JOHN ELIAS BALDACCI
GOVERNOR

STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
152 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0152

MAINE EMS

MICHAEL P. CANTARA
COMMISSIONER

JAY BRADSHAW
DIRECTOR

September 26, 2005

Members, Joint Standing Committee on Criminal Justice & Public Safety,

Throughout the summer, four work groups have met to review in detail the EMSSTAR Report and the recommendations found in the 10 assessment areas. These work groups were:

- Regulation & Policy / Resource Management / Communications
- Medical Direction / Trauma Systems
- Human Resources & Training / Public Information, Education, and Relations
- Transportation & Facilities

The charge to these work groups from the Board of EMS was to review each recommendation, gather additional data where necessary, discuss the impact of these changes on the system and then to accept, reject, or modify the recommendation. Once this is completed for all work groups, the next step will be to compile all the recommendations based upon prioritization and establish the strategies, outcomes, action items, assignments and target delivery date. This prioritized master list will serve as the foundation for developing the goals, strategies, and action plans for Maine Emergency Medical Services.

On the following pages, you will find:

- Table of all EMSSTAR Recommendations with updated comments and status
- An executive summary for each work group
- Meeting schedule and attendance list for each work group
- Meeting minutes from each work group (these have also been posted on the MEMS web site as they became available).

I will look forward to meeting with you in person on September 28, and providing additional details in response to any questions you may have.

Sincerely,

Jay Bradshaw
Director

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

ID #	Description	Law Change?	Rule Change?	Work Group Priority	Comments/Status	Date
1	**Regulation and Policy**					
1.1	Develop a consensus based policy to promulgate term limits, representation, conflict of interest, and other parliamentary matters for both the Board of EMS and the Medical Direction and Practices Board.	x	x			
1.2	Establish a stable, dedicated funding source for the state EMS system that reflects the state's commitment to protecting the health & safety of Mainers in accordance with the statement of intent associated with the Maine EMS Act.	x				
1.3	Pursue an increased appropriation and sufficient FTEs for the state EMS office to execute the existing regulatory mandates of the EMS Act and EMS regulations expected of the Board and state EMS office.	x				
1.4	Structure the EMS office with subordinate programs in alignment with the major regulatory functions outlined in the EMS Act and rules: licensure of EMS personnel, licensure of EMS agencies, examination oversight, trauma care system, and investigation and discipline of EMS personnel.	x	x			
1.5	Modify the EMS Act to repeal the portions of the section on regional councils associated with advising the board on licensure of EMS agencies, examinations of EMS personnel, and certification and decertification of EMS personnel	x	x			
1.6	Actively contract with regional councils for activities related to coordination of regional medical direction, technical assistance for local EMS agency quality improvement plans, coordination of EMS training programs upon request of local EMS agencies, and continued conduct of regional council meetings to		x			

	assure representation of the EMS community and needs.					
1.7	Clearly define the roles of the regional councils and staff and establish quantitative reporting requirements and performance accountability.	x	x			
1.8	Allow the number, boundaries, and office location for regions to evolve based on the changing needs of the local EMS system and take advantage of the annual opportunity to invite new approaches.		x			
1.9	Encourage regional councils to expand their role as the focal point for EMS system support and development.					
2	**Resource Management**					
2.1	Establish an EMS plan and state mobilization disaster plan to guide the future of emergency service delivery in the State of Maine.				In process, working with Office of Public Health Emergency Preparedness (DHHS), Regional Resource Centers (MMC. CMMC. EMMC) and MEMA.	
2.2	Create a mutual aid plan that encompasses all EMS agencies and obtain signed mutual aid agreements.				There is a statewide mutual aid template available – unknown how many agencies utilize the form.	
2.3	Accelerate the implementation of the electronic data collection system that utilizes the revised NHTSA EMS data set.				Contract approval imminent; servers purchased installed at DPS; domain names registered; introductory session conducted August 2005; training session scheduled for November 2005.	
2.4	Educate EMS providers about the capabilities of the data collection system and the customized reports and information that can be obtained from Maine EMS.				Numerous seminars conduced at conferences, through regional quality improvement activities, in Journal of Maine EMS, etc. Training scheduled at Samoset Conference November 11, 2005 (other dates & places TBA)	
2.5	Assure continued funding for the electronic data collection system that is not dependent on grant funding.				Data contract currently supported by General Funds. E-Run report project funded by variety of grants for initial implementation. Net result of e-run report implementation will be a savings in General Fund $$$ (est FY08)	

2.6	Explore means to integrate the data collection system with other public safety and health data systems.			.	Currently done as part of CODES (Crash Outcome Data Evaluation System) project. Grant application pending to expand linkage for all medical emergencies	
2.7	Implement a resource management system that can monitor available EMS resources on a contemporary basis in the State of Maine.					
2.8	Develop and implement a statewide recruitment and retention programs in cooperation with and the assistance of the Regional Councils.					
2.9	Encourage regional councils to expand their role as the focal point for EMS system support and development.		x		This is a resource offered by regional offices – MEMS has also participated when/where requested.	
2.10	Remove barriers that prevent registered nurses, physician's assistants (PA) and flight crews who possess appropriate credentials from functioning in the prehospital environment and effectively serving as a part of the EMS System.	x	x			
3	**Human Resources & Training**					
3.1	Remove the requirement for regional approval of initial training programs and place this function at the state level.		x	High	Compiling models for accreditation from other state and national boards.	September 2005
3.2	Develop and implement a process for institutional and agency approval for on-going course delivery modeled after contemporary accreditation processes that precludes the requirement for individual course approval.		x	High	Included in above	September 2005
3.3	Repeal the rule requiring pre-approval of continuing education programs. Replace it with a rule requiring documentation of course content and student participation that can be reviewed after the fact by Maine EMS.		x	High		
3.4	In cooperation with other state agencies, develop a plan to assure that EMD training is required for all personnel answering 9-1-1	x		Done	MEMS supported and worked on passage of LD 1373 – now P.L. 303 which establishes responsibilities of	September 2005

	EMS calls.				MEMS and ESCB (E-911 bureau). Deadline for implementation 1/2007.	
3.5	Explore alternative resources and partnerships to accelerate compliance with the AVOC requirement.	x		Medium	AVOC Instructor Update underway.	
3.6	Encourage increased utilization of the hospital-based video conferencing network to facilitate increased opportunities for distance education for EMS providers.			Done	Video conferencing actively used for many committees, work groups, and other agencies. Also has been used for EMT instruction in Aroostook County and on Monhegan Island.	
4	**Transportation**					
4.1	Develop a strategy and a program to analyze the response times statewide and distribute the information to each agency.			Medium (Partially Completed)	Although response time tracking exists, a strategy and program for analysis is needed.	
4.2	Revise the rules and regulations to eliminate the 20 minutes annual average response time. In its place, require all EMS agencies to develop a stated response goal using contemporary methodology (i.e. fractile response times) based on a specific needs assessment for their response area. This report should be reviewed during the annual licensure renewal process.		x	Medium	Fractile response times currently reported to all services; however, not formally incorporated into annual licensing process. Committee recommends that 4.1 & 4.2 be considered together	
4.3	Establish criteria for marine EMS transport units.		x	Low	Low incidence of marine transport - and no indication of problems with current system.	
4.4	Modify the Maine EMS Prehospital Treatment Protocols to authorize all EMS providers statewide to request air medical transport units without online medical direction.			High	Does not require Protocol change as this is currently part of the Trauma Triage Protocol. The Committee recommends a change to the statement language that "Licensed EMS providers are authorized to request air medical transport."	
4.5	Implement the Ambulance Vehicle Operators Course (AVOC) training requirement without any further postponements of the effective date			Medium	AVOC instructor updates ongoing; however, implementation statewide requires additional funding and personnel. Committee notes that equivalent courses such as Emergency Vehicle Operator's Course (EVOC)	

					should be accepted as well.	
5	**Facilities**					
5.1	Conduct a needs analysis of sending facilities to identify the staffing and scope of practice expectations for patients requiring interfacility transport.			High (in process)	Incorporated into the MDPB update of the Paramedic Interfacility Transportation Module (PIFT). Approved by MDPB, program in development with Education Committee.	Spring 2005
5.2	Perform a comprehensive review of the Paramedic Interfacility Transport Module and revise the content based on the needs analysis findings.			High	In process – the Medical Direction and Practices Board has completed its work and referred PIFT module to the Education Committee for program development. Committee suggests rewording recommendation as follows: *"Develop and implement changes to Maine EMS training, scope of practice, and protocols for all levels based on the comprehensive needs analysis."*	Spring 2005
5.3	Conduct a review of destination selection criteria utilized by EMS personnel.			High	Committee recommends that review of destination selection be included with recommendations 5.1 and 5.2 as part of a comprehensive needs analysis.	
5.4	In conjunction with the design of the electronic EMS reporting system, implement a method of assessing the rationale for destination selection made by EMS personnel for all transports.			High	As 5.1 and 5.2 are determined, this recommendation should be included. Consider including hospital personnel when assessing hospital destination selection rationale.	
5.5	Convene a Pharmacy subcommittee of the Board to investigate options for ambulance restocking that would eliminate the need for ambulance services to carry multiple drug boxes.			Medium	Establishing a single drug box system may benefit the MEMS system; however, current systems in effect do not have a detrimental affect on patient care.	
6	**Communications**					
6.1	Develop and implement a statewide EMS communications plan.					
6.2	Conduct an assessment of the existing EMS radio system. Explore the possibility of funding upgrades and enhancements with homeland security and/or public health				EMS is working with MEMA and OPHEP to write and support a Homeland Security grant to replace hospital base stations and antennas to comply with	April 2005

	preparedness funding.				upcoming FCC narrow band requirements. Next steps will be do work with these same agencies on EMS assessment and upgrades.	
6.3	Implement emergency medical dispatch statewide by partnering with appropriate state agencies that oversee the 9-1-1 system.			Done	LD 1373, which has been supported by both EMS and ESCB, was voted unanimous out to pass (as amended) at work session 5/3/05.	May 2005
7	**Public Information, Education and Prevention**					
7.1	Focus the PIER campaign on increasing the awareness of elected officials and decision-makers about the current status and urgent fiscal needs of Maine's EMS system.			High		
7.2	Develop and implement comprehensive and integrated EMS public information, education, and relations program.			High		
7.3	Elevate the priority of PIER within each agency's priorities such that it remains a critical focus at the state, regional, and local level.			High		
7.4	Establish a mechanism for rapid dissemination of policy decisions, meeting minutes, and other announcements of interest to EMS agencies and personnel.			High	EMS web site updated regularly. MEMS working with InforME to automate linkage to EMS licensing data.	August 2005
8	**Medical Direction**					
8.1	Amend Maine's EMS rules to require that every EMS agency have a physician medical director. The agency medical director should have primary responsibility for assessment and assurance of the competence of every EMS provider.		x	Low	This would be deemed a "state mandate" if included in MEMS rules/law and have significant budget implications.	
8.2	Regional medical directors should be charged to assist and facilitate the efforts of local medical directors and to participate in the development of statewide EMS protocols.				Regional Medical directors assisted in the distribution of updated protocol drafts in Fall of 2004.	Fall 2004
8.3	Develop and promulgate job descriptions for local and regional medical directors.			Done	Will be included in final work group recommendations.	September 2005
8.4	Require local and regional EMS medical				In process - MDPB working on program	April 2005

	directors to complete a nationally recognized medical directors' course within the first year of their appointment.		x		for online medical director training. First draft circulated for review/comment in Fall 2004.	
8.5	Develop and require appropriate training for any individual who will provide on-line medical direction to EMS providers.		x		See above	April 2005
8.6	Develop formal mechanisms to utilize physicians who have expertise in emergency medical services in all aspects of the Maine EMS system.			Done	Work group feels this will be accomplished through the online medical director training and development of job descriptions.	
9	**Trauma Systems**					
9.1	Develop and maintain a state trauma registry.			Medium	Agreed this is important; however, significantly more resources would be required.	
9.2	Utilize trauma registry data, patient care reporting data, and other relevant data sources to drive EMS education, quality improvement, and injury prevention programs.				(see above)	
9.3	Modify the Maine EMS Prehospital Treatment Protocols to authorize all EMS providers statewide to request air medical transport units without on-line medical direction.			High	Does not require Protocol change as this is part of the Trauma Triage Protocol. Clarification of Triage Protocol reviewed and approved by Trauma Advisory Committee on July 27, 2005; will be discussed by Medical Direction and Practices Board on September 21, 2005; and will be on the Board agenda for October 5, 2005 meeting.	
10	**Evaluation**					
10.1	Continue with the acquisition of an electronic patient care information system assuring an adequate education and implementation plan is in place to facilitate a smooth transition for local EMS agencies.				Contract approval imminent; servers purchased installed at DPS; domain names registered; introductory session conducted August 2005; training session scheduled for November 2005.	September 2005
10.2	Establish a priority in the overhauled regional contract scope for technical assistance to local EMS agencies for QI plan development/implementation; maintain the					

	obligation of QI system development at the regional level.					
10.3	Initiate a reporting system that captures performance indicators (e.g., fractile response times, clinical outcomes, etc) as opposed to inventory indicators(e.g., call volumes, number of personnel, call types, etc.)			Done	Fractile response times currently reported. Federal trauma grant approved; will be used to fund data linkage that will provide clinical outcome information.	July 2005
10.4	Establish linkage of the new prehospital care data with other sources such as the Bureau of Highway Safety, hospitals, and vital statistics.			Done	Currently done as part of CODES (Crash Outcome Data Evaluation System) project. Federal grant approved and funded to expand linkage for all medical emergencies.	July 2005

Regulation and Policy / Resource Management / Communications

The Regulation & Policy/Resource Management/Communications work group met 5 times over the summer. Membership consisted of people from all regions of the state, and various positions in the EMS system. Attempts to engage non-EMS public members was not successful.

A summary of each meeting follows:

- June 1, 2005. Introductions of each member, including EMS involvement and potential conflicts of interest were disclosed. A review of the EMSSTAR review process and recommendations was conducted by MEMS staff, and the charge to the work group was provided. It was also explained that the role of the facilitators is to prepare meeting materials, to record and distribute the minutes, and keep the meetings on track and on focused. Having independent facilitators will also allow EMS staff to participate as equal members in the work group. Meeting schedule was discussed and initially agreed to be bi-weekly and two hours in length.

- June 16, 2005. Meeting schedule was revised to be monthly meetings, three hours in length. Minutes with a "Draft" watermark will be distributed within 2 weeks of a meeting and posted to the web site as soon as possible. Considerable discussion about funding needs and whether or not any of this work could/should be done before adequate funding is identified and secured. It was agreed that work should continue, as there is a need to prioritize all the recommendations. There will likely be savings realized by some of the recommendations. Initial prioritization took place; however, the group felt that it was important to identify the core functions of the EMS system before finalizing the prioritization of recommendations.

- July 21, 2005. Core functions of the Maine EMS system were categorized as being:
    - System-wide oversight and policy formation
    - Oversight/Formation of medical protocols & policies
    - EMS administration, regulation, and coordination
    - Quality assurance and quality improvement
    - Education and accreditation
    - Public education and public relations

  Brainstorming took place about each of these areas which created a definition of what these functions mean and it was agreed that for each function, there should also be details about WHO would be responsible for each function, WHERE that function would be located, and HOW the function would be accomplished.

- August 18, 2005. Considerable time was spent discussion the progress of the work group. Some members felt things should be going faster; however, as the discussion continued, it was agreed that the significance of the potential changes was such that having the opportunity to digest and discuss information would be prudent and helpful to the "buy-in" of the EMS community. It was agreed that the work groups need to maintain a "higher level" perspective and not get too specific with details during this phase. Core function #1 was drafted.

- September 15, 2005. Core function #1 reviewed, revised, and adopted. Work took place on core functions # 2-5, with a discussion about how the organization chart of the new system might look. It was agreed that work should finish on the core functions as several of those may be incorporated into the EMS administration function. It was also agreed that the state medical director should be a full time position (comparable to the Bureau of Health, or other similar positions in state government).

Regulation & Policy / Resource Management / Communications
Meeting and Attendance Record

Facilitator: Alan Hinsey, Management Intervention Services, alan@interventionteam.com

Name	Affiliation / Location	6/1/05	6/16/05	7/21/05	8/18/05	9/15/05	10/20/05
Chief Wayne Werts, EMT-P	Auburn Fire Dept	X	X	X	X	X	
Donnie Carroll	Southern Maine EMS	X		X	X	(JL)	
Rob Tarbox, EMT-P	PACE Ambulance	X	X	X	X	X	
David Stuchiner, MD	Auburn, ME	X	X	X	X	X	
Paul Conley, EMT-P	Freeport, ME		X		X		
Carol Pillsbury, EMT-P	NorthStar Ambulance	X	X	X			
Chief Jeff Cammack	Bangor Fire Dept	X					
Alan Douglass, RN, EMT-P	Phippsburg Fire Dept St. Andrews Hospital, Boothbay Hbr		X	X	X	X	
Jay Bradshaw	Maine EMS	X	X	X	X	X	
Tim Beals	Delta Ambulance		X	X	X	X	
Ron Jones	Westbrook EMS	X	X	X	X	X	
Rory Putnam	Falmouth Fire/EMS	X			X	X	
Norm Dinerman, MD	EMMC/LifeStar of Maine				X		

Maine Emergency Medical Services
500 Civic Center Drive
Augusta, ME

MINUTES

Date: June 1, 2005

- Introductions were made, the following workgroup members attended: Wayne Werts; Donnie Carroll; Rob Tarbox; David Stuchiner; Peter DiPietrantonio; Bill Dunwoody; Carol Pillsbury; Jeff Cammack; Jay Bradshaw; Ron Jones and Rory Putnam. Facilitators were Alan Hinsey and Mike Roberts.

- The role of the facilitators, Management Intervention Services, MIS, was discussed. The facilitators are to prepare meeting materials for the workgroup. The facilitators are to keep minutes and notes and then organize and distribute them via e-mail to workgroup members after each session. They are to keep the meetings on track and focused while managing workgroup time, assignments, task lists and the agenda. They will ensure equitable and meaningful participation of workgroup members, while ensuring that consensus is reached. They are to ensure continued commitment and follow through by workgroup members. Facilitators will be responsible for preparation of status reports and the final report and documentation to the EMS project leader.

- Jay Bradshaw presented an overview of the process and the tasks that were presented to EMMSTAR.

- Expectations of this workgroup:

    1. Redesign of the EMS system at all levels; this may even include the local providers.
    2. Refine/redefine the role and functions of EMS, the Board and Regional Councils, etc.
    3. Clarify and delineate responsibility and authority.
    4. Identify those things that need to change and those that do not.
    5. There should be wide dissemination of the workgroup information and recommendations.

6. There needs to be a defined process to implement recommendations. This will result in a process that is accepted...NO Surprises.
7. There should be on-going comments from the public (e-mail: info@interventionteam.com)
8. Meetings will be open and information will be free flowing. Take advantage of the EMS web site; EMS Newsletter/Journal; Regional Coordinators; and letters from MEMS to emergency services to disseminate information.
9. Establish ground rules for meetings.
10. The minutes of meetings will be sent out in advance of the next meeting by MIS.
11. Secure funding; there needs to be solid funding of the system.
12. Define what the "system" is going to be, if there is a clear definition of the system, then it will be clear what is to be funded.
13. Formal notification from MEMS that this process has begun---with information posted on the web site. E-mails to go to MIS.

- Ground Rules:

1. Meeting agendas to be e-mailed. MIS will set the next meeting's agenda, based on suggestions of the group, before we adjourn any meeting.
2. Workgroup implementation leaders will be assigned.
3. There should be a public comment period, perhaps before and after each meeting. These comment periods should be brief, but inclusive.
4. The core group should be between 15 and 20 members. The size of the core group will be decided at the next meeting.
5. The public should also be able to comment through e-mail or correspondence to team members. Must listen to the public if they take the time to attend.
6. Meetings should be 2 hours long.

- Time Frame:

1. There is not defined time frame to complete this project, however it should not be less than 6 months.
2. Quarterly reports to the legislature are necessary to provide updates on the project. Every attempt will be made to provide the legislature with a report by January 2006 when the new session starts.
3. Two meetings per month...1st Wednesday at 1PM and the 3rd Thursday at 9AM.

- Change worksheet of action items to correspond with the numbering on the EMSSTAR report.

- The workgroup to review/compare their recommendations with the EMSSTAR report. Start thinking about priorities.

Regulation & Policy/Resource Management/Communications EMSSTAR Workgroup – Meeting Notes

June 16th, 2005, 9:00 – 11:30 am
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:

1. **Chief Wayne Werts, EMT-P, Auburn Fire Dept**
2. **Rob Tarbox, EMT-P, PACE Ambulance**
3. **David Stuchiner, MD, Auburn**
4. **Paul Conley, EMT-P, Freeport**
5. **Bill Dunwoody, EMT-P, Delta Ambulance**
6. **Carol Pillsbury, EMT-P, NorthStar Ambulance**
7. **Alan Douglass, RN, EMT-P, Phippsburg Fire Department**
8. **Jay Brashaw, Maine EMS**
9. **Tim Beals, Delta Ambulance**
10. **Ron Jones, Westbrook MES**

Not Present:

1. **Donnie Carroll, Southern Maine EMS**
2. **Peter DiPietrantonio, DO, Parkview Hospital**
3. **Chief Jeff Cammack, Bangor Fire Department**
4. **Rory Putnam, Falmouth Fire/EMS**
5. **Joanne LeBrun, Tri County EMS**

1. Review/Approval of Notes from 6/1 meeting

a. 6/1 meeting notes were approved with the following change:

    1. Ground rules #6 should read 2 ½ - 3 hours for meeting timeframes.

b. After a discussion on the best use of group time and the aggressiveness of meeting twice a month for 2 ½ hours, the group agreed to change the workgroup meeting schedule to a 3 hour meeting, with a break in the middle, once per month. The group reserves the right to meet more frequently if they need

c. Minutes will be available online following each meeting. They will be marked with a "draft" watermark until the approval of the minutes at the next meeting.

d. The next meeting is scheduled for July 21, 2005 from 9 am – 12 pm at the Maine Emergency Medical Services Office in Augusta.

2. Discuss Section 4.1 (Regulation/Policy" of EMSSTAR report (narrative sections)

a. General comments regarding Section 4.1

   i. Lack of funding limits which recommendations can be achieved
   ii. The Legislature doesn't recognize the EMS enough to give the funding needed.

      1. EMS needs to make it a priority to form a clear, organized effort in order to reach out to the Legislature in order to get the funding needed
      2. EMS community needs to be educated and re-educated (due to a high turnover rate in the EMS community) in order to unite and support
      3. A show of success may be the best way to gain legislative support

b. Comments regarding the following language: "Board and MDPB members are not fully oriented to their role and authority, and are not clearly emancipated from the fiscal and political interests of their individual affiliations"

   i. There is no board training or defined roles and expectations for the MDPB.
   ii. Feeling that their might be vested interested that come into play with MDPB members are making procedural decisions.
   iii. The MDPB has complete rule making authority, but no protocols or processes set in place.
   iv. MDPB members are appointed by the regions and approved by the board
   v. All the members of the boards are volunteer; it's hard to ask them for more time than they are already giving.
   vi. Term limits:

      1. If a member is doing a good job, should they be removed when just because their term is up and visa versa?
      2. Without term limits, there is no way to address if a member is performing a good or bad job. No review system is in place.

c. Comments regarding the following language: "...the scope of work associated with the state EMS contract does not represent the breadth of actual work managed by the regional councils, listing far fewer responsibilities than area accomplished...the management structure and workflows appear convoluted between state and regional offices.

Mechanisms and procedures within and among regions are not clearly established..."

i. There is confusion as to what is going on in other regions.
ii. EMS should be one-stop shopping
iii. Local regions vs. Centralized system

1. Do away with regional offices and offer testing and classes via community colleges
2. If regions consolidate, local flavor may disappear. The distance from the centralized offices may be negative to those who would rather stay within their region for services
3. 85% of the system are volunteers. Is this a good or bad thing?
    a. Are commitment levels and the services offered the same as paid EMS staff?
    b. If they don't want to travel, are they committed enough?

4. Perception is that larger systems use regional offices less and volunteer systems use them more.

iv. The standard of services is an important issue to address when looking at the regional offices.

d. Comments regarding the following language: "...the assessment team was very disturbed by the frequency of individuals and agency representatives reporting fear of reprisal, consequences for challenging the status quo, and discriminatory scrutiny by the region for raising these concerns.

i. There were feelings that this was a perception of "a few" – but more than an handful.
ii. It's hard to know with no review process in place.
iii. Group believes this may be an exaggerated perception; however, there is truth in it that must be addressed.

3. Review/Discuss Individual Recommendations for Section 4.1 (Accept/Reject/Modify then Prioritize)

a. The group reviewed all 9 EMSSTAR recommendations in section 4.1. They discussed each one and decided to accept; modify; or reject the recommendations. They also assigned a tentative priority (H/M/L) to each one.
b. After reviewing and discussing the all recommendations for Section 4.1, the group agreed that there needs to be a discussion and analysis about the

actual functionality of the EMS needs to come before the recommendations can be discussed or prioritized.

c. Discussion and analysis of core EMS functionality and service delivery mechanisms will determine the structure of the entire EMS system.
d. The group will start with identifying the core functions/services that need to be provided, then decide how and who will provide those services.
e. This "starting fresh" approach will help the group with prioritizing the recommendations (or modifying the recommendations)
f. Consensus on the core functions will be discussed at the next meeting. Group members are to email the consultant with the core functions as they see it for the next meeting.
g. It was also mentioned that none of the other workgroups meeting, should assume that what is currently in place in the statewide EMS system will be in place in the future.
h. In order to keep on task, representatives from each workgroup should meet to clarify progress and coordinate findings/objective among the 4 Workgroups.

4. Next Meeting:

a. Assignments:

i. Each person in the group is to email Alan Hinsey with their identified EMS core functions.
ii. Alan will design a grid of these functions for discussion next meeting

b. Housekeeping

i. Hands should be raised to avoid talking over others
ii. Be mindful to not duplicate points already made by others

c. Agenda for next meeting

i. Discussion of identified functions in order to decide a structure for the EMS system and review the recommendations in Section 4.1 to decide how to accomplish those recommendations.

d. Next Meeting:

i. July 21st from 9 am – 12 pm at the Maine Emergency Medical Services Office in Augusta.

Regulation & Policy/Resource Management/Communications
EMSSTAR Workgroup – Meeting Notes

July 21st, 2005, 9:00 – 12:00 pm
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:

1. David Stuchiner, MD, Auburn
2. Donnie Carroll, Southern Maine EMS
3. Carol Pillsbury, EMT-P, NorthStar Ambulance
4. Jay Brashaw, Maine EMS
5. Tim Beals, Delta Ambulance
6. Ron Jones, Westbrook MES
7. Chief Wayne Werts, EMT-P, Auburn Fire Dept
8. Alan Douglass, RN, EMT-P, Phippsburg Fire Department
9. Rob Tarbox, EMT-P, PACE Ambulance

Not Present:

1. Paul Conley, EMT-P, Freeport
2. Joanne LeBrun, Tri County EMS
3. Chief Jeff Cammack, Bangor Fire Department
4. Rory Putnam, Falmouth Fire/EMS
5. Steve Leach; Board of EMS/MCEMS/Augusta FD

1. Review/Approval of Notes from 6/16 meeting

a. 6/16 meeting notes were approved with the following changes:
   i. Penelope Kneeland will not participating with this group
   ii. Alan Douglass is from Phippsburg; not Bath
b. Housekeeping: Group requested a test email be sent out to the entire list's email addresses to insure everyone is receiving correspondence.

2. Discuss and reach consensus on EMS Core Function list

A general discussion was held by all attendees regarding the Core Functions of the EMS system in Maine. These discussions were used to develop the 6 Core Function categories.

1. System-Wide Oversight & Policy formation Function
2. Oversight/Formation of Medical Protocols & Policies Function
3. EMS Administrative, Regulatory and Coordinating Function
4. Quality Assurance and Quality Improvement Function
5. Education and Accreditation Function
6. Public Education/Public Relations Function

The following are some of the comments made during the discussion on EMS Core Functions.

a. Maine EMS board responsibilities

i. Concerns expressed that the EMS system seems to be addressing the same issues from 10-12 years ago.
ii. Questioned what is the constituent make up of the EMS board is technically suppose to be (Jay mentioned it is in the statute). Expressed concerns with the current "make up" of the board.
iii. Are there functions that the EMS Board should be performing that it is not? Is the EMS board overloaded with things it shouldn't be doing? Why was the EMS Board established in the beginning?
iv. Expressed the need for clarification of EMS board functions
v. Would it be possible to have the EMS Board set forth regulations through sub committees? For example, should their be a Legislative committee formed that can bring clearer focus to what actions the EMS Board is taking or should be taking?
vi. There seems to be times when the board is unengaged and not involved enough with what is going on at the staff level
vii. Some expressed concern that the EMS Board should be focused on larger policy issues, advocacy issues while letting the staff take charge of other issues where fit.
viii. Some expressed concern that the EMS Board is populated by individuals that are far removed from the expertise for which they are making recommendations.
ix. One member expressed the need to have the committee members act as "experts" on topics that he may not understand but will still need to make a decision on.
x. There is a perception that the board is "overwhelmed" because they aren't in the EMS field everyday and may not have a secure handle on what is really going on.
xi. The EMS board meets once a month for an hour +/- (17 total members and 6 involved in the EMSSTAR workgroups.) Some feel the board is not as engaged as they should be.
xii. It was suggested that the workgroup starts with the definition of what the EMS Board "should" be doing THEN design the board and populate with the correct make up
xiii. It was mentioned that the EMS Board was originally set up as an advisory board and not a regulatory board. The board's responsibilities have changed into a more regulatory board, however, the composition of the board has not evolved with those changes
xiv. Group agrees that this issue, the EMS board, the functions is performs and it's make up is a "core function" that should be dealt with. Agreed that there will need to be an overall need for a board

or oversight group to oversee the EMS system however, it may need to be charged with two separate areas; regulatory and advisory

b. MDPB and Practice, protocols and policy function

i. Should there be a full time State Medical Director?
ii. Should the MDPB and the EMS Board work together? How do they work together?
iii. What are the functions of the MDPB? Advisory? Regulation?
iv. What is the relationship to the EMS system and the EMS board
v. Is the role solely Policy issues?
vi. Are their conflicts of interest within the MDPB members?
vii. Should EMS board be the ruling board and all other boards looking to it for guidance?
viii. Some felt that the Core Function should really be the oversight of the medical protocols and policy.

c. Maine EMS Central Administration and regulatory function

i. Funding and staffing is too limited for the amount of responsibility with which they are charged.
ii. Staff carries out the approved intentions of the EMS board. Developing curriculum, establishing standards for training, acting as liaison for other state agencies and organizations, regulatory/inspection/licenses functions. Ultimately the board and its staff is responsible for testing administration of the regions, quality assurance oversight. Coordination with the overall EMS system and it's interaction with the rest of the state and the nation.
iii. Some felt the need to look at the change/evolution of the chain of command, workflow and management flow
iv. Should the workgroup design what they want without looking at what is currently being done?

d. Regional offices/councils

i. Education is a primary function. Public education, EMT/EMTI/EMTP, continuing education. Can community colleges provide this education with oversight by Maine EMS?
ii. Some feel that public relations and public education should be a separate core function
iii. Is interfacing with hospitals a key regional function?
iv. Some feel that oversight testing can be a part of central administration and licensing.
v. QA/QI is performed at the regional level, however, some are concerned that it's not being done well

vi. The regions with limited time and resources are hurt by the under representation of those regions

3. Core Function Assignments

Facilitator Hinsey will summarize all 6 Core Function statements that were discussed by the group and construction Core Function assignment sheets that each Group member MUST complete BEFORE the next meeting. The Core Function Sheets list out the "What" for each Core Function area – the group is charged with completing the "Who," "Where," & "How" sections for each Core Function category.

(See Core Function assignment sheets at the end of these notes.)

4. Next meeting

a. Housekeeping
    i. How the group would like to deal with group members who miss a number of meetings.
b. Next Meeting:
    i. August 18th from 9 am – 12 pm at the Maine Emergency Medical Services Office in Augusta.
    ii. Will finalize EMS Core Function discussion consensus work. – all members of group MUST be prepared – Must have completed the Core Function assignment sheets.

Functions of an Effective EMS system for Maine:

1. System-Wide Oversight & Policy formation Function

WHAT:

For an effective state-wide EMS system, an oversight and policy-making authority (such as a State-wide Committee or Board) must be established to have the primary responsibility for directing the overall function and mission of the EMS system. This authority will be responsible for setting the standards needed to ensure that consistent and acceptable EMS services are delivered throughout the state.

WHO:

WHERE:

HOW:

2. Oversight and Formation of Medical Protocols and Policies Function

WHAT:

For an effective state-wide EMS system, an authority (such as a state-wide Committee or Board) must be established to have the primary responsibility for setting and monitoring standard protocols and policies that will guide & direct the appropriate delivery of medical services and treatments that are administered throughout the state-wide EMS system

WHO:

WHERE:

HOW:

3. EMS Administrative, Regulatory and Coordinating Function

WHAT:

For an effective state-wide EMS system, a centralized authority (such as a centralized state agency) must be established to have the primary responsibility for managing the administrative functions of the EMS system (budgeting, interface with Legislature, coordination with other agencies/jurisdictions, a clearinghouse for information for service providers and the public, etc.) as well as being primarily responsible for the regulatory functions (licensing, certification, investigation, inspections) needed to ensure that a consistent and acceptable minimum level of EMS services are delivered throughout the state.

WHO;

WHERE:

HOW:

4. Quality Assurance and Quality Improvement Function

WHAT:

For an effective state-wide EMS system, a coordinated Quality Assurance and Quality Improvement system and procedures must be established, monitored and enforced to ensure that a consistent and acceptable minimum level of EMS services are delivered throughout the state.

WHO:

WHERE:

HOW:

5. Education and Accreditation Function

WHAT:

For an effective state-wide EMS system, service providers and administrators must receive the training and education required to allow them to deliver a consistent and acceptable minimum level of EMS services throughout the state. The education and training provided to EMS service providers and administrators must be accredited by meeting or exceeding the standards set by the oversight authority of the EMS system (see Function #1).

WHO:

WHERE:

HOW:

6. Public Education/Public Relations Function

WHAT:

For an effective state-wide EMS system, the public must be educated and informed about the core functions of the EMS system. Plus, an effective Public Relations strategy and approach must be developed and delivered to ensure that the EMS system receives the understanding and support it needs from the public to deliver a consistent and acceptable minimum level of EMS services throughout the state.

WHO:

WHERE:

HOW:

Regulation & Policy/Resource Management/Communications
EMSSTAR Workgroup – Meeting Notes

August 18, 2005, 9:00 – 12:00 pm
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:

1. **David Stuchiner, MD, Auburn**
2. **Donnie Carroll, Southern Maine EMS**
3. **Carol Pillsbury, EMT-P, NorthStar Ambulance**
4. **Jay Bradshaw, Maine EMS**
5. **Ron Jones, Westbrook MES**
6. **Chief Wayne Werts, EMT-P, Auburn Fire Dept**
7. **Alan Douglass, RN, EMT-P, Phippsburg Fire Department**
8. **Rob Tarbox, EMT-P, PACE Ambulance**
9. **Norm Dinerman, M.D., Eastern Maine Medical Center**
10. **Paul Conley, EMT-P, Freeport**
11. **Rory Putnam, Falmouth Fire/EMS**
12. **Tim Beals, Delta Ambulance**

Not Present:

1. **Joanne LeBrun, Tri County EMS**
2. **Chief Jeff Cammack, Bangor Fire Department**
3. **Steve Leach; Board of EMS/MCEMS/Augusta FD**

1. Review/Approval of Notes from 7/21 meeting

a. 7/21 meeting notes were approved.

2. General Process Discussion

a. Is the process we are using working?
   i. Some expressed feelings that the group should be moving faster however, this may be such an important process that taking proper time to digest information may be needed.
   ii. Workgroup must be timely but pay attention to the general importance of these issues, keeping a balance and not getting too bogged down.
   iii. Workgroup's "job" is to review and prioritize the EMSSTAR recommendations and report back to the board with this workgroup's recommendations.
   iv. Must keep a high level without getting too specific
   v. Clarification: Workgroup's recommendations will go to the board for review and to the legislative committee for review

simultaneously. If the legislature has issues with the board recommendations, they can challenge the board.

vi. Attendance: Alan to take attendance at the meetings and track who is attending. The group agreed they are not responsible for bringing those absent up to speed during the meeting.

3. Discuss and reach consensus on the 6 EMS Core Function "Definitions": complete the "Who, Where, and How" for each of the 6 Core Function statements.

a. Core Function # 1: The following is a listing of general discussion comments the workgroup made on Core Function #1 – see attached Draft Core Function One statement (What, Who, Wher, How) - to be reviewed and approved by Group at next meeting.

i. What: Group agreed to function as written

ii. Who:

1. One overriding elected board, similar to existing, but made up of mostly providers (not "outsiders") or elected by providers. Provider and stakeholder mix; like the MMA.
2. Board would provide general oversight including medical practices and budget input.
3. Regulatory board with statewide focus – not just an advisory board (with approval of the commissioner)
4. Hub and spoke system with a central authority
5. Statutory change? Commissioner's Role?
6. Responsible to Public
7. Need to be imaginative; vision
8. Board of Trustee format? Selectman format?
9. Maine citizens are looking for "experts" to lead the system; thus the "elected" part may be too unwieldy to handle.
10. Board of "critical thinkers" and experts
11. "School board" structure with a ruling "superintendent" which could be a physician. The board would be responsible for hiring the "superintendent"
12. Stakeholder composition is a very important issue when forming this "board"
13. Term limits may narrow the pool of qualified candidates.
14. Board has the ability to hire and fire the EMS Director and the Medical Director.

iii. Where:

1. Close to the capital (Augusta)
2. Ultimate decision making power with full oversight
3. Currently, EMS's Commissioner (Dept. of Public Safety) is part of the Executive Cabinet and sits at the table

4. Board of Nursing? Board of Medicine? Stay with the Dept. of Public Safety?
5. Under DHS does not seem like a good place to be
6. Stand alone model?
7. Who is EMS? Medical? Public Health? Public Safety? Intersection of all?
8. DPS gives EMS more opportunities; under that umbrella gives more PR leeway.
9. Stay with DPS for now, but when organizing/forming the board, design it so it can be moved to a new location later on down the line.

iv. How : To be written up by Alan for review of workgroup by next meeting.

v. See Draft Core Function #1 - attached

4. Plan next meeting

a. Review any assignments
   i. Alan to write up the "how" for Core Function 1.
b. Discuss Agenda items
   i. Continue discussing the 6 EMS Core Functions.
c. Next Meeting:
   i. Sept 15th from 9 am – 12 pm at the Maine Emergency Medical Services Office in Augusta.

EMS Core Function # 1: System-Wide Oversight & Policy formation

WHAT:
For an effective state-wide EMS system, an oversight and policy-making authority (such as a State-wide Committee or Board) must be established to have the primary responsibility for directing the overall function and mission of the EMS system. This authority will be responsible for setting the standards needed to ensure that consistent and acceptable EMS services are delivered throughout the state.

WHO:
The actual final composition of the Board will require more detailed & in-depth discussion and research, however, the work group agrees on the following essential elements for constructing an effective Oversight & Regulatory Board for EMS in Maine:

- Board members must be:
    - People who possess vision and leadership skills
    - People who are focused on Public and EMS Consumer needs first;
    - People who are experts in related EMS fields
- Balanced membership is essential; do not set up a Board consisting solely of representatives of provider groups
- The Commissioner of DPS should be a voting member of the Board;
- Board must contain knowledgeable member(s) of the Public;
- The workgroup recommends that various Board selection models be studied further: such as, 1) Board determined by election , 2) a Board of Trustees Model; 3) a School Board or Selectmen Model; 4) various methods of nominating Board members for appointment, etc.

WHERE:
The EMS Oversight and Regulatory Board should be organizationally "housed" within the Maine Department of Public Safety. The bulk of Board meetings and centralized Board functions will take place at the EMS/DPS office in Augusta.

HOW:
The actual final policies & procedures that will govern how the Board operates will require more detailed & in-depth discussion and research, however, the Workgroup agrees on the following essential elements regarding the operation of the Board:

- Board members must publicly identify any potential conflicts of interest;
- Term Limits may be considered;
- Board will have responsibility to hire/fire EMS Director and Medical Director;
- Board should not become bogged down in the minutia of research/analysis – focus should be on over-arching policy recommendations;
- Board must have input into and oversight responsibility for the EMS operating budget.

Medical Direction and Trauma Systems

The Medical Direction / Trauma Systems workgroup consisted of Emergency Room physicians and paramedics from all areas of the state. The workgroup met monthly from June 2005 to September 2005 at Maine EMS in Augusta.

A summary of the 4 meetings is listed below:

- June 9, 2005 – After introductions, the role of the facilitator and expectations of the workgroup were discussed. Consideration to solicit the participation of potential workgroup members from Northern and Downeast Maine, the Trauma Advisory Committee and the Cardiac Advisory Committee. In planning for the next meeting the group prioritized the EMSSTAR Recommendations. The group agreed to do the recommendations for the Medical Direction first, then the Trauma Systems.

- July 20, 2005 – Draft copies of the job descriptions for local and regional medical directors were distributed and reviewed. The group agreed that once the job descriptions were complete that it would include other Medical Direction recommendations.

- August 17, 2005 – Revised copies of the draft job descriptions for service, local and regional medical directors were reviewed. The group agreed that the job descriptions would not be edited further and that these revisions represented the group's final work on this recommendation.

- September 21, 20005 – Workgroup consensus on all the recommendation for the Trauma Systems, however more resources would be needed. This is the last meeting as all recommendations have been addressed.

Medical Direction / Trauma Systems
Meeting and Attendance Record

Facilitator: Randy Bumps, The Cianchette Group, randy@cianchettegroup.com

Name	Affiliatin	6/9/05	7/20/05	8/17/05	9/21/05
Steve Diaz, MD	Maine EMS	X	X	X	X
Rick Petrie, EMT-P	KVEMS & NEEMS	X	X	X	
David Ettinger, MD	Mid Coast EMS	X	X	X	X
Kevin Kendall, MD	Tri County EMS	X	X	X	X
Lori Metayer, RN, EMT-P	LifeFlight of Maine	X	X		X
Carol Pillsbury, EMT-P	Northstar Ambulance		X		
Dawn Kinney, EMT-P	Maine EMS	X	X	DRW	X
Bob Bowie, MD	St. Joseph's Hospital	X	X		
Paul Liebow, MD	EMMC		X	X	X
Beth Collamore, MD	Cary Medical Center		X		
Jim McKenney, EMT-P	Crown Ambulance		X	X	
Paul Marcolini. EMT-P	Tri County EMS	X	X	X	X
Rory Putnam, EMT-P	Falmouth Fire – EMS		X	X	
Dan Carlow	Downeast EMS		X	X	
Steve Corbin	Aroostook EMS		X	X	
Jay Bradshaw	Maine EMS	X	X		
Matt Sholl. MD	Maine Medical Center			X	
Julie Ontengco	Maine Medical Center			X	
Steve Leach	Board of EMS/Mid Coast EMS	X			

Medical Direction / Trauma Systems
EMSSTAR Workgroup – Meeting Notes

June 9, 2005, 1:30 – 3:30 pm
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
Bob Bowie, MD, St. Joseph's Hospital
Jay Bradshaw, Maine EMS
Steve Diaz, MD, Maine EMS
David Ettinger, MD, Mid-Coast EMS
Kevin Kendall, MD, Tri-County EMS
Dawn Kinney, EMT-P, Maine EMS
Steve Leach, EMT-P, Augusta Fire and MCEMS
Paul Marcolini, EMT –P, Tri-County
Lori Metayer, RN, EMT-P, LifeFlight of Maine
Rick Petrie, EMT-P, KVEMS and NEEMS

Not Present:
John Alexander, MD, Maine Medical Center
Alan Azzara, EMT-P, Northeast Mobile Health
Sean Binette
Peter Goth, MD, Miles Memorial Hospital
Chris Moretto, Med-Care Ambulance, Mexico
Carol Pillsbury, EMT-P, Northstar Ambulance
Matt Sholl, MD, Maine Medical Center
Eliot Smith, MD, Southern Maine EMS
David Stuchiner, MD, Auburn, ME

1. Introductions

a. Group members introduced themselves and service / hospital affiliations.

b. Randy Bumps introduced himself as the group facilitator and reviewed the agenda encouraging suggested additions. There were none.

2. Role of Facilitator

a. Randy Bumps explained what he understood to be his role as the facilitator and invited suggested additions or changes:

1. Prepare meeting materials for the workgroup.
2. Keep minutes and notes and then organize and distribute them via email.
3. Keep workgroup meetings on-track and focused while managing workgroup time, assignments, task lists and the agenda.
4. Ensure equitable and meaningful participation of workgroup members, while ensuring consensus is reached.
5. Ensure continued commitment and follow-through by workgroup members.
6. Preparation of status reports and final report and documentation to MEMS.

3. Process Overview

a. Jay Bradshaw presented an overview of the lead-up to and the Maine EMS Study Report that was produced by The EMSSTAR Group.

1. The Report has ten sections and a total of fifty-four recommendations, using the benchmarks provided by the National Highway Traffic Safety Administration (NHTSA).
2. The Medical Direction / Trauma Systems Workgroup is one of four sub-committees working to evaluate and prioritize the recommendations included in the Report.
3. These recommendations may result in rules changes, law changes, and the development of a 3-5 year strategic plan for Maine EMS.
4. This process workgroup evaluation and prioritization may take approximately six months with workgroup returning their recommendations to the Maine EMS Board.

4. Expectations of the Workgroup

a. Conflicts of Interest Disclosure: The workgroup members present went around the table to further elaborate on their various affiliations and memberships in related professional organizations.

b. Membership: The workgroup considered the need to solicit the participation of potential workgroup members from several parts of the state that are presently underrepresented on the workgroup roster:

1. Northern Maine: Best Colmor. ***(Dr. Diaz will contact her.)***
2. Downeast Maine: Danny Carlow, Sally Taylor, Vicky Lincoln. ***(Rick Petrie will contact them.)***
3. Trauma Advisory Committee: Dave Ciraulo. ***(Jay Bradshaw will contact him.)***
4. Cardiac Adv. Cmt.: Bud Kellet. ***(Dr. Diaz will contact him.)***

c. Outside Input: The workgroup agreed that all workgroup meetings should be noticed on the MEMS website. Furthermore, regional EMS councils will promote the various workgroup meetings as a matter of standard practice. It was also suggested by Dr. Bowie that notice to Maine Fire Chiefs also be a priority. The group also agreed that there will likely be a need for a meeting near the end of this process to invite additional comment on workgroup recommendations before forwarding a final product to the MEMS Board.

5. Review implementation tracking forms

a. The suggested implementation tracking forms will be distributed electronically by the facilitator with the minutes and agenda for the next meeting.

6. Discuss and establish timeframes and meeting dates

a. The group agreed that holding meetings on the same day as the MEMS MDPB meetings would be most convenient.
b. The group set the following meeting dates: July 20, 2005, 9-11 a.m.; August 17, 2005, 9-11 a.m.; September 21, 1-3 p.m.

7. Plan Next Meeting

a. The group agreed to prioritize the Medical Direction and then the Trauma System recommendations to expedite the agenda setting and associated assignments for the July meeting:
    1. Recommendation ID # 4.8.3 (Medical Direction):
    Highest Priority "b": "Regional medical directors should be charged to assist and facilitate the efforts of local medical directors and to participate in the development of statewide EMS protocols."
    Second Priority "e and d": "Develop and require appropriate training for any individual who will provide on-line medical direction to EMS providers." "Require local and regional EMS medical directors to complete a nationally [a state] recognized medical directors' course within the first year of their appointment."
    Third Priority "c": "Develop and promulgate job descriptions for local and regional medical directors."
    Fourth Priority "a" – *this recommendation would be a 'high' priority if the language "encouraged vs. required" every EMS agency to have a medical director*: "Amend Maine's EMS rules to require that every EMS agency have a physician medical director. The agency medical director

should have primary responsibility for assessment and assurance of the competence of every EMS provider."

2. **Assignments:**
   a. ***Dr. Diaz will be prepared to address the work of the MDPB on "e and d" at the July meeting.*** These recommendations require the participation of E.D. Directors.
   b. ***Dr. Ettinger will be prepared to lead the discussion on recommendation "c".***
3. ID # 4.9.3 (Trauma Systems):
   Highest Priority "c": "Modify the Maine EMS Prehospital Treatment Protocols to authorize all EMS providers statewide to request air medical transport units without on-line medical direction."
   Second Priority "b": "Utilize [trauma registry data], patient care reporting data, and other relevant data sources to drive EMS education, quality improvement, and injury prevention programs."
   Third Priority "a": "Develop and maintain a state trauma registry."

8. Next Meeting: July 20, 2005, 9-11 a.m., Maine Emergency Medical Services, 500 Civic Center Drive, Augusta, Maine.

Medical Direction / Trauma Systems
EMSSTAR Workgroup – Meeting Notes

August 17, 2005, 9:00 – 11:00 am
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
John Brady, EMT-P, Portland Fire Department Medcu
Dan Carlow, Downeast EMS
Steve Corbin, Aroostook EMS
Steve Diaz, MD, Maine EMS
David Ettinger, MD, Mid-Coast EMS
Kevin Kendall, MD, Tri-County EMS
Paul Liebow, MD, Eastern Maine Medical Center
Paul Marcolini, EMT –P, Tri-County
Jim McKenney, EMT-P, Crown Ambulance
Julie Ontengo, Maine Medical Center
Rick Petrie, EMT-P, KVEMS and NEEMS
Rory Putnam, EMT-P, Falmouth Fire – EMS
Matt Sholl, MD, Maine Medical Center
Drexell White, Maine EMS

Not Present:
Bob Bowie, MD, St. Joseph's Hospital
Jay Bradshaw, Maine EMS
Jeff Cammack, Bangor Fire Department
Beth Collamore, MD, Cary Medical Center
Dawn Kinney, EMT-P, Maine EMS
Steve Leach, EMT-P, Augusta Fire and MCEMS
Lori Metayer, RN, EMT-P, LifeFlight of Maine
Chris Moretto, Med-Care Ambulance, Mexico
Carol Pillsbury, EMT-P, Northstar Ambulance

1. Introductions

a. Group members introduced themselves and their affiliations.

b. Randy Bumps reminded the workgroup that the primary purpose of this process is to provide a priority list of recommendations to the Maine EMS Board based on the EMSSTAR report. After Board action, a Maine EMS strategic plan will be drafted by others. Thus, the workgroup is not expected to do the detailed work of creating specific products. Instead, the expectation is that the workgroup will prioritize the recommendations of the

EMSSTAR report and identify any additional resources that could be utilized when the time comes later to develop specific products.

2. Review / approve notes from July 20, 2005 meeting

a. No changes to the notes needed.

3. Review revised job descriptions as edited by Dr. Ettinger

a. Dr. Ettinger distributed draft Service, Local and Regional Medical Director job descriptions as edited at the July meeting.

b. The group first considered the Service level job description:

1. Agreed it should be a "functional document with the bare minimums for training requirements."
2. Agreed goal is to "bridge the chasm between providers and doctors."
3. Change (I)(a) as follows: "Must be a provider in good standing with local hospital." Eliminate all else.
4. Change (I)(b) as follows: Add "physician or mid-level provider. ED provider is preferable. Community provider with 2 years of experience."
5. Change (II)(a) as follows: "...operation of Maine EMS systems and protocols."
6. Change (II)(c) as follows: "Knowledge of on-line medical control function."
7. Change (III)(d) as follows: ...issues initiated by someone in the public or someone else in the service..."
8. Change (III)(g) as follows: Add "and be involved in and complete routine audits."
9. Concern regarding (III)(f) that insurance / liability issues, if any, be addressed to allow ride-alongs by the Service Medical Director.

c. The group then considered the Local Medical Director job description:

1. Question: Do we need this if we have good/qualified Service Medical Directors?
   A: We're more likely to have Local Medical Directors than Service Directors.
   A: We see the Local Director as working between the Service and Regional Directors.
   A: We can't mandate Service Directors, therefore, Local Directors are the next "catch."
   A: The Local Director should be the "problem-solver / disciplinarian."

2. With multiple hospitals in a region, who is the Local Medical Director?
   A: One at each hospital.
3. Will all hospitals agree to our job descriptions?
   A: We're not necessarily going to the hospital and require it.
   A: Job descriptions to be an advisory document to the hospitals.
4. If Service Medical Director can't be retained, why not say that the Local Medical Director is the next "step?"
5. Could we use past experience vs. contemporary experience to qualify?
   A: Consensus to leave as drafted without "past" experience.

d. The group agreed that all three job descriptions should be presented as recommendations.

e. The group agreed that when there are service and local medical directors we need to further define the differences between the roles no matter how similar the job descriptions appear.

f. The group moved to consider the Regional Medical Director Job Description:

1. There was consensus on the Training portion as drafted.
2. There was consensus on the Experience portion as drafted.
3. Change (III)(c) as follows: "in the field" to "out of hospital."
4. Change (III)(q) as follows: "must" to "should."
5. Change (III)(r) as follows: remove "every month."

The group agreed that the job descriptions would not be edited further and that these revisions represented the group's final work on this recommendation.

4. Plan next meeting

a. Agreed that Recommendations #4.8.3 "e" and "d" will top the agenda for the September meeting. (Require local and regional EMS medical directors to complete a nationally recognized medical directors' course within the first year of their appointment. And, develop and require appropriate training for any individual who will provide on-line medical direction to EMS providers.)

b. Recommendation #4.9.3 "c" will follow. (Modify the Maine EMS Prehospital Treatment Protocols to authorize all EMS providers statewide to request air medical transport units without on-line medical direction.)

5. **Next Meeting: September 21, 2005, 1-3 p.m., Maine Emergency Medical Services, 500 Civic Center Drive, Augusta, Maine.**

Medical Direction / Trauma Systems
EMSSTAR Workgroup – Meeting Notes

July 20, 2005, 9:00 – 11:00 am
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
Bob Bowie, MD, St. Joseph's Hospital
Jay Bradshaw, Maine EMS
Beth Collamore, MD, Cary Medical Center
Dan Carlow, Downeast EMS
Steve Corbin, Aroostook EMS
Steve Diaz, MD, Maine EMS
David Ettinger, MD, Mid-Coast EMS
Kevin Kendall, MD, Tri-County EMS
Dawn Kinney, EMT-P, Maine EMS
Paul Liebow, MD, Eastern Maine Medical Center
Paul Marcolini, EMT –P, Tri-County
Jim McKenney, EMT-P, Crown Ambulance
Lori Metayer, RN, EMT-P, LifeFlight of Maine
Rick Petrie, EMT-P, KVEMS and NEEMS
Carol Pillsbury, EMT-P, Northstar Ambulance
Rory Putnam, EMT-P, Falmouth Fire - EMS

Not Present:
Jeff Cammack, Bangor Fire Department*
Steve Leach, EMT-P, Augusta Fire and MCEMS
Chris Moretto, Med-Care Ambulance, Mexico*
Matt Sholl, MD, Maine Medical Center*

(*) Indicated interest in attending, but unable to be present.

1. Introductions

a. Group members introduced themselves and their affiliations.

b. Dr. Kendall reported that Dr. Sholl expressed interest in the workgroup, but is not present for this meeting.

c. The group agreed that the workgroup must finalize membership to include those present at the first or this meeting and those that have expressed interest but who have been unable to attend. All meetings will, of course, remain open to any wishing to observe, but the formal membership will be limited to the list above.

d. Paul Marcolini will contact John Alexander and offer him one final opportunity to join the group.

2. Review / approve notes from June 9, 2005 meeting

a. Dr. Collamore's first name is misspelled.

b. No other changes to the notes needed.

3. Recommendation ID # 4.8.3 "c" (Develop and promulgate job descriptions for local and regional medical directors.)

a. Dr. Ettinger distributed draft Local and Regional Medical Director job descriptions for the group to use in considering this recommendation.

b. The group agreed that Medical Directors should be "advocates for members of the EMS system"; that their main function is to serve in an "advisory" capacity; Regional Medical Directors should serve as a liaison between Local Medical Directors and hospitals / OLMC; Medical Directors have a QA / QI role; and Medical Directors have an "education" role.

c. The group agreed that the following "concerns" need to be addressed in the "Training" section of the draft job descriptions: how to address mid-level practitioners in the job descriptions (agreed to replace "physician" with the word to "provider"); are there hospitals that can't meet the physician standard?; "Board Certified vs. Board Eligible" (agreed that there is no definition of "Board Eligible" so the description should include a "time-certain" period for Board Certification); what constitutes EMS experience? (agreed that is covered in the next section of the job description – Experience); how to handle the need for a "state recognized" program (agreed to change phrase to "Maine EMS recognized.")

d. The group then worked on the "Experience" section of the draft job descriptions: agreed providers should have "knowledge and understanding" and "experience in prehospital emergency care…"

e. The group moved to the "Responsibilities section of the draft job descriptions:

1. There was agreement that Medical Directors should spend "some time" in the field. This requirement could be specific to hospital Medical Directors. Agreement that there is a need for a specific service-level Medical Director job description.
2. There was concern that Regional Medical Directors may limit their field experience to a single service and not "ride

along" with different services across the region. There was agreement that doctors should be expected to share their experience across these levels and "diversify" their field experience.

3. There was a concern that if the responsibilities are too demanding it would discourage medical control participation in the rural areas. The group then agreed that the job description language should be the "strongest and fullest" at the Regional Medical Director level, slightly more relaxed at the Local Medical Director level, and least demanding at the Service Medical Director level. There was consensus that the largest "gap" presently is at the Local Medical Control level.
4. There was agreement to not define actual hours required of the Medical Directors.
5. There was agreement that to "resolve" issues at the local level means simply that the issues are satisfactorily "resolved" which could include any number of various outcomes agreed to at the local level. In those cases that can't be resolved they would be "referred" to the regional level.

f. The group agreed to review the edited job descriptions at the August meeting.

4. Recommendation ID # 4.8.3 "b" (Regional medical directors should be charged to assist and facilitate the efforts of local medical directors and to participate in the development of statewide EMS protocols.)

a. Agreed that Regional Medical Directors should visit local hospitals and meet with the providers "outside of the regular meetings. This should be a 'grassroots effort.'"

b. Agreed that this issue / recommendation must be captured in the medical director job descriptions – and that is really more of a "mission statement" than a defined requirement.

c. Agreement that rural regions with fewer medical directors need to be supported in this outreach by medical directors from other parts of the state.

d. Agreed that the flow of information from these interactions must go in both directions: regional to local; local to regional; regional to state; state to regional and local, etc.

e. Agreed that once these recommendations were include in the job descriptions this (#4.8.3 "b") would be complete.

5. Recommendation ID # 4.8.3 "a" (Amend Maine's EMS rules to require that every EMS agency have a physician medical director.

The agency medical director should have primary responsibility for assessment and assurance of the competence of every EMS provider.)

- **a.** Consensus that "agency" means "every licensed EMS service.
- **b.** Agreement that it is "practically impossible to require this of every service."
- **c.** Jay confirmed that it would be deemed a "state mandate" if included in MEMS rules / law. The budget implications would be astounding.
- **d.** There was consensus that this recommendation could be considered by the MDPB when approving "add-on" protocols for certain sized / type services.

6. Plan next meeting

- **a.** Review edited job descriptions as revised by Dr. Ettinger.
- **b.** Recommendations #4.8.3 "e" and "d" will top the agenda for the August meeting. (Require local and regional EMS medical directors to complete a nationally recognized medical directors' course within the first year of their appointment. And, develop and require appropriate training for any individual who will provide on-line medical direction to EMS providers.)
- **c.** Recommendation #4.9.3 "c" will follow. (Modify the Maine EMS Prehospital Treatment Protocols to authorize all EMS providers statewide to request air medical transport units without on-line medical direction.

7. Next Meeting: August 17, 2005, 9-11 a.m., Maine Emergency Medical Services, 500 Civic Center Drive, Augusta, Maine.

Medical Direction / Trauma Systems
EMSSTAR Workgroup – Meeting Notes

September 21, 2005, 1:00 – 3:00 p.m.
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
Steve Diaz, MD, Maine EMS
David Ettinger, MD, Mid-Coast EMS
Kevin Kendall, MD, Tri-County EMS
Dawn Kinney, EMT-P, Maine EMS
Paul Liebow, MD, Eastern Maine Medical Center
Paul Marcolini, EMT –P, Tri-County
Lori Metayer, RN, EMT-P, LifeFlight of Maine

Not Present:
Bob Bowie, MD, St. Joseph's Hospital
Jay Bradshaw, Maine EMS
John Brady, EMT-P, Portland Fire Department Medcu
Jeff Cammack, Bangor Fire Department
Dan Carlow, Downeast EMS
Beth Collamore, MD, Cary Medical Center
Steve Corbin, Aroostook EMS
Steve Leach, EMT-P, Augusta Fire and MCEMS
Jim McKenney, EMT-P, Crown Ambulance
Chris Moretto, Med-Care Ambulance, Mexico
Julie Ontengo, Maine Medical Center
Rick Petrie, EMT-P, KVEMS and NEEMS
Carol Pillsbury, EMT-P, Northstar Ambulance
Rory Putnam, EMT-P, Falmouth Fire – EMS
Matt Sholl, MD, Maine Medical Center

1. **Review / approve notes from August 17, 2005 meeting**
   a. No changes to the notes needed.

2. **Recommendation ID #4.8.3 "e" (Develop and require appropriate training for any individual who will provide OLMC to EMS providers.)**
   a. Workgroup consensus on this recommendation is that the Maine EMS Board direct the MDPB to continue work on the training document currently in draft.

1. In doing so, the MDPB should solicit input from others outside the Board.
2. When the training product is finalized ACEP has already endorsed it in concept. Thus, it should go to the Maine Hospital Association for their endorsement.

b. The goal is that there be one universal training program statewide.

3. **Recommendation ID #4.8.3 "d" (Require local and regional EMS medical directors to complete a nationally recognized medical directors course within the first year of their appointment.**
   a. Refer to the workgroup consensus on Recommendation ID #4.8.3 "b" and #4.8.3 "e".

   b. The group that develops the training program should simultaneously draft a Maine-specific program component that stands alone and could be used by those medical directors who have been previously trained elsewhere.

4. **Recommendation ID #4.9.3 "c" (Modify the Maine EMS Prehospital Treatment Protocols to authorize all EMS providers statewide to request air medical transport units without OLMC.)**
   a. Workgroup consensus on this recommendation as part of the Trauma Systems portion of the EMSSTAR report.

5. **Recommendation ID #4.9.3 "b" (Utilize trauma registry data, patient care reporting data, and other relevant data sources to drive EMS education, QI, and injury prevention programs,) and Recommendation ID #4.9.3 "a" (Develop and maintain a state trauma registry.)**
   a. Workgroup consensus on the recommendations, but more resources are needed if they are to become a reality.

   b. There is currently volunteer participation in independent systems / hospitals.

   c. It is difficult to collect data from non-system hospitals.

   d. Specific to 4.9.3 "a": Does the Maine DHHS public health surveillance system have the ability to incorporate this function?

6. **Recommendation ID #4.8.3 "f" (Develop formal mechanisms to utilize physicians who have expertise in emergency medical services in all aspects of the Maine EMS system.)**
   a. Workgroup consensus that this will follow from adoption of the proposed Medical Director job descriptions and the OLMC training program.

7. **Recommendation ID #4.8.3 "g" (Develop an equitable compensation schedule to assure pay parity among regional medical directors.)**
   a. Workgroup consensus that this is outside the realm of the MEMS system as the Regional Medical Directors are engaged by the regional councils. However, the workgroup supports the recommendation.

8. **Additional consensus recommendations of the workgroup:**
   1. More important than compensation is legal coverage for state credentialed medical directors.
   2. Any regional deviations from the MEMS Prehospital Treatment Protocols must be vetted by the MDPB.

9. **No further meetings of workgroup scheduled. Meeting notes for 9/21 will be circulated to the workgroup electronically.**

Human Resources & Training / Public Information, Education, and Relations

This workgroup included 15 members that actively participated in the project and met a total of 5 times over a 3-month period.

- June 9, 2005, meeting was primarily administrative in nature and involved establishing the role of the facilitators, an overview of the process, expectations of the workgroup, and the establishing of ground rules for the group.

- June 23, 2005, meeting began the review of each paragraph in the assigned Status sections of the EMSSTAR report to determine if they were clear and precise, with the group ultimately recommending several fairly minor changes in wording.

- July 7, 2005, meeting completed the task of reviewing the assigned Status sections of the EMSSTAR report, and developed a "To Do" list of additional information that was needed to begin prioritizing the assigned Recommendations sections.

- August 4, 2005, meeting involved discussion on each of the Recommendations, to develop an understanding by the group of the sort of activities and requirements that would be involved to implement the Recommendations.

- September 1, 2005 meeting was the final meeting of this workgroup and involved the prioritization of the Recommendations in our two assigned sections, with each Recommendation listed as "High", "Medium" or "Low" priority, indicating whether or not a rule or law change was necessary, and whether or not the Recommendation would likely have a budgetary impact.

The final prioritizing of Recommendations was made on a unanimous consensus of the workgroup.

Human Resources & Training / PIER
Meeting and Attendance Record

Facilitator: Mike Roberts, Management Intervention Services, mike@interventionteam.com

Name	Affiliation	6/9/05	6/23/05	7/7/05	8/4/05	9/1/05
Steve Leach, RN, EMT-P	Mid Coast EMS	X		X		
Bill Zito	Mid Coast EMS	X	X		X	
Cathy Case, RN	LifeFlight of Maine				X	
Dan Palladino, EMT-P	Delta Ambulance, Wtvl	X	X	X	X	
Kevin Marston, EMT-P	PACE/Wells EMS	X	X		X	X
Carol Pillsbury, EMT-P	Northstar Ambulance		X		X	
Chief Daniel Moore	Wells Fire Department	X	X		X	
Brian Mullis, EMT-P	Mayo Ambulance	X	X	X	X	X
Jonathan Ward, EMT	St. George Fire – EMS	X	X	X		X
Diane Delano	Poland, ME	X	X		X	
Charlie Mock, EMT-P	Turner, ME	X	X		X	
Dwight Corning, EMT-P	Maine EMS	X	X	X	X	X
Skip Stewart-Dore	SMCC	X		X		
Chief Bill St. Michel	Durham FD			X	X	
Paul Marcolini	Tri County EMS	X	X	X	X	X
Jay Bradshaw	Maine EMS	X				X

Maine Emergency Medical Services
500 Civic Center Drive
Augusta, ME

MINUTES

Human Resources & Training / PIER

June 9, 2005

- Introductions were made, the following workgroup members attended: Steve Leach; Bill Zito; Dan Palladino; Kevin Marston; Daniel Moore; Brian Mullis; Jonathan Ward; Diane Delano; Charlie Mock; Dwight Corning; Skip Stewart-Dore; and Paul Marcolini.

- The role of the facilitators, Management Intervention Services, MIS, was discussed. The facilitators are to prepare meeting materials for the workgroup. The facilitators are to keep minutes and notes and then organize and distribute them via e-mail to workgroup members after each session. They are to keep the meetings on track and focused while managing workgroup time, assignments, task lists and the agenda. They will ensure equitable and meaningful participation of workgroup members, while ensuring that consensus is reached. They are to ensure continued commitment and follow through by workgroup members. Facilitators will be responsible for preparation of status reports and the final report and documentation to the EMS project leader.

- Jay Bradshaw presented an overview of the process and the tasks that were recommended by the EMSSTAR consultants, along with the expectations of Maine EMS and the legislature. Jay advised that the EMSSTAR report compared Maine to the National Standards.

- Expectations of the workgroup:

    1. The workgroup will develop a work plan to implement change, along with a timeline.
    2. Identify funding sources to back up changes and recommendations, secure funding. Also implement changes that save money...that won't require funding.
    3. Identify alternate educational opportunities.

4. Want to see participation by all workgroup members, which will result in positive, concrete changes.
5. There must be a cohesive effort to reach consensus.
6. There should be planning within known "realities". Understand the realities of Maine EMS's situation as it relates to the State's budgetary constraints, but make every attempt to create "own destiny".
7. There needs to be a certain level of commitment for implementation, with strong follow through.
8. There should be consistency of education throughout the region. Improve sharing of information with all providers.
9. Keep a statewide perspective – no self-interest for one's particular area...no bias.
10. Protect the State System, but realize that change is needed. Minimize turf battles.
11. Improve public awareness and education. Make sure that the public is aware of EMS systems and functions. A better educated public can more favorably affect the legislature.
12. Don't reinvent the wheel. Look to other success and existing resources, particularly in other States.
13. Prioritize the EMSSTAR recommendations, "pick the low hanging fruit". Concentrate on those recommendations that will take the least effort. Show good work and progress in reporting to the legislature in January 2006. Create a 3 to 5 year action plan for implementation.
14. Beware of political realities that as process goes forward, legislatures change. Try to insure that new legislatures will react positively to the work being done.
15. Revitalize PIER
16. Better education/awareness for the public and legislators and providers.
17. Peer education of this process is important for those not involved in this effort.
18. Peer apathy needs to be addressed. The EMS community should be enthusiastic and supportive of the effort.

- Ground Rules:

1. Start on time...end on time. Call if your going to be late or absent.
2. Work group members should be open, honest non-judgmental and respectful.
3. Meeting length should be maximum 4 hours and minimum 2 hours.
4. Video conferencing from 3 sites is available.

5. Group size should be kept at the current number, but experts should be invited when appropriate.
6. Everyone, including the public has a right to be heard.
7. Keep the process transparent.
8. May possibly add Darryl Boucher from Aroostook County to the group.
9. Meetings are open to the public; facilitators will manage public comment time.
10. Unified front outside the room once consensus is reached. If a member can't support the groups' efforts, then they should step down.
11. There was discussion regarding what the decision making process will be. A consensus model was agreed upon. The group wants to make sure that when necessary, you draw out a point of view from a member who might be reluctant to offer an opinion.
12. The workgroup asked that some items be clarified. Do work-groups report only to the Board? When consensus can't be reached, can workgroups report 2 or more recommendations to the Board? Will the Board accept the report, or can they change and refine the report?
13. "Process Check"...any concerns that group members have can be e-mailed to the facilitators for evaluation. Facilitators will bring concerns back to the workgroup when appropriate.
14. There was discussion regarding recusing one's self from a consensus vote. Only if a conflict of interest occurs, should someone recuse themselves.
15. Disclosure statement or disclosure of interest...it was discussed that a short form with these disclosures may be required. This needs to be briefly discussed at our next meeting to implement if the workgroup so desires.
16. Discussed were the requirements for a quorum to do business and come to a consensus. It was decided that 5 of the members would constitute a quorum to meet and make decisions. Less than 5 members would be OK to discuss recommendations, but make no decisions.
17. Agendas will be set at the end of meetings. E-mail additional agenda items by a date to be decided. Facilitators will determine if an additional agenda item is appropriate for the next meeting or if it should be placed in a "Parking Lot" to be discussed at a later date.
18. Break every 50 minutes or ½ way during a 3 hour meeting.
19. Workgroup will meet every 2 weeks starting June 23rd at 1PM.

Human Resources & Training/PIER Workgroup
EMSSTAR Workgroup – Meeting Notes

June 23rd, 2005, 1:00 – 3:00 pm
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
Kevin Marston, EMT-P, Wells EMS/PACE
Brian Mullis, EMT-P, Mayo Ambulance
Bill Zito, Mid Coast EMS
Dan Palladino, EMT-P, Delta Ambulance, Wtvl
Carol Pillsbury, EMT-P, Northstar Ambulance
Chief Daniel Moore, Wells Fire Department
Jonathan Ward, EMT-P, St. George Fire – EMS
Diane Delano, Poland, ME
Charlie Mock, EMT-P, Turner, ME
Dwight Corning, EMT-P, Maine EMS
Paul Marcolini, EMT –P Tri-County

Not Present:
Susan Dupler, RN, Waldo County Hospital
Steve Leach, RN, EMT-P, Mid Coast EMS
Beth Collamore, MD, Aroostook EMS
Cathy Case, RN, LifeFlight of Maine
Skip Stewart-Dore, SMCC
Chief Bill St. Michel, Durham FD
Holly Scribner, Cushing Rescue
Sue Hludik, Wells EMS

1. Review/Approval of Notes from 6/9 meeting

a. Group agreed to move from meeting 2 times per month for 2 hours in length to 1 time per month for 3 hours in length. Meetings would be scheduled for the first Thurs of every month from 1-4 with the next meeting being July 7th followed by August 4th, Sept. 1st, Oct. 6th , and Nov. 3rd

b. Group agreed that this is a small enough group that they should be able to leave the meeting in agreement without a defined consensus model.

c. Group agreed to approve the notes and housekeeping changes above.

2. **Discuss the Standards and Status of the HR and Training and PIER sections. Do they make sense? Do they mean the same to everyone? Did EMSSTAR get it right? Prioritize.**

   a. **Standard and Status 4.3**

      i. **Standard**

         1. Group agreed that the 4.3.1 Standard is an accurate description of the current status of the EMS Human Resources and Training situation considering the state has already adopted this as the standard.

      ii. The standard is appropriate and necessary, however, many rural agencies, in reality, cannot comply with the standard financially.

      iii. **Status**

         1. Group agreed 4.3.2 Status to be, overall, an accurate status of the situation; however, many feel that the group would need data to completely agree.

         2. **Current Status**: "*The human resources component of the Maine EMS system is complex and constantly changing. Larger municipalities typically rely on career EMS personnel to deliver services, with smaller jurisdictions utilizing combinations of career and volunteer personnel or paid-per-call personnel, while more rural areas are served primarily by volunteers. The system as a whole has been enjoying an increase in the number of provider personnel and a greater number of advanced life support services, attributed to the recent increased availability of advanced life support training programs.*"

            a. Group felt that some statements *may* not be completely accurate for the entire state system (i.e. specific areas).

         3. **Current Status**: *"There has been no organized assessment of current personnel need nor is there a comprehensive plan to meet those needs. Recruitment of personnel appears to be solely a local responsibility, as does the identification of the need for particular training programs."*

a. Group agreed it is harder and harder to recruit EMS personnel

b. There was a disagreement that this statement is not solely a local responsibility. System recruitment of personnel varies from region to region.

4. **Current Status**: *"State regulations require that the person attending the patient in an ambulance be trained at least to the EMT-Basic level, and standardized curricula for the training of EMS personnel across the state are utilized, most of which are consistent with National Standard Curricula. There is no statewide standard for the training of dispatchers who handle EMS calls."*

    a. This Statement could be read two different ways due to the difference between the 4 different levels of training. The Intermediate level is very different from the National Standard Curricula, which is otherwise consistent throughout the state. Across the state, all training levels do meet the National Standard Curricula minimums.

5. **Current Status**: "*Instructor/Coordinators are credentialed in accordance with state rules. At the present time, credentialed instructors wishing to offer pre-service or in-service EMS education must make application for approval to the regional council serving the area in which the course will be offered. Approval may require payment of a fee, or may require the payment of an organizational assessment to the regional council. These fees and approval requirements are inconsistent across the several regions. Requirements for approval of EMS training courses, logistical requirements, and costs for course approval vary widely from region to region.*"

    a. Group suggested moving the first sentence to #10. Then, take "credentialed instructor" out and change "pre-service or in-service" to "continued education". Strike last sentence.

    b. Group would like the status to read: "*At the present time, those wishing to offer continued EMS education must make application for approval to the regional council serving the area in which the*

course will be offered. Approval may require payment of a fee, or may require the payment of an organizational assessment to the regional council. These fees and approval requirements are inconsistent across the several regions."

6. **Current Status: "***Providers report limited availability of paramedic training programs, as well as access requirements that impede the ability of agencies to recruit and train sufficient personnel. They also report wide variations in the availability of, access to, and cost of EMS courses within and between regions. The level of medical director or physician involvement in EMS education is unclear, and opportunities for clinical training of EMS providers are limited due to low call volumes and other hospital-based training programs."*

    a. Statements are true, but word "impede" is confusing to the group as to what it really means. Group agreed that statement is generally true, specifically the second part.

7. **Current Status**: *"After completion of a pre-service educational program, the student will participate in written and practical examinations administered by the regional council. National Registry examinations are used at the First Responder and EMT-Basic level, while EMT-Intermediate and EMT-Paramedics are examined using state-developed tests. Certification test results are evaluated within and across regions."*

    a. Group would suggested taking out "will" and change to "may." Change "certification" to "licensure". Statement is unclear. Strike last sentence from statement.

    b. Group would like status to read: *"After completion of a pre-service educational program, the student may participate in written and practical examinations administered by the regional council. National Registry examinations are used at the First Responder and EMT-Basic level, while EMT-Intermediate and EMT-Paramedics are examined using state-developed tests. Licensure test results are evaluated within and across regions."*

8. **Current Status:** *"Inter-state reciprocity options exist at all levels. The state provides recognition based on National Registry and other state's credentials or by individual evaluation of applicants who are not nationally registered."*

    a. Strike "who are not nationally registered" from statement

    b. Group would like status to read: *"Inter-state reciprocity options exist at all levels. The state provides recognition based on National Registry and other state's credentials or by individual evaluation of applicants."*

9. **Current Status**: "*The state EMS agency has specific policies and procedures for credentialing of personnel. However, procedures have not been uniformly defined so that they are applied consistently at the regional level."*

    a. Group agrees to refer the definition of "credentialing" to the policy group. Otherwise they agreed this is a true statement.

10. **Current Status:** *"There are no baccalaureate level programs in EMS, and associate level programs are only sporadically available. Providers and regional representatives indicate that the state system and institutions of higher education are not significantly involved in the delivery of EMS education."*

    a. Group agreed statement is true. Group suggested adding "in EMS in Maine" and "limited" vs sporadically.

    b. Group would like status to read: *"There are no baccalaureate level programs in EMS (in Maine), and associate level programs are limited. Providers and regional representatives indicate that the state system and institutions of higher education are not significantly involved in the delivery of EMS education."*

11. **Current Status:** *"Regardless of the nature of the academic preparation or setting of a proposed educational program, the instructor/coordinator must apply for approval of each individual course, and pay fees to the regional council even though no value is added by this process. These requirements would remain even for academic institutions accredited by regional collegiate accrediting bodies and national EMS accrediting agencies. There is no system of institutional or organizational accreditation for on-going delivery of pre-service or continuing education programs. Larger agencies with designated training staff that are able to meet internal training needs using their own resources object to paying dues or fees to regions to support programs and services that they do not need."*

    a. Group suggested changing "may pay fees to the regional council." "even though in some cases no value is added..."

    b. Group would like status to read: *"Regardless of the nature of the academic preparation or setting of a proposed educational program, the instructor/coordinator must apply for approval of each individual course, and may pay fees to the regional council even though, in some cases, no value is added by this process. These requirements would remain even for academic institutions accredited by regional collegiate accrediting bodies and national EMS accrediting agencies. There is no system of institutional or organizational accreditation for on-going delivery of pre-service or continuing education programs. Larger agencies with designated training staff that are able to meet internal training needs using their own resources object to paying dues or fees to regions to support programs and services that they do not need."*

12. As a prelude to discussion purposes change regional office for regional council. Research to be done and changed for the entire document to be distributed to the all 4 workgroups.

3. **Next Meeting - Next meeting date: July 7th from 1 - 4 pm**

Human Resources & Training/PIER Workgroup
EMSSTAR Workgroup – Meeting Notes

July 7th, 2005, 1:00 – 4:00 pm
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
Brian Mullis, EMT-P, Mayo Ambulance
Dan Palladino, EMT-P, Delta Ambulance, Wtvl
Dwight Corning, EMT-P, Maine EMS
Paul Marcolini, EMT -P
Skip Stewart-Dore, SMCC
Steve Leach, RN, EMT-P, Mid Coast EMS
Chief Bill St. Michel, Durham FD
Jonathan Ward, EMT, St. George Fire – EMS

Not Present:
Susan Dupler, RN, Waldo County Hospital
Beth Collamore, MD, Aroostook EMS
Cathy Case, RN, LifeFlight of Maine
Holly Scribner, Cushing Rescue
Sue Hludik, Wells EMS
Kevin Marston, EMT-P, Wells EMS/PACE
Bill Zito, Mid Coast EMS
Carol Pillsbury, EMT-P, Northstar Ambulance
Chief Daniel Moore, Wells Fire Department
Diane Delano, Poland, ME
Charlie Mock, EMT-P, Turner, ME

1. Review/Approval of Notes from 7/7 meeting

a. Add Skip Stewart-Dore, SMCC to Present List.
b. Jonathan Ward status changed to EMT.
c. Minutes approved with above changes.

2. Continue discussion of EMSSTAR "Status" – HR & Training report

A. **Status:** "*Several providers expressed disappointment at the recent removal of requirements for certain external EMS or specialty certifications. It appeared to the team that a communications gap between Maine EMS and the provider community impeded provider understanding of the rationale for this change. EMS specialty courses (ACLS, PALS, PHTLS, etc.) appear to be available*

within the state. However, access may be limited, particularly with respect to rural providers."

1. Group feels that the word "Impeded" seems a bit strong and actually may not be the case. However, it can't be disputed that some feel there is limited access.

B. **Status:** "*There is a statutory mandate for ambulance vehicle operator training. However, the deadline for compliance has been pushed back several times for a variety of reasons related to funding and a monitoring mechanism."*

1. Group feels this is an accurate statement.

C. **Status:** "*There is a statewide critical incident stress management program available to EMS providers. This is an important component of a system to facilitate retention of EMS personnel who might otherwise leave the profession due to critical incident stress."*

1. Group feels this is an accurate statement.

D. **Status:** *"The health care community of the state is to be commended for the development of a statewide hospital-based video-conference capability in hospitals around the state. This capability, which is extraordinarily economical, is used by EMS providers to facilitate remote participation in meetings, conferences, and other functions."*

1. Group feels this is an accurate statement, however, the technology is underused.

E. **Status:** *"The state has enacted an EMS-specific line-of-duty death benefit. This is an important measure, for which those responsible should be commended."*

1. Group feels this is an accurate statement.

4.3.3Recommendations:

- *"Remove the requirement for regional approval of initial training programs and place this function at the state level."*

1. Clarification from State (D. Corning) that this recommendation is a conceptual recommendation. The actual process had not been discussed.
2. Group would like to know how many courses are actually being approved currently in order to prioritize this recommendation and develop the process.

- *"Develop and implement a process for institutional and agency approval for on-going course delivery modeled after contemporary accreditation processes that precludes the requirement for individual course approval."*

    1. Group was confused as to where the fiscal responsibility lies within this recommendation and the others. If the State takes over the training programs, how will they be funded?

- *"Repeal the rule requiring pre-approval of continuing education programs. Replace it with a rule requiring documentation of course content and student participation that can be reviewed after the fact by Maine EMS."*

    1. Feeling that the first 3 recommendations are really the "meat" of the group's responsibilities.
    2. These three recommendations are very closely linked. Before the group can tackle this, they will need the numbers regarding number of courses offered. This process can be considered a "low hanging fruit" and should be easy to do by calling the providers.

- *"In cooperation with other state agencies, develop a plan to assure that EMD training is required for all personnel answering 9-1-1 EMS calls."*

    1. Since this recommendation is currently being worked on within the legislature, the group feels this should be removed from their responsibilities.

- *"Explore alternative resources and partnerships to accelerate compliance with the AVOC requirement."*

    1. State does not have the numbers regarding current compliance because they are not tracked due to lack of funding.
    2. Can a field be added to online system to help document this?
    3. Can each provider be contacted to find out how many people are in compliance?
    4. Can AVOC and EVOC be combined? Much of the same information/training is identical covered within each.
    5. Does "alternative resources" mean the state will not be providing funding but rather hand back to the providers to find out how to fund this endeavor
    6. Insurance premiums may be a way to offset the costs involved with bringing everyone up to compliance.
    7. Group agrees with recommendation, however, in order to address this issue, funding should be allocated in order to find the current compliance numbers.

- *"Encourage increased utilization of the hospital-based video conferencing network to facilitate increased opportunities for distance education for EMS providers."*

3. Continue discussion of EMSSTAR "Status" – PIER report

Standard: *"To effectively serve the public, each agency must develop and implement an EMS public information, education and relations (PIER) program. The PIER component of the EMS plan ensures that consistent, structured PIER programs are in place that enhance the public's knowledge of the EMS system, support appropriate EMS system access, demonstrate essential self-help and appropriate bystander care actions, and encourage injury prevention. The PIER plan is based on a needs assessment of the population to be served and an identification of actual or potential problem areas (i.e., demographics and health status variable, public perceptions and knowledge of EMS, type and scope of existing PIER programs). There is an established mechanism for the provision of appropriate and timely release of information on EMS-related events, issues and public relations (damage control). The agency dedicates staffing, training and funding for these programs, which are directed at both the general public and EMS providers. The agency enlists the cooperation of other public service agencies in the development and distribution and evaluation of these programs, and serves as an advocate for legislation that potentially results in injury illness prevention."*

- **Status**: *"There is no comprehensive PIER program in place at the state level. Although they recognize the importance of public information, system members have not dedicated the necessary resources to realize the benefits of elevated public awareness. As a result of limited public awareness of its needs and limitations, the EMS community has been singularly unsuccessful in obtaining the funding necessary for it to assure critical infrastructure and the availability of its essential lifesaving services."*

1. Group feels this statement is implying that the lack of funding is due to a lack of public education.
2. People support their communities but may not see the larger funding picture.
3. Group feels that the EMS services may not see the importance in educating the public
4. Educating the EMS services on PEIR may be more important than educating the public at this point
5. Use PIER to lobby for funding to the legislature
6. Trauma Prevention is being done currently within the hospitals

7. Need to have a paid PIER person on staff; right now it is completely volunteer. The volunteerism breeds community apathy because there is such a low attendance at events.
8. Group feels this is a great idea; however, the rural services may be hard to convince AND find funding for.
9. Group feels this is an accurate statement.

- **Status**: *"Maine EMS does not have staff resources dedicated to the PIER function. In addition to lack of public awareness, there is a lack of resources devoted to intra-system communication. The Maine EMS web site contains a variety of useful information and documents; however lack of staff resources results in delayed updates of information, posting of meeting minutes, etc. The Maine EMS Journal is an excellent publication which has been in existence for many years."*

    1. Group feels this is an accurate statement.

- **Status**: *"Most of the PIER programs that have been identified on local and regional levels have been medical education outreach. There are several excellent examples of such programs around the state including those that have resulted from a partnership with EMSC, including Youth Suicide Prevention Gatekeeper Training Program, and the formulation of regional injury prevention teams. Maine EMS has participated for many years in the National EMS Week campaign, and utilizes this opportunity to recognize EMS stakeholder accomplishments."*

    1. Group feels this is an accurate statement.

- **Status**: *"However in spite of these accomplishments there are no efforts to improve system utilization, eliminate unnecessary use, or enhance public awareness of the EMS system."*

    1. There was confusion as too what "eliminate unnecessary use" means.

4.7.3 Recommendations:

- *"Focus the PIER campaign on increasing the awareness of elected officials and decision-makers about the current status and urgent fiscal needs of Maine's EMS system."*

    1. Identify legislators that are EMT's and start the education with them
    2. Work on obtaining National information in regards to other PIER programs.
    3. Educate legislators about their own local EMS and who are the point people to go to if they have questions if an issue comes up.

4. Start by educating the EMS community as to what the PIER program is.

- *"Develop and implement comprehensive and integrated EMS public information, education, and relations program."*

    1. This recommendation is dependant on the first recommendation and first educating the EMS system itself as to the importance of this program.

- *"Elevate the priority of PIER within each agency's priorities such that it remains a critical focus at the state, regional, and local level."*

    1. This is needed in order to retain funding
    2. PIER is also essential to EMS recruitment and retention.

- *"Establish a mechanism for rapid dissemination of policy decisions, meeting minutes, and other announcements of interest to EMS agencies and personnel."*

    1. This has now improved significantly via the EMS State website, however, group must also be aware that there are still those who do not have internet access.
    2. Even if dissemination of material is accomplished there may be lack of interest by individuals and service chiefs.

    3. Priorities in order: c, d, a and b

4. HR & Training "TO DO" List (info group needs in order to accurately design a work plan)

a. Continuing Education Hours: getting a list of numbers from each region regarding how many courses were approved and how many licenses were issued – Jonathan to do
b. How many FTE hours are spent processing - Jonathan to do
c. How many programs have been done in each region - Skip to do
d. AVOC numbers? Add a field to the current Licensure program online that could quantify the numbers of AVOC compliance. – Dwight to do
e. Get the numbers from MMA; International Assoc. of Fire Chiefs,; American Ambulance Assoc.; regarding the insurance premium benefits that regions can gain by having high AVOC compliance. – Steve and Paul to do.
f. Contact MMA, IAFC regarding grants available for AVOC certification

g. Partnering with Maine Fire Training to provide equivalent trainings in regards to EVOC and AVOC.
h. Evaluate the standards of AVOC and EVOC to see if they can be combined.
i. AVOC position must be put back on the Legislative Priority List and must be funded in order to meet the January 2007 deadline. ($100,000 annually)

5. PIER "TO DO" List (info group needs in order to accurately design a work plan)

Recommendation 1

a. List of those certified to PIER Train the trainer – Steve
b. Copy of Train the Trainer program – Paul (will try to e-mail)

Recommendation 2

a. Marketing plan for internal communications in order to push people to the website. Also, market to providers through the "Journal"
b. One stop shopping site including regional classes offered
c. There is no "repository" of information through the EMS website; must go to regional websites. This should be looked at to refine and move to State EMS site.

6. Plan next meeting:

a. Assignments - See To Do Lists above.
b. Next meeting: August 4th from 1-4pm at the EMS Services Office.

Human Resources & Training/PIER Workgroup
EMSSTAR Workgroup – Meeting Notes

August 4th, 2005, 1:00 – 4:00 pm
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
Dan Palladino, EMT-P, Delta Ambulance, Wtvl
Dwight Corning, EMT-P, Maine EMS
Kevin Marston, EMT-P, Wells EMS/PACE
Carol Pillsbury, EMT-P, Northstar Ambulance
Charlie Mock, EMT-P, Turner, ME
Cathy Case, RN, LifeFlight of Maine
Bill Zito, Mid Coast EMS
Diane Delano, Poland, ME
Chief Bill St. Michel, Durham FD
Chief Daniel Moore, Wells Fire Department
Brian Mullis, EMT-P, Mayo Ambulance
Paul Marcolini, EMT -P

Not Present:
Susan Dupler, RN, Waldo County Hospital
Beth Collamore, MD, Aroostook EMS
Skip Stewart-Dore, SMCC
Steve Leach, RN, EMT-P, Mid Coast EMS
Holly Scribner, Cushing Rescue
Jonathan Ward, EMT, St. George Fire – EMS

1. **Review/Approval of Notes from 7/7 meeting**

    a. Minutes approved by workgroup with no changes.

2. **Discuss – Prioritize the Action Items**

    a. **Prioritize HR and Training Action Items**

        i. 4.3.d – This item did pass and will become law in Jan. '07

        ii. 4.3.f – This system is running and available, however, the group doesn't believe it is utilized to its full potential

            1. Group would like to prioritize this as last due to the low level of importance as compared to the other action items.

iii. 4.3.a and b – should be combined as they are so closely linked

1. Group agrees that these two action items could be placed at the top of the priority list.

iv. 4.3.c – Group agreed to tackle this second

v. Action items prioritized as follows: a/b, c, e and f (in order)

b. Prioritize PIER Action Items

i. To effectively perform the following tasks, an addition to the 4.7.c should be made that includes a way to inform and market directly to the internal EMS system BEFORE group attempts to perform 4.7.c as the report states.

ii. Action items Prioritized as follows: c, b, a, d

iii. The group will address the PIER Action items after the HR and Training action items have been addressed.

c. Assignments – did we get the info that we wanted and does that information provide what we thought it would?

i. Jonathan Ward submitted educational data (summary of CEH and licensure programs data collected from the 6 EMS regions) to the group.

1. It could be possible that this data can be interpreted in very different ways. This may prove that the information may not be as useful as originally thought.
2. Group will ask Jonathan to break out this information by new programs and old programs. Should there be a presentation to the workgroup about this process? Procedure is different per each type of program (whether new or old).
3. This information could be directly related to the action item 4.3.c.
4. If the numbers are accurate, does it show that there are too many FTE hours being used?
5. Workgroup would like a presentation on the National accreditation process.
6. 4.3 b seems to be more apt to institutional (state) and 4.3.a is for individuals (regional)
7. Group suggested Dan present to the group on the following

a. Continued education information and accreditation information (NAEMS)

ii. 4.3.c - How is the new licensure process going to effect the workgroup's discussion? Group feels they need to have more accurate information in order to deal with this action item. Could group get information from other states to see how they implement CEH licensure and what their processes are? Workgroup, Charlie, Diane and Dan, to research other states and bring back the info to the next meeting. Charlie, Diane and Dan will develop questions for Dwight to e-mail to 56 other "Dwights".

iii. Request from each region: their approval process of CEH courses to see what each region is doing. This would be helpful to have so the workgroup can decide what is actually going on (this includes the state office staff's time taken to receive and process as well).

iv. Dwight reported on the AVOC numbers he collected. There cannot be a new field added to the current form, however on the new system, a field may be added.

v. How will the new licensure process effect our discussions? Drexell presented to workgroup:

1. Current system is from 1986; however, a new Oracle system is now being developed that will interface between an online web based system and a backend database. This means data could be entered real time, over the web and approved online vs. submission of a hard copy form for data entry by Maine EMS. Eventually, this will be done for both licensure courses and continued education. The intent will be to link together both National Registry information and state information. System is to take effect Jan. 07, however, this has not been approved yet by the board because of some financial concerns. The continuing education piece will not be online until sometime next year.
2. Workgroup, per Drexell's explanation, can be certain that the web based system will happen and client base system is being phased in.
3. The workgroup should be focused on designing a system that is ideal from their point of view – the system can be designed around that ideal.

vi. Dan explained he pays for all his people to go through AVOC training. Because everyone is AVOC trained, he makes up the money spent on the training with insurance premium savings.

vii. 4.3.e – Recommendation:

1. Group recommends: To broaden the review of existing programs to determine equivalency with AVOC.
2. Group to review this recommendation for the next meeting and possibly approve.
3. MMDFE has expressed interest in collaborating on funding for AVOC\EVOC training resources.
4. Add on: an AVOC position will be put back on the legislative priority list. This must be fulfilled to meet current 1/07 deadline.

3. Plan next meeting:

a. Next meeting: September 1st, 2005 from 1-3 pm at the EMS Services Office.
b. Housekeeping: If an absence of a workgroup member exceeds 2 meetings, they will no longer be invited to the workgroup meetings and will be taken off the correspondence list.
c. Next Steps: Group to continue with the priorities as listed.

Transportation and Facilities

The Transportation and Facilities committee membership included pre-hospital and hospital Emergency Medical Services (EMS) providers from throughout Maine. From June 9, 2005 to September 13, 2005, the committee met five times at the Department of Public Safety headquarters in Augusta, Maine and reviewed the ten of the recommendations made by the EMSSTAR Report.

The following bullets describe the timeline and highlights of the committee's work:

- June 9, 2005 – After introductions, responsibilities of the committee members and facilitator were outlined and ground rules established. Jay Bradshaw, Maine EMS Director presented an overview of the process, along with Maine EMS and Legislative expectations for the work to be performed. Committee member concerns included the lack of representation from physicians and from southern Maine EMS providers. The ten EMSSTAR recommendations were reviewed with work to commence at the June 21. 2005 meeting.
- June 21, 2005 – The committee now includes representation from southern Maine. Each of the ten recommendations was reviewed to determine if the statements represented the current model of the Maine EMS system. Recommendations were initially categorized as high, medium or low with the committee brainstorming issues involved with each.
- July 12, 2005 – An emergency department physician joins the committee. Discussion centers on recommendation 4.4d concerning statewide activation of the emergency helicopter service, and 4.4 a & b that involves response time requirements for EMS services. The committee requests that a representative from the Maine Health Information Center attend the next meeting to educated the group on how run report forms are collected, how the data is entered and the information (e.g. reports, statistical analysis) available from the database.
- August 9, 2005 - Presentation on the current run reporting system and response time information made to group by Jeri Kahl from the Maine Health Information Center. Committee agrees that the 20-minute average annual response time should be eliminated in favor of response time requirements based on community characteristics. Committee also recommended that all licensed EMS providers in Maine be authorized to request emergency air ambulance transport.
- September 13, 2005 – Committee completes its work and assigns high medium and low priorities to the following (see attached summary for complete listing):
    - High priority recommendations include: ensuring that all licensed EMS providers are able to request emergency air ambulance response without first consulting medical control; implementation and funding of the Ambulance Vehicle Operator Course (AVOC) training requirements as per current Maine EMS statute; completion of a needs analysis of sending health care facilities that will drive changes in scope of practice, training and protocols for prehospital EMS providers including but not limited to Paramedic Inter-facility training; and review destination selection criteria and implement a method of assessment and ongoing destination selection in coordination with the electronic run report system. High priority recommendations must be accomplished to maintain and/or improve patient care and ensure public safety.
    - Medium priority items included: the elimination of the 20 minute average annual response time requirement and development of an alternative standard for

response and for response time reporting to licensed EMS services; and elimination of multiple drug box systems. Medium priority items are those that, if left undone, would have an untoward effect on the system but are worthy of action at some time in the future.

- The only low priority recommendation concerned establishment of an infrastructure to license ambulance vehicles that operate in a marine environment (e.g. boats). Currently, a combination of public and privately owned watercraft provides patient transport from offshore islands to the mainland. Establishing a licensing mechanism for the myriad types of vessels that currently transport patients in emergency situations might not only create a complex bureaucratic process, it could result in a decrease of available craft in the event a waterborne transport is necessary. Low priority items have the least overall impact on the EMS system and will most likely receive little or no resources for completion.

Transportation / Facilities
Meeting and Attendance Record

Facilitator: Mike Roberts, Management Intervention Services, mike@interventionteam.com

Name	Affiliation	6/9/05	6/21/05	7/12/05	8/9/05	9/13/05
Chief Jim Farrell	Augusta Fire Dept	X			RA	
Paul Knowlton, EMT-P	Meridian Mobile Health		X		X	
Joanne LeBrun	Tri County EMS	X	X	X	X	
Joseph Moore	Mid Coast EMS	X	X			
Richard Doughty, EMT-P	Meridian Mobile Health		X			
Perry Jackson, EMT-P	Crown Ambulance	X		X		
Jim McKenney, EMT-P	Crown Ambulance	X	X	X	X	
Drexell White, EMT-P	Maine EMS	X	X	X	JRB	
Chief Roy Woods	Caribou Fire/EMS	X		X	X	
Rick Cheverie	Bangor Fire Dept	X	X	X		
Bob Johnson	LifeFlight of Maine	X	X	X		
Gary Utgard	Sanford Fire Dept.		X	X	X	
Paul Liebow, MD	EMMC, Bangor			X	X	

Transportation/Facilities Workgroup
EMSSTAR Workgroup – Meeting Notes

June 21st, 2005, 1:30 – 3:30 pm
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
Paul Knowlton, EMT-P, Meridian Mobile Health
Joanne LeBrun, Tri-County EMS
Joseph Moore, Mid Coast EMS
Richard Doughty, EMT-P, Meridian Mobile Health
Jim McKenney, EMT-P, Crown Ambulance
Drexell White, EMT-P, Maine EMS
Gary Utgard, EMT-P, Sanford Fire Dept
Bob Johnson, LifeFlight of Maine
Rick Cheverie, Bangor Fire Dept

Not Present:
Chief Jim Farrell, Augusta Fire Dept.
Perry Jackson, EMT-P, Crown Ambulance
Chief Roy Woods, Caribou Fire/EMS

1. **Review/Approval of Notes from 6/9 meeting**

    a. Minutes approved by group

2. **Discussion of Notes from Regulations/Policy workgroup**

    a. Workgroup was informed that the Regulations/Policy workgroup will be working on possibly starting with a clean slate with regards to the current system set up. This may or may not have an effect on this workgroup's discussions/actions.
    b. The group was reminded that because all the notes from each meeting will be uploaded online as soon as possible, they will be kept informed of what the other workgroups are working on.

3. **Discuss the Standards and Status of the Transportation/Facilities section – Do you agree with the EMSSTAR Statement?**

    a. Group reviewed the 4.4.1 Standard and agreed that the 4.4.1 Standard was an accurate statement.
    b. Group reviewed the 4.4.2 Status and agreed that the 4.4.2 Status Sections were accurate statements
    c. Overall the group agreed that the Standards/Status is a true reflection of the current state of the EMS Transportation

4. **Review/Discuss 4.4 recommendations**

- *Discuss each of the recommendations – do they make sense – do they mean the same to everyone – did EMSSTAR get it right – Prioritize*
- *Accept/Reject/Modify*
- *Any additions to the recommendation*

a. **Discussion of recommendation 4.4.a "Develop a strategy and a program to analyze the response times statewide and distribute the information to each agency"**

i. Response time reports are automatically generated quarterly, so there is a system in place. Group thought this concern may have come from individuals who may not know that this report is currently being generated.
ii. There is a strategy to improve response times, however, this would be regional, and not done by the state. Each area has their own goals and desires.
iii. Group agreed that in order to tackle this recommendation first, the group must define what response time is. Currently, there are different definitions depending on the organization. There should be a consistent way to measure the same response time, however, depending on the type of agency, the standards may be different.
iv. Objective for the group may be to eliminate the 20 min response time, and replace with response times specific to each area depending on the current data – what is truly appropriate for that area.
v. The 20 min response time was set in place because there was nothing in place at that time. Group agreed, it is now time to modify that definition with the use of statewide response time data.
vi. Group should also clarify WHO is the first responder.
vii. Have EMS run sheet data so that the group can actually see what is being discussed.
viii. Challenge is crafting a legal benchmark along with an optimal benchmark
ix. May have to be a split system response time that would account for geographic limitations and concerns
x. Use historical data to profile area or service for each region.
xi. Bring in a run report so all can see what is actually being reported
xii. Drexell to provide a copy run report, copy of data and copy of run report manual to the group for the next meeting. Statewide average, region, per service – data to be provided
xiii. Is there a way to modify run reports so that they are more accurate for everyone

xiv. Overall, group agreed this was a high priority and should be addressed along with recommendation 4.4 b.

b. Discussion of recommendation 4.4.b "Revise the rules and regulations to eliminate the 20 min annual average response time. In its place, require all EMS agencies to develop a stated response goal using contemporary methodology based on a specific needs assessment for their response area. This report should be reviewed during the annual licensure renewal process"

i. Group agreed, this recommendation should be addressed in conjunction with 4.4 a.
ii. Break down response times per services, by times…1-5 min, 6-10 min etc. Then use the percentages from each to drive concerns as to what is out of the norm
i. Analyze that data so it can be seen where the problems may be and possibly correlate those abnormalities with specific events.
ii. Again, the task of defining "response time" is key in addressing this recommendation.
iii. Group feels this is a high priority and is to be addressed 2nd (in conjunction with 4.4 a)

b. Discussion of recommendation 4.4.c "Establish criteria for marine EMS transport units"

i. Group feels this is a low priority and should be addressed last.
ii. Historically, Maine EMS has stayed away from the marine EMS transport units due to the complicated layers of regulations and policies.
iii. Currently, a combination of local providers, marine patrol, and coast guard perform this function. No one is actually responsible for the islands
iv. Now, regulations/criteria go out the window in an emergency situation – what ever is needed to be done, is done.
v. Should there be a licensed marine ambulance?
vi. Emergencies are so infrequent, is this even an issue?
vii. Group would need to know the actual numbers of emergency calls in order to prioritize this recommendation.
viii. Develop criteria should a locale desire to implement marine EMS procedures, have them in place and ready to use. Use other state's criteria as models for adoption.
ix. Data may not be clear. People who go outside a licensed EMS provider aren't recorded and can't be analyzed.
x. Recommendations could go out to each service, and guide how they operate.

xi. Contact Washington, California, Florida etc. to see what they are currently doing (check if they have their regulations online)

c. Discussion of recommendation 4.4.d "Modify the Maine EMS Prehospital Treatment Protocols to authorize all EMS providers statewide to request air medical transport units without online medical direction"

i. Group agrees this should be its first priority. Group feels this is easy to do, and currently is not required via the protocols
ii. Creates confusion and delays when required to call
iii. Depending on your region, you may be afforded different standards of care
iv. Group agreed this is a modification that must be top priority
v. Each region makes this decision. Statewide, this should be up to the EMS provider to make the call

d. Discussion of recommendation 4.4.e "Implement the Ambulance Vehicle Operators Course (AVOC) training requirement without any further postponements of the effective date"

i. Group feels this is a medium priority and is prioritized as the 3rd recommendation in 4.4 to address
ii. As a system, they feel that it is very important to have this training, but there is a lack of funding in order to implement.
iii. Group would need to provide a cost analysis to the legislature in order to gain the funding.
iv. Substitute EVOC for AVOC could be an alternative
v. Utilize national data, other state models to improve training vs. just using AVOC as the only solution
vi. Group agreed to outline EVOC and AVOC, review the actual cost data analysis and then brainstorm other avenues for funding (insurance providers, other businesses)

5. Review/Discuss 4.5 recommendations

- *Discuss each of the recommendations – do they make sense – do they mean the same to everyone – did EMSSTAR get it right – Prioritize*
- *Accept/Reject/Modify*
- *Any additions to the recommendation*

a. Discussion of recommendation 4.5.a, b and c "Conduct a needs analysis of sending facilities to identify the staffing and scope of practice expectations for patients requiring interfacility transport", "Perform a comprehensive review of the Paramedic Interfacility Transport Module and revise the content based on the needs analysis

findings", "Conduct a review of destination selection criteria utilized by EMS personnel."

i. Would like to obtain the data that is stated in these 3 recommendations. Group feels there is no evidence of such data
ii. Check with the MDPB for data
iii. Request data from the state
iv. If this is currently being handled, should the workgroup tackle these recommendations?
v. If it's not being done, it is a top priority
vi. If 4.5 c has been done, could be done better?

b. Discussion of recommendation 4.5.d "In conjunction with the design of the electronic EMS reporting system, implement a method of assessing the rationale for destination selection made by EMS personnel for all transports"

i. Group doesn't understand this recommendation
ii. Is there a way to review the rationale and compliance with protocols

c. Discussion of recommendation 4.5e "Convene a Pharmacy subcommittee of the Board to investigate options for ambulance restocking that would eliminate the need for ambulance services to carry multiple drug boxes."

i. Each hospital currently has it's own drug box requirement
ii. Group would start by finding out how each region handles this issue.
iii. Implementing a universal system could save money
iv. Option would be to take the pharmacy function out of the hospital all together; however, this would increase the prices of the medication.
v. Group will develop a short questionnaire and distribute to see if this is really a problem. Then, they can place this recommendation in the priority line up.

6. Plan Next Meeting

i. Assignments for next meeting - data requested in order to discuss many of the recommendations
ii. Discuss Agenda items
iii. Next meeting date: July 12th 1:30 – 3:30

Transportation/Facilities Workgroup
EMSSTAR Workgroup – Meeting Notes

July 12th, 2005, 1:30 – 3:30 pm
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
Joanne LeBrun, Tri-County EMS
Jim McKenney, EMT-P, Crown Ambulance
Drexell White, EMT-P, Maine EMS
Gary Utgard, EMT-P, Sanford Fire Dept
Bob Johnson, LifeFlight of Maine
Rick Cheverie, Bangor Fire Dept
Paul Liebow, Region 4 EMS
Perry Jackson, EMT-P, Crown Ambulance
Chief Roy Woods, Caribou Fire/EMS

Not Present:
Chief Jim Farrell, Augusta Fire Dept.
Joseph Moore, Mid Coast EMS
Richard Doughty, EMT-P, Meridian Mobile Health
Paul Knowlton, EMT-P, Meridian Mobile Health

1. **Review/Approval of Notes from 6/21 meeting**
    a. Minutes approved by group
2. **Review samples of "Run Reports" being supplied by Rick and Drexell**
    a. National model for rural areas using GPS for first responders? Full time EMS employees can respond to any call anywhere in the state in order to improve the response times.
3. **Verify priorities est. on June 21st and begin discussion of recommendations in order of priority**
    a. **Recommendation 4.4.d *"Modify the Maine EMS Prehospital Treatment Protocols to authorize all EMS providers statewide to request air medical transport units without online medical direction" stated by group as the first priority."***
        i. Since each region may have their own policy surrounding this topic – each region should be contacted, by the workgroup, to see what their policy states (if any).

ii. Workgroup recommends the following protocol to be recommended to either the MPB and EMS Board (whichever meets first):

1. **"Licensed EMS providers are authorized to request air medical transport. If there is any question regarding the appropriate response regarding air transport, contact online medical control. Personnel calling air medical transport must have taken the Maine EMS approved ground safety course."**
2. Workgroup to review above protocol draft (in conjunction with the region protocol provided), disseminate to entire workgroup, and vote on adoption at the next meeting.

b. **Recommendation 4.4.a & b:** ***"Develop a strategy and a program to analyze the response times statewide and distribute the information to each agency" & "Revise the rules and regulations to eliminate the 20 min annual average response time. In its place, require all EMS agencies to develop a stated response goal using contemporary methodology based on a specific needs assessment for their response area. This report should be reviewed during the annual licensure renewal process"***

i. Definition of "response time" – per the Run Report Manual pg 18; "from when the unit leaves the station and is in route to the scene…when the ambulance arrives at the destination (or scene)"
ii. Because the response time number (20) is so arbitrary, nothing is done with the information that is currently gathered. Problems could be recognized by looking at those numbers.
iii. Group suggested using past performance to track current numbers to judge how a region is performing.
iv. Parameters can be flagged within the data to monitor if problems are occurring, however, there would need to be funding to have someone responsible for monitoring those queries.
v. What is the MIC definition for response time? No clear parameters for how the run report calculations are made.
vi. Workgroup would like to have Jeri Kahl attend the next meeting to answer data and data collection questions.
vii. Electronic run reports, to be implemented within 6 months, will allow information to be instantly gathered, however, what can actually be done with those numbers.
viii. Develop a consensus on what data should be collected (what would be useful) and then have that built into the new run report program.
ix. Workgroup would like Jeri Kahl explain output reports, what data is being collected and how the info is gathered and reported on.

This would give group a better idea of what questions to ask and whether or not this process needs to be adjusted in any way

x. Getting the right sets of numbers would allow important problems to be identified and focused on that might otherwise not be identified.
xi. Group would like to speak with Jeri Kahl regarding the actual data and collection of that data before dealing with recommendation 4.4. b.

4. **Plan Next Meeting**

i. Assignments for next meeting
    1. Drexell to contact Jeri Kahl regarding attending the next meeting for a possible Q&A session.
ii. Agenda for next meeting dependant on the attendance of Jeri Kahl.
iii. Next meeting date: August 9th, 1:30 – 3:30pm.

Transportation/Facilities Workgroup
EMSSTAR Workgroup – Meeting Notes

August 9th, 2005, 1:30 – 3:30 pm
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:
Joanne LeBrun, Tri-County EMS
Jay Bradshaw, Maine EMS (sitting in for Drexell White, EMT-P, Maine EMS)
Rodger Audette, Augusta Fire
Jeri Kahl, Maine Health and Information Center
Jim McKenney, EMT-P, Crown Ambulance
Paul Knowlton, EMT-P, Meridian Mobile Health
Chief Roy Woods, Caribou Fire/EMS (sitting in for Chief Jim Farrell, Augusta Fire Dept.)

Not Present:
Chief Jim Farrell, Augusta Fire Dept.
Joseph Moore, Mid Coast EMS
Richard Doughty, EMT-P, Meridian Mobile Health
Drexell White, EMT-P, Maine EMS
Gary Utgard, EMT-P, Sanford Fire Dept
Bob Johnson
Rick Cheverie, Bangor Fire Dept
Paul Liebow, Region 4 EMS
Perry Jackson, EMT-P, Crown Ambulance

1. Review/Approval of Notes from 7/12 meeting

a. Minutes approved by group

2. Presentation by Jeri Kahl: Data and Data Collections

a. Overview of "response times?" What really goes into calculating response times?

i. Volunteers submit their times. A simple calculation is performed between those various times and then averaged for reporting purposes.
ii. If there are two times received for a response time, the earlier of the times is recorded in the system.
iii. Reports are used to try and show the service's response; when did they receive the call and when did they reach the patient's side.

iv. NEMSIS database actually has an area for the previously "unknown" items (i.e. When did you actually get to the patients side vs. just to the location.)
v. Maine EMS uses the response time report to see call received and at scene averages per service. The data is provided to services and regions so they can gauge how well they may be doing. The 20 minute rule is a guideline for the state EMS to identify where there may be problems which need to be addressed.
vi. 20 minute rule seen as a guideline. If response times reach 20 minutes, steps needed to be taken to investigate if the service. Do they need added help in an area (more vehicles, staffing etc)
vii. This reporting system has been in place for a long time without much change.
viii. Can these reports used to trend how services are operating in the different communities?
ix. Response time reports are used many times when small towns are deciding which service to contract with. Reports are looked at to see how long it takes each different service to reach their area and what the response times are to their community.
x. Annually, could we use service response time reports to create actual goals and standards for each service for the next year. Hold each service accountable for the next year's response times dependant on the prior years. This could be linked to licensure.
xi. Per Jay, Information is currently available, workgroup is charged with showing others how to look at that data. Workgroup is to find out what is important and then recommend that to the board.
xii. Within the next year, Maine EMS will be going through a major data shift from a paper system to completely digital.
xiii. There are "value added" features that capture special items within each run report. The data is available; people just need to know how and what to look for.
xiv. State EMS is charged with assembling, not the workgroup, and identifying data elements to be used when developing the new run report data collection.
xv. Annual trending could easily be accomplished by reviewing the available data. Data is available; however, there are no regulations for analyzing this data.

b. 4.4.b - Recommendation

i. Workgroup agrees that the 20 minute response times should be eliminated. The average response requirements specific to relevant community characteristics should be established.

c. 4.4.a - Recommendation

i. The strategy and program to analyze and distribute the response times is currently in place, however, it needs to be updated in conjunction with the new electronic run time reporting program.

d. 4.4.d – Recommendation

i. Workgroup agreed to accept the recommendation language: "Licensed EMS providers are authorized to request air medical transport. If there is any question regarding the appropriate response regarding air transport, contact online medical control."
ii. Workgroup would also like to recommend that the Ground Safety Course be required and brought to the Educational Committee.
iii. Workgroup is recommending this recommendation will only be presented to the EMS board.

e. 4.5.d – Clarification

i. Workgroup requested Jay clarify this item.
ii. Jay suggested the new QI module may offer a solution to this issue and clarify the situation.

3. Plan Next Meeting

i. Review Recommendations made during this meeting and approve.
ii. Next meeting date: Sept. 13th, 1:30 – 3:30pm.