National Association of State EMS Officials

Rural EMS Committee Meeting Record

Subject	Rural EMS		Date	5/7/2012
Facilitator	Jim DeTienne		Time	8:30 am
Location	Bethesda Hyatt		Scribe/ Staff	Rachael Alter

Position	Name
Chairperson	Jim DeTienne
NHTSA/Office of EMS	Noah Smith
Gold Cross/Mayo Medical Transport	Gary Wingrove
HRSA	Tee Morrison-Quinata
Wyoming State Director	Andy Gienapp
Nevada State Director	Pat Irwin
Arkansas State Director	Greg Brown
Oklahoma State Director	Dale Adkerson

Position	Name
Louisiana State Director	Stephen Phillipe
Policy Associate, National Conference of State Legislators	Hollie Hendrickson
Virginia State Director	Gary Brown
Missouri Medical Director	Samar Muzaffar
Exec Director, Minnesota EMS Regulatory Board	Pam Biladeau
Virginia Medical Director	George Lindbeck

Key Points Discussed		
No.	**Topic**	**Highlights**
1.	**Welcome & Introductions**	
2.	**Ski Patrol**	
	a. Committee and Charter Updates	Last meeting the National Ski Patrol (NSP) present to discuss teaming with NASEMSO in order to solve multiple issues regarding state-level rules. Plan it to have a joint committee to sit at the table to discuss commonalities and differences and how to bridge the gaps. Hope to have conference calls in June/July and face-to-face at the Boise Annual meeting
	b. Discussion	What are they doing for a PCR now? It's variable - depends on ski area and is not consistent patient care records; the same goes for

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		Medical Direction. What is the National Ski Patrol doing to get word out that we're working on this? Currently low key, as there is nothing in stone (still working on a formalized charter). Some Ski Patrollers coming out of training with an 'understanding' that they are exempt from state law. There will be a huge education component when and if an agreement is found. This agreement will set the standard for all other groups that may have the same issues (Industrial sites etc that do patient care 'on site').
3.	**Wildland Fire**	
	a. Incident Emergency Medical Subcommittee (IEMS) Updates	Background – IEMS relationship at first contentious, but very positive now. IEMS is representative of most agencies that respond to wildfires (federal); developed medical unit structure – every big fire has one and has a leader. New requirement is that person is an EMT (whose role is mainly focused on occupational health with lots of blisters, sore eyes, etc.) They are not administering aspirin, but it is there. They will do patient assessment, and injuries get diverted when needed, but basics are taken care of. IEMS has created a standards document with structured equipment and supply lists. Teams can now order an EMS kit. Currently IEMS is in the process of approving a PCR that every unit will use as the medical units are now keeping records. Challenges: how do you get medical people from state to state, and how do you make it work. Who do they contact in each state? Trying to structure that information better. What form, what process?
	b. Discussion	Pat Irwin: Nevada rolling out new credentialing process for Burning Man – depending on success may use process for Wildland as well. Andy Gienapp: Would be helpful to have an understanding of what a contract employee means and where their authority begins and ends.

4.	**Community Paramedicine**	
	a. AHRQ Grant Update	Work put into an AHRQ Workshop Grant - we currently can't say we have the grant, but we're close. The Community Paramedicine Discussion Paper created a lot of buzz. There are a lot of challenges which don't have specific solutions, so need to look to where to go next. These next steps need a national forum – who has learned what with panels of thoughts, success stories, Medical Direction, data, training, etc. Can collate ideas on the 2nd day. Will formalize forum in a document =-if we have a regulation issues, documentation issue, what do we do? Looking at late fall for the workshop.
	b. How do State Directors want to be updated? Discussion:	Result of last call: Need more opportunity to learn what's out there and ask questions. What do you want to keep up to speed? • Tool of a gap analysis: if you have less than this type of health care in your area, look at CP -- how do you decide what community needs CP? • Gary has a gap assessment tool in the curriculum. Is the first thing you need to do before making a decision (Not just focused on Paramedic; New curriculum focuses on the public/social health aspect of it; Clinicals are flexible to what the level of provider is) • Repository of this information (ie MN legislation / program); here are the statues, curriculum, etc • HRSA tool (Community Paramedicine Evaluation Tool) determines effectiveness of CP program – Gap Analysis (Gary's) evaluates community need • Just as important to inform people what the program is *not*. Need to be able to squelch the 'myths' in the state. • When will see results in cost savings? Have results, just not peer reviewed. 1.7 million saved for each Community Paramedic. In the pipeline, but may be several years • In the model: how are the Community Paramedics being deployed through a non-911 system? o Gary: in San Francisco, a single paramedic is driving a car, attacking the issue of homelessness; o in CO – funded by grants, and not funded by ambulance (discharge paperwork from hospital directs to CP) o Nova Scotia – original program was a clinic, demonstrating a 40% reduction in leaving island; took

		docs out of hospital at night, he goes to clinic and nurse & CP run hospital; have one ambulance service, with 3 completely different programs • Could this apply to shelters in Louisiana? Loosing public health nurses for shelters (disaster situations). Yes, great place for CP • Ride funding of Preparedness (who gets astronomically more money) to promote the program. May fund education. • Has NREMTs thought of creating a new level for CP? o Jim: it is on their radar; Bill has been asked to let the states create it. • Community Paramedic is trademarked. Program has to be delivered by a college. Curriculum is copyrighted but it is given free to anyone a credit granting institution (or state regulatory agency) • Where is the opposition coming from? o Nursing Association is concerned – when educated that this is filling gaps, not replacing them, they get more comfortable. o Challenge with MDs (medical control) – paramedics currently get from ER medical control, CP get from primary care physician (=change of thought process). o Reimbursement – need to figure out how to pay for it. ** Decision: Important to continue Information Forums and want to know about failures (what didn't work)
5.	**Joint Committee on Rural EMS Care (JCREC)**	This joint committee with National Organization of State Offices of Rural Health (NOSORH) is very active and rewarding. Result of NORSOR EMS committee & ours meeting at different times talking about the same things, so JCREC formed to consolidate issues. We have a formal MOU and a workplan – updated every year. Five members from each group are appointed to the group. Working items include: EMS & Rural Health Leadership and CP issues. Everyone is encouraged to join the monthly meetings. Originally just the two groups formally involved to make sure it would work. Several other organizations do join the calls. Question has been on the table: Should we expand formally for more representation (ie National Rural Health Association)? Want to keep this group purposeful and not open to everyone.

		• What do these groups bring that we don't already have? o Lots – they are already on the calls, but they have the rural perspective. May step up their participation for funds and resources for other projects. Will continue to include EMS specifics in the MOU to keep the mission focus.
	a. 2012 EMS Learning Session	The initial Learning Session was the genesis of the committee which was very successful, so decision made to continue planning these sessions. A lot of the state directors need travel funding which can come from the State Rural Offices. One of the main goals is to get the EMS & Rural offices to communicate and work together. NOSORH does a webinar annually before the FLEX Grant to explain what EMS is and how to support the system with Flex funds.
	b. Funding for quality improvement through CMS for EMS	JCREC is looking into how to connect into the AHRQ Patient Safety Organization structure (same that hospitals use for a protected QI environment) For example - if cots are failing in 3 different states, how to get with the manufacture to discuss issue. Ambulance services subscribing to a safety service are putting together a governing body – Request is for JCREC to be part of that body. Intent is to mix ambulance and hospital records together for a complete picture of care. Connected with EVENT – when those reports received, forwarded to the state EMS office where the event occurred. State can do what they will with the information and all reports are anonymous. Intention is to produce quarterly and annual reports in aggregate form. Patient Safety goes one step before that. Once a report is made into the organization, you are protected. Peer review can occur under that system and can monitor what is going on in the community. Vision: Ambulance services could subscribe to the system and send data in regularly. PSO would do the peer review. Create a training system under the PSO around culture of safety. Take the two products that are out in hospitals (TEAM STEPPS) and recraft to fit EMS agencies. Not natural for EMS to report mistakes made. Tying hospital and EMS records together for continuum of care. Have some funding, but will need grants for the first two years until subscriptions start coming in.
	c. Leadership Survey	JCREC is revising a survey from 2009 asking what are states doing to educate EMS service managers and medical directors. End result will be a compendium of what states are doing.