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131st Legislature, First Regular and First Special Sessions

Blue Ribbon Commission to Study Emergency Medical Services in the State

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Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSIONS

Blue Ribbon Commission to Study Emergency Medical Services in the State

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Rep. Mark Blier
Rep. Scott Cyrway
Rep. Suzanne Salisbury
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Table of Contents

Page

Executive Summary

The Blue Ribbon Commission to Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Resolve 2023, chapter 99 (Appendix A). Pursuant to that resolve, the commission consisted of the following 17 members: two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature; two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents; one member who represents a statewide association of emergency medical services providers; one member who represents a private, for-profit ambulance service; one member who represents a statewide association of municipalities; four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature; one member who represents a tribal emergency medical service; one member who represents a volunteer emergency medical service; one member who represents a county government; one member who represents a statewide association of hospitals; the Commissioner of Health and Human Services or the commissioner's designee; and the Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

A list of commission members may be found in Appendix B.

The duties of the commission are set forth in Resolve 2023, chapter 99 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate with Maine Emergency Medical Services so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to costs and funding, workforce development and sustainability, Maine EMS structure, as well as regionalization.

Over the course of five meetings, the commission developed the following recommendations:

Costs and Funding

Recommendation A-1: The Legislature should enact emergency legislation in 2024 eliminating from the Emergency Medical Services Stabilization and Sustainability Program the requirement that the EMS Board adopt rules establishing sustainability grant program requirements and should instead directly stipulate those requirements in law.

Recommendation A-2: The Legislature and Maine EMS should take all actions necessary to ensure the timely and efficient implementation of the Emergency Medical Services Stabilization and Sustainability Program and the distribution of the funding and grants associated with that program.

Recommendation A-3: The Legislature should enact legislation providing ongoing funding to the Maine Emergency Medical Services Community Grant Program and the Legislature and Maine EMS should take all actions necessary to ensure the timely and efficient implementation of that program and the distribution of associated grants.

Recommendation A-4: The Legislature should enact legislation, as proposed in LD 1751, increasing reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine.

Recommendation A-5: The Legislature should enact legislation, as proposed in LD 1751, implementing an ambulance assessment program, which would establish an ambulance service assessment fee on non-municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program.

Recommendation A-6: The Legislature should enact legislation, whether as an amendment to LD 1751 or otherwise, to implement an intergovernmental transfer program, which would authorize municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program through provider payment of the non-federal cost share.

Recommendation A-7: The Legislature should enact legislation, whether as an amendment to LD 1832 or otherwise, requiring health insurance carriers to provide coverage and reimbursement for community paramedicine services in state-regulated health plans.

Recommendation A-8: Maine EMS should conduct a funding needs analysis of communities seeking to engage in regional collaborative efforts or in the adoption of a regional model for the delivery of EMS.

Recommendation A-9: The Legislature should enact legislation, as proposed in LD 1409, to address situations where an EMS entity can be reimbursed its costs for training and credentialing an EMS provider if the provider is hired by another EMS entity within a specified period of time after the first entity's initial incurrence of those costs.

Regulation and Oversight

Recommendation B-1: The Legislature should provide Maine EMS with the funding, staffing and associated resources necessary to properly support its core functions and responsibilities: licensing and regulation of EMS entities; provision of resources and other support to licensed EMS entities; and systemic planning, oversight and stewardship of the statewide EMS system.

Recommendation B-2: The Legislature should enact legislation to facilitate the timely appointment of members to fill vacant seats and reappointment of members in expired seats on the EMS Board, including by shifting the appointing authority for some board members to the President of the Senate and the Speaker of the House of Representatives.

Recommendation B-3: The Legislature should support the proposed reorganization of the EMS Board, which would establish a 9-member EMS Board charged with the strategic direction and oversight of the EMS system as well as a 9-member EMS Licensing Board, charged with the regulation of EMS licensing.

Recommendation B-4: The Legislature should charge the reorganized EMS Board with taking all actions necessary to ensure that individuals in all areas of the State have access to transporting ambulance services, with particular focus given to those areas identified as unserved or underserved by EMS.

Recommendation B-5: The Legislature should enact legislation requiring Maine EMS to report when the EMS Board has failed to commence an initial rulemaking required by law within 90 days of the relevant effective date and to stipulate, for new programs or initiatives, that any required rulemaking be commenced within 90 days of the relevant effective date.

System Resilience and Sustainability

Recommendation C-1: The Legislature should enact legislation requiring each municipality in the State to adopt a plan for the delivery of transporting EMS within the municipality.

Recommendation C-2: The Legislature should enact legislation establishing a permanent EMS commission, to be charged with monitoring and evaluating the statewide EMS system on a continuing basis and providing recommendations to Maine EMS and the Legislature regarding necessary changes to that system.

Recommendation C-3: The Legislature should enact legislation directing Maine EMS to develop and implement a public informational campaign designed to increase public awareness of and appreciation for the essential services provided by EMS providers in Maine.

Recommendation C-4: Maine EMS should collaborate with Volunteer Maine to evaluate opportunities for funding or otherwise facilitating volunteer management and leadership training for volunteer EMS providers and to support recruitment of volunteer EMS providers in Maine.

Recommendation C-5: The Legislature should support community collaboration in the development and implementation of tiered-response systems utilizing paramedic intercept programs.

Recommendation C-6: The Legislature should enact legislation amending the Maine Emergency Medical Services Act to authorize an EMS provider to render EMS within a hospital or health care facility where the EMS provider is a contractor of the hospital or facility but not an employee.

Recommendation C-7: Using LD 1515 or other available legislative instruments, the Legislature should enact legislation necessary to better support and fund the EMS system and to better facilitate the efficient and sustainable delivery of EMS services in Maine.

I. INTRODUCTION

The Blue Ribbon Commission to Study Emergency Medical Services in the State, referred to in this report as "the commission," was established by Resolve 2023, chapter 99.[1] Pursuant to the resolve, the commission consisted of 17 members:

- Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;
- Two members who are employed or volunteer in the field of emergency medical services (EMS), including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents;
- One member who represents a statewide association of EMS providers;
- One member who represents a private, for-profit ambulance service;
- One member who represents a statewide association of municipalities;
- Four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature;
- One member who represents a tribal EMS;
- One member who represents a volunteer EMS;
- One member who represents a county government;
- One member who represents a statewide association of hospitals;
- The Commissioner of Health and Human Services or the commissioner's designee; and
- The Director of Maine Emergency Medical Services (Maine EMS) within the Department of Public Safety or the director's designee.[2]

A list of commission members may be found in Appendix B.

[1] A copy of Resolve 2023, c. 99 is included in Appendix A.

[2] As noted in the commission member list included in Appendix B, Maine EMS Director Sam Hurley served as a commission member for the purposes of the October 23rd commission meeting. After that meeting and before the November 6th meeting, Director Hurley designated Maine EMS Deputy Director Anthony Roberts as his designee to the commission and Deputy Director Roberts served as a commission member for the remainder of the commission's meetings.

The duties of the commission are set forth in Resolve 2023, chapter 99 and charged the commission to examine and make recommendations on the structure, support and delivery of EMS in the State and to maintain communication and coordinate with Maine EMS so that Maine EMS is informed of the work of the commission and the commission is informed of the strategic planning work of Maine EMS. The commission was authorized to look at all aspects of EMS, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

The commission was directed to submit a report, with findings and recommendations, including suggested legislation, to the Joint Standing Committee on Criminal Justice and Public Safety.

II. BACKGROUND INFORMATION

General background information regarding the EMS system in Maine can be found in the 2022 commission's final report, which is included in this report as Appendix C.[3]

A. 2022 Commission Process

The establishment of this commission was one of a number of legislatively-implemented recommendations of the 2022 Blue Ribbon Commission to Study Emergency Medical Services in the State. Although the 2022 commission made a number of substantive recommendations in its final report, most of which were considered by the Legislature in 2023 and many enacted into law, the members of that commission believed there were still outstanding issues to be addressed to ensure the short-term and long-term sustainability of EMS in Maine. To that end, a majority of the members of the 2022 commission recommended reestablishing the commission in 2023 to continue the important work it had begun.

Additional information regarding the process and recommendations of the 2022 commission can be found in the 2022 commission's final report, which is included as Appendix C.

B. 2023 Legislative Actions

The 2022 commission in its final report made a number of specific recommendations, all of which resulted in legislation introduced during the 2023 sessions of the 131st Legislature. In addition, many other proposals concerning or relating to the EMS system and EMS entities were considered by the Legislature in 2023. A chart outlining each of these proposals and their respective dispositions, prepared by commission staff and reviewed by commission members at the October 23, 2023 commission meeting, is included as Appendix D.

[3] Note that the 2022 report included in Appendix C does not include that report's published appendices. The full 2022 report, which includes those appendices, is available at https://legislature.maine.gov/doc/9404.

III. COMMISSION PROCESS

In conducting its work, the commission held five meetings on the following dates: October 23rd, November 6th, November 13th, November 27th and December 11th. Meeting materials, including meeting agendas and other materials, can be found at: https://legislature.maine.gov/blue-ribbon-commission-to-study-emergency-medical-services-in-the-state.

A. First Meeting - October 23, 2023

The first meeting of the commission took place on October 23rd.[4] Members began by introducing themselves, their involvement or experience with EMS in Maine, the organization or interests they are representing on the commission and their goals for the commission's work this year. Following introductions, commission staff reviewed the commission's authorizing legislation and duties and the study commission process generally. Staff also reviewed the final report and recommendations of the 2022 Blue Ribbon Commission to Study Emergency Medical Services in the State and highlighted legislation proposed in 2023 that was related to that report or to EMS generally.

Commission member and Maine EMS Director Sam Hurley next provided an update on the process for disbursement of funding under the newly established Emergency Medical Services Stabilization and Sustainability Program, reviewed the strategic plan published by Maine EMS and adopted by the EMS Board earlier that year and highlighted the Maine EMS Connectivity and Roadway Safety Project. The commission next received a presentation from Bill Montejo, the commission member representing the Department of Health and Human Services, regarding that department's role generally in supporting the EMS system in Maine and in the administration of the new Emergency Medical Services Stabilization and Sustainability Program. The meeting concluded with commission member discussion regarding desired outcomes for the commission's work this year and identification of additional information the commission should receive or review at future meetings.

B. Second Meeting - November 6, 2023

The second meeting of the commission took place on November 6th.[5] The meeting began with commission staff providing an analysis and discussion of how different states address what it means for EMS to be an "essential service" and how those other states structure and fund their EMS systems.[6] The commission next received a presentation from commission member and Maine EMS Deputy Director Anthony Roberts regarding the structure of the EMS system in

[4] Materials distributed at the October 23, 2023 commission meeting are available at https://legislature.maine.gov/doc/10402 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#127?event=89632&startDate=2023-10-23T13:00:00-04:00.

[5] Materials distributed at the November 6, 2023 commission meeting are available at https://legislature.maine.gov/doc/10413 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#127?event=89633&startDate=2023-11-06T09:00:00-05:00.

[6] A copy of a chart outlining the differing approaches taken to funding EMS by states that designate EMS as an essential service, prepared by commission staff and reviewed by commission members at the November 6th meeting, is included in Appendix E.

Maine and details regarding implementation of the Maine EMS strategic plan. Deputy Director Roberts also provided various data and information regarding EMS response, patient care and other information requested by commission members at the prior meeting. Commission member Joe Kellner next provided a presentation discussing the costs associated with providing EMS services, updating a similar presentation given to the 2022 commission.[7]

The commission also received a presentation on November 6th from Michael Colleran, Chief Operating Officer and General Counsel of the Maine Public Employees Retirement System (MainePERS), regarding the legal issues with allowing EMS providers to participate in government employee retirement plans, as has been proposed in LD 882, "An Act to Allow Nonmunicipal Emergency Medical Services Providers to Be Considered State Employees for Purposes of Certain Benefits," introduced in and voted "ought not to pass" by the 131st Legislature in 2023.[8] Finally, the commission on November 6th received two presentations on different regional EMS models, one from commission member Kevin Howell regarding a public-private partnership model and the other from commission member Mike Senecal regarding a hospital-operated ambulance service model.[9]

As described by commission member Kevin Howell, the Town of Carmel in 2018 entered into an agreement with Northern Light Health to address identified region-wide EMS issues, including insufficient call volumes, staff recruitment and retention, funding shortfalls, long response times and contractual limitations on response areas. Under that agreement, Northern Light provides some EMT staffing to the Carmel during normal business hours and EMS training to Carmel's EMS staff. Carmel provides all other needs for the operation of its ambulance service and provides an additional EMS response in the Towns of Dixmont and Newburgh, with secondary support provided by Northern Light. Carmel receives all revenues from its Carmel area responses and a split percentage of revenues for all other responses.

This agreement, which included the implementation of a common dispatch protocol, has facilitated improved response times in the covered multi-municipal region by dispatching the closest available resource and has resulted in better resourcing and a manageable financial balance for Carmel. Commission member Howell closed by reiterating that, while identification and empowering of rural hubs for EMS, as in his region, can dramatically improve the efficiency and sustainability of the local EMS system, it is important that each community contribute a fair share of the costs of EMS delivery and that each community control its own destiny when it comes to decisions about the local provision of EMS.

Commission member Mike Senecal next described the regional ambulance service model implemented in greater Franklin County as NorthStar EMS. Starting in 1995, Franklin Memorial Hospital began acquiring and operating a number of small local ambulance services, which were merged in 2003 and ultimately became NorthStar EMS, managed as a single department of the hospital, which is itself part of the MaineHealth system. EMS responses by NorthStar are

[7] A copy of commission member Joe Kellner's presentation is included in Appendix F.

[8] More information on LD 882 can be found at https://legislature.maine.gov/billtracker/#Paper/882?legislature=131.

[9] Copies of commission member Kevin Howell's and commission member Mike Senecal's presentations are included in Appendix F.

dispatched from the Franklin County Regional Communication Center, with a goal of providing a paramedic level of staffing on all ambulances by strategically positioning and coordinating ambulance placement. NorthStar has also implemented a community paramedicine program in its service area and has a backcountry medical response team that responds to calls in off-road or hard-to-access areas. In fiscal year 2023, NorthStar ambulances made more than 7,400 runs. It is currently contracted with 29 towns to provide emergency coverage, each of which contribute a municipal subsidy based on demographic data to help offset the service's operating costs. For fiscal year 2023, that combined municipal subsidy totaled $690,000 and the service operated with a net loss of $703,356.

In response to these presentations, commission member Robert Chase noted that Med-Care Ambulance, which provides ambulance services to 11 communities in northern Oxford County, is operating using a similar model to that of NorthStar, albeit pursuant to an interlocal agreement. Commission members concluded the November 6th meeting with additional discussion regarding the benefits and barriers to implementation of regional models, the importance of community self-determination in consideration of regionalization efforts and the needs of those communities for State-level support and resources as they engage in such efforts.

C. Third Meeting - November 13, 2023

The third meeting of the commission took place on November 13th.[10] It began with an opportunity for public comment, during which the commission heard from Donald Sheets of Southern Maine Community College's EMS department, Ben Harris of Goodwin's Mills Fire-Rescue, Jay Bradshaw of Sidney and Jesse Thompson of Union Fire Rescue. Those testifying each highlighted the obstacles they believe are impeding Maine's EMS growth and sustainability, including a lack of educators to teach EMT courses, low student demands for such courses and concerns about the efficacy and structure of the EMS Board.

Following public comment, the commission received a presentation on tribal EMS systems in Maine from commission member Mike Hildreth. The remainder of the third meeting was spent with commission members narrowing the focus of discussion to identify potential recommendations for inclusion in the final report. Three broad categories of identified recommendations were: (1) EMS funding; (2) responsibility for the delivery of EMS and regionalization; and (3) the structure of Maine EMS and the EMS Board. Having established these broader categories, commission members engaged in an in-depth discussion to develop recommendations designed to address responsibility for the delivery of EMS and regionalization. Before adjourning, commission chairs requested that commission members submit potential recommendations to staff prior to the next meeting for compilation, distribution and consideration at the fourth commission meeting.

[10] Materials distributed at the November 13, 2023 commission meeting are available at https://legislature.maine.gov/doc/10420 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#228?event=89737&startDate=2023-11-13T13:00:00-05:00.

D. Fourth Meeting - November 27, 2023

The fourth meeting of the commission was held on November 27th.[11] Although the meeting focused primarily on discussion and development of recommendations for inclusion in the final report, the commission did receive a brief presentation from Alexa Altman of the consulting firm Sellers Dorsey, on behalf of the Maine Ambulance Association, regarding the potential implementation of an intergovernmental transfer program and an ambulance assessment program. The remainder of the meeting was spent with commission members reviewing, discussing and initially voting on the potential recommendations members had identified and submitted to commission staff following the third meeting. At the conclusion of the fourth meeting, commission staff were directed to prepare a draft report that included the recommendations receiving a majority of initial votes from commission members during the meeting, to be reviewed and receive final votes from members during the fifth and final meeting.

E. Fifth Meeting - December 11, 2023

The fifth and final meeting of the commission was held on December 11th.[12] The meeting began with a briefing by Department of Public Safety Commissioner Michael Sauschuck regarding the implementation of the recently established Emergency Medical Services Stabilization and Sustainability Program.[13] As commission members learned, the EMS Board had very recently approved the emergency adoption of a rule implementing the stabilization funding component and that it was anticipated applications for that funding would be available imminently. The Commissioner also advised members that the development of rules to implement the sustainability grant funding component were on track to be adopted and in place by the summer of 2024. Some commission members expressed frustration with the complexity of the stabilization rule, skepticism regarding the ability of Maine EMS to adequately assist EMS entities with completing the application process and concern over the anticipated delay in the availability of sustainability grants.

The remainder of the fifth meeting was spent by commission members in reviewing the draft report prepared by commission staff and conducting substantive voting on the recommendations to be included in the commission's final published report. Commission staff reviewed with members the process for finalizing the report and commission members discussed the various legislative instruments and processes that might be utilized during the 2024 session of the Legislature to consider and implement the commission's recommendations.

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[11] Materials distributed at the November 27, 2023 commission meeting are available at https://legislature.maine.gov/doc/10492 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#228?event=89778&startDate=2023-11-27T09:00:00-05:00.

[12] Materials distributed at the December 11, 2023 commission meeting are available at https://legislature.maine.gov/doc/10495 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#228?event=89843&startDate=2023-12-11T13:00:00-05:00.

[13] More information regarding the Emergency Medical Services Stabilization and Sustainability Program is included as part of Recommendation A-1.

IV. RECOMMENDATIONS

A. Costs and Funding

In its final report, the 2022 commission recognized that "[t]he primary issue facing EMS is a lack of funding." That commission subsequently endorsed the following finding: "Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to supporting transporting EMS services in the State."[14] As described later in this report, although the Legislature in 2023 took a number of critical steps towards closing that identified funding gap, a continued lack of adequate funding for EMS entities remains a primary and significant issue for the EMS system in Maine.

Indeed, many of this commission's discussions involved consideration of measures designed to better fund and support the operations of EMS entities and to encourage greater efficiency and sustainability within the EMS system now and into the future. The commission also spent time reviewing existing funding mechanisms and programs and identifying barriers to EMS entities maximizing the use of those resources. Recognizing the Legislature's recent provision of additional and significant funding mechanisms to support the EMS system, commission members suggest that, in evaluating recommendations in this report, the Legislature identify and consider a range of funding options as necessary, including the use of existing funding and resources, available federal funding and other available public and private resources. With these considerations in mind, commission members make the following recommendations relating to the funding of the EMS system in Maine.

Recommendation A-1: The Legislature should enact emergency legislation in 2024 eliminating from the Emergency Medical Services Stabilization and Sustainability Program the requirement that the EMS Board adopt rules establishing sustainability grant program requirements and should instead directly stipulate those requirements in law.[15]

The Legislature in 2023 enacted Public Law 2023, chapter 412 (the "biennial budget"), which in Part GGGGG established the Emergency Medical Services Stabilization and Sustainability Program.[16] That program has two primary components. First, the program provides stabilization funding – financial assistance to EMS entities at immediate risk of failing and leaving their

[14] *See* 2022 report, Part IV(A), included in Appendix C.

[15] Fourteen commission members voted in support of Recommendation A-1 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[16] More information on the biennial budget bill, LD 258, can be found at https://legislature.maine.gov/billtracker/#Paper/258?legislature=131. The biennial budget was enacted as general legislation with an effective date of October 25, 2023. See also, LD 526, which provided a minor amendment to this program as enacted in the biennial budget, https://legislature.maine.gov/billtracker/#Paper/526?legislature=131.

communities without access to adequate EMS.[17] Second, the program provides sustainability grants – grants to EMS entities to increase support and develop plans for sustainability, collaboration and enhancement of efficiency in the delivery of EMS in the State.[18]

The Legislature, also as part of the biennial budget (Part A, section A-29), capitalized this program using a one-time General Fund transfer of $31 million, broken down between the two above-described program components as follows:

- *Stabilization funding* (financial assistance available under 32 MRSA §98(3))
    - For ambulance services - $10,000,000 in FY 23-24
    - For nontransporting EMS - $2,000,000 in FY 23-24
- *Sustainability grants* (grant funding available under 32 MRSA §98(4))
    - For ambulance services - $14,140,161 in FY 23-24
    - For nontransporting EMS - $3,000,000 in FY 23-24
    - For EMS training centers - $1,000,000 in FY 23-24

The remaining $859,839 of the $31 million transfer was dedicated to establish 4 limited-period positions in FY 23-24 and FY 24-25 at Maine EMS, funded through June 7, 2025, to administer the Emergency Medical Services Stabilization and Sustainability Program.

Under the Emergency Medical Services Stabilization and Sustainability Program, the disbursement of the $12 million of stabilization funding does not explicitly require the adoption of implementing rules. The commission understands, however, that Maine EMS, after consultation with the Office of the Attorney General, has opted for the EMS Board to adopt rules, on an emergency basis, for implementation of this program component.

The law does explicitly require the EMS Board to adopt rules to establish the requirements for the issuance of sustainability grants under the program. Commission members were advised by representatives of Maine EMS that the rulemaking necessary to implement the sustainability grant program component could take up to one year to complete or potentially longer. During the December 11th meeting, however, commission members learned from the Commissioner of Public Safety that the EMS Board is hoping to adopt that rule by the summer of 2024.

As discussed by commission members at multiple meetings, the rulemaking requirement for sustainability grants presents a potentially significant barrier to the efficient and timely establishment of this program and the associated distribution of the almost $19 million in available grant funding. Given this concern and, as representatives of Maine EMS suggested to commission members that rulemaking may not actually be necessary for the implementation of this grant program, commission members recommend the Legislature enact emergency legislation in 2024 to remove the rulemaking requirement for the sustainability grant program

[17] *See* 32 MRSA §98(3).

[18] *See* 32 MRSA §98(4).

and to instead, as necessary and appropriate, stipulate directly in statute the requirements for issuance of those grants.

Recommendation A-2: The Legislature and Maine EMS should take all actions necessary to ensure the timely and efficient implementation of the Emergency Medical Services Stabilization and Sustainability Program and the distribution of the funding and grants associated with that program.[19]

As previously described, the Legislature in 2023 established the Emergency Medical Services Stabilization and Sustainability Program and capitalized that program with a one-time General Fund transfer of $31 million. Of that funding, $12 million was dedicated to the provision of stabilization funding, which is financial assistance available to EMS entities at immediate risk of failing and leaving their communities without access to adequate EMS, while almost $19 million was dedicated to the provision of the previously described sustainability grants.

During multiple commission meetings, members requested information from Maine EMS regarding the specific timeline for distribution of this stabilization funding. As previously noted, during the December 11th meeting, the Commissioner of Public Safety advised members that the applications for this funding would become available to EMS entities imminently although it remains unclear to members when that funding might actually be distributed to approved applicants. At multiple meetings, many commission members also expressed frustration that such critical funding has not yet been made available to EMS entities, many of which continue to experience significant financial difficulties. Further, as previously noted, the statutory requirement that the EMS Board adopt rules to implement the sustainability grant component of this program has the potential to significantly delay the availability of the almost $19 million in funding dedicated for that separate purpose.

Although commission members expressed strong support and appreciation for the Legislature's establishment of this program and provision of the associated $31 million in funding, many members remain deeply concerned about the speed and efficiency by which that funding will actually be made available to EMS entities. Accordingly, commission members recommend that the Legislature and Maine EMS take all actions necessary to ensure the timely and efficient implementation of the Emergency Medical Services Stabilization and Sustainability Program and the distribution of the $31 million in funding and grants associated with that program, including, but not limited to, the specific measures identified elsewhere in this report.

The commission understands that, pursuant to Public Law 2023, chapter 412 (the biennial budget), Part GGGGG-3, the EMS Board is required to submit a report regarding the Emergency Medical Services Stabilization and Sustainability Program to the Joint Standing Committee on Criminal Justice and Public Safety no later than January 12, 2024. This report must include information on the actual and planned expenditures and encumbrances

[19] Fifteen commission members voted in support of Recommendation A-2 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

and applications submitted and accepted under the program and will provide the Legislature an opportunity to consider the need for additional actions to ensure the program's timely and efficient implementation.

Recommendation A-3: The Legislature should enact legislation providing ongoing funding to the Maine Emergency Medical Services Community Grant Program and the Legislature and Maine EMS should take all actions necessary to ensure the timely and efficient implementation of that program and the distribution of associated grants.[20]

The Legislature in 2022 enacted Public Law 2021, chapter 700, which established the Maine Emergency Medical Services Community Grant Program and provided a one-time $200,000 General Fund appropriation to capitalize that program.[21] The stated purpose of this program is to provide financial assistance to communities that plan to examine or are examining the provision of EMS through a process of informed community self-determination and are considering a new, financially stable structure for delivering EMS that provides high-quality services effectively and efficiently.[22] To implement the program, the EMS Board is required by law to adopt routine technical rules establishing the grant application process, which commission members understand was attempted in 2023 and failed final adoption. Commission members learned that Maine EMS intends to reinitiate the formal rulemaking process for these rules in early January 2024, however, the time frame for the distribution of this program funding to EMS entities remains unclear.

At multiple meetings, many commission members expressed their frustration that such this critical program and its associated funding have not yet been made available to EMS entities despite its enactment by the Legislature more than a year ago and voiced their concern regarding the capacity of Maine EMS and the EMS Board to timely and efficiently implement this and other important programs and initiatives. Commission members believe this grant program in particular represents a critically-important mechanism towards supporting community-driven measures that will increase the efficiency and sustainability of Maine's EMS system. For that reason, commission members recommend that the Legislature enact legislation to provide ongoing funding to this program at an appropriate level, considering all available funding options. Further, commission members recommend the Legislature and Maine EMS take all necessary steps to ensure the timely and efficient implementation of the program and the distribution of associated grants.

[20] Fourteen commission members voted in support of Recommendation A-3 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[21] *See* 32 MRSA §97; P.L. 2022, ch. 700 (LD 1859) (available at https://legislature.maine.gov/billtracker/#Paper/1859?legislature=130).

[22] 32 MRSA §97(2).

Recommendation A-4: The Legislature should enact legislation, as proposed in LD 1751, increasing reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine.[23]

LD 1751, "An Act to Maximize Federal Funding in Support of Emergency Medical Services," was introduced to the Legislature in 2023 and referred to the Joint Standing Committee on Health and Human Services (HHS).[24] Among other things, the bill as printed proposes increases to reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine. The HHS Committee ultimately decided to carry the bill over to the 2024 legislative session.

Although the commission understands that some of the proposals included in LD 1751 have been or are being considered as part of other legislative proposals, commission members generally express support for enactment of proposals represented in LD 1751 that are designed to maximize federal funding by increasing reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine.

Recommendation A-5: The Legislature should enact legislation, as proposed in LD 1751, implementing an ambulance assessment program, which would establish an ambulance service assessment fee on non-municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program.[25]

LD 1751, as previously described, also proposes implementing an ambulance assessment program, which would establish an ambulance service assessment fee on non-municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program. The commission was briefed at its November 27, 2023 meeting by Alexa Altman, a representative of the consulting firm Sellers Dorsey, on behalf of the Maine Ambulance Association, regarding the potential benefits to be achieved through the implementation of such a program.

The commission understands that this program would benefit non-municipal ambulance services by requiring the State to collect an assessment from those services and using that money as the State's share for federal Medicaid matching funds, thus increasing Medicaid rates by making supplemental payments to those services. Commission members generally express support for the enactment of such a program, which, like the previous recommendation, will also serve to maximize federal funding for many EMS entities in the State.

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[23] Fourteen commission members voted in support of Recommendation A-4 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[24] More information on LD 1751 is available at https://legislature.maine.gov/billtracker/#Paper/1751?legislature=131.

[25] Fourteen commission members voted in support of Recommendation A-5 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

Recommendation A-6: The Legislature should enact legislation, whether as an amendment to LD 1751 or otherwise, to implement an intergovernmental transfer program, which would authorize municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program through provider payment of the non-federal cost share.[26]

As previously noted, the commission was briefed at its November 27, 2023 meeting by Alexa Altman, a representative of the consulting firm Sellers Dorsey, on behalf of the Maine Ambulance Association, who described the scope of and potential benefits to be derived through the implementation of an intergovernmental transfer (IGT) program in Maine. The commission understands that an IGT program would authorize municipal ambulance services to use public funds to pay the non-federal cost share portion for federal Medicaid matching funds, thus increasing Medicaid rates by making supplemental payments to those services, similar to the ambulance assessment program described in the prior recommendation. An IGT program would be set up as a voluntary, opt-in program, allowing but not requiring municipal ambulance services to participate. Commission members understand that the reimbursement amounts paid under such a program to each participating service would be dependent on, among other things, the level of payment the service is able to dedicate as the non-federal cost share portion.

Commission members recommend that LD 1751, as previously described, be amended to include language directing the Department of Health and Human Services to include an IGT program in its Medicaid State plan and to provide support, resources and education to municipal ambulance services so that they may effectively use the program.

Recommendation A-7: The Legislature should enact legislation, whether as an amendment to LD 1832 or otherwise, requiring health insurance carriers to provide coverage and reimbursement for community paramedicine services in state-regulated health plans.[27]

LD 1832, "An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services," was introduced in 2023 and referred to the Joint Standing Committee on Health Coverage, Insurance and Financial Services (HCIFS).[28] The bill as printed requires an ambulance service to be reimbursed for the cost of treating a person, regardless of whether the ambulance service transports the person to a hospital. The HCIFS Committee ultimately decided to carry the bill over to the 2024 session.

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[26] Fourteen commission members voted in support of Recommendation A-6 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[27] Fourteen commission members voted in support of Recommendation A-7 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[28] More information on LD 1832 is available at https://legislature.maine.gov/billtracker/#Paper/1832?legislature=131.

Commission members learned that the HCIFS Committee carried over LD 1832 specifically as a vehicle for consideration of a narrower proposal to require health insurance carriers to provide coverage and reimbursement for community paramedicine services in state-regulated health plans. This proposal would not apply to MaineCare, Medicare or self-insured group health plans. To that end, the HCIFS Committee requested that the Bureau of Insurance prepare a review and evaluation of LD 1832 based on a proposed committee amendment addressing coverage and reimbursement for community paramedicine services. The review and evaluation is due to the HCIFS Committee no later than January 15, 2024.

As a corollary proposal to the MaineCare-specific reimbursement rate proposal presented in LD 1751, commission members express support for requiring health insurance carriers to provide coverage and reimbursement for community paramedicine services in state-regulated health plans as presented in a proposed HCIFS Committee amendment to LD 1832.

Recommendation A-8: Maine EMS should conduct a funding needs analysis of communities seeking to engage in regional collaborative efforts or in the adoption of a regional model for the delivery of EMS.[29]

At multiple commission meetings, members discussed the potential benefits of and barriers to community and regional collaborative efforts for the delivery of EMS. The commission received presentations, as previously described, regarding two different regional models implemented in Maine that have enhanced the efficiency and reduced the costs of providing EMS for the participating communities. One of the primary barriers to regionalization efforts identified by commission members is cost – the initial capital, start-up and operating costs of implementing a regional model are often a significant enough barrier to dissuade communities from exploring collaborative options that might ultimately reduce their EMS costs.

Commission members recognize there have recently been a number of funding sources made available to communities for these purposes, namely the grant funding available under the Maine Emergency Medical Services Community Grant Program and under the Emergency Medical Services Stabilization and Sustainability Program, both of which were described in greater detail earlier in this report. Given the diverse funding and structural needs of municipalities and regions throughout the State and the disparity in EMS available from area to area, it is unclear whether communities seeking to collaborate in the development of a regional model for EMS will have access to the level funding and support necessary for successful implementation of those models.

To that end, commission members recommend that Maine EMS conduct a funding needs analysis of communities seeking to engage in regional collaboration or the adoption of a regional model in the delivery of EMS and report the results of that analysis and any accompanying recommendations to the Legislature. Commission members believe this analysis will be critical in determining the unfilled community resource needs that must be addressed to effectively

[29] Fifteen commission members voted in support of Recommendation A-8 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

support regional collaborative efforts by communities in the delivery of EMS and further recommend the report from Maine EMS should indicate whether such an analysis should be conducted on an ongoing basis. Although the commission believes Maine EMS currently has the expertise and resources to conduct this analysis, commission members suggest that Maine EMS communicate with the Legislature regarding any funding concerns it may have in implementing this recommendation.

Recommendation A-9: The Legislature should enact legislation, as proposed in LD 1409, to address situations where an EMS entity can be reimbursed its costs for training and credentialing an EMS provider if the provider is hired by another EMS entity within a specified period of time after the first entity's initial incurrence of those costs.[30]

LD 1409, "An Act to Require Reimbursement When a Municipality Hires First Responders Whose Training Costs Were Incurred by Another Municipality," was introduced in 2023 and referred to the Joint Standing Committee on State and Local Government (SLG).[31] The bill as printed, establishes a formula to reimburse municipalities for training costs for training full-time first responders if the first responder is hired by another municipality within 5 years of the first municipality's initial incurrence of training costs. The SLG Committee ultimately decided to carry the bill over to the 2024 session.

Commission members recognize that problems with recruiting, training and retaining EMS providers are significantly impacting the delivery of EMS for many EMS entities, causing delayed response times and contributing to provider stress and burnout. Compounding those issues for municipal EMS entities in particular are where an entity incurs costs in training and credentialing new and existing providers only to have those providers leave for other employment. According to the Maine Municipal Association in its public hearing testimony on LD 1409, although it is challenging to estimate these types of costs, the average cost to provide all first responder credentialing and on the job training to the point that the provider can work "moderately unsupervised" could be in the range of $15,000 to $20,000, much of which represents the salary paid to the provider during the period of on the job training.[32]

As printed, LD 1409 proposes to implement a reimbursement mechanism to address that situation in a similar manner to the law enforcement and corrections officer training cost sharing mechanisms currently provided for in law.[33] But as acknowledged by the bill's sponsor in public hearing testimony, while the genesis of the bill was simply "to reimburse a municipality, who has paid for training in expectation that an employee will continue to work for that municipality,

[30] Fourteen commission members voted in support of Recommendation A-9 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member voted in opposition (Dow), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

[31] More information on LD 1409 is available at https://legislature.maine.gov/billtracker/#Paper/1409?legislature=131.

[32] *See* https://legislature.maine.gov/backend/app/services/getDocument.aspx?doctype=test&documentId=173002.

[33] *See* 25 MRSA §§2808, 2808-A.

if that employee moves on," the bill as proposed "isn't a perfect framework for what is a common-sense policy idea."[34]

Recognizing, therefore, that this proposal will likely be subject to further legislative discussion during the 2024 session, commission members express general support for implementation of the policy goals raised by LD 1409. Commission members recommend that the SLG Committee consider broadening the scope of the proposal to include all EMS providers and not just first responders. Further, commission members suggest the SLG Committee consider methods of ensuring equity in the implementation of any such proposal between municipal and non-municipal EMS entities so that all EMS entities are able to take advantage of any reimbursement formula and have a responsibility for reimbursement when their hiring of an EMS provider impacts another EMS entity that has incurred costs in training and credentialing that provider.

B. Regulation and Oversight

The EMS system in Maine is overseen by Maine EMS, a bureau within the Maine Department of Public Safety, in coordination with the EMS Board, an 18-member entity established pursuant to the Maine Emergency Medical Services Act of 1982. The EMS system is divided into 6 EMS regions, each with its own regional council, office and medical director. At present, Maine EMS contracts with each regional office, which are established as independent, not-for-profit 501(c)(3) corporations, to assist in oversight of training, quality assurance, medical directions and systems operation within its respective region. Based on the biennial budget enacted by the Legislature in 2023, Maine EMS is expected to have an operating budget of approximately $2.3 million in fiscal years 2023-24 and 2024-25, with the bulk of those funds originating from the State's General Fund.

Given the ongoing and anticipated changes to Maine EMS and the EMS Board, which are described in further detail below, commission members recognize that both entities may require increased funding, staffing and associated resources in future biennia to ensure the proper oversight and support of the EMS system. While Maine EMS and the EMS Board play a critical role in licensing and regulating EMS entities in the State, they must also be able to provide the resources and other support that those licensed entities need to sustainably operate. Furthermore, these two entities must ensure the systemic planning, oversight and stewardship of the EMS system, now and into the future. To support a robust and sustainable governance structure for EMS in Maine, commission members make the following recommendations relating to the regulation and oversight of EMS.

[34] See https://legislature.maine.gov/backend/app/services/getDocument.aspx?doctype=test&documentId=173001.

Recommendation B-1: The Legislature should provide Maine EMS with the funding, staffing and associated resources necessary to properly support its core functions and responsibilities: licensing and regulation of EMS entities; provision of resources and other support to licensed EMS entities; and systemic planning, oversight and stewardship of the statewide EMS system.[35]

Maine EMS is currently in the process of implementing a long-term strategic plan, which will involve substantial changes to the structure of the agency and the EMS Board, as well as to the general governance structure of the EMS system. The implementation of these changes is expected to require, among other things, the provision of additional funding and resources, including increased staffing support. The commission believes this restructuring provides an important opportunity to examine, reinforce and support the core functions and responsibilities of the agency.

Commission members suggest that these core governance functions and responsibilities of Maine EMS and the EMS Board fall within three primary areas: (1) oversight of the licensing and regulation of EMS entities; (2) the provision of resources and other support to licensed EMS entities; and (3) the systemic planning, oversight and stewardship of the statewide EMS system. Supporting each of these core functions is critical to the future of the EMS system and commission members recognize that Maine EMS must be provided with the funding, staffing and associated resources necessary to successfully implement its strategic plan. The commission accordingly supports the Legislature in its consideration of any future funding and resource requests made by Maine EMS relating to the implementation of its strategic plan and recommends the Legislature consider all available funding options in properly resourcing Maine EMS and the EMS Board.

Recommendation B-2: The Legislature should enact legislation to facilitate the timely appointment of members to fill vacant seats and reappointment of members in expired seats on the EMS Board, including by shifting the appointing authority for some board members to the President of the Senate and the Speaker of the House of Representatives.[36]

The Maine Emergency Medical Services Act of 1982 establishes the composition of the EMS Board.[37] The EMS Board is comprised of 18 members, one for each of the 6 regions represented by regional councils, and the remaining 12 members are as follows: an emergency physician, a representative of emergency medical dispatch providers, a representative of the public, a representative of for-profit ambulance services, an emergency professional nurse, a representative of nontransporting EMS, a representative of hospitals, a fire chief, a representative

[35] Fourteen commission members voted in support of Recommendation B-1 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[36] Fourteen commission members voted in support of Recommendation B-2 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[37] *See* 32 MRSA §88.

of a statewide association of fire chiefs, a municipal EMS provider, a representative of not-for-profit ambulance services and a representative in the field of pediatrics. All 18 members are appointed by the Governor and serve 3-year terms.

As commission members learned, at present 6 of the 18 board seats are currently vacant (the seats representing South Maine Region/Region 1; Northeast Region/Region 4; nontransporting EMS representative; for-profit ambulance services representative; emergency professional nurse member; and pediatrics representative).[38] Moreover, the appointment terms for the 12 non-vacant seats are all expired as of July 2023, with at least one term having expired as early as December 2020. Many commission members expressed frustration with these vacancies and lack of reappointments as necessary to support the activities of an entity that is so critically involved with the regulation and oversight of the EMS system. Commission members recognize that, as part of the implementation of the Maine EMS strategic plan, described later this report, the EMS Board is expected to be reconfigured and its membership reduced to create a separate licensing board. While the time frame for those changes is unclear, commission members are concerned that the present iteration of the EMS Board, with its 6 vacancies and 12 expired appointments, may be frustrating its ability to effectively regulate the EMS system.

To this end, commission members recommend the Legislature enact legislation to facilitate the timely appointment of members to fill vacant seats and reappointment of members in expired seats on the EMS Board. One mechanism for achieving this goal, which the commission supports, is to shift the appointing authority for some board seats from the Governor to the President of the Senate and to the Speaker of the House of Representatives. Commission members believe this to be a reasonable and appropriate mechanism by which the Legislature can facilitate the timely achievement of a fully appointed board. The commission anticipates a robust legislative discussion in 2024 regarding the EMS Board and its current composition as the Legislature considers a new bill, LD 2071, "Resolve, to Fill all Vacant and Expired Seats on the Emergency Medical Services Board."[39]

Recommendation B-3: The Legislature should support the proposed reorganization of the EMS Board, which would establish a 9-member EMS Board charged with the strategic direction and oversight of the EMS system as well as a 9-member EMS Licensing Board, charged with the regulation of EMS licensing.[40]

Commission members understand that, as part of the implementation of the Maine EMS strategic plan, the EMS Board is expected to undergo a significant reorganization, which the current board has endorsed.[41] That proposal would reduce the size of the current EMS Board from 18 to 9

[38] *See* https://www.maine.gov/ems/boards-committees/ems-board.

[39] More information on LD 2071 is available at https://legislature.maine.gov/billtracker/#Paper/2071?legislature=131.

[40] Fourteen commission members voted in support of Recommendation B-3 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[41] A copy of this proposal is included in Appendix G.

members and charge that smaller board with ensuring the strategic direction and oversight of the EMS system. That board's responsibilities would include: (1) continued implementation of the strategic plan; (2) coordinating rulemaking activities not related to personnel licensing; (3) hearing and deciding service-licensing waiver requests and appeals of disciplinary actions; and (4) approving and confirming the Maine EMS director position.

At the same time, the proposal would establish a new 9-member EMS Licensing Board and charge that board with ensuring the regulation of licensed EMS persons. That board's responsibilities would include: (1) coordinating rulemaking activities relating to personnel licensing; (2) considering disciplinary action for licensed personnel, including entering of consent agreements; (3) granting, suspending or revoking a personnel license; (4) investigating complaints or allegations of violations; (5) conducting disciplinary and administrative hearings; and (6) evaluating licensing waiver requests.

Commission members recommend that the Legislature support this proposed reorganization of the EMS Board, understanding that many of the critical details, such as the diversity of representation on these two boards, will undergo further development with public discussion, input and legislative consideration prior to implementation.

Recommendation B-4: The Legislature should charge the reorganized EMS Board with taking all actions necessary to ensure that individuals in all areas of the State have access to transporting ambulance services, with particular focus given to those areas identified as unserved or underserved by EMS.[42]

Commission members repeatedly discussed that in many areas of the State, residents lack access to a timely or sufficient EMS response, which often leads to significant negative health outcomes. EMS entities, particularly in rural areas, are often stretched very thin and have limited resources and staffing; this contributes to increased response times, provider stress and burnout. As discussed later in this report, commission members believe that the minimum standard for EMS delivery to be achieved for all residents of Maine is access to transporting EMS.

Achieving this goal in the areas of the State that are underserved or unserved by EMS – the so-called "ambulance deserts" – may prove challenging. But the recent implementation by the Legislature of a number of different programs and initiatives along with many of the recommendations in this report will undoubtedly help to better identify the "ambulance deserts" in Maine and the needs of underserved and unserved communities as well as to provide much-needed funding to support a more efficient and sustainable EMS system statewide.

Recognizing, therefore, that the previously described reorganization of the EMS Board will provide additional opportunity to consider its core purposes and functions, commission members recommend the Legislature charge the reorganized EMS Board with taking all actions necessary

[42] Fifteen commission members voted in support of Recommendation B-4 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

to ensure that residents in all areas of the State have access to transporting ambulance services, with particular focus given to those areas identified as unserved or underserved by EMS.

Recommendation B-5: The Legislature should enact legislation requiring Maine EMS to report when the EMS Board has failed to commence an initial rulemaking required by law within 90 days of the relevant effective date and to stipulate, for new programs or initiatives, that any required rulemaking be commenced within 90 days of the relevant effective date.[43]

Under the Maine Emergency Medical Services Act of 1982, the EMS Board is charged with the adoption of rules necessary to carry out the purposes, requirements and goals of that law.[44] As members learned during the first commission meeting, a rulemaking by the EMS Board to adopt the framework necessary to implement the Maine Emergency Medical Services Community Grant Program recently failed final adoption due, at least in part, to an apparent failure to meet the applicable rulemaking time frames set forth in the Maine Administrative Procedure Act (MAPA). As a result, the EMS Board will need to formally re-initiate rulemaking to adopt implementing rules for a program the Legislature established and funded in 2022.

Described earlier in this report, the newly enacted Emergency Medical Services Stabilization and Sustainability Program also requires the adoption of implementing rules for sustainability grants under that program – a process Maine EMS estimates could take one year or more. Many commission members expressed frustration with the ability of Maine EMS and the EMS Board to efficiently and timely initiate the rulemakings necessary to implement critical funding programs like these. Commission members learned that, when accounting for the additional time necessary to develop a proposed rule, an EMS Board rulemaking often takes a year or more, much of which does not involve the formal rulemaking process governed by the MAPA.

Given these recent difficulties by Maine EMS and the EMS Board in timely developing and adopting rules for critical programs, as directed by the Legislature, commission members expressed support for enacting legislation requiring Maine EMS to report to the Legislature when the EMS Board has failed to commence an initial rulemaking required by law within 90 days of the effective date of that law. That report should specify the reasons for the delay in commencement of rulemaking and the Board's plans for completion of the rulemaking process. Commission members also recommend that, for any new statutory programs or initiatives to be implemented by Maine EMS and the EMS Board with required rulemaking, the Legislature stipulate that the rulemaking be commenced within 90 days of the effective date of the proposal.

[43] Fourteen commission members voted in support of Recommendation B-5 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[44] See 32 MRSA §84.

C. System Resilience and Sustainability

While many of the measures recommended and discussed by this commission focused on the immediate short-term needs of the EMS system, the commission's members recognized that ensuring the long-term resilience and sustainability of EMS in Maine is just as critical. As previously described, following the adoption this year of a strategic plan, Maine EMS and the EMS Board are now currently engaged in a long-term reorganization of the EMS governance structure. While those organizational changes are designed to support a more resilient and sustainable EMS system, commission members recognized that there are many issues facing the EMS system beyond just its funding and governance structure.

Indeed, the commission devoted a significant amount of time to discussions regarding such issues, including: (1) the essentiality of EMS; (2) the implications posed by unserved and underserved areas, the so-called "ambulance deserts"; (3) the decline in volunteerism, especially within the EMS field; (4) the efficiencies and benefits that can be realized through the adoption of community or regional collaborative efforts in the delivery of EMS; and (5) other barriers to, as well as opportunities for, improving the resilience and sustainability of the EMS system in Maine. While the commission's previously described recommendations are unquestionably critical to ensuring a bright future for EMS in Maine, the following recommendations targeted at improving the resilience and sustainability of the EMS system are no less important.

Recommendation C-1: The Legislature should enact legislation requiring each municipality in the State to adopt a plan for the delivery of transporting EMS within the municipality.[45]

The Legislature in 2022 enacted Public Law 2021, chapter 749.[46] In addition to establishing the 2022 commission, that law also amended the "statement of purpose" of the Maine Emergency Medical Services Act of 1982 to add the following language: "The Legislature finds that emergency medical services provided by an ambulance service are essential services."[47] Commission members discussed at multiple meetings what it means to designate ambulance services or EMS as "essential services" and reviewed the approaches to such essential service designation taken by other states and the funding mechanisms for EMS implemented in those states.[48]

Recognizing that no entity in the State currently has a legal responsibility to provide or ensure the provision of EMS within a particular municipality or community, commission members discussed what the scope of that responsibility might be and who might be the appropriate entity to charge with that responsibility. Ultimately, commission members agreed that EMS is

[45] Fourteen commission members voted in support of Recommendation C-1 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[46] *See* P.L. 2022, ch. 749 (LD 1988) (available at https://legislature.maine.gov/billtracker/#Paper/1988?legislature=130).

[47] 32 MRSA §81-A.

[48] See chart included in Appendix E.

typically addressed and funded first and foremost at the local level and that each community is best positioned to decide how and at what level EMS is provided within that community. Commission members considered the implications of mandating municipalities at a minimum provide or facilitate the provision of transporting EMS within a municipality and the barriers to achieving that goal, particularly in very rural areas of the State and in the unorganized and deorganized areas that lack the governance structure of organized municipalities.

Commission members generally agreed that almost all organized municipalities in the State have in place some type of plan for providing transporting EMS, even if they do not directly provide or fund that service. Accordingly, commission members recommend that the Legislature enact legislation requiring each municipality in the State to adopt a plan for the delivery of transporting EMS within the municipality. In addition to reinforcing the essentiality of EMS within each community, commission members believe such a requirement will help to better identify those areas of the State that are underserved or unserved by EMS – the so-called "ambulance deserts." Collection of the information generated through the enactment of this requirement will undoubtedly assist the Legislature and Maine EMS in better targeting available funding to those areas of critical need.

Recommendation C-2: The Legislature should enact legislation establishing a permanent EMS commission, to be charged with monitoring and evaluating the statewide EMS system on a continuing basis and providing recommendations to Maine EMS and the Legislature regarding necessary changes to that system.[49]

As previously described, the establishment of this commission was one of a number of implemented recommendations of the 2022 commission. While the work done by both commissions has been critical in addressing many of the significant needs of the EMS system in Maine and in highlighting the scope of the problems faced by many EMS entities, due to the nature of legislative study commissions, the two commissions' time and resources were necessarily limited. Indeed, during each iteration of the commission, significant issues identified by commission members remained unresolved, most often due to a lack of time necessary to address them properly. Recognizing that there exists a continued need for this level of discussion by a diverse group of stakeholders regarding the issues facing and the future of the EMS system in Maine, commission members recommend that the Legislature enact legislation establishing a permanent EMS commission.

Such a permanent commission should be set up in a manner similar to the Maine Fire Protection Services Commission[50] and generally be charged with monitoring and evaluating the statewide EMS system on a continuing basis and providing recommendations to Maine EMS and the Legislature regarding necessary changes to that system. That commission should also be directed to consider and facilitate the implementation of measures designed to better recognize

[49] Fourteen commission members voted in support of Recommendation C-2 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[50] *See* 5 MRSA §3371.

and support the essentiality of EMS on a statewide and a regional basis as well as within each individual community.

Commission members believe that this permanent commission should have as diverse a membership as possible and that the Legislature should consider including as members any or all of the following: State legislators, Maine EMS, the EMS Board, the Department of Health and Human Services, the Maine Chapter of the American College of Emergency Physicians, the Maine Hospital Association, the Maine Ambulance Association, licensed EMS entities from both rural and non-rural areas, licensed EMS providers, Maine Municipal Association, the Maine County Commissioners Association, the Maine Community College System, the Governor's Office, the insurance industry and members of the public.

Recommendation C-3: The Legislature should enact legislation directing Maine EMS to develop and implement a public informational campaign designed to increase public awareness of and appreciation for the essential services provided by EMS providers in Maine.[51]

Commission members noted in discussions that, while most individuals expect to receive timely assistance with a medical issue after placing a 911 call requesting EMS, much of the public do not adequately understand or appreciate how that assistance is delivered, how the EMS system is designed or funded or the essentiality of the services provided by EMS entities in Maine. The commission recognized that one method of increasing public awareness of and appreciation for EMS in Maine is the development and implementation of a properly funded public informational campaign.

Commission members accordingly recommend that the Legislature enact legislation directing Maine EMS to develop and implement such a campaign and identify any funding needs that may be necessary for its successful implementation. Alternatively, if the Legislature establishes a permanent EMS commission as previously recommended, it may consider instead charging that permanent commission, in consultation with Maine EMS, with the development and implementation of the informational campaign described in this recommendation, provided that the commission has access to the resources necessary to support those efforts.

[51] Fourteen commission members voted in support of Recommendation C-3 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

Recommendation C-4: Maine EMS should collaborate with Volunteer Maine to evaluate opportunities for funding or otherwise facilitating volunteer management and leadership training for volunteer EMS providers and to support recruitment of volunteer EMS providers in Maine.[52]

As recognized by commission members, volunteer EMS providers and volunteer EMS entities provide a critical means of accessing EMS in many different communities throughout the State, particularly in many rural and hard-to-access areas. The barriers to entry, however, into the volunteer EMS field are in some ways more significant than for paid EMS and the recruitment, retention and training of volunteer EMS providers, especially those in leadership or management positions, present additional, substantial challenges.

To better address these issues and needs, commission members recommend that Maine EMS collaborate with Volunteer Maine to evaluate opportunities for funding or otherwise facilitating volunteer management and leadership training for volunteer EMS providers and to support recruitment of volunteer EMS providers in Maine.

Volunteer Maine, established in statute as the Maine Commission for Community Service,[53] describes its mission as building capacity and sustainability in Maine's volunteer and service communities by funding programs, developing managers of volunteers, raising awareness of sector issues and promoting service as a strategy.[54] Commission members believe Volunteer Maine is uniquely positioned to help identify and acquire available funding and resources and to assist in the implementation of strategies for leadership and management training and recruitment of volunteer EMS providers in Maine.

Recommendation C-5: The Legislature should support community collaboration in the development and implementation of tiered-response systems utilizing paramedic intercept programs.[55]

As identified by commission members in discussion, one particular issue faced by EMS entities is the costs and challenges associated with staffing and maintaining a paramedic level EMS. Although there exists a very real demand across the EMS system for paramedical services, many EMS calls require a lower response level. Committee members discussed opportunities for community collaboration in addressing this issue, specifically the development of tiered-response systems utilizing paramedic intercept programs within a group of municipalities or

[52] Fifteen commission members voted in support of Recommendation C-4 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

[53] *See* Title 5, Chapter 373.

[54] *See* https://volunteermaine.gov/commission.

[55] Fourteen commission members voted in support of Recommendation C-5 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

region, whereby one or more paramedic providers are shared within that service area. These types of programs allow the EMS entities operating in a multi-community area or region to more efficiently and cost-effectively target the use of paramedic level EMS to those calls where paramedical services are actually required.

While these programs hold significant potential in increasing the efficiency and sustainability of one important facet of the EMS system in Maine, the initial capital, start-up and operational costs for implementation can potentially be prohibitive. Commission members recommend the Legislature support community collaboration in the development and implementation of tiered-response systems utilizing paramedic intercept programs and identify and consider options for funding such programs, including, but not limited to, funding under the Maine Emergency Medical Services Community Grant Program and the Emergency Medical Services Stabilization and Sustainability Program.

Recommendation C-6: The Legislature should enact legislation amending the Maine Emergency Medical Services Act to authorize an EMS provider to render EMS within a hospital or health care facility where the EMS provider is a contractor of the hospital or facility but not an employee.[56]

The Legislature in 2023 enacted Public Law 2023, chapter 132, which clarified a number of laws regarding the delegating authority of a physician or physician assistant to EMS personnel or others as a medical assistant.[57] That law, among other things, amended the Maine Emergency Medical Services Act of 1982[58] as follows:

> **7. Delegation.** This chapter may not be construed to prohibit a person licensed as an emergency medical services person from rendering medical services in a hospital or other health care facility setting if those services are:
>
> A. Rendered in the person's capacity as an employee of the hospital or health care facility;
>
> B. Authorized by the hospital or health care facility; and
>
> C. Delegated in accordance with section 2594-A or, section 2594-E, subsection 4, section 3270-A or section 3270-E, subsection 4.
>
> Unless otherwise provided by law, an emergency medical services person licensed under this chapter may not simultaneously act as a licensee under this

[56] Fourteen commission members voted in support of Recommendation C-6 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), one commission member voted in opposition (Montejo), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

[57] *See* P.L. 2023, ch. 132 (LD 1396) (available at https://legislature.maine.gov/billtracker/#Paper/1396?legislature=131).

[58] 32 MRSA §85(7).

chapter and an assistant performing medical services delegated by a physician in accordance with section 2594-A or section 3270-A or by a physician assistant in accordance with section 2594-E, subsection 4 or section 3270-E, subsection 4.

Commission members were notified during the commission process that an additional amendment to this section of law may be necessary to allow EMS providers who are contractors but not employees of a hospital or health care facility to render EMS within that hospital or facility. While acknowledging there might be potential concerns or unintended consequences of implementing such an amendment, which would undoubtedly be evaluated as part of the legislative process, commission members believe such a change could better support the retention of EMS providers by EMS entities and potentially in some cases benefit both the hospital and EMS system by better facilitating interfacility transfers.

Accordingly, commission members recommend the Legislature enact legislation amending 32 MRSA §85(7)(A) as follows to authorize an EMS provider to render EMS within a hospital or other health care facility setting where the EMS provider is a contractor of the hospital or facility but not an employee:

Sec. 1. 32 MRSA §85, sub-§7, ¶A is amended to read:

A. Rendered in the person's capacity as an employee or contractor of the hospital or health care facility;

Recommendation C-7: Using LD 1515 or other available legislative instruments, the Legislature should enact legislation necessary to better support and fund the EMS system and to better facilitate the efficient and sustainable delivery of EMS services in Maine.[59]

LD 1515, "An Act to Fund Delivery of Emergency Medical Services," was introduced in 2023 and referred to the Joint Standing Committee on Criminal Justice and Public Safety (CJPS).[60] The bill as printed provides General Fund appropriations to the Department of Public Safety to support existing transportation costs of EMS, which must be reduced to the maximum extent possible through the use of public and private Medicaid match programs. The CJPS Committee ultimately decided to carry the bill over to the 2024 session and the commission understands the bill is intended to be used as a potential vehicle for proposals relating to the EMS system that will be considered and discussed during the 2024 session.

As described in this report, the commission has proposed a variety of measures designed to better support and fund the EMS system and to better facilitate the efficient and sustainable delivery of EMS services in Maine. Moreover, as previously described, there are a number of other proposals that will be under consideration by the Legislature in 2024 that commission members

[59] Fourteen commission members voted in support of Recommendation C-7 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[60] More information on LD 1515 is available at https://legislature.maine.gov/billtracker/#Paper/1515?legislature=131.

support legislative action on. Although the commission recognizes that the CJPS Committee, upon receipt of this report, is authorized to report out a committee bill to implement recommendations set forth in this report, commission members recommend that the Legislature consider all potential options, including use of bills like LD 1515, in evaluating those recommendations and in taking actions to support and fund the EMS system. Commission members recognize that the use of existing legislation, such as LD 1515, presents an expedient option for consideration and implementation of these actions early in the 2024 session.

V. CONCLUSION

While the publication of this report brings to an end the work of this Blue Ribbon Commission to Study Emergency Medical Services in the State, commission members recognize that the need to better fund, support and plan the EMS system in Maine remains. The many recommendations included in this report will help to ensure a more efficient and resilient EMS system and a more sustainable future for EMS entities. Accordingly, commission members remain committed to ensuring the consideration and implementation of these critical reforms and initiatives by the Legislature, by Maine EMS and the EMS Board and within their respective communities.

The commission would like to extend its thanks to its members for committing their time, expertise and guidance in tackling the many complex issues facing the EMS system. The development and refinement of the recommendations included in this report would not have been possible without their diverse perspectives and vital input. Lastly, the commission would like to thank the EMS providers and entities that tirelessly dedicate their time and energy to ensuring the continued success of the EMS system in their respective communities and across the State.

APPENDIX A

Authorizing Legislation: Resolve 2023, c. 99

LAW WITHOUT GOVERNOR'S SIGNATURE

JULY 19, 2023

CHAPTER 99

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

H.P. 1090 - L.D. 1701

Resolve, to Reestablish and Continue the Work of the Blue Ribbon Commission to Study Emergency Medical Services in the State

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

Whereas, this resolve reestablishes the Blue Ribbon Commission to Study Emergency Medical Services in the State; and

Whereas, the study must be initiated before the expiration of the 90-day period in order to provide sufficient time for the study to be completed and a report submitted in time for submission to the next legislative session; and

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

Sec. 1. Establishment of Blue Ribbon Commission to Study Emergency Medical Services in the State. Resolved: That the Blue Ribbon Commission to Study Emergency Medical Services in the State, referred to in this resolve as "the commission," is established.

Sec. 2. Commission membership. Resolved: That, notwithstanding Joint Rule 353, the commission consists of 17 members:

1. Seven members appointed by the President of the Senate as follows:

A. Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;

B. Two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents;

C. One member who represents a statewide association of emergency medical services providers;

D. One member who represents a private, for-profit ambulance service; and

E. One member who represents a statewide association of municipalities;

2. Eight members appointed by the Speaker of the House as follows:

A. Four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature;

B. One member who represents a tribal emergency medical service;

C. One member who represents a volunteer emergency medical service;

D. One member who represents a county government; and

E. One member who represents a statewide association of hospitals;

3. The Commissioner of Health and Human Services or the commissioner's designee; and

4. The director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

Sec. 4. Appointments; convening of commission. Resolved: That, notwithstanding Joint Rule 353, all appointments must be made no later than 15 days following the effective date of this Act. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. Within 15 days after appointment of all members, the chairs shall call and convene the first meeting of the commission, which must be no later than 30 days following the appointment of all members.

Sec. 5. Duties; meetings. Resolved: That the commission shall examine and make recommendations on the structure, support and delivery of emergency medical services in the State. The commission shall maintain communication and coordinate with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission may look at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support. The commission is authorized to hold a maximum of 6 meetings.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, notwithstanding Joint Rule 353, no later than December 6, 2023, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Criminal Justice and Public Safety.

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

APPENDIX B

Membership List: Blue Ribbon Commission to Study Emergency Medical Services in the State

Blue Ribbon Commission to Study Emergency Medical Services in the State

Resolve 2023, Chapter 99

Membership List

Name	Representation
Senator Chip Curry (Senate Chair)	Member of the Senate
Speaker of the House Rachel Talbot Ross (House Chair)	Member of the House of Representatives
Senator Brad Farrin	Member of the Senate
Representative Suzanne Salisbury	Member of the House of Representatives
Representative Scott Cyrway	Member of the House of Representatives
Representative Mark Blier	Member of the House of Representatives
Robert Chase	Member who is employed or volunteers in the field of emergency medical services and represents a community of 10,000 residents or more
Scott Dow	Member who is employed or volunteers in the field of emergency medical services and represents a community of fewer than 10,000 residents
Joe Kellner	Member representing a statewide association of emergency medical services providers
Rick Petrie	Member representing a private, for-profit ambulance service
Kevin Howell	Member representing a statewide association of municipalities
Mike Hildreth	Member representing a tribal emergency medical service
Beth-Anne Damon	Member representing a volunteer emergency medical service
Carrie Kipfer	Member representing a county government
Mike Senecal	Member representing a statewide association of hospitals
Bill Montejo	Commissioner of Health and Human Services or the commissioner's designee
Anthony Roberts	Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee[1]

[1] Maine EMS Director Sam Hurley served as a commission member for the purposes of the October 23rd commission meeting. After that meeting and before the November 6th meeting, Director Hurley designated Maine EMS Deputy Director Anthony Roberts as his designee to the commission and Deputy Director Roberts served as a commission member for the remainder of the commission's meetings.

APPENDIX C

2022 Report of the Blue Ribbon Commission to Study Emergency Medical Services in the State

State of Maine

130th Legislature, Second Regular Session

Blue Ribbon Commission To Study Emergency Medical Services in the State

December 2022

Office of Policy and Legal Analysis

STATE OF MAINE
130th LEGISLATURE
SECOND REGULAR SESSION

Blue Ribbon Commission To Study
Emergency Medical Services in the State

Members:
Sen. Chip Curry, Chair
Rep. Rachel Talbot Ross, Chair
Sen. Bradlee Farrin
Rep. Suzanne Salisbury
Rep. Richard Mason
Rep. Tim Theriault
Christopher Baker
Scott Dow
Kevin McGinnis
Richard Petrie
Melissa Doane
Brad Morris
Katelyn Damon
Carrie Kipfer
Joe Kellner
Lisa Letourneau
Sam Hurley

Staff:
Hillary Risler, Legislative Analyst
Daniel Tartakoff, Principal Analyst
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Room 215 Cross Office Building
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http://legislature.maine.gov/opla

Table of Contents

Executive Summary

The Blue Ribbon Commission To Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Public Law 2021, chapter 749 (Appendix A).[1] Pursuant to the public law, the commission consisted of the following 17 members: two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature; two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents; one member who represents a statewide association of emergency medical services providers; one member who represents a private, for-profit ambulance service; one member who represents a statewide association of municipalities; four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature; one member who represents a tribal emergency medical service; one member who represents a volunteer emergency medical service; one member who represents a county government; one member who represents a statewide association of hospitals; the Commissioner of Health and Human Services or the commissioner's designee; and the Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

A list of commission members may be found in Appendix B.

The duties of the commission are set forth in Public Law 2021, chapter 749 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

Over the course of six meetings, the commission developed the following findings and recommendations:

Funding

Finding A-1: Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to support transporting EMS services in the State.

[1] Public Law 2021, chapter 749 also amends the Maine Emergency Medical Services Act of 1982 by including a legislative finding that emergency medical services provided by an ambulance service are essential services.

Recommendation A-1: The Legislature should fund the delivery of EMS in Maine by appropriating $70 million per year for the next five years from the General Fund to support existing transporting EMS services, with such appropriation amount to be reduced to the maximum extent possible through the utilization of public and private Medicaid match programs.

Recommendation A-2: The Legislature should initially allocate $25 million of that $70 million appropriation to specifically target transporting EMS services at immediate risk of failing and leaving their service area without access to adequate EMS.

Recommendation A-3: The Legislature should further fund the delivery of EMS in Maine by appropriating $6 million per year for the next five years from the General Fund for non-transporting emergency medical services.

Workforce Development, Education and Training

Recommendation B-1: The Legislature should explore options for providing staff of non-municipal, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.

Recommendation B-2: The Legislature should fully fund the Length of Service Award Program.

Recommendation B-3: The Legislature should direct Maine EMS, the Maine Community College System, and University of Maine System to convene a stakeholder work group to explore EMS career pathways and educational opportunities in the State.

Community Paramedicine

Recommendation C-1: To facilitate the growth of community paramedicine programs in Maine, the Legislature should explore options for addressing a potential disparity created by the statutory definition and licensure requirements of home health care providers and community paramedic requirements.

Continued Study of Emergency Medical Services in the State

Recommendation D-1: During the 131st Legislature, the Legislature should reestablish the Blue Ribbon Commission To Study Emergency Medical Services in the State.

I. Introduction

The Blue Ribbon Commission To Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Public Law 2021, chapter 749 (Appendix A).[2] Pursuant to the public law, the commission consisted of the following 17 members:

- Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;
- Two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents;
- One member who represents a statewide association of emergency medical services providers;
- One member who represents a private, for-profit ambulance service;
- One member who represents a statewide association of municipalities;
- Four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature;
- One member who represents a tribal emergency medical service;
- One member who represents a volunteer emergency medical service;
- One member who represents a county government;
- One member who represents a statewide association of hospitals;
- The Commissioner of Health and Human Services or the commissioner's designee; and
- The Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

A list of commission members may be found in Appendix B.

The duties of the commission are set forth in Public Law 2021, chapter 749 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate

[2] Public Law 2021, chapter 749 also amends the Maine Emergency Medical Services Act of 1982 by including a legislative finding that emergency medical services provided by an ambulance service are essential services.

with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

The commission was directed to submit a report, with findings and recommendations, including suggested legislation, to the joint standing committee of the Legislature having jurisdiction over public safety matters.

II. Commission Process

The commission was authorized to hold a maximum of six meetings, which were held on the following dates: September 1st, September 15th, October 6th, October 25th, November 14th, and December 5th. Meetings were conducted using a hybrid format, through which commission members could choose to attend each meeting in person or remotely. Members of the public were afforded an opportunity to attend each meeting in person or view a livestream or archived video recording of each meeting through the Legislature's website. Meeting materials, including meeting agendas and background materials can be found at https://legislature.maine.gov/emergency-medical-services-study.

At the first meeting[3] of the commission on September 1st, members gave extended introductions, including information about their background and involvement in or experience with EMS in Maine, the organization or interests they are representing on the commission and any additional information that members felt relevant to share with the commission. Commission staff reviewed the commission's authorizing legislation, Public Law 2021, chapter 749, including the commission's duties, process and timeline for the commission's work. In addition, commission member and Director of Maine Emergency Medical Services (Maine EMS) Sam Hurley provided an overview of EMS in Maine and Dia Gainor, Executive Director of the National Association of State EMS Officials (NASEMSO) provided an overview of EMS nationally. The meeting concluded with commission member discussion regarding the charge and duties of the commission, commission goals and desired outcomes.

The second meeting[4] of the commission took place on September 15th and began with an overview of historical funding requests by Maine EMS and the Department of Public Safety provided by Commissioner of Public Safety Michael Sauschuck. The commission also received an overview on the cost of the provision of services by commission member Joe Kellner. The commission further discussed EMS funding across the State and, at the chairs' request, commission members Carrie Kipfer, Joe Kellner, Chris Baker, Scott Dow and Katelyn Damon provided specific funding information on their respective agencies or organizations. Butch

[3] The archived video of the first meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86335&startDate=2022-09-01T12:30:00-04:00
[4] The archived video of the second meeting is available at the following link: https://legislature.maine.gov/audio/#127?event=86439&startDate=2022-09-15T13:00:00-04:00

Russell, President and CEO of North East Mobile Health, provided EMS funding information as well from his organization's perspective.

The third meeting[5] of the commission took place on October 6th and began with an overview on EMS workforce development and training programs provided by Eric Wellman, Emergency Medical Services Project Director at the Maine Community College System and Dennis Russell, Dean, Education Department Manager and Community Paramedicine Manager at United Training Center. The commission next received a presentation on the EMS workforce provided by Glenn Mills, Deputy Director of the Department of Labor's Center for Workforce Research and Information and a presentation on community paramedicine in Maine provided by Karen Pearson, Policy Associate at the Catherine Cutler Institute at the University of Southern Maine. The final presentation of the day was an update on the Maine EMS Strategic Planning Process provided by SafeTech Solutions consultant John Becknell. At the end of the third meeting, commission members discussed the process by which future commission discussion could be narrowed to focus on potential findings and recommendations. To prepare for that discussion at the next meeting, the chairs requested that commission members suggest potential findings and recommendations prior to the next meeting, to be compiled by staff.

The fourth meeting[6] was held on October 25th and began with a presentation by the consulting firm Sellers Dorsey on behalf of the Maine Ambulance Association regarding the potential implementation of an ambulance Medicaid supplemental payment program in Maine. The commission next heard from member Chris Baker regarding the operation of and challenges unique to a joint fire and ambulance service from his perspective serving with the joint fire/EMS in Old Town. Following these presentations, the discussion turned to the potential findings and recommendations to be included in the commission's final report. Prior to the meeting, the commission had received a document prepared by staff compiling what members had identified as potential findings and recommendations and which served as a framework for this discussion. Members opted to begin the discussion by addressing the EMS funding shortfall and potential solutions. Member Joe Kellner provided the commission with a brief presentation that both sought to identify the amount of that shortfall and provide a number of options for addressing it through State funding. Following additional discussion, the members present unanimously voted to recognize that there exists a funding shortfall in the EMS industry in Maine of roughly $70 million per year and that the shortfall should be addressed through the provision of State funding in that same amount annually over a 5-year period. Although members largely agreed that reporting and accountability mechanisms needed to be built into any such distribution of State dollars, there remained a difference of opinion over whether the funds should be distributed directly, through a Maine EMS-administered grant program or through some other method. Further discussion of the specific method of distributing these funds was accordingly deferred until the next meeting.

[5] The archived video of the third meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86506&startDate=2022-10-06T13:00:00-04:00

[6] The archived video of the fourth meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86527&startDate=2022-10-25T13:00:00-04:00

The fifth meeting[7] was held on November 14th, during which the commission continued its consideration of suggested findings and recommendations and voted on which findings and recommendations to include in the final report. Staff was assigned to draft a preliminary report including those findings and recommendations receiving a majority of votes from the members present and voting at the November 14th meeting, and information regarding the substantive discussions around those findings and recommendations.

The sixth and final meeting[8] was held on December 5th, during which the commission reviewed the draft report and provided suggestions and clarifications on its substance, including re-voting one recommendation to include an additional, substantive component. The findings and recommendations, and underlying votes, of the commission are described in detail in Part IV of this report. Members who were absent at the time of the votes were given the opportunity to submit their votes and those votes are reflected accordingly. Those who were not in attendance and did not subsequently submit a vote are reflected as absent.

III. Background Information

A. Overview of EMS in Maine

The Maine Emergency Medical Services program in Maine was initially established as the result of the federal Highway Safety Act of 1966, which provided that each state must formulate an emergency medical services program or lose a percentage of its national highway funds allocated for highway construction. Previously, funeral directors had been the primary providers of ambulance services. As funeral directors were ceasing to provide this service, citizens began to create volunteer ambulance services in their place. With the new federal law, the first state-sponsored EMS medical training was developed and by 1970, the Department for Licensure of Ambulance Services, Vehicles and Personnel had been created and began to initiate licensing. Over the next few years, federal grants were awarded to fund various city and regional EMS structures and in 1982, the Maine Legislature enacted the Maine Emergency Medical Services Act of 1982, establishing the basis for the current State EMS laws.

Today, EMS in Maine is comprised of three basic entities: the Bureau of Emergency Medical Services (Maine EMS), which is based within the Department of Public Safety; the Board of Emergency Medical Services (Board), which has statutory authority for EMS system oversight; and the EMS system itself, which is the collection of clinicians, first responders, dispatch centers, resources and medical directors throughout the State.

Maine EMS provides regulatory oversight of a variety of entities. These regulated entities include emergency medical dispatchers (EMD) and EMD centers; EMS ambulance operators, emergency medical responders (EMRs), emergency medical technicians (EMTs), advanced EMTs (AEMTs) and paramedics; non-transporting, transporting and air medical services and

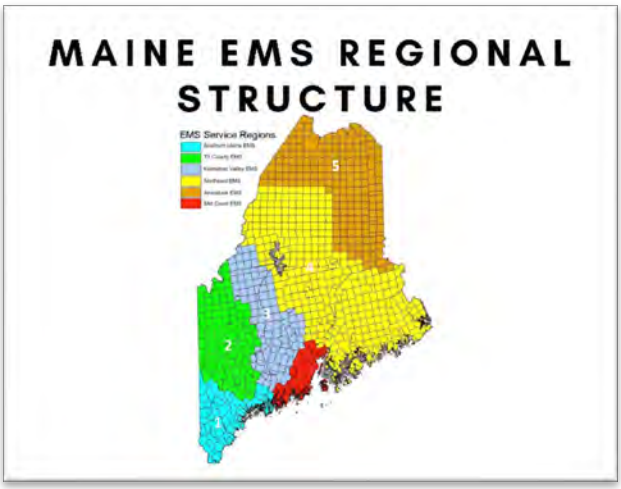
[7] The archived video of the fifth meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86572&startDate=2022-11-14T13:00:00-05:00
[8] The archived video of the sixth meeting is available at the following link: https://legislature.maine.gov/audio/#126?event=86678&startDate=2022-12-05T13:00:00-05:00

emergency vehicles (ambulances, response vehicles and air ambulances); and EMS training centers, which include instructors and coordinators and initial and continuing education courses.

As of January 2021, Maine has over 276 licensed services responsible for delivering emergency medical services throughout the State, including:

- 173 fire departments;
- 41 nonprofit, community-based EMS services;
- 35 independent municipal EMS services;
- 11 private EMS services;
- 11 hospital-based EMS services;
- 3 college-based EMS services;
- 2 tribal EMS services; and
- 1 air medical service.[9]

The State is divided into six EMS regions, each with a regional council, office and medical director. The regional EMS offices are each independent not-for-profit 501(c)(3) corporations that contract with Maine EMS to coordinate the EMS system in their respective region. Those six regions are shown in the chart on the left.[10]



The delivery of emergency medical services, however, is exclusively provided at the local level. Accordingly, how the delivery of EMS is organized and financed varies significantly from community to community. Some communities rely on municipal fire departments or dedicated EMS departments, while others may contract with private, non-profit community-based, or hospital-based EMS services. Each service model has its own challenges and advantages but regardless of the type of service and service mix, in each community EMS provides coordinated response and emergency medical care involving multiple people and agencies and has to be ready at all times to respond a call. All of these components as a whole constitute what we think of as "EMS" in Maine.

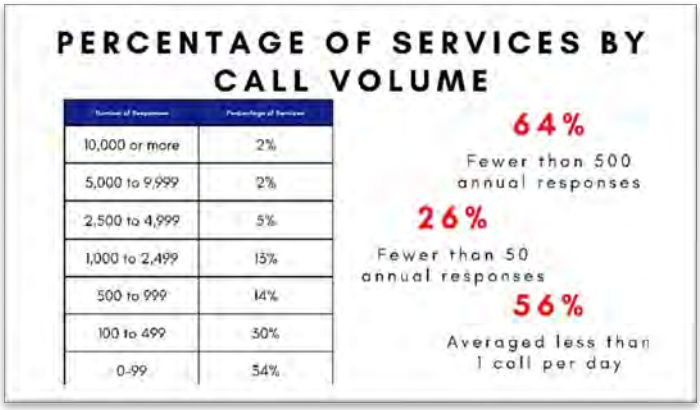
[9] *See* https://www.maine.gov/ems/whatisems.
[10] *See* Maine EMS September 1st presentation materials, which can be found at https://legislature.maine.gov/doc/8817.

B. Costs of EMS and Reimbursements

Funding of EMS is complicated, partly because each EMS service has different service mixes as previously noted, but also because of varying call volumes, geographic areas and service structures. Statewide, EMS is funded primarily through insurance reimbursement – both public and private. Public Medicare and Medicaid reimbursement is the largest funding source, although reimbursement may also be provided through hospitals or medical facilities, commercial insurers, and self-pay patients.[11] Reimbursement, and especially Medicare and Medicaid reimbursement is particularly complex.

To understand EMS costs and reimbursements, it can be helpful to start first with an understanding call volume. In 2021, there were approximately 288,273 calls for EMS. As shown in the chart on the right,[12] 911 activations accounted for 77.6% of those transports. Interfacility transport (IFT), which is the transport of a person from one medical facility to another medical facility, accounted for 21% of those transports. Community paramedicine, which represents an expanded role for EMS providers to assist with both public health and primary healthcare to underserved populations without the duplication of services, accounted for 1.1% of those transports.

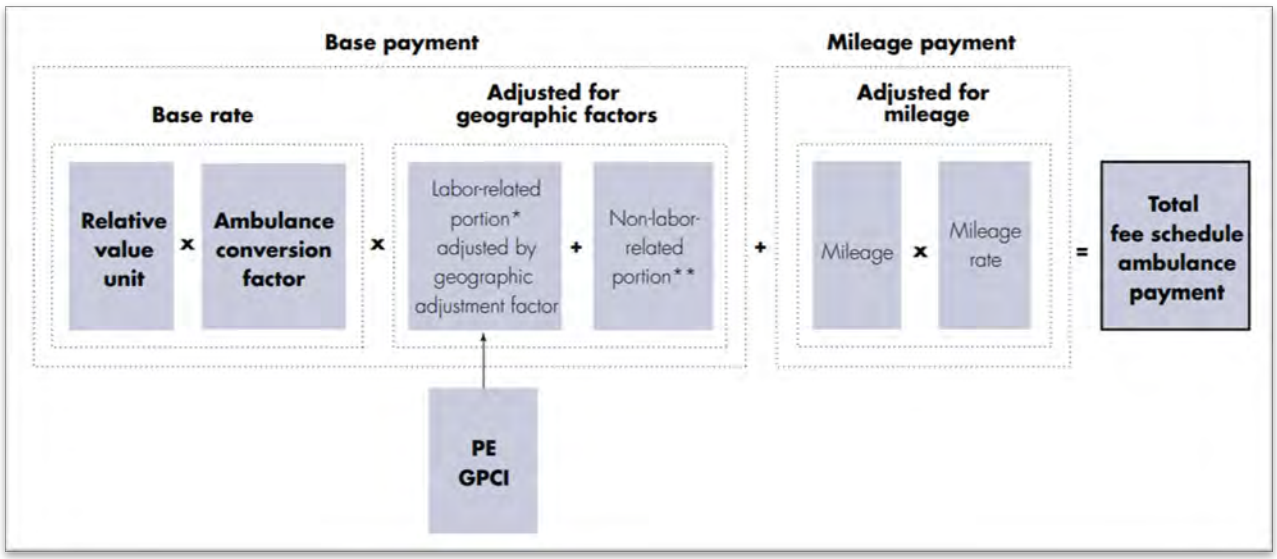
Most EMS services in Maine do not respond to a large call volume. The chart to the left shows the percentage of services by call volume.[13] Even EMS services that have a low volume of calls, however, must have the staff and equipment necessary to be able to provide a continuous, 24/7 ambulance response and services must be geographically dispersed so as to be able to respond to those calls in a timely manner. This is what is commonly referred to as the "cost of readiness." By using call volume as an indicator of "cost-per-call," a service with a low call volume will necessarily have a higher cost-per-call because all of the overhead costs to run an EMS service are spread amongst fewer calls.



[11] The commission estimates that only approximate 18-20% of funding comes from private reimbursement, although that percentage can be expected to vary from region to region and service to service.
[12] *See id.*
[13] *See id.*

There is limited data on the cost of providing ambulance services, which is contributing to low reimbursement rates. It can also be difficult to calculate the exact cost of EMS where, for example, a municipality has a joint fire/EMS department. The commission did receive information from members regarding EMS budgets from a variety of different service types, including services representing a large city service, a joint fire/EMS department, a small/rural service, a volunteer service and a regional service. In addition, commission member Joe Kellner presented on the cost of EMS and provided an illustrative sample ambulance budget.[14] For each service, a number of factors contribute to the cost of providing ambulance services, including, but not limited to: general budget items, such as salaries and wages, supplies, dispatch and billing, equipment, repairs and maintenance and fuel costs; population density; call volume and volume of transports; types of services provided; grants and fundraising; and staffing and level of staff training and use of volunteers. Of course, underlying all of these costs, is the "cost of readiness," as previously described.

Reimbursement through Medicare and Medicaid is based on the ambulance fee schedule, which has two components: a base payment, which contains seven distinct levels of ground transport ambulance service representing varying levels of service intensity, and a mileage payment. There are also add-on payments tied to the mode of ambulance transportation and/or geographic location, which include rural and super rural add-ons as determined by zip code. Rates are updated annually by the ambulance inflation factor, which is an amount equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) reduced by the 10-year moving average of multi-factor productivity. The update for 2021 was 0.2 percent. Ambulance add-on payments, which will expire at the end of 2022, include: 2% for urban, 3% for rural and 22.6% for super-rural. MaineCare pays at average Medicare rates based on the lowest geographic practice cost index (GPCI).[15] This equation can also be mapped out as follows.



16

[14] *See* September 15 meeting materials, which can be found at https://legislature.maine.gov/ems-study-meeting-9152022.
[15] *See id.*
[16] *See id.*

It is vitally important to consider, however, that a call which does not result in transport does not result in payment, further exacerbating the gap between the cost of delivering EMS and the reimbursement received. Using the data that is available and by making a few assumptions,[17] the difference between the cost-per-call and reimbursement-per-call can be estimated as follows.

Call Volume	300	600	900	1200	1500	1800	2100
Cost per Call	$2,522.06	$ 1,301.37	$ 894.47	$ 1,177.20	$ 958.99	$ 813.51	$ 709.60
Reimbursement per Call	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99
Loss per Transport	$ 2,030	$ 809	$ 402	$ 685	$ 467	$ 322	$ 218
Total Gap	$609,020.97	$485,625.81	$362,230.65	$822,253.61	$700,496.45	$578,739.29	$456,982.13

Thus, although the cost per call is much greater for a service with a low call volume, the reimbursement per call remains the same, and even for those services with the greatest call volume, the reimbursement is still not sufficient to cover the costs. This is because the reimbursement through Medicare and Medicaid is antiquated and woefully inadequate, made worse in a state as rural and geographically diverse as Maine.

C. Subsidies

The difference between an EMS service's cost-per-call and reimbursement must be made up through subsidies. Current subsidies take many forms and no EMS services in the State use the exact same model. Subsidies that are utilized include taxpayer support, municipal contributions, commercial payers, philanthropy and grants. One of the biggest subsidies underwriting EMS, however, is volunteer and underpaid labor.

EMS in Maine has been highly dependent on and values the role of volunteerism and service in the creation of locally-developed EMS services. While recognizing that volunteerism will always have a role in EMS, it is admittedly not a reliable solution to the central challenges to the long-term sustainability of the EMS system. Declining volunteerism coupled with a dependence on an underpaid workforce that hampers recruitment and retention has necessarily required greater reliance on other subsidies, thereby increasing costs to local municipalities and taxpayers. Declining volunteerism has also helped to reveal the true cost of EMS, which comes as a shock to many communities now struggling to provide those services locally.

Absent a subsidy, transporting EMS services cannot break even in the State, regardless of service mix, and all transporting EMS services are currently operating at a loss. As demonstrated in the previous chart, to break even, a high-efficiency (1,800 transports per year) service would need a subsidy of approximately $322 per transport; for a more rural, low-volume service (300 transports per year), a subsidy of $2,030 per transport is needed. Relying on current subsidies without additional State assistance is insufficient to meet the existing need for transporting EMS

[17] *See id.*

services and, as the commission heard throughout its work, all EMS services in Maine are currently operating at a loss.

D. EMS Workforce, Education and Training

As mentioned above, one of the largest subsidizations of EMS services in Maine is a volunteer and underpaid workforce. Volunteerism, however, is declining and struggles with EMS employee recruitment and retention have exacerbated problems for a workforce that is already stretched too thin. A primary contributor to these recruitment and retention issues is the generally inadequate compensation and benefits offered to many EMS employees. As noted by the Maine Department of Labor (MDOL), the average annual salary for an EMT in Maine varies, depending on location, from $29,225 to $35,542, while the annual average salary for a paramedic varies from $38,836 to $53,244. Due to the significant funding problems that all EMS services face in Maine, the compensation, benefits and working conditions generally offered to EMS employees are often insufficient to recruit and retain the workforce needed to effectively and efficiently deliver EMS across the State. Per a 2021 MDOL survey, EMS services generally reported difficulties hiring EMTs, AEMTs and paramedics and consequently have had to rely on per diem staffing and volunteer positions to fulfill their workforce needs.

At the same time that EMS services are reporting such significant staffing issues, the commission also received information suggesting an increasing recent demand for EMS educational and training programs in the State. There are multiple EMS training centers in Maine provided through regional EMS offices, private ambulance services and the Maine Community College System, which offer education and training opportunities for EMRs, EMTs, AEMTs and paramedics. Additionally, the MDOL has also partnered with other State agencies and the University of Maine System to offer continued healthcare training and career advancement opportunities for EMS staff through the Healthcare Training for ME program. Funding for many of these programs for both participants and educators remains an outstanding need and it was noted to the commission that the retention of individuals completing those programs in the traditional EMS field has been problematic.

All of these factors are contributing to bringing EMS in Maine to a breaking point. Legislative action will be necessary to ensure the short-term and long-term future of EMS in the State. Accordingly, the commission makes the following findings and recommendations.

IV. Findings and Recommendations

A. Funding

From the very first meeting of the commission, members expressed grave concern that EMS in the State is not only at the edge of a cliff but that in many areas of the State, particularly rural areas, EMS is already over that cliff. The primary issue facing EMS is a lack of funding. As established by the Legislature pursuant to Public Law 2021, chapter 749, which also authorized this commission, emergency medical services provided by an ambulance service are essential

services.[18] Funding is necessary and vital to delivering those essential services. That funding comes down to two key components: the cost of providing services – including the cost of readiness – and the funds necessary to cover those costs, currently fulfilled through Medicare and Medicaid and private insurance reimbursement and other subsidies.

The federal Centers for Medicare and Medicaid Services is currently conducting a cost study on ground ambulance services. This study is anticipated to more accurately identify how much it costs to actually deliver EMS and to result in a corresponding increase in reimbursement rates. That cost study will take time, however, and it is unlikely that any of those reimbursement rate increases will be implemented within the next five years.

In the meantime, it is critical that the State support EMS in Maine to avoid EMS service closures and to ensure that, when Mainers call for EMS, there are services able to respond wherever they are needed in a timely manner. Accordingly, the commission makes the following findings and recommendations relating to the funding of EMS in Maine.

Finding A-1: Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to support transporting EMS services in the State.[19]

While it is apparent to those involved in EMS that current funding is woefully inadequate, it is harder to determine exactly what the actual need is to ensure that EMS services have the funding necessary to provide their critical services. The commission recognized from the beginning of its work that funding this need is crucial to ensuring the survival of EMS services in Maine.

As noted previously in this report, there is limited data on the cost of providing ambulance services. Additionally, even with examining the actual cost data available, that data is necessarily deficient because it relies on the provision of EMS through volunteerism, low wages and donated labor. Without subsidies and with reimbursement rates only covering 60-80% of the cost of service, it is clear that the shortfall between cost of service and revenue is greater than $70 million.

Nevertheless, a majority of commission members recognize the importance and immediate need of funding transporting services in a way that will make a meaningful difference. Those members accordingly determined that, at a minimum, there is a need for $70 million in funding each year for the next five years – in addition to current subsidies – to support transporting EMS services in Maine.

[18] *See* Appendix A.

[19] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, McGinnis, Morris and Kellner. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

To determine the amount of this need, the commission utilized the calculation of loss per transport as explained in a presentation by commission member Joe Kellner.[20] Essentially, this calculation begins with a base rate, suggested at what is deemed to be a high-efficiency EMS service with about an 1,800 call volume annually. At that annual call volume, it is estimated that such a service will lose approximately $325 per transport, including all types of transport, such as 911 calls, interfacility transport, etc. Not all EMS services operate with that level of call volume, however, and in fact many services in Maine are rural services with a much lower annual call volume. Accordingly, the commission included a "rural adjustment" utilizing the USDA zip-code-based rurality scores to determine a multiplier. Thus, for each EMS service, the commission was able to roughly determine the amount of need per call necessary to better support that service.

The commission used this calculation method to determine that the total need throughout the State for transporting EMS services is $70 million per year, which can be broken down, depending on the chosen disbursement method, either by transporting service, by service mix or using some other methodology. This total number is essentially the minimum amount necessary to support transporting EMS services in Maine over the next five years until increased Medicare and Medicaid reimbursement rates are expected to be available.

Recommendation A-1: The Legislature should fund the delivery of EMS in Maine by appropriating $70 million per year for the next five years from the General Fund to support existing transporting EMS services, with such appropriation amount to be reduced to the maximum extent possible through the utilization of public and private Medicaid match programs.[21]

A majority of commission members recommend that the Legislature fund this identified need over a five-year period, with the funding limited to those EMS services that are currently operating in the State – or their successor organizations, if for example, services seek to regionalize or otherwise improve their efficiency – rather than be used to provide funding to new services. The commission, also emphasizes and recommends that this amount be offset through the use of federal funds. In particular, the Legislature should pursue the use of the Medicaid Supplemental Payment Program for non-municipal ambulance services and Certified Public Expenditure (CPE) programs for municipal services to maximize Medicaid matching.

For non-municipal ambulance services (for-profit, non-profit and volunteer services), federal Medicaid law allows states to establish a program under which a state collects an assessment from those services and uses that money as that state's share for federal Medicaid matching funds, thus increasing Medicaid rates by making supplemental payments to those services. Similar assessment programs have been used to benefit hospital and nursing home industries here in Maine and nationally. To establish such an assessment program, the Legislature should direct the Maine Department of Health and Human Services to collect the assessment from each

[20] *See* Maine Ambulance Association EMS Funding Proposal presentation from the October 25th Meeting, which can be found as Appendix C and at https://legislature.maine.gov/doc/9181.

[21] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Kellner, McGinnis and Morris. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

non-municipal ambulance service (for-profit, non-profit and volunteer service) and, with the funds generated from the assessment, match available federal Medicaid dollars. MaineCare would then make the corresponding supplemental Medicaid payments to these non-municipal ambulance services. Draft legislation provided by consultant Sellers Dorsey, which presented to the commission at its October 25th meeting, is included as Appendix D. Sellers Dorsey estimates that the net gain – the increase in supplemental payments minus the assessment paid – to each service will vary but, for the industry as a whole, the supplemental payments should be at least two times the amount of the assessments paid by all such services, which will help offset the funds needed from the State to meet the identified need.

For municipal EMS services, the commission recommends the use of CPE programs to help offset the identified need. A CPE program is a Medicaid financing approach by which a governmental entity, including a governmental service such as a municipal EMS service, incurs an expenditure eligible for federal financial participation (FFP) under the state's approved Medicaid State plan. The governmental entity is required to certify that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the State then claims FFP.[22] To maximize the use of the federal funds available under a CPE program, the Legislature should direct the Department of Health and Human Services to include such a program in its Medicaid State plan and to provide the support, resources and education necessary for municipal EMS services to most effectively take advantage of the program.

Recommendation A-2: The Legislature should initially allocate $25 million of the recommended $70 million appropriation to specifically target transporting EMS services at immediate risk of failing and leaving their service area without access to adequate EMS.[23]

The commission consistently recognized that there are two components to funding EMS needs in the State: (1) immediate crisis funding for EMS services at the highest risk of failing and (2) long-term funding for the sustainability of the future of EMS in the State. Accordingly, a majority of commission members recommend that of the $70 million in funding identified in the prior recommendation, during the first two years in which that funding is available, $25 million in each year should be immediately set aside in a non-lapsing fund to be targeted specifically to those EMS services at immediate risk of failing and leaving residents of those service areas without adequate EMS.

When a person calls 911, the person expects that an EMS service will provide an immediate response and be able to provide the necessary medical care and transport, if required, to the patient. There are EMS services in this State, however, that are in danger of failing due to a lack of funding, not only from low reimbursement rates but from difficulty in finding volunteers and a high workforce turnover. These services need immediate assistance and, without that assistance, their service areas will no longer have necessary EMS coverage. By specifically targeting this

[22] *See* https://www.macpac.gov/subtopic/non-federal-financing/#:~:text=A%20CPE%20is%20a%20statutorily,Act%3B%2042%20CFR%20433.51).

[23] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Kellner, Morris and McGinnis. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

funding initially to those services with the greatest need, the residents of those areas will not lose access to EMS and the immediate influx in funding will allow those services to better plan for long-term sustainability.

Recommendation A-3: The Legislature should further fund the delivery of EMS in Maine by appropriating $6 million per year for the next five years from the General Fund for non-transporting emergency medical services.[24]

In addition to the 171 transporting EMS services in the State, there are 103 non-transporting EMS services. A non-transporting EMS service is defined as any organization, person or persons who hold themselves out as providers of emergency medical treatment and who do not routinely provide transportation to ill or injured persons, and who routinely offer or provide services to the general public beyond the boundaries of a single recreational site, business, school or other facility. Non-transporting services generally respond to a location of a medical emergency to provide immediate medical care but do not provide patient transport. Examples may include fire apparatus, response cars or other non-transport vehicles.

The commission identified that non-transporting EMS services are also in need of funds. Accordingly, a majority of commission members recommend that the Legislature fund $6 million per year over the next five years for non-transporting EMS services. This infusion of funding will help non-transporting EMS services with their immediate need, thereby allowing them to put plans in place for their long-term sustainability following the five-year period.

B. Workforce Development, Education and Training

The commission dedicated a substantial portion of its time discussing and identifying potential solutions to EMS workforce issues, which are significantly impacting the delivery of EMS in Maine, leading to delayed emergency response times and to an overworked and overstressed workforce.

Recommendation B-1: The Legislature should explore options for providing staff of non-municipal, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.[25]

As previously noted, a primary contributor to the EMS employee recruitment and retention issues faced by EMS services across the State are the insufficient compensation and benefits offered to EMS employees. Although the provision of supplemental funding for EMS services

[24] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Morris, McGinnis and Kellner. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

[25] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Doane, Damon, McGinnis, Morris and Kellner. Commission member Hurley abstained from the vote and commission members Mason, Theriault and Letourneau were absent. Commission member Dow voted in opposition to this recommendation because, although he has no concerns with access to the Maine State Retirement System, he is concerned that he, as most municipal employees, have the same coverage as most other services, which is a group plan, and that municipal services will begin to lose people, and that this will just be shifting the problem around, not solving it.

proposed in the prior recommendations will allow for enhancement of employee compensation and benefits during the period in which that funding is available, the commission recognized that there are other mechanisms that might be employed to address those same concerns. One such mechanism, which was supported by a majority of commission members at the fifth meeting, is for the Legislature to explore options for providing staff of non-governmental, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.

Many of the 272 licensed EMS services in Maine are governmental services and are therefore able to provide staff with access to the Maine State Retirement System. Staff of non-governmental EMS services may be offered access to a retirement benefits package through their employer although the benefits offered to such individuals varies across Maine. Offering access to State retirement benefits and State healthcare benefits to employees of licensed non-governmental, nonprofit EMS services may serve to boost employee recruitment and retention for those services, which fill a critical need for the delivery of EMS in many areas of the State. The commission is committed to supporting the Legislature as it explores this recommendation, recognizing that facilitating this change will require the consideration of a myriad of factors and, potentially, the expenditure of State funds.

Recommendation B-2: The Legislature should fully fund the Length of Service Award Program (5 MRSA §3372).[26]

The Length of Service Award Program (LOSAP), 5 MRSA §3372, was enacted in 2015 to provide paid length of service awards to eligible volunteers. Under the program, an "eligible volunteer" is an active part-time or on-call member of a fire department or a volunteer firefighter or a licensed EMS person or ambulance operator who provides on-call, part-time or volunteer emergency medical response under the direction of a fire department chief or for an ambulance service or a non-transporting EMS. The LOSAP rewards these eligible volunteers for the service to their communities with contributions to a retirement program. Participants are generally eligible for such benefits at the earlier of attaining sixty-five years of age or 20 years of service credit.

The LOSAP can accept funding from the federal government, the State or a municipality; however, when it was established in 2015, no State funds were provided and since that time, there have only been three one-time funding initiatives enacted totaling $2 million.[27] At this time, there is no dedicated funding source for the LOSAP and it is unclear what the anticipated needs of the program currently are or are anticipated to be beyond the $2 million already appropriated. Commission members, however, believe that the benefits that can be provided through the LOSAP represent another important mechanism by which EMS staff recruitment and retention rates can be improved. Consequently, a majority of commission members at the fifth

[26] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, McGinnis, Morris and Kellner. Commission member Hurley abstained from the vote and commission members Mason, Theriault and Letourneau were absent.

[27] *See* Public Law 2021, Chapter 444, which provided a one-time General Fund appropriation of $500,000 in Fiscal Year 21-22; Public Law 2021, Chapter 721, which provided a one-time General Fund appropriation of $500,000 in Fiscal Year 22-23; Public Law 2021, Chapter 635, Section A-16), which provided a one-time General Fund appropriation of $1,000,000 in FY 22-23.

meeting support the Legislature funding the LOSAP at a level necessary to meet that program's current and anticipated future needs, with consideration given to the establishment of a dedicated funding source.

Recommendation B-3: The Legislature should direct Maine EMS, the Maine Community College System, and University of Maine System to convene a stakeholder work group to explore EMS career pathways and educational opportunities in the State.[28]

Although, as the commission heard, there exist a number of public and private educational and training programs for EMS providers in Maine that have seen an increasing demand for services, the retention of the individuals completing those programs in the traditional EMS field has been problematic. To ensure that the educational and training options available in the State are best designed and coordinated to enhance the recruitment and retention of EMS service employees in the traditional EMS field and where the staffing demands of EMS services are the greatest, a majority of commission members at the fifth meeting stated their support for the Legislature directing the convening of a stakeholder workgroup to explore EMS career pathways and educational opportunities in the State.

To ensure that a broad spectrum of experiences and backgrounds are present on the workgroup, it should include representatives of Maine EMS, the Maine Community College System, the University of Maine System, other public and private entities that provide EMS educational or training programs in the State and other individuals with relevant backgrounds and experiences in EMS education and training and in the delivery of EMS generally. To facilitate consideration of any findings or recommendations that may arise out of this workgroup, the Legislature should consider requiring the submission of a report by the workgroup outlining the activities of the workgroup and any recommendations proposed by its members, including proposed legislation where appropriate.

C. Community Paramedicine

As the commission heard during their October 6th meeting, community paramedicine is an evolving model of healthcare delivery in both rural and urban areas as EMS services look to reduce the use of EMS for non-emergency 911 calls, the overcrowding of emergency departments and healthcare costs. Community paramedicine is an important part of the EMS system in the State and has been proven to be impactful and to reduce healthcare costs. The commission supports opportunities to expand community paramedicine programs, including exploring reimbursement models and revenue streams that would support these programs.[29] There is no single model of community paramedicine – rather programs are based on community needs and services. Community paramedicine pilot projects were authorized by the 125th Maine Legislature and expanded during the 128th Maine Legislature. There have been additional

[28] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, McGinnis, Morris, Kellner and Hurley. Commission members Mason, Theriault, and Letourneau were absent.

[29] Commission member and Director of Maine EMS, Sam Hurley, noted that this is an issue that Maine EMS is currently working to address through facilitating modifications to the State's MaineCare plan to allow reimbursement for community paramedicine services.

studies, including the Lincoln County Community Paramedicine Data Collection Initiative in 2019 and, in 2022, Maine EMS contracted with the Catherine Cutler Institute to expand this pilot study and evaluate programs in Maine. The commission believes in the importance of community paramedicine but identified a potential disparity in statutory and licensing requirements and accordingly makes the following finding and recommendation.

Recommendation C-1: To facilitate the growth of community paramedicine programs in Maine, the Legislature should explore options for addressing a potential disparity created by the statutory definition and licensure requirements of home health care providers and community paramedic requirements.[30]

One of the challenges with growing community paramedicine programs is the potential overlap between community paramedics and other home health care professionals. The commission identified a potential disparity in the statutory definition and licensure requirements of home health care providers and community paramedic requirements that jeopardizes the community paramedic programs that the Legislature should address.

Title 22, section 2143 of the Maine Revised Statutes prohibits a home health care provider from providing home health services without a license. A home health care provider is defined as "any business entity or subdivision thereof, whether public or private, proprietary or not for profit, that is engaged in providing acute, restorative, rehabilitative, maintenance, preventive or health promotion services through professional nursing or another therapeutic service, such as physical therapy, home health aides, nurse assistants, medical social work, nutritionist services or personal care services, either directly or through contractual agreement, in a client's place of residence."[31] This term does not apply to any sole practitioner providing private duty nursing services or other restorative, rehabilitative, maintenance, preventive or health promotion services in a client's place of residence or to municipal entities providing health promotion services in a client's place of residence.[32] It also does not apply to a federally qualified health center or a rural health clinic as defined in 42 United States Code, Section 1395x, subsection (aa) (1993) that is delivering case management services or health education in a client's place of residence.[33] Beginning October 1, 1991, "home health care provider" includes any business entity or subdivision thereof, whether public or private, proprietary or nonprofit, that is engaged in providing speech pathology services."[34]

Community paramedicine, on the other hand, is established as "the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing episodic patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically

[30] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Doane, Damon, Kipfer, McGinnis, Morris, and Kellner. Commission member Letourneau abstained from the vote and commission members Mason and Theriault were absent. Commission member Dow voted in opposition to this recommendation, with the question of why community paramedics are not currently in the home health sector and that that would solve many of the problems.
[31] 22 MRSA §2142(3).
[32] *Id.*
[33] *Id.*
[34] *Id.*

requested or directed by a physician" and operates under the rules established by the Maine EMS Board.[35]

These overlapping concepts have created confusion over the licensure requirements for community paramedics and the licensure requirements for home health care providers and a majority of commission members believes that there needs to be clearer delineation between the requirements applicable to these two categories of regulated entities.

Accordingly, a majority of commission members recommend that the Legislature further explore this potential disparity with the goal of better delineating in statutory definitions and licensure requirements, the differences between the two roles, which will, in turn, grow and further enable community paramedicine programs in the State. Members of the commission noted that community paramedic programs do not have, and should not need, home health service licenses, as they are licensed separately under the rules established by the Maine EMS Board. Some members did caution, however, about potential unintended consequences of simply exempting community paramedics from home health service licensure requirements.

D. Continued Study of Emergency Medical Services in the State

Through six meetings, the commission heard from its members, stakeholders and others about EMS in Maine and many of the challenges to the funding, support and delivery of EMS services and regarding how all aspects of EMS, including workforce development, training, compensation, retention costs, reimbursement rates, organization and local and state support, contribute to the system. Although many of these aspects are touched on in the commission's findings and recommendations, there remain many aspects of that system and identified issues the commission was not able to fully explore or examine in its limited time.

In addition, as recognized in the commission's duties, the commission's work was conducted parallel to the strategic planning work undertaken by Maine EMS. Maine EMS contracted with a consultant, SafeTech Solutions, to engage in strategic planning process of Maine EMS and the EMS Board to put forward a vision and plan for the future of Maine EMS and to make recommendations on its short-term and long-term sustainability. The commission heard from the consultant, John Becknell, during its October 25th meeting, however, the work of the strategic planning process was not completed by the time the commission held its final meetings and voted on findings and recommendations. Accordingly, a majority of commission members make the following recommendation.

Recommendation D-1: During the 131st Legislature, the Legislature should reestablish the Blue Ribbon Commission To Study Emergency Medical Services in the State.[36]

A majority of commission members do not feel that the commission's work is complete and recognizes that there are still outstanding issues that need to be addressed to ensure the short-

[35] *See* 32 MRSA §84(4).

[36] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Kellner, Morris and McGinnis. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

term and long-term sustainability of EMS in Maine. This can best be accomplished by continuing to bring together legislators, experts and EMS providers to collaborate and advise the Legislature on the best paths forward. This need is particularly acute as the Maine EMS strategic planning process concludes and makes its recommendations to Maine EMS, the EMS Board, the Department of Public Safety and ultimately the Legislature.

From the beginning of its work, the Legislature and the commission recognized the need for the strategic planning process to inform the work of the commission and vice-versa. The commission believes that reestablishing this commission in the 131st Legislature will allow that communication to continue. A reestablished commission would be better positioned to evaluate the strategic planning recommendations as well as progress made on EMS as identified in this report. The commission discussed that the State needs to build a better, more supportive structure, but that this commission was not at a place to make specific recommendations. However, it is anticipated that the strategic plan will include recommendations on the structure of Maine EMS and the delivery of EMS in the State. Commission members noted how important it is that everyone who is involved in EMS have a voice in the structure of the delivery of services and that those voices be heard by policy- and decisionmakers. A reestablished commission will be better positioned to evaluate recommendations regarding system structure and sustainability. It is critical that the State continue to support the structure, at the state and local level, and the delivery of EMS in the State and continuing the work of this commission as proposed above will help to fulfill that important purpose.

V. Conclusion

The commission's work and publication of its report comes at a time when EMS in the State is in crisis. EMS services in Maine are at the edge of a cliff, or over it, and changes must occur to ensure that when someone calls with a medical emergency, EMS services are able and ready to assist. This requires, first and foremost, increased funding for the delivery of EMS. Current subsidies, especially volunteerism, are declining and revealing the true cost of EMS, and the State must step in to ensure that EMS does not disappear in parts of this State.

Of course, this work does not end with the commission's report and the commission hopes that the findings and recommendations contained in this report demonstrate not only the dire need within the EMS system but also the first steps towards ensuring both the short-term and long-term sustainability of the system. Members of the commission look forward to working with the 131st Legislature to refine the details of these recommendations and maintain focus on this critically important issue and Maine's EMS workforce.

Finally, the commission would like to thank all of its members and presenters for generously offering their time, expertise and advice on the complicated issues involved in funding and supporting EMS in the State. Their knowledge and perspectives were invaluable in developing the findings and recommendations of the commission. Additionally, the EMS system in Maine would not exist without EMS providers and the commission would like thank all of them who dedicate their time – often overburdened and underpaid – to serving their communities and the State.

APPENDIX D

Bills Related to EMS Considered During the 131st Legislature (OPLA)

Bills Related to EMS Considered During the 131st Legislature, First Regular and First Special Sessions

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
EMS FUNDING				
LD 258, An Act Making Unified Appropriations and Allocations from the General Fund and Other Funds for the Expenditures of State Government and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2023, June 30, 2024 and June 30, 2025	AFA	Enacted, P.L. 2023, c. 412	Public Law 2023, chapter 438, Part A, section A-38 provides a $31,000,000 appropriation to fund an Emergency Medical Services Stabilization and Sustainability Program. Part GGGGG establishes the Emergency Medical Services Stabilization and Sustainability Program within the Department of Public Safety, to be administered by Maine Emergency Medical Services in consultation with the Emergency Medical Services' Board and the Department of Health and Human Services, and transfers $31,000,000 from the unappropriated surplus of the General Fund to the Emergency Medical Services Stabilization and Sustainability Program, Other Special Revenue Funds account. Public Law 2023, chapter 438 broadened eligibility for grants under the program to all entities providing ambulance service or non-transporting emergency medical service or licensed emergency medical services training centers.	Recommendation A-2 Recommendation A-3
LD 526, An Act to Amend the Laws Governing the Emergency Medical Services Stabilization and Sustainability Program	CJPS	Enacted, P.L. 2023, c. 438	This enacted law amends the definition of "emergency medical services entity" in the Emergency Medical Services Stabilization and Sustainability Program laws to include all ambulance services, nontransporting emergency medical services and emergency medical services training centers licensed under the Maine Emergency Medical Services Act of 1982.	Recommendation A-2 Recommendation A-3
LD 1515, An Act to Fund Delivery of Emergency Medical Services	CJPS	Carried Over	This bill provides General Fund appropriations to the Department of Public Safety to support existing transportation costs of emergency medical services. These appropriations must be reduced to the maximum extent possible through the use of public and private Medicaid match programs.	Recommendation A-1
LD 1602, An Act to Implement the Recommendations of the Stakeholder Group Convened by the Emergency Medical Services' Board on Financial Health of Ambulance Services	HCIFS	Enacted, P.L. 2023, c. 468	Public Law 2023, chapter 468 makes the following statutory changes related to the financial health of ambulance services based on recommendations from a stakeholder group convened by the Emergency Medical Services' Board pursuant to Public Law 2021, chapter 241. 1. It continues the requirement that health insurance carriers are required to pay specified reimbursement rates for covered services provided by an ambulance service provider and makes clear that carriers may not limit reimbursement to only covered emergency services.	Recommendation A-3

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
			2. Beginning January 1, 2024, it requires health insurance carriers to reimburse ambulance service providers for nontransporting services at the same reimbursement rates for covered services. 3. It prohibits health insurance carriers from requiring an ambulance services provider to obtain prior authorization before transporting an enrollee to a hospital, between hospitals or from a hospital to a nursing home, hospice care facility or other health care facility and requires carriers to reimburse for those services. 4. It requires health insurance carriers to consider the requirements of the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services related to medical necessity when establishing the carrier's own policies for medical necessity. 5. It specifies the cost and performance metrics for the program for collecting and reporting cost and performance metrics related to emergency services that must be established by the Emergency Medical Services' Board in rule and adds one limited-period position to the Emergency Medical Services' Board to facilitate that program. 6. It requires the Maine Health Data Organization to report information on payments for ambulance services on its publicly accessible website.	
LD 1751, An Act to Maximize Federal Funding in Support of Emergency Medical Services	HHS	Carried Over	This bill establishes an ambulance service assessment fee on ambulance service providers in order to maximize federal funding for reimbursement to ambulance service providers under the MaineCare program. It also increases the reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine.	Recommendation A-1
LD 1832, An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services	HCIFS	Carried Over	This bill requires an ambulance service to be reimbursed for the cost of treating a person, regardless of whether the ambulance service transports the person to a hospital.	Recommendation A-3
WORKFORCE DEVELOPMENT, EDUCATION AND TRAINING				
LD 244, Resolve, Directing Maine Emergency Medical Services to Convene a Stakeholder Group to Explore Emergency Medical Services Career Pathways and Educational Opportunities in the State	CJPS	Enacted, P.L. 2023, c. 15	This enacted law directs the Department of Public Safety, Maine Emergency Medical Services to convene a stakeholder group to explore career pathways and educational opportunities for emergency medical services providers in the State. Maine Emergency Medical Services must submit a report to the Joint Standing Committee on Criminal Justice and Public Safety by January 15, 2024 that outlines the activities of the stakeholder group and includes any recommendations or proposed legislation. The committee may report out legislation to the Second Regular Session of the 131st Legislature.	Recommendation B-3

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
LD 588, An Act to Promote Public Safety and Retain Essential First Responders by Funding the Maine Length of Service Award Program	CJPS	Enacted, P.L. 2023, c. 439	This enacted law provides one-time funding in the amount of $500,000 in fiscal year 2024-25 for the Maine Length of Service Award Program, which provides length of service awards to eligible volunteer firefighters and emergency medical services personnel.	Recommendation B-2
LD 882, An Act to Allow Nonmunicipal Emergency Medical Services Providers to Be Considered State Employees for Purposes of Certain Benefits	LBHS	ONTP	This bill proposed to allow an ambulance service or nontransporting emergency medical service to participate in the State's Participating Local District Consolidated Retirement Plan as a local district so that its employees who are emergency medical services providers may receive state retirement benefits, death benefits and disability retirement benefits. The bill also proposed to allow these employees to be eligible for the state group health plan.	Recommendation B-1
LD 981, An Act to Require All Emergency Medical Services Persons to Be Trained to Administer and Dispense Naloxone Hydrochloride	CJPS	Enacted, P.L. 2023, c. 92	Effective July 1, 2024, Public Law 2023, chapter 92 requires an emergency medical services person to administer and dispense naloxone hydrochloride in compliance with protocols and training.	Not related to a specific report recommendation
LD 1409, An Act to Require Reimbursement When a Municipality Hires First Responders Whose Training Costs Were Incurred by Another Municipality	SLG	Carried Over	This bill establishes a formula to reimburse municipalities for training costs for training full-time first responders if the first responder is hired by another municipality within 4 years of the first municipality's initial incurrence of training costs.	Not related to a specific report recommendation
LD 1859, An Act to Reimburse Training Costs for Emergency Medical and Public Safety Dispatchers	CJPS	Majority ONTP Report Accepted	This bill proposed to require the Emergency Medical Services' Board in consultation with the Public Utilities Commission, Emergency Services Communication Bureau to establish a reimbursement schedule for the cost of training an emergency medical dispatcher or a public safety dispatcher when the dispatcher is hired by another governmental entity as an emergency medical dispatcher or public safety dispatcher within 5 years of the first governmental entity's incurring expenditures for the training. The bill also proposed to require a governmental entity to provide reimbursement for training costs in accordance with the reimbursement schedule.	Not related to a specific report recommendation
COMMUNITY PARAMEDICINE				
LD 883, An Act to Exempt Emergency Medical Services Community Paramedicine Programs from Home Health Care Provider Licensing Requirements Under Certain Circumstances	HHS	Enacted, P.L. 2023, c. 195	This enacted law adds community paramedicine services to the list of services exempted from home health licensing and includes conditions for the exemption. It also directs the Emergency Medical Services Board to adopt rules consistent with the home health exemption conditions.	Recommendation C-1

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
CONTINUED STUDY OF EMS				
LD 1701, Resolve, to Reestablish and Continue the Work of the Blue Ribbon Commission to Study Emergency Medical Services in the State	CJPS	Enacted, P.L. 2023, c. 99	Resolve 2023, chapter 99 reestablishes the Blue Ribbon Commission to Study Emergency Medical Services in the State for the purpose of examining and making recommendations on the structure, support and delivery of emergency medical services in the State. Resolve 2023, chapter 99 was finally passed as an emergency measure effective July 19, 2023.	Recommendation D-1
OTHER EMS RELATED BILLS				
LD 47, An Act to Amend the Law Governing Licensing Actions of the Emergency Medical Services' Board	CJPS	Enacted, P.L. 2023, c. 111	This enacted law removes an outdated reference to the revocation of a license in the laws governing the licensing actions of the Emergency Medical Services' Board.	Not related to a specific report recommendation
LD 439, An Act to Allow Death by Suicide to Be Considered a Death While in the Line of Duty	CJPS	Enacted, P.L. 2023, c. 433	This enacted law requires the applicable authority, when determining whether a law enforcement officer, firefighter, emergency medical services person, Department of Corrections law enforcement office or corrections officer has died while in the line of duty, to evaluate whether an individual who died by suicide has died as a result of events or actions experienced by the individual while in the line of duty. It also gives the Commissioner of Corrections rather than the Chief of the State Police the authority to make that determination for Department of Corrections law enforcement officers.	Not related to a specific report recommendation
LD 601, An Act to Reduce the Shortage of Municipal Emergency Medical Services Personnel by Removing Certain Vaccination Requirements	HHS	Died on Adjournment	This bill proposed to allow emergency medical services persons to provide treatment within the scope of their licenses without having been vaccinated against the COVID-19 virus or the influenza virus	Not related to a specific report recommendation
LD 727, An Act Regarding Workers' Compensation Benefits for First Responders Injured in the Line of Duty	LBHS	ONTP	This bill proposed to amend the Maine Workers' Compensation Act of 1992 to provide that if an employee employed as a first responder is injured and is also employed at an additional place of employment, the employee's average weekly wages are computed by combining the wages, earnings or salary received by the employee from each place of employment.	Not related to a specific report recommendation
LD 783, An Act to Protect Certain Private Emergency Services Personnel from Liability Under the Maine Tort Claims Act	JUD	Enacted, P.L. 2023, c. 311	This enacted law adds "mutual aid emergency response personnel" to the definition of "employee" under the Maine Tort Claims Act and also creates a definition of "mutual aid emergency response employer" under the Maine Tort Claims Act. The law provides that mutual aid emergency response personnel employed by the Bath Iron Works Corporation or its successor are considered employees for the purposes of the Maine Tort Claims Act, and also provides protection for the Bath Iron Works Corporation or its	Not related to a specific report recommendation

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
			successor under the Maine Tort Claims Act, only when the personnel are acting pursuant to a mutual aid agreement with a state or municipal entity or in response to a request for aid from a state or municipal entity.	
LD 919, An Act Regarding Licensure in the Field of Emergency Medical Services	CJPS	Enacted, P.L. 2023, c. 166	This enacted law amends the Maine Emergency Medical Services Act of 1982 to provide that the Emergency Medical Services' Board may by rule establish appropriate licensure levels and qualifications for emergency medical services persons, emergency medical dispatchers, emergency medical services educators, emergency medical dispatch centers, emergency medical services training centers, ambulance services and nontransporting emergency medical services.	Not related to a specific report recommendation
LD 1119, An Act to Clarify the Criminal Statutes with Regard to Assaults on Emergency Medical Services Persons	CJPS	Enacted, P.L. 2023, c. 455	This enacted law amends the crime of assault on an emergency medical care provider by specifying that it is a Class C crime if a person causes bodily injury to a person licensed pursuant to the Maine Emergency Medical Services Act of 1982 regardless of the location where the emergency medical care is being provided and by changing the name of the crime to reflect this amendment. The law also creates the new crime of assault in an emergency room, which a person commits if that person intentionally, knowingly or recklessly causes bodily injury to a person employed or contracted by a licensed hospital and the injury occurs in the hospital's designated emergency room.	Not related to a specific report recommendation
LD 1142, An Act to Eliminate Motor Vehicle Registration Fees for Volunteer Firefighters and Volunteer Emergency Medical Services Providers	TRA	ONTP	This bill proposed to exempt a volunteer firefighter and a volunteer emergency medical services provider from paying registration fees for a vehicle that is the primary means of transportation. The bill proposed to direct the Secretary of State to define "volunteer firefighter" and "volunteer emergency medical services provider." The bill also proposed to provide for the Secretary of State to adopt rules related to this exemption.	Not related to a specific report recommendation
LD 1268, An Act to Provide for a Local Motor Vehicle Excise Tax Exemption for Qualifying Volunteer Firefighters and Emergency Medical Services Persons	TAX	ONTP	This bill proposed to allow a municipality to provide an exemption from annual excise tax for one vehicle owned, separately or jointly, by a resident of that municipality who is a volunteer firefighter or volunteer emergency medical services person, as long as that vehicle is used to perform those volunteer services.	Not related to a specific report recommendation

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
LD 1396, An Act to Clarify the Laws Regarding Delegating Authority for Services Performed by Emergency Medical Services Personnel or Others as a Medical Assistant	HCIFS	Enacted, P.L. 2023, c. 132	This enacted law makes the following changes to clarify the laws regarding the delegating authority of a physician or physician assistant to emergency medical services personnel or others as a medical assistant. 1. It clarifies that a licensed emergency medical services person may not simultaneously act as an assistant performing medical services delegated by a physician or physician assistant. 2. It adds cross-references clarifying the authority of a physician assistant to delegate medical services to a licensed emergency medical services person in a hospital or health care facility. 3. It clarifies the laws regarding the delegating authority of a physician and a physician assistant.	Not related to a specific report recommendation

APPENDIX E

States that Designate EMS as an Essential Service: Structure and Funding (OPLA)

States that Designate EMS as an Essential Service: Structure and Funding

State	Essential Service Designation	EMS Structure	EMS Funding
California	CA. Health and Safety Code§1797.1 and §1797.2 • The Legislature finds and declares that it is the intent of the [Emergency Medical Services System and the Prehospital Emergency Care Personnel Act] to provide the state with a statewide system for EMS by establishing the Emergency Medical Services Authority within the State Health and Welfare Agency, which is responsible for the coordination and integration of all state activities concerning EMS. • It is the intent of the Legislature to maintain and promote the development of EMT-P paramedic programs where appropriate throughout the state and to initiate EMT-II limited advanced life support programs only where geography, population density, and resources would not make the establishment of a paramedic program feasible.	Each county may develop an emergency medical services program; the local EMS agency plans, implements, and evaluates an emergency medical services system consisting of an organized pattern of readiness and response services based on public and private agreements and operational procedures.	CA. Health and Safety Code 1797.98a Maddy Emergency Medical Services Fund Each county may establish an emergency medical services fund, upon the adoption of a resolution by the board of supervisors. Source of the fund is a penalty assessment imposed by counties on criminal offenses. 17 percent of fund distributed to counties to use to support EMS services.
Colorado	Co. Rev. Stat. §5-3.5-102 (1) The general assembly hereby declares that it is in the public interest to provide available, coordinated, and quality emergency medical and trauma services to the people of this state. It is the intent of the general assembly in enacting this article to establish an emergency medical and trauma services system, consisting of at least treatment, transportation, communication, and documentation subsystems, designed to prevent premature mortality and to reduce the morbidity that arises from critical injuries, exposure to poisonous substances, and illnesses.(2) To effect	• Department of Public Health and Environment provides resources and technical assistance to EMS providers in the state with the assistance of a state emergency medical and trauma services advisory council. • Colorado Board of health regulates EMS and paramedic services • Local emergency medical and trauma service providers include local governing boards, training centers, hospitals, special districts, and other private and public service providers that have as their purpose	Co. Rev. Stat. §25-3.5-603 **Emergency Medical Services Account** • A special account within the highway users tax fund; source of fund is an additional $2 fee on vehicle registrations; fees collected 3 for provisional certifications or licenses of emergency medical service providers, and fees collected for provisional registration of emergency medical responders. • Funds are used for distribution as grants to local emergency medical and trauma service providers pursuant to the emergency medical and trauma services (EMTS) grant program for training of EMS personnel and for distribution to each Colorado county for planning and coordination of emergency

State	Essential Service Designation	EMS Structure	EMS Funding
	this end, the general assembly finds it necessary that the department of public health and environment assist, when requested by local government entities, in planning and implementing any one of such subsystems so that it meets local and regional needs and requirements and that the department coordinate local systems so that they interface with an overall state system providing maximally effective emergency medical and trauma systems.(3) The general assembly further finds that the provision of adequate emergency medical and trauma services on highways in all areas of the state is a matter of statewide concern and requires state financial assistance and support.	the provision of emergency medical and trauma services. • Counties are conferred with the statutory authority to license ground ambulance services.	medical and trauma services in the county and between counties when such coordination would provide for better service geographically. There are 4 types of funding available through the EMTS funding program: • CREATE education grants - The Colorado Resource for EMS and Trauma Education (CREATE) program supports initial training and continuing education for EMS and trauma service providers working for eligible organizations in Colorado. • Provider grants - Grant funds are available to help purchase: medical and rescue equipment, communications, data collection equipment and response vehicles. Support for personnel, recruitment and retention projects and other projects is also available. Grantees must provide matching funds if funded for a provider grant. • System improvement funding -System improvement funding supports regional or statewide projects to improve the emergency medical and trauma services system. These projects address a need identified by data with clearly defined activities and evaluation measures. • Emergency grant funding -The emergency grant program assists Colorado EMS and trauma organizations that experience an emergency that seriously jeopardizes the level of EMS or trauma services within their service area.
Delaware	Del. Code 16§ 9701 The purposes of the emergency medical services systems legislation are to establish and/or identify specific roles and responsibilities in regard to emergency medical services in Delaware in order to reduce morbidity and mortality rates for the citizens of Delaware and to ensure quality of emergency care services, within available resources, through the effective	EMS statewide system is overseen by the Office of Emergency Medical Services within the Division of Public Health; EMS services are provided by volunteer fire and ambulance companies at the local or county level	Del. Code 16 §9814 **Statewide Paramedic Funding Program** • General Assembly appropriates annually an amount sufficient to reimburse 30 percent of approved costs of the statewide paramedic program; this appropriation is made in the annual Grants-In-Aid Act and is appropriated to the Office of Emergency Medical Services, Division of Public Health, Department of Health and Social Services.

State	Essential Service Designation	EMS Structure	EMS Funding
	coordination of the emergency medical services system.		• Funds distributed to a county for the purpose of supporting a county component of the statewide paramedic system may be used for direct operating costs or as debt service and financing for bond issuance for that purpose. For those capital projects with a total cost greater than $200,000, the State reimburses on a debt service basis. In no instance does reimbursement include the cost of indirect services provided by the county.
Hawaii	H.R.S. §321-221 The legislature finds that the establishment of a state emergency medical services system, including emergency medical services for children, is a matter of compelling state interest and necessary to protect and preserve public health. A system designed to reduce medical emergency deaths, injuries, and permanent long-term disability through the implementation of a fully integrated, cohesive network of components, the legislature further finds, will best serve public health needs. Accordingly, the purpose of this part is to establish and maintain a state emergency medical services system in communities that can be most effectively served by the State, and to fix the responsibility for the administration of this state system, which shall provide for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of health care services under emergency conditions, whether occurring as the result of a patient's condition, from natural disasters, or from other causes. The system shall provide for personnel, personnel training, communications, emergency transportation, facilities, coordination with emergency medical and critical care services, coordination and use of available public safety agencies, promotion of consumer	The Department of Health oversees EMS statewide with the consultation of an advisory committee and determines the levels of EMS to be implemented in each county within the service area. Ambulance service is either operated by the county or the state contracts with an ambulance service in those counties that do not provide ambulance service.	H.R.S. §321-234 **Emergency Medical Services Special Fund** • Fund consists of fees remitted from vehicle registration ($5), cigarette tax revenues, interest and investment earnings attributable to the moneys in the special fund, legislative appropriations, and grants, donations, and contributions from private or public sources. • Beginning with fiscal year 2021-2022, $3,500,000 is distributed each fiscal year to counties operating a county emergency medical services system for the operation of that system. • The remainder of the fund is distributed to the Department of Health for operating the EMS system, including enhanced and expanded services.

State	Essential Service Designation	EMS Structure	EMS Funding
	participation, accessibility to care, mandatory standard medical recordkeeping, consumer information and education, independent review and evaluation, disaster linkage, mutual aid agreements, and other components necessary to meet the purposes of this part.		
Indiana	IC 16-31-1-1 a) The general assembly declares that the provision of emergency medical services is a matter of vital concern affecting the public health, safety, and welfare of the people of Indiana.(b) It is the purpose of this article:(1) to promote the establishment and maintenance of an effective system of emergency medical service, including the necessary equipment, personnel, and facilities to ensure that all emergency patients receive prompt and adequate medical care throughout the range of emergency conditions encountered;(2) that the emergency medical services commission established shall cooperate with other agencies empowered to license persons engaged in the delivery of health care so as to coordinate the efforts of the commission and other agencies; and (3) to establish standards and requirements for the furnishing of emergency medical services by persons not licensed or regulated by other appropriate agencies.	EMS is overseen by the Emergency Medical Services Commission that is responsible for the development of a statewide EMS that must include state, regional, and local emergency ambulance service plans; promotion of statewide EMS facilities by developing minimum standards, procedures, and guidelines for personnel, equipment, supplies, communications, facilities and location of centers; and the promotion of programs for training of EMS personnel	IC 16-46-16.5-4 **Health Issues and Challenges Grant Program** • The fund consists of:(1) money appropriated for the program or to the fund by the general assembly;(2) money received from state or federal grants or programs; and (3) gifts, money, and donations received from any other source, including transfers from other funds or accounts. • More than $4 million has been awarded for community paramedicine.
Iowa	Iowa Code §422D.1 A county board of supervisors can adopt a resolution declaring emergency medical services to be an essential county service. The resolution declaring emergency medical services to be an essential service is considered and voted on for approval at two meetings of the board prior to the meeting at which the resolution is to be finally approved by a majority of the board.	EMS is overseen by the Department of Health with the assistance of an EMS Advisory Council; emergency medical service districts coordinate with local emergency medical services agencies to provide EMS services; district advisory councils recommends a funding level for the EMS services.	Iowa Code §357F.8 • Allows Emergency Medical Services Districts to impose an additional annual property tax levy on residents if a majority of residents vote to approve one. • Allows counties that adopt a resolution by majority vote of the county board declaring EMS to be an essential county service the authority to have optional taxes, including local option income surcharges and ad valorem property taxes (must be voted in an election).

State	Essential Service Designation	EMS Structure	EMS Funding
Louisiana	LA. Rev. Stat. 40:1139.1 The legislature hereby finds and declares the following: (1) Emergency medical services constitute an invaluable part of the healthcare delivery system of Louisiana and are an essential element of Louisiana's emergency preparedness system. (2) Emergency medical services will be a key element in any healthcare reform initiative. (3) Emergency medical services are a key component of any economic development program as they are essential to recruiting and retaining industry. (4) The cost of funding the Medicaid program and healthcare for the poor and uninsured in the state must be carefully managed in a manner which recognizes the challenges associated with appropriate reimbursement for services under the program. (5) Emergency medical service providers want to assure that emergency medical services are available to all residents of Louisiana. (6) It is in the best interest of the state that there exist sufficient resources to assure the availability of emergency ambulance services to the citizens of Louisiana and the creation of a statewide ambulance service district will help to ensure this goal. (7) The Louisiana Ambulance Alliance and the Louisiana Department of Health are interested in exploring the use of local revenues to enhance the delivery of emergency ambulance services through the use of certified public expenditures, intergovernmental transfers or other financing mechanisms that are in accordance with the applicable state and federal regulations.	• The Department of Health is responsible for establishing and maintaining a program for the improvement and regulation of emergency medical services in the state. • The responsibility for implementation of the program is vested in the Bureau of Emergency Medical Services. The bureau is responsible for the development of a state plan for the prompt and efficient delivery of adequate emergency medical services to acutely sick and injured individuals, and serves as the primary agency for participation in any federal program involving emergency medical services and may receive and disburse available federal funds to implement any service program. The bureau sets minimum standards for course approval, instruction, and examination.	LA. R.S. 46:2626 **Emergency Ground Ambulance Service Provider Trust Fund Account** • The Department of Health assesses each emergency ground ambulance service provider a percentage fee not to exceed the percentage of net patient service revenues permitted by federal regulations. • Funds from the Trust Fund Account are used to achieve the maximum reimbursement under federal law and appropriated solely to fund the reimbursement enhancements in the most recent formula adopted by the legislature or the secretary and distributed exclusively among emergency ground ambulance service providers for emergency and nonemergency ambulance transportation services provided.
Nebraska	Neb. Rev. Stat. §38-1203 The Legislature finds: (1) That emergency medical care is a primary and essential health care service and that the presence of an adequately	Nebraska is divided into four separate EMS regions: Western, Central, Northeast and Southeast. A dedicated EMS Specialist supports each region. The EMS Specialists provide are	Neb. Rev. Stat. §71-51-103 **Nebraska Emergency Medical Systems Operation Fund** The fund may receive gifts, bequests, grants,

State	Essential Service Designation	EMS Structure	EMS Funding
	equipped ambulance and trained emergency care providers may be the difference between life and death or permanent disability to those persons in Nebraska making use of such services in an emergency; (2) That effective delivery of emergency medical care may be assisted by a program of training and licensure of emergency care providers and licensure of emergency medical services in accordance with rules and regulations adopted by the board; (3) That the Emergency Medical Services Practice Act is essential to aid in advancing the quality of care being provided by emergency care providers and by emergency medical services and the provision of effective, practical, and economical delivery of emergency medical care in the State of Nebraska; (4) That the services to be delivered by emergency care providers are complex and demanding and that training and other requirements appropriate for delivery of the services must be constantly reviewed and updated; and (5) That the enactment of a regulatory system that can respond to changing needs of patients and emergency care providers and emergency medical services is in the best interests of the residents of Nebraska.	resource for every EMS service, EMS provider and hospital for training and technical assistance including system development, rules and regulations, statutes, protocol and policy development, documentation, quality improvement, recruitment and retention, recognition, mandatory reporting regulations, education, significant exposure procedures and systems of care.	fees, or other contributions or donations from public or private entities. • The fund is used to carry out the purposes of the Statewide Trauma System Act and the Emergency Medical Services Practice Act, including activities related to the design, maintenance, or enhancement of the statewide trauma system, support of emergency medical services programs, and support for the emergency medical services programs for children. • Any money in the fund available for investment is invested by the state investment officer.
Nevada	NRS 450.B.015 The Legislature hereby declares that prompt and efficient emergency medical care and transportation is necessary for the health and safety of the people of Nevada, and that minimum standards for such care and all persons providing it must be established.	EMS is overseen by the State Board of Health and District Boards of Health with assistance from a Committee on Emergency Medical Services; the board adopts regulations establishing minimum standards for ambulance and EMS services; health authorities adopt regulations to establish certification and licensure of EMS personnel	NRS 450B.1505 • Any money the Division receives from a fee set by the State Board of Health for the issuance or renewal of a license; an administrative penalty imposed or an appropriation made by the Legislature for the purposes of training related to emergency medical services: (a) Must be deposited in the State Treasury and accounted for separately in the State General Fund;

State	Essential Service Designation	EMS Structure	EMS Funding
			(b) May be used only to carry out a training program for emergency medical services personnel who work for a volunteer ambulance service or firefighting agency, including, without limitation, equipment for use in the training; and (c) Does not revert to the State General Fund at the end of any fiscal year. • Any interest or income earned on the money in the account must be credited to the account. Any claims against the account must be paid in the manner that other claims against the State are paid.
North Carolina	10 NCAC 13P.0201; N.C. Gen. Statutes §143-507 - §143-518 County government shall ensure that EMS are provided to its citizens; minimum service area for an EMS System shall be one county; care must be offered to residents within a service area 24 hours a day, seven days a week; personnel credentialed to perform within the scope of practice for all EMS personnel functioning in the EMS System	• Statewide EMS coordination is the responsibility of the Division of Public Health, Office of Preparedness and Response, Division of Emergency Management and the Division of Health Service Regulation, Office of Emergency Medical Services • The Regional Advisory Committees (RACs) provide direction, guidance, and coordination for each region. • There are 100 county EMS systems and one tribal EMS system consisting of multiple responders from rescue squads, critical care transport, and standard EMS providers. On the county level, planning efforts take place at the Local Emergency Planning Committee (LEPC). These LEPCs consist of stakeholders from law, fire, EMS, hospitals, Public Health, and private industry. LEPCs answer to the local Emergency Management.	N.C. §58-87-5 **Volunteer Rescue/EMS Fund** • Created in the Department of Insurance to provide grants to volunteer rescue units, rescue/EMS units, EMS units that are volunteer fire departments that are a part of a county's EMS system plan, and EMS units providing rescue or rescue and emergency medical services to purchase equipment and make capital improvements. • Department shall to the extent possible select applicants from all parts of the State based upon need. • State Treasurer invests the Fund's assets according to law, and the earnings shall remain in the Fund.
Pennsylvania	35 Pa. C.S. §8102 The General Assembly finds and declares as follows: • Emergency medical services are an essential public service and frequently the health care safety net for many Commonwealth residents. • Emergency medical services should be acknowledged, promoted and	• The Department of Health is responsible for planning, coordinating and guiding programs to promote effective and efficient operation of Statewide and regional EMS systems • State EMS Advisory Board advises the Department of Health concerning manpower and training, communications, EMS agencies,	35 Pa. C.S. §8153 **Emergency Medical Services Operating Fund** • Sources of the fund are a $20 surcharge on traffic violations; $50 fee for a person to participate in the Accelerated Rehabilitative Disposition program; appropriations and contributions. • 75% of the fund is dispersed to EMS agencies for costs related to contracts and grants, 30% of the fund allocated to EMS

State	Essential Service Designation	EMS Structure	EMS Funding
	supported as an essential public service. • The emergency medical services system should fully integrate with the overall health care system, and in particular with the public health system, to identify, modify and manage illness and injury and illness and injury risks.	regulations, and standards and policies. • Regional emergency medical services councils assist the Department of Health in carrying out the implementation of the EMS system.	agencies to provide training to underserved rural area; at least 10% of the fund provided to Ems agencies to assist with medical equipment purchases for ambulances and to regional EMS councils for the development, maintenance and improvement of EMS systems and for training, education and licensure.
South Carolina	South Carolina Act 164, 2021 Section 6-1-2020. (A) As used in this section: (B)(1) Ambulance service is hereby designated as an essential service in this State. (2) Each county governing body in this State shall ensure that at least one licensed ambulance service is available within the county. This may be provided as a county service, but also may be accomplished through other means including, but not limited to: (a) providing a license or franchise to a private company; (b) contracting with a public, private, or nonprofit entity for the service; (c) entering into an intergovernmental agreement with one or more local governments; or (d) entering into an agreement with a hospital or other health care facility. (3) A county is not required to appropriate county revenues for ambulance service if the service can be provided by any other means. (C) Municipal governing bodies also are authorized to make provisions for ambulance service within the boundaries of the municipality. A municipality may not provide and maintain, license, franchise, or contract for ambulance service outside its corporate boundaries without the approval of the county governing body, in the case of unincorporated areas, or the municipal	• Division of EMS and Trauma is under the Department of Health and Environmental Control and monitors and develops protocols, designates trauma centers, and certifies Emergency Medical Technicians, Paramedics and Athletic Trainers. • There are 4 EMS Regional Councils that provide training, consulting, and technical assistance to emergency services agencies and other allied health agencies and personnel. • Local EMS teams are the primary providers of EMS to residents.	• South Carolina EMS Association (SCEMSA) and Public Consulting Group (PCG) have partnered to develop and implement an Ambulance Supplemental Payment Program (ASPP) that will provide significant relief to South Carolina's public ambulance providers. • The ASPP program will enhance federal funding and help cover the Medicaid shortfall that exists between the cost of providing services and what Medicaid currently reimburses providers. • Upon the Centers for Medicare and Medicaid Services (CMS) approval, participation in the ASPP will allow government owned or operated ambulance providers to recover up to the federal share of the cost of providing transports that are currently paid through Medicaid Fee-for-service (FFS) and Medicaid Managed Care Organization (MCO) delivery systems. • The mechanism by which payments will be made to providers will vary based upon the Medicaid service delivery system. • Medicaid FFS - Implementation requires the submission of a Medicaid State Plan Amendment (SPA) to CMS. Once implemented, providers that wish to participate will be required to submit an annual cost report and sign a Certification of Public Expenditures in order to receive provider-specific cost-based reimbursement for Medicaid FFS transports. • Medicaid MCO - Implementation requires the submission of a Medicaid Section 42 CFR § 438.6(c) Preprint outlining the state

State	Essential Service Designation	EMS Structure	EMS Funding
	governing body if the area to be served lies within the boundaries of another municipality. (D) A county may not provide and maintain, license, franchise, or contract for ambulance service within the boundaries of a municipality that has made provisions for ambulance service without the approval of the municipal governing body of the area to be served. (E) The governing body of any county or municipality may adopt and enforce reasonable regulations to control the provision of private or nonprofit ambulance service. (F) Two or more counties and municipalities may enter into agreements with each other and with persons providing both emergency and nonemergency ambulance service for a county or counties on a countywide basis, for joint or cooperative action to provide for ambulance service."		directed payment arrangement and associated quality measures. • Once implemented, incremental enhancements for Medicaid MCO transports will be achieved through development of a per trip add-on rate that is tied to the average cost per trip for all providers submitting annual cost reports under the Medicaid FFS program. • Unlike the Medicaid FFS program, public providers will transfer the state share via an Intergovernmental Transfer (IGT) in advance of the supplemental payments being disbursed by MCOs.
Tennessee	TN Code 7-61-102 Ambulance service is hereby designated as an essential service in the state of Tennessee.	• Emergency Medical Services Board is empowered to approve schools and prescribe courses for EMS personnel, promulgate regulations governing licenses and permits, and establish standards for the activities and operation of emergency medical and ambulance services. • All county governing bodies are authorized and directed to make provisions to ensure that at least one (1) licensed ambulance service is available within their county. This may be provided as a county service, but can also be accomplished through other means, including, but not limited to: providing a license or franchise to a private company; contracting with a public, private, or nonprofit entity for the service; entering into an interlocal agreement with one (1) or	Public Chapter 1052, 2022 **Ambulance Service Assessment Revenue Fund** • Sources of the fund are quarterly assessments on ground ambulance service providers; penalties for not paying the assessment; donations from private sources and investment earnings. • Money in the fund may only be used to create directed payments for qualified ground ambulance services and to reimburse qualified Medicaid transports.

State	Essential Service Designation	EMS Structure	EMS Funding
		more local governments; or entering into an agreement with a hospital or other healthcare facility.	
Virginia	Va. Code § 32.1-111.3 The objectives of a statewide EMS Plan is: 1. Establishing a comprehensive statewide emergency medical services system, incorporating facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality; 2. Reducing the time period between the identification of an acutely ill or injured patient and the definitive treatment; 3. Increasing the accessibility of high quality emergency medical services to all citizens of Virginia; 4. Promoting continuing improvement in system components including ground, water, and air transportation; communications; hospital emergency departments and other emergency medical care facilities; health care provider training and health care service delivery; and consumer health information and education; 5. Ensuring performance improvement of the emergency medical services system and emergency medical services and care delivered on scene, in transit, in hospital emergency departments, and within the hospital environment; 6. Working with professional medical organizations, hospitals, and other public and private agencies in developing approaches whereby the many persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be	• Office of Emergency Service is responsible for the development of a comprehensive, coordinated, statewide emergency medical services plan. • The State Board of Health has designed 11 Regional EMS Councils to serve specific geographic areas of the Commonwealth. Each council is charged with the development and implementation of an efficient and effective regional emergency medical services delivery system. • Any county, city or town may provide EMS to its citizens by establishing an EMS agency.	Va. Code §46.2-694 **Four-for-Life Fund** • Source of the fund is a $4 per year charge that is collected at the time of vehicle registration • 32% of the fund is distributed to the Rescue Squad Assistance Fund for training of EMS personnel and equipment purchases. • 30% is distributed through contracts and other procurements to support EMS training programs, recruitment and retention programs, EMS development, local, regional and statewide performance contracts for EMS, technology and radio communications enhancements. • 2% is distributed to the Virginia Association of Volunteer Rescue Squads to conduct volunteer recruitment, retention and training activities. • 26% is allocated to the "Return to Locality" fund to provide local funding for training of EMS personnel and the purchase of equipment and supplies for EMS and rescue services.

State	Essential Service Designation	EMS Structure	EMS Funding
	served more appropriately and economically; 7. Conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of emergency medical services personnel, including expanding the availability of paramedic and advanced life support training throughout the Commonwealth with particular emphasis on regions underserved by emergency medical services personnel having such skills and training; 8. Consulting with and reviewing, with agencies and organizations, the development of applications to governmental or other sources for grants or other funding to support emergency medical services programs.		
West Virginia	W. Va. Code §16-4C-2 The Legislature finds and declares: (1) That the safe and efficient operation of life-saving and life-preserving emergency medical service to meet the needs of citizens of this state is a matter of general public interest and concern; (2) to ensure the provision of adequate emergency medical services within this state for the protection of the public health, safety and welfare, it is imperative that minimum standards for emergency medical service personnel be established and enforced by the state; (3) that emergency medical service personnel should meet minimum training standards promulgated by the commissioner; (4) that it is the public policy of this state to enact legislation to carry out these purposes and comply with minimum standards for emergency medical service personnel as specified herein; (5) that any patient who receives emergency medical service and who is unable to consent thereto should be	• Office of EMS is created in the Bureau of Public Health • Emergency Medical Services Advisory Council develops, with the commissioner, standards for emergency medical services personnel and for the purpose of providing advice to the Office of Emergency Medical Services and the commissioner with respect to reviewing and making recommendations for the establishment and maintenance of adequate emergency medical services for all portions of this state. • Each of the 55 counties provides some EMS services. • The state is divided into 10 EMS regions.	W. Va. Code §16-4C-24 **Emergency Medical Services Equipment and Training Fund** • The fund may only be used for the purpose of providing grants to equip emergency medical services providers and train emergency medical services personnel. • Commissioner of Bureau of Health establishes a grant program for equipment and training of EMS personnel and providers; priority given to rural and volunteer EMS providers. • Allocated $10 million in federal coronavirus relief funding to "EMS WV: Answer the Call" program to fund strategic initiatives that will bolster the state's EMS workforce and equip communities to better care for West Virginia citizens.

State	Essential Service Designation	EMS Structure	EMS Funding
	liable for the reasonable cost of such service; and (6) that it is the public policy of this state to encourage emergency medical service providers to do those things necessary to carry out the powers conferred in this article unless otherwise forbidden by law.		

Maine declaration of EMS as an essential service:

MRSA 32 §81-A

It is the purpose of this chapter to promote and provide for a comprehensive and effective emergency medical services system to ensure optimum patient care. The Legislature finds that emergency medical services provided by an ambulance service are essential services. The Legislature finds that the provision of medical assistance in an emergency is a matter of vital concern affecting the health, safety and welfare of the public.

It is the intent of the Legislature to designate that a central agency be responsible for the coordination and integration of all state activities concerning emergency medical services and the overall planning, evaluation, coordination, facilitation and regulation of emergency medical services systems. Further, the Legislature finds that the provision of prompt, efficient and effective emergency medical dispatch and emergency medical care, a well-coordinated trauma care system, effective communication between prehospital care providers and hospitals and the safe handling and transportation, and the treatment and non-transport under appropriate medical guidance, of the sick and injured are key elements of an emergency medical services system. This chapter is intended to promote the public health, safety and welfare by providing for the creation of a statewide emergency medical services system with standards for all providers of emergency medical services.

APPENDIX F

November 6th, 2023 Commission Member Presentations:

- **EMS System Funding (Joe Kellner)**
- **EMS Regionalization, One Optimization Approach (Kevin Howell)**
- **NorthStar EMS (Mike Senecal)**

EMS SYSTEM FUNDING

Blue Ribbon Commission (v2)

November 6th, 2023

BACKGROUND AND DISCLOSURES

- 12 years EMS experience, 10 directly responsible for billing and finance
- Former oversight over an EMS billing agency ($70M in annual charges)
- Currently serve as CEO – LifeFlight of Maine

PROVIDER AND CALL VOLUME DATA

- 166 Licensed Transporting EMS Services (data 1 year old)

All Transporting Agency Transport Volume					
Year	Average	25th Percentile	50th Percentile	75th Percentile	Maximum
2018	1123.6	147.5	384.0	1186.5	17400.0
2019	1272.8	167.0	374.0	1290.0	19965.0
2020	1104.1	158.8	329.0	1083.0	15658.0
2021	1211.6	191.0	399.0	1241.0	14795.0
2022	849.2	140.8	288.5	884.8	9892.0
All Transporting Agency Call Volume					
Year	Average	25th Percentile	50th Percentile	75th Percentile	Maximum
2018	1390.3	195.0	536.0	1634.0	19593.0
2019	1591.1	216.8	529.5	1760.8	21789.0
2020	1447.6	227.0	499.0	1516.0	17009.0
2021	1760.1	267.0	607.0	1950.0	20294.0
2022	1150.9	186.0	402.0	1142.0	13167.0

VEHICLE UTILIZATION

The median transports per ambulance vehicle per year in Maine is ***115***

NON-TRANSPORTS

On Average, 26% of requests do NOT result in transport and do NOT result in payment

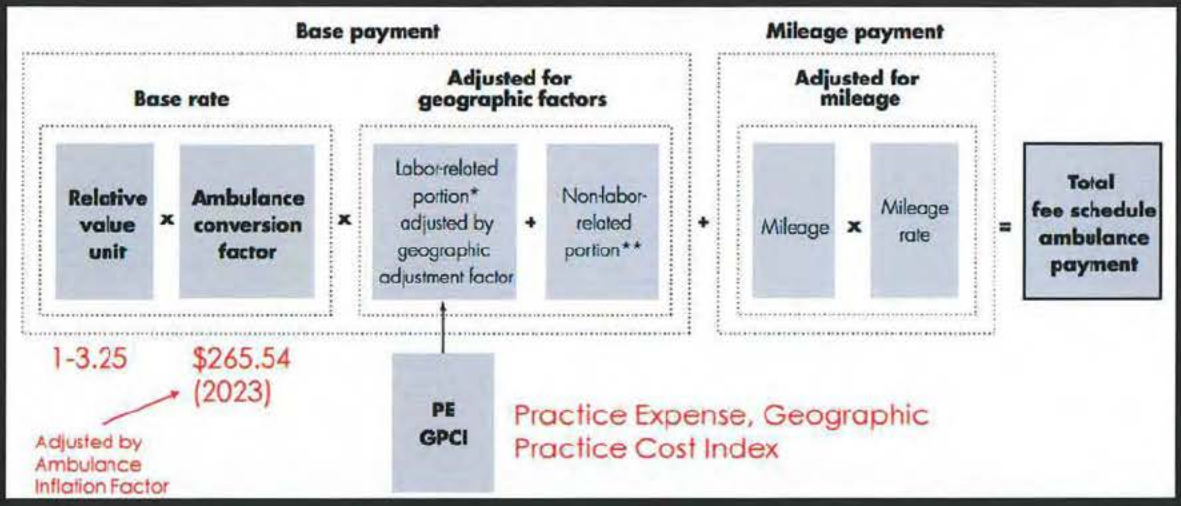
LD1602 now requires commercial payers to reimburse non-transport scenarios

STARTING AN AMBULANCE

A One-Ambulance service requires approximately $1,100,000 in cash to begin and sustain operations. Payment won't start coming until up to six months from startup

UNDERSTANDING AMBULANCE REIMBURSEMENT

AMBULANCE PAYMENT



RATE ADJUSTMENTS

This factor is an amount equal to the percentage increase in the consumer price index for all urban consumers (CPI–U) reduced by the 10-year moving average of multi-factor productivity.

2015	1.5
2016	-0.4
2017	0.7
2018	1.1
2019	2.3
2020	0.9
2021	0.2
2022	5.1
2023	8.7
2024	*2.6*

*MEDpac Ambulance Payment Basics

AMBULANCE ADD-ON PAYMENTS

- 2% Urban (urban, for example, includes all of Penobscot County)**
- 3% Rural
- 22.6% (lowest 25th percentile of all rural areas in US)

** This 2% offsets the long-standing 2% monies that are sequestered

MAINECARE

MaineCare pays at average Medicare rates **based on the lowest GPCI,** and includes ambulance add on payments based on the zip code in which the services are rendered

COMMERCIAL PAYERS

- LD1258
  - 180% of Medicare (plus rural and super rural add ons) for out of network
  - 200% of Medicare (plus rural and super rural add ons) for in network

  Methodology expires 12/31/2023. Without this, carriers' payment to out of network ambulance services will decrease dramatically, though it will introduce an independent dispute resolution process.

- LD1602 made these changes permanent and included non-emergency transportation.

FINANCIAL DEMONSTRATION

25th Percentile Transport Volume: 191 (267 requests)
50th Percentile Transport Volume: 399 (607 requests)
75th Percentile Transport Volume: 1,241 (1,950 requests)
Highest Transport Volume: 14,795 (20,294 requests)

Reimbursement averages ~$500 per transport, yet the 50th percentile cost is estimated to be over $1,900 per transport

Percentile	Volume	Net Income	Ambulances	FTEs	Net Income Per Call	Cost Per Transport
25th	191	$ (653,854.54)	1	9.8	$ (3,423.32)	$ 3,915.31
50th	399	$ (568,300.56)	1	9.8	$ (1,424.31)	$ 1,916.30
75th	1241	$ (805,613.47)	2	18.6	$ (649.16)	$ 1,141.15
Maximum	14795	$ (201,752.76)	9	83.2	$ (13.64)	$ 505.63

Percentile	No Transports	Additional Revenue if non-transports were funded*	Additional loss to adjust wages	Additional Revenue if Rural	Additional Revenue if Super Rural
25th	67	$ 29,527.50	$ (899,972.41)	$ 1,061.05	$ 23,979.74
50th	140	$ 55,416.09	$ (814,418.44)	$ 2,216.54	$ 50,093.81
75th	436	$ 172,359.30	$ (1,010,096.46)	$ 6,894.05	$ 155,805.56
Maximum	5,198	2,054,839.56	$ (2,416,813.61)	$ 82,189.76	N/A

Wage Adjustment Mid Points
EMT: 20, AEMT: 25, Paramedic: 35

*Assumes paying base rates with no mileage

The 50th percentile ambulance service, performing 399 calls per year, requires $570,000 in subsidy to break even

This number has increased to over $800 for most services, depending on payer mix

MUNICIPAL AMBULANCE SERVICES

	Urban, 1334 Calls per year (Old Town)	Super Rural (Madawaska)
Charges	$ 1,359,369.20	
Contractual Allowances / BD	$ (608,842.31)	
Payments	$ 683,003.70	$ 393,784.78
Personnel	$ 1,097,991.00	$ 431,125.00
Purchased Services	$ 26,319.00	$ 57,000.00
Supplies and Materials	$ 69,817.00	$ 40,050.00
Repairs and Maintenance	$ 36,550.00	$ 14,200.00
Utilities	$ 30,140.00	$ 2,300.00
IT	$ 4,000.00	$ 2,520.00
Other	$ 552.00	$ 16,550.00
Depreciation	$ 98,485.00	
Insurances	$ 51,477.00	
Net Income Before Allocation	$ (732,327.30)	$ (169,960.22)
Not included	Rent, Capital Equipment, Additional Personnel. Expenses split 50/50 with fire, however 86% of demand is EMS	Insurances, capital equipment, rent

501(C)3 AMBULANCES

DELTA

		Prior Year	Current Year	Prior Year	Current Year
Revenue	8 Contributions and grants (Part VIII, line 1h)		1,512,684	1,086,885	0
	9 Program service revenue (Part VIII, line 2g)	7,710,421	6,972,577	7,030,742	6,453,653
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	259,728	94,413	849,626	69,991
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		0		0
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	7,970,149	8,579,674	8,967,253	6,523,644
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)		0		0
	14 Benefits paid to or for members (Part IX, column (A), line 4)		0		0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	5,913,295	6,259,027	6,648,442	6,963,628
	16a Professional fundraising fees (Part IX, column (A), line 11e)		0		0
	b Total fundraising expenses (Part IX, column (D), line 25) ▶0				
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	2,352,604	2,353,150	2,529,448	2,555,243
	18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	8,265,899	8,612,177	9,177,890	9,518,871
	19 Revenue less expenses. Subtract line 18 from line 12	-295,750	-32,503	-210,637	-2,995,227
Net Assets or Fund Balances		Beginning of Current Year	End of Year		
	20 Total assets (Part X, line 16)	10,372,172	11,011,395		
	21 Total liabilities (Part X, line 26)	2,336,729	2,683,185		
	22 Net assets or fund balances. Subtract line 21 from line 20	8,035,443	8,328,210		

NORTHERN LIGHT

		Prior Year	Current Year	Prior Year	Current Year
Revenue	8 Contributions and grants (Part VIII, line 1h)		0	14,173.	173,515.
	9 Program service revenue (Part VIII, line 2g)	7,679,258	8,343,088	8,099,598.	8,270,453.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	-8,031	-755	-5,287.	298.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		0	8,108,484.	8,444,266.
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	7,671,227	8,342,333		
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)		0	5,948,616.	6,673,025.
	14 Benefits paid to or for members (Part IX, column (A), line 4)		0		
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)		4,589,894	2,699,491.	2,959,487.
	16a Professional fundraising fees (Part IX, column (A), line 11e)		0	8,648,107.	9,632,512.
	b Total fundraising expenses (Part IX, column (D), line 25) ▶0			-539,623.	-1,188,246.
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	8,289,140	3,930,943	Beginning of Current Year	End of Year
	18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	8,289,140	8,520,837	2,616,379.	2,394,467.
	19 Revenue less expenses. Subtract line 18 from line 12	-617,913	-178,504	4,835,458.	5,634,932.
				-2,219,079.	-3,240,465.

UNITED

		Prior Year	Current Year	Prior Year	Current Year
Revenue	8 Contributions and grants (Part VIII, line 1h)	0	44,853	0	0
	9 Program service revenue (Part VIII, line 2g)	8,977,856	8,463,961	7,698,525	8,240,307
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	7,585	-2,088	10,958	102,325
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	0	0	10,048	-14,542
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	8,985,441	8,506,726	7,719,531	8,328,090
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	4,559	3,270	2,094	0
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0	0	0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	6,350,066	6,254,834	5,731,643	6,340,670
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0	0	0
	b Total fundraising expenses (Part IX, column (D), line 25) ▶0				
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	2,833,459	2,264,369	2,071,638	2,400,220
	18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	9,188,084	8,522,473	7,805,375	8,740,890
	19 Revenue less expenses. Subtract line 18 from line 12	-202,643	-15,747	-85,844	-412,800
Net Assets or Fund Balances		Beginning of Current Year	End of Year		
	20 Total assets (Part X, line 16)	5,683,121	5,666,558		
	21 Total liabilities (Part X, line 26)	637,649	636,833		
	22 Net assets or fund balances. Subtract line 21 from line 20	5,045,472	5,029,725		

CURRENT SUBSIDIES

- Municipal contributions (space, overhead)
- Tax contributions
- Volunteer hours
- Per Capita Contributions
- Purchased Services

APPENDIX WITH ASSUMPTIONS

LIST OF ASSUMPTIONS

- Median Pay Rates
  - EMT: 17.50, AEMT: 19, Paramedic: 25
- Charge Structure 2-3x Medicare Rates
- Service Mix:
  - BLS Non-Emergency: 20%
  - BLS Emergency: 31%
  - ALS Non-Emergency: 5%
  - ALS Emergency: 41%
  - ALS II Emergency: 3%

LIST OF ASSUMPTIONS

- Ambulance Acquisition
  - Vehicle base cost: $185,000
  - Patient Securement: $50,000 (Cot and loading system)
  - Ambulance lifespan: 225,000 miles
  - Ambulance MPG: 8
  - Maintenance Cost: $0.13/mile driven
  - General medical equipment: $35,000

Mileage Factor

- Ambulance will drive 3.5 miles for every miles of patient transport

LIST OF ASSUMPTIONS

Required Ambulances

- 0-1000 Transports: 1 ambulance
- 1000-2000 Transports: 2 ambulances
- Each additional 2000: 1 more ambulance

Staffing

- EMT/Paramedic team
- 1 leadership position per three trucks, minimum of 1
- 1 senior leader for five or more trucks

LIST OF ASSUMPTIONS

Required Ambulances

- 0-1000 Transports: 1 ambulance
- 1000-2000 Transports: 2 ambulances
- Each additional 2000: 1 more ambulance

Staffing

- EMT/Paramedic team
- 1 leadership position per three trucks, minimum of 1
- 1 senior leader for five or more trucks

LIST OF ASSUMPTIONS

Payer Mix

- Medicare / Mainecare: 65%
- Commercial Insurers: 20%
- Self-pay: 15%

LIST OF ASSUMPTIONS

Billing and Dispatch

- $20.00 per call

- Average Reimbursement per Transport: $491.99
- Average Charge: $1,072.50
- Average Transport Mileage - 12

Several other assumptions of cost are included, but are based off actual data

EMS REGIONALIZATION

ONE RURAL OPTIMIZATION APPROACH

A CASE STUDY

PREPARED FOR

EMS BLUE RIBBON COMMISSION

NOVEMBER 6, 2023

Introduction

Presenter:

Kevin Howell, Town Manager – Town of Carmel

2016 – Present

CERTIFIED:

- TOWN MANAGER
- TOWN CLERK
- TREASURER
- TAX COLLECTOR
- CODE ENFORCEMENT OFFICER
- LOCAL PLUMBING INSPECTOR

CURRENTLY SERVING:

- MMA LEGISLATIVE POLICY COMMITTEE
- BOARD OF DIRECTORS, MUNICIPAL REVIEW COMMITTEE
- MAINE STATE EMERGENCY RESPONSE COMMISSION – MUNICIPAL REPRESENTATIVE

Town of Carmel, Maine, U.S.A

"Your Rural Community"

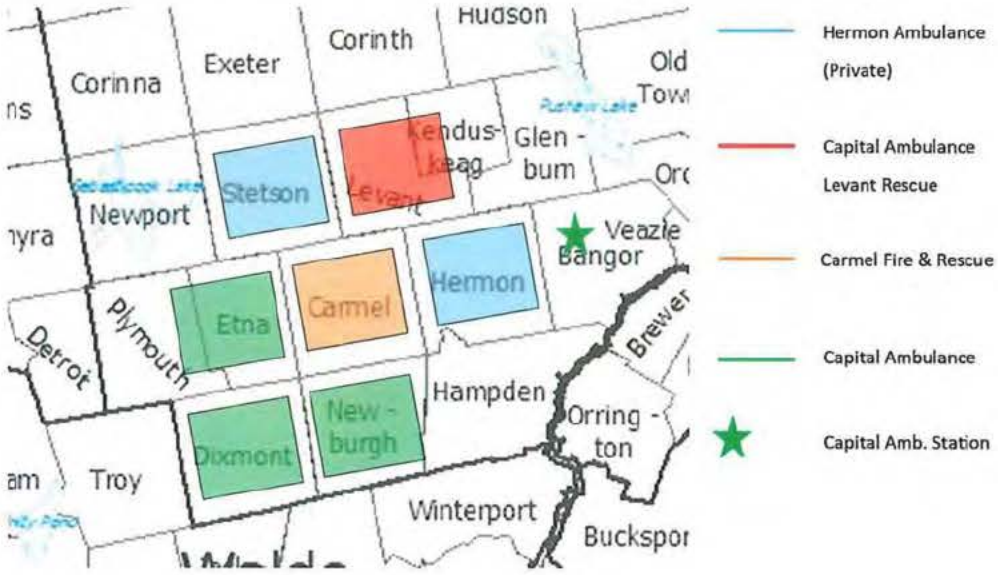
- Population of approx. 2,900
- Bedroom community to the Greater Bangor Economic Region
- Town Meeting / Board of Selectmen / Town Manager form of gov.
- Active paid fire department – voluntary response operation
- Centrally located in Southern Penobscot County along I-95

GENESIS....

WHAT'S ALL THE RUCKUS ABOUT???

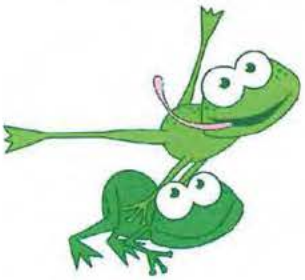
- **FRAGMENTATION IN REGIONAL EMS**
- COMPETING SERVICES
- LIMITED MUNICIPAL RESOURCES
- RURAL LOGISTICAL CHALLENGES
- FUNDING SHORTFALLS
- STAFFING CHALLENGES

WHERE WE STARTED - 2018 EMS MAP



LIFE SAFETY

IS NOT A GAME OF LEAPFROG



Challenges of small-town EMS

CALL VOLUME

Insufficient call volume to create offsetting revenue relative to cost of readiness

STAFFING

Small service, limited advancement opportunity, noncompetitive wages and benefits, no back up staff for vacation/sick/training and turnover

FUNDING

Shortfalls in funding creates local tax burden

LOGISTICS

Rural logistics create lengthy ALS aid response

ADMINISTRATION

No full time FIRE/EMS administration.

What is OPTIMIZATION?

The action of making the best or most effective use of a situation or resource.

Broadly speaking, optimization is the act of changing an existing process in order to increase the occurrence of favorable outcomes and decrease the occurrence of undesirable outcomes.

Optimization Process

Research

- OPEN MIND
- If you don't ASK – you'll NEVER KNOW!
- Consider ALL options
- THINK outside the box
- ANYTHING is possible

Testing / Implementation

- Rubber meets the road
- Staffing
- Expectations
- Logistics
- Protocol

Analysis

- How's it going?
- Quality Control
- $$$ - Is it what we thought it was?
- Is it sustainable?
- What did we miss?

OPTIMIZATION GOALS

IDENTIFY THE DESTINATION

Local (Town) priorities

- Provide quality sustainable EMS service
- Achieve manageable financial balance
- Manageable expectations (understand your limits)
- Ask for help when you need it
- Offer help when you have it

Systematic priorities

- Regional continuity
- Closest available resource
- Systematic transparency
- One common goal
- Share resources

CHALLENGE #1

CALL VOLUME

Lack of call volume results in lack of transports which results in lack of revenue.....

HOW DO WE OVERCOME LOW CALL VOLUME IN A SMALL TOWN???????

LOOK AROUND.....

NEIGHBORS IN NEED.....

CHALLENGE #2

NOT OUR CUSTOMERS

CARMEL IS NOT THE CONTRACT EMS PROVIDER FOR OUR NEIGHBORS IN NEED....
NOR ARE WE LICENSED TO BE....

HOW DO WE OVERCOME THIS???

LOOK AROUND.....

IF YOU DON'T ASK... YOU'LL NEVER KNOW.....

CHALLENGE #3

STAFFING

SMALL TOWNS STRUGGLE TO RECRUIT AND RETAIN EMS STAFF... WE CAN'T COMPETE!!

HOW DO WE OVERCOME THIS???

WAIT A SECOND... WHAT IF....

WE HAVE AN AMBULANCE, STATION, AND FAVORABLE LOCATION (HUB)....

AND YOU HAVE....

TOGETHER IS BETTER

TOWN OF CARMEL

WE HAVE:

- AMBULANCE
- AMBULANCE DRIVER
- FAVORABLE LOCATION
- AMBITION
- WILLING ADMINISTRATION
- MUNICIPAL SUPPORT SERVICES

NORTHERN LIGHT

YOU HAVE:

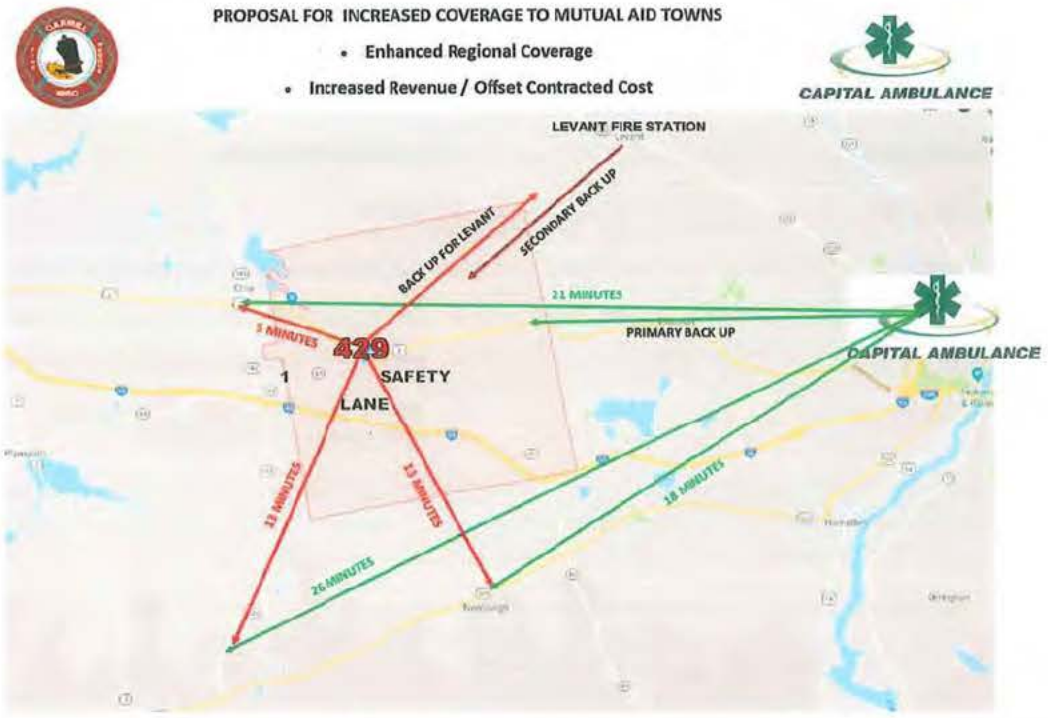
- EMS STAFF
- CALL VOLUME
- TRAINING
- ALS BACKUP
- EXPERIENCED BILLING RESOURCES
- BACK UP AMBULANCES

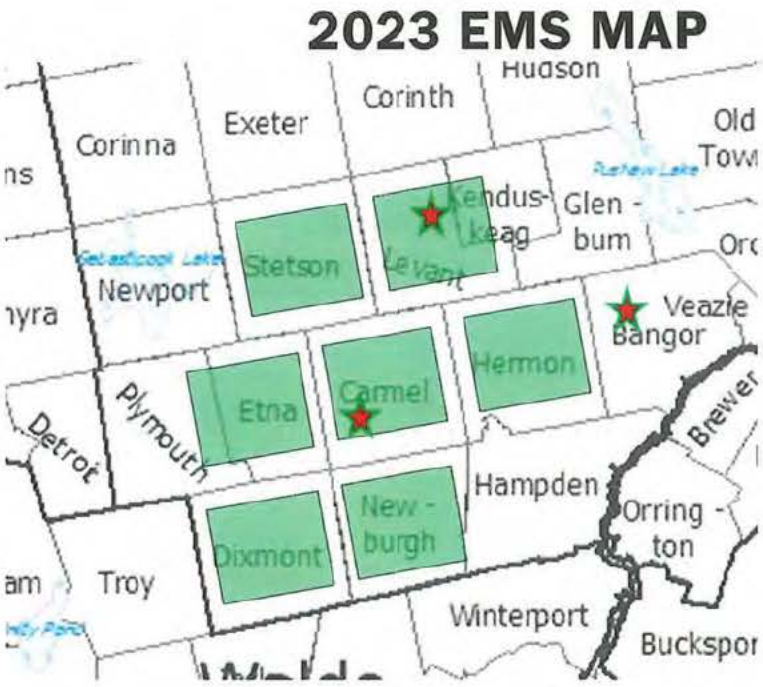
TOGETHER WE HAVE....

A SOLUTION!!

IN JULY 2018, THE TOWN OF CARMEL SIGNED A CONTRACT WITH NORTHERN LIGHT CREATING A PRIVATE / PUBLIC PARTNERSHIP THAT WILL INITIATE A QUASI-MUNICIPAL REGIONALIZATION OF EMS SERVICES TO SOUTHERN PENOBSCOT COUNTY

- NORTHERN LIGHT PROVIDES EMT (MIN)
  - REPORTING TO CARMEL FIRE STATION M-T 8AM-6PM
- TOWN OF CARMEL PROVIDES ALL OTHER NEEDS
  - (AMB/DRIVER/SUPPLIES/ETC)
- WHILE STAFFED, 429 REPONDS TO:
  - CARMEL, ETNA, DIXMONT, NEWBURGH
- TOWN OF CARMEL RECEIVES ALL REVENUES
  - (SPLITS PERCENTAGE ON OUT-OF-TOWN BILLS)
- NORTHERN LIGHT PROVIDES EMS TRAINING TO CARMEL STAFF





Northern Light Associated Service

Service Hub (amb sta.)

- CLOSEST AVAILABLE RESOURCE
- NO CONTRACTUAL CONFLICTS
- CONTINUITY IN COVERAGE
- COMMON DISPATCH PROTOCAL
  - Still fragmented (medcomm)

WHO WINS???

WE ALL DO....

INTERESTED PARTY

- CITIZENS OF CARMEL
- CITIZENS OF ETNA/NEWBURGH/DIXMONT/STETSON
- NORTHERN LIGHT
- TOWN OF CARMEL

BENEFIT

- EMS STAFFED IN TOWN (IMPROVED SERVICE)
- DRASTICALLY IMPROVED EMS RESPONSE TIMES
- RELIEF/HELP WITH STRETCHED RESOURCES
- MANAGABLE FINANCIAL BALANCE AND SUSTAINABLE EMS SERVICE

MANAGEABLE FINANCIAL BALANCE

OUTGOING

ANNUAL COSTS:

- N/L EMS CONTRACT: $50K
- AMBULANCE DRIVER: $50K
- MED. SUPPLIES: $12K
- ALS BACK UP: $16K
- AMBULANCE MAINT: $5K
- BILLING: $4K
- EMS STAFF: $25K

INCOMING

ANNUAL REVENUE:

- TRANSPORT BILLING: **$150K** (billed $175k)
  - 5 year trend of 85% capture rate

911 – WHO DO WE CALL?

DISPATCH PROTOCOL

6 TOWNS – 6 TONES

- Shift pager programed for all service towns..
- Automatic Response

BACKUP

- Closest backup stands ready
- All three hubs have situational awareness of region

Thoughts....

Fragmentation in Public Safety..

Disrupts continuity and workforce retention.

Fair Share..

Unbalanced administrative & fiscal burden.

Caution in subsidy..

Subsidies may enable sustaining an inefficient allocation of resources.

Focus on municipalities

Each town controls their own destiny

Identify and empower rural HUBS

Hub and spoke approach

Thank you

"Without change there is no innovation, creativity, or incentive for improvement. Those who initiate change will have a better opportunity to manage the change that is inevitable." - William Pollard

MaineHealth

NorthStar Emergency Medical Services

Mike Senecal Senior Director

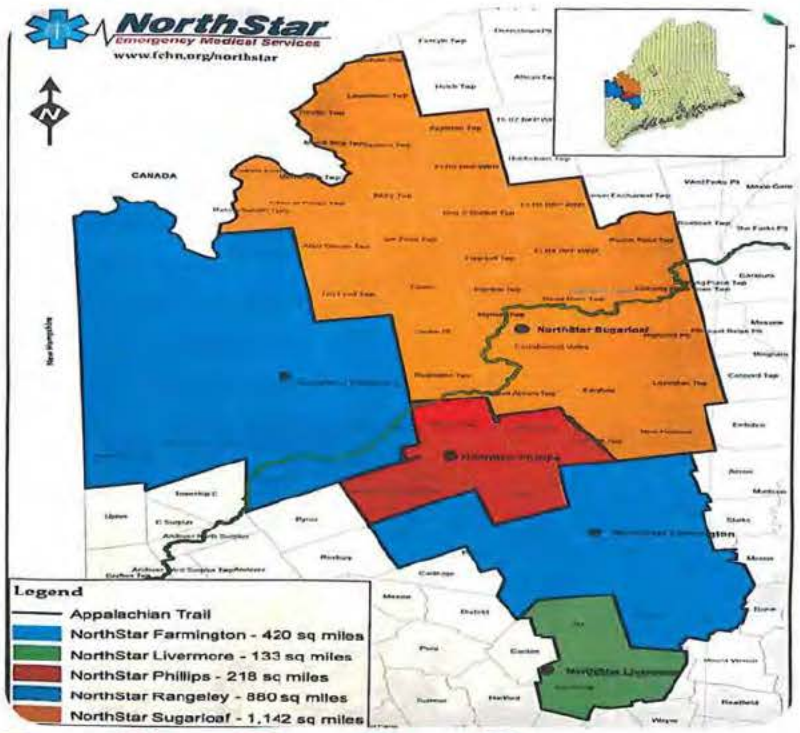
PATIENT CENTERED · RESPECT · INTEGRITY · EXCELLENCE · OWNERSHIP · INNOVATION

PATIENT CENTERED · RESPECT · INTEGRITY · EXCELLENCE · OWNERSHIP · INNOVATION

System Overview

- NorthStar is the regional ambulance service for Greater Franklin County. Our 85 EMS professionals follow their mission of positive community activities, good stewardship of resources, and respectful and excellent patient care. This mission is evident throughout NorthStar's operations with 7,000 calls per year to the 71 communities it proudly serves.
- NorthStar is dispatched out of five base locations strategically positioned throughout the region. NorthStar responds to calls ranging from medical emergencies and accidents to nursing home transfers. Average System Response Time 15:53 minutes
- Licensed to EMT level and permitted to paramedic
- In 2022 NorthStar created a Inter-facility Transport division (IFT) to support MaineHealth hospitals. IFT is a operated as a separate cost center and not part of this presentation.

Act with kindness and compassion. · Be an active listener. · Be a role model. · Set high standards. · Take responsibility. · Embrace change.



History

Starting in 1995, FMH began acquiring/operating small local ambulance services, allowing them to continue to operate independently.

- LifeStar -1995
- Sugarloaf Ambulance - 1996
- Rangeley Region Ambulance - 1999
- Community Emergency Service – 2000
- AMPS – 2000

In 2003 those five services merged into FMH-EMS under one unified set of policies and procedures, but still different departments of FMH. Shortly thereafter NorthStar was born as a regional ambulance services as a single department of FMH.

Administration

- NorthStar operates as a department of Franklin Memorial Hospital part of the MaineHealth health system.
  - Service Director
  - FMH President
  - MaineHealth System Senior Director
- NorthStar Advisory Board
  - The NorthStar Advisory Board shall review NorthStar's performance, including monitoring quality of care and service effectiveness from the perspective of patients, the communities served and emergency room providers. The Board shall make recommendations to the Board of Directors regarding long-term strategies and goals, annual operating and capital budgets, and the rationale and formula(s) for dividing public support costs between the municipalities served.

Operations

- Dispatched by Franklin County Regional Communication Center
- Staffing
  - Livermore 1- Paramedic level staffed 24 Hours/day
  - Farmington 2- Paramedic level staffed 24 Hours/day
  - Phillips 1- Paramedic level staffed 10 Hours/day
  - Sugarloaf 1- Paramedic level staffed 24 Hours/day
  - Rangeley 1- Paramedic level staffed 24 Hours/day

Note: Goal is to have all ambulances staffed at the paramedic level. Due to staffing challenges we have created strategies to coordinate responses across the system to allow the most appropriate team too answer the call i.e. determinant codes and Paramedic paradox. Some of the coverage above is covered with call shifts.

Community Serves

Community Paramedicine

- program that has emergency medical technicians (EMTs) and paramedics making house calls to vulnerable patients to educate them, monitor their condition, and if needed, provide treatment. EMTs provide patient care in the home offering services such as: vital signs and weight monitoring, high blood pressure checks, glucose testing and diabetes management, medication assistance, flu shots, and fall prevention and safety education.

Backcountry Medical Team

- NorthStar Backcountry Medical Response Team is charged with responding to ill and injured persons in an off-road environment in the forests, mountains, lakes and rivers within the NorthStar EMS response area, and, in collaboration with the Maine Warden Service and other wilderness rescue responders, providing public education as well as emergency medical care using the highest level of wilderness prehospital care providers available.

NorthStar System Status Management

- When the system is busy, crews may be strategically positioned to respond to emergency or non-emergent calls. Such standby coordination and ambulance placement for the system will be the responsibility of the Duty Supervisor or NorthStar on Call Administrator. Whenever possible, ambulance movement to standby locations should be automatic. While the majority of the responsibilities will be handled in this fashion, duty crews will provide input or assume responsibility if the Duty Supervisor is busy or unable to fulfill the duties due to call volume or location. Franklin County RCC may also assist in strategically assigning crews to cover the response area.
  - 75% of the calls are Farmington South
  - Goal is to have ambulances stage in areas statically that have the highest chance for the next call and send the closest available ambulance to the call. Dynamic versus Static
  - With increased call volumes this has resulted in the system being more responsive

First Responder Services

In the NorthStar coverage area we rely on the assistances of our 8 Licensed First Responder agencies. Wilton, Jay, New Sharon, Farmington, Eustis, Livermore, Carrabassett Valley, and Industry

- AED/CPR
- Anaphylaxis
- Bleeding control
- OD calls
- Public Assists

Factors that affect response times

- EMD
  - Utilizing 911 EMD codes to modify response for safety
    - » 2021 1171 Alpha level calls
    - » 2022 1376 Alpha level calls
- Lights and Sirens
  - 2021 55% of 911 calls
  - 2022 37% of 911 calls
- Staging for behavioral health
- Backcountry Rescues

Run Statistics

	FY23	FY22	FY21	FY20
Total Runs	7432	7399	7732	6233
Emergencies	6005	5937	5340	4891
Transfers	1240	1201	1339	1108
All others	119	176	748	107
CP Visits	68	85	305	234
Billable	5290	5285	4940	4366

Financial Summary FY23

Gross patient Revenue $12.6 million

- Contractual allowance 67 %

Net Patient Revenue $4.6 million

Other Revenue Town Subsidies $690,000

- Amount is generated from operating deficit
- Hospital has attempted to mitigate large increases

Financial Summary FY23

$6 million annual operating budget

Total Expenses $ 6 million

- $4.5 million in salaries and benefits
- $1.5 million in operating expenses
  - » Fuel
  - » Medical supplies
  - » Facilities
  - » Non-medical supplies
  - » Hospital support
  - » Capital

Financial

Year	Revenue with Subsidies	Total Expenses	Margin
2018	3,878,442	3,937,942	-59,500
2019	3,952,607	4,068,366	-115,759
2020	3,908,378	4,289,336	-380,958
2021	4,541,343	4,730,906	-189,563
2022	4,423,455	4,880,328	-456,873
2023	5,329,058	6,032,414	-703,356

Town Subsidies/Fee

The commitment to the communities we serve is to operate at a breakeven while providing a quality emergency medical transport service.

- Contracted with 29 towns to provide emergency coverage
- Contract runs from July 1 to June 30
- Advised of subsidy amount for following year by January 1
- Annual contract opt out clause
- Full disclosure of financials
- NorthStar Advisory Board

Subsidy Formula

Demographics. When the initial formula was developed, several demographic categories were considered, and the formula was narrowed down by the *NorthStar* Advisory Board to the three elements that best represented the region's diverse aspects. After reviewing the 2010 Census information, the Board felt that these elements were still valid. These are:

- **Population** (**2010** Census data). Since the ambulance business is about people, population is a broad indicator of how often the services will be used.
- **Residential Valuation** (using most current year State Equalized Values). Again, focusing on the "people" by using Residential Valuation instead of the broader Total Valuation, this is an indication of overall development in the area. This factor is weighted less than the other factors but is the only value that changes based on inflation and/or with development in the area. Use of this factor allows a small inflationary increase for *NorthStar*'s operations.
- **Housing Units** (**2010** Census data). In most towns that do not have seasonal fluctuation, the housing units correspond to the population but it is a good measure of the potential of seasonal visitors and residents (and taxpayers) and thus, along with population, is an overall measure of projected activity in the town. County Unorganized Territory (UT) information was estimated based on the latest UT annual reports and state valuation reports.

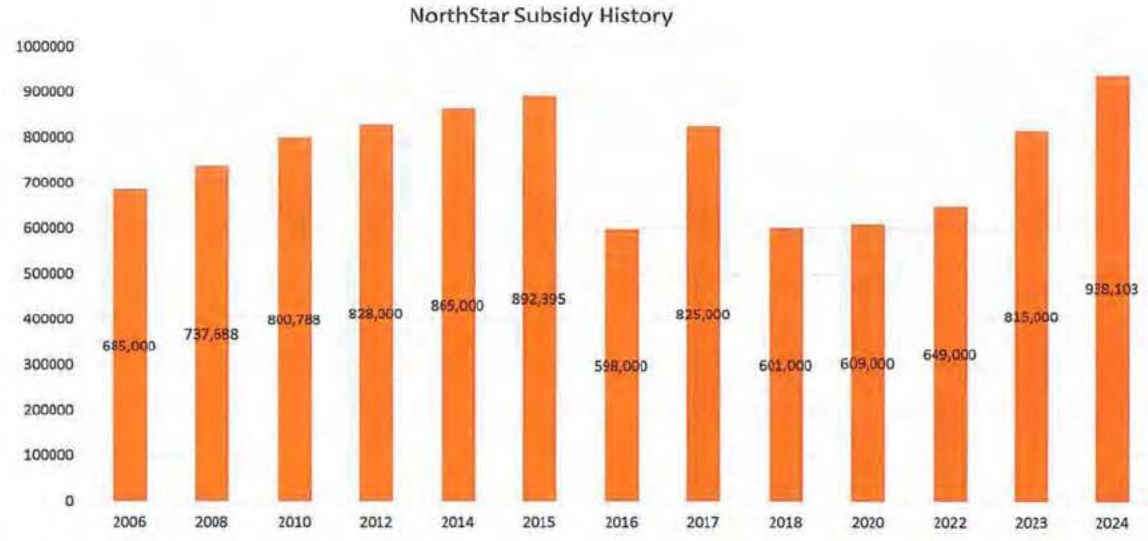
Subsidy Formula

How the Formula Works

- **Fee**. A single Flat Fee for each town and a single fee for each UT (unchanged for seven years).
- **A Dollar Value**. A dollar amount in each category is applied to each town's demographic value. Residential valuation remained flat in towns and territories serviced by NorthStar. As outlined above this factor normally allows for a small inflationary increase for operations.
- **A Distance Factor**. The center of population for the region that NorthStar serves is, in fact, in southern Franklin County. However, NorthStar has positioned crews and ambulances at strategic points around the region to assure that we respond quickly throughout the territory. Four of these five bases are crewed 24/7 to assure timely coverage of the entire area, including those in sparsely settled areas. The farther away from the center of population, there are fewer people per square mile and thus fewer runs per day. With fewer runs, there is less income to offset the expenses of keeping an ambulance ready all the time for that town.

Note: Since the subsidy is based on NorthStar's overall deficit, a distance factor is appropriate when looking at the financial impactof serving very rural areas with an ambulance always staffed and ready to respond. In this formula, the total sum of the fee and other factors described above is multiplied by this distance factor. (Specifically, the distance factor is the ratio of distance to the town from the population center point divided by the average distance). To limit the effects of both very short and very long distances the factor has been 'capped' with a minimum and a maximum ratio value.

Subsidy History



Challenges

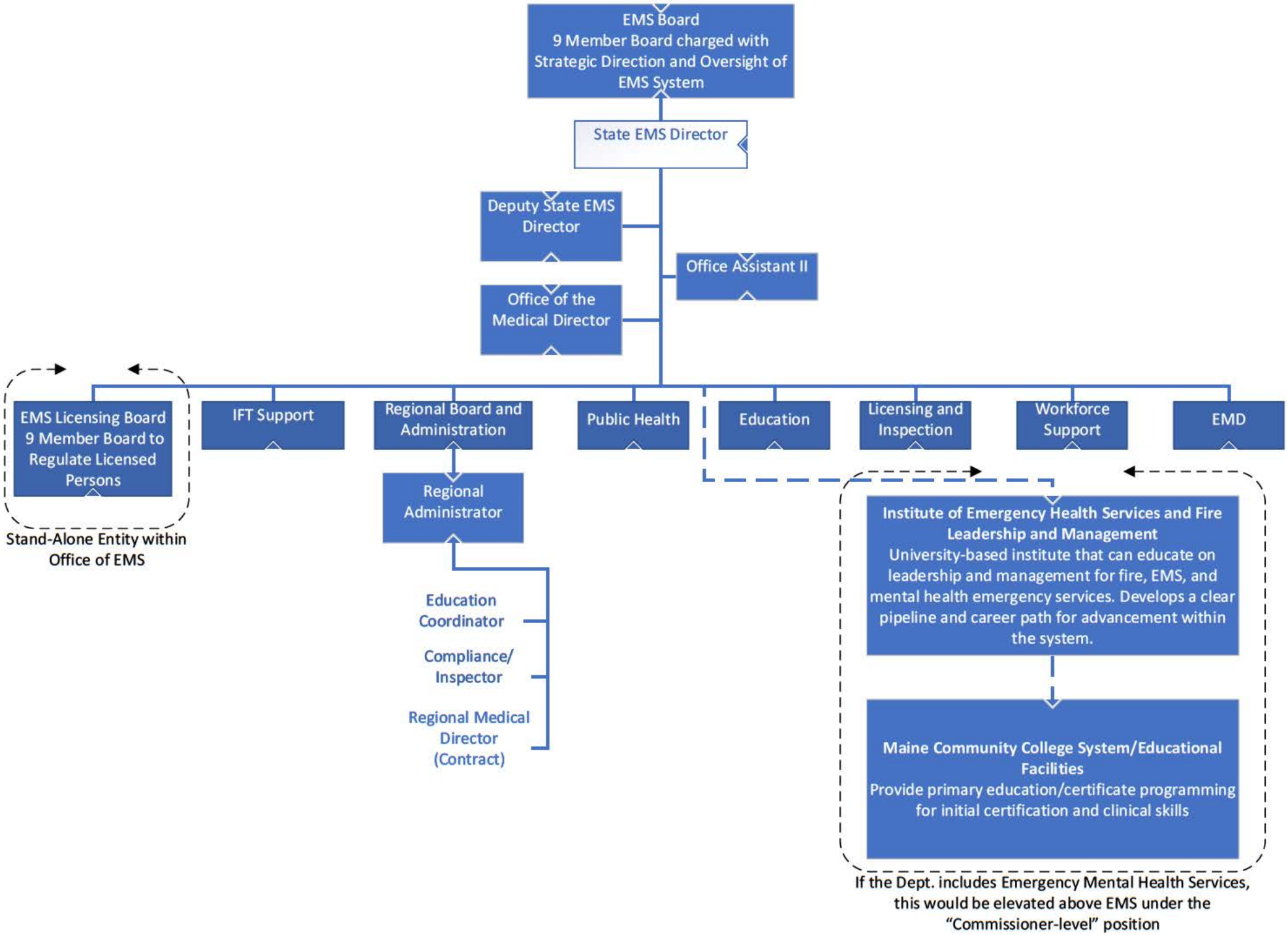
- Staffing
- Cost of readiness
- Operating expenses
- System integrity
- Reimbursement
- System Fragility
  - Cost
  - Unpredicitability

Questions?

NorthStar
Emergency Medical Services

APPENDIX G

- **Maine EMS, Structural Reorganization Proposal**
- **Maine EMS, Two-Year Action Plan**


EMS Board
9 Member Board charged with Strategic Direction and Oversight of EMS System
State EMS Director
Deputy State EMS Director
Office Assistant II
Office of the Medical Director
EMS Licensing Board
9 Member Board to Regulate Licensed Persons
IFT Support
Regional Board and Administration
Public Health
Education
Licensing and Inspection
Workforce Support
EMD
Stand-Alone Entity within Office of EMS
Regional Administrator
Education Coordinator
Compliance/ Inspector
Regional Medical Director (Contract)
Institute of Emergency Health Services and Fire Leadership and Management
University-based institute that can educate on leadership and management for fire, EMS, and mental health emergency services. Develops a clear pipeline and career path for advancement within the system.
Maine Community College System/Educational Facilities
Provide primary education/certificate programming for initial certification and clinical skills
If the Dept. includes Emergency Mental Health Services, this would be elevated above EMS under the "Commissioner-level" position

Structure of the Maine EMS System

Growth and development of the statewide EMS system will require a restructuring of the regulatory, development, system planning, and leadership framework that supports the system. The attached organizational chart is a potential pathway forward that retains significant local representation and communication; provides a pathway to address interfacility transportation concerns, workforce planning, and public health planning, while maintaining efficiencies and efficacy.

Maine EMS and the Board recognizes the need to increase efficiencies in the system while also maintaining significant local input and involvement in the process and ensuring a voice for the regulated community throughout the system. This proposed structure increases accountability for all parties involved by placing the EMS Director responsible for implementing the vision and strategic plan for the system and the EMS Board becomes charged with overseeing the strategic plan, final rulemaking, and serves as the final authority for discipline and waivers. This will allow for greater innovation within the EMS system, more nimble response to challenges, and greater efficiencies in workflow.

Responsibilities will be divided among the system with a system of checks and balances that ensures competency and accountability across the statewide structure. The overarching functions of the primary components of the structure are defined below:

- State EMS Director and Bureau Staff
    - Promulgate EMS service (non-transporting, ground, air), EMD, and system-related rules;
    - Regulate/discipline based on those rules and applicable statutes;
    - Conduct investigations in response to complaints or knowledge of violations;
    - May propose personnel licensing rules to the personnel licensing board;
    - Enter into consent agreements with regulated entities;
    - Inspect entities (announced or random) for compliance with rules and statutes;
    - Manage office staff in accordance with State of Maine HR policies, to include hiring, developing, etc.;
    - Issue service licenses;
    - Execute contracts;
    - Apply for, accept, and appropriate grant funds;
    - Manage and operate regional offices; and
    - Implement the strategic plan.
- Maine EMS Board
    - Approve and direct the strategic plan
    - Approve or reject rules for comment and final approval
    - Serve as the appeals process for service-licensing waiver requests and issue final decisions on those waivers
    - Serve as the appeals process for those appealing disciplinary decisions (adjudicatory hearings would be held in front of the Board)
    - Required to take vote to approve and confirm new State EMS Director
        - In the event the Director is not effectively executing the mission, issue a no-confidence vote
- Personnel Licensing Board
    - Promulgate personnel licensing rule

    - Regulate/discipline based on those rules and applicable statutes
    - Enter into consent agreements with personnel
    - Delegate, with consent, to the executive director of the Board or staff the authority to grant personnel licenses and to enter into consent agreements
    - Grant, suspend, or revoke a license in accordance with Title 32
    - Conduct investigations in response to complaints or knowledge of violations
    - Conduct disciplinary / administrative hearings
    - Evaluate requests for waivers related to personnel licensing
    - May propose service licensing rule to the director
- Regional Council
    - Nominate one (1) person per council to the advisory board
    - Nominate one (1) person per council to the licensing board
    - Coordinate information sharing among services and the advisory board
- Regional Medical Director
    - Manage quality assurance/improvement efforts regionally
    - Enter into consent agreements as allowed by rule established by the licensing board

MAINE EMS

TWO-YEAR ACTION PLAN

2035

PLAN FOR A SUSTAINABLE EMS SYSTEM IN THE STATE OF MAINE: *A VISION FOR 2035*

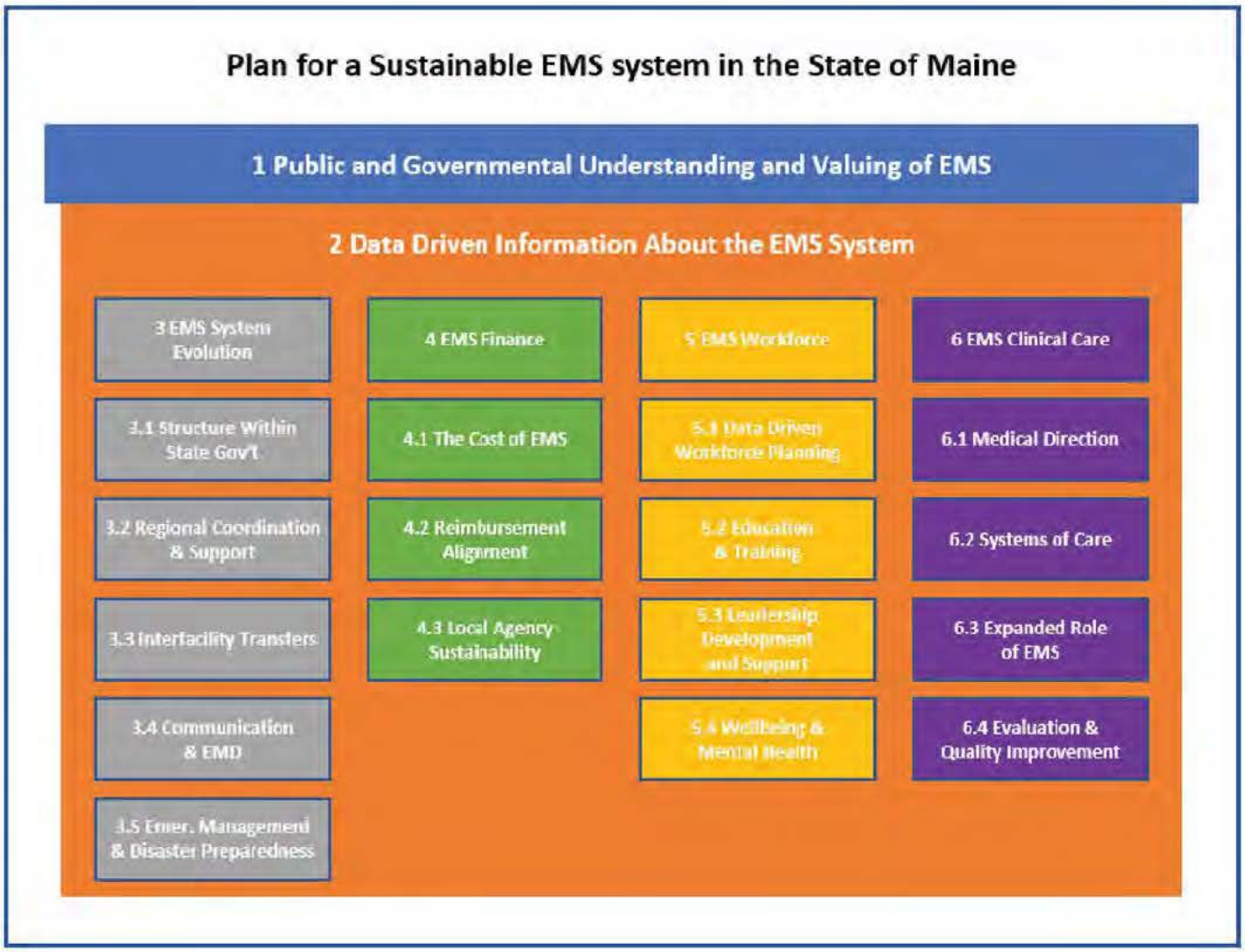
OCTOBER 27, 2023

OVERVIEW:

Maine EMS has developed this document to operationalize the *Plan for a Sustainable EMS System in the State of Maine: A Vision for 2035.* The plan has been broken down by each domain, as seen below. The Maine EMS Staff have worked for months to identify associated strategies and activities. As one might imagine, successfully implementing the Vision for 2035 will be a long road; however, we must take one step at a time to move forward. Maine EMS has also pulled out 11 strategies from across the domains to identify priorities as key areas that need to be addressed over the next two years. Beyond those 11 key strategies, the Office has also identified strategies and activities that will continue to further this plan over the next two years and beyond. Please note that the prioritized strategies represent the key areas identified by the office; however, they are not the only strategies that the office will work on.

Reference Color Coding:

Statutorialy Required Action | Statutory Change Required | Rules Change Required | Policy Required



Prioritized Strategies

The following strategies have been identified by the Maine EMS Bureau as systemic priorities for the EMS system. However, it is important to note that while these specific strategies have been identified as some of the most important systemically, there are also additional strategies and activities that will be prioritized by individual members of the office based on their individual grant requirements.

Public Government Understanding and Valuing of EMS
Strategy 3: Broaden EMS community and state/municipal/county leadership awareness of Maine EMS's work, programming, and resources.

Data Driven Information about the EMS System
Strategy 1: Improve Data Integrations
Strategy 3: Improve upon use of data for making informed decisions

EMS System Evolution
Structure in State Government - Strategy 1: Modify the EMS regulatory system structure to align with and achieve the Maine EMS Vision and Plan.
Structure in State Government - Strategy 2: Ensure reliable staffing in the Maine EMS office
Regional Coordination and Support Under a State Model - Strategy 2: Transition from the current regional model to a state-supported regional system.
Emergency Management and Disaster Preparedness - Strategy 2: Increase disaster resiliency in the Maine EMS System

EMS Finance
The Cost of EMS - Strategy 1: Enhance EMS cost reporting.

EMS Workforce
Data-Driven Workforce Planning - Strategy 3: Using data to identify workforce patterns to support sustainability and address disparities.
Mental Fitness and Wellbeing - Strategy 2: Increase access to mental health peer support and CISM trainings in all EMS Regions.

EMS Clinical Care
Evaluation and Quality Improvement - Strategy 3: Comprehensively review the Maine EMS Quality Improvement Manual to increase its relevance to EMS clinicians and encourages the use of established performance metrics.

Public Government Understanding

Notes from Plan:

Where We Want To Be: In 2035 EMS in Maine garners the attention needed to thrive and deliver the services and clinical care Mainers expect. EMS is not taken for granted. Residents and government officials regularly advocate for EMS. EMS is viewed and funded as a vital common good.1 This occurs because of ongoing efforts to inform, promote, educate and create broad awareness and shared knowledge about the EMS system, its value, the varieties of delivery models and the real and full costs of providing EMS. EMS leaders and clinicians, as well as residents and government officials, view, understand and value EMS as they do law enforcement, the fire service, public works, public health, public education, parks, emergency management and public safety answering points, etc.

Milestones/Markers of Success: a. EMS organizations, associations, agencies and clinicians across Maine have united to tell a single, powerful story about EMS and its value, cost and needs.
b. The EMS system continues to develop talking points that ensure consistent messaging is used whenever EMS is discussed in public and governmental settings.
c. EMS stakeholders always capitalize on current issues and events to deepen the public's understanding EMS, including what it does and its value, costs and needs.
d. Government officials are continuously informed and educated about the EMS system.
e. Residents of Maine understand the value of EMS, do not take EMS for granted and proactively advocate for EMS.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Ensure the EMS community within the State of Maine is knowledgeable, invested, and supportive of the Maine EMS vision and plan.							
Activity 1.1	Create an engaging 10-15 minute presentation on the vision and plan for EMS in Maine. This presentation will need to thoroughly connect the vision and plan to current issues, legislation, and the work of the Blue Ribbon Commission.	Maine EMS Staff, Maine EMS Board Leadership, Maine EMS Board, Strategic Planning Consultant (SafeTech Solutions)	Oct 31, 2023; initial review by EMS Board at July Board Meeting	Creation of work product that is easy to understand and deliver within 10-15 minutes	Maine EMS Staff Time; MS PowerPoint	Vision and Plan Overview PowerPoint Presentation; Presenter's Notes	
Activity 1.2	Deliver the presentation to EMS agencies, clinicians, educational programs, and stakeholders who are interested in the future of EMS.	Maine EMS Staff, Maine EMS Board Members	Ongoing beginning in November 2023	Documentation of each time that the presentation is delivered by members of the responsible entities to be able to try and quantify the impact of the strategy	Maine EMS Staff Time; Maine EMS Board Member Staff Time	None	
Activity 1.3	Develop a mechanism to track when, how, and to whom the presentation is delivered throughout the State of Maine.	Maine EMS Staff	31-Oct-23	Creation of a Microsoft Form that captures information about who, how, and to whom (not individual names, but general categories [e.g., EMS clinicians, EMS leadership, local political leaders, public, members of the legislature, etc.] to whom the presentation was delivered)	Maine EMS Staff Time; MS Forms	Web-based reporting tool (i.e., MS Forms) to collect information about the delivery of the presentation	
Strategy 2: Broaden community (public) awareness of EMS by facilitating relationships between EMS services and community leadership/institutions/members.							
Activity 2.1	Develop monthly press releases highlighting the work of the EMS system throughout the State of Maine	Maine EMS Staff, EMS system	Ongoing, monthly deadlines of last day of month	Count of number of press releases created per month RE positive EMS system messaging	Maine EMS Staff Time	Monthly Press Release	
Activity 2.2	Add a Public Outreach section to the Staff Update. Use this to inform agencies of opportunites to speak to their stakeholders and the public about the EMS system.	Maine EMS Staff	Ongoing, monthly deadlines two weeks before end of month	Count of number of additional sections in the Staff Update	Maine EMS Staff Time	Staff Update	
Activity 2.3	Adapt or develop trainings that teach EMS leadership and services tips and best practices for connecting with their local communities	Maine EMS	6/30/2025	Saturation of unique EMS leadership trained. Implementation of best practices.	Maine EMS Staff Time, stakeholder time, training documents/materials, grant funding	Training materials (asynchronous training, videos, handouts)	
Strategy 3: Broaden EMS community and state/municipal/county leadership awareness of Maine EMS's work, programming, and resources.							
Activity 3.1	Town hall/personal visits with MEMS staff for education and awareness about programming and the Vision	Maine EMS Staff; Maine EMS Board	Ongoing	Count the number of participants, type, and region	Maine EMS Staff Time, Stakeholder Time, Meeting Space (Virtual), SharePoint document	Survey Tool, Documentation of Participation	
Activity 3.2	Identify opportunities for Maine EMS Staff members to regularly attend and present at national/state/municipal/regional conferences, trainings, events, meetings, etc. in person.	Maine EMS Staff	Ongoing, at least one event per quarter	List of events, schedule for attendance	Staff time, travel, printing, tabling supplies, and associated fees	Presentations, swag, informational materials	

Activity 3.3	Increase audience of the monthly Maine EMS Staff Updates by creating a dedicated location on the website with a historical archive and create a separate GovDelivery optional mailing list for people to receive the updates (add opt-in option to eLicensing).	Maine EMS Staff	Ongoing, website changes by Jan. 1, 2024	Count in the number of site visits and number of subscribers	Maine EMS Staff Time, Website Developer Resources	Monthly Staff Update Newsletter	
Activity 3.4	Public information campaign to promote awareness and use of PulsePoint AED registry.	Maine EMS, EMD Committee, CARES	Ongoing beginning in November 2023	Increased number of AEDs in the registry.	Maine EMS staff time, Systems of Care Funding	AED stickers, social media, link from Maine.gov/ems, signage for training and other events.	

Strategy 4: Enhance Website presence							
Activity 4.1	Post Staff Bios on website	Maine EMS Staff	Dec-23	Current Staff Bios on website and a process during onboarding to add new employees	Maine EMS Staff Time	Bio for each staff	
Activity 4.2	Make it easy for site visitors to find and access what they need.	Maine EMS Staff	Dec-24	A staff directory having a topic table of contents	Maine EMS Staff Time	A directory to staff by topic	
Activity 4.3	Develop Frequently Asked Questions section	Maine EMS Staff	Mar-24	A frequently asked questions section with an associated table of contents	Maine EMS Staff Time	A list of FAQs	
Activity 4.4	Publish Tableau dashboards on EMS activities (Annual)	Maine EMS Staff	Jan-24	Having the tableau dashboards available on the website	Maine EMS Staff Time; DHHS Public Tableau Server	Tableau Dashboards; Website	
Activity 4.5	Define and Publish Tableau dashboards for Programs and initiatives	Maine EMS Staff	Mar-24	Having the tableau dashboards available on the website	Maine EMS Staff Time; DHHS Public Tableau Server	Tableau Dashboards; Website	

Data Driven Information about the EMS System

Notes from Plan:

In 2035 EMS in Maine is continuously improved by data-driven decision-making using trusted information. The ongoing reliability, sustainability and quality of the EMS system is dependent upon accurate information from every facet of the EMS system. A clear "why" about data and information has been established. Data-driven information is used to address the leading system issues, guide improvement and support ongoing research. Stakeholders throughout the system value datagathering processes. Clinicians are not asked to input irrelevant data. A robust, integrated data system seamlessly connects EMS with the larger healthcare system and provides and receives back valuable clinical information about EMS clinical care, from call to long-term outcome. Operational EMS is continuously provided with valuable information about system operations, including response, resources deployment, resource location, work load and costs. Because data systems continue to demonstrate value, education on data, information and data collection is routine and accurate throughout the EMS system.

As the EMS system continues to evolve (and especially in the areas of workforce, finance and clinical care), it must be able to justify decisions, costs and change with evidence and information that are rooted in data.

Milestones/Markers of Success:

a. Data collection is broadly understood and valued as necessary for improvement throughout the EMS system. Anecdotal reporting and qualitative data are supplemented by quantitative data.
b. Attention, funding, staffing and technology have been added to appropriately resource information efforts and systems. The EMS Bureau, the Regions and the entire EMS system have the technology and technological support needed to appropriately collect and analyze data.
c. Data-driven information is actually used to make informed decisions at all levels.
d. Clinicians' data entry time and efforts are respected.
e. There is robust data sharing between primary and secondary PSAPs, dispatch centers and EMS agencies, and data sharing is used to monitor and improve EMS, PSAP and dispatch center operations.
f. EMS patient care reports are connected to electronic health records and provide a feedback loop to appropriately evaluate patient outcomes at both the EMS and EMD level.
g. Data-gathering and analysis are funded and staffed appropriately.
h. All ambulances in Maine have connectivity and equipment to allow for the real-time transference of information across the healthcare system.
i. There is system-wide sharing of CAD data and real-time monitoring for best-possible resource coordination, including 9-1-1 and IFTs.
j. EMS data and information is used to monitor public health issues including bio-surveillance.
k. Systems are in place to accurately capture financial data and guide cost reporting.
l. Systems have been created to accurately capture workforce data.
m. The EMS system is actively engaged in conducting and supporting EMS research.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Improve Data Integrations							
Activity 1.1	Outcome Data Returned From Hospitals.	Data Team	31-Dec-25	Percent of EMS activations where the patient was transported having outcome data	Datasource for outcome data Willingness of hospitals/datasoruce to share	Access to outcome data for reporting and analysis	
Activity 1.2	Increase number of agencies using CAD to MEFIRS interface.	Data Team	Ongoing	Number of Agencies having CAD interface % EMS Activations having CAD Interface	ImageTrend Contract containing Interface Implementation plan/timeline from ImageTrend	Higher quality and more complete data as a result of the CAD data feed	
Activity 1.3	Migrate PCRs to NEMSIS v3.5	Data Team	31-Dec-23	100% Agency transition to NEMSIS v3.5	Staff Time; Educational Materials	v3.5 PCR Form; Educational Materials; Updated Reports/Analytics	
Activity 1.4	Migrate Community Paramedicine to Mobile Integrated Health Module	Data Team	1-Jul-24	100% Agency transition to NEMSIS v3.5 by 12/31/2023	Staff Time	MIH Form Updated Reports/Analytics	
Activity 1.5	Increase number of EMD Centers using ProQA interface to CAD	EMD Coordinator	31-Dec-25	Number of Centers having ProQA Interface	Spillman and IMC cost, IT education	Higher quality and more complete data as a result of the ProQA to CAD to MEFIRS pathway	
Strategy 2: Improve Understanding of Importance of Data and Enthusiasm for High-Quality Data Entry							
Activity 2.1	Create MEMSED training courses for NEMSIS 3.5 migration	Data Team	Oct-23	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	
Activity 2.2	Create MEMSED training courses on Data, Importance, Security and Compliance	Data Team	Apr-24	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	
Activity 2.3	Create MEMSED training courses on Data 102: MEFIRS PCR in Detail	Data Team	Jul-24	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	
Activity 2.4	Create MEMSED training courses on Data 201: Introduction to Data Analytics and Visualizations	Data Team	Oct-24	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	
Activity 2.5	Create MEMSED training courses on Data 202: ImageTrend Report Writer in Depth.	Data Team	Jan-25	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	

Activity 2.6	Implement rule requiring standardized patient care reporting as part of licensure class	Data Team; Rules Committee	Jul-24	Completed Rule Change	Staff Time; Rules Committee	Standardized patient care reporting course for use in courses leading to licensure	Rulemaking
Activity 2.7	Implement policy that states that all continuing education courses must dedicate at least 10% of their time to covering how to appropriately document the condition(s) and/or interventions covered in the course.	Data team; Board	Jul-24	Completed data policy	Staff Time; Board Meeting Agenda Item	Policy stating 10% of continuing education shall cover documentation of the topic covered	Policy
Activity 2.9	Develop a Community Paramedicine data report that is published on the website/ social media. This will serve to provide evidence of the value of quality data markers for Community Paramedicine.	CP Coordinator/ Data team	Jan-25	Quarterly report that is published	Staff Time	Data reports	
Strategy 3: Improve upon use of data for making informed decisions							
Activity 3.1	Define measures, key performance indicators (KPIs), and goals for protocols and assess efficacy of medications and procedures	Board, MDPB, QI Committee, Systems of Care Program Manager, Community Paramedicine Program Manager, EMSC Program Manager; SUD Team	1-Jul-24	Ten Specific KPIs and Measures with associated Goals	Staff Time, Stakeholder Time, ImageTrend Report Writer, SQLServer	A defined set of meaningful measures, KPIs, and goals for protocols and to assess efficacy of medications and procedures and for which decisions and actions are able to be taken or have predetermined triggers that result in action(s) (e.g., modifications to protocols, additional training) to be taken	
Activity 3.2	Provide agency level report card for measures, KPIs, and compliance	Data Team	1-Oct-24	% of agencies sent regularly delivered reports, a defined set of meaningful measures, KPIs, and goals for protocols and assess efficacy of medications and procedures and for which decisions and actions are taken or have predetermined triggers that result in action(s)	Staff Time	Recurring report delivered via email to each agency	
Activity 3.3	Provide clinician level report card for measures, KPIs, and compliance	Data Team	1-Oct-24	% of clinicians sent regularly delivered reports, a defined set of meaningful measures, KPIs, and goals for protocols and assess efficacy of medications and procedures and for which decisions and actions are taken or have predetermined triggers that result in action(s)	Staff Time	Recurring report delivered via email to each clinician	
Activity 3.4	Provide state level report card for measures, KPIs, and compliance	Data Team; Newsletter Author	1-Sep-24	Dashboard, a defined set of meaningful measures, KPIs, and goals for protocols and assess efficacy of medications and procedures and for which decisions and actions are taken or have predetermined triggers that result in action(s)	Staff Time	Addition to Staff Update Newsletter	
Strategy 4: Standardize Policies for Information Management							

Activity 4.1	Author a policy/procedure for electronic communications, meetings, and social media messaging	Data Team, Webmaster Team; Director	1-Jul-24	Publication of an approved document	Staff Time	A policy/procedure document published on SharePoint and website	Policy
Activity 4.2	Author a policy/procedure for Information access and security	Data Team; Director	1-Apr-24	Publication of an approved document	Staff Time	A policy/procedure document published on SharePoint and website	Policy
Activity 4.3	Author a policy/procedure for responding to requests for information that involve information managed by Maine EMS containing personally identifying information (PII) and personal health information (PHI)	Data Team; FOAA Team; Licensing Team; Attorney General's Office, OIT	1-Apr-25	Publication of an approved document	Staff Time	A policy/procedure document published on SharePoint and website	Policy
Activity 4.4	Develop and adopt rule requiring Health Data Security training and MEFIRS Training	Data Team, Rules Committee; Education Coordinator; Attorney General's Office	1-Apr-24	Rule in effect and renewal process built to accomodate	Staff Time	Rule stating 10% of continuing education shall cover documentation of the topic covered	Rules
Strategy 5: Streamline data entry processes.							
Activity 5.1	Develop and Implement Change Control and Notification Policy	Data Team; Director	1-Apr-24	Development and approval of a change control policy, notification process	Staff Time	Policy document	Policy
Activity 5.2	Identify and Develop monitoring process for Data Entry KPIs	Data Team	1-Jul-24	Dashboard with KPI for time/effort required to enter, validity score	Staff Time	Dashboard with KPI for time/effort required to enter, validity score	
Activity 5.3	Streamline the ePCR user interface to improve data entry processes for clinicians.	Data Team, Data Committee	Ongoing	Improvement in KPIs from Activity 5.2	Staff Time	Dashboard with KPI for time/effort required to enter, validity score	
Activity 5.4	Streamline the licensure user interface to improve data entry processes for clinicians.	Data Team, Licensing Team	Ongoing	Improvement in KPIs from Activity 5.2	Staff Time	Dashboard with KPI for time/effort required to enter, validity score	

EMS System Evolution

Structure within State Government

Notes from Plan:

Where We Want To Be: In 2035 EMS is structured and led within government to "promote and provide for a comprehensive and effective emergency medical services system to ensure optimum patient care." EMS system leadership, planning, development and regulation are structured to provide maximum support for ongoing system evolution, ensuring the public is protected and served by reliable, sustainable and quality EMS. The structure includes significant local agency and personnel representation and ensures clear lines of communication between state EMS activities and the frontline provision of EMS. The structure provides a pathway to address current and emerging issues while maintaining efficacy and efficiencies.

Milestones/Markers of Success: a. The Bureau of EMS is positioned, empowered, funded and staffed to meet its mission of being "responsible for the coordination and integration of all state activities concerning emergency medical services and the overall planning, evaluation, coordination, facilitation and regulation of emergency medical services system."
b. The positioning, empowerment, funding and staffing of the EMS Bureau are sustainable.
c. The Bureau of EMS has a balanced and collaborative relationship with an EMS Board that provides strategic guidance, checks and balances and accountability across the statewide structure and in rule-making.
d. There is clear delineation between system planning and the regulation and licensing of personnel and entities.
e. An EMS professional licensing board is created that regulates personnel licensing rules, conducts investigations and disciplinary/administrative hearings and proposes personnel licensing rules. The Bureau of EMS regulates agencies.
f. The EMS Board is small and agile with nine members representing EMS regions and key stakeholder groups. It provides guidance on EMS system planning and development, provides representative input from various EMS stakeholders and provides a check and balance in rule-making.
g. The EMS Board has the authority to develop and submit legislation directly to the legislature.
h. Independent Regional Councils made up of representatives of local clinicians and local agencies meet regularly and effectively provide regional representation for agencies and personnel on the EMS Board, to voice local issues, needs and opportunities.
i. A State Medical Director is a fulltime EMS Bureau employee and oversees all aspects of clinical care and clinical care development.
j. The 1982 EMS Act and other statutes and rules are updated to accomplish the above.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Modify the EMS regulatory system structure to align with and achieve the Maine EMS Vision and Plan.							
Activity 1.1	Support the proposed restructuring of the Maine EMS system that was endorsed by the Maine EMS Board (e.g., presenting to the Blue Ribbon Commission, advocating for change).	Legislature, Director, Board, Maine EMS Staff	Ongoing	None	N/A	Proposed Organizational Structure of Maine EMS	Statute
Activity 1.2	Obtain state-supported staffing of a policy development position within the Office to support the development of concept rules and policies.	Maine EMS Team, Board, Legislature, Commissioner's Office; Governor's Office	1-Jul-25	Position Available and filled	Legislation; Funding	Proposed Organizational Chart; Proposed Budget; Draft Appropriation Language/Legislation	Statute
Strategy 2: Ensure reliable staffing in the Maine EMS office.							
Activity 2.1	Identify and define the structure and staffing needs to accomplish statutorily required activities and those of the Vision.	Maine EMS Team, Board, Legislature; Commissioner's Office; Governor's Office	1-Jan-24	Plan created	Staff Time	Proposed Organizational Chart; Proposed Budget; Draft Appropriation Language/Legislation	
Activity 2.2	Define all duties being performed by Maine EMS staff, and identify the appropriate personnel required to successfully complete these tasks.	Maine EMS Staff; Director; Human Resources Service Center	31-Aug-24	Comprehensive document completed	Staff time	Document stating duties and responsibilities of each staff member and appropriate number of staff necessary to complete duties.	
Activity 2.3	Add new positions and transition limited-period/grant-funded positions into permanent, state-funded positions, where possible and appropriate, to ensure adequate staffing to meet the needs of the EMS system and achieve the goals in the Vision.	Maine EMS Team, Board, Legislature; Commissioner's Office; Governor's Office	31-Dec-24	Positions funded and filled	Legislation; Funding	Draft Legislation; Budget; Position Justification Forms; Position Descriptions	Statute
Strategy 3: Foster an increase in interstate collaboration							
Activity 3.1	Encourage components of the Maine EMS system to work collaboratively with our regional state counterparts (e.g., State of New York Office of EMS, Vermont Office of EMS, etc.).	Maine EMS; Board; MDPB; Attorney General's Office; Education Committee; Community Paramedicine Committee; Trauma Advisory Committee; Maine Stroke Alliance; QA/QI Committee	Ongoing	Ongoing participation in NASEMSO meetings	Staff Time; Stakeholder Time; NASEMSO membership	TBD	

Regional Coordination and Support Under a State Model

Notes from Plan:

Where We Want To Be: Local clinicians, EMS agencies, EMDs and other local EMS stakeholders have an effective voice in the statewide EMS system and experience effective local and state support. Their unique needs, opportunities, challenges and concerns are regularly heard and addressed. This is accomplished through four EMS Regions with robust regional structures that include: true representative regional councils that meet regularly; funded regional offices staffed by state employees who provide coordination, information, facilitation, guidance, outreach, compliance and clear and regular communication between all facets of the EMS system; regional medical direction; and quality improvement guidance. The regional structure promotes EMS reliability, sustainability and quality by helping local entities understand expectations, meet regulations, collaborate, develop efficiencies and address challenges.

Milestones/Markers of Success: a. Regional councils that are truly representative and effective have been established and provide input on regional needs and goals, medical direction, operational collaboration and quality improvement.
b. Regional offices are established in each geographic region and are appropriately staffed and funded.
c. Local EMS personnel and agencies experience effective support and have known resources to turn to.
d. Communication is clear, timely and effective between the Bureau of EMS, the statewide system and local agencies and personnel.
e. Cross agency partnerships and collaboration are successful and effective.
f. Agencies have ready access to guidance and support in addressing operational challenges, regulatory questions, workforce issues, medical direction, continuing education, QA/QI and wellbeing programming.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Create the framework for a regional model incorporated into state government.							
Activity 1.1	Define and articulate the needs of the EMS system regarding a regional model, including receiving feedback from stakeholders.	Maine EMS Staff, Maine Board of EMS	12/31/2024	Report on stakeholder feedback completed, Current proposed rule implemented	Staff Time, Meeting Space,	Chapter 15 of Maine EMS Rules; Public Forum; Report	Rule
Activity 1.2	Define the regional system's structure, organization, required resources, and position within state government.	Maine EMS Staff, Maine Board of EMS	31-Dec-24	Completion of a structure model	Staff Time, Board Time,		Statute
Strategy 2: Transition from the current regional model to a state-supported regional system.							
Activity 2.1	Use the framework from Strategy 1 to create a transition plan that includes future structure, communication pathways, and steps to move from the current structure to the desired structure.	Director of Maine EMS	3/31/2025	Completion of transition plan	Staff Time	Transition Plan	
Activity 2.2	Develop a budget that supports the regional offices and the services and functions identified by key stakeholders.	Maine EMS Staff, Director, Service Center, Commissioner's Office, Governor's Office	31-Dec-25	Completion of budget	Staff Time	Budget	Statute
Activity 2.3	Secure legislative changes and funding to create regional offices and positions.	Legislature; Maine EMS Director	12/31/2025	Regional offices created in each region with sufficient personnel for implementation funded	Staff time; legislative materials (including testimony)	Legislation	Statute

Interfacility Transfers

Notes from Plan:

Where We Want To Be: In 2035 interfacility transport (IFT) is viewed as a distinct, vital and necessary element of an optimally performing EMS system. IFT is coordinated statewide through a Centralized Transfer Center (CTC) that is the result of broad collaboration between healthcare systems, healthcare facilities and EMS agencies. Data and information about transfer volumes, locations, necessity, destinations, clinical care and other specialized care are used by the CTC in real-time to ensure resources are efficiently used. Patient and healthcare system needs are effectively met without eroding 9-1-1 capacity. Healthcare systems actively participate and share responsibility in supporting IFT and the CTC through funding, training opportunities and other resources.

Milestones/Markers of Success: a. IFT is viewed by EMS agencies, leaders, clinicians and healthcare systems as important and in need of systemwide study, support and coordination to ensure optimal system operation.
b. IFTs and processes that deliver IFTs are studied and well understood in a manner that guides a statewide systems approach to IFT.
c. Healthcare systems and facilities assume a shared responsibility for the coordination of IFTs through the creation, funding and ongoing support of a Centralized Transfer Center (CTC) to facilitate and coordinate a best possible delivery model of patient movement between healthcare facilities.
d. A statewide IFT system is designed to maximize efficiency, efficacy and safety.
e. The IFT system ensures the development of adequately prepared, competent and confident resources to meet critical care, pediatric and neonatal IFT needs.
f. A licensure pathway for critical care transport has been created for both clinicians and agencies.
g. Novel solutions have been developed to move patients that do not need traditional ambulance transportation.
h. Data and information about all aspects of IFTs are gathered and analyzed with an eye on what is best for patients, healthcare systems and EMS clinician and agencies.

Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Establish a resilient, efficient, and effective system for the delivery of interfacility transportation (IFT)						

Activity 1.1	Compile evidence and data to increase the understanding of the current IFT system, and propose alternatives that can improve it.	IFT Committee, Maine EMS Staff, MAA, Maine Fire Chiefs' Association, Maine Hospital Association.	1-Jul-24	Completion of research and documentation of research, Surveys, questionnaires, subject matter expert groups, and evaluations of positives and negatives.	Maine EMS, EMS Board, Maine Ambulance Association, Fire Chiefs' Association, Maine Hospital Association	Research materials of other Interfacility Transfer Programs/Methods in other states. Written, concise descriptions of successes and failures of current program.	
Activity 1.2	Identify clearly defined goals for Interfacility Transfers, both ALS and BLS.	IFT Committee, Maine EMS Staff, MAA, Maine Fire Chiefs' Association, Maine Hospital Association.	31-Dec-24	Goals checklist written	Maine EMS, EMS Board, Maine Ambulance Association, Fire Chiefs' Association, Maine Hospital Association	Clearly established goals for the direction of Interfacility Transports in the state.	
Activity 1.3	Identify key performance indicators that can be used to measure the effectiveness and efficiency of interfaciltiy transfers	IFT Committee, Maine EMS Staff, MAA, Maine Fire Chiefs' Association, Maine Hospital Association.	31-May-25	Surveys, questionnaires, and options to develop KPIs.	Maine EMS, EMS Board, Maine Ambulance Association, Fire Chiefs' Association, Maine Hospital Association	They were written and accepted KPI's for Interfacility Transports.	
Strategy 2: Develop a new licensure level for agencies and individuals to support IFT							
Activity 2.1	Establish a Workgroup to decide the roles, responsibilities, scope of practice, credentialing, education, etc. of this licensure level.	Maine EMS, EMS Bd., MAA, Fire Chiefs' Association, Maine Hospital Association	31-Jul-24	Workgroup established	Maine EMS, EMS Board, Maine Ambulance Association, Fire Chiefs' Association, Maine Hospital Association	Licensure requirements, education requirements, competency requirements.	
Activity 2.2	Draft and initiate Rules for the implementation of critical care licensure at the individual and agency levels.	Maine EMS, EMS Board, PIFT Committee	31-Dec-25	Rules created	Staff time, committee time	Rule	Rules
Activity 2.3	Develop rules to prevent 911 services from relying on mutual aid to cover emergency calls in their coverage area while the primary service leaves their coverage area for IFT	IFT Committee, Rules Committee, Maine EMS Board	31-Dec-25	Rules created	Staff time, committee time	Rule	Rules
Strategy 3: Consider the need for a centralized/singular dispatch resource for transfers							
Activity 3.1	Evaluate resources available to support a centralized dispatch, including existing agencies and protocols.	Maine EMS, IFT Committee, MHA, Priority Dispatch	1-Jan-25	Report	Staff time, committee time	Clearly established resources.	

Communication and EMD

Notes from Plan:

Where We Want To Be: In 2035 emergency communications and emergency medical dispatch (EMD) are at the center of optimizing the EMS system's response, resource use and outcomes. The EMS system's efficiency and effectiveness continuously improve because the system's status and resource use are managed by a complete and effective feedback loop and supported by quality data. The continuous improvement is the result of: emergency communications centers and EMD telecommunicators being appropriately integrated into response planning; response plans that are designed to appropriately match the caller/patient's need with the best resource in a geographic region; uniform processing of calls across the state; EMD telecommunicators having a wide variety of emergency and non-emergency resources to draw on; telecommunicators being appropriately prepared and empowered to effectively match needs with resources; the availability of technology to continuously evaluate resource status and location in real time; the use of data elements through the entire continuum of care that are pulled together to gather reliable outcomes information; and the use of outcomes information to continuously improve outcomes, the system and resource use.

Milestones/Markers of Success: a. Emergency communications, EMD telecommunicators, response plans and response data are viewed as integral to the EMS system's efficiency and patient outcomes.
b. All of the various elements of the EMS system work together to create carefully crafted response plans aimed at maximizing efficient resource use and positive patient outcomes.
c. There is increasing collaboration and increasing uniformity between call centers. Call processing is structured to match needs with the right resources, and the technology is available and utilized to support this mission.
d. A variety of resources beyond EMS response are identified and available to meet the callers' needs. These include non-emergency resources such as mental health, nurse triage, social services, poison control, etc.
e. EMD telecommunicators are prepared, resourced, authorized and empowered to match callers with the right resources. The data elements needed to evaluate and guide best-outcome response planning have been identified.
g. The system has established a process for gathering and aggregating data elements from 9-1-1 call data, computer aided dispatch (CAD) systems, Maine EMS & Fire Incident Reporting System (MEFIRS) data and the various electronic health records (EHR) used by the healthcare systems.
h. Outcomes information is used to continuously improve system response plans and resource use.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Program Coordination							
Activity 1.1	Define the role and responsibilities of the EMD Program Coordinator	Maine EMS, ESCB (Emergency Services Communications Bureau)	1-Jan-24	Completion of the Report	Staff Time, historical records	Report	

Activity 1.2	Evaluate the time required to complete identified job tasks to meet the responsibilities of the EMD Program Coordinator	Maine EMS, ESCB (Emergency Services Communications Bureau)	1-Jan-24	Completion of the Report	Staff Time	Report	
Activity 1.3	Allocate staff (staff time) to meet the needs of the system	Maine EMS, ESCB (Emergency Services Communications Bureau), Legislature	31-Dec-25	Increased staffing	Legislation; funding; staff time; office restructuring	Draft Legislation; Budget; Position Justification Forms; Position Descriptions	Statute
Activity 1.4	Promote legislation recognizing the need for an Emergency Mental Health Dispatch Coordinator	Maine EMS, ESCB (Emergency Services Communications Bureau), Legislature	1-Jan-25	Increased staffing	Staff Time	Additional staff member	Statute
Strategy 2: System Evaluation							
Activity 2.1	Evaluate EMD Centers' existing resources (software versions, interfaced programs, alternative communication technologies, Automatic Vehicle Location[AVL]) and operations (24 hour capability, use of secondary dispatch, QA plan, use of response plans, EMS and EMD feedback mechanisms) through surveys and on site inspections	Maine EMS, ESCB (Emergency Services Communications Bureau)	1-Jul-24	Completion of the Report	Staff time, travel expenses, EMD center time, survey tools and inspection checklist	Report	
Activity 2.2	Evaluate and promote the use of the 911-988 transfer policy.	Maine EMS, ESCB (Emergency Services Communications Bureau), Maine Crisis Line	1-Nov-23	User and patient feedback from direct contact.	Staff time	Data, QI, Continuing education	
Strategy 3: Quality Assurance Support							
Activity 3.1	Measure the available staff at each EMD Center qualified to perform QA and encourage under resourced Centers to send staff to Q training	Maine EMS, ESCB (Emergency Services Communications Bureau)	1-Jul-24	Increased number of qualified QA staff	Staff Time	Report	
Activity 3.2	Identify a pathway for direct access to EMD data (ProQA and AQUA software) by the EMD Coordinator	Maine EMS/ESCB (Emergency Services Communications Bureau), Priority Dispatch, OIT (Office of Information Technology), EMD Centers	1-Jul-24	MEMS and ESCB staff have direct access to EMD Centers' ProQA and AQUA software.	Staff Time, IT	Cloud based or other direct access to EMD Centers' software	
Activity 3.3	Financially support EMD Centers to meet the requirements of regular quality assurance case reviews.	Maine EMS/ESCB (Emergency Services Communications Bureau), Priority Dispatch	1-Jul-25	Increased quantity of month case reviews and increased compliance scores by Center.	Funding for staff time or QPR contract. Funds available through 911 surcharge, managed by the ESCB.	Report reflecting improved compliance with case reviews	
Strategy 4: EMD and EMS Collaboration							
Activity 4.1	Schedule regular workshops with PSAPs (Public Safety Access Points), EMS user agencies, and service-level Medical Direction to educate local systems on implementing response plans	Maine EMS Staff	Ongoing	Increased implementation of response plans.	Staff time	Workshops held and completed	
Activity 4.2	Identify opportunities for EMD representation in EMS committees and working groups	Maine EMS	1-Jul-24	Increased EMD respresentation in EMS committees	Staff time, Board approval to add representative roles as needed	List of opportunities	
Activity 4.3	Increase awareness and promote implementation of feedback mechanisms between EMS agencies and EMD centers for patient outcomes to support understanding and quality assurance	Maine EMS, EMD Centers, EMS Agencies, Hospital Liasons	Ongoing	Increased communication between EMS and EMD locally.	Staff time	Outreach, networking, websites for EMD centers, outcomes feedback for EMD centers	

Emergency Management and Disaster Preparedness

Notes from Plan:

Where We Want To Be: In 2035 the Maine EMS system is prepared and ready to meet any events that exceed the capacity of local resources. This preparation will allow the EMS system to be prepared and ready for any large-scale emergency, extraordinary event or disaster. The EMS system is no longer struggling to meet routine 9-1-1 and IFT demands, and therefore has the capacity, leadership, personnel and funding to appropriately prepare for large-scale emergencies and disasters. Planning is led at a regional level and is fully integrated with statewide emergency planning and regional healthcare coalitions. EMS in Maine is viewed as a key stakeholder in emergency management and disaster planning and has a respected place in all planning activities. Local agencies and clinicians are appropriately prepared and resourced for these activities.

Milestones/Markers of Success: a. All facets of the system actively plan for any incident, event or situation that will exceed local capacity. This planning is continuous.
b. EMS throughout Maine has an equal part in preparation, planning and response.
c. EMS throughout Maine is involved in disaster mitigation and recovery.
d. EMS throughout Maine is considered a valid and valued resource in any disaster
e. The planning for patient movement in disasters is integrated with the overall healthcare system.
f. EMS is cognizant of and prepared to respond to the disasters that are the result of climate change.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Develop and enhance relationships between State EMA and EMS							
Activity 1.1	Increase coordination and collaboration between State EMS and State EMA through regular meetings, training, and planning	Maine EMS, Maine EMA	31-Jan-24	Regularly scheduled meetings and training	Staff time	Meeting minutes	
Activity 1.2	Clarify and develop the roles and responsibilities of each agency in the State EOP.	Maine EMS, Maine EMA	31-Mar-25	Written defined roles and responsibilities of each agency in disaster response	Incident Command Training, staff time	State EOP	
Activity 1.3	Identify and train four staff members to support the State EOC as ERT members.	Maine EMS, Maine EMA	31-May-24	Develop areas where each agency may collaborate.	Incident Command Training, ERT Training and resources (WebEOC)	Training completion certificate	
Strategy 2: Increase disaster resiliency in the Maine EMS System							
Activity 2.1	Conduct a risk assessment and determine capability assessment/needs of the EMS system with MEMA current capabilities to assess assets, gaps, and/or barriers	Maine EMS, Maine EMA	30-Jun-24	Identify hazards, response needs, and gaps within the system to respond to disasters	Staff time, EMS and MEMA data	Completed capability assessment, risk assessment, THIRA	
Activity 2.2	Develop a Continuity of Operations (COOP) Plan for Maine EMS	Maine EMS	30-Jun-24	Development of a COOP Plan	Staff time	COOP Plan	
Activity 2.3	Participate in emergency preparedness exercises and training at the local or state level. Share exercise development materials with EMS services to develop and conduct their own exercises.	Maine EMS, Maine EMA, Maine CDC PHEP	30-Jun-24	Access to trainings	Staff time, exercise materials	HSEEP Resources (EXPLANs, SITMANs, Etc.)	
Activity 2.4	Develop resources and educational materials to increase knowledge in disaster preparedness and hazards, including climate change. Share information on how services can create their own continuity and disaster plans.	Maine EMS staff, Maine EMA, Maine CDC PHEP	30-Jun-24	Development of local Emergency Plans, and a plan to disseminate trainings (through regions)	Staff time, resources, local support, materials development	Educational materials, resources.	
Activity 2.5	Actively participate in and evolve from After Action Reports (AARs)/Improvement Plans	Maine EMS, MEMA, Maine CDC	Ongoing	Based on findings from AAR	Recommendation dependent	TBD based on AAR	
Strategy 3: Increase the percent of EMS agencies that have a disaster plan that addresses the needs of children.							
Activity 3.1	Determine existing disaster plans (local, county, regional) and any pediatric aspects included (or absent)	EMSC, Maine EMA, Maine EMS	31-Dec-24	Do at least 9 counties (45%) have plans that address needs of children	Staff Time	Develop template of best practices	
Activity 3.2	Evaluate gaps and opportunities to resolve	EMSC, Maine EMA, Maine EMS	31-Dec-24	Evaluate at least 9 counties (45%) for gaps in plans that address needs of children	Staff time	Determine best practices	
Activity 3.3	Evaluate current triage systems and pediatric applicability	EMSC, Maine EMA, Maine EMS	31-Dec-24	Evaluate at least 9 counties (45%) for triage plans that address needs of children	Determine current triage systems used, determine any options	Consider statewide triage system	
Activity 3.4	Encourage regional/local training exercises that integrate pediatric considerations	EMSC, Maine EMA, Maine EMS	31-Dec-24	Determine that at least 9 counties (45%) have, or have plans for, training exercises that address needs of children	Funding, committment from county, public safety agencies, hospitals, other stakeholders	Use of federal/MEMA templates for training exercise planning / implementation / review	
Activity 3.5	Evaluate pediatric tracking and reunification during disasters	EMSC, Maine EMA, Maine EMS	31-Dec-24	Determine that at least 9 counties (45%) have plans that address tracking and reunification needs of children and families	Hospital and EMS agencies	Existing methods and best practices - develop sample policies and resource lists	

EMS Workforce

Data-driven Workforce Planning

Notes from Plan:

Where We Want To Be: In 2035 the EMS system has accurate and actionable information about the EMS workforce. A proactive and ongoing data-driven, evidence-based approach to workforce planning is led by the Bureau of EMS and utilized by the EMS Regions, local agencies and communities. This process collects detailed data and information about the numbers and certification/licensure levels of needed workers, shortages and the location of shortages, the demand for workers, causes of turnover, the supply of workers and the pipeline feeding the supply, education and training issues, working conditions, compensation and benefits, the entire employment value proposition and developing workforce trends. This information is turned into actionable plans, tools and activities that support successful recruitment and retention.

Milestones/Markers of Success:

a. Workforce planning expertise has been established within the Bureau of EMS with appropriate resources and staffing.

b. EMS leaders and agencies are introduced to the concepts of workforce planning and the need for and importance of reliable data and information about the workforce.

c. Detailed workforce data is collected at state, regional and agency levels, including: the number of currently active EMS related professionals;7 geographic distribution of workers; the number of EMS related professionals working multiple EMS jobs; the number of EMS related professionals needed; the gap between the supply of EMS related professionals and the needed number of EMS related professionals; the pipeline and development of new EMS related professionals; and issues impacting turnover and retention.

d. The need, current supply, gap between need and supply and confounding factors are used to clarify the actual shortage of workers in plain numeric terms. e. Volunteerism is continuously evaluated at an agency level. This includes defining what it means to be an active volunteer, quantifying the numbers of active volunteers, assessing volunteer availability, noting an absence of a schedule or schedule shortages, and the agency trends over time. All of this is used to predict agency sustainability.

f. Systemwide predictions are made around future supply and demand based on data, information and emerging trends.

g. The EMS employment value proposition is continuously studied, talked about and addressed state-wide. The employment value proposition includes compensation, benefits, retirement programming, career paths and ladders, advancement opportunities, the subjective intrinsic satisfiers and dissatisfiers, and the general wellbeing of the workforce.

h. All of the above is regularly communicated throughout the EMS system to aid the EMS Regions in coordinating with local agencies in planning successful retention and recruitment strategies.

i. There are a variety of career paths for clinicians and growing awareness about the capacity of paramedicine as a career field and path.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Improve data collection regarding workforce							
Activity 1.1	Identify which additional workforce data (i.e., administrative staff, mechanics, etc.) we need to collect data on to better understand the capacity and needs of the EMS workforce.	Data team, Licensing Team	1-Jul-24	The existence of defined data elements/needs.	Staff, Workforce Expertise	Defining the data elements necessary to evaluate the workforce within the EMS system.	
Activity 1.2	Collect data identified in Activity 1.1 from licensed agencies as part of their licensure renewal.	Data team, Licensing Team	30-Nov-24	Adoption of a rule that requires all staff to be entered into licensure	Staff, Rules committee, Board	EMS Application (initial or renewal) collecting data elements defined in needs assessment.	
Activity 1.3	Monitor and improve logic behind delay reporting in MEFIRS, to include dispatch delays.	Data team, EMD	Ongoing	Closer alignment between anecdotal reports of staffing causing response delays aligning with measurable information	Staff, Data Committee, QA/QI Committee	Ability to assess impact of staffing on delays	
Strategy 2: Cost Reporting							
Activity 2.1	Bring on Staff Positions Allocated by the Legislature	Director	31-Mar-24	Staff Onboarded	Staff Time	Position Justification Form; New Position Number; New Job Posting	
Activity 2.2	Develop data collection form	Data team; Cost Reporting Team Member	31-Dec-24	Time to complete	Staff time, Financial Expertise	Collection instrument	
Activity 2.3	Educate about the importance of cost data reporting	Data team; Cost Reporting Team Member	2024/2025	Completion ratio	Staff time, Financial Expertise	Marketing/education materials	
Activity 2.4	Develop report from the cost data collection and identify KPIs	Data team; Cost Reporting Team Member	31-Dec-25	Reporting that provides insightful and actionable insights into the sources of reveue/funding, expenses and the balance between	Staff time, Financial Expertise	Cost Data Program(s)	
Strategy 3: Using data to identify workforce patterns to support sustainability and address disparities.							
Activity 3.1	Collect data to quantify the factors impacting work/life balance in the EMS workforce.	New Hire (Workforce Management Staff)	TBD	TBD	Legislative funding, Staff	Mechanism to measure and monitor employment factors pertaining to work/life balance.	
Activity 3.2	Collect data to quantify compensation and factors impacting compensation in the EMS workforce.	New Hire (Workforce Management Staff)	TBD	TBD	Legislative funding, Staff	Mechanism to measure and monitor employment factors pertaining to compensation.	
Activity 3.3	Identify potential career pathways and advancement opportunities within the EMS profession.	LD244 Stakeholder Group	14-Jan-24		Legislative Report		

Education and Training

Notes from Plan:

Where We Want To Be: In 2035 education and training are no longer just gateways to obtaining and keeping clinical and operational credentials but the pathway for the EMS system's future and a passport for each clinician's ongoing professional growth, development, and satisfaction. A clear distinction between education and training has been established. Not only do clinicians acquire the necessary skills and behaviors needed for their roles, a passion for knowledge and wisdom has been created that enriches the entire EMS system and its quest to improve and innovate. The quality of entry level training and education continues to be strong, locally available, affordable and adaptive to the needs of learners and Maine's geography. Education and training reach far beyond clinical and operational EMS and now includes leadership development, business administration, accounting, technology, improvement science, people and workforce management, research, and resilience and wellbeing. The EMS system has enough attention and support to have adequate educational sites, qualified educators, financial resources and technology to meet current and emerging needs. EMS education and training continues to develop in quality, availability, convenience and affordability.

Milestones/Markers of Success: a. EMS education is valued by clinicians, employers, leaders and stakeholders as an essential component not only for clinical and operational competency but for every facet of the EMS system.
b. EMS education (clinical, leadership and managerial) is available and accessible statewide, with a mechanism to provide appropriate funding for EMS education in Maine.
c. EMS education is an essential component of a career ladder, and the ladder has been connected with clear paths and credentials.
d. The academic development of leadership is recognized as essential, and programming for leadership development at all levels has been developed.
e. Possession of EMS education and credentials (clinical, leadership and managerial) are required components of EMS organizational hiring.
f. EMS education is valued as a career path. EMS clinicians wishing to expand their careers seek out education because of the multiple roles educators can fill.
g. There is a state level organization, which is seated in the college system, dedicated to the education, training, professional development and credentialing of EMS instructors.h. There is a formal, outlined training and development pipeline for EMS instructors that is phased and encompasses all levels of EMS instruction.
i. Participation in initial training for all levels is supported and not hampered by issues such as child care, lost wages and transportation. Funding for EMS education and training has become a systemwide priority.
j. The system has sustainable ways to provide continuing education hours in a manner that delivers quality, effectiveness and convenience.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Increase the percent of EMS agencies that have a process that requires clinicians to physically demonstrate clinical competency (both adult and pediatric).							
Activity 1.1	Assess EMS agencies' current practices, barriers, and opportunities for improvement as they relate to the frequency of adult and pediatric competency assessment	EMSC, Maine EMS Staff	31-Dec-24	Survey, conduct focus groups	EMS Training officers, medical directors	Summary report on barriers	
Activity 1.2	Develop awareness among EMS agencies and EMS medical directors on the importance of regular adult and pediatric clinical competency training and assessment	EMSC; MDPB	31-Dec-24	Develop quarterly promotion materials distributed statewide	Social media, website, regional distribution, conference attendance	Electornic resources and presentations to educate	
Activity 1.3	Attend statewide and regional conferences to promote clinical compentency assessments	EMSC, Maine EMS Staff	31-Dec-24	Attend/participate in state, regional and local meetings to promote adult and pediatric skills competency	Travel, build presentations	Attendance and presentations	
Activity 1.4	Analyze EMS response data to determine what types of adult and pediatric calls/skills are seen/performed by frequency	EMSC; Data Team	31-Dec-24	Evaluate at least 2 years of Maine EMS data for adult and pediatric responses	Analyze data,	Report on Maine EMS pediatric skills and responses	
Activity 1.5	Develop sample policies and resources for annual adult and pediatric clinical competencies	EMSC; Maine EMS Team	31-Dec-24	Develop a sample policy template	Eval national resources, develop policy	Sample template	
Activity 1.6	Support EMS conferences and training opportunities related to adult and pediatric clinical competency evaluation and improvement	EMSC, Maine EMS Staff	31-Dec-24	Attend at least 2 conferences annually to promote skills around adult and pediatric care	Travel, build presentations	Attendance and presentations	
Strategy 2: Improve access to initial EMS education.							
Activity 2.1	Convene a Stakeholder Group to Explore EMS Career Pathways and Educational Opportunities in the State (Resolve -- LD 244)	Maine EMS, Maine Community College System, University of Maine System, and public/private entities that provide EMS education and training	15-Jan-24	Report to Joint Standing Committee on Criminal Justic and Public Safety that outlines activities and recommendations.	Maine EMS Staff Time, Stakeholder Staff Time, Meeting Space (Virtual)	Required Report (Due 1/15/24)	
Activity 2.2	Ensure all EMR, EMT, AEMT, and paramedic classes held in Maine are posted to eLicensing at least one month before the start date so that anyone can find upcoming classes in their area.	Maine EMS Staff, Training centers, Community college system	1-Jun-24	Rates of compliance, and rates of successful course matching	Staff time, website reconfiguring, Education Committee cooperation	List of courses on MEMSEd	Rule
Activity 2.3	Identify needs to improve access to initial licensure courses.	Maine EMS Staff, Training centers	1-Jun-24	Number of EMS classes held in each region	Staff time, training center support	Needs assessment/report	
Activity 2.4	Hire additional Education staff to the Maine EMS Office	Maine EMS Staff	1-Jun-24	Successful onboarding of new staff member(s)	Staff time, grant funding	Grant application	
Strategy 3: Improve access to continued education hour opportunities for clinicians and instructor/coordinators							
Activity 3.1	Revise, standardize, and educate stakeholders on criteria for CEH course approval	Maine EMS Staff, Education Committee	1-Jul-24	Completion and validation of criteria	Staff time, Education Committee time	Criteria	Rule

Activity 3.2	Develop training(s) on how to develop and seek approval for CEH courses.	Maine EMS Staff, Education Committee	1-Jul-24	Completion of training	Staff time	Training materials and resources	
Activity 3.3	Identify and advertise grant funding opportunities for clinicians to receive compensation for attending continuing education or professional development.	Maine EMS Staff	1-Dec-25	Services access and apply for grant funding	Staff time, website, internet, grant-related expertise	List of grant opportunities posted to website	
Strategy 4: Implement and expand the Maine EMS Explorer Program.							
Activity 4.1	Identify a minimum of 3 initial Explorer sites and convene a regular cohort meeting.	Explorer Program Coordinator	Ongoing, to be completed in the Fall of 2023	Interest expressed by trial sites (verbal and written). Support from communities.	Staff time, transportation, social media	Written Statement of Interest from each site	
Activity 4.2	Develop education/training materials for Explorers, Mentors, and Services.	Explorer Program Coordinator, JMG EMS Workforce Liaison, JMG ELO team	Ongoing, to be completed by end of 2023	Completion.	Staff time, transportation, filming equipment, actors, scripts, locations, media editing software, collaboration with ELO team	Completed modules on MEMSEd and the JMG ELO	
Activity 4.3	Implement Explorer activities at trial sites.	Explorer Program Coordinator, JMG EMS Workforce Liaison, trial site personnel	Ongoing, to be completed by March, 2024	Count of Mentors and Explorers, satisfaction of all involved.	Staff time, transportation, social media, t-shirts (arranged by JMG), service time and effort	Count of Mentors and Explorers, Explorer Program Implementation Guide	
Activity 4.4	Begin subsequent rollout phases beyond the initial sites.	Explorer Program Coordinator, JMG EMS Workforce Liaison, trial site personnel, Service leaders, Educators, Schools, Towns	June, 2024	Count of services implementing Explorer Program	Staff time, transportation, social media, t-shirts (arranged by JMG), service time and effort	Count of services	
Activity 4.5	Hold monthly meetings with initial Explorer sites and the Explorer Team to promote quality improvement and share best practices.	Maine EMS staff, JMG, initial trial sites	September 2023 through May 2024	Regular meetings, discussions, and implementation of lessons learned	Staff time, service and mentor time, Zoom/Teams	Meeting minutes and recordings	

Leadership Development and Support

Notes from Plan:

Where We Want To Be: In 2035 the EMS system has an extraordinary cadre of leaders at every level. It is widely accepted that the EMS system's sustainability depends on prepared and capable leaders. The development and credentialing of leaders receive as much attention and focus as the development and credentialing of clinicians. The EMS system has identified what is needed to develop effective EMS leaders at all levels. This knowledge results in robust programming for leadership development and the ongoing encouragement, growth and support of leaders. There are clear expectations for agency leaders to have formal leadership development, and a leadership credentialing process has been developed. Leadership has become an attractive career path and the EMS system is continually looking for and preparing the next leaders.

Milestones/Markers of Success: a. Capable and prepared leaders are viewed as essential to EMS system reliability, sustainability and quality.
b. Learning leadership is no longer simply on the job, and the ability to lead is not assumed.
c. Leadership education and development are expected of all personnel who have responsibilities for coordinating, supervising, managing, directing and leading any part of an agency or the system.
d. A credentialing process has been developed, and leaders at all levels are expected to fulfill the specific competencies of the process.
e. Foundational leadership education is provided by Maine's Community College System, and Maine's colleges, universities, associations, educational organizations and agencies provide continuing education for leaders and ongoing support.
f. The EMS system is continuously developing the next generation of leaders and identifying a roadmap for EMS professionals as they advance in their careers to take on more administrative responsibilities.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Develop Course for EMS Supervision & Human Resources for Front Line Supervisors							
Activity 1.1	Identify subject matter for educational programs targeting front-line supervisors and human resources.	Maine EMS Deputy Director	1-Jun-24	Surveys, questionnaires, and meeting with stakeholders to identify subject matter needed for leadership development programs and target audiences for Front Line EMS Supervision.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Subject matter and target audiences identified.	
Activity 1.2	Develop educational programs for Front Line Supervisors and human resources	Maine EMS Deputy Director	1-Dec-24	Stakeholders review of educational programs.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Search and review for grant funding to support program. Identify subject matter experts that would be interested and participate in educational program.	

Activity 1.3	Research ways to provide educational programs with the subject area of EMS Supervision and Human Resources for current Front Line Supervisors and potential leadership.	Maine EMS	1-Jun-24	Surveys, questionnaires, and meeting with stakeholders to identify best dates and locations for programs.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Advertisement of program and distribution of educational materials.	

Strategy 2: Develop Course(s) for EMS Finance & Budget Management for EMS Administrators							
Activity 2.1	Identify subject matter for leadership educational programs for EMS Administrators and potential EMS Administrators concerning EMS Finance and Budget Management.	Maine EMS Deputy Director	1-Jun-24	Surveys, questionnaires, and meeting with stakeholders to identify subject matter needed for leadership development programs and target audiences for EMS administators for EMS Finance and Budget Management.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Subject matter and target audiences identified.	
Activity 2.2	Develop leadership educational programs for EMS Administrators and potential EMS Administrators concerning EMS Finance and Budget Management.	Maine EMS Deputy Director	1-Dec-24	Stakeholders review of educational programs.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Search and review for grant funding to support program. Identify subject matter experts that would be interested and participate in educational program.	
Activity 2.3	Research ways to provide leadership educational programs for EMS Administrators and potential EMS Administrators concerning EMS Finance and Budget Management.	Maine EMS	1-Jun-24	Surveys, questionnaires, and meeting with stakeholders to identify best dates and locations for programs.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Advertisement of program and distribution of educational materials.	

Mental Fitness and Wellbeing

Notes from Plan:

Where We Want To Be: In 2035 clinicians across Maine enjoy high levels of subjective wellbeing and know how to balance the challenges of EMS and living well. Sacrificing one's wellbeing for EMS is no longer expected, championed or modeled. Care for the wellbeing of clinicians has become a proactive effort and not merely reactive to big events or psychological breakdown. Attending to mental health has been normalized and is no longer stigmatized. Clinicians are prepared for the rigors of EMS and expected and motivated to cultivate mental fitness. Mental fitness, like physical fitness, is developed. Mental fitness programming is systemwide and encompasses the clinician experience from initial training through retirement. Clinicians participate because selfcare and caring for one another are expectations, and there is positive social pressure in each agency to do so. This results in high levels of clinician wellbeing, resilience and satisfaction, and low rates of breakdown, stress injury and psychopathology.

Milestones/Markers of Success: a. The EMS system acknowledges EMS is a high risk, high stress and high responsibility occupation that demands more than a reactive and after-event response to support mental health.
b. EMS agency leaders have been introduced to the concepts of mental fitness, subjective wellbeing and resilience as proactive measures to cultivate a better clinician experience.
c. Systemwide mental fitness programming has been developed and is continuously taught through educational institutions, training programs and the EMS Regions.
d. Clinicians are prepared for the inherent psychological challenges of EMS through mental fitness training that aids them in creating strong self-awareness and emotional awareness, resilience training, peer-to-peer support and organizational cultures that support living well and selfcare.
e. Mental fitness training, development and support begin in initial EMS training programs and continue through one's entire career.
f. Agencies have access to mental fitness training, and instructors and agency leaders are taught how to create organizational cultures that support wellbeing, are pro-selfcare and promote fitness, work/life balance and asking for help when needed.g. The EMS system has identified mental health professionals who are first responder friendly
and knowledgeable.
h. CISM services continue, are expanded and are readily available throughout the EMS system.
i. Peer support development, education and training have become standardized and readily available throughout the EMS system and are educational opportunities for clinicians interested in mental health, mental fitness and resilience.
j. Rates of anxiety, depression, PTSD and suicide in EMS clinicians are equal to or lower than the national averages for the general public.
g. The system has established a process for gathering and aggregating data elements from 9-1-1 call data, computer aided dispatch (CAD) systems, Maine EMS & Fire Incident Reporting System (MEFIRS) data and the various electronic health records (EHR) used by the healthcare systems.
h. Outcomes information is used to continuously improve system response plans and resource use.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: EMS Explorers and Explorer Mentors receive prophylactic mental health awareness training.							
Activity 1.1	Develop training module to expand awareness of mental health and teach coping and harm reduction strategies for Mentors.	Explorer Team, Maine EMS Staff, Mental health SMEs	31-Dec-23	Holding the trainings	Time, staff, mental health experts, EMS clinicians	Training module to be adapted onto MEMSEd	
Activity 1.2	Develop training module to expand awareness of mental health and teach coping and harm reduction strategies for Explorers.	Explorer Team	31-Dec-23	Uploading the trainings to JMG LMS.	Time, staff, mental health experts, EMS clinicians, video equipment, video editing software	Training module on JMG LMS	

Activity 1.3	Create network of resources among Mentors, service leaders, JMG specialists, school employees, and communities to support mental health in Explorers	Explorer Team, trial sites	31-Mar-24	Availability of mental health supports for all Explorers	Time, staff, peer resources, counselors	List of resource network members for Explorers	

Strategy 2: Increase access to mental health peer support and CISM trainings in all EMS Regions.							
Activity 2.1	Access grant funding to pay for mental health resources and CISM trainings to make them freely accessible for all clinicians.	Maine EMS Staff	1-Aug-24	Access to funds	Time, staff, grant opportunities, SMEs	Grant funding and program infrastructure	
Activity 2.2	Increase availability for individuals to be trained in providing EMS peer support and CISM trainings.	Maine EMS Staff, contractors?	1-Aug-24	At least one training per quarter per region	Time, staff, CISM training facilitators, training spaces	CISM training resources	
Activity 2.3	Create list of chaplain resources, spiritual care services, the front-line warm-line, and other peer support groups on the Stay Healthy in EMS webpage.	Maine EMS Staff, chaplaincy and spiritual care services, Stress resiliency and response workgroup	31-Dec-23	Clicks on "Stay Healthy in EMS" website links	Time, staff, Maine EMS website, Maine EMS Stress Response and Resiliency workgroup	Website	

Strategy 3: EMS Clinicians will be able to readily access behavioral health resources as needed							
Activity 3.1	Access to a list of behavioral health clinicians that are competent/experienced in working with first responders.	Maine EMS Stress Response and Resiliency Work Group	1-Feb-24	Published list of clinicians	Time from Maine EMS stress response and resiliency group, buy in from behavioral health clinicians/entities	Published document on Maine EMS website	
Activity 3.2	Maine EMS will collaborate with local behavioral health agencies to support in connecting them with individual agencies to provide trainings on compassion fatigue, accessing mental health resources, and awareness of when coworkers may need supports.	Maine EMS staff, behavioral health agencies	1-Feb-25	Number of trainings held	Time from Maine EMS staff, behavioral health agencies, and potentially some grant funding	Courses held	
Activity 3.3	Maine EMS will work collaboratively with other first responder networks to support statewide first responder mental health initiatives (such as a training).	Maine EMS staff	1-Feb-25	Number of collaborative meetings, Number of statewide trainings	Time from Maine EMS staff, time from local agencies	Trainings	
Activity 3.4	Develop a report that identifies providers who may be at risk due to traumatic events witnessed on scene. Those identified will be provided with behavioral health resources to access should they choose.	Maine EMS staff, Data Team	1-Jul-24	Creation of report	Staff time	report and auto resources	
Activity 3.5	Develop a pathway for clinicians to self-report substance use issues that is non-disciplinary.	Maine EMS staff, legislators	Dec-25	Pathway developed	Staff time, legislature, Board	Legislative change	Statute

EMS Clinical Care

Medical Direction

Notes from Plan:

Where We Want To Be: In 2035 EMS medical direction is a defined and essential role within the Maine EMS system at all levels. The engaged leadership of medical directors is integral to clinical development and quality throughout the EMS system and has become a major motivational and developmental element in the EMS clinician's experience. Gone are the days of a medical director being a minimally involved volunteer and ad hoc paper-signer. Medical directors are prepared, active and motivated and are involved and empowered by the agencies they serve.

Milestones/Markers of Success: a. Medical direction is led by a full-time state medical director and an associate medical director.
b. Regions are supported by regional medical directors who support agency level medical directors and serve as the conduit from local medical directors to the state.
c. All transporting agencies have active and engaged medical direction.
d. Cohorts of medical directors have formed and work together to serve multiple local agencies in geographical areas, increasing continuity throughout the EMS system.
e. Agency administrators and chiefs have a robust understanding of medical direction, its roles and responsibilities and its importance to clinical operations. They support this role and view the medical director as the agency's chief medical officer.
f. The medical direction role and authority in each agency is clearly defined, with job descriptions, contracts, appropriate compensation and accountability.
g. Each medical director's span of control is right-sized to allow for appropriate engagement and ensure the role is rewarding and satisfying for the medical director, agency leader and clinicians.
h. Each medical director is appropriately prepared, has a command of evidence-based medicine and EMS protocols and protocol development and is proficient in the ongoing cyclical process that continuously uses clinical evaluation to drive clinician feedback, education, mentoring and skills development.
i. Medical directors connect with frontline clinicians and notice, inspire and motivate ongoing clinical development, research, growth and exploration. Medical directors help clinicians fully realize the rewards of best-possible clinical care.k. Medical directors are integral parts of system planning, development and integration, and work with each other to ensure EMS in Maine continues to develop as a cohesive system regionally and statewide. Because of their work in emergency departments, they are an effective bridge between EMS and healthcare.
l. Medical control has become more centralized and delivered by appropriately prepared physicians who deliver meaningful support that is consistent, knowledgeable and accountable. Medical control has evolved to provide a range of services, including simply radio advice, telemedicine video support or even infield physician intercepts.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: All agencies have active and engaged medical direction.							
Activity 1.1	Update or develop a medical director guidebook. The guidebook should contain a plan to allow a medical director to be successful.	MDPB/EMS Office Staff/ Board	1-Dec-24	Guidebook			
Activity 1.2	Develop a template for a medial director job description for all agency types.	MDPB/EMS Office Staff/ Board	1-Dec-24	Job description			
Activity 1.3	Create rules requiring medical direction for all transporitng agencies. The plan should include span of control advice to ensure medical direction is not overburdened.	Rules Committee/Maine EMS Board	31-Dec-25		Time, Support from Maine EMS Board	Updated EMS Rules	Rules
Strategy 2: Regional Medical Directors are active and supported							
Activity 2.1	Develop regional medical director job description & deliverables	MDPB/EMS Office Staff/ Board	1-Dec-24	Job Description	Time, Support from MDPB and EMS Staff	Regional Med Director Job Description w/deliverables; Bylaws	
Activity 2.2	Fund regional medical director positions	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		
Activity 2.3	Provide support staff for regional medical directors to carry out their duties	EMS Office	1-Jul-25	Funding obtained	MEMS Office and Board		
Activity 2.4	Develop educational resources for medical directors that teach the nuances of medical direction in Maine. This course should focus on the administrative aspects of medical direction and should be deliverable in person and on line.	EMS Office Staff/MDPB	31-Dec-25	Completion of the educational materials and fiirst course	Time, Support, Educational Expertise	Completed educational product and first course	
Activity 2.5	Develop education for medical drectors focusing on the clinical aspects of prehospital medicine. While these procedures are commonly taught through fellowships, it may not be feasible to require fellowship training for all medical directors, therefore, in settings where the physician is providing in-field support, this course could support those activities. In an effort to workshare, this effort could be a collaborative effort with the state's EMS Fellowship program.	EMS Office Staff/MDPB	31-Dec-26	Completion of the educational materials and fiirst course	Time, Support, Educational Expertise	Completed educational product and first course	
Strategy 3: Under the Auspices of Communication Between Agency Medical Directors and Maine EMS/State Medical Direction							
Activity 3.1	Develop expectations that agency medical directors become involved in Regional Councils, or, at a minimum, host quarterly meetings, lead by the regional medical director, that focus on the needs and input of agency medical directors. These meetings are expected to develop strong relationships between the regional medical director and agency medical directors and act as a conduit for information and communication between the state to agency medical directors and from agency medical directors to the state.	EMS Office Staff/MDPB/Maine EMS Board	31-Dec-25	Development of meeting/meeting schedule/demonstration of medical direction attendance	Time, Support, System Wide Communication	Forums in each region focused on medical direction	
Activity 3.2	Given the importance and stature of regional medical directors in the state, these positions are suported by Maine EMS at an appropriate level, allowing the regional medical directors time and energy to perform the tasks asked of them. This level of support should be around 0.25 FTE.	EMS Office Staff/MDPB/Maine EMS Board	31-Dec-25	Acheivement of RMD finacial and staff support	Time, Support, Budgetary Support	Excellent communication pathways between the EMS System and Hospitals	

Activity 3.3	Agency medical directors should be working clinically within the region and affiliated with a hospital of that region. This model allows for rish levels of communication between the regional medical director and the hospital. In addition, should need arrise for high level communication with a gien hospital in a region, the agency medical director can foster that communication between the regional medical director and/or the state medical director/state director.	EMS Office Staff/MDPB/Maine EMS Board	31-Dec-25	Demonstration of communication pathways between State, Region, Local Levels	Time, Support, System Wide Communication	Excellent communication pathways between the EMS System and Hospitals	
Activity 3.4	All hospitals have a designated EMS Physician who acts as a contact, advocate and point of communication between the hosptial the EMS System (local, regional and state). This position may be filled by and agency medical director, or could be a stand alone position.	EMS Office Staff/MDPB/Maine EMS Board	31-Dec-25	Identified hospital physician contacts with each hospital in Maine	Time, Support, System Wide Communication	Excellent communication pathways between the EMS System and Hospitals	

Systems of Care

Notes from Plan:

Where We Want To Be: In 2035 EMS in Maine is fully integrated into the overall healthcare system, as evidenced by its inclusion and participation in robust systems of care for time-sensitive conditions. The Bureau of EMS continues to oversee the trauma system of care and is given statutory oversight over other EMS dependent systems of care such as stroke, STEMI, sepsis and out-of-hospital cardiac arrest. A robust system plan identifies healthcare facilities based on their capabilities to manage time-sensitive conditions including designations, data reporting, performance improvement and outcomes. EMS's role is universally acknowledged as a keystone component in the continuum of care.

Milestones/Markers of Success: a. There has been broad recognition of EMS's vital role in time-sensitive conditions such as trauma, stroke, sepsis, STEMI, out-of-hospital cardiac arrest, prenatal and perinatal conditions, pediatric care, organ and tissue donation and traumatic brain injury. This recognition includes EMD, initial response, treatment and communication, destinations and bypass, interfacility transfers and critical care transfers, and participation in data collection and registries.
b. The Bureau of EMS has statutory oversight of the stroke, STEMI, sepsis and out-of-hospital cardiac arrest systems of care.
c. A robust system plan identifies healthcare facilities based on their capabilities to manage time-sensitive conditions including designations, data reporting, performance improvement and outcomes.
d. Standardized statewide order sets have been developed for interfacility movement of patients with time-sensitive conditions.
e. EMS protocol development and education have been integrated with clinical experts in timesensitive conditions.
f. EMS clinicians have access to routine training and educational opportunities related to timesensitive conditions.
g. Registries have been established for trauma, stroke, STEMI, sepsis, and out-of-hospital cardiac arrest, and EMS and the larger healthcare system actively participate in these registries. Registries provide feedback to EMS clinicians on their patient's 30-day outcome.
h. Performance matrices have been defined for time-sensitive conditions that allow for the appropriate QA/QI evaluation.
i. EMS clinicians are included in registry reports and case reviews.
j. Maine contributes to the national dialogue on systems of care particularly related to the rural environment.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: The office will facilitate EMS agencies in being able to acknowledge, train, educate, and evaluate time sensitive illnesses.							
Activity 1.1	Define measures, key performance indicators (KPIs), and goals for time sensitive illnesses.	Systems of Care Coordinator, QA/QI Committee	1-Jul-24	Definations along with dashboard with KPI for time/effort required to enter, validity score	Staff time	Dashboard with KPI for time/effort required to enter, validity score	
Activity 1.2	All out-of-hospital cardiac arrests will be reviewed by an internal QA/QI committee, QA/QI primary contact, and/or service level medical director.	Rules Committee/Maine EMS Board	31-Dec-25	Rule in effect and renewal process built to accomodate	Time, Support from Maine EMS Board	Rule stating that all out-of-hospital cardiac arrests will be reviewed by an internal QA/QI	Rules
Activity 1.3	CARES National Report data will be disseminated to all EMS services, and hospitals, and publically published.	Systems of Care Coordinator	1-Mar-24	All CARES reports will be published.	Staff time	Publication of CARES documents	
Activity 1.4	Each year a time sensitive illness education will be available for all clinicians faciliated by a additional staff member(s) who work with the State Medical and Associate Medical Director as well as identified clinical experts to develop this material. Additional responsibilities of this new position could include the improvement of MEMSEd in an effort to make MEMSEd a "go-to" resource that is respected for it's excellence and quality education.	Systems of Care Coordinator	Each year	Educational Program	Time, support from the education committee	Training materials (asynchronous training, videos, handouts)	
Activity 1.5	Add additional staff whose solitary function is to support the MDPB's activities, including protocol development. This position would become the primary support for protocol development and evolution and would also be the dedicated support for MDPB meetings.	Maine EMS Director, Commissioner, Maine EMS Board	31-Dec-25	Approval of the position and hiring into the position	Time, Support, Communication, Funding	Approval of the position and hiring into the position	
Activity 1.6	Regional medical directors and directors, through the support provided by Maine EMS, will function to support sysmtes of care at the regional level and work closely with hospitals to develop, improve and evolve systems of care at the regional level.	MDPB, Reional Directors, Maine EMS Director, Staff, Board	31-Dec-25	High Functioning Systems of Care	Time, Support, Communication, Hospital Collaboration and Partnerships	High Functioning Systems of Care	
Activity 1.7	Regional directors are Maine EMS employees with authority provided by the Maine EMS to and are accountable to ensure prevention of message dillution and pollution in all communication from the state to local stake holders, and vice versa.	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		
Activity 1.8	Maine EMS will add an epidemiology or data analyst to support the Maine EMS efforts in data reporting and system improvement.	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		

Activity 1.9	Similar to the TAC and the MSA, Maine EMS conviene 2 additional advisory committees covering acute cardiac care and out of hospital cardiac arrest care. These committees should be made up of clinical leaders in those domains, as well as the state medical director, associate state medical director, an MDPB member and other key stakeholders from the EMS community. The purpose of all advisory committees is to: 1) develop, support, and improve staewide systems of care 2) review and comment on the state's 911 protocols 3) develop model physician ordersets for MDPB review and approval 4) support the state offices and state medical director's oversight and management of a specific condition's care	MDPB,State Medical Directors, Maine EMS Director,	31-Dec-25	Committee established with participation from all appropriate stake holders	Support from MEMS Office		

Strategy 2: Increase the percent of EMS agencies recognized through the Maine "Always Ready for Children" EMS recongition program.							
Activity 2.1	Develop and have a Board approved "Always Ready for Children" program for EMS	EMSC, EMSC Advisory Committee, Board	31-Dec-24	Approved program	Collaborate and emulate previously approved hospital "Alwasy Ready for Children" program	Program Manual	
Activity 2.2	Promote and recognize EMS agencies	EMSC, EMSC Advisory Committee, Board	31-Dec-24	10% of EMS agencies recognized	Promotion and meetings with EMS agencies	Recognition awards and process	
Activity 2.3	Establish requirement of pediatric emergency care coordinator (PECC) into EMS agency required position.	EMSC, Maine EMS Staff, Board	31-Dec-24	Is a PECC required for each licensed EMS agency	Proposal to Rules Committee, supporting resources	Proposal, supporting resources	Rules

Strategy 3: Increase usage of a Family Advisory Network (FAN) member(s) to represent the emergency needs of children in their community.							
Activity 3.1	Develop a FAN Strategic Plan Guide	EMSC, EMSC Advisory Committee	1-Oct-23	HRSA approved plan	FAN, HRSA, submission through EHB	Approved plan	
Activity 3.2	Recruit a second volunteer FAN member for EMSC Program	EMSC, EMSC Advisory Committee	31-Dec-24	Approved FAN member	FAN, EMSC Advisory Committee	2nd FAN	

Expanded Role of EMS

Notes from Plan:

Where We Want To Be: In 2035 there is broad acceptance, appreciation and reimbursement for care and service outside the traditional emergency response and transport roles of EMS. Maine's EMS system continues to identify unmet healthcare needs that may benefit from EMS resources and for which EMS can develop the necessary knowledge, skills, competencies and reimbursement. Across Maine, many agencies have embraced mobile integrated health and community paramedicine as models to address unmet healthcare needs due to rurality and other social determinants of health. In furtherance of this, medical direction, a Board of Paramedicine, the EMS Board and regulatory oversight have all recognized the need to establish clear authority for EMS to meet certain needs without supplanting existing healthcare resources and infrastructure. Services provided under these provisions are fully reimbursed by payers, and the model for delivery is considered sustainable, effective and efficient by all involved. The Maine EMS system continues to support the expansion of these types of programs through pilot programs, education and training, quality assurance and ongoing evaluation and improvement.

Milestones/Markers of Success: a. Payers of healthcare services value and recognize the potential efficiencies and are willing to pay to have EMS provide expanded services.
b. Healthcare systems and primary care see mobile integrated health and community paramedicine as valuable, effective and efficient extensions of their services.
c. The healthcare system understands and values mobile integrated health and community paramedicine as beneficial extensions of their services.
d. Expanded EMS services such as mobile integrated health and community paramedicine are seen as valuable components of the overarching healthcare system and are not seen as competitive programming among existing components.
e. The number of Mainers who have access to Mobile Integrated Health and community paramedicine continues to increase.
f. The unnecessary use of emergency departments and 9-1-1 EMS response continues to decline.
g. Mobile integrated health and community paramedicine models and programs are consistently receiving referrals from healthcare entities.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Community Paramedicine programs will be active and collaborative with other healthcare entities							
Activity 1.1	There will be 20 EMS agencies with a CP designation or license.	Community Paramedicine Coordinator	1-Jan-24	Number of agencies with a CP designation or license. Collected from ImageTrend	Community Paramedicine Coordinator will support agencies through the Designation or licensing process.	20 Designations/ licenses	
Activity 1.2	Agencies will provide 20 or more patient visits a year.	Community Paramedicine Agencies	1-Dec-25	Number of PCRs in MEFIRS.	MEFIRS reports	Report on patient visits	
Activity 1.3	Increase collaboration of other healthcare stakeholders will be included in the CP committee to ensure new voices are heard.	Community Paramedicine Coordinator	1-Sep-23	CP committee will have a home health position and hospice/palliative care position.	Board approval	New CP membership in expanded healthcare roles.	

Strategy 2: Collect and compile data to show the value of Community Paramedicine

Activity 2.1	Cutler will complete a cost avoidance data analysis deliverable that will show potential avoided costs for CP patients.	Community Paramedicine Coordinator; University of Southern Maine (Contractor)	1-Feb-24	Completed work product from Cutler received by Maine EMS.	OMS/ EMS data being provided to Cutler	Cost avoidance analysis	
Activity 2.2	The new CP Module will go live.	Community Paramedicine Coordinator; Data Team	1-Jul-24	CP Module roll out	ImageTrend System; Work sessions with Data Team	Final CP Module.	
Activity 2.3	The office will publish a quarterly report regarding CP data.	Community Paramedicine Coordinator; Data Team	1-Jan-24	Published CP data report.	Data report creation from Data Team	Quarterly report	
Activity 2.4	EMS Explorers shadow and assist Community Paramedicine professionals	EMS Explorer Program Coordinator and Community Paramedicine Coordinator	May 2024 and onward	Collaboration between Explorer and CP services	Staff time, collaboration with Explorer and CP services	Quarterly report	
Strategy 3: Increase Community Paramedicine Sustainability by Securing MaineCare Reimbursement							
Activity 3.1	Chapter 19: Community Paramedicine rules will be updated to reflect the new scope of practices, formulary and other changes to the CP process in Maine. The rules will move through the process and be approved by the board.	Community Paramedicine Coordinator	31-Jan-25	New and approved chapter 19 CP rules.	CP committee and rules committee will need to review the CP rules.	New Chapter 19 rules	Rules
Activity 3.2	The CP formulary will be approved by the MDPB and the Board.	Community Paramedicine Coordinator	1-Dec-23	Approved CP Formulary	Review by the MDPB and Board	Formulary	Rules
Activity 3.3	There will be a scope of practice for all 3 license levels of CP providers with signaled support by the MDPB and the board.	Community Paramedicine Coordinator	1-Jul-24	3 separate scopes of practice created and approved by the MDPB and Board.	CP Committee work on completion of 3 separate scopes. Review by the MDPB and the Board.	3 Scopes of Practice	Rules
Strategy 4: Development of Critical Care Paramedic Systems of Care							
Activity 4.1	Similar to community paramedicine, Maine EMS develop an additional staff position that focuses on and coordinates all critical care transport efforts across the state.	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		
Activity 4.2	Maine EMS developes clinically rigorous pathways for interesed ground EMS agencies to perform critical care transport.	MDPB, State Medical Directors, Maine EMS Director, Key Stakeholders	31-Dec-25	System of Care Created and Approved	Support from MEMS Office and Board		
Activity 4.3	All critical care transports, via ground or air, are held to similar clinical standards and are required to demonstrate proficency on a regular basis. Medical directors supporting these effforts are adequately supported	MDPB, State Medical Directors, Maine EMS Director, Key Stakeholders	31-Dec-25	CCT Agencies submit state requested QI Metrics for review by the State Medical Director, State, CCT Coordinator	Support from MEMS Office and Board, Coordination with key stakeholders		
Activity 4.4	Similar to community paramedicine, Maine EMS develop an additional staff position that focuses on and coordinates all critical care transport efforts across the state.	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		
Activity 4.5	Through the development of increased pathways for critical care transport and embracing PIFT-level care into ALS capablities when appropriate, Maine EMS evolves beyond the PIFT scope of practice, leaving the following potential IFT scopes: EMT, AEMT, Paramedic (ALS), Critical Care. The latter may be a single tier provider type (i.e., similar to the scope of LifeFlight of Maine) or Maine EMS may choose to develop tiers of critical care transport that allow the EMS Agency and EMS Agency medical director to choose the degree of criticial care transport they provide.	MDPB, State Medical Directors, Maine EMS Director, Key Stakeholders	31-Dec-25	INterested agencies submit application packet for Agency License in CCT	Support from MEMS Office and Board, Coordination with key stakeholders		

Activity 4.6	Maine EMS, the Maine EMS Medical Directors, and the Maine EMS Regional Medical Directors work closely with the Maine Hospital Association, individual hospitals, hospital designated EMS Physician representives and others to ensure all transferring physicians have a rich understanding of the Maine EMS interfacility transport system of care and are held responsible for determining the proper scope of practice for any given transport. Errors in decision making regarding transport are identified (by the receiving hospital, the transferring hospital during routine review of these cases, or the EMS Agency/EMS Agency medical director) and these errors are examined closely to ensure similar errors do not occur in the future. Regional medical directors and directors are involved in this review process to ensure EMS System awareness and support any necessary actions resulting from the review process.	Maine EMS, the Maine EMS Medical Directors, and the Maine EMS Regional Medical Directors work closely with the Maine Hospital Association, individual hospitals, hospital designated EMS Physician representives and others	31-Dec-25	Educatoinal and Reference Products for transferring physicians	Support from MEMS Office and Board, Coordination with key stakeholders		
Activity 4.7	Transferring and receiving hospitals have means of communication surrounding IFT's and patient outcomes resulting from IFT decision making are routinely communicated to receiving hospitals.	Maine EMS, the Maine EMS Medical Directors, and the Maine EMS Regional Medical Directors work closely with the Maine Hospital Association, individual hospitals, hospital designated EMS Physician representives and others	31-Dec-25	Systems of Communication that support QI Efforts	Support from MEMS Office and Board, Coordination with key stakeholders		

Evaluation and Quality Improvement

Notes from Plan:

Where We Want To Be: In 2035 Quality Assurance/Quality Improvement (QA/QI) is a foundational component of the EMS culture and permeates every facet of the EMS system. QA/QI is enthusiastically embraced and sought by clinicians, EMDs, service leaders, medical directors and the broader healthcare community. Systemwide quality practices and measures are informed by data at all levels. Quality metrics are being gleaned from all levels of the EMS system, from call-taking and dispatch through patient discharge and the clinical outcome. These metrics are consistent, data-driven, clinician friendly and supported by robust learning, growth and development. Patients reliably receive the right care, at the right time, by the right clinician. QA/QI has been destigmatized and disentangled from disciplinary mechanisms. QA/QI is efficient and does not create unnecessary burdens or redundancies. Clinicians are performing at the top of their scopes of practice, and EMS in Maine continues to expand its capacity to care for complex patients and support the healthcare system. Clinical quality is led and overseen by the State Medical Director and an active and collaborative cohort of regional and agency medical directors. QA/QI practices are implemented by competent and motivated agency quality coordinators and are supported by the system in its entirety.

Milestones/Markers of Success: a. QA/QI has become truly valued because the improvement process has been successfully applied to the top issues and concerns of clinicians, EMDs, service leaders, medical direction and the broader healthcare community.
b. All clinicians are comfortable reporting errors and view reporting as a duty and an opportunity for growth.
c. QA/QI has genuine and real accountability.
d. There is a systemwide appreciation and understanding of quality assurance and improvement science at all levels, with education and training opportunities on how to do so.
e. QA/QI is financially supported at all levels, including at the state level.
f. The complete patient record, from CAD through hospital discharge, is available to support quality assurance and improvement initiatives as well as clinician and EMD performance.g. QA/QI is understood to entail much more than finding the bad apples. Quality assurance is truly about improving the quality of clinical care when it comes to meeting a known standard. Quality improvement is truly about emphasizing the importance of raising the standard and reducing the incidents of quality issues.
h. There are innovative models to help local agencies meet QA/QI expectations including the possible use of outside contractors.
i. All entities (EMS agencies and EMD centers) are accountable and have implemented robust evaluation plans that are routinely reviewed. Plans include specific metrics, methodologies, roles, responsibilities and pathways for bringing about meaningful, systemic changes within their organizations for the betterment of patient care.
j. The EMS system has robust dashboards that provide accurate and actionable feedback on personal, agency and system performance.
k. Clinicians have increased the accuracy of their field impressions and associated clinical treatment through robust outcomes feedback.
l. QA/QI includes operational quality, ensuring response performance, the handling of IFTs and ensuring patients arrive at the right destination.
m. QA/QI and education are inextricably connected with comprehensive feedback loops in place to ensure clinician competency and best practice.
n. Agencies are adequately resourced to support QA/QI efforts and to connect and engage with clinical operations.
o. Clinicians and EMDs see meaningful improvement that is the result of their involvement in the QA/QI process.
p. QA/QI has been applied to resource deployment and ensures the efficient use of resources statewide.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Improve quality of care by defining performance initiatives based on KPIs							
Activity 1.1	Define KPIs for Maine EMS protocols where appropriate with a minimum of 10.	MDPB, QA/QI Committee	1-Jul-24	There will be performance improvement markers developed and shared with all EMS clinicians	time, analytics	KPIs	

Activity 1.2	Identify QA/QI initiatives based upon KPIs	MDPB, QA/QI Committee	31-Dec-24	There will be available access for EMS agencies to compare themselves to like sized, or agencies with other similar characteristics	time, analytics	KPIs	

Strategy 2: Develop a process to allow for sentinel event reporting, both defined and undefined.							
Activity 2.1	Define the needs for a system of sentinel event reporting	MEMS Board/QA-QI Committee/MEMS Staff	31-Dec-24	Maine EMS has a system that allows reporting of errors or mandated reporting items, that is easily accessed and frequently used without fear of punishment	time, money	Workgroup	
Activity 2.2	Define the sentinal event reporting process to include training for EMS licensees (entities and individuals) and Service Chiefs	MEMS Rules Committee MEMS QA-QI Committee	31-Dec-24	the process to report errors is clear and defined, EMS clinicians understand the process of working to prevent errors	time, support of the committees involved,	Model Process	
Activity 2.3	Develop rules requiring sentinel event reporting	MEMS Rules Committee MEMS QA-QI Committee	31-Dec-25	Maine EMS has adopted rules to support complinace regarding error reporting	time, support of the committees involved,	Rules	Rules
Activity 2.4	Develop a model for the surveillance of trends related to Sentinel events, including the identification of emerging and/or unidentified events, that includes adequate staffing for implementation	Legislature, Maine EMS Staff, Board of EMS,	31-Dec-25	Sentinel event reporting and surveillance has been appropriately authorized and funded, and a finalized model has been developed	General Fund appropriation, staff time, authorizing language, integrated electronic reporting system	Draft model document, job description, implementation plan, draft statutory change language, budgetary documents.	Statute (Maybe)

Strategy 3: Comprehensively review the Maine EMS Quality Improvement Manual to increase its relevance to EMS clinicians and encourages the use of established perfomance metrics.							
Activity 3.1	Develop scalable quaity improvement models for EMS agencies of all sizes and types	QA/QI Committee	31-Dec-25	Maine EMS has program templates that are flexible and scalable for all Ems agencies that are continuously improved upon and updated.	time, additional staff	Revised Quality Improvement Manual	
Activity 3.2	Publish performance metrics for EMS agencies and the public.	QA/QI Committee	31-Dec-25	Maine EMS has made the defined and established performance metrics availabel for public viewing in the interest of transparency.	time, additional staff	Performance Metrics	
Activity 3.3	Publish examples on how EMS entities can migrate from an exclusively quality assurance stance to a quality improvement model	QA/QI Committee	31-Dec-25	Increases in clinical performance metrics	time, additional staff	Examples of transition from QA to QI	

EMS Finance

The Cost of EMS

Notes from Plan:

Where We Want To Be: In 2035 it is recognized that sustainable funding of EMS necessitates an accurate and ongoing accounting for the full costs of EMS. The costs of all elements such as administration, the readiness of 24/7 operations, medical direction, quality assurance and improvement, initial and continuing education and training, employee turnover, vehicle maintenance, dispatch and communications, etc. have been accurately quantified and are known. Costs are no longer obscured by a lack of accounting for donated labor or below-living-wage labor. Agencies know how to quantify their costs including the costs of preparedness, response, treatment and transport, as well as all overhead. Agency financial accounting includes an understanding of all revenue sources including reimbursement for services, tax subsidies, other public monies, grants and donations.

Milestones/Markers of Success: a. The full and true costs of providing operational EMS are known.
b. Local agencies and governments are continuously educated in how to calculate the full and true costs of providing operational EMS. Tools for financial accounting are readily available.
c. The full and true costs of EMS are utilized to appropriately establish revenue sources to fund EMS.
d. There is transparency regarding the total finances of each agency, including costs and revenues.
e. Local agencies are expected to report costs, and the EMS Bureau has the resources and staff to aid local agencies in calculating cost reporting.
f. Any funds for operational EMS provided by the state should never exceed the median cost of providing services.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Enhance EMS cost reporting.							
Activity 1.1	Bring on Staff Positions Allocated by the Legislature	Director	31-Mar-24	Staff Onboarded	Staff Time	Position Justification Form; New Position Number; New Job Posting	
Activity 1.2	Develop data collection form	Data team; Cost Reporting Team Member	31-Dec-24	Time to complete	Staff time, Financial Expertise	Collection instrument	
Activity 1.3	Educate about the importance of cost data reporting	Data team; Cost Reporting Team Member	2024/2025	Completion ratio	Staff time, Financial Expertise	Marketing/education materials	
Activity 1.4	Develop report from the cost data collection and identify KPIs	Data team; Cost Reporting Team Member	31-Dec-25	Reporting that provides insightful and actionable insights into the sources of reveue/funding, expenses and the balance between	Staff time, Financial Expertise	Cost Data Program(s)	
Strategy 2: Educate EMS Administrators about Finance Management							
Activity 2.1	Identify ways to develop and offer course in Business Models	Maine EMS Staff; University of Maine System; Maine Community College	31-Dec-25	Course Evaluation(s)	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Course Materials	
Activity 2.2	Faciliate the development and delivery of educational programming covering Administrative Accounting	Maine EMS Staff; University of Maine System; Maine Community College	31-Dec-25	Course Evaluation(s)	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Course Materials	
Activity 2.3	Faciliate the development and delivery of educational programming covering Budget Development	Maine EMS Staff; University of Maine System; Maine Community College	31-Dec-25	Course Evaluation(s)	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Course Materials	
Strategy 3: Develop Processes for Agencies to Identify and Monitor the Financial and Economic Drivers of the Healthcare System(s) and related risks and opportunities							
Activity 3.1	Develop and establish metrics to quantify baseline system costs	Data Team, Deputy Director	1-Jul-24	Develop and evaluate metrics	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association		
Activity 3.2	Establish a best practices model to determine potential expenditures, cost savings, and long-term investment needs for the agencies.	Deputy Director	31-Dec-24	Evaluation of metrics, gathering data from agencies	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association		
Activity 3.3	Develop a process for evaluating Best Practices for success or non-success	Deputy Director	31-Dec-25				

Reimbursement Alignment

Notes from Plan:

Where We Want To Be: In 2035 the Maine EMS system has maximized the revenue local EMS agencies collect in reimbursement from private insurance, Medicare, Medicaid and other payers. This maximization is the result of accurate cost reporting, the accurate documentation of services, advocacy, a deep understanding of the billing process and taking full advantage of available reimbursements.

Milestones/Markers of Success: a. EMS has a clear voice and interacts with payers through the effective advocacy efforts of associations, groups, agencies or individuals.
b. Agency leaders are continuously educated in EMS finance and the intricacies of EMS reimbursement. This will be an important part of EMS leadership development.
c. The full and true costs of providing EMS are continuously calculated and accounted for. These must be communicated in a manner that fosters a genuine understanding by government and the public about the full and true costs of providing EMS.
d. EMS clinicians understand the value and importance of their documentation in cost recovery and are consistent in collecting appropriate data. Initial and continuing education for clinicians heavily emphasize the importance of documentation and teach clinicians how to document well.
e. EMS stakeholders continue to advocate for reimbursement that accounts for the cost of providing EMS.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: EMS agencies will have resources to have a more comprehensive understanding of EMS reimbursement.							
Activity 1.1	Develop Data Collection/Measurement Tool(s)	Data Team, Deputy Director; Cost Reporting Team Member	Dec-24	Having a collection instrument available and in use by agencies	Staff time, Financial Expertise	Collection instrument	
Activity 1.2	Analyze Data to measure baseline and trends in reimbursement for agencies that perform their own billing and agencies that contract billing.	Data Team, Deputy Director; Cost Reporting Team Member	Dec-25	Reporting that provides insightful and actionable insights into the sources of reveue/funding, expenses and the balance between	Staff time, Financial Expertise	Analysis of KPI surrounding revenue, expenses and financial health	
Activity 1.3	Identify variables in Reimbursement Collections	EMS Agencies; Deputy Director; Cost Reporting Team Member	Dec-25	Surveys, questionnaires, and meeting with stakeholders	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Documentation of target issues.	
Strategy 2: Identify Alternative Revenue Streams/Sources							
Activity 2.1	Educate agencies to work with counties/cities to ensure continued and consisent funding obligations; considering alternative structure and implementation of budget-line inclusion in place of outside agency funding.	Maine EMS Staff; Deputy Director	Dec-24	Surveys, questionnaires, and meeting with stakeholders	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Public/Private Payers	Educational programs and resource documents that will provide a clear understanding for EMS Administrators to educate municipal stakeholders.	
Activity 2.2	Educate agencies about reimbursement options for patients that refuse transport.	Deputy Director, Community Paramedicine Coordinator; SUD Team	Dec-24	Research reimbursement programs for non-transport, specifically.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Public/Private Payers	Educational programs and resource documents that will provide a clear understanding for EMS Administrators to fund non-transport responses.	
Activity 2.3	Help identify potential and under utilized sources (e.g., Federal programs, grants, contracts, Community Paramedicine, and foundations)	Deputy Director, Community Paramedicine Coordinator; SUD Team	Ongoing	Research reimbursement sources that have been not utilized or recognized in the past.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Public/Private Payers	Documents that identify resources for agencies to receive funding that have not been utilized in the past and have been untapped.	
Strategy 3: Identify Best Practices in Billing that Result in Higher Collection Rates							
Activity 3.1	Educate agencies on how to assess the agency's current operational financial performance in regards to reimbursement	Deputy Director; Cost Reporting Team Member; Maine EMS Staff; Regional Coordinator	Dec-24	Surveys, questionnaires, and meeting with stakeholders	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Reimbursement Consultants; American Ambulance Association	Educational programs and resource documents for EMS administrators to understand financial performance measures in regards to reimbursement.	
Activity 3.2	Educate leaders about appropriate documentation and the importance of training field clinicans.	Deputy Director; Cost Reporting Team Member; Maine EMS Staff; Regional Coordinator	Dec-24	Evaluation of metrics, gathering data from agencies	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Reimbursement Consultants; American Ambulance Association	Educational programs and resource documents for documentation programs.	
Activity 3.3	Identify best practices in billing across Maine and encourage sharing of those practices.	Deputy Director; Cost Reporting Team Member; Maine EMS Staff; Regional Coordinator	Dec-25	Evaluation of metrics, gathering data from agencies and identifying successful agencies.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Reimbursement Consultants; American Ambulance Association	Identify successful agencies as subject matter experts and encourage sharing of materials to assist other agencies.	

Local Agency Sustainability

Notes from Plan:

Where We Want To Be: In 2035 rural communities and low volume areas continue to evolve EMS operations that are appropriately staffed and financially sustainable. Rural communities and low volume areas have help in moving from unsustainable EMS delivery models to sustainable delivery models. The help comes in the form of a process that uses EMS sustainability experts to guide communities moving from unsustainability to sustainability. The process aids communities in: determining whether their current model is sustainable; calculating the full costs of delivering EMS in their community; providing information about various delivery models; determining what the community wants, needs and what potential resources are available; and providing guidance in navigating the change process. This process is made available through state funding.

Milestones/Markers of Success: a. Wide acceptance that the delivery of operational EMS in Maine will continue to evolve and change to meet needs and that some models will not be sustainable long-term.
b. The Maine State Legislature continues to appropriate adequate funding for grants to help rural communities with EMS change.
c. The Informed Community Self Determination process and similar processes are advocated throughout Maine.
d. Experts in rural EMS are developed, and the process continues to evolve as it finds success in Maine communities.
e. Models of successful evolution and change are identified and recognized.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Improve the appropriate usage of EMS in Maine's communities to lessen the burden(s) on Services							
Activity 1.1	Identify opportunites to provide Healthcare Provider Education regarding the utilization of EMS.	Maine EMS Staff	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify education with healthcare providers about EMS.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Written documentation of educational opportunities to educate the healthcare system about EMS.	
Activity 1.2	Identify actions to improve the use of EMS by community customers, skilled nursing facilities, physician offices, and medical alarms.	Maine EMS Staff	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify inappropriate/unneeded EMS responses/uses.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Maine Hospital Association; Maine Medical Association; Maine Nursing Homes; Maine Hospice	Templated educational materials for EMS agencies and clinicians to use to educate specific community customers.	
Activity 1.3	Identify actions to eliminate the usage of ambulances for different types of EMS calls.	Maine EMS Staff	31-Dec-25	Surveys, questionnaires, and meeting with stakeholders to identify inappropriate/unneeded EMS responses.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Dispatch Stakeholders	Work report outlining call types that may be handled by specific alternative resources and the pathway for an EMD Center, EMS agency, and Medical Direction to obtain IAED MPDS Accredidation (ACE) to implement OMEGA-level dispatch options for alternative response and consider Nurse Triage protocols.	
Strategy 2: Assist agencies in their procurement processes to imrove financial sustainability							
Activity 2.1	Assist in best practices for vendor bidding and contracts	Maine EMS Staff; Maine Ambulance Association	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify concurrent issues with supply chain management and successful models.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Written documentation of best practices for bidding and contracts. Development of resources to support subject matter.	
Activity 2.2	Identify ways to provide annual classes on public purchasing procedures, including the use of the state bidding process.	Maine EMS Staff; Maine Ambulance Association; Maine Procurement; Maine Municipal Association	31-Dec-24	Research public purchasing procedures and state bidding process.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Course outlines, educational materials.	
Activity 2.3	Facilitate group agency discussions on buying Co-ops/Regionalized Purchasing	Maine EMS Staff; Maine EMS Regions	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify agencies that would be interesting in discussion/developing Co-ops/Regionalized Purchasing	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Meeting agenda(s) for discussions of subject matter and educational materials.	
Strategy 3: Low-Volume EMS Agencies; Moving from unsustainable EMS delivery systems to sustainable models							

Activity 3.1	Assist in identifying low-volume EMS agencies that are potentially in an unsustainable EMS system.	Maine EMS Staff; Data Team	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify low-volume EMS agencies and issues that make the agencies possiblility unsustainable.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Identified and documented issues/challenges for low-volume EMS agencies and the definition of low-volume EMS agency.	
Activity 3.2	Identify potential pathways that would direct an EMS system towards the goal of sustainability.	Maine EMS Staff	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify low-volume EMS agencies that find ways to make their service sustainable.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Identified and documented potential/successful pathways for low-volume EMS agencies.	
Activity 3.3	Provide technical assistance and training to low-volume EMS agencies on data collection, analysis, and reporting.	Maine EMS Staff; Cost Reporting Team Member	31-Dec-25	Improved data submission from low volume EMS agencies	Time, Collaboration with low volume agencies	Low Volume Agency Collaboration Report. I don't know what would be in this, but like services will have like problems.	
Activity 3.4	Support small agencies with recruitment and training of youth interested in EMS, in order to promote the EMS workforce in their area.	Explorer team	May 2024 (phase 2), and onwards	Number of services with Junior/Explorer Programming, and number of Juniors/Explorers enrolled	Staff time, Explorer + Mentor trainings, and initial cohort group mentorship	Explorer Program Implementation Guide	