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 – January 10, 2024
Minutes

Meeting begins at 1304 (Virtually via Zoom)
Note: this meeting was originally scheduled in person at MHA but changed to virtual due to weather.

Attendees

Committee Members:
Rick Petrie, Chip Getchell, Chris Pare, Mike Choate, Tim Beals, Steve Leach, Dr. Pete Tilney, Dr. Corey Cole
(Committee Members Absent: Dr. Matt Sholl)
Stakeholders:
Courtney Cook, Jeff Austin, Andi McGraw, Dr. Kelly Meehan-Coussee, Mike Senecal, Dr. Steve Diaz, Sally Weiss, Jon Bell, Crystal Landry, Amy Drinkwater, Pat Underwood, Paul Hughes, John Lennon, Steve Smith, Rebecca Royer, Dennis Russell, Rob McGraw, Adam Royer, Butch Russell, Sam Foss
Maine EMS Staff:
Marc Minkler, Anthony Roberts

Introductions

Petrie continues as acting chair, calls meeting to order.

A quorum is present.

Minutes

Petrie asks for the December meeting minute review to be deferred until February. The committee agrees unanimously.

Additions to Meeting Agenda

None

New Business

1. Petrie states the goal of this meeting is to work with the Maine Hospital Association and identify barriers for the IFT process and to see if we can come up with collaborative solutions.
2. Austin (MHA – Lobbyist) states he, Crystal Landry (CEO – Penobscot Valley Hospital) and Christina McGuire (CEO – Mt Desert Island Hospital) were invited by Petrie to join a couple phone calls over past few months to discuss this issue. States his primary problem is trying to find an ambulance and the resulting backup in the hospital, and that patients in the ED cannot

be moved into those beds and thus wait. States there have been cases of small hospitals finally securing a bed at a larger hospital and then being unable to obtain transport. States some hospitals are considering making a go of their own ambulance services and feels this is an impact to the existing ambulance services. Cook agrees of challenges with bed availability and then inability get transportation. Senecal states coordination of resources in state is needed – who does IFTs and who does not, where are trucks and can EMS agencies work together to use capacity better and address the timing challenges. Cook states empty ambulances along I95 corridor after transporting to a distant location is needless. They should be available for IFTs. Meehan-Coussee states there is a finite number of resources and using resources better for care levels, as well as improving hospital staff time spent calling multiple agencies trying to find transport. However, there also needs to be a balance of "do they need to be moved right now" or can it be scheduled/delayed. Finding a balance of what state regulates and what sending physician directs for care during transport – finding a safe balance of risk-benefit but also has guardrails.

3. Petrie continues with need for financial support and subsidy for supporting EMS agencies, and addressing if contracts exist with 911 services to ensure 911 is covered along with IFT availability. States a 24/7 paramedic level ambulance costs approximately $1 million annually but there are not enough calls out of hospitals to support this. This puts ambulance services at financial risk, especially with current costs of business, salaries, and staffing challenges. Hospitals have found they may need to subsidize EMS transports. How are we able to continue this along with appropriate use of EMS license level, paperwork, and Medicare requirements to cover costs.
4. Getchell speaks of the immense increase of the number of IFTs, and how often hospitals will call with a large of transports at once. States might have 1 or 2 transports in the morning but are overrun every afternoon with a huge number of transports. Leach agrees and states hospitals seem to want everyone transported at once, which makes covering a facility adequately. State for fire-based services, their services receive a subsidy for being ready from their taxpayers, but when staffing another truck to cover IFTS, it is difficult to cover the cost of that truck with the few IFTs and it cannot be passed onto taxpayers. States it is a free service the hospitals receive, as they do not pay taxes, and the taxpayers shoulder the burden of this cost for readiness for the hospitals. Can fire departments share coverage and find a formula for IFTs and an equal share of transports to help defray costs to agencies, rather than who the hospital is contracted with.
5. Tilney states this is both a hospital and EMS issue. The care in IFT is different than during 911 calls and important to consider. 911 agencies follow the EMS protocols, but we have difficultly with the continuance of care from sending hospital to destination facility. States there is an issue of scheduled vs unscheduled IFTs. This is a challenge with bed availability and hospitals need to partner to make sure we have the appropriate team to manage the care rather than cobble together a crew. A challenge is also a physician changing the diagnosis to meet the crew level available and can result in bad outcomes.
6. Landry asks if we have looked at statewide data for IFTs and any trends. Petrie states the state has provided some but there is a lot of data to sort through. We can ask Maine EMS to provide

data to us to look at day of week, time of day, but there are tremendous fluctuations. We could come up with a list of things to see and request this from Maine EMS.

7. Austin states he doesn't understand the funding issue and how can there be unreimbursed runs and would like to see the data from services on this – runs completed vs runs billed vs successful collection. Is money being left on the table and free runs do not seem right. Petrie states the bad debt rate in EMS is about 35% but EMS regularly transports out of hospitals for patients who do not meet insurance reimbursements but the hospitals need to move those patients.
8. Roberts states data can be obtained from Maine EMS but that we would not be able to show how long the patient has been waiting for transport or the number of times EMS was requested.
9. Choate states that an IFT is a physician scripted event, and that the destination is impactful to family and EMS. States physicians spend hours trying to find a destination and an approach now is to call multiple facilities and whomever calls back is where the patient goes. This may not be the closest hospital and Medicare does not pay beyond the closest appropriate hospital. This adds time and expense that is unreimbursed, and delays availability for other calls. Austin asks for clarification and Choate states he believes that is not based on bed availability (i.e. if full or not). Petrie states he will pull together some reimbursement guidelines for the group.
10. Diaz states the bad debt is seen in the hospital world as well, and is under financial and staffing duress and that there is no pot of money on the hospital side. This is a national problem and states that have been successful have more public health support for EMS, and trends have shown the more rural, the more bad debt is seen. This is not sustainable.
11. Petrie states everyone is financially struggling in our rural state. We need to find a solution within the parameters we have. No single group can solve this.
12. Senecal asks if we should separate local vs long distance IFTs as they have different challenges.
13. Austin asks about work on state task forces that are long term proposals for IFTs besides short term pots of money from state. Petrie states some success with sustainability of EMS as a whole and payment for no transports. Maine Ambulance Association increased MaineCare to increase to 100% of Medicare reimbursement (of which Medicare really only pays 85% of cost of transport). Hoping to change insurance to 200% of Medicare reimbursement which with help with availability, but nothing specific to IFT. Austin also asks about number of ambulance services that were out of network and did not have a contract and a collection of payment issue. Petrie states legislation passed that involved in contract vs out of contract which has been a struggle for EMS agencies as it is a long process. Austin asks for any data on number of EMS agencies and contract status. Need to ultimately increase focus on that these transports are a service to the patient. Beals states EMS billing is often faster than hospital and EMS bills hit deductible sooner, and often these are high deductible plans, so patients are stuck with the deductible portion and choosing heat or paying EMS transport.
14. Landry states workforce is a huge issue impacting all of this. Petrie states there is a decrease of availability of EMS courses and state he knows of at least 50 AEMTs looking for paramedic classes and there are none available in the State.
15. Petrie asks for some possible solutions that we can put on the table to move forward on – anything can be put out there for discussion. Robust discussion from entire group around possibilities, with suggestions of:

   a. Possible per capita contract with EMS services
   b. Better scheduling of calls by hospitals and ensuring all the right paperwork is done as well as education on what is required for transport
   c. Regionalized center/dispatch for arranging transport that knows where state assets are in real time to reduce number of decisions/calls that sending providers need to make. A one call that could reduce time for getting transport
   d. Develop a standardized Maine state transport form – transport changes at last minute from one service to another often means hospitals have to redo IFT paperwork
   e. Hospitals that offer a bed should not be able to reassign a bed – EMS transports patient and arrives to no longer find bed available. At least have a defined process for this, especially once transport has begun
   f. Centralized bed availability, perhaps through centralized dispatch system
   g. Empower front line providers to carry suggestions and improvements to hospitals
   h. Improve efficiency of resources and regional transport
   i. Improve transports to behavioral health centers as they dictate very limited window of when a patient can arrive or loss of bed
   j. Maine EMS develop statewide education and standardized reference tool/chart/poster for hospitals and EMS of what level can be provided by license level for IFT
   k. Develop a statewide standardized physician/transfer order form
   l. Develop requirements/standards for hospital staff accompanying patients in ambulance – a patient centric staff, not just an RN, but an RN that is knowledgeable about the patient, condition, and interventions, as well as transport knowledgeable and experienced
   m. Emulate Canadian system of regionalization for EMS and ambulance placement
   n. Develop database of EMS agencies who are willing to do IFTs and any caveats (short distance, long distance) and make available to hospitals as short term solution with goal of centralized dispatch long term

16. Getchell and Petrie state Maryland uses a centralized IFT transport dispatch system, Getchell also discusses Australia uses a similar system. Also suggests an internal transfer coordinator for hospitals who are knowledgeable about EMS and hospital transfer guidelines and knowledge.
17. Cook suggests an Uber app or similar for EMS IFTs, Bell supports the concept, Senecal states something along these lines exists for Cerna/EPIC such as the program "Roundtrip" and "Statcall"
18. Petrie suggests a series of meetings and workgroups, in addition to IFT meetings on 2nd Wednesday of every month, Cook suggests less than monthly will delay progress, proposes Feb 14, 2024 at 1pm
    a. Minkler asks committee to request the time from the Maine EMS office as he is not available during those proposed times, and Maine EMS would need to provide a new staff rep to ensure public meeting
    b. Petrie will meet with Maine EMS to determine

Next Meeting Action Items

1. Review December minutes
2. Roberts will provide data from Maine EMS for transfer information
    a. Where from, to, date, time, and any information able to be quantified.
3. B.Russell will provide info on reimbursement holes and unreimbursed calls from MAA and commercial carriers.
4. Petrie will reach out to larger EMS agencies in Maine for additional info on Medicare and MaineCare reimbursement holes and unreimbursed calls
5. B. Russell will provide number of ambulance services out of contract from MAA and commercial carriers
6. Petrie will meet with Maine EMS Acting Director Roberts to determine additional meetings for IFT and staff representation to schedule the IFT meeting to be with the MHA

Adjourn

Meeting adjourned at 1459

Next meeting is February 12, 2024, from 0930 to 1100 at MHA

Minutes recorded by Marc Minkler