

**EMS ADVISORY COUNCIL MEETING  
MINUTES  
January 17, 2013  
Room 210 - 212 State Capitol**

**Members Present:** Tim Meyer, Jeff Sather, Liz Beck, Kari Enget, Terry Ault, Lynn Hartman, Diane Witteman, Curt Halmrast, June Herman, Marlene Miller

**Members Not Present:** Mark Nelson, Jerry Jurena, Lynette Dickson

**DoH Representatives Present:** Lindsey Narloch, Mary Tello-Pool, Ruth Hursman, Tom Nehring, Jan Franklund, Ed Gregoire, Amanda Roehrich, Kari Kuhn, Alan Aarhus (1:00 PM)

**Others Present:** Jim DeMell, Mona Thompson, Ken Reed, Sue Borud, Neil Frame

Tim Meyer welcomed the committee and introductions were made around the table. Tom introduced new DEMST staff members. Ruth Hursman is the new State Trauma Coordinator and Amanda Roehrich is the new DEMST Grants Coordinator. Ruth is replacing Amy Eberle, while Amanda's position is a new position in DEMST. We welcome both of them to DEMST as well as to the EMSAC.

**Approval of Minutes:**

**Motion to approve the minutes from September 6, 2012.**

Motion made by Kari Enget.

Motion seconded by Tim Meyer.

No further discussion; motion carried.

**Rural EMS Assistance Funding / Funding Areas**

Tom did a presentation about the ongoing EMS Assistance Funding Grant. (See attached slides and attached HB 1044)

Some points of interest from the experience include:

1. Still struggling with the 'intent' of this grant. 'Ambulance welfare' vs building a 'system of care'. How do we define this and convey the intent to ambulance services / funding areas.
2. There weren't many examples of good collaboration in the grant requests received. How do we define collaboration and convey this intent to the ambulance services / funding areas.
3. OMB felt that financial need was not appropriately established.
4. What to do with awardees that change their plan after awards are made. Guidelines must be established outlining redistribution of monies or reworking of grant, etc.

Discussion revolved around these issues:

- Dr Sather stated that it would be a slow process towards the ultimate goal of building an EMS system.
- Marleen stated that she sees in EMS now a mirroring of what was taking place 10 – 12 years ago in rural hospitals.
- Curt suggested adding long / short term planning as part of application.
- Dr Sather suggested adding their plan for long term sustainability.
- Although all ambulance services may not have financial statements readily available, there was discussion of the necessity of this information.
  - Help establish financial need
  - Force the issue of preparing them; leadership / management growth

- Marleen feels supportive of the movement towards building a system through state dollars rather than asking services to use their own reserves for this purpose.
- How do we address collaboration in funding areas with multiple services vs those with a single service.
- How do we prevent using these funds for agencies that may be in financial need, but also may not be necessary to maintain.
- Diane commented that she has not seen the collaboration that was planned in the grant application for her funding area.
- Dr Sather recommended driving home the purpose of have funding areas: a need for ONE ambulance service in that area, with a system of QRUs etc.
- How far can we push during this biennium?
- Substantial changes need to be made in order to keep this funding in the future.
- We need to work towards more innovation – possibly reward innovation in the scoring process.
- Possibly add some point levels for innovation, long term planning, system building

There was discussion about leadership trainings. These trainings are now full every time they are offered. People are wondering if they will be penalized if they are unable to get into a session. There is also a feeling that there is a misunderstanding that they need to complete the whole leadership academy, when actually only one person from each funding area needs to attend Level I.

Dr Sather recommended doing a presentation on innovation and collaboration at EMS conferences. This is a possibility, but the feeling was that if these presentations would be required for the grant, state funds would have to pay for attendance.

- Do financial statements get scored?
- If a funding area can support a project does that mean they don't need funding?
- If the project would set back a funding area while working towards a system of EMS do they 'need' assistance?
- Determination of need: dividing money on hand by the \$360,000 projected to maintain an agency?
- Allowing for savings for a new vehicle, building, etc.
- If funds are needed to hire an accountant to do their books, they should request this in their funding.
- Guarantee applicant reimbursement for funds being spent on accounting services? It would be required to submit for this reimbursement, therefore, if the service can afford it, they don't need to submit for reimbursement.
  - Supply a template for financial statement requirement
  - Possibly a cap of \$2,000 for financial statement creation
  - Certified by an accountant to verify
  - One page
  - Assets, expenditures, revenues, income, expenses
- Changes in the local match
  - Reimbursement not allowed
  - The definition includes revenue generated
- Collaboration
  - Collaboration vs innovation
  - Short term collaboration within a funding area
  - Long term collaboration between funding areas
- Communication
  - There was not enough communication last time
  - Develop a communication plan

- Develop a mission / vision statement for the grant
- Verification of contact information in the region
- Problem with the validity of information in the Big Picture database.
  - DEMST data only as good as provided by the ambulance services
    - Contact information
    - Vehicle roster
    - Service roster
- Caps
  - Caps or no caps on funding categories
  - Possibly create different levels of staffing caps
- Scoring
  - Points for creativity in staffing, i.e. shared staffing vs general staffing
- Staffing
  - Guidelines within staffing
  - Justification of staffing request – is the plan working towards a system of care
  - Leadership / management staffing vs clinical staffing
  - \$40,000 unless creativity is demonstrated
- Current Status:
  - Over 20 services that haven't requested any reimbursement.
  - Approximately \$200,000 waiting for approval.
  - About \$800,000 spent
  - We are more than half way through the grant period
  - \$2,922,950 budget
  - \$623,159.81 spent
  - Carryover funds are not allowed
- Plan:
  - Send an email with a date of 3/15/2013 for a request of funds
  - If no request, these funds will be reallocated
  - Email / mail
- Funding Areas
  - Ambulance services aren't ready for a reduction in funding areas yet
  - DoH didn't want to proceed with 99 funding areas last time
  - EMSAC recommends a short term plan of maintaining the number of funding areas
  - Further study needed for next grant cycle

**Motion to recommend maintaining as many funding areas as necessary to meet the definition of reasonable EMS response time requirements.**

Motion made by Tim Meyer.

Motion seconded by Diane Witteman.

No further discussion; motion carried.

### **Rules Update**

Tim and Tom will be meeting next week and will then set up public hearing.

### **Legislative Update**

The session began in January. There are several bills that will be monitored / tracked pertaining to EMS. There will also be a trauma bill which has not been assigned a number yet (SB 2226). See attached list of bills currently

being watched by the EPR section. Please go to the legislative website for further details and full version of these bills. [www.legis.nod.gov](http://www.legis.nod.gov).

Dates at the capitol pertaining to EMS include: 2/6/2013 – EMS and Hospital Day; 2/12/2013 – American Heart / SIM ND; 2/13/2013 – Public Health Day. The EMS Association and DEMST will be attending throughout these events.

### **Community Paramedic Update**

Tom informed the council that there is funding listed in the Governor's budget regarding Community Paramedic. SCR 4002 is also relating to Community Paramedic. This resolution is included in the list of bills.

### **Discussion of EMS Regions**

Tom and Lindsey attended the 911 Association meeting and have joined the 911 Association in an effort to keep up with issues pertaining to 911 / dispatchers/ and EMS.

Lindsey informed the council that Joe Lies had inquired about reconciling some of the regions. There are so many different regions it is confusing for some, i.e. trauma regions, EMS regions, EPR regions, etc. Lindsey provided copies of the various regions. EMS regions were initially created based on the numbers of services per region, but this has now become unbalanced. Curt stated that depending on how this would affect the NDEMSEA board members, they would not have a problem with changing.

Liz recommended that unless there is significant benefit that these regions should be left or join the EMS and Trauma regions.

Curt recommended **further research on this topic and placement on future agendas.**

### **Health Information Technology**

Neil Frame attended the EMSAC meeting as a guest to speak about Health Information Technology. This is an initiative that came out of the 61<sup>st</sup> legislative assembly (2011). Neil is a member of the HIT committee. (<http://www.healthit.nd.gov/about/>) "The advisory committee is charged with making recommendations for implementing a statewide interoperable health information infrastructure that is consistent with emerging national standards and promotes interoperability of health information systems for the purpose of improving health care quality, patient safety, and overall efficiency of health care and public health services."

This statewide system would allow access to patient health records at clinics, hospitals, etc as a 'health record depository' and ultimately aims to be a nationwide system. The purpose is to allow access of patient records no matter where a patient is injured or has a medical need. Neil's purpose on the HIT committee is to represent the EMS opinions and needs. Access to health records may or may not assist EMS personnel. Time and availability on the road may not make this a useful tool. The system may be more useful for community paramedics.

This system is just in its beginning stages and hospitals are just getting involved. The EMS PCR is not currently included in the system. Neils' questions are:

- should the PCR be included
- how to get the information into the system
- can the information be pushed from the current electronic PCR system

**Motion to recommend to HIT that ambulance records should be part of this system as it is developed.**

Motion made by Dr Sather.

Motion seconded by Terry Ault.

No further discussion; motion carried.

## LifeBot

Dr Sather and Ed gave a short update on the LifeBot system. This telemedicine system has been initiated in New Town and has been FDA approved. The receiving station is located in the hospital with three cameras mounted in the ambulance vehicle. The doctor can control all systems from the hospital and can hear breath sounds, read ultrasound, etc.

## Legislative Representation

Jerry Uglem lost his position in the last election due to redistricting, therefore the council is still in need of a legislative representative. This has been brought to Dr Dwelle for appointment and he has referred it back to the council for recommendation. The following recommendations were made:

- Judy Lee
- Robin Weiss
- Rich Warner
- John Nelson
- Ask Ken Tupa for recommendations

Tom will do further work on this topic.

## Questions on written summaries

Education:

Lynn Hartman brought up the concern regarding ambulances losing their intermediates and the possibility of EMT I/85s transitioning to EMTs keeping their IV certification. Dr Sather spoke of how the benefits to starting a pre-hospital IV are less than previously thought and there is rarely a lifesaving benefit. An add-on module would have to be developed in order for EMTs to maintain this certification.

A bridge course is not a possibility from I/85 – AEMT. **It will be evaluated if creation of an IV module is worth the benefit.**

Dispatch:

The dispatch subcommittee is still seeking input from the council members regarding information needed by dispatch from EMS. State Radio dispatches 24 of 53 counties and will not report anomalies to DEMST as their customer is the county and not DEMST. Suggestions for changing this include:

- put into rule in
- report liability on dispatchers per licensing requirements
- request written documentation from Greg Wilz
- Notify counties and understand that part of their contract of service with State Radio could be requesting this information

Other items Liz brought up in regards to dispatch:

- DEMST to clearly define when they want a service reported
  - 911 association does not feel they have a clear definition – won't get reports until that definition is reported.
- Lacking communication
- It will be helpful with Tom and Lindsey attending 911 association meetings
- Some 911 coordinators aren't involved with their ambulances at all
- Look to other models that do work well
- Keep dispatch issues on for future agenda items
- Council members should re-read the report and bring

**Next Meeting**

The next EMSAC meeting has not been scheduled yet at this time.

**Meeting Adjourned**