

Updated 17 May 2006

STEMI TREATMENT PROTOCOL AND DATA COLLECTION MANUAL

A Statewide Consensus Document on the Care of ST Elevation Myocardial Infarctions

Adopted November 9, 2006

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Dirigo Health Agency/Maine Quality Forum

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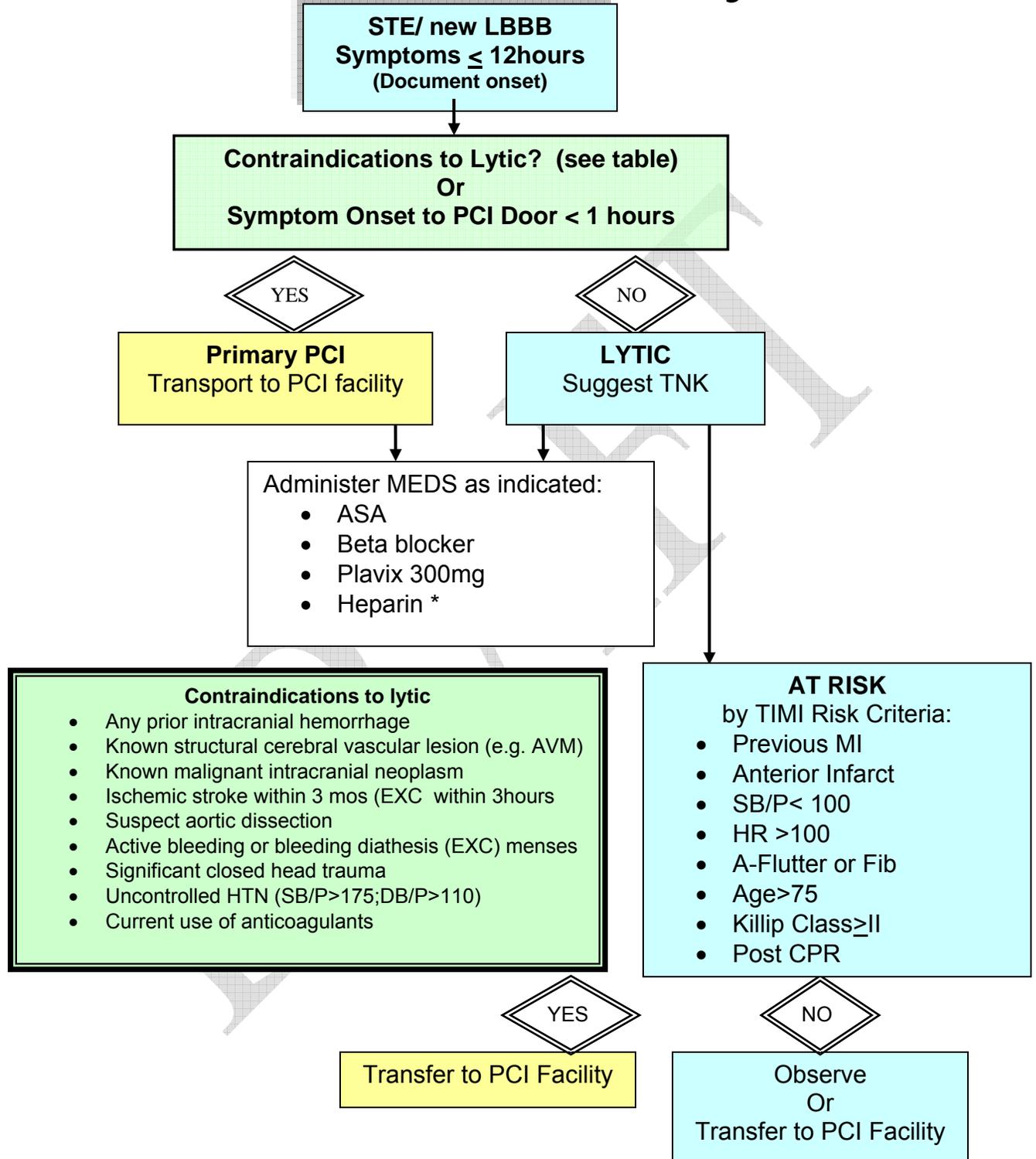
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INTRODUCTION

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STEMI Clinical Pathway



*Heparin bolus only for patients within 1 hour transport to PCI Facility – 60un/kg max 4,000units
Patient transports over 1 hour to PCI Facility continue Heparin with 12un/kg drip.

DATA ELEMENTS

Patient Eligibility Criteria

STE/ LBBB

Documentation of ST- segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to hospital arrival. Use the 12-lead ECG performed closest to the time of hospital arrival. Do not use ECGs done more than one hour prior to hospital arrival. ST segment elevation with $\geq 1\text{mm}/.10\text{mV}$ in two or more leads.

CMS definition (does not specify “new” LBBB?)

Symptom onset within 12 hours

Onset time for patients reporting symptoms initially intermittent and subsequently constant, the onset time is defined as the time of change from intermittent to constant symptoms. Patients reporting symptoms that were initially mild and subsequently changed to severe, the onset time is defined as the time of change in symptom severity. For patients with both, the change in symptom severity is given preeminence in determining symptom onset time. *The REACT Trial definition. Am Heart J 138(6):1046-1057*

Patients with symptom onset >12hours are excluded from time measures.

Variable Name	Variable Description	Variable Definition	Data Source
Demographics			
D1	Patient Last Name		
D2	Patient First Name		
D3	Patient Middle Name		
D4	Patient Date of Birth	includes month, day, and four digit year	
D5	Patient Street	physical address of patient	
D6	Patient Town		
D7	Patient County		
D8	Patient State		
D9	Patient Zip	must include 5 digit zip minimum	
D10	Patient Gender	male/female	
D11	Patient Medical Record Number	number assigned to patient by hospital	
D12	Patient Social Security Number	nine digit SSN xxx-xx-xxxx	
D13	Date of Service	date patient was treated mm/dd/yyyy	
D14	Date of Admission	date patient admitted to hospital mm/dd/yyyy	
D15	ICD-9 Code	ICD-9 Code (410.** exclude 410.7*)	
D16	Date of Discharge	date patient discharged from hospital mm/dd/yyyy	
D17	EMS Run Sheet Number	number assigned to EMS run	
Core Metrics			
CM1	Call Time (time of call to 911)	time 911 call received	
CM2	Symptom Onset Time	see “symptom onset within 12 hours”	

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Variable Name	Variable Description	Variable Definition	Data Source
CM3	Transport Method	Ambulance, Life-Flight, Self	
CM4	Pre-Hospital Lytic Time (<i>Placeholder Metric</i>)	time of fibrinolytic administered by EMS prior to hospital arrival (placeholder metric)	
CM5	Emergency Department Arrival Time	Time of patient triage (up for discussion) Earliest documented date patient arrived at the hospital. Triage Time in the ED or Cath Lab arrival Time if patient admitted directly to the Cath Lab. Registration times on the hospital "facesheets" have not been accurate due to early or late registration time entered and not actual patient arrival time. Note: Encourage documented times to be taken from the computer clocks to maintain synchronicity. Do not include times from external sources, e.g. ambulance records, physician office, lab reports or ECGs.	
CM6	Lytic Administration Time	time the lytic is administered (not ordered)	
CM7	Lytic Delay Reason	acceptable documentation of reasons for delay (need to develop list of reasons)	
CM8	Post-Lytic Open Artery Time	time of 50% reduction of initial ST-segment elevation injury pattern, with relief of symptoms	
CM9	Transfer Time	time patient left from initial hospital	
CM10	Catheter Lab Arrival Time	time patient arrives in catheter lab	
CM11	Balloon Time	time the wire crossed the lesion and resulted in TIMI > _?_ flow, Or time of first balloon inflation, stent placement or other device e.g. angiojet. deployed, or time of 50% reduction of initial ST-segment elevation injury pattern, with relief of symptoms	
CM12	PCI Delay Reason	acceptable documentation of reasons for delay (need to develop list of reasons)	
CM13	Comfort Measures Only	Documentation by a physician / PA/ Nurse practitioner the patient was receiving CMO. CMO are not equivalent to the following; DNR, living will, no code, no heroics. Comfort measures only must be documented. V66.7 encounter for palliative care. Defined from AMI abstract guidelines for CMS These patients will be excluded from time measures	
CM14	PCI Success	Y/N % STEMI to PCI-(attempted but unsuccessful not included in time measures)	
CM15	CABG	percent of STEMI that go to surgery	
CM16	Inpatient Mortality	patient died during this hospitalization. percent STEMI mortality	
CM17	One Year Mortality	patient died within one year of this hospitalization	

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Variable Name	Variable Description	Variable Definition	Data Source
EMS Centric			
EMS1	Service Run Number	run sheet number assigned to the call	
EMS2	Service Name	name of the service responding to 911 call	
EMS4	Service Number	number of the service responding to 911 call	
EMS5	Transport Service Name	name of the service transporting the patient	
EMS6	Transport Service Number	name of the service transporting the patient	
EMS7	Time Arrival on Scene	time when the responding crew arrives on the scene	
EMS8	Time Left Scene	time the ambulance leaves the scene with the patient	
EMS9	12-Lead	Y/N	
EMS10	CPR	Y/N	
EMS11	Airway	Y/N	
EMS12	Shock	Y/N	
EMS13	Symptom Complex Chest Pain/Pressure	Y/N by patient complaint	
EMS14	Symptom Complex Jaw Pain	Y/N by patient complaint	
EMS15	Symptom Complex Back/Shoulder Pain	Y/N by patient complaint	
EMS16	Symptom Complex Left Arm Pain	Y/N by patient complaint	
EMS17	Symptom Complex Shortness of Breath	Y/N by patient complaint	
EMS18	Symptom Complex Feeling of Dread	Y/N by patient complaint	
EMS19	ASA	Y/N	
EMS20	Pre-Hospital Lytic	Y/N (place holder metric)	
EMS21	Nitrates	Y/N	
EMS22	Catheter Lab Activation	Y/N	
EMS23	Receiving Institution	name of the hospital to which the patient was transported	
EMS24	Hospital Arrival Time	time the ambulance arrives at the receiving hospital	
ED Centric			
ED1	Emergency Department Arrival Time	Time of patient triage (up for discussion) Earliest documented date patient arrived at the hospital. Triage Time in the ED or Cath Lab arrival Time if patient admitted directly to the Cath Lab. Registration times on the hospital "facesheets" have not been accurate due to early or late registration time entered and not actual patient arrival time. Note: Encourage documented times to be taken from the computer clocks to maintain synchronicity. Do not include times from external sources, e.g. ambulance records, physician office, lab reports or ECGs.	
ED2	Diagnostic ECG Time (DxEKG)	The machine generated time documented on the diagnostic ECG. Note: QA machine times to synchronize with ED computers clocks. Time of ECG done within 1 hour before hospital arrival.	
ED3	Treatment Decision Time	the time that the physician ordered the Lytic administration or called to activate Primary PCI, or chose not to treat	
ED4	Lytic Ordered Time	the time the physician ordered the lytic	

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Variable Name	Variable Description	Variable Definition	Data Source
ED5	Lytic Administration Time	the time the lytic was administered	
ED6	Lytic Contraindicated	Yes/No see chart for contraindications	
ED7	TIMI At Risk	"AT RISK/NOT AT RISK" see TIMI criteria	
ED8	Cardiogenic Shock (??covered in TIMI??)	Y/N (Covered in TIMI??)	
ED9	Transfer Decision Time	time the decision to transfer was made	
ED10	ASA Time	time when aspirin was given if not given indication of why	
ED11	Beta Blocker Time	time when beta blocker was given if not given indication of why	
ED12	Heparin Time	time when heparin was given if not given indication of why. Indicate whether by bolus or drip.	
ED13	Plavix Time	time when Plavix was given if not given indication of why	
ED14	Transfer Notification	time the transporting EMS was called	
ED15	Transfer Arrival Time	time ambulance arrived at initial ED	
ED16	Transfer Departure Time	time that the patient left the ED of transferring hospital or is this the time transport(EMS) left to go to requesting hospital?	
ED17	Sending Hospital Name	name of the referring hospital	
ED18	Sending Hospital Number	referring hospital MHDO ID number	
ED19	PCI Center Contact Time	time of the call to the PCI Center	
Transfer			
T1	Transfer Departure Time	time transport(EMS) left to go to requesting hospital	
T2	Hospital Personnel On-Board	Y/N	
T3	Heparin Drip	Y/N	
T4	Medications Enroute		
T5	Increased Chest Pain	Y/N	
T6	Bleeding	Y/N	
T7	Cardiogenic Shock	Y/N	
T8	Cardiac Arrest	Y/N	
T9	CPR	Y/N	
T10	Intubation	Y/N	
T11	ED Arrival Time	Time of patient triage (up for discussion) Earliest documented date patient arrived at the hospital. Triage Time in the ED or Cath Lab arrival Time if patient admitted directly to the Cath Lab. Registration times on the hospital "facesheets" have not been accurate due to early or late registration time entered and not actual patient arrival time. Note: Encourage documented times to be taken from the computer clocks to maintain synchronicity. Do not include times from external sources, e.g. ambulance records, physician office, lab reports or ECGs.	

Variable Name	Variable Description	Variable Definition	Data Source
PCI Center			
PCI1	Catheter Lab Activation Time	time the call went out to activate the cath lab	
PCI2	Catheter Lab Arrival Time	time the patient entered the cath lab	
PCI3	Balloon Time	time the wire crossed the lesion and resulted in TIMI > _?_ flow, Or time of first balloon inflation, stent placement or other device e.g. angiojet. deployed, or time of 50% reduction of initial ST-segment elevation injury pattern, with relief of symptoms	
PCI4	PCI Delay	<p>If PCI delayed reasons for delay must be documented. Examples of acceptable documentation:</p> <ul style="list-style-type: none"> • Patient initially refused • TEE to rule out aortic dissection • Patient waiting for family to arrive to consult with re. PCI., • Patient in full cardiac arrest on arrival unable to take to cath lab until stable • Patient wants to speak to clergy first • No urgent need for PCI • Pt. taken to lab but determined to be too high risk to complete procedure at this time. • Documentation of a plan to do a PCI after the arrival date constitutes a clearly implied reason for a delay e.g. PCI tomorrow, per ED MD notation, Will schedule pt for PCI in a.m. per H&P 	
PCI5	Cardiogenic Shock	Y/N	
PCI6	CABG	Y/N did patient go to CABG surgery	
PCI7	Respiratory Failure	Y/N	
PCI8	In-Hospital Mortality	patient died during this hospitalization. percent STEMI mortality	
PCI19	1-Year Mortality	patient died during this hospitalization. percent STEMI mortality	
Discharge			
D1	Length of Stay	number of days in hospital from admission date to discharge date	
D2	ASA	Y/N if not documentation on why	
D3	Beta Blocker	Y/N if not documentation on why	
D4	Statin	Y/N if not documentation on why	
D5	ACE	Y/N if not documentation on why	
D6	Cardiac Rehabilitation	Y/N if not documentation on why	
D7	Smoking Cessation	Y/N if not documentation on why	
D8	Call 911 Instructions	Y/N if not documentation on why	

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Variable Name	Variable Description	Variable Definition	Data Source
D9	Discharge Status	Home, expired, or another facility	
Retrospective			
R1	ICD-9 Code 410.** (410.7*excluded)	All ICD-9 codes within the 410 range excluding 410.7*	
R2	Symptom Onset < 12 hours	symptom onset (see definition) < 12 hours	

Note:

[CMS extraction guideline](#)

Non-Primary PCI – A percutaneous coronary intervention (PCI) is considered non-primary when it is used for reasons that are not emergent in nature. Non-Primary PCIs include elective, rescue, and salvage PCIs. In contrast a Primary PCI is the use of percutaneous reperfusion procedure in the acute phase of ST –segment elevation MI(usually within 12 hours or less from the onset of ischemic symptoms) with the goal of restoring blood flow to the affected myocardium, thereby improving outcomes including reduced mortality rates.

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DATA ELEMENT RELATIONAL MAP

To be constructed by the vendor

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ORDER SET

In development working with order sets from multiple hospitals.

This needs the attention of the group. Should we develop a core framework order set that hospitals can adapt to fit their system? The concept is to create a set that will be included in a patient's chart and will produce most of the data elements of interest. In this way, charting the process creates the data for measuring the process.

Rather than an order set should we discuss the above principle and create a sample order set to demonstrate?

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Maine EMS 12 Lead QI Form

Date of service: _____

Patient age: _____

EMS Service: _____

EMS Service Number: _____

MEMS Report #: _____

Provider License Number: _____

Case Type: (circle one) Medical / Trauma

Hosp Med Record #: _____

Hospital Name: _____

Suspected Problem: _____

Time since onset of symptoms: _____ (minutes)

12 Lead EKG Interpretation

Sinus Afib SVT RBBB LBBB Other _____ Rate _____

STEMI? (circle one) Yes No

Leads involved _____ Elevation in mm _____

Inferior Anterior Anterolateral (circle one) Lateral Posterior

If ACS (Acute Coronary Syndrome) was suspected, was ASA given? (circle one) Yes No

Given by: EMS Patient Family/Bystander

Did you communicate your findings to the receiving hospital? (circle one) Yes No

Presented copy of 12 Lead EKG: (circle one) Yes No

Hospital Follow-up

Was the interpretation recorded on the run sheet by a paramedic? (circle one) Yes No

Was the EKG interpretation correct? (circle one) Yes No

What was your interpretation: _____ Your Name: _____

Who interpreted the EKG after the call? (circle one)

ED Physician Cardiologist Service Med Dir Regional Med Dir

Please attach a copy of the 12 Lead to this form.

Please see attached .pdf file

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This will contain the contraindications to lytic and the TIMI criteria. Do folks feel that this will be used by ED personnel?

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**Paramedic Interfacility Transport Program
Draft Revision**

Background

The original PIFT program was developed in the early 90's in response to requests from hospitals who wanted to reduce the amount of time they had to send nurses on interfacility transports with "stable" patients. Since that time, the program has gone through a number of revisions, usually in response to a request to add new, approved medications to the list. Recently, it was decided to do a thorough review of the program with the following objectives:

- A. Evaluate the need for a better definition of what patients could be transported under this program and what the crew configuration should look like.
- B. Investigate the possibility of approving drug categories rather than specific medications.
- C. Strengthen the definition of stable patient.
- D. Evaluate the Medical Control and Quality Assurance pieces of the program.

The MDPB established a PIFT sub-committee to review the program and make recommendations on potential revisions. Based on those meetings, the committee has determined the following:

- A. The program should teach classification of medications instead of individual medications. They felt that it was more important to ensure that the patient being transported was hemodynamically stable.
- B. Blood products will be added to the program (most likely in future update).
- C. Some devices that are not considered to be part of the current scope of practice for paramedics will be added to the program.
- D. There should be a patient stability statement.
- E. There should be a formal, enforced Medical Director/Quality Assurance program.

Crew Configuration/Eligible Providers

This program is being developed based upon a crew configuration of 1 paramedic providing patient care.

In order to be eligible to certified to do PIFT transfers, the paramedic must:

- A. Successful completion of the Maine EMS approved PIFT program or Maine EMS approved Critical Care Transport Program

Patient Stability

A patient is considered "stable" when there is no foreseeable likelihood of material deterioration in the condition of the patient as a result of or during the transport.

Assessment of stability will require:

1. Hemodynamic and neurologic signs which have demonstrated no deterioration from the acute presentation of the patient, or are within acceptable limits of variation on existing therapy and may be reasonably predicted to remain so during the transport without the need for further adjustments to such therapy; and
2. The pathophysiology of the patient's acute condition is known to favorably respond to the therapeutic interventions which have been undertaken at the sending hospital;

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Actions required of sending hospital and transport personnel:

1. Proactive interventions to stabilize the patient's condition and prevent deterioration; and
2. Aggressive enroute interventions to reverse or mitigate deterioration in the condition of the patient;

On Line Medical Control by the Sending Clinician or Designee

1. Shall prospectively approve the hospital to hospital inter-facility transport with due regard to the pathophysiology of the patient's condition and the interventions undertaken to achieve stability; and
2. Shall provide enroute guidance to crew members consistent with protocols.

Medications

The committee is recommending that the program teach medication categories instead of individual medications. This will ensure a more uniform program that doesn't have to be changed whenever medications come in and out of use.

Proposed Medication Classifications

- a. Anti-Infectives
- b. Anticoagulants
- c. Anticonvulsants
- d. Antidiabetics
- e. Antidysrhythmics
- f. Antihypertensives: including ACE Inhibitors, calcium channel blockers, diuretics, alpha blockers, beta blockers
- g. Antipsychotics
- h. Cardiac Glycosides
- i. Corticosteroids
- j. Gastrointestinal agents, including H₂-blockers, PPI's, and somatostatin and its analogues (somatostatin)
- k. IV fluids, Electrolytes: including dextran, albumin, hetastarch
- l. Miscellaneous: drotrecogin
- m. Narcotics: including all routes **except** epidural.
- n. Nutritional Supplements: Parenteral nutrition and Vitamins
- o. Platelet Aggregation Inhibitors: including IIb/IIIa inhibitors

Medications (continued)

- p. Respiratory medications: beta agonists, anticholinergics, mucolytics, steroids
- q. Sedatives: benzodiazepines, barbiturates
- r. Vasoactive agents: antihypertensives, pressors/sympathomimetics

Over-The-Counter Medications

It may be necessary to use medications which are not routinely part of the PIFT program but are common medications, such as over the counter medications. In these circumstances, where the medication is a routine over the counter medication, continuation of such use may be approved as long as the following criteria have been met:

1. That it was a medication that the patient had used previously without any adverse or allergic reaction.
2. That the medication would be supplied by the sending facility for the

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purpose of this transport.

3. That the sending physician would write an order for this as for any other medication to be used on the transport which includes medication name, dose, form of the medication, route of administration, and timing of initial and repeat dosing.

Devices

The group is recommending that the following devices be added to the program, with the service developing a plan to assure the competency and proficiency in the operation in any and all devices specified in this protocol:

- a. Foley Catheters: including Continuous Bladder Irrigation
- b. Central Lines: maintenance, not insertion
- c. Transvenous pacer
- d. IV pumps
- e. Chest Tubes: to water seal and Heimlich valve
- f. Maintenance of NG/OG tubes

Notes

Patient controlled pumps, G-tubes, and J-tubes are OK for transport by any level of licensure and do not require this training module.

Vagal nerve stimulators should fall under the special device protocol

Quality Assurance/Medical Control

All services participating in the PIFT program must have a service medical director who reviews 100% the PIFT runs, all the QI forms, and is available for questions on requested transfers. Also, the service must be in compliance with all regional and state QI. As well, this medical director should be an ambassador to local medical staffs who will need to change the way they practice to satisfy our requirements on the action of the sending hospital.

We have developed a standard QI form (attached) which will need to be completed on all hospital to hospital PIFT transfers. This form must be reviewed by the service Medical Director and made available to the regional and/or state QI committees upon request. They must be kept on file for a period of three years. In addition to a QI tool, these forms will provide invaluable information on PIFT runs, the medications and devices that make this a PIFT run, and variances.

Training/Education

This piece is dependant on the final approved product. Once the content has been approved by the MDPB, the program will be referred to the MEMS education committee for development of the education component.

Frequently Asked Questions

Why not vents in this program?

The intention of the PIFT update that we are doing is to standardize a stand alone program aimed at delineating an advanced practice for paramedics doing interfacility transfers. We expect patients in this program to be stable and the paramedics to be alone in the back of the ambulance. To that end, a patient on a ventilator may require one person to constantly maintain their ventilator, and if the ventilator fails or some other airway calamity occurs, the solo paramedic will be immediately and completely tied up with airway maintenance. Thus, solo provider transfer with patients on ventilators is probably not an appropriate practice.

Why Transvenous pacers, then?

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Many transfers occur with stable patients who travel to certain hospitals for permanent pacemaker insertion. In the interim, they are maintained on a Transvenous pacemaker. If this device were to fail, the patient could be paced transthoracic and the paramedic would be free to attend to other patient needs once the external pads are placed.

Why do services need their own medical director?

We are not just blessing additional skills and hoping all goes well. We are concerned with using this program in the correct venue, verifying that the paramedics have been able to assimilate the educational and psychomotor skills that are required, and that we identify and look for solutions for patients who have poor outcomes while being transferred within the realm of the PIFT program. This requires 100% QI, and requires a medical oversight that is familiar with the service, the personnel with the service, and who can meet with service participants.

The medication list has lots of powerful drugs— doesn't that mean that the patient is unstable?

We are trying to reframe how we think about stability, and using objective signs found by measuring hemodynamic and neurologic parameters. As well, we are looking at the patient's underlying problem and based on best knowledge, do we expect the patient to deteriorate despite optimal therapy enroute to another hospital. If the patient is stable hemodynamically and neurologically, and we do not expect the underlying problem to be a threat to life or limb, then a PIFT transfer within the confines of the devices listed is OK. And stability attained with medications and appropriately supporting the patient's physiology is OK. This is listed above but worth repeating.

Do I have to do a QI for a patient on an IV with KCl going from the nursing home to MRI and back?

No—we have indicated that the PIFT QI is framed to capture hospital to hospital transfers. The paramedic must be a PIFT trained paramedic, though.

What about if I took a previous program—is this just another option? No, this will become the updated and only program for those providing PIFT services. In other words, this replaces all the previous PIFT programs.

Why not blood products? We did look at blood products and this is a bigger issue that will take more time and resources both from Hospitals and EMS. We have researched the nuances and plan to go forward with blood products in a future and comprehensive PIFT program.

Medical Director Review _____ (sign)		Paramedic Interfacility Transport	
Date _____		PCR # _____	Service # _____
Sending Facility _____		Paramedic Name _____	
Receiving Facility _____		Lic # _____	
Do not complete the transfer unless attending physician, on line medical control physician and OLMC contact number provided. Must also complete whether or not communication problems anticipated enroute. Attending physician: _____ OLMC: _____ Phone: _____ Communication Problems Anticipated: _____			
Stable <u>Moderate</u> ¹ / Low ² Risk (Circle one)			
Vitals signs as documented on EMTALA form: Pulse: _____ Respirations: _____ Blood Pressure: _____ SaO ₂ %: _____		Vital Signs on arrival at facility: Pulse: _____ Respirations: _____ Blood Pressure: _____ SaO ₂ %: _____	
List all medications and their rates/doses being administered during transport:		List any interventions performed or devices used enroute:	
<input type="checkbox"/> Heparin	_____	<input type="checkbox"/> IV Start	
<input type="checkbox"/> Nitroglycerine	_____	<input type="checkbox"/> Intubation	
<input type="checkbox"/> Potassium	_____	<input type="checkbox"/> CPR	
<input type="checkbox"/> TPN	_____	<input type="checkbox"/> Defibrillation	
<input type="checkbox"/> Morphine	_____	<input type="checkbox"/> Cardioversion	
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other Airway Maintenance	
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Transvenous Pacing	
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other	
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other	
<i>Were there any titrations to medications or unscheduled boluses administered during transport?</i> If so, list medication and dose/change: _____ _____ _____		<i>Was contact with OLMC necessary during transport?</i> If so, list what was requested and if received: _____ _____ _____ Name of OLMC: _____	
Order sheet for all medications/interventions is completed, signed by Physician/PA/NP or by RN with Verbal Order, and accompanies patient chart.			
The transporting paramedic has the final decision whether or not they are comfortable in transporting the patient without additional hospital staff.			

1) Stable "Moderate Risk" Patient: A Stable patient is one who has hemodynamic and neurologic stability from therapies initiated. Therapies initiated must be expected to maintain patient stability during the transport. This patient is typically going via emergent transfer to a tertiary facility for services not readily available at a local facility. Variation on existing therapy has demonstrated no deterioration and may be reasonably predicted to remain without change during the transport without the need for further adjustments to such therapy.

2) Stable "Low Risk" Patient: A patient who has hemodynamic and neurological stability with no foreseeable deterioration. This is the patient who is not suffering from an acute illness, but has medications or interventions being administered which are outside of the scope of the Paramedic without PIFT training.

3) Unstable "High Risk" patients and those receiving interventions outside the scope of the PIFT module will require the sending facility to provide other appropriate staff to assure appropriate clinical care during transport.

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