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 – January 15, 2025
Conference Phone Number: 1-646-876-9923 **Meeting Number:** 81559853848
Zoom Address: https://mainestate.zoom.us/j/81559853848

Members present:	Dr. Matthew Sholl, Dr. Kate Zimmerman, Dr. Beth Collamore, Bethany Nash, PharmD, Dr. Seth Ritter, Emily Bryant, PharmD, Dr. Dave Saquet, Dr. Tim Pieh, Dr. Benjy Lowry, Dr. Pete Tilney (0928)
Members Absent:	Dr. Rachel Williams, Dr. Kelly Meehan-Coussee, Colin Ayer
MEMS Staff:	Marc Minkler, Jason Oko, Robert Glaspy, Wil O'Neal, Darren Davis, Jason Cooney, Melissa Adams, Ashley Moody
Stakeholders:	Chip Getchell, John Moulton, Joanne Lebrun, Eric Wellman, AJ Gagnon, John Lennon, Michael Reeney, Chris Pare, Fred Porter, Zhannae Cummings, Dr. Marcella Sorg, Dr. David Ireland, Don Sheets, Eric Miller, Alexander Rezk, Rick Petrie, Bill Cyr, Prianka Marie Sarker, Tamara Hunt, Jessica Benson-Yang, John Kooistra, Rob Sharkey, Dwight Corning, Nicholas Jackson, Steve Smith, Dr. Peter Goth, Dr. Steve Diaz

"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 0900 with a quorum. Sholl is chair.
    a. Sholl states the MDPB has not received guidance for regional medical directors or any changes in voting process and will continue with previous voting process and will not have changes until directed by Maine EMS and Maine EMS Board. All who have previously voted will be the same continuing forward until directed otherwise.

2) Introductions

3) Previous MDPB minutes
    a. Motion to approve November minutes by Collamore, 2nd by Zimmerman with minor grammatical edits. All unanimously approved.
    b. Motion to approve December minutes by Nash, 2nd by Collamore with minor grammatical edits. Sholl & Bryant abstain, all others unanimously approved.

4) State Update
    a. Office Updates – O'Neal provides update on state – Erin Ludwig is new office administrator, offer to new Education Coordinator, regional managers interviews still in process, Chapter 27 of rules

has gone out for 2nd round of public comment today, discusses LD35 and possible impacts and changes if passed, Jackman pilot project came back before Maine EMS Board, reports that changes resulted in need for a new pilot project approval, and as a result the current project was discontinued. Reports on significant and unsustainable current workload at Maine EMS office. Developed a series of goals that are likely obtainable for the 2025 year. Regional transition, Administration of sustainability grant, Community Paramedic license levels, and developing scope of practice around CCT, K9, IFT, and other aspects need an over-arching rule regarding scope of practice developed. Regional Transitioning for medical directors has been challenging due to various relationships between individual medical directors and their hospitals. Wants to ensure individual agreements are reached with each medical director due to these complexities. Focus over next weeks is administrative paperwork and fixing the legislative aspects around the 4 region model, votes, and role on the MDPB. This will likely be achieved by writing associate regional medical directors into the legislation. An amendment has been submitted addressing this. Pieh asks about how the associate medical director would be chosen (i.e. Maine EMS, MDPB, RAC). O'Neal states medical directors are appointed by the state and are agents of the state. The RAC would choose the individual and present two names to Maine EMS Board with a term set by the Board. They are not employed by the state, and the associates are appointed via the RAC but this may need and gain further clarity from legislation.

b. Sholl states ACEP position open due to Meehan-Coussee transition to Region 1 medical director. 2 nominees have been submitted and requests forming volunteers for a committee to review. Several MDPB members offer to help. The committee volunteers will be Meehan-Coussee, Nash, Saquet, Tilney, and Zimmerman.
c. Sholl reports on K9 protocol updates and Minkler spoke with app developer for addition of the K9 protocols and some minor edits for regional contacts.

5) Presentation on Overdose data from Maine EMS/University of Maine by Davis, Sorg, Sarker, and Miller. This was a merge of SUDORS data with EMS data to fill in gaps of non-fatals and decedents health history and allow for more robust analyses to inform policymakers. Goal is to better understand trajectory of individuals with SUD in Maine and how they interact with EMS.

6) Alternate Devices – None

7) Special Circumstances Protocols - None

8) Pilot Projects
    a. Sanford Ultrasound IV Access Program – Moulton shares that Sanford continued to progress with clinical time. As of January 9th, 6 of 8 of the providers have completed the clinical requirements. One more is scheduled for January 28th. Implementation date will be February 1st.

9) EMSC QI Project
    a. Minkler presents on requests for PHI access for patients under 29 days of age to survey EMS clinicians about transport methods of these patients via MEFIRS QI request. Working with Elizabeth Winterbauer to develop report, and looking to cover period of March 1, 2024 through August, 2025 for 18 months of data. Maine EMS Board has approved this. **Motion by Pieh to approve EMSC QI study, 2nd by Williams. Unanimously approved.**

10) Medication Shortages
    a. Nash reports Cyanokit still not available and not likely available until Spring 2025. Speaks of questions regarding dilution of sodium bicarb with D5, looking into options if D5 not available as Bicarb not compatible with normal saline. Vials and ampules are becoming similar in cost, and use of filter needles not needed with vials and may save steps and cost in drawing up.

11) Emerging Infectious Diseases
    a. Flu ramping up

12) 2025 NAEMSP meeting in California
    a. Several members of MDPB attended. Ritter/Pieh/Zimmerman/Sholl speak of experience and value.

13) Pink Section Updates – presentation by Williams/Zimmerman
    a. Pink Neonatal Fever (Pink 3)
        i. Change from 90 days to 60 days to align with AAP
        ii. Change lower temp threshold to 36C/96.8F to align with AAP
        iii. Add PEARL that this is specific to pediatrics to avoid confusion with adult hypothermia
    b. Add Lavendar section for OB/Childbirth (Pink 4,5,6)
        i. No changes to info otherwise
    c. Pink 6 (proposed Lavender 4)
        i. Add reference table to Newborn target O2 saturation
        ii. Retitle to "Newborn Metrics"
        iii. Pieh expresses concern about Initial O2 concentration for BVM (chart indicates 21% for 35 weeks gestation, and 21-30% O2 concentration if less than 35 weeks gestation). References conflict with NRP on Pink 7 which states no O2 with BVM initially. Minkler suggests using No O2 and specific lpm as EMS cannot effectively determine or set an O2 percentage in the field. Sholl suggests asking NICU colleagues and their approach. Pieh suggests using room air for both, which is inline with APP and address EMS field constraints as 21% works for both per the guidelines. Pieh aims for simplicity, discussion on possible 2 lpm to achieve approx. 28%. Williams agrees with keeping it simple, so supports removing the Initial O2 concentration for PPV section and leaving the target SpO2 goals. Zimmerman concurs. Minkler asks about target O2 sat as guide lists numbers for 1/2/3/4/5/10 min and providers are likely managing other care aspects of care of newborn. Zimmerman states it is not intended to mean EMS has to measure, but rather a reference if they do. Minkler asks if this is included in rules to have correct size equipment on ambulances. Williams asks if EMS has universal ability to measure newborn and pediatric pulse oximetry. Minkler expresses concern about consistency/availability of EMS agencies. Adams states the last revision added a footnote that pulse oximetry must be available for adult and pediatric patients. State this could be made more clear on the inspection sheet for EMS agencies. Sholl supports this to help ensure the right equipment is available. Pieh asks if a Pearl for goals of care might be valuable (i.e. warm before oxygenation) and could this unintentionally derail goals of NRP care. Zimmerman and Williams agree that this could be done and Sholl will assist.
        iv. Pink 7 to add that BIAD is the preferred advanced airway in the newborn, aligns with NRP best practices
        v. Pink 7 to add a Pearl that SpO2 monitor should be placed on the right hand, aligns with NRP best practices
        vi. Pink 7 to add a Pearl that "In a newborn, goal peak inspiratory pressure should be 20 cmH2O with 5cmH20 of PEEP (Paramedic level if certified via NRP and equipped)". Pieh asks if active NRP certification is required in order to use this, and Sholl states Yes. Sholl states goal is to have people certified in current best practices around airway management, including PEEP valves, through NRP. This would prevent having to develop/deploy specific Maine EMS education. Willaims hopes people would do this training. Pieh asks if there are to other education equivalents to NRP, group unsure, Pieh would like to not box us in if there are equivalents. Pieh asks about concern that existed around PEEP use in adults if condition went into cardiac arrest and increase intrathoracic pressure challenges and if this applies to this age group. Sholl does not

believe so. PEEP would only apply to this specific age group. Minkler supports this clinical management, but states he has significant concerns about the NRP requirement due to very few classes in the state, and that we would be endorsing a specific class, whereas the state has avoided any perceived endorsement of 3rd party certifications. We could certainly encourage the knowledge but to require a specific class may be challenging to make available, as well as the ability to track if someone actually had the certification when using this protocol, supports the a statement of "if so trained" but not a specific class per se. NRP or STABLE puts tremendous pressure on Maine EMS office, training centers and others to offer these classes, without instructors, cost, and and other aspects. Saquet agrees with the clinical aspect and is concerned about creep into adult care with PEEP and we may not be ready for this. Ritter asks how many current EMS providers are currently certified in NRP and what the capacity is to offer it. Asks how we track ACLS and CPR and similar, Minkler states none of these are required or tracked in Maine.

vii. Add NRP definition to purple section.

viii. Due to LFOM CPC meeting and time constraints, Pink section will be continued next month.

14) Protocol Process Update
    a. Blue, green, and yellow sections are done
    b. Pink will continue in February
    c. Orange will be the next section (Collamore, Saquet, Lowry), then Red then Purple/Brown/Black/Grey sections.

15) Old Business tabled due to time

16) Pilot Project – Delta Ventilator Pilot Program

    a. Motion to move to Executive session to discuss patient specific information by Saquet, entered Executive session at 1100
    b. Return from Executive session at 1120

17) Meeting transitioned to LifeFlight Clinical Practice Committee at 1122, minutes recorded by LFOM staff

18) "To do" items from November meeting
    a. Tilney will pull most recent PECARN data on pediatric cervical spine and review for group.
    b. Tilney will draft protocol and/or education for HEMS for operations section. If protocol, will need a white paper on it.
    c. Meehan-Coussee and Tilney will work on education for fluid bolus in trauma.
    d. Sholl will be developing a clinical bulletin regarding cyanokits.

19) "To do" items from December Meeting
    a. Revisit chest decompression need for non-traumatic causes and possible need in other protocols
    b. Tilney will provide references and evidence on burns to revisit tabled item of fluid boluses on Green 16
    c. Nash/Saquet/Pieh will work on the dilution verbiage for magnesium sulfate pediatric dose on Yellow 3
    d. Nash will research any fluid dilution incompatibilities for MEMS medications and bring back to group

20) "To do" items for February
    a. Continue Pink Section update

b. **Nash looking at dilution options for Sodium bicarb**

21) **Meeting adjourned at 1300**

22) Next MDPB meeting will be February 19, 2025, at 0930.

Minutes by Marc Minkler.