

MEACEP LEADERSHIP SUMMIT EMS EDUCATION:

PART 1: MATCHING PATIENTS NEEDS TO APPROPRIATE IFT SERVICES

PART 2: PRACTICE CHANGES IN LOCAL EMS



OVERVIEW

- **Part 1: Matching Patient Needs to Appropriate IFT Services**
 - Dr. Pete Tilney (15 min)
 - Questions (5 min)
- **Part 2: Practice Changes in Local EMS**
 - IFT Committee Work by Dr. Pete Tilney (5 min)
 - Community Paramedicine Updates by Dr. Benjy Lowery (5 min)
 - MAT and OPTIONS Referrals in the Field by Dr. Kelly Meehan-Coussee (5 min)
 - Physician Field Response by Dr. Tim Pieh (5 min)
 - Maine EMS Protocol Updates by Dr. Kelly Meehan-Coussee (5 min)
 - Questions (5 min)

“You can’t get there
from here.”

Maine EMS and Emergency Physicians Interfacility Transfers

Dr. Pete Tilney DO FACEP, FAAEM
EMT-P

April 4, 2024



Interfacility Transfers (IFT)



Context



Challenges



Levels of care in
Interfacility Transfers



The EM Provider's
Responsibility



Context

- Differentiating between 911 scene response and IFT for EMS.
- Care during an IFT is continuation of care started by staff in a facility.
 - Ancillary healthcare systems (i.e. SNF, Rehab, etc.)
 - Emergency Medicine
 - Inpatient floor medicine
 - Intensive Care Medicine



Challenges for an Interfacility Transfer

- Finding an appropriate team to do the transport based upon:
 - Availability
 - Scope of practice
 - Comfort level of diagnosis and subsequent treatment.
- Developing protocols for a dynamic care process.
- Identify that the natural progression of illness and injury.
 - What is the risk of deterioration during transport?
- Factors that can delay or prolong time in the out-of-hospital arena.



Maine EMS IFT Decision Matrix

2023 MEMS Interfacility Decision Matrix

Is the Patient Stable?

(For assistance with this question, please review the companion material included with this document)

Considerations in the assessment of "stability" include the following:

- 1) From what disease or injury is the patient suffering?
- 2) What is the natural history of the disease or injury?
- 3) Is this a "time critical" or "time sensitive" process?
- 4) What is the likelihood that the therapies, which have been initiated, will maintain the stability of the patient?
- 5) Will the selected therapies require adjustment enroute to maintain stability and is such an adjustment within the scope of practice and competency of the chosen providers?

YES

NO

What is the potential risk of deterioration in the patient's condition during transport?

Low to Medium

High

What specific treatments does the patient require in transport?

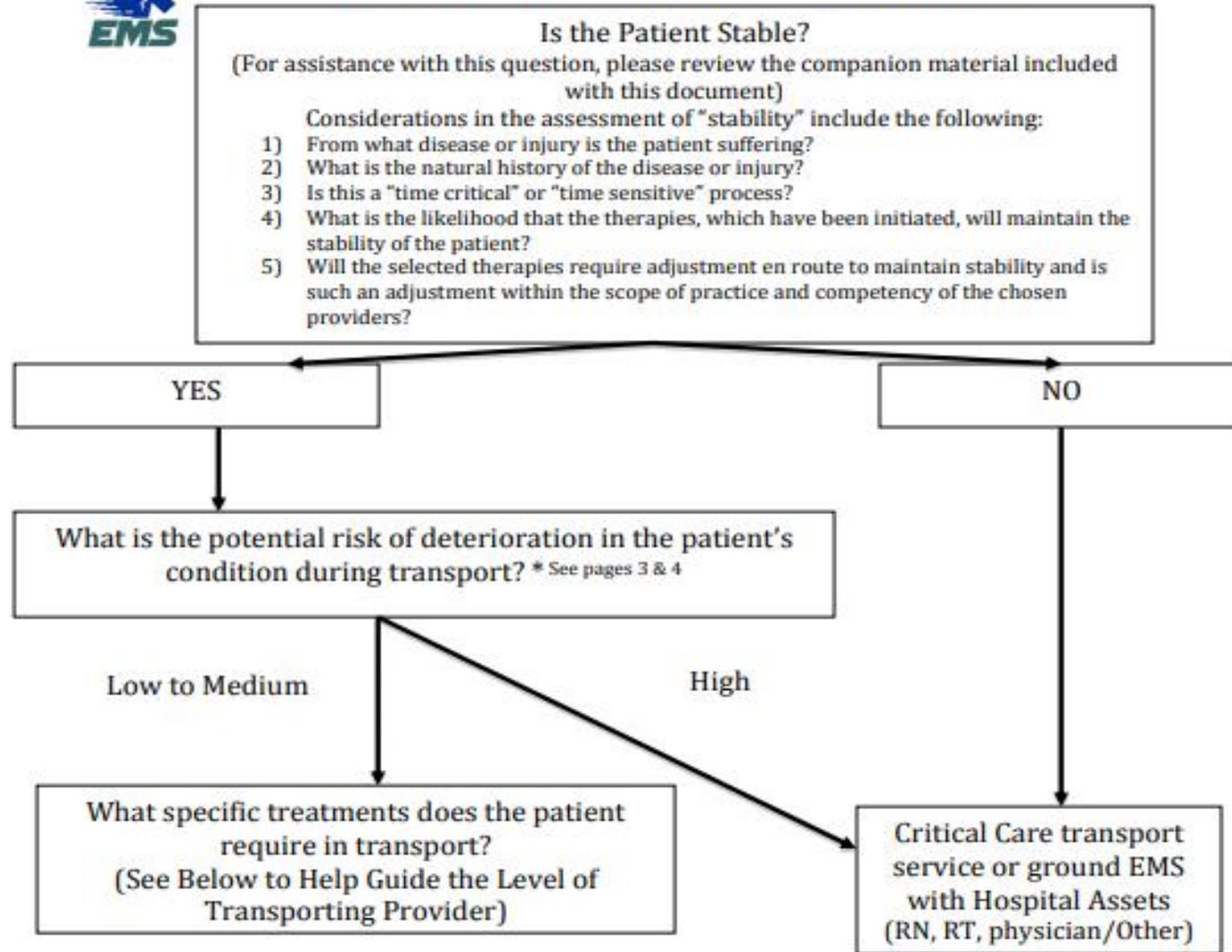
(See below to help guide the level of transporting provider)

Critical Care transport service or ground EMS with additional hospital resources (RN, RT, physician/Other)

NOTE: Also consider the need for rapid transport in time critical or time sensitive illnesses, which may demand the needs of an air-medical transport asset.



Maine EMS Interfacility Transfer Decision Tree



NOTE: Also consider the need for rapid transport in Time Critical or Time Sensitive Illnesses, which may demand the needs of an air-medical transport.

When Arranging for EMS Interfacility transfer, the following information must be conveyed to the receiving facility:

EMS Must Be Provided With the Following Information

How do I decide the level of
provider necessary for an
IFT?

Stability + Medical
Interventions required during
transport



Choose the Appropriate IFT
Provider

Definition of “Stability” – A Moving Target

Increased potential for instability:

- This cohort of patients can include those patients who may require advanced airway placement, evidence of transient hemodynamic instability, ongoing uncontrolled bleeding, respiratory distress requiring non-invasive ventilation.

Unstable:

- Any patient requiring intervention to respond to and/or stabilize mental status or vital signs within two (2) hours or (120 minutes) prior to request for transfer.
- All patients who are in the early process of evaluation or stabilization within a hospital facility requiring transfer should be considered “unstable or undifferentiated” until proven otherwise.

BLS
ALS
PIFT
SCT

| NHTA Term | Examples of Types of Need | Maine EMS Level of Care |
|--|--|--|
| Stable with no risk for deterioration | Oxygen, monitoring of vital signs, saline lock (Basic emergency medical care) | Basic EMT, AEMT or EMT – P (Depending on patient need) |
| Stable with low risk of deterioration | IV infusions, selected intravenous medications including analgesics, pulse oximetry, and increased need for assessment and interpretation skills (Advanced Care) | AEMT and EMT – P (Depending on individual patients needs and requirements) |
| Stable with medium risk of deterioration | Three lead electrocardiogram monitoring, basic cardiac medications as well as medications and devices described on the PIFT Formulary (Advanced Care +) | Paramedic Interfacility Transport (PIFT) Program |
| Stable with high risk of deterioration | Patient requiring advanced airway including those who are intubated and are on mechanical ventilation. Patient on titratable vasoactive medication infusions. (Advanced Care +). Patient whose condition has been initially stabilized, but has likelihood of deterioration, based upon the assessment or knowledge of the sending provider regarding specific illness/injury. | Specialty Care Transport Teams |
| Unstable | Any patient who cannot be stabilized at the transferring facility, who is deteriorating, or likely to deteriorate such as patients require invasive monitoring, mechanical cardiac assist devices, post-resuscitation, or those who have sustained multiple trauma. | Specialty Care Transport Teams |

Maine EMS Levels of Interfacility Transfers

- Stable with low risk of deterioration.
 - Staffed with a Basic EMT
 - Basic monitoring of vital signs and pulse oximetry.
 - May provide oxygen therapy and monitor basic equipment (i.e. foley catheters).
 - Examples would include psychiatric patients or patients requiring minimal interventions during transport.

Maine EMS Levels of Interfacility Transfers

- Stable with low risk of deterioration
- Staffed with an Advanced EMT or Paramedic
- Interventions or monitoring equipment include:
 - In addition to the equipment and skills mentioned previously
 - EKG monitoring
 - Non-medicated fluids for AEMT
 - Pulse oximetry and wave form capnography.
 - Monitoring of patient controlled PCA pumps (no titration necessary)
- Paramedic → Medications outlined by Maine EMS Protocols

Maine EMS Levels of Interfacility Transfers

- Stable with medium risk of deterioration

Paramedic Interfacility Transport Program

- PIFT transfers are for those patients who have undergone individual resuscitation and treatment but require higher level of ongoing treatment while enroute to a larger center for definitive care.
- This population of patients, however, are considered “stable with a low medium likelihood of decompensation.”
- PIFT Paramedics have an expanded scope of practice to continue certain therapies, medications and monitor specific equipment that has been utilized and initiated in a facility.

PIFT Paramedic Transfers

Medication Classes Permitted

Anticoagulants

Antibiotics

Anticonvulsants

Antidysrhythmics

Narcotics

Anxiolysis

Respiratory Medications

Intravenous Fluids

Gastrointestinal agents

Electrolytes and TPN

Equipment Permitted

Intervention approved by
Maine EMS Paramedics and

Chest tube to water seal

Previously accessed Central
lines

CBI

Transcutaneous
pacemakers

Cardiac Mechanical Assist
Devices (if not related to
the reason for transfer)

Medications and therapies NOT approved for PIFT

Anesthetics or patients requiring mechanical ventilation.

Infusions of narcotics, benzodiazepines, and ketamine.

Invasive cardiac monitoring or transvenous pacemakers.

Blood Products of any type.

Paralytics and Muscle relaxants (i.e. Rocuronium, Succinylcholine, etc.).

Titration of vasoactive agents (i.e. Antihypertensives and vasopressor therapy).

Mechanical cardiac assist devices.

Invasive hemodynamic monitoring (i.e. Arterial lines).

Specialty Care Transfers (SCT)

Stability

- Patients who are deemed as unstable or those who have a high risk for decompensation should be treated by teams trained to manage the level of acuity.

Types of teams

- Paramedic / RN
- Paramedic / RN / RT
- Paramedic / Physician (DO / MD)
- Paramedic / RN / NP (NICU or Peds teams)

Populations

- Adult Critical Care Teams
- Pediatric Intensive Care Teams (PICU)
- NICU Teams

Critical Care Transport Teams

- Capabilities should include:
 - Advanced cardiac, stroke, & trauma care
 - Multi-mode ventilators
 - Blood, plasma, and critical care meds
 - Invasive cardiac & neurological monitoring
 - I stat, ultrasound, & internal pacing capabilities
 - Transport isolettes for infants (fetal monitoring)
 - Mechanical cardiac assist devices
 - ECMO / Impella / Balloon pump and upcoming mechanical cardiac assist devices



The EM Provider's Responsibility



Requesting the appropriate level of care during transport.



Determining the patient's anticipated hemodynamic and neurologic status and stability until the arrival at the receiving facility.



EMTALA identified that the sending provider is ultimately responsible for the patient until the arrival at the receiving.



Ensure that your hospital has a relationship (with a local medical director) with the services that provide IFT care so that if a situation arises, an appropriate conversation can occur (i.e. QI)

Contact Info:

Dr. Pete Tilney DO
Cell / Text: 207-590-7446
ptilney@lifeflightmaine.org



A close-up photograph of a metal component, possibly a part of a machine or engine, with a question mark engraved on it. The background is blurred, showing other parts of the machinery. A dark semi-transparent rectangle is overlaid on the bottom right, containing the word "QUESTIONS?" in white capital letters, with a thin horizontal line below it.

QUESTIONS?

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IFT COMMITTEE WORK:
DR. PETE TILNEY

CONSIDERATIONS FOR FUTURE IFTS

- Updated guidelines for PIFT medications and equipment
- Updated education for PIFT licensing
- All IFTs may need to be reviewed by sending facility champion
 - Currently, 100% of IFTs must be reviewed by transporting EMS agency
 - Currently, all PIFT-licensed agencies must have an active agency-level EMS Medical Director

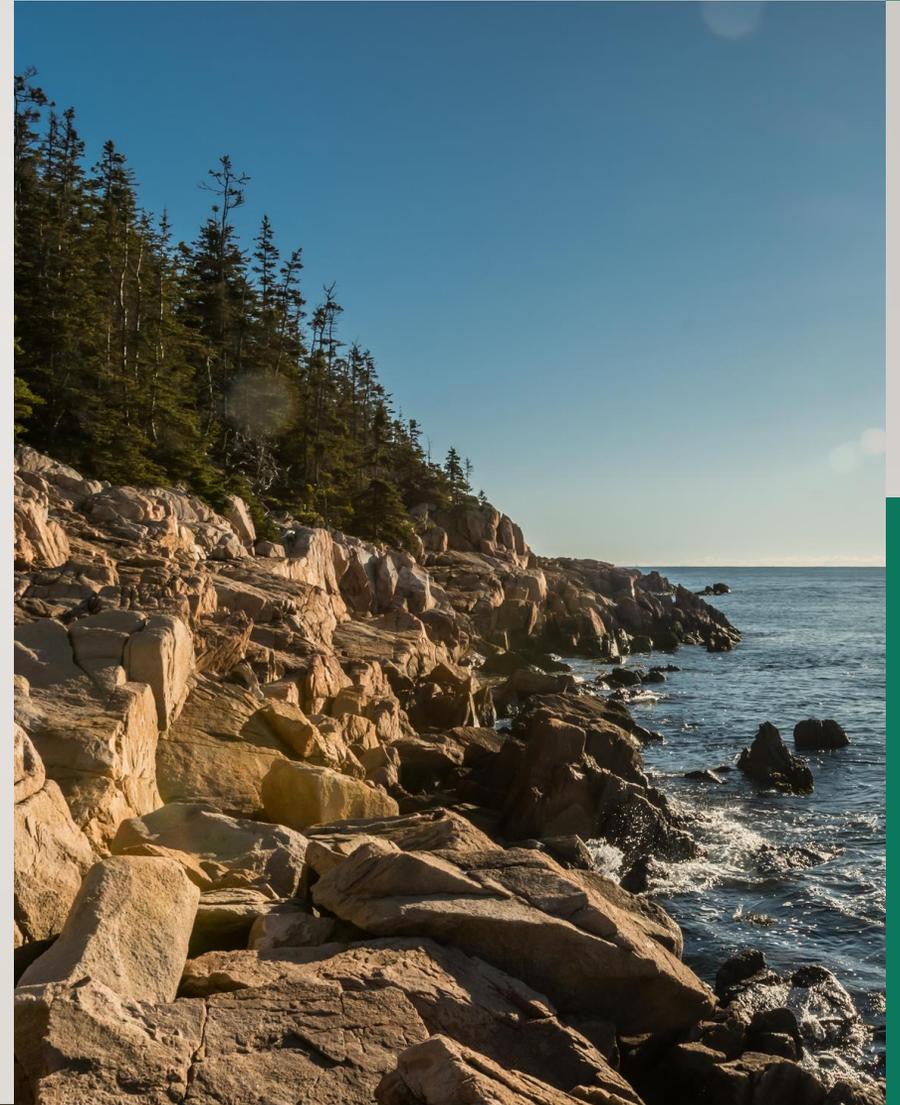


COMMUNITY PARAMEDICINE UPDATES:
DR. BENJY LOWRY



COMMUNITY PARAMEDICINE

Maine's opportunity to address ongoing health disparities through a flexible approach to preventive care that meets patients where they are.



WHAT IS COMMUNITY PARAMEDICINE?

According to LD 1427:

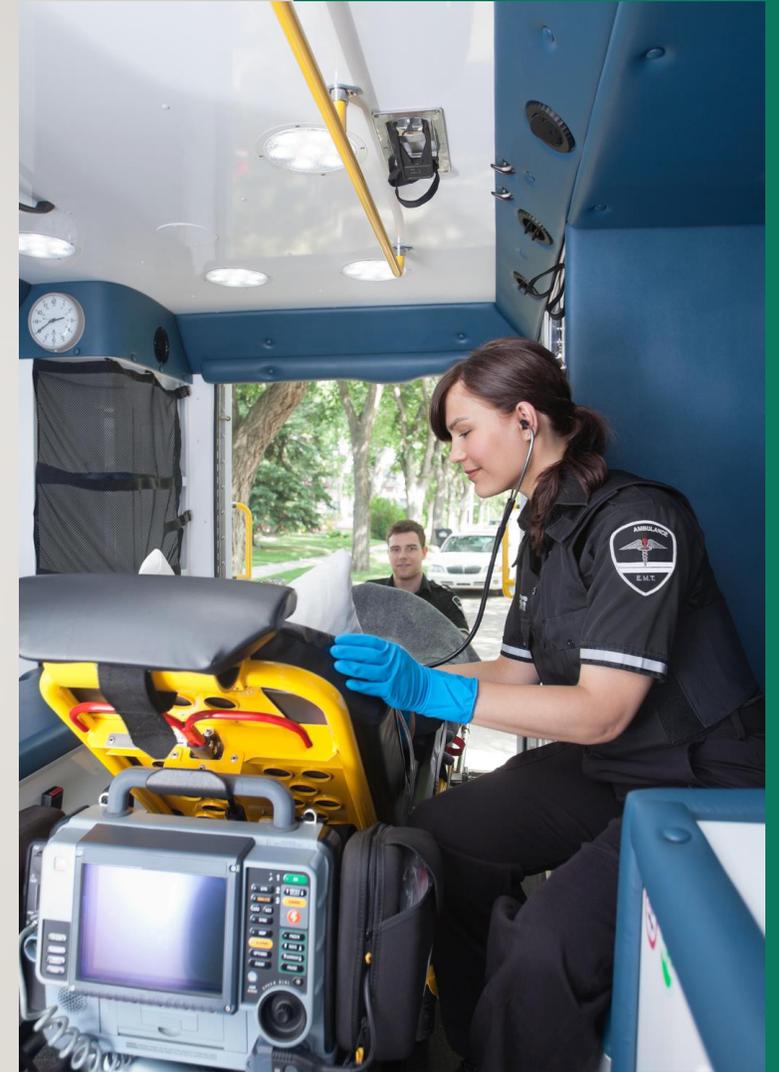
“Community Paramedicine means the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing episodic patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically requested or directed by a physician.”

CP IS:

- Episodic
- Non-emergent
- Physician ordered
- Meets the patient where they are (on the street, in a shelter, at their home etc.)
- Aligns with patient's plan of care

CP IS NOT:

- Substitute for other services
- 911 service
- Referred by the EMS provider
- Alternate route after 911 is initiated (ET3)





History

Community Paramedicine often is touted as a new concept, but Maine has been at the forefront of CP programs within the nation. CP has now been in Maine for over a decade.



2012
LD 1837 - Approved 12
CP pilot projects



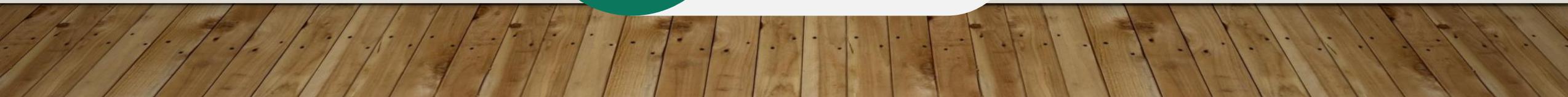
2017
LD 1427 - Removed
the pilot status



2021
Health Disparities
Grant - over \$3 mil



2023
LD 883 - Home Health
Exemption



AGENCY DESIGNATIONS

Belfast Ambulance & Rescue Service

Castine Fire Rescue Department

Central Lincoln County Ambulance

Charles A Dean Ambulance Service

Cumberland Fire Department

Delta Ambulance

Med-Care Ambulance

Memorial Ambulance Corps

Northeast Mobile Health Services

Northern Light Mayo Hospital

Northern Light Medical Transport

NorthStar

Peninsula Ambulance Corps

Portland Fire Department

Sanford Fire Department

St. George Ambulance

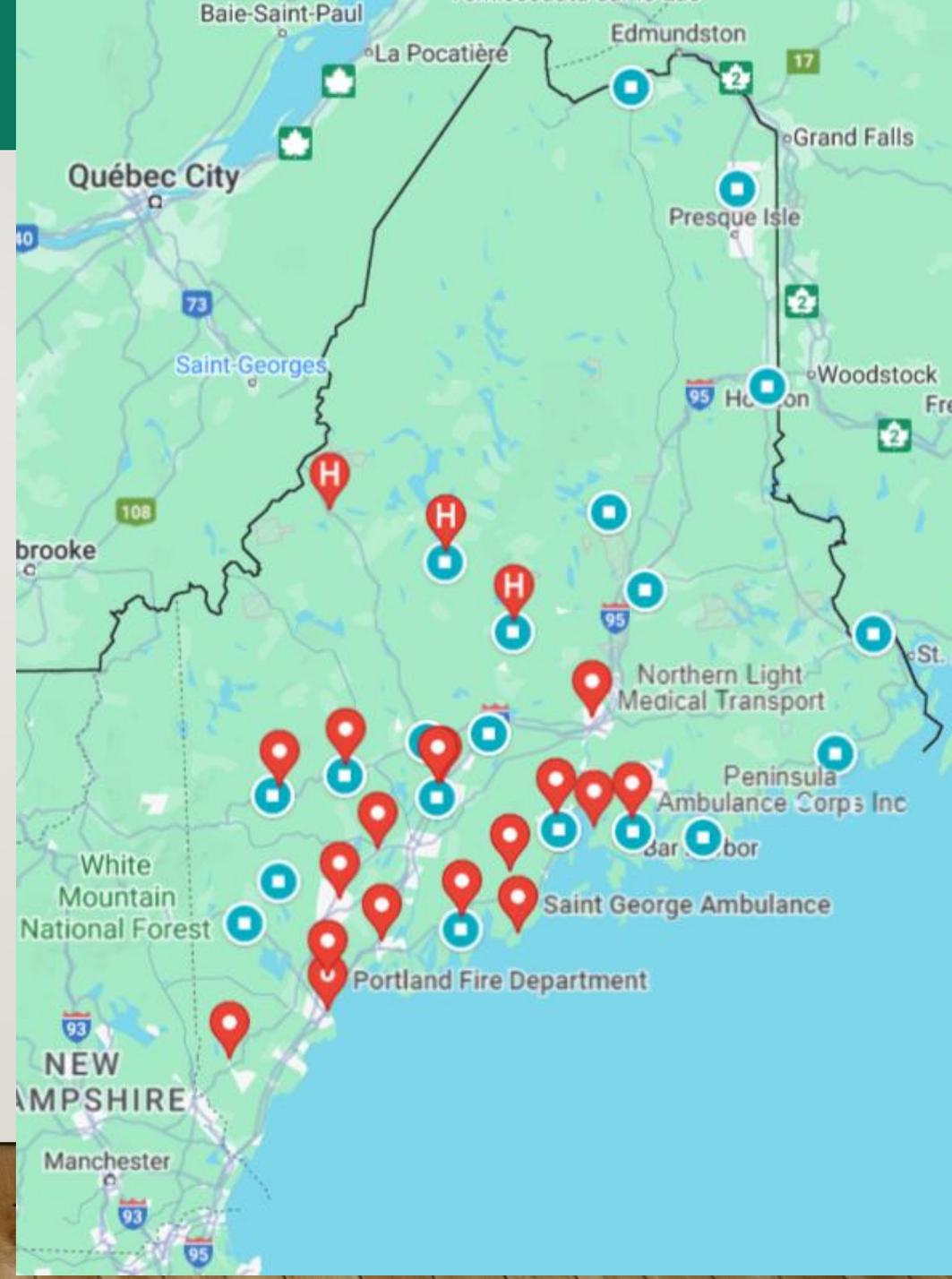
Topsham Fire Department

Union Fire-Rescue

United Ambulance Service

Waterville Fire Department

Winthrop Ambulance Service



KEY Services



MEDICATION COMPLIANCE

Includes medication administration, pick up and sorting.



HOME SAFETY

Includes fall risk assessments and wellness checks.



CHRONIC CONDITIONS

Includes Diabetes, CHF, Asthma and COPD monitoring, support and education.



FOLLOW UP CARE

Includes vital checks, blood draws and SDOH referrals.

PROJECT UPDATES

SCOPE/FOMULARY

3 levels of scopes were developed and are in final approval process with the MDPB and Board.

FUNDING

2 RFA rounds were completed to provide direct funds for initiation/expansion of CP.

EDUCATION

Bison Six Emergency Group will be developing CP education standards and a template curriculum.

ANALYSIS

Cutler Institute has completed a legislative scan, lit review and summary of services.

DRAFT RULES

A concept rules document has been reviewed by the CP committee.

REIMBURSEMENT

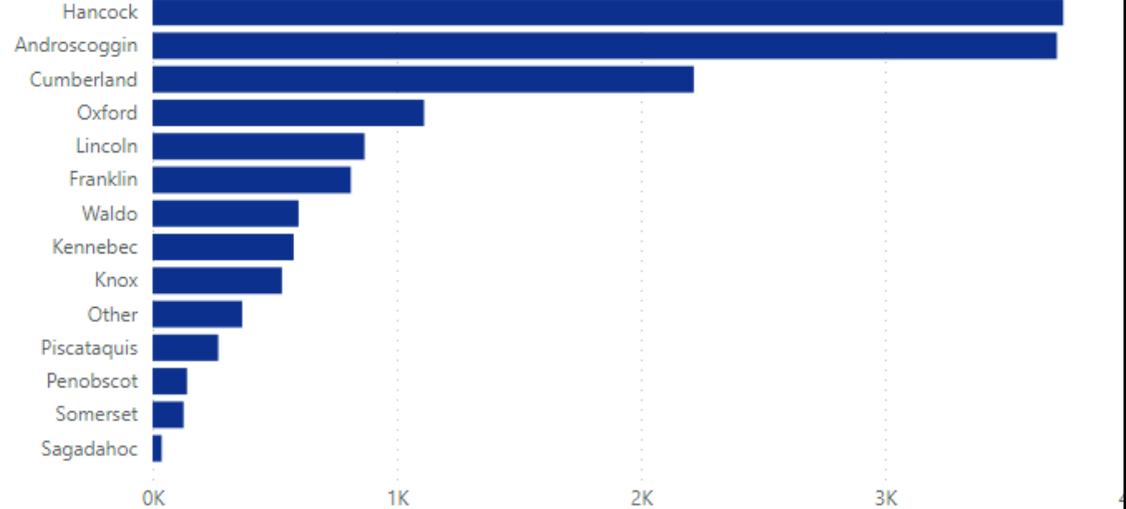
The office has been actively working with OMS towards MaineCare reimbursement.

Statistics

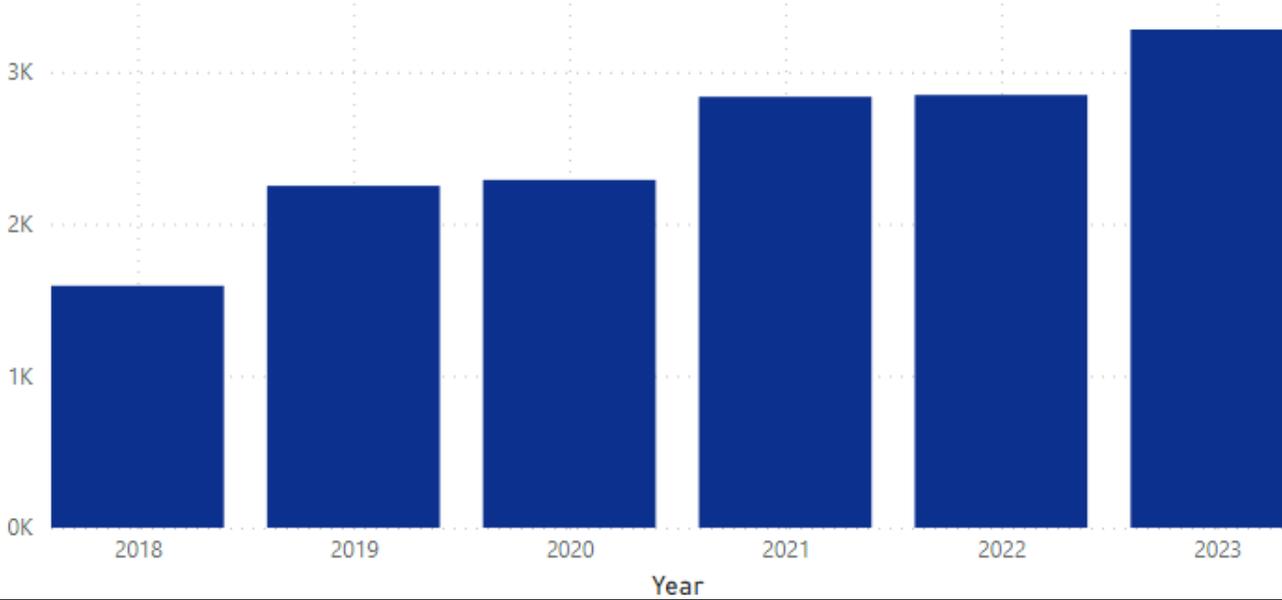
Between 2018 and 2022

- 11,749 CP visits
- 1,796 unique patients
- 1,042 have Mainecare

Mobile Integrated Health Care Encounters By County



Count of Unique Mobile Integrated Health Care Patients by Year





CONTACT



207 - 248 - 1190

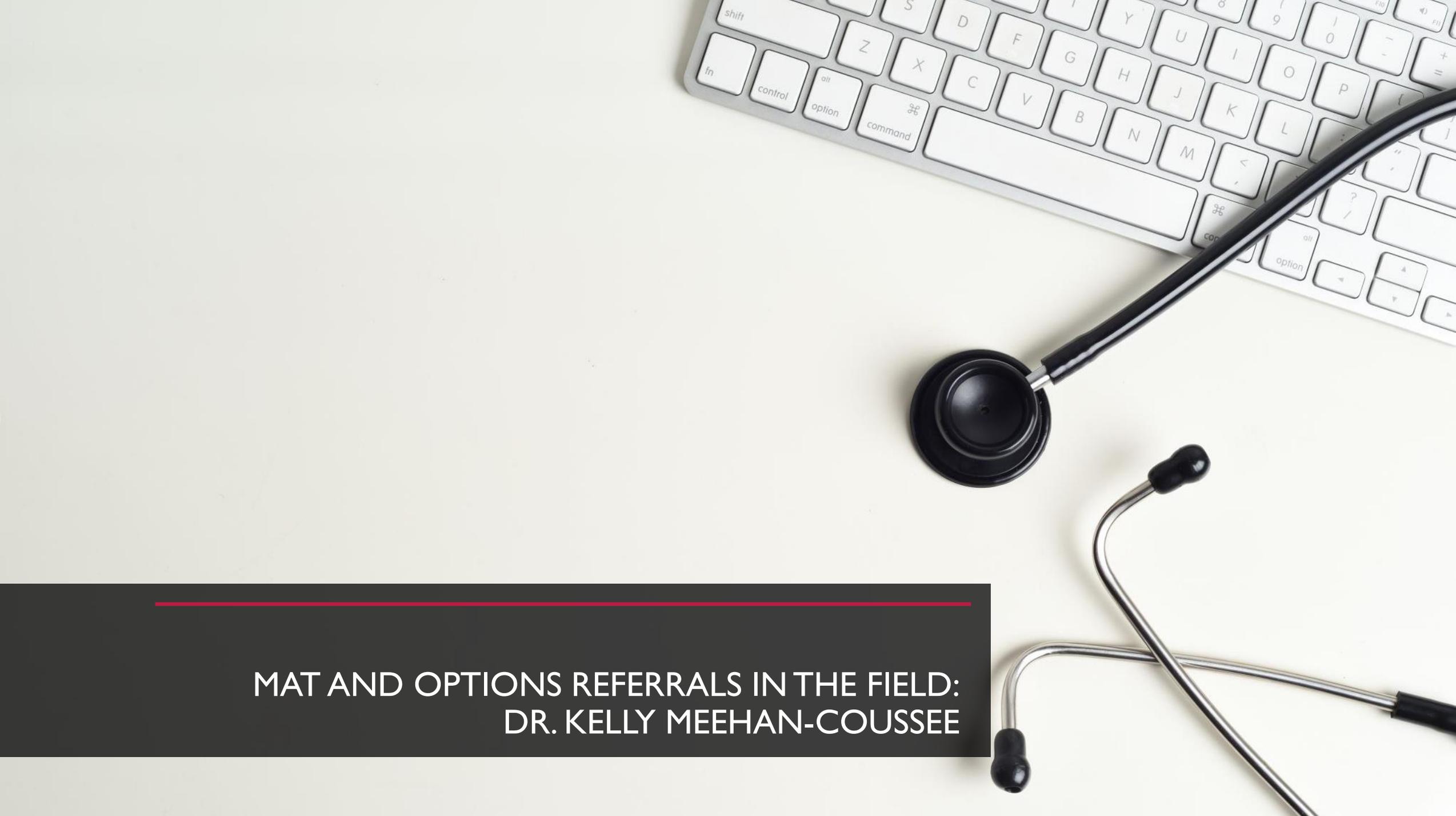


soliana.o.goldrich@maine.gov



maine.gov/ems



A black stethoscope is positioned diagonally across the right side of the image, resting on a white surface. The chest piece is at the top right, and the ear pieces are at the bottom right. A white computer keyboard is partially visible in the upper right corner, with keys like 'shift', 'control', 'option', 'command', 'Z', 'X', 'C', 'V', 'B', 'N', 'M', 'J', 'K', 'L', 'P', and 'O' visible. A dark grey banner with a thin red horizontal line is located at the bottom left, containing the text.

**MAT AND OPTIONS REFERRALS IN THE FIELD:
DR. KELLY MEEHAN-COUSSEE**

**Maine EMS Pilots One of the Nation's
First EMS Direct Referral for
Substance Use Disorder Programs
in Bar Harbor**

MAINE



EMS

EMS AGENCIES APPROVED AS OPTIONS SERVICES

- OPTIONS: Overdoses Prevention Through Intensive Outreach, Naloxone and Safety
 - 2021 DHHS initiative
- Trained EMS clinicians at approved agencies may refer directly to OPTIONS Liaisons from the field
- For more information: www.maine.gov/ems/home
 - “CONTACT US” in top right corner

- Substance Use Disorder Response Program Manager: *vacant*
- Substance Use Disorder Response Program Coordinator: [Robert C. Glaspy, Jr., BSP, NRP, I/C](#)
- Substance Use Disorder Response Program Coordinator: [Taylor Parmenter, MPH](#)
 - Direct Line: 207-248-9949

PREHOSPITAL BUPRENORPHINE TREATMENT FOR OUD

- RFP through Maine EMS
- Success in many EMS catchment areas throughout the country
- For more information: www.maine.gov/ems/home
 - “CONTACT US” in top right corner

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EMS PHYSICIAN FIELD RESPONSE:
DR. TIM PIEH

MD-3 REPORT OUT

MD 3
KENNEBEC COUNTY EMERGENCY MANAGEMENT AGENCY



UP TO DATE AS OF APRIL 1, 2024

SUMMARY OF EMS PHYSICIAN RESPONSE



Who we primarily respond to:



ACTIVITIES SUMMARY

AS OF 4/1/24



911 responses:

75



Interfacility transports:

4



Active physician care cases:

29



Teaching:

54.5 hrs



Quality assurance:

48 hrs



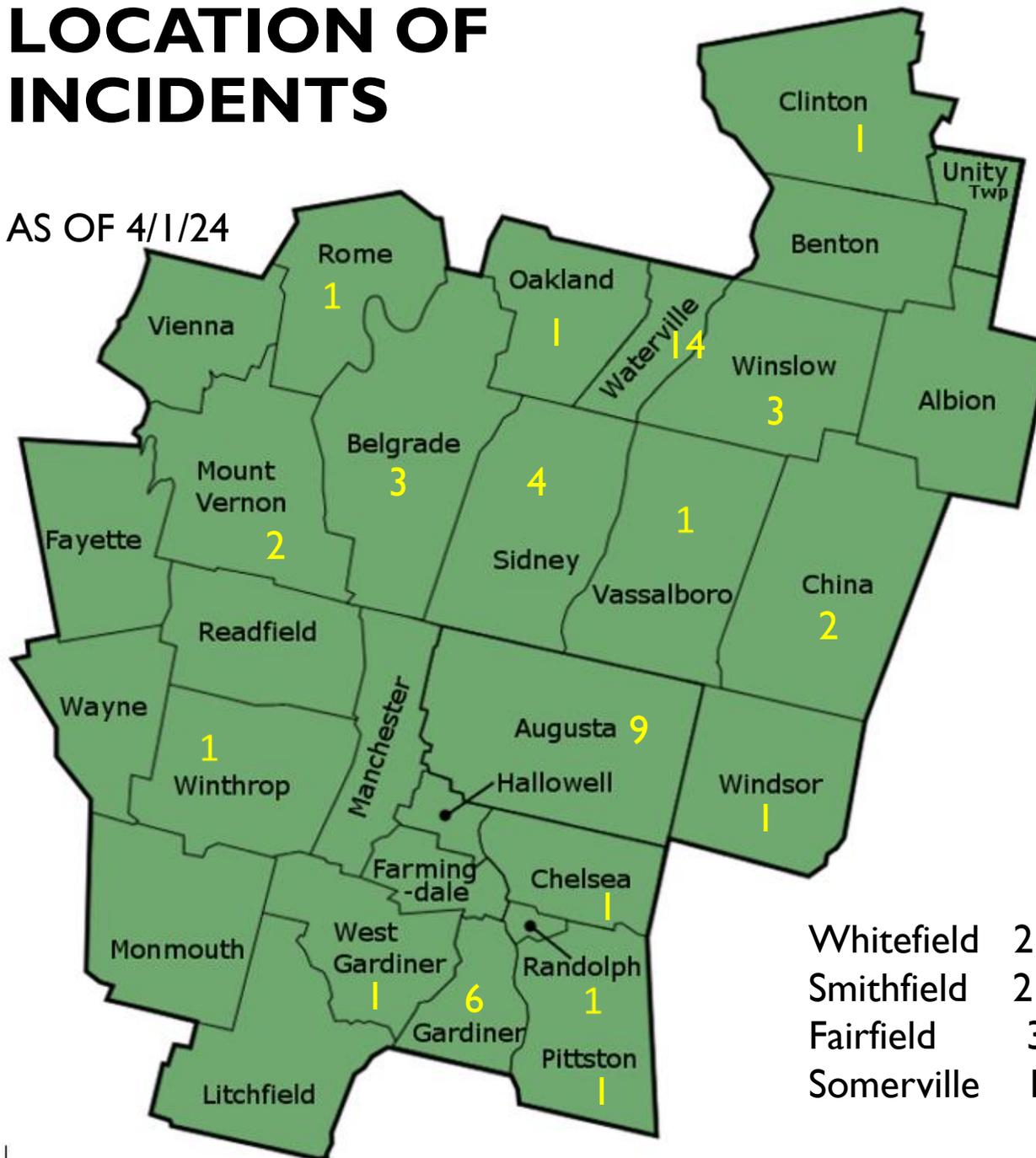
Community outreach:

53 hrs



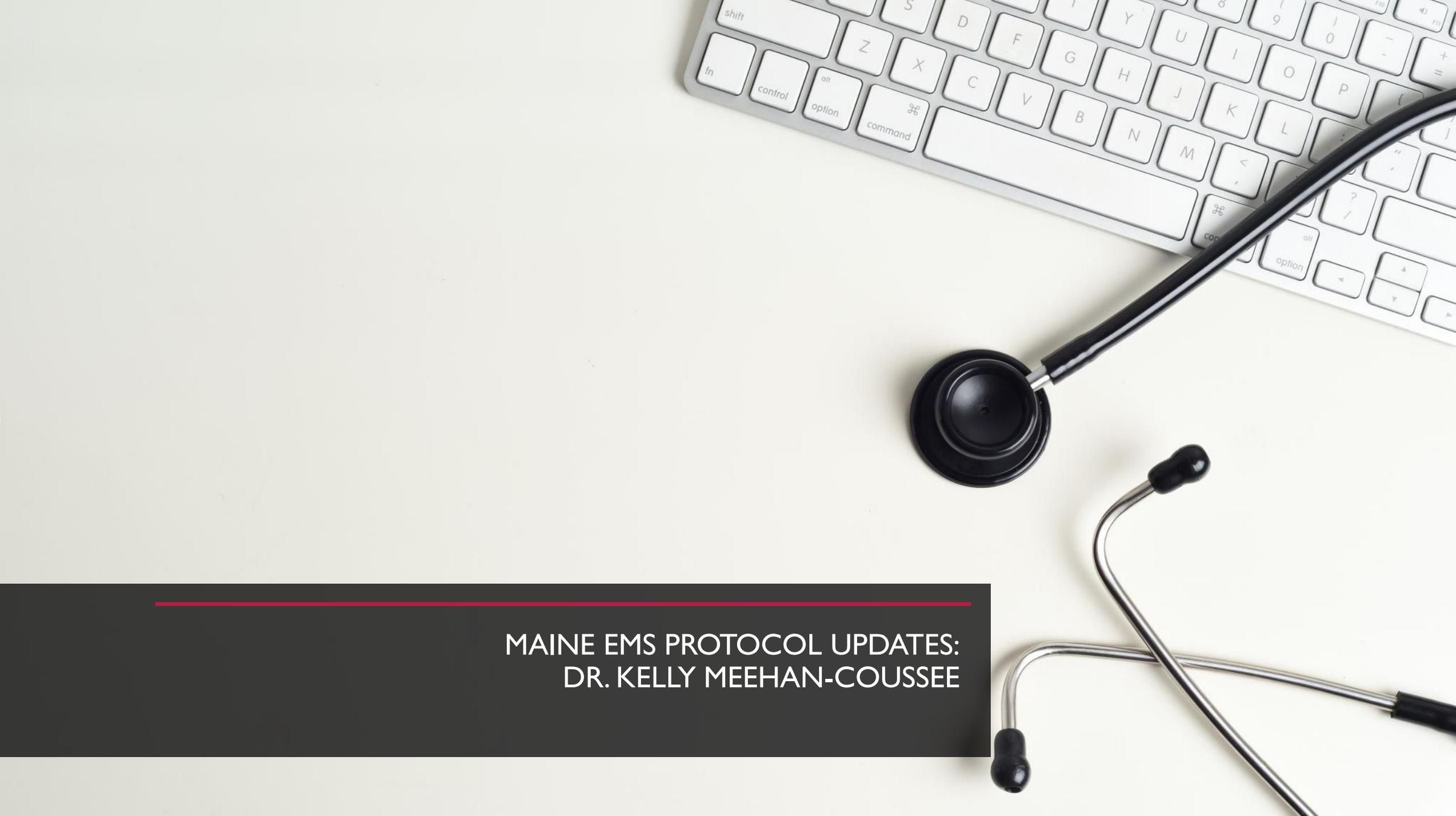
LOCATION OF INCIDENTS

AS OF 4/1/24



Whitefield 2
Smithfield 2
Fairfield 3
Somerville 1



A black stethoscope is positioned diagonally across the frame, with its chest piece resting on a white computer keyboard. The keyboard is partially visible in the upper right corner, showing keys like 'shift', 'control', 'option', 'command', 'Z', 'X', 'C', 'V', 'B', 'N', 'M', 'J', 'K', 'L', 'P', and 'O'. The background is a plain, light-colored surface.

MAINE EMS PROTOCOL UPDATES:
DR. KELLY MEEHAN-COUSSEE

Brown Section/Foreword

There were limited changes to the Brown Section in the 2023 Protocol Updates. The electronic run report completion requirement is highlighted by referring EMS clinicians to Maine EMS Rules and Regulations. Transport to Regional Destination facilities is highlighted to include all systems of care supporting the management of time critical illnesses and injuries including, ACS/STEMI and Stroke patients.

Purple Section/Definitions

The Purple Section review highlighted additional definitions, including cerebral perfusion and mean arterial pressure definitions to clarify treatment goals in the Head Trauma and Medical Shock Protocols, respectively. A definition of Pulse Pressure was added to define an early sign of hypotension in the new Trauma Triage Protocol. A definition of **Fever** is also included to support the new Fever Protocol. Definitions of Service Medical Directors and Maine Operational Physicians are also included.

Blue Section/Respiratory

The Blue Section review has removed the reference to C-collar utilization for ETT stabilization. Routine bougie utilization has been removed from the Pre-intubation checklist and Airway Algorithms in favor of a strong recommendation for the use of Bougies. The Respiratory Distress with Bronchospasm Protocol has been reorganized to prioritize IM epinephrine at the EMT/AEMT scope of practice over CPAP. Additionally, the Bronchospasm Protocol now includes: 1) the starting and maximum settings for CPAP of 5 and 10 cm H₂O, respectively, 2) a maximum dose of 16 mg for Dexamethasone, and 3) a change in the rate of infusion for IV magnesium.

Red Section/Cardiac

In the Cardiac Arrest Protocol, the MDPB created an option for administration of IV epinephrine at the AEMT scope of practice, if so trained and equipped. This is not intended to deemphasize the importance of foundational steps, including high performance chest compressions and early defibrillation. New Pediatric Cardiac Arrest and Pediatric Post Resuscitation Care Protocols have been added to provide pediatric specific recommendations during and after cardiac arrest. Updates have been made to the Adult Cardiac arrest Protocol including emphasis on Dual Sequential External Defibrillation/Vector Changes for refractory pulseless VT/VF. The Adult Post Resuscitation Care Protocol has been updated to include the mnemonic "SAVE A LIFE" as a reminder of the essential steps to stabilize a patient after ROSC. The OLMC requirement for norepinephrine has been removed in the Post Resuscitation Care Protocol (adding consistency throughout the Protocols) and highlighting the importance of adequate BP to restore perfusion in these scenarios. The Bradycardia Protocol (Pearl) emphasizes the recommendation of AP pad placement during pacing.

Gold Section/General Medical

The Gold section review in the 2023 Protocols changed the frequency of IM administration of epinephrine to every 5 minutes for Anaphylaxis and moved bronchodilator administration to the EMT level (based on the 2021 EMT scope of practice updates). The Allergy and Anaphylaxis protocol also emphasizes early consultation with OLMC for patients suffering anaphylaxis. The Diabetic/Hypoglycemic Protocol now includes doses of glucose for pediatric patients. The Seizure Protocol highlights the treatment of seizures in pregnancy and in the up to 6 weeks post-partum period emphasizing Magnesium administration as the first treatment for seizures in eclampsia. The IO route of medication administration has been added to the Seizure protocol for pediatric patients. The Stroke Protocol adds language to prompt recognition of posterior circulation strokes. This protocol change also emphasizes determination of last known well time (LKW) and communication with hospital staff regarding thrombolytic checklist findings. Finally, the Stroke Protocol now refers to “thrombolytics” vs. “TPA” as additional thrombolytic drugs are now being used to treat stroke. The Medical Shock Protocol emphasizes recognition of hypotension in Adult and Pediatric patients. The maximum dose of Dexamethasone has been changed to 16 mg in Adrenal Insufficiency which maintains consistency across the protocols. The Nausea/Vomiting Protocol now includes IM ondansetron administration for adults and pediatric patients. Doses of NOREPinephrine have been updated. Finally, the Gold 2023 Protocols include a new Fever Protocol.

Green Section/Trauma

The Green section review has updated the Trauma Triage Protocol based on recent changes to the National Prehospital Trauma Triage Guidelines from the American College of Surgeons and the National Highway Traffic Safety Administration’s Office of EMS. This change uses Injury Patterns, Vital Signs, Mechanism and EMS Clinician Judgement to identify patients with high and moderate risk of serious injury. The Spine Assessment and Management Protocol includes a newly developed algorithm that highlights C-spine immobilization decisions. The Chest Trauma Protocol further clarifies recognition and treatment of Tension PTX. The Head Trauma Protocol highlights the importance of ETCO₂ monitoring and management goals in all TBI patients and includes airway adjuncts which may be utilized in this population. The Hemorrhage Protocol emphasizes the importance of pelvic stabilization in trauma patients experiencing shock. This Protocol also highlights BP goals in the hemorrhagic shock patient. The Burn Protocol refers EMS clinicians to the Trauma Triage Protocol when determining Regional Destination. The Universal Pain Management Protocol makes note of patients with substance use disorder (SUD) to aid EMS clinicians in most appropriate pain management decision-making. The Termination of Resuscitation Protocol highlights inclusion/exclusion criteria and refers the EMS clinician to appropriate treatments for the trauma patient suffering cardiac arrest. Additional management guidance has been added to the Facial/Dental Injury Protocol for epistaxis and nose/ear trauma. The Ophthalmology Protocol has been updated to include additional assessment and management steps. Finally, a new Strangulation Protocol has been added that includes recognition

Yellow Section/Toxicologic and Environmental

Yellow section review includes removal of Activated Charcoal for the treatment of overdose secondary to ingestions. Charcoal is rarely utilized in the pre-hospital setting and is no longer routinely recommended for ingestions. The dosing of norepinephrine for TCA overdoses has been updated to allow for higher starting doses with titration for effect. The Naloxone Dispensation Protocol is now mandatory and includes patient education regarding available services. The Radiation Injuries Protocol has been updated to include anti-emetics (ondansetron) at the AEMT scope of practice. The Hypothermia Protocol is now divided into Hypothermia with or without signs of life and includes hospital-grade electric forced-air warmers, if available. Doses of NOREPinephrine have been updated.

Pink Section/Pediatric

The Pink section review introduces Oxytocin for the prevention of post-partum hemorrhage in the Childbirth section. The Childbirth Protocol also emphasizes the importance of maintaining warmth of the newborn. Also included in this protocol is the technique to maintain the baby's airway in a breech birth. In the Neonatal Resuscitation Protocol, the dose of epinephrine has been updated for consistency with NRP recommendations.

Orange Section/Behavioral Emergencies

The Orange section review highlights the importance of considering a non-psychiatric etiology of altered mental status in the Transport of Mentally Ill Patients Protocol and refers the EMS clinician to the Altered Level of Consciousness Protocol (Gold section). This protocol also refers the clinician to the Grey section Transport Protocol under the "Voluntary Committal" section. A Pearl has been added addressing the increased frequency of Pediatric Behavioral Emergencies and the importance of EMS clinicians establishing rapport when interacting with pediatric patients. Doses for midazolam and ketamine have been added for patients 10 years and older in the Delirium with Agitated Behavior Protocol. The Depression/Suicidal Ideation Protocol emphasizes treatment steps and the potential of ALS providers in patients suffering injury/ingestion. In addition, the protocol adds reminders to make note of potential substances at the scene and references the Overdose/Poisoning Protocol (Yellow section). The Agitation/Excited Delirium Protocol has been re-named "Hyperactive Delirium with Severe Agitation" per current accepted medical terminology. The Restraint protocol adds reference to pharmacologic intervention for patients who are physically restrained.

Grey Section/Operations

Grey section additions include the Landing Zone Protocol (previously in the Green section) with updated language for safety. New Protocols in this section include a Baby Safe Haven and a Transport Safety Protocol geared at protecting EMS clinicians, patients, and others on the roadways. The Death Situations for Emergency Responders Protocol now mandates referral to NEDS for deceased patients meeting potential organ/tissue donor criteria. The DNR Guidelines have been updated to acknowledge the authority of a Durable Power of Attorney. Activated Charcoal has been removed for the Maine EMS Medication list for consistency with the Overdose/Poisoning Protocol. The Telephone/Radio/Contact Numbers pages have been updated with current information

QUESTIONS?
COMMENTS.
TANGENTIAL STORIES NOT YET SHARED
ELSEWHERE...



EMS Committee

Committee Chair: Kelly Meehan-Coussee, MD

Next Meeting: TBD

Committee Mission: To serve as a forum for discussion of EMS-related topics by EM physicians from around the state where in we may provide education to Maine ACEP members on EMS issues more broadly, act as a conduit for discussion between ACEP physicians and EMS stake-holders, and, where appropriate, work with the Maine ACEP Legislative and Advocacy Committee to effect change. For more information, please visit the EMS resources page.

[EMS Resources Page Link](#)

-
- **National EMS Resources**
 - **Resources for EMS Medical Directors**
 - **How to be an EMS Medical Director in Maine:**
 - **Requirements to have an EMS Agency Medical Director**
 - **Maine EMS Physician contacts:**

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