

Governance of EMS Agencies in Idaho

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Idaho Legislature



Report 10-04

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November 22, 2010

Members
Joint Legislative Oversight Committee
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Amidst stakeholder concerns about emergency medical services (EMS) during last year's legislative session, you directed us to evaluate the governance of EMS agencies in Idaho. In this report, we outline how policymakers can establish an effective system of EMS governance that places patient care as top priority.

Our report largely validates the concerns of the Emergency Medical Services Bureau and many Idaho stakeholders. These concerns relate to issues such as duplication of and gaps in services and a lack of clarity about the jurisdiction of EMS agencies. Currently, emergency medical services in Idaho are provided by a patchwork of agencies and resources loosely tied together by a set of statutes that do not reflect Idaho's evolving EMS needs or national leading practices.

Emergency medical services in Idaho are without a doubt delivered by passionate and committed personnel—many of them volunteers. Even though these stakeholders and the local governments they serve value the merits of governance, they have been unable to reach agreement on who should be granted governing authority. Using information provided in this report, the Legislature now has a timely opportunity to take the lead on behalf of patients and taxpayers.

We thank officials from the Emergency Medical Services Bureau and stakeholders across the state for their interest, input, and participation in our study.

Sincerely,

A handwritten signature in blue ink that reads "Rakesh Mohan".

Rakesh Mohan

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Executive Summary

Governance of EMS Agencies in Idaho

Emergency medical services (EMS) are located at the intersection of three large systems: public safety, public health, and healthcare. While each of these systems serves a specific community need, emergency medical services focus on delivering patient care across all three systems. Given their unique role, emergency medical services should be defined from the patient perspective and the development of an EMS system should occur with patient needs rather than agency needs as the top priority.

With the goal of achieving optimal patient care, a task force was assembled nearly four years ago to address problems such as inconsistent levels of emergency response and coverage, conflicting medical direction, and funding disputes. Task force members agreed that these problems are largely caused by outdated and vague statutes; however, they could not agree on solutions to address these problems.

Central to the message of current national literature is a need for regionalized, coordinated, and accountable EMS systems. A governing body must have both the authority and the funding to develop, maintain, and consistently deliver quality emergency medical services. We identified seven design attributes of a well-functioning system in our review and synthesis of national literature. This report assesses the degree to which Idaho's current EMS structure has each of these attributes.

We found that Idaho has a disjointed assortment of agencies providing services from a mix of resources. For the most part, friendly working relationships may exist, but no one agency or governing body has explicit governing authority. Statute does not provide for a governing body that has the authority to limit the duplication of services, require statewide coverage, or mandate cooperation among EMS agencies. In the absence of a well-functioning and accountable system, the quality of patient care may be at risk.

Although stakeholder opinions vary widely over whether a crisis exists, for the most part, stakeholders agree that statutory changes are necessary. Idaho's statutory framework has not kept pace with the evolution of emergency medical services. Statute limits the state's ability to improve the delivery of services, leaving Idaho vulnerable to potentially negative impacts.

We recommend the Legislature update Idaho Code to reflect contemporary EMS practices, thereby enabling the Department of Health and Welfare's Emergency Medical Services Bureau and local stakeholders to begin incorporating the design attributes of a well-functioning system. The underlying principles for improving Idaho's EMS structure are basic:

1. All stakeholders should be included in a meaningful way
2. Someone has to be in charge

In chapter 5, we make seven recommendations for Idaho to begin establishing a well-functioning system and to meet the needs of stakeholders representing wide interests. Rather than attempt to account for every conceivable aspect of a new policy decision for Idaho's approach to emergency medical services, we offer a framework to begin a policy debate. This framework encourages the Legislature to establish countywide local EMS systems, create a governing authority and a medical directorate for local systems, increase the role of the Idaho Emergency Medical Services Bureau, and consider revising the funding structure for emergency medical services.

Establishing local EMS systems using the design attributes discussed in national literature is the first step to creating an overall system that holds agencies accountable for patient care. The solutions exist, but it will be difficult to develop local EMS systems without legislative leadership and stakeholder compromise.

Acknowledgments

We appreciate the cooperation and assistance we received from the Idaho Emergency Medical Services Bureau and EMS stakeholders across the state as well as assistance from the Office of the Attorney General.

Maureen Brewer and Hannah Crumrine of the Office of Performance Evaluations conducted this study. Margaret Campbell was the copy editor and desktop publisher. Brekke Wilkinson designed the exhibits.

Kathleen Sullivan, former professor and director of the Center for Education Research and Evaluation at the University of Mississippi, conducted the quality control review.

Glossary

Advanced emergency medical technician: a person who is licensed by the Idaho Emergency Medical Services Bureau to provide *basic and limited advanced care*, as determined by Idaho’s EMS Physician Commission, under the supervision of a physician licensed in Idaho.

Agencies: organizations licensed by the Idaho Emergency Medical Services Bureau to provide emergency medical services to patients in Idaho.

Ambulance service: agencies that provide personnel and equipment for medical treatment at an emergency scene and patient transportation to a medical facility.

Clinically meaningful response times: the timeframes that EMS personnel strive to meet to attain the most positive outcomes for patients. Patients may not survive if the response time is not within a matter of minutes.

Emergency medical responder: a person who is licensed by the Idaho Emergency Medical Services Bureau to perform *immediate lifesaving care with minimal equipment*, as determined by Idaho’s EMS Physician Commission, under the supervision of a physician licensed in Idaho.

Emergency medical services (EMS): services provided in response to perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

Emergency medical technician: a person who is licensed by the Idaho Emergency Medical Services Bureau to provide *basic care*, as determined by Idaho’s EMS Physician Commission, under the supervision of a physician licensed in Idaho.

Geographic response area: the demarcation of land within which an EMS agency responds to calls for service; agencies self declare this area to the Idaho Emergency Medical Services Bureau on their license application.

Governmental subdivision: a public division of Idaho, such as counties, cities, districts, or municipalities that exercise some function of local government.

High call volume areas: densely populated geographic locations that generate a large number of calls for 911 service.

Low call volume areas: sparsely populated geographic locations that generate a small number of calls for 911 service.

Paramedic: a person who is licensed by the Idaho Emergency Medical Services Bureau to provide *advanced care*, as determined by Idaho's EMS Physician Commission, under the supervision of a physician licensed in Idaho.

Prehospital: any setting outside of a hospital, with the exception of interfacility transfers, in which the delivery of emergency medical services may take place.

Nontransport service: agencies that provide personnel or equipment for medical stabilization at an emergency scene but do not provide patient transportation.

Response time: the amount of time, reported in minutes, between a 911 call for service and the arrival of an agency on the scene.

Chapter 1

Introduction

What Prompted a Legislative Study of Emergency Medical Services?

Legislative interest in Idaho's current structure of emergency medical services originated from an unsuccessful attempt to pass legislation during the 2010 session. Prior to the introduction of Senate Bill 1391, stakeholders spent nearly four years drafting EMS legislation.

Stakeholders created a task force in 2006 in response to concerns that the statutes for emergency medical services, ambulance districts, and fire protection districts should be revised to create a comprehensive EMS system.¹ The EMS Code Task Force produced more than 60 drafts of legislation and hoped to promote optimal patient care by addressing the governance of EMS agencies in Idaho. Members of the task force represented the following entities:

- Association of Idaho Cities
- Emergency Medical Services Bureau
- Emergency Medical Services Physician Commission
- Idaho Association of Counties
- Idaho Fire Chiefs Association
- Idaho Hospital Association
- Idaho State Fire Commissioners Association

According to the Idaho Department of Health and Welfare's Emergency Medical Services Bureau, additional stakeholders with vested interests closely followed the progress of the task force but did not directly participate in drafting legislation:

- Idaho Chapter of the American College of Emergency Physicians
- Idaho Chapter of the American College of Surgeons, Committee on Trauma
- Idaho Emergency Medical Services Chiefs Association
- Idaho Volunteer Fire and Emergency Services Association
- Professional Firefighters of Idaho

¹ IDAHO CODE §§ 56-10, 31-39, 31-14.

During the 2010 legislative session, the Idaho Association of Counties presented Senate Bill 1391 to the Senate Health and Welfare Committee. The bill would have established local EMS systems at the county level, and each local system would have had a governing authority. Because the membership of the associations represented on the task force and other stakeholders did not reach consensus on *who* should make up the governing authority, the bill died in committee.

The chair of the Senate Health and Welfare Committee and other lawmakers took the issue to the Joint Legislative Oversight Committee. The Oversight Committee then directed our office to study the governance of Idaho's EMS agencies. In drafting our project scope, we spoke to several legislators about their concerns. They expressed interest in learning more about the overall status of emergency medical services in Idaho, the characteristics of successful EMS systems in other states, and what next steps the state could take to decide who should be in charge of emergency medical services and at what level of government.

For this report, **patient** refers to the recipient of emergency medical services. **Stakeholder** refers to individuals and agencies involved in delivering emergency medical services.

To address the legislative issues of interest and the concerns of many stakeholders, our study focused on the following questions:²

1. How does Idaho manage the regulation and delivery of emergency medical services? What factors contribute to Idaho's current approach? What are the roles and responsibilities of the entities involved in regulating and delivering these services?
2. What are the characteristics of a well-functioning EMS system? Are there any clearly identifiable strengths or weaknesses in Idaho's current approach?
3. Are there leading practices in the design of EMS systems that can provide Idaho guidance and feasible options for moving forward in a fiscally responsible manner? How can Idaho best balance stakeholder interests with a system of governance that ensures accountability to the taxpayer and provides for optimal patient care?

² A complete description of our report methodology is in appendix A.

What Effect Does National History Have on Services in Idaho?

The concept of providing emergency medical services is relatively new but has evolved at a rapid pace. In the mid 1960s, the report *Accidental Death and Disability: The Neglected Disease of Modern Society* provided the first framework for local EMS systems and offered recommendations for improving prehospital care.³

After the report release, Congress created what is now the National Highway Traffic Safety Administration as part of the Highway Safety Act of 1966. The federal government charged the administration with improving emergency medical services across the nation and as a result, the administration developed the first national EMS education curriculum and blueprint for potential state legislation. The Highway Safety Act also provided grants to states working to improve their EMS systems.

In 1973, Congress initiated another grant program through the EMS Systems Act. The newly formed Division of Emergency Medical Services within the US Department of Health and Human Services oversaw the program. The federal government appropriated \$300 million in grants to the division for EMS improvement, expansion, and research.

The Division of Emergency Medical Services established over 300 regions throughout the country by 1978. Division grants focused on the coordination of state, regional, and local needs; however, the overall organization of the new regions was “driven by local needs, characteristics, and concerns.”⁴ This local focus, in the absence of coordination and collaboration, marked the beginning of a trend toward EMS fragmentation.

In the years to follow, the National Highway Traffic Safety Administration and the US Department of Health and Human Services were unable to coordinate federal efforts, and the two federal agencies stopped collaborating in 1981. The federal government eliminated the EMS grant program overseen by the US Department of Health and Human Services, and states began receiving block grants for preventative health and health services under the Omnibus Budget Reconciliation Act of 1981. Less federal direction allowed states to use resources at their discretion.

³ National Academy of Sciences, National Research Council, *Accidental Death and Disability: The Neglected Disease of Modern Society* (Washington, DC: NAS, 1966).

⁴ Institute of Medicine of the National Academies, *Emergency Medical Services at the Crossroads* (Washington DC: The National Academies Press, 2007), 34.

Emergency medical services became more fragmented throughout the 1980s as some states diverted block grant funds to other priorities, decreasing their involvement in emergency medical services to varying degrees and leaving cities and counties to develop diverse EMS systems. State lead agencies began to vary in their approach to authority and funding. Additionally, rural areas experienced difficulty absorbing the loss of federal grants and many began to lag behind their urban counterparts, especially in predominately rural states.

Since 1996, with the release of the widely referenced *Emergency Medical Services Agenda for the Future* by the National Highway Traffic Safety Administration, experts have continued to publish literature on the status of emergency medical services in the nation and the direction EMS systems should take. However, according to a report released by the Institute of Medicine, only a few of those goals originally identified in the 1996 report have been realized nationally.⁵

According to the National EMS Advisory Council, emergency medical services tend to suffer financially because they have not been fully integrated in the healthcare system, the public safety system, or the public health system.⁶ In 2002, Congress cut Medicare reimbursements for emergency medical services. Consequently, the primary funding now comes from local taxes and user fees rather than reimbursements. Idaho and other rural states also subsidize emergency medical services through volunteers and donations or fundraising.

In 2005, Congress gave the newly created Federal Interagency Committee on EMS statutory authority to lead collaborative agency efforts. The committee's membership includes representatives from 11 federal agencies. Despite the work of the committee, the Institute of Medicine reports that emergency medical services remain fragmented and lack many of the fundamental components of a well-functioning system.⁷

What Are the Consequences of a Fragmented System?

The Institute of Medicine reports that even though states largely consider emergency medical services an essential government service, EMS systems have not received the same level of support as other services deemed a public necessity.⁸ Further, our review of national literature found that EMS systems

⁵ Institute of Medicine of the National Academies, *Emergency Medical Services at the Crossroads* (Washington DC: The National Academies Press, 2007), 47–48.

⁶ The healthcare system is the delivery of health services by medical professionals. The public health system works toward the protection and improvement of a community's health.

⁷ Institute of Medicine of the National Academies, *Emergency Medical Services at the Crossroads* (Washington DC: The National Academies Press, 2007), 114.

⁸ *Ibid.*, 52.

have been subject to the influences of local politics, specific operating environments, and available resources in part caused by inconsistent funding and change in federal leadership (see appendix B for a list of our primary sources).

This fragmented structure has led to a number of current issues within Idaho that pose challenges. Idaho's EMS Code Task Force identified a list of problems that have developed over time:

- Absence of a framework to collaborate
- Outdated and vague Idaho statutes
- Inconsistent levels of emergency response and coverage including areas without coverage (referred to as "no man's land") and overlapping geographical response areas
- Conflicting medical direction
- Funding issues and disputes

These problems can be magnified because one problem rarely occurs in isolation. When one problem exists, a second or third problem can occur simultaneously, limiting the ability of Idaho's EMS agencies to deliver optimal patient care. The impact of these problems is discussed throughout the report.

Chapter 2

Idaho's Current EMS Structure

How Does Idaho Code Shape the Current Delivery of Emergency Medical Services?

Three sections of Idaho Code address the delivery of emergency medical services in Idaho. The ability for agencies to provide these services falls under one or more of the following three codes:

- Emergency Medical Services, Title 56, Chapter 10
- Ambulance Services, Title 31, Chapter 39
- Fire Protection Districts, Title 31, Chapter 14

Emergency Medical Services

Idaho Code § 56-1011 establishes delivery and regulation of emergency medical services to Idahoans. The Department of Health and Welfare is charged with setting standards for EMS agencies and their respective units of local government to provide emergency medical services.¹ The Emergency Medical Services Bureau, with support from the EMS Physician Commission and the EMS Advisory Committee, regulates but does not govern the delivery of emergency medical services through the licensing of personnel and agencies.

Emergency Medical Services Bureau. The bureau licenses local agencies and personnel according to their ability to meet minimum standards. Agencies are licensed by the skill level of their personnel, transport capability, and the ability to respond to medical emergencies within the agency's self-declared geographic response area. In addition, each agency must meet certain standards established by the bureau such as medical supervision, around the clock coverage, and access to dispatch.

The bureau does not receive any state general funds. Instead, the Legislature appropriates the following dedicated monies for EMS funds:

¹ IDAHO CODE § 56-1003(3)(h).

- Idaho Code §§ 49-452 and 56-1018 authorizes \$1.25 to be collected as a part of motor vehicle registration fees. Twenty-five cents goes to the registrant's county of residence for local EMS costs and \$1 goes to the bureau.
- Idaho Code §§ 49-306(8)a and 56-1018A–B authorizes the bureau to also receive \$1.50 per driver's license fee that is divided between two funds distributed through an annual grant program:
 - \$1 dedicated for the exclusive purchase of vehicles and equipment for EMS agencies
 - \$0.50 for emergency medical services

EMS Physician Commission. The governor appoints an 11-member Physician Commission.² The Physician Commission establishes the standards for scope of practice and medical supervision of personnel and agencies licensed by the bureau. To fulfill legislative intent that EMS personnel have physician oversight, the commission regulates the procedures performed, the devices used, and the medicines distributed. When necessary, the commission also makes personnel disciplinary recommendations to the bureau.

EMS Advisory Committee. The director of the Department of Health and Welfare appoints an advisory committee to assist the bureau with administering emergency medical services in Idaho. The committee's 22 members meet three times a year to review current practices and procedures and make recommendations to the bureau about personnel training, licensing, and general policies and procedures.

Ambulance Services

Idaho Code defines ambulance services as a governmental function of the county. A board of county commissioners may establish and fund an ambulance service area within its county boundaries, including city limits, when the service is not reasonably available.³ The board may determine how its ambulance service will operate and can enter into agreements with other counties, governmental subdivisions, or private agencies to provide those services. It may also adopt a user fee schedule for services provided.

Counties may fund their ambulance service by levying property taxes in one of two ways:

² The commission membership has equal geographical and rural representation, and nine of its 11 members must be physicians.

³ IDAHO Code § 31-3901.

- **Establish an ambulance service fund.** Idaho Code § 31-3901 allows the county to levy property taxes of no more than 0.02 percent of the assessed market value. In 2009, 11 counties used an ambulance service fund to provide ambulance services or to provide funding for ambulance services operated by another organization.
- **Create an ambulance service taxing district.** Idaho Code § 31-3908(4) allows a county to establish an ambulance service district, which becomes a legal taxing district governed by its board of county commissioners. To fund the ambulance service district, a county may authorize a property tax levy of no more than 0.04 percent of the assessed market value. Twenty-four counties had ambulance service districts in 2009.

Authorized by Idaho Code § 31-3905, cities may opt out of ambulance services provided by the county. However, counties retain the right to levy taxes for ambulance services on city residents.

Fire Protection Districts

Statute establishing fire protection districts says the protection of property against fire and the preservation of life are public benefits. Any portion of a county or counties may be organized into a fire protection district.⁴ These districts are governmental subdivisions of the state. An elected board of three or five commissioners governs each district, and Idaho Code § 31-1423 allows a property tax levy of no more than 0.24 percent of the assessed market value to fund each district. Idaho has 157 fire protection districts. Of those, 55 provide emergency medical services under the preservation of life clause.⁵

How Do Idaho's EMS Agencies Deliver Services?

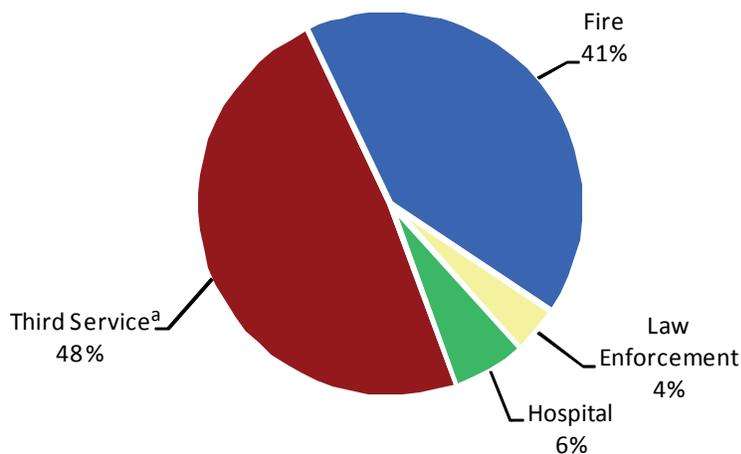
According to the bureau, about 200 licensed agencies respond to 911 calls and provide emergency medical services.⁶ Agencies responded to nearly 143,000 calls between November 2008 and October 2009. Nine counties have just one agency, and 25 counties have between two to five agencies. Eight counties have six to ten agencies and two counties have more than ten agencies. Ada County has 16—the most in the state.

⁴ IDAHO CODE § 31-1401.

⁵ Although a large portion of 911 calls dispatched to fire protection districts (or city fire departments) are for emergency medical services, these agencies are considered fire based because fire protection is one of their primary duties.

⁶ Of those, six are out-of-state agencies licensed by the Idaho Emergency Medical Services Bureau. We did not include these six in the county totals.

EXHIBIT 2.1 EMS AGENCIES BY PROVIDER TYPE, 2010

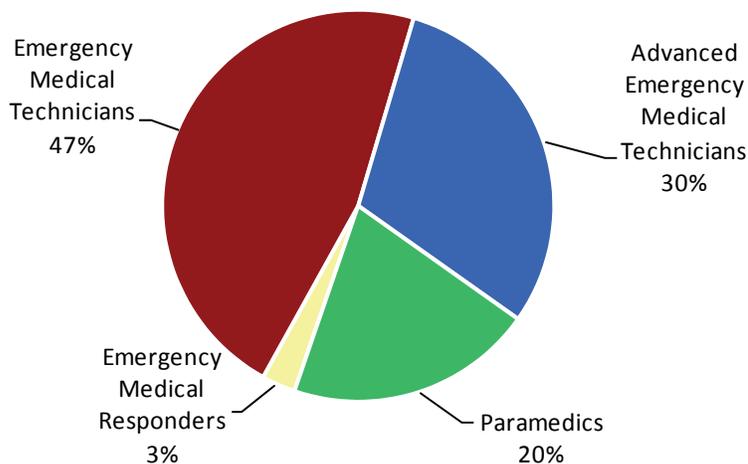


Source: Information from the Idaho Emergency Medical Services Bureau, Department of Health and Welfare, September 2010.

Note: Percentages do not sum to 100 because of rounding.

^a Agencies that are not fire, hospital, or law enforcement based and could be a for-profit or nonprofit corporation, city, or county.

EXHIBIT 2.2 HIGHEST CLINICAL CAPABILITY OF EMS PERSONNEL BY AGENCY LICENSE, 2010



Source: Information from the Idaho Emergency Medical Services Bureau, Department of Health and Welfare, October 2010.

Note: This exhibit is based on the number of licenses, not the number of agencies. The number of licenses is greater than the number of agencies because several agencies provide services at more than one clinical capability.

A variety of agencies provide emergency medical services in Idaho. As shown in exhibit 2.1, almost half (48 percent) of agencies are third service and are made up of local government and private providers. Fire-based agencies are a close second with 41 percent. In some areas of the state, law-enforcement– and hospital-based agencies also provide emergency medical services.

Idaho’s EMS agencies rely on just over 4,500 licensed personnel for services. Sixty percent of personnel are volunteers and the bureau estimates that volunteers donate about 266,000 hours in response to emergencies each year.⁷ Exhibit 2.2 illustrates the number of agencies operating at each personnel level in 2010. Forty-seven percent of Idaho’s EMS agencies operate with personnel who are licensed as emergency medical technicians.

Additionally, the bureau issues agency licenses according to the clinical level of service that the agency’s personnel can provide. There are three clinical levels of service. Exhibit 2.3 shows the clinical level of service that corresponds with each level of EMS personnel.

EXHIBIT 2.3 CLINICAL LEVEL OF SERVICE BY PERSONNEL LEVEL

	Basic	Intermediate	Advanced
Emergency Medical Responder	✓		
Emergency Medical Technician	✓		
Advanced Emergency Medical Technician		✓	
Paramedic			✓

Source: Office of Performance Evaluations, 2010.

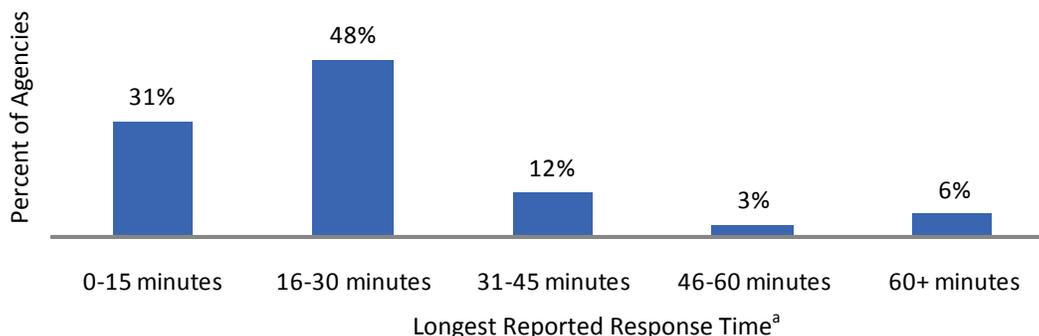
The bureau also licenses agencies according to whether the agency transports patients.⁸ With the exception of agencies that use only emergency medical responders, all other agencies may be granted a transport license if they meet the requirements. Data collected by the bureau in 2010 determined that Idaho has 105 transport agencies and 101 nontransport agencies.

As part of its 2009–2010 license renewal process, the bureau asked transport agencies to disclose their single longest response time in the previous year for their primary geographic response area. Twenty-one percent of ambulance services reported their longest response time as 30 minutes or more. Nine percent of those ambulance services reported their longest response time as more than 45 minutes. The longest reported response time by any ambulance service was 80 minutes. Exhibit 2.4 shows the longest response times for all ambulance services applying for a 2009–2010 license renewal.

⁷ The total hours does not include time spent training or maintaining emergency vehicles.

⁸ The bureau refers to transport agencies as ambulance services.

EXHIBIT 2.4 EMS TRANSPORT AGENCIES’ LONGEST REPORTED RESPONSE TIME, 2009



Source: Idaho Emergency Medical Services Bureau, Department of Health and Welfare, *Idaho EMS Agency Longest Ground Response Times 2009*, December 2009.

Note: Data reflects information self-disclosed by 100 transport agencies as part of the 2009–2010 agency license renewal process.

^a The longest reported response times are case scenarios and do not imply frequency or average response time. Instead, the exhibit highlights the possible range of longest response times across the state for transport agencies.

How Have Recent Legal Interpretations of Statute Impacted Idaho’s Current EMS Structure?

During the last decade, several legal decisions have impacted the evolution of Idaho’s current EMS structure. These decisions illustrate the ongoing struggles over governance among EMS agencies and governmental subdivisions.

Big Sky Paramedics vs. Sagle Fire District

In 2000, the Sagle Fire District passed a resolution that allowed it to transport patients whenever transport was deemed necessary. In 2001, Sagle Fire received approval from the bureau to upgrade from an intermediate life support license to an advanced life support license. Big Sky Paramedics, an advanced life support transport agency operating in the same geographic response area as Sagle Fire, filed a legal complaint with district court that same month. Big Sky hoped to stop Sagle Fire from operating an advanced life support ambulance service.

The district court preserved Sagle Fire’s authority as a fire district to provide advanced life support ambulance services. This determination was appealed by Big Sky to the Idaho Supreme Court in 2004. The Supreme Court upheld the district court decision because of a clause in Idaho Code that grants fire districts the power to perform their statutory duty to protect property against fire and to preserve life. The Supreme Court recognized the fire district’s right to determine

the operations it will use to preserve life. Both courts agreed that although the language is vague, statute allows fire districts to provide ambulance services as part of their greater purpose.

Administrative Rule Change

In 2003, the Emergency Medical Services Bureau had an administrative rule that required all agency license applications to comply with local ordinances and include evidence of local government endorsement. Nampa Fire District submitted an application to the bureau to upgrade its license to an advanced life support nontransport service. However, Canyon County did not endorse the Nampa Fire application and filed a notice of opposition.

Because this was the first time under the new administrative rule that a city and a county disagreed about compliance with local ordinances, the bureau did not have a mechanism to resolve the dispute. The bureau turned to the Office of the Attorney General for assistance.

The Attorney General's Office concluded on October 3, 2003, that the EMS statute did not allow for the bureau's new administrative rule and advised the bureau that compliance with local ordinances could not be a factor to determine the need for new or upgraded services in a geographic response area. After receiving this advice, the bureau repealed its administrative rule and Nampa Fire received its upgraded license.

Ada County vs. Kuna Rural Fire Protection District

In 2007, a new county ordinance gave Ada County authority to regulate emergency medical services within county boundaries. Ada County then sued Kuna Rural Fire Protection District for noncompliance of the ordinance, claiming that Kuna Fire expanded its level of service without consent from the county. Kuna Fire countersued, claiming it had authority under the fire protection district code and through its license from the bureau.

The district court upheld Kuna Fire's authority and declared that Ada County had no authorization to regulate ambulance services in cities or other governmental subdivisions in the county. Additionally, the court believed that the Legislature did not intend to overturn the long established fire protection district code with the addition of an ambulance service code. The court also found the Ada County ordinance violated the regulating authority of the bureau by attempting to impose additional or higher standards.

Chapter 3

EMS National Literature

What Are the Design Attributes of a Well-Functioning System?

An EMS system is the organized delivery of prehospital care to ensure appropriate and timely responses to medical emergencies. In more general terms, a system is made up of a group of interdependent entities that come together to form an integrated whole greater than the sum of its individual parts. We reviewed national literature on EMS systems to better understand how agencies responsible for delivering emergency medical services in Idaho should come together to create a unified whole.¹

Idaho's stakeholders have a common goal for creating an EMS system—optimal patient care. With this goal in mind, we reviewed and synthesized national literature on the development of EMS systems and identified seven attributes that contribute to a well-functioning system design. We discuss each design attribute in the following sections.

1. Comprehensive Enabling Legislation

States need comprehensive legislation that statutorily authorizes a lead agency to oversee emergency medical services. The Institute of Medicine released its summary of a workshop held on the regionalization of emergency care in 2010.² According to workshop participants, who included EMS officials from across the nation, states need legal power to coordinate and fund emergency medical services.

Statute should enable a single lead agency to guide, develop, and regulate the state's overall system, including a review of rules that govern performance and operations at all levels. The National Association of State EMS Officials asserts that in its effort to guide, develop, and regulate the system, the lead agency

¹ Appendix B lists the references for our review of national literature.

² Institute of Medicine of the National Academies, *Regionalizing Emergency Care: Workshop Summary* (Washington DC: The National Academies Press, 2010).

should provide or assure planning, coordination, and implementation of the system. The lead agency should have authority to develop, maintain, and enforce standards. Finally, the lead agency should create a group that represents a broad range of stakeholders to assist in guiding the system.

2. Uniform Medical Oversight

Physician oversight of EMS agencies and personnel is necessary because nonphysicians provide medical services. The National Highway Traffic Safety Administration's report on the future agenda of emergency medical services maintains that physician supervision helps prehospital care become recognized as part of the larger emergency medical care system. Physician oversight also provides consistency in all aspects of patient care, which can reduce the likelihood of error. The National EMS Advisory Council believes that uniform medical direction helps ensure that all EMS personnel use the same patient-centered treatment guidelines.

The National EMS Advisory Council and the National Association of State EMS Officials stress the necessity of a full-time, funded position for a state EMS medical director. According to the National Association of State EMS Officials, states should clearly identify and define the role of a medical director in their statute. A state's medical director should have ultimate authority and responsibility for the medical direction of the entire EMS system; this position is not advisory. The medical director can help assure that changes to patient care standards are only made when evidence supports those changes. The medical director can delegate decisions to local directors if needed to meet local needs.

3. Regionalized Systems

States should have regionalized systems to organize the care and resources of all EMS agencies operating within a geographic area of the state.³ Regional organization can most effectively meet the specific needs of patients by reducing errors and creating consistent, seamless care across the jurisdictional boundaries of governmental subdivisions.⁴ It establishes the parameters around which a patient will receive, within a clinically meaningful timeframe, the right kind of care at the most appropriate location.

A successful regionalized system must have a team approach that includes a broad range of stakeholders; a regionalized system should not be a top-down

³ A state can have any number of regionalized systems. The geographic area that encompasses a regionalized system should be based on the location and type of hospitals. However, the geographical boundaries of a regionalized system are less important than meeting the specific needs of patients.

⁴ Ambulances often transport patients throughout a regional medical area. Ambulance movement and deployment is not necessarily limited to a single governmental subdivision.

approach that mandates a one-size-fits-all structure. The National EMS Advisory Council describes a team approach as one that understands and collaborates with local stakeholders. Among other benefits, a team approach enhances communication, refines patient care guidelines, improves response times, and lowers costs by pooling resources and reducing overlapping services.

Regionalized systems require cooperation among all stakeholders and their governmental subdivisions. In exchange for a loss of some control, stakeholders should be valued for their cooperation and recognized for their autonomy. Established roles should acknowledge the stakeholder's right to be involved in the planning and development of the system. In turn, all stakeholders should understand their obligation to contribute to the overall accountability of the system.

4. Accountable System

Responsibilities for an EMS system are spread across many agencies and most of the public has limited contact with these services. Therefore, a report issued by the Institute of Medicine notes that agencies can easily evade accountability, making it difficult for policymakers to identify or fix a broken system.

Even though it may be difficult to achieve accountability, an EMS system should hold agencies accountable for performance. Accountability will help a lead agency better understand and evaluate how well its system functions and will help assure quality services.⁵

The American Ambulance Association recommends that a lead agency should establish and enforce performance standards as part of the competition for rights to a geographic response area. The system must hold agencies accountable for achieving performance requirements that are focused on outcomes as opposed to level of effort.⁶ Outcome-focused performance requirements guide system operations from the viewpoint of the patient.

5. Data-Driven System

According to the National Rural Health Association, the success of EMS systems depends on data.⁷ States promote success by collecting meaningful data and basing decisions on measurable performance from that data. A lead agency

⁵ Institute of Medicine of the National Academies, *Emergency Medical Services at the Crossroads* (Washington DC: The National Academies Press, 2007), 83.

⁶ Level of effort is based on the quantity of resources available instead of the outcomes resulting from the use of those resources.

⁷ McGinnis, K.K., *Rural and Frontier Emergency Medical Services Agenda for the Future*, National Rural Health Association (2004), accessed August 20, 2010, <http://www.citmt.org/download/rfemsagenda.pdf>.

should require EMS agencies to regularly submit data. This lead agency should have the authority to establish goals that are measurable and based on outcomes. Through the use of data, the lead agency can annually complete and publish performance reports.

Performance reporting is inextricably linked to accountability. States can promote accountability by complying with the data requirements of the National EMS Information System.⁸ This information system has a standardized format for receiving data and uses that data to validate and compare performance of systems across the nation.

6. Funding Based on Cost of Readiness

Research compiled by the National EMS Advisory Council shows that high performing EMS systems improve patient outcomes and can decrease the need for additional, more expensive care. States need adequate funding to achieve improved outcomes and cost-effectiveness. However, adequate funding cannot be provided until a state has accounted for its system's full costs.

Adequate funding should be based on the cost of readiness. The cost of readiness refers to costs associated with maintaining the resources needed to meet

Clinically meaningful response times refer to the timeframes that EMS personnel strive to meet to attain the most positive patient outcomes. Patients may not survive if the response time is not within a matter of minutes.

clinically meaningful response times in a prehospital setting. The cost of readiness depends on characteristics of the geographic response area such as size, complexity, rate of use, and the quality of services expected. Communities that wish to benefit from a high performing EMS system must support the cost of readiness if they expect quality services.

Across the nation, many communities assure residents that they will have access to emergency medical services. However, this assurance comes without a funding structure that covers the full cost of services. The primary cost of emergency medical services is maintaining readiness—even though agency reimbursement is solely based on patient transport to the hospital, not on the treatment provided or the recognition that transport may not be necessary.

Financial incentives can build a funding structure that provides quality care and maintains a viable system. Transport should not be a prerequisite for reimbursement. States should recognize the value of treating and releasing

⁸ The National EMS Information System was created in 2001 to help evaluate systems and increase communication. The information system has two goals: standardize data collection efforts of all EMS agencies and ensure that all data exported from agencies are uniform. As of 2009, 39 states were participating in some form.

patients on the scene when appropriate and reimburse accordingly. If financial incentives can be restructured to link funding with the value of services received, the factors that drive the costs for services and the payment for services received will align. See appendix C for more information on EMS funding.

7. Appropriate Delivery of Care

According to the National Association of State EMS Officials, EMS systems are responsible to the communities they serve. When the public activates a system with a 911 call, the agency response and level of care should be appropriate for the situation. The National EMS Advisory Council recommends that the appropriate response and level of care should be driven by the needs of the patient and, given those needs, driven by evidence-based medical practices. Over responding to one call may result in a lack of certain resources for a more critical call.

Additionally, too many EMS personnel at each license level, responding to calls within the same geographic response area, can negatively affect patient outcomes. Personnel need a certain level of ongoing experience to maintain their clinical skill level and deliver competent care. Some evidence exists that having too many paramedics in one geographic response area can result in a decline in clinical abilities and patient outcomes. Conversely, having fewer paramedics in the system may improve patient outcomes because personnel have more opportunities to maintain advanced skills.⁹

⁹ National EMS Advisory Council, *Guiding Principles and Core Issues in EMS System Design* (2009).

Chapter 4

Assessing Idaho's EMS Structure

Does Idaho's EMS Structure Have the Design Attributes of a Well-Functioning System?

In this chapter, we assess Idaho's approach to emergency medical services in relation to the design attributes of a successful system defined by national literature.¹ We used design attributes supported by this literature as criteria for assessing Idaho's EMS structure. In addition to our assessment, we surveyed EMS directors in other states, asking for their opinions on whether their state EMS systems have the design attributes we identified in national literature.² We also interviewed many of Idaho's EMS stakeholders. From these three sources, we formed conclusions about the status of emergency medical services in Idaho and found that generally Idaho does not meet the criteria of a well-functioning EMS system.

Does Idaho Have Comprehensive Enabling Legislation?

Answer: No

The structure of emergency medical services in Idaho dates to the mid 1960s with the initial creation of districts that tax for ambulance services. Policymakers wrote tax laws for ambulance service districts in 1966 before emergency medical services expanded and evolved.³ At that time, policymakers could not anticipate how ambulance services (a ride to the hospital) would evolve into the present array of prehospital services. Currently, the state has an informal network of many different types of agencies that provide emergency medical services; however, statute has not been fully updated to reflect this evolution.

The Emergency Medical Services Bureau has no governing authority to guide, develop, or regulate services in Idaho.

¹ See appendix B for our list of references.

² For more information about our other states' survey, see appendix D.

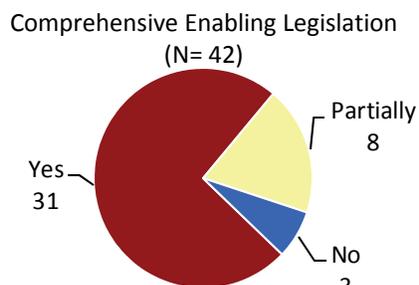
³ Two examples demonstrate how emergency medical services have expanded and evolved in Idaho: (1) nontransport agencies did not exist in the 1960s, and (2) until 1994, hearses and police patrol cars could still transport patients.

Idaho Code does not require a governing structure to coordinate and oversee the different types of EMS agencies. At least three governmental subdivisions

(counties, cities, and fire protection districts)

provide emergency medical services, and three sections of disjointed statute guide delivery.

However, Idaho Code gives neither the bureau nor anyone else explicit governing authority. In comparison, of the 42 state EMS directors that responded to our survey, 31 say that they have comprehensive enabling legislation that provides a state lead agency with the legal power to guide, develop, and regulate emergency medical services.



Stakeholder Opinions

In our interviews, some stakeholders contend that the message delivered to the Senate Health and Welfare Committee during the hearing on Senate Bill 1391 was disingenuous. These stakeholders think the committee was led to believe that Idaho’s emergency medical services are in crisis because of a lack of governance. However, at least two stakeholder groups disagree that a crisis exists. Instead, the two groups believe that by and large patient care is not suffering. These groups say that agencies are cooperative and collaborative throughout the state and are able to work together within the current statutory framework. Similarly, several stakeholders told us that any major problems are limited to Ada County.

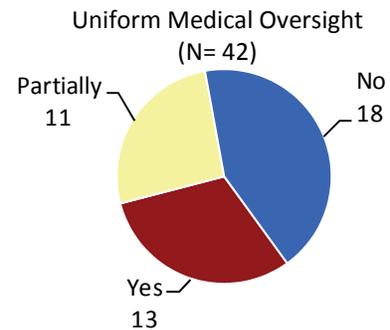
However, other stakeholder groups strongly disagree that problems are isolated to Ada County and believe emergency medical services are fragmented across Idaho and therefore legislation is necessary. Many stakeholders point to controversies over issues like patient billing and reimbursement, and disagreement over the appropriate level and type of care. Examples of these types of problems can be found in places such as Nez Perce County and the City of Lewiston, Bingham County and the City of Blackfoot, and Bonner County and the City of Sandpoint, among other areas of the state making newspaper headlines.

The existence of the EMS Code Task Force and the ongoing debate over the past several years demonstrates that many stakeholders recognize the need for someone to govern local systems. In our interviews, stakeholders discussed less about whether each local system should have a governing authority, and more about specifically *who* should make up the authority, especially given that the authority would have decision-making powers.

Does Idaho Have Uniform Medical Oversight?

Answer: No

Idaho’s EMS Physician Commission performs its duties without the assistance of a state medical director. Idaho Code does not authorize the appointment of a state medical director, a position that 24 of 42 other state EMS directors we surveyed believe they have in some capacity. In lieu of a state medical director, the Physician Commission sets the standards for medical supervision, which complies with statute that requires a physician to supervise EMS personnel.⁴



EMS personnel in Idaho operate within a scope of practice set by the commission. The commission determines the minimum standards to which personnel must be trained and establishes a maximum set of skills that personnel are allowed to perform. The commission also decides which medications and devices personnel are allowed to use to perform those skills. The local medical directors who provide physician supervision for agencies have the flexibility to determine whether they will let personnel practice up to the maximum skill set allowed by the commission.⁵

In 2008, the bureau reported a single county with 13 physicians acting as medical directors for various agencies. Agencies operating under the direction of different medical directors within the same county may not provide the same interventions, potentially interrupting patient care and introducing a risk for errors. For example, if a nontransport agency operating under “medical director A” performs a procedure that a transport agency’s “medical director B” has not authorized, the personnel from the transport agency cannot transfer the patient to the hospital. Because medical emergencies are time sensitive, transfer delays can affect patient outcomes.

Medical practices may vary within geographic response areas. These variations can lead to problems with the transition of patient care.

Stakeholder Opinions

The need for a medical authority to oversee emergency medical services at the local level was the most agreed upon piece of stakeholders’ debate on governance.

⁴ IDAHO CODE § 56-1013, 1013A. Statute gives the commission authority to set medical supervision standards, but does not grant it enforcement authority if EMS agencies or personnel do not meet medical supervision standards.

⁵ Over 80 local medical directors supervise EMS personnel throughout Idaho. According to Physician Commission members we interviewed, involvement and knowledge of emergency medical services varies among medical directors across the state.

Stakeholders understand the need for consistency among local medical directors who supervise agencies in the same geographic response area. Consistency ensures uniformity in patient protocols. In addition to a local medical authority, Physician Commission members we spoke with believe that a full-time state medical director could provide assistance to and be a daily resource for local medical directors—a role the commission does not fulfill.

Is Idaho’s EMS Structure Made Up of Regional EMS Systems?

Answer: No

To assess local systems, the bureau uses a tool that places local systems in one of three stages of maturity:

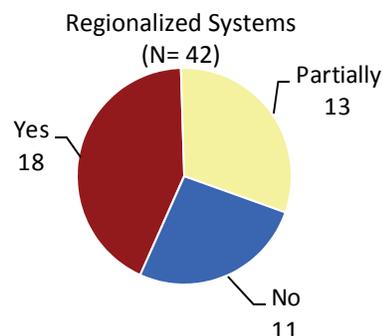
- Stage 1: agencies operate independently, focusing on individual and community needs
- Stage 2: agencies operate independently but are coordinated and supported by a regional or county authority
- Stage 3: agencies within a geographic response area operate as a unified, regional system with a single governing authority

Idaho Code does not require agency coordination across governmental subdivisions.

Bureau officials say that the vast majority of local systems in Idaho are in stage 1, with only five showing characteristics of stage 2. Some local EMS systems have tried moving toward stage 2 and have even considered creating a regionalized system (stage 3) within their geographic response area but have been unable to reach a satisfactory compromise among agencies.

Despite the lack of enabling legislation, we heard that some local systems work cooperatively with all of the agencies providing services in the same geographic response area. These local systems cooperate through the efforts of agreeable personalities, not because enabling legislation requires them to coordinate services. Consequently, local systems that may function reasonably well today could lose their cooperative structure tomorrow.

Eighteen of the 42 state EMS directors we surveyed say they have regionalized systems that provide for the integration and coordination of resources and patient care throughout their states. Thirteen more say they have partially regionalized their systems.



Stakeholder Opinions

We found that creating regionalized EMS systems in Idaho may not be an easy transition because many stakeholders seem reluctant to forfeit control. In our interviews, these stakeholders expressed a lack of faith or confidence that whoever is in charge will take care of their (or the patient’s) best interests.

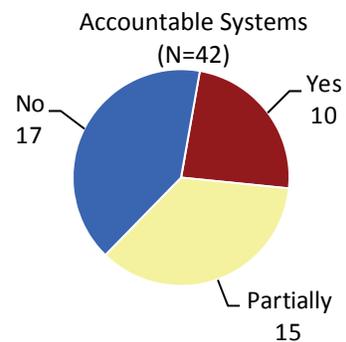
In general, stakeholders want flexibility and assurance that any revisions to statute will not undo collaborative efforts already occurring. Many stakeholders want to retain their autonomy—their implicit authority to decide the type of services available and the manner in which those services are provided.⁶ One group of stakeholders described their position in terms of sovereignty and patient care, stressing that they were not interested in control for control’s sake, but instead interested in providing the best patient care possible.

Does Idaho’s EMS Structure Foster Accountability?

Answer: No

Only ten state EMS directors we surveyed say that their systems hold EMS agencies accountable through measurable, outcome-based performance goals. Like many other states, the Idaho Emergency Medical Services Bureau is not empowered by statute to hold agencies accountable for performance. During the licensure process, the bureau cannot consider performance indicators such as the impact that a new or upgraded agency license would have on response times. Instead, statute permits the bureau to license agencies according to a set of standards, namely whether the agency has enough personnel and equipment to cover its self-declared geographic response area.

Because statute allows EMS agencies to self-declare their geographic response area, competition in locations with high call volumes can occur. Some agencies that respond to calls in low volume locations depend on user fees from high volume locations to stay in business. Competition can potentially put these agencies out of business, thereby affecting the services received by citizens living or recreating in low volume locations. New or upgraded agency licenses can threaten system stability, in turn, threatening the overall performance of the system.



The Emergency Medical Services Bureau has no statutory authority to hold agencies accountable for performance.

⁶ For example, these stakeholders want to maintain their ability to upgrade a nontransport license to a transport license or upgrade a basic life services license to an advanced life services license.

In 2008, the Legislature made changes to statute that allows the bureau to notify units of local government and agencies operating in the same geographic response area when an applicant is requesting a new or upgraded license. The bureau drafted new administrative rules to implement this legislation—rules that would have allowed the bureau to receive feedback from agencies about the impact of issuing a new or upgraded license. However, in October 2010, the Department of Health and Welfare withdrew the rules because of concern over a lack of statutory authority. The 2008 legislation stopped short of solving the question of governance and naming an authority to hold agencies accountable for system stability and performance. A governing authority could take on the role of deciding which EMS agencies can operate in a given geographic response area and at which level of service.

Stakeholder Opinions

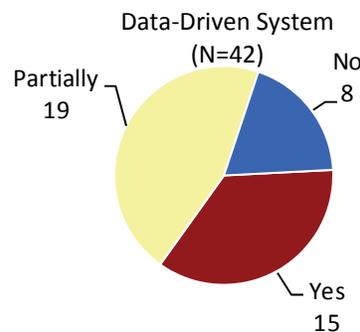
Stakeholders we heard from believe that for the sake of accountability to the patient and the taxpayer, a decision to grant an agency a new or upgraded license should be made on whether a change will improve system performance. Some stakeholders expressed concern that competition from new or upgraded agencies within their geographic response area could put them out of business.

In our interviews with stakeholders, we often heard that decision makers should consider patient care first and foremost. However, as often as we heard about patient care, we also heard from many of these same stakeholders that other stakeholders are influenced by money, ego, or control. Because of their comments, it appears that stakeholders think the patient care they provide is better than the care others provide. This sentiment helps explain why, in general, stakeholders do not want to be accountable to a governing authority that may not share their priorities.

Is Idaho’s EMS Structure Driven by Data?

Answer: Partially

The bureau is working to standardize data collection through the National EMS Information System, which strengthens Idaho’s overall EMS structure. Currently, the bureau operates a compliant data repository and exports state-level data to the national information system. However, according to bureau officials, not all EMS agencies in Idaho are compliant. The bureau has not forced compliance because agencies are still trying to update their data systems. Similar to Idaho’s current status, 19 of 42 state EMS directors we surveyed say that their EMS systems are partially data driven.



Bureau officials told us that although they hear about problems, they have no idea of the true depth of those problems. Some stakeholders suggested that agencies may struggle to comply with data collection and submission because of their rural status. Oftentimes, rural agencies rely on volunteers rather than career personnel.⁷ Idaho's heavy dependence on volunteers demonstrates another aspect of the fragility of the state's EMS structure. Agencies that rely on volunteers often must limit their focus to three issues: ensuring a response to calls for service, keeping up with training and continuing education requirements, and raising money to continue providing services.

Interestingly, the bureau also lacks data from larger, more urban areas of the state. For example, the bureau only receives financial information through agency grant applications. However, bureau officials told us that the largest agencies often do not qualify for grants so they do not apply, and therefore do not submit financial data. Consequently, the bureau lacks comprehensive, statewide information on costs and is limited in its ability to inform the Legislature about the actual cost of emergency medical services.

Without quality data, a governing authority will have difficulty understanding which areas of the state are functioning well in terms of patient outcomes and which areas could potentially benefit from more support. A lack of data inhibits the state's ability to assess (1) where regionalization could take place most effectively, (2) which agencies achieve outcome-based performance goals, and (3) if additional resources became available, where the state should allocate them.

Evaluation of emergency medical services in Idaho suffers without data, limiting the state's ability to know where improvement is needed.

Stakeholder Opinions

In May and June 2010, the bureau held town hall meetings across the state for stakeholder feedback about the new administrative rules drafted to implement EMS legislation passed in 2008. During our observations of the town hall meetings, some stakeholders voiced resistance to providing the bureau with additional data beyond what administrative rule currently requires.

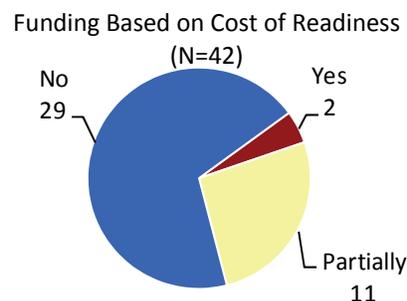
Stakeholders feel that a lack of resources limit their ability to collect and submit data even though they understand the importance of data analysis. A few stakeholders also seem particularly concerned about submitting financial data. They questioned the bureau's intended use of the data and expressed reluctance to adhere to additional criteria.

⁷ As mentioned earlier, 60 percent of the state's EMS personnel are volunteers.

Is Funding Based on the Cost of Readiness?

Answer: No

In Idaho, funding for emergency medical services comes from a patchwork of sources such as user fees, insurance reimbursement, property tax, motor vehicle service fees, volunteer subsidies, and fundraising. Bureau officials and other stakeholders said that despite the many sources of funds, emergency medical services in Idaho is not budgeted for readiness. Instead, agencies heavily rely on the goodwill and commitment of volunteers and revenue collected from patient billing. Consequently, EMS agencies may not have all of the resources needed to meet clinically meaningful response times that help ensure the patient’s chance of survival. Twenty-nine of the 42 state EMS directors we surveyed say that their systems are not budgeted for the cost of readiness.



Nine counties in Idaho do not use taxes to help fund emergency medical services.

As of 2009, nine counties in Idaho have not established ambulance service districts or set up ambulance service funds and therefore, these counties do not benefit from their authority to levy taxes. Further, bureau officials point out that the allowable levy rate for ambulance service districts of 0.04 percent is much lower than the allowable levy rate for fire protection districts. Fire protection districts can levy at a rate of 0.24 percent, a rate six times higher than the rate for ambulance service districts.

Additionally, the assessed value of property throughout the state differs. Because of the differences in both property values and population density, the funding available within each county for emergency medical services varies greatly throughout the state. Exhibit 4.1 illustrates some of this disparity and appendix C provides more detailed information.

Stakeholder Opinions <H3>

Some stakeholders we interviewed told us that any changes to Idaho’s EMS structure must address governance and funding simultaneously. These stakeholders were critical of Senate Bill 1391 because they felt the bill did not adequately address funding. However, we also heard that the task force was hesitant to alter the taxing structure already in place for fear that legislation would fail on that point alone.

EXHIBIT 4.1 COUNTIES RECEIVING THE MOST AND THE LEAST TOTAL REVENUE FROM APPROVED PROPERTY TAXES AND MOTOR VEHICLE REGISTRATIONS, 2009

Counties with the Most Total Revenue		Counties with the Least Total Revenue ^a	
County	Total Revenue (\$)	County	Total Revenue (\$)
Ada	4,026,816	Lewis	1,031
Bonner	2,302,250	Oneida	1,489
Kootenai	1,886,425	Lemhi	2,441
Canyon	1,753,235	Franklin	3,580
Blaine	1,585,969	Owyhee	3,888

Source: Information from the Idaho Emergency Medical Services Bureau, Department of Health and Welfare.

Note: See appendix C for more information on the revenue generated by all counties through property taxes and motor vehicle registration fees.

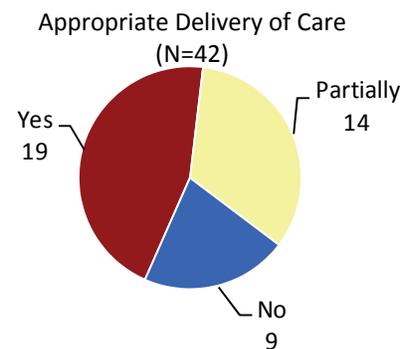
^a These five counties do not benefit from their authority to levy taxes. Therefore, the only source of the revenue listed is from the motor vehicle registration fees that these counties collect.

A few stakeholders also said that nontransport agencies should share in the money collected from taxpayers because they cannot bill for transport. Because the availability of resources across the state differs, a few other stakeholders believe that local taxpayers should make the decision as to what clinical level of services (basic, intermediate, or advanced life support) they are willing to support.

Does Idaho’s EMS Structure Ensure the Appropriate Delivery of Care?

Answer: No

Nineteen of the 42 states we surveyed say that their EMS systems ensure the appropriate delivery of care by considering the individual response and level of clinical care each call requires. However, ensuring the appropriate delivery of care in Idaho remains an unrealized goal. For example, bureau officials told us that most counties have not implemented emergency medical priority dispatch—a method that prompts dispatchers to ask specific questions of 911 callers to better understand exactly what the emergency entails, to determine what kind of services are needed, and to provide prearrival instructions to the caller.



Statute does not explicitly designate emergency medical services as an essential government service and therefore, does not guarantee access to these services for all Idahoans.⁸ Counties can establish ambulance service districts where ambulance service is not reasonably available. However, Idaho Code does not require coverage even if services are not reasonably available, and instead allows agencies to self-declare their geographic response area. The ability to self-declare a geographic response area is a major reason why market competition can take place—EMS agencies can cherry pick calls that occur in high volume locations with no obligation to respond to rural, lower volume locations.

Market competition can cause duplicate services in some areas and a lack of coverage in other areas. In geographic response areas where more than one agency responds to every call, overlapping services are especially noticeable. Two examples of areas with duplicate service are Ada County and Canyon County. Contrast these areas with some parts of the state which struggle to serve the “last mile” of the county. Bureau officials point to Nez Perce County, the region surrounding Grangeville in Idaho County, and other counties that are heavily dependent on EMS volunteers as examples of where services are in jeopardy. Especially in rural areas, the calls are few and the time to arrive on the scene, treat the patient, and get the patient to the hospital takes longer simply because of the remote location.

Market competition
can jeopardize
coverage of emergency
medical services in
Idaho.

Idaho does not issue EMS licenses according to need, which leaves the prehospital market open to competition among EMS agencies. Emergency medical services are unique because they do not fit the retail market. For example, retail users shop around for products and services. However, in an emergency situation, patients do not decide who responds to their 911 call. When coordination is not formally established, market competition drives the system, which can threaten patient care, especially in low volume locations.

Stakeholder Opinions

Members of the Physician Commission and other stakeholders we interviewed said that more personnel and higher levels of service are not automatically better for the system. According to these stakeholders, a change in the clinical level of service within the system should be a medically grounded decision based on the needs of patients rather than agencies.

⁸ IDAHO CODE § 31-3901 identifies ambulance service as a government function. However, ambulance service, albeit important, is only one component of prehospital care.

Many stakeholders also believe that some local systems have too many paramedics providing advanced life services and that the clinical level of care suffers as a result. We spoke with members of the Physician Commission who contend that the clinical skill levels of the personnel available to respond to emergencies must be balanced with the type of care required by calls to 911 for service. If the system is saturated with too many paramedics, the opportunity to practice advanced clinical skills decreases, while the need for first responders to perform basic assessments immediately upon arrival at the scene remains the same.

A few stakeholders maintain that rural areas struggling to staff an ambulance around the clock is a far bigger issue than whether every agency in urban areas is allowed to provide advanced life support services through the use of paramedics. Bureau officials agree that rural areas struggling to support around the clock coverage because of their dependency on EMS volunteers are as much of an issue as areas where agencies compete to provide services.

Chapter 5

Improving Idaho's EMS Structure

How Can Idaho Begin to Create a Well-Functioning EMS System?

Idaho's current structure for providing emergency medical services can and should be improved by taking the initial steps to meet certain criteria. The direct solutions to problems are relatively simple, but they are complicated because of the politics involved. Stakeholders have long been debating the issues facing emergency medical services in Idaho without reaching a resolution. In order for these issues to be resolved, the Legislature should take the lead by engaging in a policy debate.

This chapter does not examine every nuance of possible legislation but instead provides the framework within which a policy debate can occur. We developed the following recommendations to help Idaho create an overall EMS system that is integrated, accountable, and made up of local systems that have the flexibility and autonomy desired by stakeholders.

Idaho can begin to meet criteria we identified using the design attributes discussed in chapters 3 and 4, while also meeting the needs of stakeholders. In moving forward, the Legislature should know that stakeholders, who represent a broad spectrum of interests, generally agree on four points:

- Optimal patient care should be the first priority
- Using county boundaries as a geographical response area is the most obvious way to attain statewide EMS coverage
- A medical directorate is a necessary component of local systems
- Although stakeholder opinions vary on the severity of existing problems, the status quo cannot continue

Stakeholder commitment to optimal patient care can be considered both the greatest strength and the greatest weakness of the state's overall system; a paradox the Legislature must recognize as it seeks to improve emergency medical services in Idaho. Because personality disagreements exist over the best

way to deliver optimal patient care, stakeholders have been unable to reach consensus.

Despite these disagreements, one of the most important aspects of effectively responding to medical emergencies is the coordination of efforts. To achieve coordination, while at the same time ensuring the flexibility, autonomy, and degree of representation stakeholders prefer, governance should first rest at the local level. Our recommendations outline the minimum operational requirements for local systems that the Legislature should set. These recommendations allow flexibility for local systems to configure themselves in a way that most effectively meets their unique needs. Within this flexibility, we identified two underlying principles that Idaho must first consider:

1. All stakeholders should have the opportunity to participate in their local system by being allowed to provide meaningful input.
2. Someone has to have the authority to govern local systems and determine who will provide services and at what clinical level services will be provided.

Recommendation 1: Designate Local Systems by County Boundaries

Members of the task force and other stakeholders agree that using county boundaries to designate local systems is the simplest way to provide emergency medical services to the entire state. At a minimum, a local system's total geographic response area should include every mile of the county to eliminate areas of "no man's land" and provide coverage to every Idaho citizen.¹ Several states we researched geographically structure their systems according to county boundaries. For example, North Carolina requires every county to provide emergency medical services and has one of the most recognized EMS systems in the nation.

Establishing local EMS systems at the county level would not prohibit two or more counties from forming larger, regional systems:

- Maryland has five regional councils that coordinate emergency medical services at the county level
- Washington has eight EMS regions made up of one to nine counties with regional councils that coordinate the counties and advise the state

¹ In the most rural areas across the nation and certainly within Idaho, the population is small and the volume of EMS calls is relatively low. The patients who are the farthest from hospitals are the patients who would benefit the most from advanced life support services. However, these same patients are the least likely to have advanced services available.

In the future, Idaho could consider organizing countywide systems into regions with councils to guide them. Maryland's and Washington's regional EMS systems have been able to grow together with their trauma systems. Like other states, Idaho could benefit from developing the EMS and trauma systems together. A joint system would help provide a seamless transition of patient care from the prehospital setting to the hospital setting.

Recommendation 2: Create a Structure for Governance at the Local Level

There are several options for the composition of a local governing authority. Multiple drafts of Senate Bill 1391 identified options for local governance by elected officials. Many stakeholders support a governing authority made up of elected officials because the public can hold elected officials more accountable. We agree with stakeholders that elected officials should govern local EMS systems.

The Legislature should require every local system to create a governing authority because someone must be in charge of system accountability. We encourage legislators to consider the following two scenarios:

1. For those counties with only one licensed EMS agency, we recommend the board of county commissioners make up the governing authority.²
2. For those counties with more than one governmental subdivision providing emergency medical services within the county, we recommend a multijurisdictional board. The multijurisdictional board should be made up of the three county commissioners plus an elected official to represent every governmental subdivision that has a licensed EMS agency.

The following list identifies the major benefits of a multijurisdictional board:

- As recommended in national literature, a multijurisdictional board uses a team approach, which includes all governmental subdivisions that provide emergency medical services.
- A multijurisdictional board reflects the viewpoint of many stakeholders who strongly feel that all stakeholders should be able to meaningfully participate in the local system through shared governance.
- A multijurisdictional board that includes all county commissioners, each elected from a different district of the county, ensures that every county resident has representation. Additionally, the county commissioners can

² Nine counties have only one countywide EMS agency.

represent those nongovernmental EMS agencies that serve county residents, such as nontransport quick response units.

- When all governmental subdivisions that provide emergency medical services are included in the governing authority, the intent of Article 12, Section 2 of the Idaho Constitution is met.³ A less inclusive governing authority could undermine the jurisdiction of existing governmental subdivisions as provided for in the Constitution.

Some stakeholders with established systems are concerned that a new policy would undo the governance structure they have built. We recommend that any new policy validate their efforts and preserve their system. The Legislature should consider including a clause in any new policy that specifically grandfathers in those local systems that have already reached agreement on a governance structure, such as those that have reached stage 2 in the evolution of their systems as discussed in chapter 4.⁴

Once a local governing authority is established, the Legislature should give the local authority ultimate responsibility for credentialing the system's agencies and creating a comprehensive EMS system plan.⁵ If disputes occur within the local system as the governing authority performs these duties, the local system should ask the bureau to mediate those disputes.

Local governance of emergency medical services will help target the specific needs of local systems. We encourage local systems to form administrative advisory groups to help guide the local governing authority on system needs and goals. The comprehensive plan should detail how the local system's credentialed agencies will meet the identified needs and achieve the set goals.

- 1. Credentialing EMS Agencies.** Each local governing authority should determine which agencies' services are needed within the system and the clinical level of service for each agency through a credentialing process. This determination will allow the bureau to issue licenses according to need.

³ The Legislature can enact any general laws, but Article 12 empowers counties and incorporated cities and towns to practice police powers within the law. Police powers, a broad term for regulations that address health, safety, and welfare, are commonly referred to as separate sovereignty. Under separate sovereignty, counties can enforce regulations for the unincorporated areas of the county, and incorporated cities and towns can enforce regulations for their respective cities and towns. Separate sovereignty operates within the laws of the state.

⁴ For example, the Wood River Sawtooth EMS Association is made up of 31 agencies from Blaine, Camas, and Custer counties. The association advises elected officials from the counties, cities, and fire districts. In Kootenai County, the board of county commissioners delegated governing authority to a joint powers board, which is made up of two fire district commissioners, one city official, one county commissioner, and one position representing the interests of other agencies.

⁵ In this context, credential means to attest to the authority of each agency to operate within the local system.

- 2. Creating a Comprehensive EMS System Plan.** Each local governing authority should submit an annual EMS system plan to the bureau. The plan should specify how the local system will collect and submit data in order to hold credentialed agencies accountable for performance. The governing authority should create the plan with input from the local EMS agency administrators who have a wealth of organizational and on-the-ground knowledge.

Credentialing EMS agencies and developing comprehensive plans will create accountability and help eliminate the market competition that leads to duplicated services or lack of coverage. Other states we interviewed provide examples of different forms of local governing authorities that perform similar functions:

- The King County, Washington, system brings a broad group of stakeholders together to write its local EMS plan. The group submits the plan to the county commissioners for approval.
- Counties in California must establish a local EMS agency if they choose to provide paramedic level services. The local EMS agency is responsible for submitting an annual plan to the state lead agency for approval.
- In Maryland, local jurisdictions are responsible for credentialing agencies, quality assurance, and medical oversight. The local jurisdictions report to the state, but the state grants them flexibility to configure themselves.
- Each county in North Carolina decides the structure of its system and submits an annual plan to the state lead agency. Many counties cap the number of agencies or award exclusive jurisdiction.
- In Utah, local systems must establish the cost, level of service, and acceptable response time for the geographic response area; the state then issues a license.

Recommendation 3: Increase the Role of the Idaho Emergency Medical Services Bureau

Statewide coordination of local systems is necessary because without it, emergency medical services may continue to fragment. If a system is to function with patient care as the top priority, local systems cannot work independently of or in opposition to each other. There cannot be so much variation among local systems that together they do not form an integrated, unified whole. The bureau should oversee and coordinate the overall system while still allowing some flexibility for local systems to develop according to local characteristics and needs.

Some stakeholders support the idea of the Idaho Emergency Medical Bureau becoming the system's ultimate governing authority in addition to its current role as the grantor of licenses. They believe that the bureau is in the best position to consider system impact statewide. As the state lead agency, the bureau can operate independently and mitigate some of the personality conflicts that may impede progress at the local level.

By granting the bureau increased oversight of local systems, the state will be in a better position to hold local systems accountable for performance and the appropriate delivery of prehospital care. The bureau should have the ultimate authority for approving local systems' comprehensive EMS plans. Further, the bureau should have the authority to issue sanctions, including revoked licenses, if agencies do not comply with regulations. The bureau should not issue licenses to agencies that have not been credentialed by the local system's governing authority.

In some states, legislatures have granted the state lead agency a level of oversight and coordination greater than what statute currently empowers the bureau to do in Idaho:

- In Maryland, a governor-appointed EMS board made up of a broad group of people with diverse backgrounds has the authority to write a state EMS plan and to develop regulations to implement the plan. Additionally, the state will not license agencies that are not affiliated with and credentialed by the local EMS authority.
- In Utah, the state lead agency governs a statewide system by issuing certificates of need and acts as the system gatekeeper. If a local agency wants to provide emergency medical services, the agency has to demonstrate what need necessitates that change.
- In Washington, the Department of Health governs emergency medical services. Regional planning councils advise a state steering committee that, in turn, makes recommendations to the Department of Health, which makes the final decisions.
- In North Carolina, the state lead agency credentials agencies only after the county has signed off.

Recommendation 4: Create Local Medical Directorates

Idaho's first step toward creating uniform medical oversight should be the creation of medical directorates within local systems, an approach stakeholders generally support. Each directorate, consisting of one or more medical directors, should provide medical coordination and oversight of their local system. The directorate should be made up of local medical directors currently supervising EMS agencies in the county.

Each directorate should write a medical supervision plan, verify compliance with the rules set by the Physician Commission, and evaluate the clinical implications of system decisions. The local system should adhere to the direction of the directorate on all clinical matters. Additionally, the Physician Commission should mediate any disputes within the directorate.

State oversight and coordination should continue to occur through the Physician Commission. However, if the state wanted to further improve physician supervision of EMS personnel, the Legislature could consider authorizing the appointment of a state medical director. National literature supports this appointment and, as discussed in chapter 4, members of the Physician Commission that we interviewed believe that a state medical director could be a daily resource for local medical directors.

Recommendation 5: Consider Reviewing the Funding Structure for Local EMS Systems

Many stakeholders believe that the current funding levels do not support the cost of readiness. However, it may be difficult to determine if or where funding gaps exist because (1) the state has not determined the actual cost of readiness, and (2) EMS agencies receive funding from many sources. These funds are not typically shared among agencies, but instead support individual agencies.

The Legislature should, from a system perspective, consider revising and streamlining the different funding sources that support emergency medical services. A review of funding sources may help identify where funding gaps exist.

At least one stakeholder group contends that establishing local EMS governing authorities will require funding specifically for the authority. Senate Bill 1391 would have used the dedicated EMS revenue generated from the county's motor vehicle registration fees to fund the governing authority. However, this stakeholder group believes that registration fees are not a viable funding option for the authority because not every county generates enough revenue from this source. Stakeholders mentioned a few options that could be considered if the Legislature reviewed the EMS funding sources:

- Reset the maximum allowable levy rate for ambulance districts and let local taxpayers decide whether they support an increase. The EMS Code Task Force considered recommending that a one time reset of the levy rate be permitted but shelved the idea for fear that legislation would fail.
- Increase the dollar value dedicated to emergency medical services from motor vehicle registration fees or driver's license fees. Motor vehicle registration fees have not seen an increase since 1990. With the exception of dedicated grant funding for vehicles and equipment, driver's license fees have not been increased since 1989.

- Through Idaho Code §§ 49-306(8)a and 56-1018B, diversify the allowable uses of dedicated grant funding available from the bureau for local system development. Currently, grant funding is limited to acquiring vehicles and equipment.

The Legislature may also consider additional ideas from other states:

- California allows counties to establish a surcharge on traffic infractions
- Maryland charges a much higher fee for emergency medical services than Idaho (\$11 versus \$1.25) on its motor vehicle registrations
- Fourteen percent of all criminal fines and forfeitures go to emergency medical services in Utah

Recommendation 6: Require Local Systems to Address Funding in Their Comprehensive EMS Plans

Regardless of the extent to which the Legislature decides to revise the EMS funding structure, each local system's comprehensive EMS plan should outline how the governing authority will support the system with the funds available. At a minimum, the local governing authority should set a user fee schedule. Some stakeholders feel that standardizing user fees within the system is an important factor of equity among agencies. Currently, patients can be charged different rates depending on which agency responds to their 911 call.

In addition, we recommend the governing authority equitably share the public funds available and rely on a formula to distribute those funds equitably. A formula will help create a funding structure for local EMS systems that fully supports and acknowledges many types of agencies. Such a formula could be based on call volume, type of service, or could be weighted to benefit those agencies with geographic response areas that include rural, unincorporated areas. Each agency could then keep its own revenue generated from sources such as user fees, donations, or fundraising.

Recommendation 7: Conduct a National Technical Assistance Team Reassessment

Idaho should continue to evaluate the state's overall system after taking the initial steps to improve its structure. The National Highway Traffic Safety Administration conducts assessments of state EMS systems and offers recommendations for improvement that are grounded in leading EMS practices. In 1993, the administration conducted an assessment of Idaho's EMS system. Now 17 years later, this assessment is outdated. The National Highway Traffic Safety Administration recommends that states complete a reassessment every three to five years.

The state should conduct a National Highway Traffic Safety Administration reassessment to identify and delineate the next steps for continued system improvement. Our report assessed the design attributes of a well-functioning EMS system as they relate to governance. We did not assess other kinds of EMS system attributes—a role that a team of National Highway Traffic Safety Administration consultants could fulfill.⁶

What Is the Role of the Legislature?

Bureau officials and stakeholders across the state agree that no ideal EMS system exists. Considering stakeholders' inability within the current political climate to reach consensus about system governance, total stakeholder agreement on any new policy is unlikely. However, stakeholder compromise is both a necessity and a reality if Idaho intends to advance the function of its EMS structure.

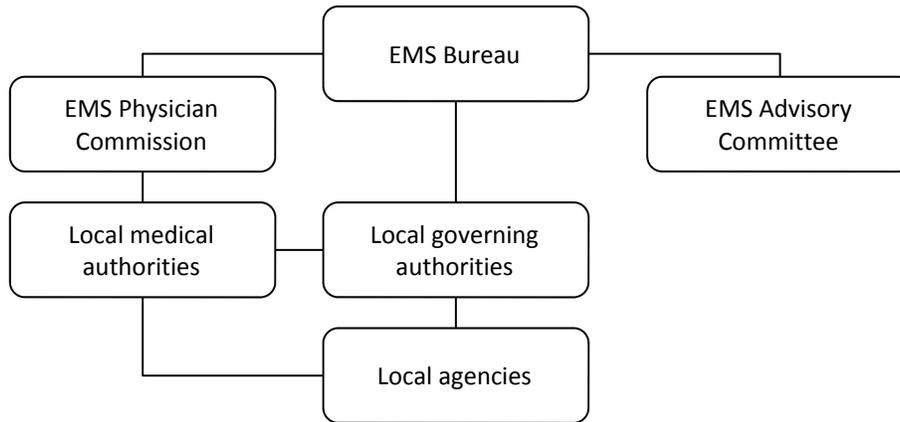
In order to take steps to improve the delivery of emergency medical services, the Legislature should take a leadership role. The Legislature is uniquely poised to authorize the establishment and development of local EMS systems by empowering both stakeholders and the bureau. Although some areas in Idaho may have already formed cooperative systems in the interest of patient care, the Legislature may conclude that mandatory provisions are needed to achieve high levels of prehospital care in all counties.

Statute is outdated, disjointed, and needs to reflect contemporary practices, regardless of the degree to which stakeholders agree that emergency medical services are in crisis. Through comprehensive legislation, the Legislature should consider updating the statutory framework that guides the delivery of emergency medical services to help Idaho develop the design attributes of a well-functioning system.

In summary, exhibit 5.1 depicts the minimal governance structure we recommend for Idaho to improve EMS delivery. Exhibit 5.2 reiterates the functions of the local governing authorities and the Idaho Emergency Medical Services Bureau.

⁶ The National Highway Traffic Safety Administration evaluates 11 components of state EMS systems: regulation and policy, resource management, human resources and training, transportation, facilities, communications, trauma systems, public information and education, medical direction, preparedness, and evaluation.

EXHIBIT 5.1 RECOMMENDED IDAHO GOVERNANCE STRUCTURE



Source: Office of Performance Evaluations, 2010

EXHIBIT 5.2 RECOMMENDED RESPONSIBILITIES OF THE LOCAL GOVERNING AUTHORITIES AND THE IDAHO EMERGENCY MEDICAL SERVICES BUREAU

	Planning	Regulation	Mediation
Local Governing Authorities	Write the local system's plan	Credential agencies	Take disputes to the Idaho EMS Bureau
Idaho EMS Bureau	Approve each local system's plan	License credentialed agencies	Mediate local system disputes

Source: Office of Performance Evaluations, 2010

Appendix A

Methodology

We designed our study to determine how emergency medical services currently functions and whether Idaho's EMS structure can be improved. We worked closely with officials from the Department of Health and Welfare's Emergency Medical Services Bureau, met with members of the EMS Physician Commission, consulted the Office of the Attorney General, and interviewed key stakeholders across the state to gain a better understanding of the unique issues facing emergency medical services in Idaho. We also attended meetings of the state EMS Advisory Council and the EMS Administrative Rule Writing Committee. Our work involved stakeholder outreach, an examination of the relevant sections of Idaho Code and Administrative Rules, a review of national EMS literature, and research on EMS systems in other states.

Stakeholder Outreach

Early in our study, we reviewed the minutes from the meetings of the EMS Code Task Force to understand the perspectives of key stakeholders. Throughout our evaluation, we interviewed over 60 stakeholders including representatives from the associations most closely involved with the task force:

- Association of Idaho Cities
- Emergency Medical Services Bureau
- Emergency Medical Services Physician Commission
- Idaho Association of Counties
- Idaho Fire Chiefs Association
- Idaho Hospital Association
- Idaho State Fire Commissioners Association
- Idaho Volunteer Fire and Emergency Services Association
- Professional Firefighters of Idaho

The purpose of our study was to conduct a policy analysis that would provide the Legislature with a framework to develop an EMS governance structure. We do not specify the names of stakeholders we interviewed in the report because (1) we want to maintain stakeholder confidentiality, and (2) we were not evaluating individual EMS agencies. The stakeholders we interviewed represented numerous EMS agencies of varying types. In addition to these interviews, we also rode with an ambulance service and a first responder, nontransport service.

During May and June 2010, the Emergency Medical Services Bureau hosted town hall meetings in 12 counties. The purpose of the meetings was to gather local stakeholder input about draft administrative rules that reflect 2008 legislative changes to Idaho's EMS statute.¹ Our observations of each town hall meeting provided us with additional insight into the types of issues facing stakeholders, including some of those in the most remote, hard-to-serve areas.

Idaho Code Examination

A review of Idaho Code and Administrative Rules relating to EMS provided us with information to understand the framework in which the state currently regulates and delivers EMS. Our analysis allowed us to assess whether Idaho meets the design attributes of a well-functioning EMS system outlined in national literature. We were also able to compare our EMS system with that of other states.

National Literature Review

The national EMS literature we reviewed described the history, evolution, and leading practices of emergency medical services. We synthesized the major publications pertaining to the design of EMS systems and assessed whether Idaho's current EMS structure meets the design attributes of a well-functioning system described in literature. We also interviewed former Minnesota State EMS Director Gary Wingrove, a nationally recognized expert in rural emergency medical services and Director of Government Relations and Strategic Affairs for the Mayo Clinic Medical Transport. Appendix B provides a list of the most important literature we reviewed.

Other States Research

The research we conducted on the design of EMS systems in other states helped us find workable options for changes in Idaho's approach to emergency medical services. We surveyed 49 state EMS directors (not including Idaho) and the District of Columbia and received 42 responses (84 percent). The survey asked respondents to provide their opinion on whether their state's EMS system meets the design attributes of a well-functioning system identified from national literature. We also interviewed eight state EMS directors and two local system representatives about their systems. More information on our research of other states' EMS systems is in appendix D.

¹ IDAHO CODE § 56-10.

Appendix B

National Literature

We used the following primary references in our national literature review.

American Ambulance Association. 2008. *EMS Structured for Quality: Best Practices in Designing, Managing and Contracting for Emergency Ambulance Service*.

Institute of Medicine. 2007. *Emergency Medical Services at the Crossroads*. Washington DC: The National Academies Press.

Institute of Medicine. 2010. *Regionalizing Emergency Care: Workshop Summary*. Washington DC: The National Academies Press.

National Association of State EMS Officials. 2010. *State Emergency Medical Services System Models Project: Model State EMS System Lead Agency - DRAFT*.

National Association of State EMS Officials. 2010. *State Emergency Medical Services System Models Project: Model Statutory and Regulatory Content for State EMS Systems—DRAFT*.

National EMS Advisory Council. 2009. *EMS Makes a Difference: Improved Clinical Outcomes and Downstream Healthcare Savings*.

National EMS Advisory Council. 2009. *Guiding Principles and Core Issues in EMS System Design*.

National Highway Traffic Safety Administration. 1996. *Emergency Medical Services Agenda for the Future*. Washington, DC: US Department of Transportation.

National Highway Traffic Safety Administration. 2009. *Uniform Guidelines for State Highway Safety Programs, Guideline No. 11 Emergency Medical Services*. Washington, DC: US Department of Transportation.

National Rural Health Association. 2004. *Rural and Frontier Emergency Medical Services Agenda for the Future*.

US Government Accountability Office. 2007. *Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly*.

Appendix C

Funding for Emergency Medical Services

Revenue Generated by Property Tax and Motor Vehicle Registration Fees

Revenue for emergency medical services through property tax levies and motor vehicle registration fees varies greatly from county to county. Exhibit C.1 illustrates the differences in county funding by providing specific levy and fee data for all 44 counties and ranking the counties by total revenue.

EXHIBIT C.1 COUNTY REVENUE GENERATED FROM AMBULANCE DISTRICTS, AMBULANCE SERVICE FUNDS, AND MOTOR VEHICLE REGISTRATIONS, 2009

	Ambulance District Revenue (\$)	Ambulance Service Fund Revenue (\$)	Motor Vehicle Registrations (\$)	Total Revenue (\$)	Ranking by Total Revenue
Ada	3,943,067		83,749	4,026,816	1
Adams	69,645		1,172	70,817	25
Bannock	883,818		18,886	902,704	7
Bear Lake		62,323	1,898	64,221	26
Benewah		1,000	3,068	4,068	39
Bingham	601,211		11,128	612,339	9
Blaine	1,578,788		7,181	1,585,969	5
Boise	91,403		2,364	93,767	24
Bonner	2,290,193		12,057	2,302,250	2
Bonneville	1,551,535		25,499	1,577,034	6
Boundary		2,651	3,020	5,671	36
Butte		15,000	896	15,896	32
Camas		29,500	403	29,903	30
Canyon	1,713,350		39,885	1,753,235	4
Caribou		121,112	2,419	123,531	21
Cassia		140,000	6,889	146,889	20
Clark		21,871	527	22,398	31

Continued on next page

EXHIBIT C.1 (continued)

	Ambulance District Revenue (\$)	Ambulance Service Fund Revenue (\$)	Motor Vehicle Registrations (\$)	Total Revenue (\$)	Ranking by Total Revenue
Clearwater	95,482		2,724	98,206	23
Custer	32,702		1,513	34,215	28
Elmore	382,028		6,863	388,891	14
Franklin			3,580	3,580	41
Fremont	236,191		3,217	239,408	18
Gem			4,921	4,921	37
Gooding	264,255		3,852	268,107	17
Idaho			4,560	4,560	38
Jefferson	24,716		5,758	30,474	29
Jerome	400,422		5,771	406,193	13
Kootenai	1,848,855		37,570	1,886,425	3
Latah			7,958	7,958	35
Lemhi			2,441	2,441	42
Lewis			1,031	1,031	44
Lincoln	114,087		1,423	115,510	22
Madison	475,306		6,295	481,601	11
Minidoka		10,970	4,701	15,671	33
Nez Perce			11,219	11,219	34
Oneida			1,489	1,489	43
Owyhee			3,888	3,888	40
Payette	408,432		5,863	414,295	12
Power	177,705		2,277	179,982	19
Shoshone		59,375	3,710	63,085	27
Teton	605,806		2,877	608,683	10
Twin Falls	658,566		19,160	677,726	8
Valley		276,858	3,809	280,667	15
Washington	267,047		2,864	269,911	16
Total	18,714,610	740,660	382,375	19,837,645	

Source: Information from the Idaho Emergency Medical Services Bureau, Department of Health and Welfare, March 2010.

Effect of Uncompensated Care

Throughout the nation, the cost and the payment of emergency medical services do not align. According to national literature, EMS systems cannot function to their potential without funding for readiness. The inability to transition to a funding model that covers the full costs of services can largely be attributed to a federal Medicare and Medicaid policy requiring that reimbursement only be made if the patient is transported to the hospital. This policy discourages EMS personnel from making treatment decisions based on patient care and instead encourages transport, even when the patient could be treated and released onsite.

In 2002, the federal government implemented a mandated Medicare fee schedule for ambulance transport reimbursement. Ambulance service agencies find the fee schedule challenging for the following reasons:

1. Agencies are required to accept the fee as full payment.¹
2. The US Government Accountability Office found the fee schedule to be six percent below the national average cost to transport a patient. It also found that Medicare patients make up 40 percent of a typical ambulance service agency's total transports.

The mix of each type of major payer (such as Medicare, Medicaid, private insurance, and the uninsured) affects the rate at which agencies collect reimbursement. Providing transport for uninsured or underinsured patients results in higher levels of uncompensated care.

¹ Medicaid rates are set by the state. Like Medicare, Medicaid rates are generally below the full cost of emergency medical services.

Appendix D

EMS Systems in Other States

We researched EMS systems in other states to give legislators information they requested about varying approaches to emergency medical services across the nation. States have unique characteristics and therefore, diverse needs. Although we found that the structure of each state's EMS system is different, legislators can use the attributes of other states' systems to design a system for Idaho that is acceptable to stakeholders and meets key criteria. We conducted interviews with several state EMS directors and distributed a nationwide survey. This appendix offers examples of the types of EMS systems in other states and provides the results of our survey.

Interviews with Other States

We interviewed eight state EMS directors about their systems. Within two of the eight states, we also interviewed one city EMS employee and one county EMS representative. We selected the states, city, and county because their systems were repeatedly mentioned in our literature review or in our interviews with stakeholders. We also selected them because of specific characteristics identified in our stakeholder interviews such as rural status, proximity to Idaho, degree of county and city collaboration, balance of local autonomy and state control, and type of agencies providing services. We did not select these states because they have perfect systems but instead selected them with the intent of providing a cross section of examples.

We asked each interviewee to explain their system by describing the role of the state lead agency, the role of local governments, the method of medical direction, the funding mechanisms, and an overview of what does and does not work well. On the following pages, we have provided a summary of their responses specific to governance and an illustration of each system's governance structure.

Montana

We selected Montana because it is both a neighboring and rural state. A legislative performance audit that specifically addresses governance was also recently conducted on emergency medical services in Montana.

Like Idaho's Emergency Medical Services Bureau, Montana's Emergency Medical Services and Trauma Systems Section regulates and supervises services through licensing but does not have a state lead governing authority.¹

The Board of Medical Examiners licenses emergency medical technicians and works closely with the EMS section. Statute does not require emergency medical services to be provided locally. The state does not have EMS districts. According to the state EMS director, Montana law allows agencies to deliver services without first determining need.

Texas

National literature and a few Idaho stakeholders brought up the Austin-Travis County, Texas, EMS system as a positive example of city and county collaboration. To better understand this system, the greater Texas system needs to be explained.²

The Office of Emergency Medical Services and Trauma Systems develops and implements the state EMS plan. There are 22 state-established regional advisory councils that help agencies develop regional transport policies. Statute does not require either counties or cities to provide emergency medical services. The state licenses agencies and certifies personnel according to standards rather than need.

Austin-Travis County EMS System

The City of Austin works with Travis County to provide ambulance services through an interlocal agreement. The city operates the system through the oversight of the city EMS director. The entire county operates as a single system with 14 emergency districts located outside the Austin city limits. The Austin Fire Department and 14 emergency districts provide fire suppression and first response on emergency medical service calls within their jurisdictions, and the city operates the ambulance service.

¹ Because Montana lacks a comprehensive governance structure, we did not include an exhibit.

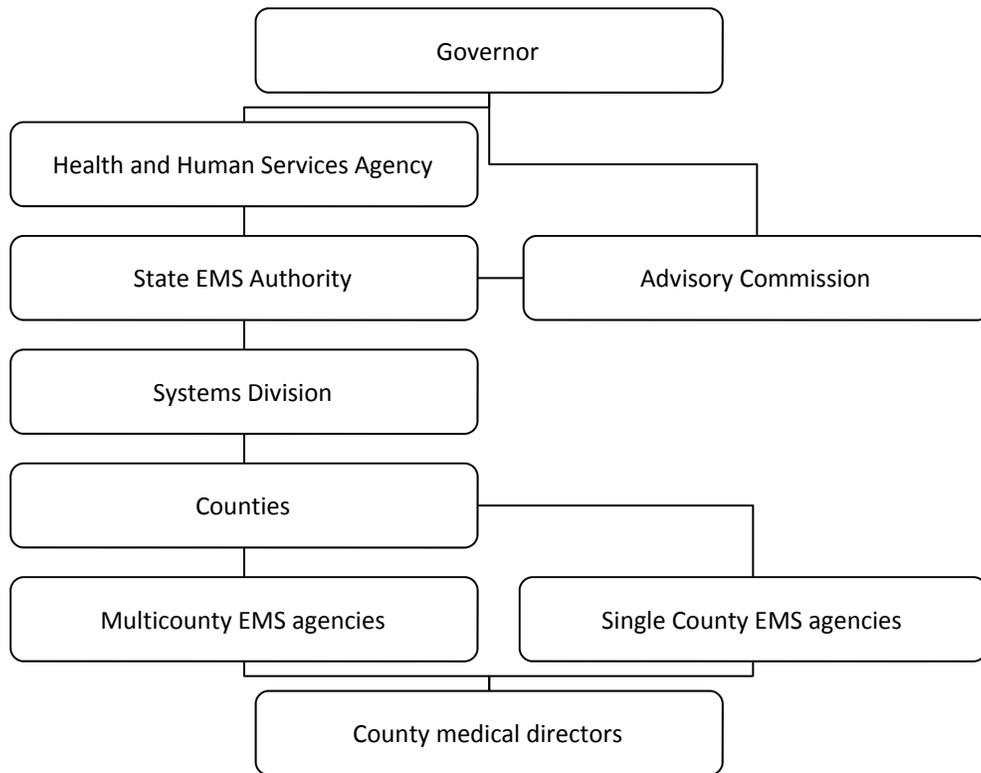
² We did not include an exhibit on the state's governance structure because national literature only highlighted the Austin-Travis County system, not the Texas system.

California

We selected California because national literature discusses the governing challenges faced by the state and highlights one local system as a strong system.³ Further, a few Idaho stakeholders pointed to California as a state that offers local autonomy through regionalization with state control.

The Emergency Medical Services Authority coordinates and oversees California's system. Counties administer emergency medical services at the local level through single or multicounty agencies. The state licenses paramedics, and the counties license emergency medical technicians as well as their own ambulances. California is divided into 354 ambulance zones determined by local EMS agencies.

EXHIBIT D.1 CALIFORNIA EMS GOVERNANCE STRUCTURE



Source: California state EMS director.

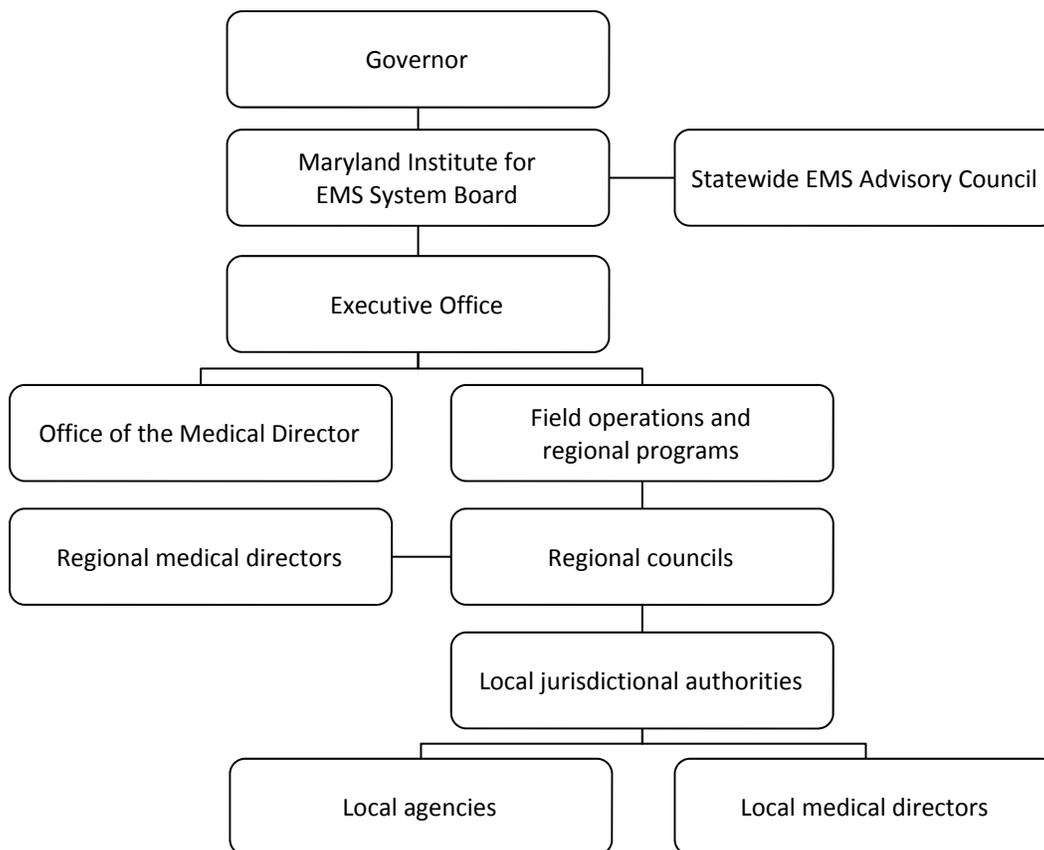
³ San Diego's regionalized trauma system, operated under the state EMS Authority, was highlighted by the Institute of Medicine of the National Academies in its report *Emergency Medical Services at the Crossroads* (Washington DC: The National Academies Press, 2007), 94.

Maryland

Participants in the Institute of Medicine’s regionalization of emergency care workshop in 2010 identified Maryland as having a strong EMS system—one of the strongest in the nation. A few Idaho stakeholders also mentioned Maryland as an example of a regionalized system under complete state control.

The state controls Maryland’s regionalized system, and the governor selects an 11-member EMS board to govern the system. Under the board, an executive office coordinates the system. There are five regional councils that coordinate issues among regions. Maryland does not explicitly require counties to provide emergency medical services. However, the EMS board will not license agencies that are not affiliated with a local jurisdiction. Each local jurisdiction must also establish a jurisdictional authority.

EXHIBIT D.2 MARYLAND EMS GOVERNANCE STRUCTURE



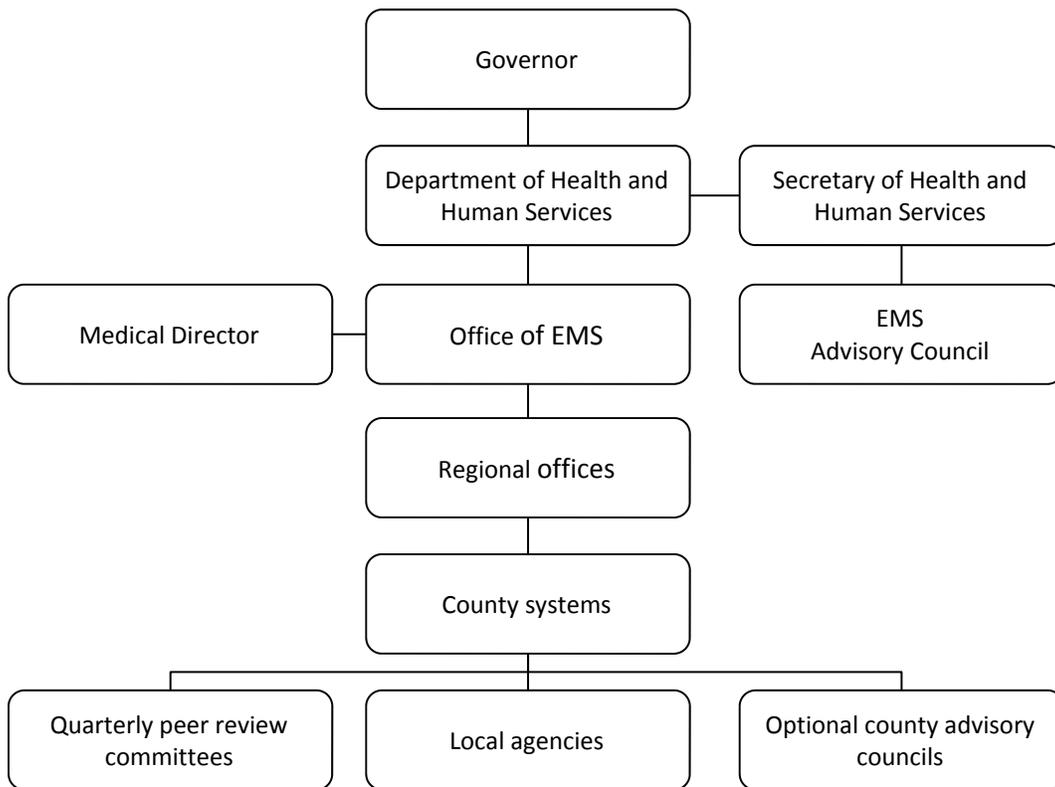
Sources: Maryland state EMS director; Maryland Institute for Emergency Medical Services Systems, “Organizational Chart,” (accessed July 12, 2010), http://www.miemss.org/home/LinkClick.aspx?fileticket=3sd3u_mR8SM%3d&tabid=144.

North Carolina

The North Carolina system was discussed in our national literature review and mentioned by a few Idaho stakeholders as a state with a successful EMS system. Although the state has ultimate authority, counties also have local control. A few Idaho stakeholders believe this approach is similar to one Idaho could take.

North Carolina’s Office of Emergency Medical Services has oversight of its system. Paramedics staff three regional offices that offer support and assistance to county systems. Statute requires counties to provide emergency medical services, and county commissioners govern the countywide systems. North Carolina has 101 county systems.⁴ The state credentials agencies only after the county has shown that the agency is a participant in the system.

EXHIBIT D.3 NORTH CAROLINA EMS GOVERNANCE STRUCTURE



Source: North Carolina state EMS director.

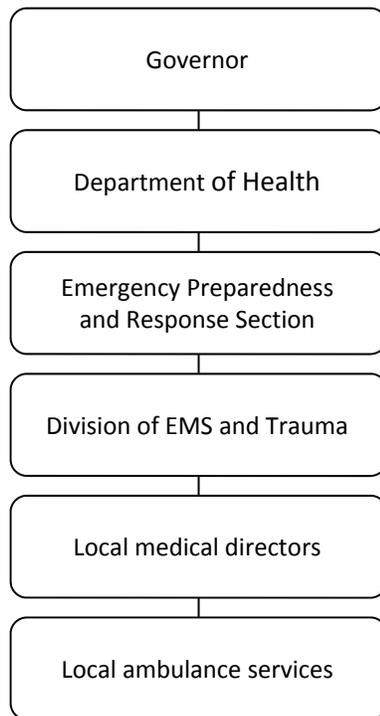
⁴ Total includes all 100 counties and one reservation.

North Dakota

We selected North Dakota because, like Idaho, it is predominately rural. North Dakota is also reviewing specific components of its system for areas of improvement. Compared with some of the other states we selected, counties have relatively little involvement in this state-controlled EMS system.

The Division of Emergency Medical Services and Trauma governs North Dakota's system. The division licenses personnel, ambulance services, and quick response units that provide ambulance services. North Dakota has 143 state licensed ambulance services. County involvement is minimal and counties do not play a role in the governance of ambulance services.

EXHIBIT D.4 NORTH DAKOTA EMS GOVERNANCE STRUCTURE



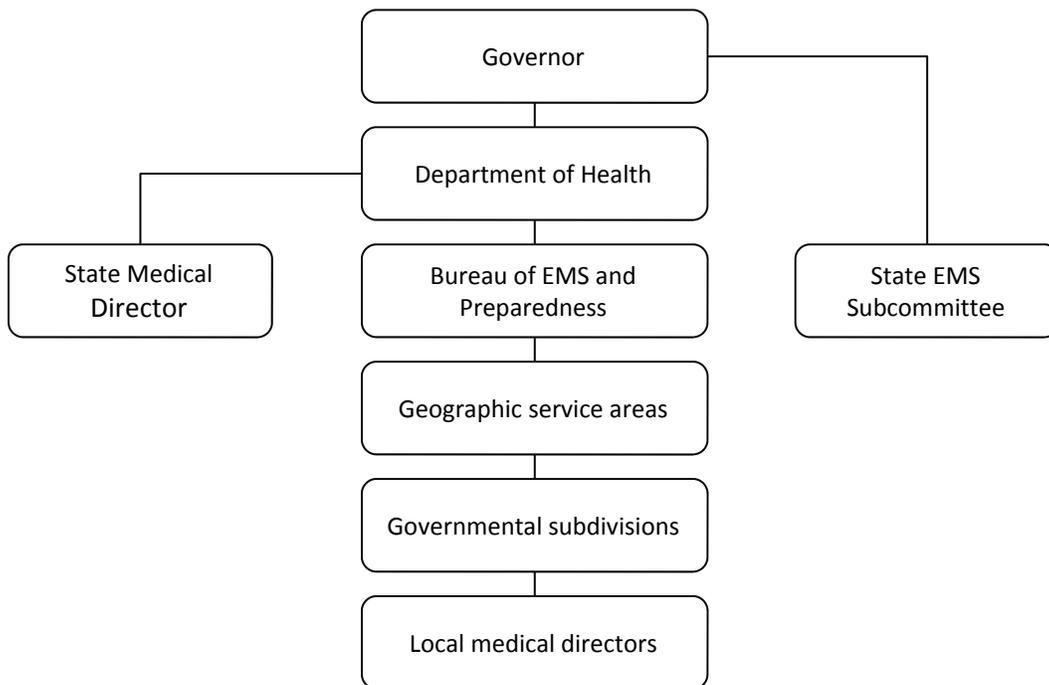
Source: North Dakota state EMS director.

Utah

We selected Utah because it is a neighboring and rural state. Emergency medical services in Utah are completely state-controlled with a competitive bid process for each geographic response area, unlike any of the other states we interviewed. This uniqueness was mentioned by some Idaho stakeholders.

The Bureau of Emergency Medical Services and Preparedness governs Utah's system. The bureau establishes exclusive geographical service areas, ensuring coverage for the entire state. Utah licenses a single agency in each geographical service area and issues a certificate of need (license) according to the goals of the governmental subdivisions.

EXHIBIT D.5 UTAH EMS GOVERNANCE STRUCTURE



Source: Utah state EMS director.

Washington

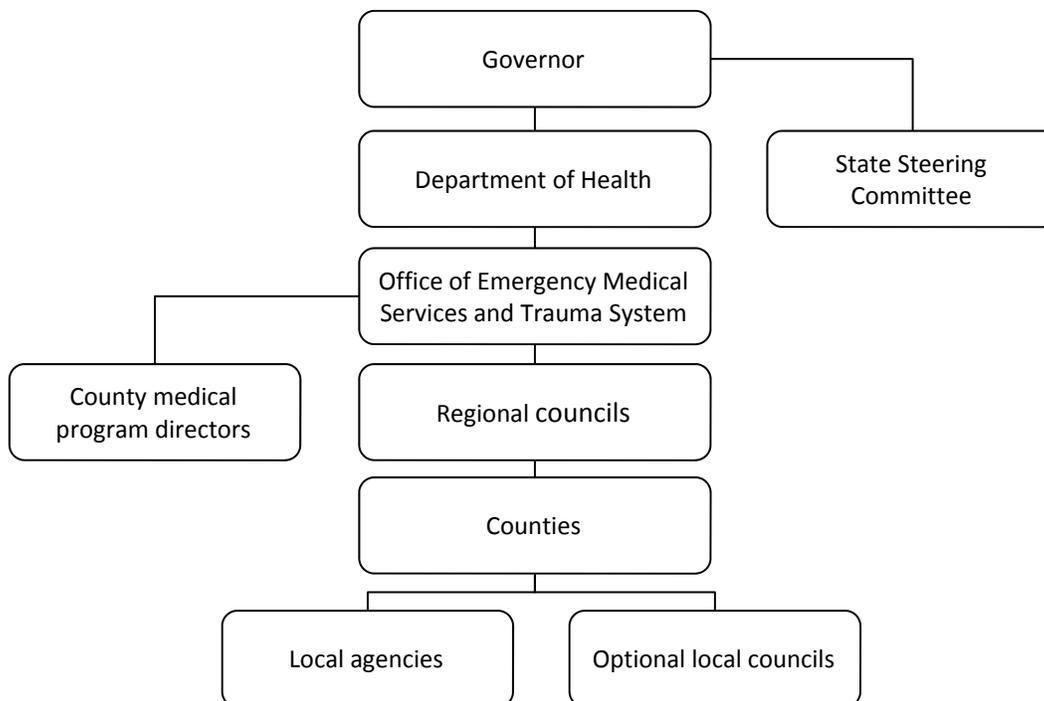
Washington was selected because national literature repeatedly mentions King County’s EMS system, and Washington is a neighboring state. Some Idaho stakeholders also mentioned the Washington and King County systems.

The Office of Emergency Medical Services and Trauma System governs the regional systems. Washington also has eight regional councils that each cover one to nine counties. Each county may also have a local council that can make recommendations to the regional council. The Office of Emergency Medical Services and Trauma System licenses local EMS agencies and certifies personnel.

King County

King County makes up one of Washington’s eight EMS regions and has a county EMS office. The county uses a six-year planning and implementation cycle that parallels a six-year EMS levy. A stakeholder group with broad representation (including one county representative) plans the levy. Every governmental subdivision (cities, fire districts, etc) gets one seat and one vote.

EXHIBIT D.6 WASHINGTON EMS GOVERNANCE STRUCTURE



Source: Washington state EMS director.

Survey of Other States

We sent surveys to 49 state EMS directors and the District of Columbia for their opinions of whether their state EMS system has seven design attributes of a well-functioning system. Eighty-four percent responded. Exhibit D.7 summarizes responses to each question. Exhibit D.8 depicts the total results of our survey by state.

EXHIBIT D.7 EMS SYSTEM SURVEY OF OTHER STATES, GROUPED RESPONSES

Question	Yes	Partially	No	Total
Comprehensive enabling legislation				
Provides for a state EMS agency with legal power to lead, develop, and regulate the EMS system	31	8	3	42
Uniform medical oversight				
Employs a state EMS medical director with statutory authority to develop medical protocols for the entire EMS system	13	11	18	42
Regionalized systems				
Provides for the integration and coordination of resources and patient care throughout the state	18	13	11	42
Accountable system				
Focuses on outcome-based performance goals a governing body can measure	10	15	17	42
Data-driven system				
Allows a governing body to understand and evaluate how the system is performing	15	19	8	42
Funding based on cost of readiness				
Accounts for all system costs within the community serviced, such as size of service area, rate of utilization, and the level of clinical care expected	2	11	29	42
Appropriate delivery of care				
Considers the individual response and level of clinical care each situation requires according to patient needs	19	14	9	42

Source: Office of Performance Evaluations, July 2010.

EXHIBIT D.8 EMS SYSTEM SURVEY RESULTS OF OTHER STATES

State	Comprehensive Enabling Legislation	Uniform Medical Oversight	Regionalized Systems	System Accountability	Data-Driven System	Funding Based on the Cost of Readiness	Appropriate Delivery of Care
Alabama	●	●	●	●	●	○	○
Arizona	●	●	◐	○	◐	○	◐
Arkansas	●	○	●	●	●	◐	●
California	●	◐	●	●	◐	○	●
Colorado	●	◐	◐	◐	◐	○	●
Connecticut	◐	○	○	○	○	○	○
Delaware	●	●	●	◐	●	◐	●
Florida	●	◐	○	●	◐	○	●
Hawaii	●	●	●	●	●	●	●
Indiana	●	○	◐	○	◐	○	◐
Iowa	●	○	○	○	◐	○	◐
Kansas	●	○	○	●	◐	○	●
Kentucky	●	●	◐	◐	◐	○	◐
Louisiana	◐	◐	○	◐	○	○	○
Maine	●	◐	●	◐	◐	○	◐
Maryland	●	●	●	◐	●	◐	●
Massachusetts	●	●	●	◐	○	○	◐
Michigan	●	○	○	◐	◐	○	◐
Minnesota	●	○	◐	○	◐	○	○
Missouri	●	○	◐	○	○	●	●

Montana	●	○	○	○	●	○	○
Nebraska	●	○	○	○	●	○	●
Nevada	○	○	●	●	○	○	●
New Jersey	○	○	●	●	●	○	●
New Mexico	●	●	●	●	●	●	●
New York	●	○	●	○	●	○	○
North Carolina	●	●	●	●	●	○	●
North Dakota	●	○	●	○	●	○	●
Ohio	○	○	○	○	●	○	○
Oregon	●	●	○	○	○	○	○
Pennsylvania	●	●	●	●	●	●	●
Rhode Island	●	●	●	○	○	○	○
South Carolina	●	●	●	●	●	●	●
South Dakota	●	○	●	○	●	●	●
Tennessee	●	●	●	●	●	●	●
Texas	●	○	●	○	●	●	●
Utah	●	●	●	●	●	●	●
Vermont	●	●	●	○	○	○	●
Virginia	●	●	●	●	●	○	●
Washington	●	○	●	●	●	●	●
West Virginia	●	●	●	●	●	○	●
Wisconsin	●	●	○	○	●	○	●

Source: Office of Performance Evaluations, July 2010.

Yes ● No ○ Partially ●

Response to the Evaluation



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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November 22, 2010

Rakesh Mohan, Director
Office of Performance Evaluations, Idaho Legislature
954 W Jefferson Street, PO Box 83720
Boise, ID 83720-0055

Dear Mr. Mohan:

We received a copy of the final draft of *Governance of EMS Agencies in Idaho* and reviewed it for technical accuracy as requested by the Office of Performance Evaluations (OPE). As a state agency, we stand ready to work with legislators and stakeholders on a solution on behalf of the emergency medical services (EMS) system in Idaho. It is essential to implement a sustainable foundation that is necessary for the stable, reliable, and accountable performance of the EMS system.

The work done by the Department of Health & Welfare Division of Public Health EMS Bureau is constrained by its legislative mandate and available resources, yet is driven by the need to protect the public and promote practices that provide the best available medical care and transportation of patients in the emergency setting. Recognizing the work that has been done to date to resolve the issues and pursue the improvement opportunities before us in the Idaho EMS system, the Department of Health & Welfare is prepared to reach a conclusion on a decisive course of action.

I would like to express the gratitude of the Department of Health and Welfare for the studious commitment that the OPE analysts made to providing a thorough and organized review of an otherwise complex public health challenge. We compliment the report's capture of the conditions present today in the Idaho EMS system, the issues that need to be addressed, and the array of improvements that could be realized through the report recommendations. Assuring the quality of the emergency medical services that respond to Idaho citizens' and visitors' 9-1-1 calls is an essential policy matter to maximize the safety and optimal clinical outcome for patients.

Sincerely,



RICHARD M. ARMSTRONG
Director

RMA:dg

Office of Performance Evaluations Reports, 2008–Present

Publication numbers ending with “F” are follow-up reports of previous evaluations. Publication numbers ending with three letters are federal mandate reviews—the letters indicate the legislative committee that requested the report.

<u>Pub. #</u>	<u>Report Title</u>	<u>Date Released</u>
08-01	Governance of Information Technology and Public Safety Communications	March 2008
08-02F	State Substance Abuse Treatment Efforts	March 2008
08-03F	Virtual School Operations	March 2008
09-01	Public Education Funding in Idaho	January 2009
09-02F	Higher Education Residency Requirements	January 2009
09-03	Idaho Transportation Department Performance Audit	January 2009
09-04	Feasibility of School District Services Consolidation	February 2009
09-05F	School District Administration and Oversight	February 2009
09-06F	Use of Average Daily Attendance in Public Education Funding	February 2009
09-07F	Child Welfare Caseload Management	February 2009
09-08F	Public Education Technology Initiatives	February 2009
09-09F	Management in the Department of Health and Welfare	March 2009
09-10F	Governance of Information Technology and Public Safety Communications	April 2009
10-01	Operational Efficiencies in Idaho's Prison System	January 2010
10-02	Increasing Efficiencies in Idaho's Parole Process	February 2010
10-03F	Use of Average Daily Attendance in Public Education	March 2010
10-04	Governance of EMS Agencies in Idaho	November 2010
10-05F	Governance of Information Technology and Public Safety Communications	November 2010

Reports are available from the OPE website at www.idaho.gov/ope/
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