter 27 rules is open for public comment. Proposed chapter 19 will go out next week for public comment. SCT and CCT discussion at Board and trying to formalize over next few years. Looking to do a regional town hall to seek input from stakeholders. We have posted an office associate position and will be posting education coordinator and regional managers soon. Taylor Parmenter has been promoted to the SUD Program Manager. States there was an opinion piece in the Bangor Daily News, states specific cost numbers were in the article about EMS costs per person and feels that the costs presented were much lower than likely the actual costs. Meehan-Coussee asks about inability to chat in the MDPB Zoom meeting and would like to find the sustainability rules on the website. O'Neal states the rules will be posted today as we had to await Secretary of State posting. Minkler states the chat function is active from his end, but that Oko is owner of the meeting and may be a setting on his end. Minkler states he is on vacation but will get the materials on sustainability posted as soon as possible today. Oko states the chat settings are set so participants can chat with host and co-host only. Oko states that is the setting he uses for all meetings. Sholl states that is fine to leave the settings as is. Oko states folks can also use the raise your hand function and the chair can opt to unmute that individual.
    ii. Saquet notes recent EMS suicide and encourages folks to take time for self care and the importance of family time and support.
    iii. Link posted in chat for Chapter 27 draft on the website.

5) Alternate Devices – None

6) Special Circumstances Protocol
    a. Sholl notes that Minkler is working with 2 families and physician on drafting a special circumstance protocol and may be ready for next meeting, work continues on it.

7) Pilot Projects
    a. Sanford Ultrasound IV Access Program – Moulton provides a written updates shared with MDPB members, states 2 GE VScan linear devices have been ordered, updating iPads and will have 2 dedicated iPads for the ultrasound device. Training plans are continuing (hoping to start in September) and devices not yet in service. Draft MOU with MaineHeath and Sanford in process. Ritter confirms that the devices are linear. Moulton states the devices have curved and linear dual use probe.
    b. Jackman – No update.
    c. O'Neal states pilot projects are very important but with so many it is challenging to manage and resource them. Will be asking the Board to limit the number of projects at any one time. States current pathways also do not indicate how to move a project from pilot to permanent (if approved) and work to better define a process for this.
    d. Portland Fire Depart MMO – Sholl states has gone past the 3-year time frame and leaders at Portland are looking to transition this to a community paramedic program, thanks all the members at Maine EMS, particularly Soliana Goldrich. Portland was unable to attend due to staffing and vacation, but that they are actively working on a transition program. Saquet states not having an off ramp is challenging, and thought we would take updates over the years and then decide a protocol or next step. Would it be wise to move a pilot project to a protocol as we work on protocols? Sholl states the projects often focus on discrete issues, discusses some previous projects that were more global, and many of the current projects are major structural changes to the Maine EMS system (such as the MMO project and the Jackman project) with many novel practices and go beyond simply creating a protocol and include rules, system building, and other substantive changes and resources needed to make permanent. Saquet states this makes sense and wonders if the MDPB needs to draft something to support these projects and move the work forward. Sholl states the Board and Maine EMS staff are working on

many of these processes to standardize pilot projects and overall policies/rules. Tilney states there are likely many pathways, and some may need more review and others can transition to protocol or end them – it would be unending otherwise. Sholl states the background work on projects are tremendous with MDPB and Maine EMS staff. Provides example of the Jackman project requiring thousands of hours by MDPB and Maine EMS staff during the establishment and continuation. Sholl states current projects are:

i. Sanford Fire Department Ultrasound Project (in first year)
ii. Portland Fire Department MMO (3 years completed)
iii. Jackman Project (nearly 3 years in)
iv. MOPAR (EMS physician project)
v. Delta Ambulance Vent Project (15 months in)

8) Medication Shortages
   a. Nash reports no significant med shortages but there are many short expiration dates (e.g. 6 months)
   b. Nash states medication costs have increased significantly and in many cases 25-50% (e.g. glucagon has doubled in price), and being judicious in how much is kept on hand is important
   c. Sholl states several hospitals have reached out about the cost of suppling EMS with medications. In some cases it is without charge. In the future EMS agencies may have to obtain DEA numbers and buy all of there own meds, but that process is ongoing. Currently only physicians, hospitals and pharmacies can possess DEA licenses (to include purchase, provision, and dispensation of medications). EMS may also have to obtain their own scheduled medications (fentanyl, ketamine, and midazolam, currently). Asks MDPB members to reach out to himself, Zimmerman and O'Neal if any questions and inquiries are received.

9) Emerging Infectious Diseases
   a. Zimmerman states concern about increasing COVID prevalence and to take respiratory precaution for any suspected cases (particularly those with respiratory and/or GI complaints). Reminds that pertussis (whooping cough) is out in the community and to remind clinicians about masking these patients, and that EMS clinicians have updated vaccinations. Nash states there is a new COVID booster that is coming out in the next few weeks. Meehan-Coussee also states an uptick in Parvovirus B19, and a case of Eastern Equine Encephalitis in New England.
   b. O'Neal states that the MEFIRS COVID notification/alerts to clinicians has been shut off but the ability to use these alerts for any infectious disease is available should it be needed and can be turned on easily.
   c. Sholl states hospital admissions have increased about 30% this month, and that although COVID variation does not seem to be as high mortality, but seem to have more complications, especially with existing medical conditions. States that with children returning to school and as cold weather closes homes up and larger groups congregate, it will be interesting to see if this impacts healthcare.

10) PIFT Update
   a. Sholl states he has met with some of the Maine EMS staff for input on process and how this fits within the overall IFT system. State definitions are a challenge (IFT/PIFT/SCT/CCT are often used interchangeably and creates confusion). O'Neal states we are trying to walk through PIFT and scope, if licensure is needed, and has generated a lot of questions based on the work that has already been done. Work continues as it is a big project.

11) LFOM Protocols
   a. Dinerman states he is seeking approval of the updated Lifeflight of Maine [LFOM] protocols and to receive comments on errors or omissions in the protocols, as well as any inconsistencies with Maine EMS protocols to ensure they interface appropriately. Asks to distribute the protocols electronically via Sholl and to take the next two months to provide comments to LFOM to discuss

changes at October CPC meeting and consider integration into protocols and approval. Tilney adds that specialists have provided input from all 3 specialty hospitals in Maine as well as from Boston, and is eager to hear thoughts and additions and feedback from MDPB. Sholl will send to MDPB members. Asks to use reply all with suggestions so all can be aware and updated for the October meeting.

12) Protocol review process
    a. Sholl shares timeline for protocol process and this month will be Gold section review and then Blue section. Schedule decided with discussion is:
        i. Sept/October – Blue Section
        ii. October/November – Green Section
        iii. November/December – Yellow Section
        iv. December/January – Pink
        v. January/February – Orange
        vi. February/March – Red
        vii. March/April – Purple/Brown/Grey
    b. Sholl reminds that updates should be no more than the 4-5 in total to avoid overwhelming changes.
    c. Sholl would like to continue protocol webinar updates for stakeholders and proposes 2nd Thursday of every other month at 1pm starting in September. Zimmerman suggests checking for any conflicts with NAEMSP in January. Sholl and Zimmerman will march dates out and share with group and then with Maine EMS office for publishing. 1st date will be Sept 12, 2024 at 1pm.

13) Gold Section Updates – Meehan-Coussee and Ritter present
    a. Some grammar edits/punctuation/format improvements
    b. 4 suggested changes
        i. Suggestion #1: Altered Mental Status protocol
            1. Add EMT 7 "For patients who suffered syncope before their period of AMS or who are still altered, a 12-lead EKG should be obtained if so trained. If appropriate refer to Syncope protocol, RED 28"
            2. May be result of medication or cardiac issues
            3. Sholl asks if we need "if so trained", Meehan-Coussee states this mirrors other protocols. Saquet states it is not mandatory for EMTs to do 12 leads. Adams states 12 lead equipment is not mandatory for EMT level services, nor is the training mandatory for EMTs. **Sholl suggests "If available and so trained". Saquet suggests making sure the entire protocol uses same terminology for these considerations. All agree. Zimmerman will review protocols and ensure consistency.**
            4. **Motion by Pieh to approve inclusion of 12 lead acquisition by at EMT scope of practice in the Altered Level of Consciousness protocol with the addition of the language from Red 2 EMT #5. Second by Saquet.** Zimmerman suggests adding this to purple or brown section to define purpose of ECG. Collamore adds to her notes for inclusion. **No further discussion. Passes unanimously.**
        ii. Suggestion #2: Amend PEARL bullet 1 in Gold 9 regarding delaying medication administration to start an IV to include magnesium in addition to midazolam for seizures.
            1. Did a literature review and spoke with OB colleagues, no great evidence of one route is better than another for magnesium, discussion of literature results.
            2. Williams asks to clarify if the goal is to give both midazolam *AND* magnesium or does it mean midazolam *OR* magnesium. Meehan-Coussee states we are not changing the protocol, but to emphasize that we should not delay giving magnesium to start an IV, just like midazolam. Williams agrees. Zimmerman suggests copying line, making an addition bullet point and changing

"midazolam" to "magnesium". Sholl expresses concern that we don't have same level evidence as midazolam IM, so unsure if magnesium is as efficacious as midazolam IM. Sholl states this is acknowledgment but not disagreement in administering IM – we just don't have a lot of evidence for it. Meehan-Coussee asks should we add "if actively seizing" for IM, and then IV if not. Nash states IV route also requires the time to set up a pump and is not just an IV push. Sholl asks about pain for IM administration of 4 grams in each buttock. Saquet states it would be cruel for a patient who is awake. Saquet asks if this going to be an issue in a "puffy" pregnant patient and thus delay treatment if unable or long delays in IV access. Feels this is best guidance, even if less evidence. Sholl wonders if this should be in protocol and not in PEARL. Ayer suggest it be in the protocol because if a provider doesn't look at PEARL but is going through the protocol, it needs to be there. Meehan-Coussee would like to amend to add language in 12.A.i around this and to also include a separate bullet that specifies actively seizing patients should receive first dose of magnesium IM unless an IV is already established. Sholl asks if OK to follow that idea and took some editing liberties to make sure it flows correctly. Meehan-Coussee agrees and will send suggested language. Saquet asks do we carry enough magnesium for this. Sholl states we do not set par level. Nash believes the suggestion is enough for initial 8 gram dose and then a subsequent dose. Minkler states the previous change was to clarify that the pregnant patient did not need to be currently seizing to receive magnesium, but only to have had a seizure to receive it and wants to ensure the intent is not to change this. Also concerned about the non-seizing patients and requirement to give IV magnesium via pump and likely discomfort by clinicians with a postictal pregnant patient and having to establish an IV, give a med infrequently used, and do so via pump and will there be reticence to delay administration until arrival at hospital. States he is confident the IM dose of 4 grams per buttock is uncomfortable, but uncomfortable beats death of mother or fetus every time. Does not want barriers to treat the patient. Meehan-Coussee agrees and wants to give IM if no IV is available and not to dilute original intent of protocol. Sholl states we can improve the overall flow of the protocol, particularly around the pregnant patients. Sholl agrees that there is likely widespread discomfort around pump use and the MDPB and medical directors need to improve pump education statewide. Pieh asks in 12.b. there are 3 different ways to give magnesium and do we have guidance on dilution. Nash will talk offline with Pieh. Saquet states he feels his region is competent with pumps, but we do need to address this if a challenge in other areas. Sholl states pump use is important to help prevent bradycardia/hypotension. Saquet asks should this be a slow IV push and remove the barrier form a pump? Sholl states he has heard variable concerns from paramedics across the states with comfort AND discomfort with pumps. States not sure we have a way to improve comfort without direct education at a local level, IV pump library education, and how to ensure competency at service level. At the same time, it may not be that medical directors are the best to teach this skill either. Sholl states there needs to be a high level of engagement by medical directors at a service to ensure competency around IV pumps. Pieh suggests developing a spot check to see how paramedics would do if given the scenario of a seizing pregnant patient and using magnesium by the protocol. Nash states she does not encourage slow push of this medication and if given too fast, there is tremendous risk of side effects.

3. **Sholl makes a motion to amend Gold 9 to mirror section 11 in section 12 to give magnesium IM first if still seizing and no IV and then clarify the dosing scheme under each clinical condition and a PEARL around pregnant patients**

to give first dose of magnesium IM. Meehan-Coussee seconds. Pieh asks how we will clarify the dosing, Sholl states the editing group will do this if OK with all. **No further discussion. Ayer no response. Passes unanimously.**

iii. Suggestion #3: Allow services to carry liquid acetaminophen for administration to children less than 5 years of age or 20 pounds.

1. Request from some services to lower age and weight to administer acetaminophen. Data from Maine EMS, vast majority of transport for fevers in children is under 5 years, and currently receive passive cooling techniques. Stakeholders also report some elderly patients are unable to chew tablets, and liquid may address both younger and older populations with concerns for chewing ability. Ritter expressed concern of inadvertent IV administration of oral mixture. Nash reports she has participated in QI review of oral mixture that was injected IV with detrimental effects. Also reports this mixture is both messy, and flavor has resulted in spitting out (and concerns of what dose the patient may or may not have received), as well as dyes mixed in oral formulation and risk of allergic reactions. Reports that they do come in a 650mg dose cup that might be an option. Zimmerman asks if there are different concentrations, Nash reports there used to be, but they are now all the same concentration (infant vs pediatric). Saquet state he has challenges with administering oral mixture and children hate it. Sholl expresses concern about inadvertent dosing because of this. Ritter states this could happen in a hospital as well. Feels none of these are critical actions/interventions but acknowledges desire to make a patient more comfortable. Pieh feels it seems straightforward and is in favor of it. Williams concerned about 3 formulations (IV, tablet, PO liquid) and wonders if everyone could receive PO liquid instead of tablet. Nash states would it be possible to let services choose tablet vs PO liquid. States this could create challenges with hospital medication agreements. Meehan-Coussee states services have expressed concerns about having to give adults 6+ tablets for dosing of acetaminophen and the tablets are huge/chalky, have no water to drink it with, and are overall difficult to administer and would like option of liquid PO. Nash states given oral meds are always a battle in hospital, but is concerned about 3 different formulations. Liquid PO acetaminophen does not taste well either. Saquet agrees about concern of 2 oral formulations. Wonders if we have done an SBAR for those patients under 5 who met the criteria of fever and if we know the 'n' for this.
    a. Saquet has to leave meeting to work clinically
2. Tilney agrees multiple formulations is difficult. Asks why the age of 5 was used. Williams states concern over motor skills and safety of ingesting the tablets. Minkler asks if this is a weight-based dose and concern about EMTs and weight -based calculation education. Asks if the data was based on 911 vs IFT and if the data was based on "fever" as a generic term, or fever that met criteria to receive intervention. Meehan-Coussee state that the dose is set and would have a table listing the dose and volume by weight and would not need calculation. Shares data of patients from 2017-2024 and fever by age group and which received acetaminophen. Sholl appreciates the data, asks in the future to have section authors share the data with MDPB beforehand for better review and consideration. Minkler states the data should not include any IFT data as the care is determined by the sending physician and not by the EMS clinician. Ritter states from briefly looking at this, there was very little treatment done on those over 5 who could have had treatment done through current protocols. **Pieh makes a motion to enact changes to protocol as written, second by Meehan-Coussee.** Sholl notes that this would not include concerns from Nash or vision of building a table for use of the medication. Pieh

agrees to add a chart for dosing to be developed. Lowry asks to restate motion. Sholl states "To allow EMS services to carry liquid acetaminophen for patients less than 5 years old". **No other discussion. Sholl, Zimmerman, Lowry, Nash, Tilney, Williams vote no. Ritter, Pieh, Collamore, Meehan-Coussee, Ayer vote yes. Motion fails.** Ritter wonders if more conversation may help shape another motion. Williams states she supports one oral formulation. Collamore asks do we need to lower age cutoff for treatment of fevers? Williams states we should probably not treat if 3 months or under because identification of fever in this age group can be vague and difficult. Ritter asks should we allow services to choose for age group of 3 months to 5 years for liquid PO. Nash asks that agencies carry proper equipment to measure this and not using their IV syringes. **Ritter makes a motion to allow EMS services to carry liquid acetaminophen for oral use as an option. They must choose between tablets or liquid (one option only) with a cutoff of liquid of greater than 3 months old, and tablets of 5 years and that services will have proper measuring for liquid oral medications. Seconded by Williams.** Sholl asks to clarify specific equipment or proper equipment. Nash states education could define this. **Sholl restates to clarify motion as "to allow EMS services to carry liquid acetaminophen for oral use but only allow one oral medication in the agency formulary. Liquid can be provided to children greater than 3 months, where tablets for children greater than 5 years or 20 pounds. Services using liquid form must use proper measurement devices that do not have a Luer lock."** Ritter agrees this is accurate. Ayer asks how do we work with hospitals who may provide different formulations. Nash states that would be a discussion with the agency and the pharmacy. Sholl states there may be future changes with supplying medications. Zimmerman asks if EMTs are taught to draw up and measure medications. She references check and inject program, but we need to ensure accountability and any needed educational lift. Meehan-Coussee also asks about education of administering liquid medication in an infant and assurance of no aspiration. Sholl asks Minkler for input, Minkler states it is likely inconsistent and Education Committee might be best source of this information. Sholl will reach out to Education Committee Chair. Adams asks if a service selects liquid medication, will that allow a top end age cap, and would it be allowed for older population. Ritter and Sholl state no, it would just be a larger dose. Minkler expressed concern of equity – if a service chooses tablets would that exclude patients under 5 years old who is only allowed to receive PO liquid, so neighboring towns or regions could have different care options and not really follow a statewide protocol and consistent equitable care for all ages of patients – would a service choose an option based on cost/ease/operations vs minimum expected care of particular populations. Sholl agrees that it does potentially create a difference amongst EMS services and care that could be rendered. Ritter states this may create conflicts and now has mixed feelings. Pieh states Minkler's point is very relevant. Suggests one agent should be liquid to allow full access. Nash states this medication has generated more discussion on this board than any other medication in the past 5 years. **Sholl restates motion. Zimmerman, Ritter, Pieh, Collamore, Lowry, Nash, Tilney, Ayer, Willaims vote no, Sholl votes yes, Meehan-Coussee no response. Motion fails.** Nash expresses concern about acetaminophen and education piece for EMTs. Sholl suggests tabling this discussion in order to obtain more information from Education Committee. **Zimmerman motions to table discussion on liquid acetaminophen until next meeting to discuss EMTs education on drawing and administration of this medication (both existing in current education**

standards and what lift may be required if absent or gaps). Ritter seconds. Minkler suggests having the Education Committee see if they can send the chair or designee to future MDPB meetings to be a resource while the state office is without an Education Coordinator. **Meehan-Coussee abstains. Passes unanimously.** Sholl states he will bring back update to the September MDPB meeting.

iv. Suggestion #4: Meehan-Coussee states one more change suggestion for Gold and Sholl asks to carry over to September meeting due to time.

14) Old Business
   a. Ops – O'Neal - no update
   b. Education Committee – Minkler – no update, did not meet in August
   c. QI – Getchell – Working on QI manual and QI markers, QI meeting today with Attorney General
   d. Community Paramedicine – Lowry – excited about the rule and Chapter 19 is out for public comment, looking at resources and education for community paramedic medical directors, sending out a survey to primary care pediatric providers for potential needs
   e. EMSC – Minkler – EMS agency survey completed, 77% response rate and aggregate results will be shared once available. September 17 will be a kick off for Pediatric Emergency Council Coordinators (PECC) statewide, a collaborative effort between EMSC and Maine AAP
   f. TAC – Sholl/Petrie – met in July, TAC has transitioned to meeting monthly to work on goals and projects, quarterly meeting will be in person. Looking to update state trauma plan and working with rural state health subcommittee and with Maine Hospital Association to improve communication between hospitals
   g. MSA – Zimmerman – no update
   h. Cardiovascular Council – no update
   i. Data – Davis/Meehan-Coussee – meets today at 3pm, working on what is the definition of a patient
   j. EMD – Adams – working on integration of emergency mental health dispatch and education grant with DHHS for an online course to allow use of an additional protocol in EMD to help with crisis transfer policy and use. Work continues on statewide AED registry and working on challenges of mapping for AEDs within each EMD center's jurisdiction
   k. Maine Heart Rescue – no update

15) Delta ventilator pilot project
   a. Report from Getchell and Diaz on 3 cases from June
      i. Case # 1: LFOM unavailable, Delta & MD3 transported on MD3 vent, CC paramedic and physician transported. Pieh states he has nothing to add without executive session. Sholl commends work of EMS and hospital for surgery stabilization at community hospital. Zimmerman asks if this is part of the pilot project as a physician is on board, Sholl states he believes it is transparency of all vent transports by Delta during the pilot project. Diaz concurs and states it flags in QI and thus it carries forward to include all cases with non-standard transfers. Sholl appreciates the visibility and comparison for the review. Zimmerman wants to ensure MDPB knows the true 'n' for cases that are related to pilot project vs all vent cases. Getchell and Sholl will work on putting the data together.
      ii. Case # 2: Pediatric transport s/p resuscitation at sending hospital, Delta on scene so transport elected ground vs air. Accompanied by RN and RT during transport. Sholl asks about medications, Getchell states no meds during transport.
      iii. Case # 3: Elderly patient s/p hemorrhagic stroke. Paramedic and RN transport. Tilney asks about analgesic. Getchell states no analgesic during transport, unsure of any prior to delivery. Getchell states narrative and v/s indicate patient comfortable. Tilney expresses concern about propofol only and that it provides no analgesia and must be addressed between sending and transport. Getchell states the transport team had orders for fentanyl and versed during transport. Getchell states no tachycardia or BP

changes or signs of discomfort. Nash states we should assume they are in pain and not wait for them to show us this and should be pre-emptively provided pain control. Sholl states staff has requested to not mention sending and receiving locations. Diaz suggest this may be an executive session discussion. Getchell states it is a little different in the back of an ambulance as it is intense scrutiny of changes. States he is hesitant to give a patient something they do not need. Sholl states this has a been a common point of conversation and perhaps we need to further discuss sedation and management of post intubated patients, and analgesics during transports. Wonders if we need statewide IFT protocols around these types of transports and benefits of such. Asks group for thoughts. Tilney states he would like to discuss offline (Tilney/Sholl/Diaz). Sholl will work on this and bring discussion back to larger group.

16) Wrap Up
    a. Sholl thanks all for their hard efforts and time

17) Next meeting to do
- **a. Sholl will share protocol webinar dates with MDPB and get them posted on website**
- **b. Sholl will share LFOM protocol draft with MDPB**
- **c. Asks all to review remaining Gold section suggestions**
- **d. Sholl to discuss with Education Committee Chair Koplovsky:**
    - **i. If EMTs are educated on drawing up liquid oral medications**
    - **ii. If EMTs are taught how to administer oral liquid medications to infants**
    - **iii. If an Education Committee representative can attend MDPB meetings**
- **e. Continue Gold section discussion and transition to Blue section**
- **f. Asks Tilney to prepare Green section and share to Sholl for distribution**
- **g. Meehan-Coussee will update her Gold presentation and share with Sholl**
- **h. Bring results of discussion regarding transport analgesia for post-intubated patients between Tilney/Sholl/Diaz back to MDPB in September.**

18) **Motion to adjourn made by Zimmerman. Seconded by Collamore. Meeting adjourned at 1259 hrs.**

19) Next MDPB meeting will be September 18, 2024, at 0930.

Minutes by Marc Minkler.