CITIZEN'S ADVISORY GROUP ("CAG")

TO

SAN JUAN ISLAND EMS ("SJIEMS")
SAN JUAN COUNTY PUBLIC HOSPITAL DISTRICT #1 ("SJCPHD #1")
SAN JUAN COUNTY FIRE PROTECTION DISTRICT #3 ("FD #3")
AND THE TOWN OF FRIDAY HARBOR ("TOWN")

MINUTES
Wednesday February 26, 2019
1:00 pm, 1011 Mullis Street

CAG representatives:
Chuck Dalldorf, Town (chair)
Rick Frazer, at large
George Johnson, SJCPHD #1
Dan Paulson, FD #3
Mark Tompkins, at large (vice chair)

Absent: None

Others Present:
Nathan Butler
SJCPHD #1 Board Recording Sec.

Catie Holstein
WA State Department of Health

Jason Norris
WA State Department of Health

Various commissioners, Fire and EMS Chiefs, and County MPD

By Phone or teleconference: None

Public Present: Approximately twenty audience members

Call to Order and Roll Call: Chair Dalldorf called the meeting to order at 1:07 p.m.

Approve Minutes: By consent the group agreed that the minutes from February 20, 2019 were acceptable.

Introductions:

Each person in the room introduced themselves. Rick Frazer introduced Catie Holstein and Jason Norris, and then they discussed their work. Both Holstein and Norris are certified paramedics, and they both work for the Department of Health in Washington State. They work on EMS related legislation in the state, manage the state EMS Trauma

councils, license EMS services across the state, provide on-site review in instances of EMS service changes, and provide discipline when needed.

Holstein noted, "EMS and Trauma is a system, and if you are changing components of the system at a local level then you will impact the system and will be impacted by the system... part of our conversation will be 'how is the system configured,' 'what's the regulatory framework,' 'what are some best practices you should consider moving forward,' 'what are the processes you need to be aware of'... and I think understanding the macro environment in EMS is very critical to your work here. If you are disconnected from what is occurring both nationally and at a state level, it may catch you off guard when you start proscribing things."

Presentation by WA State Department of Health (DOH) Catie Holstein, EMS Program Manager, and Jason Norris, Prehospital EMS Liaison:

Holstein introduced her slides and gave a prepared presentation. Slides are at the time of writing posted on the CAG webpage, http://sjcphd.org/meeting/citizens-advisory-group-cag. Slides are numbered in order of presentation and may be useful to review as reading these minutes.

Holstein began by discussing EMS legislation that determines the way that EMS service is delivered. EMS and trauma care legislation began in 1971, then in 1973 EMS provider and agency licensing was legislated, followed by Medical Program Directors in 1979, and the implementation of the Regional Councils system in 1980. Trauma System legislation was expanded over the following decades. (slide 3-4)

WA State is the first state in the nation with a trauma system and the only system with injury prevention and rehabilitation as a part of that system in state legislation. Therefore, emergency care is a full continuum of care, beginning with primary prevention, then pre-hospital response, Hospital care (or other appropriate care), then trauma rehabilitation. The state manages data regarding EMS and trauma. The DOH has many important roles in managing this system of care. (slide 5-6)

In 2018 there are around 500-550 licensed EMS and ambulance services across the state. In all levels of care, there are an average of 16,000 providers (EMTs, Paramedics, everything in between). Statewide, there is a decline in volunteers, and EMS services in rural areas are closing doors, going part-time, or merging/consolidating. This is a natural evolution to create economies of scale. Hospitals that do trauma care have been more stable; there are about 82 in Washington, including 34 that are "level 4" like PIMC on San Juan Island. (slides 7-14)

WA State EMS care is a system that works from the bottom-up rather than top-down, meaning that the State DOH does not try to manage legislation without direction from local agencies and the public. It's work has three layers of organization, beginning with the main steering committee that advises the DOH, and under them a set of technical advisory committees (TACs) that focus on particular aspects such as cost, prehospital care, hospital care, rehabilitation, injury prevention, etc.; they also work on the State EMS and Trauma strategic plan along with volunteers and agencies. This is the *advisory* layer of DOH oversite. (slide 15)

At the *planning and operational* level, the state is divided into multiple regions with Regional Councils that form regional plans, and work with local EMS and Trauma Care councils. These Regional Councils create broad "patient care procedures" which impact local councils and work with Medical Program Directors (MPDs). At the *clinical* level, these MPDs are appointed by the DOH and work directly with local EMS Agencies and providers in their counties and develop "patient care protocols." (slide 15)

The State maintains an EMS Strategic Plan, currently covering 2018-2021. It's vision, mission, challenges, priorities, and goals are all laid out in that plan. (slide 16-18)

There are six WA State EMS Regions, and San Juan County is in the North region. Martina Nichols is North Region executive Director. These regions operate on a "certificate of need" concept. They identify based on data and other input how the region should plan EMS delivery. If licensure is changed to increase number of services, or how that service is delivered, a "comprehensive needs assessment" is likely to be necessary and is required to change the regional plan. Jason Norris can provide guidance and examples on what other regions have put together. (slides 19-20)

Holstein discussed how Technical Advisory Committees work, using an example of one of the committees. (slides 21-26)

The DOH plays an integral role in developing legislation based on input from the various levels of input. For example, bill 1721 in the year 2016 allowed EMS to deliver patients to a destination other than a hospital, and bill 5591 in the year 2016 that allowed for prehospital non-emergent care, such as paramedicine. Bill 2751 in the year 2017 allowed for the use of non-medically trained drivers of ambulances in rural areas designated critical access such as San Juan County. An example of a much-requested change is allowing EMS providers to help in a hospital, which is currently not permitted. (slide 27-28)

Based on passed legislation, the DOH has full authority to develop rules (as part of the Washington Administrative Code, or WAC) in consultation with Agencies. These rules

may not exceed or conflict with the law and are enforceable. DOH rules can subject someone to a penalty or sets license or permit qualifications. (slide 29-33)

Rule making is triggered in various ways. All state government agencies are required to open rules every five years for housekeeping. The DOH is currently undergoing rule revisions and is open. There are few if any rural agencies participating. Rulemaking has three steps, beginning with *preproposal inquiry* during which public outreach and stakeholder work occurs. Currently monthly public meetings including remote access is being held. Second, is *proposal*, where a "significant analysis" is presented by staff that talks about how much money changes will cost, and the impact of each change – good and bad. The State EMS and Trauma Steering Committee approves the draft and sends it to the Code Revisor. Rule revisions are then *adopted* following review and approval by the DOH Secretary. The DOH began a review of its rules in 2017 and is halfway through stakeholding; they expect to be finished in 2020. Comments can be sent to hsqa.ems@doh.wa.gov (slide 34-39)

The Department of Health is working on many projects, particularly as the legislature is currently in session. For instance, the first statewide trauma core assessment since its establishment is being reviewed, results due in April. The DOH is also working to deal with the stress that rural agencies are undergoing. The state recently finished working on a revised stroke triage tool, is working on Air Medical Plan updates, and more. (slide 40)

Notably, the regional planning cycle is currently under revision, including in the North Region, and ends in June 2019 – though changes need to be in before June. This makes it a good time for EMS service delivery updates and licensure changes since the regional planning cycle is already open. If changes are submitted before the deadline, it will save the trouble of going through the WA State Steering Committee. This planning is done on the biennium. If unable to submit revisions now, then the plan will need changed later once the cycle is over, which is doable but will require extra time.

Holstein discussed National EMS Initiatives such as EMS Scope of Practice revisions, fatigue, amendments to the Controlled Substance Act, and the proposed move away from vocational training for EMS responders to an academic environment. (slide 41)

Besides its many projects, the DOH also monitors trends and challenges in the EMS environment such as the increase in opioid poisoning, increase in senior falls, challenges for stroke triage, and workforce shortages; also noted that firearm injuries remain steady. (slide 42)

The DOH manages Medical Program Directors in Washington State. They are appointed by the Secretary of Health, are certified in addition to their medical practice license, and fully indemnifies and holds harmless MPDs in the course of their work. They help coordinate care with local communities and work with local trauma councils which may also help fund them. (slide 43)

There is a process to change licensure. All EMS services are licensed through the DOH. The process can take 60 days to a year, depending on how many layers of review – which depends on what the proposed changes are. Including the DOH in conversations about changes will help reduce time required. A Certificate of Needs is awarded based on the "Comprehensive Needs Assessment" that must be performed and submitted to the appropriate Regional Trauma Care Council. The Districts involved in change ask the local trauma council for the change, who take it to the regional council, and then to State. Depending on questions or need for clarification, particularly with respect to the Comprehensive Needs Assessment, it can go back and forth. The State works hard to avoid arbitrary and capricious processes, and the decision must be given appropriate review. (slide 44)

Question and Answer Session – CAG (Q & A)

Q – Could you summarize the steps that are necessary for the process of consolidating EMS under the Fire District with respect to the Department of Health?

A: (1) Meet with citizens, particularly if talking about including or excluding territory. This is not a DOH requirement, but if there are jurisdictional changes the DOH will want to see the public records with regards to the changes. This is because the DOH is responsible for managing "Trauma Response Areas," or jurisdictions, which are set by the regional council. (2) Determine taxable jurisdictions, and (3) Figure out how this affects the trauma response areas. Licensure changes are the DOH responsibility.

Q: Could you explain how a license can be handed off should EMS be moved under the Fire District?

A: Licenses are NOT transferable. There are only two categories of changes: change of ownership and initial establishment of license. It depends some on the particulars of a consolidation which way it will go. Jason Norris is the one responsible for handling that. In the case of FD#3 and SJIEMS it is possible that the license may be amended depending on areas contracted for services and areas served; it may also mean all new provider numbers for Medicare/Medicaid. It is important to consult with the DOH through this process.

Q: How is this process different if the Hospital District, which currently runs EMS on San Juan Island, decides to contract with the FD#3 instead of a complete consolidation?

A: The Fire District would have to get a new license to provide EMS services as the Hospital District's EMS license is not transferable. Note that the DOH cannot reverse a transfer of EMS services to the Fire District on its own should things go poorly.

Q: Could you talk about measuring outcomes and metrics for EMS services? How do we know we're doing a good job following a merger?

A: First, are performance measurements – speed of response, calls canceled, etc. Second are clinical measurements – the statewide key performance indicators has a long list of metrics. For instance, "if you had 20 strokes, 15 were recognized as strokes, 10 went to the appropriate facility, and 5 survived with minimal deficits." Those key performance indicators are already existing, and WEMSIS is a statewide key performance index – which is currently voluntary. The regional councils have a Quality Assurance committee that looks at the Trauma Registry and WEMSIS to evaluate performance. The MPD plays a crucial role in this and is an extension of the DOH in this regard.

Q: One of the problems is how to deal with the outer islands that are in the current EMS district but not in the Fire District. How do we address these different boundaries, particularly since the Fire District may not be able to provide Fire protection to the outer islands?

A: The Trauma Response Areas are proscribed by the DOH, and they can follow taxable jurisdictions or include multiple taxable jurisdictions. Holstein said, "The key for you to remember, one, is that if you are providing services to a jurisdiction that isn't paying into that tax, sometimes that annoys the citizens, 'why am I paying taxes for them to go all the way out here,' so that's why I encourage you to talk to your citizens. The other thing is auditors – the State Auditor's Office – to make sure that you are in communication with them, because you don't want to be spending tax money doing something outside of your jurisdiction. Be transparent and have those communications with the appropriate entities." Local Agencies can tell the regional trauma councils how to proscribe response areas and give input on service delivery. The DOH wants that input from local areas, which is memorialized in the regional plan after approval. Consider how to innovate service delivery to difficult areas beyond property tax such as a subscription service.

Norris clarified the number of licenses in San Juan County. Aid BLS (doesn't transport) has 9 available licenses and 0 used, Ambulance BLS has 10 licenses and 1 is being

used, and ALS has a max of 4 licenses with 3 being used. There is room for applications, including private entities.

EMS Interim Chief Kuetzing stated that performance and clinical metrics are central to the work of EMS. FD#3 Chief Collins stated that different levels of licensure can configure EMS service delivery for optimum coverage and avoid duplication of services – even in the event of a service delivery contract for EMS with SJCPHD#1. SJCPHD#1 Commissioner Appleton asked about cost for going through the licensure process, and Holstein pointed out that the DOH doesn't charge but the certificate of need can be cumbersome. Other members of the public as well as various Agency staff and elected officials had a chance to ask questions and/or make statements.

Chair Dalldorf thanked Norris and Holstein for their assistance and visit, the rest of the Citizen's Advisory Group concurred. Holsten thanked them for their hospitality.

Public Comment:

Sharon Kivisto, Will Hamilton, Warren Appleton, Interim Chief Kuetzing, Chief Norvin Collins, and Commissioner Frank Cardenelli asked questions and/or made statements.

Adjournment: The meeting adjourned at 3:00 p.m.

_____ 3/6/2019

Signed by Chair **Date**

The original document is retained at the San Juan County Public Hospital District #1 Office at 849 Spring Street, Unit B-5, Friday Harbor, WA 98250 in San Juan County Public Hospital District #1 permanent proceedings file.

Attest: Nathan Butler, Board Recording Secretary for SJCPHD #1