STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
152 STATE HOUSE STATION
AUGUSTA, MAINE
04333

PAUL R. LEPAGE
GOVERNOR

JOHN E. MORRIS
COMMISSIONER

JAY BRADSHAW
DIRECTOR

Medical Direction and Practices Board Meeting
June 18, 2014
Minutes

MDPB Present – Dr. Randolph, Dr. Busko, Dr. Kendall, Dr. Zimmerman, Dr. Pieh, Dr. Sholl, Dr. Chagrasulis
MEMS Staff – Jay Bradshaw, Alan Leo, Jon Powers, Don Sheets
Guests – Kevin Gurney, Shawn Evans, Lisa MacVane, Christopher Dobson, Nathan Yerxa, Joanne Lebrun, Rick Petrie, Christopher Pare, Dennis Russell, Dan Batsie, Mike Poli

a. Review of May Minutes
    i. **Motion from Dr. Kendall to approve with recommended edits discussed second Dr. Zimmerman. Unanimous**
b. State Update
    i. Jay informed the group that MEMS has hired Heather McKenney to fill the Licensing Agent position
    ii. Narcan training is out for final edits and the office will have the training available for download from the MEMS web site in the next few days.
c. Community Paramedicine Update
    i. An MOU with the Muskie school has been signed to evaluate data collected by the pilot programs.
    ii. MEMS anticipates a Department Bill for the 127th Legislature . Areas of consideration include: composition of the MDPB, Community Paramedicine pilot projects, and other house-keeping changes.
d. LFOM Update
    i. There has been work with the LFOM group related to scope of practice. Dr. Sholl reviewed the desire from the MDPB to be more involved with LFOM in the protocol development process, because ultimately the MDPB must approve LFOM's protocols.
    ii. Dr. Dinerman expressed LFOM's desire to balance contemporary practice with a well-defined scope of practice. Action items were set for continued development and to meet on an ongoing basis.
    iii. Dr. Pieh – Felt the group developed an appropriate process to facilitate ongoing dialogue and protocol updates with LFOM that will meet statutory requirements and the nimble nature they need.

iv. Dr. Sholl – Discussed how the group was able to utilize the same system that the MDPB uses when developing protocols and contemplate the ideas of what is the need, what is the cost, is this being done elsewhere, etc. This helped to frame the discussion as the group went through the LFOM scope of practice document. LFOM has a defined process now developed during this meeting to do continuous updates and have those changes brought to the MDPB for discussion and approval as appropriate.
v. Dr. Pieh – summarized some of the specific topics that were discussed during the meeting. (ultrasound, pericardiocentesis, chest tubes, etc.)
vi. There will be a review of the LFOM protocols in September with a discussion and vote by the MDPB. Moving forward, there will be smaller updates as needed.

e. Request for Pilot Project Consideration – Dr. Busko
i. Dr. Sholl reviewed the process of Pilot Project approval through the MDPB and MEMS Board and the steps necessary to achieve.
ii. Christopher Dobson from Capital was present to answer questions and present the project – the goal of this program is to expand the use of Zofran ODT to the EMT level. There are 10 small services that Capital works with that have long response times for Capital. Capital has identified 72 cases where patients could have been given Zofran ODT by first responders to decrease administration time and discomfort. If approved there will be no change in the requirement for ALS response in any of these circumstances. The second are of utilization Capital would like is during BLS interfacility transports for patients who are experiencing motion sickness on long transports. Zofran ODT is inexpensive and the reduction in ALS transport bills could save patients and insurance companies money.
iii. Questions about patient age came up and Chris said the protocol would match current State protocol for utilization.
iv. Dr. Kendall asked if other agencies across the nation were doing this. There was limited information to support that this was wide spread.
v. Jay asked for differences in response time and the total number of calls that may have benefited from this therapy. 10 minutes was the average difference and 72 total calls.
vi. Dr. Busko expressed the benefit of comfort during interfacility transports for patients.
vii. Jay asked if this was going to be a change in the pharmacy agreements for the services. Rick and Dr. Busko reflected that this would mimic the current pharmacy agreement and would likely not require any change. They will review existing agreements before the pilot project request is presented to the Board of EMS Maine EMS Board.
viii. Dr. Sholl reflected that this is a fundamental change in the Scope of Practice and that we need to ensure we make this decision deliberately.
ix. Dan Batsie and Don discussed that programs are already stretched thin and this has been an ongoing struggle of educating providers. If this became a fundamental scope change it would add additional

education to courses and the time required may be taken from some other area.

x. This also adds additional difficulty to providers coming into the state.
xi. Dr. Busko asked how we currently educate providers for reciprocity. Don explained that some programs exist online such as the Spinal Ruleout and in other cases providers must be educated through a service or Training Center.
xii. Dr. Busko asked if this might not be a good opportunity to look at can/how we change scope moving forward.
xiii. Dr. Zimmerman asked if this project would be a study or simply a retrospective evaluation
xiv. Lots of discussion was had about the issues of ability to assess for known contraindications.
xv. Dr. Pieh expressed concern about the known complications and that this is for patient comfort but does not address a safety concern. Does this really rise to the level of necessity?
xvi. **Dr. Pieh Motions to approve with clarification of no use under age 4 and identifying common known side effects. Dr. Kendall Second. 5 for, 1 abstention Dr. Busko, 1 opposed Dr. Sholl It was clarified there be a monthly report to the MDPB**

Dr. Sholl expressed concern that there was no requirement for OLMC with these patients.

f. Protocol Review
   i. Blue Section – Dr Randolph
   ii. Multiple Comments came in during the webinar which prompted Dr. Sholl and Dr. Randolph to do some research into what evidence supported any changes.
      1. CPAP – Expanded use in asthma patients. There is little evidence to support benefit of this treatment. There may be some benefit in patients with undifferentiated respiratory difficulty. Dr. Randolph has proposed the addition of language to support use in the airway algorithm of CPAP in this patient population. There was a lot of discussion about tabling the discussion on asthma but to include the expanded use language in the undifferentiated patient.
         a. **Dr. Pieh proposed that we add the language to support undifferentiated patients. Dr. Zimmerman seconded. Unanimous approval**

      2. Dr. Sholl discussed that the literature is inconclusive on the end benefit of use of CPAP in asthma patients. Additionally he reached out to the ICU group and the Respiratory therapists and all were opposed to using the therapy in these patients. Dr. Sholl's thoughts were to continue with a hard stop on asthma with CPAP because of the lack of supporting evidence for this therapy. Dr. Pieh agreed that there wasn't really evidence. There was general consensus from the group to wait. Dr. Busko asked the group to endorse a process of pharmacologic intervention as opposed to BVM ventilation. There was consensus to do so in a PEARL **Dr. Sholl motioned to provide**

information in a PEARL and not include CPAP in asthma Dr. Pieh seconded. Unanimous.

3. Continuous nebs for AEMT in patients not responding to single nebs and no ALS available was brought up during the webinar
    a. Discussion about AEMT utilizing IM Epinephrine for severe bronchospasm with OLMC in patients not responding to ongoing nebulizers.
    b. **Dr. Pieh proposed that we add continuous nebs but with medical control and add IM Epinephrine Dr. Zimmerman seconded. Unanimous approval.**
4. Discussion to add Magnesium Sulfate to the Paramedic for severe bronchospasm with medical control as a last option. Motioned the addition of 2g IV over 10 mins consider by pump Motion by **Dr. Sholl; seconded by Dr. Pieh. Unanimous**
5. Breath Activated Nebulizers (BAN) - the consensus was to keep this type of language in the approved equipment list and out of protocol.
6. Dr. Chagrasulis asked that there be language added about utilizing multiple airway adjuncts. Dr. Pieh recommend that this be put in as a PEARL
7. Additionally Dr. Chagrasulis asked that we add stronger language about utilization of capnography with a BVM.
8. More direct language for using a bougie on all intubation attempts.
9. Other language changes to be more concise with definitions around continuous wave for capnography
10. Discussion around the pediatric airway algorithm will be held until the pink section review to allow for the final iteration of the PEGASUS project.
11. The group is interested in discussing format and intention. This will be ongoing as the group moves through discussion of the individual sections.
12. **Consensus is these items will be worked on moving forward.**

g. New Devices
    i. PEEP Valves – Dr. Pieh
        1. Dr. Pieh did a literature review on the use of PEEP valves and has been working this process through his regional medical control group.
        2. Dr. Sholl reviewed the process of approving new devices. Devices are brought to a regional medical director and they vet this and either bring it to the MDPB or determine that this is not appropriate.
        3. Dr. Pieh walked through the physiologic process of these devices and how they work.
        4. Patients who could be harmed: hypotensive, cardiac arrest, pneumothorax

5. **Dr. Pieh recommends that this device not be approved due to the potential risks without a great body of evidence demonstrating benefit; seconded byDr. Randolph .Unanimous approval**
    a. A notice will be sent out to services to ensure that services are aware.

ii. New Continuous Waveform Capnography device – Dr. Zimmerman
1. Dr. Zimmerman did a review of this device and by definition this meets the requirements set forth on the approved equipment list.
2. **The group felt this was appropriate and moved to allow this as meeting those goals without needing a vote.**

h. PEGASUS Update - Manish Shaw, MD, has been working to update the guidelines based upon feedback from stakeholders. Dr. Sholl will distribute the next draft as it becomes available.

i. EMD and Determinate Codes –tabled until a later date due to time.

j. Follow up on medical direction project – Dr. Sholl, Jay, and Dr. Kendall will be meeting to discuss the next steps.

k. Notification re: Changes in Child Abuse Reporting requirements
    i. There has been an update in the language about mandatory reporting for EMS in the presence of suspected child abuse of children under 6 months including
        1. Fracture of a bone
        2. Substantial bruising or multiple bruises
        3. Subdural hematoma
        4. Burs
        5. Poisoning
        6. Injury resulting in substantial bleeding soft tissue swelling or impairment of an organ.

l. Old Business
    i. Education - none
    ii. Operations – Rick reflected on the success of the EMS week supplement and that the Ops Team had a great conversation with the CDC on infection control.
    iii. IFT - Dr. Pieh gave an update on the work the group has been doing related to protocol development. Protocols under development are sepsis, chest pain, trauma, stroke and offering guidance to providers on decision making and what happens if something goes wrong.
    iv. QI – Dr. Sholl gave a report on the cardiac arrest survival project and the next steps of reporting back to services about the current success and providing education for providers, and system administrators to try and push further success.

Dr. Busko motioned to adjourn 12:35