EMS on Maine Islands

LD 841 Report

January 2026

MAINE EMS

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LD841 Overview

On June 20, 2025, Governor Janet Mills signed into law LD 841, "*A Resolve, to Study the Delivery of Emergency Medical Services to and Ferry Service Effects on Unbridged Island Communities in the State*" (Appendix A).

This resolution directs Maine EMS to

- Study the delivery of EMS to, and ferry service implications on, unbridged island communities in the State.
- Include an evaluation of the long-term sustainability of EMS to unbridged islands,
- Report on legal and regulatory requirements related to EMS to unbridged islands,
- Provide a cost comparison to EMS needs and costs statewide,
- Submit a report by January 1, 2026, that includes the findings, and recommendations of the working group.
- Present this information to the Joint Standing Committee on Transportation AND the Joint Standing Committee on Criminal Justice and Public Safety

This should be completed by a working group consisting of 8 members:

- The Director of Maine Emergency Medical Services within the Department of Public Safety, or the director's designee;
- A representative of a municipal government of an unbridged island community that is served by the Department of Transportation, Maine State Ferry Service;
- A representative of a municipal government of an unbridged island community that is not served by the Department of Transportation, Maine State Ferry Service;
- A representative who provides emergency medical services on an unbridged island community served by the Department of Transportation, Maine State Ferry Service;
- A representative of the Department of Transportation, Maine State Ferry Service;
- A representative of an organization with experience in providing air ambulance critical care transport services in the State;
- A representative of a statewide association representing ambulance services; and
- A representative of a municipal fire department that provides marine emergency medical services that are not primarily facilitated through a ferry service to an unbridged island community.

Executive Summary

The following document is an introduction and examination of EMS and related operations and data for fifteen year-round public unbridged islands in the State of Maine. While drafted in response to the request from the legislature, it is not intended as a final document but rather a starting point for discussion and perspective, and an iterative continuation of work by island communities and EMS stakeholders. The intent is to have the LD841 working group's efforts and materials be utilized to assist and shape opportunities to improve EMS on Maine Islands as prescribed in LD841.

Maine's unbridged islands are among the smallest of Maine's communities, diverse in nature but sharing marine resource-based economies. Unbridged islands with year-round populations span the entirety of the Maine coast, and while the distance in miles from mainland are not always great distances, even small trips across the water present significant time, logistics, and costs not experienced in mainland communities.

All island populations are considered rural and remote by the State's Rural Health Transformation Program and similar to other rural Maine communities are increasingly faced with high populations of older people and those aging at home needing increased medical support to safely age at home.

Similar to their community size, Maine island EMS agencies are among the smallest and lowest response volumes, with both formal and informal EMS responses to community members in need.

There are a variety of challenges with EMS both statewide and nationally, and islands are not immune to these. Island EMS clinicians and agencies face many of the same challenges, such as staffing and funding, but also face unique and complex challenges of transportation of patients. Solutions to EMS on Maine's islands is a task that will require significant future collaboration, support, and continuous evaluation and improvement at the local and state level.

Despite these challenges, island EMS agencies and EMS clinicians in Maine represent a passionate and talented group of people that truly support their communities. Their dedication to effective and compassionate emergency care cannot be emphasized enough.

We hope that this report will provide our elected leaders with insight and considerations in supporting improvements in EMS for the islanders of our state.

Workgroup

The majority of members of the workgroup volunteered their time and travel and participated in discussions, data analysis, and thoughtful insight to improve EMS on Maine island communities. This report would not be possible without their efforts. They are pleased to share this information with the Maine State Legislature and the people of Maine. The workgroup met a total of seven times over four months and visited several islands during this process. The LD841 Workgroup Members were:

Tom Judge, Project Officer, LifeFlight of Maine ***(Chair)***
Marc Minkler, Program Manager, Maine EMS ***(Report Author)***
John Dietter, Director, North Haven EMS
Sean Donaghue, Division Chief, Portland Fire Department
William Geary, Director, Multimodal Operations, Maine DOT
Ralph Munroe, Chief, Chebeague Island Fire & Rescue
Butch Russell, President, Maine Ambulance Association
Marjorie Stratton, Town Manager, Vinalhaven

Additionally, a number of island EMS leaders and stakeholders regularly attended and participated in discussions, lending their experience and expertise to assist the workgroup. Special thanks to the stakeholders participating during the meetings:

Dr. Benjy Lowry (MaineHealth PenBay Hospital & Maine EMS Region 3 Medical Director), Meghan Russo (Maine DOT), Katelyn Damon (Cranberry Isles), Ashley Moody (Maine EMS), Dr. Michael Baumann (MaineHealth-Maine Medical Center-Portland & Long Island & Chebeague Island Medical Director), Chief Marc Candage (Vinalhaven), Eva Murray (Matinicus), Chief Will Tierney (Long Island Fire & EMS), Director Fred Porter (Isleboro Public Safety), Sonja Philbrook (Swan's Island) Stan Makara (Penobscot Island Air), Erin Creelman (Penobscot Island Air), Sean Creeley (Penobscot Island Air), EMS Director Pat Lundholm (Vinalhaven), Dr. Tracy Jalbuena (MaineHealth Telemedicine Medical Director), and Don Sheets (EMS Project Manager, Maine Community Colleges)

Key Findings

EMS on islands is a complex aspect of public safety, and the workgroup addressed findings into seven categories:

1. System,
2. Medical care and resources,
3. Workforce,
4. Education,
5. Telemedicine,
6. Transportation, and
7. Finances.

System

- For the study island EMS geographic roughly divided into three areas: Casco Bay, (Peaks to Chebeague), Penobscot Bay (Monhegan / Matinicus to Islesboro), and Downeast (Isle Au Haut to Frenchboro).
- All islands share fishing/marine economies and significant differences in seasonal populations. Seasonal populations and visitors are often much higher than year-round population, increasing stress and resources needs for island EMS agencies.
- In addition to the 15 year-round islands, there are hundreds of smaller islands with seasonal populations that may require EMS and similar support from other islands or mainland EMS agencies.
    - This includes islands both in the Atlantic as well as on inland waterways and lakes (e.g., Frye Island).
- All island populations are considered rural under the State of Maine submission to the Rural Health Transformation Program (RHTP). The RHTP submission also noted aging population as part of the complexity of healthcare challenges, including access to care and workforce, which are major challenges to island communities
- 27% of the fifteen unbridged, year-round islands have no licensed EMS agencies.
- The most significant difference between island EMS and other Rual EMS agencies in Maine is transportation across the water, which presents significant logistic and time issues.
- Unlike mainland communities with contiguous towns and potential to consolidate / regionalize to improve cost efficiencies there are no scale potentials to increase cost efficiency and reduce overhead for each island EMS agency.

- There is a lack of immediately available primary care on most of the unbridged islands, and the potential need for off island transportation to access primary and urgent care is a challenge on the islands. As a result, EMS personnel often manage a continuum of primary, urgent, and emergent care. EMS personnel on the islands, much like EMS in Maine's rural communities, often serve as a bridge in helping community members understand primary healthcare needs, urgency and risks of not seeking medical care. As such, there is often a blurred line between general medical care and emergency care.
- The island EMS agencies are among Maine's smallest / lowest volume EMS agencies, with the exception of Portland Fire Department.
    - Statewide, in 2024 EMS agencies averaged 1,712 responses in 2024 (with a median of 670). Island EMS agencies averaged 52 responses (with a median of 48).
    - 20% of the fifteen unbridged, year-round islands had no documented EMS responses in 2024.
    - 13% of the fifteen unbridged, year-round islands had no documented EMS responses in the last 5 years.
    - It is important to note that 4 islands do not have a formal or licensed EMS service on their island, and thus we cannot track how many actual emergencies may have occurred without the support system of EMS.
- EMTs (Down East) and Advanced EMTs (Penobscot Bay) are the primary care providers in these regions. Very few paramedics are available in the Penobscot Bay and Down East Islands.
    - Islesboro is the only EMS agency in the Penobscot Bay and Down East Islands permitted or licensed to the paramedic level, and had 1 paramedic response in 2024, and it was from a mainland agency for a BLS patient.
- Islands in Penobscot Bay and Down East had 63 responses (16%) that included at least one physician, NP, or PA. This included
    - 48 (60%) of the responses from Islesboro.
    - 12 (27%) of the responses from North Haven.
    - 3 (1%) of the responses from Vinalhaven.
    - No Casco Bay responses included a physician, NP, or PA.
- It is important to note that while EMS crews transport a patient, or if weather conditions change and leave the ambulance and EMS crew unable to return to their island, this could result in leaving their island without EMS coverage and likely no mutual aid options unlike mainland communities being able to call neighboring EMS agencies for assistance.

Medical Care and Resources

- EMS is a critical and essential community health resource.
- Island residents often use EMS as informal medical consultation and referral for travel for decisions on further care on the mainland. Due to population size, it is also much more likely that EMS patients are family members.
- Island EMS agencies are primarily licensed at EMT or Advanced EMT level. There is limited Paramedic coverage or availability with the exception of Portland Fire and responses within the Casco Bay area.
- Several islands have health clinics
    - Islesboro, North Haven, Swan's Island, and Vinalhaven have clinics staffed with advanced care providers (Physician Assistants and Nurse Practitioners).
        - The Vinalhaven Clinic is a recognized Federally Qualified Health Center (FQHC) and is designated as an alternate destination by Maine EMS.
    - All of the clinic staff support emergency response and often respond with EMS clinicians on ambulances. There is significant variety in what formal EMS field emergency training clinic staff have completed, if any.
    - Current Maine EMS Statute and Rules require a licensed EMS clinician to respond to 911 activations. While licensed physicians are exempt from EMS licensure requirements, there is no current provision in the law to exempt mid-level practitioners (PAs and NPs) from EMS licensure requirements.
    - EMS clinicians can however utilize advanced care practitioners (PAs and NPs) alongside them in 911 activations in many instances.
    - Islands in Penobscot Bay had 63 responses (17%) that included at least one physician, NP, or PA. This included
        - 48 (60%) responses from Islesboro
        - 12 (27%) responses from North Haven
        - 3 (1%) responses from Vinalhaven
        - No Downeast or Casco Bay responses included a physician, NP, or PA
    - EMS Protocols and Rules generally require 911 emergencies to be transported to mainland hospitals, with the exception of transport to the Vinalhaven clinic as appropriate.
    - A number of the islands with clinics noted increasing challenges in recruiting NPs, and/or PAs to work and live on the islands.
- Islands have unique EMS care needs due to logistics and time including:
    - Low acuity patients may not need/want transport or emergent transport.

    - Moderate acuity patients may experience extended care times while waiting for transport.
    - High acuity patients may experience extended care while waiting for transport.
    - Transport of deceased people by ambulance non-emergently.
- Island EMS agencies often hand patients off to mainland EMS agencies due to logistics and time, allowing clinicians to return to islands for availability.
- Handoff of patient care from island EMS to other EMS agencies (mainland or air) often do not fully capture all of the data obtained by island EMS to hospital destination. Improved full data capture is needed.
- Island EMS agencies also provide water rescue in support of Maine Marine Patrol and US Coast Guard on ad hoc basis and provide/assist with EMS mutual aid for adjacent islands.

Workforce:

- Primarily volunteer, paid by call, or per diem with some salaried employees.
- Island EMS has similar challenges to mainland EMS agencies in recruiting and retaining personnel, particularly for entry-level courses.
- With the exception of Portland Fire and LifeFlight of Maine, island EMS agencies have a cadre of responders that range in license levels and ages. Nearly all are completely volunteer.
    - As seen throughout the State of Maine, the ratio of clinicians to population can vary dramatically. Island EMS agency staffing (as of January 2026) with licensed EMS clinicians is:

Licensed EMS Responders by Island EMS Agency, 2025

Agency	Licensed Clinicians*	2020 Year Round Census	Clinicians to Population Ratio
Chebeague Island Rescue	17	394	1:23
Cranberry Isles Rescue	9	161	1:18
Islesboro Ambulance Service	17	579	1:34
Long Island Volunteer Rescue	8	233	1:29
North Haven EMS	15	417	1:28
Vinalhaven Ambulance	14	1,288	1:92
Grand Total	**80**	**3,072**	**1:38**

**Data from Maine EMS Licensing, 2026*

    - In examining the mainland EMS agencies, we can also compare staffing to population ratio. Although the comparison does not reflect the time to transport patients (e.g. Vinalhaven to PenBay Hospital is much lengthier than

Augusta to MaineGeneral), as well as factors such as full-time staffing vs volunteer, we can see:

Licensed EMS Responders by Comparison, Selected Mainland EMS Agency, 2025

Agency	Licensed Clinicians*	2020 Year Round Census	Clinicians to Population Ratio
Georgetown Fire Department	36	1,057	1:29
Searsmont Rescue	16	1,403	1:87
Corinth Fire Department	34	2,900	1:85
Sullivan Fire/Rescue	14	1,219	1:87
Southwest Harbor / Tremont EMS	28	3,296	1:117
Camden Fire Department	31	5,226	1:168
Falmouth Fire & EMS	67	12,450	1:185
Augusta Fire Department	80	18,898	1:236
Portland Fire Department	269	68,403	1:254
Grand Total	**575**	**114,852**	**1:199**

**Data from Maine EMS Licensing, 2026*

- As often seen in primarily volunteer agencies, the average age of responders tends to be higher. With the exception of Portland Fire Department and LifeFlight of Maine, the island EMS agency average clinician age is 49 years, and of all island EMS agencies, six (8%) are under 30 years old, and twenty-two (28%) are under 40 years of age. Seventeen (21%) are 65 years or older.
- Night transport via water can result in particular challenges for individuals and families as the EMS crews, based on weather, can become stranded on the mainland for extended periods. This impacts availability for other responses, family life, and employment.
- Clinic medical staff (PAs, NPs, and RNs) are not currently allowed to be the primary care provider in an ambulance without EMS licensed personnel as their license and education does not generally include emergency medical care outside of institutions.
    - Physicians and flight RNs are exempt from this.
- Available workforce has lack of immediately available high quality initial and continuing EMS education. Costs and time are much higher with need for overnight accommodation. May face many hours between scheduled ferry trips.

Education:

- Islands lack access to continuing EMS education without significant undertaking, travel and cost, well beyond other mainland communities.

- Initial licensure education is a major challenge due to small numbers of students on any individual island, issues in timing of classes and commuting based on ferry schedule. Challenges to standard licensure courses include need for overnight stays on mainland to attend class, limited instructor pool on islands, practical/ labs with small numbers for hands on training on islands, and clinical rotations on mainland.
- Low patient volumes are challenging to develop and maintain practical skills and proficiencies.
- Access to high-fidelity mannequins for skills education is near non-existent.
- A hybrid learning system with support on individual islands is needed to increase and maintain EMS staffing. This includes original licensing courses as well as continuing education.
- EMS Training centers, particularly the Maine Community College System, are supportive of developing innovative programs for island agencies and the RHTP may have funding to improve rural workforce educational opportunities.
- The RHTP and Office of Rural Health are exploring new innovative workforce solutions to improve care in rural communities and may be a source of collaborative efforts to improve access to primary and EMS care.
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Telemedicine:

- EMS personnel noted a significant group of low acuity patients that currently require transport off island. With the exception of Vinalhaven, EMS has no current other options other than transport to the mainland.
- Telemedicine has significant potential positive access impacts on the delivery of medical care and decision-making support.
    - Potential use for low acuity patients who might not need transport or may be treated in place with physician decision support, and/or if delayed transport.
    - Telemedicine may support Community Paramedicine on islands.
    - Telemedicine may improve availability and consistency of on-line medical control and medical decision support, if coupled with Emergency Medicine boarded physician support.
- Telemedicine technology can be low tech telephone to full video and broad band transmission of clinical data. Complexity in delivery is based on clinical goals, patient selection, acuity, and specifics of disease states covered, population covered, skill sets of EMS clinicians, and technology support.

- There are a number of existing primary care telemedicine systems in Maine and New England, primarily focused on primary and mental health care, or hospital-to-hospital ICUs. These may be able to provide specific support depending on use case. No telemedicine system is currently designed for EMS, and for the broad number of conditions and cases that EMS manages.
- Implementation of telemedicine care would require investment in initial development, technologies, support, training and emergency medical oversight. Additional investment in robust quality and documentation systems would be required.
- Some islands have widely available broadband, but others have limited infrastructure for reliable video.
- Telemedicine would require access and physician support 24/365.

Transportation

- EMS transport from islands generally requires more personnel than mainland EMS and requires more time to complete and be available for another response.
- EMS transport from islands can be logistically complicated and challenging for EMS agencies, as well as patients and families, especially at night.
- It is common for EMS clinicians in the midst of an emergency call, outside of Casco Bay, to be forced to call multiple entities to obtain transport. There is no centralized "one-call" system for EMS transport as weather and availability are significant factors.
- EMS transport from unbridged islands is either by water or air. There is no one method that is a universal solution due to challenges of weather, fog, seasonal conditions (e.g., icing, waves, wind), availability, and distance.

<u>MARINE TRANSPORTATION</u>

- Utilizes a combination of Maine State Ferry Service (MSFS), municipal EMS boats, privately operated ferries, US Coast Guard, and private boats (e.g., fishing/lobster).
    - Maine EMS does not currently license marine vessels as ambulances.
    - With the exception of Long Island Fire/EMS and Portland Fire, no boat or ferry has EMS supplies on it.

Maine Ferry Service (Swan's, Isleboro, North Haven, Vinalhaven, Matinicus, Frenchboro)

- Ambulances are given priority for boarding on regularly scheduled trips when they are operating for emergency purposes, and when returning from such emergencies.

- State of Maine ferries are currently based overnight on four of the six MSFS islands (Vinalhaven, North Haven, Islesboro, Swan's Island). This allows for EMS transport under certain conditions. EMS transports outside of normal operating hours over the past five years averaged 33 transports per year. EMS transports are not part of the core mission of the MSFS and are not statutorily required.
- Island communities served by the MSFS with a vessel housed on the island feel this is an important asset for medical evacuation due to size of vessels and ability to handle sea conditions that are not favorable for smaller fishing type vessels.
- The use of MSFS allows ambulances to be driven on board and thus utilize equipment in the ambulance and maintain environmental controls (no other ferry system allows for this).
- Night-time emergency ferry runs may result in cancelled or delayed first trip on the following day, impacting commuting workforce, school operations, and commercial deliveries on/off island.
- Staffing of the four islands (Vinalhaven, North Haven, Islesboro, Swan's Island) with an overnight vessel consists of a 7-day rotation to assist, if possible, with medical or other public safety emergencies.
    - Ferry personnel receive a per-diem rate for on-island requirements and stay at state-owned facilities on island. They are not currently required or compensated to be on-call outside of normal operating hours.
    - Ferry staff must follow US Code of Federal Regulations (CFR) for work and duty time which can limit night emergency response.
    - Costs for staffing on four islands with required 4 to 5-person ferry crew is approximately $550,000 annually.
    - Based on an average of 34 annual transports outside of normal operating hours, the following costs are incurred by the Maine Ferry Service:
        - Direct costs for crew and fuel are approximately $1,200 per transport.
        - Cost of readiness for maintaining 4 staffed island bases is approximately $16,175 per transport (using the 5-year average of 34 emergency transports outside of normal operating hours).
        - Currently the MSFS charges the island municipality $1400 per emergency run conducted outside of normal operating hours.
    - Outside of the normal operating hours, the Maine Ferry Service follows guidelines aligned with the US Coast Guard in use for EMS transport. EMS is responsible for and must determine that a patient has an immediate / potentially life-threatening condition and that LifeFlight is not available or appropriate, nor can EMS patient's condition wait for the next, or soonest, normal ferry transport.

- The ferry Captain and crew make final determinations on requests for emergency transport. This decision cannot be mandated nor directed by MSFS management and is at the sole discretion of the captain and crew to determine if the emergency transport will occur via MSFS. The US Coast Guard has an additional 6 stipulations that must be met in order for the emergency transport to be allowed outside of normal operating hours.

Long Island Fire/EMS (Long) and Portland Fire Department (Peaks, Great Diamond, Cliff)

- Have 24/7 dedicated EMS marine vessels in Casco Bay. Long Island's fireboat is based on the island. Portland's fireboat is staffed 24/7 and based on the mainland.

Chebeague Transportation Company (Chebeague Island)

- Non-profit ferry service on island that uses on-call ferry staff dispatched at same time as EMS to provide 24/7 EMS and other emergency transportation. Ferry staff are compensated for this. Does not transport vehicles. Transports patient and crew to mainland to handoff to mainland EMS. This ferry is docked at night on the island.

US Coast Guard

- A last resort with logistical hurdles based on their operational policies. Historically the USCG provided marine transport from the islands for "life, or limb". With new Homeland Security duties, the USCG is now the absolute last resort with logistical hurdles based on their operational policies.

Other

- EMS agencies also use private marine transport on an ad hoc basis. Private fishing/lobster boats are not designed for EMS transport and may not be enclosed. On some islands it is the quickest and easiest option. Availability, vessel size, and design limit use based on sea state and weather.

Transport method for all transported patients on year-round unbridged islands, 2024

Agency & Transport Method	Patients
Chebeague Island Rescue	
Transport on stretcher inside Chebeague Island Ferry & handoff to mainland EMS	54
Cranberry Isles Rescue	
Transport by Lobster / Private Boat & handoff to mainland EMS	10
Islesboro Ambulance Service	
Transport in ambulance on Maine State Ferry & handoff to mainland EMS	33
Transport in ambulance on Maine State Ferry & Islesboro ambulance to Hospital	15
Transport by LifeFlight	3
Long Island Fire & Rescue	
Transport by Long Island Fire Boat & handoff to mainland EMS	21
North Haven EMS	
Transport by Lobster / Private Boat & handoff to mainland EMS	11
Transport in ambulance on Maine State Ferry & North Haven ambulance to Hospital	5
Transport by LifeFlight	5
Transport by Penobscot Island Air & handoff to mainland EMS	3
Transport in ambulance on Maine State Ferry & handoff to mainland EMS	1
Portland Fire Department	
Transport by Portland Fire Boat and transferred to Portland ambulance	172
Swan's Island Ambulance	
Transport in ambulance on Maine State Ferry & handoff to mainland EMS	24
Transport by LifeFlight	8
Transport in ambulance on Maine State Ferry & Swan's Island ambulance to Hospital	1
Transport on US Coast Guard & handoff to mainland EMS	1
Vinalhaven Ambulance	
Transport by Penobscot Island Air & handoff to mainland EMS	84
Transport in ambulance on Maine State Ferry & Vinalhaven ambulance to Hospital	24
Transport by LifeFlight	17
Transport by Lobster / Private Boat & handoff to mainland EMS	11
Transport in ambulance on Maine State Ferry & handoff to mainland EMS	4
Transport by Boston MedFlight	1
Transport to Island Clinic	1
Grand Total	**499**

AVIATION TRANSPORT

- Air Transport utilizes either LifeFlight of Maine or Penobscot Island Air (PIA).
    - Air transport is rarely used in Casco Bay (one use in past 5 years).

LifeFlight of Maine

- LifeFlight operates on a 24-hour basis using instrument flight rules direct from islands to hospital helipads in Maine and Boston.

- Generally, the island EMS agencies only use LifeFlight for the most critical patients with patient transport to Maine and Boston major medical centers.
- LifeFlight operates helicopters from Bangor, Lewiston, and Sanford.
- LifeFlight typically staffs with 3 - a pilot, a flight nurse and flight paramedic, or a pilot and 2 flight nurses with advanced equipment needed to manage patient care.
- LifeFlight can fly in darkness as they have instrument approach procedures as well as night vision goggles.
- LifeFlight is restricted in low visibility conditions per FAA flight minimum requirements.
- LifeFlight's airplane is too large to land on island air strips.

Penobscot Island Air

- PIA operates an air charter and mail service from the Knox County Airport to midcoastal island air strips. PIA supports island EMS transport, generally by transporting patients to Knox County Regional Airport for ground transport to MaineHealth Pen Bay Hospital.
    - PIA reconfigures aircraft as needed to assist EMS agencies with emergency, urgent, or scheduled transport.
    - Use of PIA requires island EMS clinicians to accompany and provide care for patients and is staffed with a pilot only.
    - PIA aircraft have no EMS supplies on it other than a stretcher mount which is configured as needed for transport.
    - PIA cannot fly in darkness or when instrument meteorological conditions exist (operating under visual flight rules).
    - Use of PIA requires EMS agencies to license as a Restricted Response Air Ambulance Service (RRAAS) with Maine EMS. Currently only North Haven and Vinalhaven utilize this option.

<u>TRANSPORT CHALLENGES</u>

- Late in day or night transports are particularly challenging as EMS personnel, patients, and family members may get stranded overnight on mainland.
    - May leave island unprotected by EMS stranded off island.
    - Weather may change and not allow for return flight by PIA.
    - Ferry may not be available, or ferry crew is beyond duty hours.
    - Patient gets transported to local hospital ED and is then discharged from ED when ferry is not operating.
- Overall, the total time island EMS clinicians are with a patient varies based on 4 factors:

- If the island EMS agency is able to transport all the way to the hospital (not all islands have this option).
- If the island EMS agency hands the patient off to a mainland EMS agency.
- If the island EMS agency utilizes air transport from PIA or LFOM.
- If the patient is not transported/refuses transport.

Average time from 911 call to Emergency Department arrival (not via air), from year-round unbridged islands in Maine (2024)

Region	Patient handed off to a mainland EMS agency	Patient transported to the hospital by island EMS agency	If patient refuses transport
Casco Bay	60 min	53 min	38 min
Down East	1 hour 21 min	1 hour 45 min	58 min
Penobscot Bay	53 min	1 hour 45 min	52 min

Average Times Utilizing LifeFlight of Maine for Island Transport, from year-round unbridged islands in Maine (2024)

Avg Time from Island EMS arrival to requesting LifeFlight	Avg Time for LifeFlight to Arrive	Avg Time of LifeFlight on scene	Avg Flight Time of LifeFlight from Island to ED
9 min	49 min	28 min	21 min

- Transport is typically longer for island EMS agencies, and in some cases may be further delayed by weather and ocean conditions. Transport times also vary considerably based on whether by air, community dedicated ferry/fireboat, state ferry, or private boat. By region and island, transport time ranges and average for 2024, including transports by air, were:
  - Casco Bay Agencies (1 ambulance per island)
    - Chebeague Island – 14 to 34 minutes (Avg 22 min)
    - Long Island – 10 to 60 minutes (Avg 29 min)
    - Cliff, Great Diamond, & Peaks Islands – (Avg 23 min)

    - Down East Agencies (1 ambulance per island)
        - Cranberry Isles – 18 to 41 minutes (Avg 27 min)
        - Frenchboro – *No EMS agency or ambulance*
        - Islesford – 18 to 41 minutes (Avg 27 min)
        - Swan's Island – 16 to 113 minutes (Avg 51 min)
    - Penobscot Bay Agencies (Vinalhaven has 2 ambulances, all other islands have 1 ambulance)
        - Isle au Haut – *No EMS agency or ambulance*
        - Islesboro – 14 to 109 minutes (Avg 47 min)
        - Matinicus – *No EMS agency or ambulance*
        - Monhegan – *No EMS agency or ambulance*
        - North Haven – 15 to 204 minutes (Avg 59 min)
        - Vinalhaven – 10 to 137 min (Avg 37 min)
- All of the Casco Bay islands have community dedicated EMS water transportation. No islands in Penobscot Bay or Down East have community dedicated EMS water transportation.
- There was a proposal from a previous ad hoc working group to develop a dedicated marine ambulance vessel to support mid-coast islands. To meet year-round coverage vessel would need to be > 50' length. Capital costs, operating costs, and logistics are complex as vessels would need to be staffed and of significant size for winter sea conditions. The proposal was rejected by island communities.

Finance:

- Similar to all EMS agencies in Maine, particularly rural, low volume EMS agencies, reimbursement for patient care and transport does not meet the cost of providing these services. Strategies to cover the gap include volunteer time, municipal subsidies, and philanthropy.
    - Patient reimbursement does not support costs of EMS.
    - Islands use diverse mechanisms to support EMS and medical care.
    - Islands use diverse approaches to fund EMS transportation.
- In addition to EMS costs, the cost of transport options is substantial and varied.
    - Penobscot Island Air charges approximately $770 for EMS transport, which is billed to the island community. Note, the flight cost does not include medical care. If the Island EMS agency is licensed as a Restricted Response Air Ambulance Service, the island EMS agency must provide care for the patient during flight. These services are not always reimbursed or reimbursable by insurance companies. PIA will also fly the EMS clinician back to the island (weather conditions permitting).

    - LifeFlight's charges for transport vary based on distance and the transport mileage. The variable cost for LifeFlight is approximately $2,400 per hour, and the total cost when factoring in equipment, overhead, crew cost, insurance, and readiness cost reaches, on average, $9,600 per transport. LifeFlight does however bill patient insurance as a CMS enrolled air ambulance service. Patients are responsible for any deductible or co-pay imposed by their insurance company, however LifeFlight does not, and cannot, bill the patient beyond that which their insurance company allows. For those without insurance, LifeFlight has a robust and generous charity care program. LifeFlight collects approximately 5% of its self-pay billing. Reimbursement for LifeFlight, as is the case for all EMS in Maine, does not cover the actual costs of provision of the service.
    - The Maine State Ferry Service (MSFS) is funded by state taxpayers as well as fairbox revenue. The MSFS bills island communities the transport costs outside of normal operating hours at $1,400 per transport. Ambulances are charged $172 during normal operating hours. The total cost of readiness and to house captains and crew on the islands and provided ferry transport is approximately $550,000 annually. None of these costs are covered by insurance.
    - Long Island Fire & EMS and Portland Fire Department utilize a community tax funded fireboat and do not charge for transport to the mainland.
    - Chebeague Transportation Company is a non-municipal 501(c)(3) non-profit ferry and does not charge for transport for any EMS call at any time of day.
- Under the Center for Medicare & Medicaid Services (CMS) Billing Rules if a provider/supplier, is enrolled in Medicare and provides services and bills a Medicare Beneficiary they must bill all patients for Services.
    - This means that an island EMS agency, a mainland EMS agency, or an air ambulance that bills even one patient, they must bill all patients.
    - Some agencies (e.g. LifeFlight of Maine) have charitable policies and funds that are used to assist those without insurance for EMS and transport costs.
- For the islands that are able to utilize the Maine DOT ferry for transport, the state provides partial subsidies of the ferry system, whereas EMS agencies and communities without the Maine DOT ferry must absorb the full cost of transport or provide a mechanism for transport.

Recommendations for Sustainability

During the period of the Island EMS workgroup meetings, the State of Maine filed an application and received funding for the Rural Health Transformation Program (RHTP). Many of the objectives of the RHTP are synchronous with the findings of the workgroup and offer the potential for rapid and collaborative initiatives recommended in this report.

System

- Explore option of EMR as primary care provider for use on water and air transports to hand-off to mainland EMS agencies.
- Explore options for protocols/guidance for island EMS patient sign-off / alternate destination criteria.
- Explore potential island specific EMS protocols and funding support to address unique needs of island EMS care and/or delays in transport (similar to Wilderness Protocols).
- Recognizing challenges of paramedic staffing for island EMS agencies, explore potential for community healthcare workers at EMT and Advanced EMT level to provide services within scope similar to Community Paramedic Programs.
- Perform a study to assess potential of staffing paramedics on islands.

Medical Care and Resources

- Develop guidance for possible transport to island clinics vs mainland hospital. Assess possibility and capability of North Haven and Islesboro clinics to be designated as an EMS destination similar to Vinalhaven clinic.
- Improve EMS documentation, especially with transfer of care to another agency to make sure both agencies are capturing transfer of care and time.
- Remove documentation challenge of current need for separate run report from both island EMS agency and Restricted Response Air Ambulance Service (RRAAS) when the RRAAS is the same agency and EMS clinician as from the island EMS agency.
- Work with pharmacy/hospitals to prepare for medication availability on islands for routine and extended care.
    - Medication access may also become more complicated due to possible new regulations from US Drug Enforcement Agency.
    - Laboratory testing (e.g., blood glucose) on islands may become more complicated due to potential changes to CLIA regulations.

Workforce / Education

- Work with Maine EMS licensed Training Centers to expand access to initial licensure education via hybrid and on island practical skills development. Advanced classes are even greater challenge.
- Work with funding of rural workforce development, including simulation, as a high priority for the Maine state Rural Health Transformation Project (RHTP) submission.
- Explore equipment packages for original and continuing education. This should include high-fidelity simulators and training support.
- Develop asynchronous EMS continuing education programs for island EMS agencies.
- Develop long term plans for initial and continuing EMS education.
- Work with Maine EMS licensed training centers and the Community College system to develop asynchronous hybrid EMT and Advanced EMT licensure programs for island EMS agencies.
- Increase availability of EMR programs as an important building block to sustain island EMS agencies.
- Develop EMR to EMT bridge educational programs.
- Explore options of regional / island-based collaboration for education.
- Evaluate island EMS uniqueness related to Maine EMS rules
    - Equipment needs and considerations based on island and Maine EMS rules (e.g. Unnecessary expense of stocking island ambulance at paramedic level if mainland paramedic is responding with same equipment)
    - Explore if islands can be permitted to paramedic without paramedic on roster? (e.g., by using NP/PA/Physician).
    - Maine EMS Rules do not fully address participation of advanced practice and other healthcare providers for EMS service delivery as sole providers on an ambulance during a 911 response.
- Explore opportunities in Maine Statutes to allow advanced practice providers (PAs and NPs) to be sole providers on 911 EMS responses within the Maine EMS Act of 1982
    - 32 MRS 2-B §82 “Requirement for license”
    - 32 MRS 2-B §86 “Ambulance services and non-transporting medical services”
- Establish bridge licensing programs for other health professionals (RN, NP, PA) to EMS license/recognition are also needed.

- Explore use of RHTP which highlighted value of Community Paramedic level of service, telemedicine, and other funding resources. This is potentially very valuable to island communities, but substantial barriers of education/training and financial sustainability exist.
- As many islands offer year-round and seasonal island health clinics, explore support for out of state physicians/PAs/NPs to obtain Maine licensure to staff island clinics/support EMS agencies.

Telemedicine

- Assess islands for tech support of broadband / video telemedicine.
- Explore potential for telemedicine to support on site EMS decision making.
- Assess capacity of telemedicine access to EMS trained and boarded physicians.
    - Invest in support and technology.
- State RHTP submission highlights need for improving telemedicine to rural communities, allow for expansion into support of EMS.
- Identify strategies with the DHHS Rural Health Transformation Program to develop possible telemedicine decision support for clinics and/or EMS personnel on the islands.

Transportation

- Continue to work with island EMS stakeholders to develop long term strategies for EMS transport including potential of funding marine vessels similar to Long Islands' Fire/EMS Boat.
- Assist EMS agencies in developing protocolized process for EMD centers to obtain transport resources and assist island EMS agencies with options.
- Support LifeFlight / EMS service instrument flight landing zone setups and communications to improve night and weather reliability.
- Assist Islesboro EMS to explore/develop Restricted Air Ambulance License with PIA.
- Current funding for Maine DOT and the Maine State Ferry Service do not include specific funding for providing EMS transport. One way to increase the readiness of using the MSFS as a viable option for EMS transport is to look into the costs and funding for having the island-based crew paid for being on standby during non-operating hours. This cost would be outside of the state mandate of service to the islands and would have to be covered by municipalities that benefit from vessels overnighting on island. It is important to note that all requirements from the US Coast Guard must still be met, and the go-no go decision still lies with the captain.

- Develop liability waivers for fishing and private marine vessels assisting island EMS agencies with transport.
- There is a disparity where some islands (Vinalhaven, North Haven, Islesboro, Swan's Island) have Maine State Ferry Service vessels based on the island at night and state taxpayers subsidize the cost of EMS readiness to these communities whereas other communities (e.g. Chebeague, Long, Portland) absorb the cost of readiness.
- Explore the potential of PIA upgrading their plane and landing zones at each island, providing low visibility training and having pilots on standby pay. The costs associated with these endeavors could possibly be covered by a bond bill.

OVERALL

The unique EMS needs of all of the islands in Maine cannot be addressed without long term commitment and evaluation. Along with the specific recommendations for further exploration, the Island EMS Workgroup suggests continuing input from island communities, EMS clinicians, medical directors, Maine EMS, hospitals, legislators and other stakeholders.

Assuring the sustainability of rural island EMS agencies through implementing the findings and recommendations in this study will take participation from community members, EMS clinicians, medical directors, Maine EMS, hospitals, and legislators. Additionally, collaboration will be needed across state agencies, including Public Safety, the Department of Health and Human Services Office of Rural Health, the new Rural Health

Transformation Program, the Department of Transportation, the Maine Community College System, and Department of Labor.

The efforts of this workgroup, while providing our best insights within the timeframe given, show, to some degree, a snapshot of many challenges and opportunities across the EMS system in Maine and nationally. Through collaborative dialogue and clarity, and by developing an engaged and empowered group, the health and safety of island communities can be better supported.

We appreciate the efforts generated by LD841 and hope it sets an example of the work that may continue to support Emergency Medical Services and healthcare in Maine.

MAINE ISLANDS OVERVIEW

Monhegan Island

Overview

According to the Maine State Coastal Island Registry, there are over 3,300 islands in the State of Maine. These include

- 1,846 islands registered to private owners
- 204 islands that are exempt from registering
- 1,322 islands under the State of Maine care & custody

Although there are many inhabited islands in Maine, and all would likely consider themselves a community, the intent of LD841 focuses on those public islands without bridges to the mainland *and* maintain a year-round population. This has been defined as the following fifteen (15) islands, roughly divided into three geographic areas:

Penobscot Bay Islands

Isle au Haut
Islesboro
Matinicus
Monhegan
North Haven
Vinalhaven

Down East

Cranberry Isles
Frenchboro
Islesford
Swan's Island

Casco Bay Islands

Chebeague Island
Cliff Island
Great Diamond Island
Long Island
Peaks Island

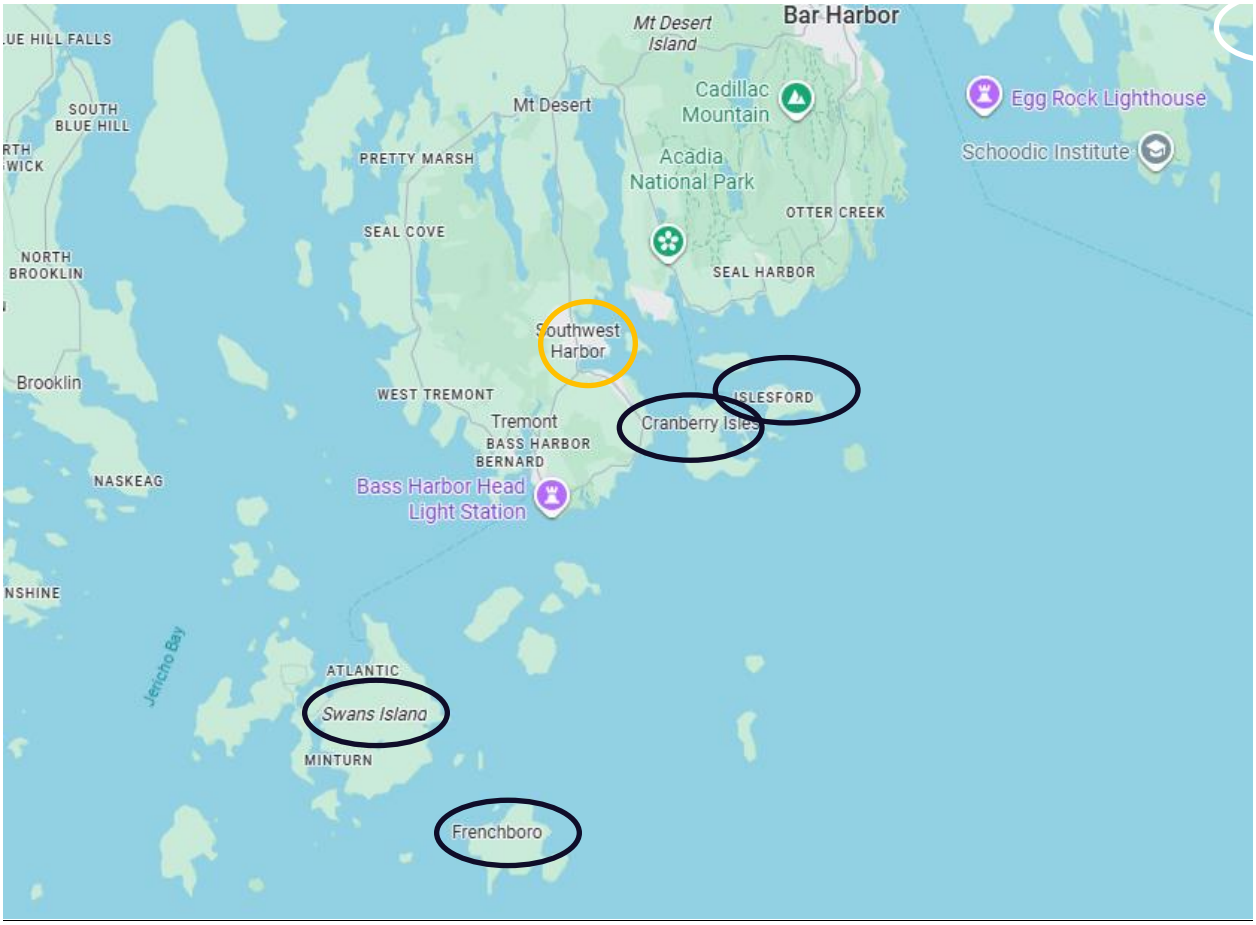
These islands all have diverse working communities with approximately 4,500 year-round residents (and significantly higher summer populations). In addition to the 15 year-round working community islands, there are hundreds of islands with seasonal to year-round population (e.g. Roque, Benner, Frye, Cushing, Little Diamond) with EMS support from other islands, seasonal EMS agencies, or mainland EMS agencies.

The following maps show approximate locations. The gold circles indicate most common landing points for transfer of EMS patients, which vary in transport times from 20 minutes to over 120 minutes.

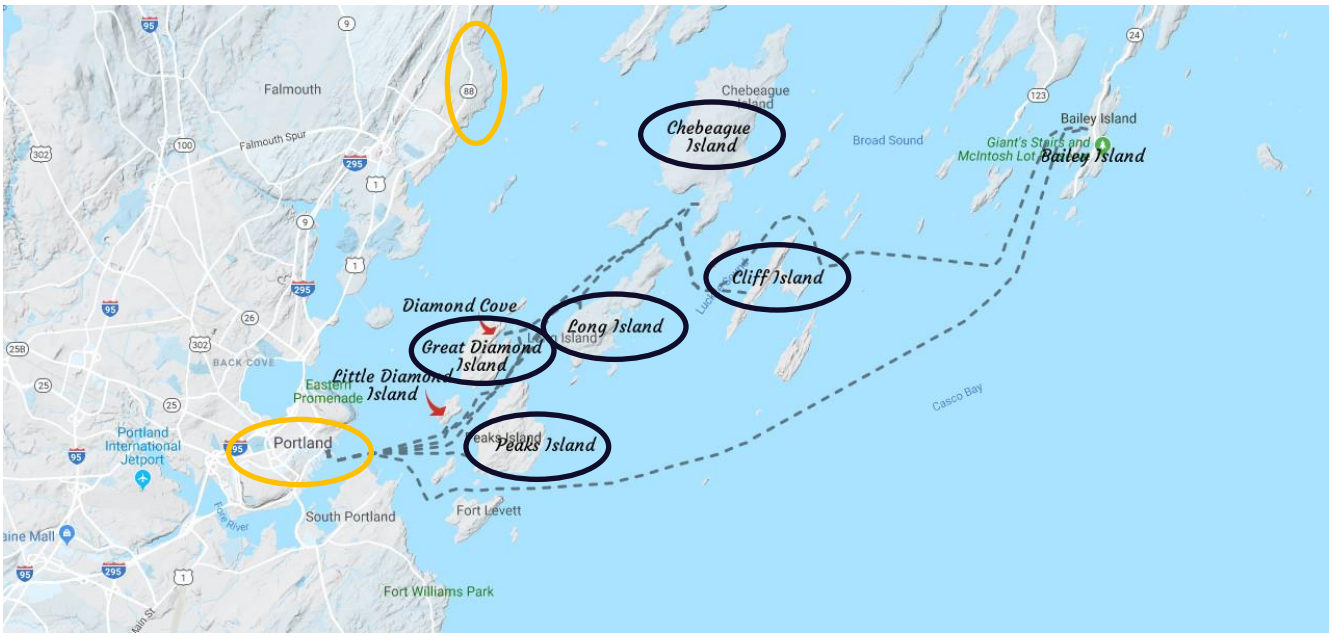
Penobscot Bay Islands

Portland Fire Boat and Peaks Island

Down East Islands



Casco Bay Islands



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Island Communities

Island	Year-Round Population*	Average Distance to Mainland	Ferry Service
Chebeague Island	394	2 miles	Casco Bay Lines & Chebeague Transportation
Cliff Island	60	8 miles	Casco Bay Lines
Cranberry Isles	161	15 miles	Beal & Bunker Ferry or Downeast Windjammers
Frenchboro	30	8 miles	Maine Ferry Service
Great Diamond Island	77	3 miles	Casco Bay Lines
Isle au Haut	87	7 miles	Isle au Haut Boat Company
Islesboro	579	3 miles	Maine Ferry Service
Islesford	40	15 miles	Beal & Bunker Ferry or Downeast Windjammers
Long Island	233	6 miles	Casco Bay Lines
Matinicus	51	23 miles	Maine Ferry Service
Monhegan	64	10 miles	Monhegan Boat Line
North Haven	417	12 miles	Maine Ferry Service
Peaks Island	927	3 miles	Casco Bay Lines
Swan's Island	356	6 miles	Maine Ferry Service
Vinalhaven	1,288	15 miles	Maine Ferry Service

**Population from 2020 Census report*

EMS ON MAINE ISLANDS

Photo by Ryan Nizolek

Delivery of Emergency Medical Services (EMS) on islands

Of the fifteen public, unbridged, year-round islands eleven have licensed Maine EMS agencies and four do not.

The four islands *without* Maine EMS licensed EMS agencies are:

- Frenchboro
- Isle au Haut (previously had an EMS agency, license expired in 2021)
- Matinicus (previously had an EMS agency, license expired in 2016)
- Monhegan Island

The eleven islands *with* Maine EMS licensed EMS agencies are:

Community	Maine EMS Licensed Agency
Chebeague Island	Chebeague Island Fire & Rescue
Cliff Island	Portland Fire Department
Cranberry Isles	Cranberry Isles Rescue
Great Diamond Island	Portland Fire Department
Islesboro	Islesboro Ambulance Service
Islesford	Cranberry Isles Rescue
Long Island	Long Island Fire Department
North Haven	North Haven EMS
Peaks Island	Portland Fire Department
Swan's Island	Swan's Island Ambulance
Vinalhaven	Vinalhaven Ambulance

The operations of EMS on each island vary greatly. Some islands are completely volunteer, while others are completely full-time. Most islands have a mixture of some paid part-time leadership and on call volunteers who receive a small stipend for time on calls and/or at training. All EMS agencies and clinicians follow the statewide Maine EMS protocols for emergency care, with the local community deciding what level of care to be provided when licensing the agency (EMT, Advanced EMT, or Paramedic level). Transportation of patients to the hospital consists of many different forms, and some islands will use multiple methods depending upon a multitude of factors (e.g., weather, severity of condition, access). When a patient wishes to be transported to a hospital, EMS agencies may:

- Transport patient via an ambulance physically driven onto a ferry and then hand-off the patient and care to a mainland EMS agency who then transports them to the hospital.
- Transport patient via an ambulance physically driven onto a ferry and continue in same ambulance to the hospital.

- Transport patient via a ferry or fireboat on a stretcher and then hand-off the patient and care to a mainland EMS agency who then transports them to the hospital.
- Transport via a private boat (e.g., lobster boat, other private boats) with EMS accompanying the patient to the mainland and hand-off the patient and care to a mainland EMS agency who then transports them to the hospital.
- Transport via a private boat (e.g., lobster boat, other private boats) with EMS accompanying the patient to the mainland and the patient is driven by private vehicle by family or friends to the hospital.
- Transport via US Coast Guard with EMS accompanying the patient to the mainland and hand-off the patient and care to a mainland EMS agency who then transports them to the hospital.
- Transport via LifeFlight of Maine helicopter, which lands on the island and then flies the patient to the hospital using their EMS clinicians.
- Transport via Penobscot Island Air which lands on the island and flies to the mainland to an airport (typically Knox County Regional Airport). Island EMS clinicians accompany the patient on the aircraft and then hand-off the patient and care to a mainland EMS agency who then transports them to the hospital.

Each method of transport has advantages and disadvantages, and each may not be available 24/7. Partnership, communication, and collaboration with mainland EMS agencies are key aspects of continuity of care.

Island EMS Licensure Summary

The following chart shows some basic overview information regarding each island and any EMS agency serving that island. In terms of Maine EMS licensure:

- License levels and other rules can be found in Appendix C and in the Maine EMS Rules at https://www.maine.gov/ems/protocols-resources/statutes
- "Licensed" – the minimum EMS clinician license level that must be present whenever the agency responds. Only one member at that licensure level is needed. If an agency is licensed at the EMT level, it must have at least an EMT clinician respond. If an agency is licensed at the AEMT level, and only an EMT responds, the agency would violate Maine EMS Rules.
- "Permitted"—this is the highest level of care and equipment that can respond to an EMS call. An agency does not guarantee it will have this level of staffing, but if it does, the equipment and medications needed for that level of licensed clinician to use are present.
    - Note a higher-licensed clinician could respond and provide care with an agency that has lower licensure but would be restricted to only being able to provide care

to the agency permitted level (e.g. a paramedic responds with an EMT permitted agency. They would only be able to provide EMT level care)

- All transport ambulances must also have at least one Licensed Ambulance Operator to drive it. An EMR, EMT, AEMT, or Paramedic can also fill this role, but not if they are providing direct EMS care in the ambulance. All Islands are considered transporting agencies as they move patients from the scene to another location.
- An EMR cannot be the only clinician in the back of the ambulance providing care. Maine EMS requires a minimum EMT in the patient care compartment.
- Currently, Maine EMS does not license boats as ambulances.

Photo by Chris Dobson

Year-Round Unbridged Islands

	Island	Political Status	EMS Agency	Own EMS transport?	Ferry Service*	Licensed	Permitted	County	EMS Region
	Chebeague Island	Independent	Chebeague Island Fire & Rescue	24/7 ferry	Casco Bay Lines & Chebeague Transportation Company	EMT	Paramedic	Cumberland	1
	Cliff Island	Portland	Portland Fire Department	Fireboat	Casco Bay Lines	Paramedic	Paramedic	Cumberland	1
	Frenchboro	Independent			Maine Ferry Service	-	-	Hancock	3
	Great Cranberry Island	Independent	Cranberry Isles Rescue		Beal & Bunker Ferry or Downeast Windjammers	EMT	EMT	Hancock	3
	Great Diamond Island	Portland	Portland Fire Department	Fireboat	Casco Bay Lines	Paramedic	Paramedic	Cumberland	1
	Isle au Haut	Independent			Isle au Haut Boat Company	-	-	Knox	3
	Islesboro	Independent	Islesboro Ambulance Service		Maine Ferry Service	EMT	Paramedic	Waldo	3
	Islesford	Independent	Cranberry Isles Rescue		Beal & Bunker Ferry or Downeast Windjammers	EMT	EMT	Hancock	3
	Long Island	Independent	Long Island Fire	Fireboat	Casco Bay Lines	EMT	EMT	Cumberland	1
	Matinicus	Independent			Maine Ferry Service	-	-	Knox	3
	Monhegan	Independent			Monhegan Boat Line	-	-	Lincoln	3
	North Haven	Independent	North Haven EMS		Maine Ferry Service	EMT	AEMT	Knox	3
	Peaks Island	Portland	Portland Fire Department	Fireboat	Casco Bay Lines	Paramedic	Paramedic	Cumberland	1
	Swan's Island	Independent	Swan's Island Ambulamce		Maine Ferry Service	EMT	EMT	Hancock	3
	Vinalhaven	Independent	Vinalhaven Ambulance		Maine Ferry Service	EMT	AEMT	Knox	3
					*Not all ferries accommodate vehicles				

	No EMS Service No formal transport to mainland
	Licensed EMS Service No formal transport to mainland
	Licensed EMS Service Existing community based transport to mainland

Note: All of the following data is sourced from the Maine EMS & Fire Incident Reporting System (MEFIRS) used by all EMS agencies and has a margin of error of 3.6%. The EMS clinician enters data, and this data relies on their accuracy and completeness in the patient care record (PCR).

EMS Volume

Of the fifteen unbridged year-round islands, three had no documented EMS responses during 2024 (two had none over the 5-year review), two islands had mainland-based agencies respond to an island during the year, and one island had EMS responses only performed by LifeFlight of Maine (LFOM). Additionally, LifeFlight of Maine responded 40 times to 5 islands in Penobscot Bay and Down East but did not have any responses in Casco Bay in 2024 (and only 1 in the 5-year review). By island, Peaks Island and Vinalhaven were the busiest. Regionally:

- Penobscot Bay Islands had 48% of EMS responses
- Casco Bay Islands had 41% of EMS responses
- Down East Islands had 11% of EMS responses

EMS Responses to Year-Round Unbridged Islands, by Island *(>10 is cutoff point for deidentification)*

Island	Agency	2024 Responses	5-year Average Annual Volume
Chebeague Island	Chebeague Island Rescue	68	72
Cliff Island	Portland Fire Department	<10	<10
Cranberry Isles / Isleford	Cranberry Isles Rescue	16	16
Frenchboro		0	0
Great Diamond Island	Portland Fire Department	<10	<10
Islesboro	Islesboro Ambulance Service	76	81
	LifeFlight of Maine (mutual aid)	<10	
	Northeast Mobile Health Services	<10	
Isle au Haut		0	0
Long Island	Long Island Volunteer Rescue	28	20
	Portland Fire Department (mutual aid)	<10	
Matinicus		0	0
Monhegan Island	LifeFlight of Maine (primary)	<10	<10
North Haven	North Haven EMS	40	45
	LifeFlight of Maine (mutual aid)	<10	
Peaks Island	Portland Fire Department	213	179
Swan's Island	Swan's Island Ambulance	56	50
	LifeFlight of Maine (mutual aid)	<10	
Vinalhaven	Vinalhaven Ambulance	226	203
	LifeFlight of Maine (mutual aid)	17	
	Northeast Mobile Health Services	<10	
Grand Total		**780**	**685**

EMS Responses to Year-Round Unbridged Islands, 2024, by County

County	Responses
Cumberland	323
Hancock	80
Knox	290
Lincoln	<10
Waldo	80
Grand Total	**780**

(>10 is cutoff point for deidentification)

911 Activations

The majority of island EMS activations occur from 911 calls. In Maine, calling 911 connects a caller to a Public Safety Answering Point (PSAP). Per data from the Maine Emergency Services Communication Bureau, over the past 5 years, there were 5,168 activations of 911 from the fifteen year-round unbridged islands. 97% were received by 5 PSAPs:

- Cumberland County Regional Communication Center (6%)
- Hancock Regional Communication Center (20%)
- Knox Regional Communication Center (45%)
- Portland Regional Communication Center (11%)
- Waldo Regional Communication Center (14%)

These 911 calls encompass calls for EMS, vehicle accidents, fires, police requests, general questions, misdials/misuses, and accidental calls. Additionally, there may be multiple 911 calls for the same incident, as well as call backs in cases of disconnection or condition changes.

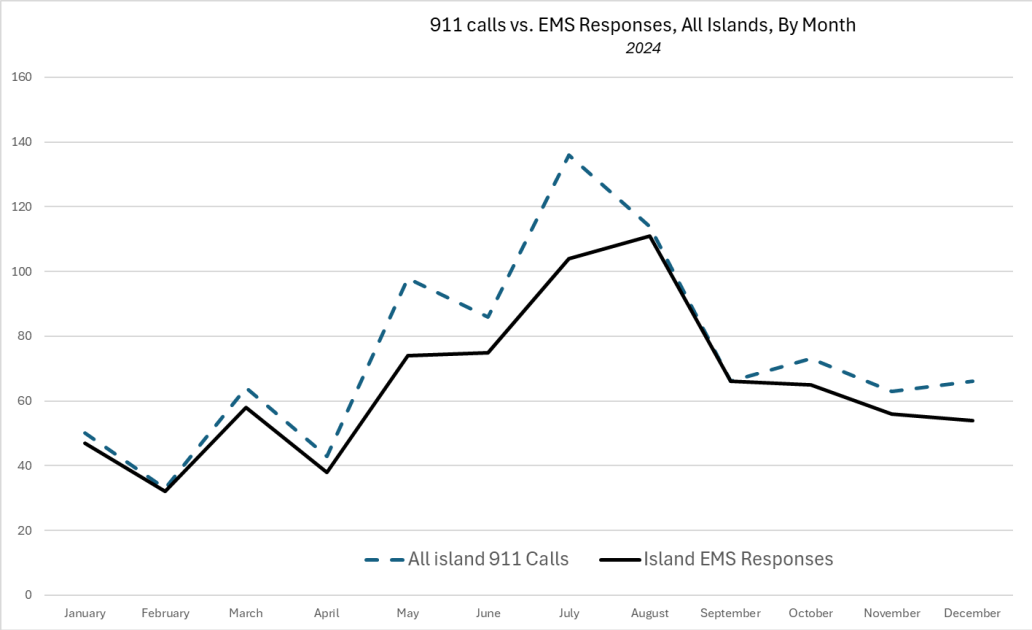
In a 5-year review (2020-2024), 70% of all 911 calls occur between 8am and 8pm, with the busiest day of the week being Wednesday. Statistically, the most likely time for a 911 call is on a Wednesday in July between 8am and noon.

Total 911 Calls, All Islands

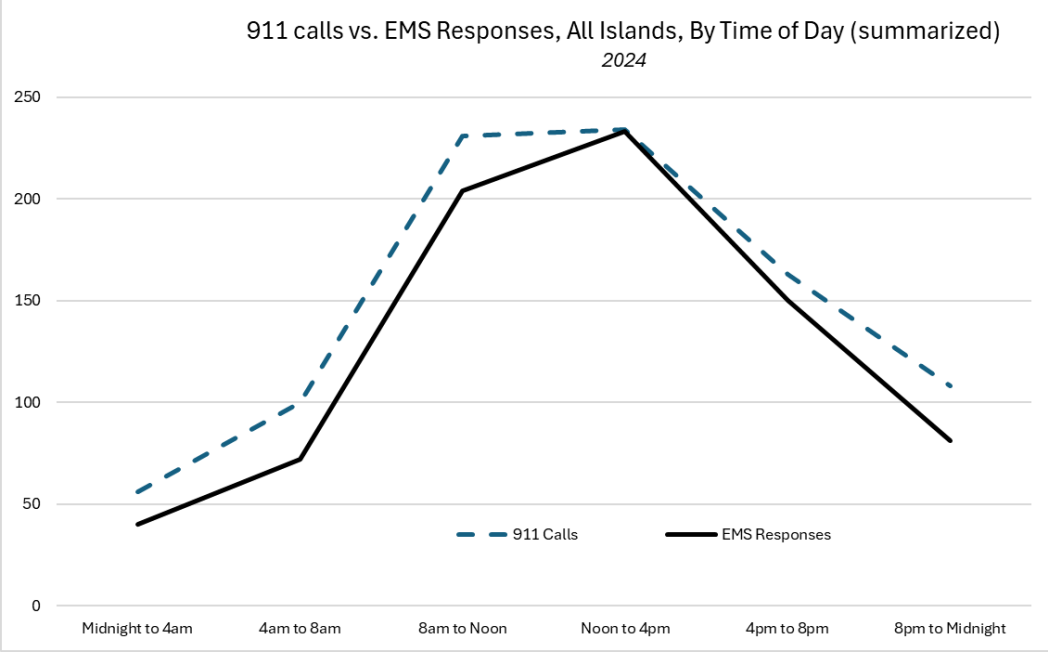
Island	Total (2020-2024)	2024 only
Chebeague Island	203	43
Cliff Island	33	<10
Frenchboro	<10	0
Great Cranberry Island	13	<10
Great Diamond Island	153	25
Isle Au Haut	16	0
Islesboro	543	74
Little Cranberry Island	50	17
Long Island	99	27
Matinicus Isle	24	<10
Monhegan Island	23	<10
North Haven	250	53
Peaks Island	418	82
Swan's Island	1,100	200
Vinalhaven	2,238	356
Grand Total	**5,168**	**892**

** These calls include calls for Police, Fire & EMS assistance. There may also be multiple calls for the same incident.*

Unsurprisingly, most 911 calls from islands occurred between May and August, with 49% of all calls to 911 in 2024 occurring in these four months. We can see in the chart below the difference between total 911 calls and EMS responses. This shows the vast majority of 911 calls can be equated to utilizing EMS. This 911 call is the beginning of EMS care, as calls receive emergency medical instructions from licensed Emergency Medical Dispatchers (EMDs). EMDs provide instructions to callers ranging from how to control bleeding to performing CPR to delivering a baby. The remaining 911 calls may be for fire, police, repeat calls, or misdials.



We can also see that this correlation between 911 calls and EMS responses holds true regardless of time of day.



Disposition of Island EMS Responses

EMS is dispatched to various types of calls, and a measure of use of EMS is the disposition of the call. The most common disposition is that EMS transports the patient; however, other conditions may arise. The patient may refuse transport, or a guardian may refuse transport for a minor. The Maine EMS Statewide protocols (https://www.maine.gov/ems/protocols-resources/pre-hospital-care-protocols) provide clinical direction on various situations and assessments to offer before a patient can refuse transport (particularly Maine EMS Transport Protocol Gray 22 & 23). Additionally, all island EMS clinicians have 24/7 access to online medical consultation (OLMC) with an emergency department physician, physician assistant, or nurse practitioner for clinical discussions to assist in transport or no transport scenarios.

In other cases, EMS may be dispatched to calls where no patient is found. EMS may be on standby at events, such as a fire, sporting events, or another community activity. This may also be the case in such events as good-intent 911 calls ("I thought I saw…") or the patient self-transports to another location before EMS arrives. An EMS response can also be cancelled in cases such as accidental 911 calls or accidentally activated alarms.

EMS Responses to Year Round Unbridged Islands, 2024, by Agency

EMS Agency	Responses*	Transported by EMS	% Transported	No Transport / Refused Transport	No Patient Found	Cancelled	(blank)
Chebeague Island Rescue	**68**	54	79%	8	<10	<10	<10
Cranberry Isles Rescue	**16**	10	63%	<10			<10
Islesboro Ambulance Service	**76**	51	67%	<10	<10	<10	<10
LifeFlight of Maine**	**40**	37	93%	<10		<10	
Long Island Volunteer Rescue	**28**	21	75%	<10			
North Haven EMS	**40**	25	63%	11			<10
Northeast Mobile Health Services	**<10**	<10	100%				
Portland Fire Department**	**227**	172	76%	28	<10	17	<10
Swan's Island Ambulance	**56**	34	61%	22			
Vinalhaven Ambulance***	**201**	142	71%	45	<10	<10	<10
Grand Total	**755**	**549**	**73%**	**133**	**21**	**34**	**18**

**There were no EMS responses to Frenchboro, Isle au Haut, or Matinicus, nor EMS agencies on these islands*

***These numbers only reflect responses to islands*

****Vinalhaven writes a separate report for flights via PIA, so # of PCRs is higher than number of patients*

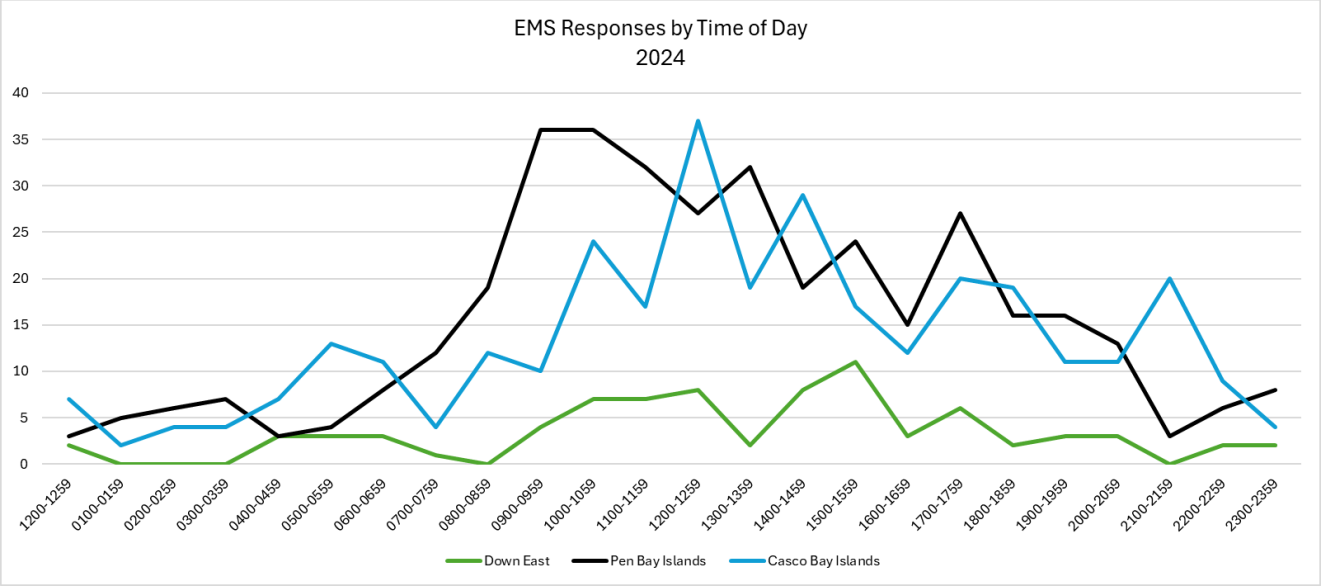
EMS TIMES

LifeFlight of Maine on Monhegan Island

Island EMS Times

Responses By Time of Day

Consistent with EMS activation times across the state, most EMS responses on the islands occur in the twelve hours from 8 a.m. to 8 p.m. In the case of the islands, 75% of overall responses arise during this time frame, with 30% of all calls occurring between noon and 4 p.m. Regionally, the only exception occurs in the Penobscot Bay Islands, where 40% of EMS calls occur between 8 a.m. and noon.



A measure that is often requested is “response time”. This is the time from when EMS is dispatched until it arrives on scene. In many cases, this time may be misleading depending upon the nature of the reported emergency. It is far safer to respond without lights and sirens for a patient with minor non-life-threatening conditions, but this may result in a longer response time than for a critical patient, such as an unconscious person. As a result, average response times can be skewed. Additionally, in the island environment, response may require travel by boat or aircraft, which can further increase response time compared to a mainland ambulance. Nearly all EMS agencies on the islands are volunteers and do not staff a station 24/7. This can result in increased time responding to the station, but this is also true on the mainland in much of Maine.

Response Times

The overall response time for all islands in 2024 was 12 minutes, and 65% of all responses were at or below this time. This excludes LifeFlight of Maine, as they generally respond from significantly further away (their average response time in 2024 was 49 minutes).

Average Response Times (except LFOM)

Agencies	Average Response Time
Overall Average	12 min
Casco Bay Agencies	13 min
Down East Agencies	14 min
Pen Bay Agencies	11 min
Total	**740**

In 2024, less than 5% of EMS responses had longer than a 30-minute response time, which can reflect travel by boat to another island that is part of the community but not where the ambulance is stationed. EMS clinicians may document a "0 min" response time when they come across a call and are immediately on scene, where they were already on standby (such as a fire), or on occasion when response times are unavailable.

Response Times (except LFOM)

Response Time	Occurrences
0 min	25
30+min	33
60+ min	5
Blank	15

Scene Times

Island EMS agencies had an overall average of 28 minutes on scene in 2024. How long EMS clinicians spend on a scene before beginning transport can vary based on treatments needing to be performed, availability of transport (e.g., it may be more appropriate to wait in a heated, comfortable home than wait for 30 minutes in the ambulance at a dock), and other clinical factors. Casco Bay Agencies had the lowest scene times, but they all have their own boat available for transport.

Island Scene Times

Agencies	Average Scene Time
Overall Average	28 min
Casco Bay Agencies	24 min
Down East Agencies	36 min
Pen Bay Agencies	28 min
LifeFlight of Maine	28 min

In critical conditions, spending less than 10 minutes on the scene is generally accepted when possible. In 2024, 35% of island EMS agencies had a scene time that exceeded 30 minutes. If an agency is cancelled, it may not have a scene time. When not cancelled, island EMS agencies' EMS clinicians may document a "0 min" scene time when the patient is immediately moved into the ambulance or, on occasion, when scene times are not available.

Island Scene Times, 2024, except LFOM

Scene Time	Occurrences
0 min	11
30+min	264
60+ min	41
Blank (when not cancelled)	9

Transport Times

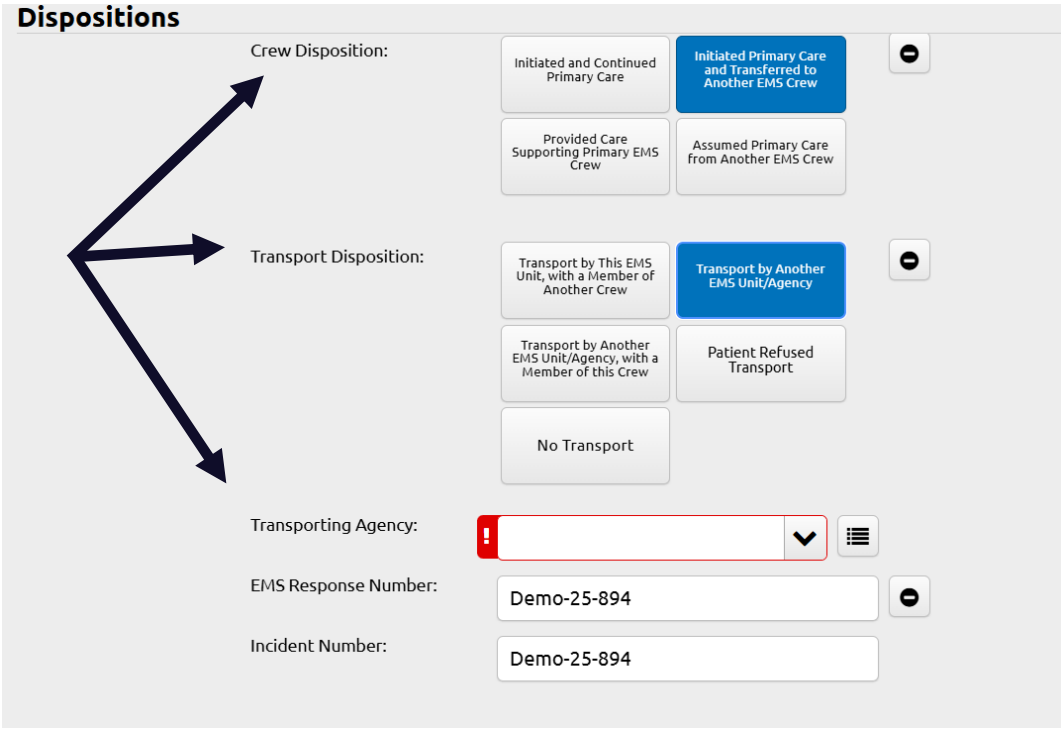
78% of the EMS patients seen on an island were transported to a hospital by EMS in 2024. The documentation in the Maine EMS & Fire Incident Reporting System (MEFIRS) of "transport time" can be challenging, as the island EMS agencies often do not transport patients all the way to the hospital and regularly hand off patient care to another EMS agency. As such, the "arrived at destination" time may represent the handoff time to a mainland EMS agency rather than a specific or traditional destination of a hospital.

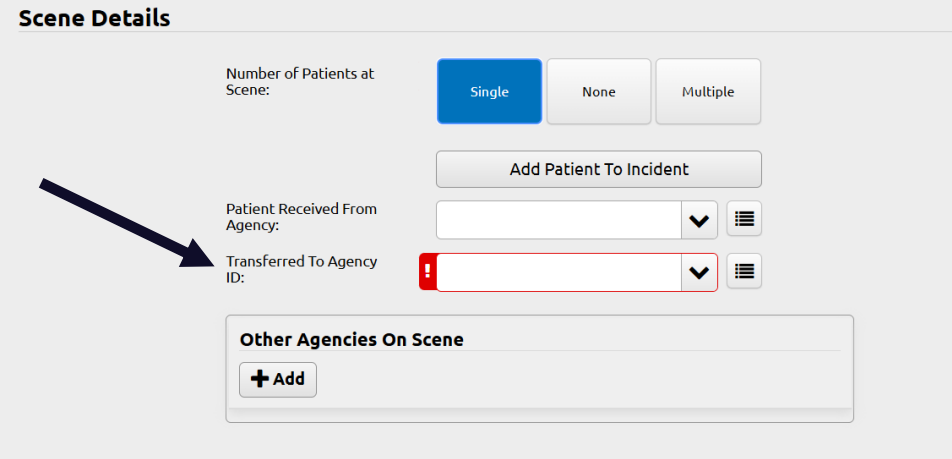
Island Transport Times, 2024

Agency	Average Transport Time
Casco Bay Agencies	16 min
Down East Agencies	46 min
Penobscot Bay Agencies	41 min
LifeFlight of Maine	21 min
Overall Average (except LFOM)	**31 min**

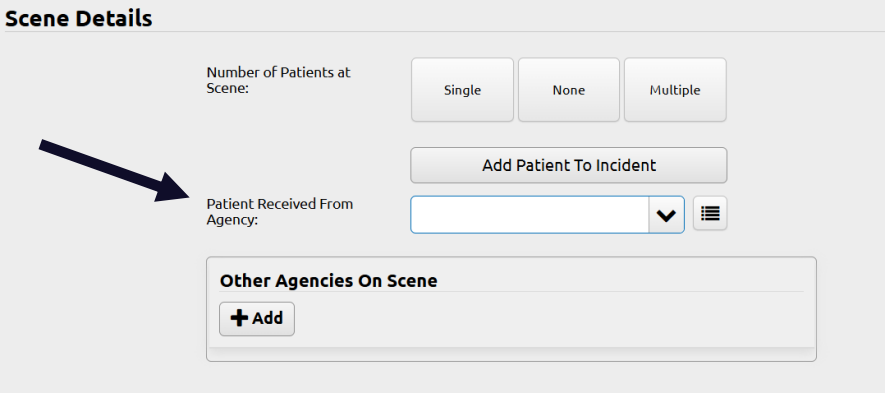
When EMS agencies hand off patient care to another EMS agency on the mainland (or via air transport), it is preferred to use a "Transferred to Agency" time. 17% of island EMS transports did not document either "arrival at destination" or "transferred to agency" time.

In cases of handing off the patient to another EMS agency, documenting "Transporting Agency" and "Transferred to Agency" and selecting the correct transport agency will link the reports so hospitals and QI can connect the complete care report.





Additionally, the receiving agency (whether ground or air transport to the hospital) should complete the "Patient Received from Agency" field to link these patient care reports.



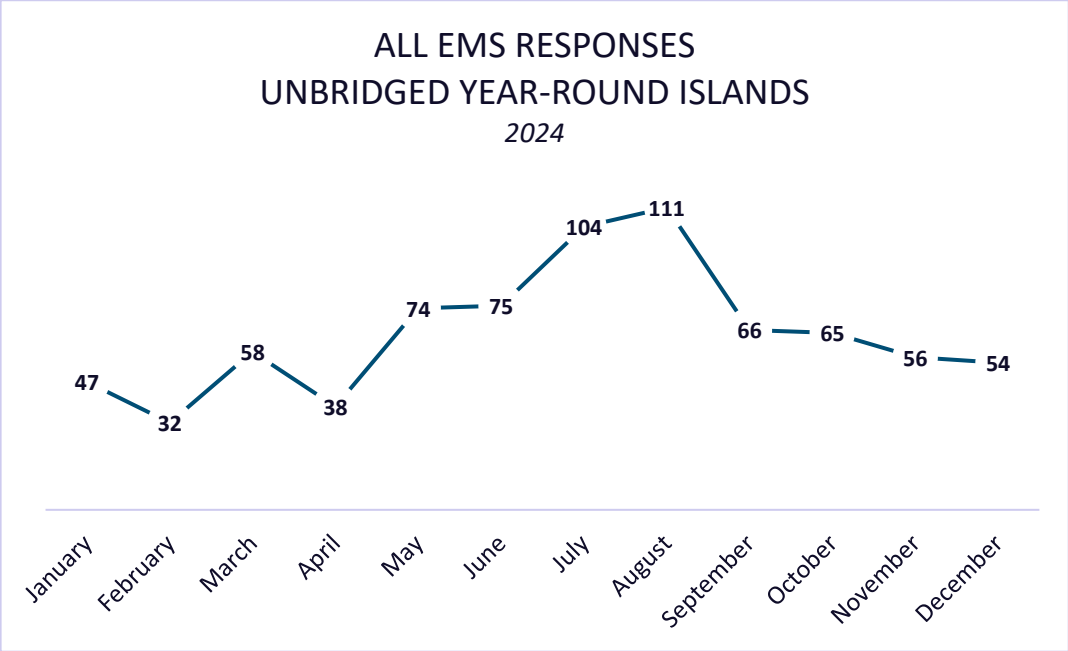
In cases where transport time is documented, the average is 31 minutes, with 50% at or below that time. An important consideration is that in 89 reports (17%), when transport was indicated to have occurred, the report did not have a documented hospital arrival or handoff to another EMS agency time.

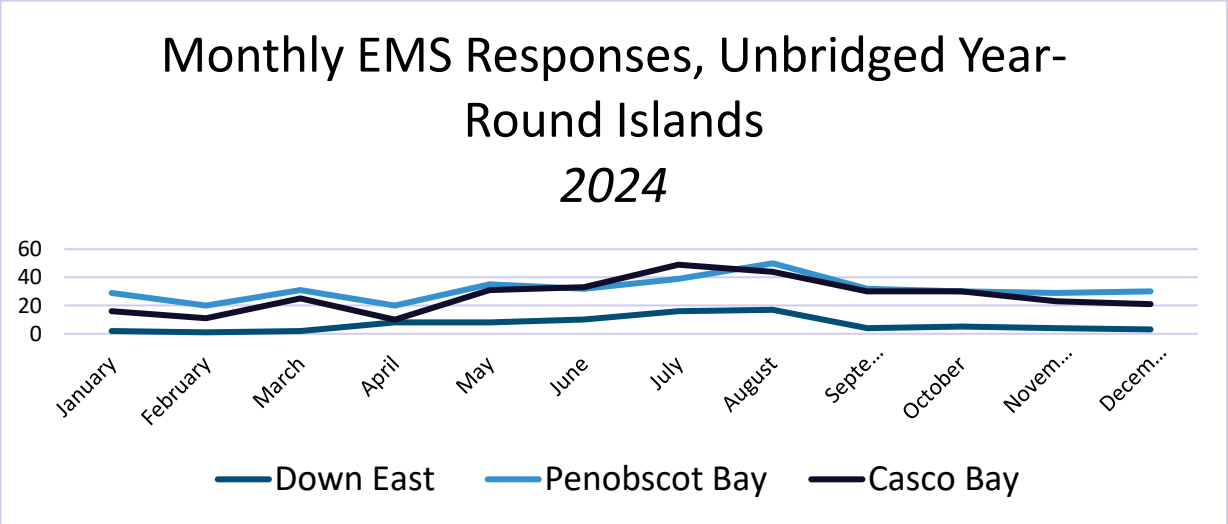
Island Transport Times, 2024 (except LFOM)

Transport Time	Occurrences
0 min	11
1-29 min	254
30-59 min	127
60+ min	56
Blank	89

Island Responses by Month

Again, unsurprisingly, most EMS responses on islands occurred between May and August, with 47% of all island EMS responses in 2024 occurring in these four months.





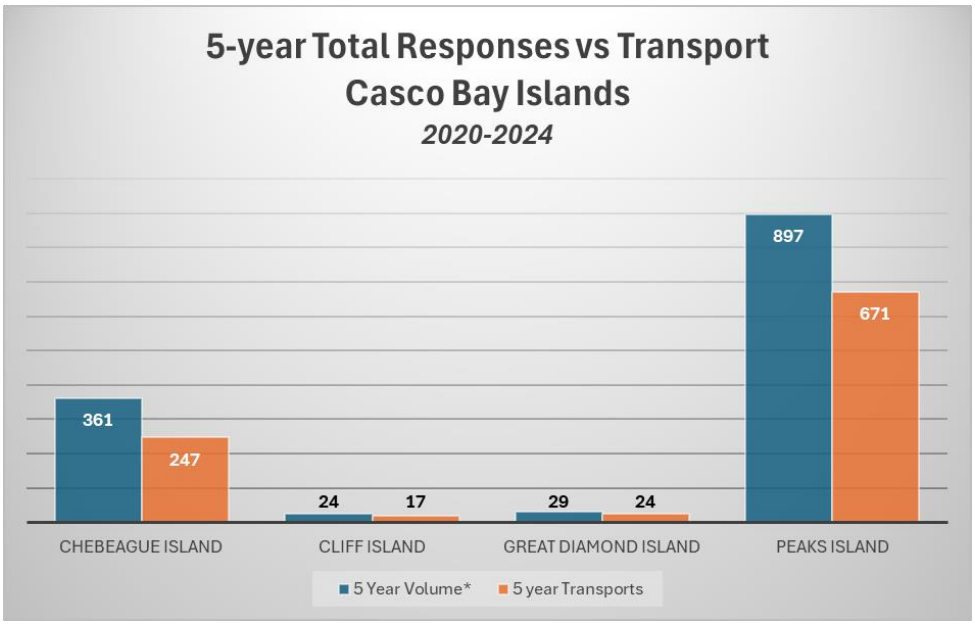
ISLAND EMS OPERATIONS

North Haven EMS, Photo by Courtney Naliboff

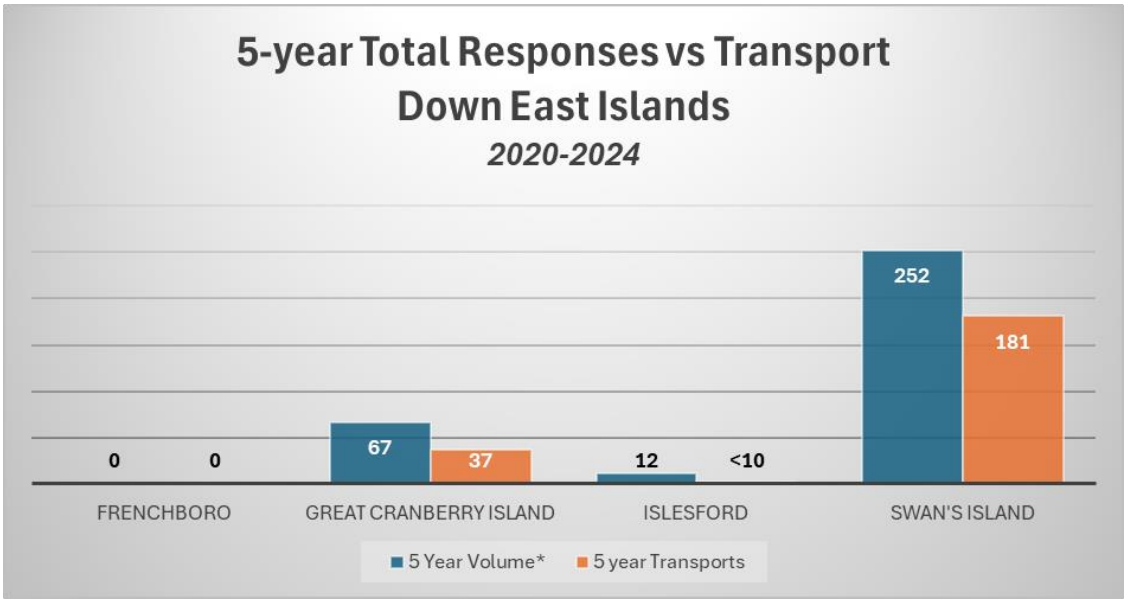
5-year volume

The total number of EMS island responses from 2020 to 2024 was 3,427, with 69% of those EMS responses resulting in patient transport. By island region, we can see the following total responses and transports (note that the * indicates that the total does not include any COVID vaccinations administered by EMS on islands).

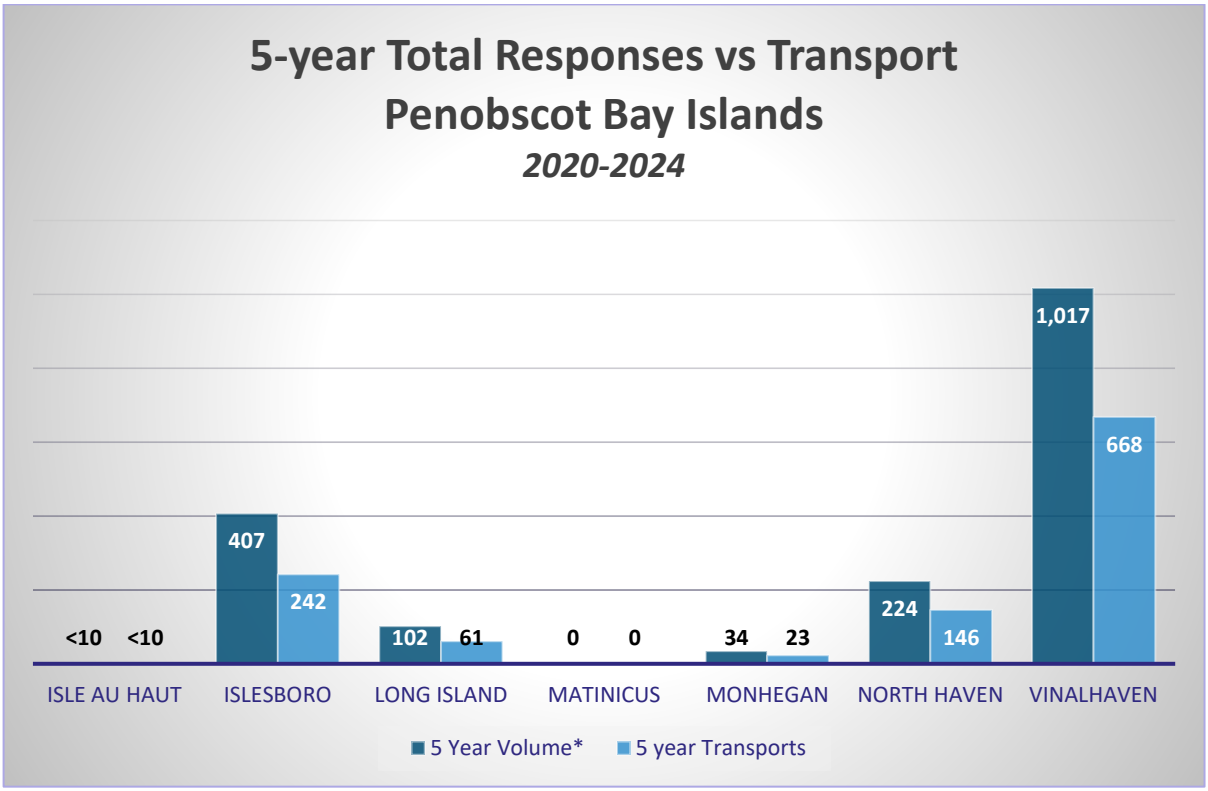
Casco Bay Islands had 1,311 EMS responses with a 73% patient transport rate.



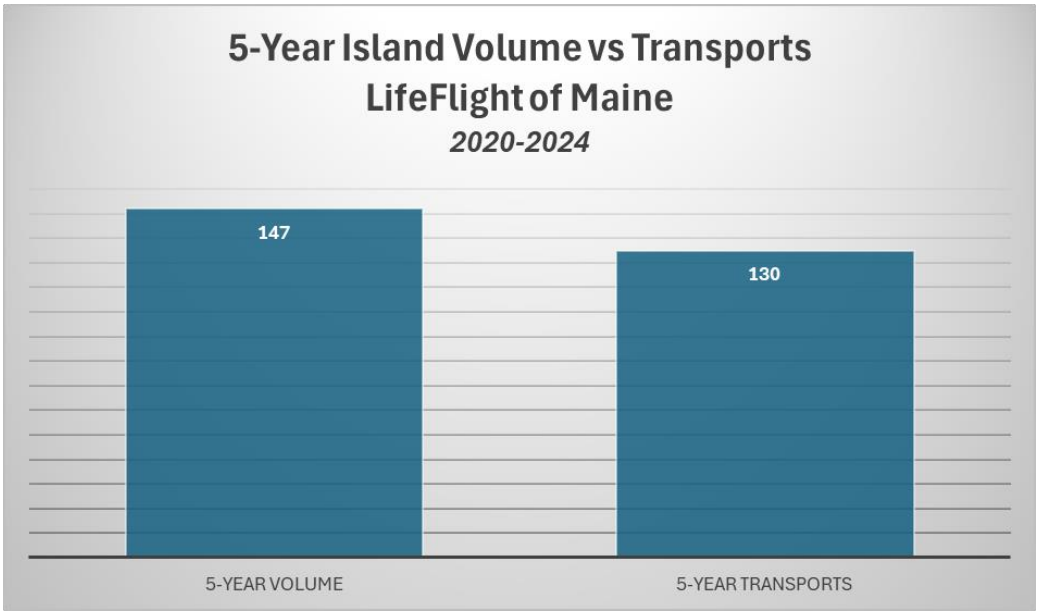
The Down East Islands had 331 EMS responses with a 66% patient transport rate.



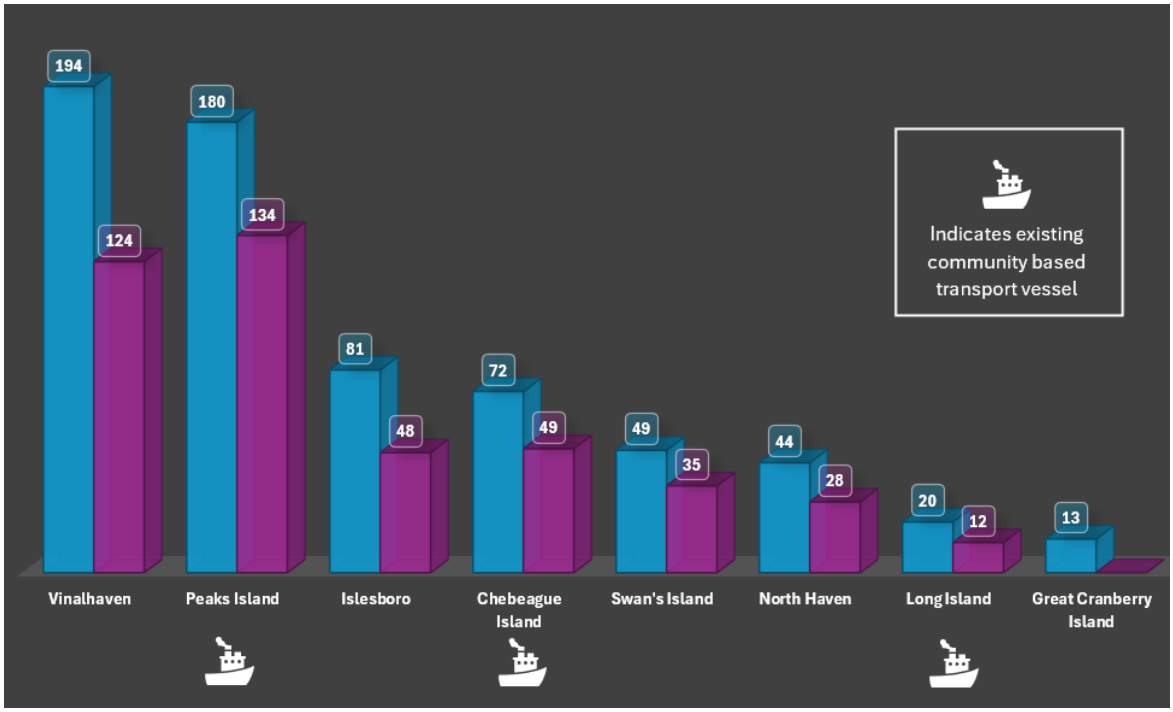
Penobscot Bay Islands had 1,785 EMS responses with a 64% patient transport rate.

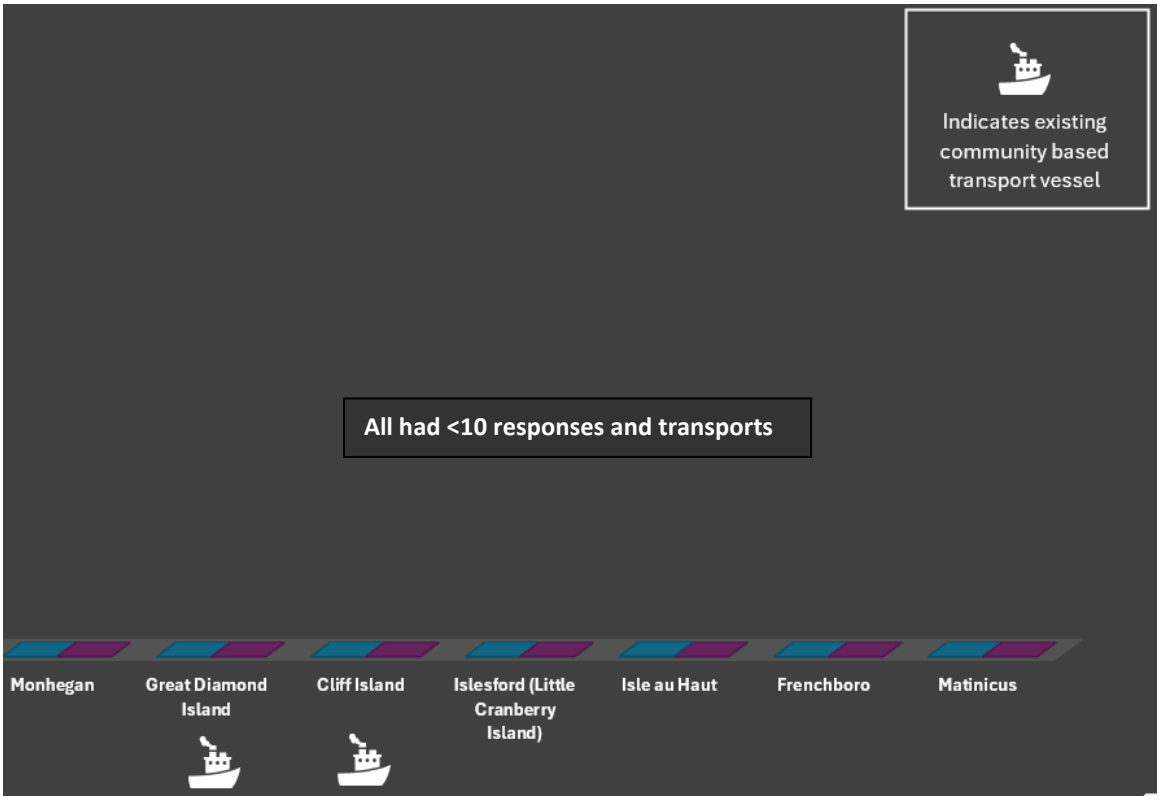


When utilized on any of the 15 unbridged, year-round islands, LifeFlight of Maine had 147 EMS responses with an 88% patient transport rate.



5-YEAR AVERAGE ANNUAL EMS RESPONSES *vs* TRANSPORTS UNBRIDGED YEAR-ROUND ISLANDS 2020-2024

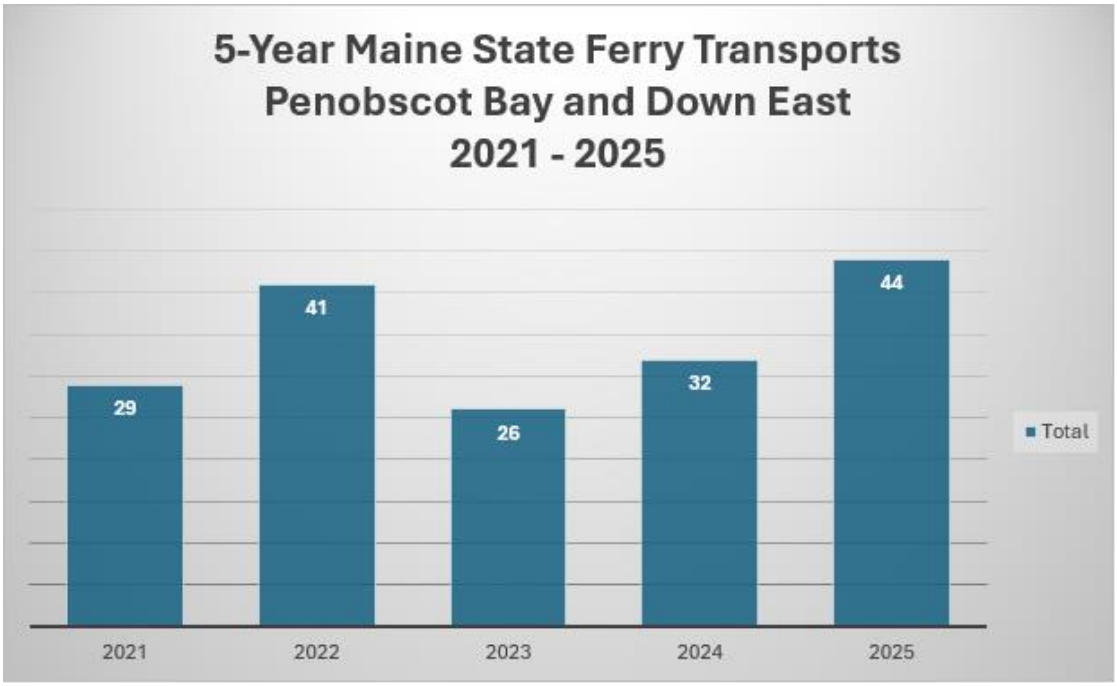




EMS Transport

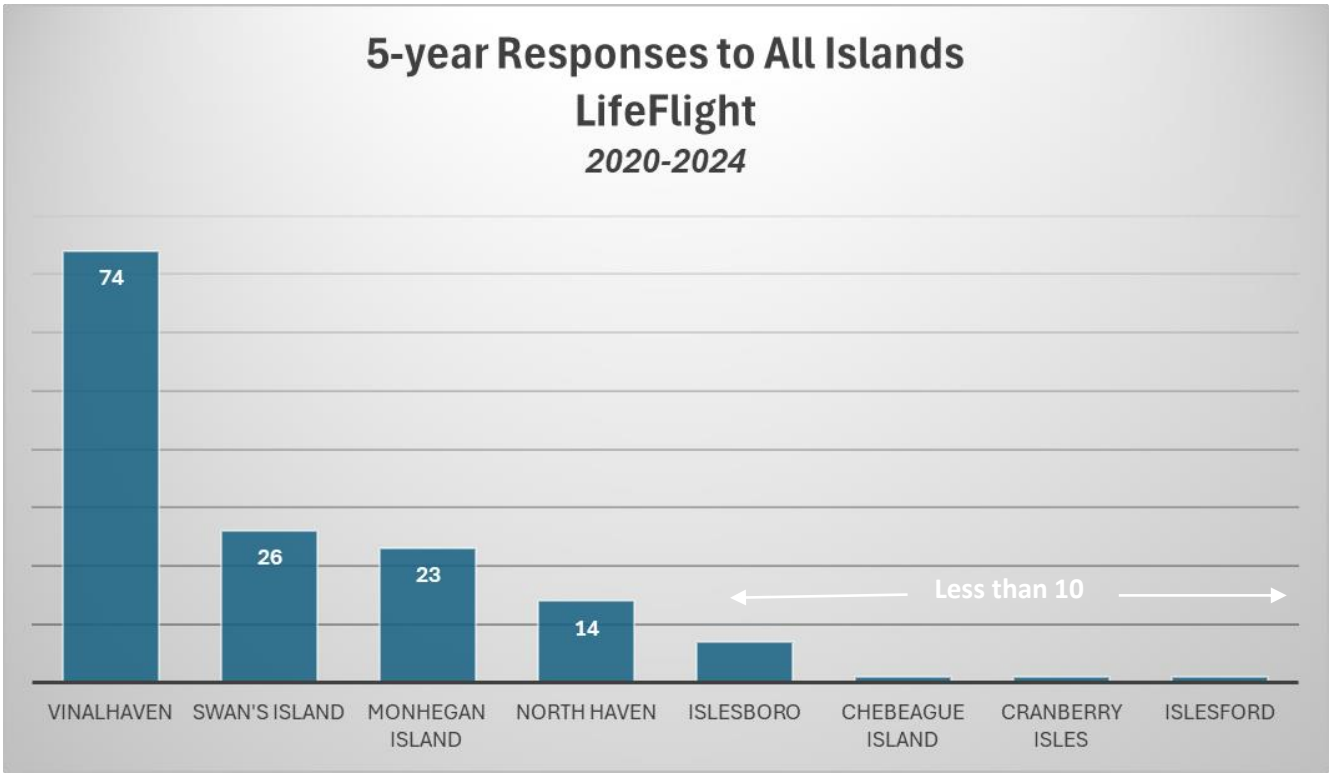
One of the most significant challenges in the island environment is patient transport. Transport may occur via boat (Ferry, municipal fireboat, US Coast Guard, private boat) or aircraft (LifeFlight of Maine, Penobscot Island Air, or other private aircraft).

From 2021 through 2025, the Maine State Ferry reports transporting an emergency trip of an ambulance 172 times from unbridged, year-round islands in Penobscot Bay and Down East. This is an average of 34 times per year. (The Maine State Ferry does not service the Casco Bay islands).



In Casco Bay, from 2020 to 2024, transports from Chebeague Island were via ferry, on the Chebeague Transportation Company ferry (on call 24/7 for emergencies) or municipal fire boat. Long Island, Cliff Island, Great Diamond Island, and Peaks Islands used municipal fire boats (with enclosed patient care areas) for transport. Note that Casco Bay Lines does not transport patients with EMS nor ambulances with patients in the 911 setting.

From 2020 through 2024, LifeFlight had 147 responses to unbridged, year-round islands. There were no LifeFlight responses to Peaks Island, Cliff Island, Great Diamond Island, Long Island, Matinicus, Isle au Haut, or Frenchboro.



Handoff

All of the year-round unbridged island EMS agencies are licensed as transporting agencies. However, only a select number of the Penobscot Bay and Down East island agencies load a patient into an ambulance, drive onto a ferry, and transport the patient directly to the hospital. All other agencies meet a mainland ambulance at a mainland dock (or airport) and transfer a patient from a boat/ferry/aircraft for final transport to a hospital. Except for the Portland Fire Department, this transfer is also a handoff of patient care to another EMS agency.

Of the 574 EMS responses to and transports from islands, 256 (45%) were directly transported to the hospital by the responding agency. Excluding Portland Fire Department, this percentage drops to 21%.

Agencies Responding on Island AND Transporting	Transports	%
Islesboro Ambulance Service	16	6%
LifeFlight of Maine	37	14%
North Haven EMS	<10	2%
Northeast Mobile Health Services	<10	1%
Portland Fire Department	172	67%
Swan's Island Ambulance	<10	1%
Vinalhaven Ambulance	21	8%
Grand Total	**256**	

318 (55%) of EMS transports from a year-round unbridged island resulted in handoffs to another EMS agency that provided transport to the hospital.

Agencies that Received Patients from Island EMS Agencies	Transports	%
Bar Harbor Fire Department	<10	1%
Belfast Ambulance & Rescue Service	<10	2%
Falmouth Fire - EMS	<10	2%
LifeFlight of Maine	30	9%
Mount Desert Fire-Rescue Department	<10	3%
Northeast Mobile Health Services	26	8%
Portland Fire Department	11	3%
Rockland Fire & EMS	<10	2%
South Thomaston Ambulance Service	113	36%
Southwest Harbor / Tremont Ambulance Service Inc	28	9%
St George Ambulance	<10	1%
Yarmouth Fire Rescue	49	15%
(blank)	29	9%
Grand Total	**318**	

Staffing

Staffing on island responses varies greatly. With the exception of LifeFlight, all EMS agencies in Maine must have at least one EMS licensed clinician on an ambulance at the EMT or higher level (LifeFlight is approved to have 2 RNs). Some islands utilize local healthcare clinicians such as Nurse Practitioners (NPs), Physician Assistants (PAs), and Physicians to supplement the EMS response. These individuals maintain independent licenses through the Maine State Boards of Licensure. If they provide care or interventions outside the scope of EMS clinicians, they must accompany the patient to the hospital. Maine statute also does not permit them to respond and perform an emergency EMS call independently in an ambulance without an EMS clinician.

Of the eleven islands with a Maine EMS licensed agency,

- 4 have an agency licensed/permitted at the EMT level

- 2 have an agency licensed at the EMT level and permitted to the Advanced EMT level
- 2 have an agency licensed at the EMT level and permitted to the Paramedic Level
- 3 have an agency licensed/permitted at the Paramedic level

LifeFlight of Maine staffs at the Paramedic/RN or RN/RN level. The staffing data below presents the regional and overall staffing information. The last two lines, Paramedic/RN and Registered Nurse, are LifeFlight staffing. Outside of LifeFlight, there were no paramedic responses on 12 of the 15 unbridged year-round islands.

Total Staffing Level, 2024

Highest Level	Casco Bay	% of responses	Down East	% of responses	Pen Bay*	% of responses	Total Responses*	% of responses
EMT	48	15%	72	90%	40	11%	160	21%
EMT, NP					17	5%	17	2%
EMT, NP, PA					<10	0%	<10	0%
EMT, PA					10	3%	10	1%
Advanced EMT	116	36%			239	63%	356	46%
Advanced EMT, NP					16	4%	16	2%
Advanced EMT, NP, PA					<10	0%	<10	0%
Advanced EMT, PA					18	5%	18	2%
Paramedic	159	49%			<10	1%	162	21%
Paramedic, RN			<10	10%	30	8%	37	5%
Registered Nurse					<10	1%	<10	0%
Grand Total	**323**		**80**		**377**		**780**	

**Frenchboro, Isle au Haut, and Matinicus had zero responses*

NP = Nurse Practitioner
PA = Physician Assistant
RN = Registered Nurse

To simplify the perspective, we can see the Maine licensed EMS clinician staffing levels by region by removing air transport and non-EMS licensed personnel. We can see that, during 911 calls:

- EMTs make up 25% of the highest staffing that responded
- Advanced EMTs make up 53% of the highest staffing that responded
- Paramedics make up 22% of the highest staffing that responded

Highest EMS Staffing Level, Excludes LFOM, 2024

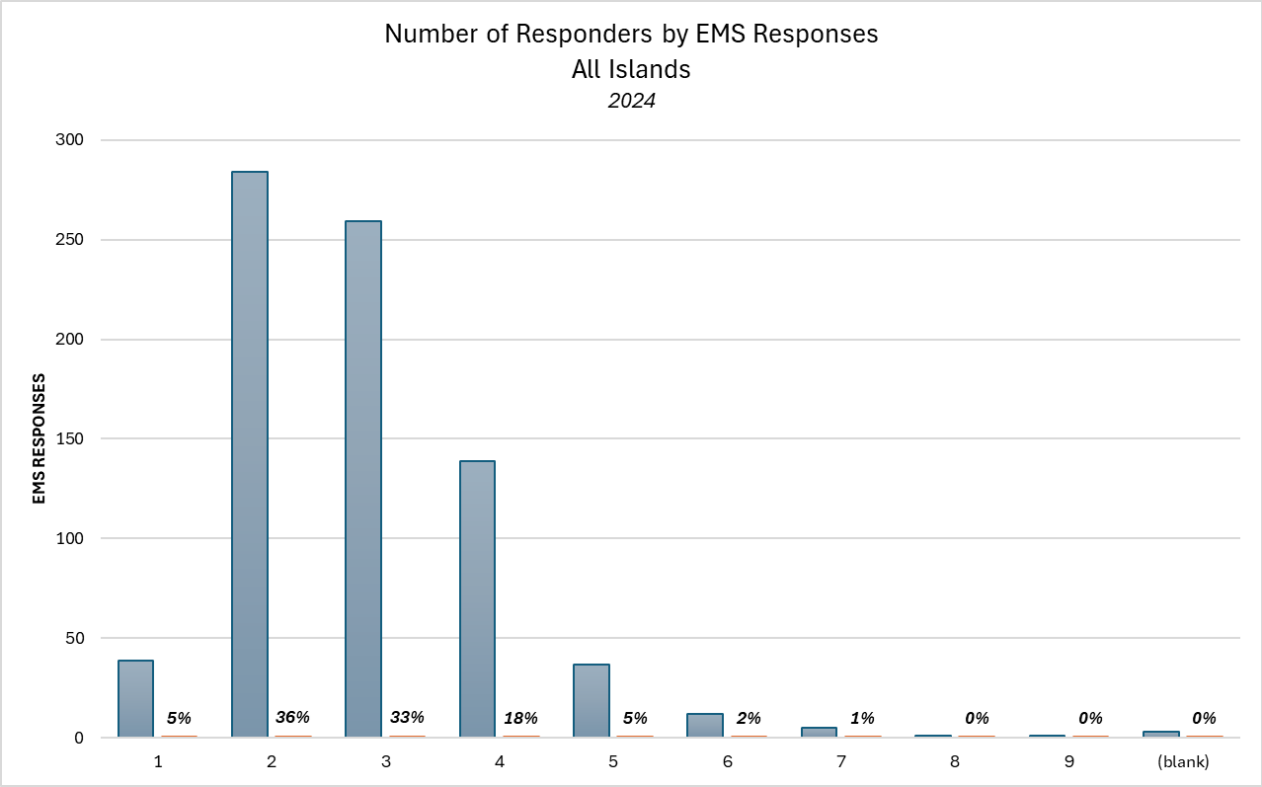
	Casco Bay Islands	Down East Islands	Penobscot Bay Islands
EMT	48	72	68
Advanced EMT	116	0	274
Paramedic	159	0	<10
Grand Total	**323**	**72**	**345**

Staffing by EMS Response

In addition to ensuring the agency responds to all 911 calls, an important consideration is the total number of responders per incident. Successful EMS care hinges upon teamwork, and each responder has a critical role in the proper care of patients. "Many hands make light work" is very accurate in EMS, with performance of multiple clinical interventions, driving ambulances, operating boats and aircraft, lifting and carrying of patients, and movement on unsteady surfaces, such as docks and boats requires additional personnel. Including non-medical

healthcare personnel such as drivers, as well as non-EMS healthcare providers, such as NPs, and PAs (but excluding LifeFlight), regionally:

- Casco Bay Islands had 2 to 4 responders documented 89% of the time.
- Down East Islands had 2 to 4 responders documented 78% of the time.
- Penobscot Bay Islands had 2 to 4 responders documented 87% of the time.



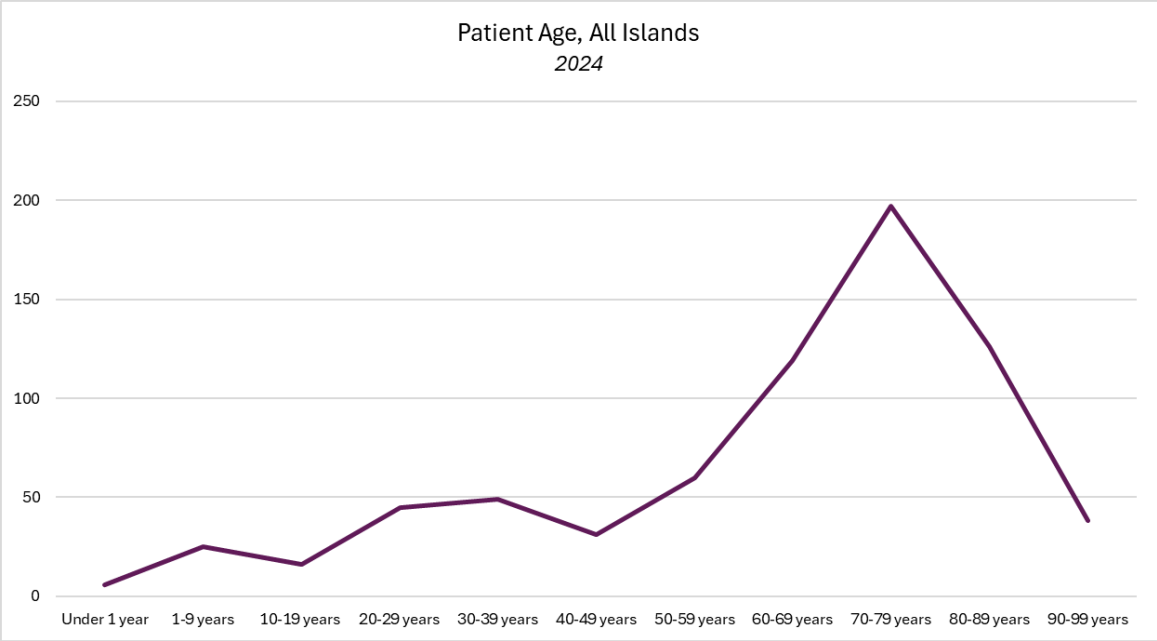
ISLAND EMS MEDICAL CARE

Vinalhaven EMS, Photo by Kris Osgood

EMS Medical Care

Patient Age

This graph highlights the higher use of EMS by older populations on islands.



EMS Primary Impressions

EMS clinicians document a "primary impression" on 911 responses, indicating the perceived primary complaint or condition. Additional complaints and issues may also be present. Consistent with mainland EMS responses, 9 out of the top 10 summarized primary impressions on the islands were the same as on the mainland. These 10 complaints accounted for 64% of all mainland responses and 67% of all island responses.

Top 10 EMS Documented Primary Impressions, 2024, Summarized

Rank	Islands	Mainland
1	No Findings or Complaints	No Findings or Complaints
2	Injury / Pain - Extremity	Weakness / Malaise
3	Cardiac Complaint (Not Cardiac Arrest)	Injury / Pain - Extremity
4	Weakness / Malaise	Cardiac Complaint (Not Cardiac Arrest)
5	Abdominal Distress	Behavioral (Not Suicide / Suicidal Ideations)
6	Injury / Pain - Head / Neck	Syncope / Altered Mental Status
7	Syncope / Altered Mental Status	Injury / Pain - Head / Neck
8	Behavioral (Not Suicide / Suicidal Ideations)	Abdominal Distress
9	Injury / Pain - Back	Respiratory Distress
10	Nausea / Vomiting	Nausea / Vomiting

Across all 15 islands:

EMS Primary Impressions, Unbridged Year Round Islands, 2024, Summarized

Primary Impression (summarized)	Responses*	% of responses
No findings or Complaints / Blank	137	18%
Injury / Pain - Extremity	73	9%
Chest Pain / Cardiac Complaint	66	8%
Weakness / Malaise	52	7%
Abdominal Complaint	47	6%
Injury / Pain - Head / Neck	45	6%
Syncope / Altered Mental Status	31	4%
Behavioral	26	3%
Injury / Pain - Back	25	3%
Nausea / Vomiting	23	3%
Stroke / CVA / TIA	23	3%
Injury / Pain - Unspecified	21	3%
Medical - Miscellaneous	20	3%
GI Complaint	18	2%
Infection	17	2%
Hemorrhage	13	2%
Injury / Pain - Hip	13	2%
Flu / Fever	11	1%
Overdose - Alcohol	11	1%
Respiratory Distress	11	1%
Cardiac Arrest	10	1%
Seizure	10	1%
Allergic Reaction	<10	1%
Pneumonia / RSV / Croup	<10	1%
Trauma - Multiple injuries	<10	1%
OB/GYN	<10	1%
Dehydration	<10	1%
Injury / Pain - Upper Chest (non-cardiac)	<10	1%
Overdose/Drug Ingestion (Non-Opioid)	<10	1%
Overdose/Drug Ingestion (Opioid)	<10	1%
Headache / Migraine	<10	1%
Bronchitis / Asthma	<10	1%
COPD Exacerbation	<10	1%
Heat Exhaustion	<10	1%
Burn	<10	0%
Choking	<10	0%
Drowning	<10	0%
Grand Total	**780**	

**Frenchboro, Isle au Haut, and Matinicus had zero responses*

EMS Procedures

Interventions performed by EMS vary based on patient clinical conditions, scope of practice, and applicable protocols. These procedures may be done by the level of EMS clinician in the right-hand column or by a RN (LifeFlight) or physician/NP/PA on islands with clinic staff responding to EMS incidents alongside EMS clinicians.

Of the 780 patients on all islands in 2024, 546 patients (70%) did not receive a procedure beyond vital sign measurement (e.g., measuring blood pressure, pulse, pulse oximetry).

As shown below, except for the last two procedures, no other procedure performed required more than an AEMT. Depending upon training, these procedures could also be performed by a physician, NP, PA, and some RNs.

Procedures beyond transport and vital sign assessment include:

Procedure	Count	Who Can Perform?
IV Access	130	AEMT, Paramedic
Blood Glucose Analysis	103	EMT, AEMT, Paramedic
12-Lead ECG	16	EMT, AEMT, Paramedic
Trauma - Wound Care	<10	EMT, AEMT, Paramedic
Splinting	<10	EMT, AEMT, Paramedic
Cervical Collar Application	<10	EMT, AEMT, Paramedic
Cold Pack Application	<10	EMT, AEMT, Paramedic
Spinal - Immobilization	<10	EMT, AEMT, Paramedic
CPAP	<10	EMT, AEMT, Paramedic
CPR	<10	EMT, AEMT, Paramedic
IO Access	<10	AEMT, Paramedic
Patient Warming	<10	EMT, AEMT, Paramedic
BVM Ventilation	<10	EMT, AEMT, Paramedic
OLMC Consultation	<10	EMT, AEMT, Paramedic
Physical Assessment	<10	EMT, AEMT, Paramedic
Defibrillation	<10	EMT, AEMT, Paramedic
i-Gel Insertion	<10	AEMT, Paramedic
LMA Insertion	<10	AEMT, Paramedic
Monitoring of Patient	<10	EMT, AEMT, Paramedic
Oral Airway Insertion	<10	EMT, AEMT, Paramedic
Oral Intubation	<10	Paramedic
Orogastric Tube - Insertion	<10	Paramedic
Grand Total	**305**	

Medications Administered

In addition to medical procedures that were performed, patients received a variety of medications based on their clinical condition. Of the 780 patients on all islands in 2024,

- 578 (75%) patients did not receive any medications.
- 25% of patients received at least one medication (including oxygen).
    - 1 in 5 of these patients received oxygen only.
- 32 patients (4%) received a medication requiring more than an AEMT.

Medications Administered on Islands (2024)*

Medication	Administrations**	Who Can Administer?
IV Normal Saline	70	AEMT, Paramedic
Oxygen	66	EMT, AEMT, Paramedic
Ondansetron	33	AEMT, Paramedic
Aspirin	28	EMT, AEMT, Paramedic
Fentanyl	19	Paramedic
Acetaminophen (IV)	13	AEMT, Paramedic
DuoNeb/Combivent	10	EMT, AEMT, Paramedic
Nitroglycerin	10	EMT, AEMT, Paramedic
Acetaminophen Chewable Tablet	<10	EMT, AEMT, Paramedic
Epinephrine 1 mg/1ml (1:1000)	<10	EMT, AEMT, Paramedic
Lorazepam/Ativan	<10	Paramedic
Albuterol	<10	Paramedic
Naloxone	<10	EMT, AEMT, Paramedic
Epinephrine 1 mg/10 ml (1:10,000)	<10	AEMT, Paramedic
Glucose Oral Gel	<10	EMT, AEMT, Paramedic
Lactated Ringer's	<10	AEMT, Paramedic
Metoprolol	<10	Paramedic
Midazolam	<10	Paramedic
Adenosine	<10	Paramedic
Dexamethasone	<10	Paramedic
Etomidate	<10	RN, NP, PA, MD, DO
Rocuronium	<10	RN, NP, PA, MD, DO
3% Saline - Hypertonic	<10	RN, NP, PA, MD, DO
Dextrose 10 %	<10	Paramedic
Dextrose 50 %	<10	Paramedic
Hydromorphone	<10	RN, NP, PA, MD, DO
Ketamine	<10	Paramedic
Lidocaine	<10	Paramedic
Magnesium Sulfate	<10	Paramedic
Methylprednisolone	<10	RN, NP, PA, MD, DO
Other Medication	<10	RN, NP, PA, MD, DO
Propofol	<10	RN, NP, PA, MD, DO
Sodium Bicarbonate	<10	Paramedic
Tranexamic Acid	<10	Paramedic
Grand Total	**309**	

**Note: Some medications listed as EMT, AEMT, or Paramedic may have been administered by physicians, RNs, NPs, or PAs.*

***Patients may have received more than one medication*

APPENDICES

Patient Care Area, Portland Fire Boat

Appendix A

LD841

"*A Resolve, to Study the Delivery of Emergency Medical Services to,*

and Ferry Service Effects on,

Unbridged Island Communities in the State"

APPROVED	CHAPTER
JUNE 20, 2025	93
BY GOVERNOR	RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-FIVE

S.P. 374 - L.D. 841

Resolve, to Study the Delivery of Emergency Medical Services to and Ferry Service Effects on Unbridged Island Communities in the State

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, emergency medical services are essential services and failing to provide these essential services adversely affects public health; and

Whereas, addressing the delivery of emergency medical services to unbridged island communities will require input and collaboration from several stakeholders; and

Whereas, this legislation must take effect before the expiration of the 90-day period in order to address these issues; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Department of Public Safety, Maine Emergency Medical Services to convene working group. Resolved: That the Department of Public Safety, Maine Emergency Medical Services shall convene a working group to study the delivery of emergency medical services to and ferry service implications on unbridged island communities in the State. The study must include an evaluation of the long-term sustainability of emergency medical services to unbridged islands, legal and regulatory requirements related to such services and a cost comparison to emergency medical services needs and costs statewide.

Sec. 2. Membership. Resolved: That the working group under section 1 consists of the following members:

1. The Director of Maine Emergency Medical Services within the Department of Public Safety, or the director's designee;

2. A representative of a municipal government of an unbridged island community that is served by the Department of Transportation, Maine State Ferry Service;

3. A representative of a municipal government of an unbridged island community that is not served by the Department of Transportation, Maine State Ferry Service;

4. A representative who provides emergency medical services on an unbridged island community served by the Department of Transportation, Maine State Ferry Service;

5. A representative of the Department of Transportation, Maine State Ferry Service;

6. A representative of an organization with experience in providing air ambulance critical care transport services in the State;

7. A representative of a statewide association representing ambulance services; and

8. A representative of a municipal fire department that provides marine emergency medical services that are not primarily facilitated through a ferry service to an unbridged island community.

Sec. 3. Report. Resolved: That, by January 1, 2026, the Department of Public Safety, Maine Emergency Medical Services shall submit a report that includes the findings and recommendations of the working group under section 1, including suggested legislation, for presentation to the Joint Standing Committee on Criminal Justice and Public Safety and to the Joint Standing Committee on Transportation. Both committees may submit legislation based on the report to the Second Regular Session of the 132nd Legislature.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

Appendix B

LD 841 Workgroup Meeting Minutes

September 17, 2025

October 6, 2025

October 20, 2025

November 11, 2025

December 1, 2025

December 15, 2025

December 29, 2025 *(cancelled)*

January 16, 2026

September 17, 2025, 2-4pm

Minutes - LD 841 EMS Islands Workgroup

Hybrid meeting at Maine DOT and via Zoom

Attendees

Workgroup Members (*all in person*): Marc Minkler (Maine EMS), Marjorie Stratton (Vinalhaven), Chief Ralph Munroe (Chebeague Island), Director John Dietter (North Haven), William Geary (Maine DOT), Tom Judge (LifeFlight of Maine), Deputy Chief Sean Donaghue (Portland Fire Department)
Absent: Butch Russell (Maine Ambulance Association)

Stakeholders:

(in person) Dr. Benjy Lowry (PenBay Hospital), Eva Murray (Matinicus), Rebecca Graham (Maine DOT)
(virtual) Katelyn Damon (Cranberry Isles), Ashley Moody (Maine EMS), Dr. Michael Baumann (Long Island & Chebeague Island), Chief Marc Candage (Vinalhaven)

Introductions

This is the first meeting of the LD841 Workgroup as prescribed by Maine Legislation. The participants introduced themselves, and the agenda was shared. The group elected Tom Judge as Chair.

Marc Minkler led a discussion about a working group tasked with creating a report on EMS sustainability, legal requirements, and cost comparisons for unbridged year-round islands in Maine, with a submission deadline of January 1, 2026. The group reviewed initial data analysis provided by Minkler covering response times, staffing, transports, and challenges specific to island EMS services, including the significant role of air transport by Penobscot Island Air and LifeFlight of Maine in transports. The team agreed to develop a more granular survey to gather additional detailed information from EMS services about operational challenges, training, and response barriers, particularly focusing on weather conditions and nighttime operations.

Island EMS Transport Logistics & Challenges

Discussed EMS non-transport rates, noting higher rates on islands compared to mainland, and explained that many island patients have alternative transportation methods or receive care/direction from NPs and PAs that respond with some island EMS agencies. The discussion highlighted the unique logistics and financial arrangements for island emergency services, including the separation of ferry operations from town funding and the town's provision of landing facilities. Discussed the challenges of emergency medical services (EMS) on islands, noting that most calls are not true emergencies but rather community first aid or convincing patients to seek treatment before conditions worsen. Group highlighted the unpredictable nature of transportation options, including ferries and air ambulances, and emphasized the importance of realistic expectations for healthcare access in remote areas. Group also stressed the ethical considerations involved in determining when

to evacuate patients, particularly those with chronic conditions who choose to live in remote locations.

Advanced Practitioners in EMS Integration

The group discussed challenges and opportunities around incorporating advanced practitioners, such as nurse practitioners and physician assistants, into emergency medical services (EMS) responses, particularly in rural areas and island communities. Group highlighted the value of using these practitioners' skills to provide better patient care while acknowledging regulatory and scope-of-practice challenges. Drs. Lowry and Baumann noted the complexities of defining protocols for advanced practitioners and the need to balance utilizing their expertise with ensuring patient safety. The discussion also touched on the use of transport services for stable patients and the importance of finding ways to effectively integrate these practitioners into EMS systems, though significant regulatory and practical hurdles remain.

Island EMS Operations and Challenges

Discussed the emergency medical services (EMS) operations on several islands, including Chebeague Island, Cranberry Isles, Vinalhaven and North Haven. While EMS services are not financially self-sufficient due to low call volumes, they align with community's mission. Group detailed the various transportation methods used, including private vessels, ferries, and air ambulances, noting the challenges posed by weather, tides, and seasonal changes. Also highlighted is the reliance on mutual aid from other agencies and the importance of coordinating responses effectively. Many described the need to have a designated responder to be “working the phones” during EMS calls to figure out the available transport options at that moment in time.

Remote Island EMS Transport Challenges

Chief Ralph Munroe detailed EMS on Chebeague Island, using the Island Ferry (a private 501c3) and their role in transport. The ferry is extremely responsive and collaborative with EMS and has a dedicated area for a stretcher and privacy for treatment. Air is very rarely used, but there are times when it is difficult to get off island, particularly in the winter/during storms.

Chief Marc Candage discussed the challenges of emergency medical services on Vinalhaven, highlighting the limited ferry service and the necessity of using Life Flight when other transport options are unavailable. He explained that the island's unique status as one of only two approved alternate destinations in Maine for EMS transport, aside from hospital emergency departments, allows for some non-emergency transports to a local clinic.

Katelyn Damon described the challenges of emergency medical transport on Cranberry Isle, noting that the ambulance service is non-transporting and relies on the Mount Desert Fire Department for off-island transfers.

Portland Fire Deputy Chief Sean Donaghue explained Portland's system for servicing islands, where a fireboat is maintained for transportation to islands, with staffed islands like Peaks Island having dedicated emergency resources and unstaffed islands relying on volunteer response. The discussion highlighted differences in response capabilities between islands like Cliff (45-minute boat ride) and Peaks (15-minute boat ride), with particular focus on the challenges of providing paramedic-level equipment and services on remote islands.
Eva Murray detailed the challenges on Matinicus Island with no formal EMS agency or system, and reliance on goodwill of neighbors and private boat owners.
Tom Judge also detailed specific challenges on Monhegan Island, noting that LifeFlight of Maine is the primary responder to any 911 EMS calls on the island, noting the implementation of instrument procedures and weather stations, and the logistical difficulties in coordinating helicopter services across the state.

Bill Geary explained that Maine State Ferry Service transports ambulances but is not involved in emergency medical operations, and highlighted regulatory constraints, including Coast Guard requirements and crew availability issues. They are working with the Coast Guard to update memorandums and potentially establish a memorandum of agreement with EMS to clarify when life-threatening injuries are required for ferry use.

Statewide Emergency Response Challenges
Marc Minkler discussed system-wide emergency response challenges across islands in Maine, highlighting the complexities of serving both year-round and seasonal communities. He explained that while this legislation focuses on year-round unbridged islands, the reality includes responding to emergencies on seasonal islands and non-island locations, often requiring mutual aid.

Island Medical Transport Challenges
The group discussed challenges and considerations around emergency medical transport to and from islands, including weather constraints, safety protocols, and patient care decisions. The discussion also touched on HIPAA considerations for treatment on ferries and boats, as well as the need for a survey to gather more granular data about island access and medical responses.

Island EMS Staffing Challenges
The group discussed challenges with staffing and sustaining EMS services on islands, particularly during peak tourist seasons. Discussion highlighted the difficulty of recruiting and retaining personnel, noting that while funding is available for on-call staff, the main challenge is finding willing volunteers. The discussion touched on the varying expectations of tourists versus year-round residents regarding emergency services, and the increasing acuity of calls, especially during summer months. The group agreed to conduct a survey to gather more information on best practices for funding and sustaining EMS services in rural areas.

Group agreed to schedule their next meeting for October 6th at 2 PM at Maine DOT with a zoom option, with the possibility of future meetings being held on islands to better understand local access challenges.

Summary created by Zoom AI, reviewed and edited by Marc Minkler

October 6, 2025

Minutes - LD 841 EMS Islands Workgroup

2-4pm, Hybrid Maine DOT and Zoom

Attendees

Workgroup Members: Marc Minkler (Maine EMS), Marjorie Stratton (Vinalhaven), Chief Ralph Munroe (Chebeague Island), Director John Dietter (North Haven), William Geary (Maine DOT), Tom Judge (LifeFlight of Maine), Butch Russell (Maine Ambulance Association),
Absent: Division Chief Sean Donaghue (Portland Fire)

Stakeholders:

Wil O'Neal (Maine EMS), Dr. Benjy Lowry (PenBay Hospital), Sonja Philbrook (Swan's Island), Ashley Moody (Maine EMS), Fred Porter (Isleboro), Pat Lundholm (Vinalhaven), William Cyr (LifeFlight), Joe Kellner (LifeFlight), William Tierney (Long Island), Eva Murray (Matinicus)

Island EMS Regulation Reform Discussion

The group discussed challenges with EMS regulations on islands, particularly regarding boat transportation. Porter suggested removing boat licensing requirements from regulations and creating island-specific protocols, while O'Neal agreed to consider and explore this change to better align rules with current and realistic operations. They explored options for patient transport, including

- Maine State Ferry (in PenBay/Downeast area)
- Municipal EMS/Fire Boats
- Casco Bay Lines (in Casco Bay area)
- Chebeague Transport Company (for Chebeague)
- LifeFlight of Maine
- Penobscot Island Air (in PenBay/Downeast area)
- US Coast Guard
- Private boats

Group discussed the need for telemedicine to improve triage on islands, particularly if transport off island is hindered by weather / access to transport / other factors. The conversation also touched on licensing issues for physicians, nurse practitioners and physician assistants, with Minkler reminding all that Maine EMS does not license these providers nor have authority over clinical practice. These levels can assume care of patients but would need to stay with the patient throughout transport to the final destination. They are also able to provide medical control under certain conditions.

Island Emergency Medical Service Regulations

The group discussed EMS and ferry regulations for islands. Geary has spoken to the local USCG commanders, and one challenge is the turnover of leadership within the local USCG. There are a

variety of agreements and policies over 40 years that conflict with each other and create confusion for consistency. Geary reviewed Coast Guard policies regarding ferry service for medical emergencies, and unofficially, the USCG states that island emergencies are not within their mission but rather emergencies with boats and on the ocean. They do not intend to respond to EMS calls on islands. Geary is working with them to get a written policy for clarity.
Geary also discussed a new draft Maine State Ferry / DOT policy that gives ferry captains discretion about making emergency runs.

Will mentioned upcoming federal funding for rural healthcare connectivity and telehealth projects. The discussion highlighted the unique position of Vinalhaven as a Maine EMS approved EMS destination for medical emergencies, one of only two such facilities outside of mainland emergency departments, and the only island with this option. The group also touched on potential bridge licensure for mid-level providers to improve emergency medical care on islands.

Island Medical Transport Protocol Review
The group discussed transportation protocols for medical emergencies on islands, particularly focusing on the decision-making process for patient transport. They explored the challenges faced by EMS providers in determining the urgency of transport and the need for clear guidelines. Lowry suggested that the workgroup recommend to the legislature the feasibility of developing island-specific protocols to help medical professionals make informed decisions about whether to keep or send patients, with a focus on reducing liability for providers.
Island EMS Data Collection Protocols
The group discussed protocols and systems needed to support EMS on islands, particularly focusing on data collection and definitions. They reviewed a draft survey to gather information about demographics, coverage areas, funding models, and staffing details. The discussion highlighted challenges in accurately tracking the number of responders, including licensed providers and other essential personnel like ferry captains, and the need to differentiate between patient care providers and logistical support staff.

Enhancing EMS Data Reporting Accuracy
The group discussed challenges in accurately reporting EMS staffing and response data, particularly regarding licensed versus unlicensed providers and the distinction in EMS service licensing rosters between active and listed available personnel. Some personnel are no longer active, and others may be seasonal only.
They explored various response configurations, including single-agency responses, multi-agency transfers, and interactions with Coast Guard and police departments, with a focus on how to properly categorize different types of responses and transports in the MEFERS data system. The discussion highlighted the need to better understand and document the various ways EMS services operate, especially in island communities, to provide clearer data for legislative purposes.

Island EMS Data Collection Challenges

The group discussed challenges with EMS data collection and billing for island communities, particularly regarding patient transfers between agencies and documentation of transport times and mileage. Identified that the current MIFERS system doesn't adequately capture the complexities of island transfers, including ferry and aircraft transport segments, and discussed the need for better documentation of patient handoffs between agencies. The discussion revealed that while island EMS services may not bill for patient transport, mainland agencies do begin billing at their first point of contact, creating some coordination challenges. Billing is also different using air agencies vs ground to ground handoffs.

Island EMS Billing Practices Discussion

The group discussed billing practices and costs associated with island EMS services, noting that while Long Island does not bill, other islands like Vinal Haven and North Haven do, with ferry services charging $1,200 for after-hours runs. They explored challenges in data collection, particularly around start times for calls and patient acuity, with Butch suggesting PSAPs might have some data. The group agreed to hold their next meeting on the 20th, with a focus on scheduling around island transportation logistics, and decided to create a survey to gather additional questions and data from participants.

Possible next steps

- Discuss with the Maine EMS board about potentially removing boat licensing requirements from rules and regulations for island EMS services.
- Explore bridge licensure options for mid-level providers to streamline their ability to provide EMS care on islands.
- Incorporate connectivity and telehealth as part of the discussion for Island Solutions moving forward.
- Get written clarification from the Coast Guard regarding their policy on responding to transportation requests from islands.
- Finalize the draft policy with the Coast Guard regarding ferry service use during medical emergencies.
- Analyze MEFIRS data to better understand the gaps in documentation when patients are handed off between services.
- Clean up and distribute the survey to island EMS services to collect more comprehensive data.
- Create a similar survey for mainland communities for comparison purposes.
- Coordinate logistics and time for hosting the next meeting on Chebeague Island on the 20th.
- All island EMS services to complete the survey once distributed.

Summary created by Zoom AI, reviewed and edited by Marc Minkler

October 20, 2025

Minutes - LD 841 EMS Islands Workgroup

Public Safety Building Chebeague Island and Zoom

Committee: Ralph Munroe, Tom Judge, Marjorie Stratton, Butch Russell, John Dietter, Sean Donaghue, William Geary,

Excused Committee: Marc Minkler (Jason Oko attending for MEMS)

Stakeholders: Eva Murray (Matinicus), Will Tierney (Long Island), Fred Porter (Islesboro), Sonja Philbrook (Swans), Katelyn Damon (Cranberry), Marc Candage (Vinalhaven), Meghan Russo (MDOT), Benjy Lowry, MD (PBMC/MH), Pat Lundholm (Vinalhaven)

Quick recap

The meeting focused on finalizing a draft survey and discussing potential regulatory changes, particularly around patient transport protocols and licensing requirements for rural and island communities. The group explored various transportation options including boats, ferries, and air services, while discussing challenges with clinical judgment, telemedicine capabilities, and the need for clear protocols in emergency situations. The discussion concluded with considerations for hybrid learning solutions, the feasibility of dedicated rescue boat services, and plans for a follow-up meeting on an island within the next two weeks.

Next steps

- Judge to send a poll to determine the next meeting date .
- Judge to coordinate with Islesboro to host the next meeting.
- Judge and Minkler to finalize the survey form and distribute it to all participants when Mark returns from vacation.
- Geary to draft a letter clarifying the Maine State Ferry Service protocols for emergency transport and share it with all islands. (Pending final approvals with USCG.)
- Judge to invite a representative from Penobscot Island Air to present at a future meeting about their capabilities. (S. Creeley, invited)
- Judge to invite the EMS liaison from the Maine Community College system to discuss educational opportunities for island EMS providers. (Hold for next meeting)

- Judge to compile recommendations regarding island-specific EMS protocols for the legislature and Maine EMS.

Summary

Survey and Regulatory Changes Discussion

The meeting focused on finalizing a draft survey and discussing potential regulatory changes. Judge emphasized the importance of legislative understanding rural and island community EMS, and mentioned that Minkler would be back for the next meeting to finalize the survey. The group discussed specific law changes needed for licensing and mid-levels, with J. Dietter bringing up some particular needs. O'Neal highlighted the need for flexible rules that address the diverse needs of different services. The conversation ended with an open invitation for participants to send questions or suggestions about the survey or potential regulatory changes.

Patient Transport Protocol Challenges

The group discussed challenges with patient transport decisions, particularly for island residents, and the legal requirements around patient sign-offs. Lowry emphasized the need for clear protocols rather than ad-hoc decisions, while Munroe highlighted the importance of working with transportation professionals and avoiding overuse of emergency services for non-urgent cases. The discussion also touched on the potential for telemedicine solutions, with Oko mentioning that Image Trend has a built-in telemedicine module, though concerns about liability and physician involvement were noted.

Emergency Transport Protocol Decision Making

The group discussed clinical judgment in emergency medical protocols, emphasizing that while protocols encourage hospital transport, patients must also consent to it. Oko highlighted the challenge of teaching clinical judgment through scenario-based training and noted that not every patient needs hospital transport. Donaghue raised concerns about the operational limitations of transporting patients to hospitals, particularly on islands, and suggested loosening rules regarding equipment levels on remote areas. The discussion touched on the difficulty of assessing low-acuity patients and the importance of balancing patient autonomy with medical advice.

Island EMS Transport Protocol Challenges

The group discussed challenges with patient transport protocols, particularly for island EMS providers. Fred emphasized the need for clear, written protocols regarding transport decisions, especially in difficult weather conditions, to protect providers from legal challenges. Munroe suggested that provider experience levels might influence transport decisions, while also noting extreme weather scenarios where transport is impossible. The discussion concluded with

consideration of bridge licensing for mid-level providers, with Vinalhaven noted as a unique case due to its status as a potential hospital designated transport destination.

Medical Boat Transport Regulations

The group discussed medical transport regulations, particularly focusing on the use of boats and ferries for patient transport. Dietter explained that mid-level providers play a crucial role in decision-making for patient transport, while Donaghue and others discussed the use of boats as extrication vehicles, noting that licensing them for billing purposes would not be ideal. The conversation also touched on the use of private vessels for medical transport in various island communities, with Lundholm and Damon sharing their experiences. The group acknowledged the need for clarity on regulations regarding patient transport by boat, particularly in emergency situations when ferries are not running.

Emergency Transportation Protocols Discussion

The group discussed emergency transportation protocols across different islands, with Candage explaining how providers follow a step-by-step list for patient evacuation, including ferries, LifeFlight, and Coast Guard options. They shared experiences about long wait times for Coast Guard assistance, with Munroe noting that in Casco Bay, the Coast Guard is typically the last resort due to their slow response time. The discussion concluded with a conversation about maritime regulations and whether emergency medical services could follow similar rules to aviation and maritime law that allow breaking rules in life-threatening situations.

Island EMS Protocol Development

The group discussed island protocols, focusing on the DOT 12-hour duty time rule and the Coast Guard's allowance for exceptions with specific criteria. They identified the need for telemedicine protocols and considered the transport of deceased persons, which is more common on islands than on the mainland. The discussion concluded with thoughts on creating an ideal EMS system, acknowledging that no single provider agency could meet all needs, and suggesting a multi-agency approach.

Medical Emergency Transport Planning Meeting

The group discussed air and sea transportation capabilities for medical emergencies, with Geary reporting on Penobscot Island Air's night-flying capabilities and potential runway extension challenges. They explored the possibility of getting PIA to present their capabilities, with Judge noting the importance of having PIA representation at future meetings. The discussion also covered the need for mutual aid, with Ralph emphasizing the importance of boat transportation for island access, while Donaghue and Philbrook highlighted the benefits of having both air and sea transport options.

Geary committed to providing clarity on ferry service protocols and obtaining a current Coast Guard letter regarding transportation capabilities.

Island EMS Education and Solutions

The group discussed challenges with EMS licensing and education on islands, noting difficulties in transporting students to classes and the need for hybrid learning solutions. They explored the possibility of bringing educators to islands to teach EMT courses and considered inviting Don Sheets from the Maine Community College system to discuss hybrid course opportunities. Russell mentioned ongoing conversations about a dedicated 911 boat for the mid-coast area, which could provide expanded scope and protocols for trained providers, as well as support for telehealth and community projects during downtime.

Island Ambulance and Ferry Proposal

The group discussed a proposal for ambulance and ferry services on islands, with Munroe explaining that some islands viewed the proposal as a potential loss of service due to concerns about exchanging ferry service for ambulance coverage. Stratton shared that Vinalhaven was considered the ideal location for a 75-foot boat, but the select board opted out of discussions due to concerns about infrastructure and $7 million annual operating costs. Russell suggested using a smaller, lobster boat-style vessel instead of the proposed 75-foot ferry, while Judge emphasized the challenge of finding the perfect boat size for all-weather operations but also sized for available infrastructure, and the economic base to support the service.

Maine Island Emergency Services Review

The group discussed the feasibility and costs of implementing a dedicated rescue boat service for islands in Maine, with Stratton presenting data showing only 4 nighttime ferry service calls per year. They explored alternative solutions, with John suggesting improving existing medical infrastructure and cross-training with mid-level practitioners as a more cost-effective approach. Geary noted the number of evacuations in any given year is dynamic ranging from 20’s to 80’s in any given year with 40 night ferry runs in the current year. The discussion then shifted to telemedicine possibilities, with participants expressing skepticism about its effectiveness for emergency situations, though acknowledging potential benefits for managing low-acuity patients and supporting community paramedicine. The conversation ended with plans to schedule a follow-up meeting on an island, likely Islesboro, within the next two weeks.

Summary created by Zoom AI, reviewed and edited by Marc Minkler

November 5, 2025, 2-4pm

Minutes - LD 841 EMS Islands Workgroup

Hybrid meeting at Isleboro Public Safety Building and via Zoom

Attendees

Workgroup Members:

(*in person*): Marc Minkler (Maine EMS), Chief Ralph Munroe (Chebeague Island), Director John Dietter (North Haven), Tom Judge (LifeFlight of Maine)

(*virtual*) Marjorie Stratton (Vinalhaven), Deputy Chief Sean Donaghue (Portland Fire Department)

Absent:

Butch Russell (Maine Ambulance Association), William Geary (Maine DOT)

Stakeholders:

(in person) Eva Murray (Matinicus), Chief Will Tierney (Long Island), Director Fred Porter (Isleboro), Stan Makara (Penobscot Island Air), Erin Creelman (Penobscot Island Air)

(virtual) Katelyn Damon (Cranberry Isles), Dr. Benjy Lowry (PenBay Hospital & Region 3 EMS Medical Director), Dr. Michael Baumann (Long Island & Chebeague Island Medical Director), Pat Lundholm (Vinalhaven), Sean Creeley (Penobscot Island Air)

Attendees introduced themselves.

Island Medevac Operations Overview

Sean Creeley, president of Penobscot Island Air (PIA), provided an overview of the company's operations, highlighting their role in transporting patients and freight to and from islands. In the last 4 years, PIA has provided 257 flights, averaging around 87 flights annually. These flights included

- 174 flights from Vinalhaven
- 40 flights from North Haven
- 5 flights from Matinicus

Flights are approximately 12 minutes to Owls Head airport (although technically they could land at any airport). Flights are billed at approximately $650. There is room for the pilot, patient, and 1 EMS provider (they report a total 1,000-pound limit), and PIA will return the EMS clinician to the island (weather permitting). They have also purchased a 36’ boat that may be an option for transport, and it is high speed with a transport time from Matinicus to the mainland of approximately 1 hour. There is no issue with oxygen, radios, or cell phones during flights, and the PIA representatives do not see any complications with EMS operations or equipment on the plane.

Stan discussed the specifics of medevac operations, including the ability to transport patients, providers, and pilots, and that flights are restricted to visual flight rules, meaning the pilots have to see and thus fly during daylight hours only. Discussed the challenges of night flights due to visibility requirements.

Remote Air Ambulance Service Challenges

The group discussed air ambulance services and their limitations, particularly for remote island communities. They explored options for transporting patients by plane or boat, considering factors like weight limits, flight duration, and patient stability. The discussion also covered licensing requirements for air ambulance services and the need for proper documentation of patient transfers. The participants agreed to catalog inventory and develop policies for different transport scenarios, while noting the importance of training local services about flight physiology and patient care during transport.

Island EMS Service Challenges

The group discussed challenges with EMS services on islands, particularly regarding run reports and patient transportation. Members expressed concerns about the current system requiring duplicate run reports (e.g. Vinalhaven EMS completes a patient care report but then have to complete a second run report if they fly on PIA and operate as Vinalhaven RRAAS. The discussion touched on Maine's EMS legislation declaring services as essential, though communities have flexibility in implementing formal services. Eva Murray noted that the system is much different on Matinicus without having a formal EMS agency. The group agreed that providing care through a Good Samaritan approach is likely all that is allowed, though they noted increasing pressure to formalize arrangements with transporting services as Maine's EMS requirements become more stringent.

Medical Evacuation Flight Challenges

The group discussed the challenges and costs associated with medical evacuation flights, with Sean Creeley highlighting the high insurance premiums and financial risks involved. They explored the differences between regular PIA flights and medevacs, noting that medevacs require prioritization over other flights. Dr. Lowry inquired about Life Flight's approach to handling medical emergencies, and Tom explained that Life Flight typically responds to calls from hospitals, 911 dispatchers, or trained medical personnel, with a structured process for assessing the severity of clinical conditions.

Island Emergency Response Protocols

The group discussed emergency response protocols for islands, emphasizing the need for structured systems and triage processes different from mainland practices. The group explored options of potential changes to protocols and waivers for transporting patients under specific circumstances, with a focus on collaboration between island services and mainland medical control. Minkler states this would be a combination of the Maine EMS Board and Medical Direction and Practices Board. It would be hard to protocolize every scenario but might be able to protocolize processes of addressing unique scenarios. Pat highlighted the importance of PIA

services for quick patient transport, while Tom and Dr. Lowry addressed the need for tailored triage systems for islands.

Island EMS Coordination

The group reviewed key topics including island EMS services and transport methods, which vary significantly across locations, and the need for better coordination between island and mainland providers. The discussion highlighted issues around patient transport, with concerns about cell service limitations and the need for better synchronization of run records between different EMS services. The group also addressed workforce challenges, noting that island EMS services rely on a mix of paid-on-call and volunteer personnel, and discussed the need for an initial education hybrid learning system to support island staffing needs.

Island EMS Service Improvement Strategies

The group discussed challenges with EMS services on islands, including limited access to initial licensure training classes and the need for better integration of nurse practitioners and physician assistants into the emergency care system. They explored options for improving medical control and telemedicine capabilities, particularly for patients requiring extended care or experience transport delays. The conversation highlighted the unique circumstances of island services, including limited mutual aid and the need for creative solutions to leverage existing local expertise.

The conversation ended with plans to refine survey topics and dates, gather input from additional stakeholders, and continue discussions on potential legislative changes to better support island EMS services.

The team planned future meetings to finalize recommendations on education, telemedicine, and finance, with a goal to present findings to the legislature in January. They also discussed scheduling challenges for upcoming meetings, considering in-person and virtual options. Group thanked Isleboro for hosting the meeting and the Maine Ferry Service for transportation.

Next steps

- Marc and Tom: Finalize survey questions and topics, then send out the survey to both comparator services and island services.
- Tom: Send out a survey to all participants to determine preferred meeting dates and finalize future meeting dates, including potential meeting on Swan's Island, targeting four more meetings before legislative report due date.
- Tom: Schedule and conduct future meetings on education and telemedicine (with Tracy Jalabina)
- Marc and Tom: Draft recommendations and circulate to group for review and comment before presenting to the legislature.
- Tom / Bill: Obtain and distribute the final protocol from the ferry service once signed off by the Coast Guard, to all relevant parties.

- All: Explore and propose recommendations for allowing NPs and PAs to participate formally in island EMS response, including possible changes to statute and rules.
- All: Consider and develop recommendations for a quality improvement/peer support system for island EMS providers, including protected QI activities and post-incident support.
- All: Review and potentially recommend changes to run report and patient handoff documentation requirements to simplify and improve continuity of care tracking for island-to-mainland transport.
- Tom: Add wilderness EMS training question to the survey, as suggested by John Dietter.
- All: Explore and recommend the development of island-specific triage and transport protocols, including potential for waivers or new protocols for unique island circumstances.
- All: Investigate and recommend improvements to online medical control/medical decision support for extended or complex patient care scenarios on the islands, including possible telemedicine solutions.
- All: Consider and recommend whether island clinics could be designated as destinations for certain EMS transports and include in recommendations.
- Tom: Send out meeting notes and proposed findings/recommendations for review and comment by group members.

Summary created by Zoom AI, reviewed and edited by Marc Minkler

December 1, 2025, 2-4pm

Minutes - LD 841 EMS Islands Workgroup

Hybrid meeting at Maine DOT and via Zoom

Attendees

Workgroup Members

- (*in person*): Marc Minkler (Maine EMS), Chief Ralph Munroe (Chebeague Island), Director William Geary (Maine DOT), Tom Judge (LifeFlight of Maine), Deputy Chief Sean Donaghue (Portland Fire Department)
- *(virtual):* Marjorie Stratton (Vinalhaven), Tom Judge (LifeFlight of Maine), John Dietter (North Haven), Butch Russell (Maine Ambulance Association)

Stakeholders:

- *(in person)* Eva Murray (Matinicus), Meghan Russo (Maine DOT)
- *(virtual)* Dr. Benjy Lowry (PenBay Hospital & Regional Medical Director), Katelyn Damon (Cranberry Isles), Ashley Moody (Maine EMS), Dr. Michael Baumann (Maine Medical Center-Portland & Long Island & Chebeague Island Medical Director), Chief Marc Candage (Vinalhaven), Dr. Tracy Jalbuena, Sean Creeley (Penobscot Island Air). Ashley Moody (Maine EMS), Will Tierney (Long Island), Sonja Philbrook (Swan's Island), Pat Lundholm (Vinalhaven)

Island EMS Survey Update

The group discussed the survey on EMS costs and operations, with only two responses received so far from Cranberry Isle and Chebeague Island. Lundholm raised questions about how to interpret questions about weather-related transportation delays, which Judge clarified were meant to track attempts and delays in transport arrangements. The group agreed to use a simple calculation of dividing annual expense budgets by the number of requests and transports to estimate costs, despite the limitations of this approach. Murray inquired about how to handle calls not directly managed by her, and Judge confirmed these should be included. Munroe shared that Chebeague's direct personnel costs averaged $220 per call, but ferry costs were not included. Judge emphasized the need to capture both direct and indirect costs to better understand the total cost of providing EMS services, especially for low-volume areas.

Fire-EMS Budget Data Challenges

The group discussed challenges in separating fire and EMS budget data, with Minkler noting that agencies often have combined budgets and it's difficult to distinguish between fire and EMS costs, especially for island services. Judge explained that while exact granular data might not be possible, they can provide a rough scale comparison that will be useful for the legislature. The discussion also touched on CMS data collection findings, which showed EMS agency per-call costs as approximately $2,600, (https://www.cms.gov/files/document/medicare-ground-ambulance-data-collection-system-

gadcs-report-year-1-and-year-2-cohort-analysis.pdf) similar to the Maine Blue-Ribbon Commission's findings for low volume agencies of approximately $2,500 (https://www.maine.gov/ems/sites/maine.gov.ems/files/inline-files/Maine-State-Blue-Ribbon-Commission-Report-On-EMS-final.pdf), though there were concerns about the accuracy of the data for island applicability.

Emergency Services Cost Analysis Review

The group discussed less visible costs associated with emergency medical services and ferry transportation, with Creeley highlighting how business disruptions impact revenue. Judge suggested including these costs in data for the legislature, noting that informal transport networks (such as lobster boats) also contribute to overall costs. Minkler emphasized the importance of finding accurate ways of documenting downstream effects in their report to the state, while Judge agreed to include capital improvements in the cost of readiness calculations.

Island EMS Report Framework Review

The group discussed a report framework covering six key topic areas for island EMS:

- Demographics
- Medical Care
- Medical Transportation
- Workforce & Education
- Telemedicine
- Finance

They reviewed the demographic section which focuses on year-round and seasonal populations, aging trends, and water distance challenges across different islands. Judge confirmed that Don Sheets would present a briefing on education at the next meeting on the 15th via Zoom, and they noted that while Islesboro Clinic is recognized as an EMS destination, similar status should be considered for clinics on North Haven and Swans Island.

Island EMS Integration with Advanced Practice Providers

The group discussed EMS rules and protocols, particularly focusing on how non-EMS licensed healthcare professionals on islands can integrate with EMS services. Minkler clarified that Maine EMS does not constrain other licensed healthcare providers, but rather defines how they integrate with EMS, including maintaining patient care after intervention. He states NPs, PAs, and physicians can certainly be a part of the response and render care within their scope of practice and references the Maine EMS “Black 1” protocol and the “Brown” section definitions of the patient’s own physician and other healthcare clinicians. Maine EMS does not regulate those licensees, however, does have certain minimum standards for EMS response, including a licensed EMS clinician on all emergency responses. Other healthcare providers could expand their knowledge and become dual licensed as the education for NPs, PAs, and physicians do not necessarily include some core critical components

of EMS response and management. The discussion highlighted specific needs on islands like North Haven where nurse practitioners and PAs work in rotation and co-respond on EMS calls, leading to proposals for revising statutes to better reflect current independent practice capabilities of NPs and PAs. The group also identified needs for enhanced documentation of patient transfers between agencies and discussed potential and the possibility of island-specific EMS protocols similar to wilderness protocols.

Island Healthcare Transportation Challenges

The group discussed challenges with medication availability and federal laws on DEA licenses for islands without immediate pharmacy access. They reviewed medical transportation options, including private boats, ferries, and air services like LifeFlight and Penobscot Island Air, noting that Coast Guard assistance is a last resort due to increased homeland security responsibilities. The discussion highlighted the need for clarification on ferry staff availability, compensation, and call response policies, with Russo and Geary tasked to provide more details. Minkler also suggested clarifying that a previous proposal for a dedicated marine ambulance was not their initiative, as it originated from another group.

Telemedicine Challenges in Island Communities

The group discussed telemedicine implementation challenges for island communities, with Dr. Tracy Jalbuena from Maine Health providing and presenting on current telehealth programs and usage. She explained that successful telemedicine requires defining specific patient populations, clinical needs, and operational requirements, along with clear success metrics. The discussion highlighted three main patient categories:

- Low-acuity patients who might avoid transport altogether
- Moderate-acuity patients requiring extended care
- High-acuity patients needing immediate advanced medical support.

The group also explored logistical challenges such as the need for 24/7 availability, while considering the feasibility of implementing such a system given population size and infrastructure constraints.

The group discussed the challenges and considerations of implementing telehealth for remote island communities, focusing on balancing population size, market complexity, and the need for a phased approach to program development. Judge and Jalbuena emphasized that any attempt would need to start with a focused, low acuity use case to build a scalable system, while Munroe raised concerns about the practicality of telehealth for Chebeague, citing logistical challenges and the frequent need for immediate action in emergency situations. Lowry highlighted the importance of legal and structural support, such as clear protocols and malpractice coverage, to ensure that telehealth decisions are reliable and defensible, particularly in high-stakes situations.

Island EMS Service Enhancement Discussion

The committee discussed improving island EMS services, with Lowry highlighting the need for potential telehealth funding and technology integration. Judge emphasized that while technology is important, the care model, marketing, data collection, quality control, and workflows are more challenging and critical factors. Minkler inquired about the feasibility of longer time length telemedicine consultations for urgent EMS cases, noting that most needs can be met with traditional phone communication. Baumann suggested involving EMS-boarded emergency physicians for complex calls, and Judge proposed LOM as a potential resource for medical advice on island calls.

Island Telehealth and Paramedicine Challenges

The group discussed telehealth and community paramedicine services for island communities, particularly focusing on how to handle low-acuity medical cases. Lowry and Baumann shared that Maine Health is already implementing telehealth services for chronic disease management through community paramedics, though challenges remain around physician availability and protocols. The island EMS chiefs, including Dietter from North Haven and Philbrook from Swan's Island, described their current challenges, particularly around night-time transports and anxiety-driven calls. The group agreed that while telehealth could help with certain cases, it wouldn't fully address the need for alternative destinations on islands where clinics exist, as demonstrated by North Haven's experience of reducing transports to the mainland by half, when compared to similar-sized islands without clinics, by using advanced practice provider island availability.

Meeting concluded at 1600, next meeting is scheduled for December 15, 2025 at 2pm

Summary created by Zoom AI, reviewed and edited by Marc Minkler

December 15, 2025, 1-3pm

Minutes - LD 841 EMS Islands Workgroup

Hybrid meeting at Swan's Island and via Zoom

Attendees

Workgroup Members (*virtual*): Marc Minkler (Maine EMS), Chief Ralph Munroe (Chebeague Island), Director John Dietter (North Haven), William Geary (Maine DOT), Tom Judge (LifeFlight of Maine), Deputy Chief Sean Donaghue (Portland Fire Department), Butch Russell (Maine Ambulance Association)

Absent: Marjorie Stratton (Vinalhaven)

Stakeholders:

(in person) Chief Sonja Philbrook (Swan's Island), Eva Murray (Matinicus)

(virtual) Bill Cyr (LifeFlight of Maine), Dr. Benjy Lowry (Regional Medical Director and PenBay Hospital), Chief William Tierney (Long Island), Katelyn Damon (Cranberry Isles), Ashley Moody (Maine EMS), Dr. Michael Baumann (Long Island & Chebeague Island), Don Sheets (Maine Community College System), Chief Fred Porter (Isleboro), Pat Lundholm (Vinalhaven)

Tom Judge opens meeting, welcomes all. Minkler expressed apologies for several members not being able to attend in person on Swan's Island and thanked Chief Philbrook for her understanding and being willing to host the meeting.

<u>Emergency Medical Services Survey Review</u>

The group discussed the status of a survey sent to island service leaders on island EMS, with Minkler reporting 7 responses, though two were from the same island (Isle au Haut). He noted that some responses contained unclear or incomplete information, such as inclusion of the number of EMTs employed seasonally by Acadia National Park. The group clarified that park rangers functioning as EMTs within park boundaries should be counted as first responders, and Lundholm explained that transfers arranged through island medical centers for non-ambulatory patients should be excluded from the survey's 911 response data.

The group reviewed and discussed updates to a document about island EMS services, focusing on costs, workforce challenges, and educational needs. Minkler shared that only three of six agencies report billing patients per the survey, and Judge noted they were examining the gap between costs and potential reimbursements. The team agreed to clarify which dataset from Isle au Haut to use, as there were variations in numbers. Dietter and Porter will be completing the survey responses. The group also reviewed and made minor edits to the workforce section of the document, including changing "evacuation" to "medical transport" and discussing potential future federal DEA regulatory changes for medications and laboratory testing. Don Sheets (Maine Community Colleges) was invited to join the conversation to discuss college programs and address the significant challenge of EMS education access for island personnel.

EMS Education for Island Communities

Discussion on challenges and potential solutions for providing EMS education to remote island communities in Maine. Discussed the difficulties of travel and scheduling for training, with many expressing interest in hybrid learning models that combine online and in-person instruction. Sheets outlined existing hybrid programs and suggested ways to adapt them for island residents, including finding local instructors and creating opportunities for peer learning. The group explored ideas for funding these programs, with Sheets mentioning Maine workforce grants as potential sources of support while acknowledging the increased costs associated with hybrid instruction.
Discussed challenges and potential approaches for delivering EMS education on islands, focusing on hybrid models combining in-person and remote learning. Sheets explained that while the community colleges haven't built a completely asynchronous class, they are open to flexible scheduling options that could accommodate island students' needs, particularly during winter when island residents often have more time. Murray raised concerns about inflexible attendance policies, suggesting the need for more reasonable flexibility, while Dietter shared insights from an EMT course in North Haven that uses a hybrid model with separate in-person and remote sessions. Minkler described a successful EMT class on he taught on Chebeague that included students from other islands, highlighting the importance of community engagement and practical components.

Coordinating EMS Training Across Islands

The group discussed strategies for coordinating EMS training across multiple islands, with Minkler sharing his experience of a successful paramedic program in New York State that rotates has instructor coordinators (ICs) at each of 4 locations (including one in another state) with in-person lectures rotating between sites while the other 3 attend live. Sheets explained that while lab components require a minimum of 3-4 students for peer learning and skills evaluation, there is flexibility in the instructor requirements, as proctors don't necessarily need to be local ICs. The discussion concluded with Sheets indicating that workforce development funding might be available for this initiative, though final approval would depend on further discussions with leadership.

Rural EMT Training and Deployment

The group discussed training and deployment strategies for emergency medical technicians (EMTs) in rural areas. Sheets emphasized the importance of deliberate planning for clinical rotations, suggesting partnerships with local fire departments and hospitals to accommodate extended training periods. Dietter highlighted the need for gradual skill and confidence building for new EMTs, proposing and encouraging volunteers to complete a first responder course (Emergency Medical Responder, EMR) (shorter time, less cost) and then offer an EMR to EMT bridge course to reduce the risk of burnout. Sheets noted that the EMR license level is underutilized in Maine, and while there is limited demand for EMR-to-EMT bridge courses, the group could consider developing such programs if island community’s express interest. Munroe suggested exposing new EMTs to different

environments and gradually increasing their independence to build their confidence. Minkler noted that by State EMS rules, EMRs cannot be the sole provider during any transport of a patient in an ambulance (i.e. on island or on ferry) and this level would need to be paired with an EMT (which could also help with confidence building).

EMS Practical Skills Training Challenges

The group discussed challenges and strategies in training emergency medical service providers, focusing on the importance of hands-on practice. Minkler highlighted the need for regular and consistent evaluation of skills, emphasizing the importance of training equipment availability across training sites. Hi-fidelity mannequins and current training equipment can come at a hefty price but is critical to success of the students. Porter and Sheets also stressed the value of pre-training criteria and retention strategies. Murray suggested involving area services with low call volume or new licensed responders to increase the size of lab sessions and provide continuing education, which Sheets supported as a creative approach to enhance training.

Local EMS Training Plans

The group discussed turning local EMS training into continuing education opportunities, with Dietter sharing that EMT courses in North Haven could be structured to provide CEH credits for facilitators. Sheets emphasized the importance of gathering collective needs from island communities to make a stronger case for training support, and Judge committed to surveying service providers to build scale and momentum. Munroe highlighted the significant impact of losing two EMTs on Chebeague and this is a big impact on response and staffing, while Damon noted challenges in organizing training during winter due to logistical barriers. The group agreed to gather information on training needs and explore funding opportunities through stabilization and sustainability funds. The availability of educators for high quality continuing education is also very limited. Sheets explained that while there was no specific funding for EMS classes, there was workforce development money available for expanding faculty and technology to deliver more hybrid education.

EMS Telemedicine

The group discussed the potential for telemedicine to manage low-acuity patients on the islands, with Drs. Baumann and Lowry emphasizing that the complexity of medical decision-making in EMS calls would be challenging to translate to telemedicine. They agreed that clearly defined clinical protocols and medical direction would be necessary for any telemedicine system to be effective. Additionally, the current usage of telemedicine is not necessarily based on EMS trained and boarded physicians, limiting the understanding and interactions between groups using telemedicine.

Remote Patient Transport Challenges

The group discussed challenges in transporting patients from remote islands, particularly focusing on cases where transport is complicated by weather or patient refusal. Murray shared an example of a

patient who feared a head injury after a fall, highlighting the need for telemedicine support in such situations. Dr. Lowry expressed concern around the language around anxiety, emphasizing the need to focus on specific injury patterns and medical conditions rather than dismissing symptoms as anxiety.

The meeting ended with plans to finalize a financial report and schedule the next meeting for the 29th, which will be held in Augusta or via tele/video conference.

Summary created by Zoom AI, reviewed and edited by Marc Minkler

January 16, 2026, 2-4pm

Minutes - LD 841 EMS Islands Workgroup

Hybrid meeting at Maine DOT and via Zoom

Attendees

Workgroup Members

(*in person*): Marc Minkler (Maine EMS), Chief Ralph Munroe (Chebeague Island), Tom Judge (LifeFlight of Maine), William Geary (Maine DOT),

(virtual): Director John Dietter (North Haven), Deputy Chief Sean Donaghue (Portland Fire Department), Marjorie Stratton (Vinalhaven)

Absent: Butch Russell (Maine Ambulance Association)

Stakeholders

(in person): Eva Murray (Matinicus)

(virtual): Chief Sonja Philbrook (Swan's Island), Dr. Michael Baumann (Long Island & Chebeague Island), Chief Marc Candage (Vinalhaven), Chief Fred Porter (Isleboro), EMS Director Pat Lundholm (Vinalhaven), Meghan Russo (Maine DOT)

Island EMS Cost Variations Survey

The group discussed the cost survey findings for EMS services across islands, with Minkler presenting the survey results on staffing, funding, and transport operations. They noted significant variations in services and costs between islands, with Portland having the highest number of paramedics and Life Flight operating at a much larger scale than other services. The team acknowledged challenges in comparing costs due to different service models and island-specific needs and discussed the need to summarize the data for legislative purposes. They also touched on the upcoming requirement for towns to have EMS plans due to recent changes in EMS being classified as a public good.

Island EMS Ferry Cost Analysis

The group discussed billing and costs related to emergency medical services and ferry transportation on islands. Minkler explained that ferry standby costs, which include housing and per diems for crews on islands at night, amount to approximately $17,000 per trip, though this is not a direct billing cost to patients. The discussion highlighted the unique challenges of rural EMS services, including higher unit costs and transportation expenses, while emphasizing the need for legislative support to address these financial burdens. Dietter raised concerns about the fairness of comparing ferry standby costs to EMS readiness costs, noting that ferries are not always used for emergency services. The group agreed to further analyze these costs for a report to the legislature, with Minkler offering to calculate per-transport standby costs for islands that submitted their budget numbers.

EMS Costs and Service Review

The group discussed EMS costs and funding, with Minkler explaining that municipalities often cover costs beyond what is billed, similar to other municipal services. They reviewed a draft report on EMS services across islands, which includes findings in seven categories including systems, medical care, transportation, workforce, telemedicine, education, and finances. The group also addressed legal questions about transporting patients to the mainland and allowing them to self-transport after landing by taking a personal vehicle, with Minkler clarifying that patients can legally refuse care at any point by following Maine EMS protocols, but that this should not be the plan. Specific scenarios involving ferries and EMS care remain unclear and should be checked with community and EMS agency legal counsel and medical directors.

EMS Transport Data Analysis Review

The group discussed transportation times for EMS calls, with Lundholm suggesting they include a range rather than a single average to better reflect the variability in transport durations. They agreed to add a section on call duration from patient contact to handoff, and Lundholm raised the importance of highlighting similarities between island and rural mainland communities to gain legislative support. Geary and Russo planned to meet with Minkler early next week to review transportation recommendations. The team also discussed incorporating Joe Kellner's (LifeFlight CEO) expertise on life flight operations into their report from recent emails between Minkler and Kellner.

Island Ambulance Service Challenges

The group discussed transportation challenges, particularly focusing on ambulance availability across islands and the limitations of ferry services. They noted that while Vinalhaven has two equipped ambulances, all others have only one, with no backup in most cases. The discussion also covered financial aspects, including the costs of island air transport and ferry services, with Porter confirming that private insurers rarely cover these expenses, leaving patients or local agencies to bear the cost.

Ambulance Ferry Cost Policy

The group discussed ferry transportation costs for ambulances, clarifying that during normal operating hours, a round-trip ferry ticket costs $172, which includes a $138 fare for the driver and vehicle plus $34 for reservation fees. They clarified that emergency runs during non-operating hours, such as at night, would not incur the regular $172 fee but involve a different charging structure. The discussion also covered what happens when EMS crews are stranded on the mainland, with Philbrook explaining that crews would be paid overtime after 3 hours and would either wait for the next ferry or arrange their own accommodation if necessary.

Ferry and Healthcare Service Review

The group discussed comparing ferry services, particularly Casco Bay Lines and state ferries, noting differences in subsidies and pricing. They agreed to include findings on service differences and

recommend further study on subsidies and costs. The team also reviewed recommendations for healthcare services, including exploring EMR expansion, community paramedicine programs, and long-term staffing needs. They emphasized the need to gather data on education requirements and projections for island healthcare services.

Island EMS Services Expansion Discussion

The group discussed several topics related to emergency medical services on islands, including the need to expand language in EMS statutes to allow nurse practitioners and PAs to practice independently during 911 responses. Dietter agreed to speak with island clinic staff about their needs, while Lundholm was asked to review documentation challenges related to billing for flights. The team also discussed potential funding for boat transportation, centralized dispatch processes, and the need for proper lighting and training for IFR flights. Porter expressed interest in exploring a restricted air ambulance license with PIA, and Russo and Geary were tasked with refining language for legislative recommendations regarding ferry services and funding.

Island EMS Sustainability Planning

The group discussed differences in emergency medical services between Casco Bay and other island communities, with Russo emphasizing the need to be cautious about fiscal recommendations that could cost millions. Donaghue advocated for exploring the sustainability of island EMS services, while Minkler suggested focusing on the conversation rather than specific recommendations. The team agreed to propose work on a two-year project to study the sustainability of EMS on the islands, and discussed developing a hybrid EMT and advanced EMT training program with the community college.

Paramedic Equipment for Island Services

The group discussed the cost-effectiveness of equipping islands with paramedic-level equipment, considering that in some cases, mainland services could provide paramedic equipment & services when needed. Porter explained that maintaining paramedic-level equipment is necessary for flexibility in staffing, as per diem paramedics may be brought in to cover gaps. Donaghue raised concerns about the Maine EMS rule requiring expensive equipment like monitors on islands with limited staffing and no assigned paramedics, suggesting the need for flexibility in equipment requirements based on island-specific needs. The group agreed to consider recommendations for differentiating equipment requirements across islands. Porter also highlighted the difficulty in recruiting mid-level providers for emergency medicine roles, emphasizing the need to maintain paramedic-level permits in some cases.

Rural EMS Staffing Solutions Discussion

The group discussed staffing challenges in rural EMS services, particularly the difficulty in recruiting PAs and nurse practitioners for ambulance work. They explored potential solutions including examining equipment needs by island and considering new licensing programs for RNs and mid-level

providers. Dietter shared a proposal from Dr. Jonnathan Busko for a rural healthcare technician role, which would involve EMTs with additional training in low-acuity procedures, though Minkler noted that many of these skills are not within the national scope of practice for paramedics. Maine EMS does not want to limit innovation but also needs to ensure that skills are supported by education, evidence, and reasonable implementation and costs. The group agreed to review these proposals and consider them for potential implementation in the future to address sustainability of EMS services in rural areas.

Recruitment Strategies for Medical Program

The group discussed challenges with recruiting doctors for a new non-profit medical program on Swan's Island, which is modeled after Monhegan's first aid station. Judge suggested exploring opportunities similar to MDI Hospital's program with Monhegan Island, where medical professionals come from out of state to help during the summer. The committee agreed to include language about this program in their recommendations, with Philbrook offering to draft the wording. Judge outlined the next steps for finalizing the report, including sending out surveys on education and finance for review, with a goal of submitting the final report to the legislature by February 1st. The group expressed appreciation for the collaborative effort and the valuable insights shared during the process.

Summary created by Zoom AI, reviewed and edited by Marc Minkler

Appendix C

Maine EMS Licensure Levels

[National EMS Scope of Practice Model]

Ambulance Operator

EMR

Emergency Medical Responders (EMRs) provide immediate lifesaving care to critical patients who access the Emergency Medical Services (EMS) system. EMRs have the knowledge and skills necessary to provide immediate lifesaving interventions while awaiting additional EMS resources to arrive. EMRs also provide assistance to higher-level personnel at the scene of emergencies and during transport. EMRs are a vital part of the comprehensive EMS response. Under medical oversight, EMRs perform basic interventions with minimal equipment. In Maine, EMRs cannot be the primary patient care clinician during transport of a patient.

EMT

Emergency Medical Technicians (EMTs) provide out-of-hospital emergency medical care and transportation for critical and emergent patients who access the emergency medical services (EMS) system. EMTs have the basic knowledge and skills necessary to stabilize and safely transport patients ranging from non-emergency and routine medical transports to life-threatening emergencies. EMTs function as part of a comprehensive EMS response system under medical oversight. EMTs perform interventions with the basic equipment typically found on an ambulance. EMTs are a critical link between the scene of an emergency and the health care system. Skills include oxygen administration, splinting, CPR, AED use, delivery of a baby, and administration of limited medications, including Narcan and epinephrine.

Advanced EMT

You must be an EMT before being licensed at this level. The primary focus of the Advanced Emergency Medical Technician (AEMT) is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system (EMS). This includes establishing IVs, basic ECG interpretation, and administration of some critical medications (including Narcan, Epinephrine, Dextrose, and IV fluids). This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. AEMTs function as part of a comprehensive EMS response, under medical oversight. AEMTs perform interventions with the basic and advanced equipment typically found on an ambulance.

Paramedic

The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system (EMS). This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Skills include the EMT and AEMT level plus comprehensive ECG interpretation, extensive medication options, and advanced airway procedures. Paramedics function as part of a comprehensive EMS response, under medical oversight.

EMD

An emergency medical dispatcher (EMD) receives and screens emergency calls, prioritizes responses based on severity, gathers crucial information like location and patient condition, dispatches appropriate emergency personnel (including ambulances, fire, and police), and provides pre-arrival medical and first aid instructions to the caller. They use computer-aided dispatch systems to manage calls and communicate with responders, requiring strong communication skills, staying calm under pressure, and knowledge of local geography and medical terms.

Appendix D

Island EMS Financial Survey

The following survey was sent out to all island EMS agencies and municipalities.

9 Responses were received which covered 14 of the 15 islands examined

Survey Question	Response
What is your name?	N/A
What is your email address?	N/A
What EMS Agency do you represent?	N/A
What is your role at your EMS agency?	N/A
What towns, cities and/or zip codes does your agency primarily cover?	N/A
What type of governance is your EMS agency?	4 - Municipal Fire & EMS 2 - Municipal 3rd service 1 - Private for profit 2 - No EMS Agency
Where does your agency receive its funding? (choose all that apply)	6 - Local Taxes 1 - Patient Billing 2 - No EMS Agency 2 - supplement with patient billing 3 - supplement with grants 3 - supplement with donations
How many licensed Paramedics are on your service?	1 - 71 Paramedics (Portland FD) 1 - 23 Paramedics (LifeFlight) 7 - No Paramedics
How many licensed Advanced EMTs are on your service?	1 - 104 AEMTs (Portland FD) 2 - 3 AEMTs 1 - 2 per diem AEMTs 6 - No AEMTs
How many licensed EMTs are on your service?	1 - 52 EMTs (Portland FD) 1 - 19 EMTs (LifeFlight) 2 - 8 EMTs 3 - 6 EMTs 1 - 1 EMT (but no EMS agency) 1 - No EMTs (and no EMS agency)
How many licensed EMRs are on your service?	8 - No EMRs 1 - 1 EMR
How many licensed Ambulance Operators (AO) are on your service?	1 - 7 AOs 1 - 6 AOs 1 - 4 AOs 6 - No AOs
On an EMS incident, how many non-EMS licensed responders do you typically have?	Range of 0 to 4

Does your agency have NPs, PAs, or physicians respond WITH your agency?	4 - No 3 - Yes (1 without an EMS agency) 2 - Sometimes
When transporting a patient, how many total agency members are typically involved? (patient care, driving, lifting, but all go to the destination)	5 - 3 or under 2 - 3 to 5 2 - 6
In a typical year, how many EMS transports do you have?	Range of 3 to 110, average is 37
In a typical year, how many EMS NON-transports do you have?	Range of 2 to 55, average is 9
What is the average distance you respond from your station to a scene (in miles)?	Range of 1 to 10, average is 1 mile
What is the average distance from a scene to a landing zone (in miles)?	Range of 2 to 7, average is 2
What is the average distance from a scene to a pier/float to meet or access a boat/ferry to transport a patient (in miles)?	6 - Under 3 miles 2 - Between 5 and 7 miles *(Excluded LifeFlight)*
What is the average distance from leaving the island to reach your most common landing point on the mainland (in miles)?	1 - Under 2 miles 3 - Between 4 and 7 4 - Over 10 miles *(Excluded LifeFlight)*
What is the average distance from your mainland landing point to your most used hospital (in miles)?	2 - Over 30 miles 1 - Between 10 and 20 miles 5 - Under 5 miles
Do you respond off island mutual aid to other islands / agencies?	5 - Yes 3 - No *(Excluded LifeFlight)*
If you respond mutual aid to other islands or agencies, what is the average distance to respond to those mutual aid locations?	Average 3-6 miles
In 2024, how many patients did your agency hand off to LifeFlight of Maine?	1 - 19 patients 1 - 4 patients 1 - 3 patients 5 - 0 patients 1 - N/A *(LifeFlight)*
In 2024, how many EMS transports did your agency transport from the scene, drive an ambulance onto a ferry, and then transport the patient to the hospital in the same ambulance?	1 - 17 transports 2 - 2 transports 4 - 0 transports 2 - N/A *(LifeFlight)*
In 2024, how many EMS transports did your agency transport from the scene, put the patient onto an EMS agency owned/managed transport boat, and then transport the patient to the hospital in mainland ambulance from same agency?	1 - 150 transports 7 - 0 transports 1 - N/A *(LifeFlight)*
In 2024, how many EMS transports did your agency transport from the scene, put the patient onto an EMS agency	1 - 25 transports 7 - 0 transports 1 - N/A *(LifeFlight)*

owned/managed transport boat, and then handoff the patient to a different mainland EMS agency?	
In 2024, how many times did LifeFlight of Maine respond and transport to a hospital WITHOUT ground EMS being present at the scene?	1 - 5 responses 8 - 0 responses
In 2024, how many EMS transports did your agency transport from the scene, transport on a ferry (not inside an ambulance), and then transfer care to a mainland EMS agency?	6 - 0 transports 1 - 3 transports 1 - 80 transports *(Excluded LifeFlight)*
In 2024, how many EMS transports did your agency transport from the scene, transport via US Coast Guard, and then transfer care to a mainland EMS agency?	7 - 0 transports 1 - 1 transport *(Excluded LifeFlight)*
In 2024, how many EMS transports did your agency transport from the scene, transport on a private boat with EMS managing patient care, and then transfer care to a mainland EMS agency?	4 - 0 transports 2 - 2 transports 2 - 7-8 transports *(Excluded LifeFlight)*
In 2024, how many EMS transports did your agency transport from the scene, transport via Penobscot Island Air with EMS managing care, and then transfer care to a mainland EMS agency?	1 - 58 transports 1 - 10 transports 1 - 1 transport (not an EMS agency) 6 - 0 transports
In 2024, how many times did a mainland EMS agency come to your island for mutual aid (transport or not)?	1 - 5 responses 1 - 1 response 7 - 0 responses
In 2024, did you have any other agency come to your island or hand off patient care to agency not listed in the previous questions? (Please list agency and approximate # of times)	2 - Once 6 - None 1 - N/A *(LifeFlight)*
Mount Desert Island Hospital	1 - Almost always 1 - Rarely 7 - Never
NL Eastern Maine Medical Center	1 - Regularly 2 - Sometimes 6 - Never
NL Maine Coast Hospital	2 - Rarely 7 - Never
MaineHealth PenBay Hospital	2 - Almost always 1 - Regularly 1 - Sometimes 5 - Never
MaineHealth Waldo Hospital	2 - Rarely 7 - Never
Central Maine Medical Center	2 - Sometimes 1 - Rarely 6 - Never

MaineHealth Lincoln Hospital	1 - Sometimes 8 - Never
NL Mercy Hospital	1 - Regularly 1 - Sometimes 1 - Rarely 6 - Never
MaineHealth MMC Portland	1 - Almost always 3 - Regularly 2 - Sometimes 3 - Never
Other	2 - Almost always 1 - Sometimes 1 - Rarely 5 - Never
In a typical year, how often is transport declined/unavailable due to weather / visibility / temperature?	2- 7-12 times 2 - 1-2 times 1 - Rarely 1 - Almost Never 3 - Never
In a typical year, how often is transport declined/unavailable due to wind?	1 - 7 times 2 - 1-2 times 1 - Rarely 1 - Almost Never 4 - Never
In a typical year, how often is transport declined/unavailable due to the condition of the ocean (e.g., waves, ice)?	1 - 7 times 1 - 1 time 1 - Rarely 1 - Almost Never 4 - Never 1 - N/A *(LifeFlight)*
In a typical year, how often is transport declined/unavailable due to duty time (e.g., marine or flight limits on hours worked)?	1 - 7 times 1 - Rarely 7 - Never
In a typical year, how often is transport declined / unavailable due to night-time hour / darkness?	1 - 7 times 1 - 1 time 1 - Rarely 6 - Never
What is the average cost per response for your agency?	$210 - $3,059, *(Excluded LifeFlight)*
What is the average cost per transport for your agency?	$210-$2,903, *(Excluded LifeFlight)*
We are billed by LifeFlight	8 - No 1 - N/A *(LifeFlight)*
We are billed by Penobscot Island Air	5 - No 3 - Yes 1 - N/A *(LifeFlight)*

We are billed by the US Coast Guard	8 - No 1 - N/A *(LifeFlight)*
We are billed by Maine State Ferry	3 - Yes 5 - No 1 - N/A *(LifeFlight)*
We are billed by mainland EMS agencies	2 - Yes 1 - Sometimes 5 - No 1 - N/A *(LifeFlight)*
We receive bills from others	1 - Yes 6 - No 2 - Blank
Do you bill any municipalities for response or mutual aid?	9 - No
Do you have any additional comments about your agency being billed by anyone (costs, others not listed, etc.)	3 responses • "PIA, Ferry, and private boat transports are billed to the town and come out of the EMS budget" • "We have no control over whether South Thomaston Ambulance or Rockland responds to pick up a patient flown to then mainland by PIA at the Knox County Airport, and there is a huge difference between those." • "No comments about billing, but we do have mutual aid through Acadia National Park seasonally"
What is your approximate EMS budget annually?	2 - Under 3,000 (No EMS agency) 3 - $40-$65,000 1 - $119,000 1 - $441,000 1 - $450,000 1 - $35,000,000
Do you bill patients transported?	5 - Yes 4 - No (2 have no EMS agency)
If you bill a patient, who sends the bill?	3 - 3rd party billing 2 - Billed direct by EMS agency 4 - Do not bill
What is an average bill for a BLS transport?	3 responses $796 to $850
What is an average bill for an ALS transport?	2 responses $1,100 to $1,748

Appendix E

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