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

J. SAM HURLEY
DIRECTOR

IFT Committee – June 13, 2022
Minutes

Meeting begins at 0930 (Virtually via Zoom)

Attendees

Committee Members:

Tim Beals, Mike Choate, Chip Getchell, Steve Leach, Chris Pare, Rick Petrie, Dr. Matt Sholl, Dr. Pete Tilney (Committee Members Absent: Dr. Corey Cole)

Stakeholders:

Isaac Benowitz, Cody Fenderson, Paul Hughes, Stephen Smith

Maine EMS Staff:

Marc Minkler, Chris Azevedo, Jason Cooney, David Davies, Darren Davis, Ashley Moody, Jason Oko

Introductions

The Maine EMS Mission Statement is read by Beals.

Beals is de facto chair as Board Rep and as this is the first meeting. A quorum is present.

Minutes

There are no minutes as this is the first meeting of the committee

New Business

Nominations are opened for chair.

Getchell nominates Petrie for Chair. Petrie accepts nomination.

No other nominations. Steve Leach moves to close nominations.

Beals states he will submit Petries name to Board Chair Brent Libby for approval.

Petrie assumes role of Chair for this meeting.

Reviewed NEMSIS and Maine EMS definitions of IFT, Medical Transport & SCT/CCT

Workplan/Goals

- Beals states the Board
  - Left goals broad and to help identify barriers to IFT in Maine
  - To ultimately approach Maine Hospital Association to assist with any barriers
- Tilney states there has been a variety of entities working on IFT aspects over the years (MDPB, Education Committee, IFT Committee). What are our goals? Concern about all working in silos and we need to bridge the gaps, to solve collaboratively.

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- Pare agrees, with goal of recommendations to the EMS Board, and that opportunities for national credentialling and education exist now that did not when PIFT began.
- Beals concurs, and states Maine EMS rules do not currently exist that address IFT, and rules primarily focus on emergency response, and are not specific enough to IFT and likely needs to be addressed.
- Sholl agrees with Beals, and would like to list out issues faced during IFT, including
    - Availability to move non-critical patients throughout Maine
    - Movement of patients that challenge traditional patient transport (i.e. PIFT and SCT and above)
    - Detailing who is responsible or shares responsibility (i.e. as a matrix)
        - Once completed, bring forward to MHA for collaboration
- Choate would like to see updates/revision of Maine EMS Decision tree, defining what critical care and critical care transports are, and if there is a separation of PIFT vs CCT
- Leach echoes concern about silos and need for a solution for IFT needs – hospital bed availability and enough services involved to move patients. Education may benefit from national standards but concerning about phasing in/impacts to services and should be done with caution and over time.
- Pare speaks of paramedic education being much more robust today vs when PIFT was implemented and now are exiting programs with much greater knowledge around interfacility transports. Instead of having a separate PIFT level, that stable patients should be able to be managed by a contemporary paramedic. Concern for lack of updates and no continuing education for current PIFT program and contemporary paramedics should already know the material when they graduate. Suggests no additional certification for stable IFT patients by single paramedic. It is the unstable patient where we have challenges and need to address.
- Moody speaks about concern that services/fire departments with a hospital in their community are challenged by "emergency" transfers and it is a lot of gray areas of who should do these or even if they are emergency.
- Minkler speaks of gray areas of what is the scope of IFT – Our EMS system of IFTs is more than the critical care transports but more of moving patients that are not the typical 911 response, but also include PIFTs that go from hospital to an outside facility (such as an MRI facility) or nursing homes that have vented patients and SCT that may be nursing home to non-hospital facility. IFT is potentially more than the perceived hospital to hospital transport.
- Choate asks about data but defers question to wait until after goals and objectives.
- Getchell speaks about "semi-stable" patients – and we need to educate providers about risk and that there is opportunity to improve risk analysis and evaluation
- Petrie is concerned by IFT definition and responsibility of state EMS oversight – conflicting info at times form state, medical directors, and Attorney General.
- Tilney shares concepts of 4 pillars to consider, and what is EMS vs PIFT vs CCT
    - Updated medications & medical therapies
    - Updated education
    - Partnership with individual hospitals
    - Partnership with individual medical directors
- Sholl expresses concerns that the patient responsibility rests with the sending physician and not the individual medical director. Most medical directors have never been educated on IFTs and we should be providing more resources on what a program should like and how to

do things such as QI and education. We need a system to capture and learn from events, but we cannot offload this responsibility to hospitals. One example is looking at what are the most common transfers and drafting sample protocols/orders to create a standard and not have to have sending physicians replicate orders every time they transfer a patient.

- Petrie asks about transfers of stable patients and possibly applying the current "PIFT" standard to be a minimum standard for all paramedics in the state and things that rise above the PIFT level to be the requirement for each service to have medical direction who has signed off on an education plan, guidelines, QI, and recertification which they submit to Maine EMS for that individual service. The hospital could go to that service for any care concerns. Sholl expresses concern that this is a topic needing exploration and is more than a meeting and if it is even a possibility. There could be many impacts that need more depth of review. Moody expresses concern about hospitals having an expectation that EMS services are not ready to provide and that hospitals wanting to move a patient and taking whomever/whatever they can. Beals agrees with Sholl that this might be moving too fast and that a paramedic coming out of school is likely not ready to do PIFT transports beyond just a certification that says they can. There needs to be a relationship between hospitals and EMS services, but we need a base standard that EMS agencies will have to rise to and maintain. Hospitals are not differentiating the variability of EMS service staffing and roles. Tilney states there needs to be certain lanes that EMS stays in. Getchell feels that Petrie has proposed a good path to go down, but does need some data or review before advancing. Pare agrees EMS may not be operationally ready for PIFT but does point out most are coming out of class with a PIFT certificate and by rules they could do a PIFT transport on Day 1, but that does not necessarily mean it is right or correct
- Petrie asks for committee to define goals/workplan. Goals are
    - Define responsibility of IFT
    - Define multilayer approach to IFT (PIFT vs SCT vs CCT and what defines the criteria/patient condition/resources for each)
    - Have Maine EMS Board define a clear current scope of practice for EMS.
        - What exists in rules currently?
        - Request definitions of scope for all EMS levels to help identify the gaps for IFT and what roles can EMS clinicians currently do.
        - NHTSA resources may help but is unwieldy to use on a day-to-day basis.
        - Current IFT scope was developed by MDPB.
    - Review data about scope of IFTs in Maine
- Focus of next meeting will be to look at types of data and other aspects of IFT data
- Schedule for future meetings is decided to be 2nd Monday of the month from 0930 to 1100.

Old Business

There is no old business as this is the first meeting of the committee

Adjourn

Motion by Getchell to adjourn, 2nd by Choate, no objections

Meeting adjourned at 1054

Next meeting is July 11, 2022 from 0930 to 1100