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 – June 17, 2026
In person and via Zoom

Members present:	Dr. Matthew Sholl, Dr. Jack Lewis Dr. Kelly Meehan-Coussee, Dr. Seth Ritter, Dr. Tim Pieh, Bethany Nash, PharmD, Dr. Beth Collamore, Dr. Rachel Williams, Dr. Pete Tilney (virtual), Dr. Dave Saquet (virtual)
Members Absent:	Dr. Bob Brown, Dr. Benjy Lowry, Colin Ayer
MEMS Staff:	Marc Minkler, Jason Oko, Wil O'Neal, Ashley Moody, Ryan Hall, Melissa Adams, Soliana Harnish, Taylor Woodbury, Jason Cooney (virtual)
Stakeholders:	Chip Getchell, Chris Pare, Judy Gerrish, Don Sheets, Brian Langerman, Don Sheets, Joanne Lebrun (virtual), John Moulton (virtual), Michael Reeney (virtual), Shawn Cordwell (virtual), John Lennon (virtual), Sean Brackett (virtual), Rob Sharkey (virtual)

"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."

The meeting begins at 0930 with a quorum. Sholl is chair.

Dr. Sholl welcomes all.

1) **Introductions**

2) **MDPB Minutes**
   a. **Motion by Collamore to approve January 2026 minutes, 2nd by Nash. Approved unanimously.**
   b. **Motion by Pieh to approve February 2026 minutes, 2nd by Collamore. Approved unanimously**
   c. **Motion by Pieh to approve May 2026 minutes, 2nd by Meehan-Coussee. Approved unanimously.**

3) **State Update**
    a. Office Updates – Maine EMS shares a video montage of well wishes from various stakeholders in the EMS community thanking Dr Sholl for his work over the past two decades as this is his last meeting as State Medical Director and Chair of MDPB.

4) **Special Circumstances Protocols** – NONE

5) **Pilot Projects**
    a. Sanford Ultrasound Guided IV Pilot Project – Moulton reports no uses last month, reviewed 2 cases from previous month with transport delays – 1 should not have waited for device and transported to ED, 1 delay due to language and interpreter issues. Training with LFOM included 8 members of Saco Fire Department.
    b. Westbrook Suboxone Pilot Project – Langerman reports (via Minkler) that initial training was cancelled and is rescheduled for July 10 due to an instructor emergency.
    c. Delta Ventilator Pilot Project – moved to end of meeting for executive session

6) Medication Shortages
    a. Nash reports no reportable shortages she is aware of. Cyanokit is back in stock but needs to be filtered due to possible contaminants.

7) **Emerging Infectious Diseases**
    a. Sholl notes preparations for the Ebola virus, including a recent webinar co-hosted with Maine CDC to raise awareness and reinforce key safety measures such as proper PPE use and donning/doffing procedures.
    b. Sholl discussed the current Ebola response planning in Maine, outlining two phases of response and emphasizing that the risk remains very low. He detailed the tiered hospital system, with Maine Medical Center in Portland serving as a Tier 3 Ebola Assessment Center, and Mass General Hospital in Boston as a Tier 1 facility capable of handling multiple patients. Training sessions are scheduled for July 28 in Scarborough and August 4 in Bangor to prepare EMS agencies across the state.

8) Protecting Patient Access to Emergency Medications Act
    a. Sholl explained that while hospital agreements with agencies are still technically possible, hospital legal departments have advised against them due to risks, though alternative supply methods may still be available through retail pharmacy arms of some hospital systems. Group discussed options for continuing education efforts and noted that the Maine Hospital Association will create a website tab with EMS resources for the PPA/EMA transition. The discussion addressed concerns about medication storage costs and potential funding. One agency already requested to downgrade their license due to

administrative burden. The meeting included data showing that only 3-4% of calls involve scheduled medications, which helps contextualize the oversight requirements and administrative burden for medical directors.

b. Discussed automated dispensing cabinets and medication storage requirements. Group noted the need for clarification from both DEA and Board of Pharmacy regarding compliance requirements for these devices. The group agreed to reach out to Jed from DEA for guidance on DEA requirements and to the Board of Pharmacy for guidance on utilization requirements

9) **Discussion** – **Equipment Definitions when noted to be "Maine EMS Approved"**

a. Sholl discusses how the MDPB and Maine EMS do not approve specific devices, but rather criteria for devices and what they must meet or do in order to be used by EMS agencies. In light of continuing work, the protocols and rules a define a number of items that must be "Maine EMS Approved" and review drafts of the following items and specifications are presented. All items carry the conditions that "**The MDPB acknowledges that in some circumstances, agencies and EMS clinicians are required to use improvised devices. However, during normal operations, commercially developed devices tend to perform superiorly, and thus, when possible, these device characteristics should be considered. These recommendations are based on the best available evidence. Please contact any MDPB member to discuss further."**

b. Needle Thoracostomy Devices - A commercially manufactured, sterile needle or catheter-over-needle device of sufficient length to reliably traverse the chest wall for the purpose of relieving tension pneumothorax (minimum length of 3.25 inches/8 cm), intended by the manufacturer for thoracic decompression and of adequate gauge to permit rapid air egress (minimum 14g but 10g preferred). In addition, devices with fenestrations are preferred if available. Proper length (minimum 8 cm), proper gauge (10 g preferred over 14 g) and fenestrations in combination have the strongest evidence for improving decompression success rates. Proper device characteristics in combination with proper initial and continued training (including indications, location of insertion, and depth of insertion) are all essential to safe and effective placement.

   i. **Motion to approve as written above by Pieh, 2nd by Meehan-Coussee. Passes unanimously.**

c. Soft Restraints

   i. Legitimate commercially manufactured medical device for the purpose of safe restraint.
   ii. Operational simplicity (easy and quick to apply during struggle)
   iii. Quick release option to address patient decompensation
   iv. Compatible with stretcher and ambulance crash-safety setup
   v. Padded, non-injurious design
   vi. Unless a single use device, easily disinfected materials
   vii. Device accommodates pediatrics to bariatric patients
   viii. Allows access for monitoring and treatment

ix. No improvised ties or generic webbing

"Commercially manufactured medical devices intended for safe restraint; improvised ties or generic webbing are discouraged. Devices must be simple and rapid to apply, incorporate a reliable quick-release mechanism, and be compatible with the agency's stretcher and ambulance crash-safety systems. Restraints shall be padded, non-injurious, unless the device is single use, must be constructed of easily disinfected materials, adjustable to accommodate pediatric through bariatric patients, and designed to allow continuous access for patient monitoring and treatment during transport."

i. **Motion by Meehan-Coussee to approve as written above, 2nd by Nash, Passes unanimously**

d. DNR Jewelry - Criteria:
   i. Easily identifiable as medical jewelry and clearly marked with language that identifies the jewelry's intention, such as: "Do Not Resuscitate", "DNR", or "POLST"
   ii. In the absence of easily available DNR or POLST paperwork, the jewelry is required to have a means of confirming the patient's DNR status. Both QR codes and account numbers with phone numbers are examples of mechanisms to confirm the DNR status.

   The jewelry should be worn in a means that is easily discoverable by EMS Clinicians, such as wearing the jewelry as a necklace or bracelet.
   i. **Motion by Pieh to approve as written above, 2nd by Nash, Passes unanimously**
e. Intraosseous (IO) Devices - Approved Intraosseous (IO) Access Systems shall be commercially available FDA approved systems. They will consist of a rotary driver, either manual or battery powered, and not spring loaded or pneumatic with needles approved for use with the device (with or without an adaptor) that accommodate all patients ages and sizes. The needle sizes shall be per the manufacturer's guidelines and must allow for access to at least one of the approved sites in current Maine EMS protocol. Providers shall receive service level training on the device and its operation.
   i. **Motion by Pieh to approve as written above, 2nd by Meehan-Coussee, Passes unanimously**
f. Group identified three devices for future consideration: the T-Piece resuscitator, the BAAM (Beck Airway Airflow Monitor) device, and the Jada suction device for postpartum hemorrhage, with plans to discuss how these might fit within current protocols and patient transport criteria.
   i. Tilney will review the BAAM and JADA, Minkler offers assistance.
   ii. Williams will review T-Piece resuscitator

10) **2027 Protocol Updates**

a. ETCO2 – On behalf of the protocol working group, Lewis clarified that the new AHA guidelines actually refer to PACO2 rather than end tidal CO2 targets, and

confirmed that specific numeric targets for end tidal CO2 should be avoided while focusing on avoiding hypo and hyperventilation.

b. Pediatric SVT – On behalf of the protocol working group, Lewis presents on adding amiodarone 5mg/kg to max of 15 mg/kg over 20-60 minutes via IV pump. This would be added to the pediatric SVT protocol in Red 26-28 based on new AHA guidelines, though concerns were raised about potential misdiagnosis and the educational burden on clinicians. Sholl states data suggests fewer than 10 cases annually in Maine. Lengthy discussion by group on risk-benefit of this change and possible misinterpretation of the underlying EKG. Sholl expressed support for including the medication while emphasizing the need to consult with educators about implementation, particularly given the very small number of patients who would require this intervention. The group decided to table the decision and seek input from the education committee, with Nash tasked to review specific dosing questions including maximum dose and administration times.
c. Seizures - On behalf of the protocol working group, Lewis presents on protocol suggestion of adding diazepam for the management of seizures. Presents a meta-analysis of comparisons of seizure medication that results in cessation within 5 minutes. Managing the cessation of seizures is the primary goal and in the literature, studies have shown that diazepam is third, and that is via PR. It is behind IM midazolam which we already carry. References the RAMPART trial and proven effectiveness of midazolam. Seizures are a lot like VF. It's easier to intervene earlier and gets harder later. And all of our therapies, therefore, should be aimed at immediately stopping a seizure and using the best agent to do so. And based on this meta-analysis, and there's lots of other evidence in the studies. But based on all of that compiled, the best medication in a person who doesn't have an IV already is using midazolam either intramuscularly or intranasally. Group discusses various considerations and possible future studies. Expresses thanks to the author and suggestion and opportunity to review this. MDPB elects not to move this suggestion forward.
d. Sepsis - On behalf of the protocol working group, Lewis shares suggestion to add antibiotics to the management of sepsis by EMS. States significant research was undertaken and that there is no compelling evidence that the inclusion of antibiotics for sepsis in the pre-hospital environment changes clinical outcomes significantly. Challenges exist with recognition of sepsis, acquisition of blood cultures, and routine provision of lab resources. Group discusses and elects not to move this suggestion forward.
e. Pending topics to cover include Ketamine IN and IM for pain control and dosing of TXA. Due to time, group elects to cover in next MDPB meeting.

11) **MDPB Staffing Updates**

a. Adams presents findings from Region 2 where agencies have 29 different medical directors and surveys were asked about their liability coverage. Only 5 responses were received. Assembled some resources about individual liability

insurance information. Shares the resources that were developed by Region 4 manager Ryan Hall. Group discussed in depth the challenges with finding service level medical directors due to liability concerns, noting that in many cases, regional EMS medical directors have been temporarily filling these roles. The group reviewed upcoming staffing needs, with particular urgency around filling the state medical director position, for which interviews are scheduled to occur after today's meeting and next week.

12) **Old Business**

a. **Education/Exam Committee** – Oko reports Edcom woring on eviewing training center standards and reviewed NREMT pass rate data that Minkler provided
b. **QI** – Getchell – finalizing QI manual, reviewing some possible QI markers, meeting next week at 1130
c. **Community Paramedicine** – no updates
d. **EMSC** – Minkler – final EMSC funding from HRSA was received, statewide ED PECC meeting tomorrow at 0900, AAP is also presenting info at this meeting
e. TAC – Moody – no report
f. **MSA** – Moody – no report
g. **Cardiovascular Council** - – no report
h. **Data Committee –** Oko – nothing to report
i. **EMD –** Adams – have not met, working on EMD protocol updates

13) Pilot Projects

a. Delta – Monthly Report – **Motion by Sholl to enter executive session under the auspices of 1 MRS 4056.F for discussions of information contained in medical records made, maintained, or received by a body or agency when accessed by the general public for those records is prohibited by statute. 2nd by Collamore. Approved unanimously.**
b. Entered executive session at 1307, exited executive session at 1315

14) **Motion to adjourn by Pieh, meeting ended at 1318**.

15) Next MDPB meeting will be on July 15, 2026, at 0930.

Minutes by Marc Minkler.