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

PAUL R. LEPAGE
GOVERNOR

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COMMISSIONER

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DIRECTOR

Medical Direction and Practices Board Meeting
July 16, 2014
Minutes

MDPB Present – Dr. Busko, Dr. Kendall, Dr. Zimmerman, Dr. Pieh, Dr. Sholl, Dr. Chagrasulis
MEMS Staff – Jay Bradshaw, Don Sheets
Guests – Kevin Gurney, Shawn Evans, Lisa MacVane, Nathan Yerxa, Joanne Lebrun, Rick Petrie, Christopher Pare, Dennis Russell, Dan Batsie, Myles Block, Dennis Russell, Leah Mitchell, Alexandria Olsson, Stephen Smith, Kerry Pmelow, Dr. Tilney, Dr. Dinerman, Michael White, Brandon Brichetto, Gerard Pineau, Sue Ann Shiffer

MDPB called to order: 9:30

1) Review of May Minutes – Dr. Kendall, Dr. Pieh unanimous with edits to clarify the frequency of reporting
2) State Update Heather McKenny has been hired and would have been here for the meeting but is currently working with the investigations committee.
    a. Narcan training is up and downloadable from the MEMS website.
    b. MOU with the Muskie school was held up in the Governor's office as it was felt this needed to go out to RFP. Jay will be working with the Governor's office to determine the best course of action moving forward.
    c. Transporting bodies of deceased patients has become a topic of discussion again around the state. Jay has met with a group to discuss how EMS integrates in this process. Jay will be meeting with the funeral directors board in September to discuss this further in hopes to find formal resolution.
3) New Devices – Veinlite – illuminated device used to assist finding veins. The device can be rotated to allow access through an opening in the border of the device. Dr. Zimmerman reports that the device has gone through the regional medical control board with approval.
4) Special Circumstances Protocols – Dr. Sholl reports that there are no new protocols to review but there will be some coming in the near future.
5) PEGASUS Update – Updates are being done to the protocols based upon the feedback from the initial review. The next version should be available in the next few weeks. Dr. Sholl is not expecting many substantial changes but some minor changes based upon feedback.
6) Protocol Review – Gold Section – Dr. Zimmerman

a. Change to move Epinephrine up the list to number 2 for treatment due to the poor utilization and timeliness of epinephrine administration in anaphylaxis.
b. Dr. Sholl has asked that some of the recommendations specifically the references to airway algorithm, diabetic protocol be globally changed for consistency.
c. Modification of Paramedic response has been a point of consternation for providers as they don't know what this means. Dr. Chagrasulis offered a historical perspective that this was originally developed when the Intermediates(AEMT) were first allowed to provide medication and that if the patient was having favorable response and short transport times the Intermediate could with medical control alter the response of a Paramedic. There was much discussion about what this meant and how best to clarify.
    i. **Consensus was to add the clinical condition that would allow this in each circumstance and to offer a definition in the purple section for global clarity, with specific clinical presentation in each of the 5 cases where this language is present. Each section will have language scripted.**
d. Question of adding oral Benadryl for pediatric patients There was concern about titrating this for weight based dosing and that this would require the addition of a liquid medication to the drug box
    i. **Consensus was to hold as there was not a strong feeling from anyone to move on this**.
e. Addition of Albuterol to the AEMT level for anaphylaxis patients as it is already in the scope. Dr. Sholl's one caveat to this is that it be stressed in the protocol that epinephrine is the priority and albuterol is a secondary.
f. Question of adding diphenhydramine to the AEMT level. There is not much literature to support benefit mortality benefit. There was expressed concern about the addition of education to an already tight level and moving further from the national scope. Dr. Sholl shared that 85-91% of anaphylaxis patients are currently being cared for by a paramedic and that in total only 30-40% of patients are receiving diphenhydramine currently.
    i. **Consensus is to stress the importance of epinephrine education and not add this to the AEMT level.**
    ii. **Cleaning up the PEARL to limit redundancy and strengthen care priorities**
g. IV Epinephrine – discussion was to keep the language about the pump but create a definition of Maine EMS approved equipment.
h. The addition of Pepcid to the treatment of anaphylaxis was tabled as all medical directors felt that there was not enough evidence to add this to the system.
i. Adult coma – question of changing the glucose reading threshold for administration of D50. Currently we use 80, and the recommendation is to change to 60. There was a lot of discussion
    i. **Dr. Pieh motioned to change to change to 60 mg/dL and second by Dr. Kendall. Dr. Zimmerman stressed that there is nothing that would preclude a provider form calling medical control if the patient was between 60 mg/dL and 80 mg/dL. Discussion to add a PEARL to the Diabetic section about the rational for change in addition to the education. Unanimous approval.**

j. AEMT needing OLMC to give D50 – Dr. Zimmerman has proposed the removal of OLMC
    i. **Dr. Pieh motion to remove OLMC for D50 at AEMT level Dr. Zimmerman second. Unanimous approval.**
k. Dr. Sholl asked the question if we keep glucagon as an OLMC med.
    i. Dr. Pieh proposed the removal of OLMC from the use of glucagon at the AEMT level. Dr. Busko seconds. Dr. Sholl expressed concern about the level of education and the potential cost. Dr. Chagrasulis felt that the delay in treatment was not in the patients' interest. Dr. Busko felt that there was not going to be much discussion about these patients and OLMC would be moving to give the medication.
        1. **4 in favor 2 opposed (Passed)**
        2. **Dr. Pieh motioned to add a PEARL about the importance of repeated attempts at IV attempt oral glucose if appropriate and then move to the IO if after 10 minutes of post administration of glucagon. Dr. Chagrasulis seconds unanimous approval.**
l. Dr. Zimmerman discussed the use of IN glucagon but there is a huge cost associated as it is a double dose. Consensus to not move with this as Dr. Zimmerman recommends there is limited benefit.
m. Dr. Zimmerman discussed the possible addition of specific fluid volumes for diabetic patients. There was a lot of discussion about the concerns of Cerebral Edema and whether this is a concern in the adult population. Dr. Sholl expressed concern about the potential to limit necessary fluid in patients who need it.
    i. **Dr. Chagrasulis motioned to add a PEARL about the clinical outcome we are looking for in these patients. Seconded by Dr. Pieh discussion and accepted amendment to add language to the definition of fluid bolus for max 40 ml/kg then call OLMC and "unless otherwise stated" Unanimous approval.**
n. Discourage sign offs of patients taking sulfonalureas through a PEARL.
    i. **Dr. Pieh motions to approve second by Dr. Sholl Unanimous approval.**
o. Seizures – Dr. Zimmerman has accepted tabling the spinal immobilization discussion for Dr. Pieh in the trauma section.
p. Dr. Zimmerman suggested clarification around the total dosing of versed in seizure.
    i. **Dr. Pieh suggested answering this through the FAQ Dr. Sholl seconds. Unanimous approval.**
q. Intranasal Versed as an option for adult seizures – the concern was that based on evidence based guidelines the total dose would be twice what can currently be absorbed. There was consensus to table the discussion to pull in additional information and stakeholders.
r. There was consensus to add the Vagus Nerve Stimulator to the patient centered home device. This will also be added to the education piece.
s. There are questions about what the language of "therapy beyond these protocols" means. The general consensus was that this was old language and could be removed. Dr. Zimmerman Dr. Pieh unanimous
t. Stroke – inclusion of stroke criteria.

i. **Dr. Sholl motioned to add some language about inclusion in the definition and the PEARL Dr. Pieh Unanimous**
ii. Matt recommended the addition of a checklist to the stroke section.
    1. **Unanimous consensus**
iii. Language change to "notify receiving hospital of incoming stroke" This was an effort to be less regionally specific with terminology
iv. Gold 12 recommendations in sepsis to use a volume amount of 30 ml/kg
    1. **Unanimous consensus**
v. Discussion of adrenal insufficiency and having the pediatric dosing added to the pediatric section
vi. Changing title of protocols to not be specific to adult pediatric while going through the table of contents adding the adult pediatric after the condition.
vii. Ketorolac for known renal colic, stones, less than 50 years old. There was discussion about how EMS would access this medication with the number of recommended restrictions. There was a lot of concern about the amount of education this would take and the benefit.
    1. **Consensus was to hold off on this addition**
viii. There will be an addition of a PEARL about prolonged QT syndrome in the use of ondansatron.

7) Meeting adjourned at 1237