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 – April 10, 2023
Minutes

Meeting begins at 0934 (Virtually via Zoom)

Attendees

Committee Members:

Rick Petrie, Steve Leach, Chip Getchell, Chris Pare

(Committee Members Absent: Dr. Matt Sholl, Tim Beals, Dr. Corey Cole, Mike Choate)

Stakeholders:

Joanne Lebrun, Crystal Landry, Christina Maguire, Jeff Austin, Dr. Jonnathan Busko, Joe LaHood, Eric Wellman, Sally Taylor, Mike Senecal, Steve Smith, Brent Libby

Maine EMS Staff:

Marc Minkler, Melissa Adams, Christopher Azevedo, Sam Hurley, Anna Massefski, Robert Glaspy

Introductions

Petrie continues as acting chair, calls meeting to order.
A quorum is not present.

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 deferred due to lack of quorum.
Meeting will continue for information purposes.

Maine Hospital Association representatives will present on IFT issues

Jeff Austin, MHA Lobbyist
Crystal Landy, CEO of Penobscot Valley Hospital
Christina Maguire (President/CEO of Mount Desert Island Hospital)

Landry states there is a lot of challenges facing the movement of patients out of hospitals to other facilities, and feels it is a crisis in EMS. Timely transport is difficult and sometimes results in loss of receiving bed. Hospitals potentially make things work by finding a nurse or physician who can go on the transport. She states that her region is 4 paramedics away from zero. States that recruiting is difficult

PHONE: (207) 626-3860 TTY: (207) 287-3659 FAX: (207) 287-6251

With offices located at the Central Maine Commerce Center, 45 Commerce Drive, Suite 1, Augusta, ME 04330

as EMS is attracted to 911 responses and not IFT roles. Feels that it is at a critical point affecting patient care and flow.
Maguire states it is challenging as they are not on the I95 corridor, and is a critical point, and their hospital is sometimes forced to use private vehicles to transport patients. States May-Nov season, local EMS does 150 transports. Looking for solutions to remove some of the risks. Feels that assets are not being used efficiently and EMS needs to structurally and strategically care for her region better. States at MDI, every transport requires 19-20 calls to find a transfer agency.
Austin states other issues exist in hospitals, but once all mechanisms are put into place, EMS transport is the last part of getting the patient moved and when patients are waiting for bed availability, and it becomes available, but now transport is not available, and the bed is lost. The family and patient blame the hospital as the staff is informing and facing these patients and families.
Petrie states it is very difficult to plan for these calls, and discusses reimbursement and sustainability, and these changes may take years to enact. There is a push by agencies and legislature to address 911 response, and hospitals have often relied on 911 agencies to assist with IFT transports, and balancing need of 911 response with costs of IFTs. Collaboration and innovation are key to improving the availability for IFTs.
Getchell expresses appreciation for MHA representatives being present and echoes the concerns brought forth.
Petrie states one ambulance 24/7 at the paramedic level 7 days a week/365 days a year costs in the order of $750,000 to $1 million, and even that is not particularly great wages. How does a service find the money to fund this with just a few transports out of a hospital per day?
Austin states not being able to transport a patient who is ready to be moved is a financial loss as the bed cannot be used for other patients in need. Although it is a paper loss, it is indeed a loss that may drive hospitals to perform their own transports with hospital-based ambulances.
Leach states it has been a long time since hospitals have participated in IFT meetings and expressed appreciation in hospital leadership attending today. Discusses difficulty of finding staff even if hospitals start their own services. States hospitals years ago contracted with singular services and thus many EMS transfer agencies were shut out and closed or stopped doing IFTS. States Augusta Fire used to do over 1,000 IFTs annually and now does less than 100 per year because of preferred provider agreements. Augusta often picks up community members to bring home and does not bill as they often are not covered by insurance, so it becomes a further loss even when transporting these IFT patients. Encourages looking at different models for possible solutions.
Libby states, although he and his service does not do IFTs, that his 911 agency is funded by a combination of reimbursement and taxpayer funding – it could not exist on reimbursement alone for 911 responses. A hospital subsidy would be able to function as the taxpayer portion of staffing an ambulance. It does not seem that a community and taxpayer should fund this for hospitals, especially as the hospitals are tax exempt. Ambulance services cannot be expected to pick up the pieces for hospitals. Taxpayers pay for a service, and hospitals may need to do this as well.
Leach agrees with this and cost for 911 ambulances to do an IFT are very high, especially when using off duty personnel.

Petrie acknowledges that Tim Beals has joined, quorum is now present, discussion continues.

Petrie states every new ambulance service cuts into limited EMS staff available statewide. Solutions may exist and all involve difficult discussions on costs, and this is very impactful to both EMS agencies and hospitals.

Landry states the models and solutions hinge upon staffing, and it is not a capacity of number of ambulances but the ambulances that have staffing on them. Recruitment and retention are key to this. At the end of the day, we have capacity but not people.
Petrie states we cannot bring paramedics in at $20/hour – those days are gone. Conversations need to include pay and incentives and roles that they do. States hospitals pay EMS more money to work in the ED than EMS can pay to staff an ambulance. Hospitals need to work with local services around realistic pay and incentive to attract and retain.
Maguire asks what part of state level work is regarding pay and incentive. Petrie states the work on increased reimbursement and/or tax rebates may be the biggest helpers to this. Solving this issue will require local relationships and solutions, as needs vary greatly across the state.
Maguire asks about central dispatch agency to track availability and capacity across the state for all agencies, Petrie states there is discussion at a strategic level statewide, but only a few states have this capability. States there is a large cost to implement and maintain this.
Getchell echoes that models exist and there is a cost, and a need for agencies to collaborate with information that previously was considered private/proprietary. Transfers are underappreciated – many are critical movements of patients (cardiac, stroke, etc) and it needs to be funded and recognized.
Petrie would like to develop goals collaboratively to achieve next steps. Asks if there should be a separate group to discuss this, Maguire agrees and would like to work on license levels, care levels, training, and measurements and accountability base don the task force report (Petrie clarifies this is the Blue Ribbon Commission report from Dec 2022). Austin also agrees to start work on the many pieces, and regional dispatch issues, and to engage for the future with a workgroup.
Petrie encourages contacting legislatures about the critical state of EMS and that if there is no EMS money and relief from the legislature, we will not be able to solve IFT transports. Suggests developing a plan to meet for late spring/summer.
Petrie suggests developing a work group in June meeting and developing a plan. Austin agrees and feels this is doable. Committee members agree. Landry offers any support needed.

Minutes
Motion to approve minutes from March 13, 2023, by Getchell, second by Leach. Unanimous. Minutes approved.

Additions to Meeting Agenda
None

Old Business

1. IFT Decision Tree
    a. Petrie states Tilney was unable to attend today but messaged the chair that he sent IFT documents to committee members and that it was also provided to the MDPB, he is working on additional materials over the next week or two

2. Transport of patients receiving blood
    a. Mike Choate is also unable to attend but messaged the chair about his research on blood products, which was shared with committee members, and references to only RNS administering blood is likely a reference to RNs vs LPNs and does not apply to EMS, which is in the national scope of practice and recomemnda bringin it to the MDPB for consideration.

b. Getchell states the "n" of patients needing blood during transport is pretty small and affects any study of this. Beals states that it may be needed for IFTs and benefit faster patient transport. Pare feels it definitely needs to go to MDPB and challenges to this work that PIFT is for the stable patient, and does blood bump someone to an unstable criteria. He feels that perhaps we need to look beyond the PIFT level and what EMS providers can do, accompanied with rigorous QI and clinical competencies. Stability become a major issue with the PIFT level. Services and hospitals may be able to achieve higher levels of care of PIFT with dedicated resources, and it may not be needed for every service or location.
c. Minkler states that the national scope is a model only, but states define how much of that to incorporate. Suggests looking at transports where hospitals send staff – is it because the hospitals "want to" vs "need to" – often staff from hospitals bring no additional equipment but certainly bring their knowledge. Is there opportunity to find cases where there are gaps in EMS education and may alleviate hospitals having to send staff by both educating EMS, and using QI/competency and that perhaps it can be more than just blood – are there other opportunities to engage EMS at higher levels and save nurses for hospital staffing.
d. Getchell moves to request MDPB to look at blood product usage by EMS during IFTs. Leach agrees. Petrie will send this request to the MDPB and ask Data committee to see how often hospital staff accompanies EMS.

3. Request from Board
    a. Petrie states the Maine EMS Board has requested a brief report on goals, objectives, achievements, and goals by end of May to help with chair transition to Chair-elect Drinkwater and formalize where all committee are at and their roles.
    b. Petrie asks for input from committee and to write this at the May meeting and then submit this.
4. Petrie asks if Dr. Cole is still a member, and can we inquire about her attendance. Minkler states he will reach out or Petrie can as he prefers. Minkler will reach out to Dr. Cole.

New Business

1. None

Next Meeting To Do's

1. Petrie will send request to the MDPB to review possible blood usage in PIFT/IFT updates
2. Petrie will ask Data committee to see how often hospital staff accompanies EMS on IFTs
3. Minkler will reach out to Dr. Cole about maintaining her continued role with IFT due to lack of attendance.

Adjourn

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

Meeting adjourned at 1056.

Next meeting is May 8, 2023, from 0930 to 1100

Minutes recorded by Marc Minkler