Montana Emergency Care Systems
PO Box 202951, Helena MT 50620 (406) 444-3895 http://MontanaEMS.mt.gov
MONTANA DPHHS
Emergency Medical Services | Trauma System | Injury Prevention | EMS for Children Program

Montana Emergency Medical Services

Report to
Education and Local Government Interim Committee
January 2016

Table of Contents

Introduction

Emergency Medical Services (EMS) is an essential element of Montana's emergency care system. Over 3,000 EMS personnel on 270 licensed EMS services provide approximately 100,000 9-1-1 responses each year. Many more personnel work in hospitals, clinics and other settings. EMS services also provide additional services such as interfacility and nursing home transfers that are not urgent, but an essential service to the community. Many EMS providers and services stand by at athletic and other community events as well as engage in prevention activities such as child safety seat education.

Except for Montana's more populated cities, much of this work is covered by volunteers. Men and women in our communities that pay for their own training and sometimes organize bake sales to pay for a new piece of equipment on their ambulance. These EMT, paramedic and nurse personnel deal with an extraordinary range of conditions and severity on a daily basis—from minor illnesses to massive traumas. The work they do is challenging, stressful, at times dangerous. It is also highly rewarding and EMS providers are highly respected by the public. Working conditions for these personnel are physically demanding; back injuries are especially common.

Development of Montana's EMS system began largely in the 1970's and it has evolved from EMS services run out of mortuaries with personnel who only knew very basic first aid to well-equipped vehicles and well-trained EMTs and paramedics.

However, EMS services continue to be faced with a number of challenges including:

Workforce – It continues to be more and more difficult to recruit and retain a workforce that has been primarily composed of volunteers. The current workforce is aging and retiring at an increasing pace and the pool of new volunteers in rural communities gets ever smaller.

Education – Traditional methods of educating and training EMS providers is very labor and time intensive. It takes hundreds of hours to educate students enough to become proficient and competent to provide patient care. New generations of students expect more contemporary teaching methods such as distance education and use of technology that is not always accessible in rural communities.

Funding – As with all government and community services, competition for limited funding creates challenges for services to maintain even basic operational expenses.

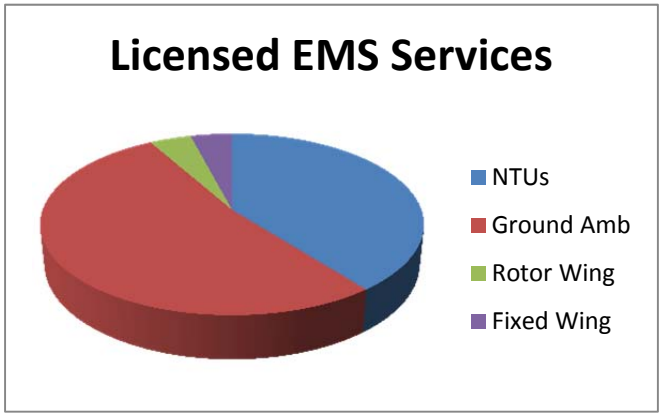
Reimbursement – Historically, EMS services are only reimbursed for transporting a patient to an emergency room. The cost of readiness of even a volunteer service is significant and CMS Medicaid reimbursement does not typically meet the costs of the EMS service. New models of providing better care at less cost, (e.g. community health EMS) are not currently reimbursable without payment reform.

The EMS system includes the continuum of prevention, citizen response, 9-1-1 dispatch, tiered response by emergency services, EMS service response, hospital care and rehabilitation to home. This is a high level summary that focuses on what people traditionally consider EMS – the EMTs and EMS services who respond to provide care and transportation to ill or injured patients. It is designed to give the reader a broad perspective of the state of Montana EMS and it's challenges so that any proposed solutions can be put into perspective.

Montana EMS Services by the Numbers

The Montana EMS and Trauma Systems Section, DPHHS licensed 270 EMS services in 2015. This includes:

- 106 Non-transporting services
- 141 Ground ambulance services
- 11 Fixed-wing ambulance services
- 11 Rotor-wing ambulance services



Licensed EMS Providers

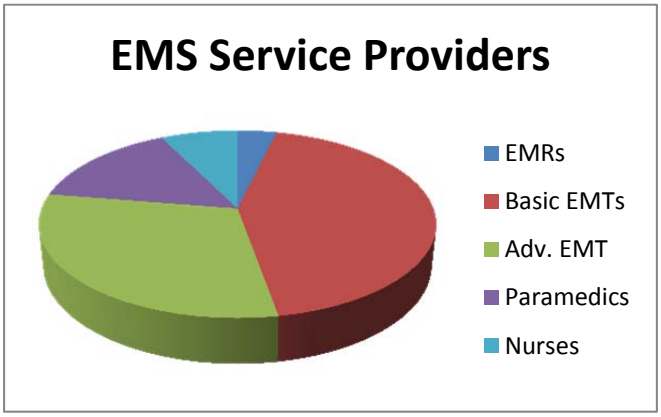
Of the 260 Emergency Medical Responders licensed by the Board of Medical Examiners,
134 serve on licensed EMS services.

Of the 2,730 Emergency Medical Technicians licensed by the BOME,
1,560 serve on EMS services.

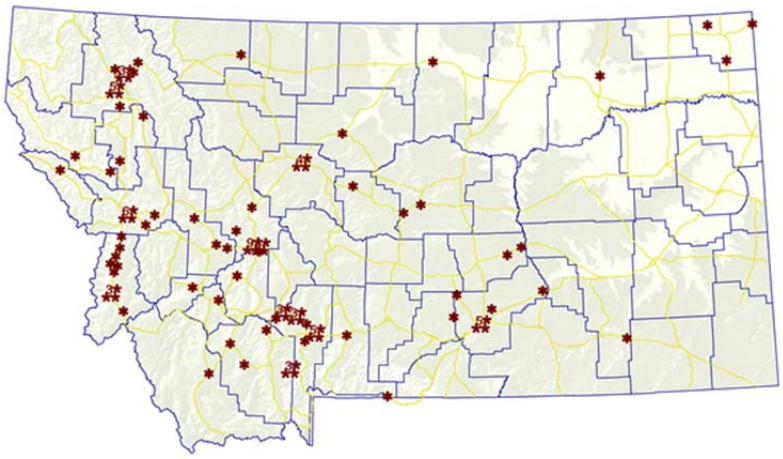
Of the 1300 Advanced EMTs licensed by the BOME,
1,090 serve on EMS services.

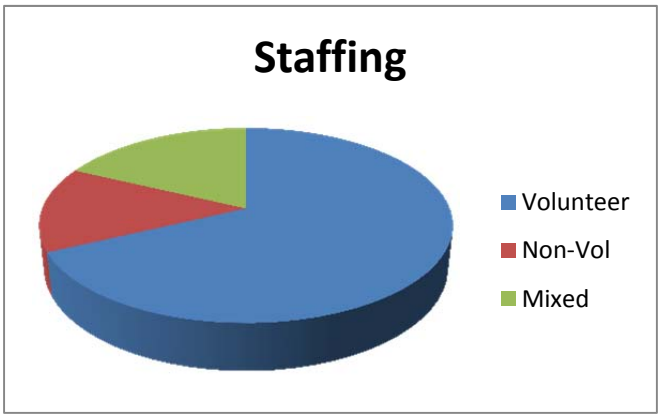
Of the 760 paramedics licensed by the BOME,
540 serve on EMS services.

EMS services are also staff by 265 nurses. Many serve on air medical services but numerous are key providers on rural EMS services.



Non-transporting units are groups of providers with jump kits and radios who are dispatched with an ambulance. They are typically in smaller communities without the resources to maintain an ambulance service. They are generally closer to some calls than where an ambulance is dispatched from or in more urban communities they respond with the ambulance to provide more resources or perhaps ALS care. They may respond in dedicated vehicles (e.g. rescue van or fire squad truck) or may respond in their personal vehicles.



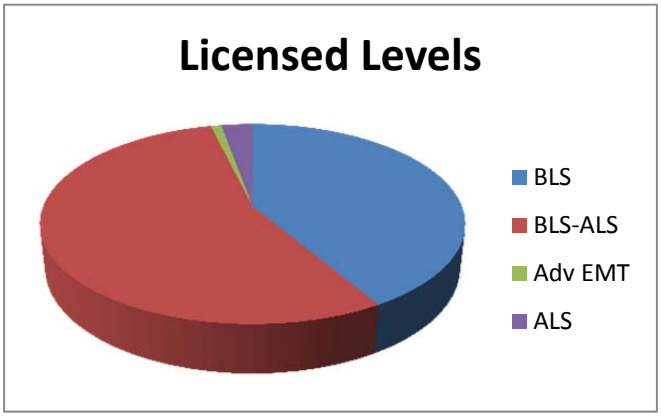


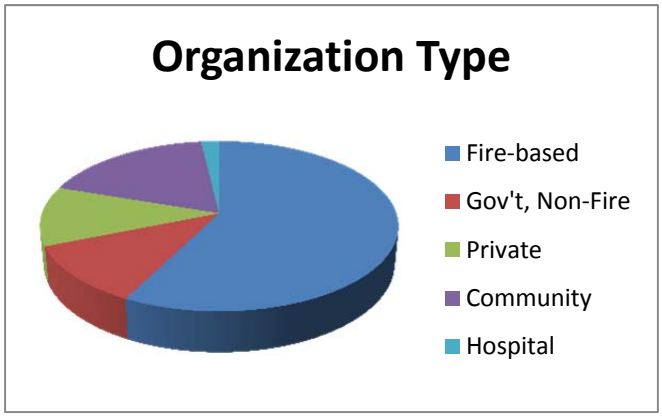
Of the 106 NTUs:

- 72 are volunteer services,
- 15 are non-volunteer (mine rescue teams, airport units, some fire departments)
- 19 have mixed volunteer/paid staffing

Licensed Levels

- 44 are Basic Life Support
- 58 are BLS w/Authorization to provide ALS
- 1 is Advanced EMT Level
- 3 are Advanced Life Support

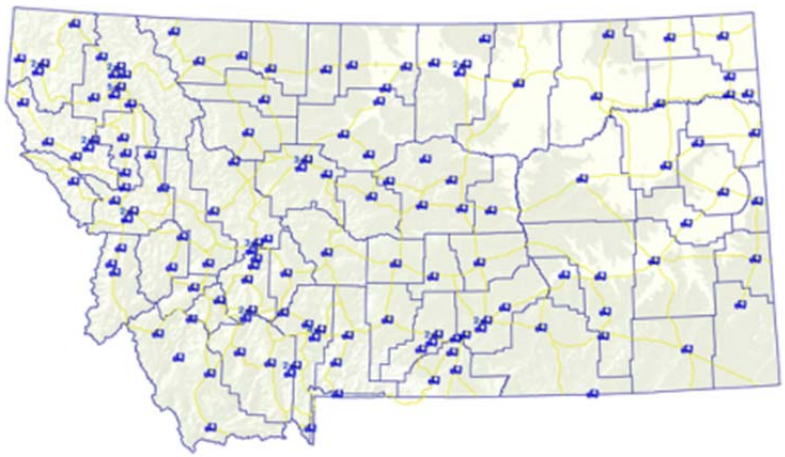


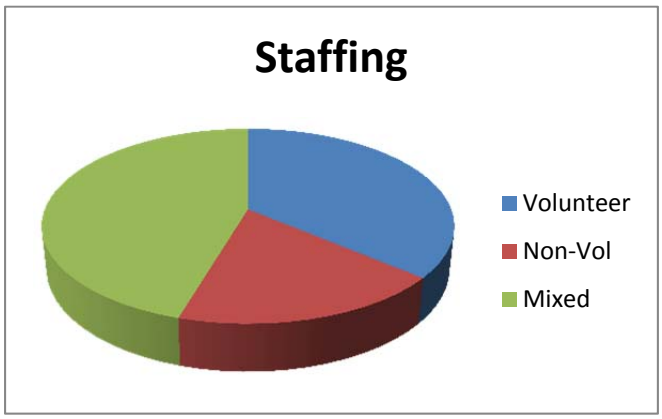


Organization Type

- 61 are fire department based
- 12 are government, non-fire
- 12 are private
- 19 are community, non-profit
- 2 are hospital-based

Most **ground ambulance services** are licensed to provide 24/7 9-1-1 response. A few are licensed but only market for interfacility transfer services or contract work.



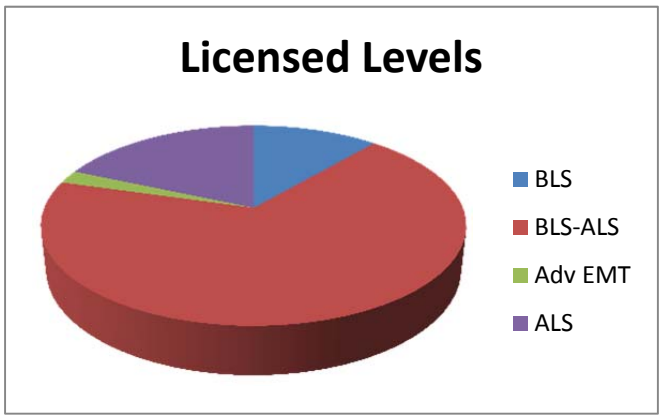


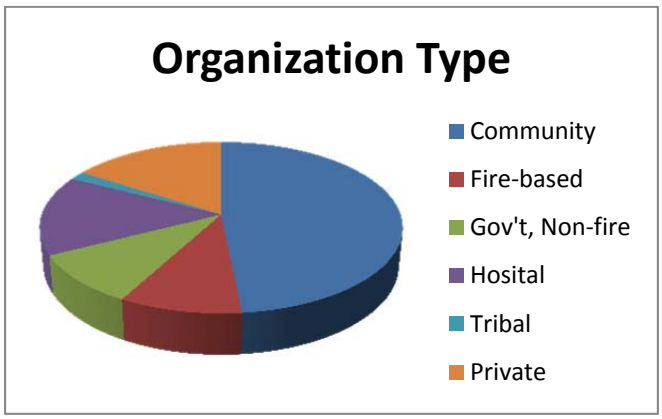
Of the 141 ambulance services:

- 51 are volunteer
- 26 are non-volunteer
- 64 have mixed paid-volunteer staffing (many are smaller services with a paid manager or a few full time staff to supplement the volunteer providers).

Licensed Levels:

- 16 are BLS
- 96 are BLS w/auth to provide ALS
- 3 are Advanced EMT
- 26 are Advanced Life Support.





- 63 are community-based
- 32 are fire-based
- 12 are government, non-fire
- 11 are hospital-based
- 2 are tribal
- 20 are private

All of the 11 **rotor-wing services** are private or hospital based advanced life support services.

Ten of the **fixed-wing services** are private or hospital-based with one licensed at a BLS level with authorization to provide ALS level.

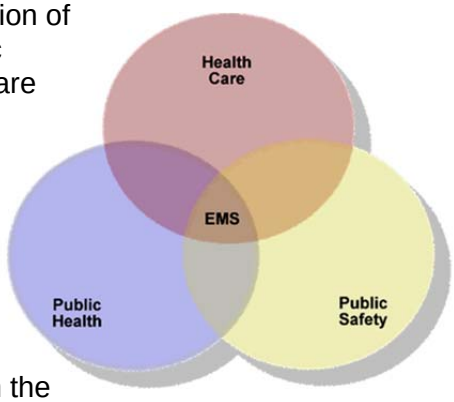
Leadership, Organization and Policy

Background

Montana's EMS authorizing statute provides that the public welfare requires assistance and encouragement for the development of a comprehensive emergency medical services program for Montanans. (http://leg.mt.gov/bills/mca/50/6/50-6-101.htm). The Department of Public and Human Services, EMS and Trauma Systems Section (EMSTS) is responsible for the leadership, development and regulation of the system.

Statutes also authorize the Board of Medical Examiners in the Department of Labor and Industry to administer a program for emergency medical technicians. (http://leg.mt.gov/bills/mca/50/6/50-6-201.htm). Their role includes the licensing of EMTs and paramedics, credentialing of EMS medical directors and activities to ensure that EMS providers deliver proper treatment to patients in their care.

EMS is an intersection of public safety, public health and health care and therefore has overlapping roles and responsibilities. This also creates a divided professional identity. Often EMS is not regarded with the same recognition as law enforcement and fire. Despite significant increases in education and skills, career EMS personnel salaries are well below comparable positions such as firefighters and nursing.



While EMS is considered an essential public service, it has not always supported statutorily and financially at the state and local level as well as fire, law enforcement and other essential services are. Governments who have to make difficult funding decisions may fund EMS at a disproportionately smaller amount than other services that are required through statutes.

Under Montana statutes, the department is granted the general authority to supervise and regulate emergency medical services. (http://leg.mt.gov/bills/mca_toc/50_6_3.htm). Historically, the EMSTS Section has used a regulatory approach that regulates minimum licensure, minimum equipment and basic standards of care. The Section is moving towards a more contemporary model which will implement measures, performance and accountability. The different components of the EMS system will be improved through the development of well-defined benchmarks, methods to collect data and to measure performance against those benchmarks.

The EMS and Trauma Systems Section brings together multi-disciplinary, multi-agency stakeholder bodies and committees in the collaborative assessment and development of a system that encompasses the emergent illness or injury event from its prevention, where possible, to its mitigation. This includes the department's Emergency Care Council. In partnership with key stakeholders, the Emergency Care System Strategic Plan identifies goals and strategies; determines how success of program activities will be measured; and helps align program activities with the section mission and vision.

Challenges and Opportunities

- Continue to engage stakeholders and providers in emergency care system development.
- Utilize the Emergency Care Council and focus workgroups (data, medical directors, air medical) to guide implementation of goals in the EMS strategic plan.

Workforce

Background

Montana's emergency care system cannot provide optimal care for injured and ill patients unless necessary personnel are adequately educated and available in sufficient numbers throughout the state and in all areas of the system.

Innovative efforts are needed in the recruitment, education and retention of qualified personnel throughout the emergency care system. While workforce issues are not unique to rural areas, they are more persistent. Key challenges include difficulty in recruiting and retaining both volunteer and career EMS providers.

Volunteers clearly are an important element of the EMS workforce - three-fourths of Montana is covered by volunteer EMS services. In areas that do have paid or career staff, salaries are often not commensurate with the cost of living and EMS providers are easily lured elsewhere with higher paying opportunities. Additional factors contributing to the staffing shortfalls are issues such as overall cost and time for training, time commitments, difficulty getting time off from employers and low patient volumes.

Educational programs are important in EMS services that do not receive a high volume of patients. Much of Montana's EMS education is provided locally in rural systems with few resources and support. Most education is 'financed' by the individual EMT who must travel long distances to limited opportunities. Local EMT courses draw students from an ever limiting pool of volunteers. Communities invest a vast amount of time and energy to add only a few new EMTs to their rosters.

There are few examples of centralized instruction or regionalization of resources. The application of newer technologies such as video interactive learning, internet or telemedicine-based training and satellite television classes can address some of these issues.

With all healthcare professions, the workforce is aging and there doesn't appear to be a sufficient pool of new providers to replace these aging healthcare professionals. Some EMS services are already facing critical shortages.

Traditionally, EMS has focused on emergency transport and interfacility transfers for emergency and non-urgent situations. However, a continuing shortage of health care professionals coupled with economic and social factors is leading to discussions to utilize EMS providers in community paramedicine roles that can build a paid workforce for EMS services.

Without recognition and support, many volunteers question whether their commitment and efforts are appreciated. "Value added" recognition and reward systems - providing volunteers with suitable forms of reward - would assist in the retention and recruitment of more volunteers. Strategies should be targeted at:

- Volunteers individually;
- Emergency services organizations;
- Employers of volunteers; and
- The community

Urban and private services also report problems with recruitment and retention. Paid services are not always competitive with compensation fire services and hospitals. Montana's paid services are at times viewed as 'training grounds' and stepping stones to jobs in other professions and other states.

Recruitment and retention of staff requires strong organizational leadership. Too often, those leading rural EMS services lack formal training and education in management and leadership that are critical to their organizations. Education of EMS service medical directors and service managers need to be developed and implemented. Delivery of this training must be sensitive to the time and travel constraints of EMS service providers.

Challenges and Opportunities

- Develop and implement strategies to enhance the ability of EMS services to recruit and retain EMS managers and EMTs.
- Provide EMS service leadership education to service managers.
- Support development of community health EMS programs.
- Develop and implement contemporary education strategies to enable better and appropriate education for rural communities.

Medical Oversight

Background

Physicians need to be involved in planning, implementing and evaluating all medical aspects of the system. In addition, state medical direction can provide access to best practices, system quality management and research to ensure the safest and highest quality care for patients.

EMSTS utilizes physicians on various committees to provide medical advice to the Section. The Board of Medical Examiners (BOME) has acquired a half-time state medical director to advise the board on EMT issues and provide technical assistance to local EMS medical directors.

As the need for medical services in rural areas grows, utilizing current EMS providers in community health EMS programs is being explored. These expanded role programs come with both challenges and opportunities and medical oversight for the development and implementation of community health EMS is essential.

EMS medical directors provide medical oversight to EMS services and have responsibility for overall management of medical operations for the service. While many EMS services are fortunate to be able to have access to physicians or physician assistants who can provide these services to EMS services, there is no comprehensive program to recruit, retain, educate and support them for their time and expertise.

Physicians who wish to provide appropriate medical oversight to local EMS services have challenges. Many physicians in rural communities are the only local care provider; their practice is busy and it's difficult for them to find time to adequately assist with training, medical oversight and performance improvement activities.

EMS services completing a 2009 survey described the level of offline medical direction they have available to them:

- 34% of services reported that they had no medical director or had a medical director that was minimally available.
- 25% of services reported having a medical director who routinely reviews calls, takes an active role in EMT education and actively considers EMT skills and capabilities.
- 35% of services reported their medical director takes an active role in offline medical direction including oversight of ongoing quality or performance improvement.

To provide adequate medical oversight, the medical director should have a working knowledge of prehospital patient care issues and the unique workings of the EMS system. A web-based program that provides local medical directors general information about their responsibilities is available. However, there is no other ongoing training program available to local medical directors to help ensure they are comfortable and competent with their role.

Service medical directors have broad responsibility for the medical aspects of an EMS service and there is a need for guidelines and education which provides direction about how to conduct EMS service performance improvement.

Challenges and Opportunities

- Develop and implement strategies to support education of medical directors for EMS service medical oversight and performance improvement activities.
- Develop and implement strategies to support medical directors through mentorship and regionalization.
- Include physician input into development of community health EMS programs

Financial Infrastructure

Background

Montana's legislature has identified and appropriated general funds to help support DPHHS's statutory responsibilities to oversee the development of an emergency care system. Additionally, other sources of grant funds are utilized, when available, to support EMSTS projects and strategies.

Unlike fire and law enforcement, EMS is not a 'mandated', essential service. As such governments at times have to make difficult funding decisions and many EMS services receive minimal funding to support their operations. In the majority of Montana communities, emergency medical services rely on volunteers to deliver emergency care. Without volunteers, most local government units would find it very difficult, if not impossible, to fund even basic level EMS services.

Only a fraction of the true cost of providing EMS service is ever recovered through patient charges. Rural EMS services serving large geographic areas with a low population density face unique challenges:

- Even though they rely on volunteers, rural services tend to have high per-trip costs because of the lower volume of transports as compared to urban and suburban providers;
- Rural services tend to have longer transports making reimbursement for increasing mileage costs important to their overall payments;
- Because rural residents may have fewer alternatives for transportation to hospitals, rural ambulances transport more patients whose conditions do not allow for Medicare reimbursement.

Per a 2007 report from the Government Accountability Office, Medicare reimburses many ambulance services at less than their actual costs of providing service. GAO determined that on average, Medicare repaid urban ambulance providers at 6% below their average costs, and rural providers at 17% below.

Ambulances and equipment used to provide emergency medical services represents a substantial capital investment. Historically, much of the support for equipment and training needs in rural areas comes from the volunteers own pockets, community fund-raising events and/or limited governmental subsidies.

House Bill 85, passed in the 2009 legislative session, allocates $1 million / year to help volunteer services purchase equipment for patient care, communications and training.

Reimbursement for EMS has been tied primarily to the transportation of patients to an emergency room. Additionally, reimbursement is available only to the ambulance service that actually transports the patient to a healthcare facility. It does not support a rural, tiered systems approach in which response by multiple types and levels of EMS services may be essential for quality patient care.

While strategies such as community health EMS hold promise for better patient care and at less cost to the medical community, these programs are not currently billable and reimbursable services for EMS services. New funding mechanisms need to be implemented to compensate EMS for providing choices that are clinically appropriate and based patient needs. For cases where non-transport is clinically appropriate, EMS units should be rewarded, not penalized, for pursuing on-site treatment and appropriate disposition.

Challenges and Opportunities

- Seek potential funding sources to support Montana EMS services and help assure financial viability of EMS services.
- Develop new reimbursement strategies that support alternative delivery models for EMS (community paramedicine).

Response and Transportation

Background

Montana's Emergency Care System encompasses all healthcare providers including dispatch, first response services (fire and law enforcement), EMS services and healthcare facilities that interact to assure that the patient gets the right care, in the right place, in the right time. Leadership and coordination of communications and dispatch, specialty care centers, triage and transport protocols and regulations is essential to quality patient care.

Appropriate response and transportation is critical to ensuring that EMS personnel and equipment are delivered to the scene in a safe, cost effective and timely manner and that the patient is appropriately transported to and between healthcare facilities.

Statewide, uniform standards and regulations exist for the inspection and licensure of non-transporting and transporting EMS services (ground and air). EMS services are licensed for two year periods. Current requirements for service licensure include documentation of the service vehicles (with basic equipment on each vehicle), radios (with minimum channel configuration), licensed EMTs or other authorized personnel and various requirements for record keeping, sanitation and maintenance.

Integrated air medical resources, fixed and rotor wing, are an essential element of the emergency care and health delivery system. There is a need to clarify the role of these and other critical care services and to enhance policy with respect to operations, safety, quality and utilization.

Most of Montana is rural and it faces numerous logistical challenges such as delays in discovery and access to dispatch, long distances to EMS and hospitals, and limited financial as well as professional resources.

Central medical dispatch encompasses the coordination and management of limited healthcare resources such as prehospital advance life support and hospital specialty care services. Implementation of central medical dispatch needs to be broadened to enhance coordination of EMS response, to limit issues such as 'helicopter shopping' and to track availability of limited resources.

Challenges and Opportunities

- Assess and characterize the infrastructure and state of EMS services and develop strategies to support the organization, workforce and strategies that improve service availability.
- Provide mechanisms such central medical resource management to identify and assure adequate and appropriate EMS response and transportation for ground prehospital responses.

Regionalized Systems of Care

Background

The goals of regionalized systems of care include provisions of optimal care through development and effective utilization of resources, cost effective delivery of care and a reduction of the incidence, morbidity and mortality of injury and illness.

Regionalized systems of care in Montana need to be inclusive, voluntary, pre-planned response networks that include all resources with the capability to care for the patient. Program development includes all health care professionals working within a multidisciplinary team approach that results in implementation of standardized care processes and improve patient outcomes.

Montana's trauma system development is a model for the integrated development of other time sensitive diseases, such as stroke and STEMI. Likewise, integrated development of care for special patient populations such as pediatrics or burns should replicate this roadmap.

System planning efforts for these diseases should include, but not be limited to, provision for uniform geographic coverage of response and transport services, triage and transport protocols, rendezvous and intercept issues, and mutual aid. Local and regional plans should be based on a standardized, formal assessment of local resources and result in emergency care plans focused on the needs of the patient.

Challenges and Opportunities

- Develop and implement strategies to improve integrated and accountable systems of regionalized emergency care for time-sensitive diseases such as trauma, STEMI, stroke and pediatrics.

- Evaluate issues with interfacility transport of patients and develop strategies to improve challenges.

Public Access and Communications

Background

Montana has 58 public access points (PSAPs), which provide basic 9-1-1 services to 100% of Montana's population. As of 2011, nineteen PSAPs provided enhanced 9-1-1 service to 62% of the population and two areas had wireless enhanced 9-1-1 capabilities.

There is a need for standardized Emergency Medical Dispatch training courses and EMD programs in all Montana dispatch centers. The Emergency Medical Dispatcher who receives the 9-1-1 call is one of the most important elements of emergency care because they are the entry point into the system.

Priority dispatch provides the goal of "sending the right resources to the right person, at the right time, and doing the right things for the patient until help arrives". The goal of EMD is to provide the appropriate response (e.g. ALS/BLS, special rescue) to the patient without over utilizing resources.

Reliable communications is an essential component of an overall emergency care system. An effective communications system is the lifeline that connects all elements of emergency care. Communication makes it possible for individuals to assure a prompt and appropriate response. Communication provides the essential linkages that allow system providers to have the timely, reliable information they need to do their jobs effectively. A well-integrated communications system has the ability to adapt to an event of any scope or scale and would provide for interoperability among the various participants. Such a system ensures easy patient access, appropriate patient care and optimal use of resources.

The ability for prehospital care providers, especially ambulances, to communicate with hospitals is a fundamental requirement of a modern emergency care system. Emergency medical technicians must be able to receive on-line medical direction by radio to provide the best care to their patients and to use a radio to notify hospitals of the number and types of patients being transported to their facility. In many cases, prehospital care providers use the commercial cell phone system for their field to hospital communications. However, the commercial telecommunications system can be unreliable, particularly during local, state or national emergencies. These conditions point out an essential need for an interoperable communications system for emergency care operations.

Many EMS agencies and hospitals have successfully procured radios on the new digital standard. Utilizing DPHHS hospital preparedness funds, hospital base stations (many literally over 20 years old!!) have been upgraded to the digital standard.

Signed into law on February 22, 2012, the Middle Class Tax Relief and Job Creation Act created the First Responder Network Authority (FirstNet). The law gives FirstNet the mission to build, operate and maintain the first high-speed, nationwide wireless broadband network dedicated to public safety. FirstNet will provide a single interoperable platform for emergency and daily public safety communications.

Challenges & Opportunities

- Facilitate statewide implementation of Emergency Medical Dispatch programs.
- Develop and implement strategies to improve and enhance EMS communications capabilities through the State digital radio system.
- Engage with FirstNet development activities in Montana.

Medical Response to Disaster

Background

Montana's emergency care system needs to enable the scaling up of day-to-day operations to meet the needs of larger, all-hazards events. It is essential that mass casualty responses involve logical expansion and extension of daily practices and not the establishment of new practices reserved for large scale events.

The emergency care system plays a vital part in the medical aspects of response to a disaster, whether local or large-scale. Coordination of emergency care providers with public safety agencies, government and the medical community is essential.

The numbers of casualties resulting from a mass casualty incident can easily be large enough to overwhelm not only the public health and medical services of the affected communities, but also entire state. Disaster response plans should be developed and exercised to address local, regional and state disaster management, communication, treatment, and destination of casualties.

Emergency care system data is critical for resource utilization for disasters. The ability to know what resources are available in a timely manner with respect to equipment, personnel, and expertise is essential. There is a need for real-time data to be collected at the local level and provided to the state to integrate with mutual disaster responses.

Personnel and volunteer responders are a significant resource required in larger numbers for staffing disasters for needs such as triage, patient care and transportation of severely injured or ill patients. Efforts to identify and credential volunteer health practitioners prior to an incident are important so that qualified individuals are prepared for response.

Surge in resources also includes equipment and supplies. It is likely that a rapid increase in demand will be accompanied by interruption of normal supply and delivery in an all-hazards event.

The most significant challenge in any disaster has always been and probably always will be difficulties with communications. As part of a broad revision of the state's frequency plan, the EMS component was revised to reflect contemporary use of EMS and mutual aid frequencies for both day-to-day and disaster use.

Numerous incident management and incident command courses have been conducted in the state. Many EMS and hospital providers have participated in these and other out-of-state training opportunities. However there is no documentation system to easily identify who has taken the training and how long ago they may have been trained.

Challenges and Opportunities

- Develop, plan and exercise medical response to disaster plans.
- Develop and implement central medical resource data and communications systems to support day-to-day as well as disaster responses.

Information, Evaluation and Performance Improvement

Background

Montana's emergency care system needs to utilize internal and external data systems that provide information to support programs and drive change that can improve patient care and emergency care system operations.

Every system evaluation and performance effort requires data to provide an accurate basis for making decisions. A comprehensive, data-driven performance improvement program is needed to effectively plan, implement and monitor the emergency care system. EMSTS is responsible for evaluating the effectiveness of services provided to victims of medical emergencies. Therefore, the section needs to be able to report what impact has been made on the patients served by the system.

To continue to build and implement strong system development and performance improvement programs, data from several systems are being employed for analysis, including:

- Trauma registry – state and hospital registries that characterize emergency care response to patient suffering severe trauma
- Prehospital registry – a developing database which characterizes the response and care provided by EMS services
- Additional data systems such as poison control data, Fatal Accident Reporting System (FARS), traffic crash records, death certificates and emergency department discharge data.

Beginning in 2016, EMSTS is implementing a new EMS information data solution. Through this program, an active, data-driven performance improvement process will be implemented. Data-driven system performance indicators need to be identified, tracked and reported and strategies to improve current system performance indicators need to be implemented.

System users need to routinely utilize performance indicators (including outcome measures) and attributes to gauge the effectiveness of the emergency care system against state and national parameters. These standards, criteria and outcome measures need to be used to evaluate resource utilization, scope of services, effectiveness of policies and procedures, and patient outcome.

Challenges and Opportunities

- Implement a comprehensive prehospital information and evaluation program.
- Implement a prehospital ePCR data collection system that supports performance and evaluation of the EMS system, EMS services and EMS providers.
- Develop a 'services of excellence' program for EMS services who implement performance improvement as a core element of their services.

Challenges & Opportunities for Education & Local Government Interim Committee Consideration

What do you do when someone calls 9-1-1 and no one responds? Recruitment and retention of EMS staff is already reaching a critical shortage for many EMS services. Entire communities are left uncovered at times because there is no one to respond. Service operations are being minimally funded, especially in rural areas and decisions about what the community wants and what they are capable of paying for are needed.

Among all the challenges and opportunities, the committee might consider:

- Explore designating EMS as essential service much the same as fire and law enforcement have been and find appropriate means to fund EMS services for at the least their cost of readiness.

- Support a study of the "state of the state" of Montana EMS services – There currently is no clear baseline of where EMS services are now with staffing, funding and other challenges and where they project they will be in the next 3 years or 5 years. There is no consensus of what the key challenges are and what the priority solutions might be.

- Support implementation of EMS service manager education and assistance. EMS is a business with staff, budgets and other management challenges. Explore funded education for managers, regionalization of management and other solutions.

- Support increasing the opportunities and capabilities of the EMS education system. Provide education and assistance for local EMS educators. Support regionalized EMS education that utilizes technology to decrease the time and commitment of local providers to educate small groups of students.

- Support medical director education and assistance. Explore regionalization and mentorship opportunities to assist the local medical director in assuring EMS services provide high quality patient care.

- Explore recognition strategies for volunteer providers such as those considered in the 2009 legislature. Provide incentives such as a retirement program, tax breaks and other activities that will help with recruitment and retention. Utilize funding that does not require general funds as much as possible. (e.g. Explore utilizing health policies to fund a retirement program in the same manner that the fire retirement program is funded by fire insurance).

- Implement alternative EMS service delivery models such as community health EMS / community paramedicine. Support implementation of these concepts such that the EMS services may have a higher-trained, paid workforce that helps the service have more stable funding. Implementation requires some reimbursement reforms to pay for alternative transport options or alternative delivery of services.

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