**EMS Regional Council Open Forum**
**6 June 2006**
**Summary Report**

## Background

Based upon the Joint Legislative Audit & Review Commission (JLARC) findings in 2004 and previous studies and initiatives, the Office of Emergency Medical Services (OEMS), and the Executive Committee of the EMS Advisory Board (Executive Committee) announced at the EMS Advisory Board in February 2006 that there would be feasibility study conducted on the EMS Regional Councils in Virginia.

In May, 2006 at the EMS Advisory Board meeting, the Chair announced that an Open Forum was scheduled for June 6, 2006. The purpose of the Open Forum was to allow all interested parties the opportunity to assist in defining the elements of for a Request For Proposal (RFP) for the Regional Council Feasibility Study. Also in May, the OEMS Director and Chair of the EMS Advisory Board requested the services of Renaissance Resources (Renaissance) to facilitate the Open Forum and develop the RFP for the EMS Regional Council Feasibility Study.

On May 26, 2006, the Director of OEMS on behalf of the Chair of the EMS Advisory Board emailed an Open Forum invitation and a pre-meeting survey requesting input from Regional Council Directors, the Regional Council Advisory Board representatives, the President/Chair from each Regional Council Board of Directors and the OEMS Program Managers. The original email is included in Appendix A.

After the pre-meeting survey due date of June 1, 2006, Renaissance compiled the summary data based upon the survey information on the 13 pre-meeting surveys received. Further, Renaissance developed a power point presentation for the Open Forum. The presentation was reviewed and approved by the Director of OEMS and the Chair of the Advisory Board prior to the Open Forum. After the meeting, the presentation survey results were amended upon the direction of the OEMS Director as one additional survey was sent to the Director on June 5, 2006. The amended presentation is included in Appendix B and the 14 pre-meeting surveys are found in Appendix C.

The OEMS Open Forum was held on June 6, 2006 at the Double Tree Hotel in Charlottesville, VA. There were 45 attendees. The list of attendees is found in Appendix D. The remainder of this Summary Report will list a chronological summary of the meeting.

The meeting began with an overview of the EMS Regional Council Feasibility Study process steps, an explanation of the role of the facilitator, a review of ground rules and a summary of the pre-meeting surveys.

Following the overview, the attendees were asked to identify themselves, and their position. Next, the attendees were to

1. Identify the key forces they saw that would impact EMS in Virginia in the next 20 years and
2. List one thing they wanted to get out of the meeting.

The results of those questions are listed on the next page.

**Key Forces Impacting EMS in Virginia in the next 20 years**

- Improved technology; much more new technology; potential for more robotics & telemedicine
- Increasingly Information Based Medical Care System
- Less fragmented approach to EMS system
- Increasing Population; Aging/Elder Population; Anticipated sedentary lifestyle impact
- Many baby boomers moving to Virginia demanding increased level of service
- (Gridlocked) Traffic System
- Freestanding facilities – More consolidation of Medical (Hospitals) Systems
- Hospitals become pinnacle in EMS System
- Overtaxed Healthcare Systems
- Trend of people needing someone to take care of them
- ALS will become non-existent with Volunteer Agencies
- Not enough people for EMS (level of providers will not be there)
- Vastly realigned (EMS) service area boundaries
- More effective use of Volunteer (less) & Career (more) staffing
- EMS will become primarily a paid system, overall the system will be weakened
- There is not enough money for paid people and volunteer staff training with ALS is gone.
- Increased number basic level providers, fewer Advanced or EMT-P; less involvement from OMDs
- There will be numerous diversified plans.
- There will be fewer hospitals – Mega Hospitals – with different ways of transport; hospital based commercial Services increased
- Air Evacuation will grow
- EMTs will be better trained, more mobile.
- No or fewer volunteers
- Pre Hospital care will be mandated, government will own everything
- There is an impact on EMS by the military medical services; affects what/how we provide EMS services.
- There will be increased clinical sophistication; better training; and complex IT systems
- EMS is a healthcare entity; EMS must become a more evidence based science.
- Potential future role as "Wellness Doc in the Box" in the field
- EMS will still involve airway, breathing, & circulation; future will include preventive medicine; and wellness/health promotion training; more out of hospital service.
- EMS is in significant transition; education system must respond; more cross training
- EMS must address how generation X, generation Y and other races learn.
- (Proper) Recognition of EMS profession will be a wrestling match with other professions
- Population will be more diverse; must address language, culture, and new diseases.
- Need to pool resources; better manage funding demands; OEMS to be an equal partner ($) with other public safety departments
- Recruitment problems will continue, no one is coming on; maybe recycle baby boomers
- Recruitment & Retention (Attrition) will be major issues; must shorten recruitment time

**Key Forces Impacting EMS in Virginia in the next 20 years continued**

- Compensation will increase for EMS profession
- Integration of communication systems –standardization of information gathering
- Statewide better defined command structure; Leadership needs shared vision for the next 20 years; there needs to be visionary leadership in EMS; More balanced based approach, impact of healthcare funding
- Trend from volunteers to paid staff towards 100% paid; there will be competition for dollars among public services; must spend wisely; increasing expectations of public.
- Accountability to local government will increase; more municipality involvement; more funding from locality for EMS
- There will be more private service (EMS) providers
- Trend towards more hospitals providing transport.
- Move to Regionalism and cooperation working together – Regional Councils lead the way in that cooperation.
- More involvement with public safety departments
- Injury Prevention linked to decrease in call volumes
- Changing expectations of community leadership (Mentoring)
- Greater integration with Public Safety Department
- Paradigm shift is happening so fast
- Need to enhance BLS Services; fewer ALS providers need to be optimally reallocated
- Volunteers need a voice

**What do I want to get out of this meeting?**

- Cohesiveness; reduce suspicions; increase trust.
- Customer driven; system fit the community—All systems not the same.
- Foundation for an objective study.
- Around patient care mission.
- System geared to rural, some move made to include volunteer.
- Basic level of a plan to meet needs of system in 20 years.
- Good feeling about what we do today
- Zeroing in where EMS can make the greatest impact to save lives –BIG PICTURE.
- Direction for Regional Councils for state
- Open dialogue; Diversity of Councils
- Discussed/addressed, Consistency, Working together.
- Did not waste my day.
- Process for 20 year implementation
- Consistent Info for today and increase honest discussion – where would you like to be.
- How to make it happen; Trust.
- Flawless boundaries standardize EMS system to take of needs
- Still deliver service at grass roots level
- Underlying reason for this meeting
- Clear understanding of goals process.  Consensus on driving process
- Address specific not revamp entire system.
- Why this issue; why now.

**What do I want to get out of this meeting? -continued**

- Know EMS Mission Statement.
- Diversity with Common Goals
- Help the System go forward
- RFP Scope, Purpose, Deliverables
- Help the System go forward
- Stay on focus of meeting.
- Discuss what our needs are.
- Open to others; mold system to 20 year model.
- Group Focus
- Clear consensus where we are – where need to get.
- Get out seat, political involvement.
- Monitor Strategic Plan
- Where we are & how to get there.
- Take away feeling there is another reason we are here.
- Increase communication with state a 2 year view.
- Systematic accountability & reliability.

Next, attendees were asked to list the key advantages of the current EMS Regional Council structure. Using the Pre-meeting summary categories depicted in the Open Forum presentation, the group identified the following current structure advantages. Note the advantages are listed in order of number of responses.

| Advantages of Current Regional Council Structure | | |
|---|---|---|
| **# Responses** | **Advantage** | **Comment** |
| 18 | Offer flexibility to meet unique and varying needs of constituents (7) | Responsiveness |
| 13 | Allow for local government involvement, cooperation and consensus building (9) | |
| 11 | Provide flexibility to EMS System – acting as contractors for specific projects or regional initiatives (4) | |
| 7 | Provide for "grass root" support for EMS (5) | |
| 6 | Councils engender "trust" with Agencies | |
| 3 | Allows ability to obtain local funding for shared regional projects (3) | |
| 2 | Promote consistency in protocols (3) | |
| 1 | Councils are not-for-profit entities and allow for gifts in kind and partnering with organizations like United Way | |
| | Low administrative costs | |

**The group also identified the following additional advantages to the current structure of the Regional Councils:**

- Providers feel ownership
- Allows us to be more responsive
- Creativity allows for training ALS/BLS
- Work with Hospitals
- Air Medevac system – effective
- Better span of management, better control
- Local funding through councils
- Local training coordination, Buy equipment regionally
- Not bogged down with bureaucracy; dynamic, address needs of region
- Respond more quickly to needs of Regions
- Trust
- Cost Effectiveness
- Abdicating collectively
- Best Geographic representation
- System wide approach
- Trauma Triage, gives a voice at the end of the phone
- We provide what state cannot (Hands on training)
- Numerous issues are better addressed regionally
- Contractual – This work better -- responsive
- Grass Roots involvement
- BSN
- Establish history and familiarity in regions
- Training supplied state can
- Face to face contact, Different entities a voice
- Training hands on
- Ability for agencies to have one to one with issues that need to be addressed
- Responsiveness)
- Regional Councils coordination role for disaster planning, etc.

Next, the group summarized the most significant advantages of the current EMS Regional Council structure.

**Summarizing Advantages**

- Accessibility
- Responsiveness
- Planning Coordination
- Flexibility purchasing responsiveness
- Grass roots representation
- Training

At this point in the meeting, the issue of a break down in the trust between the OEMS/Executive committee and the Regional Councils was raised and discussed. The general sentiment expressed by several Executive Directors of the Regional Council was that they were "blind-sighted" by this study and felt that there was an underling "motive" to have the study at this particular time. The Director of OEMS suggested that this study had been talked about for months and should not come as a surprise. He mentioned the JLARC report, previous studies conducted by OEMS and strategic initiatives that directly addressed the need for the EMS Regional Council Feasibility Study. He emphasized that

the purpose of the Forum was to allow the Councils the opportunity to impact how and what the Regional Council Feasibility study would entail.

**Majority consensus for moving forward past the trust issue was achieved by OEMS and Executive Committee agreeing to communicate with and involve the Regional Councils in the process steps of the Feasibility Study going forward.**

The group then moved to identify the disadvantages of the current Regional Council structure. Again using the disadvantages identified in the pre-meeting survey, the group attendees identified the disadvantages using a round robin approach. The disadvantages by number of responses are listed in the table on the next page:

| Disadvantages of Current Regional Council Structure | | |
|---|---|---|
| # Responses | Disadvantage | Comment |
| 15 | Lack of standardizations around policies and procedures (3) | Board Structure does not allow |
| 14 | Inconsistent program and services offerings (6) | Board Structure does not allow |
| 14 | Limits in funding (4) | |
| 13 | State contract funding process issues: annual not multi-year, inequitable across regions (6) | |
| 12 | Regional Councils are understaffed (5) | |
| 10 | Existing boundaries of Council service areas not in line with other public safety agencies services areas and do not recognize flow of patients etc.(2) | |
| 8 | Lack of visibility of OEMS within state government, inability to partner with other public safety departments as well as the physical location of OEMS, impact the overall effectiveness of the Regional Councils (7) | |
| 8 | Mandates handed down from State without providing additional funding and staffing (2) | Boundary Issues within region |
| 7 | No regulatory authority (3) | Disparity in Accounting; Salaries |
| | Not sufficient coordination and cooperation between Councils and OEMS | |
| | Lack of accountability and needless duplication of Council administrative services | |
| | Lack of competitive benefits packages of Council staff | |
| | Less than objective decision making by Councils relying on local financial support | |
| | Smaller Councils lack resources to provide improved services | |
| | Inconsistent management experience, direction and leaders by Executive Directors and Board of Directors | |
| | A majority of Councils rather than obtaining matching local funds depend on State for the majority of their operational expenses. | |
| | OEMS understaffed | |
| | Councils lack recognition | |
| | Pre-hospital care is not mandated | |
| | Shared Resources between councils | |

| Disadvantages of Current Regional Council Structure Continued | | |
|---|---|---|
| # Responses | Disadvantage | Comment |
| | EMS System does not understand what councils do - Marketing | |
| | Less than objective decision making due to reliance on local funding | |
| | Prehospital care not mandated | |
| | Inconsistencies in standards of patient care Protocols | |
| | Disparity in Boar involvement | |
| | No authority to fulfill contract requirements | |
| | Consistency of Plans | |
| | Multiple ways of doing things<br>Opportunity for 'kingdoms' to be built that are self-serving rather than serving the needs of EMS constituents and patients<br>Lack of coordination on critical EMS preparedness planning, between regions and throughout the Commonwealth. | |

The group was than asked to list any other concerns they might have in terms of elements of study in the RFP. Those identified are listed below.

**Other Concerns:**

- Emergency Physicians not encouraged to be part of the system to become OMDs. More direct & span of control for regions.
- Service Area Boundaries.
- Focus of Study should include System, Set-up from top down.
- What needs are not being met?
  - Provider Surveys
  - State
  - Patient care
  - Funding/Contracting Impact

- Regional Council Purpose/Mission defined - EMS is an Emergency responder not a First responder. EMS is more of an emergency responder than a healthcare provider. Form Follows Function

The group then moved to identify the core services of the Regional Councils. A partial list was developed:

**Core Services**

- Regional Plans
- Regional Medical Direction
- Regional Coordination
    - RSAF
    - CISM
- Diversity
- Awards Program
- Consolidated Testing
- Unmet needs.
- Communication between localities.

It was further recommended that a SWOT analysis on the Core Services would be beneficial.

Lastly, the Chair asked by a show of hands who felt the group should move forward on the Feasibility Study. Following a discussion the group agreed to move forward if OEMS/Executive Committee agreed to include the Regional Councils in the RFP process to include representation on the RFP Review Committee.

In summary the following decisions were reached by the group:

**Decisions agreed to by the group**

1. Majority consensus for moving forward past the trust issue
2. Agreement to move forward with the Regional Council Feasibility Study
3. EMS is an Emergency responder not a First responder. EMS is more of an emergency responder than a healthcare provider.

The following actions were agreed to by the group:

**Actions agreed to by the group**

1. Open Forum Presentation and Surveys should be sent to all attendees
2. OEMS/Executive Committee would communicate with and include the Regional Councils in the process steps of the Feasibility Study
3. The RFP Review Committee will be identified by the Executive Committee and include representation from the Regional Councils

Lastly, the following issues will need to be addressed by OEMS/Executive Committee at some later date.

**Issues Identified that should be addressed later**

Why this issue; why now?
Placement of the office in state government.
Improved Contract with State and Regional Councils.
Cost Effectiveness/Cost Efficiency of Regional Councils