2026 Montana Trauma System Legislative Report:

Strengthening Emergency and Trauma Care Across Montana

Pursuant to 50-6-402, Montana Code Annotated (MCA), the Department of Public Health and Human Services, Emergency Medical Services (EMS) and Trauma System Section submits this report to the Legislature in accordance with 5-11-210 MCA regarding the effectiveness of Montana's trauma care system.

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MONTANA DPHHS
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

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EXECUTIVE SUMMARY

Since the 2025 Legislative Session, Montana has made meaningful progress in strengthening its emergency and trauma care system. New opportunities to improve emergency and trauma care have emerged across our rural and frontier state, driven by new investments, improved collaboration, modernized data systems, and innovative approaches.

Despite this progress, the emergency care system is under increasing strain. Injury remains one of the leading causes of death in Montana. At the same time, trauma centers and Emergency Medical Services (EMS) agencies continue to face workforce shortages, rising costs, long transport distances, and increasing demands for service. In many communities, especially in rural and frontier areas, EMS is the first, and often the only, health care resource immediately available during an emergency. At the same time, trauma centers are facing rising costs associated with maintaining readiness, workforce training, and the specialized resources required to care for severely injured patients.

One of the most significant challenges identified in this report is that the emergency care system has evolved, but many of the policies and funding mechanisms that support it have not. EMS has become a crucial part of Montana's health care infrastructure. Yet, reimbursement continues to focus primarily on patient transportation rather than the clinical care, readiness, and community support EMS provides every day. Similarly, trauma centers absorb significant costs to maintain a level of preparedness that benefits all Montanans, regardless of whether those costs are fully reimbursed.

This report highlights the progress made since the 2025 Legislative session, identifies the challenges that continue to affect Montana's emergency and trauma care system, and outlines opportunities for future legislative consideration. Continued investment in both EMS and trauma systems will be essential to ensure that Montanans have access to timely, high-quality emergency and trauma care regardless of where they live.

PROGRESS SINCE 2025 SESSION: MOMENTUM AND SUCCESSES

SECURING NEW FUNDING AND PROGRAM INFRASTRUCTURE

One of the most important developments since the 2025 legislative session is the federal investment in the Rural Health Transformation Program (RHTP)[1]. RHTP provides five years of federal funding to stabilize and modernize rural health care delivery throughout Montana, including emergency and trauma care.

RHTP supports several short-term initiatives to strengthen Montana's emergency care system, improve access to services, and help communities address local health care challenges. While these projects are still in the early stages of implementation, they represent an important opportunity to test new approaches and build sustainable infrastructure that can support rural health care systems in the future.

ADVANCING RURAL TRAUMA CARE THROUGH INNOVATION, RESEARCH, AND COLLABORATION

Montana continues to be a national leader in rural trauma system development by creating solutions that reflect the realities of providing care in a large rural and frontier state. Many of these efforts have been driven by collaboration between hospitals, EMS agencies, state partners, and clinical leaders from across Montana.

One example is the development and implementation of the Montana Brain Injury Guidelines (MT-BIG). Created specifically for Montana's rural environment, MT-BIG provides guidance for the care of patients with minor traumatic brain injuries. The guidelines help hospitals determine which patients can safely remain in their local community for treatment and observation and which patients require transfer to a higher level of care. When appropriate, this approach can reduce unnecessary transfers, preserve limited EMS resources, and allow patients to remain closer to home.

Interest in MT-BIG has grown beyond Montana as other rural states look for ways to address similar challenges related to access, transportation, and specialty care.

Montana's two Level I/Comprehensive Trauma Centers are also contributing to a growing body of research focused on rural trauma care. Current projects are examining

[1] Montana Department of Public Health and Human Services. (2026). *Rural Health Transformation Program*. https://dphhs.mt.gov/RuralHealthTransformationProgram

topics such as injury patterns, transfer processes, access to specialty services, and patient outcomes in rural and frontier communities. This work helps improve understanding of the challenges facing rural trauma systems and provides data that can inform future system improvements.

The Montana Committee on Trauma (MT COT), a subgroup of the Governor-appointed State Trauma Care Committee, has also become more active over the past two years. Committee participation was expanded to include all trauma medical directors from facilities statewide, creating more opportunities for collaboration, mentoring, and shared problem-solving.

Unique to Montana, this model has received national attention as an emerging best practice for rural states—exemplifying how meaningfully engaging rural practitioners can strengthen trauma system performance, improve patient outcomes, and elevate community voices in trauma system planning and decision-making.

BUILDING ON PROGRESS: REMAINING CHALLENGES IN EMERGENCY AND TRAUMA CARE

Many of the improvements described in this report rely on a strong EMS system that can respond to emergencies, transport patients, and connect communities to higher levels of care when needed. Even the strongest trauma system cannot function effectively if ambulances and trained EMS providers are not available when patients need them. Across the state, EMS agencies continue to struggle with staffing shortages, volunteer recruitment and retention, rising operating costs, a transportation-based reimbursement model, and increasing demand for services.

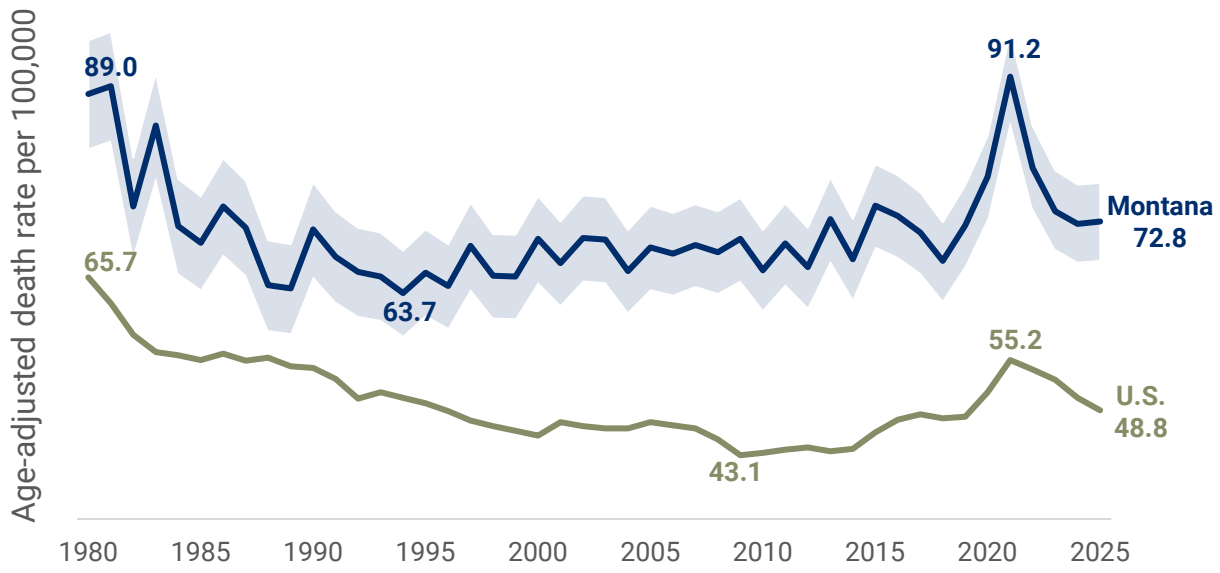
EMS providers are often the first point of contact for injured patients and play a vital role in connecting patients to appropriate care. In Montana, that frequently means traveling long distances and providing care in remote areas with limited resources. As workforce and financial pressures continue to grow, many communities are concerned about their ability to adequately staff ambulances, which, in turn, affects response times, ambulance availability, and access to interfacility transportation. (See **Appendix A** for patient stories about EMS staffing and availability).

The RHTP will provide valuable support for several EMS and trauma-related initiatives. However, the challenges facing Montana's EMS system have developed over many years and will not be solved through a single funding source or program. Continued investment, collaboration, and long-term planning will be necessary to ensure that emergency and trauma care remains available to communities across Montana.

CHALLENGES THREATENING MONTANA'S EMERGENCY AND TRAUMA CARE SYSTEM

Injury remains one of the leading causes of death and disability in Montana. As illustrated in **Figure 1**, injury mortality rates in Montana continue to exceed national averages and have increased in recent years[2]. These trends place growing demands on Montana's trauma centers, EMS agencies, and rural hospitals.

FIGURE 1: INJURY DEATH RATE IN MONTANA AND U.S. 1980-2025



Notes: Data excludes poisoning and overdose. Shaded areas around the Montana estimates represent the 95% confidence intervals. Data Source: Montana Office of Vital Statistics and CDC WONDER

TRAUMA CENTERS UNDER INCREASING PRESSURE

Montana's trauma centers play a critical role in caring for injured patients and supporting the statewide trauma system. They provide emergency and specialty trauma care for patients in urban, rural, frontier, and tribal communities. At the same time, trauma centers are experiencing higher patient volumes, workforce shortages, and increasing operational costs that make it more difficult to sustain trauma services.

[2] Centers for Disease Control and Prevention, National Center for Health Statistics Mortality Data. 1980-2025. *CDC Wonder Online Database*: https://wonder.cdc.gov/deaths-by-underlying-cause.html
Montana Office of Vital Statistics Death Data.

Over the past decade, several Montana hospitals have reduced their trauma capabilities or chosen to no longer maintain trauma designation[3]. These decisions are often related to staffing shortages, financial pressures, and the increasing demands of maintaining a trauma program. **Figure 2** illustrates the current distribution of Montana's designated trauma facilities and highlights counties without a designated trauma center. As shown, many rural and frontier regions rely on a limited number of designated facilities, requiring patients to travel significant distances to access definitive trauma care.

"Although the patient was stabilized, a critical gap emerged when no transport resources were immediately available to move him to definitive care…. The patient's condition required specialized trauma care that could not be provided locally, yet nearly six hours passed before transport could be arranged."

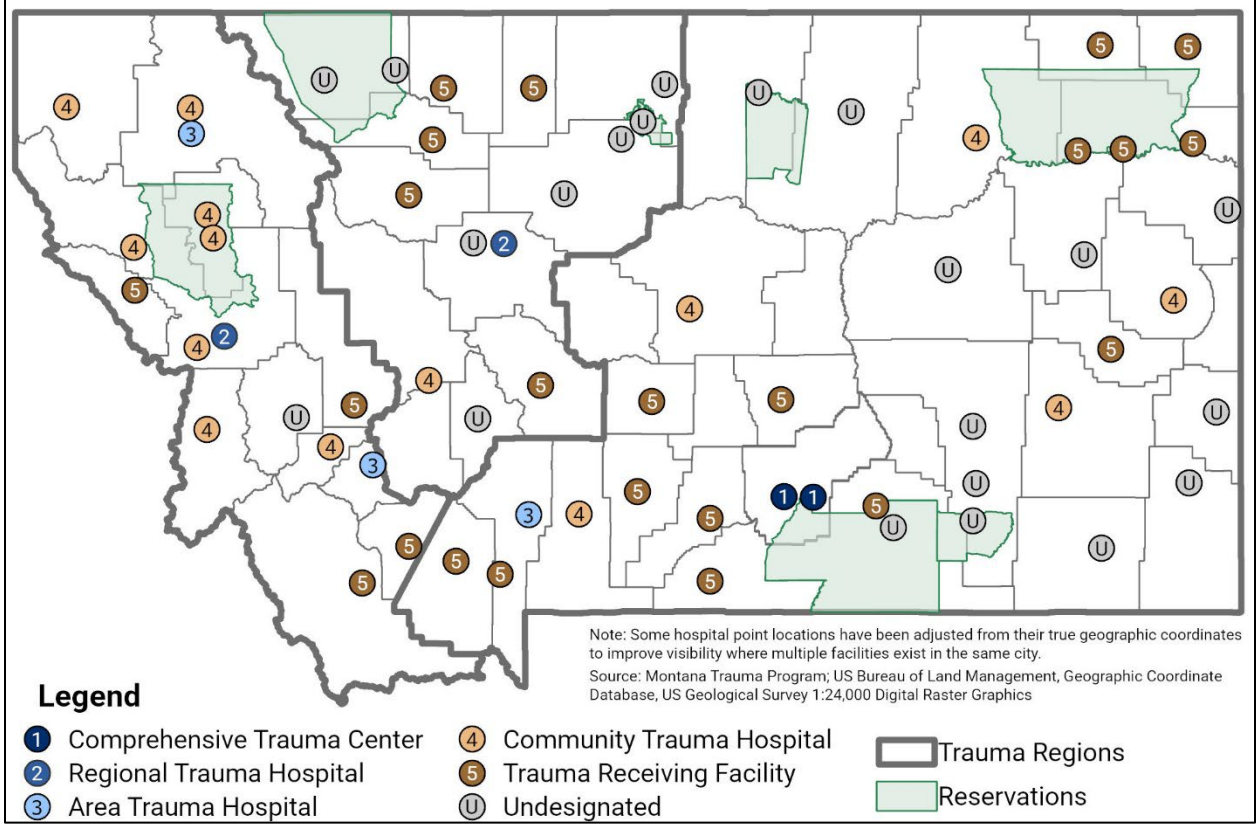
See Appendix A: Patient Story 1

When a hospital reduces or loses trauma services, the effects are most often felt in rural and frontier communities where the next closest trauma center may be several hours away. As a result, some Montanans must travel farther to access trauma care than they did in the past. (See **Appendix A** for patient stories related to access to trauma care.)

These challenges are also present in Montana's tribal communities. Most tribal reservations in Montana do not have a designated trauma facility located on reservation lands[4]. Patients who experience serious injuries often require transportation to facilities outside their communities for specialty trauma care. Long travel distances, transportation barriers, and limited local health care resources can all contribute to delays in receiving definitive care.

[3] Phillipsburg, Crow Agency, Northern Cheyenne, Forsyth, Colstrip, Cutbank, Malta, and Havre
[4] Undesignated reservation facilities: Northern Cheyenne, Crow Agency, Blackfeet, Rocky Boy, and Fort Belknap

FIGURE 2: MONTANA HOSPITALS BY TRAUMA DESIGNATION STATUS, 2026



Maintaining trauma readiness requires ongoing investment in training, equipment, and program infrastructure[5]. Trauma centers must ensure physicians, nurses, advanced practice providers (APPs), and other clinical staff maintain trauma-related knowledge and skills through continuing education, simulation training, and performance improvement activities. As health care costs continue to rise and staffing remains limited, many facilities struggle to allocate the time and resources needed to meet these requirements. (See **Appendix A** for patient stories related to system readiness.)

[5] Ashley DW, Mullins RF, Dente CJ, Johns TJ, Garlow LE, Medeiros RS, Atkins EV, Solomon G, Abston D, Ferdinand CH; What are the costs of trauma center readiness? Defining and standardizing readiness costs for trauma centers statewide. *American Surgeon*. 2017 Sep 1; 83(9):979-990. PMID: 28958278. https://pubmed.ncbi.nlm.nih.gov/28958278/

Montana's health care workforce is also changing. In 2025, Montana became one of only 10 states where the combined number of advanced practice providers (nurse practitioners and physician assistants) exceeded the number of physicians. Montana employs approximately 1,260 nurse practitioners (NP) compared to 1,090 physicians.

"Initial assessment raised concern for internal hemorrhage, but advanced imaging and surgical capability were not available locally…. The team relied on limited staff and resources overnight while coordinating care with a Level I trauma center over 200 miles away…. Through close monitoring, teleconsultation, and early activation of transfer protocols, the patient remained stable enough for delayed transport."

See Appendix A: Patient Story 3

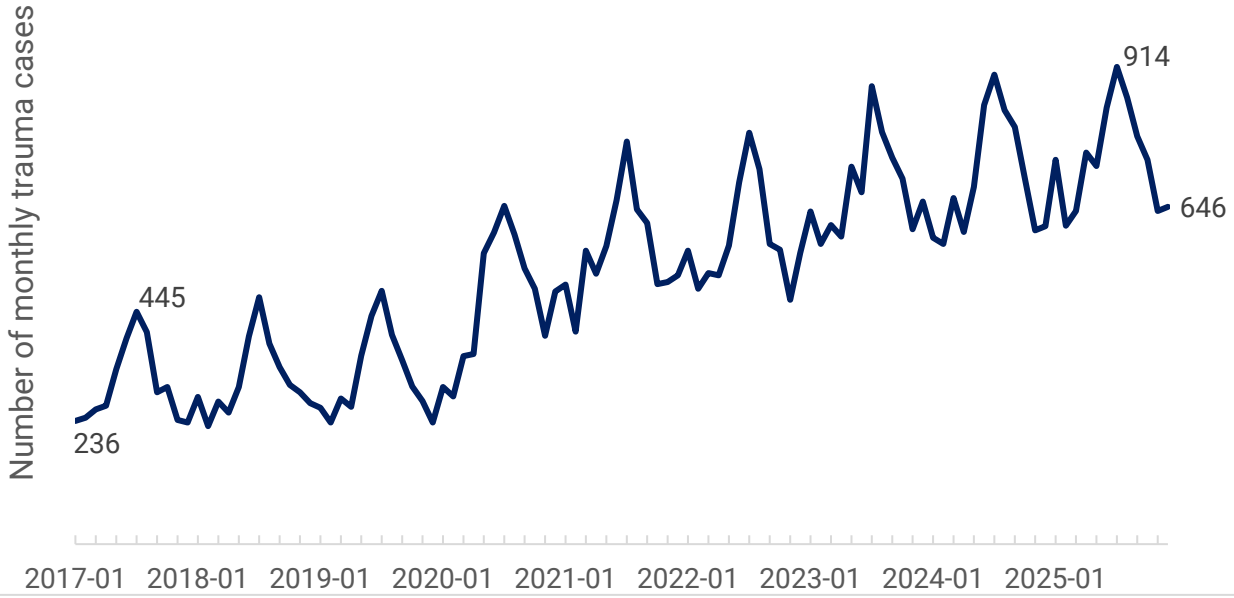
During the same period, NP employment increased by 20%, while physician employment declined by 10.7%[6]. In many rural communities, advanced practice providers are often key to delivering health care and are increasingly involved in the care of injured patients. As this workforce continues to grow, it is important that trauma education, training, and performance improvement efforts support all members of the trauma team.

Trauma centers also face increasing administrative and operational responsibilities. State law requires hospitals to collect and submit trauma data to the Department of Public Health and Human Services (DPHHS) to support trauma system evaluation, performance improvement, injury prevention, and statewide reporting[7]. To meet this requirement, the Montana Trauma System Program provides a statewide trauma registry platform for participating facilities.

As shown in **Figure 3**, the volume of trauma registry cases submitted by Montana hospitals has increased substantially over time, reflecting both growing patient volumes and expanded participation in the statewide trauma system. This growth has significantly increased the workload for hospital trauma registrars, trauma program staff, and the state trauma registry program, while also driving greater demand for data storage, quality assurance, technical support, and reporting capabilities.

[6] Taylor, M. (2026, June 17). *10 states where APPs outnumber physicians: 6 notes*. Becker's Hospital Review.
[7] Montana Secretary of State**.** *Administrative Rules of Montana*, ARM 37.104.212. Available at: https://rules.mt.gov/browse/collections/aec52c46-128e-4279-9068-8af5d5432d74/policies/ef71e180-c8c2-4abf-a666-14674b39d614

FIGURE 3: NUMBER OF TRAUMA REGISTRY CASES PER MONTH JANUARY 2017 - DECEMBER 2025



The trauma registry is a critical component of Montana's trauma system, but the cost of maintaining and modernizing the system continues to increase. Software licensing, vendor fees, cybersecurity requirements, system upgrades, and data integration needs have all contributed to rising costs. As Montana continues to improve its data systems and reporting capabilities, identifying sustainable funding for the trauma registry will be important to ensure that hospitals can continue to meet statutory reporting requirements and that the state can continue to use data to guide trauma system improvements.

EMS WORKFORCE, SUSTAINABILITY, AND RESPONSE CHALLENGES

EMS agencies across Montana continue to face significant workforce and financial challenges. Recruitment and retention of volunteer and career staff remain difficult, operating costs continue to increase, and many communities struggle to maintain adequate ambulance coverage. Unlike fire protection and law enforcement, EMS is not currently designated as an essential service in Montana. As a result, EMS services are organized and funded differently across the state, with many communities relying heavily on volunteer providers to meet local emergency response needs. Workforce shortages, recruitment challenges, and financial pressures continue to impact EMS agencies, particularly in rural and frontier areas. A growing number of

states have designated EMS as an essential service in an effort to address similar challenges[8]. However, any such designation also requires identifying sustainable funding to support the additional responsibility and expectations placed on EMS agencies.

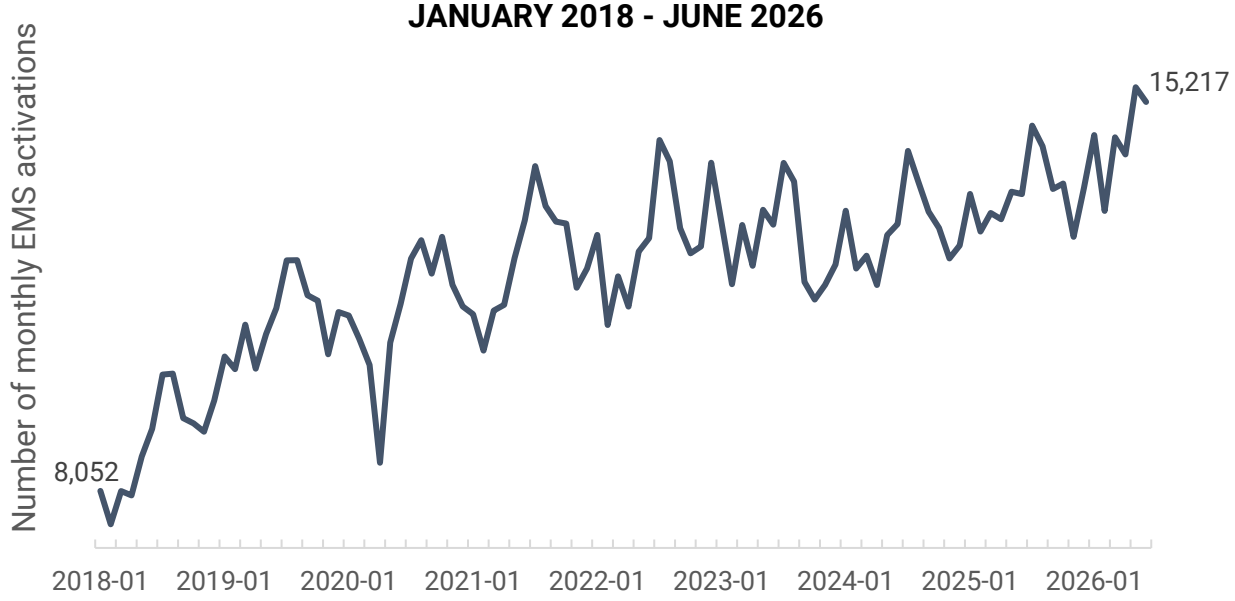
EMS is expected to provide increasingly complex medical care, help reduce strain on overcrowded emergency departments, support community health initiatives, and work closely with hospitals, public health, and emergency management partners.

The challenge extends beyond workforce shortages and funding. The role of EMS itself has changed dramatically over the past several decades. Today's EMS providers do far more than transport patients to the hospital. They respond to traumatic injuries, medical emergencies, behavioral health crises, disasters, and public health emergencies. They are expected to provide increasingly complex medical care, help reduce strain on overcrowded emergency departments, support community health initiatives, and work closely with hospitals, public health, and emergency management partners.

Figure 4 demonstrates the growing demand placed on Montana's EMS system. Monthly EMS activations have nearly doubled, increasing from 8,052 calls in January 2019 to 15,217 calls in June 2026. This sustained increase in call volume has occurred while many EMS agencies continue to face workforce shortages, financial constraints, and challenges in maintaining operational readiness.

[8] N. Hassanein, "More states push to recognize EMS as 'essential service,'" *EMS1*, 2023. https://www.ems1.com/politics/articles/more-states-push-to-recognize-ems-as-essential-service-ClUlBa0k2kdZoHV7/

FIGURE 4: NUMBER OF EMS ACTIVATIONS PER MONTH JANUARY 2018 - JUNE 2026



The challenge is that while EMS has evolved into an essential part of the health care system, its financing has not. Most reimbursement continues to be tied to transporting a patient rather than to the care provided or the readiness required to respond at any hour.[9] An EMS crew that treats a patient at home, connects them with follow-up care, or safely avoids an unnecessary emergency department visit may provide exactly the right care. Yet, the system often provides little or no reimbursement for those services. Ambulance services are paying for highly trained clinicians, medical equipment, medications, communications systems, and 24-hour emergency response capability, but the funding model still largely recognizes the ambulance ride rather than the health care being delivered.

This mismatch is especially challenging in Montana's rural and frontier communities, where long transport distances, limited health care resources, aging populations, volunteer staffing models, and small tax bases place additional strain on local EMS agencies. In many of these communities, EMS is more than a transportation service; it is a vital part of the health care infrastructure that helps hold the system together until patients can reach the next level of care. Investments through the RHTP will provide important support for strengthening Montana's EMS system, but they represent only

[9] P. Beamon, "EMS cannot continue to be treated as a transportation service," *EMS1*, June 22, 2026. Article: "EMS cannot continue to be treated as a transportation service," EMS1, June 22, 2026

one part of the long-term solution. Addressing workforce shortages, ensuring sustainable funding, and recognizing EMS as an essential component of the health care system will require continued collaboration and long-term investment. (See **Appendix A** for patient stories related to volunteer EMS.)

"The responding EMS providers were volunteers who had just completed full workdays… volunteer EMS agencies are the backbone of Montana's trauma system. Supporting these providers through resources, training, and retention efforts is critical to ensuring timely emergency care in rural and frontier areas."

See Appendix A: Patient Story 4

ONGOING OPPORTUNITIES FOR LEGISLATIVE CONSIDERATION

Many of the challenges described in this report are not new. They have been identified in previous legislative reports and continue to affect the ability of Montana's EMS and trauma systems to provide timely, high-quality emergency care. Recent investments through the RHTP represent meaningful progress and will help strengthen portions of the system. However, they are not intended to solve the larger workforce, funding, and system resource challenges that have developed over many years.

Across the country, states are modernizing EMS policy to better reflect the role EMS plays as both a health care and public safety service[10]. As Montana continues to strengthen its emergency and trauma care system, there is an opportunity to consider policies that better align with EMS's role today. EMS has evolved into a critical component of Montana's health care and public safety infrastructure. Yet funding and reimbursement continue to be based largely on patient transportation rather than on the full range of care and readiness that EMS provides. Likewise, trauma centers continue to absorb significant costs associated with maintaining trauma readiness, workforce training, data collection, and statewide system support. Ensuring that both EMS agencies and trauma centers remain sustainable will be essential to maintaining access to emergency care, particularly in rural and frontier communities.

[10] Emergency Services Legislation Database. *National Conference of State Legislatures (NCSL).* June 2026. https://www.ncsl.org/health/emergency-medical-services-legislation-database

The following recommendations from previous legislative reports remain relevant and warrant continued consideration.

SUPPORT EMS WORKFORCE DEVELOPMENT AND SUSTAINABILITY

- Continue evaluating options to strengthen the long-term sustainability of EMS across Montana, including consideration of EMS as an essential service with sustainable funding.
- Work with EMS stakeholders to identify sustainable funding strategies that better reflect the role of EMS as health care infrastructure, including authorization of an ambulance provider assessment to increase Medicaid reimbursement for both private and public model ambulance services[11].
- Explore reimbursement models for all payor types that support assessment, treatment, and referral of patients when transport to an emergency department is not medically necessary, similar to programs implemented in several neighboring states.
- Continue investing in EMS workforce recruitment, retention, education, leadership development, and volunteer support, particularly in rural and frontier communities[12].

SUPPORT TRAUMA CENTER READINESS

- Establish a grant program to help offset the costs associated with trauma readiness, staff education, performance improvement, trauma registry participation, and uncompensated trauma care.
- Explore sustainable funding sources, including recreational marijuana tax revenue or other dedicated funding mechanisms, to support trauma system readiness.

[11] Eleva group. EMS treat no transport reimbursement. 2023 Summary. Interim Committee November 5, 2025: Link to Interim Committee report from 2025: EMS treat no transport reimbursement. 2023 Summary

[12] EMS Agenda 2025. *National Association of State Emergency Medical Services Officials (NASEMSO).* Link to EMS Agenda 2025. National Association of State Emergency Medical Services Officials (NASEMSO)

CONTINUE INVESTMENT IN DATA AND SYSTEM IMPROVEMENT

- Continue supporting modernization and long-term sustainability of the statewide trauma registry and EMS data systems.
- Strengthen integration of EMS, trauma, and other health care data to evaluate patient outcomes better, identify system gaps, and guide future policy decisions.
- Continue supporting statewide quality improvement, research, and innovation initiatives that improve access to emergency and trauma care, particularly in rural and frontier communities.

Montana has made progress in strengthening its trauma system over the past two years. Maintaining that momentum will require continued collaboration among state agencies, health care organizations, EMS agencies, trauma centers, legislators, and local communities. A strong trauma system depends on a strong EMS system, and together they form a critical part of Montana's health care infrastructure. Continued investment in both systems will help ensure that Montanans have access to timely, high-quality emergency and trauma care regardless of where they live.

APPENDIX A

EMS/TRAUMA SYSTEM PATIENT STORIES

The following stories are all based on actual events that occurred within Montana's trauma and emergency care system. They reflect real experiences shared by EMS agencies, hospitals, and health care providers and demonstrate both the strengths of our statewide trauma system and the challenges faced in delivering emergency care across our rural and frontier communities.

To protect patient and provider privacy, all protected health information (PHI) and identifying details have been removed. These stories help illustrate the real-world impact of policy decisions and funding on the patients, providers, and communities served by Montana's trauma and EMS system.

STORY 1 - THE SIX-HOUR WAIT: WHEN TRAUMA TRANSPORT ISN'T AVAILABLE

SITUATION: A young adult suffered a severe gunshot wound to the head while in a remote area of Montana. The local volunteer EMS service had ceased operations approximately two years earlier due to ongoing staffing shortages, leaving no ground ambulance available to respond. As a result, family members were forced to transport the critically injured patient to the nearest Level IV trauma center themselves. Upon arrival, the trauma team rapidly stabilized the patient and began coordinating transfer to a higher-level trauma center capable of providing neurosurgical care.

CHALLENGE OR OPPORTUNITY: Although the patient was stabilized, a critical gap emerged when no transport resources were immediately available to move him to definitive care. Air medical services were unable to fly because of heavy wildfire smoke, and despite contacting multiple ambulance services across the state, no ground ambulance was available to complete the transfer. The patient's condition required specialized trauma care that could not be provided locally, yet nearly six hours passed before transport could be arranged. This case illustrates the unique challenges rural Montana faces when geography, weather, and limited EMS resources converge during a time-sensitive emergency.

OUTCOME: Once air transport became available, the patient was flown to a regional Level II trauma center, where he received additional trauma care before being transferred out of state for a higher level of specialized neurosurgical treatment. He

ultimately made a remarkable recovery. The outcome reflects both the lifesaving care provided by the rural hospital that stabilized him and the expertise available through Montana's trauma system once definitive care was reached.

WHY THIS MATTERS: This case demonstrates that excellent clinical care alone is not enough if patients cannot be transported to the right facility promptly. Rural hospitals can stabilize critically injured patients, but access to specialty care often depends on reliable ground and air transport resources. When weather, workforce shortages, or ambulance availability delay transfers, patients with life-threatening injuries may face increased risks.

STORY 2 - WHEN MINUTES MATTER: COORDINATING PEDIATRIC TRAUMA CARE ACROSS RURAL MONTANA

SITUATION: A previously healthy adolescent suffered severe injuries after being ejected from an amusement ride in a rural Montana community. The patient arrived at a Level III trauma center in extremely critical condition and required immediate lifesaving care, including placement of a breathing tube to help him breathe. Trauma evaluation revealed a devastating traumatic brain injury and a high-grade splenic injury with ongoing hemorrhage.

CHALLENGE OR OPPORTUNITY: The patient required rapid access to services not available locally, including pediatric neurosurgical care and specialized pediatric trauma support. While transfer arrangements were being coordinated, the local trauma team performed emergency surgery to control life-threatening bleeding by removing his spleen. Simultaneously, the on-call pediatric physician worked with regional referral partners to identify the most appropriate receiving facility.

A significant challenge emerged when weather and operational limitations prevented the local air medical service from transporting the patient. As a result, the transport team from the receiving hospital had to travel to the referring facility before the patient could be moved. Although this unavoidable circumstance delayed transfer, the coordinated efforts of multiple hospitals, physicians, transport personnel, and regional trauma resources ensured continuity of care during a critical period.

OUTCOME: The patient was successfully stabilized, underwent life-saving surgery, and was transferred to a higher level of pediatric specialty care capable of managing complex neurologic injuries. Despite the coordinated efforts of multiple hospitals,

physicians, transport teams, and specialists, the severity of the patient's injuries ultimately proved unsurvivable, and the patient later died.

Throughout the event, providers across the state worked together to ensure the patient received the right care at the right place and time, despite significant geographic and transportation challenges.

WHY THIS MATTERS: This case highlights both the strengths and challenges of delivering trauma care in Montana. Rural hospitals play a critical role in providing immediate life-saving treatment, but optimal outcomes often depend on rapid access to specialty resources located many miles away.

It also underscores the importance of a mature statewide trauma system. From the initial emergency response to stabilization at a rural trauma center, to coordination with pediatric specialists and transport teams, each step required seamless communication and collaboration across multiple organizations. While the patient's injuries were ultimately not survivable, the coordinated efforts of health care professionals throughout the trauma system provided the best possible opportunity for survival. They ensured that every available resource was mobilized on the patient's behalf.

Strong interfacility relationships, reliable transport resources, and clear transfer pathways remain essential for Montana's trauma patients, particularly children and other critically injured patients requiring specialized care that may only be available in a few locations across the state.

STORY 3 - DELAYED TRANSFER ACROSS FRONTIER DISTANCE

SITUATION: A middle-aged patient presented to a critical access hospital, Level V trauma facility, in eastern Montana following a high-speed rollover on a rural highway. Initial assessment raised concern for internal hemorrhage, but advanced imaging and surgical capability were not available locally.

CHALLENGE OR OPPORTUNITY: Severe winter weather grounded air medical transport, a common challenge across Montana’s vast geography. Ground transport required several hours across long, sparsely populated stretches of highway. The team relied on limited staff and resources overnight while coordinating care with a Level I trauma center over 200 miles away.

OUTCOME: Through close monitoring, teleconsultation, and early activation of transfer protocols, the patient remained stable enough for delayed transport. Upon arrival, the patient underwent emergent surgery and survived with a favorable recovery.

WHY THIS MATTERS: This case highlights how Montana's distance, weather, and resource variability can delay definitive care, reinforcing the need for reliable transport infrastructure and sustained support for rural hospitals.

STORY 4 - VOLUNTEER EMS IN A FRONTIER COMMUNITY

SITUATION: A pediatric patient was injured in a farming accident in a remote Montana community, miles from the nearest hospital. A local volunteer crew provided EMS response.

CHALLENGE OR OPPORTUNITY: The responding EMS providers were volunteers who had just completed full workdays, which reflects the reality of many Montana communities where emergency care depends on neighbors answering the call. They faced limited staffing, long on-scene times, and extended transport to the nearest facility with pediatric capabilities.

OUTCOME: Despite these challenges, the team provided rapid assessment, airway support, and coordinated communication with the receiving hospital. The patient was stabilized and successfully transferred onward to higher-level care, ultimately recovering.

WHY THIS MATTERS: Volunteer EMS agencies are the backbone of Montana's trauma system. Supporting these providers through resources, training, and retention efforts is critical to ensuring timely emergency care in rural and frontier areas.

STORY 5 - SEVEN CALLS, NO AMBULANCE: A RURAL TRAUMA SYSTEM CHALLENGE

SITUATION: A volunteer county-based BLS (Basic Life Support) EMS crew was paged out at approximately 10:30 p.m. to a 24-year-old male who sustained a firework injury to his right hand. He was brought to the local critical access hospital, which is a Level V trauma receiving facility. He initially had uncontrolled bleeding to his right hand and upper arm, which were controlled with tourniquets and later with pressure dressings. He had significant chest trauma that required emergent needle decompression. He arrived at the facility at 11:02 p.m.; the trauma team immediately realized the need for a higher level of care. Therefore, the first ALS (advanced life support) team was called at 11:10

p.m. Over the course of the next hour and a half, seven ALS crews, including rotor, fixed wing, and ground crews, were contacted for the transport of this critically injured patient to a higher level of care. All seven declined to come to get the patient, either due to the weather or not having an ALS crew available.

CHALLENGE OR OPPORTUNITY: This patient was critically injured and required immediate surgery. Unfortunately, at the Level V trauma-receiving hospital, there is neither an operating room nor a surgeon available. There were no ALS crews available to transport this patient to definitive care. The nurse working in the ED that night was also employed as an EMT on the local county EMS crew. The nurse cannot practice as an RN while on the ambulance, only as a BLS EMT crew member, as per county rules and regulations. He had to remain in the emergency department for 2.5 hours, which far exceeds industry standards of care.

OUTCOME: Fortunately, the patient remained relatively stable while in the rural ED. With the emergent needle decompression and doses of pain relief medication, he did relatively well. At 2:30 a.m., staff were notified that a ground ALS crew was available to transport the patient; however, it was requested that the local BLS EMS crew rendezvous with the ALS crew. The trauma team was not comfortable sending this patient with only a BLS crew. Fortunately, the nurse working in the ER that night was orienting a new hire, who was an experienced ER nurse. The decision was made to have the nurse, who is also an EMT, ride in the ambulance to monitor the patient during transport to the rendezvous point. Because she could only practice as a BLS provider, the patient had to go 1.5 hours without any pain relief medications during the transport.

WHY THIS MATTERS: The patient's hospital course was significantly complicated by the delay in getting to definitive care. If there were more ALS crews available throughout the state, he may have been able to be transferred earlier in his stay at the rural hospital, significantly reducing his morbidity.

STORY 6 - COORDINATED TRAUMA SYSTEM SAVES TIME-SENSITIVE PATIENT

SITUATION: An elderly patient in a small Montana town experienced a ground-level fall with signs of traumatic brain injury. EMS recognized the severity early and initiated trauma system activation.

CHALLENGE OR OPPORTUNITY: Given Montana’s regionalized trauma system, EMS decided to bypass a closer facility and transport directly to a Level I trauma center

with neurosurgical capability, adding transport time but improving access to definitive care.

OUTCOME: The receiving trauma team was activated before arrival, expediting imaging and intervention. The patient received timely care and was discharged with minimal deficits, returning to independent living.

WHY THIS MATTERS: In Montana, where distances are vast, the ability of EMS to triage and route patients appropriately is critical. This case demonstrates how coordination across the system improves survival and functional outcomes.

STORY 7 - RURAL HOSPITAL SUSTAINING TRAUMA DESIGNATION

SITUATION: A small Montana hospital serving a geographically isolated population faced ongoing challenges maintaining trauma designation due to workforce shortages and limited access to specialty services.

CHALLENGE OR OPPORTUNITY: Through collaboration with larger trauma centers, participation in statewide education, and shared performance improvement efforts, the facility strengthened its processes and met system expectations.

OUTCOME: The hospital maintained its trauma designation, preserving local access to emergency care for a large rural catchment area where the next nearest hospital may be hours away.

WHY THIS MATTERS: Maintaining trauma designation in rural Montana preserves access to critical emergency and trauma care for communities where the nearest alternative may be hours away. It helps ensure rural hospitals remain prepared to stabilize and treat injured patients, supports local EMS and regional partnerships, and strengthens the resilience of Montana's statewide trauma system despite ongoing workforce and resource challenges.

STORY 8 - WHEN WEATHER DELAYS CARE, SYSTEMS MUST FILL THE GAP

SITUATION: A patient in a remote Montana community, a grandparent and primary caregiver, presented to a small emergency department with stroke symptoms in the early morning hours.

CHALLENGE OR OPPORTUNITY: Dense fog and winter conditions grounded air transport, delaying access to a stroke-capable center. In a state where distance and weather are constant barriers, the local team faced a critical window of time with limited resources, relying on telemedicine to connect with specialists hundreds of miles away.

OUTCOME: Treatment was initiated locally through remote consultation, stabilizing the patient until transport became possible. The patient ultimately regained significant function and returned home to their family.

WHY THIS MATTERS: No Montanan's outcome should depend on the weather. Investments in telehealth and rural emergency resources ensure patients receive life-saving care, even when transport is delayed.

STORY 9 - A CHILD'S OUTCOME DEPENDS ON SYSTEM COORDINATION

SITUATION: A young child visiting rural Montana with their family suffered serious injuries during a summer incident, turning a routine day into a life-threatening emergency.

CHALLENGE OR OPPORTUNITY: Specialized pediatric trauma care was not available locally. Providers coordinated across multiple facilities, including out-of-state partners, to arrange a transfer spanning hundreds of miles, all while stabilizing a critically injured child.

OUTCOME: Through coordinated efforts, the child safely reached definitive care and ultimately recovered, returning home to their family.

WHY THIS MATTERS: For Montana's children, access to specialized care often depends on long-distance coordination. Sustaining transport networks and interstate partnerships ensures that geography does not determine a child's chance of survival.

STORY 10 - SMALL TEAMS CARRY A HEAVY LOAD

SITUATION: After multiple crashes on a rural interstate, a small Montana emergency department was suddenly responsible for several critically injured patients, each representing a family waiting for answers.

CHALLENGE OR OPPORTUNITY: With limited staff and no immediate backup, providers took on multiple roles simultaneously. This is the reality in many rural communities, where a handful of clinicians must respond to high-acuity events without the resources of larger centers.

OUTCOME: Through teamwork and adherence to trauma protocols, all patients were stabilized and transferred appropriately.

WHY THIS MATTERS: Montana's trauma system depends on small, highly committed teams. Addressing workforce shortages and supporting rural providers is essential to maintaining timely, high-quality care across the state.

STORY 11 - PREVENTION CHANGES THE STORY BEFORE IT STARTS

SITUATION: Providers in a rural Montana community repeatedly cared for patients with severe injuries from high-speed crashes, many involving individuals not wearing seatbelts.

CHALLENGE OR OPPORTUNITY: Recognizing a preventable pattern, health care teams partnered with EMS, schools, and community leaders to launch a locally driven injury prevention effort.

OUTCOME: Over time, providers saw fewer severe injuries and more patients arriving after crashes with survivable outcomes. Community awareness increased, and behavior began to change.

WHY THIS MATTERS: The most effective trauma care is prevention. Supporting community-based injury prevention efforts reduces long-term health care costs and saves lives across Montana.

STORY 12 - WHEN THE SAME VOLUNTEERS ANSWER EVERY CALL

SITUATION: A rural volunteer EMS agency with 14 volunteer EMTs consistently has only 4 or 5 responders available for most emergency calls. Many volunteers have full-time jobs or other commitments that limit their availability.

CHALLENGE OR OPPORTUNITY: Reliance on the same small group of responders places increasing demands on those individuals, creating a significant risk of burnout and volunteer attrition. Recruiting new volunteers is particularly challenging, as many in

the current workforce are nearing retirement age and fewer younger individuals are entering volunteer EMS.

OUTCOME: A small core group of volunteers continues to respond to most emergency calls, while recruitment of younger volunteers remains limited, raising concerns about the service's long-term sustainability.

WHY THIS MATTERS: Many rural Montana communities rely on volunteer EMS agencies as their primary source of emergency medical care. As the volunteer workforce ages and recruitment declines, the responsibility for responding to emergencies falls on fewer individuals, increasing the risk of burnout and reducing system resilience. While financial support can help, additional strategies, including tuition assistance, tax incentives, expanded training opportunities, employer-supported leave, and statewide recruitment initiatives, may be needed to attract and retain the next generation of EMS volunteers and ensure continued access to emergency care in rural communities.