

South Dakota EMS Stakeholder Group Meetings
July 23, 2015
Summary of Meeting Activity

Emergency Medical Services (EMS) stakeholders from across South Dakota met again on July 23, 2015, in Pierre to continue the discussion on challenges facing EMS in South Dakota. This was the third of four meetings hosted by the South Dakota Department of Health, Office of Rural Health.

Stakeholders included ambulance service leaders, state legislators, representatives of state government, fire service leaders, hospital administrators, state EMS associations, and representatives from various other relevant organizations.

Participants were welcomed and again introduced themselves, as there were several new participants.

The meeting began with a review of the stakeholder committee's charge and its agreements for how it will operate.

The goals of this meeting were to:

- Review the group's work so far;
- Discuss and make recommendations concerning minimum staffing and hardship exemptions;
- Discuss the EMS program (review its current focus and operation) and how the program might best serve rural EMS in South Dakota; and
- Make plans for the final meeting.

Work so far:

In meeting one the group identified the following as issues they wanted to address: sustainability, EMS at the state level, funding for EMS, medical direction, advocacy, data and a few other miscellaneous topics. By far, the topics garnering the most attention were sustainability and EMS at the state level.

In meeting two the group identified the following preliminary recommendations:

- Implement programs, activities, and efforts to support EMS workforce recruitment and retention;
- Modify the hardship exemption program;
- Develop, educate and support EMS leaders through leadership and management education;
- Develop technical assistance opportunities for rural EMS agencies that assist communities in changing from unsustainable to sustainable models; and
- Consider different staffing models for both 911 response and interfacility transfers.

Discuss and make recommendations concerning minimum staffing and hardship exemptions:

The group reviewed the conversation that began at the last meeting about sustainability, minimum staffing and the hardship exemption program.

The conversation restarted with a review of the background of EMS nationally and how it developed as it relates to EMS staffing.

Facilitators presented information on a non-scientific poll of EMS leaders who participate on a national listserv. Of the respondents from 25 states, 23 of the 25 states reported minimum staffing for a Basic Life Support (BLS) unit as being one Emergency Medical Technician (EMT) and something less than an EMT. The “other than EMT” staff level varied from state to state. For example, some required just a driver, some a driver with emergency vehicle operations training, and some the certification of emergency medical responder.

The group reviewed responses to a survey that had been sent to all EMS agencies in South Dakota during the first three weeks of July. The survey sought opinions on the following questions:

- Should SD modify the minimum staffing requirement? (Currently two EMTs)
- Should SD change or eliminate the hardship exemption?

Fifty-eight (58) agencies responded representing a broad cross section of service sizes. Twenty-two (22) of the respondent agencies reporting having used the hardship exemption during the past 5 years.

Those using or having used the hardship exemption reported the following:

- 15 (68%) agencies reported that the exemption had improved their ability to respond to calls;
- 6 (27%) agencies reported that the exemption had improved their ability to recruit new EMTs or paramedics;
- 9 (40%) agencies reported that the exemption had increased community support for their service;
- 4 (18%) agencies reported that the exemption had helped them devise an effective plan for recruiting and keeping EMTs or paramedics;
- 4 (18%) agencies reported that the exemption had improved the quality of care they are able to deliver to patients; and
- 7 (32%) agencies reported that the exemption had not improved their situation, other than enabling them to be compliant with the laws.

All of the respondents reported the following opinions about minimum staffing:

- 56% agree or strongly agree that staffing minimums should be changed to one EMT and a driver and the hardship exemption should be eliminated (29% disagree and 15% are neutral);

- 40% disagree or strongly disagree that staffing minimums should remain two EMTs (30% agree and 30% are neutral);
- 43% agree or strongly agree that changing minimums to one EMT and a driver will significantly improve rural services' ability to recruit volunteers (28% disagree and 29% are neutral); and
- 41% agree or strongly agree that changing minimums to one EMT and a driver will significantly impact the quality of clinical care (26% disagree and 33% are neutral).

Forty agencies offered comments about minimum staffing. Below is a sample of comments.

- Patients should get quality care, not just the minimum.
- We simply do not have the people to be EMT's. Yet the people we do serve still need emergency health care.
- I do not feel that changing the minimums to an EMT and a driver will improve services. Communities will still continue to have issues with finding personnel that can drive the ambulance, take time off from other jobs to volunteer or work on an ambulance.
- Keeping the requirement at two EMTs per crew with no other way to run will cause a loss of ambulance services. That will put strain on other services to pick up the service to those areas.

The group moved into four small groups to discuss two main questions:

- Should South Dakota modify the minimum staffing requirements?
- Should South Dakota change or eliminate the hardship exemption?

After about 30 minutes people were asked to change groups while a recorder stayed at each table to ensure continuity of the discussion. After about an hour of discussion the groups reported the following:

Group 1's feedback

- Minimum staffing should be one EMT plus something less than an EMT (unsure what the requirements for the "less than an EMT" should be).
- Eliminate the hardship program.
- Should not be anything less than the minimum standard for staffing allowed.
- State should engage in service quality assurance monitoring.
- Consider a trauma level style system of designation for EMS that allows different staffing levels.
- State should monitor medical director who in turn monitors the ambulance service.

Group 2

- Minimum staffing should be one EMT and a trained emergency vehicle operator driver.
- Eliminate the hardship program.

- Consider developing an access critical system similar to the system in place for hospitals and nursing homes.

Group 3

- Minimum staffing should be one EMT plus something less than an EMT (unsure what the requirements for the “less than an EMT” should be).
- Eliminate the hardship program.
- State should modify the minimum staffing requirement.
- There should be some requirement around the “other” staff person.
- Have a transition time for new staffing requirement.

Group 4

- Minimum staffing should be one EMT and emergency vehicle operator trained driver.
- Eliminate the hardship program.

The consensus of the stakeholder group was to recommend to the Department of Health to change the minimum staffing requirements for ambulance services to be one EMT and something less than an EMT.

The group also recommended that the hardship exemption program be eliminated and no variance be allowed less than the minimum standard.

Currently the minimum staffing requirements are contained in South Dakota rule and law. The Department of Health will need to investigate what action would be required to implement a change to minimum staffing requirements.

Discuss the EMS program (review its current focus and operation) and how the program might best serve rural EMS in South Dakota:

The group next began a conversation around how the EMS program could help rural EMS in South Dakota. To facilitate the conversation both the EMS program and the Board of Medical and Osteopathic Examiners (BMOE) gave presentations to the stakeholder members on their unique role in regulating EMS in South Dakota. The EMS program focuses on BLS personnel and ambulance services while BMOE focuses on licensure and regulation of Advanced Life Support (ALS) personnel.

The stakeholder group broke into small groups to discuss and develop possible items to consider as recommendations. The following were suggested:

Group 1

- Uniform licensing process for basic and advance level providers;
- Streamline process for approving and monitoring education program;
- Do less regulatory functions and more technical assistance;

- Education and support for local medical directors;
- Statewide medical director;
- Use NEMSIS data; and
- Review current laws and review for needed adjustment.

Group 2

- Consolidate the functions of the BMOE and EMS program into one organization;
- Use NEMSIS data to drive statewide quality measures;
- Ensure NEMSIS data is collected and submitted;
- Statewide medical director;
- Background checks for EMS personnel;
- Increase public awareness and understanding of EMS through the EMS program office;
and
- EMS program staff not needed at opening and closing of classes, instead free up their time to do more technical assistance.

Group 3

- More leadership training and networking;
- Review and update state rules and laws;
- Develop standards for ensuring and measuring instructor performance;
- Develop quality measurement system; and
- Provide technical assistance services.

Group 4

- Support service and service medical director for quality functions;
- Qualifications and requirements for service medical directors;
- Review and update state rules and laws;
- Statewide definitions and rules and expectations for BLS and ALS services; and
- Qualifications for instructors.

Several large themes emerged. These were:

- Review and update of the rules and statutes governing EMS;
- Consider multiple ambulance license levels (BLS, ALS, etc.);
- The EMS program having more time to provide technical assistance to services;
- Consolidate the functions, now in two different agencies, into one single agency;
- Develop and implement statewide Quality Assurance (QA) measures;
- Implement a state medical director;
- Develop minimum expectations and qualifications for EMS educators;
- Continue leadership development and training;
- Streamline the EMS program role in EMS education/continuing education;
- Advocate for EMS (public awareness); and

- Background check for all EMS providers.

The group validated the themes and wanted the facilitators to organize them into recommendations.

Make plans for the final meeting:

For the final meeting the group will review its work and make final recommendations to the Department of Health.