- PUBLIC MEETING -

Hope Board of Selectmen
Meeting at 6:30 p.m.
Tuesday, November 10, 2020
Hope Town Office/Zoom
-AGENDA-

This meeting may be livestreamed: https://townhallstreams.com/towns/hope_me

This meeting may be attended via Zoom: https://zoom.us/j/5851802397
Meeting ID: 585 180 2397

Call to Order:

-

Agenda Adjustments/Approval:

-

Public Comment:

-

Minutes:

- October 27, 200:
- November 5, 2020:
- **November 9, 2020:**

Town Administrator Report:

New Business:

- Broadband Update:
- **EMS Development Project:**

Old Business:

- Appointments to the Roads Advisory Committee:

Other Business:

-

Warrants:

-

Adjournment:

-

MINUTES OF SELECT BOARD MEETING
Hope Select Board
Tuesday, October 27, 2020
6:30 PM
Hope Town Office/Zoom
View the meeting in its entirety at
https://townhallstreams.com/towns/hope_me

Board Members Present:

- Sarah Ann Smith *(via Zoom)*, Brian Powers Jr., Thom Ingraham, Bruce Haffner, and Amy Gertner

Others Present:

- Samantha Mank, David Herrick, Amy Powers, Chris Sewall, Elizabeth Tibbets, Ellie Goldberg, Paul Smith, Mary Ireland, Dick Crabtree, David Hall, Patti Bosken, Juanita Hunt, Olivia Powers, Margaret Morse, Bill Jones, Chris Pinchbeck, Lindsay Pinchbeck, Nancy Ford, Entwife, Maine Media Workshop, and iPhone

Call to Order:

- The meeting was called to order by Sarah at 6:31 PM.

Minutes:

- 10/6/20: Amy made a motion to approve and accept the October 6, 2020 minutes. It was seconded by Thom.
  Motion passed 5-0
- 10/13/20: Thom made a motion to approve and accept the October 13, 2020 minutes. It was seconded by Amy.
  Motion passed 5-0

Public Comment:

- Thom made a quick announcement for the members of the Select Board to be sure to check the news tomorrow for a major announcement regarding the school and surrounding Towns from Lincolnville Telephone. He reiterated that it is “big news”.

Town Administrator’s Report:

- Everyday and everything has been about the election.
- The ballot drop box was delivered and Brian installed it yesterday.
- The second DS200 ballot counting machine arrived. There is a possibility that we may even be able to keep it.
- There have been 679 absentee ballots requested and 550 have been returned. 19 ballots

from overseas have also been requested.

- On October 15th there were 1,292 registered voters in Hope, today there are 1,307 registered voters.
- There will be an election/ballot clerk training tomorrow. Chelsea will be leading that training session.

New Business:

- Resignations/Vacancies:
    - Planning Board – John Fallows: John Fallows submitted a letter of resignation from the Planning Board. Amy made a motion to accept John's resignation. It was seconded by Thom with thanks.
      Motion passed 5-0
    - Additional Committee Vacancies:
        - Planning Board
        - Appeals Board
        - Cemetery Committee
- Appointments:
    - Planning Board: Thom made a motion to appoint Marie Berry to the Planning Board to serve a 5-year term in a vacancy that was unfilled in July. The motion was seconded by Amy.
      Motion Passed 5-0
    - Recreation Committee: Thom made a motion to appoint Marie Berry to the Recreation Committee. It was seconded by Amy.
      Motion passed 5-0
    - Cemetery Committee: Amy made a motion to appoint Mary Berry to the Cemetery Committee. It was seconded by Thom.
      Motion passed 5-0
    - Roads Advisory Committee: The Select Board reviewed a list of names for people to serve on the Roads Advisory Committee: Bruce Haffner, John Monroe, Doug Merrill, Patrick McGrath, Todd Snyder, Bill Pearse Jr., Rick Bresnahan. Additional names to consider include Ed Crowley, Chris Pinchbeck, James Guerra, and Rick Catalano volunteered although he is not a Hope resident.

      Bruce wanted to remove Mike Ames from the list because he recorded Bruce without his knowledge and Bruce doesn't want to work with someone who does that.

Thom said that since there is a problem with the list, that the matter should be tabled until the next meeting in order to see if something can get worked out.

Brian said it has been the practice in the past to not discourage people who are willing to serve.

Thom said that he would be willing to have a conversation with Mike Ames to see if Bruce and Mike would be able to work together.

Bruce said that Ellie Goldberg would also like to be on the Roads Committee as well.

The matter was tabled until the November 10th meeting.

- Interim Town Clerk – David Herrick: The Town Administrator introduced David Herrick to the Select Board. David responded to an article in the Village Soup asking for former or retired clerks who are able to help, to contact the Town Office. David answered that request. Thom thanked David for coming forward. Brian asked if David would consider being a substitute for any possible future staffing needs. David said, yes. Bruce made a to confirm David's position as the Interim Town Clerk and to appoint him as the Election Warden for the November 3rd election. It was seconded by Thom.
  Motion passed 5-0

- Election Clerk/Ballot Clerks: The Town Administration provided the Select Board with a list of twenty-nine (29) people who had come forward to help with the election. Thom made a motion to approve and appoint the entire slate of people as election/ballot clerks. It was seconded by Amy.
  Motion passed 5-0

- North East Mobile Health (Ambulance) September Report: The Select Board reviewed the September report and offered a "thank-you" and "great-job" to the Towns ambulance provider.
- FY 2021 Proposed Knox County Budget: Reviewed the proposed budget

Board of Assessors:

- Suspend as the Select Board and Convene as Board of Assessors: Bruce made a motion to suspend as the Select Board and to convene as the Board of Assessors. It was seconded by Thom.
  Motion passed 5-0
- Tree Growth Withdrawal Penalty – Jeff Lord & Nancy Dowling: Thom made a motion to approve the Tree Growth Withdrawal Penalty in the amount of $4,960. It was seconded by Amy.
  Motion passed 5-0

- Farmland Withdrawal Penalty – Gwen Brodis: Amy made a motion to approve the Farmland Withdrawal Penalty in the amount of $389.59. It was seconded by Thom.
  Motion passed 5-0
- Adjourn as the Board of Assessors and Reconvene as the Select Board: Thom made a motion to adjourn as the Board of Assessors and to reconvene as the Select Board. It was seconded by Amy.
  Motion passed 5-0

Old Business:

- None

Other Business:

- Thom asked about the timeframe for the trees in True Park being removed. The Town Administrator will check to see where the Town is on their schedule.
- Thom also wanted to follow up about having the South Hope Fire Station upstairs door installed.
- Thom asked there was any update on the Covid-19 virus being in Hope.
- Thom made a motion that all members of the Select Board have access to Maria Fox's report to keep at the Town Office. Thom wants Bill Kelly to show the Board the report commissioned by the Select Board which the Chair of the Select Board has in hand why we have to be in the same room with him in order to see it. Thom said that it is a good practice to have read the material before the meeting with the attorney. Amy seconded the motion. There was additional discussion.

  Bruce called for a vote on the motion.

  Thom wanted to know the legal basis for the Select Board not getting to read the report until later. The motion was amended: Maria Fox's report, commissioned by the Hope Select Board be made available to the Select Board or provide a legal basis for why we cannot have access to our report, and we will give him until noon on Thursday October 29th. The report will not leave the building. The amended motion was seconded by Amy. There was additional discussion and chats on the Zoom.
  Motion passed 3-2 ***(Sarah & Brian)***

Warrants:

- The Select Board reviewed the warrants. Thom made a motion to approve and sign Warrant #'s 33, 34, and 35, 30, and 31. It was seconded by Bruce.
  Motion passed 4-0-1 ***(Sarah)***

Adjournment:

- Thom made a motion to adjourn at 8:02 PM. It was seconded by Amy.
  Motion passed 5-0

MINUTES OF SELECT BOARD MEETING
Hope Select Board
Thursday, November 5, 2020
6:30 PM
Hope Town Office/Zoom
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Board Members Present:

- Sarah Ann Smith, Brian Powers Jr., Thom Ingraham, Bruce Haffner, and Amy Gertner

Others Present:

- Samantha Mank, Bill Kelly, Paul Smith, Dick Crabtree, and Ellie Goldberg

Call to Order:

- The meeting was called to order at 6:30 PM by Sarah. Sarah made a review of the agenda and explained how the meeting process was going to happen.

Executive Session: Pursuant to 1 M.R.S. §405 (6)(E) – Legal Issues w/ Town Attorney:

- Brian made a motion to enter executive session at 6:36 PM. It was seconded by Thom. **Motion passed 5-0**

Regular Session: Any action needed resulting from Executive Session:

- Bruce Haffner has recused himself from a pending personnel matter.

Executive Session: Pursuant to 1 M.R.S. §405 (6)(A) -Personnel Matter: Tabled

Regular Session: Any Action needed resulting from Executive Session: Tabled

Adjournment:

- Meeting was adjourned at 10:45 PM

MINUTES OF SELECT BOARD MEETING
Hope Select Board
Monday, November 9, 2020
5:30 PM
Hope Town Office/Zoom
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Board Members Present:

- Sarah Ann Smith, Brian Powers Jr., Thom Ingraham, and Amy Gertner

Others Present:

- Samantha Mank, Bill Kelly, Hunt

Call to Order:

- The meeting was called to order at 5:32 PM by Sarah.

Executive Session: Pursuant to 1 M.R.S. §405 (6)(A) -Personnel Matter:

- The Select Board enter executive session at 5:34 PM.
- The Select Board exited executive session at 7:42 PM

Adjournment:

- Brian made a motion to adjourn at 7:42 PM. It was seconded by Amy.
  Motion passed 4-0

Town Administrator's Report
November 10, 2020

- Reminder that the Town Office will be closed tomorrow in observance of Veteran's Day
- The November 3rd election ran fairly smoothly. There were 1,343 registered voters in Hope. 511 Democrat, 269 Unenrolled, 52 Green Independent, and 411 Republican. There were 808 absentee ballots requested and 808 were issued. 790 ballots were returned prior to election day. The remainder were either returned on election day or not returned. There were 20 UOCAVA absentee ballots requested and 20 were issued. 17 were returned.
- There were many poll workers who came and gave their time. Some actually spent the entire day. We are grateful for those who participated as it made for a smooth and productive day.
- In April, I passed out the EMS project that is being spear headed by the Towns of Camden and Rockport. Mr. McGinnis is once again reaching out to found out if Hope wants to participate. I've handed the documented out to you again this evening.
- There have been a couple of applicants send resumes for the vacancies. I am going to re-advertise and broaden the net a bit.
- There are 7 outstanding 2019 RE accounts totaling $12,913.85 with liens that will go to automatic foreclosure on February 16, 2021 if accounts remain unpaid.
- There are 25 outstanding 2020 RE accounts totaling $47,946.47 with liens that will to automatic foreclosure on February 10, 2022 if accounts remain unpaid.
- There are 1021 RE accounts for 2021, totaling $1,623,510.89. The second half of taxes are due on April 30, 2021.
- Since the last regularly scheduled Select Board Meeting on October 27, 2020, the daily cash out has not been out of balance.

Receipt Search Report

Actual Date Between 10/28/2020 and 11/10/2020, Receipt Types: 2,4,5,10,90,91,99,800

Receipt Summary

	Type	Count	Amount
2	TRASH BAGS	1	80.00
4	SNOWMOBILE REGISTRA	1	46.00
5	ATV REGISTRATION	2	58.00
10	BUILDING PERMIT	3	825.00
90	Real Estate Payment	27	19,425.33
91	Tax Lien Payment	3	3,827.79
99	Motor Vehicle	52	15,463.92
800	Dog Registration	4	24.00
		93	39,750.04

From: Kevin McGinnis
To: Samantha Mank
Subject: FW: Interview for EMS Development Project
Date: Monday, November 9, 2020 9:09:23 AM

Good Morning,

I am forwarding this to another email address, in hope that I can connect with you on the project described below. I would like to invite you to attend the upcoming steering group for the project on the next two Thursdays at 4 PM by Zoom. I would also like to update you on the steering group and interview you, as mentioned below, as part of my effort on this. I know the dates below have passed, but if you can suggest a couple of times this week before the steering group meeting, I will do my best to make one of them work.

Thanks!

Kevin
Kevin McGinnis, MPS
207-512-0975
kevin@mcginnis.ws
Mail:
57 Central Street
Hallowell, Maine 04347

From: Kevin McGinnis
Sent: Friday, October 30, 2020 10:16 AM
To: SMank@hopemaine.org
Subject: Interview for EMS Development Project

Good Morning, Ms. Mank,

As I believe you may know, I am working to assess the emergency medical services (EMS) resources and needs of the area for the future. While I am under contract with Camden, Rockport and the Hospital, as a town official and a part of the four town EMS response network, your assistance in this would be a great aid in my understanding the issues involved.

I know this is a busy time for a Town Manager, so I really mean it when I say that I would greatly appreciate up to 45 minutes of your time for a discussion of your perspective on the subject. Given the limitations we are all experiencing, between the pandemic and the variability of bandwidth resources to support video conferencing, I am relying on the plain old telephone for most of these conversations.

If you can provide contact information for the Fire Chief and Hope members of the EMS

Performance Review Committee, that would be helpful as well.

Please let me know a couple of time available for the interview in the next week from the openings below. If none of these work in your schedule, please suggest a couple of 30-minute opportunities you might have. Weekends and evenings are possible as well. I will do my best to meet your scheduling needs.

Tuesday, November 3: 7 AM to 4 PM
Wednesday, November 4: 7 to 11 AM or 4 to 6 PM
Friday, November 6: 7 AM to 6 PM

Thank you. I look forward to talking with you!

Kevin

Kevin McGinnis, MPS
(207) 512-0975
kevin@mcginnis.ws
Mailing Address:
57 Central Street
Hallowell, ME 04347

DRAFT EMS System Development

TBD:
Are Camden and Rockport doing this completely together?
Hope and Lincolnville participation

Phase I: Community Education
One of more Community Forum(s) sponsored by Towns of Camden and Rockport and PBMC.

Goal: Educate citizens and leaders on potential EMS system design and configuration, EMS needs broad picture, current issues in EMS, and present Independent Self Determination Model as next step followed by open discussion of community needs.
Moderators: Chosen by Towns
Presenters: T. Judge and Dr. Chris Michalakes
Timeline: Early April.

Phase II. IDS Project Development (may be concurrent with Phase I
Meeting of stakeholders to design project with stakeholders and agree on contract.
Consultant: Kevin McGinnis
Timeline early April

Phase III. IDS Project
Consultant:
Data gathering with stakeholders and Maine EMS includes FD's, Knox PSAP, Northeast, PBMC
Develop agreed comparators list
One or more community forums to explain project and options to citizens and gain buy in.
Moderators: Chosen by Towns (I am also willing to assist in this)

Community Survey
Meetings with stakeholders / interviews of community
Data analysis
Options Appraisal including finances and performance expectation
Draft system design options
Draft report to Town leaders and hospital
Community Forum(s) to present draft report and get feedback

Timeline April-August

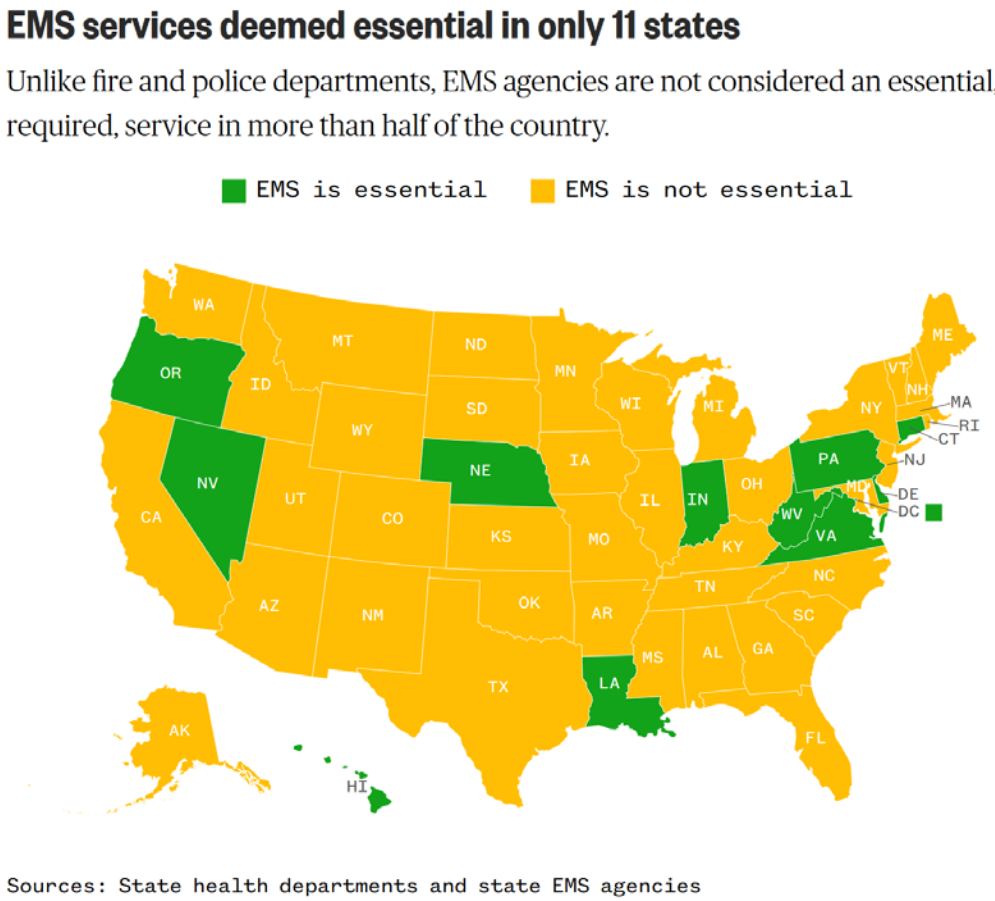
Phase IV: IDS Final design and presentation
Consultant:
System design development and presentation to Town Leaders
Consensus on system design
Community Forums to present final options to communities
Timeline Sept- Oct.

Phase V.
Transition as necessary
Begin Fall 2020
I am willing to assist with this.

Proposed Title: Engaging Rural Maine Communities to Rescue Their Patient Safety Net and Shape the Future of Emergency Medical Services

Introduction

It would be a surprise to most people that with very rare exceptions (estimates vary between four and fourteen states) , emergency medical services (EMS) have not been considered an "essential service" assured by state statute or by other incentives such as fire department rating impact on the cost of homeowner's insurance. [1-3] It would also surprise most Mainers to learn that state EMS experts believe that the local availability of EMS is jeopardized in a dozen or more rural Maine communities today.



Source - https://www.nbcnews.com/health/health-care/there-s-shortage-volunteer-ems-workers-ambulances-rural-america-n1068556. Another source states that only California Colorado, North California, and Oregon deem EMS as essential. [1]

In most cases, citizens expect that emergency medical services are available should they need them. Moreover, they expect those services to have a very high level of capability to handle complex, life-threatening problems. A 1993 consumer survey conducted for Maine EMS revealed that 87% of respondents expected that a 9-1-1 call for a heart attack in their home would be answered by the highest level of equipped and trained paramedics. Popular media representation of EMS since then has continued to paint this capability.

In most urban areas, municipalities, health systems, or private companies have developed EMS systems that approximate these expectations. In rural communities, however, mostly volunteer based-EMS providers have struggled to remain viable let alone meet the very high standards of urban-based EMS systems. In rural areas, volunteer ambulance services have tended to be the foundation of ambulance response. Through the 1970's these services seemed to find an adequate supply of community members willing to take first aid, first responder and EMT courses and serve for a variety of personal incentives.

The 1980's brought new pressures on EMS agencies, particularly the rural volunteer-based model. Changing economic factors caused families to increasingly need more than one paycheck and to be able to less afford volunteering their time. Basic training requirements, including course hours and testing, became a more significant imposition to being able to serve on an ambulance crew. While advanced EMT and paramedic life support capabilities offered the temptation for ambulance services to do more for patients with enhanced equipment and training, the requisite training, experience, staffing and continuing education to provide advanced care became more prohibitively burdensome on a volunteer basis.

A declining supply of volunteers together with the need to incent staff to be on call and pay for their time while on calls forced many rural ambulance agencies to adapt their staffing models from purely volunteer-based to a mix of paid and volunteer staff. In addition, patient billing and local government subsidy revenue were often added to the traditional volunteer-based bake sales and suppers to enable agencies to pay staff. However, these transitions occurred as local effort dictated and not as a matter of routine EMS planning. In many cases, rural EMS evolved as the result of local relationships among local EMS leaders, politics, and/or agency mergers resulting from an untoward incident, staffing pressures, declines in patient volume, and/or other local factors.

While many Maine EMS agencies have transitioned to a purely paid or mixed staffing model and are able to boast of having paramedic response, progress has stagnated in many rural communities. This is largely because of increasing workforce challenges with lower volume services unable to generate sufficient patient-based revenue to meet increasing pay requirements to compete for advanced EMTs and paramedics. A number of these rural communities have also suffered hospital and specialty medical office closures over the same period. Moreover, EMS agencies in these areas experience greater call volumes from patients underserved by primary/preventive care, have longer transports to remaining facilities, and are increasingly being called upon by those facilities to do interfacility transfers for patients from their community. All of these pressures exacerbate the challenge of adequate EMS response to a citizenry that may be unaware of the response limitations that may periodically but increasingly exist. In the extreme, their first awareness of the problem occurs when the ambulance service closes its doors. This occurred in 2018 with eight days' notice, leaving Ellsworth and 17 other Maine towns without service. A Bangor regional EMS agency stepped in to cover that area, but the resulting solution for some of those towns remains uncertain as they debate continuing to use Ellsworth-based resources or try to support their own.[4]

It is often said that all politics are local. The same can be said of EMS. Despite federal and state EMS training, recruitment and retention tools dissemination, volunteer ambulance service leadership development, and other improvement programs, few have successfully mitigated the on-the-ground challenges that local EMS agencies and rural communities face. In addition, ambulance certification/accreditation programs, which assure some level of quality response, are not financially practical for most rural EMS agencies. As a result, local rural EMS problems persist and the same "solutions" seem to stay in vogue with agencies and/or their ability to provide adequate service level at risk and their communities served unaware of what is available when they dial 9-1-1.

For this reason, state and national EMS leaders have proposed a different approach to local, rural EMS planning. The model, labeled "Informed Community Self-Determination" (ICSD; originally termed just "Informed Self-Determination"), is designed to engage citizens in rural communities in a supported discussion and assessment of their EMS system with the goals of helping them understand what EMS capacity they currently have and, based on an assessment of specific options, what they could expect in the future (and at what cost).

In the remainder of this brief, we describe the ICSD model and its applicability to rural EMS in Maine. In the final section we discuss the community engagement approach used in the ICSD model and how it might be offered in Maine.

ICSD: A New Community-Engaged EMS Planning Model

The *Rural and Frontier EMS Agenda for the Future,* a book published by the national Rural Health Association in 2004[4], proposed the ICSD model of community-engaged planning to help communities and local EMS agencies co-design EMS services that fit with local resources and capacities and that reflect community preferences. Most simply stated, the concept of "informed community self-determination" is designed to credibly inform taxpayers regarding the type and level of EMS they currently have, reveal flaws or limitations for the agency to address (shared in the ICSD discussion only as it affects the community's choice of options; otherwise just shared with agency leaders), explain alternative levels of basic or advanced care and types of response that could be available, approximate the cost of adopting those alternatives, and facilitate a taxpayer decision to fund their current coverage or adopt a new plan. Specifically, ICSD provides a process in which:

- An outside expert or entity conducts an objective evaluation of the EMS service using a standardized evaluation tool.
- The evaluator reports openly on the level of care, method/speed/availability of response and any issues which affect those factors.
- The evaluator reports to the agency leadership any deficiencies which jeopardize service performance in order that they can be addressed by leadership or entered into the ICSD discussion as indicated.
- Based on accepted national practices and state EMS law and regulations, options are presented and their implementation and cost impacts explained in terms of tax-base effects.
- The community holds a meeting(s) of taxpayers and/or their representative decision-makers to select a level and type of service it desires and establish the level of funding needed to implement and sustain it.

According to the 2004 *Agenda* report,

As a result of informed self-determination, communities without access to systems of advanced levels of care, and/or that have difficulty raising sufficient crew to always respond, devote financial resources and/or find alternative methods of making more effective use of existing resources (e.g., community paramedicine approach or combination of other community jobs) to increase levels of care and staff availability. Annual EMS system evaluations are done by a local team including community members and local leaders, using the standards, recommendations, and baseline data contained in the original community EMS system assessment report. These evaluations are shared with the community, along with public education on the appropriate use of the EMS system.

A basic premise of the 2004 Report and the proposed ICSD model is that every rural/frontier community should have the opportunity to have a community EMS system assessment conducted by an objective technical assistance team from outside that community. The model presumes that the assessment team would conduct a local, on-site evaluation to provide a baseline review for community and agency leaders of their local EMS system's current capabilities.

With the baseline assessment and options analysis completed, the assessment team provides information to the community and engages it in a discussion of their current EMS services and capacity, its performance, and options for adjusting existing services and their costs. Finally, the process guides community decision-makers in assessing and choosing the type and level of EMS that it desires and the means by which those services can be funded.

Some of the key elements of the community engagement strategy and process include decisions regarding:

- Who needs to be part of the process
- How to convey the key information needed
- Framing the goals of the discussion
- Facilitation of the discussions
- Getting to consensus

Tools for Implementing ISD

Since 2004, some ambulance service evaluations have incorporated the informed self-determination principles and process. In Maine, it was used successfully in planning efforts in St. George in 2010 and throughout Franklin County in Maine in 2001 to 2003. Nationally, however, It gained little momentum, largely because the ISD approach and process lacked a standard template with which to train statewide cadres of evaluators who might employ the methodology. In response to this lack of momentum, the Joint Committee on Rural Emergency Care (JCREC), a committee of the National Association of State EMS Officials, the National Organization of State Offices of Rural Health, the National Rural Health Association, the National Association of EMS Physicians, and the National Rural Health Resource Center – Technical Assistance and Services Center, has formally embraced the concept of ISD in their workplans and in an upcoming follow-on document to the 2004 *Agenda*. In addition, the Federal Office of Rural Health Policy is also allowing states with funding from the Medicare Rural Hospital Flexibility Program (FLEX) to explore its use in community EMS evaluation projects.

In 2019, two members of the national EMS agency evaluation community received grant funding to create and publish a draft template for "Informed Community Self-Determination" ("ICSD") which is now available for ICSD use. Further support has been received to enable it to undergo additional consensus review nationally, and specific piloting in Wyoming in 2020. It is intended to provide states and EMS evaluation teams more a more structured process and specific tools for employing ICSD in their EMS evaluations. This template is currently being employed in a western state project, and its expanded use is expected.

Implications for Maine

Experienced state and regional EMS system leaders have identified at least a dozen rural Maine community EMS structures at risk for failure across the state. These are communities where EMS has undergone regionwide change and individual communities are pursuing different options, such as in the greater Ellsworth area. They may be individual EMS agencies where leadership and/or workforce are unstable. Some isolated populations may be losing health care services that require them to travel outside the community, often using EMS transportation to

do so, or seek other resources locally, such as EMS, for health care not normally provided by those resources.

In one such isolated community, its EMS capability, while limited to basic level care, is essentially intact. However, the long-established local health clinic is faced with personnel and financial resource challenges that, without other solution, will leave the community without the night and weekend urgent care resource it currently enjoys. The only recourse, other than a 60 to 90-minute drive or ride to a hospital, will be to call EMS to either transport them or to provide ad hoc treatment in place with the patient subsequently refusing transport. This could significantly increase the call volume with long roundtrips to those hospitals, without sufficient volume to enable a full-time paid service, and jeopardize what service now exists. A variant of the ICSD process is being used to enable the community to decide whether it wants weekday-only clinic coverage scenario to become reality or whether it wants to pilot transitioning to off-hours coverage by telehealth-supported community paramedicine physician extenders. The weekday-only option carries no tax increase while the 24/7 access option would increase property taxes. If this ICSD variant produces the former result, increased pressure on local EMS may require another ICSD process, but for its EMS resource, in the future. If it produces the latter result, a marriage between EMS and primary care resources may evolve that addresses their mutual security. Either way, the community will be informed of the consequences of choice they make.

Affording communities a process by which they may choose the type and level of EMS/community paramedicine care and response they prefer and are willing to pay for requires expense. It also requires process dexterity when more than one community and set of decision-makers are involved.

The ICSD template was created and reviewed by EMS systems professionals with extensive agency evaluation experience in Maine and other rural settings around the country. It prescribes a process utilizing, ideally, two evaluators. The resources required and its process includes:

- (*Sixteen hours plus up to eight hours travel and expenses, assuming one evaluator travels;*). Initial logistical preparation and development and execution of an agreement between the community (generally municipality (ies)) and EMS agency (including a visit to the community for meeting among principals) on:

    - what the evaluation entails including process, community interaction and reports,
    - evaluator access to records, personnel, community members and agencies, facilities and equipment,
    - form of community meetings to receive information and make decision on options, and
    - process for implementing community decision and reviewing progress annually.

- (*Twelve hours*). Pre-visit administration and completion of surveys on agency organization and performance. Preparation of results to inform inspections and reporting.

- (*Forty-eight hours on-site and up to sixteen hours travel assuming two evaluators; plus local travel, lodging and related expenses*). Visit by evaluators to inspect records, facilities, equipment, and to perform PCR run review and conduct approximately thirty interviews. Phone interviews are only utilized for follow-up information or as a last resort for interviewees who are otherwise unavailable. Interviews with hospital and other personnel may require travel outside the locale.

- (*Thirty-two hours*). Establishment and costing of options, preparation of report and other reporting, logistical and administrative details.

- (*Twenty hours on-site and up to sixteen hours travel, assuming two evaluators; plus local travel, lodging and related expenses*). Hold community meeting for reporting, option discussion, and option selection.
  A
- (*Five hours*). Completion and delivery of final report. Logistical and administrative detail completion.

Evaluator resources required are approximately 173 hours, or $10,380 at $60/hour. At an average travel distance of 200 miles ($116 at $0.58/mile), lodging/meals/incidentals at $160/person/day, the travel projected above would cost approximately $2,500. The total direct

expenses required would then be approximately $12,880. A ten percent administrative overhead charge would bring the total to just over $14,000.

This figure assumes average travel within Maine and, by subject matter expert opinion, an average ICSD process. It also assumes that there is essentially one community/municipality and decision-making process. This was the case for the St. George ICSD process in 2010, but not the 2001-2003 Franklin County experience with 21 towns/plantations and several unorganized townships. The logistical implications and therefore, costs, may vary widely. It may be necessary to adjust the scope of the process to accommodate complexity. In Franklin County, the options for decision-makers to choose among were reduced to: basic level, paramedic level, or no service from the five EMS bases that now consitute NorthStar EMS (all chose paramedic level). Multiple communities currently being served by a single EMS agency often already organize together to contract with that agency. The logistical complexity may be less than it first appears as a result.

In order to assure that needs for ICSD may be met in Maine, and that the processes used are uniform, performance-improved, reliable and well-coordinated, it may be advisable to establish a cadre of evaluators coordinated under the umbrella of Maine EMS or another qualified entity. Assuming that evaluators are experienced paramedic service chiefs, a one-day training program followed by a one or two ICSD-process apprenticeship with an experienced evaluator should suffice.

Conclusion

Informed Community Self-Determination holds promise for addressing the increasingly distressed situation in which rural EMS agencies find themselves today. Recent changes in the MaineCare funding of ambulance service, and the increasing potential for the funding of community paramedicine types of service make the future brighter. But short of a legislated declaration as an “essential service” accompanied by the State funding necessary to assure the patient safety net, the immediate infrastructure needs of EMS in rural Maine can only be addressed by the communities EMS serves. The ICSD process can help the taxpayers of those communities make decisions about how robust that safety net will be.

96Template for Emergency Medical Services Informed Community Self Determination (ICSD)

1. **Introduction to the EMS ICSD Program: The Rural EMS Challenge and ICSD**
   Rural communities have been increasingly challenged to maintain and improve their emergency medical services (EMS) coverage. The volunteer foundation of such services has weakened or crumbled. Increasing requirements for successfully providing advanced EMS care that agencies seek are less sustainable when provided on a volunteer basis.

   Community members often do not have accurate expectations about the type and level of EMS response that a 9-1-1 call will bring. It often takes a failure in response, or a response different than expected, to bring the issue to the community's attention. That can result in additional challenges for an agency that may not be survivable. Finally, the decline in rural community medical services and hospitals has increased the pressure on EMS agencies to maintain access to those services through increased 9-1-1 responses when patients wait for declining health to become an emergency and through longer transports to remaining hospitals.

   To mitigate the impact of this deteriorating situation, state EMS offices, federal funding agencies, and others have tried to improve volunteer EMS agency management through training and to improve recruitment and retention of volunteers and other staff. Community paramedicine has evolved to improve local access to health care and lessen the declining state of a local population's health which leads to increased 9-1-1 calls. But this, too, often adds pressure to local EMS to provide more without any more resources.

   The Rural and Frontier EMS Agenda for the Future, a book published by the national Rural Health Association in 2004 with support from the Federal Office of Rural Health Policy, suggested a solution to this cycle of decline now called "informed community self-determination" (ICSD). Variants of the approach have been employed by EMS agency evaluation services, but it did not gain nationwide momentum. Only recently has this standard template been developed by agency evaluation leaders to enable ICSD to be used widely. With further experience with the ICSD process it has the potential to be used to train statewide cadres of evaluators who might employ the methodology.

   In the past several years, the Joint Committee on Rural Emergency Care (JCREC), a committee of the National Association of State EMS Officials, the National Organization of State Offices of Rural Health, the National Rural Health Association, the National Association of EMS Physicians, and the National Rural Health Resource Center, have embraced the concept in their workplan and in an upcoming follow-on document to the 2004 *Rural and Frontier EMS Agenda…* book. The Federal Office of Rural Health Policy is also allowing the concept to be explored in community EMS evaluation projects with its FLEX funding program.

   Often, EMS agency evaluations, even provided by objective outside parties, result in minor changes without resulting in change to major organizational or resource issues. They rarely

contain an integral component linking the evaluation and the "fixes" suggested with action by taxpayers or those representing them to pay for fixing the issues.

Informed self-determination provides a process in which:

- An objective evaluation of the service is completed by an outside expert or entity using a standardized evaluation tool.
- The evaluator reports on issues which jeopardize service performance and their impact on response and the and level of care provided.
- Options are presented within accepted national practices and state EMS law and regulations, and their implementation and cost impacts explained.
- The community holds a meeting(s) of taxpayers and/or their representative decision-makers, selects a level and type of service it desires, and establishes a level of funding needed to implement and sustain it.

The ICSD process is intended for EMS response areas that are rural, relatively isolated, and do not have multiple EMS resource options. In urban and suburban communities, there are generally a number of EMS provider options available from which to choose. While it is important that those making the selection of EMS provider be well-informed about EMS standards of care and operation, they can benefit from resources such as a dedicated "public utility model" (permanently employing a governmental agency for EMS selection and oversight) or an *ad hoc* consultant to help with an EMS agency request for proposal and contracting process. With these aids, the responsible governmental or other entity can then choose from fire-based, private, municipal third party and other options.

2. The Informed Community Self Determination Process

a. Conduct Pre-Visit Checklist

The Pre-Visit Checklist (Appendix A) establishes the process and timeline to be followed in arranging an ICSD Program for a community.

b. Execute Client/Site Agreement

The Client/Site Agreement (Appendix B) assures that the community sponsors and the ICSD evaluator have common expectations for the process and product of the ICSD Program for the community. Importantly, while it requires an evaluation, community decision-making process, and a community informed determination of EMS status and funding (so that the community emerges informed), it does not require that anything change from the status quo. There is no pre-process commitment to change or to any level of new funding.

c. Administer Pre-Visit Questionnaire

The questionnaire content, some revised to match the Performance Measure Based ICSD Evaluation Tool below, is based on the following three resources. The first is used for all ICSD processes, while the latter two are used as appropriate (based on EMS agency experience as described in Appendix C).

i. Wisconsin *Attributes of a Successful Rural Ambulance Service* survey
ii. Wisconsin *Best Practices for EMS Time-Critical Diagnoses* survey

iii. *Rural Community EMS Agency Transformation Readiness Assessment and Resources* survey (https://www.ruralcenter.org/tasc/rural-community-ambulance-agency-transformation)

d. Arrange Visit Schedule

i. Initial Evaluation Tour (three days on site utilizing Performance Measure Based ICSD Evaluation Tool (Appendix D) and Pre-Visit Questionnaire results (Appendix C)):
    1. Service Inspection (facilities, vehicles, equipment)
    2. Document Review (e.g. financials, governance, SOPs, operational data, PI/QI data, HR policies, schedules)
    3. Interviews
        a. Service leadership (e.g. officers, board)
        b. Service members (sample of all positions and license levels)
        c. Community leaders (e.g. municipal, school, other thought influencers)
        d. Police
        e. Fire
        f. Hospital
        g. Dispatch agency

ii. Community Meeting (one day on site)
    1. Goal for Today's Meeting – Decision or Recommendation to Authorized Decision-maker
    2. Report Presentation
    3. Options Presentation
    4. Discussion of options
    5. Decision Process
    6. Post-meeting Participant Survey

e. Create Report

i. Executive Summary
    1. Brief EMS/Jurisdiction Environment
    2. Significant Findings
    3. Recommendations Summary

ii. EMS History and Environment

iii. Jurisdiction Description

iv. Service History and Health Care/EMS Environment

v. Performance Measure Based Evaluation (Appendix D)
    1. Recommendations for basic clinical, operational, administrative and policy-setting improvements (regardless of options selected below)

vi. Options Development
    2. Options based on adjusting response/operations performance
    3. Options based on adjusting level of care
    4. Potential operating model options based on 1 and 2
    5. Cost of operating model options

d. **Conduct Visits** (as above)

Appendix A.

Emergency Medical Services (EMS)

Informed Community Self-Determination (ICSD) Program

Agency Pre-visit Check List

The ICSD Program your Agency has requested consists of some work on your part prior to the evaluation site visit, the site visit itself, development of the evaluation report, presentation of the evaluation report, a Community forum to present the report, a decision on changes to the Agency by the authority body(ies) for the Community evaluated.

This is a check list of the items your Agency should provide to the evaluators prior to the visit.

Done (Date)	Item to be Completed	Completion Deadline
	Complete the EMS ICSD Agreement, obtain required signatures, and submit to ICSD evaluation team.	Two months prior to visit.
	Receive and complete the Paramedic Foundation Survey based on the Wisconsin Office of Rural Health "*Attributes of a Successful Rural Ambulance Service Survey*" and "*Best Practices for EMS Time-Critical Diagnoses Survey"*	One month prior to visit.
	Submit all run statistics from local, regional and/or state sources to evaluation team.	Three weeks prior to visit.
	Submit all performance measurement, quality improvement and similar data collected for up to prior three years to evaluation team.	Three weeks prior to visit.
	Submit any records of positive or adverse interactions with state EMS licensing agency at any time in Agency history to evaluation team.	Three weeks prior to visit.
	Submit any records of awards or adverse/contested legal actions at any time in Agency history to evaluation team.	Three weeks prior to visit.
	Submit a list of all potential interview subjects including name, position held with regard to Agency, phone number, email address, and any notes helpful to scheduling an interview. These should include: • All Agency employees. • All Agency board members or others with authority over Agency. • Agency medical director(s). • Agency dispatch center leadership. • Agency receiving hospital(s) EMS representative, ED nurse manager, ED physician medical director. • All members of the Community authority body which funds or has the potential to fund the Agency Community from a tax base. • Other Community leaders (e.g. town manager, public works director). • Leadership of police, fire and other agencies with which the Agency routinely works during emergency responses. • Community school district leaders (e.g. school board leaders, principals, superintendents).	One month prior to visit.
	Submit Agency bylaws, standard operating policies and procedures, and any a copy of any forms routinely used by the Agency for its operations to the evaluation team.	Three weeks prior to visit.

	Submit any manuals, instructions or other documents that describe requirements for employment at the Agency to the evaluation team.	Three weeks prior to visit.
	Submit Agency financial records for past three years.	Three weeks prior to visit.
	Prepare employee files for inspection by evaluation team.	One week prior to visit.
	Establish a date for the Community forum and prepare a plan for advertising it to all town residents.	Two months prior to visit.

Appendix B.

Emergency Medical Services (EMS)

Informed Community Self-Determination Program

Agreement

Definitions

EMS Agency Informed Community Self-Determination – A process in which a community's authorized decision-makers are provided sufficient information on their current EMS level and type (of response operation and patient care) to determine whether it is sufficient or requires change and how much they are willing to authorize spending for that.

Community – The primary population served by the EMS Agency which has a single governmental unit authorized to make funding decisions about that EMS Agency. If the EMS Agency serves multiple populations, each with its own governmental authority, the governmental authorities must describe how the informed community self-determination (ICSD) process can be reasonably implemented with representation of those authorized to make funding decisions for all populations served.

ICSD Provider- The organization implementing the informed community self-determination process for the Community.

EMS Agency - The organization(s) providing primary emergency medical service response and transport for the Community.

Agreement

The Community consists of: _____. The authorized government authority/authorities of the Community is/are:

_____.

The EMS Agency is: _____.

The ICSD Provider is: _____.

The Community and EMS Agency agree that it would be beneficial to conduct an ICSD process. They also agree, and the ICSD Provider concurs, that the ICSD process will be conducted during the following time-frame: _____.

The Community and EMS Agency agree that they will, to the extent of their ability and authority, provide those records, forms, data, interview subjects, access to EMS Agency facilities/equipment/supplies/dispatch service, and other items or people that may reasonable be requested by the ICSD Provider for the purpose of this process.

The Community agrees to hold at least one forum to be attended by the public and a majority of Community authorized governmental decision-makers and that, at or following this forum, those

decision-makers will make a formal decision on the level and type of EMS Agency service they desire and how that will be funded. Nothing in this agreement requires that EMS service or its funding type and amount must change, just that those making this decision have had an opportunity to be informed by the ICSD process.

The ICSD Provider will conduct the process utilizing the *Emergency Medical Services Informed Community Self-Determination Template* that has been provided to the Community and EMS Agency leaders.

For the Community (Name, Signature, Title):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

____ (Check if Addendum with Additional Undersigned)

For the EMS Agency (Name Signature, Title):

_____ _____

For the ICSD Provider:

_____ _____

Appendix C.

Informed Community Self Determination Performance Measures Based Evaluation Tool

Performance Measure 1		Administration Management	
Indicator		**Measure**	**Agency Progress**
1.1	System Design and Participation	*Agency is part of a regional EMS system designed to maximize resources such as dispatch, first response, mutual aid, back-up coverage, continuing education and disaster preparedness.*	
1.2	Data Collection and Record Keeping	*Agency collects data on all aspects of its operation including personnel, education and training, responses and response times, clinical/patient interactions, supplies, equipment maintenance, and financial records*	
1.2	Organizational Chart	*Agency has an organizational chart outlining leadership structure and describing the roles and responsibilities of leaders, administrators, managers, supervisors, training personnel and boards*	
1.3	Strategic Plan	*Agency has a written and current strategic plan*	
1.4	Management Preparation	*Agency managers and leaders have received documented education or instruction in EMS management*	

Evaluator Observations:

Evaluator Recommendations:

Evaluator Discussion:

Performance Measure 2		Finance	
Indicator		**Measure**	**Agency Progress**
2.1	Budget	*Agency has written annual budget and complies with budget*	
2.2	Bookkeeping	*Agency maintains accurate financial records*	
2.3	Revenue	*Agency has identified reliable revenue sources commensurate with budget*	
2.4	Billing	*Agency bills for patient transport using appropriate billing practices or an appropriate billing agency*	
2.5	Reserves	*Agency has reserves of at least 25 percent of its annual operating budget*	

Evaluator Observations:

Evaluator Recommendations:

Evaluator Discussion:

Performance Measure 3	Staffing		
Indicator		**Measure**	**Agency Progress**
3.1	Certification	*Training and certification of agency members matches agency licensure*	
3.2	Roster	*The number of agency staff members is appropriate to service provided. An agency providing 24/7 EMS response and transport with at least two members on call at all times must have at least 14 active members. This is based on each member being on call no more than 24 hours in any give week.*	
3.3	Call Schedule	*An agency providing 24/7 EMS response and transport must have a posted call schedule with designated shifts and specifically assigned staff*	
3.4	Scheduling	*An agency providing 24/7 EMS response and transport must have a policy that limits call shift length to what is reasonable and safe. Personnel are not on call for days at a time and have adequate time off between scheduled shifts.*	
3.5	Staff Activity	*Staff members listed on roster must be active. This means each staff member takes at least 1 call shift per month (unless prevented by illness or other extenuating circumstance).*	

Evaluator Observations:

Evaluator Recommendations:

Evaluator Discussion:

Performance Measure 4		Response	
Indicator		**Measure**	**Agency Progress**
4.1	Reliability	*Agency responds to 100 percent of requests for emergency service*	
4.2	Records	*Agency obtains response time data from dispatch agency and maintains accurate response time reports for all calls*	
4.3	Timeliness	*Time from response unit notification to vehicle wheels rolling is less than 8 minutes*	
4.4	Travel Time	*Time from wheels rolling to providers arrive at patient side is appropriate for miles traveled, scene situation and weather conditions and reflects knowledge of service area*	
4.5	Scene Time	*Scene time reflects protocol compliance and sound clinical judgment*	
4.6	Transport Time	*Time from wheels rolling with patient loaded to arrival at care facility is appropriate for miles traveled and weather conditions and reflects knowledge of destinations*	

Evaluator Observations:

Evaluator Recommendations:

Evaluator Discussion:

Performance Measure 5		Clinical Performance	
Indicator		**Measure**	**Agency Progress**
5.1	Patient Care Protocols	*Agency has medical director-approved patient care protocols reflective of staff training and license level*	
5.2	Medical Director Engagement	*Agency has designated physician medical director and monthly contact with medical director for clinical care review*	
5.3	Skill Verification	*Agency conducts annual clinical skills review*	
5.4	PCR Review	*Designated staff person reviews all patient care reports and verifies protocol compliance*	
5.5	Continuing Education	*Service provides or supports ongoing continuing education commensurate with state and national certification requirements*	

Evaluator Observations:

Evaluator Recommendations:

Evaluator Discussion:

Performance Measure 6	Safety and Reliability		
	Indicator	**Measure**	**Agency Progress**
6.1	Inspection and Maintenance	*Agency conducts and documents regular vehicle and equipment inspections and performs regular maintenance on vehicles and equipment*	
6.2	Driving Instruction	*All staff members have received emergency vehicle driving instruction*	
6.3	Universal Precautions	*Staff practices universal precautions on all calls and patient contacts and maintains appropriate cleanliness of vehicle and equipment*	
6.4	Safe Practices	*Agency practices scene safety on all calls with safety vests, vehicle positioning and appropriate traffic control*	
6.5	Records	*Agency maintains records on all work-related injuries and illnesses.*	

Evaluator Observations:

Evaluator Recommendations:

Evaluator Discussion:

Performance Measure 7	Inter-Agency Relations, Prevention and Public Awareness	
Indicator	**Measure**	**Agency Progress**
Mutual Aid	*Agency has clear and written mutual aid agreements to provide coverage to its service area when agency resources are not available*	
Dialogue	*Agency maintains regular communications with neighboring agencies and participates in regional dialogue and planning*	
Coordination	*Agency has formal and practiced disaster and multi-casualty incident plans with other agencies*	
Prevention Programs	*Agency participates prevention activities such as seat belt awareness, bike helmets, drunk driving awareness etc.*	
Public Awareness	*Agency engages in activities within community that foster better understanding about medical emergencies how to utilize EMS. Programs include pubic CPR training, public access AEDs, health fairs, community presentations.*	

Evaluator Observations:

Evaluator Recommendations:

Evaluator Discussion:

Appendix D

This Appendix contains three evaluation tools for use prior to assessment visits.

The first, the ***Wisconsin Ambulance Service Assessment***, will be used as a base-line self-assessment measure to guide further information seeking in the service evaluation.

The second, ***Best Practices for Time-Critical EMS Diagnoses***, is a follow-on survey that seeks advanced information on operational preparedness and will be administered for services that have exhibited more clinical/operational sophistication. That survey is undergoing revision and is not currently included.

The third, ***Rural Community EMS Agency Transformation Readiness Assessment and Resources*****,** will be administered for services that have ventured into EMS 3.0 planning.

1. Wisconsin Ambulance Service Assessment 2016

Thank you for taking the time to complete the 2016 Wisconsin Ambulance Service Assessment. The information collected will be used to identify EMS agency needs throughout the state and to target support and funding.

If you have questions about this assessment how the information will be used, please contact John Eich, Director of the Wisconsin Office of Rural Health, at (608) 261-1890 or eich@wisc.edu.

A national group of EMS providers and advocates have identified 18 attributes of a successful EMS agency. For the purpose of this assessment, each of those attributes has been described in 5 ways. Please read each description and then select the one that most closely matches your agency.

Operations Attributes

A Written Call Schedule

1. Non-existent. Pager goes off and anyone available responds.
2. Informal, ad-hoc agreement exists between the crew.
3. Written and distributed schedule exists, but for less than one week at a time.
4. Written and distributed schedule is for one week or more, but empty spaces are not filled, waiting for personnel to show up.
5. Written and distributed schedule is for two weeks or more. Empty spaces are filled prior to shift beginning.

Continuing Education

1. No continuing education is offered.
2. Continuing education that meets minimum requirements needed to maintain licensure is offered (internally or externally).
3. Continuing education above minimum requirements needed to maintain licensure is offered.
4. Continuing education based on quality improvement and/or quality assurance findings is offered.
5. Continuing education based on quality improvement and/or quality assurance findings, with Medical Director and/or hospital input, and taught by a certified educator is offered.

A Written Policy and Procedure Manual

1. There are no documented EMS policies and procedures.
2. There are a few documented EMS policies and procedures, but they are not organized into a formal manual.
3. All EMS policies and procedures are documented in a formal manual but crew members don't refer to/use/update it systematically.
4. All EMS policies and procedures are documented in a formal manual and crew members refer to and use it systematically. It is updated, but not on a schedule.
5. All EMS policies and procedures are documented in a formal manual and crew members refer to/use/update it systematically. It is written to the level of detail necessary that anyone from the crew could step in and do the job correctly.

Incident Response and Mental Wellness

1. There is no incident response and mental wellness debriefing.
2. There is informal and positive debriefing and support from more experienced crew members.
3. There is informal and positive debriefing and support from more experienced crew members. Dispatch occasionally notifies the EMS agency on a predetermined set of calls (pediatric, suicides, fatalities, trauma, etc.), which are addressed informally by agency leadership.
4. Agency leadership has training in Incident Response, is consistently notified by Dispatch at the time of possible incident, and has a policy of debriefing impacted crew member(s).
5. All of #4, plus professional counseling sessions are offered at reduced or no charge to crew members impacted. Follow-up with impacted crew members is standard procedure.

Finance Attributes

A Sustainable Budget

1. There is no written budget.
2. A budget has been developed; however, it is not followed.
3. A budget is in place and financial decisions and actions are based upon it.
4. A budget and policies are in place regarding proper purchasing procedures, purchase limits and authorizations, and procedures for procuring equipment either not in the budget or over the stated budget. An operating reserve of at least three months is in the bank.
5. A budget and polices are in place regarding proper purchasing procedures, purchase limits and authorizations, and procedures for procuring equipment either not in the budget or over the stated budget. An operating reserve of at least six months is in the bank and the reserve has been in place for at least one year.

A Professional Billing Process

1. Services are not billed.
2. Services are billed, but claims are submitted by an individual (internal or external) with no formal training in healthcare billing.
3. Services are billed, but claims are submitted by an individual (internal or external) with limited training in healthcare billing.
4. Services are billed and claims are submitted by someone with skills and training in healthcare billing, but without established HIPAA-compliant billing policies or policies to handle claims that have been denied or with a balance due.
5. Services are billed and claims are submitted by a certified biller (internal or external) or billing service, in a timely manner (fewer than 30 days), with established HIPAA-compliant billing policies and policies to handle claims that have been denied or with a balance due.

Quality Attributes

Medical Director Involvement

1. There is a medical director in name only. He/she is not actively engaged with the EMS agency beyond signatures.
2. The medical director reviews cases but not within 30 days and provides very little feedback.
3. The medical director reviews cases within 30 days and provides very little feedback.
4. The medical director reviews cases within 30 days and provides a good amount of feedback, but waits for the EMS agency to engage him/her. When asked, he/she responds to hospital ED/ER contacts on behalf of the EMS agency regarding the agency's clinical protocols and actions.
5. The medical director is an integral part of EMS, pro-actively engaging the agency to review cases, providing a good amount of feedback; delivering education to the agency; and advocating for the agency to hospital ED/ER contacts.

A Quality Improvement/Assurance Process

1. There is no plan to collect, analyze, or report EMS agency performance measures.
2. Performance measure data is collected about the EMS agency but not analyzed or reported.
3. Performance measures are analyzed and reported but no feedback loop exists for continual improvement of the EMS agency.
4. Performance measures are reported and a feedback loop exists for general improvements.
5. Feedback from performance measures is used to drive internal change to: (1) improve the patient experience of care (including quality and satisfaction), (2) improve the health of the community (e.g., success of screenings, education); and (3) reduce the cost of health care services (e.g., reducing EMS costs, and/or utilizing EMS to reduce overall healthcare costs).

Contemporary Equipment and Technology

1. The EMS agency has only the minimum equipment/technology required by licensure. The budget does not allow additional equipment/technology acquisition.
2. The EMS agency has the minimum equipment/technology required by licensure, plus a minimal budget for additional equipment/technology acquisition.
3. In addition to the minimum equipment/technology required by licensure, the EMS agency has some advanced equipment/technology. There is a minimal budget for new equipment/technology acquisition and a formal replacement plan.
4. In addition to the minimum equipment/technology required by licensure, the EMS agency has some advanced equipment/technology. There is an adequate budget for new equipment/technology acquisition and a formal replacement plan.
5. In addition to the minimum equipment/technology required by licensure, the EMS agency has some advanced equipment/technology. There is an adequate budget for new equipment/technology acquisition and a formal replacement plan. There is a formal maintenance plan provided by trained/certified technicians or engineers.

Quality Attributes continued

The Agency Reports Data

1. No operational/clinical data are submitted to regulators.
2. Operational/clinical data are submitted to regulators, but not often within the designated timelines (locally, statewide, or nationally).
3. Operational/clinical data are submitted to regulators within the designated timelines.
4. Operational/clinical data are submitted to regulators within the designated timelines. Areas for improvement are identified using an established quality improvement/quality assurance process by the EMS agency.
5. Operational/clinical data are submitted to regulators within the designated timelines. Areas for improvement are identified using an established quality improvement/quality assurance process, and goals and benchmarks are used to improve performance. Summary reports are regularly shared publicly with the community.

Public Relations Attributes

A Community-Based and Representative Board

1. There is no formal board oversight.
2. The board consists of internal EMS agency members only.
3. Voting board members are from the EMS agency AND some combination of elected officials, hospital leadership/staff, and/or governmental administrators.
4. Voting board members are ONLY some combination of elected officials, hospital leadership/staff, and/or governmental administrators.
5. Voting board members include all of #4 AND at least one engaged patient representative.

Agency Attire

1. There is no identifying EMS agency attire.
2. There is identifying EMS agency attire, but it is not adequately protective.
3. There is identifying EMS agency attire, which is adequately protective, but elements of it are purchased by the members.
4. There is identifying EMS agency attire, which is adequately protective, and all of it is purchased by the agency.
5. There is identifying EMS agency attire, which is adequately protective and purchased by the agency. A written policy identifies what attire is required and how it is to be provided, cleaned, maintained, and replaced.

Public Information, Education, and Relations (PIER)

1. There is no plan for addressing PIER.
2. The EMS agency is in the process of developing a PIER plan.
3. There is a PIER plan, but no funding dedicated to its implementation.
4. There is a PIER plan that has funding dedicated to its implementation.
5. There is a PIER plan that has funding dedicated to its implementation, someone identified as responsible for PIER, and a recurring evaluation of its success.

Involvement in the Community

1. 911 emergency calls and inter-facility transports are responded to but no public education courses are offered.
2. Occasional basic public education courses, like CPR/AED and First Aid training, are offered.
3. Frequent basic public education courses, like CPR/AED and First Aid training, plus other EMS-related training are offered.
4. A robust array of public education courses and other training are offered and the EMS agency is active in community promotions at various events.
5. The EMS agency offers a robust array of public education courses and other training, organizes or assists in planning health fairs, is a champion for a healthy community, is an active partner with other public safety organizations, and is seen as a leader for community health and well-being.

Human Resources Attributes

A Recruitment and Retention Plan

1. There is no agreed-upon plan nor substantive discussion on recruitment and retention.
2. There is no agreed-upon plan but there have been substantive discussions on recruitment and retention.
3. There is an informal, agreed-upon plan and people have been tasked with addressing the issues of recruiting new crew members and retaining existing crew members.
4. There is a formal written plan and people have been tasked with recruiting new crew members and strategizing methods to keep current crew members active (such as compensation, recognition and reward program, management of on call time, adequate training).
5. There is a formal written plan and people have been tasked with recruiting new members and retaining existing crew members. There is a full roster with a waiting list for membership.

Formal Personnel Standards

1. There is no official staffing plan or formal process for hiring new personnel (paid and/or volunteer).
2. There is a staffing plan and documented minimum standards for new hires.
3. There is a staffing plan, documented minimum standards for new hires, and an official new-hire orientation.
4. There is a staffing plan, documented minimum standards for new hires (including background checks), an official new-hire orientation, and systematic performance reviews/work evaluations.
5. All of #4 plus there is a process to resolve personnel issues.

An Identified EMS Operations Leader with a Succession Plan

1. There is an identified EMS Operations Leader (e.g., Chief, Director, Director of Operations, EMS deputy chief or captain within a fire agency), but he/she has not had any leadership training.
2. There is an identified EMS Operations Leader with some leadership training, but he/she was not selected by a recruitment process.
3. There is an identified EMS Operations Leader with some leadership training and who was selected by a recruitment process, but there are obstacles to full functioning (such as lack of funding or no succession plan).
4. There is an identified EMS Operations Leader with comprehensive leadership training and who was selected by a recruitment process, but there are obstacles to full functioning (such as lack of funding, no succession plan).
5. There is an identified EMS Operations Leader with comprehensive leadership training, who was selected by a recruitment process, and who is fully capable and prepared to effectively lead the service. There is also a succession plan in place to appropriately handle the transition of the leadership role.

Human Resources Attributes continued

A Wellness Program for Agency Staff

1. There is no wellness program for crew members.
2. Written information is available for crew members regarding physical activity, healthy food options, and tobacco cessation.
3. All of #2 AND occasional educational programming regarding healthy lifestyles is offered, and there is policy support for healthy food options at meetings.
4. All of #3 AND there is policy support for healthy lifestyle opportunities during work time.
5. There is a structured wellness program following national recommendations. Crew members are actively encouraged with agency-funded fitness opportunities, healthy food choices, and disease- prevention programs like tobacco cessation.

2. Best Practices for Time-Critical EMS Diagnoses

Currently under revision. To be added.

3. Rural Community EMS Agency Transformation Readiness Assessment and Resources

Assessing the Core Competencies of Your EMS Agency to Provide Fuller Service and Greater Value Patient Care in the Decline of Community Healthcare and Hospital Access

Prior to the early 1970's and the advent of modern emergency medical services (EMS), ambulance services were primarily sources of transportation for the emergently ill and injured. Essentially, a "horizontal taxicab" service was the mainstay of the evolutionary "EMS 1.0" stage. Following studies and pilot projects leading to the federal EMS Systems Act of 1973, EMS as we know it today, the evolutionary "EMS 2.0" stage of the last forty years, developed across the country. Over the past twenty years, the need for a further transformation of EMS has become evident.

While EMS is geared toward intervening in high acuity and other injuries and medical emergencies, a significant portion of the patients it is called to help do not have an emergency of this sort. Further, EMS has continued to be largely funded on a fee-for-service basis, and mainly for the transportation it provides. At the same time, the healthcare system is moving away from dependency on fees assessed for a volume of services it provides and toward a people-centered, value-based operation that rewards positive patient outcomes.

Transformation to a next evolutionary stage is a necessary step if EMS is to play an integral part in the changing healthcare system and thrive. Some call this next phase, logically, "EMS 3.0". It may become especially important for rural EMS agencies to embrace as other sources of healthcare in their communities evaporate and the threat to their own traditional, volunteer-dependent existence as an emergency-only safety net heightens.

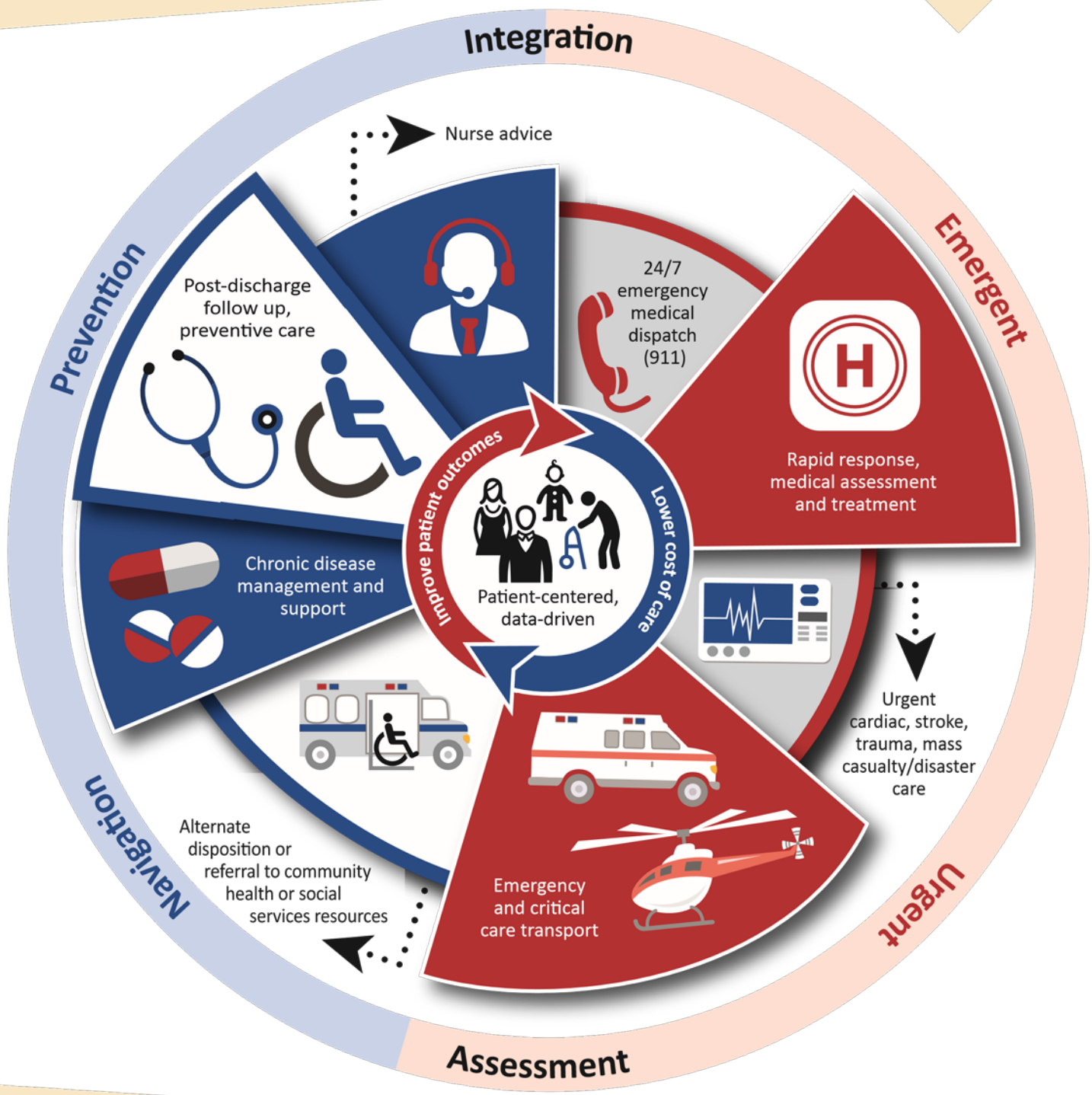
The next generation rural EMS agency must develop new core competencies. These should aid it to begin to apply its resources to address gaps in the community's healthcare continuum, beyond emergency medical response, and take advantage of the funding streams that will reward that activity. Fortunately, EMS is well positioned for this role with its 24/7/365 resource availability in the community and its credibility as an expected, respected and welcomed source of medical assessment and care in people's homes. This is particularly true of rural EMS, which has long been a recognized community medical resource.

Key to transforming from EMS 2.0 to EMS 3.0 is for EMS agency leaders to embrace the need to apply its practitioners and other resources to address these community healthcare needs and thereby improve the patient care experience, improve population health of the community, and reduce healthcare expenditures.

The following infographic by the National Association of EMTs is useful in understanding and explaining this transformation. It may be found at NAEMT EMS 3.0 Infographic.

EMS 3.0

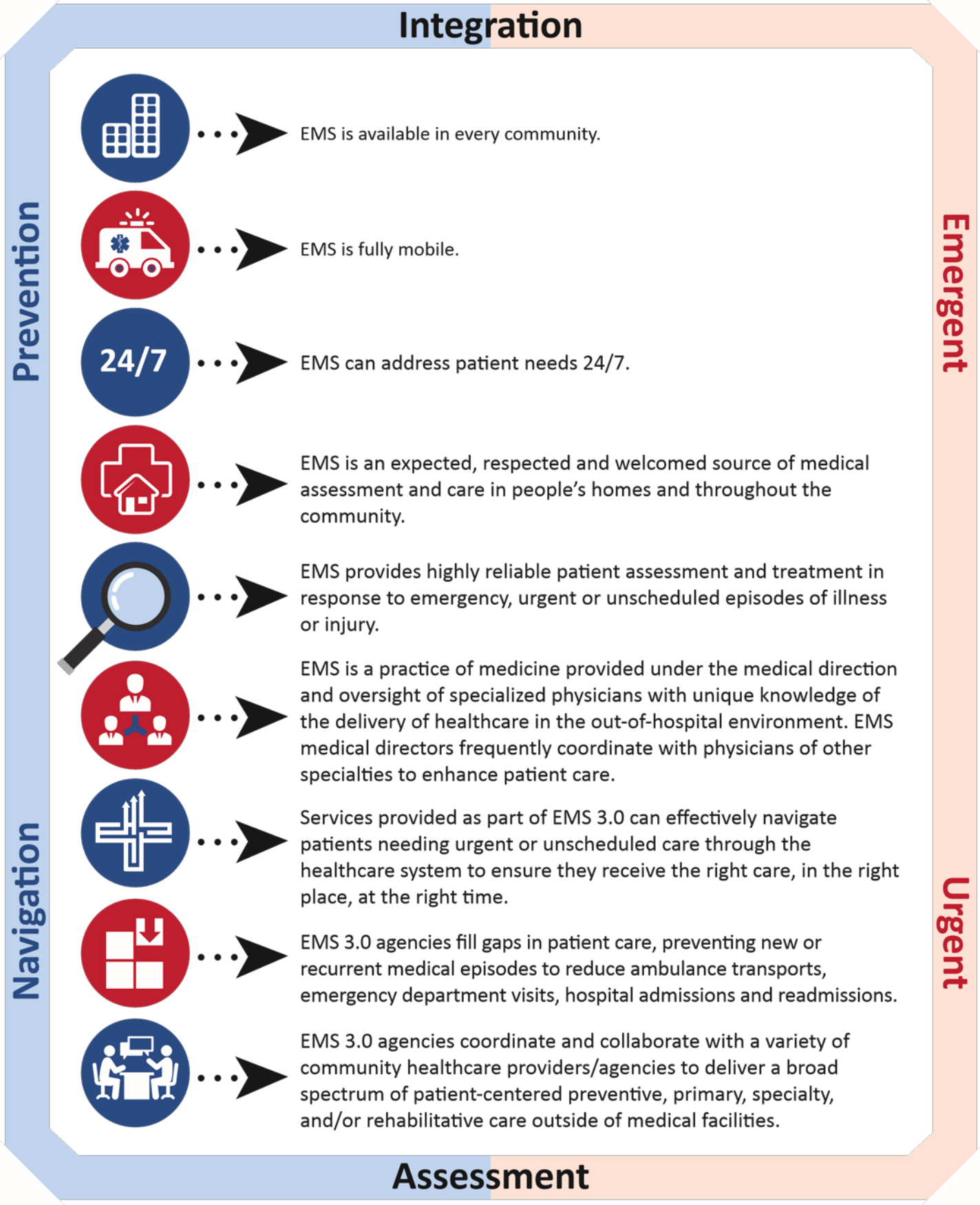
Our nation's healthcare system is transforming from a fee-for-service model to a patient-centered, and value and outcomes-based model, known as "Healthcare 3.0." Emergency Medical Services (EMS) can contribute to this transformation by filling gaps in the care continuum with 24/7 medical resources that improve the patient care experience, improve population health, and reduce healthcare expenditures – this is "EMS 3.0."



EMS is uniquely positioned to support our nation's healthcare transformation by assessing and navigating patients to the right care, in the right place, at the right time. EMS 3.0 can help our nation achieve its healthcare goals.

NAEMT
Advancing the EMS profession

EMS 3.0 can help transform our nation's healthcare system by filling gaps in the care continuum with 24/7 medical resources that improve the patient care experience, improve population health, and reduce healthcare expenditures. Here's how:



In order to capture the power of the transformation described above, rural EMS agencies, their leadership and staff must develop certain core competencies in the areas listed below (from the Baldridge Excellence Framework for Health Care):

The primary goal of the **Rural Community EMS Agency Transformation Readiness Assessment and Resources** is to help EMS agency leaders assess the state of their agency's readiness in these core competencies (so the following Self-Assessment is organized accordingly). It also provides references and other tools to assist rural EMS agency leaders to succeed with moving from "volume to value" in their agency's culture and operations and to develop their EMS personnel and other resources into a more rounded healthcare access point for their community.

Leaders are encouraged to complete the assessment periodically to monitor their progress and receive updated resources to guide the journey in this direction.

Related Content

You may select any of the core competencies below to take you to a list of relevant documents/resources to help your transformation in these areas:

(Put in link to Rural Community EMS Agency Transformation Core Competencies webpages each listing one of the following Core Competencies Documents/Resources lists; see the following file for content for each of those pages:
Documents-Resources Content for Core Competencies Webpages 3-31-19)

- ***Leadership***
- ***Strategic Planning***
- ***Patients, Partners, and the Community***
- ***Data, Collection, Management, and Analysis***
- ***Operations and Processes***
- ***Workforce***
- ***Outcomes and Impact***

(Put in button for following link to Self-Assessment)

Take the Self-Assessment

Link

SELF-ASSESSMENT INSTRUCTIONS

Please indicate your agency's level of engagement in the critical transformation success factors needed on a scale of: High, Moderate or Low. If you have not yet started on this success factor, please indicate N/A.

Some terminology:

"EMS 3.0" means achieving operational and clinical effectiveness in contributing to improved population health, patient care experience (in illness and wellness care) and reducing heath care costs. Consistent with EMS Agenda 2050, it is people centered – focusing on the patient, family and other people involved in the patient care episode, and practitioners.

"Senior leadership" includes your most senior EMS official (e.g. EMS chief, executive director, chief executive officer) and those considered that agency's primary operational, administrative and clinical leaders.

"Leadership team" includes senior leadership and the board or official to whom the most senior EMS official reports.

"Staff" implies all members/employees of the agency unless referring to specific community paramedicine activities and then it means just those practitioners assigned to those activities.

Readiness Assessment Core Competency Critical Success Factors

Each assessment table below represents a critical success factor in the **Rural Community EMS Agency Transformation**.

Please indicate your agency's level of engagement in **LEADERSHIP** activities that contribute towards EMS 3.0 transformation.

	High	Moderate	Low	N/A
I am aware of the critical role of population health in value-based reimbursement models.	○	○	○	○
Senior leadership and mid-level managers/officers understand the critical role of population health in value-based reimbursement models.	○	○	○	○
Leadership provides periodic messaging to volunteers and paid staff regarding broadening our agency's EMS value to our communities and population-based healthcare in general.	○	○	○	○
The leadership team is focused on creating a culture change towards providing wellness and chronic care disease services in addition to emergency illness and injury intervention/care and medical transportation services.	○	○	○	○

Please indicate your agency's level of engagement in **STRATEGIC PLANNING** activities that contribute towards transition to EMS 3.0.

	High	Moderate	Low	N/A
The leadership team incorporates EMS 3.0 concepts into its strategic planning.	○	○	○	○
The leadership team can communicate the agency's vision and strategies for transitioning to all staff.	○	○	○	○
Leadership communicates the principles of EMS 3.0 to our governing board regularly.	○	○	○	○
My agency educates patients, partners and the community on the agency's vision and strategies for the transformation through various modes, including social media.	○	○	○	○

Please indicate your agency's level of engagement with activities that contribute towards the improvement of population health with **PATIENTS, PARTNERS and the COMMUNITY**.

	High	Moderate	Low	N/A
My agency participates in a community health assessment process to identify both strengths and needs to best serve the people in the community.	○	○	○	○
Staff receives ongoing education and support for effectively engaging multiple community stakeholders to coordinate transitions of care aimed at reducing hospital re-admissions, unnecessary 911-EMS and ED use, and improving wellness.	○	○	○	○
My agency has a strategy to provide health assessments and education to the community at events such as a county fair, and on a scheduled basis at places like community centers.	○	○	○	○
Staff coordinates care with multiple stakeholders to address a patient's underlying needs and social determinants of health.	○	○	○	○

Please indicate your agency's level of engagement for **DATA COLLECTION, MANAGEMENT and ANALYSIS** activities that contribute towards population health.

	High	Moderate	Low	N/A
Staff are educated on electronic patient care record (e-PCR) capabilities for managing population health.	○	○	○	○
My agency analyzes data (e.g. actuarial, clinical, patient satisfaction, operational) to improve patient care and efficiency.	○	○	○	○
My agency surveys patients regarding their satisfaction with specific wellness services and care provided and uses the results to distribute wellness information and guide wellness care.	○	○	○	○
My agency engages in an ongoing cycle of performance improvement based on data collected for improving the health of patients and quality of care.	○	○	○	○

Please indicate your agency's level of engagement of **OPERATIONS and PROCESSES** that contribute towards population health.

	High	Moderate	Low	N/A
Staff performs operational, clinical and business processes as efficiently as possible.	○	○	○	○
Staff utilizes health information technology (e.g. electronic patient care records, health information exchanges and telemedicine) to manage care effectively.	○	○	○	○
Staff routinely consult primary care providers or other patient care coordinators responsible for the patients enrolled or otherwise seen in community paramedicine activities.	○	○	○	○
Community paramedicine e-PCR are integrated with medical office, hospital, and other electronic health records for ease of communication among all practitioners responsible for a patient's ongoing care.	○	○	○	○

Please indicate your agency's level of engagement of activities that contribute towards a resilient, change-ready **WORKFORCE**.

	High	**Moderate**	**Low**	**N/A**
The leadership team offers ongoing staff education on how to provide safe, high quality, person-centered care.	○	○	○	○
The leadership team support a staff culture that is adaptable in the change towards prevention and chronic disease management.	○	○	○	○
Staff are role models of health and wellness in the community.	○	○	○	○
Senior leadership supports a culture of staff safety and physical and mental wellness.	○	○	○	○

Please indicate your agency's level of engagement of activities that contribute towards population health **OUTCOMES and IMPACT**.

	High	Moderate	Low	N/A
My agency publicly reports all quality and community health needs outcomes for activities in which it participates.	○	○	○	○
My agency collaborates with multiple stakeholders and payers to identify shared savings opportunities.	○	○	○	○
My agency regularly engages the community in forums designed to educate about and collect their specific input on programs and services we provide.	○	○	○	○
My agency participates in value-based private payer contracts and CMS shared savings models.	○	○	○	○

Results Delivery

Please complete the following to receive assessment results and a list of tools and resources that will guide you towards population health.

Name

Agency

City

State

Email

Confirm Email

Organization type (Check one)

- ☐ Independent for-profit EMS agency
- ☐ Independent non-profit EMS agency
- ☐ For-profit hospital based
- ☐ Non-profit hospital based (if chosen, the following shows up as a yes or no question)
    - o Is your hospital a federal designated critical access hospital?
        - ☐ Yes

- ☐ No

- ☐ Fire-based EMS agency
- ☐ Law-enforcement based EMS agency
- ☐ City/town/county EMS agency

Workforce:

Do you consider your staff to be:

- ☐ Career/Paid
- ☐ Volunteer (may include "pay" and other incentives considered to be significantly less than Career/Paid rates)
- ☐ Mix of Career/Paid and Volunteer

(End of Self-Assessment)

Self-Assessment Scoring and Weighting

General Scoring:

- 5 points for "High"
- 3 Points for "Moderate"
- 1 point for "Low"
- 0 points for "N/A"
- Total scale of 0 to 140 points (seven categories with four items per category, possible 20 points per item)

Report Feedback to Respondent:

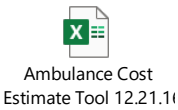
- We provide an overall score and a table with sub-scores by category listed high to low scoring for future progress measurement.
- We provide a link to the complete list of documents/resources categorized as above.
- We provide score-based feedback as follows:
    - Total Score 100-140: "You are well on your way to rural EMS agency transformation. Take a look at the following link (Wisconsin Attributes of a Successful Rural Ambulance Service and workbook) to verify the strength of your basic EMS operation, and the following reference (NAEMT transformation description) to make sure that all components of the transformation are on your radar. While you are making more progress than most, you may want to take a look at the documents and resources in the area you felt needed the most work (insert link to lowest sub-score category documents/resources list from file: **Documents-Resources Content for Core Competencies Webpages 3-31-19** {or lists if ties exist})."
    - Total Score 50-100: "You show strong signs of preparing for the rural EMS agency transformation. Take a look at the following link (Wisconsin Attributes of a Successful Rural Ambulance Service and workbook) to verify the strength of your basic EMS operation, and the following reference (NAEMT transformation description) to make

sure that all components of the transformation are on your radar. While you are making more progress than most, you may want to take a look at the documents and resources in the area(s) you felt needed the most work (insert link to lowest sub-scoring category documents/resources list from file: **Documents-Resources Content for Core Competencies Webpages 3-31-19** {or lists if ties exist}).”

- Total Score 0-50: “Congratulations on preparing for the rural EMS agency transformation. One of the first considerations in the transformation is to make sure that you have a strong basic EMS operation upon which to build other components. Take a look at the following link (Wisconsin Attributes of a Successful Rural Ambulance Service and workbook) to gauge the strength of your operation and shore up those which need addressing before or during the transformation you seek. You should also review the following reference (NAEMT transformation description) to make sure that all general components of the transformation are on your radar. You can take advantage of our other documents/resources (insert link to overall list from file: **Documents-Resources Content for Core Competencies Webpages 3-31-19**) and select those in the categories you scored lowest in or which otherwise seem the most useful.”
- Any ***Leadership*** score of less than 10 would result in a paragraph added to the above summary paragraphs, saying: “You scored yourself lower than the median (10 out of a possible 20 points) in the Leadership category. Since any transformation effort requires strong leadership commitment at the highest levels of the organization to be successfully implemented and sustained, we suggest you take a look first at the following resources (link to Leadership documents/resources list).”

Appendix E. Model Options Cost Estimator Tool

See attached “Ambulance Cost Estimate Tool”:



Candidates to serve on the Roads Advisory Committee

Bruce Haffner – Select Board Member

John Monroe – Road Commissioner Exofficio Member

Doug Merrill

Mike Ames

Patrick McGrath

Todd Snyder

Bill Pearse Jr.

Rick Bresnahan

Ed Crowley

Chris Pinchbeck

Ellie Goldberg