

Vermont EMS Advisory Committee
Meeting Minutes
December 5, 2012 – 9:30 a.m.

Attendees:

Randy Terk, EMS Districts 7, 10 & 12	John Vose, VAA
William Hathaway, VSFA	Mark Considine, EMS District 8, 9, 11 & 13
Jim Finger, EMS District 10	Kate Soons, EMS Districts 1, 3, 4 & 6
Debra Bach, Nurse Manager (via phone)	Mike Leyden, VDH EMS
Mike Paradis, EMS District 2/ & 5	Ray Walker, VDH EMS
Tracy Dolan, VDH	Steve Jeffrey, VLCT
Patrick Malone, IREMS	Matt Vinci, PFFV
Dan Wolfson, MD, VDH EMS	Dan Manz, Essex Rescue
Donna Jacob, VDH EMS	Chris Bell, OPHP & EMS
Jill Olsen, VAHHS	Carl Matteson, District 11 & Ludlow

Meeting called to order at 9:32 a.m.

Minutes of August 22, 2012

Kate Soons requested that the minutes reflect that she represents Districts 1, 3, 4 and 6. There were no other corrections.

Work Plan for Committee – EMS Plans for Towns

Chris reported that of the 31 states who responded to a survey about EMS plans:

- 7 require response plans for some form of governmental unit below the state level
- 19 do not
- 5 have some variation between the two extremes

Per the VLCT rep, Steve Jeffrey, there is no statutory obligation to provide EMS, police or fire protection. Voters decide the role. He asked why the state would not come up with a plan if they considered it important.

Randy suggested that requiring town plans may enhance the towns' knowledge of EMS.

John Vose noted that municipalities are required to update E911 when primary EMS providers change.

Chris Bell said that the EMS office regularly receives calls from towns, asking what would happen if EMS coverage were not provided. Office staff walk the callers through a conversation of where a 911 call would route. When asked, Chris said he was not sure that there is a statutory responsibility to respond to 911 calls.

Dan said it boils down to who is responsible for assuring EMS service. The statute gives responsibility to the EMS districts with municipal officials, but is silent on who funds EMS. He felt the plan was irrelevant. If the service is too expensive or a different EMS model is desired, it boils down to the town level to tax and pay for it. Steve Jeffrey agreed, saying it is the voters who are responsible for paying for it. He again noted that if the state wanted a plan, the state should be doing it. If towns want a plan, they can do one but local control means that the towns get to decide, not have it mandated.

Randy said he thought having a plan would raise the awareness within a town, but did not need to be tied to the provision of funds for EMS. Bill Hathaway pointed out that by mandating town plans, it could be establishing an unfunded mandate.

The group had a lengthy discussion about sending out a survey to either town officials, service leadership or some variation thereof. Steve noted that if town surveys are kept at one page in length, the committee can expect to receive approximately 60% back. The difficulty is that the survey may be filled out by a clerk or the town treasurer and never be seen by the select board.

Matt Vinci read a statement suggesting that the state recommend towns create EMS plans.

Pat Malone suggested amending the Emergency Operations plans within towns to include an EMS plan component.

Chris reminded the committee that they are not charged with reaching a consensus. Its role is to be advisory—it is acceptable to not reach consensus.

Dan suggested that perhaps EMS services know better what each of their particular towns does. If the goal is to promote officials to think about EMS, perhaps it would be wise to gather the information from services and provide it to the towns in an educational format.

For the sake of discussion, Pat “seconded” Matt’s “motion.” Chris told the committee that there had been no adoption of parliamentary procedure, nor had a chairperson been elected.

John Vose said that in the 22 years Upper Valley has been providing service to communities, select board members have changed many times over. Some of the members may not have a clue how EMS has come to be provided in the area, but all of his 9 towns cooperate to see that coverage is provided. If one were to pull out, it would have a huge effect on the others. Currently, each town may have no real idea how their decisions might affect all of the others.

The discussion about a survey continued, with some members brainstorming ideas of who should receive the survey or gather the data and then how to share it.

Decision: Survey towns using multiple channels such as Doodle or Survey Monkey, and share the survey with heads of service to encourage them to discuss EMS within their towns.

Action item: The committee members are to submit questions to ytems@state.vt.us by Friday, December 14. These will be collated and returned to members by December 21.

Work Plan for Committee - Response Times

Chris opened the discussion about response time standards. Of 31 states who responded to the survey, 11 use an approximate time of 5 minutes “out of the chute.” No states have a statewide response standard; they have requirements for response. If standards exist, localities set the standards, not the states.

Tracy Dolan asked for a definition of “response time standard.” Chris said there is not one, but he believed the legislative intent was probably time to scene. He read the pertinent section of statute to the group:

§ 906. EMERGENCY MEDICAL SERVICES DIVISION; RESPONSIBILITIES

To implement the policy of section 901, the Department of Health shall be responsible for: (5) developing volunteer and career response time standards for urban and rural requests for emergency services.

Chris reread the statute again. “The Department of Health shall be responsible for developing response time standards” but they do not need to be established in rule.

Randy mentioned #12, which specifies the districts develop protocols to establish response time protocols. He asked what it means that the districts will develop protocols vs. VDH establishing response time standards. Chris said #12 under 25657 is a new addition to 24 VSA 2657.

He noted that the intent is to have broad discussions with this committee and EMS providers. There will be no penalty.

Matt Vinci said that the legislative discussion had been about establishing benchmarks.

John Vose noted that the task will upset many towns, because again it will appear as an unfunded mandate to ensure EMS coverage within X minutes. A town may be happy now to receive EMS within say 25 minutes. To impose a statewide response time would mean that a new agency may have to be created just to meet the mandate, with no funding behind it. To specify an X minute response to Ferdinand isn't a benchmark. It's different than putting the wording into contract.

Deb Bach asked how a decision could be made with so many variables...traffic, weather, road closures, is the crew sitting in the running truck? She noted that benchmarks might be possible, but questioned protocols. Chris Bell suggested a 4-box matrix describing Urban/Career, Rural/Career, Urban/Volunteer and Rural/Volunteer. He said it might be possible to find scientific data to support a response time standard in the case of things like cardiac arrest. It might be more of a goal to strive for. He observed that choosing to live in Vermont recognizes the fact that residents may be far from police, fire, EMS or even grocery stores.

Randy again referred to #12, which calls for protocol to be developed. He said that #5 and #12 appear to be conflicting one another in their required actions.

Mike Paradis noted that after insurance companies balked, pizza delivery can no longer be guaranteed in 30 minutes. He doubted response time requirements would be received any differently. Chris noted that the discussions might expand when to use lights, sirens, etc.

The group discussed what “response time” means. Some suggested an “out of chute” time while others suggested arrival at the patient’s side or arrival street-side. Steve Jeffery questioned whether an attorney for a deceased would have opportunity to sue a service whose response time was 3 minutes more than the benchmark.

Kate Soons wondered about establishing a definition for response time. If the interest is protecting the public, the fix might not be to have an inexperienced EMT driving foolishly rather than improving the “out the chute” time. Jeffrey noted that providers also have to drive to the chute, and there are liability issues there as well. Kate said in some cases that is true, and that was yet another reason to make recommendations on improving the “out the chute” times. Perhaps sending a crew chief to the scene while another gets the ambulance, or other configurations that may work for a particular agency but not for another.

Randy related history in District 12 with this type of issue a few years ago. The fix was an enormous task and involved only 12-13 squads. Randy said he felt it would require a lot of flexibility to develop rule or protocol at a statewide level. The first failing will be for some unique combination of circumstances that was not thought of. Matt said he felt the statutory language was broad. The language mirrors NFPA response time standards that are out there already. Matt disagreed with the “fix it once it breaks” philosophy. Chris said the office had purchased NFPA 1710 and 1720. NFPA 1710 (urban) lists response times around fire services, but no EMS response times. In 1720 there was no specific number at all involving rural response times.

Dan mentioned several words he had heard in the last few minutes that needed to be further defined or considered. He questioned the word “standard,” which sounds enforceable, and the definitions of “urban” and “rural.” “Response time” is undefined—out-of-chute time or travel time to the scene? If a first responder gets to the scene first, does the clock stop? If a first responder gets to a scene first and radios back to the ambulance to slow the response time to no lights, no sirens, does that alter the clock? What do volunteer and career mean? There exist many varieties of services in Vermont, and many shades of compensation as well. Cardiac arrest calls represent about 1.5% of EMS calls. There exists scientific data that suggest that response times in those instances do make a difference to outcome. But is there scientific data behind what difference a response time makes in the rest of the calls?

Chris noted this had simply been an update and that no action was required.

Consolidation of Districts

Chris said these were two additional charges to the committee, but that there had been no action items identified to date.

Randy said he spoke to his district medical advisor, who is not in favor of it. If 3 districts were consolidated into one, he would not have the face-to-face time with the providers in the district. He won't see 2/3rds of the providers because the majority of those calls will go to another hospital. He's concerned with QA/QI. Yes, he can have access to siren, but it's not the same as knowing and seeing the providers. There have been instances where providers have had restrictions placed on their certification.

Chris read the statute: "Provide a recommendation on whether VT EMS districts should be consolidated, such as along the geographic lines used by the 4 Public Safety districts established by VSA 5."

Steve asked what relationship that [public safety districts] would have to EMS service. He described himself as the person least informed about EMS issues, but said to him it would seem the hospital catchment area makes the most sense. That's where the patient will end up and where you'll get most of your medical advice.

Kate asked if it was possible to survey the DMAs. Randy's point is well taken, and that was something that was expressed at the last meeting. Is there currently something broken? In the spirit of credentialing and medical control, she said she would be interested in hearing what the DMAs have to say.

Chris said that the DMAs have not been polled. In the interest of not creating too many surveys, the DMAs have all been invited to have input on protocol development on February 6. That might be a good time to approach them with this question. The meeting is only to DMAs, in the sense that they are the only ones that will be fed at the meeting. There are two additional public meetings in January asking for protocol input from EMS providers and administrators. The office can then follow up with the DMAs that do not come.

Mike Paradis asked if there was another board group that has been meeting, saying that his DMA seems to think he is on the EMS advisory committee also. Chris said that his DMA is on this committee as a representative of the Vermont Emergency Department Directors. Mike said that explained why they were both talking about the same thing at district meetings.

Mike Paradis said both Districts 2 and 5 are not interested in consolidating districts. Their concerns are more to strengthen districts' rights and get guidance on how to proceed with issues like transitioning and credentialing. No specifics on rights were given.

Hearing no further discussion, Chris said the topic would be brought up to DMAs. Steve asked if other states had been surveyed. Chris said that had not been done, but it could be done at the committee's preference. He asked how the survey should be configured.

Kate noted that some of the larger states that have huge regions have statewide protocols and are more state legislated. John actually noted that a lot of states do not have statewide protocols. NH does, but MA does not, and CT has regions the size of Vermont.

Action: After the discussion, Chris said the office would survey other states to ascertain what basis their regions/districts are established, and what authority/powers do they have, how is funding handled.

Tracy excused herself at 11:10 a.m.

911 Coverage With Regard to Non-Emergent Transports

Understood background: Complaint is believed to have come from a constituent to a legislator. An agency accepted a non-emergency transport, and during that time, received a 911 call, which was subsequently handled by mutual aid.

Chris read the section of statute: “Provide a recommendation whether the state should establish directives addressing when an agency can respond to a non emergency request for transportation of a patient if doing so will leave the service area unattended or unable to respond to an emergency call in a timely fashion.”

John said no. He said once again, the state is telling communities what they can or cannot do. John said he would love to hear the VAHHS input on this. To the hospital, clearing a patient out is important to the overall intake and function of a hospital and an EMS system.

Matt disagreed. He suggested doing that by establishing response time standards. He asked why the group would not want to have a conversation about an agency should leave their primary responsibility to do a non-emergency transport and not be able to respond to a 911 call?

John said that is a discussion that needs to occur between the 911 service and the community. If Colebrook wants to let 45th Parallel do a transport and rely on a mutual-aid agency agreement to allow that freedom, what right does the state have to say no. He continued by saying that if towns are in agreement, it should not be the state’s right to wade in. The legislative got itself involved in a singular instance that now has to be addressed at a statewide level. It is the prerogative of a town to establish what is or isn’t acceptable for their citizens.

Matt asked what the department’s leverage would be if a service did not respond to a call or didn’t have an agreement. Mike Paradis noted that a 911 call isn’t answered by a singular service. When an ambulance service has only one ambulance, that’s why mutual aid exists. Matt said this issue was specific to a 911 call. Mike Paradis disagreed, saying that once they looked into the issue it was a bunch of errors within the district on a particularly busy night that resulted in a singular incident. The service got stuck with a non-emergency transport and thought they had a back-up crew.

Chris noted that agencies as part of licensure state that they are available to cover their area 24/7 - 365. That coverage, however, can be through mutual aid. Chris said he could not think of another section of rule that would be violated if they didn't have a crew for a particular call.

Chris said that occasionally we hear from agencies who are trying to increase funding. They contract with hospitals to take non-emergency discharges on either a rotational basis or on a certain day of the week. Sometimes even at a higher level of service that they provide normally within their service. On one day of the week, the agency's one paramedic has volunteered to go sit near a hospital with their ambulance and crew to take discharges. This allows billing at the paramedic level and provides necessary funding to their service and thus their community. This is just one of many variations on the theme.

John asked about an agency having multiple trucks. One of 2 rigs leaves to go on a transport. The second crew takes a 911 call. When another 911 call comes in, where does that leave the service being penalized? It's that level of complexity that needs to be considered.

Deb Bach noted she wears multiple hats. As a former town official, she would be concerned that small local, volunteer services can't provide care for their community members on both a 911 and a non-emergency transport basis. Yet she'd be concerned if an agency wasn't always available to serve their community. However, as a service leader, it would be detrimental to take that level of funding away from the service. As a nurse manager, it's important that this not become a battle between services. This would leave a hospital waiting for discharge assistance.

Randy said in looking at the language of the law, his answer was no, the state should not be telling a community or a service what to do, and then go figure out how to pay for it. The primary duty of a service is to respond to 911. A non-emergent transport should be secondary, and done if there is sufficient resources to do it. It should be addressed in the EMS rules and the answer should be no, the state should not get involved. Deb Bach agreed. It should be worked out at a district level to ensure that there is always mutual aid, whether regarding 911 or transfer calls. In EMS, someone always has the other guy's back.

Matt said no, but because it appears that there is already a mechanism that addresses it. Kate agreed, because of the mutual aid mechanism. Chris added that the state does have the authority to address issues that may arise. He asked if the agenda item should be taken off until the point that the report is being drafted.

Action: The group is in consensus. The item has been taken off the agenda until such time as the report needs to be drafted.

Next meeting

Next meeting Wednesday, March 6 from 9:30 a.m. – noon

Service Licensure Cycle

Kate asked about changing the cycle of EMS licenses, particularly with regard to Medicare/Medicaid licensing. Chris said he wasn't sure that there was a benefit to discussing it, but said he believed that the cycle is in rule. Rulemaking will have to be opened, and he wondered about biannual licensing vs. annual. John Vose said there had been discussions about credentialing in the past that acknowledged that an agency meeting credentialing requirements might only have to relicense every 2 or 3 years. Kate said she felt annual licensing is prudent and it allows the district an opportunity to check in with services and the state on issues of performance and compliance. John and Kate had a short discussion about credentialing.

Chris noted that even now, a district can come to the state Board of Health mid-year and ask for a provisional or conditional license for an agency. Districts are used to an annual agency review. Kate agreed that credentialing will help, but felt that having to gain signatures from district officials bears some weight with them. But at the same time, by not meeting deadlines, it cuts things very close for services to meet other insurance/licensing obligations.

Randy suggested every other year with an annual update of information. He did not feel a Board of Health review every year was required. Chris noted that agencies are required to notify the office of head of service changes. Personnel are now being tracked through SIREN. It does not necessarily tell us about agency affiliation but other checks and balances could be built in.

Chris explained that agencies that bill Medicaid/Medicare have to go through that renewal process as well as the EMS relicensure process. The agency is required to show the Division of Vermont Health Access (the regulatory agency that covers insurance reimbursement) a copy of their EMS service license in addition to all of the other paperwork DVHA requires. VDH talked to DVHA and agreed to provide a spreadsheet of relicensed services, but the agency had to still submit the rest of their paperwork to DVHA.

Dan said that forever it's been January 1 to December 31. The last time the rules were rewritten, we backed the process up a full month to the first of October to begin the licensure process in EMS, so that there would be a month-long buffer to get licenses in to Medicare/Medicaid. But it left the licensure period as still ending December 31. He suggested perhaps backing up the renewal process a bit further, but he urged the Advisory Committee not to alter the January 1 to December 31 licensure period. To do so would require the agency to submit their EMS license in September.

Chris thanked the group for the advice.

Centralized Dispatch

Randy asked about centralized dispatch, saying that in the southeastern part of the state, dispatch out of Keene Mutual Aid works well. He wondered if such systems exist in other parts of Vermont, saying he felt it should.

Chris pointed out that he was discussing disaster response, not centralized dispatch. He explained that a system should be put into place in the future to allow services from around VT to respond during the case of disaster. Once we respond beyond Brattleboro, we really don't have plans in place.

Randy noted that Keith Flynn is interested in the thought of centralized dispatch as well. They address it from the standpoint of fire but had not looked at it from an EMS angle.

Action item: Add centralized dispatch as a discussion item in the future.

Mike Leyden noted he had met with the E911 board yesterday, and discussed the data from the newest round of relicensure. They looked at service areas for transport and first response agencies, making sure that 911 staff is consistent with how they dispatch services to calls. Discussion will be ongoing and more reports will be forthcoming.

Quick Updates

Online Learning Management System: The contract is still working its way through the Department of Health. No details can be released until there is a contract in place. He believes that the IT review is the last hurdle, and then it'll take 6-8 weeks to get it signed.

Matt asked about the timing of the contract. Chris said the contract is being written for a one-year term, and can be extended for two more one-year terms, based on performance and satisfaction. Matt noted that Ways and Means Committee was not happy about the funding.

Regional CE: Calls with District Chairs and Trainers will be occurring once the cost of the LMS is finalized. It's the remainder of the \$150,000 that will be in play.

Transition: A train-the-trainer course was held for 46 of the 67 current or new I/Cs. Thumb drives have been ordered and will be mailed out to each of the ICs that have been transitioned, so that they can then begin their own rollouts and trainings. Chris noted that while there remains several years to get this task done, he encouraged everyone to accomplish transition sooner rather than later. Providers need to be transitioned in order to use their new skills, once the protocols are in place.

Protocols: Meetings will occur in January to solicit comments on protocol revisions. Chris encouraged evidence-based suggestions, preferably in draft form. The state is looking at a wide variety of protocols as well as those recently adopted in New Hampshire which are based on the NSOP. Draft protocols will then be reviewed with the medical advisors, hoping to gain consensus from them so that we have a statewide

protocol rather than various district differences. Protocols will be released in May so that they can go live approximately 2 months later. Personnel who learn the new skills in transition or in class, they still cannot perform the skill until the new protocols provide authority and guidance to do so.

Each IC will also be receiving a text for their pertinent level, as well as each district will receive a full set of the 4 texts (EMR transition textbooks do not exist, so an initial EMR text will be provided).

There is a discount code that services or districts can use to purchase texts. The discount codes are provided in a README file on the thumb drive as well as the memo that comes with the drives.

Credentialing: No updates.

Service Relicensing: All 180 agencies have been relicensed by the Board of Health last week. A couple agencies were issued conditional licenses, one with a specific plan in place and one that was given guidance to establish an action plan.

Conference: Approximately 600 attendees were scheduled to attend, although that amount may have been adjusted when the hurricane forced the cancellation of Tuesday and Wednesday classes. Chris said that we're still awaiting evaluations. Moving forward, it's likely that the same timing and type of format will be used next year, but that the conference will be combined with the health care preparedness conference. This will allow for both EMS and HCP tracks on one day and EMS tracks on the other 3 days. Other venues around the state will be considered and the conference management will have to go out to bid. Peak attendance was around 470.

Pat Malone commended the decision to cancel Tuesday and Wednesday, noting that while it was a difficult decision, it seemed the right one.

SIREN: Changes and updates are very close to being finalized. A mass communication will go out to heads of service and SIREN administrators outlining changes. Chris noted that these are all changes that service leaders, providers and administrators have requested, plus input from other stakeholders. Many non-pertinent negatives have been eliminated.

Action item: Kate requested that when communications are sent to heads of service, a copy also be sent to district chairs.

Mike noted that SIREN continues to evolve and that this is one excellent benefit of an electronic data gathering tool.

Chris reminded everyone that mandatory reporting begins January 1. Chris explained that some of the agencies that are not yet compliant are those which use a third-party software for which a data bridge to SIREN has not yet been built. The delay has been the

finalizing of the data dictionary. Once the dictionary is finalized, the third-party vendors can complete their bridging tasks. All of the agencies that utilize third-party vendors have been advised that they can receive a variance on the January 1 deadline if they advise the office how long they expect the bridge development to take place.

ImageTrend will be here in January to do further admin training.

Laptops: They have been ordered. Apparently Panasonic has to build them to order and they should be received in February. Every agency licensed as an ambulance service will be offered a Toughbook. There will be no choice about whether it is a new or refurbished Toughbook, as there will be a mix. There will be a random drawing to determine who gets refurbished ones. Most of them will be new, though. Approximately a 7:2 ratio of new to used. If more are received at a later date, first responder agencies interested in reporting into SIREN may also possibly be provided with one.

EMSC: PEPP course and train-the-trainer module at the conference had to be cancelled. The office is working with IREMS to provide courses around the state. In addition, with funding from EMSC grant, a PEPP instructor package and 20 texts have been purchased for each district.

Training Coordinator: Still in the recruiting process.

Rulemaking: No plans in place yet, and once commenced, it's a 6-8 month process.

Recruitment and Retention: Chris said that recruitment and retention remains an ongoing issue. We want to know what we can do to help. A survey a couple of months ago suggested developing a campaign to recruit folks into EMS. We want to do that. We have one position whose job is medical reserve corps volunteers. That individual retired and we're getting ready to refill that position. Another open position is being changed into a recruitment/retention position. Those folks will work not only on public health but also EMS recruitment. It's the hope to create an integrated campaign to funnel interested people toward agencies, training or both. Agencies relicensing with only a handful of personnel put both the agencies and the communities in tenuous situation. John Vose noted that everyone working for his service also works someplace else.

Mike Paradis noted that some of the providers who are either letting go or threatening to let go of their certification are providers that should be letting it go anyway. Two handfuls of people have been retained on roles when they were of no use to the service.

Kate noted that great continuing education opportunities are being provided to meet the new requirements.

Pat noted that in '07/'08, IREMS wrote a white paper on recruitment and retention and that he could share it. Matt Vinci noted that a lot of recruitment and retention had been done in the fire service on the career side, but not so much on the volunteer side.

Action item: Recruitment and retention as an action item.

Chris said that one question that had been asked to agencies was whether or not they were paid, and what that looked like. That data is being collated and will be shared.

Chris said he'd seen Pennsylvania's "RollWithIt.Com" recruitment website. While admittedly a bit cheesy, it's a media campaign that links to agencies and educational institutions in a potential provider's agency. It ran 8-9 years ago and they still see the payoff all these years later. They're above the baseline that they were at before the campaign.

Adjourned at 12:08 p.m.

Respectfully submitted by
Donna Jacob