South Dakota Community Meetings on EMS

South Dakota Office of Rural Health – EMS Program

October – December 2018
Background

• EMS Office within DOH prior to 2003
• 2003 to 2015 EMS Office within DPS
• 2015 Executive Reorganization to DOH
  – 2015 Summer Stakeholder Meetings
  – 10 Recommendations | 4 Topical Areas
    • Workforce
    • Quality
    • Infrastructure
    • Sustainability
  – All initial objectives met—many infinitely ongoing
Background

• Minimum Standards Legislation
• Emergency Medical Responder Legislation
• Scope of Practice—worked directly with SDMOE
  – BLS Administrative Rules-Complete | ALS-Future
  – BLS Guidelines Statewide
• ImageTrend ePCR Implementation
• Various other deliverables met
• EMS Program—Regulatory yet a “catch all”
EMS Leadership Classes

• Provided over the course of 5 years
• 4 levels of classes
• Assisted with the development of Leaders
• Club vs. Business Concept
  – Focused on EMS Service Directors
    • Many times employees themselves
    • Open, comfortable, welcoming, and
    • Safe area to vent and learn
• We were missing something? The Owners
Purpose of Community Meetings
Survey followed by 8 Regional Sessions

• Bring more awareness to EMS and its challenges
• Foster an ongoing conversation
• Present findings from survey
• Solicit input from community leaders and residents
• Provide an update
• Strengthen relationships
Who we are

• Marty Link, Director of EMS and Trauma, Assistant Administrator, Office of Rural Health
• John Becknell, PhD, SafeTech Solutions, LLP
EMS in Community Life

- Quality of life element
- Essential part of healthcare and life safety
- Out of view until needed
- Facing challenges in SD
- 2016 survey
- 2018 survey
South Dakota Community Leader EMS Survey 2018

Purpose

• Learn more about how EMS is understood & viewed by:
  + community members
  + city and county government officials
  + city and county employees
  + local community and business leaders

• Prepare for community meetings

• Deepen conversation and understanding between communities and Department of Health, Office of Rural Health and EMS Program
Survey Response

- 243 respondents
Key findings

• Staffing, funding and certification requirements
• 97% view EMS as an essential service
• 76% view their community as benefiting from learning more about EMS and sustainability
• 63% do not view the current staffing model as sustainable
• Estimating value of volunteer labor is difficult
• 40% view local service as having adequate numbers for safe and humane staffing
• 30% agree residents provide adequate financial resources
• 32% agree residents would subsidize or increase subsidies for EMS
• 13% agree that local EMS would be open to merging, consolidating or working with other regional EMS
• 30% aware of delayed or missed calls in past 2 years
Development of EMS in South Dakota

• Follows a national trend in 1966-1980s
• Development of EMS in South Dakota
  – Locally and organically
  – No mandate
  – No statewide planning
  – Resource deployment
  – Limited funding
  – Use of donated labor
Organizational structure

agency ownership

Municipal, township or county 48 (37%)
Not for profit 38 (29%)
Taxing district 11 (8%)
Private for profit 10 (8%)
Hospital 10 (8%)
Fire 6 (4%)
Joint powers authority 1 (1%)
Other (tribal, federal, unknown) 6 (5%)

Ownership / Structure of Agency

- Municipal, township or county: 37%
- Not for profit: 29%
- Taxing district: 8%
- Private for profit: 8%
- Hospital: 8%
- Fire: 4%
- Joint powers authority: 1%
- Other (tribal, federal, unknown): 5%
Populations served

46 agencies (36%) serve populations of 1,000 or less
85 agencies (65%) serve populations of 3,000 or less

Less than 500....................... 11 (9%)
500-1,000............................. 35 (27%)
1,001-3,000......................... 38 (29%)
3,001-5,000.......................... 13 (10%)
5,001-10,000....................... 11 (8%)
Greater than 10,000............. 22 (17%)
Approximate annual call volume

95 agencies (73%) have 500 or few calls per year

<table>
<thead>
<tr>
<th>Call Volume Range</th>
<th>Number (Percentage)</th>
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<tbody>
<tr>
<td>Less than 100</td>
<td>45 (35%)</td>
</tr>
<tr>
<td>100-200</td>
<td>28 (21%)</td>
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<tr>
<td>201-500</td>
<td>22 (17%)</td>
</tr>
<tr>
<td>501-1,000</td>
<td>11 (8%)</td>
</tr>
<tr>
<td>1,001-5,000</td>
<td>19 (15%)</td>
</tr>
<tr>
<td>Greater than 5,000</td>
<td>5 (4%)</td>
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Agency information
distance traveled to nearest hospital

74 agencies (57%) do not have hospital in their community
Of those agencies 52 travel more than 20 miles to a hospital
Agency information

level of clinical services

<table>
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<tr>
<th>Type</th>
<th>Response</th>
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<tbody>
<tr>
<td>Exclusively BLS</td>
<td>52 respondents (40%)</td>
</tr>
<tr>
<td>Both BLS and ALS</td>
<td>56 respondents (43%)</td>
</tr>
<tr>
<td>Primarily ALS</td>
<td>22 respondents (17%)</td>
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</tbody>
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Level of Clinical Services Provided

- Exclusively BLS: 40%
- Both BLS and ALS: 43%
- Primarily ALS: 17%
Agency staffing

95 agencies (73%) utilize volunteer labor

How Agency is Staffed

- Predominantly volunteer: 78 (60%)
- Mixture of volunteers and paid staff: 17 (13%)
- All paid staff: 35 (27%)
Numbers on rosters

73 agencies (56%) have 15 or less on roster

10 or less 31 (24%)
11-15 42 (32%)
16-30 36 (28%)
31-40 6 (5%)
Greater than 40 14 (11%)
Active on rosters

62 agencies (48%) have 10 or less on their roster

<table>
<thead>
<tr>
<th>Number of Active Members on Roster</th>
<th>Count</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>10 or less</td>
<td>62</td>
<td>48%</td>
</tr>
<tr>
<td>11-15</td>
<td>34</td>
<td>26%</td>
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<tr>
<td>16-30</td>
<td>21</td>
<td>16%</td>
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<tr>
<td>31-40</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Greater than 40</td>
<td>9</td>
<td>7%</td>
</tr>
</tbody>
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Number of Active Members on Roster

- 10 or less: 48%
- 11-15: 26%
- 16-30: 16%
- 31-40: 3%
- Greater than 40: 7%
Missed or delayed calls
missed or delayed calls in 2015-2016
(only volunteer agencies)

Missed calls due to lack of staff availability

- YES 29 (32%)
- NO 62 (68%)

Delayed response due to staff availability

- YES 26 (29%)
- NO 65 (71%)
Decline of volunteerism

- Economic changes
- Social/community changes
- Generational change
- Demands of role and work
- Regionalization of healthcare
Approximate annual cost

- $443,176 for one 24/7 staffed EMS unit
  - $70,000 (Vehicle, facility, equipment, supplies, fuel, insurance, etc.)
  - $373,176 for labor 2 workers 24/7 (based on 2017 value of volunteer hour in South Dakota $21.30 from BLS and Independent Sector)
Funding for EMS in South Dakota

• Transportation fees – private insurance, Medicare, Medicaid
  – Approximate BLS charge $750
  – Approximate ALS charge $1,200
• Subsidy of volunteer labor
• Tax subsidy
• Financial donations and equipment donations
The future

• Reliable, sustainable, quality
• Local pride and independence
• Sustaining volunteerism as long as possible
• Knowing when change is needed
• Preparing for EMS 2.0 in South Dakota
• Visioning project
• Local preparation
ImageTrend ePCR

• Data use
  – Opioid and Naloxone Use
  – Attempted Suicides
  – Chute Times
  – Injury Prevention

• Data Accuracy
  – Narrative vs. medication/procedures
  – Karen--NEMSIS
Upcoming Events

• 1 Day Leadership Retreats
• Tribal Summit
• Community Leader Brochure
• County Assessment
• License Management System
• Naloxone
• Helmsley Trust Initiative