Interior Region EMS Council, Inc.
Strategic Plan

January, 2012

Section I: Background and Assumptions

Mission Statement: ***The Interior Region EMS Council strives to reduce the human and economic costs of accidents and illnesses through continual improvement of emergency care and education.***

Goal Areas:

A. **Training**
B. **Data Collection**
C. **Equipment**
D. **Communications**
E. **Community Outreach**

Resources and Evaluation:

- Focusing on the injured and ill in our region, our primary resources are trained, equipped and organized responders supported by regional office's human and financial resources such as:
  - Regional staff and contractors
  - Our board
  - Regional office financial and physical resources
  - Subregional coordinators
  - Minigrant funding

- An efficient and effective measurement tool for progress is the number of communities that are able to provide viable EMS services. A good measurement for viability is their ability to qualify for our region's minigrants or receive state certification as a BLS or ALS ambulance service, depending on their community needs as described below.

  Note: *Minigrant funding is not a requirement of the state funding we receive, is not guaranteed and may be reduced or eliminated in the future. In using this as a measurement for progress, we intend that our current mini-grant qualification criteria, or similar, will continue to be a reasonable measurement of the viability of a functional EMS service. Our current mini-grant qualifications are attached for reference.*

Section II: Community Response Requirements and Classification System

For the purposes of planning, our region contains 58 distinct communities or service areas, 8 within the Fairbanks North Star Borough (FNSB) including cities, and 50 in rural areas.

We have established two general classifications that include a variety of communities within each, but they share the following common basic factors:

- Whether they need and can sustain a state-certified ambulance service ("Certified Ambulance Communities")
- Whether they need and can sustain some sort of EMS service other than that ("First Responder Service Communities")

Classification factors include:

- Size
- Distance from higher care – in terms of time, distance, geography
- Community resources

The two general classifications are intended to be descriptive and to develop consistent relevant, achievable goals and objectives for communities. *They are not intended to be limiting in any way and communities are encouraged to determine the level of EMS that they feel is appropriate and sustainable.*

"First Responder Service Communities" (47 total): ***Communities whose needs do not require state certified ambulance capability. There may be a need for patient transport or sheltering capabilities, but not to the level of state BLS or ALS ambulance certification.***

1. Small Rural Off-Highway Communities (31)

Definition: Rural off-highway communities that might have a Community Health Aide or Practitioner (CHA/P) and have, or should have, an organized support system of people trained in CPR, first aid, or first responder/ETT.

Transportation need: They need the ability to safely protect and transport patients to the local clinic or for transfer to an air ambulance, but not necessarily vehicular transport. Transportation is by air to higher care.

Communities in this category:

1. Alatna
2. Allakaket
3. Arctic Village
4. Beaver
5. Birch Creek
6. Central*

12. Evansville / Bettles
13. Healy Lake
14. Hughes
15. Huslia
16. Kaltag
17. Koyukuk

22. Nikolai
23. Nulato
24. Rampart
25. Ruby
26. Stevens Village
27. Takotna

7. Chalkyitsik
8. Chicken*
9. Circle*
10. Coldfoot*
11. Eagle City and Village*
18. Lake Minchumina
19. Livengood*
20. Manley Hot Springs*
21. Minto*
28. Telida
29. Tetlin
30. Venetie
31. Wiseman*

** These communities are connected by road to Fairbanks, but transport to hospital by ground ambulance is usually too rough or too long.*

2. Small Rural Highway Communities (10)

Definition: Rural highway communities outside of the Fairbanks North Star Borough that might have a Community Health Aide or Practitioner (CHA/P) or mid-level provider (MLP) and have, or should have, an organized support system of people trained in CPR, first aid, or first responder/ETT.

Transportation need: Vehicular transport of patients for transfer to an air or ground ambulance but not to the final facility.

Communities in this category:

1. Alcan Border
2. Anderson
3. Dry Creek
4. Dot Lake
5. McKinley Park
6. Mentasta Lake
7. Northway Village / Junction
8. Slana
9. Tanacross
10. Whitestone

3. Mid-sized Rural Off-Highway "Hub" Communities (4):

Definition: Rural off-highway communities that might have a mid-level provider (MLP) and have, or should have, an organized support system of people trained in CPR, first aid, or first responder/ETT.

Transportation need: Transportation is by air to higher care and they need vehicular transport to and from the airport, but not certified ambulance capability.

Communities in this category:

1. Ft. Yukon
2. Galena
3. McGrath
4. Tanana

4. Fairbanks North Star Borough First Responder / Non-Transporting Areas (2)

Definition: Emergency services providers in the Fairbanks North Star Borough who need the capability of providing organized and trained first response until an ambulance arrives. They need a mix of paid and volunteer providers.

Transportation need: These areas are included in certified ambulance service areas and therefore do not need transport capability.

Communities in this category:

1. North Star VFD
2. Ester VFD

"Certified Ambulance Communities" (11 total): ***Communities whose needs indicate they should maintain state certification as a BLS or ALS ambulance Service***

1. Larger Rural Highway Communities (5)

Definition: Rural highway communities outside of the Fairbanks North Star Borough that might have a Community Health Aide or Practitioner (CHA/P) or mid-level provider (MLP) and have, or should have, a well-organized, reliable support system of people trained to the EMT level with support by others trained as first responder/ETTs or CPR and first aid.

Transportation need: Vehicular transport of patients to higher care facility via highway or to the nearest airport, probably through a certified ambulance service.

Communities in this category:

1. Cantwell
2. Delta Junction / Big Delta
3. Healy
4. Nenana
5. Tok

2. Fairbanks North Star Borough Ambulance Service Areas (5)

Definition: Areas within the Fairbanks North Star Borough (FNSB) designated by the Fairbanks North Star Borough as transporting services, the level determined by the Borough. They need a well-organized, reliable support system of people trained to the EMT level with support by others trained as first responder/ETTs or CPR and first aid.

Transportation need: Vehicular transport of patients to a care facility via highway or to the nearest airport, probably through a certified ALS or BLS ambulance service.

Communities in this category:

1. Chena Goldstream Ambulance Service Area
2. City of North Pole Ambulance Service Area
3. Salcha Ambulance Service Area
4. Steese Ambulance Service Area
5. University of Alaska Fairbanks Ambulance Service Area

3. Urban communities (1)

Definition: Large incorporated urban population areas which need a full time paid EMS system consisting of EMTs and paramedics, the level of response needed is determined by the City.

Transportation need: Certified full time professional ALS ambulance.

Communities in this category:

1. City of Fairbanks

Section II: Goal Areas and Two and Five Year Objectives

Terms Used in Goals and Objectives:

As described above, our region has 58 distinct communities or EMS service areas. There are 50 rural communities (outside of the Fairbanks North Star Borough) and 8 distinct service providers within the Fairbanks North Star Borough, including the cities. The following terms will be used in the goals and objectives:

- Rural First Responder Services or Community: The 45 rural communities listed above which probably do not require a state-certified ambulance service.

- Rural Certified Ambulance Services or Community: The 5 rural communities listed above which probably should have state-certified ambulance service (either BLS or ALS).

- FNSB/City First Responder Services: The 2 services within the Fairbanks North Star Borough (FNSB) EMS system described above which are designated by the FNSB as non-ambulance services.

- FNSB/City Certified Ambulance Services: The 6 state certified ambulance services within the Fairbanks North Star Borough.

A. Training

Goal: To provide and facilitate appropriate and sustainable training for EMS providers and the public in the region.

Background Information:

- 18 (40%) of the 45 rural first responder communities currently have adequate personnel to provide viable EMS services as measured by their ability to qualify for minigrants.

- The 2 FNSB first responder services currently have adequate personnel to provide viable EMS services as measured either by their ability obtain state certification as an ALS or BLS EMS provider agency or to qualify for minigrants - although they do not receive mini-grants because of current mini-grant policy.

- All 11 of the rural and FNSB/City communities identified as those that should have certified services are currently certified.

A-1 Two year objectives (end of 2013):

a. 22 (50%) of the 45 rural first responder services will have personnel adequate to provide viable EMS services as measured by their ability to qualify for minigrants and/or be state certified as ambulance service. Personnel within the community that will be required to meet this objective are:
   - "A person who is currently trained at least to the Emergency Trauma Technician (ETT) level available at all times."
   - Functional definition: a minimum of 4 ETT trained and available

b. 2 (100%) of the 2 FNSB first responder services will continue to have personnel adequate to provide viable EMS services as measured either by their ability obtain state certification as an ALS or BLS EMS provider agency or to qualify for minigrants (if they were eligible).

c. 11 (100%) of the 11 currently certified ambulance services and any others identified at that time, will have certification in place which includes adequately trained personnel as described in state regulations.

A-2 Five year objectives (end of 2016):

a. 28 (62%) of the 45 rural first responder communities will have personnel adequate to provide viable EMS services as measured by their ability to qualify for minigrants.

b. 2 (100%) of the 2 FNSB first responder services will continue to have personnel adequate to provide viable EMS services as measured either by their ability obtain

state certification as an ALS or BLS EMS provider agency or to qualify for minigrants (if they were eligible).

c. 11 (100%) of the 11 currently certified ambulance services and any others identified at that time, will have certification in place which includes adequately trained personnel as described in state regulations.

Rationale for both two and five year objectives: the critical objective for rural first responder services is not the percentage, but the number: adding two rural communities per year to the number that have viable EMS services as measured by their ability to qualify for minigrants is a reasonable goal considering existing viable services will need "maintenance".

B. Data Collection

Goal: ***To Promote Research and Data Collection Relevant to EMS.***

B-1 Two year objectives (end of 2013):

a. 11 (100%) of the 11 currently certified ambulance services and any others identified at that time, will be providing data through the Aurora Data System.

b. 23 (50%) of the 47 rural and FNSB first responder services will be providing data to the regional office ***through the annual regional survey report or the Aurora Data System.***

c. 12 (25%) of the 47 rural and FNSB first responder services will be providing data to the regional office ***through the Aurora Data System***.

B-2 Five year objectives (end of 2016):

a. 11 (100%) of the 11 currently certified ambulance services and any others identified at that time, will be providing data through the Aurora Data System

b. 29 (62%) of the 47 rural and FNSB first responder services will be providing data to the regional office ***through the annual regional survey report or the Aurora Data System.***

c. 18 (38%) of the 47 rural and FNSB first responder services will be providing data to the regional office ***through the Aurora Data System***.

Rationale for both two and five year objectives: the critical objective for rural first responder services is not the percentage, but the number: the intention is that adding two rural communities per year to general data reporting and two that report through Aurora is a reasonable goal considering that services that are already providing data will need "maintenance".

C. Equipment

Goal: ***To provide appropriate and sustainable equipment for EMS providers and systems in the region and to serve as a regional center for distribution of surplus equipment.***

General Equipment Objectives

C-1 Two year objectives (end of 2013):

a. IREMSC will conduct an analysis of equipment that is currently on hand for each minigrant recipient as part of the minigrant process.

b. IREMSC will develop regional "Recommend Equipment Lists" for the various types of services that are not certified ambulance services.

c. Required equipment lists for certified services are already in place as part of the state certification process.

C-2 Five year objectives (end of 2016):

Note: As described elsewhere in this plan, by the end of 2016, our objective is that 28 rural and 2 FNSB first responder services will be providing viable EMS services as measured by their ability to qualify for minigrants. If those numbers are different at that time (higher or lower), the percentages listed below will apply to those different numbers.

a. 90% of all rural first responder services that provide viable EMS services as measured by their ability to qualify for minigrants will have all of the equipment that is recommended for their level of service. (based on the recommended equipment lists developed in C-1b above).

b. 100% of all FNSB first responder services will have all of the equipment that is recommended for their level of service.

c. 100% of all certified services will have all the equipment that is required for state certification at their level.

d. Regional recommended equipment lists and equipment required for state certification will be used to evaluate need and determine top priorities in any IREMSC capital funding activities.

e. Additional equipment, beyond those recommended and required equipment lists will be considered for IREMSC capital funding activities only if it is demonstrated to be

medically necessary and appropriate for the level of service, and will generally be of lower priority than the recommended and required equipment.

Patient Transport Equipment Objectives: *Patient transport equipment is defined as a method of safely and securely protecting and transporting a patient that is appropriate to the community's needs and infrastructure*.

<u>C-3 Two year objectives (end of 2013):</u>

a. IREMSC will conduct an analysis of patient transport equipment that is currently on hand for each minigrant recipient as part of the minigrant process.

b. IREMSC will develop regional guidelines for the type of patient transport equipment that is appropriate for the various types of services that are not certified ambulance services.

<u>C-4 Five year objectives (end of 2016):</u>

a. Based on the number of communities that have appropriate patient transport equipment as determined by C-3a and C-3b above, two additional communities will obtain appropriate patient transport equipment each year, years three through five. In other words, six *additional* communities will have appropriate patient transport equipment by the end of five years.

b. 100% of all certified services will have appropriate patient transport equipment.

D. Communications

Goal: ***To promote adequate EMS communications systems throughout the region for EMS providers and the public.***

Background Information:

- Communications systems may include any form of communication from the most basic (i.e. word of mouth), to the most advanced telecommunications technology.

- 18 (40%) of the 45 rural first responder communities currently have adequate communications systems to provide viable EMS services as measured by their ability to qualify for minigrants.

- The 2 FNSB first responder services currently have adequate communications systems to provide viable EMS services as measured either by their ability obtain state certification as an ALS or BLS EMS provider agency or to qualify for minigrants - although they do not receive mini-grants because of current mini-grant policy.

- All 11 rural and FNSB/city communities identified as those that should have certified services are currently certified.

D-1 Two year objectives (end of 2013):

a. 22 (50%) of the 45 rural first responder services will have an organized communications system adequate to provide viable EMS services as measured by their ability to qualify for minigrants. This includes:
    - The ability for the public to call for EMS when needed.
    - The ability to contact EMS providers to respond when needed.
    - The ability to contact higher level of care when needed
    - The ability to contact other EMS and non-EMS agencies when needed.

b. 2 (100%) of the 2 FNSB first responder services will continue to have an organized communication system adequate to provide viable EMS services described above.

c. 11 (100%) of the 11 currently certified rural and FNSB/city ambulance services and any others identified at that time, will have certification in place which includes adequate communications as described in state regulations ***and also including***:
    - The ability for the public to call for EMS when needed.
    - The ability to contact EMS providers to respond when needed.
    - The ability to communicate with their EMS providers during a response
    - The ability to contact and communicate with higher level of care when needed.
    - The ability to contact and communicate with other EMS and non-EMS agencies when needed.

D-2 Five year (end of 2016):

a. 28 (62%) of the 45 rural first responder services will have an organized communications system adequate to provide viable EMS services as measured by their ability to qualify for minigrants. This includes:
    - The ability for the public to call for EMS when needed.
    - The ability to contact EMS providers to respond when needed.
    - The ability to contact higher level of care when needed
    - The ability to contact other EMS and non-EMS agencies when needed.

b. 2 (100%) of the 2 FNSB first responder services will continue to have an organized communication system adequate to provide viable EMS services described above.

c. 11 (100%) of the 11 currently certified rural and FNSB/city ambulance services and any others identified at that time, will have certification in place which includes adequate communications as described in state regulations and also including:
    - The ability for the public to call for EMS when needed.
    - The ability to contact EMS providers to respond when needed.
    - The ability to communicate with their EMS providers during a response
    - The ability to contact and communicate with higher level of care when needed.
    - The ability to contact and communicate with other EMS and non-EMS agencies when needed.

Rationale for both two and five year objectives: the critical objective for rural first responder services is not the percentage, but the number: adding two rural communities per year to the number that have viable EMS services as measured by their ability to qualify for minigrants is a reasonable goal considering existing viable services will need "maintenance".

E. Community Outreach

Goal: ***To educate and promote awareness of EMS issues and systems on the part of the public, policy makers and EMS services and develop new and maintain existing EMS systems in the region.***

Education and Public Awareness Objectives

E-1 Two year objectives (end of 2013): IREMSC staff will:

a. Complete an inventory of key contacts:
    - All communities in the region.
    - Organizations with region.
    - Organizations in other parts of the state.
    - Statewide policy makers - legislative, organizational and governmental.
b. Contact all communities in the region by phone or in person.
c. Visit 2 off highway hub communities and 2 smaller communities nearby to each. The purpose of these visits will be to provide general information and technical assistance on EMS training and response and to gather information that might be needed to accomplish this plan.
d. Visit all highway-accessible communities. The purpose of these visits will be to provide general information and technical assistance on EMS training and response and to gather information that might be needed to accomplish this plan.
e. Directly contact legislative, governmental and other policy makers.
f. Directly contact other EMS organizations in the state.
g. Develop a region wide forum for regular discussion and coordination.
    - Representative civilian ground and air EMS services
    - Representative military, state and federal ground and air EMS services
    - Dispatch centers
    - Others as identified
h. Develop informational materials:
    - Brochure
    - Website

E-2 Five year objectives (end of 2016): IREMSC staff will:

a. Maintain the contact inventory and update it as needed
b. Visit three additional (total of five) hub communities and 2 smaller communities nearby to each for the purposes described above.
c. Conduct an additional visit to each highway-accessible community for the purposes described above.
d. Meet with legislative, governmental and other policy makers at least once per year.
e. Meet with other EMS organizations in the state a minimum of once per year.

f. Conduct a minimum of four meetings with the region-wide forum described above during this time.
g. Update informational materials described above.

Squad Development and Maintenance Objectives

Background Information:

- Squad policies and protocols may vary from the most basic to the most advanced, but need to be organized in a way to be known to all responders and support personnel. technology.

- 18 (40%) of the 45 rural first responder communities currently have adequate policies and protocols to provide viable EMS services as measured by their ability to qualify for minigrants.

- The 2 FNSB first responder services currently have adequate policies and protocols to provide viable EMS services as measured either by their ability obtain state certification as an ALS or BLS EMS provider agency or to qualify for minigrants - although they do not receive mini-grants because of current mini-grant policy.

- All 11 rural and FNSB/City communities identified as those that should have certified services are currently certified.

E-3 Two year objectives (end of 2013):

a. 22 (50%) of the 45 rural first responder services will have policies and protocols adequate to provide viable EMS services as measured by their ability to qualify for minigrants.

b. 2 (100%) of the 2 FNSB first responder services will continue to have policies and protocols adequate to provide viable EMS services as measured either by their ability obtain state certification as an ALS or BLS EMS provider agency or to qualify for minigrants (if they were eligible).

c. 11 (100%) of the 11 currently certified rural and FNSB/city ambulance services and any others identified at that time, will have certification in place which includes adequate policies and protocols as described in state regulations.

E-4 Five year (end of 2016):

a. 28 (62%) of the 45 rural first responder services will have policies and protocols adequate to provide viable EMS services as measured by their ability to qualify for minigrants.

b. 2 (100%) of the 2 FNSB first responder services will continue to have policies and protocols adequate to provide viable EMS services as measured either by their ability obtain state certification as an ALS or BLS EMS provider agency or to qualify for minigrants (if they were eligible).

c. 11 (100%) of the 11 currently certified rural and FNSB/City ambulance services and any others identified at that time, will have certification in place which includes adequate policies and protocols as described in state regulations.

Rationale for both two and five year objectives: the critical objective for rural first responder services is not the percentage, but the number: adding two rural communities per year to the number that have viable EMS services as measured by their ability to qualify for minigrants is a reasonable goal considering existing viable services will need "maintenance".

IREMSC MINI-GRANT QUALIFICATIONS
(Effective 7/1/03)

A: INTRODUCTION

Mini-grants are intended to assist those emergency medical services that use volunteers in the provision of emergency medical care in their service area and are not a part of a publicly funded municipal or borough EMS system.

B. DEFINITIONS

1. VOLUNTEER: One who supervises or provides patient care without compensation for the service. For the purposes of this definition, compensation consists of salaries, wages, run stipends or any other form of compensation directly linked to the service provided. A volunteer may receive reimbursement for out-of-pocket expenses incurred as a result of voluntary service.

2. VOLUNTEER EMS ORGANIZATION: An EMS Provider organization which routinely and customarily utilizes volunteers in the direct provision of EMS.

3. AMBULANCE SERVICE: Service with an ambulance or transport vehicle that is a state certified ambulance service as defined in 7 AAC 26.230 A & B Emergency Medical Services Outside Hospitals.

4. FIRST RESPONDER SERVICE: A service that does not transport patients and meets the following criteria. The First Responder Service must:
   - A) Be organized;
     1. As part of a fire department, emergency medical service or local government with four or more responding members.
     2. And designate one person as the person responsible for the daily management of the service;
     3. And have written Policies regarding how the responders will be called out; written policies regarding training; written policies on the maintenance and custody of equipment/supplies; and, written Policies regarding chain of command within the service.
   - B) Have a person who is currently trained at least to the Emergency Trauma Technician (ETT) level available at all times.
   - C) Have written policy for the timely evacuation and/or transport of all patients.
   - D) Have a designated response area.
   - E) Respond to ALL medical emergencies within their response area.

F) Record all medical information for each patient for which care was provided on a State-approved report form. Maintain a copy of each patient report on file consistent with current statutes regarding medical record keeping.

5. BOROUGH OR MUNICIPAL SERVICE: Service that is located in a municipality or borough that has EMS powers and supports EMS with public funds.

C. ELIGIBILITY

1. To be eligible for a mini-grant the service must be a volunteer ambulance or first responder service as defined in this policy.

2. The service must meet the following requirements:

3. Not be a borough or municipal service as defined in this policy.

4. If applying as an Ambulance Service - must meet the requirements as set forth in 7AAC 26.22O;23O;65OA, and be formally organized as defined in Section B.5.a) of this document.

5. If applying as a First Responder Service, must comply with Section B. 4. of this document;

6. The service, including First Responders, must agree to complete the Annual Ambulance Survey and submit it through IREMSC to the State EMS Office in a timely manner;

7. The service must agree to provide documentation as requested to Interior Region EMS Council. Inc.;

8. The service must agree not to discriminate for any reason, including religious preference, race, color, creed, gender, national origin, or financial status, in the provision of emergency medical services.

9. The service must apply no later than September 1st, of each fiscal year.