Rural and Frontier Emergency Medical Services Agenda for the Future:

A Service Chief's Guide to Create Community Support of Excellence in EMS

Rural and Frontier EMS Agenda for the Future:

A Service Chief's Guide to Creating Community Support of Excellence in EMS

U.S. Department of Health and Human Services

Health Resources and Services Administration

Office of Rural Health Policy

This document was prepared under HRSA contract # 250-03-0022, U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy.

Contents

Foreword v

Introduction...1

What is the Rural and Frontier EMS Agenda for the Future? 1

Community Assessment and Planning...5

Introduction and Background 5

Key Recommendations from the *Rural & Frontier EMS Agenda for the Future* 6

Specific Tasks 6

Integration and Regionalization...7

Introduction and Background 7

Key Recommendations from the *Rural & Frontier EMS Agenda for the Future* 9

Specific Tasks 10

Quality and Performance Improvement..11

Introduction and Background 11

Resources for Quality Improvement Project Development......................................13

Key Recommendations from the *Rural & Frontier EMS Agenda for the Future* 14

Specific Tasks 14

Conclusion 15

Contact Us:...16

APPENDIX A: About the *Rural & Frontier EMS Agenda for the Future*............................17

APPENDIX B: REMSTTAC Stakeholders 19

Foreword

The Rural and Frontier EMS Agenda for the Future, published in 2004, was a landmark document that focused attention on the issues specific to the survival and improvement of EMS in rural America. Much of what is included in the document is aimed at policy makers at various levels of government. However, it also contains many practical ideas and concepts that can, and should, be implemented at the local EMS agency level.

This serves as a companion document to the report and identifies some of the tasks that can be started in almost any rural and frontier EMS agency. We recognize that taking on additional tasks as a volunteer overseeing a rural agency may seem impossible. However, the action items listed in each section are, in most cases, small steps that can be accomplished over time.

We hope that each of you will choose at least one of these tasks to tackle in your community. By completing these activities you will make a difference to your agency, your community and your patients.

Marcia K. Brand, Ph.D.
Associate Administrator for Rural Health,
HRSA

Nels D. Sanddal, Director
Rural Emergency Medical Services and
Trauma Technical Assistance Center

***Rural and Frontier EMS Agenda for the Future*: A Service Chief's Guide to Creating Community Support of Excellence in EMS**

INTRODUCTION

"Rural America is unique and requires unique solutions."
-David Sniff, National Rural Health Association

Ensuring access to high-quality EMS services is growing more and more difficult for EMS ambulance agencies in rural areas around the country. Many rural EMS agencies are finding that it is:

- challenging to understand and successfully respond to changing reimbursement policies, regulation, and community needs,
- hard to recruit and retain quality staff (paid or volunteer),
- complicated to keep up with changing technology,
- challenging to meet the needs of an increasingly elderly population, and
- difficult to "make ends meet" financially.

In order to succeed in the future, rural EMS agencies must galvanize community support, develop strong partnerships and collaboration, and utilize new systems to measure performance and enhance quality. Achieving any of these goals is difficult; succeeding in all three areas seems like an overwhelming task. However, there are resources to help rural EMS agencies address these challenges. One such resource is *the recently published report, the Rural and Frontier EMS Agenda for the Future. This guide summarizes some of the key elements of the Rural and Frontier EMS Agenda for the Future,* and describes the changing health care environment so that rural EMS services can best position themselves to succeed in the future.

What is the *Rural and Frontier EMS Agenda for the Future*?

The Rural and Frontier EMS Agenda for the Future is a 2004 report that describes an optimal future for rural EMS and describes changes that would be required for rural EMS to achieve that vision. Several associations worked together to complete the report and invited hundreds of EMS professionals and other interested people to submit comments regarding the current rural EMS system, and to suggest important systems changes that must occur for rural EMS to remain viable.

The partner organizations that decided to undertake the project were the National Association of State EMS Officials, the National Organization of State Offices of Rural Health, and the National Rural Health Association. With funding from the U.S. Department of Health and Human Services Health Resources and Services Administration, Office of Rural Health Policy, these organizations set up a Web site to accept comments from any interested parties and also sponsored a 1-day meeting that was attended by over 100 individuals who represented ambulance services, other health care providers, and numerous associations and government agencies. A final report was

published in October of 2004 (read more about the development of the "Agenda" Appendix A).
The partners had several purposes when they decided to undertake this project. First, they wanted to lay out a policy agenda for political leaders and rural EMS advocates. They wanted to provide guidance to influence policy makers whose decisions can have an impact on the future of rural EMS. However, the partners also believed that the *Rural and Frontier EMS Agenda for the Future* could serve as a guide for local and State EMS agencies, and their communities, in developing realistic plans for the future based on available resources. Ultimately, sound local decision-making will ensure the ongoing success of EMS in any community. With that in mind, A Service Chief's Guide to Creating Community Support of Excellence serves as a companion document to the *Rural and Frontier EMS Agenda for the Future* and is created specifically to provide information, tools and resources to rural EMS leaders and their partners. Specifically, this guide will help EMS agencies address issues around the topics of:

1) *Community Assessment and Planning.* A deliberate planning process involving broad representation from the community (including representatives of health care, education, public safety, business, government, citizen consumers, and other "stakeholders") should be used to guide system decisions in rural communities. EMS is generally poorly understood in rural areas. EMS agencies cannot afford to plan for the future without involving the community (which should help develop community support). The planning process should examine at the current situation, a "visioning" process to describe what the community would like EMS to become in the future, and an honest dialogue regarding the type of system the community is willing to support in the long term. Most rural and frontier EMS systems are currently under-funded. Expansion and upgrading of existing systems without solidifying community commitment to funding could result in deeper financial hardships.

2) *Integration and regionalization.* Historically, these words have had a negative flavor in rural areas, but it is important that rural EMS providers embrace these concepts. Integration does not mean that a local EMS system has to become a part of a larger organization and lose its independence. But in today's environment, EMS must collaborate closely with local health care systems, public health, and public safety. EMS agencies may also want to form closer connections with other "sectors" in the community. Regionally, EMS needs to think about its role in the continuum of health care delivery. Centers for Medicare and Medicaid Services and other Federal agencies have already begun demonstration programs to base reimbursement on quality. In rural areas, measures that demonstrate quality across the entire spectrum of care, including EMS, will be selected for "pay for performance" systems in the coming years. This includes such things as participation in programs that improve outcomes for such issues as trauma, cardiac, burns, and stroke. Being part of an organized and pre-planned system has measurable benefits to those in need of services.

3) *Quality and Performance Improvement.* As mentioned above, Medicare and other payors/purchasers of health care services are moving toward systems where payment is based, in part, on performance in accordance with standardized quality measures. Regulators may follow the trend in years to come, by requiring that regulated agencies demonstrate that quality improvement systems are in place. Patients deserve to be treated by organizations that are committed to reducing errors and providing the highest possible quality services. Quality Improvement and Performance Improvement (QI/PI) systems are dependent on processes to gather and analyze data and methods to use this information to improve systems performance.

This guide provides information about existing resources and tools that are available to local EMS leaders who undertake community planning and establish strong QI/PI efforts. The information is designed to help keep rural EMS services viable next year and well into the future. To survive, however, there is another important role for rural EMS, and that is the role of advocacy. An unfortunate byproduct of the lack of understanding of rural EMS is that oftentimes it is overlooked when policy decisions are made, or poor policy decisions are made on behalf of rural services. It is important that rural EMS be a strong and vocal advocate, and to educate the general public and policy makers at a local, State, and national level about the importance of a quality EMS system in rural areas. In this guide you will find information that will help you, as a local EMS leader, use strategies and techniques to advocate on behalf of your system.

The remainder of this guide is broken into the three general focus areas summarized above: community assessment and planning, integration and regionalization, and quality and performance improvement. Each of the three sections is further broken down into three discrete parts, an <u>introduction and background</u> statement, a list of specific <u>key associated recommendations</u> from the *Rural and Frontier EMS Agenda for the Future* that support the section, and a brief list of <u>specific action items</u> that might be implemented to move a rural EMS system closer to the attainment of at least some of *Rural and Frontier EMS Agenda for the Future's* recommendations. Many rural EMS agencies will have already completed some of the tasks. Target those tasks and activities that make the most sense for your service. There is also a brief guide to advocacy at the end of this document. Advocacy is the word used to describe involvement of an agency in the political process. To be successful you have to do more than simply go about your business and provide good service; it is also imperative that you work with decision-makers to help them understand rural EMS needs and issues. This advocacy guide will provide some ideas about ways to get involved in the political process (see Appendix B). That process may seem intimidating or even mysterious to some. If you are among those, don't worry. This guide will take away some of that mystery and show you some simple ways to get involved, and help position your service for success.

COMMUNITY ASSESSMENT AND PLANNING

Introduction and Background

> "…Despite the last 30 years of experience and intense media profile, EMS remains mostly a mystery to the public. They know we will show up when they call 9-1-1, but the public knows very little about who we are, how we are organized and funded, and quality in the system." – Tom Judge, CCT-P, Executive Director, LifeFlight of Maine

Comprehensive advanced life support (ALS) services are difficult to establish and maintain in systems with low call volumes, because of the high fixed costs associated with ALS services and the challenge of being able to recruit, retain, and adequately reimburse highly-trained paramedics. As a result, the more remote a rural area, the less likely one is to find advanced life support (ALS) levels of EMS available in that area. However, even in rural areas many residents may expect that ALS care is readily available. In areas where EMS is heavily dependent on volunteers, and services are limited to basic life support (BLS), the general public may be surprised to learn that paramedic care is unavailable.

In rural areas, many of which have a limited (and perhaps shrinking) resource base, community support of EMS should not be taken for granted. If EMS is to sustain community support, it is critical that the community understand the challenges EMS faces. Rather than shying away from community scrutiny, EMS should help communities accurately understand the services they provide, other service options that exist, and the cost of the options. This education needs to start at a basic level. Indeed, many people outside of health care do not even realize that different types of EMTs (basic, intermediate, and paramedic) exist. The community needs to understand the costs of maintaining EMS in both financial and human resources so they can make an informed decision about the level of service that is possible. Rural EMS services should promote a community-based EMS assessment and planning process and encourage community decision makers to determine the type and level of EMS they desire and the means to fund the system. You need to ask, "How can we add value to our present system?"

A number of community EMS assessment and planning programs have been developed for rural areas in the United States. Two State EMS offices have developed community technical assistance team processes, and in these States expert teams visit communities to assist in the process of community assessment. Another process was developed by a not-for-profit agency with funding support from the Federal Office of Rural Health Policy. The Critical Illness and Trauma Foundation (Bozeman, Montana) offers their "EMS Community Planning and Integration Guide" online at http://www.citmt.org/Training.htm#Community%20Planning. This process includes a system self-assessment as well as perception surveys conducted with a variety of community sectors (health care, public safety, school system, media, government, etc.). Regardless of the approach you decide on, you will probably need some outside help. Your EMS Office, State Office of Rural Health or the Rural EMS and Trauma Technical

Assistance Center (REMSTTAC) may be able to help you find resources to provide assistance with the assessment process.

Key Recommendations from the *Rural & Frontier EMS Agenda for the Future*

- Develop a national template for community EMS system assessment and informed self-determination processes to help communities determine and be accountable for their own EMS type, level, and investment (Ch. 8).
- Fund processes for community EMS system assessment and informed self-determination. Consider regional and statewide resources (e.g. aeromedical services) in implementing these processes (Ch. 8).
- Foster the development of a culture of volunteerism and community service through local schools in partnership with community agencies (Ch. 5).
- A national EMS service leadership and service management training model should be developed and shared with all State, territorial and tribal governments. This model should include successful practices in EMS volunteer and paid human resources management (Ch. 5).
- Conduct an ongoing assessment by rural/frontier EMS agencies and local hospitals of their resources and needs and search for common educational opportunities (Ch. 7).
- Emphasize optimal interdisciplinary care of the ill or injured patient, including complex event management such as cardiac arrest and multiple casualty incidents (Ch. 7).

Specific Tasks

1. Establish a local planning group that consists of EMS stakeholders, local political/policy leaders, medical community leaders, and public health leaders to develop an EMS system development plan at the community level. This group can become the catalyst for the implementation of a focused effort to identify future directions in the development of your local EMS system. You may want to choose a facilitator for this group. Oftentimes you can find trained facilitators in your area. County extension agents are often a good resource for this activity, particularly if they utilize the tools available through REMSTTAC.

2. Ensure that your agency is represented at regional and statewide activities in EMS system development. This would include attending key meetings, monitoring Internet information resources such as list serves, and maintaining an awareness of opportunities that may be helpful to your local efforts in EMS development and planning.

3. Assign individual liaisons to key partners in the local EMS system. The liaisons should be responsible for developing relationships with those components of the community that can support your EMS mission. By having these liaison relationships in place, your partners can learn more about the needs of EMS as well as giving EMS providers an opportunity to understand the web of relationships necessary to support health care in rural communities.

INTEGRATION AND REGIONALIZATION

Introduction and Background

> "Rural and frontier EMS providers must be well integrated with their public safety partners in this era of domestic preparedness in order to operate more effectively in disaster situations. But EMS providers must learn to integrate as well with community health, medical, and nursing partners if they are to bring the level and type of care to the community that it expects and are to continue to operate at all. Our survival depends upon it." – Kevin McGinnis, MPS, WEMT-P, Program Advisor, National Association of State EMS Officials and Crew Chief, Winthrop Ambulance Service (Maine)

In many rural areas populations are aging. Older populations mean that the need for all types of health care services increases. However, at the same time many rural communities are finding it hard to maintain current health care services because of declining rates of reimbursement, challenges in recruiting and retaining health care professionals, and a declining tax base as a result of shrinking population. As other resources dwindle, communities may increasingly call on EMS providers not only for traditional emergency services but also for a range of informal care, evaluation, and advice. These services are often provided in "no transport" situations, which may be the reason that isolated communities often have "no transport" rates much higher than the State average. These locally developed solutions to fill a gap in the community's health needs have been called "EMS-based community health services" or "community paramedicine." In some cases these "no transport models" of care may impose additional burden on rural and frontier EMS systems due to loss of revenue. In other cases such care models may provide opportunities to bolster human resources by establishing paid positions at local hospitals.

How can rural EMS respond to this growing demand for both traditional and non-traditional EMS services? Many experts believe the key to rural EMS' survival and success will depend on the ability of EMS providers to successfully link with partners including nearby EMS providers, local public safety, and especially the health care system.

EMS should be able to draw upon fire department, emergency management, law enforcement, and public works resources (as well as resources from nearby EMS) as needed, based on the presence of mutual aid agreements. If such agreements are not in place, EMS agencies should contact their State Bioterrorism Hospital Preparedness Program (BHPP) or their Department of Emergency Management for assistance. Each State has a BHPP, funded through the Health Resources and Services Administration, and each State program is tasked with providing technical assistance to local EMS to develop such mutual aid agreements. Information is available at http://www.hrsa.gov/bioterrorism/.

Rural and frontier EMS should also work closely with medical oversight to ensure that they are part of teams representing the continuum of care to enhance triage, transport and treatment decisions that make effective use of local resources and ensure a disposition in the patient's best interest. Many States have State trauma programs and within those programs, regional trauma teams or councils exist that work to enhance trauma care in their regions. Other local and State teams are working to enhance the continuum of care for stroke, heart attack, and other acute medical conditions that require emergency treatment. Sources of information on these programs are State Quality Improvement Organizations (http://www.cms.hhs.gov/QualityImprovementOrgs/) or State FLEX programs (http://tasc.ruralhealth.hrsa.gov/). Strong medical oversight is a key part of the development of such initiatives. However, little formal training exists for rural practitioners who are often trained in family practice or general internal medicine, to become well versed in providing medical direction for EMS. Currently, a collaboration led by the Critical Illness and Trauma Foundation is migrating the NHTSA medical director training program to an interactive Web-based format (http://www.citmt.org/training.htm).

Regional approaches to consider are many. The most common regional cooperatives are Quality Improvement-based systems. In Kansas, the State FLEX program has funded the development of three such regional QI initiatives. In each case, a regional EMS provider has worked with smaller EMS agencies in the area to develop a common run form and to collect and analyze run form data from these agencies. The regional agency then brings all participating EMS units together on a regular basis to share information, explore best practices in care among the sharing agencies, and promote adoption of these best practices region-wide. EMS should involve emergency department and other hospital personnel in this process, as they may have valuable insight into the quality of care based on their observations of EMS when they arrive with a transported patient. In some cases EMS services have partnered with local physicians, and together they have worked with specialists in regional referral centers to develop standard protocols among the specialists in the referral centers.

EMS agencies in a region may also wish to form a collaboration to pursue a joint purchasing arrangement that will allow them to purchase equipment and supplies at lower prices, and to rotate stock regionally to ensure that supplies do not have to be discarded due to non-use prior to expiration dates. One example of such a buying co-op is the North Central EMS Cooperative (NCEMC), another network: the Western EMS Network (WEMSN) is forming to similarly serve western States. State EMS offices (www.nasemso.org) and State Offices of Rural Health (www.nosorh.org) are places to search for information on such programs.

Formalized agreements between nearby EMS services may also allow the integration of paid staff into units that have essentially relied on volunteer service. It may seem like a stretch for small basic life support (BLS) units to consider moving to a model that includes paid staff. However, the nature of volunteerism is changing in rural America. It is becoming more difficult to recruit young volunteers who themselves are willing to spend time away from their jobs, families, and other pursuits to volunteer for the

demanding job of EMT. Finding volunteer staff to work during standard business hours can prove very difficult, as employers can be reticent to allow employees to leave work when they realize that long transports to a distant medical center may mean that an employee is away from the job for hours at a time. There are examples of services that have brought paid staff into their organizations and created ALS systems in environments that historically were based on BLS services. However, this usually entails integration of several local EMS units, a political and operational process that is, admittedly, very difficult to achieve. We are not suggesting that an ALS system is needed in each area. That decision should be part of the community planning process described in the first section and supported by historical EMS response data. A well-trained BLS system with strong relationships to area health care organizations may be the right solution for many rural areas, but even these systems will likely need to move toward a model with paid staff.

This goal might also be accomplished through integration of EMS and a local hospital, another process that might sound intimidating...to both sides! Different cultures among EMS and hospitals has often meant that there is an important, yet uneasy, relationship between the two. However, integration can have important benefits. Integration may be defined as close collaboration or sharing of resources. Integration can provide services access to new resources. Integration provides EMTs the chance to work in other prehospital and in-hospital settings. Another potential benefit is the chance to generate new revenues for the ambulance service. For example, some EMS units owned and operated by Critical Access Hospitals receive cost-based reimbursement for Medicare and Medicaid patients. Analyses have shown that cost-based reimbursement for emergency services can result in significant additional Medicare and Medicaid revenue. For more information about cost-based reimbursement, contact your State FLEX program. State program contacts for the FLEX program can be found at http://tasc.ruralhealth.hrsa.gov/.

Key Recommendations from the *Rural & Frontier EMS Agenda for the Future*

- Encourage EMS-based community health service program development through the funding of pilots, cataloguing of existing successful practices, exploration of opportunities for expanded EMS scopes of practice, and ongoing reimbursement for the provision of such services (Ch. 1)
- Federal, State, and local programs addressing all-hazards planning, and addressing the specific needs of special rural populations, should include EMS as a categorical component. Statewide and border State networks of formal regional EMS mutual aid agreements, including EMS licensee recognition, should be established (Ch. 1).
- The Indian Health Service should integrate tribal EMS-based community health service and Community Health Representative programming, and consider the use of both tribal and non-tribal sources of care (Ch. 1).
- Facilitate the use of subscription services as a part of the overall funding of the EMS safety net infrastructure, in cooperation with State insurance authorities (Ch. 4).

- Form, and fund through county, regional, State, or Federal tax dollars, rural/frontier EMS operational or service contracting networks in those areas where they provide economies of scale, improved access to EMS care, improved quality and/or increased tax payer value (Ch. 4).
- Implement EMS based community health programs and services through an interdisciplinary approach involving EMS operational and medical oversight components and primary care professionals (Ch. 6)
- Development of State/regional stockpiling, and sharing of expensive training devices such as mannequins and patient simulators (Ch. 7).
- Among local, State, Federal, and national EMS and public health agencies (and other agencies with prevention roles), cooperatively develop and fund community health advocacy roles and prevention programs for rural/frontier EMS personnel that are mutually beneficial (Ch. 9).
- Provide formal Emergency Medical Dispatch to every caller seeking EMS (Ch. 10).
- States should establish formal plans for roadside call-box, satellite, and/or cellular networks to effectively cover all rural/frontier primary roads (Ch. 10).
- EMS leaders should continue to develop ongoing paths of communication with State and Federal telecommunications interoperability and Intelligent Transportation Systems industry planning entities (Ch. 11).
- EMS-based community health services pilots and programs should have a physician supervised evaluation system (Ch. 14).

Specific Tasks

1. Review and update existing mutual aid agreements with neighboring services. Consider including "administrative/planning" mutual aid in these agreements that will institutionalize an expectation of routine communication with neighboring services and institutions. By developing a culture of cooperation and communication, agencies concerned with providing health care in rural communities can develop into strong regional consortiums.

2. Identify specific needs and opportunities within your own agency and look for resources outside of your agency that may be able to provide resources to address these needs. Approach these agencies and ask for their input and assistance. This can become the basis upon which strong regional relationships can be built. In most communities, resources exist that aren't used due to the fact that someone just never asked. Be the one to ask!

3. Invite local elected officials and policy makers to attend your organization's meetings on a regular basis. Seek opportunities to provide reports of your ongoing activities and needs at county commission meetings, local service organizations, etc.

QUALITY AND PERFORMANCE IMPROVEMENT

Introduction and Background

> You have to remind yourself sometimes….your arrival at the end of the driveway is a significant event in the lives of those who call for help. It is not just another call. It is a moment likely to be incorporated into family lore as "the day the ambulance came."
>
> You try to act accordingly. To meet the expectations. To simply – *help*. You won't always live up to the hype. "What we're going to do…" I was saying, when the woman on the couch interrupted me.
>
> "Oh, I know," she said, "I've seen *Paramedics* [TV show]." This is like telling your Little Leaguer you expect him to yank a Randy Johnson fastball over the left-field wall. We are basic-level emergency medical technicians. We have skills, but they are *basic*. We can't always match what you see on TV….- from *Population 485*, by Michael Perry (writer and volunteer firefighter/EMT)

It is true that public expectations of EMS are high. Often times in rural areas, the expectations may be unrealistic. But EMS providers, whether individual prehospital care providers (EMT-B, EMT-I, EMT-P) or the service providers themselves, are all interested in meeting expectations, and in helping to the best of their abilities. Also, it must be stated that high quality prehospital care does not relate to the level of care provided (ALS & BLS). Basic life support services can provide high quality care. EMS providers do strive to continuously improve the quality of services they provide to their patients and to enhance their overall system performance. It is central to the mission of EMS to provide the best care possible. However, traditional methods used within health care and sometimes in EMS to enhance quality (often referred to as "quality assurance") are limited in their ability to truly make advances in improving the quality of services delivered. It is thus important for EMS to begin to adopt new methods to enhance quality. It is something patients will expect and demand, and in the future, the ability of EMS providers to document the quality of care they provide may influence their levels of reimbursement. Purchasers of care, like the Medicare program, have already begun basing payments to some types of health care providers on the basis of "pay for performance." In such systems, providers must demonstrate their involvement in Quality Improvement (QI) efforts, or even demonstrate actual improvement in quality on the basis of some predefined set of measures.

QI systems can be simple or complex. If your system is just beginning a QI program, start simple. Determine several areas where you believe your system could show improvement. Select a clinical area, and perhaps also a non-clinical area (form completion, recruitment progress, billing efficiency, etc.) and discuss the issue. First, discuss how you can measure the issue. If you want to improve some aspect of timeliness, for example, describe how you can measure the current "baseline" level of

performance and how you can measure improvement. Then, set a target for performance that describes how much you want to improve. For instance, you might want to improve the time from when a dispatch call is received to when the ambulance leaves the station. If it currently takes 20 minutes and you think that could be improved, set a target for improvement, such as: "We will decrease the time from dispatch call to time the ambulance leaves the station by 30%". Your goal would be to have a 16-minute response time. You then have to make plans on how you can improve your performance to reach your goal. Perhaps you have read about a process another ambulance service used to improve their response time, and you decide to try that approach. Or you could simply ask other area ambulance services for ideas.

One way to generate these ideas is by creating a "benchmarking" system. This is accomplished when a group of health care providers agree to share information through a systematic process so that everyone in the group can see who does something particularly well. The group of providers agrees to measure the same process, and to share the resulting data amongst themselves. Providers that may be struggling with a particular activity can ask those services that seem to be doing well for advice and assistance, thus allowing everyone to benefit from this mutual effort. Several State Flex programs have used Federal funding to support the development of benchmarking systems. In Kansas, for instance, the Flex program provided start-up grants to three groups of ambulance services that came together to do benchmarking. In each instance, one ambulance service took the lead in discussions among a number of area EMS providers about creating a common run form, focusing on certain elements that were measured by the run form, and sharing the information among one another through reports and monthly meetings when the services got together to share lessons learned and "best practices." These networks also provided computers to each ambulance service so that they could enter the data into a computer, which made the comparisons among the services easier to accomplish.

Another place to get ideas on performance improvement is from hospitals where you transport patients. Have you ever sought input from Emergency Department staff in the hospitals where you transport? They might be a valuable source of information. State Rural Hospital Flexibility Program (FLEX) programs are encouraged to support this type of integration and collaboration, so you should contact your State FLEX program to see if they may have resources or assistance that could help you develop this type of process.

Of course, once a service has gathered ideas on ways to improve a process, they should implement those changes. It is ideal to implement one change at a time so you can measure the impact of the change. Implement one change and then continue to evaluate the issue, and after 1 or 2 months determine if the change made a difference. If it did, you might be satisfied with that and move on to look at other measures. Or perhaps you are still not satisfied and think you could enhance performance even more. Perhaps you institute another change and once again measure progress in that area of concern.

Don't continue to evaluate the same parts of your service forever. Choose one or two areas and show that you can make improvements. Then move on to another area. Put together teams that can oversee the process. These teams can include internal staff, but

as we discussed above, consider other resources – other ambulance services, hospital personnel, perhaps even community members (who represent the patient perspective). Of course, it is critical to involve the service medical director in this process.

Resources for QI Project Development

Of course, taking on QI projects takes time and resources. You may feel you don't have sufficient staff to take on this added responsibility. If that is the case, please realize there are many resources available to help you move forward. As mentioned before, FLEX programs often have (or are aware of) resources that can help develop these projects. There are also organizations in each State, funded by the Medicare program, to help health care providers develop QI programs. These organizations are known as Quality Improvement Organizations, or QIOs (find your QIO online at http://www.cms.hhs.gov/QualityImprovementOrgs/). Each State QIO is different, so your QIO may, or may not, have resources that are pertinent to EMS.

You may also be able to identify volunteers within your communities who can help. A great recruiting tool is to provide opportunities for area youth to learn about EMS. Would you consider asking the local high school if they would like to offer an internship(s) to a student to help your service develop a QI program? Approaching a larger ambulance service in the area to see if they would be interested in helping with program development is another way to not only establish a QI program, but promote cooperation and regionalization as well.

Many hospitals have well developed QI programs. Do you believe an area hospital might be willing to help you? You might find assistance from a small local hospital, or perhaps a tertiary facility further away. You may feel that you don't have a good working relationship with these facilities, but we urge you to take the step, to start talking with these hospitals. Caring for patients who arrive through the ER is of critical importance to hospitals, and they are very interested in working to ensure that the continuity of care from one provider to the next is as good as it can be. Your area hospitals, if they are like most, will be happy to begin talking with you about creating joint QI opportunities. For instance, a collaboration between area EMS, community hospitals and cardiac specialists in a referral center might come together to help determine how to improve the entire continuum of care for a heart attack patient who lives in your community, from the time he/she places a 9-1-1 call to the time they receive treatment in the tertiary facility. A project of this type was initiated by the Minneapolis Heart Hospital. Working with community ER physicians and area EMS providers, they were able to improve system "hand offs" and communication and significantly reduce the amount of time it took to get transported patients onto the operating table for life-saving angioplasty.

Key Recommendations from the *Rural & Frontier EMS Agenda for the Future*

- Make data that are collected through information systems at State and Federal levels available for community based assessment and research, and provide tools to promote community-based research (Ch. 2).
- Compensate EMS medical directors for the EMS medical oversight services that are provided. The level of compensation should be equivalent to the level of compensation the physician would experience (for the equivalent hours) in their normal clinical practice (Ch. 6).
- Require that EMS medical directors be physicians, but encourage the use of physician extenders and regionalized arrangements of medical oversight to increase the EMS medical oversight resources in rural/frontier areas (Ch. 6).
- EMS medical directors must actively participate in local, regional, and State EMS program planning and implementation. States must seek out and include rural/frontier medical directors for these purposes (Ch. 6).
- Encourage EMS-based community health service program development through the funding of pilots, cataloguing of existing successful practices, exploration of opportunities for expanded EMS scopes of practice, and ongoing reimbursement for the provision of such services (Ch. 1).
- Implement EMS-based community health programs and services through an interdisciplinary approach involving EMS operational and medical oversight components and primary care professionals (Ch. 6).
- EMS-based community health services pilots and programs should have a physician supervised evaluation system (Ch. 14).
- Fund the availability of training and tool kits to encourage effective local service/system quality improvement processes (Ch. 14).
- Implement and maintain a local EMS information system at every local EMS service/agency. Maintain data on every EMS event in a manner that is timely and able to drive the quality of the EMS system service and patient care delivery (Ch. 13).
- As needed, share costs and resources required to implement and maintain an EMS information system among multiple systems to achieve an economy of scale (Ch. 13).
- EMS systems must provide analyzed and descriptive information on service and patient care delivery that they provide to their EMS personnel, administration, and community (Ch. 13).
- EMS-based community health services pilots and programs should have a physician supervised evaluation system (Ch. 14).

Specific Tasks

1. Contact your State/regional EMS office to locate data collection resources that may already be available to your agency. Many States are working to establish and enhance their statewide data collection systems and resources may be readily available that can provide an appropriate capability for your agency.

2. Consider developing a relationship with the local high school or community college to gain assistance in developing a data gathering system that works for your community and area providers. Many institutions of this nature look for opportunities to place students in "real life" situations and provide local technical assistance in the development of data collection systems.

3. Develop a "quality improvement" team within your service to identify areas of potential improvement in both patient care and administrative areas of service. Empower the team to look into all aspects of service operation and develop a plan to implement a quality improvement plan of action.

We hope that you have found this document useful and practical. Hopefully, it has stimulated your thinking about how your service might be improved or solidified, how you might better engage the public or how you might work with other agencies. We look forward to receiving your comments and thoughts on how we might improve this document in subsequent editions.

Contact REMSTTAC:

Thank you for using the ***Rural and Frontier EMS Agenda for the Future*****: A Service Chief's Guide to Create Community Support of Excellence in EMS**. We're interested in your feedback on the use and utility of this product. If you have comments or suggestions for improvement, please contact us at:

Health Resources and Services Administration, Office of Rural Health Policy
5600 Fishers Lane, Room 9A-55
Rockville, MD 20857
Phone 301-443-0835
Fax 301-443-2803
http://ruralhealth.hrsa.gov/

REMSTTAC
300 North Willson Avenue
Suite 802-H
Bozeman, MT 59715
Phone 406-587-6370
Toll Free 866-587-6370
Fax 406-585-2741
info@remsttac.org
http://www.ruralhealth.hrsa.gov/ruralems

APPENDIX A: ABOUT THE *Rural and Frontier EMS Agenda for the Future*

In 1996 the National Highway Traffic Safety Administration brought together a broad set of experts and advocates to create the *EMS Agenda for the Future.* This document was supposed to set out a broad vision for the future of EMS. However, because rural America presents such a unique set of challenges to the provision of Emergency Medical Services, the National Rural Health Association, the National Association of State EMS Directors, the National Organization of State Offices of Rural Health and the Federal Office of Rural Health Policy came together in 2003 and 2004 to target the national goals outlined in this report that were most critical to rural communities. These partner organizations were responsible for the publication of the *Rural and Frontier EMS Agenda for the Future*.

Their goal was to inspire and inform a number of different audiences. For rural advocates it was to serve as a policy blueprint for the future. For political leaders, it was designed to outline what needs to be done, and what needs to be funded, to ensure that quality EMS care is available in even the most remote, frontier communities. And for rural communities nationwide, the partners hoped that the new document would serve as a tool for what communities could do with available resources and how they could plan to sustain and enhance EMS services in the future.

The *Rural and Frontier EMS Agenda for the Future* was built on the same format as the 1996 *EMS Agenda for the Future*. It proposed continued development of 14 key EMS attributes:

- Integration of Health Services
- EMS Research
- Legislation and Regulation
- System Finance
- Human Resources
- Medical Oversight
- Education Systems
- Public Education
- Prevention
- Public Access
- Communication Systems
- Clinical Care and Transportation Decisions/Resources
- Information Systems
- Evaluation

A process for developing the document began in 2003. Volunteer writing and editorial teams helped in the direction of a draft document that was posted to the NRHA web site in fall 2003. From January to June of 2004 over 235 individuals from over 100 organizations provided comments about versions of the document that were routinely posted to the Web site. These included about 100 individuals including local ambulance directors, State EMS officials, State rural health officials, and a range of policy experts provided input during a 1-day session preceding the May 2005 National Rural Health Association Annual Rural Health Conference. The document was first released to the public in October 2004 at the annual meeting of the National Association of State EMS Directors (now the National Association of State EMS Officials).

Fulfilling the vision identified in the Rural and Frontier EMS Agenda for the Future requires the application of significant Federal, States and local resources as well as committed leadership at all levels. Because significant policy and funding decisions at Federal and State levels are critical to future success of rural EMS, the *Rural and Frontier EMS Agenda for the Future* focused, in large part, on those policy makers. However, the project partners also recognize that action at the local level is just as important, if not more important, to the future of EMS in rural communities. We recognize that rural and frontier EMS providers are acutely aware of the challenges they face. As such, this new "Service Chief's Guide" has been created in hopes of arming local EMS providers with information about possible future directions for rural EMS system development to ensure their survival, advancement, and growth. It is meant to serve as a companion document to the *Rural and Frontier EMS Agenda for the Future*, and we encourage rural EMS leaders to learn about and use that original document. It is available for free download at http://www.citmt.org/download/rfemsagenda.pdf

APPENDIX B: ACKNOWLEDGEMENTS

This service chief's guide was made possible by funds provided by ORHP and the Rural Emergency Medical Services and Trauma Technical Assistance Center (REMSTTAC) and the Kansas Department of Health and Environment. Special thanks for producing this guide go to Chris Tilden from the Kansas Department of Health and Environment, Office of Local and Rural Health and to REMSTTAC staff Nels Sanddal, Director; Heather Soucy, Program Support Specialist; Joe Hansen, Assistant Director and Teri Sanddal, Associate Director; and members of the Service Chief's Guide Workgroup at REMSTTAC.

Nels D. Sanddal, B.S., Co-chair
Director
Rural Emergency Medical Services and Trauma Technical Assistance Center

Chris Tilden, PhD, Co-chair
Interim Director
Kansas Department of Health & Environment

Contributors and Reviewers:

Dennis Berens
Director
National Organization of State Offices of Rural Health
Nebraska Office of Rural Health

Dean Cole
EMS/CISM Program Administrator
Nebraska Health and Human Services System
EMS Program and Public Health Assurance Division

D. Randy Kuykendall, MLS, NREMT-P
Chief, Emergency Medical and Trauma Services Section
Colorado Department of Public Health and Environment
Health Facilities and Emergency Medical Services Division

Fergus Laughridge
EMS Coordinator/ Program Manager
Nevada State Health Division – EMS
Bureau of Licensure and Certification

Kevin K. McGinnis, MPS, EMT-P
Program Advisor
National Association of State EMS Directors

Mary Sheridan
Director
State Offices of Rural Health
Idaho Department of Health and Welfare

Ron Seedorf
Outreach Coordinator
Colorado Rural Health Center

APPENDIX C: REMSTTAC STAKEHOLDERS GROUP

Jane Ball, Executive Director
EMSC National Resource Center
Trauma-EMS Technical Assistance Center

Eli Briggs, Policy and State Affairs Manager
National Rural Health Association
Government Affairs Office

Bethany Cummings
Rural Affairs Ad Hoc Committee
National Association of EMS Physicians

Drew Dawson, Chief, EMS Division
National Highway Traffic Safety Administration

Tom Esposito, Medical Director
Rural EMS and Trauma Technical Assistance Center
Loyola University Medical Center

Blanca Fuertes, Past Project Officer
U.S. Department of Health and Human Services
Health Resources and Services Administration
Office of Rural Health Policy

Tommy Loyaconno, Representative
National Association of Emergency Medical Technicians

Christian L. Hanna, Rural Site Director
Children's Safety Network
National Children's Center for Rural Agricultural Health and Safety

Bob Heath, EMS Education Coordinator
Nevada State Health Division

Marilyn Jarvis, Assistant Director for Continuing Education
Burns Telecommunications Center
Montana State University

Doug Kupas
Rural Affairs Ad Hoc Committee
National Association of EMS Physicians

Fergus Laughridge, Program Manager
Nevada State Health Division
EMS Bureau of Licensure and Certification

Tami Lichtenberg, Program Manager
Technical Assistance and Services Center
Rural Health Resource Center

Patrick Malone, Director
Initiative for Rural Emergency Medical Services
University of Vermont

N. Clay Mann, Professor, Associate Director of Research
Intermountain Injury Control Research Center
University of Utah

Evan Mayfield, CDC Public Health Advisor
New York Department of Health

Charity Moore, Research Assistant
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

Carol Miller, Executive Director
Frontier Education Center
National Clearinghouse for Frontier Communities

Daniel Patterson, AHRQ-NRSA Post-Doctoral Research Fellow
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

Davis Patterson, Research Associate
WWAMI Center for Health Workforce Studies
University of Washington

Ana Maria Puente, Project Officer
U.S. Department of Health and Human Services
Health Resources and Services Administration
Office of Rural Health Policy

Kristine Sande, Project Director
Rural Assistance Center
University of North Dakota Center for Rural Health

Dan Summers, Director of Education
Center for Rural Emergency Medicine
West Virginia University

Chris Tilden, Interim Director
Kansas Department of Health and Environment
Office of Local and Rural Health

Robert K. Waddell II, Secretary /Treasurer
National Association of EMS Educators

Bill White, President
National Native American EMS Association

Gary Wingrove, Program Development
Technical Assistance and Services Center
Rural Health Resource Center

Jill Zabel, Healthcare Consulting
Wipfli LLP