Emergency Medical Services in Montana:
Crisis on the Horizon

A Comprehensive Status Assessment

Funded by the Department of Public Health and Human Services – EMS and Trauma Systems Section, Montana Hospital Association, and The Montana Healthcare Foundation

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Executive Summary

Between February of 2019 and June of 2020, management staff from 42 hospitals and 61 EMS agencies were surveyed by trained interviewers to identify threats to Montana's EMS System and to identify recommendations for strengthening the EMS System. The survey and report were sponsored by the Department of Public Health and Human Services and the Montana Hospital Association.

Key Challenges

- Some EMS agencies are unable to respond to 9-1-1 calls because of staff shortages,
- EMS agencies are experiencing declining revenue,
- There is a lack of trained medical direction for EMS agencies,
- Hospital and EMS staff noted that there are challenges in navigating the two departments regulating EMS and EMTs, and
- EMS lacks a unified voice to describe their needs and to request assistance.

Recommendations

- When practical, volunteer EMS agencies should seek to organizationally align with fire services, hospitals and clinics,
- DPHHS should create and share public information toolkits with EMS agencies,
- Create a pathway for the nurse practitioners to serve as medical directors,
- DPHHS should build on the Legislature's actions to create Community Paramedicine by seeking out reimbursement opportunities,
- Continuously evaluate the roles and functions of the state agencies overseeing EMS and EMTs to better support the needs of the EMS community,
- EMS stakeholders should support the development of an EMS advocacy organization, and
- The state agencies overseeing EMS and EMTs should continue and expand education opportunities through video conference, regional and local training.

Introduction

Prior to the late 1960's, medical care for persons suffering from serious illnesses or injuries provided prior to hospital arrival was limited or often not available at all, particularly in rural areas of the country. Care that was available was often provided by funeral homes whose primary purpose was to drive as fast as possible to the nearest hospital.

In the early 1970s the shoots of a modern Emergency Medical Services (EMS) System began to sprout. Federal support became available that led to the development of regional based EMS systems. That Federal support has diminished over the decades, now, the primary responsibility for the ongoing development, maintenance and funding of the EMS system has come to rest squarely at the state and community levels.

Like the rest of the nation, Montana began the development and formation of its EMS system roughly fifty years ago. Thousands of lives have been saved and the quality of life has been improved for many others over the ensuing decades. Like many other rural areas of the nation, Montana has been heavily reliant on the dedication of volunteers to respond to the telephone, radio, or pager when someone is in need of immediate stabilization, treatment, and transportation as a result of a motor vehicle crash, heart attack or other sudden medical emergency.

It has become evident in recent years, however, that the viability of this medical system cannot be carried solely on the backs of a volunteer workforce. Social, health care and economic drivers have eroded the cohesiveness of many rural communities, populations have dwindled, and the volunteer pool has aged or is non-existent. Montana's rural EMS system is in crisis; without action it will continue to deteriorate and calls for help will not be answered.

There is a need to identify the challenges and pressures on Montana's 143 EMS agencies licensed to treat and transport individuals to appropriate health care destinations. Armed with the information contained in this report, strategies can be implemented at the state, county, and community levels to shore up the erosion of this essential health care service.

A public-private partnership was formed between the Montana DPHHS – EMS and Trauma Systems Section and the Montana Hospital Association to conduct this comprehensive survey with the goal of describing threats to the EMS system from key participants and then to present solutions to address those threats.

The survey was conducted using online surveys and face-to-face conversations with EMS agency managers and hospital leadership by trained interviewers. The results of the survey and interviews were compiled and used in the development of this report which we hope can be used to strengthen Montana's EMS system.

Montana's Emergency Medical Services in Crisis

At a time when Montana needs them the most.

Some Emergency Medical Services Agencies in Montana can no longer reliably respond to calls for help.

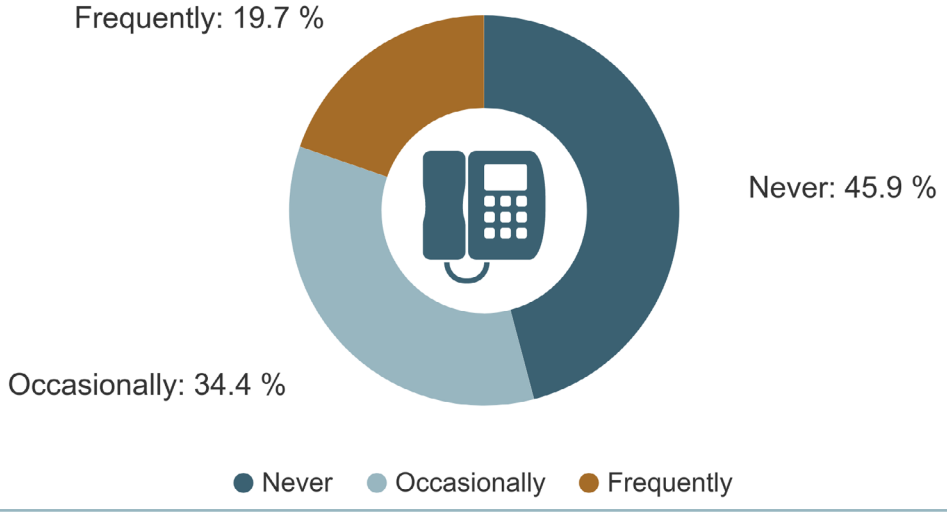
> "We are unable to provide coverage for >25% of 911 calls, particularly during the weekdays 6 a.m. to 6 p.m."

During the startup and early years of Montana's EMS system there was a plethora of volunteers. The rosters were filled with young, capable, and excited volunteers eager to provide a necessary service to their community members and to strangers just passing through. Fast forward to today when forty-one percent of the EMS agencies who responded to this survey reported having fewer than 15 members on their roster.

However, during the interviews local leaders noted that generally only 3-5 volunteer members listed as being on their service could be relied upon to respond routinely when the 9-1-1 pager tones were sounded. Some have family obligations such as child or elder care much of the time, others live too far from town to respond within an acceptable time frame, and many work during the day in other communities and cannot respond. The net result is that all too often emergency responses are delayed, or the response must come from a neighboring community.

Figure 1

Difficulty Responding to 9-1-1 Calls



"I'm a farmer in my real life. We don't have as many EMTs now, we've got a lot of people that work out of town. So…for us on average is a three-hour call from start to finish."

"For those who hold jobs out of town, they have to make a tough decision. It's 4:30 now, if I go on this ambulance call can I get back in time to get to work?"

There are many reasons for this crisis —

These are among the most challenging.

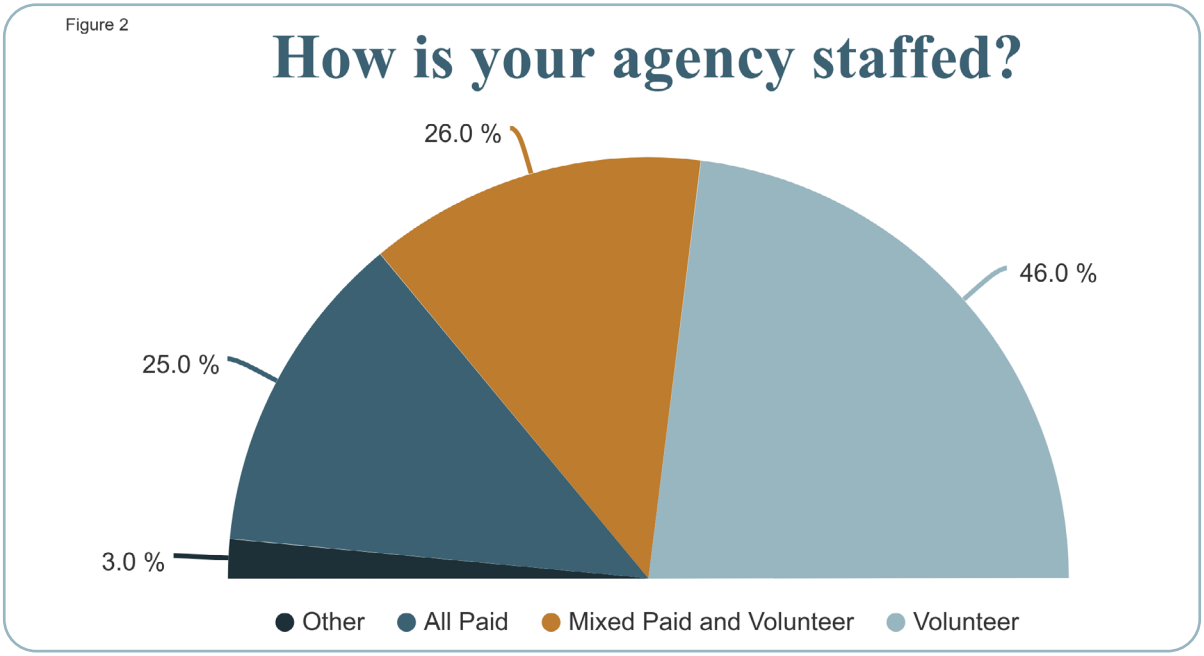
1. Staffing

Most EMS agencies rely on the availability of highly-trained volunteers. Maintaining volunteers is crucial, however 39 of 61 EMS agency managers or directors rated retaining staff as moderate to great difficulty.

> "Well, there are times when we flat-out have nobody and that's a staffing issue. And you know if you have a 30-minute delay it is because somebody that wasn't on call had to respond."

Not unexpectedly, nearly three quarters of the EMS agencies rely heavily on volunteers to respond to 9-1-1 calls (Figure 2). This speaks to the 'neighbors helping neighbors' spirit that is part of what makes Montana an attractive place to live and work. This model has worked well for five decades. However, it is becoming increasing less viable for a variety of reasons. These include a generational shift in priorities, dwindling volunteerism and rural population bases, work and professional obligations that may cause the residents to work elsewhere during the day.

Figure 2



Of course, the staffing challenges are related, at least in part, to funding. Two finance questions ranked high on the list of risks to EMS response within the community. The first relates directly to the staffing issue "Figuring out how to move from volunteers to more paid staff". Clearly salaried or otherwise compensated staff is seen as a key to increasing participation and ensuring the ability to respond. Tax incentives to offset the costs of becoming and maintaining EMT certification for volunteers will also help.

The other funding issue presents a stark picture, and immediate need. "Obtaining enough financial support to meet current costs". This statement suggests that even with the current reliance on volunteers, funds are insufficient to meet costs associated with the service.

Observations from Hospital Executives

The future of EMS in most communities is impacted by a lack of new EMTs interested in participating in EMS. There is a sense, in most communities, that volunteerism is markedly decreased in all areas (church, schools, 4-H, etc.).

Additional challenges noted by local EMS Directors/Managers

"… you don't see the young people stepping up like they did before I mean, you know, we live in a world where everybody's about themselves instead of about everybody else. And I think that is the one piece that could really affect our service…"

"We're an all-volunteer service… we are running two-man crews…it is getting really difficult to try to maintain any semblance of call schedule."

2. Recruitment

The potential volunteer pool is shrinking in many rural communities. Recruiting staff was rated as moderate to great difficulty by 56 of 61 EMS agency managers or directors.

> "It's something important to us and we like to do it so we make it work. But not a lot of people want to volunteer anymore. It's hard and I don't know… we have racked our brain trying to figure out what the answer is to that question, but I don't know."

Recruitment of new members proves to be an ongoing and, in some cases, seemingly impossible challenge in some communities. As evident in Table 1, the perceived barriers to recruitment most often center around time commitments. Responses that have been received by EMS leadership as they are trying to convince someone to volunteer include "family commitments," "takes too much time," "job or social commitments," and "training requirements." These commitment considerations are punctuated by the "cost of training" and "inadequate/no pay."

Table 1
Barriers to Recruitment

Family commitments	48 (79%)	Physical demands of the work	13 (22%)
Training requirements	41 (68%)	Other	12 (20%)
Takes too much time	41 (68%)	Declining financial support	10 (17%)
Job or social commitments	39 (64%)	Little or no recognition or rewards	8 (14%)
Inadequate/no pay	37 (61%)	Poor recruitment and retention efforts	7 (12%)
Lack of interest to attend training	27 (45%)	Danger/risk of EMS	5 (9%)
Cost of training	24 (40%)	Medical liability	3 (5%)
Stress and exhaustion of EMS work	21 (35%)	Health hazards	2 (4%)

These findings paint a grim picture for the maintenance of an EMS response system that is so dependent on the goodness of people's hearts. When asked to identify the greatest challenges to the agency's current and future ability to provide quality and timely prehospital care, the following answers rose to the top:

1. "A small group of people carrying most of the schedule"
2. "Availability of staff during specific times"
3. "Advancing age of current staff/impending retirements"
4. "Unable to cover call with current staff"

Observations from Hospital Executives

EMS is not considered an essential service in Montana, so it is not afforded the same benefits/protections as fire and law enforcement. Pay structure, opportunities for advancement, fringe benefits and retirement packages are vastly different between EMS and other essential services. Legislative awareness and commitment are weak.

Additional challenges noted by local EMS Directors/Managers

"… when it comes to recruiting new EMT volunteers, we rely on word of mouth… we've done some little flyers up at the post office that kind of a thing saying hey, we're going to run an EMT course and that's really it. We don't have a recruitment program where you go out and beat the bushes…"

3. Training

The training to become an EMT or paramedic requires time away from family and other commitments. An EMT course may require up to 140 hours of classroom and hands-on training and then an additional 60 hours of continuing education every two years to maintain certification. A paramedic course could easily take more than 1,100 hours and a similar amount of continuing education every two years Training requirements were mentioned by 67% of respondents as a barrier to recruitment.

> "Almost all the trainings are in Billings or Helena or on the other side of the state…It is a hardship for a volunteer service for us to send three people and have them stay in a motel and pay for their food."

As emergency medicine in general, and prehospital EMS specifically, has evolved and matured over the past half century, training has become more complex and time consuming. Recent advances in the care of trauma, bleeding control, stroke and heart attack have changed treatment provided not only in the hospital but in EMS as well.

As is evident in Table 1, more than 67% of respondents note training requirements as a significant barrier to participation. Family commitments are understandably noted by 79% of respondents. Time (67%) and cost (39%) of training present additional challenges for volunteers. On-going continuing education requirements, necessary to maintain competence and confidence, particularly in rural low volume agencies also contributes to attrition among volunteer crew members.

Observations from Hospital Executives

It was noted that initial and ongoing education is expensive and largely unsustainable in the rural environment. The standard requiring paramedic education programs to be accredited has severely limited ability to provide advanced training in rural communities.

Additional challenges noted by local EMS Directors/Managers

"… we had a gentleman from King County Washington who flew here to do an education thing. There were two of us and that's humiliating to me, you know. Granted, the American Heart paid for that, but I hear from the volunteers, we want more training, we want more, but then they don't show up."

"… we started out two years ago with 21 people in the class ended up cutting the class off after the third one because we were down to two people and both of them were from out of town weren't even going to be responding in our area… So, it just wasn't worth it, you know."

4. Certification

Certification of EMTs and paramedics is a Board of Medical Examiners function, and licensing of EMS agencies is a DPHHS function. A common theme from hospital and EMS management is that this creates confusion and additional difficulty for providers.

> "We were all nationally registered in fact we had to be nationally registered and then when the state came down with their new registration guidelines, and we didn't have to be nationally registered it wasn't worth it for us."

Another certification challenge relates to test anxiety for adult learners. Many of the individuals who are willing to become volunteer EMS providers are non-traditional students, who may be many years past their last formal education experience. Some of these individuals experience test anxiety and while they may have excellent scores on the written exam, may fail the hands-on exam. It is incumbent upon training staff to ensure not only clinical competence is attained throughout the coursework but that enough testing opportunities are provided to alleviate some of the anxiety when the student sits for a certification exam.

Observations from Hospital Executives

The necessity for EMTs and EMS agencies to communicate with both the Board of Medical Examiners and the DPHHS was concerning among the respondents. It was noted both by EMS and hospital personnel that it is confusing at best and counterproductive at worst to have the functions of EMS split between two governmental agencies. It results in mixed messaging and challenges in certification in particular.

Additional challenges noted by local EMS Directors/Managers

"… she's been through the EMT class twice and she is just as quick and sharp as anybody, but she just freezes up on that test and just can't pass that test. So, I don't know if we'll get her to take it again."

5. Financial Support

Relying solely on donations or minimal insurance payments from billing no longer covers operational costs. Ninety-five percent of responding EMS agencies bill insurance to generate revenue.

> "…we apply for a lot of Grants because that kind of keeps our equipment up to date. Otherwise, we wouldn't be able to do it without grants. Now we get absolutely no support from the city council. In the summer we will do different little raffles…"

Regardless of whether the agency is fully volunteer, mixed paid and volunteer or fully paid, funding is often tenuous at best. Fees for services are difficult to collect and are for some insurance types such as Medicaid, reimbursed at rates well below actual costs. Billing is tedious and complex and requires excellent documentation of activities completed in the field. Successful billing is often beyond the skill set and time availability for volunteer agencies. Collection and reimbursement rates fall short of supporting the agency. Third party billing services are often used and, of course, retain a portion of the collected revenues. As noted in Table 2, approximately 95% of the agencies who responded attempt to collect fees for their services.

Table 2
Agency Funding

	%	#
Fee for Service	95%	58
Donations / fund raising	52%	32
Subsidized by taxes, taxing district, city or county	51%	31
Subsidized by hospital or other entity	10%	6

Shortfalls in revenues received from patient billing are supplemented by one or more methods. Donations and fund-raising events garnered the second highest number of responses followed closely by public funds from taxation in some form. Although the ratio of grant funding to other fundraising and donation activities is not calculable, survey responses suggest that it is substantial, particularly in major equipment acquisition. Other fundraising events cover the philanthropic landscape from pancake breakfasts to walkathons to raffles. The success of these efforts is variable depending on the level of community support.

Public support comes in several ways, including city or county general funds or special ambulance taxing districts. The relationships between county commissioners/city councils and agency leadership varies substantially. In some cases, EMS personnel are employees of the taxing entity.

Similarly, some agencies are subsidized or owned outright by a hospital. Again, relationships are variable with EMS personnel sometimes feeling that the ambulance service is lost in the other challenges facing the hospital. There were differing perceptions of the relationship depending on whether it was being described through the lens of hospital or EMS agency personnel.

Observations from Hospital Executives

With many of Montana's health care facilities facing their own financial challenges, it was not surprising that EMS funding was noted to be an issue. Billing services and collection rates vary across agencies. Reimbursement rates are notably low, and opportunities exist to maximize reimbursement through improved documentation and billing processes. Improved reimbursement billing and collection processes are necessary to support sustainability. Hospital professionals feel that since most rural communities report an extremely low Medicaid payor mix, Medicaid payment structure/payment changes will not help in any meaningful way, many of the EMS agencies hold a different view.

Limited grant funding is noted to exist from both public and private sources although as was evident in discussions with prehospital personnel, some communities struggle with, or are intimidated by, grant application processes. There may be an opportunity to connect experienced hospital-based grant development staff with EMS personnel to assist and support their efforts. Exploration of other granting entities should be undertaken.

Additional challenges noted by local EMS Directors/Managers

"So, we do not have any tax contributions at this time. So, it's all through donation and through billing at this time... Tried to do a levy but that hasn't happened yet. And we would do that in order to try to be able to staff at 24/7 with paid EMTs."

"… and they need a psych patient to go up to St Pete's, and we do that and it costs us, you know, $600 to run that car… and my collection on that's about a hundred seventy-five bucks, right so we eat that so that that's problematic right?"

"… we just took out a loan to get our cots and one ambulance was down and we had to put in a new motor. So, we did some fundraisers for that."

6. Community Awareness

Montanans have unrealistic expectations of volunteer EMS capability and capacity. Learning how to 'Tell the EMS Story' was identified by both hospital and EMS management as a critical need if they were to be successful at raising awareness about the challenges facing EMS.

> "Considering we are here for the well-being of the general public… I think if the general public knew the hoops we have to go through and the lack of support that we get, I think they'd be outraged just as much we are."

In the smallest frontier communities, it appears there is strong support for and appreciation of the dedication of the small group of EMS responders. In the larger communities it is an assumption that the services will be provided along with fire and police. With respect to the rural communities, between frontier and more urban the community support is more variable. It appears that in many cases residents do not know how the agency is constituted or managed. Inaccurate assumptions are made about the paid status of the responders and the level of care they provide. Most agencies have limited capacity for building community support, such as a public information officer.

Observations from Hospital Executives

EMS is not considered an essential service in Montana, so not afforded the same benefits/protections as fire and law enforcement. Pay structure, opportunities for advancement, fringe benefits and retirement packages are vastly different between EMS and other essential services. Legislative awareness and commitment are weak.

Additional challenges noted by local EMS Directors/Managers

"How can I present this to the public so that they understand that EMS is not tax funded, that it is not required by law, that we have to rely on volunteers. Just being able to do that would be great if we could all figure that out and be able to change that attitude a little bit."

7. Medical Direction

Medical oversight improves patient care through performance improvement. Of the 61 EMS managers and directors that responded, 17 reimburse their medical director for services provided to the EMS agency.

> "The PAs and the Docs are under the Board of Medical Examiners but nurse practitioners are under the Board of Nursing… there are a lot of good nurse practitioners out there that would fill the role very well and I think that the state could consider an application or a waiver process… I could see where that could be a benefit to rural areas."

Medical direction refers to the relationship between a physician or surrogate who oversees the medical care provided by EMS personnel. There are two types of medical direction, on-line and off-line. The former refers to live communication between the physician and the EMS provider during the actual provision of care. This occurs infrequently, usually in the most difficult patient care scenarios. Off-line refers to the development and/or oversight of patient care instructions… guided expectations for the provision of care by illness or injury type, such as a heart attack or stroke.

Once established, the medical director is also involved in the oversight necessary to confirm adherence to the protocols and to establish performance measures to improve patient outcomes. This process involves reviewing EMS patient care reports (all, randomly selected, or targeted). Strategies are identified to improve individual or collective agency response. The medical director is also responsible for signing off on competency assurances for each individual and, in rare cases, for initiating disciplinary action directed towards an individual EMS provider. Some medical directors work with multiple EMS agencies, and most have their own full time practice.

Observations by Hospital Executives

Current regulation allows medical direction to be provided only by physicians and physician assistants. Nurse practitioners are currently not allowed to provide oversight and direction. This limits options for local oversight in some communities. Quality expectations and quality processes standards are not in alignment statewide. Quality assurance, quality improvement, and performance improvement processes are highly variable among and between agencies and by injury or illness conditions.

Additional challenges noted by local EMS Directors/Managers

"They only have so much fight in them, they are full time… they have a full-time job somewhere else; you know, they take on us for free. I don't know if all medical directors do it for free, but I know ours does."

"He was a volunteer medical director, but they pushed him to a point where he said I can't do this… I mean, it just was a lot. It's so much to explain."

8. Innovative Leadership

There are potential answers to EMS leadership challenges, but one size will not fit all. This is made more difficult as many EMS agencies (26 of 61) do not have a hospital in their community and 49% of EMS managers have no formal leadership preparation.

Local:

"As director… it's an odd role honestly because it's not really a job. It's not really a hobby it is just something that we end up doing. My roles generally are… I do all the all the drug ordering all the medications all the supplies. I do the scheduling — some of the day-to-day operation stuff."

Nearly one half (48%) of the respondents reported that the EMS director or manager was strictly volunteer with another 10% noting that the person was paid for fewer than 20 hours per week. There are some innovative approaches to the various challenges facing each agency. While a paid manager does not make the problems of recruitment, training, scheduling, and response disappear, it does allow for focused efforts to overcome or mitigate them.

Observations by Hospital Executives

Hospital leadership noted that successful EMS agencies are dependent on the people who run them (or are deeply involved).

Additional challenges noted by local EMS Directors/Managers

"Our ability to respond, it's one retirement away, it's one accident away from folding. And with this huge area we cover with the low population density. It's a matter of life and death and honestly it is."

"But then again, you know when some big decisions come down from the County, you don't necessarily have people with a medical background. You know, when the Commissioners want to make a decision, they make a decision, but they're not thinking from a medical standpoint."

Regional:

…parts of the state's EMS program are really good. DPHHS' education program has been doing Regional offerings and the training is great and it brings people together."

During the federal funding period of the 1970s, EMS regions were developed to deal with multi agency issues in an attempt to streamline responses and avoid the duplication of expensive resources. The regions were active in the beginning when there were funds to support travel for attendance. There were full time regional coordinators to keep things moving forward between meetings. There was state and federal oversight to ensure the timely completion of goals and objectives.

Significant progress was made in several areas in terms of communications, equipment and training. Following the loss of direct federal funding for EMS in 1981, the EMS regions dwindled and eventually disappeared. A regional structure for trauma care does exist but focuses mainly on hospital issues. It does however provide a potential framework to expand to deal with prehospital EMS issues.

Observations by Hospital Executives

Interfacility transfers create a significant strain on volunteer agencies and hospitals and will likely need regional solutions. Experience has shown that if key members of the government, hospital, EMS agency, and community are willing to "stay at the table", they are able to find creative solutions to problem solving.

Additional challenges noted by local EMS Directors/Managers

"…Toole, Shelby, Conrad, Chouteau area that is a huge area. And when you look at the amount of paramedics and services and ambulances, it gets a little bit scary! … it would be nice if the hospital in Cut Bank, Conrad or Chouteau could say… we've got a patient that needs to go to Great Falls. They can't fly. The weather is bad or whatever. I'm going to call this one call number and get a transport."

Statewide – Governmental:

"I mean Staffing is our biggest problem. I don't know how they can help with that, but maybe educating the public to the needs, you know volunteering and stuff. I mean, it's funny only people in the system understand how many people are volunteers, you know, they understand that 90% of the services are volunteer and the community doesn't know that and I think public education is the biggest thing that needs to happen."

The EMS and Trauma Systems Section of the Montana Department of Public Health and Human Services has been a consistent voice providing leadership and oversight to the Montana EMS system since its inception. It has assisted local communities with a variety of issues through training, technical support and limited funding.

They have been successful at obtaining federal and private grants to support the development and maintenance of the systems. Using these funds, the EMS and Trauma Systems Section supported the implementation and distribution of a data collection system which allows for local and statewide performance improvement activities. Specific training has been provided in the areas of pediatrics, geriatrics, opioid reversal, controlling life threatening bleeding and other focused areas of care. Additionally, they have been responsible for initiating and supporting our trauma centers across the state.

Since 2004, the training and licensure activities for individual recognition at various levels such as EMT and Paramedic has been performed by the Department of Labor – Board of Medical Examiners. The EMS and Trauma Systems Section has been responsible for providing educational opportunities for EMTs, EMS and trauma data collection and reporting, licensing EMS agencies, supporting trauma system development and leading injury prevention activities. This bifurcation of responsibilities added to the frustration of many local

EMS agency leaders. It sometimes became unclear where to go for what. There is interest in moving all functions back under the EMS and Trauma Systems Section.

Observations by Hospital Executives

The challenge of working with two state agencies, the Board of Medical Examiners and the Department of Health and Human Services' EMS and Trauma System Section, was concerning. It was noted both by EMS and hospital personnel that it is confusing at best and counterproductive at worst to have the functions of EMS split between two governmental agencies. It results in mixed messaging and challenges in training and certification.

Additional challenges noted by local EMS Directors/Managers

"Remodel of the licensing program and making it a more modern making it jive with the National Registry again. Like it used to be, it was very simple. It seems a lot more complicated now to have two different kind of parallel systems."

"… I believe that the ability to have some kind of a retirement fund or they get some kind of benefit like volunteer firefighters have."

Statewide Non-Governmental:

> "Well, we need a prehospital organization that is willing to step up and do things, so that's my next soapbox. … That would be one of the things see, there has to be a voice for EMS out here in Montana".

While there is no singular voice representing the needs of EMS agencies or their personnel in Montana, there is a non-profit organization that has existed for more than 30 years. That organization's focus is organizing statewide conferences and training. Many respondents noted that a statewide advocacy organization will be critical in resolving the many challenges currently facing the statewide EMS system.

Observations by Hospital Executives

"Statewide, Medical Director collaboration is limited, and medical directors are varied in their experience and training. Hospitals have an obligation to see EMS as a partnership to services in the community. The Montana Hospital Association has stepped up as an advocate."

Additional challenges noted by local EMS Directors/Managers

"I don't feel like EMS in Montana will truly progress without a collective voice. And I think the state would love that. It's so much easier to respond to a single voice than 500 voices."

"… the fact that the EMS program is collaborating with the Montana Hospital Association gives them a lot more to leverage."

Addressing the Issues

1. Staffing

The agencies who had the least significant challenges in staffing were those who were closely affiliated or integrated with another public service or a health care entity. Both models have pros and cons. In relative terms, fire services and healthcare organizations are better financed than stand-alone volunteer EMS agencies. In fire/EMS based agencies, there is often an incentive to transition from EMS to strictly fire due to advancement opportunities and associated pay differential. Hospitals can create an atmosphere where the EMS function is more like an appendage than an integrated division of the organization.

Recommendations:

1. Staffing: Wherever practical, EMS agencies should explore aligning with fire departments, hospitals or other health care entities (clinics), to gain access to more formal reimbursement and benefits.

    1a: Fire departments should create pathways for advancement and subsequent pay and benefits within the EMS division
    1b: Health care entities should explore the possible use of EMS personnel in a community paramedicine model to help maintain patient health and avoid unnecessary repeat hospital visits.
    1c: Regional response systems should be developed. This is particularly a need for interfacility transfer and to backfill neighboring community needs when the primary unit is already engaged.

2. Recruitment

Agencies who have worked to engage and raise community awareness on an ongoing basis seem to have the fewest challenges with recruiting new members. This speaks to the need for public information and awareness campaigns, the development of which are beyond the capacity of most agencies.

Recommendations:

2. Recruitment: The EMS and Trauma Systems Section should oversee the development and distribution of public information campaigns that stress the value and necessity of community EMS agencies and encourage volunteerism.

    2a: Local EMS agencies should explore the possibility of alternate sources for personnel. These might include school cadet, auxiliary, and reserve corps programs.
    2b: Local EMS agencies capitalize on all available opportunities to share the recruitment materials noted above. This might include news media, church bulletins, and presentations to governmental (county commissioners) and civic groups (4H)

3. Training

The cost of continuing education significantly impacts the EMT and the EMS agency. Volunteers who have full time jobs struggle to find the time to respond to calls, let alone travel out of town for training. EMS agencies frequently pay for the training expenses of personnel, but this reduces funding available for other operational needs.

Recommendations:

3. Training: Opportunities for regionalization of training should be explored. This might include academy like operations which include over-night and food accommodations.

   3a: The Board of Medical Examiners and the EMS and Trauma System Section should seek to increase the opportunity for distance education through currently available subscriptions such as "EMS at Night" and others. When new items or procedures are added to the scope of practice, a distance learning module should be produced and distributed.
   3b: The Simulation Truck and similar mobile training units, as well as various on-site training delivery groups should be encouraged and financially supported to offset costs to rural and wilderness communities.
   3c: There should be continued expansion of affordable broadband access to rural and frontier communities to facilitate distance learning opportunities.
   3d: Web-based communication and education lessons learned during the COVID-19 Pandemic should be reviewed and incorporated into long-term education strategies.

4. Certification

Over previous decades, certification processes have become more complicated. National and state testing and continuing education requirements are not consistent, often causing confusion and frustration.

Recommendations:

4. Certification: Processes should be designed to reduce the burden on EMS providers and agencies without impacting the quality of education. Rules, regulations, and administrative procedures should be updated.

   4a: Written practice tests emulating certification exams should be made available to all students.
   4b: A coaching/tutoring process associated with the practice tests should be developed to assist students with understanding how to evaluate questions, eliminate obvious false distractors and choose the correct answer. Key concepts in test anxiety reduction should also be included.

5. Funding

The volunteer model that was put in place in the 1970's has outgrown its utility for a variety of reasons. The aging of rural and frontier Montana, economic pressures, migration toward the opportunities afforded in larger communities, and changing attitudes regarding community service has severely depleted the ability to recruit, train and maintain volunteer personnel. Transitions to funded agencies seems inevitable. Funding support models will need to be adaptable and scalable to meet the needs of each community.

Recommendations:

5. Funding: EMS should be designated as an essential service available in each community. Funding streams should be established at state, tribal, county and municipal levels based on the size of the community and the needs of the agency.

   5a: Every effort should be made to transition strictly volunteer agencies to paid or partially paid entities.

At the entry level, funding a part-time agency coordinator should be engaged, at the high end of the scale, all personnel should be compensated for their time and effort. This might include a structure with some full-time paid employees and supported by part-time paid personnel.

5b: Avenues to improve reimbursement rates should be explored, particularly those reimbursements associated with Medicaid. Standards for third party billing entities should be established to ensure that maximum return on recovery fees are being met. If an EMS agency is affiliated or integrated with a health care facility, billing should be accomplished through that entity (following specific training on EMS coding and data collection software). EMS personnel should be oriented to the need for completeness of patient care records not only for continuity of care but also to increase insurance collection.

5c: The Department of Public Health and Human Services' Medicaid Program and the EMS and Trauma System Section should explore options with CMS to establish 'Treat/no Transport' and 'Treat and Refer' billing codes for state approved Community Paramedicine programs. In the long run there is a potential cost savings since the program would help promote community health and decrease unnecessary hospital visits.

5d: Grant writing training and assistance should be provided by The Board of Medical Examiners and the EMS and Trauma System Section. A menu of potential grant funding opportunities should be made readily available and alerts for new grant opportunities and associated deadlines should be included.

5e: A retirement fund, like that for volunteer firefighters should be established for EMS personnel.

6. Medical Direction

Prehospital medical care continues to evolve. Newer concepts in terms of the treatment of heart attack, stroke, external bleeding, spinal immobilization, community paramedicine and other treatment approaches require constant upgrading for each agency. The opportunity to add additional skill sets for personnel in an incremental fashion requires medical guidance. Just as prehospital resources have been strained over ensuing decades, so too have those of hospitals and clinics. Opportunities exist to better integrate and utilize these dwindling resources that will benefit EMS and rural hospitals.

Recommendations:

6. Medical Direction: Agency oversight and performance improvement should be supported by qualified and engaged medical directors. This is particularly key as new medical concepts and approaches are introduced into the prehospital environment.

6a: To facilitate medical oversight, regulations should be amended to allow qualified Nurse Practitioners to provide medical direction. In the most remote communities, the NP often represents the highest level of medical training in the community. They are familiar with the health care status, risks and needs of the community.

6b: Regionalization of medical direction should be explored for those communities where medical resources are limited.

6c: Compensation for medical directors should be available for those who wish to receive it. The task of medical direction, even for the smallest agency, requires significant dedication and commitment.

7. Leadership

The key to all healthy and robust systems, whether public or private, is strong leadership at the helm. Just as

in a military command there are various levels of leadership. In the case of Montana, EMS leaders exist at many levels, they need to be encouraged and supported. Others need to be recruited, trained and given the resources they need to fulfill their mission. A non-governmental means of advocating for and promoting EMS in Montana is essential to informed decision making.

Recommendations:

7. Leadership: Local, regional, state and non-governmental resources, activities and actions will be needed to ensure Montana's EMS system is protected.

   7a: Regulations pertaining to qualifications for medical oversight of local EMS agencies should be amended to allow Nurse Practitioners to serve in that role.
   7b: Sources of support should be identified to offset the costs associated with Simulation Truck and other external sources of training.
   7c: Consideration should be given to re-establishing regional EMS councils to create and execute plans to ensure timely coverage of EMS across the region and to develop interfacility transfer resources.
   7d: Management training for agency level personnel should be continued and expanded to include orientation processes for elected officials and community leaders.
   7e: A statewide, representative advocacy organization should be developed to help promote EMS across the state and to inform and educate legislators, county commissioners and city officials concerning the need for regulatory and financial support.

Appendix 1: *Methodology*

Goal

Ascertain the nature and extent of threats to Montana's EMS community using a survey process involving hospital executives and EMS service managers.

Methods

The EMS and Trauma System Section collaborated with the Montana Hospital Association to conduct a combination of in-person, telephonic and on-line surveys of executive staff at 42 hospitals and agency managers and directors for 61 EMS agencies. Data collection was conducted by trained interviewers and the analysis and report drafts were done by Nels Sanddal, Ph.D., and by Michelle Skinner, Eleva Group.

Dates

The survey and analysis were performed between February 2019 and June 2020.

Uses

This report provides new information on the status of, and threats to, Montana's EMS system. It will assist legislators, policymakers, hospital administrators and EMS service managers in understanding threats to the EMS system and steps to reduce those threats and to strengthen the EMS system.

Appendix 2: *Quantitative Survey*

EMS System 2019

Q1 Name of your agency

Answered: 61 Skipped: 0

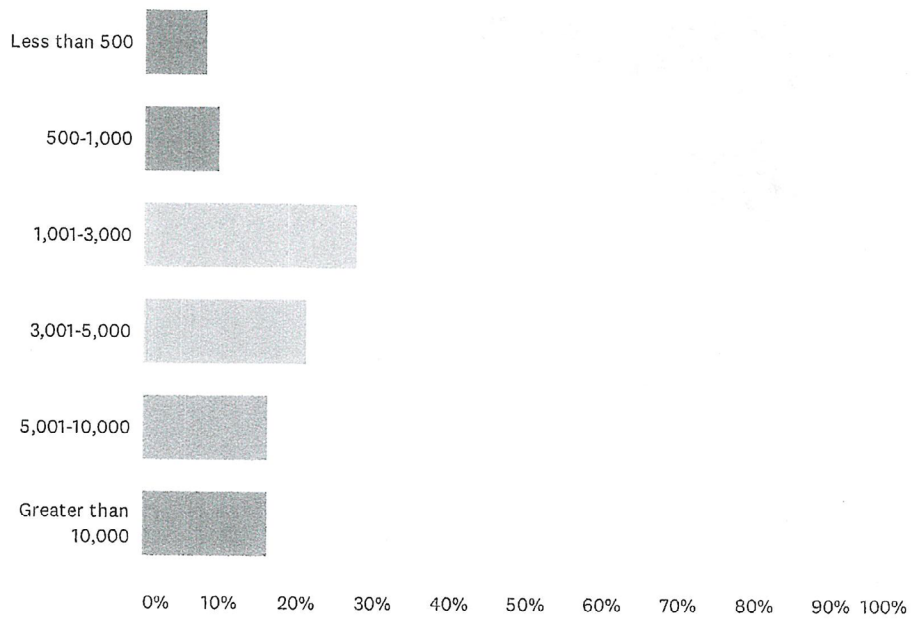
Q2 Name and contact information for primary agency contact person

Answered: 61 Skipped: 0

ANSWER CHOICES	RESPONSES	
Name	100.00%	61
Company	0.00%	0
Address	100.00%	61
Address 2	0.00%	0
City/Town	100.00%	61
State	100.00%	61
ZIP Code	100.00%	61
Country	0.00%	0
Email Address	100.00%	61
Phone Number	100.00%	61

Q3 Approximate population of your service area (choose one)

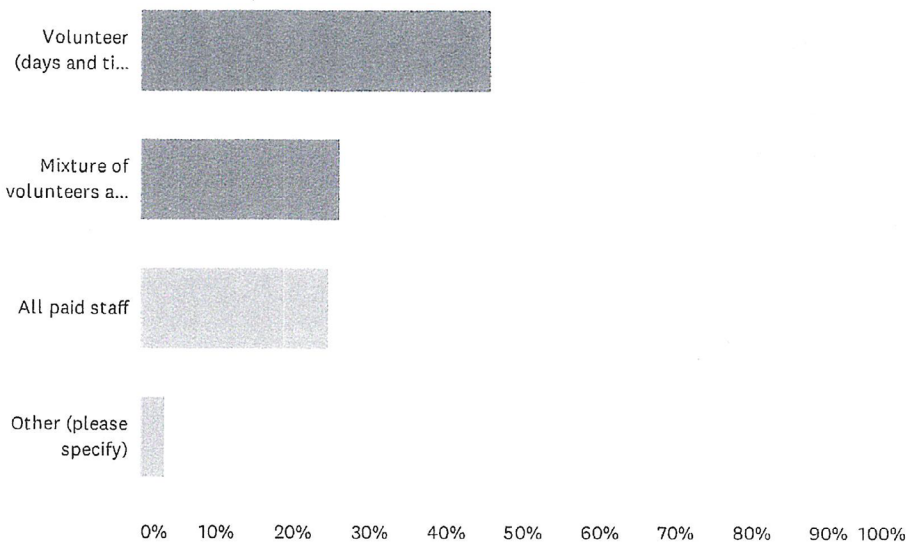
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Less than 500	8.20%	5
500-1,000	9.84%	6
1,001-3,000	27.87%	17
3,001-5,000	21.31%	13
5,001-10,000	16.39%	10
Greater than 10,000	16.39%	10
TOTAL		61

Q4 How is your agency staffed? (choose one)

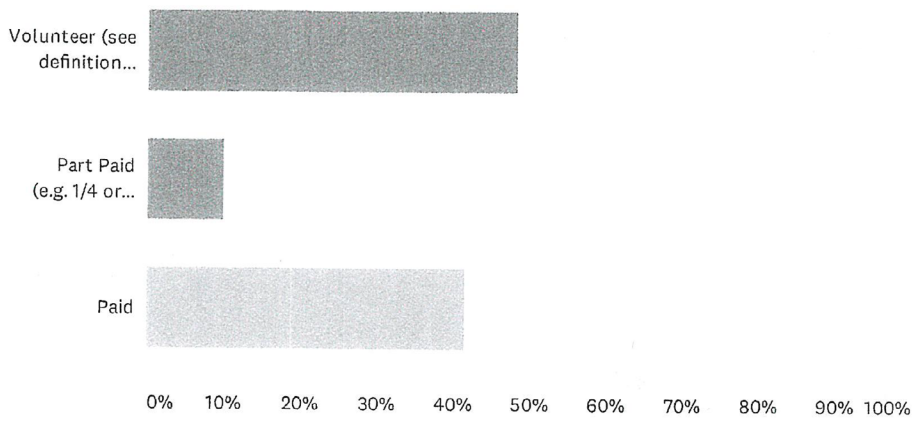
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Volunteer (days and times chosen by individual and not for a private ambulance or agency)	45.90%	28
Mixture of volunteers and paid staff	26.23%	16
All paid staff	24.59%	15
Other (please specify)	3.28%	2
TOTAL		61

Q5 If your agency is volunteer or mixed volunteer/paid, which of the following best describes your service manager.

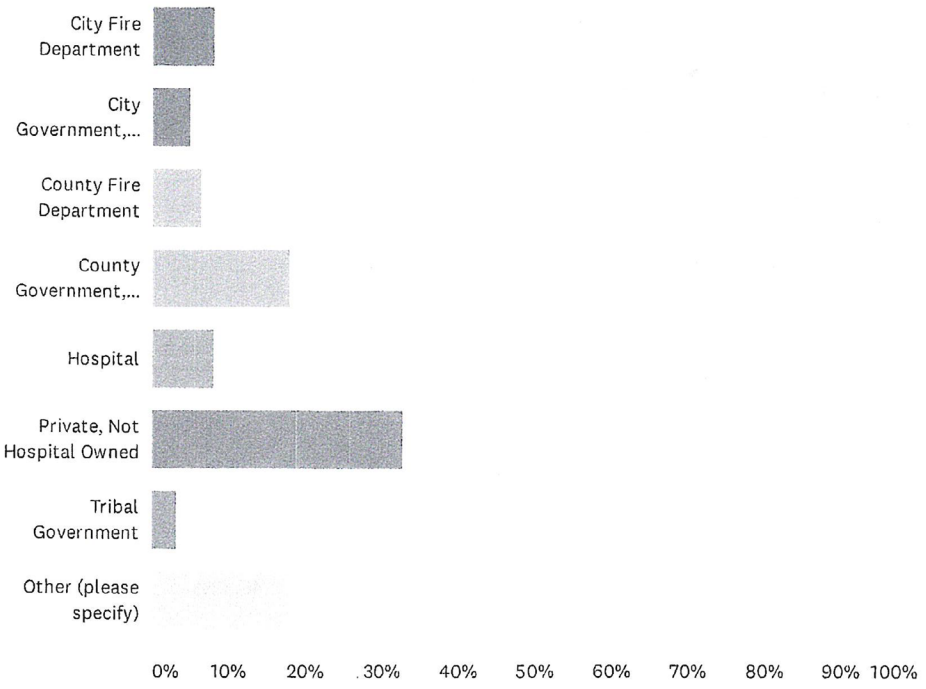
Answered: 60 Skipped: 1



ANSWER CHOICES	RESPONSES	
Volunteer (see definition above)	48.33%	29
Part Paid (e.g. 1/4 or 1/2 time)	10.00%	6
Paid	41.67%	25
TOTAL		60

Q6 Type of organizational ownership? (choose one)

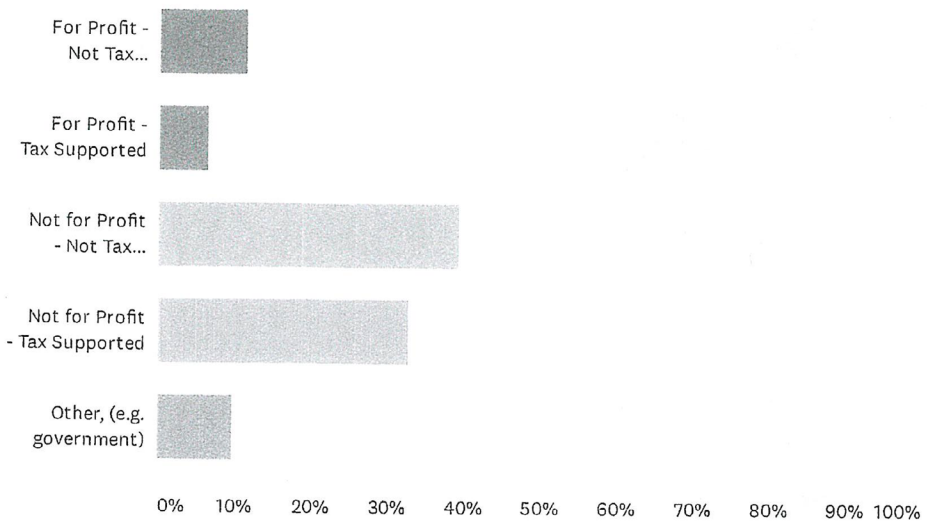
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
City Fire Department	8.20%	5
City Government, Non-Fire	4.92%	3
County Fire Department	6.56%	4
County Government, Non-Fire	18.03%	11
Hospital	8.20%	5
Private, Not Hospital Owned	32.79%	20
Tribal Government	3.28%	2
Other (please specify)	18.03%	11
TOTAL		61

Q7 Organizational Tax Status (choose one)

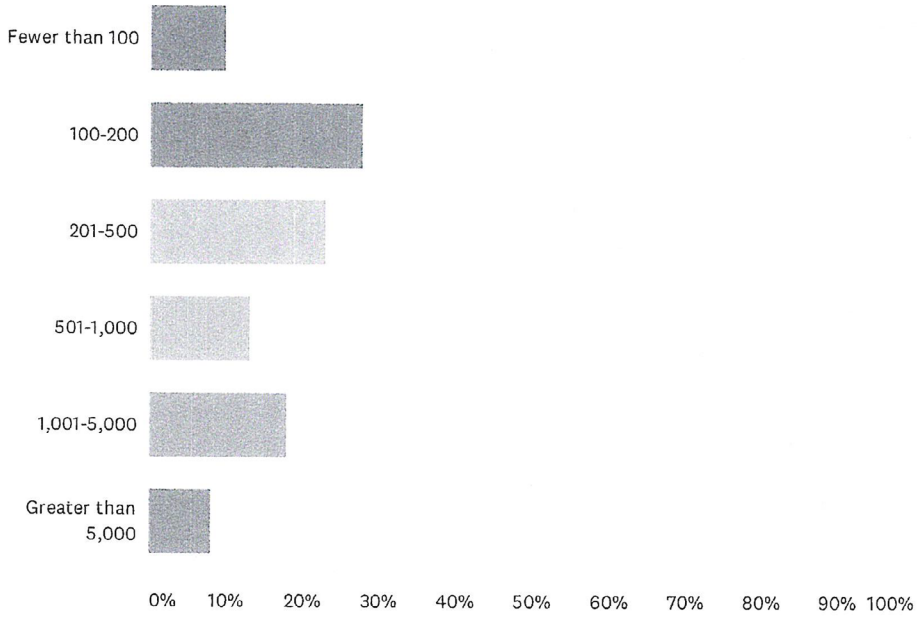
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
For Profit - Not Tax Supported	11.48%	7
For Profit - Tax Supported	6.56%	4
Not for Profit - Not Tax Supported	39.34%	24
Not for Profit - Tax Supported	32.79%	20
Other, (e.g. government)	9.84%	6
TOTAL		61

Q8 Approximate annual call volume (choose one)

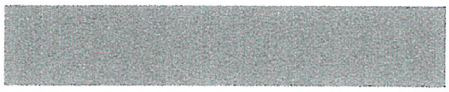
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Fewer than 100	9.84%	6
100-200	27.87%	17
201-500	22.95%	14
501-1,000	13.11%	8
1,001-5,000	18.03%	11
Greater than 5,000	8.20%	5
TOTAL		61

Q9 Approximate percent of above calls that are transfers (slide to percentage)

Answered: 61 Skipped: 0

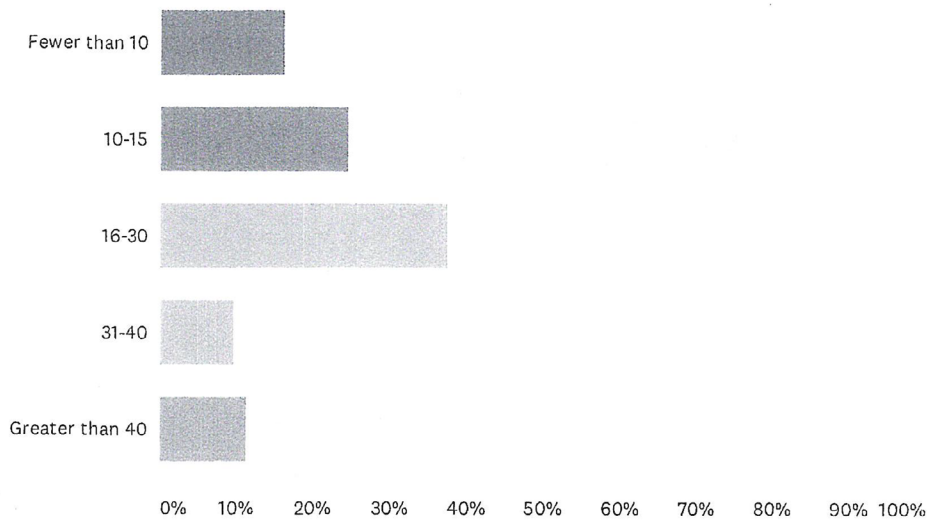


ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
	29	1,770	61

Total Respondents: 61

Q10 Number of employees, volunteers or members on your roster (choose one)

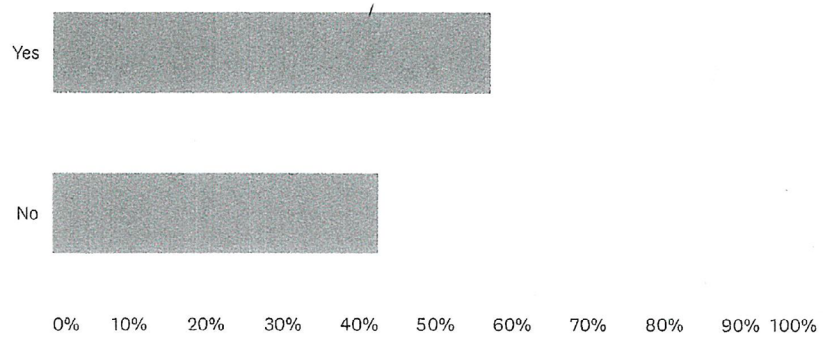
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Fewer than 10	16.39%	10
10-15	24.59%	15
16-30	37.70%	23
31-40	9.84%	6
Greater than 40	11.48%	7
TOTAL		61

Q11 Is there a hospital in the same community where your headquarters or main station is located?

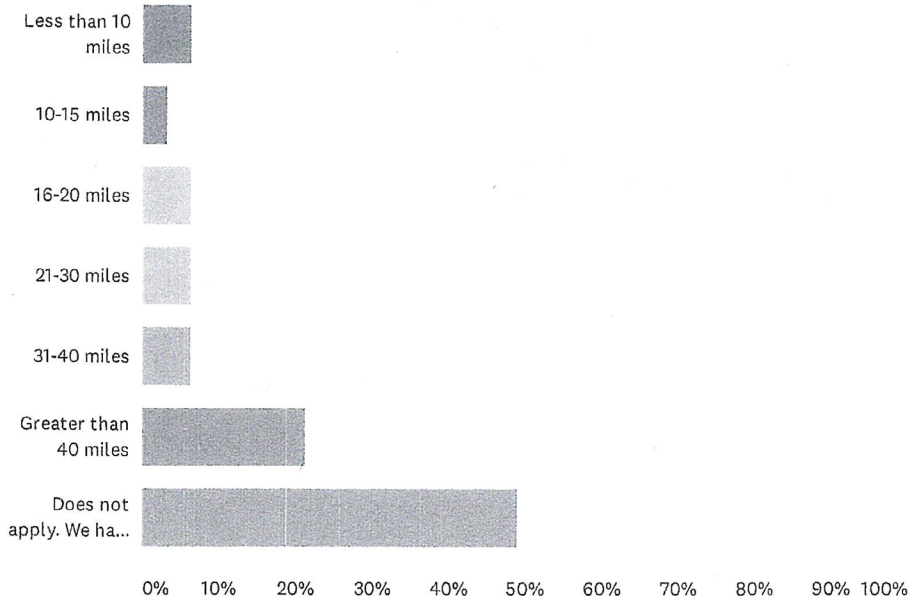
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	57.38%	35
No	42.62%	26
TOTAL		61

Q12 If you do not have a hospital in your community what is the approximate transport distance from your primary station to your main hospital receiving facility? (choose one)

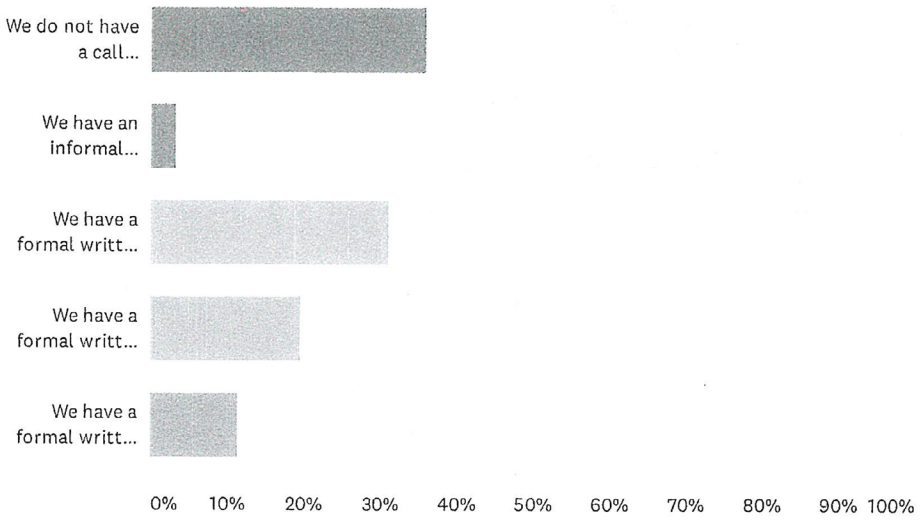
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Less than 10 miles	6.56%	4
10-15 miles	3.28%	2
16-20 miles	6.56%	4
21-30 miles	6.56%	4
31-40 miles	6.56%	4
Greater than 40 miles	21.31%	13
Does not apply. We have a hospital in our community.	49.18%	30
TOTAL		61

Q13 How is your service staffed? (please choose one of the following that best describes your agency)

Answered: 61 Skipped: 0

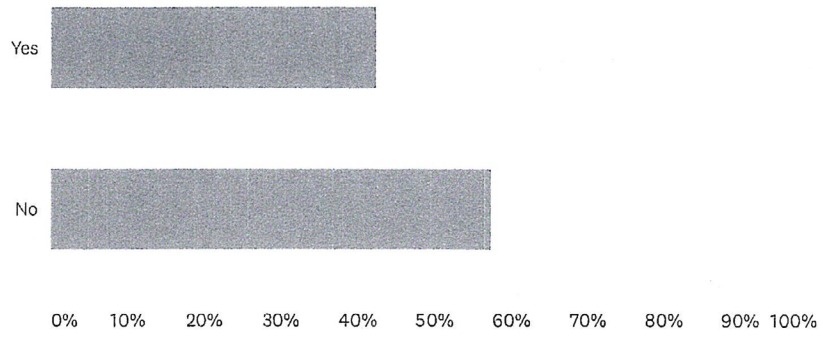


ANSWER CHOICES	RESPONSES	
We do not have a call schedule. Pages go out to everyone and those who are available respond.	36.07%	22
We have an informal unwritten schedule that exists between the staff (everyone keeps track of who is available).	3.28%	2
We have a formal written schedule but often have empty slots at certain times of the day and week.	31.15%	19
We have a formal written schedule that is consistently filled.	19.67%	12
We have a formal written schedule that identifies crews for primary and backup responses.	11.48%	7

Total Respondents: 61

Q14 Existing service members vote to approve new members.

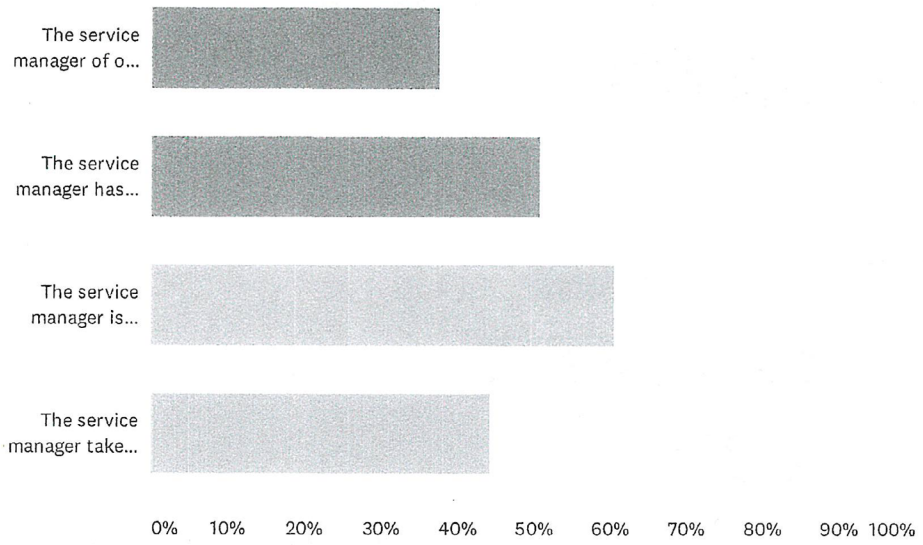
Answered: 59 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	42.37%	25
No	57.63%	34
TOTAL		59

Q15 Please tell us about the service manager for your agency. (Choose all that apply).

Answered: 61 Skipped: 0

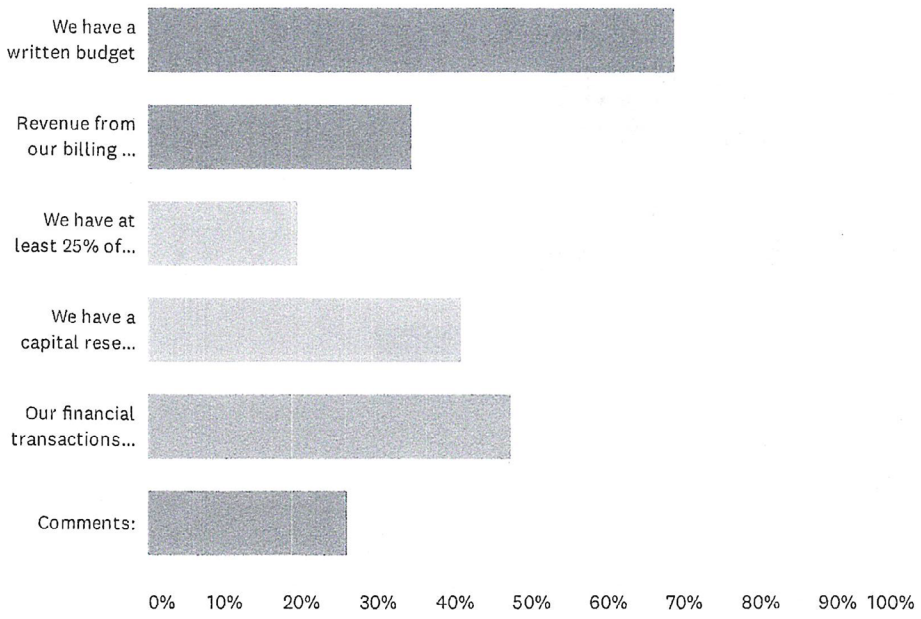


ANSWER CHOICES	RESPONSES	
The service manager of our organization is recruited and hired by a board or group of persons who are not employees or volunteers or members of the service.	37.70%	23
The service manager has formal leadership preparation (education and training in leadership).	50.82%	31
The service manager is authorized and empowered to discipline, terminate or remove staff from the roster.	60.66%	37
The service manager takes more than 20 hours of ambulance call time in a week.	44.26%	27

Total Respondents: 61

Q16 Please tell us about your financial practices (choose all that apply).

Answered: 61 Skipped: 0

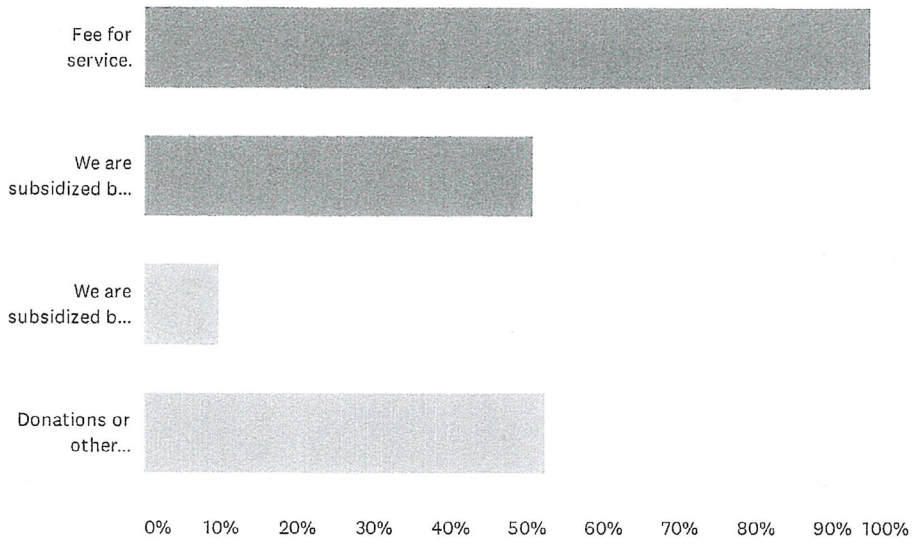


ANSWER CHOICES	RESPONSES	
We have a written budget	68.85%	42
Revenue from our billing for transports covers all our expenses	34.43%	21
We have at least 25% of our annual budget in reserves	19.67%	12
We have a capital reserve for ambulance replacement	40.98%	25
Our financial transactions are audited annually by an independent third party	47.54%	29
Comments:	26.23%	16

Total Respondents: 61

Q17 What source(s) of revenue supports your service? (choose all that apply)

Answered: 61 Skipped: 0

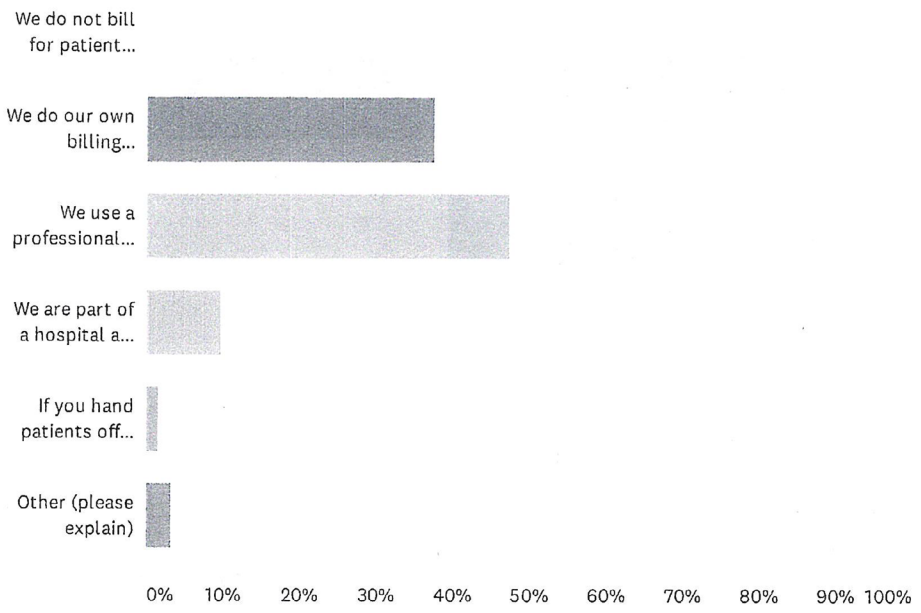


ANSWER CHOICES	RESPONSES	
Fee for service.	95.08%	58
We are subsidized by public money (taxes, taxing district, municipal or county funds).	50.82%	31
We are subsidized by a hospital or other entity.	9.84%	6
Donations or other fund-raising activities.	52.46%	32

Total Respondents: 61

Q18 Billing practices (choose one)

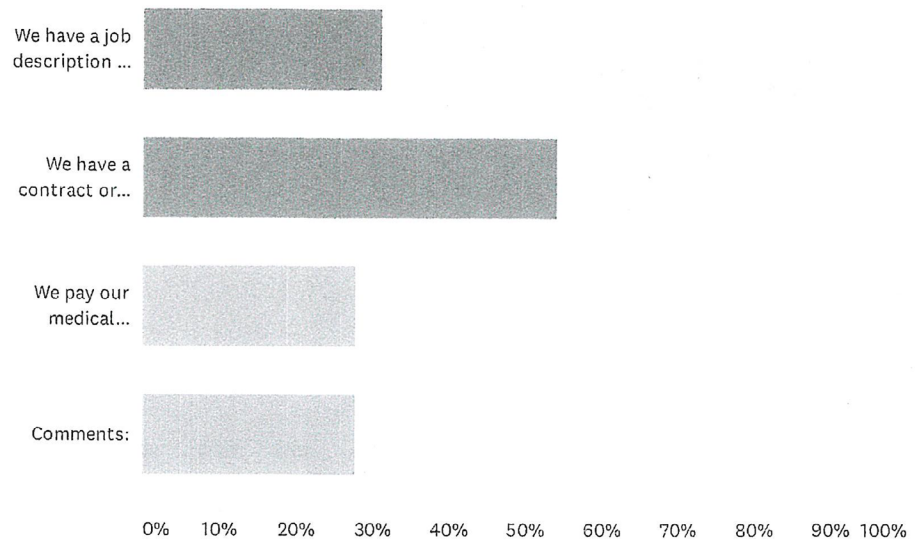
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
We do not bill for patient transports	0.00%	0
We do our own billing internally	37.70%	23
We use a professional billing service	47.54%	29
We are part of a hospital and the hospital bills for us	9.84%	6
If you hand patients off to a higher level of care do you have a contract for reimbursement of costs with the transporting agency?	1.64%	1
Other (please explain)	3.28%	2
TOTAL		61

Q19 Please tell us about medical direction in your organization (check all that apply)

Answered: 61 Skipped: 0

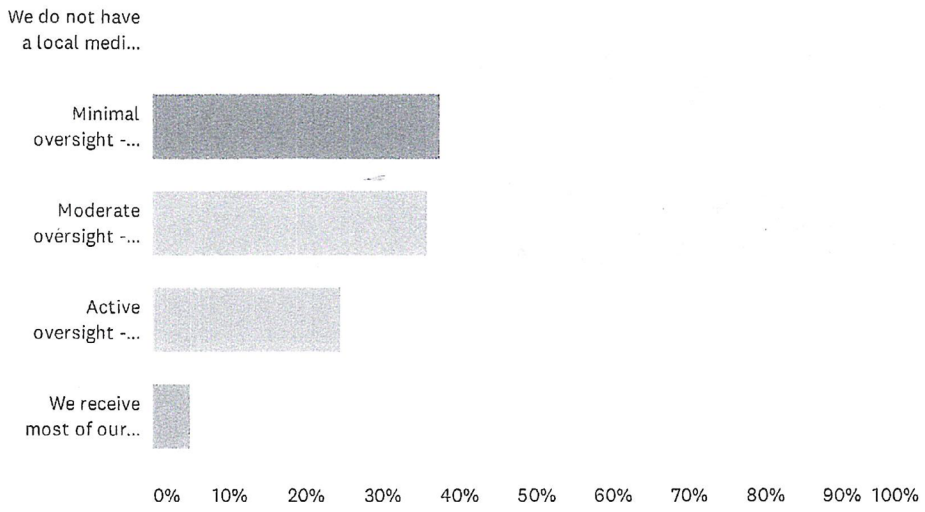


ANSWER CHOICES	RESPONSES	
We have a job description for our medical director	31.15%	19
We have a contract or letter of agreement with our medical director	54.10%	33
We pay our medical director (e.g. stipend, license fee, etc.)	27.87%	17
Comments:	27.87%	17

Total Respondents: 61

Q20 What is the level of participation of your medical director?

Answered: 61 Skipped: 0

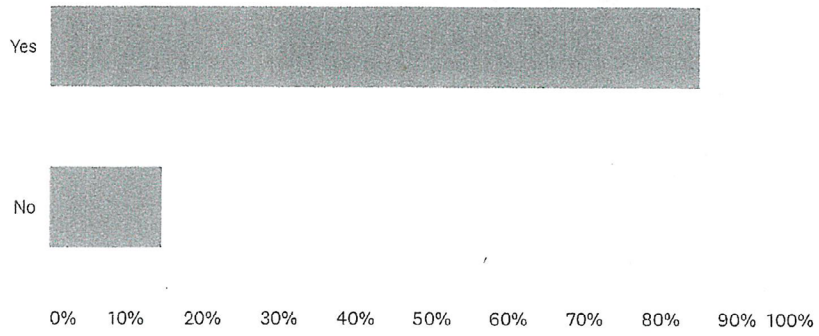


ANSWER CHOICES	RESPONSES	
We do not have a local medical director.	0.00%	0
Minimal oversight - gives advice when asked, signs forms when required, provides education when scheduled	37.70%	23
Moderate oversight - routinely reviews calls, considers competency when signing for education and re-certification, takes an active role in on-going education	36.07%	22
Active oversight - oversees an ongoing QI program, solicits documentation of competency before signing for re-certification, oversees initial and ongoing education	24.59%	15
We receive most of our medical guidance/oversight from a medical professional other than our medical director e.g. other MD, PA, NP or RN.	4.92%	3

Total Respondents: 61

Q21 Does your agency have a physical meeting/training space in the same building where your ambulances are located?

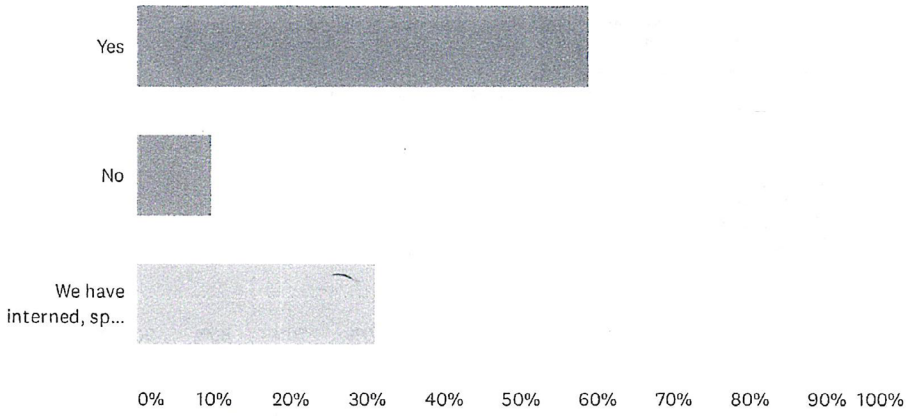
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	85.25%	52
No	14.75%	9
TOTAL		61

Q22 Does your agency have high speed (>30 mbs) at your meeting location?

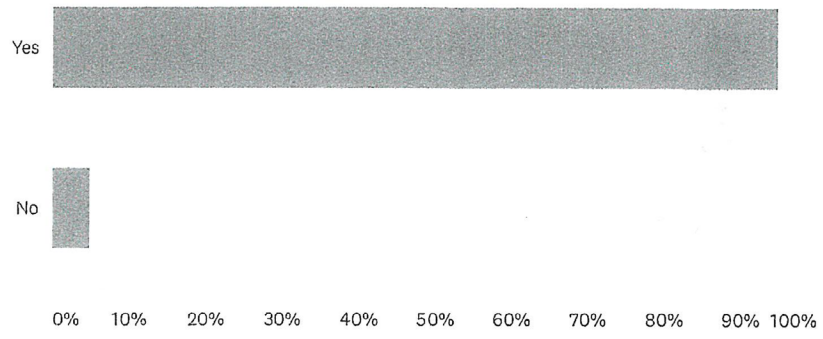
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	59.02%	36
No	9.84%	6
We have interned, speed unkown	31.15%	19
TOTAL		61

Q23 Does your agency have a computer at your meeting location?

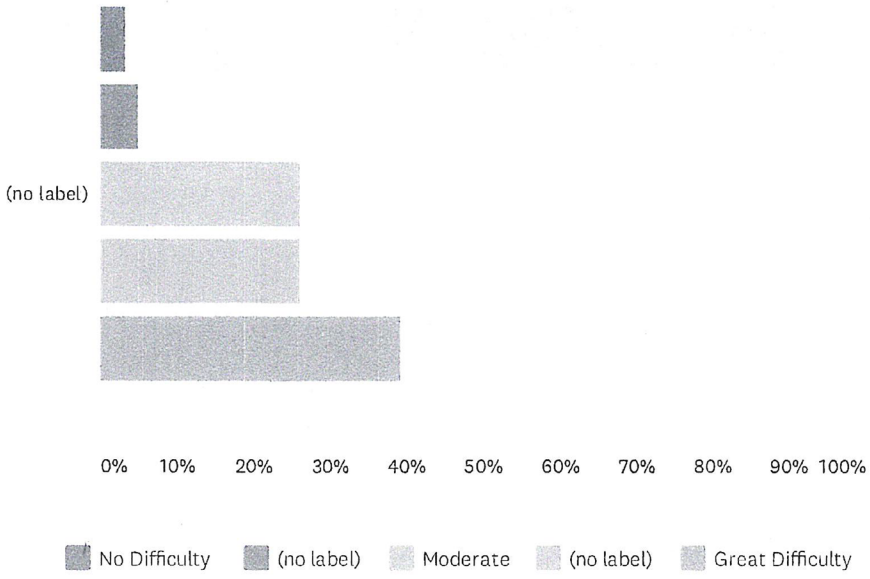
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	95.08%	58
No	4.92%	3
TOTAL		61

Q24 To what extent does your agency have difficulty recruiting staff?

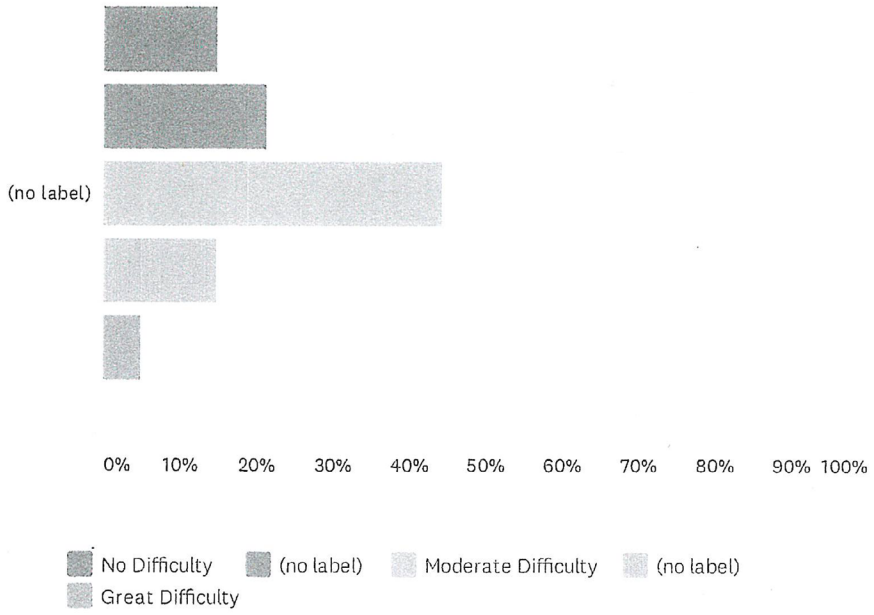
Answered: 61 Skipped: 0



	NO DIFFICULTY	(NO LABEL)	MODERATE	(NO LABEL)	GREAT DIFFICULTY	TOTAL	WEIGHTED AVERAGE
(no label)	3.28% 2	4.92% 3	26.23% 16	26.23% 16	39.34% 24	61	3.93

Q25 To what extent does your agency have difficulty retaining staff?

Answered: 61 Skipped: 0



	NO DIFFICULTY	(NO LABEL)	MODERATE DIFFICULTY	(NO LABEL)	GREAT DIFFICULTY	TOTAL	WEIGHTED AVERAGE
(no label)	14.75% 9	21.31% 13	44.26% 27	14.75% 9	4.92% 3	61	2.74

Q26 What is the average length of service affiliation for your personnel

Answered: 61 Skipped: 0

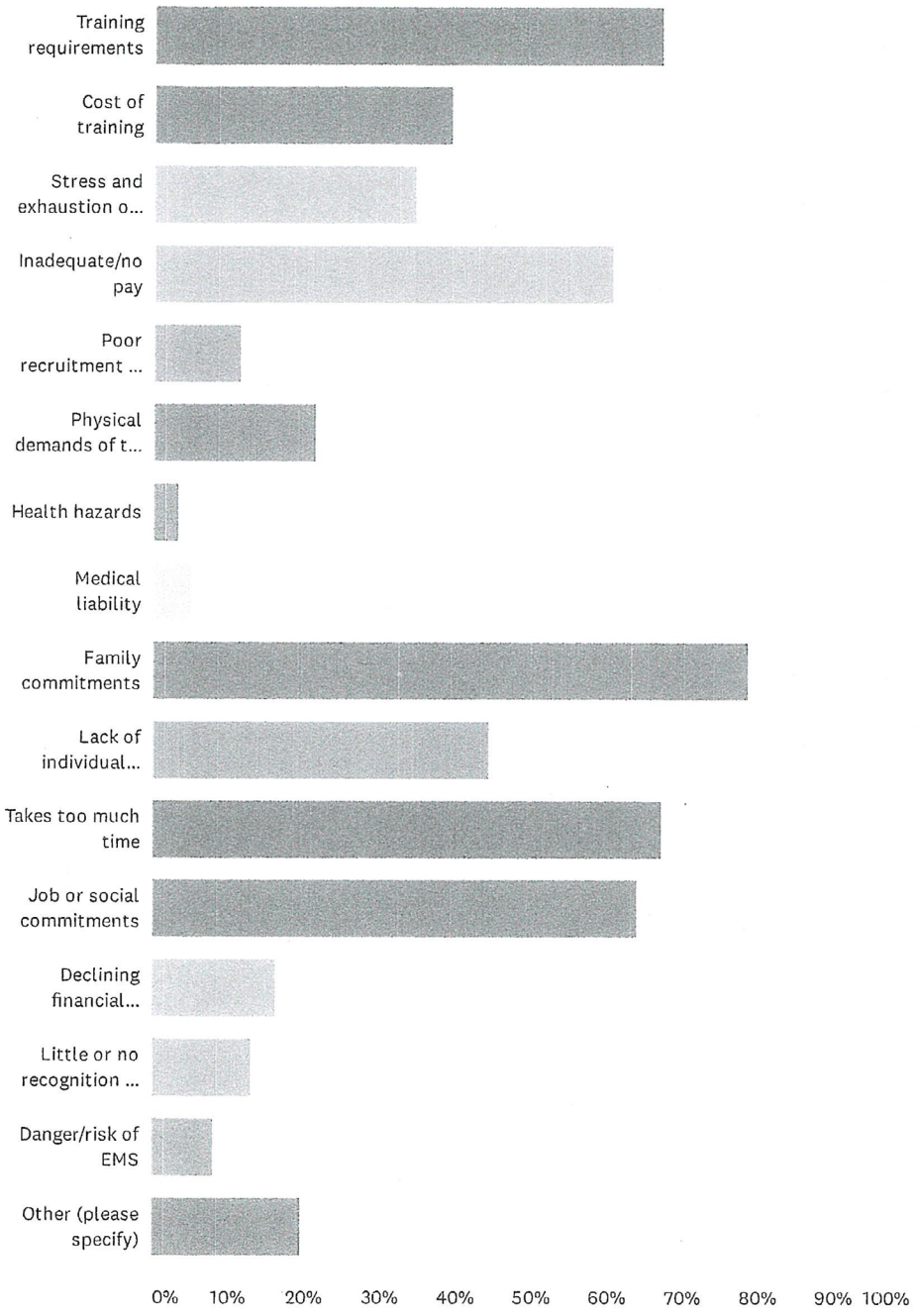
0 10 20 30 40 50 60 70 80 90 100

ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
	51	3,086	61

Total Respondents: 61

Q27 What following issues are key barriers to recruitment of local individuals into EMS? (check all that apply to your agency)

Answered: 61 Skipped: 0

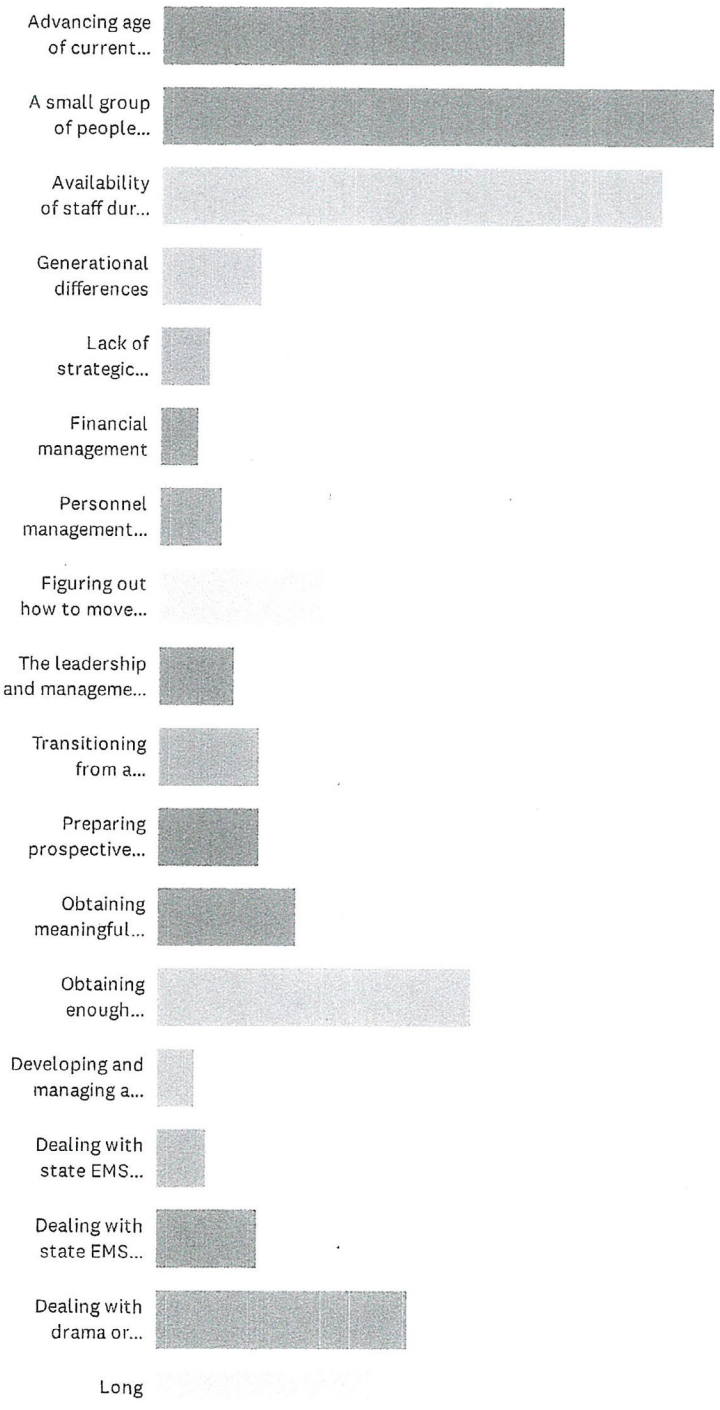


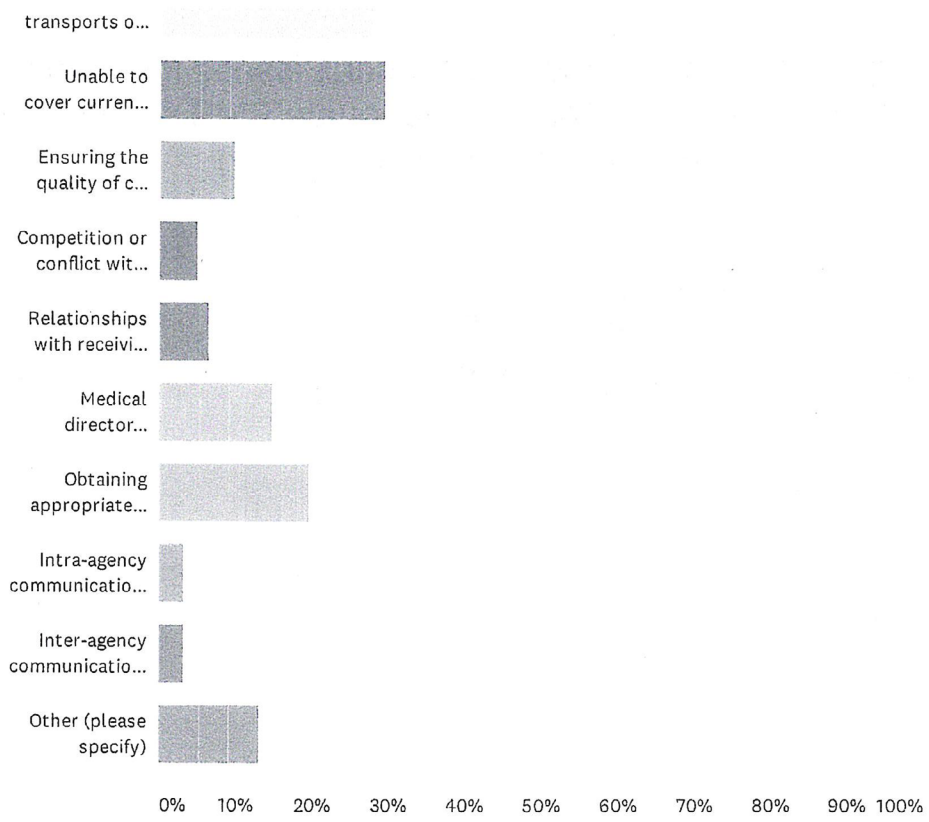
ANSWER CHOICES	RESPONSES	
Training requirements	67.21%	41
Cost of training	39.34%	24
Stress and exhaustion of EMS work	34.43%	21
Inadequate/no pay	60.66%	37
Poor recruitment and retention efforts	11.48%	7
Physical demands of the work	21.31%	13
Health hazards	3.28%	2
Medical liability	4.92%	3
Family commitments	78.69%	48
Lack of individual interest to attend training/education	44.26%	27
Takes too much time	67.21%	41
Job or social commitments	63.93%	39
Declining financial support	16.39%	10
Little or no recognition or rewards	13.11%	8
Danger/risk of EMS	8.20%	5
Other (please specify)	19.67%	12

Total Respondents: 61

Q28 In your opinion, what are the most serious issues that hamper your agency's ability to continue to provide adequate EMS services to your community? (check all that apply)

Answered: 61 Skipped: 0



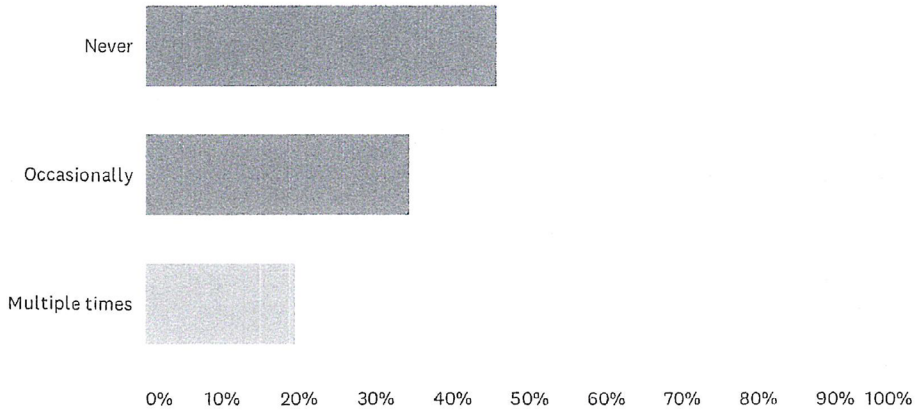

transports o...
Unable to cover curren...
Ensuring the quality of c...
Competition or conflict wit...
Relationships with receivi...
Medical director...
Obtaining appropriate...
Intra-agency communicatio...
Inter-agency communicatio...
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Advancing age of current staff/impending retirements	52.46%	32
A small group of people carrying most of the schedule	72.13%	44
Availability of staff during specific times	65.57%	40
Generational differences	13.11%	8
Lack of strategic planning	6.56%	4
Financial management	4.92%	3
Personnel management within the service	8.20%	5
Figuring out how to move from volunteers to more paid staff	21.31%	13
The leadership and management of the agency	9.84%	6
Transitioning from a club-like structure to more of a business-like structure	13.11%	8
Preparing prospective staff to pass the National Registry exam	13.11%	8
Obtaining meaningful community support for agency	18.03%	11
Obtaining enough financial resources to meet current costs	40.98%	25
Developing and managing a budget	4.92%	3
Dealing with state EMS Agency licensing rules and regulations	6.56%	4
Dealing with state EMS individual licensing rules and regulations	13.11%	8
Dealing with drama or conflict among staff	32.79%	20
Long transports or inter facility transfers	27.87%	17
Unable to cover current call volume with available staff	29.51%	18
Ensuring the quality of care provided by staff	9.84%	6
Competition or conflict with other agencies	4.92%	3
Relationships with receiving facilities	6.56%	4
Medical director involvement	14.75%	9
Obtaining appropriate vehicles or equipment	19.67%	12
Intra-agency communication while on responses	3.28%	2
Inter-agency communication while on responses	3.28%	2
Other (please specify)	13.11%	8

Total Respondents: 61

Q29 In the last year, has your service experienced delays in responding to 9-1-1 calls due to staffing shortages? (greater than 15 minutes from notification to wheels turning on ambulance)

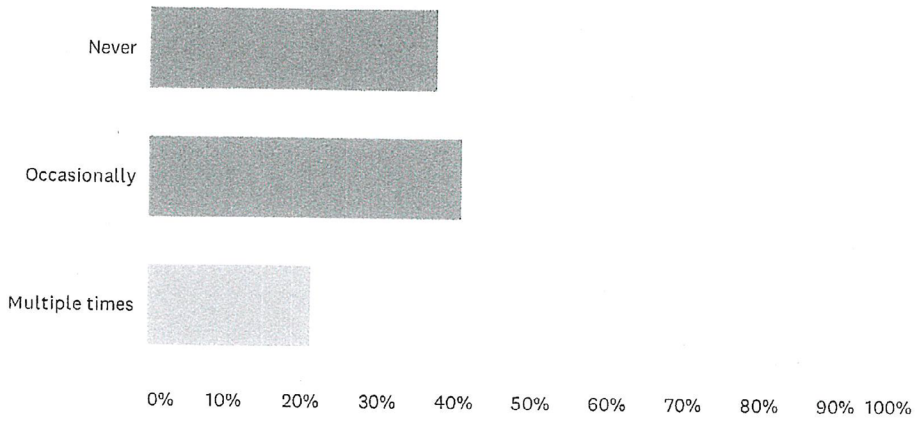
Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Never	45.90%	28
Occasionally	34.43%	21
Multiple times	19.67%	12
TOTAL		61

Q30 In the last year, has your service experienced delays in being able to staff and respond to inter facility transfers due to staffing shortages?

Answered: 61 Skipped: 0



ANSWER CHOICES	RESPONSES	
Never	37.70%	23
Occasionally	40.98%	25
Multiple times	21.31%	13
TOTAL		61

Appendix 3: *Qualitative Survey*

State of Montana EMS Systems – 2019-2020 Qualitative Questions

Thank you for taking time out of your busy schedule to talk with me. The purpose of this project is to determine the state of well-being of EMS services across the state. The feedback that you have already provided in the form of your on-line survey will be combined with information obtained in this discussion will be combined with similar feedback from other services to provide a picture of the current state of EMS in Montana with an eye toward system improvements at the state, regional and local level.

First, a little housekeeping, do I have your permission to record our conversation. It will be used to help create a snapshot of the status and challenges facing EMS agencies in Montana. May I record of our conversation?

All interviews will be used in the analysis and report development. Unless you give us permission to do so, information will not be specifically attributable to you as an individual. May we have permission to use your name should we use any direct quotations from this interview or the on-line survey you have completed?

Before we get started, do you have any questions for me?

Tell me about the greatest successes that you have had as a service in the past 12 months?

Probe: Any dramatic responses?
Probe: Any life saves?
Probe: Excellent recruitment results?
Probe: High training attendance, etc.?
Probe: Community support?
Probe: Great collection rate?

What is the organizational and governance structure of the service?

Probe: Is it working
Probe: Is it efficient and effective?
Probe: How would you improve it?

Describe the role and activity level of the service's medical director?

Probe: Wish he was more/less engaged?
Probe: More knowledgeable on EMS?
Probe: Up to date on current trends and approaches?

What general category of patient care does your service excel in?

Probe: Injury care?
Probe: Illness care? Stroke, heart attack?
Probe: Psychological emergencies?
Probe: Infants and children?
Probe: Elderly?

What category of patient care presents the greatest challenge for your crews?

Probe: Injury care?
Probe: Illness care? Stroke, heart attack?
Probe: Psychological emergencies?
Probe: Infants and children?
Probe: Elderly?

Describe your relationship with the hospital staff that you transport patients to most frequently.

Probe: If indicated by patient condition, do they have staff standing by?
Probe: Do they listen to and acknowledge your verbal summary of the patient's condition?
Probe: Do you work well together as team?
Probe: Is there any way that they could be more supportive of your efforts.

What is your role and responsibility as a service manager?

Probe: How long have you been performing in that role?
Probe: Are you compensated for your role as EMS service manager?
Probe: How much longer do you see yourself in that role?

Tell me about the process by which you became the service manager.

Probe: Was it a role that you wanted?
Probe: Is there an heir apparent?

Is it ever difficult for the service to assure that coverage is available in the event of an emergency?

Probe: What is the average "chute" (from notification to wheels rolling) time of your responses?
Probe: If you experience delays, what is the root cause of the difficulty?

Tell me about your most recent recruitment campaign effort to recruit new members.

Probe: How many people responded?
Probe: How many actually survived the required training and are taking call?

List three of the most positive attributes of your service and why you feel they are important.

Probe: Available to respond in a timely manner?
Probe: Dedicated and competent crew members?
Probe: Good cooperation with the hospital?
Probe: An engaged medical director?
Probe: Superior training?
Probe: Cooperation and collaboration with neighboring services?

If you could start with a blank piece of paper what would the design and operation of the service look like?

Probe: Is your vision attainable under current structural limitations?
Probe: Are there incremental steps that could move you closer to that ideal?
Probe: If things don't change what do you think the overall health of the service will be 5 years?

Probe: Can it survive under current conditions?
Probe: If the service had to close, who/how would emergency response be handled?
Probe: What do you think needs to change?
Probe: Is the crew supportive of your efforts?
Probe: Is the leadership/oversight, e.g. board or government, supportive?
Probe: Do you have the authority and respect to do your job?
Probe: Do you have the resources (money and personnel) to ensure timely, high quality, emergency medical care to your community?

How can the state or regions help you?

Probe: What needs to change?
Probe: Training and certification requirements?
Probe: Service licensure requirements?
Probe: Raise level of visibility through promotional campaigns?
Probe: Develop recruitment assistance packages?
Probe: Remote education and training opportunities?

Appendix 4: *Hospital Survey Summary*

EMS Survey Project

Outcomes from Consultant engaged by MHREF (Eleva Group, Michelle Skinner, Principal.)

Michelle's work with the 42 hospitals surveyed was summarized as below. The comments and details from which these themes are drawn are extensive; a few observations not reflected in these bullet points include the need for mental health transport (described as a critical need by several specific facilities) and reflections on possible collaboration and regional models by one or two facilities.

The points below give a summary of relatively common themes across the group. This is a summary of what is intended to be one-half the work of this project; DPHHS is continuing its effort to perform similarly in-depth interviews with non-hospital EMS services around the state. Michelle worked closely with DPHHS' initial contractor to structure the questions and the scope of the interviews; the plan is for the combined results to be merged into one report in order to give a full picture of the challenges and opportunities around EMS throughout the State. Completion of DPHHS' work is necessary before that broader picture can be presented.

A list of the facilities interviewed follows the summary of themes.

Site Visit Summary as of September 9, 2019
Facilities Complete: 42

Emerging Themes

- EMS is not considered an essential service in Montana, so not afforded the same benefits/protections as fire.
    - o Legislative influence is lacking
- Interfacility transfers create a significant strain on volunteer agencies and hospitals - likely need a regional solution.
- Ongoing education: quality and availability limited.
- Grant $ accessibility/education.
- Friction and lack of communication between BOME and State is concerning.
- Billing services are vastly different across agencies.
- Quality expectations and quality processes standards are not in alignment.
- Initial and ongoing education is expensive and largely unsustainable in the rural environment.
- Medical direction allows only for MD or PA (not NP). This is difficult in some communities.
- Reimbursement is low and opportunities exist to ensure alignment with maximum reimbursement available.
- Reimbursement enhancements are necessary to ensure sustainability.
- If key members are willing to "stay at the table", they are able to find creative solutions to problem solving.
- Many successful programs are dependent on the people who run them (or are deeply involved).
- The standard requiring paramedic education programs to be accredited has severely limited ability to provide advanced training in rural communities. Communities are exploring relationships with colleges/universities to provide accredited programs without the cost of college/university. Many are also exploring/experimenting with on-line programs.
- Most rural communities report a very low Medicaid payor mix, so Medicaid payment structure/payment changes will not help in any meaningful way.
- Most QA/QI/PI is formalized only under the trauma program and is not expanded to medical patients.

- The future of EMS in most communities is impacted by a lack of new members interested in anticipating in EMS. There is a sense, in some communities, that volunteerism is markedly decreased in all areas (church, schools, 4-H, etc.), however, in other communities the commitment to volunteerism is very strong.
- The "SIM truck" is very helpful and popular for providing quality, external education in rural communities (EMS and hospital), however cost is prohibitive outside of grant funded programs (currently sepsis and STEMI).
- Some communities struggle with or are intimidated by the grant process. May be an opportunity to connect people together to assist/support.

Location
Bozeman Deaconess Hospital
Ruby Valley Hospital
Granite County Medical Center
Marcus Daly Memorial Hospital
Livingston Health Care
Beartooth Billings Clinic
Big Horn County Community Hospital
Dahl Memorial Healthcare
Glendive Medical Center
Holy Rosary Healthcare
Rosebud Health Center
Pioneer Medical Center
Wheatland Memorial Hospital
Central Montana Medical Center
Ft. Belknap Service Unit
Daniels Memorial Healthcare
Sheridan Memorial Hospital
Roosevelt Medical Center
McCone Health Center
Garfield County Health Center
Roundup Memorial Healthcare
Broadwater Health Center

Mountain View Medical Center
St. Peter's Medical Center
Deer Lodge Medical Center
Madison Valley Hospital
Prairie Community Medical Center
Big Sky Medical Center
North Valley Hospital
Phillips County Hospital
Community Hospital of Anaconda
Barrett Hospital
St. Luke Community Hospital
Clark Fork Valley Hospital
Cabinet Peaks Medical Center
Marias Medical Center
Community Medical Center
Providence St. Joseph Medical Center
Kalispell Regional Medical Center
Francis Mahon Deaconess
Northern Montana Health Care
Fallon Medical Complex
Northern Rockies Medical Center
Fallon Medical Complex
Liberty Medical Center