

**EMS ADVISORY COUNCIL MEETING
MINUTES
September 15, 2011
Dakota Room, Job Service North Dakota**

Members Present: Tim Meyer, Curt Halmrast, Kari Enget, Liz Beck, Lynn Hartman, Doug Anderson, Dr Jeff Sather, Gerald Uglem, June Herman, Terry Ault, Mark Nelson (10:45), and Marlene Miller

Members Not Present: Jerry Jurena

DoH Representatives Present: Tim Wiedrich, Alan Aarhus, Amy Eberle, Lindsey Narloch, Kari Kuhn, Linda Zahn, Tom Nehring, Ed Gregoire

Others Present:

Welcome and Introductions

Tim M. welcomed the members to the second meeting of the EMS Advisory Council. Introductions were made around the table.

Minutes for EMSAC meetings will be emailed to the chair persons for initial approval. They will then be emailed to all council members. Minutes will then be approved by vote at the following meeting. Upon final approval by council members they will be posted on the DEMST website (<http://ndhealth.gov/EMS/EMSAC.html>).

Arrangements were discussed for future payment of EMSAC working lunches. Each council member will be expected to bring \$9 to pay for the lunch which will still be brought in. Council members may then put this \$9 on their reimbursement form along with their other expenses.

Tim Meyer, Curt Halmrast, Tom Nehring and Ed Gregoire previously met to discuss the functionality of the EMSAC. Curt and Tim M. flipped a coin to decide the leadership responsibilities of the chair position. Tim M. will act as chair for the first year with a one year term with Curt following with a two year term. Members were then randomly assigned to a 1 or 2 year term by drawing numbers from a 'hat'. Members are allowed to serve unlimited terms.

Two-year term members

Marlene Miller
Jeff Sather
June Herman
Kari Enget
Lynn Hartman
Mark Nelson

One-year term members

Gerald Uglem
Doug Anderson
Diane Witteman
Liz Beck
Terry Ault
Jerry Jurena

Mark Nelson drew from the last two remaining numbers upon his arrival, leaving Jerry Jurena with the remaining number.

Tim Meyer and Tom Nehring will be leaving at 2:30 to attend a board of pharmacy meeting regarding rule changes that will affect ALS ambulance services carrying medications. Curt will run the meeting in Tim's absence.

It was decided that the council members should begin with work on HB 1044. Four main topics from the bill were decided upon for group breakout sessions for discussion. The following groups were handpicked by Curt, Tom, Ed and Tim M.

Funding areas: Tasked with looking at what's in statute and creating bullet points for what they think a funding area should look like.

Marlene Miller
Liz Beck
Kari Enget
Jerry Uglem
Curt Halmrast

Reasonable cost: Tasked with determining the estimated average operating cost of running a service.

Lynn Hartman
Jerry Jurena
Diane Witteman
Ed Gregoire

Local match: Tasked with referring to guidance from statute and discussing suggestions for what can be used for local match.

Doug Anderson
June Herman
Terry Ault
Amy Eberle
Tom Nehring

Service areas: Determining the requirements and how service areas should be assigned / managed.

Jeff Sather
Mark Nelson
Lindsey Narloch
Tim Meyer

Approval of minutes from the August 18, 2011 meeting

A motion was made and seconded to approve the minutes as written. There was no further discussion; motion was carried unanimously.

Open meeting laws (Kari Kuhn)

With the EMS Advisory Council now being mandated by statute it is subject to the open meeting laws. The open meeting laws that will have the greatest effect on this council include:

1. Changing of the recorded meaning of quorum: by law a quorum equals one half or more of the council members present. The EMSAC purpose states one over half. This will be changed in the EMSAC purpose and the new version will be sent to council members.
2. Posting of meeting notices: the council is required by law to post meeting notices prior to every meeting. Notices are to be posted at the same time the members are notified. Notices no longer need to be sent to the Secretary of State office, but may simply be posted on the agency website. Notices for EMSAC will be posted on the DEMST website prior to each meeting. A schedule of upcoming EMSAC meetings was disbursed to council members and has been posted on the website. All upcoming meeting locations are currently scheduled in the capitol building. Cancellations or changes will be sent to council members and posted on the DEMST website prior to the scheduled meeting date. This responsibility will lie within the DEMST office.
3. Recording of all votes: all motions and votes must be recorded and are open record. Procedural votes do not require a roll call vote unless requested. Non-procedural votes, especially those pertaining to decisions regarding funding issues do require a roll call vote. This responsibility will lie with the chair person and the recorder.

4. Minute requirements: all minutes / recordings from this council are public record. The requirement for minute recording is very minimal and the level of detail desired is up to the chair person / council members.

Final report Rural EMS Improvement Project (see attached *Final Presentation*)

This was sent electronically to all members and printed copies were available at the meeting. This is the final report from SafeTech, Inc. to be kept in your EMSAC binder.

Data Review (Lindsey)

This data was electronically sent to all council members prior to the meeting. Please contact DEMST if you need it sent to you again.

Lindsey reviewed the data documents with brief discussion. Tim Wiedrich suggested that the council seek an objective point of view on the data from an epidemiologist such as DoH's Dr. Pickard. The council concurred. Tim W. will talk to Dr. Pickard about this.

Tim Meyer asked the council if they have any thoughts or ideas on data needs for Lindsey to report on at each council meeting. Lindsey feels that the data available may be more useful in rating funding areas rather than determining them.

There was some discussion about the possibility of obtaining the census data to be used in ongoing data analysis. It was also debated whether or not 'current' census data is correct with the population fluctuations in the state mainly due to oil impact. It was also stated that the man camps and temporary 'citizens' should not be considered in deciding match levels for an upcoming grant process as they will not impact the per capita match available for funding areas.

Options for obtaining current data included 2010 census, Blue Cross / Blue Shield, and SafeTech, Inc.

Review of HB 1044 (see copy of HB 1044 in EMSAC binders)

Council members divided into four groups for discussion over the topics listed above. The group was then reconvened with the following bullet points presented:

Ambulance Service Areas (Tim Meyer reporting)

- Recommendation for a study on public safety dispatch in the state of North Dakota.
- Ambulance areas are determined by 911 coordinators as stated in statute with assistance from the Division of EMS and Trauma.
- The Division of EMS and Trauma will limit ambulance operators based on the needs of the areas.
- Political subdivisions (city and county government) can come to the state with complaints on the level of service being provided. The Division of EMS and Trauma will evaluate any complaints and make recommendations if necessary.

Local Match (Doug Anderson reporting)

- Funding areas will have a lot to do with determining local match details.
- There are some points of local match outlined in statute from HB 1044
- Ensure that all areas are utilizing any availability to mill levies and taxes
- Agencies should be billing at least at the Medicare level, there is currently no mandate for billing

There was concern expressed about convincing EMS agencies to educate their local leaders and get them involved and understand the situation and to get assistance for EMS agencies with things such as mill levies that the agencies may not completely understand.

If taxes are collected they should be considered part of the local match. If an area is having trouble meeting their local match requirements they should consider enacting it. Agencies may not be aware that this money is available.

Senator Uglem questioned the setup of fire districts that do not follow county lines and establish their own tax districts and whether this is an option for ambulances as well.

Reasonable Cost (Diane Witteman reporting)

The group reviewed the costs viewed as reasonable costs realizing there will be a variation.

- Ambulance (for one ambulance) – basic major equipment; minor equipment; insurance; maintenance; fuel; licensing; building costs to house the ambulance
- Billing and logistics – legal; medical direction
- Staffing – education; uniforms; wages / benefits (should consider specifying continuing education above and beyond those covered by state dollars already) – considering a roster of 14 to maintain comfortable continuous coverage with EMTs
- Other – marketing; recruitment; retention
- Estimation came in close to SafeTech's = \$75,000 / year

Other things to consider are substations and QRUs. Staffing options would also need to be taken into consideration such as volunteer staffing or on call / per run wages.

Funding Areas (Gerald Uglem reporting)

This group discussed pros and cons over various possibilities.

- Maintain all current ambulances as funding areas
 - Cons:
 - Can the council justify spending state money to maintain services within 10 miles of each other
 - Career ambulances may not want / need funding
 - Too much dilution of funding – breaking down the funding amount to a very small portion per agency
 - Pros:
 - A possible perception of fairness amongst agencies
- 88 areas as originally specified in HB 1044 – cities with hospitals and population over 1,000; 9/20/30 response times; critical areas not covered by other criteria.
 - Cons:
 - 26 of these areas have two or more services
 - 3 of these areas have 3 or more services
 - No determination how to deal with these areas of multiple services
 - Pros:
 - Covers North Dakota geographically with EMS services
 - Gives justification to the definition of reasonable EMS
- 74 – 76 areas (88 minus the 14 paid services)
 - Cons:
 - Could be double dipping or over coverage in some areas
 - Pros:
 - Covers North Dakota geographically with EMS services
 - Gives justification to the definition of reasonable EMS
 - Allows more money to divide amongst the funding areas

- County lines as funding areas; possibly divided into 18, 6 or 4 regional areas as county lines tend to split things too much.
 - Cons:
 - County lines have nothing to do with response areas
 - Too many variables within a county
 - Limits regionalization / cooperation to those within the county lines whether it's a good fit or not
 - Pros:
 - Easier
 - Ease of taxation purpose
 - Creates ownership at a county level

The group requested a map showing the 74 rural services; blocking out the 14 paid services. This map was originally distributed by the EMS Association. Lynn Hartman expressed concern with blocking out these 14 areas. As he stated, the problem with excluding a service due to the number of calls taken is the increase in the number of no-pays as well as the fact that smaller services rely more and more on metro services with the stress of increasing calls for them.

There was discussion about the possibility of revisiting the definition of reasonable EMS and the response times and population limits outlined in that document; possibly looking into patient outcome v response time or chute time v response time. If services are meeting chute time, they are responding as quickly as possible. Longer required response times could greatly reduce the number of funding areas. Senator Uglem responded in support of keeping the definition as is. He feels that collaboration should be encouraged as necessary to accomplish the goals outlined in the definition as written.

The funding areas will be dynamic and reviewed on a regular basis.

The question was raised about whose responsibility it will be to decide the process for fund distribution once it has been awarded to a funding area. The belief is that the process will include an application detailing a description of how the money will be utilized to ensure EMS coverage over that funding area.

Dr Sather recommended we look at the fire district set up and compare the funding distribution process.

Tim Meyer suggested forming a subcommittee to discuss this topic in further depth.

Gerald Uglem (subcommittee chair)

Liz Beck

Kari Enget

Marlene Miller

Dr. Sather

Curt Halmrast

Tom Nehring (unofficial)

Lindsey Narloch (unofficial)

Ed Gregoire (unofficial)

This subcommittee will meet the evening of October 19 (6 – 10PM) (location to be announced) and report back to the EMSAC at the regularly scheduled meeting on October 20th.

EMSAC Picture

Pictures were taken of the EMSAC. Tom Nehring asked for anybody in opposition of having their picture published. No opposition was given.

DEMST Rule Changes

Ed briefly discussed proposed upcoming rule changes.

EMT-I / 85 curricula hasn't been updated since 1985 and is now converting to the Advanced EMT (AEMT) level. AEMT course is approximately 150 – 200 hours with a variety of added skills that will be very beneficial to North Dakota. Ed posed the question to the EMSAC regarding developing a state licensure for EMT – I / 85 or giving current I/85s a choice of becoming EMTs or transitioning to the AEMT level. The EMSAC did not favor the development of a state licensure. Dr Sather agreed that AEMT will be a big step for ND, especially in rural areas. He also felt active EMT-I/85s should be encouraged to advance to the AEMT level. The amount of effort and dollars spent to create and maintain a state certification for EMT-I / 85 is not worth it. Other states are generally maintaining national registry certifications. Modules can then be added at the AEMT level education if desired, this is a state decision. This level does not eliminate the need for paramedics as they will maintain higher levels of advanced assessment and advanced airway, etc.

The suggestion was made to complete a survey of the current EMT-I / 85s explaining the advantages of the new AEMT level and the possible options.

“33-11-01.2-15. Required advanced life support care. (Proposed) When it would not delay transport time, basic life support ambulance services must call for a rendezvous with an licensed advanced life support ground ambulance, or an advanced life support or critical care air ambulance if the basic life support ambulance is unable to provide the advanced life support interventions needed to fully treat a patient exhibiting:

1. Traumatic injuries that meet the trauma code activation criteria as defined in section 33-38-01-03.
2. Cardiac chest pain or acute myocardial infarction.
3. Cardiac arrest.
4. Severe respiratory distress or respiratory arrest.

5. Stroke”

The recommendation is being made to add stroke to those things that BLS services must intercept with an ALS service. This recommendation was met with no questions from the council members.

Curt questioned the addition of the word ‘licensed’ in the previous paragraph referring to ‘Required advanced life support care’. A BLS licensed service with ALS capabilities may be closer and able to respond sooner than an ALS licensed service. There would need to be a mechanism for communication in place to know if / when the service is capable of responding in an ALS capacity. This should be defined in licensing.

The auto extrication course is in the process of being turned over to the North Dakota Firefighters Association (NDFA). DEMST is working closely with them during this transition.

There will be some clean up done in wording throughout the rules.

Tim Wiedrich began discussion regarding the lack of immediate delivery of patient care information to hospitals by EMS.

“33-11-01.2-10. Other requirements. (proposed)

5. Each ambulance run must be reported to the department in the manner and in the form determined by the department within 30 days of the run.
6. All ambulance services must give the receiving licensed health care facility a copy of the run report within 72 hours of the run.

Tim W. would like to see this changed to immediate delivery of information upon patient arrival in order to maintain a continuum of care. Historically it has been a mandated requirement of licensure for an ambulance to leave patient care information when the patient is left at the facility. EMS loses its value if their procedures aren't documented and this information isn't transferred to the next caregiver.

Tim W. would like to integrate the current system of handhelds and software that is utilized for disaster patient tracking into the system of communication used by EMS. He commented that the technology is there for real time tracking; however it is not clear yet as to who would be responsible for the additional cost. He sees this as an incremental change.

Lindsey stated that the infrastructure is there but may not be being used properly by all ambulances. It is currently possible for an ambulance to do their documentation while en route to the hospital. These PCR's done online are available at any time for hospital viewing. Some services do immediate transfer of information and some never do a transfer of information. This could be an education issue as well as a system improvement issue.

“33-11-01.2-06. Other requirements for substation ambulance operation.

- ~~1. A substation ambulance operation and all of its assets must be fully owned and operated by a headquarters ambulance service. A substation ambulance may not establish a separate business structure independent of the headquarters service.”~~

Diane Witteman stated that she is in favor of the changes regarding substation rules. It has been difficult for an EMS agency to think of turning over their assets to the headquarters service to become a substation. One agency should not have to ‘lose everything’ in order for them to collaborate with another agency.

Community Paramedicine (Curt Halmrast)

There was a brief overview of the handout from Curt regarding a paramedicine program in Eagle County Colorado. Marlene stated that she has seen several presentations about this type of program at national conferences over the last few years. People are very excited about it and this may be a possible speaker topic at an upcoming conference in North Dakota. Dr. Sather stated that it seemed to be a good tie in with current home health programs.

Initiated Measure 2

Curt informed council members that Initiated Measure 2 is an up and coming hot topic. This is a petition to eliminate all property taxes, pool taxes and acreage taxes, effective January 1, 2012. The measure would replace the lost revenues with allocations of various state level taxes and other revenues, without restrictions on how these revenues may be spent. The measure will be voted on in the primary election on June 12, 2012.

<http://www.nd.gov/sos/electvote/elections/considered-measures.html>

Interim tax committee

Curt wanted to make the council members aware that the interim tax committee has met recently and is throwing around ideas related to sales and use taxes for healthcare organizations. At this point this seems to be more concerning to hospitals and clinics than EMS, but NDEMSEA will keep an eye on things. Fuel tax was also listed in the discussion points.

Other Business

No other business was presented.

Next Meeting

Kari is working with a local hotel to make arrangements both for council members coming in for the subcommittee meeting as well as the EMSAC meeting. Please let DEMST know at least two weeks prior to the scheduled meeting date if you will be needing accommodations.

The next meeting is scheduled for October 20, 2011 in AV Rooms 210 – 212 of the Capitol J-Wing. Agenda will be sent prior to the meeting date.

Meeting Adjourned