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 – February 13, 2023
Minutes

Meeting begins at 0932 (Virtually via Zoom)

Attendees
Committee Members:
Rick Petrie, Dr. Pete Tilney, Chip Getchell, Tim Beals, Chris Pare, Mike Choate, Dr. Matt Sholl
(Committee Members Absent: Steve Leach, Dr. Corey Cole)
Stakeholders:
Bill Cyr, Tom Gutow, Steve Smith, David Ireland, Paul Hughes, John Lennon, Sally Taylor
Maine EMS Staff:
Marc Minkler, Jason Oko, Jason Cooney, Anna Massefski

A quorum is present.

Introductions
Petrie calls meeting to order.
Attendees provide introductions.
The Maine EMS Mission Statement is read by Petrie.
"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 providers. 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 providers, communities, and residents of the jurisdictions that we represent."

Minutes
Motion to approve minutes from January 9, 2023, by Beals, second by Choate. 4 In favor, 0 opposed, Sholl abstains, Pare & Tilney not yet present. Minutes approved.

Additions to Meeting Agenda
Getchell requests addition of discussion item to involve hospitals in IFT discussion and data collection.

Old Business
1. Committee Chair Update
    a. Maine EMS Board Chair Libby has not yet confirmed the nomination of Rick Petrie as chair from June 13, 2022, meeting. Petrie will remain as acting chair.
        i. Petrie asks if there is any objective as we proceed, no objections.

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b. Resolution of language for question on IFT care and emergency medical treatment for the Maine EMS Board – Update on request.
    i. Maine EMS Board met in February and discussed. Beals states the Board endorsed the letter originally sent to the IFT Committee, with the note that the Maine EMS Board is unable to address some of the EMTALA questions as it is a federal question. Getchell thanks Chair Libby, Director Hurley, and AAG Morgan for their efforts in answering these questions.

2. IFT Decision Tree
    a. Tilney not yet present, no update.
    b. Sholl reminded the committee that the work will be brought to the MDPB for consideration and approval. Petrie asks if this will go to the Maine EMS Board for a vote, Sholl states that previous versions have not, as it is part of the PIFT protocols but states it will be presented and shared to ensure they are up to date and aware of any changes. If there are substantial changes, then it would likely go before the Maine EMS Board.
3. Transport of patients receiving blood (Choate)
    a. Choate states he does not have an update but reminds that it is within the national scope of practice for paramedics.
    b. Petrie asks what the goal of consideration of blood transport.
        i. Beals states the impetus would be to facilitate an easier IFT so as to not require hospital staff during transport due to staffing shortages at hospitals.
        ii. Choate adds that IFT decision tree would still protect regarding stability and feels that blood superseded the definition of stability, and this is not always the case.
        iii. Minkler asks the group regarding Beals statements of EMS services having to wait in EDs for blood products to finish infusing. Question is "How often are agencies facing this wait time, and the patient is deemed otherwise stable while receiving blood infusion?" – Are services tracking this? Getchell states no data, but anecdotally there are cases of GI bleeds that are otherwise stable, does not feel that blood infusion equates to instability. Minkler asks if there are mechanisms for services to track this to better understand frequency and info around this. Petrie states it would be a good idea, but it is not an easy way to track through MEFIRS and might be something services due at a local level. Oko states that this might be trackable under "scene delay" in MEFIRS, which automatically triggers a question for on-scene times for an IFT of 30+ minutes. Getchell states for his agency, there would be no scene delay, as his service delays response if blood infusing and does not respond until it has been completed. Choate states the current IFT decision tree minimum stability criteria potentially conflict with blood infused as a result of vital sign changes/mental status.
        iv. Petrie asks if more research is needed or desire to send a request to MDPB to allow blood infusion in stable patients. Petrie asks:

1. Choate to provide further info on administration of blood infusion by hospital prior to LifeFlight arrival and if continued or changed.
2. Oko will report on data for delays in hospital-to-hospital IFTs from MEFIRS

4. *(Tilney & Pare join)*
5. Tilney states he does not have an update for the IFT decision tree work in reference to #2 (above), no questions from committee.
6. Notes from IFT Transport subcommittee were distributed.
    a. Oko discussed some data elements that could be examined based on the subcommittee's work.
    b. Oko provides data on
        i. IFTs from July 1, 2021, through Dec 31, 2022 on Initial Patient Acuity compared to Final Patient Acuity (Red/Black/Yellow/Green) and other data (below)

Count of PCR Number	***Final Patient Acuity***				
Initial Patient Acuity	**Critical (Red)**	**Dead without Resuscitation Efforts (Black)**	**Emergent (Yellow)**	**Lower Acuity (Green)**	**Grand Total**
Critical (Red)	628		103	21	**752**
Dead without Resuscitation Efforts (Black)			1	32	**33**
Emergent (Yellow)	73	1	3,789	696	**4,559**
Lower Acuity (Green)	27	11	348	39,359	**39,745**
Grand Total	**728**	**12**	**4,241**	**40,108**	**45,089**

Year	(All)																		
Count of Patient_Care_Report_Number	Destination Location Type																		
Scene Location Type	Airport	Alternative Care Site	Assisted Living Facility	Clinic	Dialysis Center	Drug and/or Alcohol Rehabilitation Facility	Home	Hospital	Hospital-Emergency Department	Hospital-Non-Emergency Department Bed	Medical Office/Clinic	Mental Health Facility	Not Recorded	NULL	Nursing Home	Nursing Home/Assisted Living Facility	Other	Other EMS Responder (air)	Oth EM Res nd (gr nc
Airport	6						3	58							3		2	1	
Assisted Living Facility			34		15		32	36							28		29		
Clinic	1		1	6			8	532				3		1	93	1	38	2	2
Dialysis Center			12		13		135	195			2			3	768		44		
Hospital	319	29	2418	637	222	8	4407	33291	5	13	65	2192	8	90	17935	190	5042	145	3
Mental Health Facility							2	12				22				1	12		
Nursing Home	1	2	45	109	914		150	1589	1	2	189		1	3	192	2	413	1	
Other	18		5	9	6		28	173						2	147		208		
Other-Unlisted	7	3	252	38	349	5	261	1629	6	1	99	18	4	115	1097	16	504	2	1
Rehabilitation Facility	1		1				13	51			7				126		87		
Urgent Care								90			2				10		4		
Grand Total	**353**	**34**	**2768**	**799**	**1519**	**13**	**5039**	**37656**	**12**	**16**	**364**	**2235**	**13**	**214**	**20399**	**210**	**6383**	**151**	**6**

Year	2021
Scene_Location_Type	Hospital
Destination_Type	(Multiple Items)

Row Labels	Count of Patient_Care_Report_Number
Medical Specialty Care (Other, Not Listed)	3041
Cardiac Specialty	1825
Extended Care	1399
Psychiatric/Behavioral Care	1170
Surgical Specialty Care (Other, Not Listed)	941
Trauma / Orthopedic Specialty Care	630

Year	2022
Scene_Location_Type	Hospital
Destination_Type	(Multiple Items)

Row Labels	Count of Patient_Care_Report_Number
Medical Specialty Care (Other, Not Listed)	5176
Cardiac Specialty	4048
Extended Care	2446
Psychiatric/Behavioral Care	2389
Surgical Specialty Care (Other, Not Listed)	2281
Trauma / Orthopedic Specialty Care	1191
Diagnostic Testing	1117

Oko notes there are some challenges are patients may fall in multiple categories (i.e., does a pregnant patient in a MVC fall into Trauma/Orthopedic Specialty Care *or* Maternal/Neonatal *or* Obstetrics & Gynecology *or* Pediatric Specialty Care)

Count of Patient_Care_Report_Numbers	Type of Service Requested				
Highest Level	Interfacility Transport	Medical Transport	PIFT (Paramedic Interfacility Transfer)	Specialty Care Transport	Grand Total
Physician	4	8		3	15
Physician Assistant	5	18			23
Registered Nurse	290	142	24	349	805
Paramedic	35519	11674	4807	721	52721
Advanced EMT	8393	2263	1	117	10774
EMT	12894	2112	1	592	15599
No License Found	56	20	5	1	82
Grand Total	**57161**	**16237**	**4838**	**1783**	**80019**

Choate states prior to Feb 1, 2023, the LFOM data set appears in IFT and not in SCT, if at all, based on a previous waiver and different patient care reporting systems. Petrie will reach out to the Data Committee for some collaboration on insights.

New Business

1. IFT language on Maine EMS website
    a. Petrie states there was a change in some of the language on IFTs that created some confusion, and asked Director Hurley to remove the info. Beals expresses concerns on service billing data for CMS. Petrie asks about draft replacement language, Pare states it seems reasonable to achieve Maine EMS goal of educating public and services. Minkler states the page is not new and has been on the website for at least a year. It was based on hospital requests to operationally understand PIFT vs SCT and that generally SCT equals hospital staff due to patient condition/scope of care. PIFT is different and hospitals were confused about what level to request, and that the language is not based on billing purposes. If a hospital requests SCT transport, Maine EMS does not require a paramedic – does this conflict with availability of a PIFT staffing, which an agency may think it has to send. Petrie disagrees and states EMS agencies do not differentiate between PIFT and SCT, and that PIFT is SCT, and hospital staff is defined by agencies as critical care transport (CCT). Beals and Smith state SCT is a CMS term and is not used widely by EMS. Oko states there is no CCT in MEFIRS as transport type, and that services use PIFT or SCT, so it is widely used by agencies. There are two fields used to collect data regarding the level of the call – "type of service requested" which include 911-Scene, IFT, PIFT and SCT. The second is the CMS level of care provided (ALS level 1, ALS level 2, PIFT, etc.). This creates a disconnect between hospital requests and how clinicians document, and the idea of CCT. The CMS service level is required, but EMS has pushed back as they did not have good info on which to use, but definitions were added to assist with this. Choate states PIFT and SCT were added in MEFIRS as a customized data element due to previous lack of differentiation, and perhaps NEMSIS updates allow the change and removal of PIFT and to use the term SCT or CCT. Oko state NEMSIS 3.5, scheduled for July 2023, and this field will follow NEMSIS definitions. Choate asks if this issue really matters as everything we need and want will occur in the NEMSIS 3.5 update.

b. Petrie asks for the group's position on a statement proposal of what IFT means.
    i. Choate advocates that CCT is not simply adding a nurse to an ambulance but is it a greater depth of organization and education for transport.
    ii. Petrie states Maine EMS is working on rules definition to better define these types of calls, Getchell suggests waiting to see the proposals and provide assistance with the development of these.
    iii. Petrie recommends any reference to IFT be removed from the Maine EMS website until rules are determined. **Getchell proposes that "Maine EMS is requested to remove any definition of IFT from the Maine EMS website until updated rules are finalized to clarify these transports". Unanimous approval by Committee.** Minkler asks for clarification – this is not achievable as the website contains decades of references to IFT in minutes and other documents, and motion as proposed is not achievable without months of work and cost to globally scrub this. If the singular web page of IFT is the concern, this can be achieved. Minkler places the link in the chat and committee confirms this is the page of question, all members approve this clarification.

2. Getchell is interested in partnering with hospitals and engaging with them to obtain hospital data to include with the efforts of this committee. Petrie suggests perhaps involving Maine Hospital Association in this. Petrie suggests inviting an MHA rep to the next IFT meeting. Tilney states he could reach out to the MHA if provided contact info, Petrie states he will provide contact info to Tilney, and to report back at next IFT meeting.

Next Meeting To Do's

1. Choate to provide further info on administration of blood infusion by hospital prior to Lifeflight arrival and if continued or changed.
2. Oko will report on data for delays in hospital-to-hospital IFTs from MEFIRS
3. Petrie will reach out to the Data Committee for some collaboration on insights.
4. Petrie will provide MHA contact info to Tilney, who will reach out and provide a report at the next IFT meeting.

Adjourn

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

Meeting adjourned at 1052.

Next meeting is March 13, 2023, from 0930 to 1100

Minutes recorded by Marc Minkler